Derks / van Kalmthout / Albrecht
Current and future Drug Policy Studies in Europe

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Current and future Drug Policy Studies in Europe

Problems, Prospects and Research Methods

Edited by

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General Introduction and some Remarks on European Drug Policy Research

JACK DERKS, ANTON VAN KALMTHOUT &
HANS-JÖRG ALBRECHT[1]

1. Introduction

The process of increasing European integration and the concomitant abolishing of borders and border controls between member states is creating new problems and new challenges for policy makers engaged in the field of psychotropic substances, especially the illegal ones. The problems connected with this phenomenon include the trafficking of these drugs and the role of organized crime in this, as well as problems arising from the mobility of drug users and abusers and the way European societies in general deal with these persons. The coexistence of such an old problem field and a new international order has resulted in growing interest for those countries which seem to be continuing the development of a drug policy which deviates from the traditional ways of tackling the problem. These countries include the Netherlands, Spain and Denmark, none of which in practice has followed the mainstream policies of drug control in Europe. This deviation from mainstream policy has occurred not so much in respect to formal legislation, but rather in the implementation of drug laws. The apparent paradox that while criminal statutes provide for criminal penalties, soft and - in some countries, hard - drugs may be purchased in small amounts without the risk of criminal prosecution or punishment creates conflicts between European countries.

[1] The editors express special thanks to Prof. J. Lehto and Prof. L. van Outrive for their activities in COST A-6 Working Group 1 leading to this book.

2. European cooperation

At the end of 1992, COST (EUROPEAN COOPERATION IN THE FIELD OF SCIENTIFIC AND TECHNICAL RESEARCH) - a Europe-wide framework for the coordination of state-funded research - addressed the drug phenomenon. Within the COST framework, the programme 'COST A-6' was launched, the full name of which is 'EVALUATION OF ACTION AGAINST DRUG ABUSE IN EUROPE' (Chair: Prof. Dr. Dr. A. Uchtenhagen – Switzerland, and Dr. J. Derks – the Netherlands, Vice-chair). During the course of the programme, the following countries (listed in alphabetical order) took part in it: Austria, Belgium, Croatia, Denmark, Finland, France, Germany, Greece, Italy, the Netherlands, Norway, Poland, Portugal, Sweden and Switzerland. These countries agreed on the following objectives for the action[2] (Chapuis & Bernard, 1997):

> „... to gain information concerning the impact of various drug policy concepts and measures on the extent, nature and consequences of drug abuse. This study should contribute to providing an improved and rational basis for drug policy measures, and to enabling those concerned to identify topics for a shared European drug policy, in contrast to topics where national or regional solutions are more appropriate. A secondary objective is to improve knowledge on the feasibility and the modalities of evaluation studies in the field of drug policy, of preventive and therapeutic interventions against drug abuse, and to invite more widespread and appropriate use of those modalities. The development of adequate instrumentation and methodology for evaluative purposes is included. A third objective is to establish working relationships with international and national scientific networks in this field. A fourth objective has been defined as preparing or facilitating multicentre evaluation studies." (p. 21).

Within the COST A-6 programme, a working group named Working Group 1 (EVALUATION OF POLICIES, POLICY CHANGES AND SOCIETAL RESPONSES TO POLICIES) addressed drug policy issues. This volume is a product of the inter-European cooperation within this working group. Several organisations heavily supported the work of the working group needed for this volume; by allowing scientists and other personnel to spend time in the COST-A6 action or/and by granting financial support for the action. These organisations were: the Max Planck Institute for Foreign and International Criminal Law in Freiburg i.Br., Germany (Prof. Dr. H.-J. Albrecht, director); The Catholic University of Brabant in Tilburg, the Netherlands (Associate Professor A.M. van Kalm-

[2] M. Chapuis & V. Bernard, COST Activity Report Social Sciences 1995-1996. European Commission, Directorate General XII, Science, Research and Development, 1997 (EUR 17606 EN).

thout); The Netherlands Science Organization NWO (D. Jaeger, PhD[3]) and the Netherlands Ministry of Health, Welfare and Sport (Mr A.D. Keizer[4], head of the section Drugs, Alcohol and Gambling Policies).

3. Starting points of Working Group 1 of COST A-6

The first starting point was the notion that there was (and still is) an urgent need to realize an in-depth description and analysis of national drug policies in Europe, and comprehensive secondary and tertiary analyses of data on these policies in order to enable an adequate comparison of the differences and similarities between European drug policies. Second, in order to enhance the probability of a successful action with respect to this part of the work of COST A-6, a pragmatic approach was favoured. This means that the actions of COST A-6 should fit in with or be attuned to current actions outside COST A-6 (for example, actions from the Commission and the EMCDDA in Lisbon, or research initiatives from other parties).

The third starting point concerns the notion that drug policies should be studied on several levels. First, a distinction should be made with respect to the formulation and implementation of drug policies on a. the local and regional levels; b. the national level; and c. the level of formulating national policies as far as they are a part of drug policy at European international level (European Union; Council of Europe). Moreover, the study of drug policies should have a special focus on the interaction between these levels. Second, a distinction should be made with respect to policies on the level of laws, judicial procedures and police activities (law enforcement), and those on the level of (public) health care and relief work. Here too relevant factors concerning the differences at the levels of (inter)national, national and regional/local drug policies should be taken into account. Third, a distinction that must be incorporated into the study concerns the differences between the formulation of drug policies and their implementation. On all these levels, the different objectives of drug policies and the different target groups of drug policies should be taken into account.

The fourth starting point concerns the notion that at the moment the objectives of drug policies are primarily divided along the lines of a. *harm reduc-*

[3] Dr. Jaeger was also member of the Technical Committee of COST Social Sciences, under which COST A-6 operates.

[4] Mr Keizer is also member of the Management Board of EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) in Lisbon, Portugal.

tion; b. *prevention and treatment;* and c. *repression and prohibition.* Not infrequently, these objectives are interdependent and it can be observed that they influence each other, in both a positive and a negative sense. A very important factor is that here also the different target groups of drug policy should be recognized, such as drug *users* and *addicts, traffickers* and *dealers* of drugs, and *producers* of drugs.

4. Suggestions for comparative European drug policy research

The comparative analysis of drug policies should be based on a perspective of implementation. Thorough analysis of policy implementation is a prerequisite for evaluation studies as well as for explaining and understanding the control of drugs. Only this will allow the identification of variation in European drug policies and the assessment of the differential impact of such policies. Therefore the scope of analysis must be wider than that which is offered by comparative legal studies alone, as policy implementation includes not only legal statutes but also the basic conditions of applying law in terms of funding and resources, administrative or private programmes, organizational and institutional issues, and the structure of political systems. Implementation then extends the scope of research to the process of creating policies and information on the actual outcomes of policies in terms of data concerning the resources that are invested in the drug problem (e.g public expenditures for health or repressive approaches, staff involved in counselling and treatment or in policing and control), on input and output of treatment systems, police suspects, convicted drug offenders, etc.

The first thing to do should be to discuss the question of what drug policy actually means in order to identify relevant actors and activities. As drug problems are conceived as cross-sectional problems (which can be seen e.g. in the various national plans to combat drug problems), a broad meaning of drug policy is suggested, one that covers the basic structures in the creation and implementation of drug policies. Here, the private and the public sectors and, within the public sector, criminal justice and health departments, refer to different axes of drug policy development and various forces which may shape the implementation of drug policies. But it must be remembered that the state plays an essential role in the development of drug policies, and this first becomes evident in the strict regulation of illegal drugs. It is especially by completely outlawing certain drugs that the focus is put on the aim of controlling behaviour. State policies that aim at control may be analysed from two ex-

tremes, each representing a basic model of control: a model based on criminal law, and an administrative model of control (public health or medical approaches would fall under this last model).

A model of control based on criminal law emphasizes a retrospective view of behaviour, deciding upon its criminal or legal nature. This approach resembles a zero-sum game, in which the options are reduced to either winning all or losing all. The administrative approach, however, essentially is based upon a prospective view of behaviour with prevention as an essential element. Furthermore, administrative control relies on discretion and bargaining as a means to seduce the client into changing behaviour. Intertwining administrative systems and criminal law brings about numerous problems, as has been shown e.g. in the case of environmental offences, tax offences, economic offences, etc. The primary problem here concerns the conflict of goals, a conflict that seems to be inevitable and may be easily demonstrated when confronting a legalist perspective on drug problems (aiming at the detection, conviction and sentencing of offenders) with a public health perspective (aiming at improving health or minimizing health risks).

From the viewpoint of public health, the question would be: how much criminal law is needed to achieve compliance with health regulations? From the legal viewpoint, however, the question would be: how far should health-related issues be considered in the process of enforcing criminal law? In case of the first understanding of the nature of a drug offence, criminal law plays but a marginal role in supporting general health policies. Criminal law is then merely an annexe to administrative law. In case of the second understanding, criminal law dominates insofar as other strategies must comply with criminal law and may be evaluated according to criminal statutes.

The perspective will then allow for analysing drug policies as developing within a system of different organizations and institutions and as a product of interactions between differing expectations, interests, values and objectives. Furthermore, this allows inclusion of both the criminal justice system and the health system in the question of which model of control prevails. Interactions may be expressed in terms of conflicts between health professions and criminal justice agencies over the question of e.g. maintenance treatment, risk minimizing programmes or obligations to provide evidence in criminal proceedings.

In the analysis of the implementation of drug policies, reference must be made first of all to the creation of drug laws and to the definition of the drug problem underlying drug laws, as the use of positive law represents a core

element in policy-making. This in turn demands a historical perspective which will be of paramount importance for the comparative part of the study. The basic problem of international or intercultural comparative studies - that is, to find or construct comparable units of analysis - can be solved only if the specific meaning of drug policy in a given society or country (or parts thereof) and elements of control are understood adequately. But this specific meaning of drug policy can be grasped only if the historical roots of current control systems as well as the historical development of these systems are taken into account. Drug policies are 'historically patterned' and can be compared to each other only if the respective histories support comparative analysis. Here, the last 30-40 years should be included, as it seems that in most European countries the origins of modern drug policies are located in the 1960s. Explanation of the creation of drug policies and its core elements in terms of drug laws should include at least three different approaches. These approaches concern the concept of the moral entrepreneur, the instrumental or technological approach to policy-making, and finally a systems' view on drug policy and drug laws stressing that drug policy and drug laws are but a part of a general trend observable today in the development of policy-making.

With the concept of the moral entrepreneur, the focus can be put on moral, normative and expressive aspects of drug policies. These include current discussions on legalization, drug use and human rights, or those constitutional debates which go beyond the question of whether a given drug policy may be assessed as being efficient in terms of reducing drug problems.

The instrumental approach to the understanding of drug policies and drug laws usually emphasizes youth protection and the protection of public health, public order and traffic safety. With the instrumental approach, therefore, the focus is on prevention and herewith on the question of how the demand for and supply of drugs may be reduced. More recently, the scope of prevention has been widened to include the reduction of harm associated with drug use. Within the context of preventive policies, a series of measures have been developed and tried out; these include general awareness campaigns, enforced and voluntary treatment of drug dependence, methadone and heroin maintenance, needle exchange programmes, stiffer sentencing, border interdiction, international police and judicial cooperation, international economic aid, etc.

The basic question which arises from the third perspective concerns risk management in modern societies and, further, the role law and especially criminal law should play in organizing risk management in modern societies. From this perspective, drug laws could be but a facet of general trends in risk

management assigning special importance to criminal law. Offenses created in criminal drug laws are essentially 'endangering offenses', a technique today widely used in European criminal legislation to ensure e.g. traffic safety, a proper natural environment, the well-being of economy, public health, internal security and, ultimately, feelings of safety in the public. Here, the focus switches from the results of human behaviour to risks attributed to human behaviour, while on the other hand easily portrayable interests or values traditionally protected by criminal law (e.g. human life, property, etc.) in certain fields have been exchanged for abstract interests (e.g. public health) which risk lacking any meaningful profile (at least in the context of criminal law). Here, a comparative approach addressing other fields where risk management is sought through criminal law (e.g. the natural environment) may provide answers to the question why outcomes of criminal law enforcement are rather different in different societies.

While common comparative research usually centres on a single research question and on pre-designed research instruments that are evenly applied in the different countries studied, the research strategy we suggested puts the focus on a four-step procedure. In the first step, the concept of drug policy is broken down into a series of research topics that are thought to represent the essential elements of drug policies. In the second step, each of these topics is outlined in terms of a short introduction and a list of themes (to be converted in a questionnaire-type of document) containing the basic issues to be covered in order to provide meaningful information. Then, in the third step, international working groups should be built up around these topics, with the task of producing reports focused on the specific topics. Finally, the fourth step deals with drawing comparative conclusions. In this, firstly comparative conclusions should be drawn with respect to the single research topics based on a comparative evaluation of the topic reports itself. These comparative findings must then be put together in a final effort, which should result in a summarizing, comparative report on drug policies in Europe, their creation and implementation, and an assessment of their consequences.

5. Research design considerations

In the light of increasing European integration, the Treaty of Maastricht and the developments in Central and Eastern Europe, it is necessary to involve a large number of European countries in the evaluation of drug policies. Additionally, the incorporation of a number of Central and Eastern European coun-

tries (Hungary, Poland, Slovakia and the Czech Republic) should be considered.

The research work plan was based on focusing on a number of central topics relevant to European drug policies. These topics were chosen as the most important pieces of the complex phenomena which are constituted by these policies. On the one hand, these topics should be, to a certain degree, considered separately (sufficiently so as to study and to conduct secondary and tertiary analyses on these themes in different task groups); however, on the other hand these topics are of course strongly interrelated. The total research programme has been designed and grouped around these topics. The relevant information concerning the topics was identified and analysed by a number of national experts from European countries forming a multinational task group. In Working Group 1 of COST A-6 the following ten topics were discussed and agreed on as important aspects of the drug policy phenomenon. These ten topics concern the following themes: 1 Use and misuse of statistics in making drug policies; 2 Confrontation between legislation and implementation; 3 Construction of national drug policies; 4 Prohibition and legalisation / normalisation debates; 5 Construction of national drug-treatment and harm-reduction policies; 6 Influence of the drug problem on other policies, and vice versa; 7 Interest of other organized groups in drug policies; 8 Prevention policies (supply, demand and harm reduction); 9 Human rights of drug users; and 10 Construction of a European drug policy.

6. Outlook

It is clear that full implementation of a research programme as outlined in those ten topics is difficult in terms comparative research. But, in order to gain valid knowledge concerning the most relevant drug policy concepts, it is necessary to proceed along these lines.

In this volume, the first steps on this path are taken, as an extension and follow-up to the earlier work done at the Max Planck Institute in Freiburg, Germany[5]. Hereafter a limited number of the topics described above will be addressed.

The focus of the chapters in Part B of this volume is on the construction of national drug policies. We realize that a limitation of the descriptions in this part is caused by the restricted geographical area from which the drug policies

[5] Hans-Jörg Albrecht & Anton van Kalmthout. *Drug Policies in Western Europe.* Max Planck Institute, Freiburg, Germany, 1989.

covered originate. The under-representation of drug policy descriptions from southern European origin should be a major concern for future actions. A huge amount of work has to be done in the future to sharpen the methodological tools for drug policy research, to broaden the scope of the work to that which is necessary for integrated and comprehensive knowledge in the field, and to extend the work to the full geographical area important to policy makers at the European level and beyond.

In order to contribute as much as possible to the debate on the methods of comparative drug policy research, this volume starts with a section (Section A) focussing on methodological and conceptual issues, and is followed by a section (Section B) dealing with the construction of current national drug policies in a number of European countries.

Section A starts with an introduction by Van Kalmthout and Albrecht to methodology, concepts and findings of comparative analysis. After this, Klaus Mäkelä (Finland) formulates a number of lessons from research in the alcohol field which drug policy researchers should take into account. Ragnar Hauge (Norway) then presents an inventory of problems which arise in statistical studies within the drug field. Section A contains then a contribution from Victoria Berridge (United Kingdom), who underlines the necessity of adopting a genuine historical perspective while carrying out drug policy studies. Michael Farrell, Paul Griffits and John Strang (United Kingdom) cover the fundamentals of health policy concerning drug addiction by elaborating on the main issues of health policies in this field. Adelmo Manna and Franco Moretti (Italy) elaborate on current conceptual problems of drug policy studies by describing the complexities of narcotics policy in their country.

Section B presents the efforts of a number of European countries to influence the drug phenomenon by policy-making. The Swedish attempts to create a drug-free society are described and analysed by Leif Lenke and Börje Olsson. The Polish policy-making in a rapidly changing society are described by Jacek Moskalewicz and Grażina Świątkiewicz. Hans-Jörg Albrecht covers the diverse policy-making activities in Germany. French policy-making, mainly focusing on the control of drug use and drug traffic, is described by Marie-Danièle Barré. The efforts of Norway to develop a treatment and harm-reduction policy are described by Helge Waal. The development of Dutch drug policy - seen by some as an example to be followed and detested by others - is presented by one of its architects, Léon Wever. Pekka Hakkarainen and Lau Laursen wind up Section B with two more presentations of Nordic drug policy-making: the developments in Finland (Hakkarainen) and those in Denmark (Laursen).

Section A:
Methodology and basic Concepts of Comparative Research on European Drug Policies

Methods, Concepts and Findings from Evaluation Research on European Drug Policies

HANS-JÖRG ALBRECHT & ANTON VAN KALMTHOUT

1. Introduction

The topic of drug policy evaluation in a comparative perspective has arisen – especially since the second half of the 1980s – mainly for three reasons. First, the drug problem is perceived to be a major problem in most industrial and now also in developing and transitional countries. Secondly, there is evidently a need to 'share experiences', in particular in Europe where the drug problem has become a major topic of concern for the EU. This need can be divided into the rather modest aim to learn about what is being done in terms of drug policies in other countries, and the wider goal of contrasting different drug policies for evaluation purposes. Thirdly, there is an obvious need for reliable and valid data on the nature and extent of drug problems and related issues upon which political debates and political planning can be based. The latter – the documentation of research and the Europe-wide collection of data – is being dealt with by the European Monitoring Center for Drugs and Drug Addiction[1]. Attempts are also being made to collect drug-related data internationally and on the basis of predesigned instruments[2].

In setting the framework of the endeavour to evaluate drug policies from a European perspective, the primary question is what objectives should be

[1] See the most recent account in *EMCDDA: Annual Report on the State of the Drugs Problem in the European Union.* Lisbon 1998.

[2] Taylor, B., Bennett, T.: *Comparing Drug Use Rates of Detained Arrestees in the United States and England.* Washington 1999.

pursued. It then has to be discovered what type of research in terms of methodology, theory and data collection has already been carried out. Furthermore, we have to consider what can be learnt from current and past evaluation research in other fields – fields that could represent parallels to the drug policy topic. With evaluation, moreover, the outcomes of comparative research as well as proposals concerning future developments in evaluation research have to be accounted for, and finally the relationship between research and policy has to be taken into account by asking whether policy and policy makers can be advised by comparative evaluation research.

Methodology is a crucial point in comparative social science research. Although the concept of scientific research is basically comparative in nature (as the French sociologist Durkheim has pointed out in his work on the process of research), intercultural, international or cross-national research methodology has not received the attention it should have received. This is especially true if one takes into account the paramount interest cross-cultural comparative research receives today in the social sciences, moreover in criminology[3] and especially in policy research. On the other hand, it has been deplored that comparative social science research has produced little if any meaningful scientific knowledge in the last decades.

When thinking about cross-national research – and this is part of the issue concerning method – three basic questions need to be considered, i.e.:

- What is international comparative research?
- Why do we want to do international comparative research?
- How does this type of research differ – if at all – from other research?

The first question does not present that many problems, as international comparative research is characterized by using information or data stemming from more than one nation-state. The question why international comparative research is wanted then requires an answer to the question why primary or national research is carried out. There are several answers to this. The most obvious goal of comparative research is theory development. This goal is linked to the endeavour of explaining social phenomena, which in turn requires a thorough description of the social phenomena in question. Then, identification of variables which can be manipulated is sought, while finally comparative research is concerned with policy

[3] Adler, F.: Presidential Address: 'Our American Society of Criminology, The World and the State of the Art.' *Criminology* 34(1996), pp. 1-10, pp.4-6.

evaluation. From these primary goals of research, we may delineate the answers to the question why international comparative research is needed and what differences can be observed between international comparisons and national research. Here, three main targets can be distinguished:

1. To facilitate the generalization of empirical observations and theoretical considerations, and to demolish incorrectly assumed universalisms [4]. However, comparative research seems to be the only way to overcome the *ceteris paribus* clause which characterizes most of social science research[5].

2. To discover to what extent a social or cultural phenomenon which is relatively constant within a specific society has a broader range of variation when a number of different societies are compared, and to broaden in this way the informational basis of decision-making. This is of particular importance within the framework of the EU, where decision-making affects all member countries and therefore must rely on sound information concerning what impact decision-making is likely to result from extending EU regulations to member states, which in turn requires basic and specific information concerning normative etc. structures in those countries.

3. To discover to what extent cross-national variation may be explained by variation in other variables (which, moreover, may be subject to manipulation).

From this it is evident that international comparative research is above all a question of methodology, because it is defined by the application of a more or less specialized method. This method concerns comparisons of nations (or cultures) and is motivated by the possibility to obtain deeper and more reliable knowledge on certain phenomena and processes of change. To put it very crudely, international comparative research serves as a quasi-experimental design in so far as within modern nation-states meaningful variation with respect to theoretically important structural variables or with respect to legal, economic, etc. frameworks are in many cases no longer present. On the other hand, the specific difference of the comparative method is embedded neither in the process of comparing per se nor in the comparison across nations. The comparative approach is used as a standard procedure in any social science research. The specific problem accompanying international comparative research concerns the system

[4] Scharpf, F.W.: The Uses of Comparison in the Social Sciences. In: Max-Planck-Gesellschaft (ed.): *Internationalität der Forschung* (*Internationality of Research*). Rosenheim 1997, pp. 63-76, p. 69.

[5] Scharpf, F.W.: opus cited 1997, p. 72.

boundness of the social, cultural and legal phenomena to be made the subjects of research. In turn, the key problem in international comparative research is the degree to which equivalence can be established with respect to those basic categories or variables of research which are bound to a specific system or nation, or whatever expression is used to describe the basic entity or basic unit of international comparative research[6]. Equivalence in comparative research certainly does not mean identity. Identity cannot be established between different nations; moreover, identity is not welcome at all as differences should exist in order to be able to draw conclusions on assumptions which are dependent on variation in dependent and independent variables. Ultimately, it will be necessary to reconstruct within each nation or culture those causal chains which can explain national differences, once such differences are established.

2. Objectives to be pursued

In general, when launching comparative drug policy research it is argued that there is a need to share experiences and to generalize empirical observations and theoretical considerations. From an interventionist perspective, it is important to know to what extent a social or cultural phenomenon that is relatively constant within a specific society has a broader range of variation when a number of different societies are compared; it is also important to know to what extent cross-national variation may be explained by variation in other variables that are first of all subject to manipulation and then likely to have an impact on drug-related goals. It is essentially the last objective which in evaluation research seems to be the most important.

As regards drug policies, the most pressing question associated with intervention concerns the outcomes of prohibitive regimes based on criminal law. The last 40 years of prohibitive regimes have not had an outcome that would be unanimously accepted as positive, and have certainly invoked serious criticism and substantial allegations that criminal law has had and still has disastrous, unwanted side effects.

The crucial point, then, is the question of predicting what consequences will possibly follow changes in prohibitive regimes ranging from e.g. implementing various types of harm reduction policies to implementing policies of depenalization or the complete legalization of drugs.

[6] Zedner, L.: 'In Pursuit of the Vernacular: Comparing Law and Order Discourse in Britain and Germany'. *Social & Legal Studies* 4(1995), pp. 517-534, pp. 518-519.

Thus, the basic question concerns how to predict the likely consequences of changing prohibitive regimes. Here, three strategies can be addressed[7]:

- Drawing conclusions based on existing theory and research
- Quasi-experimental programme evaluation
- Projecting the effects of depenalization or decriminalization on the basis of an analogy to other places or time periods, substances or behaviours.

Drawing conclusions based on existing theories on drug use will not provide a safe basis, as current drug-use theories are first of all rather soft and the complex nature of changes in prohibition would make it difficult (and this also applies to hard theories) to account for and identify net effects – in terms of increases or decreases in drug use – of changes in policies.

Quasi-experimental programme evaluation (as has been carried out with e.g. the Swiss heroin trials and various methadone maintenance programmes) is equally as subject to serious problems when trying to draw conclusions based on them concerning their possible impact on the development of drug use and drug problems. Furthermore, the problems increase if such projections are transferred to other cultures or other national settings[8]. From limited experiments, projections on how various drug problem indicators will develop in the future can only be made with respect to those assumptions that have been subject to tests through a controlled experiment. Then, the national contexts to which experiments have been adapted vary, and as little is known on the particular effects such contexts might have had on the outcome of quasi-experiments, the transfer of findings in terms of projecting them into the future of other cultural or national contexts usually does not amount to more than mere speculation.

Projections of effects of policy changes are therefore most often based on analogies. We may differentiate here between two types of analogical reasoning, one drawing upon other time periods (where other policies had been implemented), the other upon other places in terms of territories or space falling under different types of regime.

Such analogies have been drawn in the past, for example with respect to: experiences with legal cocaine and heroin in the second half of the 19th

[7] MacCoun, R., Reuter, P.: 'Interpreting Dutch Cannabis Policy: Reasoning by Analogy in the Legalization Debate'. *Science* 278(1997), pp. 47-52.

[8] See e.g. Bammer, G. et al.: 'The Heroin Prescribing Debate: Integrating Science and Politics'. *Science* 284(1999), pp. 1277-1278.

century (when these drugs were relatively accessible and sometimes freely available in Europe and North America); marijuana depenalization in US states in the 1970s; alcohol prohibition in 1919 in the US, and its repeal in 1933; and the British heroin prescription model of the 1960s[9].

3. An outline of comparative evaluation research in the field of drug policies

Although evaluation research is always comparative, most evaluation research – and in particular studies that seek to summarize existing knowledge on the implementation and outcomes of drug policies and drug-problem-related measures – is a traditional summary of the state of the art. Such studies have been carried out rather often in an attempt to draw conclusions with respect to preventing the spread of HIV among IV drug users, the outcomes of maintenance programmes, needle exchange approaches and harm reduction policies in general[10], heroin distribution[11], and non-prosecution policies. However, this approach to summarizing and systemizing research – which is most elaborately implemented in theory-based meta-analysis – ultimately does not take into account the specific cultural, legal and social framework or environment within which the studies summarized have been implemented.

A series of comparative studies carried out under the auspices of UNICRI Rome were published in the 1970s and 1980s. These studies were Investigating Drug Abuse (1976)[12], Combating Drug Abuse and Related Crime' (1984)[13], and 'Drugs and Punishment' (1988)[14]. The 1976 study on

[9] Strang, J., Gossop, M. (eds.): *Heroin Addiction and Drug Policy: The British System.* Oxford 1994.

[10] Nadelmann, E., McNeely, J., Drucker, E.: 'International Perspectives'. In: Lowinson, J.H. et al. (eds.): *Substance Abuse. A Comprehensive Textbook.* 3rd ed., Baltimore 1997, pp. 22-39.

[11] Krausz, M., Uchtenhagen, A., van den Brink, W.: 'Medizinisch indizierte Heroinverschreibung in der Behandlung Drogenabhängiger. Klinische Versuche und Stand der Forschung in Europa'. *Sucht* 45(1999), pp. 171-186.

[12] Moore, J.J.: *Investigating Drug Abuse. A Multi-National Programme of Pilot Studies into the Non-medical Use of Drugs.* Rome 1976.

[13] Bruno, F.: *Combatting Drug Abuse and Related Crime. Comparative Research on the Effectiveness of Socio-Legal Preventive and Control Measures in Different Countries on the Interaction Between Criminal Behavior and Drug Abuse.* Rome 1984.

[14] Cotic, D.: *Drugs and Punishment. An up-to-date interregional survey on drug-related offences.* Rome 1988.

drug abuse in various countries was in fact based on what are called 'country studies'. This type of approach was justified by pointing to the great differences between various countries as far as the quality and quantity of the available data are concerned. It was mentioned that it would not be feasible to go at the very beginning into a predesigned effort to compare drug abuse, as the differences observed in official databases seemed to be too large. This argument obviously concerns the system boundness of important variables. Comparing these different country studies and drawing conclusions from such comparisons allow the authors to argue that the cross-cultural perspective conveys a "shallow and distorted picture". In fact, the study is not a comparative one, but rather presents various individual 'cases' that are lined up and then individually evaluated.

The aim of the 1984 study was to gain insight into the relationship between the severity or harshness of penal sanctions and the levels of drug-related crimes experienced in various countries. With the outlined study, it was undoubtedly difficult (if not impossible) to compare different systems. Again, the specific problem of international comparative research was touched upon, but no conclusions were drawn by describing the problem of comparing different systems on the basis of databases linked to these different systems. It was therefore decided to reduce the dimensions which should be included in the study by focussing on the 'harshness' of the systems, on the 'seriousness' of addiction, and on the range of criminal offences thought to represent the most important crimes (homicide, rape, robbery, fraud, bodily injury and various types of property offences). Harshness and seriousness were scaled on the basis of various items (which were drawn, in the case of harshness, from the penalty levels provided by penal laws). Fictitious cases were used in order to obtain comparable data (responses of the system) on the sentencing of drug offenders. Again, this type of study is not comparative, although the restrictions and the choice of variables are obviously made in order to establish equivalence between the research units. But why the categories introduced should be regarded as equivalent is not explained. The policy implications concluded from the findings pointed essentially to the fact that penal sanctions are associated with increased levels of drug-related crimes.

The 1988 study aimed at providing an up-to-date picture of penal provisions for drug-related offences and on trends in sentencing drug offenders. In so far, only legislation on drugs is compared in terms of contrasting the legal framework without attempting to relate the framework to possible

policy outcomes. However, information on sentencing (i.e. the implementation of drug laws) was received only for a selection of the countries covered by the study. Most countries included in the analysis could not provide statistical information broken down into type of offence, offenders, types of drugs, etc. The results of this research are therefore restricted to an outline of trends in the development of both basic and procedural laws.

In 1983, a multi-city study on drug abuse was implemented by the Pompidou Group. This study was based on a comparative design, including various indicators on drug abuse. A first report was published in 1987, and a follow-up report appeared in 1994[15]. The multi-city study is somewhat more elaborated in terms of comparative methodology, as the indicators used are based on standardized instruments and on various approaches to the concept of drug abuse. Here, too, it is acknowledged that it is difficult to make valid and meaningful comparisons between countries and cities[16], as most of the data collected and used in the analysis are patterned along historical, administrative and other lines which differ from country to country and are thus difficult to assess and control. The problem of historically, culturally and nationally patterned data and behaviour, then, is addressed as a problem of interpretation of data which was thought to be best dealt with by research staff familiar with the cities included in the comparative survey. In this way, the data collected on the basis of a uniform and standardized instrument are interpreted in a qualitative setting provided by researchers familiar with the respective city and capable of using additional (though not collected) information from other sources. In so far, the particular context of the data collected is accounted for by a more or less qualitative approach intertwining specific knowledge and specific information on cities with quantitative, uniform data-collection procedures applied to the range of cities included in the research. Another key element in the process of comparing the data explicitly concerns the data collection procedures and the definitions used in framing basic indicators and in setting up variables.

Here, the annual reports from the EMCDDA on the State of the Drugs Problem in the European Union should also be mentioned. Based on quantitative data collected via a (as much as possible) standardized method, these reports attempt to provide a qualitative insight into such questions as

[15] Pompidou Group: *Multi-city study: Drug Misuse Trends in Thirteen European Cities.* Strasbourg 1994.

[16] Pompidou Group: Opus cited, 1994, p. 3.

the prevalence of drug use in EU countries, trends over time, new emerging patterns of drug use, and the supply and availability of various drugs [17].

A 1989 study on European drug policies summarizes the existing knowledge and expert perceptions on the state of drug policies in European countries[18]. The focus was on discovering trends in the development of drug policies and drug legislation (including both the basic and the procedural law). Moreover, an extension was made in so far as normative trends in terms of legal debates and discourses on national drug policies have been included along with mere empirical data and information on the implementation of drug laws and the magnitude of drug problems. A somewhat similar follow-up (originating from Switzerland) was carried out in 1991 in a small-scale overview of drug policies in Europe. During the 1990s, the pace at which European research developed increased significantly, due in particular to initiatives of the European Drug Monitoring Center. So, for example, a study on the evolution of repressive and medical systems of control of drugs in European countries includes France, the Netherlands, Switzerland, Italy and Great Britain[19]. However, from the viewpoint of the comparative method, the goals of this study were explicitly limited to the exchange and discussion of information.

Reuband (1992) compared drug policies and their outcomes in Germany and in the Netherlands in an attempt to arrive at valid conclusions concerning the correlation between the formation and implementation of drug policies and various indicators used in describing the magnitude of the drug problem as well as achievements of drug policy goals[20]. Reuband's study is by far the most elaborated as regards the use of various indicators of prevalence and incidence of drug problems. Moreover, the study thoroughly reconstructs German and Dutch drug policies and their actual implementation, thus establishing a framework within which drug problem indicators may be interpreted.

Comparative research has recently dealt with the drug situation in Scandinavian countries[21]. This study covers policy aspects as well as drug use

[17] EMCDDA: opus cited, 1998, p. 10.

[18] Albrecht, H.-J., van Kalmthout, A.: *European Drug Policies*. Freiburg 1989.

[19] Cesoni, M.L.: *Usage de Stupéfiants. Politiques Européennes*. Genève 1996.

[20] Reuband, K.-H.: *Drogenkonsum und Drogenpolitik. Deutschland und die Niederlande im Vergleich*. Opladen 1992.

[21] Hakkarainen, P., Laursen, L., Tigerstedt, Ch. (eds.): 'Discussing Drugs and Control Policy. Comparative Studies on Four Nordic Countries'. *NAD Publication* No. 31, Helsinki 1996.

prevalence and incidence, although no attempt was made to evaluate the various and differing Scandinavian drug policies. The main objective was obviously to describe major elements of national drug policies as well as prevalence and incidence of drug use in order to contrast descriptions of drug policies and drug problems identified in four Scandinavian countries with each other. Such descriptions are then used to elaborate similarities and differences, although the approach cannot be used to test hypotheses on causal relationships between drug policy and outcome measures such as prevalence and incidence of drug use. However, this type of approach is certainly promising, as it allows for a deeper understanding of how drug policies developed in individual countries and where the differences come up.

A similar, though broader comparative study has been done by Reuband on the basis of prevalence figures on drug use and other drug-related empirical information. The data are given in Table 2 (along with additional information obtained from other surveys). The conclusion drawn from comparing survey data for various European countries was that "different policies might go with similar levels of prevalence and similar policies might go with different levels of prevalence"[22]. The very same conclusion is drawn for heroin use and the number of addicts (see Graphs 1 and 2)[23].

MacCoun/Reuter[24] analysed Dutch, American, Danish and German survey data in order to estimate the effects of the Dutch depenalization strategy (adopted in 1976), which tolerates coffee shops and the possession of small amounts of cannabis. In an attempt to answer the question whether Dutch drug policy – which, according to MacCoun/Reuter, can be described as progressing gradually from depenalization in 1976 to de facto legalization in the period between 1976 and 1986[25] – they contrast several Dutch cities with other locations (US, Denmark, Germany) making use of drug surveys matched along survey period, type of prevalence measured and age groups covered. Furthermore, they introduce longitudinal data drawn from US, Norwegian and Dutch surveys. However, the latter cover

[22] Reuband, K.-H.: 'Drug Use and Drug Policy in Western Europe. Epidemiological Findings in a Comparative Perspective'. *European Addiction Research* 1995, pp. 32-41, p. 36.

[23] Reuband, K.-H.: opus cited, 1995, p. 38.

[24] MacCoun, R., Reuter, P.: 'Interpreting Dutch Cannabis Policy: Reasoning by Analogy in the Legalization Debate'. *Science* 278(1997), pp. 47-52.

[25] According to MacCoun/Reuter, progress is indicated through the evolution of formal guidelines for the operation of coffee shops and non-prosecution policies, p. 49.

Table 1: Drug-related prevalence data and other drug-related survey data for Scandinavian countries

	Denmark	Finland	Norway	Sweden
Lifetime prevalence of cannabis	30.1	7.3	8.3	11.4
Used cannabis during the last 6 months	4.1	1.1	1.8	1.2
Lifetime prevalence of hard drugs *	5.4	1.3	2.0	3.4
% advocating imprisonment as response to cannabis use	14	38	31	43
% advocating imprisonment of more than 10 years for smuggling 300 grams of heroin	18	13	23	21
% attitude: punishment is too lenient for drug crimes	67	48	57	65
N drug offences known to the police 1992 (/100,000)	350	70	330	350
Sentenced drug offenders 1992 (/100,000)	170	30	70	60
Unconditional imprisonment /100,000 1992	16	4.5	16.9	17.4
Imprisoned for 2 or more years /100,000 1992	1.9	0.9	2.1 **	3.1
Max. imprisonment for drug offences	10 years (15 years)	10 years	21 years	10 years
Drug police /100,000	5.7	2.9	4.6	6.3

* Hard drugs: cocaine, amphetamine, heroin; ** Norway: 3 years and more

Source: Hakkarainen, P., Laursen, L., Tigerstedt, Ch. (eds.): *Discussing Drugs and Control Policy. Comparative Studies on Four Nordic Countries*. NAD Publication No. 31, Helsinki 1996.

Table 2: Lifetime prevalence of cannabis/drug use in the general population and in selected age groups

Year	FRG	Holland	England	France	Austria	Switzerland	Denmark	Sweden	Norway	Finland	Spain	Greece
1981			5								20	
1982	6	9										
1983												
1984		10			15						21	6
1985									7		15	
1986	5											
1987	9	6				13/27*/25*						
1988						29*		8			13	
1989						21*/10**	22		19 (Oslo)		12	
1990	8/ 16*			27		23*/13**						
1991		12		21/ 22*		16/22*/ 12**						
1992	7***	15*	26	19/ 21		21*/14** 21*	30	11	8/8	6/7 11*	15*	9***
1993				15+						6/7		
1994	14		28/29*		10+		37/43*				22+	
1995	21*		42+	26*						6+	22*	
1996								11*				
1997								8+				

* young age groups (< 30 years); ** older age groups (> 30 years); + 15-16 years old; *** city samples and 12 month prevalence.

Sources: Reuband, K.-H.: 'Drug Use and Drug Policy in Western Europe. Epidemiological Findings in a Comparative Perspective'. *European Addiction Journal* 1(1995), pp.32-41, p.34; Hakkarainen, P., Laursen, L., Tigerstedt, Ch. (eds.): *Discussing Drugs and Control Policy. Comparative Studies on Four Nordic Countries*. NAD Publication No. 31, Helsinki 1996; ISDD: www.isdd.co.uk/UK trends and updates; Junger-Tas, J., Terlouw, G.-J., Klein, M.W. (eds.): *Delinquent Behavior among Young People in the Western World*. Amsterdam, New York 1994; EMCDDA: opus cited, 1998, pp.16-18; *Observatoire Français des Drogues et des Toxicomanies: Drogues et Toxicomanies. Indicateurs et Tendances*. Paris 1996.

Holland only for the period from 1986 onwards. In the period from the end of the 1960s until the mid-1980s, only scattered research on drug use prevalence is available. As regards this period, which is most important for estimating effects of depenalization or de facto legalization, trend lines from a Dutch study summarizing some 20 surveys for the period prior to

1984 were drawn. The trend computed from this study shows a decline in lifetime prevalence from 1971 onwards, with a reversal around 1984/1985. From 1984 onwards, marked increases can be observed. From the comparison they conclude that the US rates of marijuana use increased until 1979 and then declined steadily until 1992. The Norwegian trend in cannabis use shows a marked increase until 1972, and then fluctuates around a flat trend until 1992. From 1992 to 1996, all surveys indicate considerable increases in cannabis use among young people.

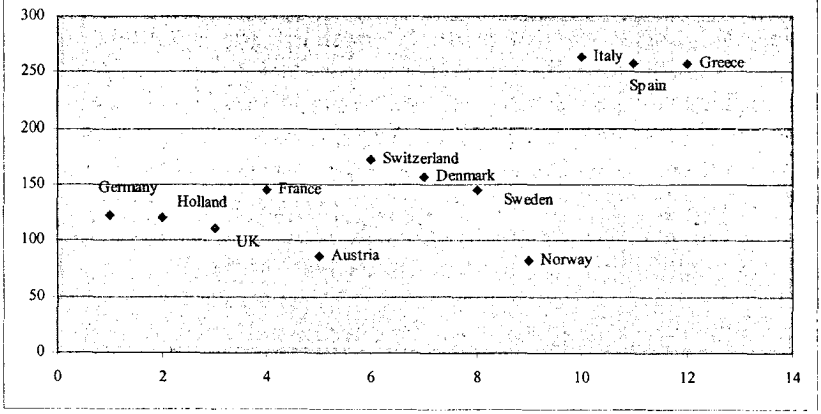
MacCoun/Reuter conclude from this comparison that the 1976 depenalization decision in the Netherlands had no effect per se, but that the gradual commercialization and widening of access to cannabis via coffee shops in the period between 1986 and 1992 led to an increase of use among young people. However, several caveats accompany this conclusion. First, as increases in cannabis use during the first half of the 1990s demonstrate, other variables might explain the differences between trends observable in the countries covered by the study. Then, even if the trend line in Holland could be regarded as representing the causal effects of Dutch drug policies, difficulties would arise out of attempts to transfer the findings to other cultural and national contexts.

Another effort to compare North American and European drug policies and their outcomes are documented in Reuter/Falco/MacCoun 1993[26]. The aim of this effort was to compare drug problems and drug policies across Western Europe and North America along various dimensions and indicators. It was concluded that although in political debates in North America quite often references are made to European drug policies, only very little information was actually available on the nature and outcomes of drug policies in different countries. The authors point at the differences in the availability of drug use surveys and the problems arising from such differences. However, they describe on the basis of available information the heroin waves that affected both North American and Europe between the 1960s and early 1980s, and point at different experiences with cocaine and crack. Estimates of the number of drug addicts and the number of drug-related deaths are obviously not strongly correlated. Marijuana use is fairly widespread among young people in both the US and Europe, although prevalence rates based on youth surveys in general are higher in the US. Differences between North America and Europe seem to exist in drug-

[26] Reuter, P., Falco, M., MacCoun, R.: *Comparing Western European and North American Drug Policies. An International Conference Report.* RAND, Santa Monica 1993.

related crime, with the US displaying higher rates of involvement of addicts in property and violent crime than European countries do. Finally, the implementation of drug policies is considered. It is concluded that despite rather uniform wording of the law, there are marked differences regarding implementation in terms of drug arrests, sentencing and other elements (e.g. drug testing). It is concluded, then, that beyond the consensus on the importance of prosecuting and punishing drug suppliers, disagreement on goals prevails between the US and Europe. In Europe, it is argued that despite considerable differences in the rhetoric on drug policies, fewer differences exist with respect to practical policies where it is suggested that throughout Europe the highest priority is given to harm reduction[27]. The results are less conclusive as regards comparative issues. However, it is concluded that "far too little exchange of information ... across the Atlantic as well as within Europe" has so far taken place[28].

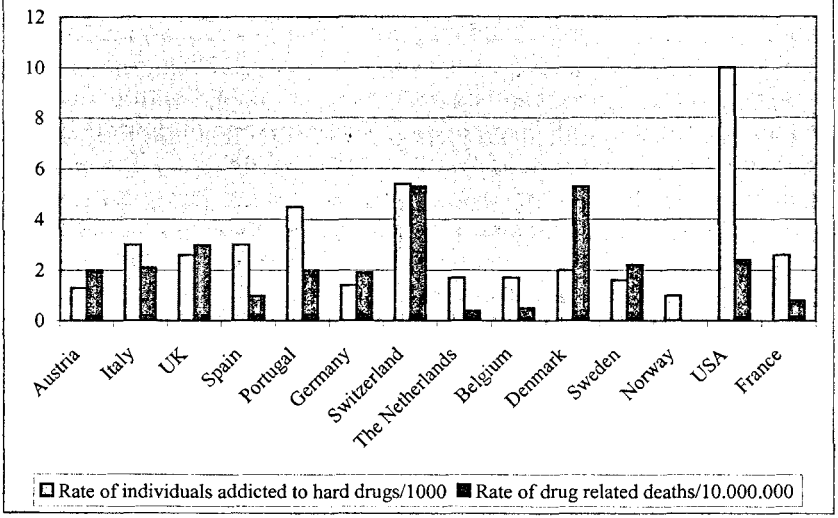
Graph 1: Estimates on hard drug use (per 100.000)



Source: Reuband, K.-H.: Drug Use and Drug Policy in Western Europe. Epidemiological Findings in a Comparative Perspective. European Addiction Research 1995, pp. 32-41, 36.

[27] Reuter, P. et al.: opus cited 1993, p. 24.
[28] Reuter, P. et al.: opus cited 1993, p. 27.

Graph 2: Hard drug addiction and drug related deaths in various western countries



Source: EMCDDA 1996

A study focussing on identifying policy models in the drug field across Europe was published in 1996[29]. The aim was to present various drug policy models from a comparative perspective and to develop a typology of drug policies. However, the final goal is not very clear. It is argued that by developing typologies of drug policies, the classification of a specific drug policy or theory would be possible and that such typologies could serve as an (empirical) point of departure for the development of drug policy scenarios. Moreover, such typologies should also serve as a basis for decision-making in the drug field[30]. However, it is by no means clear how these goals should be achieved, as the authors also state that the comparative study does not attempt to evaluate the different drug policy models identified. By reducing the goals in this way, no more than description is actu-

[29] Cattacin, S., Lucas, B., Vetter, S.: *Drogenpolitische Modelle in Europa. Eine vergleichende Analyse sechs europäischer Realitäten.* Zürich 1996.
[30] Cattacin, S. et al.: opus cited 1996, p. 18.

ally sought in terms of collecting information on various elements of drug policies across borders. Included were the cities Frankfurt, Göteborg, Lyon, Modena and Rotterdam, and the canton of Wallis in Switzerland. In addressing the economic, cultural and social context of these places, it is argued that they are all located in the same (Western European) culture and exhibit similar economic conditions. That, it was concluded, would suffice to compare the drug policies implemented in the cities covered by the study. Moreover, the mere appeal to the European culture and similar economic conditions (though not spelled out) is said to justify classification of the study as being based on a "most similar research design". The results – which are essentially based on a content analysis of newspapers, interviews of key persons, review of documents and legal material, and visits to project sites – leads to the presentation of three basic models of drug policy, i.e. the harm-reduction, the therapy, and the control model[31].

A series of articles have covered such general topics as basic control models in the field of illicit drugs[32]. In this, obviously 'ideal types' of drug control models should be traced by identifying their basic elements. The problem of this type of analysis concerns the apparent lack of empirical data. What is produced is a somewhat weak association between drug and drug problem indicators on the one hand, and the existence of certain control models among a range of countries on the other hand.

The WHO has carried out several comparative surveys on legislation focussing on drug and alcohol abuse treatment. The comparative methodology used is based on an approach which seeks to be sensitive to historical backgrounds, the meaning of the wording of the law and the identification of trends in the discourse on drug policy as well as the implementation of drug laws. The sources used were the complete texts of national legislation as published by the UN division of narcotic drugs, complete texts of legislation and summaries of such texts published in the international digest of health legislation, personal communications from professionals in the country surveyed, and the UN's and national governments' legislative document depositories.

[31] Cattacin, S. et al.: opus cited 1996, pp. 218-219, pp. 221-224.

[32] See e.g. Kaizer, G.: 'Präventionsmodelle des Betäubungsmittelrechts im internationalen Strafrechtsvergleich'. In: Institute of Comparative Law (ed.): *Law in East and West.* Waseda University Press: Tokyo 1988, pp. 911-925.

Table 3: Basic models of drug control in Europe

Dimensions	Harm reduction	Therapy	Control
Goal	Minimizing problems caused by addiction	Helping/healing addicts	Drug-free society
Fundamental values	Individual integrity	Social integrity	Integrity of the community
Prevention	Individual responsibility	Deterrence	Deterrence
Support	Multiple therapeutic offers; reintegration; maintenance	Emergency units; individual treatment; less support in reintegration; maintenance marginal.	Abstinence therapy; reintegration; maintenance marginal; street work
Control	Control of drug supply; tolerance of small-scale trafficking, possession and use; alternative therapy instead of prison.	Control of drug supply; tolerance of use of drugs; therapy instead of prison.	Control of drug supply and drug demand; separate drug prisons; therapy instead of prison for addicts.
Coordination	Intensive coordination; institutionalized conflict-resolution approaches	Coordination within the therapeutic framework	Intensive coordination.
Policy elements	Individual responsibility; trial and error policy; experimental state; participation of private organizations.	State responsibility towards the addict (the sick individual); technological state; marginal role of private organizations.	State responsibility for the addict; welfare state; moralizing politics; participation of private organizations.
Main advantages	Pluralistic and flexible responses; integration of state and society	Coherent therapy chains; respect for individual autonomy	Avoidance of major conflicts.

Source: Cattacin, S., Lucas, B., Vetter, S.: *Drogenpolitische Modelle in Europa. Eine vergleichende Analyse sechs europäischer Realitäten.* Zürich 1996, pp. 218-219.

A comprehensive analysis of the comparative development of alcohol policies and their interactions with alcohol problems was published in 1981 by Mäkelä et al[33]. Here, a macro approach was used to gain insight into the social, economic, cultural and historical context within which alcohol policies developed in the countries included in the survey and within which alcohol indicators (with respect to production, consumption, alcohol-related problems, etc.) are then interpreted. The advantage of this approach in international comparative alcohol research lies in the fact that alcohol control, alcohol problems and alcohol-related behaviour are historically, culturally and nationally patterned social phenomenon, and that the approach used is well suited to account for such patterns. What was done was the creation of a meta-level of data analysis and interpretation of data for each country on which the alcohol control as well as alcohol problem 'stories' for each of the countries then could be reconstructed. These stories were then compared to each other based on yet another meta-level of analysis. The development of drug policies may be reconstructed very much in the same way as was done with alcohol policies [34].

4. Evaluation of crime and delinquency prevention programmes

Evaluation research on the prevention of crime developed parallel to evaluation research on drug policies. However, the basic questions put forward by evaluation research in this field are rather similar to those put forward in the drug policy field. As regards crime prevention policies, a major question evaluation research seeks to answer concerns whether crime rates are dependent on variation in criminal justice responses, for example, in terms of the use of imprisonment or other types of sanction. Crime prevention programmes – in particular prison-based rehabilitation and treatment programmes – have then been subjected to evaluation research. Finally, treatment approaches have been a major target of evaluation research.

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[33] Mäkelä, K. et al: *Alcohol, Society, and the State: A Comparative Study of Alcohol Control*. Toronto 1981; see also Davies, P., Walsh, D.: *Alcohol Problems and Alcohol Control in Europe*. London, New York 1983.

[34] See e.g. Eisner, M.: 'Determinants de la Politique Suisse en Matiere de Drogue. L' exemple du Programme de Prescription d' Heroine'. *Deviance et Societe* 23(1999), pp. 189-204.

Looking at the results of evaluation research in the crime policy field, we can see that the more feasible it seems to use the traditional experimental approach to evaluation, the less we find international comparative research. Comparative and international research in the evaluation of crime policies is found when questions are put forward which include variables that cannot be manipulated or experimentally controlled (within one system), like for example the threat and the actual use of imprisonment or other penalties for drug use, etc. Differences in crime policies, however, do not seem to be related to crime and delinquency rates, nor to the rates of incidents of serious crimes or of recidivism.

This outcome is rather similar to what has so far been observed with respect to drug policy evaluation. In a 1995 article, Reuband concluded that the rate of drug-using young people and the incidence of drug problems are obviously not dependent on the type of drug policy adopted in a country[35]. Drug use and drug problems are dependent on variables other than those usually considered in official drug policies. Research also shows that the demand for drugs and drug use are not dependent on variation in criminal drug laws or on variation in drug law enforcement[36]. Drug use is best explained by the strength of association with peers who use drugs. Drug waves – such as that of cannabis in the 1960s and the heroin epidemic in the 1970s – were obviously driven by the emergence of youth cultures, as is the case with the increase in the use of amphetamines and ecstasy in the 1990s.

5. Complexity of drug policy goals and operationalization

What has been and still is the dominant objective in comparative evaluation research is the use of differences in drug policies in order to establish causal links between certain drug policy elements and various types of drug problems. As regards the goals of drug policies, the major goal of drug control systems is to protect public health. But obviously this goal is much too complex to be dealt with seriously within the framework of evaluation research. Although the major interest of drug policies lies in the goal of improving public health, it is evident that public health has more of

[35] Reuband, K.-H.: 'Drug Use and Drug Policy in Western Europe'. *European Addiction Research Journal* 1(1995), pp. 32-41.

[36] Reuband, K.-H.: 'Drug Policies and Drug Prevalence'. *European Journal on Criminal Policy and Research* 6(1998), pp. 321-333.

an ideological or political potential than the potential of providing clear-cut goals for evaluation research. The first step in designing evaluation research in the drug policy field addresses the problem how to operationalize public health. The goal of making evaluation research manageable leads to attempts to divide the concept of public health into researchable sub-items and the simplifying of drug policy goals. Among the indicators used in drug policy evaluation, first of all prevalence figures of drug use have to be considered – and the bulk of research reviewed earlier has made use of prevalence studies. However, by launching systematic data collection on drug use in various countries on the basis of predesigned sampling approaches and data collection instruments, valuable knowledge can be produced which in the long run may serve as indicators in policy evaluation. So, for example, the Arrestee Drug Abuse Monitoring Program produces (among other data) self-report and urine analysis data on the use of various drugs among arrested offenders[37]. Then, the number of addicted drug users ranges prominently among indicators of drug problems. Another indicator concerns the progression from soft to hard drugs, or the 'stepping-stone' theory. Rates of death attributable to illicit drugs have also been assigned particular importance when making estimates of the magnitude of the 'drug problem'. The 'hard use of soft drugs' was recently made a target of research, too[38]. Finally, health problems attributable to illicit drugs in terms of admissions to emergency units, psychiatric institutions, etc. are made a significant part of the concept of the drug problem.

Such variables are regularly constructed to serve as 'indicators' of the drug problem. The size of the drug problem as observable from the size of the indicators is then used as a measure of how large the impact of illicit drugs on public health is. These indicators are accessible through public surveys and official health and crime data concerning the statistics. However, what can be observed with respect to this type of approach to drug policy evaluation is that:

- there are too many (independent) interfering variables (and not enough cases in terms of countries)[39];
- there is no sound theoretical concept of 'drug problem' or 'drug policy';

[37] Taylor, B., Bennett, T.: *Comparing Drug Use Rates of Detained Arrestees in The United States and England.* Washington 1999.

[38] See Aquatias, S. et al.: *L'usage dur des drogues douces. Recherche sur la consommation de cannabis dans la banlieue Parisienne.* MILDT/MESR Paris 1995-1997.

[39] See also Scharpf, F.W.: opus cited 1997, p. 71.

- basically, the outcome of such evaluation may be summarized by 'no effect' or at least 'no systematic effects'.

Besides the indicators mentioned above that are used to construct the drug problems and which therefore should serve to get closer to the concept of public health, another type of indicator appears, one obviously linked to the drug problem but referring to a concept of secondary drug problems. With such indicators, the indirect effects of drug policies (and in particular, of prohibitive drug policies) are highlighted, among them for example the number of suspects, the number of prison inmates, incidence and trends in crime at large, as well as incidence and trends in drug-related (property) crime. By including such secondary drug problems, drug policy evaluation becomes more complicated as such indicators of secondary drug problems in themselves carry another concept of explaining the drug problem. It is clear that variables such as the number of suspects, the number of prison inmates or crimes committed are directly linked (at least on the surface) with criminal drug legislation and drug law enforcement. As a consequence, the problem of data interpretation arises. Trends in the number of suspects and convicted and sentenced offenders can in principle be explained by theories of drug law enforcement[40] and for theories on the development of individual or collective characteristics in illicit drug use. A parallel can be drawn with crime and delinquency research, where conflicts between social control approaches and etiological theories of crime have never been resolved.

There is yet another field from which indicators for consequences of drug policy can be drawn. First, we can expect that drug policies will have consequences on criminal law in general as well as on strategies on law enforcement. It is evident that with drug control new demands for the reform of substantial and procedural criminal law arose, and that these con-

[40] See e.g. the Swedish example, where policy changes at the end of the 1960s caused drug offences figures as recorded by police to drop from some 44,000 in 1969 to 17,000-20,000 between 1970 and 1979. The drop was due to changes in prosecutorial policies that brought about a shift from street-level control to concentration on serious drug trafficking (from 1972 on non-prosecution policies applied to cases involving possession of not more than a week's user supply). In 1980, the policy changed again with the tightening up non-prosecution policies. From 1980 onwards, only such amounts could be eligible for non-prosecution that could not be subdivided. This again caused police recorded drug offence figures to soar (from 22,500 in 1979 to 68,000 in 1982), see Swedish National Institute of Public Health: *A Restrictive Drug Policy. The Swedish Experience*. pp.9-10.

tributed to significant changes in basic and procedural criminal law in the 1980s and 1990s. Secondly, drug control policies have led to a dynamic process which continuously shapes the way drug control is implemented and the type of agencies that become involved with the task of drug control. Recently, we have observed, for example, a growing concern for administrative- and civil-law-based drug control strategies. These trends become visible in the way open drug scenes are managed and the way the administration interferes in cases of drug abuse (by, for example, revoking driving licences, closing down coffee shops, imposing interdiction orders, making seizures on the basis of customs laws).

6. Evaluation research and drug policy development

A basic question, then, concerns the relationship between policy-making and evaluation research. As far as we know, this relationship is a very complex one. Drug policy is obviously not dependent on the outcomes of evaluation research nor on knowledge about their outcomes. From comparative surveys and comparative evaluation research, it seems that so far only those pieces of evaluation research that fit into mainstream policy have been picked out. If we contrast Dutch and Swedish drug policies, for example, we see that on the one hand trends in basic indicators of drug problems are interpreted as positive outcomes of soft approaches and risk-reducing drug policy approaches in the Netherlands[41], while on the other hand Swedish official accounts of drug policy outcomes link Swedish trends to the repressive and zero tolerance lines which make up the core of Swedish drug policy[42]. The falsification principle adopted for scientific reasoning obviously allows for such selective use of evaluation research for developing and justifying policy strategies. Changes in the drug policies therefore obviously develop along their own dynamics and must be explained through other concepts.

[41] Ministry of Foreign Affairs et al.: *Drugs Policy in the Netherlands. Continuity and Change*. Rijswijk 1995; van Dijk, J.: 'The Narrow Margins of the Dutch Drug Policy'. *European Journal on Criminal Policy and Research* 6(1998), pp. 369-393, p. 393.

[42] See Swedish National Institute of Public Health: *A Restrictive Drug Policy. The Swedish Experience*. Stockholm 1993; see also Tham, H.: 'Swedish Drug Policy: A Successful Model?' *European Journal on Criminal Policy and Research* 6 (1998), pp. 395-414, explaining the declining rate of drug users (observable until the beginning of the 1990s; from 1993 onwards, rates are again increasing) with changes in other variables (e.g. the general declining rate of youth crime, low unemployment among youth, etc.).

7. Summary and conclusions

Voices have become more sceptic in recent years as regards the opportunities and possibilities to learn from analogies drawn from examples from and experiences in other countries. What can be said, then, is that international comparative drug policy evaluation should aim at the following goals:

The comparative approach – in the narrow sense of the term – should be widened to also include the question how certain elements of drug policy spread. Here, the discussion on heroin distribution should be taken up and made a topic of research from the perspective of how the heroin distribution policy is currently debated and how this debate is adopted in various countries. The Swiss heroin trials have become a central concern in many European countries by serving as a point of reference for national debates on how drug policies should be revised. Recently, for example, the directorate of the German Federal Medical Association unanimously decided to support heroin trials in Germany. The basic justification was drawn from the evaluation of Swiss heroin trials and a positive assessment of their results[43]. However, the Federal Ministry of Health insists that the findings of the Swiss heroin trials have no value at all for German drug-policy-making. In the Netherlands, heroin trials commenced in July 1998 partly based on the findings from the Swiss heroin trials. Before finally deciding on the introduction of heroin-dispensing schemes, the Dutch government wants to have experimentally produced knowledge on how heroin maintenance works out within the context of Dutch drug policies[44].

To conclude, it seems essential for future comparative drug policy research that:

- Drug policy research should in general become international research in so far as a main goal should consist of providing and documenting information and basic knowledge on the variety of drug policies in, for example, Europe in order to allow for informed decision-making.

[43] Spiegel, No. 11/1998, PP 178-179: 'Befreiung aus der Sucht'. Shortly after presentation of the evaluation outcomes of Swiss heroin trials, the cities of Cologne, Karlsruhe, Frankfurt and Hannover applied to the Federal Government for permission to introduce heroin trials.

[44] See Parliamentary Paper 24077, which contains the proposal on the Dutch heroin experiment.

- Drug policy research should be broken down into rather narrow steps, which on the basis of short-range theories would allow tests of clear hypotheses which are not vulnerable to different theoretical interpretations. Examples could be the immediate impact of drug law enforcement on trends in prison populations and prison regimes, links between ethnic minorities, immigration and drug markets, as well as trends in criminal justice indicators.

However, comparative research on drugs will become more important to European governance the more European policies are developed as central policies that should be implemented across Europe. In order to discover how such centrally developed policies will perform in the various member countries, it is essential to know about the likely responses that will result from the specific cultural, political, administrative and social systems within which such policies should be implemented. It is here that specific drug-related knowledge is indispensable for tailoring policies to all these different contexts[45].

[45] Scharpf, F.W.: opus cited 1997, p. 74.

Comparative Social Research as a Collective Process: Some Lessons from the International Study of Alcohol Control Experiences[1]

KLAUS MÄKELÄ

Introduction

This paper looks at comparative social research as an intellectual *process*. Seen from this perspective, the overriding task is to develop and sustain within the project group a common frame of reference or, as a minimum requirement, a mutually understandable field of discourse. This may seem self-evident, but the task requires continuous interaction at all levels of the research undertaking from operational definitions of comparable measures to conceptual interpretations. The nature of the task also varies depending on what kinds of data are used and how the project is funded and organized.

Varieties of comparative projects

Comparative projects vary along several dimensions that have an impact on the research process and on the organization of the project group:

- To what extent will the study rely on previously available data, and to what extent will new standardized data be collected?
- How strict will the requirements be that are put on the technical comparability of the data to be presented?

[1] Revised version of a paper presented at the Workshop of Working Group 1 (Evaluation of Policies, Policy Changes and Societal Responses to Policies) of COST A6 (Evaluation of Action against Drug Abuse in Europe), 9-11 December 1994, Warsaw, Poland.

- Will the data be mainly analyzed centrally or nationally?
- Are participant groups centrally or nationally funded?
- What are the general relationships between the national and cross-national aspects of the study in terms of reporting and publishing?

The dimensions listed above bring about extremely complex combinations, but it is helpful to identify a few typical cases.

1. The old cross-cultural project led by Charles Osgood on the measurement of meaning with the semantic differential (Osgood & Suci & Tannenbaum, 1957) provides a classic example of a centrally designed, funded and analyzed study where a lot of effort was spent on achieving technical comparability. Data from some 30 cultures were collected with the aim of establishing universally comparable measures of the affective meaning of any cultural objects (Osgood & May & Miron, 1975).

2. In a number of Nordic drinking surveys, nationally funded and independently functioning research groups have aimed at collecting highly standardized and comparable new data on attitudes towards drinking and patterns of drinking that have been analyzed both nationally and cross-nationally (for example, Bruun & Hauge, 1963; Hauge & Irgens-Jensen, 1990; Mäkelä, 1986).

3. The International Youth Project represents an attempt to reanalyse previously collected data following – to the extent that is possible – uniform principles (Ahlström & Harford, forthcoming). The reanalysis was carried out and reported nationally in 18 countries, and the comparative implications were summed up by the editors of the same volume in which the national reports were published.

4. The Collaborative Alcohol-Related Longitudinal Project goes one step further. In this project, data from 39 longitudinal drinking surveys previously carried out in 15 countries have been stored and analyzed centrally (Fillmore et al., 1991; for an example of substantive meta-analyses, see Fillmore et al., 1994).

5. In International Studies in the Development of Alcohol Treatment Systems (ISDATS), authors from sixteen countries produced national case descriptions of the structure and history of their alcohol treatment systems largely independently from each other but adhering to a common format (Klingemann & Takala & Hunt, 1992). The national case studies were published in one volume, which also included an introduction and an afterword, written from a comparative perspective by the editors.

6. The International Study of Alcohol Control Experiences (ISACE) and the International Collaborative Study of Alcoholics Anonymous (ICSAA) produced – in addition to individually authored special articles – two types of final reports, a collectively authored international report (Mäkelä et al., 1982; Mäkelä et al., forthcoming) and a collection of national case studies including a comparative essay written by the editors (Single & Morgan & de Lint, 1982; Eisenbach-Stangl & Rosenqvist, forthcoming). Both studies were mainly based on previously collected statistics and qualitative material, but in the latter project new systematic survey data were also collected. Another similar study is the Baltica Project on the prevalence and social construction of social problems in all countries around the Baltic Sea (Simpura & Tigerstedt, 1992).

By illustrating the variability of comparative projects, I want to draw attention to the importance of participants being aware of which type of project they are launching and of how this affects the collective research process. In particular, it is helpful to have a clear view of how the national and cross-national aspects of the undertaking are related to each other, and at what stage and by whom the comparative and international conclusions and implications will be drawn together. As a matter of fact, it may be useful both to have a clear picture of what the ideal final report looks like *and* to have a fall-back alternative if everything does not go ideally. The fall-back alternative of course is seldom shown in formal planning documents, but it helps when carrying out the project if somebody has a blueprint of a second best alternative in the event that problems arise. Improvising surrogate solutions after a disaster is not always that easy.

The International Study of Alcohol Control Experiences

The International Study of Alcohol Control Experiences (ISACE) is already an old project, but it may still be the most recent parallel to the study of drug control policies in Europe. I thus hope that our experiences may be of at least some limited relevance to the COST project.

The ISACE project originated from a planning meeting held in late 1976. At the first working meeting in early 1978, the participants agreed upon the scope and purpose of the project and adopted comprehensive guidelines for data collection. At the second working meeting in 1979, a first outline of the final report was adopted. A draft report was discussed at the third working meeting in 1980, and the report was finalized at the fourth

working meeting in 1981 and published later in the same year. Thus the process from the first planning meeting to the finished product required a little less than five years.

The task of ISACE was to analyze the social history of the post-war alcohol experience in seven countries. The study was mainly concerned with the state's role in managing the production and distribution of alcohol. The goals of the project were:

(1) to trace the historical development of alcohol control policy, its determinants, and its effects on the levels and patterns of alcohol consumption in the seven societies, and
(2) to assess the potential influence of control policy on the consumption of alcohol and its adverse consequences.

In the study, the term 'alcohol control' referred to any government measures that relate to the purchase, production or trade in alcoholic beverages, whatever the aim of such measures may be. Thus, the government measures which constitute the alcohol control system were defined independently of their motives.

The guidelines for data collection identified four broad areas of interest:

A. General social structure & demographic composition
B. Political and economic interests, processes and attitudes related to alcohol production and consumption
C. Alcohol consumption
D. Drinking-related problems; societal definitions of and reactions to drinking problems.

In this context, areas B and D merit closer attention. Area B was subdivided as follows:

B.1. International context
B.2. Economic structure and significance of alcohol production and trade
B.3. Other organized interests and popular attitudes
B.4. Control systems
B.5. Prices.

Area D was similarly broken down into subdivisions:

D.1. Cultural perceptions of consequences
D.2. Control and treatment facilities and programmes
D.3. Statistics on drinking problems.

The national and cross-national aspects of the project were closely intertwined. The guidelines for data collection provided a common frame to enhance comparability, but participant groups were to decide individually which aspects were the most important to study in their particular society. In the course of the project, a total of 68 working papers on selected aspects of the experience in each society were presented and discussed. The participants also produced more general national reports that were published in a companion volume to the joint international report (Single & Morgan & de Lint, 1982).

The final report of ISACE

The alcohol control experiences elucidated in the final report of ISACE (Mäkelä et al., 1982) provide a window on the overall development of post-war societies - societies whose populations shared experiences in increasing consumerism, more and varied leisure time, and an internationalization of lifestyle and culture. By examining alcohol control, we gained new insights into broad historical shifts - such as the rise in social welfare, mobility and affluence - and into the emergence of new cultural patterns. Consequently, the report addresses broad historical and structural issues as well as the more conventional alcohol research questions.

The discussion begins with alcohol consumption, production, and trade. To the classical causal-explanation mode of thinking, this is to begin in the middle. "The degree of control affects the level of consumption which, in turn, affects the rate of problems" would be a formulation attractive to many alcohol and drug policy analysts and a paradigm into which much previous work would fit. But as the work of trying to make sense of the historical record proceeded, we were forced beyond the bounds of this paradigm. Particularly at our societal level of analysis, control and consumption and consequences became multi-dimensional domains rather than single variables. Equally important, we came to see that there was no single direction of causality among the domains, but that all were caught up in a complicated network of interactions that also involved more general cultural processes beyond the three domains. Thus, causal priority no longer provided a guide as to which strand of the network to pick up first. Patterns of alcohol consumption, alcohol problems and control systems had to be looked upon as aspects of the same historical phenomena.

The report starts with the recent history of drinking as consumer behaviour and of alcohol as a commodity. Drinking is discussed in the same way as one would discuss the consumption of any other commodity - commodities not seen as being linked to particular social problems. We first identify as our study period one phase in the recorded history of wet and dry periods. We then describe how the increase in consumption was accompanied by a diversification of drinking, how the relationships of drinking to other social activities were transformed, and in what ways the cultural meanings attached to drinking changed. Alcohol production and trade are then discussed. First, we want to identify the parallel changes in the cultural significance of drinking and in the status of alcoholic beverages as an economic commodity. Second, the description of the structure of alcohol production and trade provides a background for subsequent discussion of the determinants of control policies.

Next, we describe in what ways changes in drinking were reflected in the magnitude and mixture of alcohol problems. In view of the intimate relationships between the social reaction to drinking and the consequences of drinking, we also examine changes in the management of alcohol problems, the expansion of treatment services, and the division of labour between the police and social and health authorities.

In our analysis of alcohol control policies, we first describe the outline and historical background of the control systems as they existed at the beginning of the study period. Changes in control systems and their determinants are then analyzed, with special reference to the lack of preventive considerations in the relaxation of control processes. In the last section, the shift in government action on alcohol, from control policies to problem management, is discussed in terms of general changes in the role of the modern state. A separate chapter deals with the effects of control policies, not only on consumption and alcohol problems but also on the alcohol economy.

Possible lessons in relation to the task of developing a common frame of reference

Participants of any collaborative project are usually a mixed bunch. Not only do they represent different cultural traditions but quite often their professional background is variable. The concrete social issues they face in their home countries vary a lot. Particularly with politically inflammable

issues like alcohol and drug policies, ideological commitments often are difficult to transcend. Developing a common frame of reference therefore is an important and often exacting task.

A research group should of course aim at conceptually more coherent solutions than international diplomatic negotiations. Constructing a common understanding or a common frame for disagreement requires time and goodwill. Based on the experience of the International Study of Alcohol Control Experiences and other similar projects, we may identify a few practical techniques and procedures that build up and sustain a mutually understandable field of discourse.

It pays to draw up rather detailed guidelines for data collection at an early stage of the project. These guidelines help in collecting data that is as comparable as possible, but they have a wider function as well. Detailed discussions of what aspects of the phenomenon deserve attention and how they should be described help to foster a mutual understanding by breaking up large disagreements into smaller pieces.

Another important principle is that the national and comparative aspects of the study should be worked upon in a parallel and intertwined fashion. It is wise to encourage the preparation of working papers with authors from more than one country. Assuming that the project group aims at a joint international report, it is helpful to draft an outline of that report at the very start of the project. The drafting of sections of the joint report should also begin very early on. It is tempting to postpone the work on the international report until the national case studies have been prepared, but that way one loses the continuous and mutual interaction between the national and international aspects of the drafting process. Also, often the best way of ensuring comparability between national case descriptions is the early involvement of all participants in the process of writing the comparative report.

Possible lessons with respect to research strategies

In line with general European research policies, the emphasis of the COST project on drug policies is on evaluation. The task of describing and analyzing national drug policies over time is, however, basically a social historical task. Evaluation discourse too easily suggests that alternative policy measures amount to a kit of tools of various degrees of efficacy. Guided by research, is it the task of enlightened policy makers to choose

the best combination of tools. As we all know, however, drug policies are determined by a complex interplay of social forces. The task of policy oriented research therefore is as much to shed light on the historical dynamics and determinants of policies as to evaluate their efficacy in any technical sense. It is worth pointing out that in the long run studies of the former type often have a deeper impact on practical policies than more technically oriented evaluation studies. If the aim of the European Union is to find a common ground for the drug policies of the member states, is it important to provide Commission funds for joint studies comparing the historical experiences of each country. Based on this conviction, I should like to end my presentation by putting forward for debate a few simple theses concerning research strategies.

1. Identify the social determinants of drug policies before attempting to assess their effects.

2. Discuss drug use and drug treatment and control as component parts of the same historical process. Increases or decreases in drug use and shifts in drug policies often reflect the same underlying social and cultural currents. It is therefore misleading to assume unidirectional causal links from policy measures to the incidence of drug use and drug-related problems.

3. Look at the interplay of historical forces in terms of interests, structures and actors. Analyze key actors in terms of their professional and political interests before describing their value commitments. Representatives of law enforcement aim at preventing drug-related crime, but they also want to increase their own resources. Treatment agencies want to diminish the suffering of their clients, but also want to expand their services.

4. Identify and analyze policy measures that are relevant to the drug situation independently of their stated motives and goals. For example, one should not pay too much attention to what rhetorics policy-advocates use; that is, do they speak the language of supply reduction, demand reduction or harm reduction?

5. Analyze the problem-handling apparatus as a set of important autonomous actors. The availability of drug-related services in itself affects the recorded incidence and nature of drug problems, and professional expert groups play an important role as pressure groups competing for publicity and resources. At the same time, it is useful to discuss various branches of the problem-handling apparatus as part of a whole and

irrespective of whether their stated goal is treatment or control. For example, the single best descriptor of a country's drug policies may be the distribution of publicly funded drug-related overnight stays in various types of institutions run by various authorities and private organizations (jails, prisons, general and psychiatric hospitals, drug treatment units, recovery homes, shelters, etc.). There can be dramatic shifts in where drug users spend their nights, and often these shifts bear little relation to explicit policy goals or conscious changes in policy.

6. If you want to formulate recommendations, postpone the task to the very end of the project. Otherwise, a lot of energy will be spent on ideological tactics.

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Problems in Comparative Statistical Studies of Drugs

RAGNAR HAUGE

1. Introduction

Most countries produce statistics regarding different aspects of drug use and drug problems. Looking at the European scene all or nearly all countries have at least some statistics on drug offences and drug offenders - produced by counts being made at certain stages in the criminal justice process. Most countries also have data concerning the quantity of illegal drugs seized by the authorities. Similarly, data concerning some health aspects of drug use and abuse are produced. Many countries report data on drug-related deaths, the number of HIV seropositive and Aids cases registered or the number of addicts in treatment.

1.1 Statistical data as indicators

In the political debate such data are extensively used. They are presented in the mass media accompanied by comments from journalists and commentators, interpreted by experts of many kinds, and used as arguments for political initiatives. The data - or the trends revealed by the data - are seen as indicators of the drug situation and of the efficiency or inefficiency of the existing drug policy. A rise in the number of offenders arrested, in drug-related deaths or in the quantity of drugs confiscated are seen as an indication of a rising drug problem, which in turn demands certain preventive political action, while a drop in the figures is seen as an indication of decreasing problems due to an efficient political strategy.

Such data are also frequently used in international comparisons. If the number of persons arrested for drug offences, the number of drug-related deaths or the quantity of drugs confiscated in one country is higher than in another country - or the rise is steeper - this is often interpreted as an indication of the first country having greater drug problems than the second. To draw such a conclusion presupposes, however, first that the data which are being compared are comparable, and secondly that the data reflect the drug problems in the countries concerned.

It is common knowledge, however, that statistical data are influenced by a host of external factors. The number of offences registered in different countries may vary because of differences in the law, for example, differences as regards the substances classified as drugs or whether or not use is criminalized. They may also vary because of differences in police priorities and police efficiency. Drug offences are victimless crimes and in most cases there are seldom people involved who are interested in reporting them to the police. Instead the police must on the basis of proactive policing bring the offences to light. This means that statistics on drug offences to a great extent will be a reflection of the priority given to such crimes, the manpower allocated to them and the efficiency of the police. The same is true as regards other data on drugs. The definition of drug-related deaths may differ from country to county, as may the way in which such deaths are classified. The quantity of drugs confiscated depends not only on the quantity being illegally brought into the country, but also on the efficiency of the customs and the police. And the ways in which offences, deaths or confiscated drugs are reported, processed and presented in the statistics may cause further difficulties when comparing data from different countries.

But even if the actual data are difficult to compare across countries, comparing the trends revealed by the data might prove fruitful. One may assume that within one and the same country the definitions, practices and other factors which influence the data remain the same. The trends revealed by the data might therefore give a correct picture of how arrests, drug-related deaths or the quantity of confiscated drugs develops over time within each of the countries concerned, and these trends may be compared across countries.

This leads to the second question: do such data really say anything about the drug problem? Using the data themselves or the trends as indicators of the drug problem in a country implies believing that they measure some-

thing other than what they really measure. The implication is that the underlying drug problem expresses itself in drug arrests, drug-related deaths or quantities of drugs confiscated. This may of course be true. If it is, one would expect the trends for the different indicators to reveal the same pattern.

In this paper I will look from these perspectives at some of the drug statistics that are available from Nordic countries. The questions I will raise are, first, to what extent is it possible to find comparable data from Nordic countries? And, second, do the data really tell us something about the drug situation in the respective countries? I will limit myself to data obtained from criminal statistics and death statistics, which are among those most used in international comparisons. This is not surprising. Such data are easy to get access to, since most countries publish official, statistical data on crime and deaths on a yearly basis. Such data probably also are among the most reliable, in the sense that they depict fairly accurately the number of crimes and criminals actually handled during the different stages of the criminal justice process and the number of deaths registered by the authorities. And finally, such data are easy to compare. The criminal statistics from different countries are more or less based on the same entities, whether it is the number of crimes registered by the police, offenders arrested or convicted, or persons in prison. And as regards deaths, there is an international diagnostic manual in the International Statistical Classification (ICD) issued by WHO.

But before looking at Nordic statistics, I will try to illustrate the problems inherent in international comparisons by using data from a European study.

1.2 An illustration: The Multi-City Study

An illustration of the problems involved in comparing data from different countries is exemplified by the Multi-City Study carried out under the auspices of the Pompidou Group in the Council of Europe. In one of the most thorough and ambitious projects of its kind, researchers from member states collected different kinds of data relating to the drug situation in the capital of or one of the major cities in their country. The data from the project are reported in *Multi-City study: Drug Misuse Trends in Thirteen European Cities.* (Richard Hartnoll; 1994. Strasbourg: Council of Europe.). Among the data presented in this report are those taken from criminal statistics and death statistics.

Table 10 in the Multi-City Study report presents the number of "police arrests" for drug offences, and Table 9 presents the numbers of "drug-related" deaths. On the basis of the population figures for the respective cities, I have in Table 1 calculated the rate of arrests per 1000 inhabitants in 1991 (or 1990 for Helsinki, London and Rome, where data for 1991 is not given) in the respective cities. These calculations are based on the population figures presented in the report, since the data for some cities seems to include also neighbouring communities outside the city limits. Table 1 also shows the rate of drug-related deaths in the cities concerned per 100 000 inhabitants. These figures are taken directly from the Multi-City report.

Table 1: The number of police arrests for drug offences per 1000 inhabitants, and drug-related deaths per 100 000 inhabitants in some European capitals and major cities in 1991 (Source: Hartnoll 1994 Table 10 and 9)

	Police arrests Rate per 1000	**Drug-related deaths Rate per 100 000**
Amsterdam	2.0	
Copenhagen	19.7	19.1
Dublin	4.8	-
Geneva	2.9	5.2
Hamburg	4.8	11.3
Helsinki	1.6[2)]	0.03
Lisbon	0.9	6.1
London	2.9[2)]	
Oslo	8.2	12.0
Paris	1.8[1)]	9.5
Rome	1.0[2)]	2.6
Stockholm	1.9	5.6

Note: [1)] 1989 [2)] 1990

As regards arrest rates, the data presented in Table 1 show great differences between the cities. Copenhagen has more than 20 times as many arrests per

1000 inhabitants as Lisbon (these two cities are the extremes). Oslo also has a high arrest rate, one nearly ten times as high as Lisbon. Other cities with a fairly high rate of arrests are Dublin and Hamburg, although the figures are considerably lower than those for Oslo and especially Copenhagen. At the bottom, along with Lisbon, one finds Stockholm, Paris, Helsinki and Rome. Amsterdam is also among the cities with a comparatively low arrest rate. Using these data as indicators of the drug situation, one comes to the conclusion that the drug situation varies considerably between the cities. Lisbon and Rome have very small drug problems, while Copenhagen and Oslo are marked by serious problems.

Also as regards drug-related deaths, Copenhagen and Oslo stand out as the two cities with the highest rates; Helsinki has the lowest rate, followed by Rome. Lisbon and Paris, however, where the drug problem is small if judged from the arrest rates, have a relatively high rate of deaths.

But are these data really comparable? Although the figures regarding arrests according to the heading in the table are based on "police arrests", we are in notes to the table informed that they relate to "persons arrested" in Amsterdam, "total violations" in Copenhagen, "persons charged" in Dublin, "arrests and possession figures" in Geneva, "offences" in Hamburg and Helsinki, "persons suspected" in Lisbon and Stockholm, "arrests" in London and Paris, "cases charged" in Oslo, and "persons reported for trafficking and personal use" in Rome. This means that the data presented have been selected at different stages in the criminal justice process in the different countries, and also that they differ in regard to whether they count persons, acts or decisions. Even if the data in themselves are reliable - in the sense that they portray the actual number of violations, arrests or charges or persons suspected, arrested or charged - they are not suited for comparisons.

Looking at the arrest data, it seems to be the case that as a rule cities which count offenders occupy the lower part of the table. This holds true for Paris, Rome, Amsterdam, Lisbon and Stockholm. On the other hand, Copenhagen, Oslo and Hamburg - which count offences - are the cities with very high arrest rates. Some cities, however, deviate from this pattern: Helsinki has a low arrest rate, although the data is based on offences, while Dublin has a high arrest rate, although based on offenders.

Also as regards the data on drug-related deaths one may ask whether they are comparable. The notes to Table 9 in the Multi-City report state that for some of the cities the data relate to direct or acute drug deaths (Amster-

dam, Geneva, Lisbon), to direct and indirect drug-related deaths (Hamburg, London) or to drug-misuse deaths (Copenhagen). The sources of the data also differs: in London they are based on coroners' records, in Norway on reports from the police, and in Paris on reports from OCRTIS, while in most of the cities the source is not mentioned. One can therefore not rule out the possibility that the differences between the cities may be due - at least to a certain extent - on differences in definitions of drug-related deaths and different practices as regards the reporting of the data.

The intentions behind the Multi-City Study, however, is to use the data collected to say something about "drug-misuse trends" in the cities concerned. The argument is that the trends in the data may be compared, even if the actual data cannot be compared directly. Therefore in Table 2 I have calculated (based on the figures given in Tables 10 and 9 in the Multi-City report) the changes from 1981 to 1991 in the cities concerned. As regards "police arrests" the change is calculated on the basis of the absolute figures given in Table 10, while for drug-related deaths (for which Table 9 gives only rates) it is based on the change in the rate per 100 000 inhabitants. In a number of cities the time series does not cover the whole period, as shown in notes to the table. If the time span is less than 9 years, the percentage in the table is put in brackets.

On the basis of Table 2 one may conclude that in most cities there has been a sharp increase in the arrest rate during the period concerned. Most alarming is the situation in Geneva with a rise of more than 400 percent, while in Hamburg, Copenhagen and London the number of arrests has doubled. Stockholm is the only city where there has been a decrease; Amsterdam and Paris have had a fairly stable situation. Based on this table - taking the trends as indicators of changes in the drug situation - the conclusion would be that in Stockholm the drug situation has greatly improved, in Amsterdam and Paris the situation seems to have been under control, while most of the other cities have had a great increase in drug problems, with the situation being especially out of hand in Geneva, Copenhagen and Hamburg.

However, a closer inspection reveals that the trends seem to differ according to the kind of data one uses for comparison. In the three cities with the greatest increase (Geneva, Copenhagen and Hamburg) the trend in Table 2 is based on data on offences, while the figures for the five cities with a decrease or the smallest increase (Stockholm, Amsterdam, Paris, Lisbon and Rome) are all based on data concerning offenders. One may therefore

Table 2: Changes in the number of "police arrests" for drug offences and in drug-related deaths per 100 000 inhabitants in some European capitals and major cities from 1981 to 1991 (Source: Hartnoll 1994, Tables 10 and 9)

	Police arrests Percentage change	**Drug-related deaths Percentage change**
Amsterdam	4	20
Copenhagen	222	16
Dublin	129[1)]	-
Geneva	415	16
Hamburg	227	927
Helsinki	101[2)]	-
Lisbon	(76)[3)]	(460)[8)]
London	198[4)]	38[4)]
Oslo	93	224
Paris	(8)[5)]	188
Rome	(81)[6)]	86
Stockholm	-30[7)]	-14[7)]

Notes: [1)] 1982-1991 [2)] 1982-1990 [3)] 1989-1991 [4)] 1981-1990 [5)] 1984-1991 [6)] 1983-1990 [7)] 1983-1991 [8)] 1987-1991

ask whether perhaps the trends differ because of the kind of data upon which they are based.

This may be illustrated by data from Hamburg, Helsinki and Oslo where data concerning both offences and offenders are given. And as Table 3 shows, the trends differ considerably according to what kind of data one uses.

If one calculates the rise from 1981 to 1991 on the basis of offences in Hamburg, the result is 227 percent, while the rise calculated on the basis of offenders is 102 percent. In Helsinki the rise is 101 percent based on offences, but only 30 percent based on offenders. In Oslo the situation is the opposite, with a rise of 93 percent based on offences and 180 percent based

Table 3: Changes in "police arrests" for drug offences and drug offenders, respectively, in Hamburg, Helsinki and Oslo (Source: Hartnoll 1994 Table 10)

	Percentage change in persons arrested	Percentage change in arrests
Hamburg	102	227
Helsinki	30	101
Oslo	180	93

on offenders. If one compares the trend as regards offenders in Hamburg and offences in Helsinki, one will therefore find exactly the same development - a doubling in the numbers from 1981 to 1991 (1990 in Helsinki). If one does the comparison the other way round - comparing the trend regarding offences in Hamburg and offenders in Helsinki - one will get a totally different result: in that case, the increase in Hamburg is nearly eight times as high as in Helsinki.

But how do the trends as regards "drug arrests" compare with the trends in "drug-related deaths", as shown in Table 2? Not surprisingly the covariation is rather small. Geneva - which has the strongest increase in drug arrests - is one of the cities with the smallest increase in drug-related deaths. The same apply to Copenhagen. Conversely - Paris which has the smallest increase in arrests - has a strong increase in deaths.

Despite the fact that the data collected through the Multi-City Study is better than in most other international studies, they give a good illustration of the problems involved in making comparisons between countries.

2. Nordic criminal statistics

The possibility of doing international comparisons based on criminal statistics - as well as on any other statistical sources - is probably better the more similar culturally and otherwise the countries in question are. From this perspective the Nordic countries stand out as ideal: they have a close historical fellowship, languages akin to each other, and strong political, social, religious and cultural bonds.

2.1 The legal framework

As regards the definition of narcotic drugs it is more or less the same in the four Nordic countries (Denmark, Finland, Norway and Sweden). According to legislation, all drugs covered by the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Drugs (with later amendments) are regarded in a legal sense as narcotic drugs (or "euphoriant" drugs, which is the term used in Denmark). This means that besides "traditional" narcotic drugs (like cannabis, opiates and cocaine), also drugs like barbiturates, benzodiazepines and amphetamines are classified as narcotic drugs. There are however small differences between the countries in the sense that pharmaceutical products containing small quantities of drugs may be classified as narcotic drugs in one country but not in another. Each country may also decide that drugs other than those covered by the conventions may be regarded as narcotic. On this basis, Norway and Sweden have recently classified khat as a narcotic drug, while this is not the case in Denmark and Finland. The differences between the countries as regards the definition of narcotic drugs are, however, negligible and without any practical consequences.

The four countries are also very similar with regard to their definition of which acts constitutes a drug offence. The legal provisions in all countries states that all kinds of unauthorized handling of drugs classified as narcotic are punishable, be it production, import, export, obtaining, possessing, safekeeping or handing over to others. However, the unauthorized use of drugs is not prohibited in Denmark, as opposed to the other three countries.

One area where the countries differ from each other - or rather, where Norway differs from the other countries - is as regards the punishments stipulated. While the maximum punishment for a drug crime in Norway is 21 years imprisonment, in the other three countries it is 10 years. In these countries the punishment may however be set somewhat higher if the offender is sentenced for more than one drug offence.

The criminal proceedings in all four countries are more or less similar. When the police investigation is concluded the case is sent to the prosecuting authority. The prosecutor may (except in Finland) impose a fine if the offender consents to this, or decide that the prosecution be waived on the condition that the offender does not commit any offence during a stipulated future period. Or - as is the case as regards more serious offences, and with all drug cases in Finland - the prosecutor may send the case to the courts. If

the person is found guilty in court he or she may be fined or given a prison sentence, which may be conditional or unconditional. In Sweden, instead of being given a conditional prison sentence, the person may be sentenced to supervision by the probation service.

2.2 Production and presentation of criminal statistics

Data from the different stages in the criminal justice system as regards drugs are collected and presented by different bodies. The most reliable data are collected by the Statistical Bureaus and presented in the annual criminal statistics. By law the criminal justice system is required to give the information needed to the bureaus, and as professional producers of statistics the bureaus follows strict procedures in defining the categories used and validating the data collected. But the data presented in the criminal statistics may of course suffer from any flaws in the original data supplied by the police or other bodies.

The police and other bodies within the criminal justice system also produce data themselves. When these data concern the same areas as those covered by the statistical bureaus, one will often find discrepancies. An example: in Norway the number of homicides known to the police in 1990-1992 was according to the criminal statistics 47, 50 and 46, respectively, while the central police in their annual statistics reported 41, 51 and 40. However, the police and other criminal justice bodies also produce data which are not included in the criminal statistics. In some cases one therefore has to rely on these data, even though information on how they are defined and collected may often be imperfect.

Table 4 presents some of the drug data available from the criminal justice system in the Nordic countries and the sources for those data. Some of the data stemming from sources other than the Statistical Bureaus may be based on estimates (e.g. the number of drug abusers in prison), and the time series available may only cover a short period (e.g illegal drug prices). It would be possible to find some of the missing data by using existing data from the Statistical Bureaus (e.g. the number of drug offenders in prison), but that would cost time and money. The table is in no way complete: to complete it would entail the detailed examination of all statistical material presented by the different bodies.

The official criminal statistics, which by far is the most important source of information, present a lot of data concerning drug offences and drug offenders from different stages in the criminal justice process - from the offence becoming known to the police till the sanction is decided. However, each country has to a certain extent its own traditions regarding which data is collected and how these data are treated and presented. A result of this is that it is difficult to find corresponding data covering all four countries. This is illustrated in Table 5 which maps some of the major kinds of data one finds in the criminal statistics in the different Nordic countries.

The result is disquieting. Only as regards the number of offences known to the police, offences cleared up, and suspected persons in cases cleared up are there data selected at the same stage in the criminal justice process where the unit counted is the same in all four countries (in Norway, however, only from 1990 as regards offences known to the police, and in Denmark only until 1990 as regards suspected persons in cases cleared up).

Table 4: Some statistical information available concerning the criminal justice system in relation to drugs in the Nordic countries

	Denmark	Finland	Norway	Sweden
Central statistical bureaus:				
Criminal statistics	Yes	Yes	Yes	Yes
Police administration:				
Drugs confiscated	Yes	Yes	Yes	Yes
Illegal drug prices	Yes	Yes	Yes	No
Prison administration:				
Drug offenders in prison	No	Yes	No	No
Drug abusers in prison	Yes	No	No	Yes
Drug abusers admitted in prison	No	No	No	Yes

Table 5: Information given in the criminal statistics regarding drug offences and drug offenders in Denmark, Finland, Norway and Sweden

	Denmark	Finland	Norway	Sweden
Offences known to the police	Yes	Yes	From 1990	Yes
Offences cleared up[1)]	Yes	Yes	Yes	Yes
Cases in offences cleared up[2)]	Until 1990	Yes	Yes	No
Suspected persons in cases cleared up[2)]	Until 1990	Yes	Yes	Yes
Penal sanctions imposed	Yes	No	Yes	No
Persons sanctioned[1)]	Yes	Yes	No	Yes
Unconditional prison sentences	Yes	No	Yes	No
Persons given unconditional prison sentences[1)]	Yes	Yes	No	Yes

Notes: 1) In Sweden data concerning drug offences against the act regarding punishment for smuggling of goods is not included. In the statistics all smuggling offences regardless of the kind of goods involved are put together.

2) In Norway all cases and all persons suspected are counted, regardless of whether punishment can be applied or not due to lack of criminal responsibility, etc., while in the other countries only cases/persons which/who can be punished are included.

2.3 *Drug offences known to the police*

Since the number of drug offences known to the police is one of the very few types of data which can be compared across the four countries, let us have a closer look at them. Table 6 gives the number and the rate per 1000 inhabitants in the period 1985-1992.

Table 6: The number of drug offences known to the police in the Nordic countries and the rate per 1000 inhabitants 1985-1992

	Denmark		Finland		Norway		Sweden	
	total	rate	total	rate	total	rate	total	rate
1985	7 918	1.5	2 323	0.5			37 568	4.5
1986	8 829	1.7	1 973	0.4			39 536	4.7
1987	10 594	2.1	2 221	0.5			43 725	5.2
1988	12 985	2.5	1 914	0.4			30 647	3.6
1989	14 161	2.8	1 889	0.4			35 163	4.1
1990	13 925	2.7	2 546	0.5	11 176	2.6	28 015	3.2
1991	17 294	3.3	2 491	0.5	13 063	3.1	32 114	3.7
1992	17 863	3.5	3 336	0.7	14 020	3.3	30 729	3.5

The most surprising result is the great similarity between the countries - with the exception of Finland - in the number of drug offences per capita known to the police. This is a fairly recent phenomenon, however. The development from 1985 until 1992 seems to indicate a trend towards a common level: while the rate in Denmark (which was at the low end in 1985) has risen, in Sweden (which had the highest rate in 1985) it has fallen.

How should this be interpreted? If one takes the number of drug offences known to the police as an indicator of the drug situation, one may conclude that the differences between the countries - with the exception of Finland - gradually has diminished over the few last years, and the drug problems seem to be at the same level. In Finland, on the other hand, the drug problem is considerably smaller than in the other three countries.

As regards Finland this is in accordance with common belief, which maintains that the drug problem in Finland is much smaller than in the other Nordic countries. On the other hand, common belief holds that the drug problem is more widespread in Denmark than in Norway and Sweden, contrary to what the data seem to indicate. One explanation for this discrepancy between data and common belief could be that since use of drugs is not criminalized in Denmark, the number of offences known by the police would have been considerably higher than in Norway and Sweden if use had been included.

If one looks at the trends revealed by the data, one may draw the conclusion that the drug problem has been on the increase in Denmark - and to a

certain extent in Norway - while it has diminished in Sweden. This conclusion, however, presupposes that the priority, manpower and efficiency of the police in relation to drug offences has been the same throughout the period concerned. This, however, cannot be ascertained on the basis of the information available.

2.4 The severity of punishments

Drug criminality ranges from very minor offences - such as the use and possession of drugs for personal use, if this is criminalized at all - to serious crimes, such as the professional dealing in drugs involving million of dollars. It is reason to believe that the seriousness of the drug criminality varies from country to country: in some, production and professional dealing in drugs may flourish, while in others there is no domestic production or professional dealing of drugs, and the drugs are taken into the country by small-scale, amateur dealers.

The Nordic criminal statistics do not as a rule give information as to the kind of drug crime committed. The Danish and Swedish statistics are an exception in that in some tables sale and smuggling (Denmark) or production, sales and possession (Sweden) is specified, but in most cases the different drug offences are put together in one and the same category, which is the case in Finland and Norway. And even when sales, as an example, is specified, sales may range from a few grammes of cannabis to large quantities of heroin, and does therefore not say much about the seriousness of the crime.

One may however argue that the seriousness of drug crimes may be seen from the punishments imposed. By comparing the punishments imposed, one might be able to say something about the seriousness of drug criminality in different countries. One may of course argue that the level of punishment says more about the degree of repressiveness in the criminal justice system in the respective country than anything else. However, by comparing countries which, like the Nordic countries, are fairly similar, one may maintain that the punishments imposed may be used as a measure of the seriousness of the crimes.

One may therefore ask whether there are differences between the Nordic countries as to the punishments imposed for drug offences. Trying to answer this question, however, illustrates once more the problems involved in utilizing criminal statistics for comparative purposes. First, the Norwegian

statistics do not give the number of offenders sanctioned or sentenced - the units used in the other countries - but instead the number of sanctions and sentences. Comparing Norway with the other three countries is therefore difficult. Sanctions and sentences will however correspond rather closely to the number of offenders sanctioned or sentenced, because few offenders will be sanctioned or sentenced more than once in a year.

A second problem is more severe. In the criminal statistics the length of the prison sentences is classified differently from country to country, as illustrated in Table 7. If one wants to identify groups who get the same punishment in the different Nordic countries, it is impossible to find the same dividing line. The only group of sentences common for Denmark, Finland and Sweden is prison sentences of over 2 years. However, is not possible to separate this group in the Norwegian statistics. In addition, the Norwegian classification was changed in 1987 from 1-3 years and over 3 years, which makes comparisons with data before 1987 even more difficult.

Table 7: Classification of the length of longer prison sentences in the criminal statistics in the Nordic countries. Years of imprisonment

Denmark	Finland	Norway	Sweden
over 2-3	2	1-under 3	over 1-2
over 3-5	over 2-4	3-under 5	over 2-4
over 5-8	over 4-under 8	5-under 7	over 4
over 8-12	8 and more	7-under 9	life
over 12	life	9-under 11	
life		11-under 13	
		13-under 15	
		15-24	

A third problem lies in the Swedish statistics. Sentences for offences against the Act on Smuggling is not given separately for drugs, but included in the total number of offences against the Act.

Finally there is a general problem. Offenders who are sanctioned for more than one offence in the same sentence are classified in the criminal statistics according to the offence carrying the heaviest punishment. This means that some minor drug offenders who are sanctioned for the use or possession of small quantities of drugs as well as other offences are not

classified as drug offenders, since the penalty carried by the law for possession or use is small. With regard to more serious drug offences, this is usually no problem because the maximum penalty in these cases is fairly high. But also here one is faced with the problem that the punishment imposed in these combined cases covers not only the drug offence, but also other offences.

With these reservations, Table 8 shows the percentage of offenders sanctioned for drug offences who were sentenced to an unconditional prison sentence and to an unconditional prison sentence of more than two years, respectively, for a drug offence in the Nordic countries.

Table 8: The percentage of drug offenders given an unconditional prison sentence, and the percentage given an unconditional prison sentence of over 2 years in Denmark, Finland and Sweden, and 3 years and more in Norway 1985-1992

	Denmark		Finland		Norway		Sweden	
	Uncond	Over 2 years	Uncond	Over 2 years	Uncond	3 years and more	Uncond	Over 2 years
1985	11.9	2.0	13.5	1.6			27.2	4.5
1986	11.4	1.6	12.7	1.1			28.8	3.1
1987	11.1	1.8	15.1	2.2	31.5	4.0	33.7	4.2
1988	12.3	1.9	16.3	2.1	28.9	4.2	33.9	4.8
1989	11.8	2.0	19.4	4.8	28.4	4.2		
1990	11.6	1.1	19.7	4.9	26.1	2.5	29.3	4.1
1991	9.5	1.5			25.3	3.4	29.4	5.3
1992	9.3	1.1			23.9	2.9	29.0	5.3

Note: Only offences against the penal drug law are included in Sweden, since data regarding offences against the act on smuggling is not given for drugs specifically.

If we compare the three countries which should be more or less directly comparable (Denmark, Finland and Sweden), we find obvious differences. In Denmark the rate of imprisonment for drug offences is considerably lower than in Finland, and even lower than in Sweden. These differences are probably even more pronounced than in the table. This is because, first, the use of drugs is not an offence in Denmark and seldom or never leads to a unconditional prison sentence. If use had been criminalized in Denmark as in the other Nordic countries, this would have raised the total number of drug offenders sanctioned, which in turn would have lowered the per-

centage of offenders sentenced to an unconditional prison sentence. Secondly, smuggling offences, which often carry a severe sentence, are not included in Sweden. Had those sentenced for smuggling drugs been included in Sweden, this would probably have raised the percentage of unconditional prison sentences.

Table 8 shows not only that fewer drug offenders are given an unconditional prison sentence in Denmark than in Finland and Sweden, but also that in Denmark longer sentences are less often imposed than in the other two countries. As regards the relation between Finland and Sweden, there existed clear differences between them in the 1980s, in that both unconditional sentences and long prison sentences were more often used in Sweden than in Finland. Since 1989 the use of long prison sentences in Finland has risen to almost the same level as in Sweden.

As mentioned above, the data from these countries cannot be compared directly with the Norwegian data, partly because the Norwegian data is based on sanctions and sentences, not on persons sanctioned and sentenced. However, there is reason to believe that this does not have any significant influence. One may therefore conclude that the Norwegian rate of imprisonment for drug offences is fairly close to the rate in Sweden. The use of longer prison sentences is more difficult to compare since the Norwegian data does not include the group of drug offenders who get unconditional prison sentences for periods of between over 2 and under 3 years. It is impossible to say how big this group is, but it is likely to be fairly substantial. If we take this into consideration, we may conclude that also the use of more severe penalties in Norway is nearly on the level with Sweden - and Finland.

With regard to the change over time, it seems that the use of unconditional imprisonment for drug offenders and the use of long sentences has gone down a little in both Denmark and Norway, while it has increased in Finland and been fairly stable in Sweden. The use of longer prison sentences seems to have gone slightly down in Denmark and Norway, while the tendency in Sweden and especially Finland has been increased use.

If we use these data as indicators of the seriousness of the drug problems in the four countries - although a comparison, for technical reasons, is difficult - the conclusion would be that drug criminality is less serious in Denmark than in the other three Nordic countries, and a little less serious in Finland than in Norway and Sweden. In regard to the development over time, especially in Denmark but also in Norway the drug criminality gradu-

ally has become less serious, while in Finland and especially in Sweden the development has been the opposite.

It is, however, easy to find objections to interpreting the data in this way. One may maintain that the punishments imposed do not mirror the seriousness of the offences being committed, but rather the sentencing practice of the courts. That Denmark has a low level of drug offenders sentenced to an unconditional prison sentence is due to drug offences being regarded as less serious by the courts than the courts in the other countries. The fact that the use of such sentences has decreased in Denmark and increased in Sweden is due to changes in the attitudes of the criminal justice system towards drug offences: in Denmark in a more liberal and in Sweden in a more repressive direction.

3. Nordic death statistics

The official statistics from the statistical bureaus in the Nordic countries give little information as regards drugs as a health and social problem. The only exception is the statistics of causes of death which gives the number of deaths due to drugs. In diagnosing the cause of death, the International Statistical Classification (ICD) is used. Finnish statistics, however, do not give detailed enough information (at least not for a non Finish-speaking reader) of the different death diagnosis in relation to the ICD classification. Finland is therefore omitted in Table 9, which gives the absolute figures and rate per 100 000 inhabitants of deaths with drug addiction as the underlying cause.

Table 9: The number of deaths with drug addiction as the underlying cause (ICD 304) and the rate per 100 000 inhabitants in Denmark, Norway and Sweden 1986-1992

	Denmark		Norway		Sweden	
	total	rate	total	rate	total	rate
1986	4	0.8	44	10.6		
1987	5	1.0	43	10.3	71	8.5
1988	10	1.9	48	11.4	56	6.4
1989	7	1.4	45	10.6	57	6.7
1990	9	1.8	70	16.5	64	7.5
1991	6	1.2	88	20.6	62	7.2
1992	15	2.9	104	24.3	67	7.7

Table 9 shows that the similarities between the countries which was found in Table 7 in regard to drug offences known to the police have vanished. Instead the differences between the countries - especially between Denmark and Norway - are extremely large. According to statistics, about ten times as many persons die from drug addiction in Norway as in Denmark, while Sweden lies in between these two with more than three times as many deaths as in Denmark, but three times fewer than in Norway. In regard to the development over time, in 1990 Norway experienced a drastic increase in deaths due to drug addiction, while the situation remained stable in Denmark and Sweden.

It is fairly obvious that at least some of the differences between the countries must be explained by the diagnostic practice followed in the different countries, and cannot be due to factual differences in the number of drug-related deaths. Most deaths diagnosed as caused by drug addiction in Norway must have been given another diagnosis in Denmark, and it seems that also in Sweden the diagnostic practice must be different from the two other countries.

Table 10: Drug-related causes of death 1992 in Denmark, Norway and Sweden

	Denmark	Norway	Sweden
304: Drug addiction	15	104	67
Poisoning due to:			
E850: Analgesics, etc.	101	3	14
E852: Other sedatives	3	1	0
E853: Nevroleptica, etc.	0	3	5
E854: Psychoanaleptica	0	2	6
E855: Other psychoactive drugs	7	1	5
E858: Other drugs	25	1	7
Subtotal	171	115	104
E950: Suicide by substances	285	109	306
E980: Poisoning by substances	105	22	251
Total	541	246	661
Rate per 100 000 inhabitants:			
Drugs	33.0	26.8	12.0
Drugs and substances	104.6	57.4	76.3

One way to try to solve this problem might be to include other drug-related kinds of diagnosis. The ICD system also opens up the possibility of diagnosing poisoning by or suicides using drugs as causes of death. Table 10 shows some of the different kinds of diagnosis which may be more or less drug-related, and how they were used in 1992 in the different countries.

Table 10 gives a picture totally different from that in Table 9. If the definition of drug-related deaths is broadened to include deaths due to poisoning by drugs as well as deaths due to drug addiction, the rate of deaths per 100 000 inhabitants comes to 33 in Denmark, 26.8 in Norway and 12 in Sweden. If deaths due to suicides and poisoning by "substances" - which also includes drugs - the picture changes once again. Denmark is still at the top, however, with a rate of 104.6 per 100 000 inhabitants, while Norway with 57.4 and Sweden with 76.3 change places.

But there are other sources which give data regarding drug-related deaths. In Denmark and Norway the police collect information regarding drug-related deaths which they present in their annual reports. The number of deaths from 1985 and onwards is shown in Table 11.

Table 11: Drug-related deaths reported by the police in Denmark and Norway in 1985-1991, total and per 100 000 inhabitants

	Denmark		Norway	
	Total	Rate	Total	Rate
1985	150	2.9	53	1.3
1986	109	2.1	55	1.3
1987	140	2.7	60	1.4
1988	135	2.7	63	1.5
1989	135	2.4	64	1.5
1990	115	2.2	75	1.8
1991	188	3.6	96	2.3

The Danish statistics are collected by the local police. Autopsies are carried out in all cases of death believed to be related to the misuse of drugs, and such deaths are reported to the central police authority as a drug death if the death was found to be due to:

"a) use/abuse of drugs classified as euphoriant,

b) intake of other drugs, if the deceased was known as a user/abuser of euphoriant drugs,

c) intake of other drugs (not alcohol) if the intake may be due to a wish to be intoxicated (e.g. glue, thinner etc),

d) manslaughter or homicide where the perpetrator is intoxicated by euphoriant drugs."

Although the definition of a drug-related death - which in the Danish police data includes also suicides among abusers by intake of substances other than drugs and deaths committed by drug abusers - is slightly different from the one used in Table 10, the subtotal in Table 10 is fairly close to the police figures. However, since Table 11 does not give data for 1992 the numbers cannot be compared directly.

How a drug-related death is defined in Norway is more uncertain, and the same applies to how the police collect their information. The number of deaths reported by the police, however, corresponds fairly well with the number of deaths due to drug addiction in Table 9, although the police data is somewhat higher.

4. Concluding remarks

What conclusions - if any - may be drawn from the foregoing? Some may come to the conclusion that official statistics are useless in comparative research. But in my opinion one need not draw such a negative conclusion. Comparisons using official statistical data can make sense. But two preconditions must be present, as mentioned at the outset: one must compare comparable data, and one must not draw conclusions over and above what the data actually reveals.

How then does one arrive at comparable data? Using data from official statistics presupposes knowledge about how the data are collected, processed and presented, and - not least - what they are about. Drug offences and drug offenders are different entities, and persons suspected of drug offences are not the same as persons arrested for drug offences, and both differ from persons charged for drug offences. The same is true as regards other kinds of data concerning drug use and drug users, and the consequences of drug use. For example, as regards drug deaths the diagnostic practice may differ from country to country, which make comparisons difficult or impossible, even if one may be able to find comparable data by analyzing the statistics and regrouping the diagnoses.

Before one can start to compare data from different countries, one must therefore make sure that the data measure one and the same thing. This however requires intimate knowledge of both the statistics and the system from which the data are collected. For this reason comparative research is seldom a one-man job; instead, it is a joint project between experts from all the countries involved.

Comparative, cross-cultural research based on official statistics is often hampered by the fact that although comparative data do exist, they are not easily available. Official statistical publications contain only a small selection of the data collected, and those which are published are often presented in a way that makes comparisons with official statistics from other countries problematic. The data presented in Table 9 may serve as an example. For Norway, data regarding the number of offenders sanctioned is not given in the criminal statistics and the length of the prison sentences is grouped differently than in the other countries. This, however, does not mean that such data is not available. The files in the Statistical Bureau contain the information needed, but it is not processed or published. The same is true in regard to many of the missing data from one or more countries shown in Table 5.

Often, therefore, the problem with finding comparative data is not that the data do not exist, but the selection of data and the way in which they are grouped in the statistical publications. The ideal would be that the statistics were presented in a uniform way in all countries. But this will probably never be realized. Even in the Nordic countries, where the statistical bureaus cooperate fairly closely, there are great differences between each country's statistical publications. And in other European countries, the differences are even greater, and a uniform presentation is even more difficult to reach.

There is, however, another possibility. By utilizing the files of the statistical bureaus one will be able to construct new categories and get at data not published in the statistics, which may be used in cross-cultural comparisons. This may be costly and laborious, but if international comparisons are seen as important, then time and money should be spent on reproducing the data needed.

However, the second and most important question still remains unanswered: are such data of any use? The usual answer is that they can be used as indicators of drug use and drug problems in the different countries. This may be true, but it is just as likely that it is not. The statistics on drugs are

first and foremost administrative statistics which tell us something about the systems from which they are obtained. Criminal statistics tell us about the activities carried out by the different agencies involved in the criminal justice system - the police, the prosecution authorities, the courts and the prison system. If the number of persons arrested for drug offences changes, the reason may be increasing drug use and drug problems. But at best this is only one of a multitude of factors that plays a role. Changes inside the system - such as changes in the manpower or resources allocated to the police - or in the way policing is carried out - e.g. in relation to disturbing groups of street users - will influence the number of arrests. Changes outside the system - such as changes to the treatment system or the general policy towards drugs - will also play a role.

The same goes for the other kinds of data regarding drug use and drug problems. The number of drug addicts in treatment tells us first and foremost about the workload within the treatment system. An increase in the number of addicts in treatment may be due to an increasing drug problem, but it is just as likely that it is a sign of increasing resources within the treatment system. Changes in drug-related deaths may be due to factors such as a change in the purity of drugs on the street, changes in the paramedical system aimed at treating overdoses, or changes in the age composition of the drug-using population.

Information on how a system functions may, however, in itself be of interest. Looking at Table 6, which shows that the rate of drug offences becoming known to the police (at least as regards Denmark, Norway and Sweden) has moved towards a common level, one may think that the drug policy in the three countries (at least on the police level) are getting closer to each other. Table 8 - which shows the differences between the countries in regard to their use of unconditional prison sentences and long sentences - may be interpreted as a measure of the degree of repressiveness of the drug policy as practised by the courts. The increase in drug-related deaths in Norway may say something about the deteriorating social situation of the users.

Even if the data on drug use and drug problems are of little use as indicators of the drug situation, they may be of value as indicators of the drug-control system. By comparing data concerning drug offenders known to the police, the sentencing practice in drug cases and the drug offenders in prison one is able to get an understanding of the role and the priority given to the criminal justice system in the respective countries. By comparing

data concerning addicts in inpatient and outpatient treatment one will be able to assess the weight given to treatment. In themselves these data may be of limited interest: their importance lies first and foremost in that they are necessary for understanding the social system surrounding drugs.

European Drug Policies: The Need for Historical Policy Perspectives

VIRGINIA BERRIDGE

Introduction

I come to this subject from a dual angle, as an historian of British drug policy, and as an analyst of contemporary and almost contemporary policy, in particular in relation to Britain through the work of the AIDS Social History Programme and through previous work for the Drug Addiction Research Initiative and Who-Euro's European research initiative.[1,2,3]

Two recent papers in *European Addiction Research* set the framework. Karl-Heinz Reuband's cross national perspective on epidemiological findings made the important point that the prevalence of both cannabis and 'hard drug' use bore little relationship to type of policy in operation in the particular country, despite the widespread belief that there was such a relationship.[4] However, Reuband did not take his remarks forward to one logical conclusion; that is, that we need to understand how and why those policies were put in place and have changed over time. Also in the first issue of the new journal, Richard Hartnoll's survey of European drug research noted that although research has become increasingly policy led, there were rela-

[1] Berridge, V., AIDS in the U.K.: The Making of Policy, 1981-1994. Oxford: Oxford University Press, 1996.

[2] Berridge, V., Drugs Research and Policy in Britain: A Review of the 1980s. Aldershot: Avebury, 1990.

[3] Berridge, V., Drug research in Europe. London: ISDD, 1989.

[4] Reuband K.H., Drug use and Drug Policy in Western Europe, Eur. Addict. Res. 1995; 1:32-41.

tively few policy studies; some of the more interesting contributions, he thought, had come from historians.[5]

These comments are the starting point of this paper. It aims to make the case for what I term 'historical policy analysis'. I should first explain what I mean by these terms. By policy analysis, I mean more than a survey of the legal frameworks surrounding drug control. Policy for the health area has been described as

> '... courses of action that affect the set of institutions, organisations, services, and funding arrangements of the health care system. It goes beyond health services, however, and includes actions and intended actions by public, private, and voluntary organisations that have an impact on health.'[6]

For drugs, of course, we would also have to include the criminal justice system in this matrix. But this type of analysis is a dynamic process, looking at the interaction of such interests both currently and over time.

This brings me naturally to history. Historical perspectives and the understanding of processes and of changes and continuities over time are central to policy analysis. We cannot understand how we have developed the policies we have if we operate without a look back to where we have come from. History in this paper is used in two senses: historical perspectives from what has been called the 'deeper past'; and the 'contemporary history' of more recent policy developments. The study proposal makes recommendations for work in both these areas.

I will cover the following areas:

Part I: 1. Contrasting national policies; the 'contemporary history of policy'
2. Historical legacies from the deeper past

Part II: Research questions and a research agenda

[5] Hartnoll, R., Research on illicit drugs in Western Europe: an overview. Eur Addict Res 1995, 1:3-11.

[6] Walt, G., Health Policy. An Introduction to Process and Power. London: Zed Books, 1994.

Part I:

1. Contrasting national policies

Enormous effort has been expended at a European level in recent years to try to arrive at agreed figures on an agreed harmonised basis. The Pompidou Group's multi-city study has been working away at the problem for many years; and the new European Observatory on Drugs has as a primary focus the harmonisation of monitoring systems. As an historian, I find this immense focus on surveillance and epidemiology an interesting phenomenon, and it is a point to which I will return. Suffice it to say at this stage, that there is a strong descriptive and epidemiological focus to current research. Policy makers want numbers, however fragile and imperfect those might be.

Within this desire for harmonisation at the epidemiological level lie significant national differences. The culture of control, the balance of control, the personnel involved and the public face of control can vary significantly from one country to the next. There can also, as I will argue, be differences between that public face of control and what is actually going on on the ground. But there is very little comparative analysis available on drug problems and policies.[7,8] There are significant national differences and different interpretations of the general framework of international law. The variations represent divergent perceptions of drug problems as well as different historical experiences in dealing with drug addiction.

A number of potential research issues can be considered here:

1.1 Recent policy histories

Within Europe, the Netherlands is most strongly publicly identified with tolerant drug policies, although Spain has laws which are more explicitly tolerant. Italy has also veered between tolerant and less tolerant approaches since the 1970s. At the other end of the policy spectrum lie most of the

[7] Albrecht, H.J., Kalmthout, A. van, eds., Drug Policies in Western Europe. Freiburg: Max Planck Institute, 1989.

[8] Reuter P., Falco M., MacCoun R., Comparing Western European and North American Drug Policies. An International Conference Report. Santa Monica: Rand Corporation, 1993.

Northern European nations. France, Germany and the Scandinavian countries are closer to the American prohibitionist model. Britain falls somewhere in the middle, with a public policy which has veered since the early 80s and the return of the Conservative government between an overt 'war on drugs' stance and, post-Aids, an overt 'harm reduction' one. There are blurred boundaries between the two, as I will indicate below.

Let us look at these countries in more detail. In Italy, until 1990, the possession of moderate amounts of drugs for personal use was not a punishable offence. Then the Socialist Premier of the day, Bettino Craxi, started an anti-drug crusade. In 1990, the law was changed to make possession punishable by penal sanctions if the amount of the drug exceeded the average daily dose established in the law. Below this level, administrative sanctions were applied, although the user could agree to rehabilitation. The prison system became overburdened, with no evidence that the drug problem was lessening. So in 1993 a referendum gave majority support for making possession of drugs in whatever quantities for personal use subject only to administrative penalties. As before, these would be waived if the user agreed to rehabilitation.

In Spain also, since the end of the Franco era, attitudes have been tolerant: fines have been the main sanction against possession. Opinion polls have recently shown a move to favour tighter controls. Some cities have introduced a ban on drug consumption in public and there are plans in Madrid for steep increases in fines. Public attitudes in both countries may have been shaped by the fact that the great majority of users live with their families - drug users have tended not to be viewed as a criminalised underclass, although these views may be changing.

Moving to the opposite pole, the general Scandinavian situation has a focus on repression. The Danish criminologist, Jurgen Jepsen, in a paper he prepared for the Florence seminar on European drug policy strategies, commented on the particularly repressive nature of the Swedish tradition. The use of drugs was criminalised in 1992, and the Swedish police force has chased drug users with a vigour as great as any American police force. The whole atmosphere is characterised by heavy moralistic overtones, and supported also by research - the psychiatrist Nils Bejerot for many years presented findings which indicated that repressive action led to decreased use of drugs. There is also an extensive social service and treatment system, with some use of compulsory treatment. It used to be said that all the other Scandinavian countries, with the exception of Denmark, followed this

line, which is, of course, all of a piece with traditional policies of alcohol control as well. Recently, however, Denmark too appears to have fallen into line with a higher police presence in the drugs field.[9]

What of the two highest profile European nations in the drugs arena? Take the Netherlands first. In Holland, the 1976 Opium Act tripled the penalties for dealing, but an administrative framework was established which allowed the de facto legalisation of possession. For cannabis only, the drug was allowed to be sold from designated premises. In the early 1980s, the Dutch turned to a methadone rather than a heroin maintenance system; there has also been a small morphine maintenance experiment. Hence all those television documentaries in the mid to late 80s which seemed to move automatically from the Amsterdam methadone bus onto interviews with the 'Liverpool mafia' in the UK. Two points can be made; one that the 'image' of Netherlands policy was always perhaps more liberal than the reality. Eddy Engelsman, responsible for drug policy in the Ministry of Health, maintained a high profile at the European level, and the image was buttressed by researchers working for the Ministry. The Ministry of Justice, both in public and in research terms, was much more low profile. In practical terms, however, the Dutch have gone in for tougher sentencing in relation to dealing rather than possession. Pressure to change policy has come from internal changes (Engelsman's departure left a vacuum on the health side); from neighbouring countries, Germany in particular, and from France, which refused to ratify the Schengen Convention because of concerns about the Netherlands and 'drug tourism'. It seems unlikely that the Dutch will reverse their policies, but there may be a licensing system and possibly the limitation of sales to Dutch nationals to stem the influx of drug users across the borders.

Finally Britain, where the key feature since the late nineteenth century has been policy determined by the medical profession. I will return to this point when I discuss historical legacies. Suffice it to say that even in the 1980s, at the height of the overt 'war on drugs' policy promulgated by Conservative politicians, Britain also had an 'in house' health policy. It never made the headlines, no TV documentaries were made about it. Its general aim was to replace policies of abstinence introduced by the London clinic psychiatrists and to broaden the range of services and bring them into the

[9] Jepsen, J., Implementation of national drugs legislation. EUI colloquium papers. European Scientific seminar on strategies and policies to combat drugs. European University Institute, Florence, 1993.

community. The concept of the minimisation of harm from drug use rather than outright abstention was part of this emergent health package.

This very brief and imperfect survey of some recent and current policies in some European countries is intended to make a particular point about research directions. We have much policy focused research, but we have little research which looks at the general tendencies in recent policy in a dynamic sense. We need interviews with policy makers, access to government manuscript documentation, focusing on constructing the real cut and thrust of policy making rather than the bland end-products.

1.2 The impact of Aids

Another area ripe for policy analysis is the impact of Aids. In a belt of Southern Europe covering Spain, S. France and Italy and in some countries of Eastern Europe including Poland, the 'flash point' would seem to have occurred among drug users. This is also true of individual cities, such as Edinburgh in the UK. Once HIV is introduced into a drug using population, it can spread with great rapidity. In Edinburgh, where HIV among drug users was first detected in 1983, prevalence was 51% by 1985. There is no satisfactory explanation of the north-south divide on this issue in Europe, but the variation in HIV prevalence may be related to the difference in time of the original introduction of HIV to individual countries. As Mildred Blaxter has noted in her recent survey of worldwide Aids policies, high rates of infection among drug users can lead to high rates in prisons and a rapid increase in heterosexually transmitted cases of Aids. A high prevalence of infection can lead quickly to second-generation heterosexual transmission, that is to infection among those with no direct overlap with high risk groups. In Europe, as in the US, it also leads to increasing prevalence in disadvantaged groups or areas.[10]

Aids has led to the promotion of harm reduction techniques among drug users. The most public expression of this policy approach has been via syringe exchange. The UK, the Netherlands and Switzerland have active needle exchange programmes as an attempt to limit the spread of HIV. Italy had availability of injecting equipment through shops and pharmacies throughout the 1980s, but HIV has nevertheless spread among addicts injecting themselves. Germany, France and Belgium have relied more on the

[10] Blaxter, M., AIDS: Worldwide Policies and Problems. London: OHE, 1991.

promotion of syringe cleaning techniques but also have retail outlets. The advent of HIV and high rates of HIV in some European prisons has also led to pressure for a radical overhaul of the role of imprisonment as a response to illicit drug use. It has been estimated that 30% of the European prison population has a drug problem.

Individual countries have obviously adopted or modified their existing policies in response to HIV and its perceived threat. In Germany, for example, 'treatment' as opposed to abstinence has come higher on the agenda and methadone maintenance is now a possibility. In Britain, several commentators have seen the overthrow of the 'war on drugs' stance and its replacement by harm reduction after the 1988 ACMD report. I would see it as more complex than that. Aids, like war, presented a golden opportunity for the revisionist health lobby round drugs to seize the initiative and to advance pre-existing policy objectives of harm minimisation. These had in fact formed the basis of drug policy in various forms since the 1920s. Nor is there any certainty that those objectives will remain unambiguously as the basis of policy. Already with the publication of a new government strategy on drugs, there is talk of backtracking on harm minimisation.[11] The change wrought by war, as we historians have analysed, is often differently interpreted in a perceived peacetime situation.[12] Undoubtedly similar policy agendas have prevailed in other European countries. But again, there has been little of a dynamic policy analysis input here, and the epidemiological tradition of research has remained strong.

1.3 Eastern Europe

So far I have focused to a great extent on Western Europe, but the rapid changes occurring in eastern Europe and the former Soviet Union are also affecting the nature of European drug problems and policies. Illicit drug production has expanded substantially in the newly independent Kazakhstan and there is much talk of drug trafficking emerging as a means of livelihood for displaced former Soviet security and armed forces. Certainly there have been changes to the 'Balkan route'. This was a multitude of overland paths from Afghanistan and Pakistan through Iran and Turkey.

[11] New drug strategies for England and Scotland. (News report). Druglink 1994: 9(6);6-7.

[12] Berridge, V., Aids and British drug policy: continuity or change?: In Berridge, V., Strong, P., eds., AIDS and Contemporary History. Cambridge: Cambridge University Press, 1993.

The war in the former Yugoslavia has disrupted this supply route, redirecting S.W. Asian heroin through the Eastern Mediterranean, and opening up a more circuitous northern land route through Bulgaria, Romania and Czechoslovakia into Germany. A new land route has also opened up through the Central Asian republics of the former Soviet Union.

Apart from the trade route questions, the political changes in E. Europe have also led to rapid changes in the drug abuse situation. Many in these countries and in the international agencies are now expecting that they may soon be experiencing problems on a level comparable with W. Europe. Previously, the lack of contact with drug cultures in W. Europe, extensive social control mechanisms, and the lack of access to convertible currency sheltered these countries to some extent from the drug events of the 1970s and '80s. Work which Jablensky has done on central and Eastern Europe as part of WHO-Euro's European Summary of Drug Abuse indicates that domestic illicit drug markets exist in the majority of central and eastern European countries; that opiates are the most important substance used and heroin is becoming available; and that IV drug use is spreading.

Two countries in particular already have quite long established drug problems: the former Yugoslavia, and Poland. In Poland, there was the existing use of 'compote' or Polish heroin, a home-made extract of poppy straw. But already there are significant problems with HIV. The virus was first detected in Warsaw in August 1988 and 1350 HIV infected persons had been identified by July 1990, 727 of whom were intravenous drug abusers. Some recent developments include the criminalisation of possession; compulsory diversion to treatment; and the prohibition of poppy growing.[13] Who-Euro is also focusing its drugs work on Eastern Europe. As it programme report for January 1992 comments:

> Up-to-date drug abuse policies in the countries of central and eastern Europe have been characterised by a relative imbalance between measures aiming to reduce the supply and control accessibility, and measures aiming to lower the demand, with over emphasis on the former and insufficient attention to the latter. These policies will now no longer be *appropriate nor acceptable* (author's emphasis). New policies will have to be developed, based on a good balance between control of the supply of drugs and demand reduction, adding also components of harm reduction as appropriate. The experience of countries with a much longer history of drug abuse problems and their management will be relevant.

[13] Danziger, R., Discrimination against people living with HIV and AIDS in Poland. British Medical Journal 1994; 380:1145-47.

It was pleasing to see WHO referring to the necessity of an historical perspective. But the declaration, although well meaning, also brings reminders of an earlier period of policy flux in S.E. Asia, when outside models and interventions were put in place without regard for indigenous patterns of use.[14] WHO-Euro is of course, sensitive to those concerns. But this is not true of all the external players; the danger, as always, is that inappropriate external forces may dictate the new policy agendas. It may perhaps expecting too much for these fascinating processes of change to be the subject of policy study.

2. Historical legacies from the deeper past

So there are clear, and divergent patterns of control and policy in individual European countries. Those variations strongly reflect different historical experiences, cultural patterns and policy making scenarios. Let us turn to look at a number of historical areas where research input is in need of development.

2.1 National cultures and responses to drug use

Looking across Europe, one can identify a general pattern of legislation dealing with 'dangerous drugs' in the twentieth century, in part stimulated by the demands of international law, in part by the fears of expansion of a drug subculture in the postwar period, and especially in the 1960s and '70s. Take Norway as an example. There, as Ragnar Hauge has pointed out, the Opium Act of 1928 instituted a system whereby the control of drugs was a concern for the medical profession alone. Those addicted to morphine, cocaine or psychoactive drugs were able to get them through their doctor, whose judgement could not be easily overruled. Import, sale and unauthorised handling were punishable under the Opium Act. However, the maximum penalties were low, and the same as in the 1927 Alcohol Act; the view was that the illegal handling of alcohol and drugs should be treated alike. After World War II, the balance started to shift. The 1950s saw more stringent controls on physicians' ability to freely prescribe, and forms of compulsory treatment were also introduced. Fears of a youth subculture

[14] McCoy A.W., Read C.B., Adams L.P., The Politics of Heroin in South East Asia. New York: Harper and Row, 1972.

using a wider range of drugs led to a shift from a primarily medical to a penally focused system with increased penalties across the board. In 1964, a new law, the Drug Act, replaced the old Opium Act of 1928 - a change in part made necessary by ratification of the 1961 Single Convention.[15]

The Netherlands eventually, although not initially, took the opposite line. There was a system of prohibition in the 1950s and '60s. But the focus of policy was revised by means of a working party, the outcome of which was the 1976 Act. This introduced the distinction between soft and hard drugs and the institution of treatment programmes. These focused increasingly on improving the social behaviour and physical condition of the addict rather than on complete withdrawal - hence the reliance on methadone.[16] Some commentators have located the origin of the pragmatic policy from the 1970s onward in the Dutch experience in governing Indonesia. Opium maintenance there supported large numbers of users until Dutch rule ended after World War II. Marcel De Kort and Dirk Korf, in their study of drug control, emphasise the continued importance of the Netherlands, both in drug production and as a staging post in trading routes, whether legal or illegal, even after the introduction of the import/export certificate system in the wake of international drug control after World War I.[17] David Downes has taken this further, locating the permissiveness of the 1970s response in parallel desires to avoid the dual failures of US prohibition on the one hand and British heroin maintenance on the other.[18]

France and its drug control history is a less well known example. Formal legal control dates back to 1916 - but it was not until 1953 that legislation defined the user as 'sick' rather than bad. Compulsory treatment was envisaged, although never implemented. A further law, passed in 1970, epitomised in its title the duality of the French response: 'Health and the fight against drug addiction and repression of traffic and abuse of illegal narcotics'. Patrick Mignon, in a survey of the politics of the drugs issue in France, has referred to what he calls 'the intimate relationship between drug

[15] Hauge, R., Drug problems and policies in Norway. (Paper prepared for Rand Corporation conference on European drug policy, Washington, May 1991.)

[16] Engelsman, E., Dutch policy on the management of drug related problems. In Ghodse H.A., Kaplan C.D., Mann R.D., eds., Drug Misuse and Dependence. Carnforth: Parthenon, 1990, 35-47.

[17] De Kort, M., Korf, D.J., The development of drug trade and drug control in the Netherlands: a historical perspective. Crime, Law and Social Change. 1992: 17:123-44.

[18] Downes, D., Contrasts in Tolerance; post-war penal policy in the Netherlands and England and Wales. Oxford: Clarendon Press, 1988.

policy and politics in France', with the drugs issue taken up by both Left and Right, from different perspectives, since the 1970s.[19] The treatment system remains psychoanalytically based, and very different from that in other western European nations, but methadone maintenance is expanding from a low base. There have also been moves to national coordination since the 1970s, with the DGLDT (Delegation Generale a la Lutte contre la Drogue et la Toxicomanie).

What is lacking, for these as well as for most other European countries, are policy histories which explain why and how particular country traditions have developed, what the reality of policy is and has been, as opposed to the public presentation. Does the harsher German response in some states - at least until recently, for methadone maintenance is now being introduced on a limited basis - derive from the different traditions of German public health, to which both Richard Evans and Paul Weindling have drawn attention?[20,21] How does the German tradition relate to the historic role of the medical profession? The early German writers on addiction, Edward Levinstein, for example, were notable for their belief in abrupt and punitive methods of treatment.[22]

In Britain, more is known, although there are no historical policy studies of the period post-1926 and before the 1980s. British policy was medically dominated. A battle for control between the Home Office and doctors in the 1920s left the medical profession in control, albeit within a system run from the Home Office rather than the newly established Ministry of Health. Maintenance prescribing was legitimate, and was the result rather than the cause of Britain's low number of addicts over the next forty years. But in the 1960s this pragmatic policy shifted its focus as numbers (and types of people) using drugs changed. Drug prescribing moved from primary care and general practice to a specialist model; licensed doctors in DDUs were the only ones who could prescribe heroin and cocaine. In the 1970s, the focus shifted yet again - away from heroin maintenance and towards a con-

[19] Mignon, P., Drugs and Drug policy in France. (Paper presented to Rand Corporation conference on European drug policies, Washington, May 1991).

[20] Evans, R., Death in Hamburg: Society and politics in the cholera years, 1830-1910. Oxford, Clarendon Press, 1987.

[21] Weindling, P., Health, Race and German politics between national unification and Nazism, 1870-1945. Cambridge: Cambridge University Press, 1989.

[22] Levinstein, E., Morbid Craving for Morphia. (Die Morphiumsucht). London: Smith Elder, 1878.

cept of active treatment through short-term methadone prescribing. Throughout these twists and turns, one constant remained the dominant policy influence of the medical profession and the considerable degree of autonomy it retained.[23,24,25,26,27]

The cry for more of these histories of the dynamics of policy development is not simply historical self-interest. We can use such histories in cross national perspective to identify common (and differing) themes and inputs which go to determine particular national policy responses. It is of particular importance that such histories do not remain drug centred but are also located in differing national histories of health and social policy development. The differing relationships between the medical profession, other agencies and the state are especially relevant here. So too is the differing degree of politicization of the drugs issue over time. The contrast between French and British systems could be well worth exploring in this respect.

Part II:

Research themes and a research agenda

I would like to stress the need for a greater degree of collaborative research at the European level into these types of issues. Much effort has been, and continues to be, expended in developing more and more numbers; both European and individual national efforts in this direction underline the dominance of epidemiology in postwar health policy making. In the drugs arena, epidemiology helps to underline the need for a health rather than a penal response; it also serves a further policy purpose by underlining the threat to non-users as well as users. The different European agencies have also made

[23] Spear, B., The early years of the 'British system' in practice. In: Strang, J., Gossop M., eds., Heroin Addiction and Drug Policy. The British System. Oxford: Oxford University Press. 1994.

[24] Berridge, V., Drugs and social policy: the establishment of drug control in Britain, 1900-1930. British Journal of Addiction 1984: 79:17-29.

[25] Stimson, G.V., Oppenheimer, E., Heroin Addiction. Treatment and Control in Britain. London: Tavistock, 1982.

[26] Smart, C., Social policy and Drug Addiction: a critical study of policy development. British Journal of Addiction. 1984: 79:31-39.

[27] Strang, J., Gossop, M., Heroin addiction and drug Policy: The British System. Oxford: Oxford University Press, 1994.

efforts to gather basic information - often duplicating efforts (for example, both the Commission Secretariat and WHO-Euro have gathered information about research and research networks in Europe). Some themes where research effort could focus are given below.

1. Professionalism, voluntarism and the state

Among these themes would be the role which professionals have played. The history of the professional input into the drug policy arena has been significant. In Britain, two models operated in the nineteenth century and the early years of the twentieth. Management of supply operated through the pharmacy profession and management of the user by the medical profession, initially through the inebriates and lunacy legislation.[28] In the post-World War I period, a crucial shift away from pharmaceutical regulation and towards medical control took place. For much of the twentieth century, then, this has been an area of medical entrepreneurship. But the range of professions has widened in the last decade in line with the 'new public health' approach.

How this operates again varies according to particular national cultures. Reuband, in a recent survey of German drug policy, has commented on the involvement at the policy level of medical personnel and psychologists. Countries which have more liberal drug policies, such as Spain and the Netherlands, he argues, have lead policy makers with sociological backgrounds.[29] In Britain, too, the main expert advisory group on drug policy has broadened its input in recent years to include sociologists, probation officers, representatives of the voluntary sector and others. In Eastern Europe, the role of the medical profession has remained of paramount importance. The history of those changes in professional input remains largely unexplored and could inform discussions in the 1990s about which professionals are appropriate.

The range of professionals is broadening - and the professional response is also dependent on what Misztal and Moss in their survey of Aids policy making have called 'the participatory traditions of civil society'. The rela-

[28] Berridge, V. & Edwards, G., Opium and the People. Opiate use in nineteenth-century England. London: Yale University Press, 1987.

[29] Reuband, K.H., Drug use in Germany and national policy. A review of empirical evidence. (Paper presented to the Rand Corporation conference on European drug policies, Washington, 1991).

tionship between voluntarism and the state is an important dimension, both historically and currently. Many, but not all European countries, have a strong voluntary, often religious input into service provision in the drug area - for example, the religious based therapeutic communities for addicts in Italy. The form of service provision and professional input is dependent on the historically determined relationship between the voluntary sector and the state.

In most European countries, however, drugs do remain an issue for professionals - and user input into policy is limited. The 19th-century consumers of laudanum had no need for self organisation and few countries other then the Netherlands have encouraged the formation of user organisations. Mainliners in the UK is one Aids related example. But drug users have remained fragmented by comparison with the range and professionalism of the gay groupings which have emerged around Aids.

2. Fear and crisis

Fear and crisis have also determined the focus of particular national policies. In Britain, the influence of a wartime 'emergency' determined the focus of the Dangerous Drugs Act of 1920, the country's first drug-specific control legislation. Fears of a cocaine epidemic among British soldiers mixing with prostitutes in London - a fear which later investigations proved illusory - allowed the passage of wartime regulation.[30] Perceived crisis, the model of epidemic spread, the impact on the general population, have continued to determine the focus of national controls. In the 1960s in Britain, the power of doctors to prescribe controlled drugs for the relief of addiction was limited to those doctors licensed by the Home Office (the justice ministry) because of fears of addiction as a 'socially infectious disease'.

Such fears have had their impact on public opinion and here the role of the media has been significant. Historically, drug use became part of the fear of deviant minorities, the Chinese, whose opium 'dens' were often little more than ordinary social clubs, but which took on an alluring and mysterious image,[31] and also women, whose general weakness seemed to make them peculiarly prone to the danger of morphine injection. This was a po-

[30] Berridge, V., War conditions and narcotics control: the passing of Defence of the Realm Act Regulation 40B. Journal of Social Policy. 1978; 7:285-304.

[31] Berridge, V., East End opium dens and narcotic use in Britain. Lodson Journal 1978; 4:3-28.

tent sensational package for the media. From the 1920s onward into the 1980s, drug use has provided potent images for the media in all European and North American countries; a public opinion hostile to drug use and ignorant of its complexities has been the result.[32] Drug use, as these images underline, evokes a fear of damage to the individual, but also of national and racial decline. For politicians it has provided a convenient issue which always attracts wide popular support. Drugs can be easily associated with criminality or immigration; campaigns give the image of 'doing something' about drugs while in reality doing relatively little.

3. International influences and national policies

From the national to the international - if we remain at the level of national differences, it is easy enough to forget that drug policies nationally are also the outgrowth and the legal follow-on to a system of international control of drugs which was established in the early years of the present century.[33,34] This was one of the earliest examples of an international legal system, as distinct from the general spirit of international cooperation in many health areas (alcohol, for example) which marked the end of the nineteenth and beginning of the twentieth centuries.[35]

The origins of the system are instructive from our present day perspective. The dangers of drugs had something to do with it, but international power politics also played a significant role. Control began as an attempt by American missionaries to bring to an end the opium trade in the Far East, moves which were also supported by US power politics in that area. A desire to expand US markets and influence in the Far East was dependent on the ending of the debilitating opium trade.

This was a pattern of involvement which has had a familiar ring ever since. And the Far Eastern control system expanded, almost despite itself, into an international system which became fully operational after the First

[32] Kohn, M., Dope Girls. The Birth of the British Drug Underground. London: Lawrence and Wishart, 1992.

[33] Lowes, P.D., The Genesis of International Narcotics Control. Geneva: Librairie Droz, 1966.

[34] Stein, S.D., International Diplomacy, State Administrators and Narcotics Control. Aldershot: Gower, 1985.

[35] Howard-Jones, N., The scientific background of the International Sanitary Conferences. Geneva: World Health Organisation, 1975.

World War. Hence came the impetus for all those laws passed in the 1920s. What it led to also, was a determined attempt to impose, at least in some countries, US-style policies of prohibition. Parts of the system are still recognisably the inheritors of that early control mechanism. After the Second World War, further agencies have been added, most notably the WHO to take account of the health dimension. But the role of the UN agencies and of control policies established at that international level remains of central importance, as does the role of the United States as an international moral and policy entrepreneur in the drug policy field. Recent changes in Eastern Europe have brought increased influence. The development of national policies has, at least in principle, to measure itself against this mandatory system. Its history, in particular in recent times (despite an admirable survey by Bruun et al., *The Gentlemen's Club*) remains to be written.[36]

Also in the postwar period, but in particular since the late 70s, a specific pan-European dimension has emerged. In recent years, there has also been much development in the European Community, in the European Council, the Commission and also the European Parliament. These more recent developments have so far been largely unanalysed, although a working group of COST A6 is beginning to examine them from a policy science perspective.[37,38] They too have their history. The type of study which Bruun et al. carried out for international drug control could also be applied to policy studies of the West and Eastern European dimension.

4. Models from the history of drug policies

National cultures and policies are important. But the history of drug policies also throws up models which are worth discussion. Those models include open availability, legal regulation, medical control, and public health regulation. The inter-relationships between them are complex. Some commentators see in the open availability of opium in the nineteenth century a possible model for the present. Others reflect on the subsequent history of

[36] Bruun, K., Pan, L., Rexed, I., The Gentlemen's Club. International Control of Drugs and Alcohol. Chicago: University of Chicago Press, 1975.

[37] Hunter, W.J., Drugs: a priority in 'public health'. (Paper prepared for European scientific seminar on strategies and policies to combat drugs, Florence, December 1993.)

[38] Van Lindt, H., Drug Research in the Member States of the European Union and Cross-Border Networks of Researchers: Instruments of an Anti-Drug Strategy? Eur Addict Res 1995; 1:12-19.

drug policies and the different models which have emerged. A crucial tension here is that between penal and medical forms of control, often reflected in the historic location of which Ministry has central policy responsibility for the issue. In Britain, for example, it was the Home Office - the justice ministry - which won the battle for responsibility with the newly established Ministry of Health in the 1920s, and which has retained that responsibility ever since. The addict notification index is held there and not in the Department of Health. In the Netherlands, by contrast, the Health Ministry plays the leading role. In France, between 1986 and 1988, the Ministry of Justice took on responsibility for the drugs issue, which had previously been in the hands of the Ministry of Health and Social Affairs. These administrative divisions underline the division of opinion as to whether the addict/user/abuser is a sick person to be treated or a delinquent to be incarcerated. The concept of 'sickness' also can vary between countries. In Britain the postwar revival of the 'disease' view of addiction, stimulated by the work of Jellinek at WHO and by parallel American developments transmuted into that of 'dependence' in the 1960s and '70s, a mingling of physical and psychological approaches. Subsequently the notion of 'problem drug use' underlined the new power relationships within drug policy and the broadening and increasingly non-medical 'policy community' for drugs.[39] In France, in contrast, the psychoanalytical tendency in drug treatment has been stronger; whereas in some Eastern European countries, Russia most notably, biomedical and genetic approaches to addiction continued to hold sway long after they had fallen from fashion elsewhere.[40]

The issue, then, is not as simple as a complete opposition of penal and medical. Often the forms of control which are proposed vary only in their particular location. Compulsory treatment has been a favourite of the medical profession in a number of European countries at different historic conjunctures. In both Austria and Germany, for example, drug dependent prisoners can be diverted to health services[41]. Pre-trial diversion has also been

[39] Berridge, V., Aids and British drug policy: continuity or change?: In Berridge, V., Strong, P., eds., AIDS and Contemporary History. Cambridge: Cambridge University Press, 1993.

[40] Anokhina, I., Paper on Addiction.

[41] Fehérváry, J., Drug Policy in Austria. In: Albrecht, H.J., Kalmthout, A. van., eds., Drug Policies in Western Europe. Freiburg: Max Planck Institute, 1989. 63-88.

introduced in Britain, in part because of the need to keep drug users out of prison in the wake of Aids.[42]

Nor is the health response as simple as it seems. Health responses can also take different forms. A classic opposition is the distinction made between prevention and cure, between what can be termed a 'public health' as opposed to a clinical approach. In the wake of Aids, which has in particular affected drug users in the southern European countries, we have heard much of a 'new public health' response to drugs. Prevention is on the agenda as much as cure. Some commentators have looked back to the nineteenth century antecedents of public health, certainly in the British context referring to the great battles against environmental disease and poor housing.[43] But the public health of the 1980s and '90s is a rather different concept. Its focus has narrowed away from the nineteenth century concern with the environment towards a concern for individual responsibility and individual lifestyles.[44] This type of focus has underpinned the adoption of media campaigns, of education as a strategy within European countries.

But if we look further into this new focus on prevention, we can also see that the barriers with treatment and cure are blurred. National countries policy responses to drug use in the wake of Aids have notably focused on methadone maintenance, a medical treatment here presented as a prevention strategy. A clinical intervention is being redefined as a form of public health approach.[45] Another feature is a new emphasis on relationships between the health and criminal justice systems. Criminal justice has also notably adopted the language of prevention[46]. Whether the balance of power will incline to the health, criminal justice or clinical sections remains to be seen.

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[42] Berridge, V., Aids and British drug policy: continuity or change? In: Berridge, V., Strong, P., eds., AIDS and Contemporary History. Cambridge: Cambridge University Press, 1993. 135-156.

[43] Stimson, G., AIDS and HIV: the challenge for British drug services. British Journal of Addiction. 1990:85; 329-39.

[44] Lewis, J., What price Community Medicine? The Philosophy, Practice and Politics of Public Health since 1919. Brighton: Wheatsheaf, 1986.

[45] Farrell, M., Neeleman, J., Gossop, M., Griffiths, P., Buning, E., Finch, E., Strang, J., The Organisation and delivery of methadone treatment in the European Union. Report to DG V of the Commission of the European Communities, 1994.

[46] New drug strategies for England and Scotland. (News report) Druglink 1994: 9(6);6-7.

How to start? The role of contemporary history

The areas sketched out for consideration in this paper are potentially large and could entail extensive work. There have already been studies of the legislative basis of individual national policies. These are essential building blocks. But there is also a need for studies of the recent histories and current politics (as opposed to legal framework) of national and European policies - a dynamic framework in which researchers can look at which interests operate to shape policy and how these are changing over time. Ideally, such comparisons should also incorporate comparative studies of alcohol and smoking policies, as the contrasts in social response and in theoretical perceptions are significant. Some valuable studies have been initiated recently (for example, the Rand study), but the focus is the relevance to US drug policy and its reform. What would be a good and realistic starting point? Periodisation of drug policy varies from one country to another, although all were affected by the establishment of international control after the First World War. The recent history of different national drug policies could be one possibility. Those who have been involved in policy change since the 1960s are mostly still alive, although some are now in retirement. A cross national study which interviewed perhaps six key policy makers (including medical and bureaucratic personnel) in each of a number of European countries would provide valuable documentation and reflection on the events of the past three decades. At the moment, little is known about, for example, the genesis of the 1976 Act in the Netherlands, or the changes in policy in the UK in the 1960s. Europe is, so it has been argued, a 'natural laboratory for the testing of drug policies'.[47] The historical experience of European countries should feed into that developing policy analysis.

[47] Goos, C., Workshop discussion report. In: Normand C.E.M., Vaughan, J. P., eds., Europe Without Frontiers. The Implications for Health. Chichester: John Wiley and Sons, 1993.

Finding the Balance for different Policy Options

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Introduction

Despite some of the difficulties in finding the balance between prevention and treatment, the biggest challenge across the field of tobacco, alcohol and other drugs has been to maintain momentum at a national and a policy level to address the significant health and social burden associated with all forms of drug related problems and dependence. Nicotine dependence is the commonest form of dependence, followed by alcohol dependence with other forms of drug dependence affecting the smallest section of the population. The levels of problems associated with consumption are in far greater proportions than those of dependence, but are more difficult to measure. Despite such levels of burden and high levels of association of problems across nicotine, alcohol and other drugs there are fairly modest resources directed at prevention and treatment in comparison to the expenditure and cost of such consumption. At a policy research, prevention and treatment level there is a need for ongoing analysis, articulation of the level and association of problems, advocacy for coherent and cost effective social responses and a general heightening of awareness of the profundity of the issues involved. This chapter provides a broad sweep of the issues and attempts to integrate across substances and between policy, prevention and treatment.

In the initial section, the key concepts of supply reduction and demand reduction and harm reduction are outlined. Concepts of addiction or dependence and the relationship between consumption and harm are explored from a public health perspective, and then the role of the health sector in prevention and treatment is outlined.

The terminology of the drug field is subject to ongoing change indicative of attempts to change, refine and specifically define terms that are viewed as vague or pejorative. The political overlay of the field also results in the evolution of new terminology that serves to indicate policy priorities.

A. Supply Reduction and Demand Reduction

The casting of policy along a dichotomous line of supply reduction versus demand reduction has led some governments to concentrate on a single option, rather than to see both as important approaches to the control of drug problems. Up until the mid-seventies, considerable emphasis was placed on controlling availability particularly of medically prescribed drugs and other non-medically prescribed drugs. Prior to the 1970s the limited availability of many of such substances gave emphasis to the then optimistic option of significantly limiting availability of many dependence producing drugs. The continued rise in the level of substance related problems has resulted in serious questioning of the capacity of governments to achieve widespread limitation of availability of a range of substances.

The result of this has been to reemphasise the role of the general population in limiting its consumption through an awareness of the risks involved in substance consumption and a general health awareness. The currency of the term 'demand reduction' came into general use when some of the developed countries recognized the need to accept some responsibility for the international flow of these drugs. Such countries needed also to demonstrate that they were involved in concerted action in their own countries if they were to demand of other countries a reduction in the production of important cash crops. Thus demand reduction campaigns were also part of a concerted effort to reassert the legitimacy of supply reduction policies. They were also part of the ever more insistent demand of developed countries that developing countries be pressed to take even more action to reduce drug production. The international flow of drugs of dependence is bidirectional with most countries involved in both production and consumption. Countries with high levels of production of specific substances are increasingly recognised to also carry a substantial problem burden from the consumption of indigenously produced substances as well as from imported substances.

Theoretically there is no major conflict between supply reduction and demand reduction options: irrespective of the legal status of the substance, both dimensions would be taken into consideration as aspects of policy op-

tions. With some legal substances, supply is limited through such actions as restricting outlets, limiting age of purchase, taxation and by limiting drugs to medical prescription only. The role of supply reduction has been paradoxically underutilized in relation to both tobacco and some of the psychoactive substances (such as benzodiazepines) in many developing countries, resulting in an overall short-term and long-term detriment to public health.

However, substantial divergence has occurred between the two options in relation to resource allocation. The efficacy of both options remains limited, leaving substantial demands on a range of criminal justice, health and social welfare agencies. The limited resources of most countries need to be sensibly allocated. Each group articulating a particular case has a vested interest. Those advocating the interests of the health sector criticise the disparity of funding between health/social welfare funding and enforcement/criminal justice funding. The law enforcement and criminal justices agencies command the largest share of the resources. There is a need for more critical scrutiny of the expenditure incurred in controlling supply and in enforcement activities with a particular emphasis on cost and efficacy of procedures such as imprisonment. In the arena of illicit drugs, it is clear that there are substantial country-to-country variations in the balance between demand reduction and supply reduction, with an excessive reliance on supply reduction and enforcement strategies in many countries and an inadequate range of prevention and treatment interventions.

The advent of HIV has placed a new emphasis on interventions to reduce the harm associated with drug use and particularly injecting drug use by predominantly health promotion efforts and developing safer injector programmes. Such interventions are based on the assumption that with the provision of information, education and support, drug users can modify their her behaviour in a manner that is beneficial to their health. This involves a respect for persons, and their sense of individual responsibility can be crucial to disease prevention.

The protection of human rights is a necessary component of prevention and care. Many health promotion advocates assert that interventions such as imprisonment for drug use per se may be inappropriately harsh, lack deterrence value and undermine drug users' human rights in a manner that seriously hampers broader health promotion and public health strategies aimed at drug users, and obstructs access to care for drug users.

Probably one of the key achievements of the demand reduction strategy has been to inseparably link prevention and treatment approaches in the un-

derstanding that the professionals involved in both of these fields are intricately interlinked and that the provision of adequate treatment is an important aspect of an overall prevention strategy. Treatment systems provide an important channel of access to a difficult to reach population. There is some evidence that the European countries who specifically address the issues of alcohol from a control perspective, with policies on taxation and restriction on availability, are also the countries most likely to expend significant resource on the prevention, treatment and research into alcohol problems. This would seem to indicate that those who seriously address one dimension are also likely to be addressing the other dimensions, again indicating that both supply reduction and demand reduction are likely to fare better in societies which give adequate priority to tackling substance related problems.

Demand reduction is discussed in the global context of an escalating production and consumption of tobacco, alcohol and other drugs. The health toll of substance consumption rests most heavily on communities who can least afford to carry it. The catastrophes of poverty, war, famine, migration and AIDS place huge resource burdens on the health sector of many countries. The environmentally and economically deprived communities, in both developed and developing countries, are the ones most likely to carry a substantial part of the burden from substance consumption, and are also the communities least likely to receive the resources to empower them to change their environment for themselves and their children.

Resources are required to galvanize the community in the promotion and encouragement and sustenance of change. The time has come for the health sector to vigorously advocate its case with a clear consensus on a health driven strategy for drug use. Public health should be the champion of substance problems for the 90s. This is part of an overall strategy to increase the involvement of all of the health care sector in responding to substance problems. Such an approach also requires leadership from specific interest groups.

B. Harm Reduction

The ICD 10 classification defines 'harmful use' as: a pattern of psychoactive use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected drugs) or mental (e.g. episodes of mental disorder, secondary to heavy consumption of alcohol). The term harmful use has superseded drug abuse in an attempt to more

specifically define the types of harm which are the appropriate area of concern for policy makers and practitioners.

Harm reduction is not necessarily anti-drugs, nor necessarily pro-drugs (Strang 1993). He or she expresses support, opposition or indifference to a proposed public or personal health approach or a proposed legal or social response solely on the basis of the extent to which it increases or decreases the amount of harm consequent upon the drug use in question. A predetermined position on drug use as intrinsically 'bad' or 'good' has no meaning in this consideration, where the response is determined solely by the extent of observed or anticipated harm which results from the drug use. Thus the champion of harm reduction is neither for nor against increased civil rights for drug users; neither for nor against the increased availability of drug substitution programmes, or drug-free programmes; neither for nor against the legalisation or decriminalisation of drug use; neither for nor against diversions from the criminal justice system - except in so far as one or other of these choices influences the nature and extent of harms consequent upon the drug use (Strang 1993). There are some areas of possible overlap or confusion.

The legalisation debate: there is often confusion between calls for harm minimisation (with specific harm reduction elements in policy and practice) and calls for the legalisation or decriminalisation of some or all aspects of use, possession, supply, etc. of drugs which are currently illegal. This confusion may generate an opposition to harm reduction proposals which actually emanate from an opposition to the legalisation proposals

Harm reduction and the prescribing debate: Some of the greatest harm reductions have probably been achieved in areas where prescribing is a marginal consideration - for example the public education about the risks of cigarette smoking and the risks of sharing needles and syringes, and the subsequent substantial changes in the smoking and injecting practices of the populations involved in these behaviours (either ceasing the practice or moving to adaptations of the practice so as to avoid or reduce the likelihood of accruing harm). Many if not most abstinence-orientated services have now taken on board AIDS prevention and associated harm reduction goals so as to enable the drug user to survive the phase of drug dependence without irreversible damage to health.

Abstinence is an excellent means of achieving harm reduction and harm minimisation - in so far as the abstinence can be securely achieved and robustly held. The problem arises with the high number of instances of fail-

ing to attain abstinence, or of breakdown of the abstinence. Indeed it may even be the case that the pursuit of abstinence results in a more catastrophic return to drug use when it occurs (the abstinence violation effect described by Marlatt and Gordon 1985).

Heather (1992) has outlined the use of the term harm reduction in the alcohol field. Harm reduction as applied to the interpretation of treatment interventions outlines the importance of focusing on problems other than drinking behaviour, with the aim of improving a client's life and personal wellbeing. In particular client groups there may be a strong case for giving precedence in treatment to relatively modest gains in social, inter-personal, vocational and physical status over radical changes in drinking behaviour. Those drinkers who have received treatment for their drinking problem and continue to drink but whose levels of consumption and problems are lower than their pre-treatment levels. Interpretation of their treatment outcome on the basis of the percentage who have achieved total abstinence is likely to lead to an overly pessimistic interpretation of treatment efficacy.

The advent of HIV and AIDS has had a major impact on the delivery of services to drug users. The key impact was the realisation that services should be prepared to work with drug users who did not wish to stop using drugs with the aim of helping the drug user minimise the harm incurred from drug use by working in a multistage process to reduce the levels of injecting and to reduce the overall level of drug use. It is clearly possible to work within the framework of an intermediate range of goals without losing sight of the overall long-term aim.

The principles of harm reduction are equally applicable to the criminal justice enforcement strategies. The development of a diversion from criminal justice to treatment and a reallocation of resources within the criminal justice system from prison to local police enforcement might reduce harm to drug users and to their fellow citizens. Others have argued along similar lines that low-level police enforcement could have a harm reducing effect resulting in decreased availability of drugs to novice drug users, thus heightening the threshold for young people to gain access to drugs. Such examples are merely to clarify that harm reduction need not remain the province of demand reduction strategies and other health and social based strategies alone. Another possible example of harm reduction in the supply arena is the study of drug spillage along drug transit routes. Such spillage may have a profound impact on local community organisations and health. It is also possible for such spillage to be associated with the seeding of HIV along those

routes, resulting in rapid and effective transmission of HIV to vulnerable communities. Such issues may need to be taken into consideration when established trafficking routes are disrupted, where displacement can occur into a previously unaffected community.

The same consideration that has been given above to the concepts of harm reduction and harm minimisation can presumably be applied to the same phenomena acting in the opposite directions in maximising harm. Perhaps the main importance of the concepts of harm augmentation and harm maximisation (Strang 1993) might be to draw the attention of policy makers and practitioners to the impact of their decisions on the resulting harm to individuals and society as a whole.

C. Addiction and Dependence

Paradoxically the term addiction was abandoned because of its stigmatizing connotations. Just as the drug treatment field had established terms such as problem drug user that were less value laden, those dealing with tobacco rediscovered and rehabilitated addiction. The US Surgeon General in 1988 published a historic report concluding that the processes underlying addiction to nicotine are similar to those of other addictive drugs such as alcohol, heroin and cocaine. This policy link of nicotine with addiction has resulted in major confrontation between the tobacco industry and the US Government, as the latter proposes to define nicotine as a drug and to allocate monitoring responsibility to the Food and Drug Administration. There is gathering scientific consensus on the utility of the concept of dependence (WHO 1993) and increasing understanding of the psychological and biological processes underlying it. Environmental factors appear to play a dominant role in substance use disorders, however. Of the total population experimenting with a drug, a smaller section may develop dependence. The first two phases are influenced by psychosocial factors and drugs effects, but repeated use of a drug may result in compulsive drug use where the substance itself has strong motivational properties and appears to govern much of the individual's behaviour. Most of the drugs that are misused can be readily self-administered to animals. Animal studies generally report that 80% of the animals tested for intravenous cocaine or heroin self-administration learn to self-administer the drug. The important implication of this type of study is that it suggests that pre-existing conditions (such as psychopathology, etc.) are not necessary for the drug to exert its control on behav-

iour, and that continued exposure to the drug is adequate to motivate drug taking behaviour.

Research on the biology of reinforcement, craving and tolerance continues to grow. In particular knowledge about the reinforcing properties leading to drug seeking behaviour have been well delineated (Bozarth 1991).

D. Consumption and Problem Indicators

The best available information on patterns of consumption and patterns of behaviour modification is provided in the field of alcohol and tobacco studies - both in general population studies and in longitudinal studies of changing patterns of drinking behaviour over time. The WHO-published report Alcohol Public Policy and the Public Good (Edwards et al. 1994) provides a comprehensive overview of the public policy issues in alcohol. It concludes that a shift in drinking behaviour among the moderate drinkers is likely to have a greater impact on overall health-related morbidity in a society.

Overall this range of patterns of consumption leads to the conclusion that there is a need for a *three-pronged approach to prevention of alcohol problems*: **firstly**, aimed at reducing national per capita consumption; **secondly**, reducing the quantity and frequency of binge consumption; and **thirdly**, measures focused on particular risk groups.

Within the field of alcohol studies, the key indicators used to estimate levels of problems have been the level of liver cirrhosis and its relationship to per capita consumption. Fights, work absenteeism and accidents were used as indicators of acute intoxication problem episodes. Data on alcohol related health service and criminal justice burden would be helpful indicators of the social costs of alcohol consumption.

The distribution and consumption pattern of tobacco is straightforward, with the majority of consumers being nicotine dependent, and no country has yet achieved a sustained rate of decline in smokers greater than about 1% per year. Tobacco kills 150,000 smokers in the UK and approx 400,000 in the US annually. Peto estimates a 10 million per year worldwide death rate from smoking by the second decade of the next century.

The apparent difficulties of constructing a clear picture of patterns and costs of alcohol consumption in the general population indicate the difficulties in attempting to ascertain similar information on illicit behaviours. The patterns of consumption of other drugs are categorized as experimental, recreational or regular and dependent. The models of population consumption are substantially different and may be different for different substances.

Firstly, the overall level of drugs ever used will be small by comparison to alcohol or tobacco. Secondly, a substantial part of the population who have used drugs will have done so only on an experimental basis. Thirdly, those who have used more regularly may be predominantly relatively infrequent regular users.

Frequent regular users will form a minority of the total population. Because of the lack of data on large-scale consumption to date, and the overall low population rates of regular high-dose consumption it is not possible to state any formal relation between levels of cannabis consumption and health-related consequences from a broad population perspective. However it is now apparent that there is a sizable and growing population of long-term heavy cannabis consumers, and there is a need to describe in detail the characteristics of this population.

Those regularly consuming cocaine or heroin are likely to form less than 1% of the total population. It is not clear which proportions consume in a non-dependent fashion, but this will be influenced by frequency of use and route of administration. However it is likely that the majority who consume heroin, and less possibly cocaine, on a regular basis will be dependent. A RAND corporation study modelling cocaine supply and demand estimates that over time the smaller group of heavy consumers account for the majority of the consumption (Rydell and Everingham 1994)

Using models of population consumption of alcohol, it might be inferred that the consumption of all types of drugs would be lower in low drug consumption countries. However, this premise is so critical to demand reduction policies that it is dangerous to infer without adequate comparisons across populations and across a range of drugs consumed and across patterns and modes of consumption.

It is likely that a complex interaction model newly influenced by local cultural and social factors will strongly influence patterns of consumption and it may not be possible to look at the interaction between different substances. It might be more feasible to study single substances across different culture to understand the dynamics of use, problem use and dependence. The three-pronged approach to prevention is equally applicable with prevention efforts aimed at:

1. minimising the total population consumption of specific drugs;
2. minimising the risks from binge use and related risk behaviour associated with pattern of use, and;
3. measures focused on particular identified risk groups.

There is a need for precise case definitions and descriptive terminology. The advent of HIV has increased the necessity to have detailed, reliable information on the nature and range of drug use within communities.

There is a need for a national framework for the collection of data on drug use. There is also a need for standardised methods of information gathering to improve cross-national comparison of drug use and drug problems. In the United States, information is collected on drug use in the General Household Survey and also as part of the Epidemiological Catchment Area survey of mental health and the National Comorbidity Survey, but this will be beyond the response of many countries. Such surveys are costly but are likely to give some indication of the prevalence of use of a range of drugs. There is likely to be under-reporting of such activities. However, annual or biannual studies will still provide important data on underlying trends if a consistent methodology is used. As well as household surveys a number of countries also conduct regular school-based surveys to provide information on the patterns and trends of drug use among the young population.

These two types of studies can provide useful data on the numbers of people who have ever used specific drugs as an indication of lifetime use and the number who have used in the last month as an indication of regular use. Thus with the development of instruments and improvement of methodology it should be possible to have a reasonable estimate of the frequency and quantity of use of a range of drugs in the general population. However the use of drugs such as heroin or other drugs where the prevalence is 1% or less requires a large sample frame to provide useable data. In both the school and the adult population careful attention needs to be paid to sampling bias, where in school-based studies failure to include truants and in the general household survey failure to take account of particular institutions such as prison may result in significant underestimates of problematic drug use.

Social indicators of the consequences of varied patterns of drug use include such measures as drug seizures, arrests and imprisonments provide crude indicators of shifting trends in drug related crime, but simply reflect the level of policing activity. Health related data on hospital admissions, accident and emergency department episodes, drug related deaths, levels of hepatitis B, C, D and HIV provide an iceberg index of drug related activities. Many of these are poor indicators because of the incompleteness of the data. Process indicators collected on the population making contact with a range of helping services may be used to provide a better picture. Indicators such as average duration from drug use and from drug injecting use to presenta-

tion to service, average duration from developing dependence to use of service, average duration from developing dependence to injecting drug use, average duration from commencing injecting to contact with needle exchange or other safer injector programmes, patterns of risk taking behaviour such as injecting and sharing injecting equipment.

Any national prevalence studies need to be complemented by local prevalence studies allowing for the marked geographical variation in prevalence. For purposes of treatment and prevention there is a need to have some estimate of local prevalence and pattern of drug use. Such studies will provide information to compare the use of a range of substances between metropolitan, small urban and rural areas.

It is estimated that one-fifth to one-third of problem drug users make contact with treatment services. There is no good data to indicate that the population using the service is demographically different from those not using it. Indeed some of the US studies comparing in-treatment and out-of-treatment samples of heroin and cocaine users indicate similar levels of problems for both cohorts.

The advent of HIV has even further emphasised the importance of having good epidemiological data on the prevalence of injecting and non-injecting drug use in the community. There is major regional variation in the prevalence of HIV among injecting drug users in the UK and in Europe. Anonymised HIV saliva sampling has been conducted on a range of people in contact with services and some out of contact samples. There is considerable risk of sampling bias in these studies. The proportion of drug injectors estimated to be infected varies widely between Southern and Northern Europe. Reports from Thailand, India and South America indicate ongoing pockets of epidemic spread among injecting drug users and some non-injecting drug users. Such variation in HIV prevalence may be related to the level of knowledge and perceived risk of HIV at the time of introduction of HIV to the individual countries. The two frequently identified factors in rapid spread appear to be (1) lack of AIDS awareness (2) opportunities for efficient mixing of the drug injecting population (Des Jarlais and Friedman 1993).

Many of the consequences of substance consumption are hidden. Alcohol was the original silent epidemic. An important task for the health sector is make publicly manifest the high health costs resulting from particular behaviours.

Interest is now concentrated on identifying particular populations such as women, young people, street children, school truants, ethnic minorities and indigenous peoples, and prison populations. A range of methods has evolved because of the difficulties inherent in studying drug using behaviour. Qualitative studies of difficult to access populations are essential for broader understanding and an informed, culturally sensitive response to drug using populations. Such ethnographic work needs to be conducted within particular subpopulations and across different cultures.

New issues arise with the use of performance enhancing drugs, particularly drugs in sports. Sports is an arena that was viewed as the constructive alternative to drug use. Now sports has become an arena of major political interest and high-profile drug use. The tight supervision of top level competitive sports aims to eliminate the use of anabolic steroids. However such supervision is unlikely to reach the broad mass of amateur competitive athletes who have been sent the clear message that certain drugs substantially enhance performance, thus providing a real inducement to drug use. Again steroid using athletes remain aloof from drug using cultures and do not identify themselves as drug users. Some bodybuilders are likely to be involved in injecting steroids. Such populations need to be targeted with information on the HIV risks of sharing injecting equipment.

It is not appropriate to talk of drug users as heroin users or cocaine users but to explore the drug repertoire of individuals, many of whom use a range of substances particularly within the recreational pattern of drug use. New patterns of drug use spring up around styles of house music or rave parties. Drugs such as MDMA and LSD have a resurgence among a new generation. The longer term implications may be considered in relation to this group's readiness to use psychoactive drugs to achieve particular mental states, or may be assessed in terms of the risk of such young people moving onto more dependence inducing drugs.

Overall it is likely that there are as many patterns of drug use as there are people, and new patterns of use will continue to evolve. Specific forms of behaviour may become more stereotyped when people become involved in compulsive or dependent drug use.

E. National policy formation on prevention and treatment

In the context of both national and international policy formation health is frequently a minor consideration compared to other financial and sectoral

interests. The complexity of the overall factors influencing individual and public health limits the overall impact of the health sector on policy formation. Many other factors will influence the health of individuals and general public health, such as general standards of living - including housing, income, education, exercise and leisure, diet, use of addictive substances, general social supports, environmental health - far more than the actual provision of health care and health promotion. The control of dependence producing drugs and the minimising of individual and public health burdens arising from addictive substances should be a universally agreed, important policy objective. The establishment of priorities and clear objectives is complicated by a variety of influences competing to set the priority agenda. Policy makers in some countries may have limited input on substance problems from health and social welfare professionals in the treatment, research, training and policy dimension. Indeed health itself may not feature on some policy agendas. In countries where there is professional advice and input on policy formation, the consideration of health issues may form only one part of the overall determinants of decision making. Health may be a weak player on the overall agenda where the vested interests of the producer sector may have a dominant input; alternatively, sectors such as the communications and media industry may have an important influence on minimising the restrictions on promotion and advertising of substances. And finally in the arena of illicit drugs where enforcement and criminal justice has traditionally played the dominant role, there may be a major reluctance to clarify, emphasise and promote the role of the health sector. Also the general public may hold views at variance with the exhortations of the health policy advocates. Finally, government will frequently balance these different sectors, and where there is a major lack of consensus, issues are less likely to be implemented.

There may be an absence of government policy limiting the promotion and distribution of tobacco and alcohol. Rapid growth in the consumption of tobacco may lie very low on the overall political agenda as an issue requiring control policies. It is frequently difficult for health related issues to compete with other financial and political considerations in the determination of social policy. The range of vested interests involved in the promotion and distribution of licit products is considerable. The benefits of sales and taxation revenue need to be balanced against the longer term health consequences of such consumption. Also the clear unfettered promotion of some legal substances stands incongruously alongside the moral condemnation of

the use of illicit substances some of whose health consequences may be of a lesser magnitude (Desjarlais et al. 1995).

There is clear evidence from many countries that the use of substances such as alcohol and tobacco can be curtailed by a range of laws, regulations and practices, and the consequent health burden can be reduced. The ambitious aim of completely prohibiting the use of illicit drugs has not been achieved; however there are no adequate data available to clarify whether alternative policies would have resulted in greater or lesser problems associated with illicit drug use than presently exists.

Overall across both the licit and illicit substances it is inevitable that a clearly articulated drug control policy will exist for the foreseeable future. A drug control policy is an essential tool for fostering health promotion, irrespective of the legal status of individual drugs, and the absence of such policies would result in substantial public health costs. However it is important that such policies be heavily informed by the health sector considerations that are based on a public health perspective with an emphasis on overall health gain, individual health promotion, individual responsibility, respect for individual human rights and a determination to minimise individual and social harm resulting from criminal justice control policies. A costs benefits analysis of a range of alternative policy options is a vital element in the planning of a healthy public policy on both licit and illicit drugs. Countries may limit domestic production and consumption of a range of substances, but there are particular ethical issues when companies operate differently in export markets incurring substantial health problems for those countries to which they sell tobacco or other psychoactive drugs. It is important to recognise the need for research and training; however, the source of financial support for research if provided by producer interests may surreptitiously subvert any research that does not protect the interests of the producers.

F. Prevention

The task of prevention and treatment are closely linked, and many of the key players in a given society will be intimately involved in both prevention and treatment. However there is still a clear need to target the broad population. This may be done through mass media approaches which can have the important function of setting issues on the social agenda and managing to create dialogue in the society around certain subjects. The limitations of this method of mass communication have to be understood in planning such approaches. Campaigns with modest goals conducted over a sustained period

of time are more likely to achieve concrete results than expensive episodic overambitious projects.

There are again **three prongs to the approaches** for mobilising effective prevention and health promotion campaigns for substance users.

The first important dimension is that the placing of the issues of substance problems on the political agenda in order to effect behavioural change in the broad community of people who take alcohol and drugs at some stage of their lives to ensure that there is a minimum of drug and HIV risk taking behaviour in the whole community and that there is adequate knowledge of the health related consequences of the variety of substances consumed. In particular the message of safer sexual practice needs to be transmitted to the whole community. Given the broad spread and varied nature of drug users in the community, it is likely that the behaviour of drug users will reflect the behaviour of the whole community.

The second dimension is ensuring that an adequate range of services is provided and effectively utilised both for those who wish to utilise them and for others who could be encouraged to utilise them and who would derive benefit from such contact. Ensuring good access to health care is central to this.

The third dimension is the need for an agreed common agenda whereby the individual rights of those involved with substance use are recognised and the task of health promotion involves maximising on individual responsibility and a clarity that little can be achieved without the active cooperation of the relevant individuals.

Prevention may be achieved by reducing the extent of drug use and the extent of injecting, but also by reducing the extent of the risk associated with each event of usage. Prevention messages need to be tailored to the specific cultures to which they are addressed taking into account the particular religious, social and cultural differences of individual societies and individual groups within those societies.

Clear objectives need to be set for prevention messages. The prevention agenda should be based on careful monitoring of the rates of substance use and good detection of the negative consequences of such use. In particular, campaigns should be based on focused efforts to reduce the identified health burden which is the consequence of substance consumption. A clear and simple example is the approach to the initiation of tobacco smoking; however, despite strenuous efforts in many European countries some 25% of children are smokers by the time they leave school.

There are three prongs to the combined interventions of prevention and treatment. There are general health promotional strategies aimed to reduce recruitment to drug use and to minimise the harmful consequences of such use. There are community based resources to respond to basic health care consequences and to promote the cessation of drug use, and there are specialist responses for those who do not manage to modify their behaviour despite encouragement and self-determination.

Both prevention and treatment need to work with the current rather than attempting to swim upstream in a flood. For this reason careful attention should be paid to the pattern of individual and community change, and there should be a reasonable picture of the natural history and life careers of substance use in different cultures. The movement into and out of problem drug use may be indistinct. Overall such demarcation has important implications for the discussion of aetiology. Do we discuss the aetiology of experimental drug use, recreational drug use or compulsive drug use, and how clear is the line between these patterns of drug use?

This is also relevant in discussing patterns of modification of drug using behaviour or the cessation of drug use. A large number of people who use drugs modify their pattern without recourse to professional help. What are the natural cessation patterns, and what are the environmental and intrapersonal factors that facilitate such patterns of change? There is a need for better population based studies of the pattern of substance use over time to better define the relationship between drug use, problem drug use and drug dependence. The role of self-help and use of a range of cessation patterns require further study. There is a particular need to identify the range of cessation activities that people use, and to actively promote self-cessation activity rather than foster the assumption that people always require professional interventions to modify their behaviour.

G. Treatment

The filter between prevention and treatment is a self-efficacy filter. The provision of health promotional information will motivate some to modify their behaviour. A US study of the general population pattern of smoking cessation found that 90% of successful quitters and 80% of unsuccessful quitters had stopped on their own by abrupt cessation and withdrawal. Nearly 50% of those who attempted on their own were successful, compared to 23% of those who had used cessation programmes. However it was not until after they had failed on their own on more than two occasions that people chose

to use some form of assisted cessation method. Thus the key approach is self-help and community based, but if such approaches are encouraged there must be resources to assist those who attempt and do not succeed. Thus it is possible that health promotional approaches will increase treatment demand by raising levels of health awareness.

A variety of service delivery will exist ranging from the most basic, unskilled to the highly trained specialist. A key aim of a service should be the delivery of basic health care. Many people with significant substance problems have major physical morbidity which frequently goes unattended because of negative discriminatory attitudes to people with substance problems.

There is no issue of specialism in advocating access to health care. In most countries access to health care is a basic right. Indeed in societies where people do not have proper access to health care and advice it is likely that they will also suffer discrimination in employment, housing, social welfare and a broad range of factors that will have important bearing on their overall health.

A primary focus should be the delivery of basic health care to the drug user and minimising the harm the injecting drug users risks. To this end much of Europe, Canada and Australasia have implemented needle exchange schemes and others have promoted educational campaigns to promote the cleaning of injecting equipment and the reduction of sharing. Such programmes might be more aptly titled 'safer injector' programmes, where there is a service specifically targeted at injecting drug users with the aim of promoting a healthier behaviour with the elimination or reduction of HIV risk taking behaviour. The adoption of safer injection programmes appears to have been associated with the stabilization of HIV seroprevalence among drug injectors in New York, Amsterdam and San Francisco. But this stabilisation may be a result of other sources of information than the safer injector programmes, and the programmes cannot be directly linked to such stabilisation. However these programmes have achieved only limited penetration of these programmes to the broad injecting community. In many communities risk taking behaviour persists, at a lower level, despite the availability of sterile equipment.

The prescribing of drugs in the management of opiate and benzodiazepine dependence distinguishes this approach from methods used in the approach to alcohol dependence. Such prescribing has become an important component of treatment in many countries. Politicians and criminal justice agencies

may see the promotion of substitute prescribing as an useful part of an overall crime reduction strategy. Substitute prescribing such as methadone is seen to have an important role in the general service response to HIV. Numerous reports have documented low levels of HIV among methadone maintenance patients in environments where there are otherwise high levels of seroprevalence. There are limitations to how far such data can be extrapolated. In a study comparing different methadone programmes and their impact on HIV seroprevalence, Ball and Ross (1991) specified features that differentiated the programmes that were effective in protecting against infection with HIV: the dose of methadone, the quality and the intensity of counselling and medical services offered, and the overall relationship between staff and clients were all found to be related to reduction in injecting drug use. Farrell et al. (1996) have described the variation in the level of methadone prescribing in the EU member states. There is a need to determine appropriate standards and estimates for the provision of such treatments with an effort to ensure that where resources permit, adequate and effective treatment is provided. Prescribing should be seen as part of an overall health promotional intervention. There is now also widespread misuse of prescribed pharmaceutical agents, such as the benzodiazepines. The resources involved in substitute prescribing will not be available to many health services, and individual treatment approaches need to be balanced against the fundamental principle of universal access to basic health care.

Conclusion

Overall across both the licit and illicit substances it is inevitable that a clearly articulated drug control policy will exist for the foreseeable future. A drug control policy is an essential tool for fostering health promotion, irrespective of the legal status of individual drugs, and the absence of such policies would result in substantial public health costs. However it is important that such policies be heavily informed by the health sector considerations that are based on a public health perspective with an emphasis on overall health gain, individual health promotion, individual responsibility, respect for individual human rights, and a determination to minimise individual and social harm resulting from criminal justice control policies. A costs benefits analysis of a range of alternative policy options is a vital element in the planning of a healthy public policy on both licit and illicit drugs. A strong public health perspective on drug consumption and a clear picture of the im-

pact of drug consumption on society should assist in the development of appropriate social and public health policies that properly address the complexity of the problems being tackled.

The central argument of this paper is that there is a direct continuity between control policy, harm reduction, treatment and prevention and that these policies should be assessed by their capacity to reduce a range of identified harm indicators across a range of different drugs consumed. The refinement of the measurement of such harm should strongly support the development of rational and objective policies of demonstrated efficacy that can be modified in order to maximise the scale of health and social benefit.

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Current Conceptual Problems in Western European Narcotic Policy: an Illustration from Southern Europe

ADELMO MANNA & FRANCO MORETTI

1. Introduction

The problems confronted in this paper are the most relevant issues regarding drugs policy in Italy, particularly concerning the questions set by the present law, ranging from the recent proposals on the subject of legalising soft drugs, to the "dualism" hypothesised within the punitive treatment, i.e. between security measures and measures alternative to detention.

The comparisons between pre- and post-referendum legislation is included within this viewpoint, with particular attention to the concept of "average daily dose" and the Supreme Court's judgments on the subject of "private usage".

"Law in progress" is a term that could be used to describe the drugs discipline. Since the reform in 1990, it has experienced an instability that does not seem to have subsided. Such instability is due, on the one side, to questions regarding the fundamental assessment of the drug phenomena and, on the other side, to the several solutions of criminal policy drawn up to counteract it.

Italy has the right to be considered not so much a drug-producing country as a country of transit, refining and – especially – of high levels of drug consumption. The private use of drugs offers a very complex evolutionary pic-

ture, since it is closely linked to the political and social changes that have occurred over the last 30 years.

Making a brief chronological digression, it can be affirmed that whereas in the 1970s the consumption of drugs was linked to youth protest, in the 1980s it was linked to the general economic boom that determined the loss of key values (for example, that of political commitment), right up to the 1990s where consumption has gone through a standardisation process with the consequent growth of so-called hidden use, constituted not only by occasional but also habitual users (for example, weekend consumption).

After a period of 15 years of enforcement of law – law of an innovative nature compared to previous laws that drew inspiration from the concept of drug addiction as an illness and thus from the "no liability to punishment" for the use of drugs concept – we have arrived, after a troubled passage, at the 162/90 law, that updates, integrates and in part replaces the previous one. In this law the dominant and, in certain aspects, "revolutionary" motive is the concept of unlawfulness in the use of drug substances, although it does also involve a backward turns, i.e. to the law of 1954, that sanctioned – albeit penally and not administratively – the possession of drugs for private use.

The legislator of 1990 recognised the failure of the most repressive criminal policy's models, such as the American model, and decreed the different principle of prohibiting the private use of drugs or psychotropic substances and any unauthorised use of these substances, shaping the sanctionary response in relation to the two aspects of the illicit conduct, variously combined: the motive for consumption and the quantity of drugs consumed. The quantity of psychotropic substances related to the illicit conduct and the ascertained motive of this conduct constituted in fact, in the original formulation of the law, the key parameters by which to distinguish between an administrative offence and a criminal offence. It was an administrative offence when the illicit conduct had occurred for exclusively private use of drugs by the agent, and involved quantities of drugs or psychotropic substances of no more than the "average daily dose"; and so there was a criminal offence – leaving aside the motive of the conduct – also in the case of exclusively private use of drugs, when the amount was greater than the average daily dose; there was likewise a criminal offence when the quantities substances was not greater than the average daily dose, though without the requisite of the private motive of the conduct.

It is worth underlining that the administrative sanctions were still to be enforced for those who, for private use, illicitly imported, bought or were in

possession of a quantity of substances no greater than three times the average daily dose, if this turned out to be a dose normally taken within 24 hours.

The consequence was a reduction in the number of illicit conducts penally relevant, when included in the concept of the average daily dose.

The referendary consultation, having brought about the abrogation of the so-called average daily dose, has led to a substantial change in the drugs discipline, since this concept in the original formulation of the law constituted the discriminatory point between an administrative offence and a criminal offence, though most parts in the doctrine had put forward strong perplexities with regard to the so-called average daily dose, especially with reference to soft drugs.

However, it has to be underlined that the abrogation brought about by the referendum, though welcomed, has nevertheless produced a series of enforcement difficulties.

In fact, as previously stated, with the disappearance of the discriminatory point concerning the average daily dose, problems of probatory investigation have arisen, either for the substances that do not create addiction or whose modality of use does not leave visible traces, or for occasional users. It cannot go unmentioned that the new regulation could provoke drugs-pushing activities, especially concerning the consumer-vendor figure, i.e. the one who purchases larger quantities of drugs and is categorised as a drug addict.

2. Current Italian Criminal Policy Regarding Narcotics

2.1. The effects of the referendum abrogating narcotics regulations

The abrogating referendum, which was held on 18 & 19 April 1993, affected a subject – narcotics laws – that has been characterized by various changes of plans and background uncertainties, which appeared right from the beginning in the laws governing this matter.

The provisions of law no. 162 of 1990 exposed their flanks to considerable criticism, for they "restored" a decisively more repressive regime.

Every form of non-therapeutic use of drugs was forbidden, their conveyance for whatever reason and their possession for personal use being subject to criminal sanctions, should the amount of drug and issue be found to exceed the so-called average daily dose, the law providing a range of ad-

ministrative sanctions for possession (for personal use) of quantities not exceeding an average daily dose. This, within an obvious prospective of the "symbolic use of criminal law", devoid of any considerations concerning the concrete effectiveness of the criminal sanction, and concerned exclusively with conveying a message, the "symbol", in fact, of stigmatization at the moral level of a particular form of behaviour.[1]

It was then the very concept itself of the average daily dose that was set up to form the discriminant between the administrative liability and the criminal liability to prosecution of possession for non-therapeutic personal use.

The problems that were raised regarding this new law principally concerned its substantial ineffectiveness – which arose from the rigidity of its application – from the standpoint both of general prevention and of that special prevention that is wholly limited to consumption.

The abrogating referendum was proposed for just this purpose: to eliminate – that is, the concept of and therefore the limit on – the average daily dose.

The abrogating effect of the referendum had, however, even if we greeted it favourably, concretely created – at least in our opinion – a so-called legislative void in the subject.

If in fact before the abrogation mentioned the role of element differentiating between cases having administrative importance and those having criminal importance was constituted by the quantitative limit of the average daily dose, today instead it is on the equivocal purposes of "personal use" and, therefore, on an element subjective in nature that a basis must be taken to affirm whether an activity is subject to criminal sanctions or is subject to administrative sanctions, since currently the area of consumption is on the one hand delimited exclusively by the end in question, and on the other by the "purpose of selling it".

In other words, the problem is to ascertain concretely an aim, in the sense that in the case in which the importing, the purchase or the more generic conduct of possession have been carried out with the direct will for personal use, the acting subject will be subject to administrative sanctions as per art. 75, while in the case in which this conduct is accompanied by the purpose of pushing the drug, the same behaviour will be punished by the

[1] *Manna*, Legislazione simbolica e diritto penale: a proposito della recente riforma legislativa sugli stupefacenti, in: *Bricola-Insolera*, (ed.), La riforma della legislazione sugli stupefacenti, Padova, 1991, p. 19 et seq.

serious criminal sanctions provided by art. 75 of DPR (decree of the President of the Republic) no. 309/90.

This new legislative system thus poses a number of problems. In the first place, the purpose of personal use constitutes a rather imprecise formula. It in fact, for example, does not permit distinguishing between use by the occasional consumer and that by the habitual one, between the drug user and the drug addict.[2]

Still considering the conceptual aspect, a further problem is involved in the fact that there is not, in the positive regulations on narcotics, an explicit normative definition of the purpose of pushing, and, therefore, the boundaries of this element appear rather fuzzy.

The seriousness of this problem comes to the fore with greater force when it is considered that, as noted, it is this particular purpose that forms the premises for the application of criminal sanctions as provided by art. 73, since the criminal intent of pushing is the only element that characterizes the conduct contemplated by this last-named law.

The category of specific criminal intent has generated in legal doctrine a number of problems and has been the subject of sundry criticism,[3] since it is made to configure as the scope or a particular and ulterior purpose that the agent must take as his aim, but that need not to be effectively achieved for the crime to be described.

It is nothing more than the expression of a psychic attitude, that is, a purely internal and spiritual fact that thus inevitably poses a number of problems in relation to the ascertainment of its concrete existence, since the criminal intent must, in fact, as for that matter all the other elements going to form the case, be proven.

At the level of criminal intent the ascertainment has as its object the consciousness of and will toward the typical objective fact (and the knowability of the law), elements that are to be deduced both from the evaluation of all the circumstances that may have had a real significance on the wilful determination of the acting subject, and also, by resort to common "maxims of experience".

These latter constitute "symptomatic indices" in the sense that, if the subject has acted in conformity with these rules of experience, this is

[2] Cf. *Palazzo F.C.*, Consumo e traffico degli stupefacenti (profili penali), Padova, 1993, p. 97.

[3] On this point cf. *Fiandaca-Musco*, Diritto penale, Pt. generale, 2nd ed., Bologna, 1989, p. 273.

enough to make it believed that the psychological fact to be proven has in fact been demonstrated, and thus the existence of criminal intent.[4]

Well then, as regards narcotics, before the abrogating referendum the notion of the average daily dose and that is, the quantitative criterion, acted as a maxim of experience, in the sense that the objective fact itself of the possession of an amount of substance exceeding that "permitted" brought with it the demonstration, even if implicit, of the purpose of pushing. With the abolition by the referendum of this notion, and with the consequent emergence of the purpose of pushing as the only element differentiating between conduct that is liable to administrative sanctions and that liable to criminal sanctions, with reference to the ascertainment of criminal intent the resort to such rules of experience is no longer of help, since the subject of this ascertainment becomes only and exclusively the specific criminal intent to push. All this brings out the complex problems that an ascertainment of this kind bears with it, there being at issue in fact the need to prove a purpose that does not permit, as after all is logical, a demonstration in "sense-perceptual" terms, but only indirectly.

What then comes out is the need, in relation to the subject at issue, for the quantitative criterion even if after a suitable revisiting, which is an irrenouncable quid for the purpose of getting past these problems, since it permits in effect the reduction to acceptable terms of the psychological investigation, eliminating that is the danger of transforming it into a true *probatio diabolica*. Otherwise, there is the danger that there will emerge the hoary problem concerning the so-called *dolus in re ipsa*, a term by which is indicated, as is well known, a particular phenomenon of probatory simplification, in the sense that the existence of criminal intent is deduced from the characteristics themselves of the conduct.[5]

2.2 The approach of the Court of Cassation

Within this uncertain panorama the 1st criminal section of the Supreme Court of Cassation found itself having to lay down the law. By its sentence no. 504 of 9 June 1993 it was affirmed that after the referendum, since the pure and simple possession even of substantial amounts of nar-

[4] More generally, as regards the various problems relative to the ascertinment of criminal intent, cf. *Fianda-Musco*, op. cit., p. 274, as well as *Mantovani*, Diritto penale, 3rd ed., Padova, 1992, p. 328.

[5] *Bricola*, Dolus in re ipsa, Osservazioni in tema di oggetto e di accertamento del dolo. Milano, 1960, passim.

cotics does not constitute in itself a crime, the judge is required to carry out an ascertainment on a case-by-case basis in order to establish what the nature of this possession concretely is.

To this purpose the court listed a number of symptomatic indices, elements that "only in part are determinable in the abstract" and which serve to found the judgment of the court in all those cases in which the activities of pushing do not appear obvious from sure elements of proof deducible from the evidence and the arguments of the trial.

These symptomatic indices, which the Court enunciated only "in purely indicative fashion", are:

- The state, or not, of drug addiction of the accused;
- The environmental context in which the accused lives and any relations had with persons implicated in drug traffic;
- The accused's capacity to purchase in relation to the amount and quality of the narcotics possessed, and to market prices;
- The amount and quality of the narcotic possessed in relation to the personal needs of the accused, to his age and to his reasonable period of survival;
- The amount and quality of the narcotic in relation to the process of natural decay of its narcotic effects and to the difficulties of conserving it for a particularly long time.

The court also held that, besides these, the judge "must take account of every other circumstance that he may deem concretely useful in demonstrating or in excluding that the accused had in whole or in part assigned to pushing the narcotic substance of which he was in possession". The Supreme Court displays, by this pronouncement, that it fully understands what the problems of a purely exegetic order are that the referendum has brought up. The symptomatic indices enunciated by it serve in fact for the purpose of reducing the indeterminateness of the normative case, to fill, that is, the legislative void that negatively influences, from the standpoint of the certainty of law and of the explicitness of criminal law, a void that is filled by exegetic-interpretative criteria, which take on a valence of jurisprudential "stopgap", in that they go to define cases that are left by the law in a fuzzy and confused state, and are devoid of objective references.

On a more accurate analysis of these indices, however, it does not escape us that they are rather generic and, therefore, not fully useful for the purpose of forming a substitute for the law itself: it does not then appear ex-

haustive to found upon such criteria the judge's evaluation of the nature of the possession in the concrete case.

Furthermore, if the thing is examined well, many of these symptomatic elements display a substantial correspondence with the indices of seriousness of the crime and of the capacity to commit crimes as provided by art. 133 of the criminal code, of which the judge must take account for the purposes of concretely metering the punishment.

When the Court speaks of "The state, or not, of drug addiction of the accused", one seems to be able to discern in effect a parallelism with the factual criterion concerning the capacity to commit a crime, constituted of the motives for committing crimes and of the nature of the criminal: in fact, to take into consideration the subjective state of addiction to narcotics means, in other words, to proceed to make an overall evaluation of the personality of the acting subject, with explicit reference to the typical components of his character.[6]

Also the element indicated by the Court as "The environmental context in which the accused lives ..." is substantially similar to the index of capacity to commit a crime, provided by art. 133 no. 4, which refers the judge, for the purpose of concretely metering the punishment, to an examination of the conditions of the criminal's individual life, family and social, and this for the purpose of calculating the incidence of socio-environ-mental factors in the process of the genesis of the crime.

The other indices enunciated in the sentence, under items 3), 4) and 5), refer instead to the modes in which the particular behaviour is exhibited, in relation both to the criminal action carried out concretely, and also to the study of the person of the accused. These symptomatic elements all display a noteworthy affinity with the factual criterion for metering punishment inherent in the seriousness of the crime, constituted "of the nature, the kind, the means, the object, the time, the place and of all other aspects of the action".

On the other hand these parallelisms cannot surprise us: In fact the Court, for the purpose of reducing the indeterminacy of the criminal case relative to the activity of pushing, could not do other than adapt some indices, enunciated by the legislator for directing the activity of the judge in

[6] In the sense that the psyche of the criminal is composed of both a biological base (so-called temperament) and his character, which is dynamic, being the result of the interaction between temperament and outside environment. Cf. *Mantovani*, op. cit. p. 657.

metering punishment, to its own needs, and thus not conflicting with its typically nomophylactic function.

But then, in its praiseworthy attempt to reduce the indeterminacy of the criminal case, it runs the risk instead of confusing the problems regarding the concrete metering of the punishment with those regarding the concrete ascertainment of the specific criminal intent, superposing two phases, that of the existence of the crime, and that of the metering of the sanction, which must instead, and necessarily, remain distinct, both at the theoretical level and at the level of application.

The sentence in question thus does not hold good as the complete solution to the problems raised by the referendum's action, and therefore it appears suitable to wonder if, for the purpose of reducing the indeterminacy these facts give rise to, it is not better that there be a new operation by the legislator, at the general and abstract level. In fact, in legal doctrine circles, but also at the ministerial level, there has been for some time a demand that a position be taken by the legislator, despite the fact that, in other circles, the uselessness of such has been affirmed.

2.3. Recent proposals for laws on the legalization of the distribution of so-called light drugs

After the outcome of the referendum abrogating provisions of narcotics law, as well as the clarifying decisions made by the Court of Cassation, it is understood that the next step cannot help but be attempts, and right at the legislative level, to legalize the distribution of the so-called light drugs.

In fact the national conference on drugs, held in Palermo in June 1993, launched definite signals aimed at cutting down to size the ideological clash on the question, privileging an approach that aimed at reducing the damage.

The "Ongoing Forum for policies aiming at reducing the damage caused by drugs" has in fact – and doing so as well through four proposals of law presented to date by members of parliament sympathizing with the Forum – tackled the following questions: 1. surpassing of the system of punishing the consumption of drugs; 2. prevention of inconvenience for those most exposed to the consumption of narcotics; 3. limited and controlled experimentation in the administration of drugs; 4. reform of the structures working with drug addicts.

It is at once to be added that in Italy, and this too for obvious prohibitions that exist in its laws, controlled drug administration has not been able

to enjoy that interesting phase of experiment that it has had in other cities, especially in the countries of Northern Europe.

Hence the proposed laws, which in what follows will be, even if summarily, examined and which have as their object a fifth priority identified by the Forum: the legalization of light drugs, and this in order to split off the circuit of the illegal market in heavy drugs from that in substances that have been called "non-drugs".[7]

These proposals for law consist in a first one, presented at the initiative of Deputy *Corleone* on 20 July 1994 to the Chamber of Deputies, and bearing no. 979, from which two others arise, of more or less identical content: one the bill, at Sen. *Manconi's* initiative, bearing no. 1318, communicated to the president of the Senate on 24 January 1995, and the other a proposal for law bearing no. 2362, put forward at the initiative of many deputies coming from various parties, but in general all belonging to the so-called centre-left area, to which are to be added a number of Radical party deputies, presented to the Chamber on 5 April 1995.

One thing had in common by these proposals for law, clearly inspired by the Dutch criminal policy as regards narcotics, is the intent to separate the market in heavy drugs from that in light drugs, in order to remove the market in light drugs from the control of the criminal organizations dealing in narcotics.

It is in fact affirmed as a fact by now generally recognized that the transition from the consumption of hashish and marijuana to that of cocaine and heroine "does not take place owing to a toxicological continuity, but rather owing to a marketing continuity".[8]

If in fact the marketing continuity is interrupted, it is argued by the proponents, on the one hand the economic power of the narcotics transnationals will be reduced, they losing control of the market in light drugs, and on the other the market pressure on the demand for heavy drugs will diminish.[9]

The influence then of the criminal policy in force on this subject in Dutch legislation consists essentially in recognizing that drug addiction is not to be considered a problem that mainly regards criminal justice, but rather one that concerns health and social well-being.[10]

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[7] Cf. proposal for law at the initiative of Deputy Corleone, filed on July 20th 1994, no. 379, p. 2.

[8] Cf. proposal for law "Corleone", cit. p. 3.

[9] Cf. proposal for law "Corleone", loc. ult cit.

[10] Cf. proposal for law "Corleone", loc. ult cit.

It is to be brought out, finally, that from empirical data available, what can be clearly seen is the lack of any evidence for a connection between the use of *cannabis indica* and criminal behaviour, nor is there one between this use and the insurgence of mental illnesses or the use of the so-called heavy drugs.[11]

Hence the proposals for law in question, which, in their article 1, establish the general conditions through which it is deemed possible to effect the transition from a prohibitionistic system to one of the legalized type as regards distribution of the so-called light drugs.

This provision of law in fact permits the "cultivation for marketing purposes, the production and the sale of cannabis indica and of its derivatives", by a special administrative authorization, without prejudice to the repressive provisions of law concerning the clandestine international traffic in drugs.

The last two paragraphs of art. 1 establish as well the so-called standards on negative advertising on the packages of product assigned to retail sale and the prohibition on their sale to minors younger than sixteen years.

Art. 2 sets the criminal sanctions and the revocation of authorization for violators of the prohibition on selling to minors younger than sixteen years of age, or permits to these same consumption on their own premises.

Art. 3, in defining the non-liability to punishment of the cultivation for personal use of cannabis indica and of its conveyance to third parties in small amounts for immediate consumption, reconfirms the force of the provisions of law as per art. 73 of the narcotics consolidation act, for those cultivating, producing or selling the substances in question without the necessary licences, using in this fashion the model of the crime of abstract danger, since founded on the lack of authorization. [12]

Art. 4 lays down the prohibition on advertising, direct or indirect, cannabis indica or products derived from it, and the sanctions for violation of this prohibition, without prejudice to creative works that are not for advertising purposes and are safeguarded by the law on author's rights.

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[11] Cf. proposal for law "Corleone", cit. p. 5.

[12] Cf. in this regard, for all, *Fiandaca*, Le tipizzazione del pericolo, in sundry authors, Beni e tecniche della tutela penale, Milano, 1987, p. 49 et seq., as well as *Parodi Giusino*, Su alcune consequenze, riguardanti i reati di pericolo, dell'applicazione die principi posti a fondamento della sentenza no. 364/88 della Corte costituzionale, in sundry authors, Responsabilità oggettiva e giudizio di colpevolezza, Napoli, 1988, pp. 213 et seq.

At issue then, as anyone can see, is a so-called crime of opinion, of which, despite the adverse criticism of this model by qualified doctrine,[13] attentive most especially to questions of a constitutional order concerning the safeguarding of freedom of expression, use has anyway had to be made, evidently owing to the sensitivity and importance of the subject to be regulated by law.[14]

Art. 5, finally, obliges the Prime Minister to present a yearly report on the status of the law's enforcement and on its effects, setting a number of parameters for its evaluation tied to consumption, to its characteristics, to the relationship between consumption of light drugs and of other drugs, to any persistence of the clandestine market in the substances in question, and to the agreements reached internationally with countries producing cannabis indica.

The solution proposed in fact also makes it possible to accentuate the characteristics of a "phase that is necessarily one of transition, and experimental in nature" that, according to the proponents, "must go through a further sedimentation of a broadcast culture as regards the tolerability of the consumption of light drugs".

It should at once be noted that these proposals of law have not as yet found any generalized consensus in parliament, since, and especially by the parties belonging to the centre-right coalition, a rather decisive refusal has been opposed to them, both for ethical reasons, which, however, do not very well reconcile with a "lay" conception of criminal law, and because founded on the conviction – denied by the proponents of the bills in question – that the legalization of light drugs could dangerously facilitate the passage to the so-called heavy drugs.

As things stand now it is therefore hard to foresee that these proposals of law can, at least in the short term, contribute to changing the consolidation act on narcotics.

One prospect, *de iure condendo* can however be found also in recent positions taken by jurisprudence casting doubt on the constitutional legitimacy of some provisions of the consolidation act.

We are referring to the question of constitutionality raised by the GIP (magistrate dealing to preliminary investigations) with the court of Rome handling the proceedings against the Hon. Marco Pannella and other Radi-

[13] *Fiore*, I reati di opinione, Padova, 1972.
[14] *De Vero*, Tutela penale dell'ordine pubblico, Milano, 1988, Spec. p. 16.

cal party exponents, who, for purposes of provocation, recently distributed light drugs in the streets of Rome, free of charge.[15]

The magistrate referred the question to the Council of State, deeming art. 73, fourth paragraph, of the consolidation act (which criminally sanctions the conveyance, for any reason, of small amounts of narcotics) in conflict with the principle of equality, in relation to the safeguarding of personal freedom and the principle of legality in criminal matters.

In substance, according to the investigating magistrate, the conveyance of small amounts of light drugs free of charge would constitute conduct the equivalent of, from the standpoint of the disvalue of the fact, personal use, so that, just like this latter, it should be free from punishment. At the same time the liability to criminal prosecution of the conveyance of light drugs would be unreasonable, if it is considered that these are no more harmful than other substances – alcoholic liquors, tobacco and psychopharmaceuticals – not forbidden within the Italian legal system.

The question is now being sifted by the Constitutional Court. It should anyway be brought out that, while the second question raised by the judge dealing with to preliminary investigations appears convincing, the same affirmation does not appear possible as regards the first, it instead giving rise to some perplexity.

The action of the conveyance, even if free of charge, of small amounts of light drugs, which is not to be traced back to the possibility of collective use, is in fact a behaviour that is ontologically different from that of personal use, with the consequence that an iron-clad equivalence of the two for criminal purposes does not appear, at least *prima facie* to be easily justified.

It is anyway opportune, for a better and more in-depth analysis of this aspect, to await the decision that will be pronounced by the "judge over the laws" (the Constitutional Court), which, we hope, will take on the question submitted to it within a context devoid of the exigencies peculiar to a "symbolic" use of criminal law.

3.4. The treatment of addicts who commit crimes

3.4.1 Between non-custodial measures and security measures

The basic criterion inspiring the legislative reform of 1990 as regards the care, recovery and punishment of the drug addict, is to give incentives –

[15] Cf. La Repubblica, October 19th 1995, p. 16.

even, or especially, by the threat of imprisonment – to the "spontaneous" submission to therapeutic programmes, where the strictly clinical aim is accompanied by the maintenance care involved in the restructuring of the personological equilibrium of the addict.[16] The legislator has undertaken, then, a substantially mixed solution, hinging that is around a system of "braided" therapeutic measures and sanctions, made mutually interdependent.

In line with a trend that is not just European, our legal order too has thus introduced the so-called treatment instead of punishment model, which involves the use of therapeutic communities as "alternatives" to imprisonment.[17]

For the consumer of narcotics the current legal picture envisions, in fact, a series of measures that make it possible to avoid jail, which is to be resorted to only when everything else has failed.

More precisely, according to the terms of art. 89 of law 162/90, precautionary custody in jail may not be provided when the accused is a drug addict who is undergoing a therapeutic programme aiming at his recovery within an authorized structure, without prejudice to precautionary requirements of exceptional importance.

With reference to the person condemned, instead, besides the possibility of requesting suspension of the punishment, there is that of obtaining assignment on a trial basis to the social service, to continue or to undertake therapeutic activity on the basis of a programme, without taking away from the obligation laid on the penitentiary administration to provide the drug-addict convict that medical care and assistance needed for his rehabilitation, together with the local health unit, and to outfit sectors of the prison for the purpose (art. 90, law 162/90).

The structure forming the fulcrum of the system for recovering and rehabilitating addicts is the so-called therapeutic community.

This was fully recognized by law no. 162/90, borne witness to, firstly, by the provision made for regional and provincial registers for these communities (art. 116), as well as by the provision made, as per art. 132, for state contributions to those registered.

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[16] Regarding that, *D'Amico*, Sfida alla droga - Comunità terapeutiche come e dove, Milano, 1985, p. 12.

[17] Permit me, in this regard, to refer the reader to *Manna*, L'imputabilità ed i nuovi modelli di sanzione - dalle "funzioni giuridiche" alla terapia sociale, Torino, 1197.

Over the past few years these rehabilitation structures have increased considerably in number, going from 207 to 422;[18] from 1984 to 1992 their number increased by an average of 13.4 % per year , while the public structures increased by only 4.3 annually.[19] About 85 % of the existing communities are legally structured as associations or cooperatives; the rest are *de facto* associations, a kind of spontaneous maxi-family.

The current laws on the subject require, as a legal condition for the applicability of the communities for the "outside's" execution of criminal sentences delivered against drug addicts, the presence of a recovery programme having therapeutic content, worked out by the community together with the local health unit or with other bodies expressly indicated by the law, whose suitability is, anyway, borne witness to by a public health structure for drug addiction.

From the standpoint of the effectiveness of the system introduced by the most recent legislation ("treatment instead of punishment" and the assignment on trial to the social service), perplexities cannot help but arise considering that the free and voluntary election by the addict of treatment is the necessary condition for the success of that same treatment. The consequence is that when this treatment is set up as an alternative to imprisonment, it is very likely that a situation will be created in which a true choice is absent, whether on the user's part, whether on the therapeutic structure's part, so that persons with scant motivation can gain access to the structure, with the danger that the treatment is perceived only as "better" than jail.[20]

The fact that a programme is "alternative to imprisonment" in a certain sense places the two realities on the same level, since an idea of a rehabilitation route that is at the same time coercive in nature is proposed, and just for this reason the person being treated will feel that less commitment and willpower on his part is needed. The mechanism of coercion creates, fur-

[18] Data gathered in the document made up by the Chamber of Deputies and by the Senate of the Republic - 10th legislature - Bills and reports - Roma, 1991; Cf. on the subject, *Coluccia*, Tossicodependenza e percorsi terapeutici: esperienze a confronto, Padova, 1993.

[19] Cf. Solivetti, Tossicodipendenza in Italia: qualche cambiamento in atto? in: «Bion» n. 2, Aprile 1993, p. 4 and therein, p. 6.

[20] Permit me to refer the reader to *Manna*, L'imputabilità ed i nuovi modelli di sanzione, cit., as well as *Pietralunga*, Una ricerca sulle funzionalità degli strumenti deflattivi del penitenziario, le misure alternative alla detenzione pre/post giudizio per i tossicodipendenti: analisi dei primi risultati di una ricerca sul loro funzionamento, in: «Bion», no. 2, August 1993, pp. 35 et seq.

thermore, a negative continuity between attitudes within the community: one has to "defend" himself against both, one must "resist", since both the one and the other are based on coercion mechanisms.[21]

Furthermore, not to be underestimated either is another argument, exactly the opposite of that set forth to this point.

When looked at clearly, in fact, in the name of an absolute safeguarding of the consent to treatment, there is the danger of underestimating the quite as important needs of the community's safety, relative to persons who have, when all is said and done, committed a crime.[22]

Positions like the one just criticized appear, in fact, more in tune with a prospective of the legalization of narcotics. A certain conditioning of the will of the drug addict who has committed a crime, is, truly, inevitable, and this, for that matter, differentiates the situation considered till now from that of the drug addict who has not as yet committed a crime, for whom there must instead hold good the absolute respect for his free therapeutic option.

In light of what has been observed, the system of the alternative measure of assignment on trial to the therapeutic communities may very well be a useful "starting model" for the lawmaker.

This, note well, not to create only a "special right" for the drug addict, but rather to place it within the more just *sedes materiae* and avert, at the same time, the danger of unjustified damage done to the principle of equality.

Within a prospect of the reform of the security measures inspired by the system of treatment instead of punishment, it is to be hoped that the institutes of social therapy and the therapeutic communities will be the replacements for the old judicial psychiatric hospital, which, inexplicably, as things stand now, is still considered to be a valid means for treating both the mentally ill and the drug addicts.

3.4.2 Treatment or punishment: Results and balance

The working up of a balance sheet of the results achieved by the communities in relation to the therapeutic programmes carried out in terms of overcoming the problems of drug addiction and, where these facts are known, also in terms of the reduction in the rate of recidivism, is, as things stand

[21] *Ciotti*, Controllo penale a programma terapeutico, il rischio delle «Comunità contenitore», in: «Bion», no. 1, April 1993, pp. 70 et seq.

[22] V. on this subject *Manna*, L'imputabilità ed i nuovi modelli di sanzione, cit.

now, a task bristling with difficulties. First of all, in most cases the workers have never posed themselves the objective, which, frankly, makes one wonder not a little.

Where, on the other hand, data is brought forth, it appears for the most part extremely generic, or anyway not recent, so much so as to suggest extreme caution in viewing the reliability and truth of the percentages of successes, which are, however, significantly clustered around 70 %.[23]

For that matter, the inadvisability of making any facile equations, such as the cessation of narcotics consumption meaning the achievement of a condition of real social integration, is punctually indicated by the workers themselves.

It is anyway to be brought out that, while taking account of what has just been set forth and of the various limitations, both of a dogmatic character and of an operational one, of the "treatment instead of punishment" model, this model has nonetheless enabled many addicts to avoid being uselessly subjected to the rigours of the prison system.

And therefore a priori positions contrary to this system are not persuasive.[24]

The promulgation of law no. 162 of 26 June 1990 was, in fact, preceded by a doctrinal and scientific discussion centring, in many of its aspects, on the problem of the consent of the drug addict to his being subjected to de-addicting or social-rehabilitative therapies.

It has been brought out in this regard that the complex of principles flowing together in art. 32 of the Constitution represents an insurmountable obstacle as regards any coercive assistance, even if motivated by the emergency nature of the drugs phenomenon in Italy.

But if looked at carefully, however, in the name of an absolute safeguarding of the consent to treatment, the danger is run of underestimating the quite as important needs for protection of the community safety against persons who have, when all is said and done, still committed a crime.[25]

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[23] On this data empirical studies have been carried out at the local level, and their results are set forth in "La memoria del divenire", in "La droga", an updating seminar for the SERT of the Emilia-Romagna region, 1993.

[24] Cfr. in this regard *Pavarini*, La pena tossica. Carcere e misure limitative della libertà per il condannato e l'imputato tossicodipendente, in: *Bricola* and *Insolera* (a cura di), La riforma della legislazione penale in materia di stupefacenti, Padova, 1991, p. 113.

[25] See on the subject *Manna*, L'imputabilità ed i nuovi modelli di sanzione - dalle "funzioni giuridiche" alla terapia sociale, etc. cit.

Positions like that just criticized appear, in fact, more in tune with a prospect for the legalization of narcotics, which – even if probably bearer of greater advantages over the prohibition approach, at least in terms of the "efficiencies" of the criminal-law system, as a whole – appears nonetheless to be a road needing generalized consent in order to profitably work, and this consent does not appear obtainable, at least in the short to medium term.[26]

A certain conditioning of the will of the drug addict who has committed a crime is therefore inevitable, and this, for that matter, distinguishes the situation so far considered (this too as per art. 32 of the Constitution), from that of the drug addict who has not as yet committed any crime, for whom absolute respect for his free therapeutic option must hold good.

In light of these remarks, the system of measures alternative to assignment on trial to a therapeutic community may well form a useful "starting model" for the law makers. This, note well, not just to create a "special law" for drug addicts, but rather – introducing it too into a catalogue of more modern security measures, already for some time "put in order", from a substitutive standpoint, as true alternatives to punishment for those who are not chargeable[27] – to place it in the more correct *sedes materiae* and avoid, at the same time, the danger of unjustified damage to the principle of equality.

Within a prospect of the reform of the security measures inspired by the treatment-instead-of-punishment system, the social therapy institutes and the therapeutic communities must take the place of the decrepit judicial psychiatric hospital, inexplicably, as things stand, still (considered) good both for the mentally ill and for the drug addict.

However, considering the analogy, by now more than once remarked on, between therapeutic communities and social therapy institutes, the former could represent the "alternative" for drug addicts who have committed a crime.[28]

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[26] Cfr. *Manna/Barone Ricciardelli*, The limitations and formalities of criminal law provisions concerning narcotics: considerations on legislation in Italy, in *Albrecht/van Kalmthout*, Drug Policies in Western Europe, Freiburg i. Br., 1989, 195 et seq.

[27] Thus, *Musco*, La misura di sicurezza detentiva - Profili storici e costituzionali, Milano, 1978, especially with reference to the German experience, currently on loan in Italy too in the Draft of a new criminal code, worked up in 1992 by the "Commissione Pagliaro"; Cfr. Documenti Giustizia, 1992, 3, 305 et seq.

[28] Underscoring these analogies too, and authoritatively, is *Kaiser*, in: *Arnold*, Bericht über die Kolloquiumsdiskussion "Zur Evaluation der Sozialtherapie – Ergebnisse zu

Anyhow, if it is true that the legitimacy of a measure is to be subordinated to its efficacy, the fact that some 70 % of the therapeutic programmes undertaken in these communities report success, and that the rate of recidivism of those coming out of the social therapy institutes has sensibly dropped (by 10-15 %), it does not appear possible to doubt the wellfoundedness of such a prospect of reform.[29]

It is finally to be brought out that, for what specifically regards the therapeutic communities, the system introduced in the German federal laws on narcotics appears anyway preferable, in its demand for a specific "causal connection" between the fact of the crime and the condition of drug addiction, for there to be assignment on trial to the social service.[30]
This not only because otherwise, as with us, the benefit runs the risk of possessing too wide a radius of action, it being able to extend as well to crimes having nothing to do with the state of drug addiction, but also, within a prospect for reform, since it appears more suited to the need for a close relationship between the fact of a crime and the correlative criminal sanction, within a viewpoint that intends to truly privilege special prevention.[31]

einer experimentellen Längsschnittstudie zu Justizvollzugsanstalten in Nordrhein-Westfalen". Zeitschrift für die gesamte Strafrechtswissenschaft 106 (1994), 890 ss.

[29] Cfr. however for some criticism, *Ortmann*, Zur Evaluation der Sozialtherapie. Zeitschrift für die gesamte Strafrechtswissenschaft 106 (1994), p. 782 et seq., which expresses the wish most of all for a treatment "outside walls", which however runs the danger of undervaluing the need for society's safety.

[30] Cfr. *Baumgart*, Illegale Drogen - Strafjustiz - Therapie, Freiburg i. Br., 1994, p. 397 et seq.

[31] Permit, for further treatment, the reference to *Manna*, Imputabilità, pericolosità e misure di sicurezza: verso quale riforma?, in: Rivista italiana di diritto e procedura penale, 1994, p. 1318 et seq.

Section B:
The Construction of National Drug Policies:
Some examples from various European countries

Introduction to the Section

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Perspective

„Social problems are social constructions", according to social constructionism (Spector& Kitsuse, 1977). „A social problem exists primarily in terms of how it is defined and conceived in society", as Blumer (1971) put it. The body of possible solutions is limited by the primary definitions. When the perspective of a problem is defined, the horizon for possible solutions is also fixed. It is therefore important to analyze the definitions by which the drug problem is conceived while studying the construction of national drug policies. Other important components in the analysis of policy formation are social actors and the processes of collective definition. Phrased in the language of social constructionism, an analysis of the policy formation in the area of social problems should be focused on three different components: (1) *claims concerning the definition* of a problem, (2) *claim makers* who are making competing claims, and (3) *claim-making processes* where competing claims are presented, evaluated and measured (see e.g. Best, 1989).

A number of different social actors can operate as relevant claim-makers in the construction of national drug policy. Initial public attention to a social problem is often paid by individual citizens or by grass-roots organizations, social movements and pressure groups (Best, 1989). For instance, organizations for the parents of drug users and those for drug users themselves are typical grass-roots claim makers specialized in the drug issue. But the first

alarm can come from the side of public organizations, too. Lindgren (1993), who studied drug policy in Sweden, argues that social constructionism as a theory developed mainly in the USA perhaps reflects best the dynamics of American society and underestimates the role of the authorities in the first phases of the process of collective definition. State authorities can discover a problematic condition and start to define a social problem by themselves, and it seems that they even can maintain such a definition by controlling the information on it (Lenke & Olsson, this volume). Important social changes, such as the transition processes in the former communist societies of Eastern Europe, can bring new actors into the arena or enhance the influence of old actors, such as the penal administrative authorities (see Moskalewicz & Swiatkiewicz, this volume). There is general agreement that in the later phases of problem definition the role of the authorities is very important (Blumer, 1971, Best, 1989).

Especially influential claim makers are those actors who manage to acquire the status of being the first specialist on the topic. *'Ownership of public problems'* is the concept used by Gusfield (1981) when referring to the ability and power of an actor to create and influence the public definition of a problem. The status of problem owner is typically aspired to by different kinds of professional groups or different departments of state administration. Competition between the medical professions and judicial authorities - or respectively, between social- and health care and law enforcement - over the ownership of the drug problem is a well-known phenomenon in the Western world.

The problems with and around drugs have a very special position within this theoretical perspective. Few social problem fields are 'managed' by so many ministries of national governments: i.e. those of Social Welfare, Health, the Interior, Justice, Education, Finance (related to Customs), Defence, and Foreign affairs. In some countries, for example in the Netherlands (see Wever, this volume) and France (see Barré, this volume), especially the Ministry of Public Health and that of Justice are involved in a territorial fight around the formulation and the execution of drug policy. Different authorities, working on the basis of very divergent starting points, are responsible for specific aspects of drug policy (see Albrecht, Barré and Wever in this volume). In practice this inevitably leads to an "inconsistency in objectives, conflict of interests, and paradoxical contradictions between objectives, territorial discrepancies in the implementation of the law and the prevalence of an ideological discourse" (Albrecht, this volume, and Barré, this volume). Sometimes national authorities, for example in the Netherlands try to reconcile the irreconcilable (see Wever, this volume). A claim maker who has achieved the privileged status of

problem owner holds a strong influence on public opinion which, in turn, is an important reference for the action of politicians and political parties. This can be observed very clearly in those countries where the role of the church is important, for example the Catholic Church in Italy (see Manna, this volume), which on the one hand emphasizes the definition of the drug problem as a moral problem, and on the other hand puts much effort into ameliorating the social and psychosocial consequences of the drug problem.

Also researchers from different disciplines of science and humanities are typical claims makers appealing to their special expertise in the definition of social problems (Best, 1989). During recent decades, in which there have been increasingly limited financial means for research, a battle has been fought between several scientific disciplines for competence and territory, a battle in which the aggression of the medical disciplines has come to the fore. The tendency of the medical disciplines to define social and societal problems as (public) health problems (accompanied with the implicit claim that solutions to the problems are in the offing, of course only after further huge investments in medical research and development are made) constituted a dominant factor in the domain of policies concerning drug-related problems.

It goes without saying that in modern societies the mass media play a very important role in the construction of social problems. A striking example comes from Denmark, where the debate over compulsory treatment is still very lively. Its influence on public opinion is hard to overemphasize. We know that the picture the media give us about different social problems is often one-sided and uncomplicated. The media tend to over-simplify reality. For instance, the media do not systematically cover all forms of crime and victimization: they emphasize some crimes and ignore others, and they sympathize with some victims and blame others. As Barak (1994) puts it: „Media portrayals of criminals tend to be one-dimensional reflections of the crimes commonly committed by the poor and the powerless and not those crimes commonly committed by the rich and powerful". In some emotionally sensitive cases, the influence of the media on the public can be so strong that it causes effects which have been called „moral panics" (Cohen, 1973). It is clear that emotionally the drug problem is a very sensitive issue. The Mafia, drug lords and other drug sellers are generally seen as a menace to society, a phenomenon that lends itself to 'over-reporting' in the media. The concept of moral panic has been regarded useful to, for instance, the analysis of drug discussion in the United States during the late 1980s (Goode & Ben-Yehuda, 1994). It is this moral panic that totally frustates the debate about the question whether it would be more ra-

tional to fit policies in the field of soft drugs in with alcohol rather than hard drugs policy.

However, the agency of the media is a complicated question, because it also forms an important arena for other claim makers. Modern society can be characterized as a media society. A claim maker who wishes to have an effect upon the construction of a problem will try to get his or her voice heard in the arenas of the mass media. Articles, press conferences, media announcements and interviews are typical direct interventions of the claims makers in the media. A more hidden way for a claim maker to get his/her view into the media is by acting as a news source, which usually presupposes a certain authority. News is a product of transactions between journalists and their sources. It is even reasonable to argue „that the real reporters are source spokepersons, who do all the essential 'signwork' within their organization in order to produce an acceptable news account. The reporter for the news organization then functions as an 'editor', determing what aspect of his material will be used ..." (Ericson et al., 1989). In the following section of this volume, the main actors and sources of news in the construction of the drug problem in several European countries will be identified.

Other important public arenas where social problem definition evolve are those of public authorities and of political debate and action. Arenas of public authorities are important for the preliminaries for the legislation on the one hand, and for the implementation of the official plans of action on the other hand. According to Blumer (1971), in order to acquire full social recognition, a social problem candidate has to pass through five different stages of the process of collective definition: (1) the emergence of social problems, (2) the legitimation of social problems, (3) the mobilization of action, (4) the formation of an official plan of action, and (5) the implementation of the official plan. Arenas of political debate and action have a critical role in the legitimation of a social problem and in the mobilization of action against it. In the formation of official plans of action, the role of political arenas is decisive.

Parliament, government and political parties as well as (in countries such as Finland and France) the office of the president are the most important national political arenas. Records of legislative dicussions in national parliaments offer especially interesting and compact source material for studying the construction of the drug problem in the different countries. Hilgartner and Bosk (1988) argue that feedback from and interaction between different arenas of public discourse can be regarded as a central characteristic of the process through which social problems are developed. It is of great advantage to the analysis

that indications from different public arenas can be found, politically weighed in the records of the arenas of parliament. Only those claims that manage to get political support will survive in the debate. Parliament - which, with its legislative power, is at the top of the hierachy of the arenas for public discussion - can be seen as an arena where the process of defining and redefining a social issue takes place in a concentrated form (Blumer, 1971). In the struggle between different claims and their supporters, those claims and arguments that manage to get most political power and support will be the most succesful in the formation of an official plan of action as well as in the institutionalization of a social problem. As is shown in Chapter 16, in the debate on the moral issues connected with the drug problem, the Finish parliament has been eager to change the government bill, a phenomenon otherwise not so common in Finland.

The contributions to this volume show that several events or epochs can be distinguished in the construction of national drug policies. The first one is the definitory process which led to national drug legislation. Several authors conclude that this legislation is mainly a response to actions at the international level (Laursen, this volume, and Wever, this volume) rather than to developments in the national situation. It was not until the late 1960s and early 1970s that domestic concerns culminated in more nationally-oriented processes of drug legislation, making the differences in starting points and objectives of the different actors and claim makers more manifest. Despite the formal bond with international treaties, this led to a phase during which the official drug policies of the different European states increasingly diverged. These divergences were abundantly covered in the political debate and by the media. However, a comparison of implementation practices clearly shows that today these apparently diverging policies are converging more and more (Wever, this volume, and Albrecht, this volume).

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Swedish Drug Policy in Perspective

LEIF LENKE & BÖRJE OLSSON

Introduction - a massive drug policy

The ultimate objective of Swedish drug policy is the achievement of *a drug-free society*. What originally was a utopia formulated by anti-drug organizations within the framework of moral ideologies has since the beginning of the 1980s been fully adopted by parliament and the government as the principle goal to which all drug policy measures are to be subordinated (Swedish National Institute of Public Health – SNIPH, 1993). Together, these measures form what might be called a comprehensive and massive drug policy, which during the 1990s has become redirected towards more repressive measures on behalf of "social" prevention, treatment and rehabilitation in general.

If we look at the different measures utilized in Swedish drug policy, there is however nothing unique about them. Information, prevention, law enforcement, treatment and rehabilitation are standard measures in most countries where something like a comprehensive drug policy is conducted. What might be unique - apart from the definite aim of a drug-free society - is the *massiveness* of Swedish policy, not only in relation to what other countries invest in drug policy measures, but also in relation to the extent and character[1] of drug abuse and drug problems in the country.

[1] One peculiarity of the Swedish drug problem is the strong domination of injected *amphetamines*. Only about *one-third* of Swedish IV users are heroin users. The total number of *persons who have used drugs intravenously during the last twelve months* in Sweden has been estimated at ca. *15,000* (Olsson, O., Byqvist, Gomér, 1993).

In this article, we will outline current Swedish drug policy and its historical roots in order to provide an understanding of its character, which some claim to be unique. We will also try to delineate and evaluate the most important claims regarding Swedish drug policy and its effect on the drug problem.

Historical roots

As in most countries, the use of drugs, which in modern times have legally been defined as narcotics, has a long history in Swedish society. Best documented is the use which in some way is related to medical practice. Studies of the use and conceptions of narcotics (opium, morphine, heroin, cocaine, amphetamines, cannabis, LSD, etc.) during the 19th and first half of the 20th century indicate that they were frequently used as pharmaceutical preparations, and had mainly positive connotations. No clear-cut drug policy existed before the 1960s. In relation to today's standards, the limited control of drugs and their use existed as integrated parts of medical regulations. If a comprehensive definition of the drug problem existed at all, it was as a private and medical problem in sharp contrast to its public and socio-legal definition dominating today (Olsson, B., 1994).

Obviously, important changes occurred in the patterns of drug use and the social composition of users between the end of the Second World War and the beginning of the 1960s. Perhaps the most important single factor was the introduction of synthetically produced amphetamines (or other stimulants of the central nervous system) at the end of the 1930s and beginning of the 1940s. Attitudes towards the medically motivated use of such substances were primarily positive, and few negative consequences were reported. Therefore, this activity was not initially identified as a part of the drug problem, despite the fact that use rapidly spread among the population. This widespread use was however recognized in an early study.

> "It can be estimated that in 1942-1943 there were about 200,000 users of amphetamines in Sweden, corresponding to 3 per cent of the adult population. About two-thirds (140,000) were occasional users - one-third taking the drug only once, and one-third 2-4 times per year. Of the rest, some 60,000 would be taking the drug between several times a year and twice a month, and some 4,000 around once a week, all these taking 2-3 tablets on each occasion. Higher doses would be taken by some 3,000, from several times per week to daily, in doses of up to 5-10 tablets per day. The number of excessive users was small, around 200, these showing different somatic and psy-

> chic symptoms of abuse, taking up to 10, 50, 100 tablets per day on a more or less continuous basis" (Goldberg, 1968, p. 4).

Measures were also introduced to reduce the high consumption of amphetamines: in 1939 they were subject to prescription, and in 1943 the Swedish Medical Board distributed a circular letter in which all doctors in the country were informed of and warned about the risks of amphetamines. In 1944, important parts of the Swedish Drug Ordinance became effective also for amphetamines. This led to a substantial decrease in sales of amphetamines by pharmacies - from more than 8 million doses in 1942 to about 4 million in 1943. However, this reduction was temporary, and during the next 16 years, sales increased by 725 percent and amounted to 33 million doses in 1959.

Growing concern about the extensive use of amphetamines, accompanied by an increased awareness of risks associated with these and other drugs, led to additional administrative control efforts and to legal measures, such as the classification of amphetamines as narcotics. In just a few years, between 1959 and 1965, legal sales of amphetamines dropped by 82 percent, from 33 million to 6 million annual doses.

Obviously, these measures were well suited to curb the less intense forms of amphetamine use, especially amphetamine use among middle- and upper-class people who mainly used them in order to combat fatigue, to reduce weight, or just to have fun. However, more intense forms of amphetamine use continued to increase, especially among criminals, prostitutes and other groups on the margins of society. The annual number of persons convicted for drug offences serves as one indicator of the turn from legal drug use to illegal drug abuse. Between 1954 and 1957 there were only a handful of convictions per year. In 1959, when the legal selling of amphetamines was stopped, 50 persons were convicted, a number which increased to approximately 320 persons in 1965 (Narkomanvårdskommittén, 1969).

In sum, a drastic change in the structure of consumption occurred during the 1940s, 1950s and the first half of the 1960s. (It should be mentioned that the use of other drugs, such as heroin, cocaine, and cannabis, played a subordinate role during these years). As Table 1 shows, from being characterised by a large number of occasional or experimental users and a very low number of intensive abusers, the drug problem underwent a shift so that the former groups were reduced to a fraction of their earlier levels, whereas the numbers in the latter groups increased.

Table 1: Estimated number of amphetamine users in different user groups in the years 1943, 1959, and 1965[2]

User group	1943	1959	1965
Occasional	133,000	175,000-225,000	40,000-60,000
Experimental	60,000	75,000-125,000	20,000-30,000
Regular	4,000	7,500-12,500	12,500-17,500
Abusers	3,000	2,000-3,000	2,225-3,225
Severe abusers	200	500-1,000	1,000-1,500

The explanation for this change is that individual use was very sensitive to the intensified control of amphetamines, and that this coincided with an increased awareness of the involved risks. Moreover, drug abuse increased as a result of the easy availability of these substances. In that drug abuse had a strong subcultural base, at the same time health care resources that could help individuals leave the group were almost non-existent (Olsson, B., 1994). The subcultural base also meant that the consequences of drug abuse in part were different due to the group's general situation, and in part became visible since the group was already known as one made up of deviants. Social problems and criminality more and more became the visible offshoot of drug abuse. Parallel to the growing attention aimed at subcultural abuse, the focus on medical abuse, the non-medical abuse among the general population, and mentally disturbed abusers decreased.

In sum, the institutionalisation of the drug problem, in terms of specific laws, police forces, treatment facilities, etc., had barely begun by the mid 1960s. Legislation was expanded and sharpened, the police were granted greater resources, and a special drug prosecutor was appointed. But otherwise, large-scale institutionalisation was not to materialise until after the Commission on the Treatment of Drug Abusers completed its work, that is, near the end of the 1960s. At that time, the development had in part assumed a new character. The abuse of amphetamines among subcultural groups continued as before, but young people had now become involved by the introduction of cannabis into Sweden following international trends.

[2] The estimates are based on Olsson, B., 1994, pp. 204-208. Estimates have been possible for only the few years for which fairly good data have been presented.

This further accentuated the conception of drug use as one of our country's most serious public and social problems.

As regards the development of experimental and more serious use of drugs from the late 1960s up to today, there seems to be general agreement on the following interpretation (SNIPH, 1993, CAN, 1996). Experimental use, most often measured through surveys in different populations (see for instance Graphs 1 and 2), shows an increasing trend until the beginning or the middle of the 1970s. From then on, it levelled off and in many groups a substantial decrease can be noticed. The 1980s show comparable low and stable levels of experimental drug use, which seem to have turned into an increasing trend during the very last years of the 1990s. More severe forms of drug use, for instance incidence of intravenous use (Graph 3), show a similar picture. The late 1960s show an increasing trend, but already at the years around the turn of the decade, the incidence starts to diminish. From about 1973 and onwards, the incidence has been stable on a low level. The introduction of different drug policy measures, which are described in the following sections, should be understood in relation to this, far from dramatic, development of the Swedish drug epidemic.

The formulation of a restrictive drug policy

The 1960s

The mid-60s can be characterised as a time when the use of drugs publicly was articulated as a serious - and growing - problem, but where the situation is unclear with regard to problem analysis, action proposals, and the implementation of proposed measures. Lindgren (1993) identifies three drug policy strategies in his analysis of the establishment of narcotic drugs as a public problem in the 1960s: *the control and sanction strategy, the treatment and reform strategy, and the legalisation strategy.* The years 1965 to 1969 have been termed a period of investigation (Stensmo, 1979), and it is probably correct to interpret the simultaneous advocating of different perspectives as a fight over the "true" definition of the drug problem.

The legalisation strategy was the least influential of the three. Nevertheless, it received quite a lot of attention from the mass media, but this was due to a few influential persons who advocated this strategy. Their influence on Swedish drug policy during these years was, however, limited. The proponents of the strategy were in many respects linked to the international

"protest movement" of the time, and among their claims were that such drugs as cannabis, LSD and other hallucinogens should be sold at pharmacies. Their only real success was that they together with some physicians involved in drug treatment provided ideas and gave legitimacy to a temporary experiment where amphetamines and opiates were prescribed to a limited number of addicts in Stockholm between 1965 and 1967. After that, the legalisation strategy disappeared, from both the media and policy debate[3].

The control and sanction strategy was revitalised during the latter part of the 1960s. Parts of its roots can be found in the tradition behind the establishment of international drug control at the beginning of the century. The *availability* of drugs was stressed as a major factor of concern together with their *dependence-producing* capacities as the main causes of addiction. Furthermore, the spread of addiction was seen as though it were an epidemic of a contagious disease. Law enforcement with strict sanctions in combination with compulsory treatment - the latter because addicts were conceived as lacking insight into their "disease" - were seen as the most important drug policy measures.

It is also obvious that the control and sanction strategy was heavily influenced by thoughts and ideals dominating the Swedish temperance movement (Lenke, 1991). Moral aspects played an important role, and drug use was conceived as a threat to values advocating work, duty, and faithfulness (Lindgren, 1993). The hedonistic lifestyle connected to drug use posed in this respect a threat not only to the individual user but to society in general. Another important actor in favour of law enforcement measures was the police. In Sweden, the police have been one of the most influential actors in influencing drug policy. The creation of a National Police Board in 1965, when the police became nationalised and could centralize and boost their information and propaganda, further strengthened its role. Examples of such information and propaganda activities are the production of a comprehensive drug policy document which by far extended their area of competence (Rikspolisstyrelsen, 1989), publications of several pamphlets on drug issues in close cooperation with certain anti-drug organisations, the opening of a special drug information centre at the Police Academy, and the police as perhaps the most influential agency providing drug informa-

[3] The consequences of this extremely liberal prescription project are uncertain, but it probably had very limited impact on the already ongoing epidemic (Lenke and Olsson, B., 1996a, forthcoming).

tion to pupils in public schools. This central role of the police as an extremely influential group is hardly found in any other European country (Lenke and Olsson, B., 1994).

The treatment and reform strategy was inspired by a general critique of the capitalist society characteristic of the period. Inequality, unfair distribution of material resources and bad social conditions were focused upon and attributed as an important cause of addiction. A general social reform policy was seen as an important countermeasure to reduce the risks of becoming addicted. For the individual addict, *treatment instead of punishment* was the rhetoric parole. The strategy appeared radical, not only because it presented its society critique, but also since it had its strongest allies among "new" disciplines and professions which grew strong during this period. They were, among others, sociology, social medicine, psychodynamic oriented psychiatry and psychology, together with social work. In general, it can be said that the treatment and reform strategy was more successful in influencing the public debate than the conducted policy. This, however, was to partly change in the 1970s.

The definitional process during the late 1960s led to the implementation of different measures. The main points concerned law enforcement, such as the new Narcotic Drugs Act in 1968 which replaced the old Narcotics Ordinance. These measures meant that the maximum penalty increased from 2 years' imprisonment in 1962, to four years' in 1968 and six years' in 1969. In 1968, the government presented a "10-item programme", the main parts of which were accepted by parliament in 1969. This meant among other things the allocation of substantially increased resources and power to the police and customs, increased international law enforcement collaboration, and Swedish initiatives to include amphetamines and other drugs in the Single Convention from 1961.

Some efforts - but less substantial ones - were made to strengthen measures such as information on drugs, preventive work and treatment. One reason for this was that treatment mainly was a responsibility for regional counties and local communities.

The 1970s

The great concern about drugs during the 1960s led not only to the formation of control and other drug policy measures, but also to the initiation of epidemiological and other research projects. Thus, trend data on drug use and misuse are available from the late 1960s and the early 1970s (CAN,

1996). According to these data, the recruitment from criminal or other subcultural groups to the frequent or heavy use of amphetamines already had reached its peak during the first years of the 1970s. The decline seems to have continued until the mid-70s when heroin found its way onto the Swedish drug market. The same can be said about the experimental use of drugs (mainly hashish) which in large seems to have followed the development of international youth culture trends.

Compared to the previous decade, the 1970s saw no major deviation from the drug-policy road Sweden had embarked upon. Sharpening of the penalties continued: the maximum penalty for aggravated drug crimes was raised to 10 years' imprisonment in 1972. This satisfied for some years the demands for powerful action against more severe forms of drug criminality, especially crimes with international connections. During most of the 70s, the attitudes towards and measures taken to combat street dealing and possession for personal use were, in comparison to today's Swedish standards, very liberal. Since 1968, it had been possible to waive prosecution if a person possessed small amounts of drugs for personal use. In 1968 the amounts for cannabis and amphetamines were set at 2-3 grams and 100 tablets, respectively. The main reason behind the possibility to waive prosecution was to avoid unnecessary conflicts between law enforcement measures and treatment.

From 1977 and onwards this praxis started to be questioned. Among other things, it was claimed that drug dealers had adapted to the situation in that they now avoided carrying anything but small quantities of drugs. This made it more difficult for the police to take legal action against drug trafficking. As a result, the local prosecutor in Stockholm decided not to waive prosecution for the possession of heroin or cocaine. The police also started to more actively tackle street-level dealing. In line with the critique, the public prosecutor instituted new rules in 1980, where prosecution should occur also for very small quantities of drugs. Only if the quantity of cannabis or amphetamine was impossible to subdivide into smaller portions could waiving be considered. For heroin, cocaine and other hard drugs, waiving became practically impossible.

Even if the allocation of resources and development of treatment methods was intensively discussed from time to time, the general impression is that treatment measures did not develop in parity with control measures. It has been shown (Stensmo, 1979) that when control policy measures are compared with treatment and social policy measures in general in order to

combat drug problems during the 1970s, the public efforts have mainly been put on the former type of measures. When investments or other types of efforts were made concerning treatment and other social activities (including prevention), they were limited to setting up committees to investigate future policy or to allowing some government subsidies to local communities or non-governmental organisations (NGOs) for them to set up or to expand treatment facilities.

During the 1970s, the drug policy discourse centred around the question whether or not it should be possible to utilize compulsory treatment for adult drug addicts. This issue also had a significant impact on many other drug policy issues, since it reflected different approaches to drug addiction and its causes.

The 1980s

The late 1970s and early 1980s is claimed to be a period when Swedish drug policy took a turn in favour of a considerably more restrictive approach. In the public discourse, it is even claimed that this turn constitutes a break with the policies of the 70s, which today rhetorically is labelled as liberal. No doubt new and stiffer law enforcement policies did imply a more restrictive or even repressive drug policy, but it is doubtful whether one can say that this constituted in a qualitative sense a totally new policy. As was described above, the foundation of a restrictive policy was laid already in the late 60s, and what happened during the years around 1980 can probably best be described as a strengthening of certain policy measures which already were an important part of the overall drug policy.

The development of drug use did not undergo any major changes during the 80s. In 1979, the extent of heavy drug abuse[4] was estimated at 10,000 - 14,000 persons in a national case-finding study. A second nationwide case-finding study was carried out in 1992, and gave an estimate of 14,000 - 20,000 heavy drug abusers. Assuming that the true prevalence figures fall somewhere in the middle of these intervals, the increase of heavy drug abuse amounts to about 40 per cent, of which the major part can be attributed the 1980s. Looking at other indicators (seizures, drug offences, drug abusers in prisons and on probation, etc.) the increase should be concentrated in the first and last years of the decade (CAN, 1996). If the age dis-

[4] Heavy drug abuse was defined as all use of narcotic drugs through injection (regardless of frequency) or daily or almost daily use if administrated in other ways.

tributions between the two investigated years are compared, they suggest that the incidence must have been low in the lower age groups (Olsson, Orvar et. al., 1993).

Experimental use of drugs as reflected in school- and conscript surveys shows a slight increase in life-time prevalence during 1980 and 1981. Thereafter, the proportion that has tried drugs shows an annual decrease until the middle of the decade. During the remaining years of the 1980s, the prevalence figures stayed at this low level (CAN, 1996).

Even if data indicates that 1) the major decreases in the experimental use of drugs and incidence to more severe forms of drug use occurred already in the 1970s (see Graphs 1, 2 and 3), and 2) the prevalence figures for heavy drug addiction levelled off during the same time period, Swedish drug policy changed in a more distinct way during the 1980s compared to the 1970s. The most significant changes concerned law enforcement (stiffer drug laws, extended resources and power to the police and customs) and an expansion of the treatment system.

The more repressive development of law enforcement was signalled already during the last years of the 1970s. We will come back to the reasons for this at the end of the article, but the new centre-liberal-conservative coalition government which was in power between 1976 and 1981 certainly had made drug policy a higher-ranked policy issue. As well as ruling out most of the possibilities for the waiving of prosecution in 1980, drug laws were sharpened. In 1981, the maximum penalty for drug offences was raised from 2 to 3 years' imprisonment, and the minimum penalty for aggravated offences was raised from 1 to 2 years' imprisonment, and the possibility of 16 years' imprisonment was introduced for recidivism in aggravated offences. The maximum penalty for minor drug offences was raised to 6 months' imprisonment in 1985, and in 1988 the consumption of drugs was criminalized after intense pressure from various groups.

If increased repressive measures - especially those targeting lower levels, such as street dealing and drug use - was one important tendency in Swedish drug policy during the 1980s, the expansion of the treatment system was another (the latter as a conscious response to the threat which the HIV virus posed to intravenous drug users). In contrast to many other countries, Sweden did not embark upon the road of harm reduction as a major strategy to limit the HIV epidemic. On the contrary, measures such as needle exchange programmes and (at least initially) methadone maintenance programmes were conceived as something negative since they counteracted

the main goal of Swedish drug policy: a drug-free society. If the authorities were to provide drug users with clean needles or other harm reduction measures, it would send completely wrong signals about society's view on the use of drugs.

Instead, the main policy became the "offensive drug treatment strategy". By a massive investment in treatment, all drug users should be reached and offered treatment. By this, it was thought, the spread of HIV could be limited in a better way than by harm reduction measures (SNIPH, 1993). Even if this was not achieved, the strategic choice was nevertheless conceived as correct since drugs were conceived as a bigger threat to society than HIV/Aids. Not all drug addicts, however, will accept treatment when offered. Therefore, a special faculty for the compulsory treatment for adult addicts was introduced when the social welfare legislation was reformed in 1982. Compulsory treatment was maximised at four months, during which addicts primarily were to be motivated to continue with voluntary forms of treatment. Through this legislation the main drug discourse issue stemming from the 70s culminated. From now on, the question of the criminalization of drug use itself evolved as the main issue which divided people and organisations into different drug-policy camps.

Looking back at the 1980s, it can be concluded that Sweden conducted a comprehensive and massive drug policy in all respects: prevention, repression, and treatment. Towards the very end of the decade it became obvious that the balance between different policy measures had changed: repression was strengthened on behalf of prevention and treatment. At least two important reasons for this can be distinguished. First, the moral organisations in conjunction with the police successfully managed to exercise influence on public opinion, politicians, the mass media and others, thereby pushing the policy in a considerably more repressive direction. Second, the negative development of the economy, which now began to be obvious, gave rise to political ideologies which prescribed reductions of public spending, resulting in substantial reductions of treatment and other preventive activities in the 90s. For instance, in Stockholm the economic resources spent on substance misuse care decreased by 50 per cent from 1991 to 1995 (Blomqvist, 1996).

Finally - and perhaps most importantly, even if these are not seen as "pure" drug policy issues - social policy in general and the full employment policy (both signs of the traditional Swedish welfare state) started to lose ground. As have been shown, factors like these are of importance, not only

to limit the incidence of drug use, but also probably in order to rehabilitate "old" addicts (Lenke and Olsson, B., 1996b). At the turn of the decade, these tendencies were the most important, as the traditional *restrictive* policy was redirected towards a more *repressive* one.

The 1990s

The years around 1990 will no doubt go down in the history of Europe as being of great significance. The processes of disintegration in the East and integration in the West had important implications in a variety of fields. Drug use and drug policy were no exceptions. In Sweden it meant that the actuality of drugs was renewed. Even if surveys and indicators reflected a drug situation where the incidence rates of different forms of drug use had stagnated on the lowest levels since drugs had first become a public problem in the 1960s (CAN, 1996), it was still possible to put the drug question forward as a continuous menace and threat to society. Due to the rapid and radical changes in Europe, drugs started to be seen as a foreign threat which, if the drug policy was not again strengthened, was expected to invade the country. The enemy did, so to speak, "move abroad" (Tham, 1995).

The fear of a foreign threat was in certain respects substantial, even if it is disputable to what degree this was actually the case. At least three circumstances can be distinguished. First, the opening of the borders with the East, the general orientation towards the West and Western market hegemony, and the breakdown of old (control) structures led to an upheaval of drug production and distribution from these countries. Sweden's geographical position certainly gives rise to worries in this respect. Second, the dismantling of custom controls, and third, influences from drug liberal ideas from the continent.

During the election process concerning Sweden's entrance into the EU, the heat of the Swedish drug policy climate became extraordinary illuminated. The Minister of Justice found it necessary to appear in the media and try to calm people's fears about the drug issue. Together with the Conservative Shadow Minister of Justice, a statement was made saying that the drug threat was not large enough to keep Sweden out of the EU. Nevertheless, the fight against drugs was said to be even better fought within the Union in cooperation with the initiation of Europol - an interesting remark considering the fact that the head of Europol had appeared on Swedish television many times, stating that cannabis, as a "soft" drug, could not be

regarded a severe enough problem to be of any priority to Europol. As everyone knows, in a drug-free society cannabis - as a stepping stone to other drugs - is believed to be the "real" threat to youth and society. Drug policy, thus, had suddenly become a "national project" (ibid.).

As regards drug policy developments and drug trends during the 90s, a few things deserve to be mentioned. The development towards a more repressive balance of the policy continued. One important issue was that prison was included as a sentence for drug use, giving the police the power to conduct urine or blood tests in order to secure evidence of drug use. This led to intensified police actions against street-level dealing and personal drug use. Another issue was that the weak public economy made it more difficult to continue with preventive and treatment measures as active and extensive as before. A break in drug trends also appeared. The experimental use of drugs, as reflected in surveys, increased for the first time in many years. Among conscripts, for instance, life-time prevalence almost tripled between 1991 and 1996. The studies also reflect more positive attitudes to drug use, and the use of drugs (e.g. ecstasy and LSD) in connection with parties (raves, etc.) attracted certain groups of young people. Finally, various indications of an increased recruitment to more severe forms of misuse appeared (CAN, 1996).

Policy determinants

So far our chronological description of Swedish drug policy has touched upon several issues which in different ways have influenced its development. In this section we will focus on two factors which we consider as especially important in this context. They are the strength and influence of Non-Governmental Organisations (NGOs) and the impact of the Swedish welfare society.

Non-Governmental Organisations

A special feature of the Swedish drug policy is the strong impact of non-governmental organisations (NGOs). In Sweden there exist mainly four different organisations focusing on drug policy. One is the National Association for a Drug-free Society (RNS), with its roots in the labour and temperance movements, and among social workers. A second is Hassela Solidarity, which evolved around a treatment centre. A third is the National Swedish Parents Anti-Narcotics Association (FMN), the fourth, the Swed-

ish Association for Help and Assistance to Drug Abusers (RFHL), which is a client organisation. Further, many other organisations, primarily focusing on sports, youth, politics, etc., integrate drugs as an important theme in their activities.

A common pattern of the first three organisations is that they have roots in the Swedish radical temperance movement[5]. Therefore, they also from the beginning advocated compulsory treatment, and rejected any form of "harm reduction" activities in drug policy. They acted as pressure groups, and have gradually achieved their goals. Their main goals were to include drug offenders in the *Compulsory Treatment Act* for alcohol abusers (1982) and to *criminalize the use of drugs* (1988) and make it possible to use drug testing (urine tests) to prove illegal drug use (1993). They also advocated strong reinforcement of the police, and that police activities should concentrate on the level of *street dealing* rather than on higher levels (years in brackets indicate attained legislation).

The tactic of these organisations has been to cooperate closely with the police, who in turn have benefited substantially by receiving increased resources and powers. These organizations have also initiated – or at least supported – political party competition, and thereby supported a "war on drugs" atmosphere which was stronger than that found anywhere else in Europe. This means that "more repression in drug policy" has increasingly become a standard item on the political agenda of the conservative parties, especially around general elections and when the Conservative Party is in opposition[6].

A special characteristic of Swedish drug policy which NGOs have helped establish is the very close cooperation between them and governmental and other public bodies. A unique unity around drug issues has evolved which, for instance, has led to a willingness among Swedish social workers to closely cooperate with the police. Another trait is the willingness of parents organisations to demand repression and police interventions against drug users, who are the daughters and sons of the members.

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[5] Lenke (1991) has analyzed the temperance movements in Europe and classified them into moderate and radical branches. The *moderate* branch, dominating in Central Europe, tolerated beer and directed its policies against "hard" liquor. The *radical* branch, dominating in the Nordic countries and North America, banned all forms of alcohol. Some even ranked beer as an even more dangerous drink than hard liquor. This was according to their theory of beer being a "stepping stone" to liquor.

[6] A cross-border analysis of the party political aspects of European drug policies is given in Lenke and Olsson (1996b).

A final comment on the impact of these organisations is that they counteracted, as did the temperance movements before them, the hegemony that was held by the medical profession in the drug policy area in the 1950s and 1960s.

The Swedish Welfare Society

The concept "welfare society" encompass a wide range of ideas which have had a tremendous influence on several areas of Swedish society. No doubt such ideas and their realization must be considered in order to understand Sweden's response to drug problems. Important elements of the welfare society ideology are, among others, equality, social security, collective responsibility, and the belief in a strong and active state/public sector. Mutual moral values will be strived for and supported in a society built on such cornerstones, and a relatively strong degree of normativity will evolve.

When the use of drugs was defined as a severe social and public problem in the 50s and 60s, very strong negative moral connotations were attached to it. At the same time, however, a person who is involved in any form of deviant behaviour, no matter how disliked it may be, should be given the chance to "come back" to "normal" society. Further, if the individual lacks the capability, refuses or for any other reason fails to take the steps needed to return to a "normal" life, it is the duty of the welfare society to intervene. A phrase often heard in the Swedish drug (and alcohol) debate is that "society cannot silently accept that an addict is abusing him- or herself to death". Primarily, however, society should offer and provide instruments and resources which voluntarily can be used by the individual, but in a few extreme cases, such as severe forms of drug use, compulsory measures can be utilised if other measures fail. These ideas are clearly expressed in the social security and health care acts which provide the basic regulations concerning the prevention and treatment of drug problems. This principle of intervention, as an expression of solidarity, could probably be the one that distinguishes the Swedish social democratic form of welfare society from more clear-cut liberal forms.

This somewhat oversimplified analysis illustrates the mechanisms through which a welfare society operates in relation to its addicts. Apart from the concern for those already involved in addiction ("everybody has a right to and should be helped to achieve a good life"), the most important drug policy measures are those aimed at demand reduction, albeit through

the creation of the good welfare society where people do not "need" drugs, through the allocation of extensive resources for information and primary prevention, or through the establishment of an efficient and far-reaching control apparatus. The belief in the capacity of the state and public institutions to counteract drug problems in combination with the moral rejection of drug use itself has made possible the official, utopian goal of Swedish drug policy (to achieve a drug-free society), and provides us with an understanding of the development of the *massive* drug policy described in this article. Finally, in an important policy document (SNIPH, 1993, p. 32) it is stressed that "...the basic principle of drug policy is the duty of society to intervene ...".

On this latter point - that is, the belief in the capacity of the ("good") state to act not only on economic and social issues, but also on the moral aspects of life - the Swedish welfare model deviates from models in most other countries where the welfare society does not reach beyond socio-economic issues.

Available empirical data and their influence on drug policy

In many respects, social constructivism is a fruitful approach when analyzing developments of drug policies. So far we have discussed various factors and forces behind the Swedish response to drug use, but we have left out the empirical base and its influence on the definitions of drug problems and on the specific countermeasures undertaken. In this section we will highlight some of the epidemiological data already mentioned, and how they have been utilized to legitimize certain policy measures.

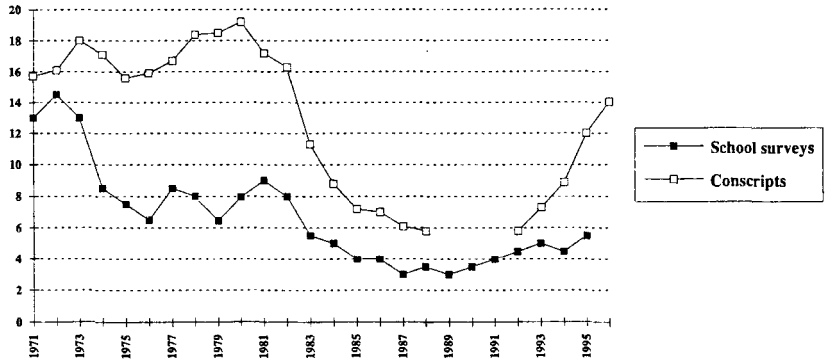
We have seen that drugs did not attract public concern before its use spread among groups of people already conceived as deviants, mainly criminals. In a way, this pinned down the qualitative conception of the drug problem, which has remained more or less unchanged since the 1960s. Since the early 1970s, when the first epidemiological studies were initiated, we have had a continuous fight over the dimension of the problem. Basically, this fight can be described in two different ways corresponding to the time periods before and after the late 1980s. Before that time, especially NGOs and other groups acting as moral entrepreneurs claimed that the level of abuse was higher than admitted by official bodies, and that the use of drugs was continuously growing. Therefore, stricter policy and especially more resources should be applied to drug control and other preven-

tive measures. The government and others officially responsible for the policy tried to moderate these claims. In both cases, more or less fruitful attempts were made to back up the arguments with epidemiological data. It is not easy to isolate the effects of the political utilization of these data, but throughout the period drugs continued to be one of the hottest public issues, and consequently a growth in policy measures occurred.

This claims-making process is probably a standard pattern when social and public problems are formulated. Even if it is hard to find empirical evidence for a rapid increase in drug use through surveys or other epidemiological data, it seems always possible to mobilize alternative data or evidence which is claimed to refute such a picture. During the last years of the 1980s, the dispute over the scope of the problem started to change. Previous opponents began to refer to epidemiological data as proof of a successful drug policy. First, these claims were only heard abroad when Swedish drug policy was contrasted to more liberal European ones. The domestic discourse continued as before for a few more years, but at the turn of the decade it changed in line with the argumentation put forward abroad.

The coherent message from now on was: Swedish restrictive drug policy has been successful, as reflected especially in data showing extremely low levels of experimental drug use among adolescents (Graph 1).

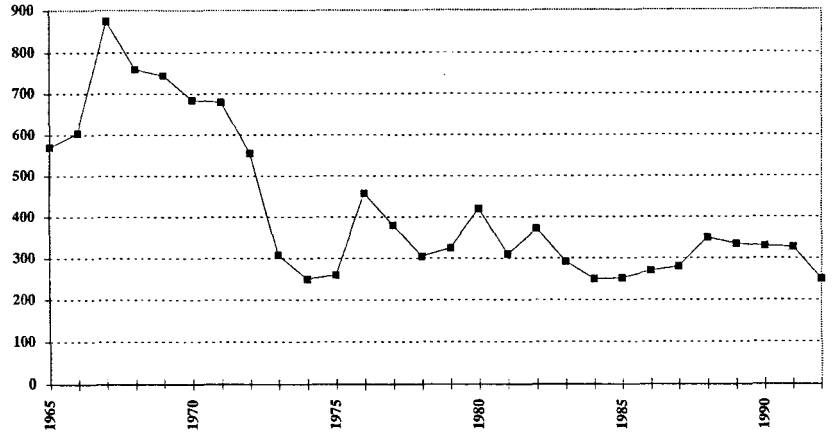
Graph 1. Drug use among Swedish youth. Conscripts and school surveys. Percent "ever used". 1971-1996.



Another indicator frequently used to interpret the development of drug use in Sweden and to assess the success of drug policy is statistics on the num-

ber of arrestees at the Stockholm remand prison who on inspection have needle marks (Graph 2).

Graph 2. Drug use incidence (intravenous) detected at Stockholm remand prison 1965-1992. Absolute numbers.



Basically, these data show the same picture. The growth of drug use which occurred during the 60s culminated at the end of this decade if we look at intravenous use, and in the early 70s if we look at experimental use among young people.[7] During the 80s, the figures either continued to decline, but not as fast as earlier, or stabilized at relatively low levels. The first half of the 1990s seem to constitute a break in these trends. Experimental use started to increase, according to the surveys presented, and several indications appeared of increased numbers of persons involved in the severe form of drug use (CAN 1996, pp. 126-128).

It is interesting to see how these figures have been used in the drug policy discourse in the last five years or so. The basic, and generally accepted,

[7] Drug use life-time prevalence among conscripts shows a somewhat different picture. The peak occurred during the very last years of the 1970s. However, if we look at the proportion who had used drugs during the last month, the decline started already before 1975. Since conscripts are older than those participating in the school surveys, their life-time prevalence figures might reflect drug-use experiences from earlier years. A dramatic increase in "Refuse to respond" at the beginning of the 1980s also creates serious problems of interpretation, especially as it parallels a decrease in the reported use of drugs.

message is that the Swedish drug policy model developed since the first years of the 80s has been very successful.[8] The interpretation is clearly expressed by, among others, Olsson, O. (1996, p. 61) in a report translated into English by the Public Health Institute and the Swedish Council for Information on Alcohol and Other Drugs (CAN) in order to reach an international audience: "The drop in new recruitment in Sweden for both experimental and heavy abuse /... / indicates that Swedish drug policy in the 1980s was successful, and more successful than in the 1970s". As can be seen from the referred figures (Graph 1-3), this conclusion is hardly supported by the data.

Those who would like to follow the scientific discussion on how to interpret the Swedish empirical data can be referred to Kühlhorn et al. (1996) and Tham (1996). The former argue that increases in control and repression have been systematically followed by decreases in drug use. The latter instead argues that drug misuse in Sweden has a long and steady decreasing trend that is rather unrelated to changes in control measures. A main argument is that the decrease was strongest in the 1970s, a decade that in the discourse is referred to by drug-control activists as "ultra-liberal".

Strictly speaking, however, the uncertain quality of epidemiological data combined with the absence of clear-cut operationalizations of drug policy measures and their hypothesized causal links to drug trends make a reliable evaluation of Swedish drug policy effects extremely difficult. Further, and as we have stated elsewhere (Lenke and Olsson, B., 1996b), other structural factors within which drug policies have to operate must be considered in order to understand both the development of drug use and the efficiency of any drug policy. Therefore, the use of Swedish data (may they be true or false) first and foremost illustrates their importance in the construction of the drug policy.

[8] In short, it is a policy where control policy measures have gained importance (i.e. criminalization of use, introduction of urine tests on a wide scale, street-level police strategies, more severe punishments, etc.), but, at least until the most recent years, emphasis has also been on other preventive measures and on treatment. Harm reduction measures which have been important elements of drug policies in many other countries have been strongly opposed by the authorities (low threshold institutions, needle exchange programmes, information on safe drug use, etc.) (SNIPH, 1993).

The current situation

The lines of argument in the current drug control discourse could be organised in two main categories. The first is the official view as presented by SNIPH and others. The second is a broad critique of the official view as presented by Tham (1996). In the following section we will present the main views and give our comments which can be seen as a modification and specification of Tham's argumentation.

The official line is built on a theoretical model formulated within alcohol policy research (Bruun et al. 1975), which says that negative consequences of alcohol are a direct function of the level of alcohol use in society. The argument is that if the general level of alcohol consumption can be decreased, the negative consequences of alcohol (i.e. 'misuse') will decrease. Thus, misuse closely follows use and cannot be counteracted without minimizing the general use of alcohol.

This model is applied to illegal drug use as well (Olsson, Orvar 1996). Thus, a decreasing trend in drug use – even experimental use – is seen as an indication of success as also serious forms of drug use will – sooner or later – decrease as well.

Tham's critique is, in short, that:

a) the decrease in the use of drugs in general does not necessarily affect really problematic drug use and its consequences, and
b) the decrease must not be a consequence of the drug policy, and
c) the many new repressive traits of drug policy cannot be defended as the limited marginal positive effects do not outweigh the massive negative consequences of the policy.

Our position in this controversy is close to Tham's, and we will in the following section present his argumentation together with our own comments. We will then give some final comments on certain topics that we believe have a more general interest to the drug policy discourse.

Experimental versus heavy use

Tham presents empirical evidence in support of his critique, and says that although the trend in general *drug use* was decreasing, the *drug deaths* among addicts has not decreased at all since the 1970s (ibid. p. 190). For older addicts there is even a strong *increase* in deaths. Nor has the inci-

dence in intravenous drug use decreased since the 1970s. (We will return to this argument below).

SNIPH, however, also argue that besides the reduction in experimental use, a marked reduction in the recruitment of younger IV-users took place during the 1980s (Olsson, Orvar 1996). This has been shown in a comparison of two case-finding studies of 1979 and 1992. Another argument is that the average age of IV-use onset has increased (Kühlhorn 1995).

This illustrates the very complex analytical problem, one magnified by the inconsistency of findings and the huge number of empirical indicators from which to choose.

One such problem deserves special comment due to its strong potential relevance. The problem concerns age. Decreasing trends of drug use in *lower ages* as well as *increased average age* among drug users is often used as an indication of a positive development. In some sense it certainly is. In another sense, however, it could simply mean that the appearance of the drug problem is changing, and that drug use is as frequent, but is delayed some years as regards incidence. (This process is illustrated in Norwegian surveys, where the time series for 16-year-olds decreases during the 1980s but increases for the 20-year-olds). (Christie and Bruun 1995, p. 140).

This phenomenon illustrates the danger of just using time series for the youngest age groups to give an early warning of what will come. The same goes for using *increased* average age to indicate a *decrease* in the incidence among the population studied.

In spite of strong decreases in some (experimental use) incidence indicators, the total number of *heavy drug users* increased substantially during the 1980s. According to SNIPH's second case-finding survey (CAN 1996), the increase was around 40 percent (p. 6 above). Another estimate is even higher (close to 100 %) (Kühlhorn et al. 1996b, p. 183).

In one important respect, the second case-finding study showed a very significant *decrease*. This decrease was in the lower age category (20-24 years), which decreased by about 60 % (Skog 1993).

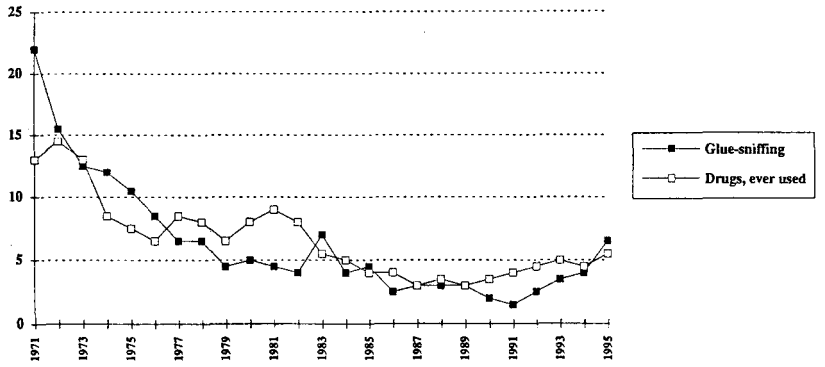
To sum up, there is a difference in opinion whether and exactly when the drug problem decreased in the 1970s and 1980s. Our position is that there were general decreases in experimental as well as 'heavy drug' use incidence in *one age category* in the 1980s. Our interpretation of the factors causing that reduction differs, however, from both that of SNIPH and to some extent that of Tham. This will be discussed in the following section.

Drug policy versus other factors

Tham also argues that the strongest decrease in drug use indicators actually took place *before 1980*, the year when the new repressive trend in drug policy started. He attributes this decrease to a break in the 1970s in the post-war trend in juvenile delinquency in general (Tham 1996).

We agree with him that the decreasing trend in drug use is not a single phenomenon in the Swedish social field (Graph 3).

Graph 3. Use of drugs and glue-sniffing. School-survey data - Age 16. Sweden 1971-95. Percent "ever used".

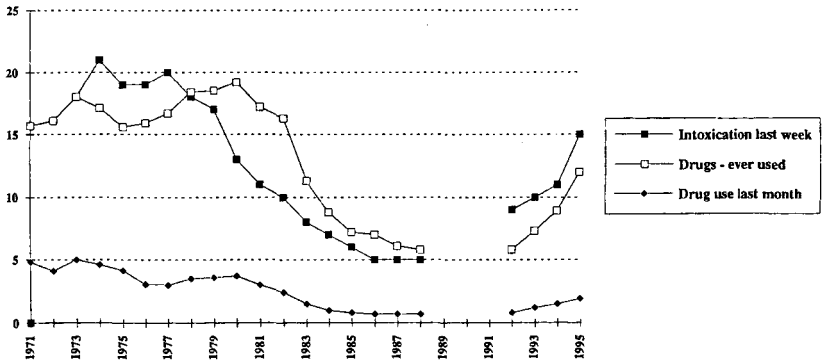


In Graphs 3 and 4A it can be seen that there were decreasing trends in glue-sniffing as well as alcohol intoxication (Graph 4A) among youth, and that these trends parallelled the decrease in drug use. Glue-sniffing and alcohol intoxication have little to do with drug policy, especially the repressive parts of it.

As the downward trend in experimental drug use is the real cornerstone in the official argumentation for the 'new' policy, it deserves closer examination. We would suggest that a reasonable interpretation is that the downward trend was *a consequence of alcohol control policy measures directed at juvenile drinking.* (2). Juvenile drinking dropped significantly when in 1977 alcohol-potent beer was banned from grocery stores. The drug and alcohol prevention programmes in schools was from 1977 until the middle of the 1980s without comparison in an international perspective. Likewise,

increased juvenile drinking was a precursor of the upward trend at the beginning of 1990s (Graph 4A).

Graph 4A. Alcohol intoxication and drug use among conscripts in Sweden 1971-95. Percent.



Thus, we think that other factors than repression are just as - and sometimes much more - important to explain the lowering trend in juvenile drug use that took place during 1980s. In the Swedish case, several risk factors have to be taken into account in judging its drug problem and its development. One is that Sweden has a peripheral position in relation to the European drug trades, especially for heroin.

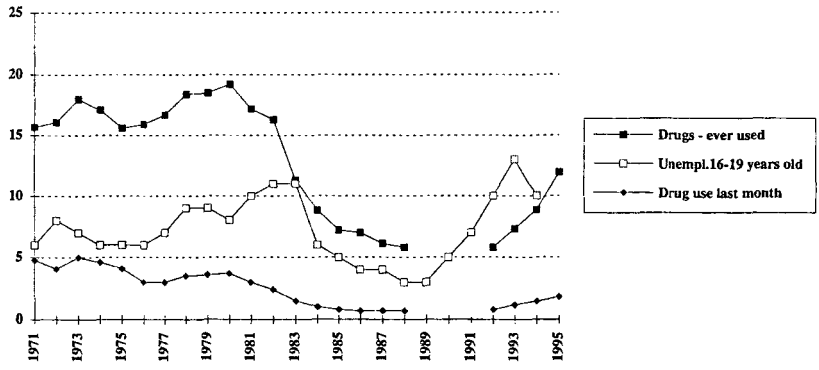
Another risk factor in the Swedish case is early onset of criminality, and also youth criminality had stabilised already in the middle of the 1970s. Mass unemployment among youth - a risk factor related to drug use in Europe (Lenke and Olsson 1996) - did not occur until very recently in Sweden (1993). The immigrant population is rather well integrated, and their children have lower crime rates than their parents (von Hofer, Sarnecki and Tham 1997) and the general level and ambition of social policy has been very high in an international comparison. In our opinion, thus, as changes in *social risk factors* have not been taken into consideration in the Swedish case, the *repressive* pillar of the Swedish drug policy has been strongly overstated.

As regards *the other cornerstone* in the official argumentation – that the recruitment of young 'heavy addicts' decreased during the 1980s – we agree that this probably happened. As the decrease found in the comparison be-

tween case-finding 1 (1979) and 2 (1992) can be placed exclusively in the *second* part of the 1980s (Lenke & Olsson 1997), we do not however think it was a consequence of the police crackdown of 1980-1982 (1a). Instead we follow Skog's (1993) interpretation that the observed decrease was partly *a consequence of the HIV epidemic.* This epidemic caused alarm in IV-user groups but triggered also a massive outreach and treatment programme without comparison in Sweden or elsewhere.

Besides, youth unemployment - which was not an alarming problem before the 1990s - dipped during the 1980s and showed its 'lowest ever' value in the years 1988-89. (Graph 4B).

Graph 4B. Youth unemployment and drug use in Sweden 1971-1995. Percent.

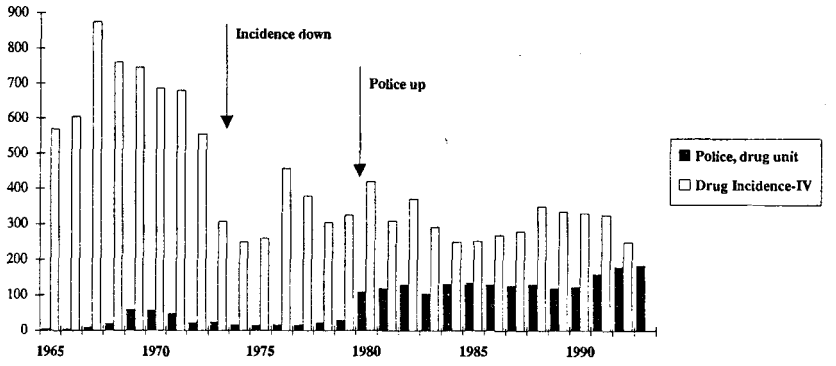


The repressive pillar of drug policy

As mentioned above, advocates of the 'new' drug policy in Sweden stress that the policy has been extra effective since 1980. This is the year when the police were strongly reinforced, and began directing their interest at the street-level - that is, at drug users and their possession of small quantities of drugs. The number of drug convictions increased from 4 000 to 8 000 between 1979 and 1980. This crackdown is claimed to have led to the decrease in drug use described above in Graph 1, a claim that has been called into question. This police crackdown is also claimed to have caused the decrease in IV-use incidence in Stockholm (Graph 5).

During a presentation to the National Board of Police at their 1995 National Conference, the governmental research director (1B) stated that "when the number of drug squad personnel is increased, the IV-incidence goes down" (Kühlhorn 1996a).

Graph 5. Incidence of intravenous drug use and drug police resources in Stockholm 1965-1993. Absolute numbers.



Our interpretation is almost the opposite. The fact that the IV-use according to the graph went down *five years before* the strong increase in police reinforcement clearly supports Tham's argumentation above. Further, the fact that a five-fold increase in drug-squad resources does not show any effect on the IV incidence illustrates how low the marginal net-effect from this form of drug policy can be.

Another test of this new control approach has taken place during the 1990s. As a measure to 'finally' minimise influx into drug using behaviour, the use of drugs was criminalized in 1988. To make it possible to force suspected users to take urine and blood tests, the right-centre government added a prison sentence (maximum 6 months) to the law in 1993. Some ten thousand urine/blood tests have been made over the last years (Rytterbro, 1996). No-one (outside of the police) has claimed that this measure has had any significant effect on any aspect of the drug misuse situation. (See the strong *increase* after 1993 in Graph 1).

We also think that the application of the 'new' drug policy has not been supported by its list of merits during the last five-year period. As a conse-

quence of economic problems in the 1990s, a systematic reduction has been made in the social welfare aspects of Swedish drug policy. Police officers have in fact taken the places of social workers in outreach activities, and rehabilitation facilities have been reduced, making it even more difficult to reintegrate drug users.

Thus, repressive aspects have been maximized, as suggested by the anti-drug campaigners (Bejerot 1988). In spite of this, incidence indicators have not moved in the way expected by the proponents of the 'new 'policy. Instead of decreasing, indicators of incidence of drug use started to show a strong *increase* during the 1990s, especially among young people.

As a matter of fact, several control measures introduced in Sweden during the last decades have not come up to expectation. Compulsive treatment, as an example, does not show positive effects on heavy drug users (Ågren 1994). And the opposite, the legalizing period between 1965 and 1967 did not lead to a significant increase in drug abuse incidence (Lenke and Olsson, B. 1996b), and even the methadone programme has gained wider support. This, however, does not mean that a restrictive policy has *no* effects on the level of the drug problem in society. There is, for example, broad consensus that the successful choking of the *upper level* of amphetamine distribution in Stockholm at the beginning of the 1970s had positive effects on drug use and incidence rates (Lenke 1979, Bejerot 1981, p. 69).

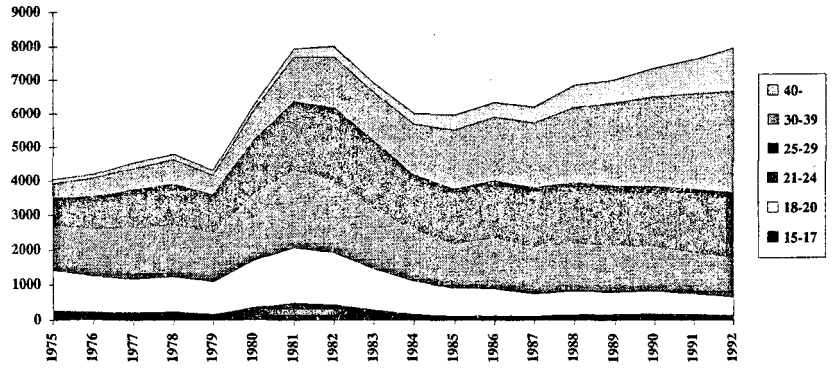
Of course there is strong reason to expect that the repression and the enormous efforts and resources have produced at least some effects. It is, however, astonishing that these potential effects have been so difficult to corroborate empirically.

Against this background, one cannot take the low-age indicators as evidence of a successful development - especially when it is far from clear to what extent - if at all - the huge amount of repression that is used against the ageing group of drug users really affects the very young ones. This question is of course crucial as it is not claimed that repression has had any positive effects in decreasing the existing population of heavy drug users, only to have reduced *incidence* among younger persons.

In Graph 6, the police crackdown of 1980-82 is illustrated with the number of convictions for drug crimes. Kühlhorn has calculated the number of prison months meted out for drug crimes, and found that the amount had increased from 7 000 months/year for the period 1973-75 to 14 000 months/year for 1990-93 (Kühlhorn 1996b, Table 8). One has to look very

closely to see *any* signs of success in this graph. Besides, if there are marginal decreases, the question of causality has not been answered (1C).

Graph 6. Convictions for drug crimes by age groups. Absolute numbers.



Thus, to sum up, there are three sets of argumentation regarding the epidemiological development of the Swedish drug problem. First, the official line saying that the recruitment of young drug addicts went down drastically during the 1980s and stressing the repressive elements of the 'new policy' that was introduced in 1980 as the cause of the decrease (SNIPH 1993, Kühlhorn 1996a, b). The second line is Tham's (1996) questioning the size of the reduction and placing the cause of the reduction in a general downwards trend starting well before the 'new policy' was introduced.

Thirdly, our own interpretations, which are rather close to Tham's. However, instead of a 'decreasing trend' causing the low levels of juvenile drug misuse in the 1980s, we point out three specific explanations for the decreases of the 1980s. One regards the reduction in experimental use in the beginning of the 1980s, which we believe was generated by alcohol policy measures directed at juvenile alcohol misuse, but also affecting drug use. The other regards a reduction in IV-use among young people found in the second case-finding study. As this reduction took place in the second half of the 1980s, it was probably not an effect of the 1980 police crackdown, but rather an effect of the HIV epidemic together with the 'lowest-ever' rate of youth unemployment.

Law and order: the party political dimension of drug policy

The repressive trend in Swedish drug policy is according to our understanding not the consequence of a rational process in which steps are taken and evaluated and new steps are added. In fact, for the first twelve years of the 'new drug policy' era, every proponent said that no improvements had been seen and that therefore more repression had to be added. Thus, the reason for the development of the 'new' drug policy in Sweden is not necessarily a consequence of a 'strong case' as regards an especially successful drug policy. Rather, the policy and the approach illuminate a strong need to counteract and neutralise an aggressive law-and-order campaign in Swedish internal party politics. The drug issue has become just another theme on the conservative 'law and order' campaign that started at the beginning of the 1970s. The defence strategy from the social democrats (most often in power) has been to - more or less quickly - give in to never ending demands for stricter control and more repression in the drug policy (Nilsson, 1991). This experience was a common feature in European countries with left-wing governments during the 1970s and 1980s (Lenke and Olsson, B., 1996b). In Sweden, this defence strategy has been made easier for left-wing voters to accept by systematically adding treatment measures to the repressive bills, thereby creating a policy with unusually high levels of repression as well as treatment.

The actual 'Swedish experience' (to quote the SNIPH Swedish White Book (1993)) thus is perhaps not that repression works in drug policy. It is perhaps rather that when a law-and-order campaign is launched in a society with decreasing drug trends it is not enough to call for further reduction of the problem. 'Drug-Free Society' is a much better concept, one which launches the campaign and keeps it alive by its inner logic and dynamics.

The lack of rationality is also increased by the fact that the game of party politics creates a vast sphere of influence for radical - and sometimes fanatical - NGO members in the decision making processes and within public authorities and organisations.

The extreme overtones in proposals and arguments necessarily delegitimise the drug policy in academic circles and among scientists. A large number of Scandinavian drug researchers are critical of the repressive parts of the drug policy, and distance themselves from it. In other areas, such as in the field of alcohol policy, support from these circles has been valuable for the creation and maintenance of a coherent policy.

A final comment

The Swedish drug policy case has gained an increasing interest even abroad. It is presented as a 'restrictive and successful policy'. As has been shown in this article, the picture is hardly as positive as claimed and the causes of the positive signs are complex. One message from our analyses is that there has been a systematic move away from a balanced and restrictive drug policy towards a policy built more and more on one single pillar, i.e. law enforcement and repression. Preventive measures such as keeping young people in work and restricting juveniles access to alcohol, etc. have been abandoned during the 1990s and all indicators of drug problems have again turned up.

This is not the place to make comparisons with drug policies in other countries. Instead the Swedish drug policy is divided into different phases in order to test claims of potential success and factors behind observed variations in drug use and drug problems.

As a final comment to the current situation, we think the dismantling of social welfare measures in the drug problem area has left Sweden in a rather dangerous situation as regards a possible 'second generation' of drug problems. Will Stockholm really be able to cope with a (potential) second wave of heroin, such as for example that which hit Hamburg so devastatingly at the end of the 1980s? Hamburg relied almost exclusively on law enforcement in the 1980s, but was unable to hold back the new heroin epidemic. And will Swedish authorities rely primarily on police power when it comes to keeping the mass of unemployed youth - immigrants and others - away from drugs?

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Notes

(1A) Taking into consideration that no decrease at all took place in the age category 25-29, it is possible to state that the decrease in incidence took place in the later half of the 1980s. Thus, it can hardly be said to be a consequence of the police crackdown at the beginning of the 1980s. We rather support Skog's interpretation that the decrease was a consequence of the panic following the HIV epidemic, and that a similar decrease was observed in Norway during the same period (Skog 1990, Skog 1993).

(1B) Kühlhorn is research director of the National Crime Prevention Council, which is a department within the Ministry of Justice.

(1C) Kühlhorn et al. (1996b) claims that he has found positive effects of convictions. He does not however present his calculations. Nor does he meet the most basic preconditions for ARIMA analyses, and has at the most 23 observations in his analyses.

(2) Alcohol misuse as an important precondition for juvenile drug misuse has been stressed by the Stockholm Youth Treatment Centre - "Maria-pol". (DN-Stockholm 1994-11-23).

Construction of a National Drug Policy in Poland

JACEK MOSKALEWICZ & GRAŻYNA ŚWIĄTKIEWICZ

Introduction

Present-day Poland offers a good opportunity to trace the process by which national drug policy is formulated and constructed. In the Spring of 1994 the Polish parliament ratified the 1988 Vienna Convention, which has to be followed by changes in national drug legislation. Discussion of the question of new regulations is visible in the mass media that play a paramount role in the redefinition of the drug problem in Poland (Świątkiewicz, Moskalewicz, 1994). Part of the discussion concerns the evaluation of the previous law on drug abuse prevention (1985). In a way, this study may benefit from the current discussion, and at the same time may perhaps contribute to the formation of the drug policy.

The aim of this study is to reconstruct a process of what constructivism calls the collective definition of drug problem (Blumer 1971), or rather of processes which led to its different definitions during different historical periods in Poland. The symbolic meaning of claims expressed in the public debate and formulated in drug legislation will be discussed following ideas elaborated by Gusfield (1963, 1981). The role of available epidemiological data in a public discourse will also be considered.

To understand the current public discourse on drug abuse one has to look back to the beginning of the 1980s and study drug abuse against the wider background of the political events of recent decades. Drug abuse as a public issue has developed parallel to fundamental transitions of the political life of the country.

Beginning of the public debate

Since the late 1970s the major narcotic drug in Poland has been kompot - also known as Polish heroin - which is produced by its users from domestic poppy straw. The kompot epidemic began prior to the 1980s. At that time, however, it was a hidden problem. Articles and reports in the popular media on the domestic drug scene were censored, and rarely published. The problem was reported as being strongly associated with or even caused by capitalism, which did not offer the younger generation any prospects. By this definition, the system of real socialism claimed its moral superiority over capitalism. Drug abuse as a social problem of a socialist society was not officially recognized.

It suddenly became a public issue during the first legal period of Solidarity's existence, at the beginning of the 1980s. Like many other (previously hidden) social questions, it started to be openly and loudly discussed. The mass media showed the public dramatic pictures. The increasing interest of the media was accompanied by rapidly growing numbers of young people who were admitted to treatment.

Drug abuse was made a public issue by the first non-governmental organization for prevention and treatment of drug abuse - Monar - which was led by its charismatic leader, Marek Kotański. Monar, which began its activities in 1978 but blossomed at the beginning of the 1980s, initiated the creation of a network of specialized rehabilitation services based on the Synanon model and which slowly replaced psychiatric approaches in drug treatment. Therapeutic communities located far away from mental hospitals attracted a lot of clients. The new American approach seemed to promise successful recovery.

Other actors who pretended to own the problem of drug abuse were also professionals, mostly from the field of drug treatment. Solidarity, which was preoccupied with other political and social issues, including the alcohol question, was absent from the newly created drug arena. In a way, drug abuse seemed to be a "friendly problem" for the government, or played the role of the "good enemy", to use the term proposed by Christie and Bruun (1985). Unlike the alcohol question, major actors in the drug arena did not blame the existing political system. On the contrary, they were able to mobilize schoolchildren, who defined the problem as a one of weak will:

> "Many thousands of us have no possibility to recover from a disease into which we have fallen, most frequently because of our own fault." (Apel młodzieży, 1981).

This quotation comes from an appeal signed by 1500 pupils from a dozen or so post-primary schools in Warsaw, which was addressed to all possible authorities, including the Central Committee of the Polish United Worker's Party. The regional branch of Solidarity was second to last in a long list of addressees.

It was argued that drug use is a reflection of generational conflict, rather than a manifestation of societal crisis:

> "You adults, you know little about us, you do not feel us. Let us, together with people who understand this problem, work out and implement our own programme to save us from drug abuse." (Apel młodzieży, 1981).

The problem was defined by the media as a danger for the mental, physical and moral health of young persons. Dramatic examples of the individual degradation of young people were presented:

> "It starts as usual, first, second, third time, just for fashion. Sometimes because of school and/or parents. After kompot you are better. No problems ... You do not go to school, you are not at home. You are interested in nobody and nothing but drug use ... You wander for one year, two, three. Overdose. First aid. Hospital." (Dux, 1981).

To attract public attention and increase fear and consternation, the media and professionals presented larger and larger numbers of addicts.

> "Alarming growth has recently been noted in drug abuse. In 1980, the civil militia recorded 8 350 persons suspected of being connected with drug abuse. The latest study by the Psychoneurological Institute estimates this number as being as high as 30 000, the Ministry of Health and Social Welfare as 100 000. According to estimates made by the Drug Treatment Centre in Garwolin and journalists who specialize in this field, the number of young people who use drugs, mostly of domestic origin, is much higher at around 500-600 000 persons." (Społeczny Zespół Ekspertów, 1981).

And finally, clinical arguments were used to underscore even more the seriousness of the problem. Long treatment and rehabilitation were advocated as the only remedy. In a discussion among professionals published in a weekly for teenagers, there was consensus concerning the following opinions:

> "Detoxification which is carried out in hospital and which lasts about two weeks is necessary, but is only the beginning of a long and strenuous process of recovering patients to normal life". "We have concrete experiences that an efficient help for drug addict requires an investment of 2-3 years of good (inpatient) care." (Dąbrowska, 1981).

As defined by the media at that time and by professionals, drug abuse emerged as a convenient issue. It shifted the public's attention away from more profound problems, and explained problems of the younger generation at the individual rather than structural level. The individual character of the problem was underlined by proposed solutions involving individual medical treatment and rehabilitation. This way of defining drug abuse brought benefits to professionals who improved their professional status, received more public attention and were able to generate more funds.

Because of the coexistence of political and professional interests, for a number of years drug abuse was defined as a medical problem of young people with its causes located in the family, school and personality dysfunctions.

Foundations of the 1985 legislation

For a short time, public discussion on drug abuse was interrupted by martial law. After martial law came to an end, however, the military government sought a new civil legitimization by expressing its interest in urgent social questions, including crime and other social ailments. The relaxation of the severe regulations of martial law and the disappearance from the streets of thousands of military men were followed by a significant increase in crime, including violent crime and moonshining. Also drug abuse was on the rise. Medical statistics noted a four-fold increase in admissions in less than five years. This rapid increase was confirmed by police statistics.

It was decided that new temporary regulations would be included in the penal code to prevent any further growth in crime rates. At the same time, an idea of a separate law on drug abuse had matured. This was an outcome of the previous public debate in which drug abuse was recognized as a severe social problem. This was confirmed by public opinion polls, which identified drug abuse as one of the country's most important social problems (CBOS 1985, 1986).

A new law on preventing drug abuse was passed by parliament on 31 January 1985 (Dziennik Ustaw Nr 4/85 poz. 15). It represented a very comprehensive legislative attempt to manage and prevent a social problem. It covered the control of supply as well as demand reduction, supported the actions of voluntary organizations, and laid the legal foundations for the treatment and rehabilitation system. Drug treatment was free of charge and voluntary. According to the law, up to 1 % of the money obtained through alcohol sales should go into a special fund for preventing drug abuse.

Provisions concerning availability control were and still are controversial. The cultivation and harvesting of poppy and hemp in defiance of the provisions of the law was punished by imprisonment. The production of narcotic or psychotropic drugs, their import, export or transport, as well as trafficking in them or offering them to other persons in defiance of the law were also punishable crimes. However, the use of drugs and their possession was not criminalized.

In comparison to the former legislation of 8 January 1951 on pharmaceutical and intoxicating drugs and sanitary commodities, the 1985 law represented a certain liberalization (Dziennik Ustaw Nr 1/51 poz. 4). Previously, drug use was not punished. The use of drugs, however, in the company of another person was penalized with up to one year of imprisonment. Possession was treated as a misdemeanour, with a penalty of detention of up to three months or a fine.

The high priority given to the issue was symbolically confirmed by the establishment of the Interministerial Commission on Drug Abuse Prevention at the Council of Ministers. The Commission was chaired by a Deputy Prime Minister.

Post-1985 period

Worries were expressed that such liberal legislation would be followed by the dynamic growth of drug abuse and drug trafficking with all its possible consequences. However, this did not happen. Drug abuse as measured by medical statistics started to decline in 1985. A year later, police data confirmed this trend, which lasted until the 1990s.

It would be superficial to argue that declining trends should be attributed only to or mainly to new legislation. Several complementary interpretations can be discussed here.

Supply-reduction model

As mentioned earlier, the major raw material for kompot was the poppy, which was cultivated all over the country without any special restrictions. Already in 1984, a year before the new law was passed, the Council of Ministers introduced some regulations which reduced the acreage of cultivation. The law itself introduced further limitations. The total acreage had

gradually been reduced from ca. 20 000 to 4 000 hectares. Thus, although the raw material for drug production was not totally eliminated, its availability was significantly reduced. One can assume that this measure prevented "newcomers" from drug abuse. "Old" addicts were able to get by and still produced kompot for their own use and for their close friends. Due to the relative scarcity of poppy, however, they were very much less likely to produce for an "open" market.

These imperfect restrictions could also be seen as a kind of unintentional harm-reduction strategy. A total ban on poppy cultivation would lead "old" addicts to invent other channels of supply, like smuggling, robbery and such like, methods which are usually associated with more serious problems.

Demonstrable effect of new legislation

One could ask how such a liberal legislation could have been adopted in a country where martial law had been imposed just three years earlier, and where some of its repressive regulations were still in force. The drug law was meant as a token of goodwill from the state authorities, demonstrating its interest in the health of the younger population. Moreover, the military government desperately wanted to change its moral image and to show that, wherever possible, it is open to liberal, humanistic solutions.

In this way, drug abuse became an issue of priority well before the law was eventually passed, and several months after drug abuse and its legal aspects had been widely debated in the national and local media. In this climate of concern, provisions of the law were carefully implemented and executed, and voluntary initiatives were offered support and encouragement by local authorities.

Socio-cultural model

During the four or five years of sudden growth between 1979-1984, the social composition of the drug using population underwent significant changes. At the beginning of that period, the majority of drug users were young persons from white-collar families, with higher than average education. As a group they enjoyed a higher social status. Drug abuse became a fashion for youngsters from the higher strata of society, and those who used

drugs constituted an attractive group of reference. For many, participation in such a group meant increasing their own social position and self-esteem. It was no wonder that young people of working-class origin tried to join them or imitate their habits.

After several years, however, addicts from the lower strata became the majority. According to statistics provided by the police, the entire two-fold growth of addicts recorded in 1980-1985 could be attributed to the influx of youngsters from working-class families (Watson, 1990). Addicts as a group and the drug subculture lost their appeal and ceased to attract very many newcomers.

Non-violent drug arena

Thanks to this liberal approach, drug abuse in Poland differs remarkably from drug abuse in countries where more a repressive policy is in force. The Polish drug subculture is virtually free of violence and crime. The number of violent crimes is extremely low, and almost all crimes committed by addicts are related to the home production of kompot. Consequently, the number of addicts in prisons has never exceeded several hundred, which is less than 1 % of all prisoners throughout the country. Unlike many other countries where the proportion of addicts in prison population varies between 30 and 50 %, Polish penal institutions have not become a melting pot where the drug and criminal subcultures undergo mutual diffusion.

Advent of the HIV question

It could have been predicted that drug injecting would become a major route of HIV transmission in Poland due to the pattern of use and the shortage of disposable syringes and needles. Sharing injecting equipment was widespread not only because of cultural atterns and but also out of necessity.

The idea of launching syringe exchange programmes to prevent an HIV epidemic was considered as early as 1986/87. It was not, however, a technical decision only. At the time, hospitals suffered from a lack of medical equipment, and disposable syringes were not available even on surgical and maternity wards. Despite existing evidence that syringe exchange programmes would consume only ca. 1 % of total demand, the decision was

not taken. It was morally difficult and politically risky to say "yes" to syringe exchange in such circumstances.

The first case of HIV infection among intravenous drug users was recorded in the summer of 1988. Within ca. 18 months the number had increased to more than 500 (Szata, 1993). The syringe exchange programme started almost as soon as the first cases of infection were reported. One could assume that such a quick decision was possible thanks to the previous debate in which a technical consensus was reached.

Transition period

The bloodless revolution of 1989 promised radical changes for the good in all spheres of public life. Those who represented the new political order were almost unanimously supported by society. This support manifested itself in 1989, in the first democratic elections for the senate, when those associated with Solidarity won 99 of the 100 seats. The enthusiasm for and social approval of the new government lasted for over a year (Kolarska-Bobińska, 1994). During that period, Poland experienced the thorough reconstruction of its political and economic system, a phenomenon which affected most Polish families. Rapid transitions in all spheres of life have been associated with a remarkable increase in existing social problems and have given birth to new problems, such as unemployment and homelessness (Jarosz et al., 1991).

The most dramatic new problem which followed economic changes was unemployment, which had been practically non-existent for the previous forty years. At the beginning of the 1990s, labour offices recorded 56 000 job seekers; toward the end of that year, this number exceeded 1 million, representing 6.6 % of the country's manpower. Three years later, the number was approaching 3 million (close to 17 % of total manpower). It is only since 1994 that this rate has slowly been declining. Unemployment is unevenly distributed. In some regions it is as high as 40 %, and the majority of school-leavers cannot expect to find a job. In addition to high numbers, the social and psychological effects of unemployment have been more disastrous in Poland than in countries that have had more experience with this problem and which have lived with unemployment for decades (Balcerzak-Paradowska, 1993).

Another high-growth problem during the transition period was crime. After several years of stabilization during the second half of the 1980s, in

just one year crime increased by 60 %. This was related to a number of factors. First of all, the climate of anomy so typical of sudden social changes reinforced a tendency towards antisocial behaviour. Secondly, rising poverty and growing discrepancies in the distribution of wealth contributed to this process. And finally, increasing crime could be related to changes in law enforcement. In 1989 and 1990 the police underwent a crucial restructuring and personnel purge. More than 50 % of policemen were either fired or decided to leave the force. The police, preoccupied with self-reformation, had less time and fewer resources to devote to prosecution. Moreover, enforcement agencies had to learn how to work effectively in the new, more democratic context, a context within which their work was under more control from democratic institutions and the public. In addition to ordinary crimes, the country witnessed more and more economic crimes, a phenomenon which could have been expected in such a transition period.

In general, society's feeling of security has decreased. In addition to economic deprivation and decreasing job security, people are frightened of becoming a victim of theft or violence. Economic scandals in which public figures were involved have decreased the trust and understanding of the new rules of the game.

As for substance abuse, there is a lot of evidence that alcohol consumption increased remarkably at the beginning of the transition period (Sierosławski, 1992; Lehto, Moskalewicz, 1994). Recorded sales - which had offered a good measure of trends in alcohol consumption for the last hundred years - are nowadays heavily underestimated, due to privatization and an unprecedented disorganization of the alcohol market. First admissions for alcohol psychoses, recognized in Poland as a problem most sensitive to changes in alcohol consumption (Wald, Jaroszewski, 1983), increased by ca. 50 % from 10.3 per 100 000 in 1988 to 13.4 in 1990 and to 15.4 in 1991. Growing consumption reflected by alcohol psychosis was later confirmed by liver cirrhosis mortality, which has increased in recent years mainly among men (Moskalewicz, 1993).

Against this background, the increase in drug abuse could be described as modest. It seems that the impact of the transition period on drug abuse was delayed as compared with other problems. According to the indicators which are at our disposal, the first signs of increase were noted in 1990-1991, when the rate of hospital admissions due to drug dependence increased by 14 and 26 %, respectively. In following years, however, the recorded rise varied between 2 and 10 %. The police recorded a similar trend.

According to a 1994 school survey, ca. 10 % of students from post-primary schools had tried illegal drugs (solvents included) during the year preceding the interview. This ratio had doubled since a study carried out two years earlier (CBOS 1994). However, the proportion of those who admitted drug use in the month prior to the interview was less than 5 % and more regular users represented less than 1 % (Zieliński, 1992).

Social perception and political reflection

A series of nationwide public opinion polls carried out in the 1990s (CBOS 1995) showed that during the transition period there was declining concern about drug abuse as compared with the mid-1980s. According to a local study conducted in the Gdańsk region, drug abuse ranked 9th among 12 social problems in terms of perceived prevalence, and 8th in terms of perceived urgency of solving (Moskalewicz, Świątkiewicz, 1996). Also in other local studies, drug abuse seems to be less important in the public's perception than other acute problems, including unemployment, poverty and crime (Świątkiewicz, 1994).

It can be argued that a relatively low social perception of drug abuse corresponds with its "objective" position among other social problems. Nevertheless, time and space devoted to this issue in political debate and in the media is out of any proportion. Drug abuse is presented within a context of violence, organized crime, international mafia and big money. The need for special enforcement is advocated. Both the printed media and television frequently show the brave actions of special anti-terrorist police forces. More and more often drug abuse is claimed to be a problem of law and order. The previous definition, which stressed the juvenile nature of the problem and saw its solution in treatment and rehabilitation, has vanished from the public debate. Its focus now is on changes in existing legislation. The previous law on preventing drug abuse (31 January 1985) is considered to be too liberal and contrary to international standards. A large proportion of media reports are devoted to problems of the police, which claims to be powerless due to the liberal character of current law (Świątkiewicz, Moskalewicz, 1994). New, more repressive drafts of the law have been proposed. All of them envisage the criminalization of drug possession. When the first version of this paper was drafted (1994) it was very likely that new legislation would be passed by parliament in the near future. All political forces seemed to have some interest in this solution. Post-communist par-

ties which had just regained power wanted to distinguish themselves from the inheritance of the past. Changing such a controversial law adopted under the ancient regime would symbolize a sharp rejection of the values of their predecessors. Right-wing parties in general are in favour of more repressive laws to help regain moral order and security in a society rotted by the ideologies of communism and liberalism. And finally, parties from the political centre perceived changes in drug legislation as a part of a package of measures that have to be taken in order to adapt Polish legislation to international (Western) standards and as a step towards membership of the European Union.

In the meantime, the political consensus concerning drug legislation has disappeared. Although the government sent a more repressive draft of the law to parliament, the penalization of drug possession is unofficially questioned even within the present government. One major argument comes from the prison administration, which would have to swallow all the potential consequences of penalization, including a sharp increase in the number of addicts in prison. A draft of the new law is also opposed by people from the left of the political centre, as well as by a small party, the Labour Union, which claims to represent the real left in contrast to post-communists. All these forces are attempting to reestablish a previous definition of drug abuse which was more in line with the traditional values of the political left. Unintentionally, the question of drug abuse became a hallmark of political affiliation.

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Drug Policies and Drug Problems in the Federal Republic of Germany: Construction, Development and Trends

HANS-JÖRG ALBRECHT

1. The history of German drug laws

Both the history and the development of drug control in Germany are in many ways comparable to those observed in most European countries. Similarities grew considerably during the last decades with the EU formulating common policies also in the field of drug control. In Germany, the origins of criminal legislation in the field of psychoactive and other drugs can be traced back to the first decades of the 20th century[1]. The so-called Opium Law of 1929 represents the first major legislative effort to bring drugs under administrative and criminal law control. The Act on Opium and Opium Derivates can be considered as the first step towards a criminal-law-based approach to drug control. While for 40 years only minor changes occurred with respect to these statutes, the 1960s saw the commencement of a debate on drug policies which centered around the issue of cannabis and finally developed into a full-blown moral panic preoccupied with assumptions about the possible disastrous effects of cannabis-smoking on rebellious German youth in the second half of the 1960s when student unrest coincided with the emergence of new youth cultures. This panic led to a completely new piece of drug legislation in 1971, the name of which – the Narcotics Act (*Betäubungsmittelgesetz*) – was aimed at narcotics in general, but was basically a 'cannabis law'. The Narcotics Act was again revised in 1981[2]. In 1981, the federal parliament responded to the

[1] Scheerer, S.: *Die Genese der Betäubungsmittelgesetze in der Bundesrepublik Deutschland und in den Niederlanden*. Göttingen 1982.

[2] Act on Narcotics 28 July 1981, *Bundesgesetzblatt* I, p.681.

arrival of heroin on the German drug scene in the mid-1970s. The amendment of the Narcotics Act in 1981 was therefore labelled the 'heroin law'. The policy driving the 1981 legislation essentially was guided by the goal to use a 'velvet glove' with respect to drug users and an 'iron fist' towards drug traffickers and drug distributors[3]. This is why the core of the 1981 law comprises increased threats of punishment for trafficking activities and offers to drug addicts to replace punishment through drug treatment. During the 1980s, the legislative efforts turned to the problem of drug-trafficking and organized crime in general. The prohibitionist approach to drug control adopted in Germany contributed to the creation and boosting of new needs to cope with follow-up problems of criminal prohibition in terms of organized crime, illegal profits and general problems of securing efficiency in the investigation of (so-called victimless) drug crimes, where the traditional triggers of social control activities – i.e. individual victims and complainants – are no longer operational. The focus has switched completely to the problem of organized crime in general with the most significant Law on Drug Trafficking and Other Types of Organized Crime (15 July 1992) and other legislation aimed at organized crime control. The major correlates of drug legislation during the last four decades can be summarized as extending police and prosecution powers, bringing in new investigative techniques, and threats of increasingly tougher penalties.

The development of drug laws in Germany is characterized by the following trends:

a) Maximum penalties for drug offences have been increased. For serious drug crimes, the Narcotics Act now provides for 15 years of imprisonment (the maximum term of imprisonment available in German criminal law, besides life imprisonment).

b) The range of punishable acts has been enlarged with upgrading acts representing mere attempts of participation and transforming them into independent criminal offences.

c) The scope of drugs falling under the Narcotics Act has been widened.

d) Illicit drugs are not defined explicitly in the Narcotics Act, but a reference is made to lists of drugs annexed to the statutes which may be extended to new substances without legislative activities or the involvement of parliament. These lists divide illicit drugs into three groups: those which may be prescribed (by physicians), those which are not allowed to be pre-

[3] Kreuzer, A.: Therapie und Strafe. 'Versuch einer Zwischenbilanz zur Drogenpolitik und zum Betäubungsmittelgesetz von 1981'. *NJW* 42(1989), pp.1505-1512.

scribed but may be trafficked and used for other purposes, and those which may not be prescribed, trafficked or possessed for any purpose. Cocaine is listed with those narcotics which for certain specified purposes may be prescribed. The same applies to amphetamines. Heroin and cannabis – the most widely distributed illicit drugs – may be neither trafficked nor prescribed.

e) An attempt has been made to separate drug addicts from non-addicted drug traffickers and drug dealers by providing the possibility to dismiss criminal cases or postpone enforcement of prison sentences if the prison sentence does not exceed two years and the offender agrees to be treated in a licensed treatment unit[4].

f) The focus of legislative activities has been shifted from the drug problem itself to the problem of organized crime in general (which includes also organized drug-trafficking).

g) Although during the 1970s and the beginning of the 1980s the medical profession has been marginalized in the approach to drug control (through very restrictive regulations concerning drug prescription and especially methadone maintenance), the second half of the 1980s and the 1990s saw quite significant developments with facilitating methadone maintenance and restrengthening the role of physicians[5]. This was partially due to the perception that the threat of Aids had to be responded to by way of adopting harm reducing approaches to drug-injecting users.

h) During the 1990s, legislation took a bifurcated approach. While criminal substantial and procedural law reform is aimed at the issue of organized crime at large, the focus in the narrower field of drug legislation and drug policy has been put more and more on harm reduction approaches[6]. This is evidenced by 1992 legislation which explicitly exempts needle exchange programmes from criminal liability. Furthermore, methadone maintenance programmes have been extended and the power of indi-

[4] Kreuzer, A.: 'Therapie und Strafe. Versuch einer Zwischenbilanz zur Drogenpolitik und zum Betäubungsmittelgesetz von 1981'. *NJW* 42(1989), pp.1505-1512.

[5] See also Eisner, M.: 'Determinants de la Politique Suisse en Matiere de Drogue. L´exemple du Programme de Prescription d´Heroine'. *Deviance et Societe* 23(1999), pp. 189-204, p. 199 for Switzerland.

[6] Adams, M., et al.: 'Drogenpolitik. Meinungen und Vorschläge von Experten'. Freiburg 1989; die Beiträge in Neumeyer, J., Schaich-Walch, G.(Hrsg.): *Zwischen Legalisierung und Normalisierung. Ausstiegsszenarien aus der repressiven Drogenpolitik.* Marburg 1992; Böker, W., Nelles, J. (eds.): *Drogenpolitik wohin?* Sachverhalte, Entwicklungen, Handlungsvorschläge. Bern u.a., 2nd ed. 1992.

vidual physicians to prescribe methadone on a case to case basis has been widened. Legislation which will admit medically supervised 'shooting galleries' (*Druckräume*) is on the way. Finally, the new government (which has been in office since the autumn of 1998) has eased the way towards implementing heroin prescription experiments similar to those in Switzerland, the Netherlands and those German municipalities which apply for it.

2. The general policy towards drugs, drug users and drug markets

In Germany, the implementation of policies and legislation is essentially entrusted to individual states (*Länder*), although legislation, in particular as regards drugs, remains a federal tasks. In so far, in Germany, too, national planning to combat illicit drugs has led to the creation of a National Drug Control Plan designed to coordinate drug policies and drug policy implementation[7]. National drug policy planning is justified as providing the basis for uniform implementation of policies as well as coordination and cooperation between the various actors in the drug policy field. With the National Drug Control Plan, drug problems basically are conceived as representing cross-sectional problems as facets of the drug problem concern various administrative departments, including those concerned with the interior, health, finances, economics, family and youth, education and finally criminal justice. However, the first and possibly one of the most important questions concerns whether national planning with respect to drug problems actually should be handled differently compared to other equally important social problems. Indeed, most social problems within the context of modern societies are cross-sectional in nature and therefore could also deserve national planning and programming. Environmental problems, mass unemployment, poverty, migration, traffic safety and crime problems all are characterized by a multitude of dimensions and a multitude of causes. All these problems affect both the private and the public, local and federal levels of government, as well as various administrative sectors on different policy levels. Why then do drug problems deserve special attention compared to other important problems, which according to public opinion rank much higher in virtually all European countries than illicit drugs do? An answer to this question is not easily given. On the one hand, it seems that the concept of prevention is driving the search for coor-

[7] *Nationaler Rauschgiftbekämpfungsplan.* Bonn 1990.

dinated governmental and social actions, while on the other hand illicit drugs seem to represent a policy issue which on the surface does not create that many conflicts over competencies and powers between the various subsystems in state administrations. Although, the topic of prevention is highlighted today in all problem-solving state strategies (e.g. delinquency and crime), the drug policies devised in National Strategies go beyond the traditional preventive approaches adopted in the field of crime and other social problems. The policy which emerges is trying to link primary, secondary and tertiary prevention within a drug-specific organizational framework. The goal is to achieve a streamlined system of drug control. In the German National Plan, the goals pursued concern:

- the mobilization and coordination of all private and public agencies, groups, etc. which basically might have functions in the fight against illicit drugs;
- the provision of a common superordinate goal for all these agencies and groups;
- the mobilization of new resources which may be invested in the fight against illicit drugs [8].

When identifying factors influencing coordination and cooperation, two types of potential actors have to be differentiated besides the different policy levels (federal, state, local). On the one hand, there are those potential actors who are professionally active in one way or another in enforcing drug laws, treating drug addicts or preventing drug problems. On the other hand, there are those potential actors who are not engaged in some type of drug-related profession but might be involved as the preventive concept actually identifies all segments of society as having some importance in addressing the issue of drug abuse. But with respect to public administrations, the various departments and agencies which will be involved in the endeavour to reduce drug problems are not committed to an overall goal validated by law or contract. All sectors of society will surely agree with the proposition that drug problems should be reduced and risks associated with drug abuse should be minimized. But these goals and the means which may be suggested to achieve them are rather vague and are not easily categorized into clearly defined operations which the different agencies should carry out in order to achieve the common goal. Although all drug-related agencies basically deal with the same problem (i.e. drugs), the or-

[8] *Nationaler Rauschgiftbekämpfungsplan* 1990, p.11.

ganizational reactions towards the problem are not the same. Therefore, opportunities in implementing consistent and effective inter-agency controls are limited. The vagueness of objectives and the procedures with which to achieve them may serve to hide these problems, but this is at the risk of having no impact at all on agencies' performance. Furthermore, the vagueness of objectives makes the evaluation of drug policies a difficult undertaking. In addition, cooperation and coordination will depend on whether different types of agencies (e.g. health administration and police) or the same type of agencies but on different policy levels (federal and state police/local police) are concerned.

Coordination and cooperation, then, largely depend on finding a common objective which can serve to minimize inter-organizational conflicts and allow the development of uniform organizational reactions. One of the most important sources of conflict is rooted in the differences between the general models of behaviour control employed in policy- and decision-making by criminal justice agencies on the one hand and those employed by administrative agencies on the other hand. Basically, with respect to drug policies two models of control have to be reconciled within a framework of coordination. These models concern the zero-sum game underlying the criminal justice approach to control behaviour, and the models based upon bargaining, discretion, persuasion, etc. prevailing e.g. in the health or general administrative system. Research from other policy fields underlines the problems which must be faced when trying to integrate those competing models of control[9]. The main consequence of this type of policy was a hegemonic status of the criminal law element within German drug policy. Criminal law serves to define the limits of other approaches to drug problems, as criminal drug offence statutes may at any point be invoked in order to evaluate any action taken with respect to drugs. This is most significantly expressed in those criminal statutes which define the criminal prescription of drugs by physicians as well as the 'catch-all' offence statute of facilitating or supporting the use of illicit drugs. These types of offence statutes are used strategically in conflicts over the general course drug policies should take[10].

Official German drug policy has always put the emphasis on the supply side of drug markets. This emphasis is evidenced by the extended penalties

[9] See Albrecht, H.-J., Leppä, S. (eds.): *Criminal and the Environment*. Helsinki 1992.

[10] See Körner, H.H.: 'Das Betäubungsmittelgesetz – ein gesetzgeberischer Flickenteppich'. *Strafverteidiger* 1994, pp. 514-519, p. 519.

which are available for the import, trafficking or distribution of large amounts of drugs. Stopping drugs at the borders and eliminating drug distribution networks are among the most prominent goals of drug law enforcement. In addition, international cooperation is sought in order to extend criminal investigations to drug-producing and drug-exporting countries. The emphasis laid on the supply side is justified by the well-known assumptions on reducing the availability of drugs, keeping the prices of drugs at a rather high level, and discouraging potential drug traffickers from supplying drugs on German territory. On the other hand, the policy addressing the drug user and the demand side of the market displays ambivalent attitudes towards drug use and addiction. Although the German criminal justice system is bound to the principle that self-injuries or mere immoral behaviour should not be made criminal offences (i.e. the consumption of illegal drugs is not a punishable offence), there are some signs that drug users might again be made an explicit target of criminal law. As behaviour which is seen as being a prerequisite for drug consumption (e.g. the possession or purchase of drugs) is a punishable offence, it is clear that criminal drug law is basically extended to the addict and to the drug-abusing individual. But new (punitive) concern for the drug user is expressed in voices arguing that drugs are dangerous only because there are people who are willing to use them. The argument goes that black markets depend on demand, and those who are active in keeping black markets running by expressing demand should therefore be made the targets of criminal law enforcement in order to reduce the supply of drugs by reducing the demand. This position was expressed in a proposal to provide for a two year detention period for mere illicit drug use (independent of the type of drug consumed)[11]. However, a majority in neither the political system nor the professional systems support such an extremist approach towards drying up the demand in drug markets.

3. Criminal drug law: offence statutes, penalties and procedural issues

The basic definition of so-called ordinary drug offences is provided by § 29 I of the Narcotics Act. This basic definition encompasses production,

[11] Katholnigg, O.: 'Ist die Entkriminalisierung von Betäubungsmittelkonsumenten mit scharfen Maßnahmen zur Eindämmung der Betäubungsmittelnachfrage vereinbar?' *Goltdammers Archiv für Strafrecht* 137(1990), pp.193-200.

trafficking, importing, exporting, acquiring, selling, possession, transit, purchase, advertising, financing drug-trafficking, trafficking and commerce in narcotics, public announcement of opportunities to purchase or consume drugs, illegal prescription of controlled drugs by physicians or illegal supply by pharmacists. The penalties provided include imprisonment of up to 5 years or a fine (which may range between 5 and 360 day fines). Trafficking in 'look-alikes' or selling or supplying substances which simulate real drugs are also treated as drug offences (§ 29 VI Narcotics Act).

Ordinary drug offences may be exempted from punishment if only minor amounts of drugs were involved and the drugs were intended for personal use only (§ 29 V Narcotics Act).

Certain aggravating circumstances increase the minimum penalty to 1 year and the maximum to 15 years (§ 29a Narcotics Act). These aggravating circumstances concern an offender of 21 years or older who procures drugs for a minor of 18 years or younger or an offender of 21 years or older who seduces a minor (of 18 years or less) to traffic in illicit drugs. Furthermore, an aggravated drug offence is established if somebody produces, possesses, procures or distributes considerable amounts of drugs (the wording of the law is "non-minor amount of drugs"). Superior Court rulings have established what 'considerable', 'minor' and 'normal' quantities of drugs are, i.e. 7.5 grams of cannabis (tetrahydrocannabinol), 1.5 grams of heroin (hydrochloride), 5 grams of cocaine (hydrochloride) and 10 grams of pure amphetamine are considered considerable amounts, leading to a minimum penalty of 1 year of imprisonment. On the other hand, 0.15 grams of heroin, 300 micrograms of cocaine and up to 6 grams of hashish are considered to be minor amounts, allowing exemption from punishment by the criminal court according to the aforementioned § 29 V of the Narcotics Act.

The minimum penalty is increased to 2 years of imprisonment (§ 30 Narcotics Act) if an offender is a member of a criminal enterprise or is trafficking drugs professionally, or if an offender procures drugs which cause the death of the drug user of if considerable amounts of drugs are imported. In 1992, the minimum penalty was increased to 5 years of imprisonment for those cases where considerable amounts of drugs are produced, trafficked or imported/exported and if the offender is member of a continuing criminal enterprise which specializes in drug-trafficking.

As regards criminal procedures, drug control arguments have played a paramount role in legitimizing the introduction of new investigative tech-

niques and other procedural elements, which in fact changed the traditional criminal process characterized by repression based on reaction into a proactive and preventive instrument of risk administration. The Narcotics Act provides for the possibility to make a drug offender a crown witness, which essentially interferes with the principle of legality on which German criminal procedural law was once based. The crown witness may avoid punishment entirely or receive a reduced sentence if the information he/she supplies enables police and public prosecutor to clear up other drug offences (§ 31 Narcotics Act). In addition, wire-tapping, mail surveillance, the use of informants and (a legally restricted type of) undercover agents (the so-*called verdeckte Ermittler*, or covert investigator), buy operations and controlled delivery are available in the investigation of drug offences. Explicit provisions in procedural laws cover wire-tapping (§ 100a no.4 Criminal Procedural Code) and mail surveillance; these provisions are not specific to drug offences but cover a multitude of serious crimes in the case of wire-tapping and all criminal offences in the case of surveillance and seizure of mail (§ 99 Criminal Procedural Code). While the searching of premises at night is restricted, these restrictions do not apply in the case of premises which are known as places of drug-trafficking (§ 104 Criminal Procedural Code). Pretrial detention then may be ordered in serious cases of drug offences not only under the regular conditions of the risks of escape or obstruction of the course of justice, but also if there are reasons to assume that the suspect will continue to engage in serious drug offences (§ 112a Criminal Procedural Code). The Law on Organized Drug Trafficking and Other Types of Organized Crime (which came into force in 1992) introduced statutes explicitly allowing the use of undercover agents (in its restricted version of the *verdeckte Ermittler*) and the use of various technical devices in the investigation of serious (organized) crime. Recently, electronic surveillance of private premises has been allowed by another amendment of criminal procedural law.

4. Drug-trafficking and 'going after the money': forfeiture of drug profits and money-laundering control

The 1990s saw important changes in the field of substantial criminal law with respect to money-laundering and the forfeiture of illegal profits. In 1992, the federal parliament voted in a bill which introduced two penalties that are supposed to become efficient tools in combating organized crime,

especially organized drug-trafficking through facilitating the forfeiture of ill-gotten gains. These two new penalties concern the confiscation of property (*Vermögensstrafe*, § 43a German Criminal Code), and extended forfeiture of crime proceeds (*erweiterter Verfall*, § 73d German Criminal Code). § 43a German Criminal Code authorizes criminal courts to sentence an offender to the penalty of confiscation of property if a criminal offence statute provides for this penalty (§ 30c of the Narcotics Act refers to this penalty if aggravated drug offences are concerned) and if the offender is sentenced to a term of imprisonment exceeding two years. If these requirements are fulfilled, the criminal court may order confiscation of an amount of money the upper limit of which is set by the value of all of the offender's assets and property. No differentiation is made between ill-gotten gains and property stemming from illegal sources on the one hand and those parts of the property which come from legal sources. With the penalty of confiscation, all those problems of forfeiture which were embedded in the requirement of ascertaining the criminal origins of proceeds faded away. It is no longer necessary to establish links between certain pieces of property and some specified criminal offences. With 'extended forfeiture' the court is authorized to order, independent of individual guilt, the forfeiture of assets or property if an offence provides for this measure and if the assumption is justified that these assets or property were proceeds of criminal offences (§ 33 of the Narcotics Act refers to extended forfeiture if aggravated drug offences were committed). Constitutional concerns were raised throughout the parliamentary debates on the penalty of confiscation and the extended forfeiture. It was argued that the penalty of confiscation and extended forfeiture violate the constitutional right to property, and moreover that neither sanction complies with the rule of law, because the principle of individual guilt is violated. It is therefore expected that German criminal courts will be rather reluctant to make use of confiscation and extended forfeiture because of the constitutional problems associated with these sanctions.

Money-laundering has also been made a criminal offence (§ 261 German Criminal Code). Here, the laundering of money stemming from drug-trafficking leads to a penalty of up to 5 years of imprisonment or a fine (up to 360 day fines). In addition, the Money Laundering Control Law (*Geldwäschegesetz*) requires financial business, banks and other commercial enterprises that are likely to handle considerable amounts of money to pass information relevant to money-laundering activities to criminal justice

agencies. Whenever a bank employee suspects money-laundering activities, he/she must inform the police; transfers are then frozen for a certain period of time. Furthermore, with this law banks were obliged to collect information on clients transferring sums of money exceeding 20,000 DM and to keep records on such cases for a certain period of time. With such obligations, the private sector has – for the first time and involuntarily – become heavily involved in drug law enforcement.

5. The constitutional debate: has prohibition gone too far?

In the early 1990s several district courts stopped criminal drug trials, arguing that some of the criminal drug statutes as available in the Narcotics Act infringed basic human rights. According to the Constitution, in case of such assumptions on the unconstitutionality of legal provisions, courts must stop proceedings and present the case to the Constitutional Court[12]. In 1994, the Constitutional Court responding to these motions held that criminal drug laws outlawing the purchase and possession of controlled substances for personal consumption in principle do not infringe on human rights[13]. However, the Constitutional Court also ruled that the dramatic differences in non-prosecution policies could not be accepted because these differences would amount to a serious violation of the right to equal and non-discriminatory treatment. The Constitutional Court then argued that under certain conditions, criminal prosecution concerning minor quantities of illegal drugs (the cases decided upon included cannabis) could amount to excessive state intervention and seriously infringe upon the principle of proportionality. Violation of the principles of equal treatment and proportionality thus would necessitate both mandatory non-prosecution and similar policies of non-prosecution throughout Germany and in cases involving minor quantities of drugs. However, the additional conditions to be fulfilled in order to be eligible for mandatory non-prosecution mentioned in the verdict are: the offence must not have occurred in a prison, school, university, military unit or such like. To understand the decision of the Constitutional Court, some information on the German criminal process is of eminent importance. The German criminal justice system is fed-

[12] District court Lübeck, motion as of 19.12.1991, *Strafverteidiger* 1992, pp.168-178; see also Kreuzer, A.: *Cannabisprohibition verfassungswidrig?* Sucht 1992, pp. 201; motion of the district court Hildesheim as of 26.3.1992. *Deutsche Vereinigung für Jugendgerichte und Jugendgerichtshilfen-Journal* 1992, pp.117.

[13] Bundesverfassungsgericht (Federal Constitutional Court) *Neue Juristische Wochenschrift* 1994, pp. 1577.

eral. This means that although criminal law and drug laws are federal laws and the individual states are empowered to legislate in these fields, the implementation of law is entrusted to the individual states. Each state runs the police, the public prosecutors office and the administration of criminal courts. There is no way in which the federal system may interfere with the implementation of criminal law on the state level. The public prosecutor has a monopoly in prosecuting criminal cases or bringing cases to the criminal court. Although in theory it is still said that the German criminal procedure is characterized by the principle of legality, in terms of statutory power and practical outcomes the German public prosecutor is entitled to a good deal of discretion in deciding whether or not to prosecute a criminal case. The statutory basis for dismissing a case lies in the criminal procedural law and in the drug laws. Art. 153, 153a Criminal Procedural Law say that a case may be dismissed (either unconditionally or under the condition that a fine is paid or a community service order fulfilled) if the case is of a petty nature or if the conditions attached to dismissal are sufficient to respond to the case. In the drug law, dismissal is possible if a minor amount of controlled drugs was involved and if purchase, possession, etc. was for personal use only. In both statutes, discretion and the control of discretion play a major role. Dismissal rates vary widely in Germany as a consequence of each state being responsible for implementing basic criminal law and procedural law.

Questioning its constitutionality, district courts state that the Narcotics Act – as far as it makes the possession, purchase, import, etc. of minor amounts of drugs a criminal offence – violates the constitution on the grounds that such criminalization infringes:

a. The right to be treated equally by state law (here it was argued that alcohol and tobacco although more dangerous than cannabis are not included in the drug laws, which in principle would amount to unjustified differentiation between alcohol and tobacco users on the one hand and cannabis users on the other hand).

b. The right to personal and individual freedom (here it was argued that the constitution guarantees individual freedom and allows restrictions on freedom only on the ground that these restrictions can be deemed to be proportional to the goals which are pursued by restricting individual liberty; as drug laws – so it was argued – protected public health, all those acts which merely aim at the personal use of drugs could not violate public health but individual health at most.

c. The privacy right (here it was said that an essential part of the right to privacy concerned the right to get drunk or to get 'high' on whatever drugs or substances an individual chooses, independent of the risks the individual creates for him-/herself).

d. The principle of proportionality as criminal prohibition of drugs created the very risks they are supposed to counteract. With the principle of proportionality, a three-step test is carried through: 1. the state intervention must in principle be able to achieve the goals to be pursued by the intervention in question, 2. the intervention must be necessary (which means that no other less serious means of intervention can be imagined which would lead to the same results as the more serious one), 3. if an intervention is deemed to be able to achieve the goals pursued and is regarded as necessary (i.e. no less intrusive means are available), then the third step requires weighing the restrictions placed upon the individual (here by criminal law) against the benefits (resulting from criminalization). The district courts argued that the criminalization of a drug-using person essentially results in negative side effects and thereby in far greater damages to public health and society at large (e.g. in terms of organized crime, drug-related property crime, etc.) than are prevented by criminal drug laws criminalizing drug users.

The Constitutional Court argued that the Narcotics Act in all its parts did not violate the Constitution, and that the federal parliament had done no wrong in criminalizing drug possession with the intent to merely consume. In particular, the Constitutional Court ruled that:

a. The right to equal treatment was not violated because the federal parliament in differentiating between such controlled drugs as cannabis, heroin, etc. on the one hand and alcohol and tobacco on the other hand made a difference which can be justified (essentially based on the argument that alcohol and tobacco are culturally-integrated drugs, and because – although research on the negative and damaging effects of cannabis is inconclusive – it could not be ruled out that damaging effects might be demonstrated in the future).

b. The right to personal freedom was not violated because with criminal drug laws so-called endangering offences have been introduced which do not threaten punishment for drug use itself but for the possession of controlled drugs, which carries the risk that these drugs may be distributed and therefore could create risks for public health.

c. The right to privacy does not include the right to do harm to oneself.

d. The principle of proportionality was not violated by criminalizing the possession, purchase, etc. of minor amounts of drugs, as the benefits of criminalization were not – as was assumed by the courts – outweighed by the negative side effects of criminalization.

Although the Constitutional Court essentially held that criminal drug laws in principle do not violate the constitution, it did confirm that the type of criminal law used to protect public health and the way criminal drug laws are implemented could indeed violate both the right to be treated equally and the principle of proportionality. However, the Court concluded that those possible infringements can be avoided by properly applying criminal drug laws and making use of policies of non-prosecution in a consistent manner.

The reasons leading the Constitutional Court to the conclusion that it was possible that the implementation (and creation) of criminal drug laws violated the constitution concern the following:

a. The implementation of criminal drug laws had led to widely differing rates of dismissal or non-prosecution among the individual states. The Constitutional Court declared that such a practice could not be tolerated in the light of the Constitution, especially Art. 3 (which requires equal treatment).

b. By using endangering offences to protect public health (which do not require the provision of any evidence of actual damage done to the public health, as would be required in case of result offences), the Constitutional Court argued, it can be imagined that the offence statutes also cover behaviour which creates rather low and sometimes negligible risks to public health. This would hold true in particular in those cases where the drug offence consists of possessing (purchasing, importing, etc.) small amounts of drugs (in particular cannabis) for personal use only. In such cases, the Constitutional Court said, although threatening punishment essentially should be seen as legitimate (as also in these cases it could not be ruled out that some of the drugs could come into the possession of persons other people than the one possessing them for personal use), the actual risk to public health would be so low that criminal punishment would amount to a disproportionate response (as a consequence of the third step in the test mentioned above).

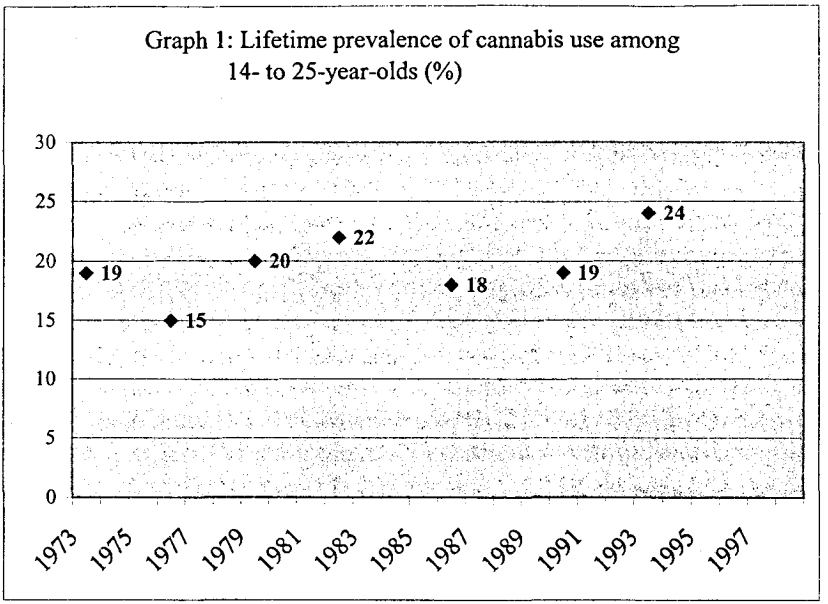
The Constitutional Court concluded from a) and b) that infringements of the principle of proportionality and the right to equal treatment – although in principle possible – could be avoided by developing and implementing a

consistent and uniform policy of non-prosecution of a range of drug cases, whereby the main characteristics defining the range of such cases which must be dismissed involve a minor quantity of a controlled drug and possession, purchase and/or import for personal use. Therefore, as a consequence of the Constitutional Court's decision, possession (but also import or purchase) of small amounts of cannabis (essentially not threatening public health) must not be prosecuted because such prosecution would be disproportionate. In order to implement the right to equal treatment, such non-prosecution must be based on the same criteria throughout Germany. The problem which arises from this decision is that there is no way to develop and implement such a policy of uniform non-prosecution if there is no consensus among individual states. This is why the arguments developed by the Constitutional Court should have led to a rule that the legislator is obliged to change the law and incorporate the said criteria (small amount and personal use) as basic offence characteristics.

6. General trends in drug use and in the developments of drug problems

Trends in the development of substantial and procedural criminal law also have to be contrasted with trends in drug use and drug problems. In particular, it has to be sorted out whether and, if so, to what extent drug problems are self-made problems due to an excessive use of criminal law. The hypothesis of drug control problems has been extensively debated since the mid-1980s; however, the conflict between prohibitionists arguing that the meagre results of law enforcement are due to deficits in law enforcement and partisans of the argument that less criminal law would lead to fewer drug problems is not even close to resolution. A solution to this conflict is not likely to emerge because, basically, the conflict is over normative issues, and not over issues that could be decided by way of cost-benefit analysis or other social science research.

The use of illicit drugs started to spread as a social phenomenon in the late 1960s when cannabis became a casual drug widely used by young people and essentially linked to the then emerging youth subcultures. Research on the prevalence of cannabis use shows that prevalence rates reached a peak at the beginning of the 1970s and remained rather stable until the beginning of the 1990s, when cannabis use again increased. This is evidenced not only by the increase of lifetime prevalence of cannabis use



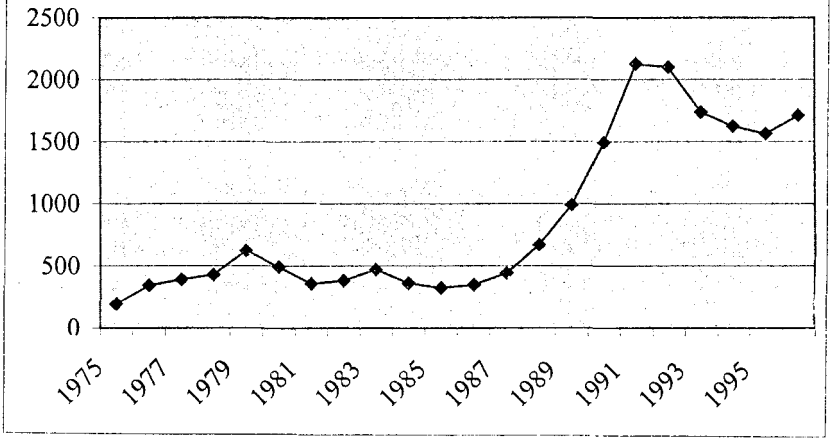
Source: *Bundeszentrale für gesundheitliche Aufklärung: Die Drogenaffinität Jugendlicher in der Bundesrepublik Deutschland.* Köln 1994, p. 51.

between 1990 and 1993 (from 19 to 24%), but also by the increase of rates of current cannabis users (from 6 to 10%)[14]. According to recent research, cannabis users represent a rather heterogenous group. However, current cannabis users evidently do not differ from the general population in terms of psychological or psychiatric norms[15]. The problematic use of cannabis seems to be linked to other problems encountered by users, and seems to be a coping strategy to compensate for deficits in problem-solving resources[16]. Cannabis (and to a lesser degree marijuana) remains in Germany the predominant drug used by youth. In so far, Germany is not different from other European countries, and it is fair to say that cannabis has become a well-established casual drug which certainly will not disappear that easily in the future. The use of heroin spread in the 1970s and remained rather stable until the beginning of the 1980s. In general population sur-

[14] Kleiber, D., Soellner, R.: *Cannabis-Konsum. Entwicklungstendenzen, Konsummuster und Risiken.* Juventa: Weinheim, München 1998, p. 229.
[15] Kleiber, D., Soellner, R.: opus cited, 1998, p. 231.
[16] Kleiber, D., Soellner, R.: opus cited, 1998, p. 232.

veys, lifetime prevalence rates do not exceed 1% in the west of Germany, 'last years' use' prevalence rates amounted to 0.4% in 1995 [17]. When it comes to 'last month' prevalence rates, the numbers are – as can be expected – too small to be reliable. Estimates of the number of current heroin users range between 80,000 and 160,000, depending on estimate procedures [18]. However, the group of heroin users is the most visible, at least in those cities where open drug scenes have developed. The group of heroin users also displays the heaviest toll of drug-related deaths in Germany. However, the peak in drug-related deaths observed in 1991 is not associated with increasing numbers of heroin users, but reflects overdose problems and deterioration of the health status brought about by high purity heroin and in particular also with Aids.

Graph 2: Drug related deaths in Germany



Source: *Bundeskriminalamt: Polizeiliche Kriminalstatistik 1996.* Wiesbaden 1997.

In Germany, cocaine reappeared (major cocaine waves had occurred in the 1920s) at the beginning of the 1980s, with powder cocaine still presenting the main drug of choice among coca-derived substances. Crack is available

[17] Simon, R., Tauscher, M., Gessler, A.: *Suchtbericht Deutschland* 1997. Hohengehren 1997, pp. 148-153.

[18] Reuband, K.-H.: 'Drug Policies and Drug Prevalence: The Role of Demand and Supply'. *European Journal On Crime Policy and Research* 6(1998), pp. 321-336, p. 332 gives an average of estimates of 110,000 drug addicts.

on German drug markets; however, its use has never reached the epidemic proportions observed in various US metropolitan areas. Lifetime prevalence of cocaine use among adult men in the western part of Germany was 3% in the mid-1990s[19]. From the beginning of the 1990s, ecstasy became a drug widely used in certain new youth cultures, in particular those linked to mass events (e.g. the Berlin 'love parade'). Of course, the drug use situation is still very different in the east of Germany. Although an increase in the use of cannabis has been observed in the 1990s in the New Bundeslaender, incidence and prevalence are nowhere near the rates in the west of Germany.

Research during the 1980s and 1990s has confirmed that in particular addicted heroin users (many of them multi-drug users) have suffered severely from such diseases such as HIV and hepatitis (mainly as a result of needle-sharing). A substantial number of them are subject to the disadvantageous conditions prevailing on open drug scenes and black markets, and are therefore subject to considerable risks to life, health and social well-being. Thirty years of experiences with treatment offers have shown that there is a hard core of heroin users who cannot be persuaded to enter or to stay long enough in drug-free therapy modalities. Although drug research has helped a lot in understanding the onset and course of drug-using careers as well as drug markets and the biochemical functioning of various drugs, a point of serious conflicts is – as mentioned earlier – the answer to the question whether it is the drug itself or the criminal-law-based control of drugs that explains the type and extent of problems exhibited by heroin users. It follows that there is no consensus on the question whether drug policies should be aimed at reducing drug problems through facilitating access to hard drugs and making consumption of drugs less risky, or at strict criminal-law-based control of markets and drug-free offers of treatment to drug-dependent individuals.

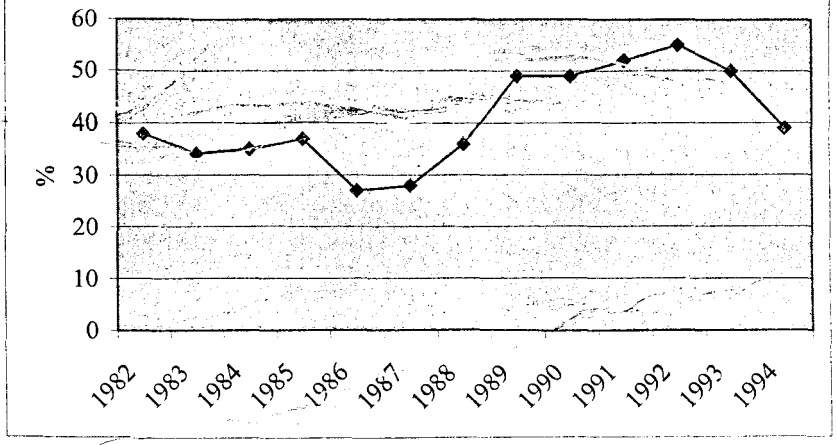
7. General trends in drug law enforcement and the implementation of drug policies

While in the 1960s an annual average of slightly fewer than 1,000 drug suspects were recorded in federal police statistics, in the 1980s this figure increased to more than 50,000. Since then the figure has risen sharply, with over 90,000 drug suspects at the beginning of the 1990s. In 1998 approxi-

[19] Simon, R., Tauscher, M., Gessler, A.: opus cited 1997, p. 147.

mately 177,000 suspects were recorded in police statistics. As regards convictions and sentencing, in the early 1960s some 100 individuals were sentenced annually on the basis of the Opium Law. In the mid-1980s, almost 20,000 were sentenced each year on the basis of the Narcotics Act. In the second half of the 1990s, the number of adjudicated and sentenced drug offenders hovered at around 30,000. The effects of these trends in law enforcement and sentencing can also be observed in the prison systems. In the 1960s, drug offenders were virtually non-existent in German correctional facilities; however, in the 1980s, every 10th prisoner had received a sentence because of drug law violations, and in the 1990s in some state prison systems the proportion of drug offenders within the prison population exceeded 50%, as can be seen e.g. in the prison system of Hamburg (Graph 3).

Graph 3: Proportions of drug offenders within the Hamburg prison system

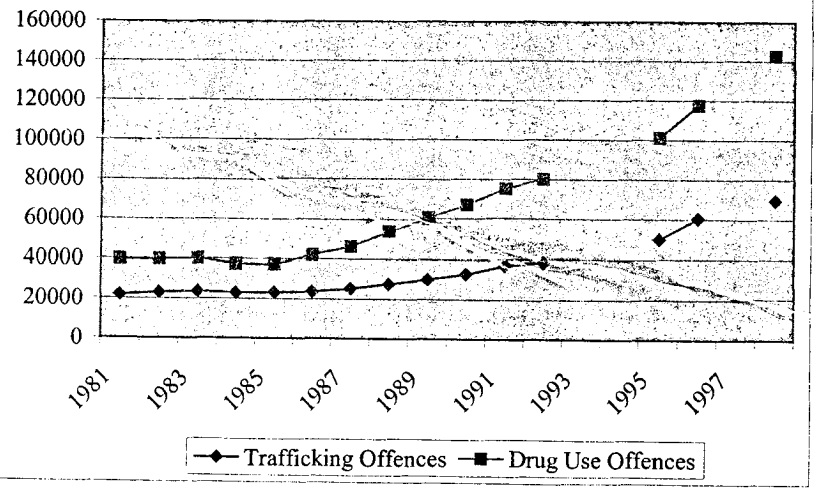


Source: *Unpublished Prison Data*. Justice Department Hamburg 1996.

Prison overload problems in the 1980s were partially due to a sharp increase in long prison sentences following serious drug cases. The proportion of prison sentences of two or years for drug crimes amounted to 0% at the end of the 1960s and 10% in 1976; in 1991, about 27% of all prison sentences of two years or more were related to drug crimes. In 1997, ap-

proximately 30% of prison sentences of 2-5 years, 25% of prison sentences of 5-10 years and 15% of prison sentences of 10-15 years originated from drug cases (see Graph 6). Basically, the data on drug offences and drug offenders reveal that for a long time cannabis outweighed hard drugs, although its proportion has recently decreased. For example, in 1986 cannabis offences made up two-thirds of all drug cases known to the police; the proportion dropped steadily to 40% in 1992 but jumped again to well over 50% in the second half of the 1990s (Graph 5). Furthermore, most drug offenders still come into contact with the police because of mere possession of drugs and possession of cannabis. On the other hand, police data demonstrate that law enforcement is preoccupied with small amounts of drugs. Most offenders who come to the attention of police and criminal justice agencies are drug users. This trend became especially marked during the 1990s, when the gap between the numbers of police-recorded drug use offences and drug-trafficking offences widened dramatically (see Graph 4). The development in Graph 4 illustrates that law enforcement efforts are likely to hit hardest a group of drug users (and in case of heroin, to a significant extent at the same time also drug sellers) which is most vulnerable to covert and deceptive enforcement patterns.

Graph 4: Police recorded trafficking and drug use offences



Source: *Bundeskriminalamt: Polizeiliche Kriminalstatistik.* Wiesbaden 1982-1999.

The report of the federal government on the implementation of the Narcotics Act in the years 1985/1987 reveals that 80% of all criminal investigations concerned small amounts of drugs for personal use[20]. This trend was confirmed in a new analysis of drug enforcement data covering the years 1988-1990. Although a significant percentage of criminal investigations are dismissed according to §§ 153, 153a Criminal Procedural Code, a substantial number of criminal adjudications and sentences involved small amounts of cannabis (up to 5 grams). The analysis covered approximately 90,000 final decisions of drug investigations. Of these, approximately 65,000 were court decisions, of which approximately 12,000 involved sentencing for possessing 5 grams or less of cannabis, and a further 12,000 sentencing for possessing 50 grams or less of cannabis. Almost 40% of the criminal sentences meted out in cases of drug offences therefore concern rather minor quantities of soft drugs.

An analyses of data on the prison population of the state of Hessen in the mid-1980s shows that approximately a third of offenders imprisoned for of drug offences are addicts, and that approximately half of those offenders imprisoned for trafficking more than 500 grams of any drug were a typical courier. It is especially the courier of cocaine who is likely to receive a rather long term of imprisonment. But in general, today the bulk of imprisoned drug offenders is still characterized by either drug addiction or low-level drug-trafficking.

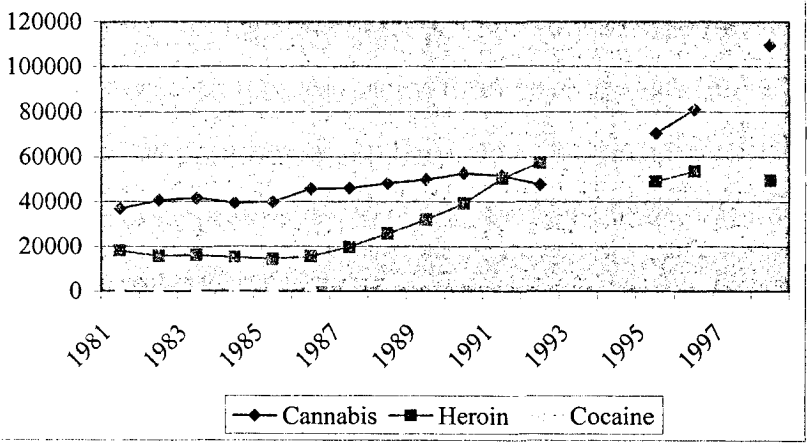
The structure of sentences in the case of drug offences is primarily characterized by the heavy use of fines. During the 1990s, approximately 50% of (adult) drug offenders receive fines. On the other hand, a substantial proportion of drug offenders are subject to long prison sentences.

In particular during the 1990s, new control policies have been developed which rely heavily on the goal of preventing the emergence of open drug scenes. In pursuing this goal, administrative measures are increasingly used to disturb drug markets and to try to prevent drug users and small-scale dealers from frequenting certain places. Current police laws empower police to a impose a range of coercive administrative measures, which essentially are legitimated by the prevention of risks and dangers. Among such measures are an order to leave a certain place, the interdiction to stay in certain places, administrative fines and detention for the purpose of en-

[20] Bericht der Bundesregierung über die Rechtsprechung nach den strafrechtlichen Vorschriften des Betäubungsmittelgesetzes in den Jahren 1985 bis 1987 vom 11.4.1989. BT Drucksache 11/4329.

forcing interdiction orders. These policies are developed and implemented on the local level, as the power to maintain order in general is vested in municipal bodies. Recent information on the use of these types of administrative measure in the municipality of Osnabrück demonstrates that they are frequently used. Within a period of approximately 4 years (1995-1999), close to 2,500 interdiction orders were imposed along with 119 administrative fines and 176 detention orders[21].

Graph 5: Police recorded drug offences broken down by type of drug

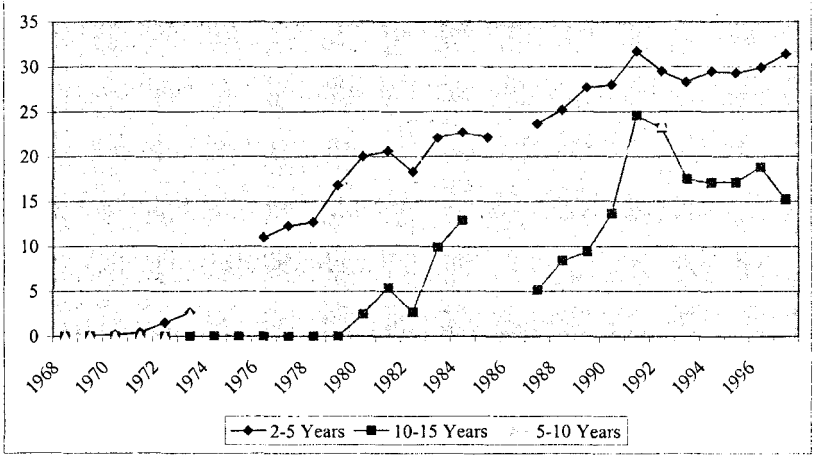


Source: *Bundeskriminalamt: Polizeiliche Kriminalstatistik.* Wiesbaden 1982-1999.

However, the most common response to small drug cases is a non-prosecution decision by the public prosecutor. This is where regional differences in implementing drug policies can be observed. Regional differences have always been an important element in the implementation of criminal law. Regional differences in general reflect differences in approaches to specific types of crime and differences in the overall sentencing philosophy adopted in the criminal justice systems. In the case of drug law implementation, differences seem to have become more marked since

[21] Hunsicker, E.: Zur Kriminalität der Spätaussiedler. Die Bedeutung des Phänomens am Beispiel der Stadt Osnabrück. *Kriminalistik* 53(1999), pp. 520-524, p. 521.

Graph 6: Long prison sentences for drug offenders in % of all long prison sentences



Source: *Statistisches Bundesamt Wiesbaden: Strafverfolgungsstatistik.* Wiesbaden 1970-1999.

the mid-1980s, when the basic consensus which carried drug law reforms between the period preceding the first major drug law of 1971 (which was a response to the wide use of cannabis during the student and youth movement in the 1960s) and the last major amendment of 1981 (which was basically justified by the heroin epidemic of the second half of the 1970s) broke up. Now there are conflicts on the one hand over the promises and the prospects of harm-reduction policies in responding to open drug scenes and the heroin user, and on the other hand over the creation and implementation of cannabis policies.

On a descriptive level, these conflicts became visible essentially in sentencing outcomes and in non-prosecution policies[22] and, furthermore in the interpretation of (side-line) criminal drug statutes addressing such behaviour as "providing opportunities for drug use", etc.

[22] Ambos, K.: 'Recht auf Rausch?' *Monatsschrift für Kriminologie und Strafrechtsreform* 1995, pp. 47, p. 48.

Regional differences regarding general ordinances for regulating the prosecution and non-prosecution of drug offences*

State dismissal rates 1985/1987 **	Definition of minor quantities of drugs			Prior arrests	Additional conditions
	Cannabis	Heroin	Cocaine		
Baden-Württemberg Dismissal rate: 26%	3 units of consumption	-	-	First timers Only	Non-prosecution only in case of first offenders. In case of soft drugs, possession and purchase for personal use, drug user is socially integrated and agrees to treatment
Bavaria Dismissal rate: 6%	3 units of consumption (approx. 6 grams)	-	-	-	Cannabis only; no arrests in 12 months preceding current offence
Berlin Dismissal rate: 76%	Up to 6 grams: mandatory non-prosecution; 7-15 grams: non-prosecution at the discretion of public prosecutor	-	-	-	
Brandenburg Dismissal rate: n/a	3 units of consumption	-	-	In case of prior arrests, dismissal not excluded	
Bremen Dismissal rate: 22%	10 grams	1/10 up to 1 gram	1/2 up to 2 grams	-	
Hamburg Dismissal rate: 19%	Quantity corresponding to the content of a matchbox	1 gram	1 gram	In case of addicts, prior arrests not considered; in case of non-addicts, dismissal may be granted with up to two priors.	Cannabis consumption in prisons does not preclude dismissal
Hessen Dismissal rate: 8%	Up to 6 grams: mandatory; 7 to 30 grams: at discretion of public prosecutor	1 gram	1 gram	-	
Mecklenburg-Vorpommern	5 grams	-	-		Dismissal in cases with certain circumstances only
Niedersachsen Dismissal rate: 12%	Up to 6 grams: mandatory dismissal; 7-15 grams: dismissal at discretion of the public prosecutor	1 gram	1-2 consumption units		

Nordrhein-Westfalen Dismissal rate: 21%	10 grams	0.5 gram	0.5 gram	1 prior arrest does not preclude dismissal	Cannabis consumption in prisons does not preclude dismissal
Rheinland-Pfalz Dismissal rate: 23%	10 grams	-	-	Prior arrests do not preclude dismissal	
Saarland Dismissal rate: 33%	Up to 6 grams: mandatory; 7-10 grams: dismissal at the discretion of the public prosecutor	-	-	Prior arrests do not preclude dismissal	
Sachsen	2-3 consumption units	-	-	-	Information on exact quantities falling under the category of 'minor quantities' are not published; cases involving hard drugs are never dismissed.
Sachsen-Anhalt	3 consumption units/up to 6 grams	-	-	Only in case of first offenders (except addicts)	
Schleswig-Holstein Dismissal rate: 39%	Up to 30 grams in case of cannabis; up to 100 grams in case of marijuana	1 gram	5 grams	Prior arrests do not preclude dismissal	

* Source: Körner, H.H.: 'Die Entpoenalisierung und die Entkriminalisierung von Cannabiskonsumenten mit geringen Cannabismengen zum Eigenkonsum'. *DVJJ-Journal* 3/1996, pp. 232.
** Rate of criminal drug cases dismissed 1 January 1985-31 December 1987; source: *Bundestagsdrucksache* 11/4329.

With the type of side-line offence statutes mentioned above, criminal drug law can in principle be applied to a whole series of harm-reduction activities. Differences in interpreting and implementing criminal drug statutes had immediate effects on such health policies as needle-exchange programmes, methadone maintenance, prescription of controlled drugs, provision of facilities where heroin can be shot up under safe conditions, etc.

Another source for the emergence of differences and conflicts can be found in the drug law itself, as the Narcotics Act displays basic characteristics of modern criminal law. These characteristics concern the introduc-

tion of open and vague concepts, and an unseen extension of criminal law and its intertwining with administrative law. With drug laws, the question is put forward what role criminal law should play in organizing risk management in modern societies. Drug laws are but one facet of risk management through criminal law. Offences created in criminal drug laws essentially are endangering offences, a technique today widely used in European criminal legislation to ensure e.g. traffic safety, proper natural environments, the well-being of the economy, public health, and internal security. The focus switches from the results of human behaviour to risks attributed to that behaviour. The questions which arise in this respect point to a basic dilemma of drug policies based on criminal law. These questions surely cannot be answered by focussing on one risk (i.e. drugs) alone. On the other hand, the problem arises of how to define a drug offence, which in turn concerns the problem of which model of control should be adopted as a basis for a national and uniform strategy. Drug offences are usually part of administrative or health laws and do not contain complete descriptions or definitions of what a drug or a dangerous substance is. Drug offences are not completely defined by legislative bodies but are open to discretionary decision-making within the Ministry of Health, the Ministry of the Interior or some other administrative authority. Intertwining administrative systems and criminal justice brings upon numerous problems, as has been demonstrated e.g. in the case of environmental offences and tax offences, etc. The primary problem here concerns the conflict between goals which seems to be inevitable and may be easily demonstrated when confronting a legalist perspective on drug problems that aims at the detection, conviction and sentencing of offenders, with a public health perspective aimed at improving health or minimizing health risks.

Today, German states are far from having developed and implemented a uniform policy of non-prosecution. While some have adopted guidelines requiring non-prosecution in cases involving amounts between 10 and 30 grams of cannabis and 0.5 and 1 gram of cocaine and heroin, others have not even issued guidelines. Regional differences are still rather marked for the sub-groups hard drugs (cocaine, heroin), drug possession in the military and in prisons, and the possession of drugs by juveniles.

As regards harm reduction policies, regional differences still exist in particular with respect to the scope and conditions of methadone maintenance. Moreover, some states allow for needle exchange in prisons and the operation of shooting houses. The prescription of methadone by physicians

in individual cases was facilitated some years ago by a supreme court decision, which held that good medical practice as defined by regional and federal associations of physicians (which in principle are rather restrictive towards the prescription of methadone) must not be followed by criminal courts when deciding whether the prescription of a controlled substance amounts to a criminal offence. Needle-exchange programmes on the other hand have been the subject of a specific and rather exceptional legislative act. The federal parliament added to the drug offence statutes a clause saying explicitly that the operation of needle-exchange programmes does not fall under any drug offence statute.

Another example of continuing differences and conflicts in implementing drug policies concerns the city level and heroin prescription. In 1991, the city of Frankfurt applied to the Federal Office of Medicaments for permission to distribute heroin to a group of 100 heroin addicts in order to provide the possibility to do proper research on the questions whether with controlled and legal distribution of heroin a hard core of heroin users can be reached with positive outcomes, and whether the regime of heroin should be changed by placing that substance among those which legally can be prescribed. The application was based on Art. 3 of the Narcotics Act, which says that solely for the purpose of scientific research or for reasons of major public interest, list 1 substances (such as heroin) may be permitted to be treated as list 2 and list 3 substances. This move by the city of Frankfurt was not unique. At the beginning of the 1990s, the states Hessen and Hamburg brought (unsuccessful) motions to the Federal Council demanding the introduction of explicit legislation allowing for the medical prescription of heroin. The obvious interest of large municipalities in developing alternative drug policies with respect to hard-core heroin users lies in those problems usually associated with large groups of hardened heroin users, e.g. enormous health problems, drug-related property crime and all sorts of public disorder[23]. The Federal Office turned down the application, saying that there was no need for scientific research because there was enough evidence from research carried out in other countries, and because there was ongoing research in Switzerland. Therefore, additional research in Germany was not needed. The Office then argued that Art. 3 demanded both scientific and public interest, and that there was no public interest in performing heroin trials. The Office also brought forward arguments derived from Art. 5 of the Narcotics Act, which says that per-

[23] See Egg, R. (ed.): *Drogenmissbrauch und Delinquenz*. Wiesbaden 1999.

mission granted according to Art. 3 for scientific reasons must not be granted if there is no guarantee that the distribution of list 1 drugs can be controlled properly, or if the purpose of the Narcotics Act would be opposed to the type of research intended. Here, the Office said that the research plan created risks of heroin ending up on the black market. The Office then argued that the purpose of the drug law precludes research on the effects of heroin distribution, because the aim of the research could ultimately lead to placing heroin under the regime of those drugs which can legally be prescribed. Thus, the Office argued that the purpose of the drug law was to reduce the use of drugs. Therefore, scientific research possibly leading to the distribution of drugs (if research outcomes were assessed to be positive) could not be tolerated because that would not comply with the purpose of the drug law. The city of Frankfurt then sued the Federal Office before the administrative court of Berlin. Although the administrative court did not accept the arguments of the Federal Office, it ruled that the decision to deny the heroin trial in Frankfurt was invalid. However, the case will now be closed as the new federal government has in principle accepted that heroin distribution experiments will be carried through in those municipalities which apply for permission[24]. But by introducing heroin prescription, the conflicts over the general direction of drug policies will not be resolved.

8. Conclusions

As regards cannabis policies, in some parts of Germany the situation may be paralleled with that in the Netherlands, although the Dutch position towards soft drugs is not a principled but a pragmatic one. In principle, the current Dutch policy with respect to cannabis may be turned over from one day to another (in fact, important changes have recently been implemented regarding coffee shop policies). In Germany, on the contrary the Constitutional Court's decision has the status of a federal statute (which may not be turned over by parliament).

- The Constitutional Court's decision does not represent an explicit decriminalization policy, but one of non-prosecution (and equal treatment).
- There has been no legislative (federal) response to this decision.

[24] Schmidt, L.G.: Heroin-Modellversuch der Bundesregierung nach dem Arzneimittel- (AMG) und Betäubungsmittelgesetz. Sucht 45(1999), pp. 156-157.

- There exists implementation of (formal) policies of non-prosecution in some German states, and not in others. As there is no federal jurisdiction over prosecution policies, the implementation of the Constitutional Court's verdict has to be based on consensual policy decisions in the individual states. The outcome up to now shows very clearly that a consensus was not reached and that regional differences continue to exist.

However, although the cannabis decision did not change the general structure of German drug policy, it was the culmination of a long-term process focussed on the normative issues and the question of values which have to be tackled first when framing drug policies. The problem of whether the criminalization of drug use or other types of drug-related behavior sought through UN conventions (1961, 1971 and especially 1988) violates basic human rights because of the repression of cultural and religious traditions as well as discrimination against groups and individuals because of their being different or making choices which do not harm other individuals have to be addressed[25]. The answer will not be provided by cost-benefit analysis or social science research, nor by the debate over a constitutionally guaranteed right to consume drugs actually exists, but by how and where the limits of criminal law on the one hand and limits on individual freedom of choice are set.

The heroin prescription line of drug policy also demonstrates that the core problem is a normative one and is not something that can be resolved through evaluation research and experiments. Research on heroin distribution shows[26] (if interpreted optimistically) that over an extended period of time, more drug users – even when supplied with heroin – stop taking drugs than continue with their habit. On the other hand, the pessimistic interpretation would suggest that a substantial proportion of the groups supplied legally with (what are now) illicit drugs (of their choice) will not be able to lead an abstinent life or improve in terms of health, employment,

[25] See Kappeler, M.: *Drogen und Kolonialismus*. Frankfurt 1991; Caballero, F.: *Droit de la drogue*. Paris 1989; Husak, D.N.: *Drugs and Rights*. Cambridge 1992; Pearson, G.: 'Political Ideologies and Drug Policy'. Paper presented at the Third European Colloquium on Crime and Public Policy in Europe. Noordwijkerhout, 5-8 July 1992; Köhler, M.: Freiheitliches Rechtsprinzip und Betäubungsmittelstrafrecht. *Zeitschrift für die Gesamte Strafrechtswissenschaft* 104(1992), pp.3-64, p.27; Szasz, Th.: *Our Right to Drugs*. New York et al. 1992.

[26] Krausz, M., Uchtenhagen, A., van den Brink, W.: Medizinisch indizierte Heroinverschreibung in der Behandlung Drogenabhängiger. Klinische Versuche und Stand der Forschung in Europa. *Sucht* 45(1999), pp. 171-186.

etc. What can be learned from these experiments also concerns the limits of social and legal intervention at large. There is a group of chronic drug users who are rather resistant to all attempts aimed at improving their situation. We may suggest that for this group it is not the drug nor the conditions in open drug scenes or on the black market which are responsible for this group's dangerous or even destructive behaviour patterns, but other social and individual problems which cannot be overcome by responding to a drug problem.

What will be the outcomes of experiments with medically prescribed heroin, in terms of immediate research results and policy guidelines? As far as the development of policy guidelines is concerned, the question must be addressed whether one can actually expect that findings from evaluation research will play a prominent role in framing mainstream drug policy. A sceptical view seems justified. Findings from evaluation research can play a decisive role only if the controversial questions to be resolved with respect to legal access to heroin address the costs and benefits of drug policy options. But this approach supposes that drug policies – be they health- or criminal-justice-based – actually are justified on a cost-benefit basis or may be criticized because of poor cost-benefit ratios. Although cost-benefit considerations do provide serious arguments, they do not account for the whole of any drug policy. At the core of the controversial questions lie normative and moral issues. These normative and moral issues turn up again if the model of the sick individual must be exchanged for a drug user making rational or moral choices. The sickness model is largely confined to opiate use and opiate dependence. Other drugs (e.g. cocaine, amphetamines, cannabis, etc.) do not fit easily into such an approach.

Staying within the cost-benefit framework of drug policy debates, it seems reasonable to remember the experiences from rehabilitation research and their use in framing correctional policies. Here, two lessons can be drawn. First, even elaborated evaluation designs leave enough opportunities for alternative interpretation of research findings (and justifying various policy options). Second, the significance of rehabilitation research findings depend not only on the rigorousness of research designs, but more so on the basic theory used in explaining criminal behaviour as well as crime control. Most probably, heroin prescription will develop into an additional option besides other types of treatment, and is likely to be confined to a small group of long-term heroin users for whom heroin is seen as a last resort. But the introduction of such last resorts will not affect the

magnitude of drug problems in terms of black markets, organized crime, drug-related deaths and drug-related crime, nor will it change the overall character of drug control.

French Policy for Controlling the Use and Trafficking of Prohibited Substances

MARIE-DANIÈLE BARRÉ

The control of the use and trafficking of prohibited substances is governed by the 1970 law "prescribing health measures for fighting against drug abuse and punishing trafficking and illegal use of poisonous substances". According to this law, the use of prohibited substances - including individual and private use - is a punishable act. The definition of a substance as illicit is based on both international agreements and national regulation. Within the framework of international agreements, national regulation classifies substances as narcotics on the basis of a list issued by the Ministry of Health.

The responsibility for defining drug-related policy devolves on an interministerial committee responsible to the prime minister. This "interministerial committee for the control of drug abuse" is in charge of "defining, running and coordinating government policy with respect to the control of drug use, and especially, action aimed at prevention and rehabilitation". The ministries involved are those in charge of Social Welfare, Health, Interior, Justice, Education, Budget (Customs), Defence and Foreign Affairs. This committee, created on 8 January 1982, has met six times at variable intervals. The fifth and sixth meetings were held in September 1993 and September 1995, respectively, and both were marked by the adoption of a government plan for action, of which more will be said below.

The permanent agency of this committee is the Délégation Générale à la Lutte contre la Drogue et la Toxicomanie. The local correspondents of this agency are the "regional committees for controlling drug abuse", created in 1985. Their members include experts, elected officials and representatives

of citizens' groups, in addition to representatives of the State agencies. "Drug-related policy" is essentially a State policy, since its two basic components - penal policy and sanitary policy - are the concern of the State. Only prevention falls within the responsibility of cities.

Clearly, the subject of drugs involves a great many institutional actors. This fact calls for three remarks:

- incompatibilities between the specific logics by which the various administrations involved operate is practically unavoidable. For instance, the controversy around the free sale of syringes, a measure adopted in 1987, brought two opposing logics into play: for the representatives of the public health department, refusal to do so was tantamount to "not assisting a person in danger", whereas the representatives of the penal agencies viewed this measure as "incitement to consume narcotics", both of which are criminal, punishable acts.
- a change in any one aspect of drug-related policies has repercussions that may threaten a complex fabric, interwoven between the various institutions, and built out of their working habits and the stakes involved. For the control agencies, for instance, criminalization of the use of narcotics represents a stake that extends far beyond the simple punishment of an offence, since they have turned it into an informational and surveillance tool: "decriminalization of the drug user (sic) [...] would be to abandon the signalling of individuals who are led by drug abuse to commit numerous types of crimes[1]".
- the fact that different authorities (municipality, State) are responsible for specific aspects of drug policy for which interrelations may be conflictual (prevention, health care, repression), is not favourable to the development of local initiatives and innovative policies.

In short, aren't all these the ingredients - perhaps not quite for immobilism - but at least for a degree of inertia? And this indeed is the question that comes to mind when one looks at how drug-related policy is constructed[2].

[1] La Tribune du commissaire de police, n° 60, March 1994, p. 24.

[2] See B. de Celis' analysis (1992) of the failure of attempts at legislative reform in 1977-78 and 1986-87, p. 215, 218.

1. The criminal justice framework since 1970

We will take a look at the evolution of the texts, laws and ministerial instructions regarding the use and trafficking of narcotic substances, with special attention to the recent period. For the less recent one, J. Bernat de Célis made a complete description[3].

1.1 Evolution of the legislation

Although one of its explicit purposes is the organization of health care for consumers of prohibited substances, the 1970 law has been claimed to establish the primacy of the judicial sphere over the health sphere in this domain, since once the judicial authorities are informed of an offence of use, it is up to them to choose - the criterion being recidivism - between a criminal procedure and handing the case over to the health authorities, by means of a "treatment order". The treatment order supposes that the drug user follow a specific treatment under the supervision of health authorities. If the offender fails to follow this treatment, he or she may be sentenced by the judge.

It is important to note that the law does not make any distinction between different substances: the offence of use of whatever prohibited substances is liable to a prison term of two months to one year. Likewise, possession - which logically accompanies use - is punished more severely than use itself: by a prison sentence of two to ten years. When the substance is imported, even for personal consumption, the consumer may be accused of trafficking. As a result, and although the border between users, dealers and traffickers may be quite fuzzy, in case of conviction for trafficking a sentence of up to 20 years in prison, doubled in cases of recidivism, is prescribed.

This law has been modified repeatedly, and especially:

- In 1983, for the implementation of the exclusion from the country of foreigners convicted of trafficking.
- In 1986, a new offence, "petty dealing", was created. A sentence not exceeding five years is prescribed for this incrimination. If an offence is punishable by a prison sentence of less than five years, a quick treatment of the trial is possible. Therefore by lowering the maximum

[3] Bernat de Célis (J.), 1989.

length of the sentence for cases of petty trafficking, the lawmakers allow for the immediate trial of user/dealers and actually fashioned a more repressive tool.

- In 1986, the offence of trafficking in narcotics was made punishable by a sentence of a safety period of 18 years[4].
- In 1987, the punishment was augmented in cases of sales to juveniles. Also, a reduced term or exemption from sentence-serving may be pronounced for repentant offenders. Last, the laundering of drug money was made an offence.
- Since then, all of the legislative modifications tend to reinforce the control of drug trafficking. The new criminal code, in effect as of 1 March 1994, prescribes more severe punishment for every offence linked with organized crime, and for drug trafficking in particular. When the latter is carried out within the framework of an organized group, it is punishable by up to 30 years of criminal detention. The leader or organizer of any such group is punishable by a life sentence. The safety period may be extended to 22 years in this case.

Lastly, new rules have been added to the criminal procedure, the argument being the control of drug trafficking. Officers of the judicial police agencies are not guilty of a punishable offence when "they acquire, possess, carry or deliver narcotics" with the consent of the Public Prosecutor's office.

1.2 Analysis of the implementation of the 1970 act: ministerial instructions that modify or reinforce its punitive thrust

The implementation of the law has been considerably modified, at various times, by a number of official instructions on its enforcement. We will see two points in particular: the question of distinctions based on the nature of the substance consumed and the question of treatment for users/dealers.

1.2.1 Nature of the substance consumed

This is an important point, since it is here that the key point in the arrangement prescribed by the 1970 law - "the treatment order"- stumbles.

[4] A "safety period" means that no mitigation of the sentence is possible.

The Pelletier Report, the first of three successive reports commissioned by the government since 1970 to evaluate the situation[5], points out that as a rule the treatment order is an inadequate procedure for hashish users. One paradoxical conclusion of this report is that while complete application of the law is not advisable, its abrogation is not desirable either.

"*While we would not reconsider the illegality* of use of hashish, the practice, now commonly applied in the Paris area, of not systematically prosecuting and seeking a prison sentence for simple users of hashish should be generalized on an experimental basis."[6]. This is formulated in the 17 May 1978 instruction which strongly encourages public prosecutors to refrain from prosecuting hashish users, and instead to issue a warning to them. This introduced a distinction based on the nature of the substance used.

This distinction was to disappear later on. In the 12 May 1987 instruction, the distinction is no longer between substances, but is based on the nature of use: occasional or regular. Moreover, under the designation of occasional user, the instruction only considers the case of a "socially well-integrated user", who should be given a warning. A treatment order is recommended for all cases of regular use.

The 15 February 1993 instruction - aimed at reinforcing the prescription of treatment order, too seldom used in the opinion of the ministry of Justice - contains a discrete allusion to the notion of the addictiveness of a substance as a criterion for prescription of such a treatment order.

It is not until the 28 April 1995 instruction that a decision-making criterion explicitly combining the nature of the substance and the nature of use is formulated: "treatment orders should only be issued for users of narcotics such as heroin and cocaine, or for those *cannabis users who are heavy, repeated consumers, or who consume it in conjunction with other substances (medications, alcohol, etc.).*[7]". In all other cases, dismissal with a warning or notification to the health authorities is recommended. This reverts back, 17 years later, to the spirit of the 1978 Pelletier Report.

[5] Pelletier (M), 1978. Trautmann (C), 1990. Henrion (R), 1995.

[6] Pelletier (M.) 1978, p. 219, emphasis added by author.

[7] Underlined in the instruction.

1.2.2 Definition of users

In the 1971 and 1973 instructions for enforcement, the possession, acquisition and even importing of small amounts of a substance are assimilated to use. Conversely, in case of resale, the offence is qualified as trafficking. This trend is corroborated by a 1977 instruction pointing out that in practice, this had not necessarily always been the case: "whereas drug users involved in resale were formerly widely viewed as requiring medical treatment only, it is preferable that severe prison sentences be demanded more frequently for these people, in view of the threat of growing proselytism, and also, to give an example". The 1978 instruction confirms the assimilation of possession of a small amount of a substance to use.

The 17 September 1984 instruction is characterized by the introduction of a new category, the "user/dealer", for whom it is important to "determine whether trafficking does not in fact prevail over use".

The 12 May 1987 instruction abrogates all earlier instructions. It defines three categories: use, use/trafficking, and trafficking. The user/trafficker should be considered essentially as involved in trafficking. No mention is made of the possession of small amounts.

The 2 October 1992 instruction on responses to urban crime confirms all of the provisions of the 1987 one.

The last report commissioned by the government, the Henrion Report, discusses these problems once again and suggests two modifications to incriminations[8]. First, the creation of an "offence of importing for personal consumption", liable to a prison sentence not exceeding one year, as in the case of use; and secondly, the assimilation of possession for personal consumption to use. No echo of these proposals may be found in the latest government plan for action. Were they adopted, these two proposals would simply bring us back to the provisions of the 1971 and 1973 instructions.

2. The officially declared drug policy

A look at the last two government plans - those for 1993 and for 1995[9] - points to the major axes of the policy officially declared by the present

[8] Henrion, 1995, p. 129.

[9] Which only covers one year; a new plan will be devised next year.

government. A new reference, broader than the need to "reduce the risks of contamination by the HIV", is developed: it alleges the "need to reduce all of the societal risks induced by drugs", therefore embracing all of the measures needed to prevent drug use, develop health care and fight social exclusion, but also enhanced punishment of trafficking.

2.1 Fighting social exclusion

Assertion of the need for integration or reintegration tends both to fortify the present system and to promote some changes.

For instance, the justification of the treatment order is reasserted here. The treatment order, initially a rather symbolic measure, has been increasingly resorted to since 1990 and has now become a relatively more acceptable health intervention measure (3600 treatment orders were pronounced in 1990, 6981 in 1994, and 5760 individuals were actually subjected to this treatment measure in the course of that year[10]). Then, in the last instruction on the subject, dated 28 April 1995, it is interesting to note that the grounds justifying it have been broadened: "aside from its obvious utility as a health measure, it also allows a first contact between the drug user and the social work agencies".

The most visible changes pertain to methadone substitution programmes and the attitude toward the so-called "users who do not request care".

France has recently developed methadone substitution programmes. The number of candidates accepted for this prescription rose from 52 in 1993 to 1695 in 1995. Methadone is first to be prescribed in a specialized centre. Then, following a follow-up phase in such a specialized centre, it can be prescribed by a medical doctor who is a general practitioner. Over half of French *départements* have no such specialized centre at the present time. The prescription of buprenorphine follows less restricting conditions: it can be made directly by a general practitioner.

Last, there is increasing acknowledgement of the idea that health and social integration policies should not ignore "users who do not request care". This ambiguous expression makes its appearance in the 1995 government plan; it apparently designates users who do not themselves request withdrawal. For the first time users are designated in such a way that they are to be taken into account neither as offenders nor as sick persons who can only

[10] Carpentier (C) and Costes (J.M.), 1995.

be recommended to undergo medical treatment. "Social integration" is a separate chapter within the plan. Some of the measures recommended there were formerly included in the chapter on care: this is the case of programmes for syringe replacement, emergency housing and the improved hospital reception of drug users admitted for physical ailments. In January 1995 there were 32 approved syringe replacement programmes[11], as against 3 in April 1993. It was only in March 1995, however, that the regulation was modified so as to authorize the delivery of syringes elsewhere than in pharmacies.

However this tentative policy to fight exclusion has its limits due to the repressive law. For example, a place for the "clean injection" of prescribed medicines, opened by an association aiming at providing social support and help for drug users, had to close. The argument was that these medicines were used illegally.

2.2 Punishment of trafficking

The only punitive provision of the 1970 law that continues to be proclaimed as such is the punishment of trafficking. The punishment of drug use is only justified through encouragements to resort to treatment orders, and the alleged need to take users in for questioning, in order to fight trafficking. For example, the 1993 government plan presented the measure - implemented in 1994, and consisting of issuing normalized police reports for arrested users so as to simplify the job of the policing agencies - under the heading "control of trafficking". However punishment of use is a patent fact. In 1992, 12 253 offences of drug use were penalized by the courts.

The September 1995 plan, reiterating the one of September 1993, in this respect prescribed heavier punishment for trafficking when a juvenile is involved. Similarly, punishment could be imposed on any individual in contact with drug users who is unable to account for his/her standard of living.

Also, trafficking provides the government with an opportunity to emphasize the international dimension of the problem, and above all to stigmatize foreigners living in the country, irrespective of whether or not they are legal immigrants. The 1970 law calls for an additional sentence for foreigners in case of trafficking - banishment from France - an interdiction that may be definitive, and which entails, since 1983, the *ipso jure* escor-

[11] Carpentier (C) and Costes (J.M.), 1995, p. 91.

ting of the foreigner to the border once the main sentence has been served. The 1987 instruction, still in effect, specifies that "in the case of foreigner dealers, the pronouncement of banishment from the country should be systematically demanded, except for extremely specific circumstances". In the same spirit, the 1995 plan announces a forthcoming instruction that will "encourage public prosecutors to be more systematic in their call for sentences including prohibition of residency or banishment from the country [...], and to work in conjunction with other institutions (prison administration, prefecture, etc.) to make sure that these sentences are effectively enforced without delay".

Conclusion

If a drug policy is supposed to be a consistent body of objectives and means, it is hard to speak here of a policy because of the potential contradictions between objectives, the territorial discrepancies in the implementation of the law and the prevalence of an ideological discourse.

Contradictions between different objectives such as the repression of the use of illicit products, prevention and health care have been quite often underlined. Recently the Henrion Report repeatedly emphasized the incompatibility between strict enforcement of the law and the implementation of prevention measures aimed at drug users: "the policy aimed at reducing risks requires that compromises be made with respect to the punishment of drug users".

Territorial discrepancies in the implementation of the law appear for example through differences in the number of convictions for use of illicit products compared to the number of treatment orders pronounced. Although these figures may reflect to some extent different situations, they mainly reflect different ways of reacting to drug use. According to the Ministry of Justice[12], in 1991, some judges pronounced treatment orders for heroin users only and others pronounced them mainly for cannabis users.

Ideological discourse still prevails. For example, the relation between drug and crime is always put forward in public discourse, to justify the repression of use, without any definition of drug or use vs abuse, and despite the fact that this relation has been largely presented as a very complex one

[12] Bilan des réponses apportées à l'usage de produits stupéfiants, Direction des affaires criminelles et des grâces, ministère de la Justice, 1992

in scientific works abroad[13] and more recently in France[14]. Also drug use is always referred to as a plague, therefore reinforcing the role of the State to fight against it. Recently the designation of the Netherlands' policy as responsible for a large part of the trafficking in cannabis does not account for the larger part of trafficking with Morocco.

However, even if there is no proper process of construction of a drug policy as such, it should be noted that prevention has developed and that an informal debate on the revision of the law is going on.

Many associations play an important role in the slow development of a harm reduction policy by promoting prevention projects for drug abusers. It has been the case for syringe replacement and for methadone programmes.

At last a debate on the revision of the law is going on, although not on the political agenda. The French approach to drug use seemed to be problematic enough to prompt the National Consultative Committee on Ethics, which is independent from the government, to decide by itself to address the question of drug use. This committee underlined in its 1994 report that "the fact that the distinction (made in France) between licit and illicit drugs does not rest on any coherent scientific grounds"[15]. In the meantime, the preparation of the Henrion Report was the occasion for numerous consultations, including public hearings, some of which were broadcast on television. One of the outcomes was that 9 out of 17 members thought that cannabis use should be depenalized. Moreover even if "the majority (9 out of 17) were partisans of the penalisation of use of illegal drugs other than cannabis [they do] recommend that its continuation be accompanied by a thorough reworking of the legislation".

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[13] Brochu (S), 1995.

[14] Barré (M.D.), 1994, 1995, Setbon (M), 1995.

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Construction of National Drug Treatment and Harm Reduction Policy: Norway

HELGE WAAL

Introduction

Words and concepts might start to live their own lives. In this volume the concept of social constructivism is a core theme; that is the view that social problems primarily exist in terms of how they are defined and conceived. Decisive influence is attributed to claims-makers who bsucceed in defining the problems through a claims-making process (see Hakkarainen in this volume).

Obviously constructivistic perspectives might inspire ideas on the shaping of policy. They might, however, also inspire the illusionistic view that problems do not exist if they are not defined. Norwegian drug policy is best understood as an attempt to meet concrete social problems in the light of Norwegian culture and traditions. Within this perspective, several claims-makers have in different periods had their impact.

Development

The last half and the turn of the former century was a founding period in Norwegian social policy. The ideas of an enlightened, liberal, middle class collided with the traditions of puritan religious groups, peasants' organizations and a growing labour movement in a period of strong national awakening and nationalism. The period was also characterized by industrialisation and increasing social problems. Out of this matrix arose the idea of a system with public participation and state responsibility basic to a series of

laws and regulations on subjects from the public schools and child-care system (Stang Dahl 1976) to mental health (Ericsson 1974) and the judiciary system (Hauge 1974) adopted during the last decade of the century.

First period: Primacy of norms and public responsibility (- 1930)

The foundations of Norwegian drug policy can clearly be traced back to these years. Bergersen Lind (1974) has described a developmental period that lasted almost until 1930 (see also Hauge 1988). The liberalisation of sales restrictions in the first half of the 19th century had caused large increases in alcohol use and severe alcohol problems. A growing temperance movement formed alliances with the labour movement and gained significant influence in parliament. A law regulating all sales of alcohol passed parliament in 1904 and an increasing private import of medical drugs containing opiates and cocaine was forbidden. Prohibition was decided by referendum in 1919. At that time the temperance movement had 257 000 members in a population of 2.6 million.

Norwegian drug policy should be understood on this basis. A strong labour movement has to a large extent integrated temperance ideals with a national policy of state welfare, ideas to a large extent accepted also by the conservative and liberal political parties. Consequently the regulation of alcohol distribution has been seen as an obvious national duty both on moral and health-related grounds. The use of other substances is met with public animosity. According to Hauge (1988) and Bergersen Lind (1974), it had few consequences when The Hague convention of 1913 was accepted by parliament through adoption of a specific opium law, as the basic regulations had been adopted earlier.

Second period: The rise of the health definitions (1930-1965)

This first and primarily normative period can be said to have expired with the second referendum that ended prohibition in 1928. The ideology of temperance and the normatively founded regulations seemed insufficient. There was a need for new types of regulations. A law on the state monopoly on alcohol was passed in 1931. As the Geneva Convention of 1925 necessitated amendments to the opium law, this law was altered in 1928 to

cover drugs according to the administration's decisions - at that time cannabis was included - and to provide a maximum sentence of six months imprisonment for drug crimes. Distribution was more heavily regulated through a new law on the rights and duties of physicians (1927), even though this law basically dealt with the physicians' sovereignty where it came to prescriptions. In 1932 "The law on temperance problems" laid down the cornerstones of a treatment system. Local temperance boards were authorized to place dependents in care and custody, voluntarily or involuntarily, and to protect their families.

The prime claims-makers were the ordinary political parties, the physicians' union and temperance organizations. According to Hauge (1988) the police claimed - in vain - that there was a need for higher penalties. Basically the use of drugs was perceived to be a medical problem and the responsibility of the health authorities.

Throughout the next decades the influence of the medical profession increased during a period that might be said to have lasted until 1965. In this "health dominated" period the temperance movements and other non-governmental organizations founded treatment institutions for alcoholics. These institutions soon became publicly financed and were finally coordinated as a nationwide system headed by a medical director. Drug abuse was infrequent, and the few addicts mostly obtained their drugs from prescriptions, were treated by physicians and committed to psychiatric or medical hospitals.

For several years, psychoactive drugs caused insignificant problems within this system. But in the same way as increasing unregulated use of morphine caused concern in the second half of last century, increasing abuse of and dependency on prescription drugs gradually came into focus. Investigations demonstrated increasing dependency problems in hospital populations (Anchersen 1947, 1952). The health authorities were alarmed by the Swedish amphetamine problem and by reports of a growing number of patients on high-level prescriptions of morphine. The result was parliamentary debate and law reforms (Ot. prp. nr. 52 1957). According to Hauge (1992) the central health authorities by then knew of 700 patients on constantly high or increasing level dosages of morphine, barbiturates or other dependence-producing drugs. This caused concern. It was revealed that six physicians in private practice prescribed 2.4 % of all the morphine used in the whole of Norway. Consequently, restrictions on the physician's freedom to write prescriptions were introduced in a new law in 1957. The health

authorities were given the power to limit or withdraw the licences of physicians considered guilty of malpractice. In addition increased resources were allocated for treatment. The state clinic for addicts opened in 1961 as a specialised centre for addicts not treatable in ordinary institutions.

When then the 1961 Single Convention on Narcotic Drugs became a subject, preexisting laws and regulations already covered the provisions of the convention. Even so the convention actualised law reforms. The newspapers had published reports on rising drug problems in the US, and the Attorney General asked for amendments to meet what he perceived as an increasing danger of professional drug criminality. When parliament as a consequence of the convention adopted a new law to replace earlier opium laws, this "Act Relating to Medicinal Goods" from 1964 contained provisions for the illegal distribution of "narcotics". The maximum penalty was increased to two years unconditional imprisonment. The definition of drug use as a health problems was nevertheless undisputed.

As to the drugs marked, the restrictions on medical prescriptions had caused reductions in supply for some hundreds of patients and demands for substitute drugs were noticeable. But few secured drugs by illegal means. In a follow-up study of addicts treated in psychiatric hospitals, Retterstøl and Sund (1965) found that only 15 % had ever used illegally procured drugs.

Third period: Fighting an epidemic (1965 - 1975)

Some signs of increasing concern were obviously present as early as the first years of the 1960s. But the decisive new influence for a change in policy came in Norway - as in almost all other western countries - in the mid-sixties, through the broad cultural waves of youthful protest and experiments with new habits, patterns and intoxicants that caused increasingly strong public reactions. Drug-using adolescents gathered in the castle park in Oslo, playing their guitars, smoking cannabis and displaying their flower-power look and outlook. Gradually an open drug scene grew in one of the most valued public areas. Several novels, most written by authors who participated in the groups, describe this period. One account is given by two journalist from a prominent Oslo newspaper ("Dagbladet"), based on their reportages. The book describes both the experiences of the participants and the public's reactions (Bentzrud & Markussen 1981).

Three types of factors challenged the accepted drug policy. First of all, drug use was associated with cultural and political opposition and the users were young people initially often from the "best circles". The picture of the traditional addicts seemed obsolete. Secondly, the drugs were unfamiliar to the public, parents and authorities - at least, to begin with. Opiates and amphetamines soon appeared on the scene. Thirdly, the method of distribution was completely new. Unitl then drugs had almost exclusively been procured through prescriptions. Now the prime source became young people going abroad. Soon private commercial initiatives flourished, and more professional distributors were suspected. There were rumours of drug barons and mafia connections.

As might be expected, three attitudes were prominent. The political right - with considerable public support - conceived the problem primarily as one of law and order. The cry was for the suppression of unwanted behaviour. The liberal left was partly fascinated by the cultural expressions, and warned against the criminalisation of otherwise law-abiding adolescents. One vocal advocate of this view was a well-known criminologist, Nils Christie (1967). The solutions advocated by the left were education and integration. The third attitude dominated the central government. Karl Evang, the health director and head of the central administration, throughout the post-war period had had a strong influence on health policy, committed to building a strong national public health service as a prominent problem solver in society. He had the ear of successive series of governments. In addition, he played a significant role in WHO. His own background was that of an epidemiologist with special interest in social medicine, tuberculosis, sex education and child and adolescent psychiatry, as described by his biographer (Nordby 1989). His view was that Norway had experienced an epidemic where the contagious practice of drug taking spread through the contacts between users and non-users in a virginal population. The vulnerable were in particular those who were ignorant of the dangers and those with diminished resistance through psychosocial difficulties. Drug use was seen as a symptom of societal ills and individual handicaps. The task was to limit infection as much as possible, isolate and - if necessary - punish those risking the health of others and to treat those falling ill. Evang (1971, 1972). The strategies were formulated along the lines of epidemic prevention (Evang 1971).

The new drug policy was mapped out in a governmental paper (Stortingsmelding nr 66 1975-76 "Om narkotikaproblemene") which Evang pri-

vately considered to be a textbook for politicians and key personnel (from conversations with Evang). An inter-ministerial national council on drugs was to coordinate and strengthen drug-demand and drug-supply reduction efforts within all ministries. Regional councils should coordinate local activity. Drug distribution was to be penalized and prevented by increased emphasis on customs control and drug-squad efforts. Preventive and treatment efforts were to be integrated within the ordinary social and health care and educational systems. Specialized outreach teams were to motivate and help wayward adolescents. The open drug scenes were thought to be contagious and should be fought through surveillance, frequent police actions and by methods such as ploughing the grass under to make it unfit for gatherings. The traditional alcohol treatment system was judged insufficient. The aim became to create specialized drug treatment units and teams in psychiatric institutions. These were to be supplemented by non-traditional institutions in treatment communities, as well as by the use of foster families, specialized rehabilitative efforts and specialized pedagogical measures (Waal 1980). Attempts were made to persuade the media to present drug news in a less exiting and more pedagogic way.

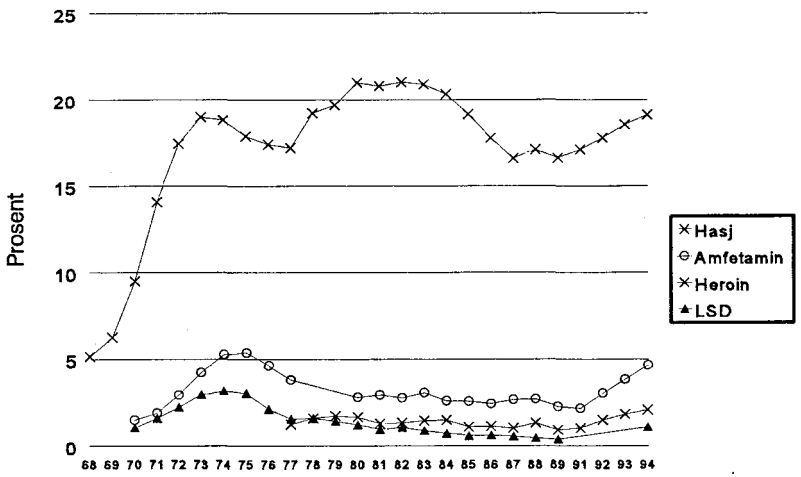
The fourth period - the war on drugs (1975-1985)

Evang's views received broad support from the claims-makers on social policy, many of whom had experience as therapists, and from prominent pedagogues, many of whom had connections with influential political circles. A restrictive policy combined with comprehensive preventive and treatment-oriented measures was adopted by parliament. Soon however increasing criticisms were heard in both parliament and the press. Death by overdose and reports on drug criminality with alarming descriptions of drug-using milieus became a hot subject. As is interesting to note, epidemiological research actually supported the effectiveness of the already existing policy. Figure 1 shows the prevalence of drug experimenting in Oslo found by yearly postal surveys carried out by SIFA (National Institute of Alcohol and Drugs Research).

As can be seen, there was a steep rise during the period 1966 to 1973. By 1974 this rise had peaked, and a later increase in restrictive measures does not seem to have significantly influenced the development.

Nevertheless, a more stern, restrictively-oriented undercurrent gradually increased in momentum. The governmental council on criminal law (headed

*Figure 1: Drug experimentation by Oslo Youth aged 15-20 (ever used) Sliding 3-year averages**



by a well-known professor of law, Johs Andenæs) was assigned in 1966 the task of evaluating the maximum penalty for drug crimes in view of the increasing drug problem. The council suggested moving serious drug crimes from the Act Relating to Medicinal Goods to the Penal Code with an increased maximum penalty of five years. Parliament increased this level to six years, and in the period to come, all public debates seemed to conclude with decisions on a further increase in the level of punishment; in 1972, 10 years; in 1981, 15 years; and in 1984, to a maximum penalty of 21 years imprisonment. In 1984, the use of drugs was reclassified from a misdemeanour to a crime. Methadone has had some use in maintenance, but in 1976 the health authorities alarmed by negative treatment experiences and some cases of fatal overdose by methadone, imposed new restrictions. Methadone was only to be used by institutions, and not for maintenance purposes.

The reasons for this development are difficult to grasp. The strong punitive attitude is in contrast to Norwegian judiciary policy (that is, one of

* Courtesy of National Institute on Alcohol and Drugs Research.

low-level sentences) and, as shown above, the figures for drug-abuse development were not particularly alarming. One reason was the dramatic accounts of drug problems that alarmed the public. An association of parents ("Parents against drugs") was founded in 1969 and acted as a pressure group for restrictive measures and compulsory treatment. This association became increasingly influential (Lorentzen & Stang 1992). Another was the influence of the US message of "the war on drugs", declared by President Nixon and loudly supported by President Reagan. Norway has had throughout the post-war period a well-known westwards orientation - a tendency sometimes coined by the political left as "attempts to be the best pupil in the class".

What happened was that the original policy based on social medicine and epidemiology gradually was replaced by a policy of war. This can only be understood if one considers additional cultural factors. First of all, the sentiments of radicalism and optimism had vanished in a revival of the political right. Secondly, a Swedish NGO from the political left ("The National Association for a Drug Free Society") had gained considerable influence. An affiliated Norwegian organisation could count among its members prominent figures on social policy, for instance, the professor of social medicine in Oslo, Per Sundby, and the head of the National Clinic on Adolescent psychiatry, Per Nyhus. The latter served for a while as Secretary of the State for the Ministry of Health and Social Services. Significant claims-makers on the political left accepted the necessity to fight for the victims of drugs through compulsory treatment, the criminalisation of drug use and support of police functions. The traditional defenders of a liberal judiciary policy were split. In this situation, the views of the right met with little opposition, and the situation became characterised by bid and overbid. The Labour party tried to take the offensive in 1982-1983 and proposed a maximum penalty of 20 years, only to be overbid by the political right suggesting amendments implicating 21 years. In 1985 the political right went into the election campaign with the suggestion that the supply and demand reduction efforts should be coordinated by a "drugs general" endowed with an almost military authority.

The fifth period: Integration, moderation and regional development (1985 -)

The heavy emphasis on criminalisation and supply reduction reached its height in 1985. Parliament adopted the policy of a drug-free society and

declared its determination to fight against all illegal drugs. But at the same time a new governmental paper, St.meld.nr 13 (1985-86) Om narkotikaproblemene og narkotikapolitikken (On the drug problems and the drug policy) stated that any further increase in repressive measures would be unproductive and advocated the primacy of research and the integration of services.

Criticisms of the level of restrictiveness also became more vocal. In particular the heads of the Institute of Criminology and the Institute of Sociology of Law at Oslo University pointed out the dangers implicit in untraditional police investigation methods, and the harm inflicted on traditional low-status groups through stigmatisation and high-level punishment. In a well-known book, Christie and Bruun (1985) stated that drugs had become a substitute enemy for the real social problems in a war that endangered civil rights and consumed resources needed for other purposes.

In the same period, the HIV epidemic became a public concern. On the one hand, this brought about cries for sterner punitive measures; on the other, proposals for strengthened treatment services and harm-reduction measures won support. Gay organisations, those in charge of HIV-preventive measures and the Central Council on Drug Problems were significant claims-makers. The distribution of clean needles and the propagation of harm-reduction information became prominent priorities. Proposals for methadone programmes were however rejected, as the central health authorities were opposed in principle to maintenance treatment. Later limited experimental projects have been accepted, but the basic principle is that of abstinence-oriented treatment. The main emphasis has been on building a comprehensive, abstinence-oriented treatment system, gradually incorporating harm-reduction measures.

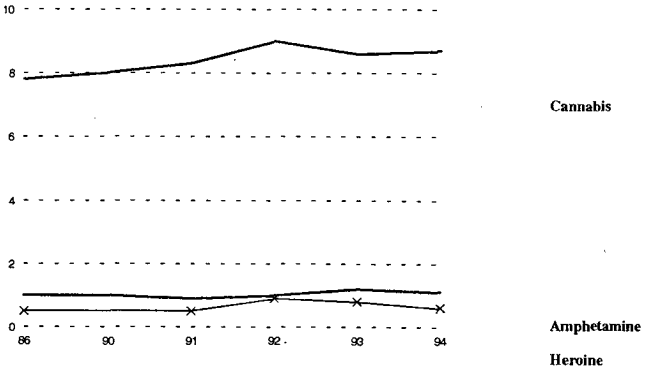
A new governmental paper, St. meld.nr 69 (1991-93) Tiltak for rusmiddelbrukere (Measures for substance-abuse problems), described the development and suggested new measures. The aim has been to integrate child-care law, educational laws, temperance law, mental health-care law and law on regionalised responsibility for health institutions as a foundation for a joint care-system (Waal 1988). The law on social care and the law on temperance problems were replaced in 1992 by a joint law on social services. A new child-care law from 1992 determines the responsibilities and tasks concerning those younger than 18.

This choice of policy has made it necessary to strengthen the existing systems to meet the additional burden of drug-abuse problems. There have

been two periods with special funding for the child-care system (1986-89: 150 million NOK, 1989-1993: 500 mill NOK), and one period with investments in substance-abuse treatment (1988-1992: 400 mill NOK). Governmental guidelines were developed in 1987 to map out the demand-reduction and treatment strategies (Faglige og organisatoriske synspunkter på tiltak overfor rusmiddelmisbrukere). These guidelines advocate the integration of efforts concerning legal and illegal substances of abuse, differentiated according to the types of social problems involved, more than according to the types of drugs used. Institutions with tasks connected to life phases (pregnancy, the newborn, parenthood, schools, vocational tasks, adolescents and adult type of problems) are supposed to develop specific strategies and ways of collaboration. Further, and partly because of worries over the HIV epidemic, the Ministry of Social Services launched a "plan of action" to run from 1989 to 1993. Nationwide regionalised training courses were arranged for health and social services personnel and for administrators and politicians with the aim of increasing competence in substance-abuse prevention and treatment. This plan specified that 300-350 new treatment places should be opened in that period. Finally, in 1992 a handbook for those working with substance-abuse problems in the municipalities was published (Rusmiddelarbeid i kommunene. Håndbok for planlegging og organisering).

The Present Drug-use Development

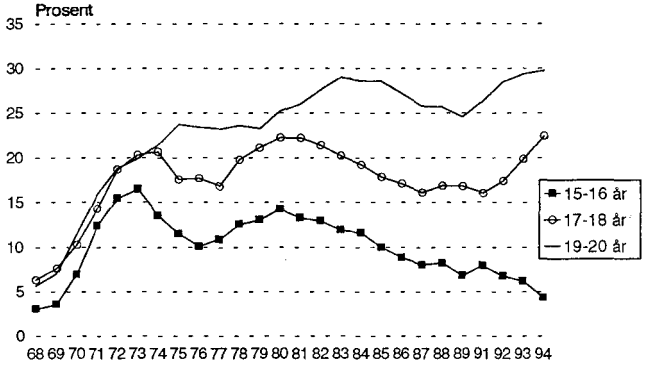
*Figure 2: Prevalence of drug experimenting (ever used). Sliding 3-year averages**



* Courtesy of SIFA (National Institute of Alcohol and Drugs Research).

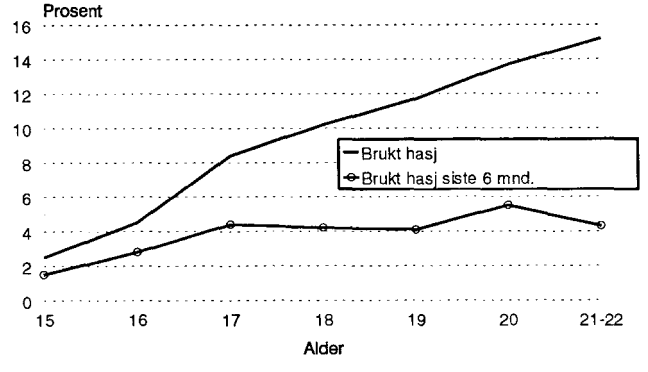
The figures on drug-use experimentation provide some information. The Oslo prevalence (Figure 1) is presented above. Household surveys sampling the whole country have been available since 1986 (Figure 2). As can be seen, the national figures indicate a quite stable situation.

*Figure 3: Drug experimentation in age groups in Oslo (ever used). Sliding 3-year averages**



Figures are also available on the drug use in different age groups. Figure 3 demonstrates some recent increase in cannabis use in the groups aged 17-18 and for those 19-20. This increase does not involve the youngest.

*Figure 4: Drug experimentation and drug use. Ever used and used last 6 months. 1991-1993 average in Oslo**



* Courtesy of SIFA (National Institute on Alcohol and Drug Research).

Figures on more recent use do not however indicate a rise in ongoing cannabis use. Figure 4 compares the experimental (ever used) with recent use (used last 6 months) in relation to age. As can be seen, there is no increase in recent use.

In addition to yearly postal surveys, data are also available from national interview-based surveys with representative samples from the population of 15 or more in 1987, 1991 and 1994 (SIFA research). As is shown in Table 1 this gives prevalence figures similar to but slightly higher than the postal surveys. One reason for this might be that the number of subjects reached in the same age groups are higher in the postal survey. In addition the questions were rephrased in 1994 with a consequent steep increase in percentage unanswered excluded from the prevalence estimates (From 1.9 to 9.9 %) It is believed that the rise is partly explained on these grounds as the postal survey has larger samples in the respective age groups. But it is also

*Table 1: Use of cannabis. Interview-based national data. Sample size: 1985= 1972, 1991= 2002, 1994= 2222**

Age in years	Ever used cannabis (%)			Used last 12 months (%)		
	1985	1991**	1994**	1985	1991**	1994**
15-20	10,3	11,1	17,6	4,9	6,3	13,5
15 +	7,0	8.2	10.8	1,8	2,5	3,7

** Data weighted with respect to age, sex and place of residence.

possible that cannabis use is on the increase concomitant with the interest in "party drugs", such as ecstasy and amphetamines, presently in vogue in most of Western Europe. The average user of cannabis claims to have used the drug 59 times in the last year, i.e. about once a week. The highest frequency is found in the age group 18-20 where the users describe nearly twice a week use (1991 figures).

While the development of drug use and experimentation is quite well researched, there are less data on the population of hard-core users. As is well known, addicts often do not answer letters, and often change addresses. This limits the reliability of postal surveys that indicate that among the 15-20 age group, about 1 % in Oslo and 0.5 % in the rest of the country have

* Courtesy of SIFA (National Institute on Alcohol and Drug Research).

used amphetamine or heroin. About the same percentage admits to the use of drugs by injection. This indicates an estimate of 5-8000 serious abusers (Hauge & Irgens-Jensen 1989). In 1988 the Ministry of Social Services asked the municipal social service authorities to count the number of "active intravenous drug user". They came up with a figure of 6500 addicts. (Hauge & Irgens-Jensen 1989).

The best estimate is probably given by Skog (1990) who combines data from different sources:

- Firstly he examines the reliability of the prevalence figures found in surveys through other data.
- Secondly he draws on known prevalence of drug use among the known numbers of HIV-positive clients.
- Thirdly the prevalence of intravenous drug use in prisons is known through injection mark studies and this is used combined with known frequencies of arrests.
- Fourthly he has had the possibility to use the NARKSYS, the police data system with information both on known drug-users of different drugs sentenced or suspected and on drug squad surveillance findings.
- Fifthly he builds on mortality data, both from the police and from the central bureau of statistics. The known number of overdoses is computed as 50 % of mortality in the drug-using population. As a large number of follow-up studies indicates a yearly mortality rate of 2 - 2.5 % the total number of intravenous drug users as well as the present number (reduced by deaths) can be estimated.
- Finally he uses information from detoxification institutions on numbers, average age, sex ratio, follow-up studies on maturing out, figures on abstinence, etc. This information is computed using probability estimates. The conclusion is that Norway had a rising population of intravenous drug users in the 1970s that had reached its maximum before 1985. By 1990 a population of 8000 - 10 000 persons had ever used drugs through injections. Of these
- 4000 - 5000 were active, frequent intravenous drug users
- 1000 had died, of whom 50 % of overdoses
- 1000 - 1500 had quit for various reasons
- 2000-3000 had been infrequent users and never established a habit

Skog described a cohort development with marked reduced recruiting, probably to a large extent due to the HIV epidemic. Several signs indicate a population stable in numbers where the quitters equal the starters. The cohort effect caused a definite increase in average age and consequentially an increase of mortality. Recruiting by those below 20 is low (confirmed by the surveillance data of NARKSYS).

Both amphetamine and heroin users are included in these figures. The figures would have to be reduced to estimate the number of intravenous heroin users. The sex ratio is male/female 7/3. About 50 % of the population with serious drug-use is found in Oslom and 70 % in the Oslo region including nearby counties.

The current treatment and harm reduction system

Providing services to substance-abuse patients is integrated in the decentralized public care system with a primary local level, a secondary county level and a tertiary regional level. Each level is supposed to serve the corresponding population. This means that 439 municipalities and 19 counties are supposed to constitute a comprehensive, decentralized and integrated treatment system based on cooperation between local municipalities and counties. Non-governmental organizations are supposed to supplement and fit into a basic structure of publicly planned and financed institutions. (St.meld.nr 69 1991-93 "Tiltak for rusmiddelmisbrukere").

Each **municipality** has a local health and social services board with planning and management responsibilities, one or more social services centres and one or more health centres. All substance abusers have the right to treatment for health problems. The social services centres are to ensure minimum living standards which include a place to live and a minimum subsistence level. They also have the duty to initiate treatment for abuse problems. This means

- to contact substance abusers and motivate them to undergo treatment
- to establish municipal treatment systems
- to develop methods of collaboration with the social network of the abusing person
- to ensure continuity of care when an addict is in institutional care and plan for sheltered living quarters
- to have comprehensive knowledge of specialized treatment possibilities within the county.

The child-care offices, which are part of the social services centres, are responsible when the abuse is a problem of minors and when problems of parents threaten the welfare or upbringing of a minor. When pregnant women have abuse problems, this entails, for instance, establishing collaborative efforts between kindergarten and health and social services. For parents with older children, it might entail establishing joint efforts between the primary school and social services systems.

As to the **current situation**, all municipalities have functioning health and social care boards and corresponding centres. Outreach units were according to the Ministry of Social Affairs by 1994 found in 50 municipalities. Special advisers on temperance and substance-abuse matters are employed in most municipalities with drug-abuse problems.

Nevertheless there are several problems. The typical social service centre often has a heavy caseload that impedes casework. Complaints are often heard from angry clients. Virtually no addicts live on the streets, but a relatively high number live in hospices of poor quality. There are few adequate sheltered living quarters and halfway houses. A positive sign is the development of increasing competence in social services centres. Of some interest is the increasing use of "responsibility" teams, small teams built on cooperation between caseworkers in different public services involved in therapeutic work with one client.

It should also be mentioned that the child-care system has been allocated resources to enable it to catch up with its caseload and to take an active course in child and juvenile matters. Some work is also being done to develop cooperation with the public school system in order to involve teachers in caretaking measures. Of particular interest are local projects where the social service system and the educational system combine forces in non-traditional teaching for pupils with behavioural problems, often including the abuse of illegal substances. Crisis social-services are available in most cities. The principal choices of this policy are found in a governmental document on how to strengthen the child-care system in order to avoid imprisonment of adolescents with serious behavioural disturbances (NOU 13. 1985/86).

The **counties** have to ensure that the county

- has a continuous treatment chain with systems for entrance, detoxification and crisis intervention and a comprehensive range of institutional care and treatment.

- is able to supplement and strengthen the resources of the municipalities,
- has outpatient services
- has developed a system of coordination between institutions for substance abuse and psychiatric, health care and child-care institutions.
- observes the development of substance-abuse problems in the municipalities.

From this follows that the counties are supposed to develop a plan of services that include detoxification units, outpatient services, inpatient units with rehabilitative competence and therapeutic community ideology and short-term services. Special services for subgroups such as women, couples, hard-core addicts, and immigrants should also be available.

Not all counties have been able and willing to develop services according to these guidelines. A national database on treatment institutions has recently been developed (NIDAR). According to this registry there are 214 institutions treating patients with substance abuse. Of these, 180 have completed the NIDAR forms. In 1994 these institutions had 2646 employees; 106 physicians/psychiatrists, 195 psychologists, 369 nurses, 302 social workers, 153 with other types of health and social work education, 783 with other types of training, and 748 unskilled.

Table 2: Treatment institutions in Norway. Overview of types and capacities. (Source NIDAR)

Type of treatment	**Available in: (Number of institutions)**	**Capacity 1994 (Number of places available)**
Inpatient	132	2600-2700
Daycare	22	150-200
Aftercare	31	400-450
Outpatient	73	3000-3500*

* Calculated as therapy sessions per week

These figures include treatment for alcohol use disorders. Of the 180 facilities, 143 reported patients with alcohol-use disorders, 135 disorders caused by illegal drugs, and 129 by prescription drugs. In addition, 139, 119 and

113 reported patients with mixed abuse, multi-determined abuse or combined abuse, respectively. The last three categories probably overlap. 37 institutions stated that they would not accept patients who abused illegal drugs. 29 stated that they would not accept patients with alcohol-use disorders only.

The institutions had a wide range of approaches and ideologies. 24 said that they accepted clients without previous detoxification, acute or in crisis. 16 described themselves as sociomedical outpatient units and 29 as special outpatient teams for juvenile drug-users. There were 19 substance-abuse clinics - a concept from the services for alcohol disorders. 14 were resort places for alcoholics, 42 were "living and learning communes" - a concept from the drug-abuse tradition. 19 offered long-term sheltered living for chronic addicts and 28 described an aftercare profile. Several of the institutions had combined services. 61 stated a religious basis while 117 stated themselves to be neutral in religious matters.

Detoxification service

Most counties integrate alcohol detoxification and drug detoxification, partly within somatic hospitals and partly in combined substance-abuse institutions. Five counties have specific drug detoxification units. Oslo, which has the most serious problems, has one detoxification and crisis unit, one low-threshold unit for drug addicts and two for alcohol addicts.

Outpatient services

Specialized psychiatric teams for young substance-abusers give individual, family and counselling services. Currently there are 29 teams in 17 counties, and this means almost full nationwide coverage. In addition the 16 sociomedical units serve as outpatient units for all types of substance abuse.

Institutions for treatment and rehabilitation

- All counties except one have at least one combined treatment centre. These are often restructured alcohol abuse centres, broadened to give family therapy and individual counselling. Most employ an approach involving combined in- and outpatient therapy.
- Most counties have at least one long-term rehabilitation-oriented institution with vocational training. Oslo has three, one of which is low-threshold.

- The counties have a varying range of specialized units for particular target groups. In Oslo there is one for juvenile addicts, one for women, one with wilderness trips and encounter ideology, and one specialized rehabilitation centre.
- Structured therapeutic communities (Phoenix House-type institutions) have been established in four counties, serving neighbouring counties in each region.
- Psychiatric hospitals have substance-abuse units in four counties.

In addition, the **child-care service** in each county is supposed to have crisis units with competency for observation and treatment planning. The treatment units are in particular strengthened foster families and "treatment communes". Ordinary child-care youth homes receive those with light or moderate abuse problems. Of particular interest are communes of the Swedish "Hassela ideology" type that build on involuntary detention authorized through the child-care law. The juvenile addicts live together with non-abusing adults. The basic ideology is to share life situations and responsibility for communal welfare in a pedagogic structure with increasing freedom and responsibility.

Some of the communes have developed the capacity for adult addicts, and others have from the start operated as what are known as "working and living collectives (communes)" for adults. In these communes the addicts are supposed to live for a period of 1-3 years, developing a new lifestyle. Most counties cooperate with such communes, often started as independent foundations.

Finally it should be mentioned that the child-care system is supposed to have single mothers' homes that are staffed to take care of female addicts who try to keep abstinent in order to retain parental authority over their children.

The regional level is supposed to supplement the county level as some types of treatment are too specialized for one county. The counties are therefore grouped in seven regions, each with a "competency centre". Within these regions the counties are supposed to develop joint planning. The competency centres are allocated extra government resources and are supposed to ensure quality development, stimulate evaluation and, if possible, do research. Each centre is also supposed to develop special competency in one particular field, for instance, female addicts, children of parents with substance abuse, and so forth.

Funding principles

Each level is allocated a lump-sum budget. The resources for treatment and prevention are part of the general grants for health and social purposes, with some initial extra funds earmarked for substance-abuse purposes. The guidelines are supposed to stimulate continuity, cooperation and local responsibility.

Each county has overall financial responsibility for all types of health and treatment institutions accepted in the county plan. But while the use of health institutions is free of cost for the municipalities, the use of social institutions (child care and substance abuse) carries a municipal fee comparable to cost of local measures. If institutional care becomes cheaper than local level care, this is supposed to influence choices of action.

Most non-governmental institutions operate within the frame of public budgets and county planning, but some also work without public support. This means that the local municipality will have to bear the total cost unless the families or employers are willing and able to do so. In these cases the municipality might decide to award grants from the budget for economic social assistance.

Basic concepts and principles

The basic ideology found in governmental papers is one of a drug-free society. Abuse is accordingly defined as all use of legal drugs that cause difficulties or suffering and all use of illegal and medical drugs for intoxicating purposes. All recreational use of illegal drugs would be seen by most as abuse and signs of maladjustment.

This does not automatically mean that the treatment goals must be total abstinence. According to research on treatment of alcoholism, reduced or controlled consumption might in some cases be more realistic treatment goals. In drug-abuse evaluation, reduced consumption level and less destructive abuse patterns are seen as acceptable goals. But few if any inpatient institutions would for instance accept cannabis use among clients. On the other hand, outpatient units would not demand immediate abstention, but accept a willingness to reduce problems. The primary goals - particularly in outpatient services - are reduced abuse-, social- and psychological problems through increase in competence and problem solving.

Coerced treatment

Three types of legal systems authorize coercion. Originally the 1932 law on temperance problems authorized coerced treatment in resorts for alcoholics for a period of up to two years. But these provisions have been out of use for many years now. The law on psychiatric care has been of more consequence and has sometimes been applied when mental diseases are suspected or obviously present. This law authorizes involuntary observation in institutions for three weeks and treatment for repeated six-month periods with no definite limit. Finally, the child-care law authorizes involuntary treatment for minors.

None of these laws are frequently used. The most prevalent basis for coercion is the penal code and the prison law. Treatment has to some extent been made a condition for suspended sentences. More prevalent is transferral from prison while serving sentences. According to the prison law, prisoners with addictive disorders can apply for transferral. In addition special contract prisons are available. These have pedagogic and vocational possibilities and might assist the application for transfer to treatment if indicated. One particular project has been developed along the lines of a structured therapeutic community with one unit in a contract prison followed by transfer to units outside in a continuous treatment process. Follow-up indicates promising results.

The legal reforms of 1992-3 have brought some changes. According to the new law on social services, the local social services centres have the right to initiate involuntary treatment for a period of three months. The prerequisite is that the addict's life and/or mental health is endangered, that the abuse is enduring and serious, that voluntary care has been in vain, and that coercion is necessary in order to observe, plan treatment, obtain contact and ensure immediate recovery from serious conditions. The decision has to be made by a county board headed by a judge. The new child-care law has similar provisions, but without the three-month limit.

In addition, the law allows the possibility of "self-binding". The addict might sign a contract that authorizes the institution to detain him/her for three weeks from the time he/she wants to leave. Such a contract might be made a condition for entry into treatment.

This law on social services has been applied only in a negligible number of cases. The child-care law has been used somewhat more, particularly to place juveniles in communes.

Harm reduction

Governmental papers have been trying to estimate the harm caused by substance abuse ever since the mid-sixties. Harm related to alcohol use is particularly well researched. Every 15th admission to somatic hospitals has been estimated to be related to the use of alcohol (Aasland et al. 1990). Every 10th consultation given by general practitioners concerns similar problems (Aasland et al. 1989). Six out of 10 "long-term" clients at the social services centres have substance-abuse problems, often mixed abuse of alcohol and other substances (Hjermstad 1989). Problems of abuse are also prevalent among cases handled by the child-care system (Grinde 1989). The harm caused by the use of illegal drugs alone is difficult to estimate. The obvious harms are connected to the mortality rates, the HIV prevalence and increased psychiatric and somatic morbidity. In addition, drug use is of obvious significance for the level of criminality. Norway has experienced the same increase in criminality as other countries, but this is only partly caused by drug use as the development started before the drug-use epidemic.

Obviously the largest problems are related to use of legal psychoactive substances. In terms of mortality, nicotine is of prime importance, while alcohol causes the most serious social problems and greatest number of accidents. Norwegian policy is heavily influenced by alcohol research. This concludes that the most effective approach in harm reduction is the limitation of the total consumption, and that the degree of availability is of proven importance (Edwards et al. 1994). This has also been the basic view concerning illegal substances. The concept of secondary harm - harm caused by criminalisation - has been at the periphery of attention. The concept of "control damages" was, however, introduced in the governmental paper on drug problems from 1984/85, largely as a result of criticism by criminologists (Christie & Bruun 1985).

The HIV epidemic changed this picture. After some debate, methods to reduce the spread of infection were accepted. Those not able to achieve abstinence also came more into focus. Reduction in suffering and increase in life quality became more of a goal in its own right.

Needle exchange programmes were officially accepted from about 1985/86, and most areas with drug-abuse problems have acceptable needle availability. Some cities have needle vending machines and some have delivery programmes. Oslo has an ambulatory bus that delivers free condoms

and free needles. These are also available in some outreach facilities. In Oslo an average of 400-500 000 needles are dispensed each year. This is more than 100 needles per addict, as Oslo (450 000 inhabitants) has at most 3-4000 addicts with a needle habit.

An increase in the number of drug deaths caused Oslo to launch an "overdose project" in 1993. Ambulances drivers were trained to take special precautions, and a special "overdose team" was contracted. This team, the police and the social service centres can call on a special project that might fund "help without strings". Funding and priority of intake can be obtained when an addict seems to be in a crisis period, even if the addict does not have motivation for long-term treatment or total abstinence from drugs.

Methadone programmes

Methadone was introduced in Norway in the 1960s and was used for some years in detoxification and maintenance treatment. Evaluation at that time did not indicate success. Problems with overdoses and an increase in prescriptions caused the health authorities to take a restrictive attitude. It was made a priority to build a drug-free treatment system. The increasing use of methadone was stopped by regulations in 1976.

The HIV epidemic modified this policy. A special programme for AIDS patients was developed in 1988 to make cooperation with addicted patients easier. This was evaluated positively. The non-responders to drug-free treatment were also focused upon. A trial programme for "hard-core opiate addicts - not helped in drug-free treatment" - began in 1994. Half-time evaluation indicates that methadone is going to be included as a standard procedure. These programmes are strictly controlled, with several exclusion criteria. Presently methadone is legally available only in Oslo and only through these programmes. The Ministry of Social Affairs will finalise a new governmental paper on drug policy. There are no low-threshold methadone programmes, and none are planned for the future.

Costs

The costs of drug treatment and harm reduction in Norway are virtually impossible to estimate. Several of the measures depend on ordinary municipal social and health care centres. Others are covered by the budgets of psychiatric hospitals and other health institutions. On top of this, the bud-

geting does not distinguish between the funding of measures for legal and illegal substances. A very rough estimate is given in St.meld nr. 69 (1991-92). According to this governmental paper, 1 billion NOK were at that time allocated yearly for all substance-abuse treatment purposes.

This figure is only a rough one. However, the costs of some activities can be calculated separately. Detoxification centres cost about 2000,- NOK/day and long-term institutional care for addicts 900-1500 NOK/day. Most treatment facilities aim at treatment periods of one year or more. Most - or at least many - addicts have had several periods of between 3 and 15 months in such institutional care. The costs are obviously considerable. Concern about this is growing.

Minimum standards

According to governmental guidelines each county is to ensure the availability of a specified set of interventions and treatment on institutional and specialized level as described above. The counties are also supposed to ensure that similar facilities are available within the child-care system. There are also guidelines for municipalities' responsibilities, but their situations and drug problems vary too much for standards beyond the obligation to have health and social care centres.

Other regulations within the legal system (child-care law and social services law) set minimum standards for the welfare and civil rights of the addict in treatment. There are regulations concerning living space, the supervision of welfare, rights to privacy and so forth in both substance-abuse and child-care institutions. Government representatives on the county level have inspection duties.

Priorities

The priority is drug-free treatment. Governmental papers state that detoxification and low-threshold institutions are to be readily available. This priority is influenced by mass media pressures and lobbying from parents' organizations. Treatment facilities and professions have also made their voices heard. The stated policy is that any addict who wants treatment should have access to it. Comprehensive treatment should be available all over Norway.

The next priority follows the degree of individual suffering and the type and degree of social problems. Consequently there is priority for HIV-in-

fected addicts, pregnant addicts and addicts with parental responsibilities. Further priorities will probably particularly be addicts with psychiatric disturbances and immigrants, as currently these are poorly covered.

Current debates in parliament and the media might bring other priorities into focus. Harm reduction has lately been increasingly focused upon. The methadone programmes were hotly debated and opposed, but lately criticism in the media has been aimed in the opposite direction, i.e. at the scarcity of places.

Research and Perspectives

Research on substance-abuse problems is insufficiently developed. The National Institute on Alcohol and Drugs Abuse has a strong tradition in epidemiology and is working to extend its research portfolio. The National Institute on Public Health is the centre of studies on the HIV epidemic. Several departments within Oslo University (for instance, Department of Behavioural Medicine, Department of Psychiatry, Department of Preventive Medicine) have carried out projects. The National Institute of Forensic Chemistry is a centre for biologic research. "Bergensklinikkene" - a centre for substance-abuse treatment institutions, in Bergen - has developed a research centre in collaboration with the University of Bergen in which the Faculty of Psychology is heavily involved. The list could be made longer. In order to stimulate research the Norwegian Research Council has carried out two five-year programmes on substance-abuse research. The first (1986-90) concentrated on prevention with emphasis on the basic principles of policy, the consequences of control strategies, the evaluation of drug-demand reduction projects and longitudinal epidemiological studies. The main results are presented in a final report (Waal & Middelthon 1992). The next programme (1991-1995) focused on the evaluation of treatment, the consequences of criminalisation and on substance-abuse culture. A main aim was to stimulate networking and the building of research competency. A new programme will be developed this year, and it is expected that the consequences of the international development, the possible problems for the welfare state and treatment evaluation with the focus on cost effectiveness will be central themes.

In **treatment research** there has been a prominent tradition of studies into the treatment process, and of uncontrolled and quasi experimental follow-up studies. Within these traditions there are studies from The State

Clinic for Addicts, Dikemark Hospital, Oslo Outreach Facility, Avd Lien Therapeutic Community, several other therapeutic communes, labour market rehabilitative efforts and outpatient treatment. Of more recent date is a follow-up of 8 communes (Andresen 1991) and a comprehensive evaluation and follow-up of Tyrili, a large project that accepts compulsory treatment of adolescents (child-care law) and transferrals from prison (Tjersland 1995). This study gives strong evidence that living and learning experiences within a framework of compulsory institutionalization might produce particularly good results with adolescents, findings which are supported by Swedish studies (Berglund et al. 1991) A prospective study of patients entering Veksthuset (a Phoenix House-type institution) is in its final stage, giving information on differential effects in relation to mental health problems and personality traits (Ravndal & Vaglum 1991, Ravndal 1994). The methadone project is at present being followed in a prospective study, comparing results with data from Veksthuset. There is also a project comparing recidivism between those transferred to treatment and those serving their whole sentence in prison. One particular project makes use of economic theory to estimate cost effectiveness of treatment and rehabilitation. This project demonstrates large societal net profits even from costly therapy projects (Berg & Andersen 1992). This project is being continued in a study of five different institutions.

In sum these studies indicate that on follow-up, almost all groups will improve compared to their status before treatment[1]. On average between 35 - 55 % will be in a good or totally abstinent situation after five years. Projects with few therapeutic potentials and negative selection of patients might achieve a figure as low as 20 %. About one-third will have deteriorated, and a somewhat lower percentage will have improved without achieving a satisfactory situation.

Several of the studies find a degree of improvement that co-varies with length of period in treatment, often taken as a sign of therapeutic impact[2]. Measures such as outreach and labour rehabilitative measures will by themselves improve prognoses but cannot replace treatment efforts. Some significant findings are that addicts with psychotic traits or high levels of

[1] As most addicts seek treatment in times of crisis, some improvement is to be expected as a "regression towards the mean". One of the instruments often used, DTES - Drug Taking Evaluation Scale - tries to take this into consideration.

[2] Obviously the selection problem is unsolved. Those staying in treatment might be those with the best prognoses.

anxiety have other needs than hard-core opiate addicts with antisocial personality disorders (Vaglum 1979). Family therapy measures are important when addicts are still involved with their families. Small units that function as a family or as a base for a "new start in life" seem to produce significantly better results than average. Depressive and near psychotic (schizoid/schizotypal) addicts have a high drop-out rate unless their specific needs are met (Ravndal E, Vaglum P 1994). Most addicts with serious dependency tend to have multiple sets of problems. Treatment ought to follow patients three to five years, both within and outside institutions.

The findings are in line with other research (Rounsaville et al. 1986, McLelland et al. 1989).

As investments have increased, the interest in efficiency and effectiveness has grown. The Ministry of Social Services financed a survey of treatment research and cost/benefit studies (Jonson 1993, Nygård 1993). Some of the conclusions are that treatment does improve prognosis, even though no specific approach is effective for all addicts. Neither does any specific approach demonstrate overall better results. Cost-effect studies confirm that treatment reduces societal costs for those treated, but it is on average difficult to show that high-cost treatment in institutions is more effective than low-cost measures in non-institutional care. This seems to be true at least for addicts without too-complex types of problems.

Another prominent line of research has been to develop common instruments for comparative evaluations. Since 1985 there have been attempts to develop and evaluate basic registration forms usable in all types of treatment institutions. A basic registration form has now been tried out in a project headed by the State Institute of Alcohol and Drugs Research that covers characteristics of clients in the treatment system. As a first step, 14 institutions from the Oslo region participated in a pilot study in 1991-1992. Secondly, institutions that primarily serve clients with abuse of illegal drugs were invited to participate in a nationwide study. Of about 100 institutions, 75 answered positively. Data from the pilot study were recently published (Arner et al. 1995). Data from the 1992-94 study are now available. Table 3 gives an overview.

Through these studies quite comprehensive data has been gathered on a large population in different types of institutions all over the country. The aim is both to map out a baseline for later studies by different institutions and to study characteristics of the population and of the treatment. There is data on how the referrals are handled, the intake and termination proce-

Table 3: Clients in substance-abuse treatment. Overview data from pilot and main study

	Pilot study (1990-1991)**	**Main study (1992-1993)**
Number of referrals*	2896	5496
Number of intakes*	999	2741
Male/female ratio	62/38	64/36
Younger than 20 (%) n=intakes	4	15
20 - 29 (%)	57	53
30 - 39 (%)	36	28
40 or over (%)	2	4
Treated in outpatient teams (%)	**	52
Treated as inpatients (%)	**	35
Treated in therapeutic communes (%)	**	14

* NB. Several institutions only participated for a limited period during the study. The figures should therefore not be understood in terms of capacity or caseload during the whole period.
** Data from the pilot study includes figures from detoxification services.

dures, and on the institutions themselves. Furthermore, there are demographic data on the clients, data on their abuse histories and some qualitative data on the clients' perceptions. The work on analyses is currently progressing.

A few findings can be mentioned. Obviously the institutions often consider the abuse as mixed and a relatively high number of clients - particularly those in the outpatient teams - have abuse dominated either by alcohol or cannabis There are obvious regional differences as particularly the inpatient units of Oslo give a high figure of opiate use.

Of some concern are figures of type of exit from treatment. Only one-fifth fulfil treatment as planned, while about one-third leaves contrary to advice. Somewhat less than one-tenth is expelled.

The main project covers one of the two detoxification units in Oslo. This facility had in 1992 647 and in 1993 1039 intakes for detoxification and observation. There was only a slight male dominance, and 78.5 - 80 %

were heroin addicts. Somewhat more than half fulfilled their intake contracts and left as planned.

In 1995 a national database was started linked to the National Directorate for the Prevention of Alcohol and Substance Problems and containing an anonymous registrar of addicts in treatment. Costs and flow of patients will be followed on a national basis. The basic form has been modified to be usable also in institutions for alcohol disorders. A catalogue of supplementary research instruments is in progress. The EuropAsi is translated and will be distributed in the catalogue.

Evaluation has for some years been a sort of honourary word. All facilities are supposed to report their evaluations to the county through annual reports. At first this was met with considerable suspicion but is now increasingly found useful. At present there is accordingly considerable interest in systematic registration and evaluation procedures.

Quality control has been increasingly emphasized during the last few years in both the health and social services. The field of drug-abuse treatment is lagging somewhat behind. One reason is the lack of generally accepted criteria. In order to obtain financing from public resources, the institutions have to describe ideology, treatment techniques and treatment goals. Staff qualifications are also focused upon, but as approaches differ, standards vary.

Elements of an evaluation

Effectiveness

As research indicates a stable or diminishing population of serious drug abusers, it might be thought that this proves the effectiveness of treatment. Cohort studies give a somewhat less positive view. In his estimate of intravenous drug use, Skog (1990) calculated the development in cohorts born since 1960. His conclusion is that the cohort of addicts decreases as much because of high mortality as because of quitting. In addition it is not known whether treatment or other life events are the main causes. Obviously the average age of addicts is increasing. In the whole addict population this finding is a sum of consecutive annual cohorts. The sum effect is caused by the decrease of serious abuse in new cohorts. This causes increase of age in the population and provides at the same time some explanation for the increase in mortality.

Availability

Even though a nationwide treatment system has been developed, parents' organizations, the media, the police, and individual clients often complain that availability is insufficient. Sometimes the addicts want to be admitted during times of scarcity, or have lost motivation when entrance is offered. Often admission is wanted in one institution when a place is available only in another. While availability in general could be said to be acceptable, co-ordination and differentiation is insufficient.

Particularly criticized are the social services centres in urban areas. High demands, reduced funds for social care benefits and stressed social workers result in barriers that might discourage drug dependents.

Another problem is that the structure of responsibilities and the system of financing sometimes function as limitations. Use of institutions funded by the county is covered, but treatment elsewhere has to be bought by special county funds ("guest patients" budget) or by special funding from the municipal health and social care boards. There are often complaints that such funding is difficult to obtain. Consequently the addict is supposed to seek treatment in a facility that he/she might not feel will be beneficial to him/her.

Efficiency

The degree of contact with the most dependent addicts is important. As is demonstrated in interviews with addicts in prison (Skretting 1992) and in interviews with HIV-positive addicts, most heroin addicts have had contact with outreach, detoxification services, or low-threshold services. But the prison interviews indicate that less than half of those primarily using amphetamines had any contact the year prior to the interview. Observations from the needle exchange projects further indicate that many infrequent users are unknown to the treatment system. Some subgroups obviously keep out of touch. Almost all addicts get social services but this is often a rudimentary contact in order to obtain financial support.

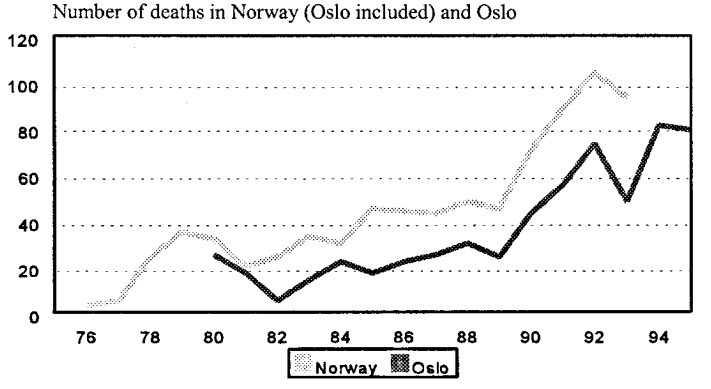
An indication of efficiency is the degree of treatment completion. The national registrar investigation seems to indicate that about 20 % of treatment periods in outpatient or long-term inpatient units are ended by mutual consent. Repeated treatment periods in the same facility are prevalent, but often the contact ends abruptly without further information. The addict

might stay out of touch or is then taken into another institution without transferral of treatment responsibility or systems of cooperation that could ensure continuity. Nevertheless re-intakes are less prevalent than first-time intakes and a high number of clients quit their contact with the treatment system. As most heroin addicts with an ongoing problem will have contacts with the treatment and/or social services system, this should indicate some success or at least a reduced degree of problems.

Accordingly a rough status for the treatment system is that capacity is believed to be sufficient but that effectiveness should be improved by coordination, reformulation of treatment goals, differentiation and by special approaches, such as maintenance treatment.

Mortality

Figure 5: Drug attributed deaths



Source: Statistics Norway and National Bureau of Crime Investigation

As Figure 5 shows, the mortality among drug addicts in Norway has been on the increase since the beginning of the 1980s. The gradual increase reflects the increasing average age in the drug-using population. When the figures are divided into age groups (Bretteville-Jensen 1994), the finding is that there is no increase in mortality below 24 years. The steep rise in 1988-9 must however have had additional causes. From a slowly increasing level in 1989 with 24 deaths in Oslo and additional 21 in the rest of the country, the level rose until it reached its maximum in 1992 with 73 in and 27 out-

side Oslo. In spite of harm-reduction measures such as overdoses-team, low level entrance into treatment ("help without strings"), the mortality is disappointingly high, and seems so far to have stabilized at about 80 drug-related deaths each year in Oslo and another 25 in the rest of the country. In addition to the increase in average age, the increase in the purity of drugs, the decrease in price and possibly also increased life difficulties are believed to have had effects. It should be emphasized, however; that follow-up of known drug-using populations give a yearly mortality rate of 2 - 2.5 % which is about the same as found in Amsterdam (Buening et al. 1995). The large differences in mortality figures are probably related to difference in diagnostic and statistical practice.

HIV infection

Figures giving the prevalence of HIV sero-positivity in the drug-using population are thought to be quite precise. Testing procedures are anonymous, counselling services are of adequate standard, and much is being done to develop competency and knowledge in outreach and treatment institutions. Statistics from detoxification services, prisons, outreach and dispensing services show that almost all addicts are tested, often repeatedly. On this basis the statistics are thought to be reliable. The finding is a prevalence of HIV sero-positivity in Oslo's addict population of 5 - 10 % depending on the subgroup criteria. In 1994 the number of HIV-positive addicts in the whole of Norway was 339, half of these in Oslo and two-thirds in the Oslo region.

Table 4: Number of newly diagnosed cases of HIV and AIDS by year

New cases of:	84	85	86	87	88	89	90	91	92	93	94
HIV infection	1	71	99	68	32	23	18	13	12	11	11
AIDS	0	1	0	2	1	3	10	15	6	12	16

Figures from: Alcohol and Drugs in Norway, Rusmiddeldirektoratet/SIFA 1995.

As can be seen from Table 4, the rate of infection has stabilized at a level of about 10 cases each year, while the number of AIDS cases increases as a cohort effect. Those developing immune deficiency contracted their disease during the early and middle 1980s.

This relatively positive development is the sum effect of different harm-reduction measures. Obviously, cured addicts seldom contract the virus. Needle dispensing and cleansing procedures are also thought to be effective, as is methadone maintenance that decreases the injection practice. Only the two first measures are in operation in Norway. This indicates that the situation is controllable without any low-threshold methadone programme. Methadone is judged to be of importance primarily to those who are growing older and do not have the ability to stop abuse.

Drug-related crime

Table 5: Sanctions in cases involving narcotics crime, by type of crime. 1980-1993

	Penal code §162	Act Medic. Goods	Total
1980	70	617	687
1981	95	820	915
1982	97	859	956
1983	191	1.063	1.254
1984	337	1.433	1.770
1985	477	1.303	1.780
1986	531	1.504	2.035
1987	1.203	840	2.043
1988	1.389	1.043	2.432
1989	1.469	1.301	2.770
1990	1.610	1.542	3.152
1991	1.839	1.536	3.375
1992	1.928	1.686	3.614
1993	2.050	1.531	3.581

Note: Figures are not completely comparable over time as use of drugs was reclassified from being a misdemeanour to being a crime. From then on these breaches of the law were registered in the crime statistics as crimes under the Act Relating to Medicinal Goods. At the same time a series of crimes under this law were changed to crimes under the Penal Code. There were also procedural changes.

One problematic consequence of Norwegian drug policy is the high emphasis on criminalisation. There are high numbers of arrests, and the sanctions imposed are on the increase. It should be remembered however that users are not prosecuted according to the penal code. Sanctions imposed for use only are almost exclusively fines not requiring court procedures.

In 1993 (Crime statistics 1993), 1531 sanctions were imposed according to the "Medicinal law". Of these, 1335 were settled with fines. Courts decided fines in an additional 65 cases. 99 cases were settled with unconditional imprisonment and the rest with intermediate sentences. 2040 cases were sentenced according to the penal code. Of these 862 unconditional sentences of imprisonment were passed (42 %), including combined sentences. 786 (39 %) received suspended sentence, and the rest a fine or community service. Not all these crimes were considered serious. Within the group 296 were convicted for "serious drug crimes". 261 (88 %) were sentenced to imprisonment, often for several years. By now, a high percentage of the prison population are serving sentences for committing drug crimes.

Table 5 gives an overview of the development in the number of sanctions according to drug laws (Figures from Alcohol and Drugs in Norway 1993). As can be seen, there has been a significant increase in drug-related sanctions. Noteworthy are the changes related to the altered laws in 1985, when drug use was criminalised.

Public support of drug policy

In spite of some criticism from liberal academic circles and some parts of the mass media, the Norwegian drug policy seems to have massive public backing. Surveys (Skretting 1991, Ödegård 1995) demonstrate an almost unanimous support and, interestingly, this seems also to pertain to most of the drug-using population (Skretting 1991). Presently some new trends are nevertheless noticeable. One is that some significant claims-makers have changed or modified their views. One example is Professor Johs Andenaes, a well-known senior scientist in law, who originally headed the commission deciding on the policy of criminalisation of cannabis. He has now changed his mind and publicly advocates decriminalisation. Research also casts doubt on the necessity and effectiveness of the high level of sentences (Waal & Middelthon 1991).

Concluding observations

It seems fair to state that the drug problem in Norway is relatively under control and at a low level compared to most other countries in Western Europe. It is also noteworthy that the level of drug experimentation has been stable or decreasing, particularly among the youngest, and that the population of serious abusers is fairly stable or decreasing. The average age of users is increasing and attitudes towards drug use remain negative in most of the population. HIV prevalence is also low and the number of annual sero-converters very small. Accordingly, there is some evidence in favour of the Norwegian drug policy. A partial explanation of this, however, could be the country's location at periphery of Europe, and a homogenous population and sound economic situation. In addition there are some signs that the problems might again be on the increase as far as "party drugs" are concerned.

The strength of the Norwegian drug-abuse and harm-reduction treatment system lies in its nationwide coverage and satisfactory capacity relative to the addict population. The social security system and the traditions of outreach and an accessible health care system are among the positive sides. The system is further strengthened by the model of continuity from local to county level and by the emphasis on problem solving, but obviously these goals are often imperfectly reached. The system is also insufficiently differentiated according to specific treatment needs. Maintenance treatment is insufficiently available.

On the negative side we have the high mortality rate. One explanation might be that addicts suffer from stigmatization and low self-care ability. But critical examination of the figures casts considerable doubts on the conspicuous differences often pointed out in comparison to, for instance, the Netherlands. As the total mortality seem to be on par, the probable explanation is methodological. Nevertheless the mortality rate in Norway is highly unsatisfactory.

To some degree this might stem from the relatively stern Norwegian policy that brings with it a high level of criminalisation - "control damages". The number of sentences are high, and increasing. Most offenders are fined, but a large number are imprisoned, and the level of sentences is not infrequently out of proportion to the general tradition in Norwegian judiciary practice.

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Review of Dutch Drug Policy

LÉON J.S. WEVER

1. Introduction

When the foundations of international drug policy were laid 100 years ago, the Netherlands played a prominent as well as a reluctant role. Even then there were fundamental differences of opinion with other countries, such as the USA. And even the present debates on the effectiveness of drug policy are not new.

This chapter presents two major developments. The first is the development of a national drug policy on a continuum between repressive and permissive extremes. In due course one sees that a growing number of variants are being tried out and that there is continuous pressure to go to the extremes. For example, in the public debate on drug policy, sometimes the same people and organisations plea for compulsory treatment as the ultimate form of repression and for the legalising of drugs as the ultimate form of permissiveness. In the Netherlands even the authorities are trying to reconcile the irreconcilable. Health authorities and treatment institutions aim for abstinence from drug use, but at the same time for reducing risks of continuous drug taking. The law enforcement agencies both fight and allow the drug phenomenon. In this respect the emergence of drug problems and drug policies can be analyzed as a social construction (Hakkarainen), with different competing claims-makers.

The second major development described in this chapter deals with the successes and failures of government policies regarding drug use. In order to judge these developments one should know what the policy objectives are or have been and what instruments are available to achieve the targets. This chapters shows that over the past decades, the policy objectives in the

Netherlands have become less ambitious and more realistic, and that a growing variety of instruments has been used. Nevertheless, practice shows that any drug policy is doomed to fail as long as one continues to attempt to influence the international world trade in drugs with non-economic means. Again, it is interesting to see whether "the best" policy is determined by proven effectiveness. One may very well argue that it is not evidence-based policy which really influences political decision-making. Effective claims-making processes are perhaps more important in putting specific issues on the public agenda and in choosing between policy options. It is important to note that drug policy consists of specific choices, and that choices other than the present ones can also be defended.

This chapter concentrates on a review of Dutch drug policy in the past decades.

Section 2 presents a short summary of the birth of international drug policy, in so far it decreases the freedom of policy-making in the Netherlands. Until the 1960s this was not noticed. The Netherlands had its drug legislation, but lacked a drug problem. But this all changed in the 1960s, when the use of cannabis and LSD became popular. The authorities reacted in a traditional tough way, i.e. with penal measures. Drug use grew to be a manifestation of an anti-authoritarian counter culture.

Section 3 discusses the basics of present drug policy. Since the beginning of the 1970s, as a part of the political and societal criticism of the criminal justice system, drug policy has been directed more at prevention and treatment than at criminal justice. This is the time of the retreat of the penal system.

Today's drug policy emerged at the beginning of the 1980s. Drugs are increasingly being seen as a part of social developments such as unemployment, immigration and crime. The authorities use the criminal justice and the treatment system as instrument for controlling social problems, and not so much as a means to reduce drug use.

However, during the last 10 years growing attention has been paid to the "sharp edges" of drug use: Aids, drug-related petty crime, and "revolving-door patients". Then the existing drug policy needed adjustment again, and particularly the criminal justice system searched for new instruments. Section 4 deals with this development.

Finally the question is: what next, after 25 years of drug policy? In sections 5 and 6 recent developments are discussed and related to the changing international context.

2. A birds'-eye view of the history of drug policy

The basics of Dutch drug policy were laid down in the 19th century. Three developments were of decisive importance: the moral concern for the fight against "the evil of addiction to narcotic drugs", the professionalisation of medicine, and the opium politics in the Dutch East Indies, nowadays Indonesia. To put it bluntly: priests, doctors and economic administrators discovered drug use as a problem and joined hands in claiming its control.

2.1 International moral concerns

The moral rejection - or what is seen as such - of psychoactive substances is far from being a new phenomenon. Europe has a rich history of fights against coffee, tobacco, alcohol and opiates (Van de Wijngaart, 1991). The combination of fear of strange substances and strange behaviours might be an explanation for the often religious as well as politically inspired efforts to stamp out a human basic need: pleasure.

In the 19th century, the need to fight opium and cannabis was expressed on all continents. In the United States the powerful and puritan British elite was confronted with the consumption habits of Chinese and African workers, which were difficult to understand and control (Musto, 1973).

In North Africa and India the authorities were worried about the use of cannabis and opium by the people. China and Britain even fought a few wars over the trade in opium. China wanted to abolish this trade, and Britain did not agree with that. Even in those days, opiates constituted a major moneymaker and China was a large consumers' market. Even the Dutch government profited from the opium trade in Asia until World War II.

The strongest claims as to the (moral) harmfulness of drugs have been made by the Americans, who have mobilised many countries all over the world in order to make international agreements on the curbing of drug trafficking. The first worldwide convention against drugs was agreed upon in 1912 in The Hague, the government seat of the Netherlands. But at the time there was no international organisation to execute the convention. Against the will of the USA, the Netherlands had the honour of taking that responsibility, which was taken over by the League of Nations after World War I (Van Luijk, 1990).

2.2 *Medical professions*

It was not only moral disapproval or fear of strange cultural phenomena which inspired the international community to take action against drugs: a second factor of great importance was the birth of the medical profession in the 19th century (Berridge, 1987). By then it had become clear that not everybody is qualified to treat the ill or to dispense medicines. A medical professional group emerged, with limited "entrance" because of quality demands. Governments supported this societal development with legislation and state control of the medical profession.

It was not only for medical but also for economic reasons that doctors decided that they must exert much influence on the selling of drugs. Because as long as drugs - of which opiates are the major painkillers - could be bought anywhere without restraint, there was no need for the ill to visit a doctor. Therefore it was in the interest of the medical profession to limit the sales of drugs such as opiates to themselves. And even today, there is a continuous debate on the question which drugs can be bought with or without a doctor's prescription.

2.3 *Dutch colonial experience*

In the early 20th century, the use of opium in the Dutch East Indies (now the Republic of Indonesia) was a relatively normal phenomenon. Before World War II the Dutch government executed a drug policy which in some ways resembled today's policies. Opium addicts were not prosecuted, but were allowed to buy opium on a doctor's prescription. If opium addicts wanted to get rid of their addiction, they could be treated in an addiction clinic. The legal opium sales were organised by the Dutch government, and it was a moneymaker. In 1920 more than 6 % of government expenditure was covered by opium sales to more than 150,000 addicts. That percentage is higher than the present contribution of tobacco and alcohol excise duties to the income of the state.

In the 1930s the "Dutch model" was recommended by an investigation committee of the League of Nations (the Ekstrand Committee). The debate was not finished because of the outbreak of World War II.

The so-called opium-regie (opium policy) was abolished by the Japanese during the war as one of the symbols of Western colonialism. Under pressure from the American government (which, according to plans at the time,

was supposed to be the liberator of the Dutch East Indies), the Dutch government withdrew the opium-regie in 1944. (Meijring, 1974; Van Luijck, 1990).

2.4 Single Convention on Narcotic Drugs

Since the beginning of this century an increasing number of international agreements have been made in order to fight illicit drug trafficking. The two world wars are also important in this respect. With the peace treaty of Versailles (1918) the former combatants agreed to implement The Hague Treaty of 1912 on drugs. The executive role of the Netherlands was then taken over by the League of Nations. In 1919 the Netherlands got its own Opium Act.

After the second world war, the United Nations - successor to the League of Nations - started work on all sorts of peaceful activities. This resulted inter alia in the Single Convention on Narcotic Drugs (1961), by which all trade in narcotic drugs was prohibited worldwide. The parties to the convention agreed to limit drug trade to medical and scientific purposes only. All illicit trade was to be suppressed by penal measures.

In the 1963 Dutch parliamentary debate on this convention, the positive colonial experiences with a non-prohibitionist policy was not mentioned. Apart from some critical questions posed by the Dutch Labour Party as to the usefulness of prohibiting the cannabis trade, the convention was accepted and the international restriction on Dutch drug policy became a fact. By then the Netherlands had a national drugs legislation and international obligations to fight drugs, but had no drug problem. But this was about to change.

2.5 The 1960s

In the 1960s, the use of illicit drugs became popular mainly among the young. Drug use was one of the many new societal developments characterised by the rejection of authority. The authorities did not know how to react to these strange phenomena, and in the beginning their reactions were tough. These developments were seen as something to be dealt with by the police and the criminal justice system on the basis of the Opium Act.

However, the use of drugs is not an entirely new phenomenon for the Dutch authorities. Although in the sixties the use of cannabis, LSD and amphetamines became increasingly popular, drug use had been common

for a long time among small groups of Chinese immigrants (opium), doctors (morphine), and artists and sailors (anything). As long drug use was not a public phenomenon, it apparently was tolerated.

However, in the 1960s societal and political criticism of the authorities' repressive actions emerged. This has affected the way Dutch drug policy has since been developed.

3. The background to present drug policy

In the late 1960s and early 1970s the criminal justice system was increasingly seen as an ultimum remedium - a final remedy - and alternatives for penal interventions were developed. This movement affected drug policy. But what is of equal importance for the emergence of present policy are the societal developments, the existence of addiction treatment facilities and the general social policy of the government.

3.1 A new drug policy

Looking back, it is strange that the Dutch colonial experiences with a tolerant drug policy did not play an explicit role in the development of today's policy. At the end of the 1960s an increasing number of politicians, scientists and other experts criticized the government's drug policy, which by then was dominated by law enforcement. This criticism had to do with a critical attitude towards the criminal justice system and the prison system in particular. A trend began towards decriminalisation, by which several types of crimes are no longer prosecuted or by which alternatives for prison sentences are sought.

The criticism of drug policy regarded two main issues. Firstly, the question whether the possession of drugs - in particular, cannabis products with their relatively mild health effects - should be a crime. Secondly, many objected to the penal approach to drug use. They thought it senseless to imprison young people just because they possessed drugs while there were other means of controlling drug use, such as prevention and treatment.

A government-installed expert committee (Baan Committee, 1972) and a private expert committee (Hulsman Committee, 1971) advised the government to restrict the use of the criminal justice system in drug policy. The Hulsman Committee also advised legalising cannabis.

All this led to a change of the Dutch drug legislation in 1976. Although some major political parties and the Minister of Health, Ms Vorrink,

wanted to implement the advice of the Hulsman committee, it did not happen. The main argument against legalising cannabis was one of foreign policy: according to the United Nations Single Convention on Narcotic Drugs, the Netherlands is obliged to penalise the possession of drugs such as cannabis except for scientific and medical purposes. The Dutch government did not want to change her international obligations. This debate was the first challenge to the dominant policy strategy. Since then, the international context has always explicitly restricted the policy options regarding drugs.

Nevertheless - within the framework of existing international conventions - under the new Opium Act of 1976 the possession and selling of up to 30 grammes of cannabis is no longer a crime, but a misdemeanour, comparable to driving too fast. This is the basis of the distinction in Dutch drug policy between cannabis and the drugs with so-called unacceptable risks.

Another important change in the Opium Act is that the maximum penalties for possession of cannabis and hard drugs, such as heroin, are much lower than the maximum penalties for selling and trafficking, which were increased.

The 1976 change in the Opium Act was a signal from government and parliament that law enforcement should concentrate on (international) drug trafficking and not on drug users and small-scale dealers. The 1976 Directives of the Public Prosecution Department allowed the-then existing practice of small-scale cannabis sales within youth centres by so-called house dealers. At the moment this legislation and these directives are still the basis of the law enforcement approach toward drug users and small-scale dealers.

Since the mid-1970s the criminal justice system has left room for alternative approaches to the drug problem. Prevention, social welfare and treatment are seen as more important tools of drug policy. The Minister of Health is the coordinating minister for drug policy. Drug policy is prepared by an interministerial steering group, chaired by the Director General for Health. This steering group pays most attention to the development of a nationwide network of treatment agencies and the coordination of the Dutch input in international drug policy.

3.2 Societal developments

Although heroin has become increasingly popular since the early 1970s, the government has not been able to do much about it. They are reluctant to put

heroin users in jail. This is true not only for drug use, but for all sorts of social and moral problems.

There is one additional complication. Heroin use has become increasingly popular especially among immigrants from Surinam, which was a Dutch colony until 1975. Furthermore, in the bigger cities a concentration of problems with unemployment, bad housing and social integration has emerged. For some groups participation in the heroin world becomes a fairly normal and meaningful way of life. Drug dealing has become a social reality, including the emergence of economic interests for people without serious economic alternatives. (Janssen and Swierstra, 1982).

The development of drug problems partly takes place in conjunction with other social problems. This is another reason why the authorities cannot look at the drug problem as an isolated phenomenon that can be simply dealt with by confiscating drugs and punishing drug users and dealers. This is another explanation of the reluctance of the criminal justice system in Dutch drug policy.

3.3 The availability of treatment services

In the early 1970s several residential addiction clinics and ambulatory counselling centres for alcoholics (such centres already existed in most parts of the Netherlands) started helping drug users. These facilities focus mainly on abstinence, as they do in their approach to alcohol addicts. This does not work, at least not for most of the people who seek help. Since then all sorts of "alternative" services have emerged, as also happened in psychiatry and youth services. The "alternative drug treatment services" offer simple help: a shelter, day activities and primary medical care. They can exist because the clients can pay for them, since many of them receive social welfare funds. Furthermore the central government and some municipalities provide money as well. Both the traditional abstinence-oriented and the "alternative" forms of treatment are supported by the State. The responsibility for the ambulatory addiction counselling centres has been taken over from the Minister of Justice by the Minister of Health.

3.4 Social policy

The Netherlands has a large system of publicly funded health care, social security and social welfare, which mainly has been built up since the 1960s. In practice all citizens are entitled to health care and a minimum in-

come. In all larger municipalities a variety of social welfare facilities, such as youth centres, neighbourhood centres and social work, have been set up. In this tradition of social welfare for all citizens, it is only normal that attention be paid to people with drug problems. The authorities choose to provide a lot of money for these services.

In short, the criminal justice system leaves room for other approaches to drug problems. Both the health system and the social welfare system already have facilities available for alternative approaches. The growth of these facilities has been brought about by the political willingness to provide sufficient funds. In the early 1980s, however, the problems in the bigger cities determined the further development of Dutch drug policy.

4. The normalisation of drug policy

The drug policy as we know it today has developed since the early 1980s. There is an explicit connection with societal developments, such as unemployment, immigration and crime. The central and local authorities are using the police and the treatment agencies as a means to control social problems, rather than primarily as a means of reducing drug use. By giving much financial and policy support to municipal governments, the central government is helping regional networks to implement all sorts of drug treatments. Cannabis policy is no longer a real matter of discussion.

Drug policy contradictions are increasing. On the one hand the government wants to "normalise" drug problems (in other words, it does not want to treat drug problems as something special, but as a part of normal social problems), and on the other hand has set up all sorts of specialised health and judicial agencies. So the criminal justice is said to play a reluctant role, but at the same time more and more inmates in prison are drug users, albeit not punished for drug offenses but for drug-related crimes, such as shoplifting and burglary. Another contradiction is that the use and small-scale dealing of cannabis is tolerated, whereas its production and import is not.

Several periods can be distinguished in the last 15 years of drug policy. During the early 1980s a fairly radical shift in the approach toward drug users emerged. In the mid-1980s there was a period of evaluation and reorientation. And in the second half of the 1980s much government attention was paid to issues such as crime and Aids among drug users. Today - as we'll see in Section 5 - crime and public order problems have become the dominant factors in the public debate on drug policy.

4.1 A radical policy shift

In the early 1980s many municipalities thought that drug problems were out of control. Some city areas were controlled by drug dealers and drug users, and experienced severe public order problems. Local authorities exerted considerable pressure on the government to take radical action. The proposals varied from the free medical distribution of heroin to heroin addicts, to compulsory treatment in specialised prisons. A government advisory body - the Council for the Harmonisation of Welfare Policy - advised to radically alter (i.e. liberalise) drug policy in order to improve its consistency (Harmonisatieraad Welzijnsbeleid, 1980).

The common background of these and many other proposals is that the then-existing addiction treatment centres - mainly inpatient addiction clinics and ambulatory addiction counselling centres - were not able to reach many drug addicts. In those days they set high demands with respect to the motivation of drug addicts to kick their habit. But one also saw that a law enforcement approach in the city areas concerned was not effective. Something had to be done.

The Ministers of Health, Welfare and Justice decided to change drug policy with respect to drug users. The main feature of this policy shift was that the existing treatment centres should lower their demands and new types of treatment centres should be promoted and supported. The aim of the policy was to not only stop drug use but also increase the physical and social functioning of drug addicts, even if they continued to use drugs. Since then, throughout the country methadone maintenance programmes and social welfare oriented treatment centres, such as daycare and street-corner work, have been set up. Serious efforts have been made in the field of housing, education and work. The central government was in a position to implement this policy, because of the provision of large sums of money, because it exerted pressure on municipalities and the existing treatment centres (which were financially dependent on the government), and of course because no-one had a better alternative. A description of the treatment facilities is given in the appendix to this chapter.

The call for increasing possibilities for compulsory treatment and medical heroin dispensing by the municipalities was then denied by the central government. In the end all agreed that it was better to improve the existing services in the way described above. At the same time it was clear that there should be a decentralisation of drug policy, since the cities were con-

fronted with the problems and had the possibility of a more comprehensive approach. In Amsterdam an experiment with the treatment of heroin addicts with morphine was allowed as a sort of compromise (Derks, 1990).

Also within the more traditional forms of inpatient treatment, several changes occurred: cooperation with outpatient community-based facilities, the setting up of crisis and detoxification centres for short-term treatment, and a differentiation of treatment forms. All these developments were supported by the Minister of Health.

The Minister of Justice just about stayed out of things. Small experiments took place with special addiction wards in prison.

4.2. Evaluation and reorientation

In the mid-1980s two incidents led to another, more fundamental reorientation of drug policy by the government. Firstly, drug policy was together with many other policy fields subject to a "scrutiny investigation" by the government. Secondly, the results of a government sponsored sociological research of drug use were published.

Each year the government decides to review specific fields of policy with the purpose of finding ways to do the same thing with fewer financial means. The 1986 review of the effectiveness and efficiency of drug policy lead to the following conclusions:

- A judgement of the effectiveness and efficiency of drug policy was not possible because of a lack of evaluation data.
- Research data from other countries (i.e. the USA) showed that the duration of contact of treatment agencies with drug users is of more importance than the type of contact. This supported the government's methadone policy.
- The existing preventive measures (information, early intervention and law enforcement) had not been effective in reducing drug problems.
- The health of drug addicts in the Netherlands is better than the health of drug addicts in other countries.

The government decided that it is not wise to implement financial cutbacks, that the treatment system should be organised more efficiently, that more evaluation research should be undertaken, and that greater attention should be paid to preventive measures.

A government sponsored sociological research into the lifestyle of drug addicts led to the concept of the "normalisation" of drug problems. This research induced great enthusiasm in the government's main policy advisors, especially those of the Ministry of Health and Social Welfare, as can be seen from the public speeches the ministers gave at the time. In 1985 the interministerial steering group on alcohol and drug policy used this study to critically analyze current drug policy. The main conclusions of this group were that a large part of present drug problems is caused by drug policy itself, and that treatment agencies are mainly occupied with the elimination of the negative effects of the worldwide illegality of drugs. The steering group had to accept that the legalisation of drugs was not politically feasible, and advised treating drug problems just like the many other social problems a modern society is confronted with, without moral and emotional overtones. Drug use and drug users should not be treated as something special. In other words, drug policy should be "normalised" (Engelsman and Wever, 1986). The concept of normalisation gave another impetus to the pragmatic, non-moralist approach of drug policy.

4.3 Crime

Since the mid-1980s a lot of political attention has been paid to petty crime, which is easily related to drug addicts who need money to support their habit.

The level of petty crime is constantly rising, and it seems that the massive treatment approach has not changed things. Although drug policy officially is based on the reluctant attitude of law enforcement toward drug users, in practice ca. 40 % of addicts in the cities have confrontations with the police each year (Bieleman, 1995). Nevertheless the government still relies on the effectiveness of existing treatment facilities, which were set up only a few years earlier. But more than 30 % of the prison population experience a drug problem. And because of parliamentary pressure during 1988 the government is now paying more attention to the role of the criminal justice system in the treatment process. The aim is to improve the use of existing legal instruments to exert pressure on addicts to enter treatment. Within the prison system new forms of detention and treatment are being used, such as so-called drug-free wards. Within the framework of parole or conditional sentencing, more use is being made of treatment alternatives to detention.

The government maintains its negative position toward introducing new legal instruments for compulsory treatment.

The fight against drug trafficking is running its own course. Police and the judicial authorities have acquired more possibilities for detecting drug crimes. A novelty in Dutch penal law is, for example, the introduction of the prohibition of preparatory actions before one can speak of drug trafficking. The penal courts have provided the police with even more powers, even though their actions seem to contradict the law.

On the international level, cooperation between law enforcement agencies grows stronger every day. This is shown for instance in practical affairs, such as the stationing of liaison officers from foreign police services in the Netherlands. But also for the first time since the early 1960s the Dutch government has signed various new international drug conventions, such as the Vienna Treaty (1988) and the Schengen Treaty (1989).

By the late 1980s one could clearly see a revival of the criminal justice system in Dutch drug policy. Nevertheless the health approach received new impetus because of the emergence of the Aids epidemic.

4.4 Aids

One can easily link to drug addicts not only the rising crime rate but also the rising number of HIV and Aids cases. Shared needle-use and frequent sexual (prostitution) contacts are the obvious reason for this.

From the onset, the health minister chose a pragmatic approach to Aids. Prevention policy for drug users contains the following elements:

- The risk groups should be reached by the already existing networks of low-threshold treatment facilities, especially methadone maintenance programmes and street-corner work.
- The prevention aims should be realistic and connect with the way of life of drug users, i.e. a plea for safe drug use instead of stopping drug use.
- Unorthodox measures are used, such as needle-exchange programmes in police stations and the use of junkie organisations.

The drug treatment system therefore got a stronger role to play in prevention of health problems. The government thinks that the protection of public health is more important than the reduction of drug use.

In the international debate on drug use, the Dutch Aids and drugs policies seem to have strengthened the Dutch position. A growing number of countries have introduced or strengthen the so-called harm reduction approach, which earlier had been seriously criticised. An example may is the World Summit on Drugs - organised by Margaret Thatcher, then Prime Minister of the United Kingdom - which accepted the Dutch proposals for harm reduction as a useful policy, despite overt opposition from the USA.

On the international level, therefore, the health approach of drug policy seems to come a little closer to the dominant penal approach. (Wever, 1992).

5. Recent policy developments

On the national and the international level, the development of drug problems and drug policies seems to be continuing rapidly. In the Netherlands the health approach and the law enforcement approach seem to have converged. The growing concern over public nuisance, which often is related to drug users, has however led to a tougher approach toward addicts and dealers. In the European Union the words "warfare" and "welfare" are both used in debates on drug policy and in the Maastricht Treaty (1991).

5.1 Government memorandum on addiction problems

In 1992 for the first time in 10 years the government presented a comprehensive policy memorandum on addiction problems (Nota verslavingsproblematiek, 1992). This memorandum evaluated current policy and contains arguments for the administrative decentralisation of drug treatment policy (from the central government to the major municipalities). Some conclusions are:

- The accessibility of the treatment system is very high, since 60 to 80 % of all drug addicts keep in contact with treatment services.
- The variety of drug services is wide, especially in the larger cities.
- For the clients of drug treatment services and other health services, it often is not clear what one may expect from these services.
- In many regions, the comprehensiveness and efficiency of the treatment services could be improved.
- Drug treatment services have their limitations: they may help reduce crime problems, but cannot solve them.

The government accepts as a matter of fact that the criminalization of drug use causes problems which have no relation to the chemical characteristics of the substances involved, but rather to the illicit context of its production, trade and use.

Again parliament is asking for compulsory measures, but the government is still not willing to propose new legislation on that. And for the first time in two decades the cannabis policy is being debated. In many cities the sales of cannabis - which according to the legislation is a criminal offense - is permitted in so-called coffee shops. This seems to be an effective way of separating the cannabis and hard-drugs markets. But nevertheless in some cities, especially those which attract tourists from neighbouring countries, the coffee shops are causing serious public order problems. And since the cannabis market is an illegal, one there is a growing illegal financial market as well.

5.2 The Maastricht Treaty

In the 1990s, many European organisations have dealt with drug problems, each of them from its own angle. Especially the European Union is playing an increasingly prominent role. A very important political moment was the Maastricht Treaty of 1991. This treaty empowers the EU to deal with drug policy, and obliges member states to cooperate in law enforcement activities. The European Commission now has the power to take action in the fields of research, prevention and health promotion. Two things are important here: firstly, drug policy has become part of European policy making, and secondly, drug policy is a matter not only of law enforcement but also of health policy. By the way, it is because of an intervention by the Dutch Minister of Health that drugs became an explicit subject in the health paragraph contained in the Maastricht Treaty.

Of course the legal provisions of an international treaty do not immediately change drug policy practices. But it is important to note that at the European level it is officially recognised that drug policy is not only a matter of law enforcement.

5.3 Drugs policy in the Netherlands: continuity and change

The conservative Christian Democratic Party dominated the Dutch government from 1977 to 1994. In this period - as we have seen above - Dutch drug policy was certainly not of a conservative nature. In 1994 there was a

new government which wanted to review and adjust drug policy again. Now, for the first time, the government is made up of social democratic, left-liberal and liberal-conservative parties. Two of the three parties want to liberalise Dutch drug policy. A new policy memorandum was published in 1995 with three main features: firstly, the simultaneous restriction and liberalisation of the cannabis market (a typical Dutch compromise); secondly, experimentation with the medical distribution of heroin to heroin addicts; and thirdly, the introduction of prison facilities for the treatment of convicted drug addicts.

The revision of the cannabis policy is related to the public nuisance caused by so-called coffee shops, in which the small-scale sales of cannabis is tolerated. Much of the nuisance is caused by drug tourists from neighbouring countries. By reducing the level of tolerated possession from 30 to 5 grammes, the government is trying to curb public nuisance. The government also wants to minimize the contradictions of cannabis policy. Apparently it is difficult to explain why the authorities tolerate small-scale sales by coffee-shop owners, but prohibit the delivery of cannabis to these shops. Therefore the government wants to tolerate the small-scale home growing of cannabis plants.

The second main new policy feature is the medical dispensing of heroin to heroin addicts. In some cities experiments will be set up in order to reach the several hundreds of drug addicts who can no longer be treated by the existing facilities.

The third feature - treatment prisons - may be seen as an answer to a long lasting political debate on compulsory treatment. Most political parties have always been in favour of extending the possibilities for compulsion, but the government has always been opposed to it. This is now changing.

Another important factor of drug policy is the 1996 report of the parliamentary enquiry committee on police detection methods. This committee examined police practices and found out that many innovative policing measures were secretly carried out, without any judicial control and thus seriously infringing on the penal legal system. A striking example is that the police have secretly involved themselves in importing and distributing large quantities of cannabis. This was done in order to get to the higher echelons of organised crime. The paradox is clear: one accepts the distribution of drugs in order to combat its distribution. The major reason for these covert operations is the necessity to fight organised drug crime. The major objection is its secrecy and lack of any form of control.

The drug policy memorandum and the parliamentary report are currently subject to fierce political debates. The outcome of these debates is uncertain at the moment of writing.

6. Review and prospects

Problems of drug use and drug policies are and always have been constantly changing. It is difficult to predict the course that drug policy in the Netherlands will take. The international context will presumably be the most important factor. Looking back, it is possible to describe some trends in the previous 25 years. The most important is that since the 1970s there has been broad consensus in Dutch politics on the main features of drug policy: firstly, limiting drug trafficking and helping drug addicts, and secondly, making a distinction between cannabis and hard drugs. Nevertheless, one also can see that the social and political basis for this consensus is diminishing. The major cause is the public nuisance of drug-related phenomena in the cities.

6.1 Trends

What trends have we seen in the Netherlands?

Firstly, the acceptance of the existence of drug problems as an inevitable feature of modern society. The government is no longer trying to eradicate drug use as such, but rather to limit individual and societal risks related to drug use.

The second trend is that the government is continuously changing its policy in order to adjust it to changing circumstances. Innovative developments in the field of criminal justice, public administration or health care and social welfare are incorporated easily. Examples are the needle-exchange projects of the drug treatment centres, or ecstasy quality-controls during house parties.

The third trend is that drug policy - contrary to other policy fields - has always had the advantage of an increasing level of expenditure. This may show the confidence that Dutch politics expresses in its drug policy: it is not only words. The per client expenditure for drug treatment in the Netherlands is higher than elsewhere (Wever, 1992).

Fourthly, despite its contradictions, Dutch drug policy is characterised by some integration and rationalisation efforts. In one way or another contradictions in drug policy are explicitly harmonised as much as possible. An example is the cannabis policy, in which small-scale sales are tolerated and

large-scale sales opposed. These compromises are possible because of a societal and political consensus on policy aims with a relatively low level of ambition.

The fifth trend is a reappraisal of the criminal justice system and other forms of repression. The normalisation of drug problems means that drug users - just like anyone else - are held responsible for their (criminal) behaviour. Furthermore the criminal justice system is used to support treatment aims (e.g. "drug-free wards" in prisons or the new treatment prisons).

The sixth trend is the decentralisation of public administration. The bigger cities always have been at the forefront in the continuous renewal of drug policy. This went together with a growing responsibility for treatment and police systems.

6.2 Results

Twenty-five years of government policy clearly has not led to the eradication of drug use and all its negative social features. Since the mid-1980s a lot of research into many aspects of the drug problem has been supported by the government. There are both positive and negative results of Dutch drug policy.

Positive in that the number of addicted drug users seems to be stable. This is despite the relatively easy availability of drugs (Driessen, 1990; Bieleman, 1995). The number of young addicts has been on the decline since the mid-1980s. For many years now the number of drug-related deaths has not exceeded 100 (Buning, 1990; Amsterdam Municipal Health Service, 1994).

It is also positive in that the use of cocaine has not risen quickly, and that cocaine users in a non-deviant setting are able to control their use (Cohen and Sas, 1994). By the way, the possibilities for self-control and safe drug use in a deviant setting should not be underestimated (Grund, 1993).

Another positive result is that there is contact with a large group (ca. 75 %) of drug addicts, in particular through the methadone programmes (Driessen, 1990). These programmes contribute to a stabilised way of life and a decrease of drug-related crime (Grapendaal et al, 1991). Furthermore there is a growing demand for withdrawal therapies (Buning, 1990).

And then there are the negative results. Negative in that after some years of stabilisation, the number of young cannabis and ecstasy users has risen rapidly since the late 1980s, as has the number of medical complications related to the use of these drugs (NIAD, 1995).

It is also negative in that a group of therapy-resistant addicts has emerged, addicts who have been addicted for many years and are not capable of maintaining themselves in a socially acceptable way.

Another negative result is that there is no a proper answer available for the young drug users who are active in crime and who often belong to immigrant groups.

And finally, negative in that the tolerant policy towards cannabis has resulted in the growth of a very large illicit financial market.

6.3 Prospects

What can we expect from drug policy in the coming years? History has shown that the problems related to drug use can take surprising courses. There is no reason to think that this will be different in the coming decades. But it is not very likely that the magnitude and the character of drug problems are the main factors in drug policy. This was not the case last century. Until now traditional beliefs seem to have been more important than facts and figures.

Two scenarios are feasible. The first is one of a further repression of all actors on the drugs market (production, trade and consumption). This means a strengthening of the politics of prohibition and the elimination of drugs, drug suppliers and drug consumers.

The second scenario is one of other means of controlling the drugs market, not (only) with law enforcement, but also with economic and social policy means. This for example means a reinforcement of the economic support of drug production countries in the Third World, the protection of consumers against unsafe products and a prevention policy directed at the reduction of drug-related risks. In other words, this scenario does not imply the eradication of drug use.

These scenarios are in conflict with each other, because prohibitionist politics decreases the room for alternative policy instruments. It will be the international political context that will determine what scenario will be used.

6.3.1 International drug policy

The official strategy of United Nations drug policy is based on the reduction of demand and of supply. There are signs, as explained above, that repression is not the only international policy strategy. However, on the in-

ternational level there is neither the tradition nor the institutional framework for developing and implementing a policy aimed at demand reduction. The tradition - formalised in international drug control treaties - is entirely directed at the control of trafficking. This is also true for international organisations: the few that are interested in the demand side of the drug problem, such as the World Health Organisation and the Council of Europe, have neither the political power nor the means to change the dominant drug control strategy. Because of its strong basis, the chance for survival of the traditional repressive drug policy is large.

European integration has led to an increasing coordination of national drug policies. This is shown by the growing role of the European Union. In the field of drug policy, countries such as Germany, Belgium, Netherlands, Luxembourg and France have made agreements. The main features of these agreement are that the countries will respect each others' legislation and law enforcement practices, as long as they do not interfere with each other. Especially France is exerting great pressure on the Netherlands to harmonise its drug policy with French policy. France wants the Netherlands to stop tolerating the small-scale sale of cannabis. Although all indications suggest that French drug policy is less effective than Dutch drug policy, the French government does not bother too much about facts and figures. One may wonder why.

The Netherlands experienced the same situation with Germany a decade ago. Both countries then decided to invest in understanding each others policies. This resulted in close cooperation in the field of international law enforcement and the introduction in several German states of methadone programmes and cannabis policies which resemble the Dutch situation.

6.3.2 Prospects for Dutch drug policy

The international political context will presumably limit the further development of Dutch drug policy. This is the price that perhaps must be paid for European integration. Legally, the Netherlands is increasingly embedded in binding international regulations. Therefore the non-prohibitionist policy strategy is under pressure. The international focus on supply reduction and law enforcement will eventually also influence national priority debates on the financing of drug policy options.

However this is not yet the case. In the Netherlands there is still a broad political consensus on drug policy and the wish to invest more in pragmatic

and effective means than in a moral convictions. Interventions are becoming primarily based on whether drug use and drug sales are causing public nuisance problems, or in the case of organised crime. Both in the treatment system and in the criminal justice system new routes are constantly being explored. A recent example is the introduction of the medical distribution of hard drugs to hard-drug addicts.

Although most Dutch citizens want to get rid of the public nuisance related to drug use, and most political parties are demanding tougher intervention by the authorities, foreign pressure like that exerted by the French is counterproductive.

The "war on drugs" cannot be won. This is an economic reality. Never in history have authorities managed to ban any product which was demanded by consumers, which producers wanted to make, and which traffickers wanted to sell. On the other hand it is very well possible that because of worldwide prohibition, at least in the western world there will be relatively few problematic drug users (compared with alcohol and nicotine addicts), albeit that the risks connected to this prohibition for consumers and society are large.

A policy that is directed at the reduction of risks related to drug use and drug policy will probably be the most effective and feasible in the coming years. As long as no-one has a final solution, it is of utmost importance that governments continuously create room for innovative approaches. By the way, an effective government policy is not the same as an actively intervening policy. In many sectors of society we see a policy philosophy of the retreating government, which seems to work out positively. It could perhaps be worthwhile for such a philosophy to be applied to drug policy as well.

Appendix

Drug treatment services

The emphasis on the reduction of the demand for and risks of drug use in Dutch drug policy means that most policy efforts have been directed at the development of assistance and treatment services for drug users. Treatment for alcohol or drug problems in these services is free. Four types of services can be distinguished: outpatient consultation bureaus for alcohol and drugs, municipal methadone programmes, social welfare services for drug users,

and residential treatment facilities. This section includes a brief description of the major organisational and operational characteristics of these institutions.

Medical and social services: the Medical Consultation Bureaus for Alcohol and Drug Problems

The Medical Consultation Bureaus for Alcohol and Drug Problems (CADs) are autonomous, non-governmental but publicly funded institutions, the entire costs of which are borne directly by 23 municipalities and 19 probation boards. Seventy-five percent of these funds are provided by the central government through these municipalities. The remainder is financed by the Ministry of Justice through the probation boards.

The CADs are (mental) health institutions specifically oriented towards addiction problems. The institutions operate on the principle that the care, treatment and assistance they provide should be irrespective of the legal (or moral) status of the object of addiction. Although the CADs primarily provide non-residential mental health care, their services are strongly oriented towards social welfare, as the majority of their staff (1000 in all) are social workers.

The objectives of individual CADs may vary somewhat from overcoming addiction through treatment to stabilising the condition of addicts by supplying methadone on a "maintenance basis". A variety of methods are used, including psychotherapy, group therapy, material assistance, family therapy, counselling, and advising groups of parents.

An increasingly important area of the CADs' work consists of advising and training teachers and members of more general health and welfare services, such as general practitioners and youth workers. This part of the work aims at enhancing the competence of the more general agents in the field of public health and welfare as far as (drug) addiction problems are concerned. The CADs are partly linked to the judicial system, both operationally and organisationally. This is of especial importance in the field of drug addiction. The CADs cooperate with the probation service in a programme of early assistance to arrestees. These are visited in police cells within 48 hours of arrest. Arrested heroin addicts are offered methadone, and efforts are made to establish contacts that will lead to the acceptance of assistance and counselling during and after detention in penal institutions.

Recently the CADs have also been fulfilling major preventive tasks in the field of Aids control (needle exchange, information and education).

The nationwide network of CADs comprises 16 main branches, 45 subsidiary branches and 45 consulting rooms. The total budget amounts to DFL 80 million per year.

Municipal methadone programmes

In several of the larger cities, municipal authorities have set up their own methadone programmes, run by the municipal health services. The budget of the municipal methadone programmes is - as far as paid for the central government - DFL 7 million per year.

Methadone may be supplied on a reduction basis (the dose is gradually reduced) or on a maintenance basis (a constant dose). Methadone is now supplied either by a CAD or the municipal health service in virtually all population centres with a drug problem. Like the CADs the municipal health programmes have a central role in the field of Aids prevention. Presently methadone is supplied daily to 6500 addicts in ca. 55 municipalities. Roughly 75 % of the clients receive methadone in a maintenance scheme. This means that on average ca. 40 % of the supposed drug-addict population in the Netherlands is in daily contact with methadone treatment. It is estimated that on a yearly basis ca. 60-80 % of the addict population is in contact with treatment or assistance facilities for drug users.

Social welfare services for drug users

The social welfare projects for drug users constitute a part of a wide range of social welfare services especially aimed at young people. Traditionally these institutions have focused on multiple-risk groups where addiction problems may occur together with unemployment, ethnic minority status and other indicators of marginality. These welfare projects are typically subsidised on a local level, where facilities may be optimally suited to meet the most urgent needs. The types of projects listed below are all intended to be easily accessible and to have the widest possible outreach. They concentrate on different types of aid, often for young problematic drug users. Typical social-welfare drug programmes are: open-door centres for specific groups (such as street prostitutes or tramps), street-corner work, ethnic or

religious therapeutic communities, night centres for homeless addicts, and social rehabilitation projects for (former) addicts, comprising such facilities as supervised housing, vocational and social-aptitude training, assistance in adjusting to a lifestyle that includes regular work, and possibly aftercare following some form of treatment.

A number of services are targeted at specific groups on the basis of their religious affiliation or ethnic and cultural identity. Some of them work nationwide. The total budget for these services amounts to ca. DFL 55 million, covering 66 projects in 45 municipalities. Roughly 50 % of the total sum spent on these kinds of assistance to addicts is allocated to the four major cities - Amsterdam, Rotterdam, The Hague and Utrecht. Roughly 35 % of the total sum is earmarked for projects in one or other of the four major cities for ethnic minorities from former Dutch colonies. Within this last category attention to different minority groups more or less mirrors demographic developments within Dutch society. Consequently assistance to addicts of Surinamese origin (South America) has increased considerably, while it has decreased sharply where Moluccans (Asia) are involved. Most recently, more social welfare programmes for young drug users are being directed at (the children of) migrants from Mediterranean countries, who are turning to drugs in greater numbers. Some 550 people are employed in these services.

Residential facilities

Residential facilities for the treatment of drug addicts and alcoholics are located throughout the Netherlands, providing a total of 1000 beds. In this type of addiction treatment, often no sharp distinction is made between alcohol and drug addiction.

These facilities exist either as an independent clinic or therapeutic community or as a special unit within general (psychiatric) hospitals.

Various types of treatment are available:

- crisis intervention and detoxification, which may last between two days and three weeks, and
- clinical treatment, lasting from three months to a year and aimed at overcoming addiction.

These facilities cost ca. DFL 100 million per year and are funded from contributions made under the Exceptional Medical Expenses (Compensation) Act, which is part of the Dutch public health insurance system.

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Construction of National Drug Policy in Finland

PEKKA HAKKARAINEN

1. Introduction

The roots of modern drug policy, especially primary classifications into medical drugs and narcotic drugs, are to be found in the 19th century (Berridge & Edwards 1987). The expansive development of international drug control started nearly a hundred years ago during the first Opium Conference, held in Shanghai in 1909 (Bruun et al. 1975). In Finland there was some use of morphine and cocaine in the first decades of the 20th century, and a limited epidemic of heroin use in the 1940s (Westling & Riippa 1956), but the abuse of narcotic drugs was not considered a significant social problem until the end of the 1960s. Before then, Finland had adopted international narcotics agreements only passively in its own legislation (Rosenqvist 1974; Hakkarainen 1992). Drug use was considered a medical problem requiring only some specific measures from the health care system.

As in other Western countries, the Finnish drug scene changed dramatically in the 1960s (Hakkarainen 1994). The non-medical use of drugs among the younger generations increased rapidly, and marked the emergence of a totally new pattern of drug use. The most typical drug in this new pattern of use was cannabis. The misuse of medical drugs and the inhalation of chemical solvents increased too. Other popular drugs used were LSD and amphetamines. The new users emphasized the psychoactive effects of drugs and the symbolic meanings of their use. Especially cannabis and LSD were ideologically connected with the protest movements of the

1960s, which challenged middle-class values and life-styles. A drug market based on smuggling also emerged. This was the background to a process of collective definition where drug use was considered a serious national problem, requiring for the first time the extensive mobilisation of Finnish society. This national process of problem definition, which started in the 1960s and culminated in the 1972 Narcotics Act, is the central landmark in the construction of current drug policy in Finland.

Another event of great importance in the construction of Finnish national drug policy was the 1994 law reform. In this paper I shall firstly study the definitional processes behind these two important events - the legislation contained in the 1972 Narcotics Act and the 1994 law reform. I shall look at how these processes started and progressed, how the drug problem was defined, and who acted as claims-makers behind competing claims. Secondly, I shall survey the role of drug education and drug treatment within Finnish drug policy. Finally, I shall consider in more detail the central claims-makers and the competition over ownership of the drug problem. As data I shall use parliamentary records, governmental drug policy programmes, expert committee reports, statistics, research reports and mass media data.

2. The 1972 Narcotics Act: The Formation of a Prohibitionist Drug Policy

As already mentioned, the Finnish drug scene and the construction of a national drug problem underwent a total change in the 1960s. The process of defining a new drug problem started first in the mass media in the mid 1960s. It is interesting to note that individual citizens had an active role in paying initial attention to the problem. The writers of the first articles concerning the use of prescription pills among youngster groups mentioned that they had had many phone calls from parents and other adults concerned about the situation. The public asked the press to pay attention to the issue. However, society's recognition and legitimation of drug use as a social problem was not an easy process, but one of struggle and conflict.

After the first few articles, the media - especially the press - took the role of an active claims-maker in the construction of the drug problem. The press began to publish a growing number of articles and reports on drug use among young people, claiming that drug use should be recognized as a se-

rious social problem within Finnish society. At first the national authorities had reservations. Representatives of both law enforcement and social and health care claimed that, as there were no drugs on the streets, drug use in Finland was only an insignificant and marginal phenomenon, and warned that the press was exaggerating the problem. However, the media, which was behaving like a moral entrepreneur, pushed its point in spite of resistance from the authorities. Some young journalists went out onto the streets and bought hash, and ridiculed the authorities for not knowing the real situation. The mobilisation of action started when the Narcotics Drugs Committee was appointed by the Cabinet in 1968. When the Committee confirmed that drug use among the young - a phenomenon known all over the Western world - had got a footing in Finland, it proposed new legislation. By the end of the 1960s drug use had achieved a recognized and legitimate status, even among the authorities, as a social problem within Finnish society.

General understanding about the need for new narcotics legislation was reached among the relevant social actors at the beginning of the 1970s, and in October 1970 the government put a new Narcotics Act before parliament. In addition to the national requirements, the government's proposal reflected the need for better application of the International Narcotics Conventions (especially the Single Convention, Vienna, 1961) and for better standardization of Nordic criminal sanctions.

There was a fierce political debate in parliament about the government's proposal. It is interesting that parliament took a very active role in defining drug policy and changed the government's proposal in many respects. For instance, parliament agreed that the maximum punishment for a narcotics offence should be increased from the proposed 6 years imprisonment to 10. The most debated subject in parliament was the question of defining the concept of a "narcotics offence". There was common consent that the preparing, producing, dealing, selling and buying of narcotic drugs as well as their possession should be criminalized and included in the concept of a narcotics offence. In spite of this, there was great disagreement about the definition of "the use of" narcotic drugs. According to the government's proposal, the use of narcotics as such would not have constituted a criminal offence; however, parliament's Ordinary Law Committee recommended criminalization. The Finance Committee supported the government's stand, whereas the Grand Committee - after drawing lots - decided to support criminalization. In the crucial vote, the government's proposal was defeated

by a vote of 92-80, and the use of illegal drugs was defined as a narcotics offence.

The act laid down two years imprisonment as the maximum punishment for drug use. The idea was that this would give the police authorities full arresting powers to intervene in the use of drugs. Parliament argued that in practice the use of narcotics should be punished with a fine, or not punished at all. However, when implementing this plan of action, law enforcement took a somewhat harder line than parliament had intended. Prosecutions for the use of drugs had nearly always led to a fine. The number of cases in which prosecution was waived decreased considerably after the first years of the 1970s (Kontula 1986, 158-161).

It can be said that the criminalization of drug use emerged as a key question determining the dimensions of the struggle between different claims-makers in the construction of Finnish drug policy. In parliament, opinions about the criminalization of use were clearly divided along the axis between the political left and right. The left opposed criminalization, and considered the narcotics problem a consequence of other social problems. In addition they argued that drug use should be considered a disease rather than a crime: the individual drug user should be seen as a sick person needing treatment and rehabilitation. The solution to the problem could therefore be found in social reforms and better treatment systems. Supporters of criminalization saw that the reason for the drug problem was young people's curiosity and wish to experiment, and an atmosphere sympathetic to drugs. The political right and centre stressed that parliament should clearly show young people that society does not accept drug use. The criminalization of use was seen as *a preventive measure* of great importance. It was believed that the threat of punishment would deter people from experimenting with drugs.

However, more obscure implications were also involved in the background to the debate. Enactment of the act took place at a time of political tumult within Finnish parliamentarism. The fact that an election was approaching further polarized the political contest between parties, and the narcotics question took on a symbolic significance: drug liberalism and opposition to the prohibition of drug use were associated with leftist policy. The drug problem was also presented in a more general context of social change. In particular, when the Narcotics Act was taken together with the liberal attitudes reflected by the earlier Alcohol Act and Abortion Act, criminalization became a symbol associated with the moral direction being

taken by society. Those who supported criminalization thought it time to reject excessive liberalism and to point out to young people the border between acceptable and unacceptable behaviour. Drug use was defined primarily as *a youth problem*. The aim of criminalizing drug use was to control the behaviour of curious and experimental young people.

If we consider the claims of the different professional experts invited to the hearings of parliamentary committees, we can state that all the various police authorities argued strongly for the criminalization of drug use, while medical professionals and authorities were divided on the matter: some argued for criminalization, and others against. The enactment of the 1972 Narcotics Act can be said to have enhanced the importance of law enforcement. The drug issue was seen as *a law and order problem*, rather than a public health or medical problem. The model of control policy chosen was a model of criminal justice. The main responsibility for containing the problem shifted from the medical professions to the police authorities.

3. The Law Reform 1994: From Juvenile Delinquency to Professional Crime

The latest definitional process of great importance in the construction of Finnish drug policy is the 1994 law reform. The government's proposal for the reform was put before parliament in 1992. It had been prepared by the expert group for narcotics crime, working within the framework of the penal code reform project set up by the Ministry of Justice. In 1993 the proposal was debated and dealt with in parliament, and the act came into force at the beginning of 1994.

There were two specific, different motives for the reform. First, a total reform of the country's penal system was being carried out, and the intention was to review the provisions of the separate Narcotics Act and include them in the new penal code. The government's proposal argued that drug crime must be seen as a central feature of the criminality of our time. This is a very interesting definition. It reveals that the drug problem had reached a more legitimate status in the field of criminal policy than it had before. The core of drug crime is now seen as a professional enterprise rather than juvenile delinquency.

The second central basis for the reform was the accommodation of the Finnish legislation into the new international agreements. It was thought that ratification of the Vienna Convention (Convention against Illicit Traf-

fic in Narcotic Drugs and Psychotropic Substances, 1988) presupposed especially that provisions concerning the preparation and promotion of narcotic offences would be added to the Finnish legislation. According to the Vienna Convention, money laundering would also be criminalized. Legislation which would make money laundering a criminal offence was presupposed also by the EU directives included in the EEA (European Economic Area) convention, which Finland was about to ratify. Provisions concerning money laundering and the preparation and promotion of narcotic offences were voted through parliament by a large majority. This decision strengthened the definition of the drug problem as one of professional and organized crime with tempting economic interests.

I think we can conclude that *a transformation from the problem of juvenile delinquency to the problem of professional crime* can be seen in the construction of drug policy in this law reform. However, the old Narcotics Act was still considered a very important preventive measure, and there was a colourful debate about the criminalizaton of drug use at this time too. The expert group which prepared the reform of the Narcotics Act proposed that the maximum penalty for the use of drugs should be reduced from 2 years imprisonment to a fine (Huumausainerikokset 1991). The group recommended that, in practice, prosecution in cases of drug use should be waived. When the group delivered its proposal to the Minister of Justice, she immediately declared in front of TV cameras and other mass media that under no circumstances would she consider presenting such a proposal to the Cabinet. According to the minister, the expert group's proposal would send the wrong message to the world. Reducing the penalty for the use of drugs would give the impression that Finland was changing the course of its drug policy in a more tolerant direction. The Minister of Justice argued that this kind of message would encourage youngsters to experiment with drugs and stimulate the interest of foreign drug dealers in the Finnish drug market.

The expert group's proposal was sent back to be proposed again. In the government's proposal to parliament the penal scale for drug use was restored to its former condition, as laid down in the 1972 Narcotics Act. In parliament, the government's proposal was criticized because, for instance, the proposed penal scale for drug use would deviate from the normal practice followed in the penal code reform (written provisions should correspond with the penal practice followed in courts). However, the public's view of the law reform as a symbolic message guided the debate in a cer-

tain direction. Supporters of alternative proposals faced an impossible task when they tried to explain that their proposal was not a welcome message to drug dealers and new drug users. The frustrated chairman of the Ordinary Law Committee claimed that the widespread publicity which appeared during the preparation stage of the reform had caused a severe "disturbance" in the treatment of the reform in parliament. Proposals for reducing the penal scale for drug use were labelled by the mass media as "wrong messages". Juridical and other considerations were subordinated to the politics of image. The minister had succeeded, in collaboration with the media, in arousing a kind of moral panic over the symbolic message contained in the law reform.

The statements of the experts and authorities invited to the hearings of the Ordinary Law Committee can be divided into three groups: claims for the decriminalization of drug use; claims for reducing the penal scale for drug use, as proposed by the expert group; and claims for the scale to remain unchanged, as proposed by the government. The government's proposal got the strongest support from the police authorities, the temperance movement and organizations for the parents of drug users. It was also the stance adopted by the majority of the Committee members.

During the plenary sessions of parliament, not one representative proposed the decriminalization of drug use. The best result for the proposals suggesting a reduced penal scale for drug use was a vote of 63-200. It is interesting to note that opinions were once again divided along the usual political lines. Most representatives of the political left, and the Greens as a whole, supported a reduced penal scale. However, a clear majority voted in parliament for the government's proposal. It was commonly believed that the prohibitionist drug policy followed for years had been the right one. The government's proposal stated that, as a user- rather than a producer country, Finland's duty in the international struggle against drugs was to try to effectively diminish the demand for drugs among the Finnish population. The government's stance adopted in parliament, although keeping the penal scale for drug use unchanged, deviated from the normal practice in the penal code reform. Thus, because of the politics of image, narcotics legislation got special treatment as a preventive measure in the penal code reform.

Another topic widely debated in parliament was a provision allowing prosecution to be waived in circumstances where a drug offence is only a slight one and does not reduce general obedience to the law, or when a person who has committed an offence can show that he or she has begun

treatment at an institution recognized by the Ministry of Social and Health Care.

The most debated subject in the discussion was the definition of a "slight" drug offence, an offence involving either use or possession of drugs which - according to the government's proposal - should not result in a charge. Examples of "slight" drug offences given in the government's proposal were an adult using drugs at home or a small group of regular users using drugs at somebody's home. These examples were strongly criticized by the representatives of the conservatives and the political right (the Coalition Party, the Finnish Christian League and the Finnish Rural Party), who argued that they would be disastrous for police work and, in their extreme form, allow the establishment of "opium tents" in Finland. Activists from parents' organizations lobbied enthusiastically in the corridors of parliament in support of this criticism. However, the proposed amendments to the government's proposal were rejected in parliament by a great majority. It was believed that prosecutors are capable of finding the right interpretation in the implementation of the provisions of the law reform. Thus, this can be seen as strengthening the prosecutors' and courts' powers (of discretion) over those of the police.

Provision concerning the displacement of punishment by treatment was adopted in parliament by common consent. I think this can be seen as a step

Figure 1: Social Construction of the Drug Problem and the Drug Policy in Finland

	Definition of the Problem	**The Course of the Control Policy**
1900 -	Medical problem	**Medical control** (doctors, prescriptions, sale bans and treatment)
1972 -	Juvenile delinquency	**Criminal control policy** (police, criminal code, prohibition, criminalization of drug use)
1994 -	Professional crime	**Criminal control policiy** (criminalization of money laundering etc., substitution of treatment for punishment, methadone maintenance

toward a policy of harm reduction. It is perhaps the case that *the construction of the drug question as a problem of professional crime led to drug users who commit small-scale offences being considered victims of economic interests, and thus to making it possible to take this step toward a policy of harm reduction.* The changes in the construction of drug policy are summarized in Figure 1.

4. Drug Education and Treatment in the Finnish Drug Policy

The cornerstone of the national drug policy, as stated in Finnish governmental drug policy programmes, is to maintain attitudes unfavourable to drug use among the population. We have already seen that the criminalization of drug use is considered an important step towards achieving this aim. Another important measure is drug education, especially that given in schools by teachers and police officers. Organizations for the parents of drug users have also been very active in the field of drug education.

As regards treating drug users, the emphasis of the policy has clearly been in the general public health and social services. Some specialized services for drug users were established in the beginning of the 1970s, but these were reduced because of the lack of patients in the middle of that decade. Since then, the official treatment policy has been that we do not need specialized services for drug users in Finland. In addition to the lack of patients, another argument for the policy has been that specialized services would institutionalize the drug problem as a special kind of sickness within the health care system and strengthen their clients' identity as narcotics addicts.

It is a commonly held belief among public health and social services authorities that the basic characteristics of drug addiction are similar to those of other addiction problems. So, it has been seen that if drug users are in need of specialized services they could be treated within the extensive alcohol treatment system (Kinnunen et al. 1995). A special feature of drug treatment in Finland is that the borders between the use of illicit drugs, alcohol and licit medicines are often confused. It is estimated that annually ca. 10 000 persons seek treatment for a drug problem and that 90% of them are multiple drug users (Nuorvala & Lehto 1992). A mixed use of alcohol and psychoactive medicines is the most typical case. The number of hard drug users is somewhere between 1000 and 2000 persons. The confusion

over the borders between different kinds of drugs has also supported the argument in favour of the alcohol treatment system.

However, a definition of drug users or drug addicts as persons demanding specialized drug treatment services has gained some footing since the mid 1980s. Some drug treatment units have now been opened, and it is obvious that there is a real need for them. The utilization rate of the beds in the specialized units has been very high (ca. 90%) (Hakkarainen & Kuussaari 1996). Today even those responsible for treatment policy agree that - in addition to the general public health and social services, and alcohol sanatoriums and A-clinics - specialized treatment units for drug users should be provided (Lehto 1992). Even the setting up of methadone treatment centres has been under serious consideration since the beginning of the 1990s (Hakkarainen & Hoikkala 1992; Opioidiriippuvaisten ... 1993).

Until now, the organization of treatment for drug users has been weak and confused (Kinnunen et al. 1995; Hakkarainen & Kuussaari 1996). The role of the treatment system in the general drug policy has been subordinated to the criminal control policy. However, as noted, in the latest development in the definition of the drug problem and the construction of drug policy, some signs of a strengthening in the status of the treatment of drug users can be seen.

5. Ownership of the Drug Problem

As we have seen, *the mass media* have played an important role in the construction of the drug problem and drug policy in Finland. In the 1960s, the media pushed its claims for the recognition of drug use as a social problem in spite of the strong resistance from the authorities. In the 1990s, it created a moral panic over the law reform's message. In addition, the mass media has continuously reported the development of the drug situation, and it is obvious that the drug problem is one of its favourite subjects. However, in the light of a comparative study carried out in the spring of 1990, newspapers in Norway, Sweden and Denmark appeared to write more about drugs than those in Finland (in Norway, even twice as much as in Finland) (Skretting et al. 1994).

One central feature in the construction of a social problem in the mass media is that editorial staff act as gatekeepers of public discourse rather than as moral entrepreneurs. As gatekeeper of the public discourse, editorial staff have the power to select whose opinions get the best coverage. On

the other hand, the media is dependent on its sources, and especially on the expertise of those sources. And, of course, the claims-makers are also interested in trying to use the mass media strategically for their own purposes in the construction process of a social problem. Let us look at this interaction between journalists and their sources more closely. The following table shows the central claims-makers of the drug problem in newspaper coverage during 1966-88. All the experts on domestic drug problems cited in the articles included in the newspaper collection of the Library of the Finnish Alcohol Monopoly (N= 3501) have been classified into different categories of claims-makers.

Table 1: Proportions (%) of the different claims-makers in newspaper coverage of drug issues in 1966-1988

Experts	**1966-1972**	**1973-1983**	**1984-1988**
Police	27	54	34
Customs	4	7	3
Justice	2	8	2
Health care	23	7	19
Pharmacy	1	1	2
Social care	22	8	10
Education	2	1	-
Temperance	1	2	2
Research	8	6	8
Parents org.	-	-	9
Politicians	1	2	3
Foreign exp.	3	-	-
Drug users	1	2	2
Other	5	2	6
	100 (261)	100 (230)	100 (491)

Source: Hakkarainen 1992

According to the table, in the newspapers the most visible claims-makers in the construction of the drug problem have been the police authorities and the representatives of social and health care. *Researchers* with expertise in scientific research have had a minor but rather steady share of the coverage. *Two organizations for the parents of drug users* have emerged as the strongest grassroots claims-makers since their establishment in the 1980s.

The emotional expertise of the parents has been given remarkable coverage in the media. Parents have been especially concerned about the lack of treatment possibilities. In the media, the mothers of drug users have told touching stories about the difficulties of finding appropriate treatment for their drug-using children. In addition to their activity in the arenas of the mass media, parents' organizations have created direct contacts with members of parliament, making claims especially for methadone treatment and the compulsory treatment of under-age drug users. Although not revealed by the table, drug users (cannabis smokers) founded in 1991 the Finnish Cannabis Association, an association for the decriminalization of cannabis use. The association publishes a biannual magazine and has had some of its statements printed in newspapers, but has not been accepted by the official Finnish Association Register.

Although *the police*, the most dominant claims-maker in newspaper coverage, ignored drug use as a social problem in the 1960s, they no longer do so today. Along with the specialization and institutionalization of the narcotics police, the role of the police authorities has changed from a reserved social actor to an active claims-maker presenting regularly in the media its views about the development of the drug situation. Naturally, representatives of the police have a legitimate place on every official expert committee considering drug policy, and are habitually heard in the hearings of parliamentary committees concerning drug issues. Thus, the police can work as a definer of the problem and policy in many different arenas. Representatives of the police put themselves forward as experts on crime and street life in the public discourse.

Representatives of the health care and medical professions, who are also important claims-makers in the public discourse, have special expertise concerning the effects of drugs, the consequences of drug use, and the treatment of drug users. Among medical professionals, drug use is typically seen as abuse and disease. Because of the Finnish system, *representatives of the social services* also have great expertise in the treatment and social rehabilitation of drug users. In the views of the social welfare authorities, drug use has been seen typically in the context of other social problems.

Thus, different kinds of claims of expertise are involved in the struggle over the ownership of the drug problem. All the central claims-makers have their own special competence area and strength. However, it can be stated that, because of the prohibitionist drug policy, the expertise of the police is the most valued and powerful in the public discourse, and in the construc-

tion of drug policy. As stated elsewhere (see Kasinsky 1994), the police with their expertise in crime and street life are the public's primary definers of crime and its control.

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The Case of Compulsory Drug Treatment – Construction of Drug Policy in Denmark

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In 1992 the Danish Parliament passed a bill on the detention of drug addicts in treatment centres. This bill permits the limited use of compulsory treatment.

The possibility of using compulsory treatment was a decisive departure from the principle of voluntary treatment that had been the cornerstone in the treatment of addicts in Denmark.

Since the middle of the 1970s the most controversial subjects in the Danish debate on drug policy have been the principles of treatment together with the level of sentences for using and trafficking in illicit drugs.

Throughout the 1980s the principle of voluntary treatment was generally agreed upon. Thus, during a general debate on drugs in 1979, the Social Democratic Minister of the Interior and Justice, stated that

> "the treatment of drug addicts must be based on voluntary treatment, realising that it is impossible to make people change their aim and way of life by using compulsion. Consequently the cooperation and motivation of the drug addict is essential to the treatment". (Report of Parliamentary Proceedings, The Parliamentary Debates 1979/80, page 1181 ff.).

During a similar debate in 1984, the Conservative Minister of Social Affairs, representing the political opposite, shared this point of view, though he had a more varied attitude towards compulsory treatment.

> "Situations might occur in which the addict probably would benefit from more vigorous measures to make him stay in treatment. Nevertheless, I must conclude that compulsory treatment is an unacceptable principle". (Report of Parliamentary Proceedings, The Parliamentary Debates 1983/84, 5838).

At the beginning of the 1990s the debate on the treatment of drug addicts turned radically away from the dominant agreement on the principle of voluntary treatment. Various quarters demanded compulsory treatment, specifically referring to the experiences in Sweden.

The purpose of this article is to unveil how this change in an important part of the drug policy was constructed and, more generally, to synthesise the experiences of how a national drug policy, specifically that of Denmark, is constructed.

The empirical sources on which the conclusions of this article are based include mainly media material, primarily from the daily press. On that basis an attempt is made to analyze how the process of construction behind the "Act of compulsion" proceeds, and how different actors in the field of drug policy try to influence this process.

The debate on drugs has a tendency to flare up suddenly. This is probably due to the moral character of the subject, a view well supported by numerous analyses and studies. In a society in which a lot of other social affairs are based on modern rationalism, this accounts decisively for the fact that the drug debate is filled with mythology.

The illegal character of drug taking, the control system, the arguments of other professional actors as to how dangerous drugs are, and the ignorance of the large majority of the population as to the drugs and the lives of the drug addicts, are all elements which through the media form conceptions and pictures including mythical parameters.

You may add to the theme the famous thesis of Bruun and Christie describing drugs as the good enemy - which means that a given drug discourse serves any other purpose than that of a rational and applied effort to minimise the harm related to the use of mind-expanding drugs (Bruun/ Christie, 1985). From that perspective the domain of drugs seen as a public phenomenon of politics provides some interesting research fields, especially the interaction between the media debate, the political and administrative process and a given drug policy.

Theoretical Perspective

The theoretical basis behind this work is constructionism and discourse analysis. The main attention of constructionism is directed towards the definitional processes, in which a social condition is turned into an institutionalised social problem.

More specifically, the scientific interest is directed towards the mechanisms of the construction of social reality and different actors participating in this process. This activity is called claims-making, while actors are called claims-makers (Spector/Kitsue, 1987).

The constructionism consists of several schools. The so-called strict constructionist approach has been heavily criticised. The criticism has drawn attention to a tendency in strict constructionism to treat the factual conditions as constant, and only the definitions as varying (Laursen, 1994).

The problem can be considered serious, and constructionists have made attempts to find a solution. The solution has been called contextual constructionism (Best, 1989), which this work finds useful. According to this, one should recognize and investigate conditions regulating the claims-making activity. Statistical indicators of the drug problem could be such conditions. Actors' statements and claims can, and should be, discussed on the basis of all information sources available, i.e. statistics and other public records. They should of course be treated as social constructions, but by using them, the claims-making activities can be placed within their proper social context.

Constructionism has been both researched and submitted to debate by Bourdieu, this being of great importance to this work as well (Bourdieu, 1990; Bourdieu, 1984). His concern is to exceed the contrast between subjectivism and objectivism, which are the philosophical pillars of both constructionism and its sociological contrast - structuralism. Bourdieu distinguishes between structures and representations. He establishes the fact that the objective structures, such as statistics of drug abuse, are constructed by disregarding the subjective representation of the actors, e.g. the demand for a specific drug policy. These structures form the basis of representations or demands, and determine the structural forces which influence interactions. On the other hand Bourdieu points out that the representations have their (own kind) of force, and that their aim is to change or preserve structures (Bourdieu, 1990).

The usability of the discourse analysis, constituting the second part of the theory, is to unveil the mechanisms behind this claims-making activity. In the discourse analysis the hidden dependence behind the visible expressions, for instance in the political and ideological debate, are analyzed.

Discourse analysis in this work is primarily based on Michel Foucault (Foucault, 1973; Foucault 1977a; Foucault 1977b; Marti 1988). A dis-

course is a relatively bounded set of arguments, organised around a specific diagnosis of and solution to some social problems.

Discourses are situated within a field of debate, wherein speakers struggle with one another to establish meaning, earn legitimacy and mobilise consensus on belief and action. One of the common modes for speakers is to structure their discourses around various sets of poles, that condense what the debate is about, what can be discussed and what problems can be addressed.

Fields then become primary sites of contention, where competing speakers battle over which poles will govern debate, because control over them enables some speakers to set agendas and guide the direction and content of debate.

It is important to note that the discourse is not dealing with an object; if anything, it is producing its own object. Traditionally, discourse analysis concentrates on the discussion and not on the participants.

However, one should consider essential both the actual discourse and the participants in the discourse. Thus, those to be brought into focus are the actors as speakers in the discourse and those from a group of actors, who turn into agenda-setting actors.

The mass media play an essential part in the total group of actors in the drug policy debating field. Above all, the mass media are setting the agenda. Mass media engage in structuring and "sorting out" reality for us.

This is an important part of their influence as agenda-setters and opinion-makers. It is not certain whether they succeed in telling us exactly what to think about a particular problem, nevertheless, they largely succeed - as Eide and Hernes put it - in telling us what is important, what should be discussed, what is a problem or what states of affairs require social and political action (Eide and Hernes, 1987).

On this theoretical basis the process behind the development of the "Act of detention" will be analyzed.

Background

The debate on compulsory treatment, which started in January-February 1991, was based partly on a police action taking place in an area of Copenhagen, called Vesterbro, and partly on the foundation in December 1989 of a private treatment centre, named Egeborg, which is based on the Minnesota model and situated on one of the many Danish islands, Lolland.

In August 1990 the Copenhagen police started the action on Vesterbro with the declared intention of cleaning up parts of the town by dispelling the drug addicts and traffickers to other areas of the town. In a relatively short time an "open drug scene" - which is characterised by many social problems- had sprung up in this part of town. At the request of, among others, the shopkeepers, the catering trade, the hotels and the tenants' associations the police now began breaking up this drug scene.

From the very beginning the police pursued a very active media strategy, using among others the television news.

In connection with the Vesterbro action the Minnesota treatment centre initiated a cooperation with the police. By means of the contact that the police had with the drug addicts on Vesterbro, patients were drawn directly to the centre. The treatment centre was just as active in its contact to the media as the police were. Demonstrations in front of the Copenhagen Town Hall were organised by former, now clean, drug addicts.

It was no mere coincidence that the demonstrations took place in front of the town hall, nor was the cooperation between the police and the treatment centre. Both parties had and have a very critical attitude towards the way the local authorities in Copenhagen treat drug addicts, as it is considered very soft.

In the summer of 1990, the Egeborg treatment centre pressed the local authorities in Copenhagen to pay for the treatment of their drug addicts in the centre, even if they had not been sent to Egeborg by the local authorities, but rather as a result of the cooperation between the police and the treatment centre. The city agreed to pay for the treatment for a three-month trial period staring on 1 September 1990. This date is of great importance, because it coincides with the implementation of the police action on Vesterbro and the cooperation between the police and Egeborg.

In the following a closer look at the discourse on compulsory treatment will be taken, especially on actors and their arguments which dominated the construction of the new treatment policy. The discourse can be divided into three stages.

The three Stages of the Treatment Discourse

The newspapers, radio and TV form the most important battlefield for the different actors as they try to place themselves/create their image in the public debate. The news coverage of the events on Vesterbro from the

summer of 1990 till the turn of 1990/1991 was sporadic and characterised by frequent reports, in which the police were the most important agenda-setting actor .

At this stage, the media - providing the arena - and the police - as the visible and active party - were almost the only actors taking part in the discourse. The subject was the police work and possibilities of control in the streets while the Vesterbro action was going on. The question of treatment was hardly mentioned in the media and nothing in the public nor the political debate indicated that compulsory treatment was a topic of discussion.

On 1 January 1991 the trial period expired as to treatment at Egeborg paid for by the local authorities. The City of Copenhagen decided not to pursue the cooperation with Egeborg, mainly because of a critical official report which characterized the methods of treatment at Egeborg as similar to compulsory treatment. Upon this announcement the situation exploded, and all the rules of establishing a new discourse were set to work.

The object of compulsory treatment was created in the process, which thus was started. In the middle of February the discourse on compulsory treatment was fully established, and linked to the policy process. The following analysis examines the part played by the media during the development of the discourse on compulsory treatment.

In addition, the strategy of the drug policy actors at this stage of the discourse will be illuminated. The empirical foundation comprises cuttings from four national newspapers[1]. The material covers all statements on the subject of compulsory treatment in these papers in the period from 25 December 1990 to 15 February 1991. Thirty-seven cuttings were collected, and their content was analyzed, concentrating especially on the most important agenda-setting actor mentioned in each cutting. Subsequently they were divided into three groups representing the three stages of the discourse.

The first stage covers the period from the last weeks of December 1990 until the middle of January 1991. So far the journalistic actor was still covering and presenting the views of other drug political actors. In particular the media stressed the methods of the treatment centre, which consistently were construed as compulsory treatment, and the press coverage was almost unambiguously positive. However, referring to the situation on

[1] The four national newspapers are "Politiken" (a large social liberal daily), "Morgenavisen Jyllands-Posten" (a large liberal-conservative daily), "Det Fri Aktuelt" (a minor social democratic daily) and "Information" (a minor radical democratic daily).

Vesterbro, representatives of the police were among the first to demand compulsory treatment. In the daily papers they attacked the principles of voluntary treatment and the therapists.

The deputy director of the Copenhagen police force, Anne-Mette Møller, told the daily Det Fri Aktuelt:

> "The overwhelming majority of the drug addicts whom we meet on Vesterbro receive treatment, nevertheless they are buying drugs. We must admit that the well-known treatment methods and systems are inadequate. It is time that we set aside the flabby humanitarianism and start the discussion on compulsory treatment." (Det Fri Aktuelt, 4 January 1991).

The director of the Drug Information Bureau of the National Police Force, Mogens Lundh, told the daily Morgenavisen Jyllands-Posten:

> "For 20 years the police have saved more drug addicts from dying than the treatment authorities have. Constantly approximately 1000 drug addicts are imprisoned, but this is compulsory detoxification in a negative sense ... They (the therapists) experience a kind of threat as the attitude towards compulsory treatment is changing. It is a question of ideology.The principles are influenced by the era of 1968. After 20 years they must acknowledge that this is the wrong method. It is a bitter pill to swallow, but we never were in doubt." (Morgenavisen Jyllands-Posten, 9 January 1991).

These two important statements, which were both placed in central positions in the newspapers (i.e. on the front pages as top stories) became essential as agenda-setters for the coming policy-making process. They unambiguously claimed that the use of compulsion in treatment would solve the problems which the police met in the streets of Vesterbro.

At this stage the politicians played the obtrusive part, catching the signals from other actors. Some politicians rejected the principle of compulsory treatment, some subscribed to "compulsory treatment on a voluntary basis", while others fastened on to the necessity of a debate on the subject. When the Minister of Health summoned the Ministers of Social Affairs and Justice to explore the possibilities of legalising compulsory treatment, the legal and political process slowly began.

At this stage therapists and officials in the public treatment system maintained a remarkably defensive profile. They are important actors too, and are often considered to be the institutional opposite of the police. On the few occasions when therapists, such as physicians with a wide experience in treating drug addicts, had the opportunity to criticise the compulsory treatment, their views were placed rather unfavourably - at the end of

the articles. They never played an active part in the media subject to investigation.

The first stage was over by the middle of January, and the second stage started. This stage, being rounded off in the beginning of February, was characterized by the dispute over payments between Egeborg and the local authorities of Copenhagen. The latter finally gave notice that they were terminating the agreement with Egeborg; however, this notice did not stop the police from establishing contact between drug addicts and Egeborg. A leading police officer from the Copenhagen police force, Vagn Ludvigsen, stated:

> "We will continue to establish contact with Egeborg, until we are asked to stop." (Information, 18 January 1991).

Now the debate concentrated on ends and means in the treatment, on expenses in both the public and the private system and on results in the form of cured drug addicts. The professional therapists in the public treatment system were much more active at this stage. Contrary to the first stage, the press presented substantially more views on treatments.

In the total picture of the actors, some of the changes seem to be of great interest. At this stage a number of life stories from addicts appeared in the press, along with statements from relatives of drug addicts, primarily from groups of parents. Contrary to the very active part played by the police during the first stage, they now seem to have dropped out of the picture. In the same way, politicians' discourse disappeared. The media, which previously had stood back, leaving room for other actors, now actively started formulating political views in their leader columns.

The third stage, which started at the beginning of February, marked the change to a more traditional phase. The main question of the debate was no longer compulsory treatment or voluntary treatment. The trend was now to clarify how the compulsory treatment of addicts should be implemented. Above all the trend was set by the Minister of Health. After the above-mentioned joint meeting with the Ministers of Social Affairs and Justice, she announced that the government had agreed to introduce a bill on the compulsory treatment of drug addicts. Government officials would begin drafting the bill, which should be based on voluntary treatment under a contract. At the same time the great majority of the Danish parliament agreed with the intentions of the government.

Not until this late stage did treatment personnel and other experts in the treatment field began to express their doubts about the prevailing ideas.

Consultant Peter Jepsen, from the Copenhagen outpatients clinic for drug addicts, commented on the bill for compulsory treatment "on a voluntary basis":

> "A legislation concerning compulsory treatment 'on a voluntary basis' should be carefully prepared, because the voluntariness forms a problem. (...) A drug addict is not free when he or she makes such a contract. Drug addicts only ask for treatment when everything crashes, and they cannot cope with their lives. Under those circumstances drug addicts are willing to accept almost any demand - just to get treatment. Consequently it is not a contract on a voluntary basis." (Information, 11 February 1992).

During this third stage new aspects which had germinated during the previous stages began to appear in the total media picture. It was during this third stage that the press in its leading articles actively tried to influence the coming policy. In this the papers grouped partly according to their declared political and editorial line, and partly in accordance with the subsequent results of the vote in parliament. Both spokesmen and sceptics as to the compulsory treatment had their mouthpieces and media support, outlining at the same time the ideological differences in the attitudes towards drug addicts and their treatment. Morgenavisen Jyllands-Posten - which during the first stage had printed in prominent places the police demand for compulsion - said in a leading article:

> "To all appearances it turns out to be 'compulsory treatment on a voluntary basis' - (...) drug addicts are not in a normal situation - owing to their abuse they have lost the ability to make a free and independent choice (...) unfortunately, experience shows that the afflicted drug addicts are unable to cope with their own situation. They are so addicted to the dangerous drugs that they need some assistance to quit their abuse - even if it means that they to a certain extent are declared incapable of managing their own affairs." (Morgenavisen Jyllands-Posten, 10 February 1991).

The daily paper, Information, was the mouthpiece of those sceptical about compulsion. In a leading article, the newspaper took the following view:

> "If compulsion becomes the new wonder cure to save citizens forming the less decorative part of society, the treatment of drug addicts in Denmark will be a disgrace. Feeling powerless in the face of the drug problem, it is of course a measure which immediately suggests itself. However, in the present circumstances most of treatment personnel reject the idea of compulsion. A drug addict will not become clean unless she or he is motivated to do so." (Information, 11 February 1991).

The issue of compulsory treatment disappeared from newspaper columns almost at the same time as the legislative drafting of the bill was started.

During the political process, the work of parliament was not reflected to any appreciable extent in the papers until the following year, when the bill was passed, either during the introduction of the bill nor during the readings. Obviously it was solely due to the comparative consensus on the special Danish compromise concerning "compulsory treatment on a voluntary basis". The compromise already appeared in the opening of the public discussion, but on the other hand it might only reflect the function of the mass media as the agenda setting force.

Discussion

The discourse on compulsory treatment passed through three stages, which have been illustrated by material collected from the press. The nature/character and the central points of the discourse during the three stages have been changed by the contact and function of the statements made by different actors.

The first stage was the important agenda-setting stage, during which the idea of compulsory treatment was created and brought up for discussion. At the same time, it was the real policy-making stage.

The special Danish compromise concerning compulsory treatment on a voluntary basis was reached, and the guidelines/framework of the discourse were given. At this point it was decided what could be said and what could not be said during the discourse, among others that the Swedish model for compulsory treatment was useless and therefore was not to be introduced in the debate. This was definitely confirmed by the subsequent legislative work.

It should be emphasised that it was not a question of compulsory treatment in the traditional sense. The intention was to keep drug addicts in treatment on the basis of a contract, into which they enter voluntarily. Within this framework the second stage developed into a policy cementing stage, which evaluated the previous proceedings and assessed the possibilities of the given framework.

The third and last stage was characterised both by the conclusion of the ideological policy-making and by the development of a more specific policy. The last statement alludes to the fact that some of the ideas, which later became more crucial issues, were discussed rather intensely during the legalising work. For instance, the practical aspects of detention, questions concerning the rule of law and economic conditions for this kind of treatment.

The actors in this discourse can be divided into two groups: the mass media as an important arena of the discourse, and the other actors as institutional or personal participants regarding the problems and control of drugs.

In the discourse on treatment, the police force was the important agenda-setting actor, and thus providing the main framework, it defined the further development. The police force was the real policy-making actor. Based on Gusfield (see Introduction by Hakkarainen) it might be said that the police successfully defended their ownership of the drug problem as a public problem. This occurred in interaction with the press, which in the main passively left room for the formulation of the policy.

During the subsequent stages, the rest of the actors occupied positions farther down the hierarchy. Politicians, for instance, played the role of picking up the signals. The treatment personnel were unintentionally the policy cementing actors, who were restricted and impeded by the framework of the discussion. During this process, the status of the mass media changed from a passive to a more active part, presenting their independent and institutional practice. Thus, the mass media indirectly stabilised the discourse.

What is the purpose of the discourse analysis? First it may expose the mechanism behind the construction of the drug policy in general and the individual parts of it. Secondly, it may qualify the debate.

The debate originated from a basis outside the treatment sector and complexes of problems related to this. The debate emanated from the new policy strategy, consisting of increased street control and the removal of addicts from a district of Copenhagen which has many social problems.

It will be difficult for the individual actors to act objectively on the problems, if they have neither insight nor any recognition of the interaction between the origin and the development of the discourse.

Similarly, they will have difficulties in adapting their own views to the debate strategies of other actors. It may increase the actors' reflections on their own role and views, and thus the analysis of the discourse may improve the argumentation in general.

Naturally, this is not the only purpose. The achievement of the purpose depends on the use of the discourse analysis. From their own intentions, all the actors may use their knowledge of the discourse process to cement and establish their identities as framework authorities.

This takes us to the another central point. Why was the demand for compulsory treatment constructed? Based on the former theoretic comments on the dialectics between objective circumstances and the construction of subjective reflections and demands, there is reason to presume - as far as the objective's circumstances are concerned - that the question of compulsory treatment was brought up either due to increasing drug problems or due to insufficient results from the present treatment system and the social agencies.

As to increasing drug problems, which may be illustrated - with the usual methodological reservations - on the basis of drug statistic indicators, they did not show a serious trend. Drug related deaths had decreased from approximately 140 in 1986 to 110 in 1990, and did not increase seriously until 1991. The number of drug addicts with Aids increased a little between 1989 and 1990. In the same period, the number of drug addicts in prison remained unchanged at around 950. The number of drug addicts subject to treatment increased a little from 3300 in 1989 to 3600 in 1990. However, the number of new clients in the treatment system decreased when expressed in percentages. Nor could an increasing drug problem be proven by statistics concerning drug related crime. The number of cases remained unchanged at about 15 000 both in 1989 and in 1990[2].

The demand for compulsory treatment did not emerge from an evaluating discussion of ends and means in the treatment policy or from empirical investigations into the inadequacy or success of specific treatment methods. If this had been the background of the discourse, the demand for compulsory treatment would probably have failed very quickly owing to the long Danish tradition of voluntary treatment. Presumably, the lack of a rational basis for the debate is the reason why the act of detention of addicts in treatment is not being used anywhere in Denmark.

On the other hand, it must be emphasized that for a long time the treatment system in Denmark had been undergoing a crisis due to a treatment pessimism in general, which mainly was based on insufficient economic resources. The result of this was a serious lack of treatment sites in a differentiated system, which furthermore had the effect that the treatment system largely was characterized by methadone treatment without the necessary control. At that time, methadone was almost solely prescribed by general practitioners without any additional social-pedagogical measures.

[2] Source: Annual Report on Drugs, National Board of Health, 1992.

Thus, the demand for a new policy was grounded neither on new objective conditions nor on specific changes in the treatment system. So, this indicates that an institutional criticism brought up the discourse on compulsory treatment and furthermore a fight for the rights of the "drug problem" between various institutions involved in the issue of drugs.

You may ask whether there were any other intentions buried in the demands for compulsory treatment, in pursuit of the best possible conditions for drug addicts trying to quit the abuse. It is difficult, in fact almost impossible, to prove statements on intentions and motives. However, as far as some of the crucial actors are concerned, it may be considered if their choice of strategy is based on a certain amount of self-legitimacy.

One could ask if the active attitude of the police was a question of establishing their identity as an active and necessary institution in the fight against drugs - a question of legitimating a severely criticised police action or legitimating the demand for a more rigorous control in general?

Such a hypothesis cannot be confirmed within the framework of this paper, but can only be posed as a question for further research. However, it is evident that the police force was the predominant policy-making actor, and that the discourse on compulsory treatment concerned not only specific treatments, but also power strategies and institutional legitimacy.

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