Pompidou Group

From a policy on illegal drugs to a policy on psychoactive substances

Richard Muscat
and members of the Pompidou Group research platform

Council of Europe Publishing
Editions du Conseil de l'Europe

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French edition:
D'une politique sur les drogues illicites à une politique sur les substances psychoactives
ISBN 978-92-871-6479-7

The opinions expressed in this work are the responsibility of the authors and do not necessarily reflect the official policy of the Council of Europe.

Cover illustration: Sara Whomsley
Proofread by the Documents and Publications Production Department (DPPD), Council of Europe
Layout: Jouve, Paris

Council of Europe Publishing
F-67075 Strasbourg Cedex
http://book.coe.int

ISBN 978-92-871-6480-3

Printed at the Council of Europe

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Pompidou Group

The Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (the Pompidou Group) is an inter-governmental body formed in 1971. Since 1980 it has carried out its activities within the framework of the Council of Europe, and 35 countries are now members of this European forum, which allows policy makers, professionals and experts to exchange information and ideas on a whole range of drug misuse and trafficking problems. Its mission is to contribute to the development of multidisciplinary, innovative, effective and evidence-based drug policies in its member states. It seeks to link policy, practice and science.

By setting up its group of experts in epidemiology of drug problems in 1982, the Pompidou Group was a precursor of the development of drug research and monitoring of drug problems in Europe. The multi-city study, which aimed to assess, interpret and compare drug use trends in Europe, is one of its major achievements. Other significant contributions include the piloting of a range of indicators (Treatment-demand indicator) and methodological approaches, such as a methodology for school surveys which gave rise to the ESPAD (European School Survey Project on Alcohol and other Drugs).[1]

The Research Platform has superseded the group of experts in epidemiology active between 1982 and 2004. There has been a change of function, from developing data collection and monitoring methodologies to assessing the impact of research on policy. This started with the 2004 Strategic Conference on linking research, policy and practice – lessons learned, challenges ahead, which identified as a major gap the lack of exchange of knowledge.

The Research Platform's prime role is to support better the use of research evidence in policy and practice, thus promoting evidence-based policy. It also draws attention to the latest issues arising from drug research in the social and biomedical fields and promotes interaction between research disciplines such as these and psychological drug

1. See the list of Pompidou Group documents and publications at the end of this publication.

research. Reports on these subjects have been published regularly. One of the latest achievements is the online register on current drug research projects, set up in 2007 in collaboration with the EMCDDA (European Monitoring Centre for Drugs and Addicts) to improve the lack of exchange knowledge.

This book opens with a synthesis commissioned by the Pompidou Group from Richard Muscat, Professor in Behavioural Neuroscience at the University of Malta. It follows a request, from the Federal Office of Public Health, for information on the ways in which drug policy is formulated and applied in other countries. This information should feed the discussion launched by the Swiss Federal Commission for Drug Issues about "evolving from a policy on illegal drugs to a policy on psychoactive substances".

One result is this book, containing 17 retrospective analyses by members of the Research Platform of their countries' drug policies, taking into account the social and cultural context. Their contributions here will help reflection on how to move from separate policies on alcohol, tobacco and drugs to one policy that deals with all psychoactive substances.

Contents

1. Synthesis

Richard Muscat, Professor in Behavioural Neuroscience, Department of Biomedical Sciences at the University of Malta, Chair of the National Drug Commission in Malta

1.1. Background

Following the presentation by our Swiss colleagues, Mr Markus Jann and Ms Diane Steber-Büchli, at the first Research Platform meeting of this Pompidou Group work programme (2007-10), on the move to consider a change from separate policies on alcohol, tobacco and drugs to one that incorporates all substances, it was decided by the members of the platform that this issue should be tackled by preparing résumés on the development of drug policy in member countries, based on the context, political ideology and scientific evidence.

The résumés reflect the development of drug policy in the country concerned, taking into account at national level any ratification of UN conventions, adoption of EU drug strategies or major changes that may have influenced the path taken by the country – changes that have resulted in the actual state of play in that country today.

In addition, the development of drug policy has been framed in the context of that particular country, its size, geographical position and relation to its neighbours, the state of the drug problem and public opinion. This analysis in turn has been supported by consideration of the political context of the time – that is, the political ideology. Finally, the development of drug policy in each country has been recorded, including the way evidence from science has been taken into account, or not, and the reasons for this.

It needs to be stressed that this account of drug policy is strictly at national and not local level, though there is some insight into whether national drug policy has been followed at local level or whether ideas were first developed at local level and then provided the impetus for national policy. However, implementation of policy at local level will be addressed by referring this issue to the Prevention Platform and the

Treatment Platform, who will undertake a study – similar to this one, but reduced in extent – of what actually occurs in the fields of prevention and treatment.

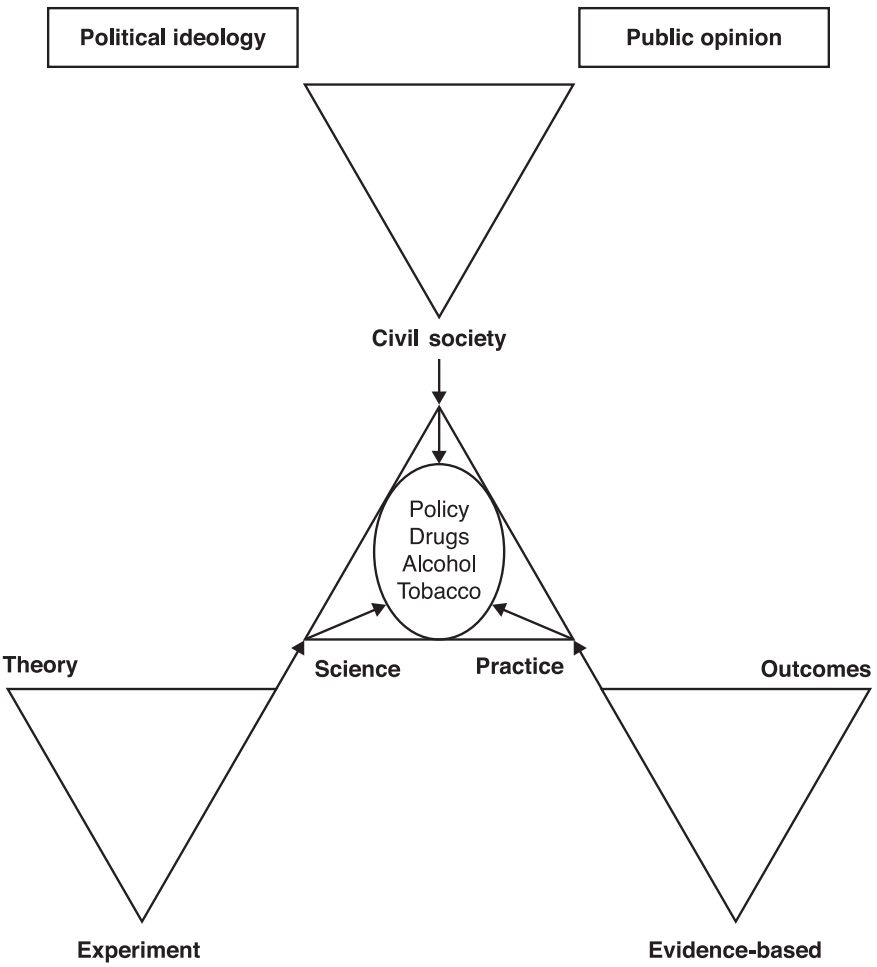
Treatment has been taken into account, by an overview of the publication by the Treatment Platform on the availability of treatment systems in 15 member countries. In effect, this exercise was an indirect way to acquire information on whether specific treatment facilities are available for drugs only or rather for all psychoactive substances? Moreover, are such programmes in line with policy and do they have legal support, as is the case for example with harm-reduction measures?

The 17 countries that submitted their résumés taking into account the specifications outlined above were: Cyprus, Czech Republic, Estonia, France, Germany, Hungary, Ireland, Luxembourg, The Netherlands, Norway, Poland, Portugal, Romania, Slovenia, Switzerland, Turkey and the United Kingdom. Their individual résumés follow this synoptic review.

1.2. Civil society, science and practice

It is argued in this review that policy formulation in the area of substance use is influenced by three main factors: civil society, science and practice. These in turn can be modified by factors that may influence the development of one policy or, for that matter, all the separate policies for the substances concerned. The substances under the spotlight may be grouped under three main headings: illicit drugs, alcohol and tobacco.

Figure 1.1: The proximal and distal factors influencing policy



The diagram gives an overall schema of the way in which the three proximal factors – civil society, science and practice – and six distal factors, namely, public opinion, political ideology, theory, experiment, evidence base and outcomes may each in turn influence the direction of policy, whether it be one, unified policy or a separate one for each area.

Civil society, in effect, reflects the standpoint of the citizens of a country and it may in turn reflect public opinion and political ideology. If public opinion and that of the political parties are one, then it would appear that civil society has one voice with regard to the strategy and what policy best suits the country. However, it is not too surprising to find

that sometimes public opinion runs counter to political thinking and so, depending on timing, policy direction may take a different turn to that voiced by public opinion or in some cases it may follow only that direction. Public opinion is mainly monitored by the media, be it television or the press and lately, public opinion surveys conducted, for example, by Eurostat that endeavour to gauge the public's "feelings" on matters related to EU policy in a number of areas.

The world of science also provides the means to ground policy formulation. Research into substance use runs into millions of euros if one also takes into account the major player in this field, the USA. In addition, the number of published papers in this field has grown tremendously over the past twenty years and our knowledge of the subject has concurrently increased at a similar rate. There will always be controversy on which theory is most likely to stand the test of experiment and, more importantly, the test of time.

But it would appear that a basic understanding of why such substances seem so attractive is at last within our reach: in the main, it is related to the fact that these substances hijack the natural pleasure pathways within our brains and that's why people seek relief in the use of these substances. It is also becoming apparent that our genes may make some of us unwittingly more predisposed than others to use such substances; this is demonstrated by the fact that dependency may run in families. Drug epidemiology also provides testament to the fact that the overall incidence and prevalence of substance use seems to be on the increase. Thus, neuroscience and epidemiology seem to provide basic, emerging evidence, which any policy of note in this area should at least take cognisance of.

Practice deals with the problem, namely addiction and dependency, which are typically the normal result of the chronic use of such substances. Practice involves the day-to-day management of problems related to substance use: health, psychological, social or matters within the justice system. Modern practice is governed by examples of "good practice", being evidence-based and also based on proper outcomes – what is now known as performance management. These issues are not as straightforward as they appear and, in some cases, practice on the ground may run contrary to the policy in question. An example is the ongoing debate of whether harm-reduction practices *per se* run contrary to the 1988 UN Convention on Drug Abuse.

Moreover, it stands to reason that policy formulation in this area should take note of current practice, but this – at least from an epidemiological point of view – seems even further from reality. For example,

the collection of standard data on those seeking treatment for specific substance-abuse problems and the use of such data in policy formulation both seem to be rather rare, with the exception of Ireland and to some extent Slovenia, where such a connection is demonstrated in the policy document that states the reason for introducing that particular policy (Hamish Sinclair 2006, Pompidou Group, Council of Europe Publications).

Prevention also falls under the guise of practice for this exercise. Mainly, it deals with trying to stop use before it starts, but nowadays it also includes secondary prevention (tackling those most at risk) and tertiary prevention (aimed at those who have started using, but are not addicted or dependent). Information on the role of prevention in policy formulation has been sought from the Pompidou Group's Prevention Platform for this exercise and from documents sourced in the European Monitoring Centre for Drugs and Addiction (EMCDDA).

In view of the above, this book looks at policy development in this area from the standpoint of the 17 countries' submissions, in the hope of gleaning some insights into the process itself, why some countries have opted for a separate policy for each substance and why others have favoured one policy for all. The review is anchored by three main factors – civil society, science and practice – and how these may have influenced the current state of affairs.

1.2.1. Civil society

Switzerland

In Switzerland, public opinion is monitored yearly. Since 1994, the percentage of people stating that drugs are a serious issue has dropped from a 76% high to a 14% low today. The turning point would appear to be in 1994, when the issue of the Needle Park in Zurich came into international prominence and resulted in public discontent and a negative perception of Switzerland by outsiders. This led to political intervention: the drug scene was closed down, low threshold services were introduced and substitution programmes were expanded along with heroin-assisted treatment. Over time this resulted in a reduction of drug-related deaths, HIV and hepatitis infection, while severely dependent users have stabilised at the lowest level to date.

Swiss drug policy was actually established in 1970 and updated in 1991, 2002 and 2006. The policy updates were based on four pillars:

prevention, treatment, harm reduction and law enforcement. The legal foundations of the Drug Policy are based nationally on the Narcotics Act 1965 and internationally on the UN Conventions of 1961, 1971 and 1988.

German-speaking Switzerland is still seen as more liberal, whereas French-speaking areas are considered more rigorous in law enforcement. Also, the young generation is more liberal across the board, compared to the older generation. Nonetheless, a final attempt was made in 2007 to introduce a rational "hemp policy with effective protection for young people". After several years of discussion on cannabis (hemp) policy, political opinion has changed – from a more liberal towards a more conservative point of view. In autumn 2008 a popular vote will decide on future cannabis policy. It is expected that the change in political opinion will be reflected in public opinion. If, as expected, the popular initiative fails, discussion of a more liberal cannabis policy will stop there for the time being.

In the end, public perception seems to be rooted in acceptable and non-acceptable norms of behaviour when it comes to drug issues.

France

In France, the government was the main player in the 1980s and 1990s with respect to drug policy. This was from the perspective of law enforcement, mainly because of the lack of evidence about the drug problem, since no formal studies had been conducted. The need to respond to the emerging HIV problem in the late 1980s resulted in a shift, first of all from law enforcement to health – that is, risk-reduction policies – and then in 1995 the setting-up of large-scale substitution programmes. The co-ordinating body, the Joint Ministerial Task Force for combating drugs and drug addiction (MILDT), was tasked to support the Ministry of Health and for the first time was seen as an active body; as a consequence, it was made responsible directly to the Prime Minister in 1996.

Public debate on drug issues really came to the fore with the publication of the Roques Report of 1997, which argued that all substances altered the state of mind – whether they were legal or illegal, including alcohol and tobacco – and the results of such use might turn out to be irreversible changes in brain morphology. As a result of this debate, political ideology and possibly public opinion had a role in pushing the move from law enforcement and prohibition to risk reduction.

Ireland

In Ireland, civil society is involved in shaping policy, by means of two instruments. On the one hand, social partnership provides a tool through which government and various bodies – such as trade unions, business organisations and the community and voluntary sectors – talk to one another. On the other hand, there are public opinion surveys such as the one on knowledge, attitudes and beliefs, but also now the Eurobarometer. Drug-related crime, criminalising of drug use and harm reduction seem to have been the main issues. However, it would appear that public opinion has indeed had a major input by keeping alcohol and drugs policies apart. Thus politicians have been rather slow to suggest that they might be combined into one policy, but now the first signs of such a move are appearing.

The Joint Oireachtas Committee in 2007 suggested that alcohol should be included in a new substance-misuse policy rather than be included in the Drug Strategy. In effect, policies related to drugs, alcohol and tobacco have developed independently, but it is only now – possibly because of the need for organisational support and resources – that a substance-misuse policy has been contemplated for the first time.

Germany

Over the last 10 years, Germany has seen a shift in its political attitude towards drug addiction: now "help comes before law enforcement", which in effect is a move akin to the UK model or more appropriate to health and social issues. In fact, in 1998, the Federal Drug Commissioner was transferred from the Ministry of the Interior to that of Health. In 2005, the four mainstays of drug policy were established: education, prevention, treatment and law enforcement.

Another major political landmark was the replacement of the Drugs and Addiction Commission by the National Board on Drugs and Addiction. This is made up of members from government, municipalities, non-government associations, research organisations and (importantly) funding organisations. This has resulted in the suggestion in 2006 that the Action Plan for Fighting Drugs and Addiction should attempt to reduce the prevalence of smokers, teenage alcohol use, and experimental and regular cannabis use in the young age cohort (12-25 years old). This change in slant at the macro level now needs to occur at the micro level and the impact needs to be evaluated.

United Kingdom

In the UK, separate policies for drugs, alcohol and tobacco are in place, and there is little if any integration of the three. However, all are based on the premise of prevention, treatment, education and control of supply. This separation may be a result of the fact that the first National Drug Strategy was established in 1998, and that for alcohol came later, in 2004. The alcohol strategy was founded on harm-reduction principles, whereas the drug strategy was more abstinence-based.

Also, public opinion on the use of drugs and alcohol has mainly focused on the issue of public nuisance that results from drug dealing and drinking heavily. Politically, over the last 10 years, drug use has had a high profile because treatment was shown to reduce it, which therefore raised the possibility that getting people into treatment might reduce drug-related crime.

Netherlands

Unlike the current trends in Switzerland, France, Ireland and Germany, but much in line with the UK, the Netherlands has in place separate policies for alcohol, tobacco and drugs. They are all based on the premise of preventing health risks and negative consequences for society; and thus, depending on the impact of the substance in question in each case, different objectives are defined in each of the policies. The unwritten expectation is that the government respects the concept of the freedom of the individual. Much open debate on drug issues continues in Dutch society, and this too has been anchored by the principle of the public good.

Thus the chief aim of Dutch Drug Policy is health protection and health-risk reduction. With these in mind, the four main objectives of such a policy are to prevent drug use and treat and rehabilitate drugs users, reduce harm, prevent production and trafficking, and diminish public nuisance. Hence different ministries are given responsibilities for different aspects of the aforementioned policy: the Ministry of Health, Welfare and Sport for prevention and care, the Ministry of Justice for drug-related crime, and the Ministry of Internal Affairs for local government and police. With regard to alcohol and tobacco, the aim is to reduce problem drinking and prevent smoking by reducing availability of the latter and restricting use in the former.

Portugal

The Government of Portugal first gave responsibility to institutional structures such as the Presidency and the Council of Ministers, to

control trafficking, introduce prevention measures and monitor the situation, in 1976. This followed the democratic revolution of 1974, which also saw the annexing or granting of independence to the colonies with the resultant influx of returned migrants. This was followed at the end of the 1980s by a National Plan to Fight Drugs. Subsequently, following the spread of HIV and prison overcrowding, this gave rise in 1999 to the National Plan to Fight Drugs and Drug Addiction.

Between 1999 and 2004 a number of laws and action plans were put in place, but these in effect resulted in the creation of the Institute for Drugs and Drug Addiction and the move to perceive the drug problem as health-related. In line with this thinking, administrative penalties were introduced for possession for personal use as well as treatment options. It is now that the government has invested the Institute of Drugs and Drug Addiction with responsibilities for both drugs and alcohol in an attempt to modernise existing services and also downsize public administration.

Luxembourg

Luxembourg and Malta are the two smallest countries in the EU and both have a population of about 400 000. Luxembourg is situated between Germany, France and Belgium, and since 1983 – with the rise in the drug problem and thus the appearance of institutions such as Drug Assistance for Young People – an effort has been made to put in place a Drug Strategy to counteract the impact of such a rise. Following elections in 1999, drug issues now reside in the competency of the Ministry of Health, which is aided and abetted by an Inter-ministerial Drug Addiction Group and a drugs co-ordination unit.

The first Drug Strategy was unveiled in 2000 to cover the period to 2004, and a second has come on stream for the period 2005-09; this takes on board the principles of the EU strategy 2005-12. The main changes to result are an increase in the number of low-threshold facilities and the changes in the basic law of 2001, foreseeing a distinction between and alleviation of penalties according to the drug offence (simple use or/and trafficking) and the substance type involved, changes updating the law of 1973. The 2001 law was an attempt to cover harm-reduction measures even though debates on these issues had started in 1993, when a law on the legalisation of cannabis (use and trade) was rejected. Luxembourg, like most other countries, has ratified the UN conventions of 1961 and 1988.

Czech Republic

As in Portugal, but much later (the early 1990s), one result of the change in democratic style in the Czech Republic following the fall of the Berlin Wall was a change in lifestyle, with more open borders and a more open market, which included the illicit drug trade. The government responded by instituting a Drug Commission together with its first drug policy (for the years 1993-96) based on very little information. However, the policy itself established, amongst other things, a system for monitoring the drug situation. The second drug policy (covering the years 1998-2000) was based on a first attempt to use drug indicators that reflected the situation. Interestingly, in this second update, the concept of a drug-free society was dropped and an attempt was made to target effective financial measures. The third drug policy (for the years 2001-04) was an attempt to plug gaps in service provision in prevention and treatment and to introduce the concept and instruments of evaluation for the demand-reduction programmes.

Presently, the fourth drug policy is in operation, covering 2005-09. In this, an attempt has been made to include alcohol and tobacco, which up until now had been the remit of the Ministry of Health. However, that ministry has been preoccupied with the sustainability of the country's health-care system, though initiatives were launched in 1992 and 1994, along with a further law in 2000 for the protection of public health. In effect, there are initiatives on alcohol and tobacco in this latest strategy, but it would appear that the political will to implement them is not there, as a result of the public perception that alcohol and tobacco are not drugs.

Poland

Alcohol policy in Poland predates drug policy by possibly a century and so the two issues are handled separately by two parallel administrations. Drugs seem to have become an issue in the 1960s, but not till the 1970s did the government act and even then only in a minimalist fashion. In the 1980s, however, NGOs took up the initiative, even before the changes at the end of the 1980s that heralded a new era in the 1990s.

The National Bureau for Prevention was established in 1993 by the Ministry of Health, with responsibilities in the areas of prevention, treatment, rehabilitation and re-integration into society. The Bureau itself does not implement policy, but contracts with NGOs to do so. In 2001, the Council for Counteracting Drug Addiction was established and charged with drawing up the first drug policy, the National

Programme for Counteracting Drug Addiction. Public opinion came to the fore with the required changes in Polish legislation on drug issues in 2006, as required by the EU *acquis*. The Ministry of Health organised consultation with society and there was extensive media coverage of the debate, especially in relation to allowing possession of minimal amounts of drugs for personal use. In the end, law on drug addiction did not change the penal provisions, but from the demand side it influenced the general aims of current policy in the direction of integrating responses to drug and alcohol problems in the domains of prevention and treatment.

Slovenia

The first Slovenian drug policy came into being following independence in 1991. The second one, for the period 2004-09, was produced by the Government Office for Drugs following consultations with the respective ministries and civil society, in response to EU accession and the adoption of the *acquis*. This in turn was approved by the National Assembly.

With the re-organisation of government in 2004, responsibility for national drug policy is now held by the Ministry of Health. The need for prevention and treatment of drug and alcohol use has now been acknowledged by the government, but it remains to be seen whether some form of integration is established in issues that overlap, while continuing to provide separate facilities for problems that require specific expertise. However, there now seems to be the political will, as significant funds have been diverted to cover drug issues.

Hungary

The Drug Strategy in Hungary was launched in 2000 by the Ministry of Youth and Sport. It does not cover alcohol or tobacco because the Public Health Programme, launched in 2003 by the Ministry of Health, deals with the latter substances. However, it has been stated that, in regard to prevention, they are considered as one; and, in therapy, the treatment agencies assist those with multiple substance-use problems. The Co-ordination Committee on Drug Affairs is responsible for implementation of the drug strategy, but after a Twinning Project in 2005 and the report of 2006, some further re-organisation has been recommended.

Romania

It seems that the first policy response to the drug problem in Romania was the formation of the Inter-Ministerial Commission for the Preven-

tion of Illegal Drug Use by a Common Order. Its main remit was to implement the National Programme for Preventing and Fighting Drug Use. It was only in 2003 that a National Drug Strategy came into being, covering the period 2003-05 and the misuse of both licit and illicit drugs. In addition, the National Anti-Drug Agency was established to implement and co-ordinate activities of the new policy.

The policy itself was designed on the basis of national and international studies along with available local statistics and practice in the field. For example, the policy document took into account the high prevalence of substance use in the age cohort of 15-24 years old and it proposed the subsequent restrictions on the availability of the substances in question. A new Drug Strategy was put in place for 2005-12, in line with the EU strategy for the same period, to give impetus to revising the legislative framework to reflect the *acquis*.

Estonia

At the end of the 19th century and start of the 20th century, alcohol was the main substance of abuse in Estonia, and the Acts put in place in that period reflected this fact, but only up until 1940. From that year, legislation pertaining to the Soviet Union came into force. The years at the end of the 20th century and the beginning of the 21st century were notable for a general rise in drug problems.

The return to Estonian law, when independence was regained in 1991, was followed by the first Act in 1997 that covered all substances, the Narcotic and Psychotropic Substances Act, containing measures relating to criminal justice, prevention, treatment and rehabilitation. Even so the Alcohol Act was enacted in 2001 to regulate production, sale and consumption by minors. The government has put in place national prevention programmes for both drugs and alcohol, the first from 1997 to 2007; the latest, running from 2008 to 2012, focuses only on drugs, and not on alcohol or tobacco. In addition, a programme for harm reduction ran during the years 1997-2007.

Cyprus

Cyprus is an island in the eastern Mediterranean Sea and is the most south-eastern member of the EU. Problems related to drug use seem to have had their origins in the turmoil that followed the social upheavals in 1974, arising from the Turkish invasion and the Lebanese civil war. The major breakthrough in policy measures to handle the drug problem came with the introduction by Parliament in 2000 of the Prevention of the Use and Dissemination of Drugs and Other Addic-

tive Substances Law, which established the Anti-Drugs Council. The council, chaired by the President of Cyprus, consists of government ministers and is responsible for policy formulation in the field of licit and illicit drugs. The Cyprus Monitoring Centre is also hosted by the Council, and thus the Council would appear to have first-hand information on the drug situation.

The first National Drug Strategy, for 2004-08, has been released. It has two pillars: supply reduction and demand reduction, not only of illicit drugs but also of alcohol and tobacco. However, government priorities have favoured the drug issue and thus the issues of alcohol and tobacco would appear to have lost out. This has been justified to some extent by the results of public opinion surveys conducted in 2005 and 2006, which made it clear that drug issues rated a close second to the continuing national problem of the divide, and alcohol and tobacco were perceived as much less harmful than illicit drugs.

Norway

Norway is the only Scandinavian country contributing to this exercise and thus may not be representative. With this in mind, it is apparent that, until 2000, Norwegian policy was to control alcohol use primarily through regulation and drug use primarily by prohibition. Over the past twenty years, the approach has been to include both drugs and alcohol in policy papers and reports discussed in Parliament. This resulted in the first strategy-cum-action plan, covering 2003-05 and including both drugs and alcohol, followed by a second, which is simply a continuation of the first for the period 2006-08. Co-ordination of this plan is the responsibility of the Ministry of Health and Care Services, together with the seven other ministries directly involved.

The Directorate for Health and Social Affairs is responsible for implementing the plan and is helped by the seven regional competence centres on drugs and alcohol, as well as the five regional health authorities responsible for specialist interdisciplinary treatment. Thus Norway advocates the holistic approach to social and health problems that are related to substance use. Special emphasis is given to preventing use of any substance by children and youth.

Turkey

Turkey has recently updated its former National Policy and Strategy Document on Drug Addiction, Prevention, Monitoring and Control, which ran from 1997 to 2007, replacing it with the new Strategy Document on Prevention, Monitoring and Management of Drug Addiction,

2006-12. The new strategy is comprehensive, focuses mainly on illegal drugs and covers the same five pillars as in the EU strategy. The Turkish National Focal Point for Drugs and Drug Addiction is responsible for the implementation of the strategy as well as its evaluation.

1.2.2. Science

It is interesting to note that, in the majority of cases where science is cited, it mainly refers to drug epidemiology. This may not be so surprising, in that politicians usually ask questions about the size of the problem and whether this is growing or not, so that prevalence and incidence values are the order of the day.

Switzerland

Drug problems normally refer to those arising from psychoactive substance use, which have mainly come to prominence since the 1960s and 1970s. In Switzerland the consumption of psychoactive substances is traditionally quite high. For epidemiological data collection and monitoring, the focus is now to be on all psychoactive substances and not just drugs.

The views of Swiss policy makers and the public have primarily focused on illegal drugs, and not alcohol or tobacco, nor for that matter non-substance-related dependency. Professionals have also had a segregated outlook, because programmes for prevention, counselling and treatment are run by the relevant professionals in distinct fields. But the revisions of ICD 10 (International Classification of Diseases, version 10), based on findings in neuroscience, have resulted in calls for a more integrated view of dependency problems, irrespective of the substance. This in turn has led to suggestions to set up a Commission to deal with all kinds of policy questions on addiction and dependency.

France

As France has a very active neuroscience community, especially in the field of drug addiction and dependency, it was no surprise that the public and government alike were able to accept the findings of their own scientific community that all psychoactive substances hijack the brain's reward pathway. For their research to be accepted, scientists had to communicate their findings in everyday parlance without essentially overestimating or underestimating the value of the findings, and it would appear that neither of above occurred. The second important development was the emergence of the Drug Observatory in 1995,

putting in place the mechanisms by which France could get to grips with the size of the drug problem. In 2002, it was estimated there were 14 million people who regularly drank alcohol, 13 million smokers, 1.7 million regular cannabis users and about 200 000 heroin users.

Ireland

In Ireland from the 1990s onwards, it seems that research – epidemiology, in the main – began to be systemised in a way that would provide the necessary information for policy makers. This began with the treatment-demand indicator, which was extended nationwide in 1995 and provided the bases for developing local drug task forces. In 1997, it was suggested that a National Advisory Board on Drugs should take on the role of research; this came into effect in 2000 after a two-year development phase. In 2006, the Health Research Board (which initiated the treatment-demand indicator) changed its name to the Alcohol and Drug Research Unit and in its first year published a report proposing better integration of services for alcohol and drugs. The last prevalence survey of households in 2002/03 reported that one in five had used an illegal drug, cannabis was the most popular drug, more men than women consumed illegal drugs (particularly in the younger age groups) and the older cohorts used sedatives, tranquillisers and antidepressants.

United Kingdom

Unlike most countries, the UK adopted the disease model of addiction a long time ago, and thus treatment not punishment has been the order of the day. The attempt to get the right balance between abstinence and maintenance will always be a concern, and it was only after the health implications raised by HIV in the 1980s that the balance started to shift to the latter. Drug data on the prevalence of drug use in school children, youth and the rest of the population have been made available over the last ten years. The UK appears to be one of the EU countries with the highest rate of problem drug users, in fact 10.15 per 1 000 of the population.

Germany

Drug epidemiological data in Germany appear to have been available for at least twenty years. Whether prevalence values were obtained from full surveys or from mathematical estimates using different data sets is not known. Lifetime use of illegal drugs, as in most EU countries, increased from the 1960s, but prevalence rates increased considerably between 1986 and 2003. Moreover, heroin use became a factor in the 1970s.

In 2000 it was estimated that the number of problem opiate users lay between 112 000 and 186 000. Drug-related deaths hovered at around 500 for the 1980s, increased significantly in the 1990s to a level of 2 000 and decreased from 2 000 to a level of 1 296 in the most recent report, that of 2006. In the 18- to 24-year-old cohort, use of cocaine, amphetamine and ecstasy is around 5-6% for lifetime prevalence, though the figure for cocaine increased between the 1980s and 1990s and is now stable again, whereas that for ecstasy increased in the 1990s and post-2000 has stabilised again. Prevalence figures for alcohol and smoking are also available and it would appear smoking is on the decrease in 2006 as compared to 1995, whereas the prevalence of risky social drinking has risen over the same period.

Netherlands

The Trimbos Institute in the Netherlands is contracted by the Ministry of Health, Welfare and Sports to provide national drug data in respect of prevalence estimates, problem drug use, treatment data, drug-related deaths and drug morbidity.

Portugal

As in the Netherlands, in Portugal it is the Institute for Drugs and Drug Addiction that is mandated by the government to provide information on the drug situation following the implementation of public policies between 1999 and 2004. Figures for prevalence of drug use in the population were obtained following a national population survey in 2001, and estimates of problematic drug use were also made in 2001. Information on use in school-age children is available, as ESPAD (the European School Survey Project on Alcohol and other Drugs) has been conducted since 1995 and every four years since, that is 1999, 2003 and 2007. Further information on this particular cohort is available through the HBSC (Health Behaviour in School-age Children) study and also national school surveys, the last one completed in 2006 following the 2001 exercise.

Luxembourg

The national EMCDDA focal point for Luxembourg came into being in 1994 and now sits in the CRP-Santé, the National Public Research Centre on Health. A key task among the functions of the unit is to develop and maintain the national drug monitoring system, RELIS, which allows the provision of drug data on the current situation and results in the annual report to the EMCDDA. This in turn is the key

document that informs policy makers on emerging trends and the impact of interventions.

Czech Republic

In the Czech Republic it was suggested that alcohol and tobacco be included in drug policy, as a result of the latest scientific findings that both substances have addictive and dependency properties, just as illicit drugs do. Drug epidemiology began after 1993 and was more or less established by 2001 to provide background information on the state of the drug problem for the 2001-04 drug policy as well as the latest one, that for the period 2005-09. In addition, this latest policy and accompanying action plan provides for an alcohol and tobacco monitoring centre.

Poland

Akin to the Czech Republic, Poland is moving to integrate the responses to drug and alcohol problems in the domains of treatment and prevention, as a result of the scientific evidence suggesting similar mechanisms as the root cause of dependency, independent of the substance in question. Epidemiological data collection is conducted by the Institute of Psychiatry and Neurology, which also issues an annual report on the state of the drug problem.

Slovenia

Drug epidemiology was the focus of public health, but now is the responsibility of the focal point within the Ministry of Health in Slovenia.

Hungary

Again drug epidemiology is under the care of the Hungarian national focal point, which came into operation on 1 January 2004 and is found in the Ministry of Health.

Romania

The Ministry of the Interior in Romania hosts the National Anti-Drug Agency (NAA), having the national focal point as an independent department within the NAA through which drug epidemiology data are compiled on a yearly basis and forwarded to the EMCDDA, European Commission and national bodies involved in co-ordinating drug-related activities (Ministry of Health, Ministry of Education, Ministry

of Labour, the Parliament and so on). Studies on the prevalence of drug use are becoming more and more common – for example, the General Population Survey conducted in 2004. ESPAD studies that look at prevalence in the 15- to 16-year-old cohort were conducted in 1999, 2003 and again in 2007. A study of "Prevalence of drug use in the prison system in Romania" was carried out at national level in 2006. All these epidemiological studies keep track of substance use and abuse by including both alcohol and illicit drugs monitoring in their study design. Therefore comparative analysis and correlations between alcohol abuse and other types of drugs are facilitated.

Estonia

In Estonia, the national focal point within the National Institute for Health Development produces a yearly report on the drug situation and forwards it to the Ministry of Social Affairs.

Cyprus

As outlined above in the section on civil society, the Cyprus Monitoring Centre would appear to be ideally placed to influence policy, since it is hosted by the Anti-Drugs Council, which is responsible for policy formulation. The only caveat at present is that limited information is available on the drug situation, with the exception of the drug indicators related to prevalence of drug use in the 15- to 16-year-olds, problem drug use, treatment demand and drug-related deaths.

Norway

A special emphasis is made by Norway, in their two action plans and strategy for drug- and alcohol-related problems, on young children and youth, based on the scientific evidence that delaying the onset of first drug use and drinking reduces the number of problems related to such use later on. It is also worth highlighting that the strategy, which includes all substances but makes reference to drugs and alcohol, is based on scientific findings that all substances affect the brain and thus behaviour.

Turkey

Turkey has little or no information related to drug epidemiology, with the exception of school studies, namely the ESPAD conducted in six cities in 2003. It suggested that with the new strategy this lacuna will be tackled by the implementation of drug epidemiology studies.

1.2.3. Practice

Whether practice follows policy or vice versa is a matter of debate, but the management of practice would appear to follow policy, whereas in cases of prevention, treatment and counselling these are more likely to be dictated in the first instance by the needs of the individual.

Switzerland

A case in point is the Swiss experience, in which the separation of service provision for drugs, alcohol and tobacco is now moving towards an integrated one, in line with individuals presenting with multiple substance use and the resulting dependencies.

France

In a similar way, the professionals in France also requested to move away from specialised centres for dugs and alcohol and have a more coherent system. Such a system did in fact come into being with the Public Health Act (2002), which put in place centres for treatment, supervision and prevention of addictions that brought together the previous separate entities.

Ireland

The 2001-08 National Drug Strategy for Ireland on the one hand provides for a reduction in the availability of drugs and on the other hand gives access to treatment for people with drug misuse problems. On two counts the strategy has had to overcome – or practice has had to come to terms with – two main issues, those of harm reduction and the provision of separate services for drugs and alcohol outside the health domain. Harm-reduction practices have been available but they receive "very limited validation in Irish laws and policies generally". As regards the latter issue, the realisation that drug services treat drug users for alcohol problems as well, it was suggested that treatment options be extended; but the problem that arises is that those not suffering from any mental health problems fall under the provision of social inclusion services, and not health as is the case for drug services.

United Kingdom

With the emphasis on the disease model of addiction, over most of the 20th century in the UK, the general practitioner was responsible for treating drug users. This changed to some extent with the new laws in

1967 requiring those prescribing methadone for example to apply for a licence. This resulted in drug dependency units, mainly in London, being set up and licensed to specifically treat drug users. Subsequently, with the rise in opiate use in 1980s and the spread of HIV, provisions for services outside London were increased but it was the Mersey Regional Health Authority that introduced harm-reduction practices, which were not fully approved by the government then. A number of these practices are now funded by the government, given their awareness of the value of such an approach.

All treatment to date has been available free of charge under the auspices of the National Health Service. Following a government-commissioned report in the 1990s that suggested treatment did indeed work, the main emphasis of the first drug strategy in 1998 was to treat people with such drug-use problems, with the result that now access to such is also available to those in the criminal justice system as a result of the Drug Intervention Programme of 2003.

Germany

In Germany, as in the UK, access to all types of drug treatment services is available, ranging from low-threshold centres, counselling and detoxification, to specialised in- and out-patient services, substitution and rehabilitation. However, it would appear that these services are directed primarily at drug users and not to users of other substances, but interaction does seem to occur between the different service providers.

Netherlands

Dutch drug policy is founded on the revamped Narcotics Act of 1928, updated in 1976, in which a distinction was made between hard drugs, those that present unacceptable risks, and soft drugs, which were seen as less dangerous. So too has treatment followed in the same vein. Harm-reduction practices for hard drugs are a major feature, with the availability of heroin prescription for those extreme cases where no other treatment seems to have had success.

Portugal

In the 1980s in Portugal, the Ministry of Health set up the first specialised treatment centre for drug dependency. This was followed in the early 1990s by the introduction of the Service for Prevention and Treatment of Drug Addiction, which consolidated all the existing treatment services in the main urban areas, as well as increasing the number of available treatment centres and types of treatment in all city districts.

Again, the introduction of public policies between 1999 and 2004 and the shift in perception of the drug problem to one that is health-related resulted in the introduction of harm-reduction measures by the new agency, the Institute for Drugs and Drug Addiction. This had come to the fore following integration of the other agencies, in an attempt to better co-ordinate efforts and make the best use of the resources on offer.

Luxembourg

Substitution treatment in the form of methadone appeared in 1989 in Luxembourg and in 1993 syringe exchange programmes were also introduced. It is of interest that the legal frameworks to support such practises were only enabled in 2002 for substitution treatment and in 2001 and 2003 for syringe exchange. Moreover, the first "consumption room" or "injection room" was opened next to the railway station in the city centre in Luxembourg in 2005. These changes reflect both political and public opinion for the need to have in place practical measures that directly address the situation in question. As such, treatment practices have provided the impetus for a change in attitude from one of abstinence to a range of services that include harm-reduction measures.

Czech Republic

Interventions in the Czech Republic seem to have increased since their inception in the 1990s. To date most services would appear to be on offer, from low-threshold services and therapeutic communities to aftercare programmes. A current problem that has emerged relates to the inclusion of those with alcohol-related problems, but this is not supported by the extra finance that is required, as funds are rather limited.

Poland

Drug intervention services in Poland were established by NGOs in the early 1980s, in response to the non-acceptance of such individuals in psychiatric wards and the general intolerance of drug dependants by society as a whole. The services developed were thus based on the needs of this particular cohort and included out-patient services or counselling centres, detoxification units located in hospitals and long-term rehabilitation centres run mostly by NGOs.

Slovenia

Since the mid-1990s, the government of Slovenia has provided funds for the development of treatment services that range from day centres,

therapeutic communities, substitution programmes and needle-distribution programmes, to vans that operate throughout the country providing counselling services, information, clean needles, syringes and condoms.

Hungary

It transpires that in Hungary the treatment network looks after both those with drug and alcohol problems.

Romania

Treatment in Romania is provided by the Ministry of Health. Detoxification is centred in Bucharest and other facilities are available within the psychiatric wings of general hospitals. In the last two years, NAA (the Romanian National Anti-Drug Agency) has developed a nationwide network of counselling, treatment and prevention centres, which offer integrated services for both licit and illicit drug addicts. The network is in the course of developing and adapting its range of services to the clients' demands.

In 2008 an evaluation project was conducted in order to assess the quality and accessibility of the services offered by the national network of counselling, treatment and prevention centres (CPECA). The main recommendations of this assessment were to point out the need to widen the range and focus of the specialised treatment and counselling services for the alcohol-addicted population.

Estonia

The National Institute for Health Development is responsible for disbursing funds for drug treatment in Estonia.

Cyprus

Treatment in Cyprus has been and is the responsibility of the Ministry of Health, and falls within the Mental Health service domain. In 1991, a special unit was opened to treat both drug and alcohol dependants. The Anti-Drugs Council now co-ordinates all the efforts in this sphere and is attempting to strengthen the treatment options provided by the Ministry of Health. In this case it is noteworthy that the legal instruments for the treatment of drug addicts have been in place since 1992, but the operating regulations as yet have not been issued and thus a number of government treatment centres have not come into being.

Norway

Drug and alcohol treatment in Norway are provided by the five regional health authorities and organised in the same treatment centres, even though some centres may have better expertise with alcohol rather than drugs and vice versa.

Turkey

Treatment for drug abuse in Turkey is now being tackled with the implementation of the new strategy, covering the years 2006-12. It will be evaluated by the National Focal Point.

1.3. Discussion

To the question posed at the opening of this review – which countries opt for an integrated policy for psychoactive substances, rather than a single policy for each? – at face value one can state that the majority opt for a separate policy for each of the substances. The minority of countries favouring a policy that encompasses all are Switzerland, France, Ireland, Germany, Portugal, Czech Republic and Norway. If one then would identify which of these in effect has moved to embrace this move in each of the domains (or pillars as they are often referred to) then Norway would appear to stand out from the list of countries. At the other end of the scale, where a policy document refers to incorporating all substances but at the same time the political will to do so is absent, is the Czech Republic. However, this assessment is affected by the fact that one needs to take into account the three axes that provide the basis for this review – civil society, science and practice – or, more to the point, the context for them.

In essence it is the axis that represents civil society – made up of two factors, public opinion and political ideology – that really drives the selection of the option. In truth, it is really the political ideology in most countries that determines the outcome, even though nowadays public opinion is making a difference. For example, in the case of the Czech Republic cited above, it is the perception of the politicians that the public regard the use of alcohol and tobacco not in the same vein as that of drugs. It is thus hardly surprising that politicians are not willing to apply the same yardstick to these substances as that applied to illegal drugs, because their political careers nowadays to a great extent depend on the public at large. The same is true to some extent with Ireland's attempt at inclusion of all substances in one policy:

again, politicians have been rather reluctant to do so as a result of public opinion, but now an attempt is to be made to include alcohol in a substance-misuse policy and not in the drug policy.

Another important factor in the development of policy options in this field is the relatively recent introduction in some countries of liberal democracy. This has resulted in a steep learning curve, in which the political entities have had to learn to cope with the changes as well as learning to interact with the public in portraying their political platforms. Concurrent with such a major change has also been the aspiration of a number of newly democratic countries to join the EU and thus adapt their regulations and drug strategies to be line with the said bloc. Consequently, the main pre-occupation has been to have legislation in place that respects the *acquis* and, more to the point, to have a system through which one is able to monitor the drug situation and produce yearly reports on the situation and responses. In effect, this may be viewed as a positive step because, prior to accession, most countries outside the EU bloc had no drug strategies of note, or for that matter the structure through which the situation could be monitored. This caveat to some extent was addressed by activities often conducted under auspices of the Pompidou Group, such as the development of the treatment-demand indicator and the ESPAD study.

In effect, if one had to make an assessment based on the evolution of policy in the area of substance misuse, then most countries – be they western, or central and eastern, Europe – had some form of instrument to regulate alcohol, but provision for drugs in the main came about after the 1960s, with the exception for example of the UK. Thus, depending on the political context of the country, the evolution of drug policy has been a recent event for most and maybe this factor plays a large part in the thinking of whether to have one policy for all or single policies for each substance. However, it is clear that in the UK and the Netherlands, countries with a long history of democratic rule and experience of drug- and alcohol-related problems in the policy domain, the choice has been to keep the substances apart but the underlying basis has been to help those in need. It will be of interest to see what happens next year in the Netherlands with the updating of the 1995 Act.

Science would appear to be the weakest link, in terms of influence on policy, of the three axes. It is very apparent that, apart from Norway, France and the UK, hard science – that is, neuroscience in particular – has not had a major impact on the development of policy. That said, it may be that access to neuroscience for policy makers is not made easy. The Roques Report in France did indeed have a major impact and

possibly this was because the writer was able to explain the sometimes difficult concepts in everyday language that could be understood by the audience addressed. This very issue is at the heart of making better use of the abundant data available in this rapidly advancing field. Norway also makes it explicit why their policy including drugs and alcohol has been adopted; science has shown that all substances affect the brain. Moreover, the rationale for prevention is also made plain and is based on the scientific findings that stopping early use prevents problems later on.

Drug epidemiology, however, seems to be on a sounder footing than neuroscience in relation to the ability of a number of countries to collect drug information on the five key indicators and thus have estimates of the prevalence of substance use for the population and school-age children. In turn, this may be attributed to the Epidemiology Group of the Pompidou Group, which came into existence in the late 1980s and only came to an end with the introduction of the focal points within the existing EU bloc. The group was responsible for developing indicators of drug use in cities throughout Europe, as well as the treatment-demand indicator and the ESPAD survey. Thus, it may depend which ministry hosts the body concerned, whether it is better located to influence policy. In real terms this should not be an issue because the government should be able to draw on all its resources in formulating policy, but in practice it might happen. The example already cited is that of a former study conducted by the Pompidou Group, which examined the impact of the collection of data on treatment on policy. It was not at all apparent that any of countries in the study, with the exception of Ireland and Slovenia, made use of such data in formulating drug policy.

Consequently the use of findings from neuroscience or drug epidemiology as a base for drug policy or a substance-misuse policy seems not to be the norm. A number of reasons may be put forward to account for this, as mentioned above, but in the long run it is imperative that science is accommodated if policy is to be based on evidence. An example in which science has indeed had an impact is a study in UK, which showed that treatment in fact did work, with the result that now drug policy is geared to attempting to get people into treatment that need it. An example from the same country, in which this time the scientific evidence has been ignored by policy makers, is the re-classification of cannabis from class C to class B. Thus, science alone cannot be the sole source of information for policy making, but the point being made here is that at least it is considered in its entirety.

The treatment perspective, unlike the science perspective, has indeed had an impact on policy. The fact of the matter may be that individuals present for treatment with a number of problems due to substance misuse, and thus professionals in the field have had to address these. Examples of such can be found in Switzerland and also in France, Portugal and Norway. Professionals in France welcomed the Public Health Act of 2002, which brought together different entities with different expertise under one roof so to speak.

A further example from treatment was the introduction of harm-reduction measures by the Mersey Regional Health Authority in the UK, following the spread of HIV in the mid-1980s. Then these measures were not fully approved by government, but now are indeed so. In Ireland the introduction of harm-reduction measures by the treatment-service providers is not fully supported by legislation, or for that matter policy, at present. In Luxembourg, substitution treatment has been available since the late 1980s, but it is only lately that the law enabling this has come into being. By contrast, in Cyprus, which is probably the only example at present, the laws enabling centres for treatment have been in place since 1992. Thus, in principle these came into being before the need; however, this again is tainted to some extent in that the need has now appeared, but the centres are still not able to open because no operating regulations have come into force.

Prevention, strictly speaking, is not treatment but is considered here briefly in passing. In most countries it would appear that educational programmes promote healthy living lifestyles, with all substances included in the structured programmes.

Finally, the choice between opting for one policy that covers all substances or a single policy for each of the main substances, drugs, alcohol and tobacco, is not a simple one. This mainly depends on the evolution of policies in the area of the country concerned, the context and now the need to include science as a consideration in the decision-making process.

1.4. Conclusions

Just to reiterate, it is clear from the above overview that the 17 countries participating in this exercise stand along a continuum when it comes to the option of whether to have all under one or to have a single policy for each substance. Some countries opt for one policy, including Switzerland, France and Norway, whereas the UK and the Netherlands

would appear to be at the opposite end of the pole. The other countries seem to fall in between, with some having a bias towards the single policy whereas others show a bias towards an independent one for each substance.

The common denominator among all the countries, however, seems to be one overarching consideration, that of health. Consequently, this prime factor seems to be the one that guides most policy options and thus it may not matter which path one takes in deciding to select either a single policy for all substances or an independent one for each. However, this is to some extent affected by the context, the evidence base and the practices one wants to have in place, but this aspect is dealt with below. The real issue seems to be one of health and, as such, maybe it is time to frame any substance use in this context and thus have some form of global policy or, as a start, a Council of Europe initiative on this front.

In relation to the model put forward in this overview that may be adopted to guide one in choosing which policy option to take under the umbrella of health, it is paramount to note that the model itself has not had the time to be developed in a manner that would aid such a choice. Thus it is suggested that the Research Platform undertake this as one of its initiatives in the next two years. It would be of interest to determine how each of the proximal and distal factors provides input into the choice, and how these in turn may provide some insight for future decision making. A short paper on this suggestion is to be prepared by the Netherlands, with feedback provided by Germany, to be presented to the members of the Research Platform for consideration at their meeting in January 2009.

A major issue to emerge in the preparation of this overview was the realisation that science *per se* plays a minor role in the decision-making process. It would appear that there are a number of issues at stake. Since the remit of the Research Platform is to support better the use of research evidence in policy and practice, thus facilitating the development of evidence-based policy, it is suggested the group takes this issue on board and examines why this would appear so.

Three issues in particular need to be addressed, that of the co-ordination of research efforts, the access to information and finally the communication of findings in a format that is digestible by policy makers and the public at large. With regard to access to information, the group has launched a second version of the Research Register, which aims to provide information on who is doing what in drug research. In respect to the communication issue, a first summer work-

shop for young researchers has been organised in the Netherlands to tackle this issue. These two activities are just a start to tackling the issues highlighted above and thus it suggested that the Research Platform make further progress in bettering the use of science in policy making, particularly over the coming two years.

2. The national drug strategy in Cyprus

Neoklis Georgiades, Director of the Cyprus Monitoring Centre for Drugs and Drug Addiction

2.1. The Cypriot context

Cyprus is the south-easternmost nation of Europe, situated in the eastern Mediterranean very close to the countries of the Middle East, at a strategic crossroads between Asia, Africa and Europe. It has a population of 749 200, mainly Greek-speaking, with Armenian, Maronite, Ladino, east European and other minority language groups. The political system is parliamentary and democratic: a president is elected by majority vote, and elected political party representatives convene in Parliament.

The problem of drug use appeared in the wake of the Turkish invasion in 1974 and the beginning of the Lebanese civil war. The relocation of two thirds of the population of the island, both Greek and Turkish Cypriots, created havoc and tremendous social problems. The social structure as it had existed for centuries suddenly collapsed. The process of socialisation as well as social control that existed in the small Cypriot social unit, the village, has in effect vanished. The security, financial and social support, and psychological well-being that the extended family offered were replaced by insecurity and a struggle for individual survival. Such negative social changes interfered with the homeostasis of the Cypriot family and created psychological problems accompanied by excessive use of alcohol and illegal psychoactive substances.

Furthermore, the civil war in Lebanon brought large numbers of Lebanese refugees to Cyprus. In fact, the port of Larnaca was the only route to and from Lebanon. Before the civil war, Cyprus was already being used as a transit location for the distribution of drugs to Europe. This picture worsened, with Cyprus becoming the only gateway open to Lebanese drug traffickers, so that the island became the transit location for all drugs going to Europe. Eventually, some quantities remained in

Cyprus and were used by Lebanese living on the island as well as by some indigenous Cypriots.

After 1974, licit drug use became a widely accepted norm. Alcohol and tobacco were perceived as substances appropriate to use for self-medication, and later on also as substances offering relief from problems of social isolation and assisting in social gatherings and other events.

2.2. Empirical data on drug use

In Cyprus, there is a considerable lack of scientific research studies and surveys of social issues, including the drugs phenomenon. Before the establishment of the Cyprus Monitoring Centre, no reliable data were available.

However, the treatment-demand data indicate 423 persons seeking treatment in 2005, and 560 in 2006. According to the data, the treatment seeker's profile is typically a Greek-Cypriot male, 28 years of age, unemployed, IV user, with a seven-year history of drug abuse. Similarly, the profile of a typical person recorded as a drug-related death can be summarised as Greek-Cypriot male, 30 years old, opiate dependent. According to the Special Registry of deaths, in 2004[2] there were 17 drug-related deaths recorded, followed by 14 in 2005, 17 in 2006 and 16 up to September in 2007.

The problem drug-use indicator for 2005 indicated 949 heroin users. Given that the population of Cyprus in the age range 15-64 was 497 300, the estimated number of problem drug users is 1.9 in 1 000 inhabitants and the 95% confidence interval corresponds to 1.53-2.55 per 1000 people.

In 2006 a general population survey that was based on standardised European research guidelines was carried out. The aforementioned survey produced the following major results:

- It is estimated that 34.2% of the population has smoked tobacco in the last month;
- One in five smokers consume more than 20 cigarettes per day;
- 50.4% of the population has consumed alcohol in the last 30 days and almost 7.8% has been intoxicated in the last month;

2. Please note that no numerical death data were available prior to 2004.

- Almost 12.5% of persons consuming alcohol in the last 6 months have driven a road vehicle following the consumption of more than six drinks;
- Cannabis remains the most widespread illicit substance of abuse;
- Of all persons aged 15-64 years, 6.6% declared lifetime use of cannabis, corresponding to 32 800 persons;
- 21.1% of persons who have used cannabis have continued its use in the last 30 days;
- The use of illicit addictive substances is significantly higher amongst men;
- The average age of first use of cannabis is 20.1 years;
- 61% of respondents consider a user of illicit substances as being diseased rather than criminal;
- 11% of persons believe that people should be allowed to use cannabis.

2.3. Drug problems as perceived by the public and policymakers

According to the public opinion poll Kyprovarometro (RAI consultants, 2006), the drug problem is perceived as the most serious social problem after the political situation. In 2006, 35% of respondents to this poll in considered drugs to be the primary social problem; this percentage is similar to that in 2005 (34%). It may be worth mentioning too that the same source mentions a significant rise in 2006 in public perceptions of drinking as a cause of road accidents. During the period 2001 to 2005, road accidents were perceived as being alcohol-related by 4-5% of the population, but in 2006 this percentage rose to 12%.

There has been a significant shift in the perception of the seriousness of the drug situation in Cyprus over the years. The proportion of individuals who in previous years thought the drugs issue "not so worrisome" or just "worrisome" has decreased considerably. Persons who found the problem "not worrisome" in 2005 and 2006 remain at 1%. In 2006, 87% of respondents considered the drugs problem "very worrisome" (compared to a similar 88% of respondents in 2005) and 12% found the problem "quite worrisome" (compared to 10% in 2005). It may be presumed that this shift in perception could be due to the publicity the issue received after the announcement of the number of drug-related deaths and other harmful consequences of drug use. A further point may be included here that, following the establishment

of the Cyprus Monitoring Centre, drug-related information was made broadly available to the public, especially through the media, who exposed the problem repeatedly and certainly with a higher frequency than in previous years.

Drug users are largely perceived by the majority of respondents in the general population as being more like patients (61%). It is noteworthy that only a small proportion of respondents perceived users as being more like criminals (5.2%), though a larger proportion of respondents were ready to perceive drug users as being both criminals and patients (13.6%). Tentatively, this finding may suggest that the public at large is likely to feel that treatment for addiction is the best response to the drug issue, while some suppression and law enforcement are simultaneously perhaps seen as necessary measures by public opinion.

Experimentation with ecstasy is least disapproved of, as compared with heroin or indeed "occasional use" of marijuana. It is interesting to note also that heavy daily smoking (10 or more cigarettes per day) is perceived as being more innocuous than occasional use of marijuana, which could indicate that there may be some ignorance of the harmful effects of smoking in the general population.

As regards the mass media, in a random three-month analysis of articles appearing in all daily newspapers during 2006, the most common themes related to:

- Drug Law Enforcement Unit seizures and arrests;
- drug-related deaths – police announcements on drug-related deaths and articles by parliament members and/ or civil citizens;
- annual report of the Cyprus Monitoring Centre for Drugs and Drug Addiction;
- drug decriminalisation – debate on the issue among civil citizens and parliament members;
- drug use in prison – discussion on the lack of treatment options in prison, and police seizures within prison.

It is interesting to note that there were no major recurring themes concerning drugs issues discussed in Parliament or in parliamentary committee meetings in 2006, nor were any significant changes made to the existing legislation or any major drugs legislation passed. The issues brought forward for discussion during 2006 by individual ministers to this committee included:

- observed delay in the establishment of the national drug substitution programme, and problems caused by it;
- Health Ministry update on the operation of a treatment programme responding to the needs of under-age users and substance-dependent persons;
- treatment for drug users in Cyprus and abroad, and measures that need to be implemented;
- the need for free treatment provision for substance-dependent persons.

Individual ministers also brought forward issues which were discussed in the Parliamentary Committee on Crime and Drugs/Addictive Substances. The issues included an update on staffing, equipment and operational activities of the police DLEU (Drug Law Enforcement Unit).

Other issues brought forward for discussion by parliamentary committees included:

- the need for greater awareness-raising regarding drugs in schools;
- an update for the Parliamentary Committee for Crime and Drugs/Addictive Substances on the problem of drugs and addictive substances;
- an update on the CAC (Anti-Drugs Council) Action Plan;
- the drugs problem in the National Guard and ways to combat it;
- problems in the application of the Treatment of Substance Users (1992) Law;
- the co-ordination of competent services and voluntary organisations for the protection of school pupils against smoking and drugs/addictive substances;
- the need to provide incentives for private businesses to employ persons with special needs and former drug users.

The above issues may offer a sampling of the concerns of policy makers in Cyprus, both in the last year and in the years preceding.

2.4. Legal foundations of drug policy

The Narcotic Drugs and Psychotropic Substances Law of 1977 came into force in 1979 and has been amended several times since. It defines controlled substances and contains tables categorising them. It includes

strict provisions on their import, export, manufacture, possession and use, and defines relevant offences and respective sentences. It gives the Council of Ministers the power to issue regulations to facilitate the implementation of its provisions and the Minister of Health the power to issue orders defining controlled substances, amongst other things. Such regulations and orders have been issued as provided.

The Care and Treatment of Drug Addicts Law of 1992 provides, *inter alia*, for the creation of rehabilitation and other medical centres, though such centres are not yet operational.

The Law on the Prevention of the Use and Dissemination of Drugs – Establishment of the Anti-Drugs Council (2000) was amended twice in 2002. The basic scope of this law is to create the legal background for the implementation of European Council Regulation 302/93. Furthermore, it provides for the establishment of the Anti-Drugs Council (CAC) and contains detailed provisions on the duties and powers of this Council. The National Committee for Drugs, chaired by the President of Cyprus, consists of representatives of six government ministries and is responsible for making policy regarding drugs and drug addiction. The CAC is responsible for the drafting, co-ordination, monitoring and implementation of the National Drug Strategy. The National Drug Strategy 2004-08 includes two main Action Plans: Drug Demand Reduction and Supply Reduction. The two Action Plans are divided into various environments specifying their objectives and actions, and designating the institutions responsible for their attainment.

As the national co-ordinating mechanism of drug issues in the country, the Anti-Drugs Council's mandate includes the planning, co-ordination and evaluation of all actions, programmes and interventions aimed at universal, selective or indicated levels of drug prevention. It is also responsible for alerting and providing accurate information to the public about drug issues, and for carrying out consistent research about the drug phenomenon in the country. The priority remains combating drugs, so all relevant departments are taking political and legislative action to improve the co-ordination of activities and the efficiency of measures towards this target. The Council acts as a liaison between the Republic of Cyprus and other foreign organisations on drug-related issues, as well as having the responsibility for promoting legislative or any other measures in an attempt to effectively prevent the use and dissemination of drugs.

Furthermore, the Cyprus Anti-Drugs Council is the body responsible for the strategic design, development and implementation of the National Drugs Strategy and the National Action Plan on Drugs, in alignment

with the EU Drugs strategy. The Council also has overall responsibility for the establishment, support and monitoring of the Reitox National Focal Point and the National Drugs Information System.

Controlled substances

Controlled substances are classified by the Minister of Health when imported for the first time. The level of control suggested by the International Narcotics Board and the Conventions signed by the Republic of Cyprus are both taken into account, as well as local patterns of abuse or social diversion, for example.

The first schedule of the Narcotic Drugs and Psychotropic Substances Law of 1977 classifies controlled substances in three groups – Class A Drugs, Class B Drugs and Class C Drugs – according to the risk of harm to public health and their abuse potential. Class A drugs have the highest abuse potential whereas Class C drugs have the lowest. Levels of punishment are directly linked to this classification.

Drug use and possession

Use of controlled drugs is criminalised under section 10 of the law of 1977, which originally prohibited the use of prepared opium, cannabis or cannabis resin and in 1992 was extended to apply to all controlled drugs listed. The 1992 amendment (s.15) also changed the sentencing provisions of the Third Schedule of the 1977 law.

Use or possession of a Class A or B drug is now punishable with a maximum of a life sentence. The maximum sentence for use or possession of Class C drugs is 8 years. It is also an offence to buy or be supplied with a controlled drug without authorisation.

Following amendment of the 1977 law in 2003, s.30A of the law introduced limits on quantities for personal use, whereby possession of more than that limit creates the rebuttable presumption that the person intended to sell the substance. A table of limits within this section includes three or more cannabis plants, 30 or more grammes of cannabis or its products, or 10 grammes or more of prepared cocaine or opium (or its products). This was deemed necessary because of the difficulties of proving in court an intent to sell.

The state of "addiction" is legally recognised. In the Care and Treatment of Drug Addicts Law of 1992, an "addicted person" means a person who, due to taking drugs or psychotropic substances as provided in the Narcotic Drugs and Psychotropic Substances Law of 1977, or due to

taking other substances which may lead to dependence, has become dependent on such drugs or substances.

The Cyprus authorities are very strict on drug-related issues so usually, when there is illegal activity concerning drugs, prosecution will follow. However, in rare cases the Attorney General may give directions for non-prosecution, if s/he considers that the circumstances of the case justify such a decision – this is the power of the Attorney General to be exercised in any criminal case. Nevertheless, following an amendment in 1992, s.30(2) of the 1977 law states that the Court may not impose imprisonment of more than one year to a first-time offender aged under 25 when the offence relates to personal use only.

Trafficking is covered in various laws: the 1977 law prohibits production, or being concerned in the production, of a controlled drug; supplying or offering to supply a controlled drug or being concerned in the doing of either activity by another; having possession of a controlled drug with intent to supply it to another; cultivation of the cannabis plant or the *Papaver somniferurn* plant. Penalties for trafficking may be up to life in prison for a Class A or B substance, or 8 years for a Class C substance.

Police have established the Drug Law Enforcement Unit whose main aims are to combat drugs and co-operate with other agencies involved in preventing and combating drug trafficking. The Police and the Department of Customs and Excise have signed a Memorandum of Understanding on drug-related issues. Contact points have been designated in order to co-ordinate actions derived from the provisions of this Memorandum.

Also, the Department of Customs and Excise is in close co-operation with other government bodies on law enforcement issues, such as the Ministry of Commence, Industry and Tourism and the Pharmaceutical Services.

Prevention, care and treatment

The main law on this issue is the Care and Treatment of Drug Addicts Law of 1992. Under the provisions of this law, convicted persons with an addiction may serve their sentence in a detoxification or rehabilitation centre if the Court orders them to do so. The law also provides for the treatment of addicted minors and there are provisions whereby such minors will be detained in such centres for treatment. This measure is only permitted if ordered by a Court of competent jurisdiction, following a relevant application by the guardian of the minor or

by such other person who is in a position to know the circumstances of the person concerned.

Unfortunately there are no such treatment centres under government supervision yet available, and the operating regulations for them have not yet been issued. However, the government is now working on existing centres, so this option should soon be available.

2.5. The development of Cyprus drug policy

Up to 2000, the interventions taking place in Cyprus – both demand reduction and supply reduction of illicit drugs – were implemented unsystematically. A lack of co-ordinated efforts was observed in the governmental sector as well as the non-governmental one. Treatment lay basically in the hands of the Ministry of Health, Mental Health Services, which created a special unit in 1991 to treat both drug addiction and alcoholism. Prevention programmes took place in schools, led by volunteer teachers outside the school classroom, and the drug addict was basically considered a criminal. Civil society joined its efforts in what became a wave of considerable concern, while at the same time the scientific data available remained significantly quite scarce.

In 2000, the Cyprus Parliament passed the Prevention of the Use and Dissemination of Drugs and Other Addictive Substances (establishment of the Anti-Drugs Council) Law, thus creating the supreme co-ordinating body for drugs (both legal and illegal) in the country, known as the Cyprus Anti-Drugs Council (CAC). The CAC's main role was to co-ordinate all efforts in the governmental and non-governmental sector, ensuring that all actions fell within the spirit and philosophy of the National Drug Strategy.

The first National Drug Strategy was drafted in 2004, as a result of a European Union twinning project between Cyprus and Spain. The process involved an intense consultation process between the Cyprus Anti-Drugs Council and the ministries involved (Health, Justice and Public Order, Education and Culture, Interior, Defence, and Labour and Social Insurance), as well as the NGOs. The context in which this development took place was Cyprus' accession to the EU and its commitment to introduce all relevant mechanisms and structures in order to implement agreed policies.

The National Drug Strategy encompasses the dimensions of demand reduction and supply reduction for both legal and illegal substances.

However, due to the social demand for immediate action on illegal drugs, as well as the understaffing of the CAC, the Council directed all efforts towards illegal drugs, aiming at strengthening prevention programmes and structures within the Ministry of Education and Culture, as well as treatment options offered by the Ministry of Health. The few actions included in the Action Plans specifically addressed to alcohol and tobacco were thus relatively low on the Council's priority list.

International context

Apart from what has already been mentioned above, Cyprus regularly participates in the horizontal working group for drugs at the European Union. Also, the Cyprus Monitoring Centre is co-funded by the EMCDDA, in whose proceedings it actively participates together with other EU member states. In addition, national experts on drugs are regular participants and speakers at international conferences.

Relationship between drug policy and alcohol/tobacco policy

Data regarding licit or illicit drug use remain limited and have only been available since the mid-1990s. According to the ESPAD survey (1995, 1999, 2003 series), increases have been noted in lifetime use of 40 cigarettes or more per day, and in smoking during the last 30 days among the school population. Furthermore, a recent general population survey (2006) revealed that 34.6% of the sample had been drunk at least once in their lifetime. The survey also revealed that 51% of the participants believed that the use of five alcoholic drinks per weekend represents a moderate to high risk.

Legal developments, civil society actions, fatal alcohol- and other drug-related traffic accidents, and their intense exposure by the media, have all assisted in the beginning of a mentality shift regarding the harmful consequences of licit drugs. Although several laws regulating the sale and use of substances existed, the respective social norms did not allow their enforcement, thereby maintaining a situation of absolute tolerance of alcohol drinking and tobacco smoking.

Among the influences that have helped to partly change public opinion on licit drug tolerance have been the International Convention against Smoking, which entered into force in 2005, the introduction of an anti-smoking campaign in Cyprus by the Health Commissioner, and amendments to the Protection of Health (Control of Smoking) Law – which includes provisions such as the prohibition of tobacco supply to a minor, prohibition of tobacco advertising and prohibition of smoking in public places – and to the Law on the Sale of Alcoholic Drinks. This

shift is also evident in the involvement of civil society, with pressure groups (such as parents) lobbying at parliamentary level, aiming to promote enforcement of the Law on the closing hours of night clubs and encourage the notion of the designated driver.

The increase in alcohol- and poly-drug-related fatal traffic accidents and their exposure through the media assisted in increasing public awareness of the harmful consequences of alcohol use. Media campaigns targeting the youth population alone also helped in reducing the tolerance of licit drug use.

The National Drug Strategy (NDR) 2004-08 was the initial part of a global social policy dealing with licit and illicit substances. Relatively detailed drug demand-reduction and drug supply-reduction action plans accompany the strategy. The strategy adheres to the principles and guidelines of the European Drug Strategy. It is clearly stated that "Cyprus will strengthen the prevention of drug consumption and its negative consequences for health and social integration, following a comprehensive approach that will not only focus on illicit drugs but that will give very special attention on other legal substances, particularly alcohol, tobacco and psychoactive substances that produce dependency or can be abused".

It is stated that two of the main pillars of drug prevention will be: "The prevention of recreational consumption and abuse of legal and illegal substances with a special focus on new synthetic drugs and cocaine" and "Prevention of risk consumption of legal drugs such as alcohol, tobacco and psychoactive substances that produce dependency or can be abused". It is also stated in the National Drug Strategy that co-ordination of all services involved and participation of all members of civil society will be promoted and encouraged.

In the Action Plan on Drug-Demand Reduction, the question of alcohol and tobacco is addressed in three environments (sub-chapters): the Working Environment, the Recreational Environment, also the Legal Framework, and indirectly in the School Environment.

In order to understand the NDR and its contents as they apply in Cyprus, we need to examine the influence of a) the institutions assisting in creating it and b) other EU strategies. The first NDR was a product resulting from a twinning project with Spain and Greece. Thus, the Cypriot strategy was greatly influenced by the Spanish. As previously mentioned, licit substances were included in the strategy, although licit substances were socially acceptable, in an attempt to create a holistic strategy with concrete and measurable actions. In addition,

despite the lack of data, there were clear indications of the dangers of alcohol consumption, for instance the alcohol-related fatal traffic accidents, which alerted the strategy makers and motivated them to include alcohol in the strategy.

Further, following the country's accession to the EU, attempts were made to align with EU policy and with other international organisations. The inclusion of alcohol and tobacco in the first drug strategy comprised the beginning of a new era regarding their social acceptance. In conclusion, licit drugs in Cyprus are still perceived as less harmful than illicit ones. However, there is evidence of a gradual shift in this perspective at all levels, political and social. A holistic drug policy (including licit and illicit psychoactive substances) will assist in the creation of a well-structured and integrated prevention and treatment system. Consequently, prevention and treatment availability will increase.

2.6. Theory versus practice

Having said all of the above, some points need to be made about the discrepancy between official treatment of the drugs issue and actual practice and the state of this issue in Cyprus. In particular, we can observe a lack of emphasis on research findings as pertaining to policy making. At the same time, undue emphasis is placed on political decision making. Consequently, there is a lack of available funding for the kind of scientific research projects that experts identify a need for.

Despite public appreciation of the drugs issue, which has already been discussed, drugs and other social issues do not appear as a priority on the political agenda. This may be a result of the overwhelming importance assigned to the Cyprus national issue, which is also perceived by the public as being of primary importance, though it needs to be said that drugs are in second place after the national issue in the estimation of the public.

3. Czech drug policy and its link to tobacco and alcohol policies

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3.1. Development of the drug scene

In the beginning of 1990s, illicit drug use appeared much more widely in the Czech Republic, as it did in other central and eastern European countries, as a consequence of liberalisation of society after the fall of the communist regime. Changing values and lifestyles, the weakening of social security and control, low understanding of drug problems and the absence of relevant legislation, together with the opening of the market and higher availability of drugs, led to a high increase of illicit drug use in the Czech Republic. Until 1990, the illicit substances in the Czech Republic included domestic production of marijuana, a home-made opiate called *braun* and a home-made methamphetamine called *pervitin*. The drug market hardly existed and the number of drug users was very low.

After 1990, the Czech Republic started to act as a transit country for heroin, and a drug market (both supply and demand) was created. At the end of 1990s, the Czech Republic became a target country for illicit drugs as well, the number of drug users (both experimental users and problem drug users of heroin and *pervitin*) started to increase, and drugs were mostly imported but domestic production continued as well (*pervitin* has remained the most popular problem drug until now). An open drug scene was created, drug criminality started to appear to a greater extent, and all types of illicit drugs became much more available. Since about 2002, the number of problem drug users has stabilised, while the experimental use of marijuana, ecstasy and other synthetic drugs has continued to increase, especially among young people.

For more details on the current situation in the field of drug use and its consequences, see the Annual Report on the State of Drugs in the Czech Republic in 2005 (Mravčík et al. 2006).[3]

3.2. Development of drug policy

Drug policy in the Czech Republic does not have a long history. At the start of the 1990s, experts and professionals began to warn against the expected increase in illicit drug use (in line with the overall trend of convergence with other European countries), but no action was taken until 1993 when the Czech Republic adopted UN Conventions. Only after that did the government establish the first advisory body, the National Drug Commission, and adopt the first drug policy document called "Concept and Programme of Drug Policy for 1993-96" (Bém et al. 2003). The document presented the first situation analysis in the field of drug use (based on the very little information available at that time). First, the principles of drug policy and priorities were defined:

- repression – to combat drug-related criminality, especially organised crime,
- administration – to create bodies in line with international legislation,
- prevention – to support primary prevention,
- information – to establish a system of monitoring the drug situation.

Despite the aim of primary prevention, this programme included action to creating different types of service for drug users, such as low-threshold centres, therapeutic communities and day centres, that did not yet exist at that time. The document defined basic instruments for co-operation on national and regional levels, and for strengthening the role of NGOs working in the area of services for drug users.

The National Drug Commission is an advisory body of the government; it consists of the Prime Minister and those ministers dealing to a certain extent with drugs (Education, Health, Social Affairs, the Interior and the like). Their task is to formulate common and complex strategies of drug policy, and co-ordinate drug policy and its implementation on national and regional levels.

3. See: www.drogy-info.cz/index.php/english/publications/czech_annual_report_on_the_2005_drug_situation.

The second document "Concept and Programme of Drug Policy for 1998-2000" was able to evaluate the successes and failures of the preceding period, based on first indicators of drug epidemiology. The Concept from 1998 called for a balanced approach covering reduction in both drug supply and drug demand; the focus of the Concept was on instruments and mechanisms such as financing, defining a minimum network of services, evaluation of quality and effectiveness (e.g. defining quality standards) and training. Its main principles called for a pragmatic approach with realistic objectives: for instance, the objective of a drug-free society was abandoned, the focus should be on targeted measures that had proved effective and financing should be targeted on those interventions where quality was assured and results could be evaluated (Bém et al. 2003).

In the second part of 1990s, legislation in the field of drug-related crimes was drafted, such as the Law against the Legalisation of Revenues from Criminal Activities No. 61/1996 of the Collection (including money laundering) and the Law on Addictive Substances No. 167/1998 of the Collection defining handling psychotropic substances and precursors. In the 1990s, the Penal Code (from 1961) was modified to adapt to the obligations stemming from international agreements and conventions; four drug-related paragraphs now refer to possession of drugs for other persons or for own use, unauthorised production of drugs and propagation of drugs. In the 1990s, the nature of a balanced approach between repression and legalisation of drug use was strongly debated. Discussion has continued more or less until the present and from time to time the topic gets into media and public debates.

While the first two strategy documents focused on creating mechanisms for co-ordination of drug policy, and creating and implementing programmes of prevention, treatment and rehabilitation, the "National Drug Strategy for 2001-2004" focused on the missing types of programmes and services in the field of prevention and treatment, on creating instruments for evaluation of their quality and effectiveness and on improving collaboration in the field of drug-supply reduction. The National Strategy defined seven areas of drug policy: (1) primary prevention, (2) treatment and rehabilitation, including harm reduction, (3) legislation and drug-supply reduction, (4) financing, (5) professional training, (6) international co-operation and (7) co-ordination (Meziresortní protidrogová komise, 2000). The main objective of the National Strategy was to create a co-ordinated, effective and balanced framework of drug policy by means of prevention, treatment, rehabilitation and repression interventions that corresponded to the needs of target groups and were based on evidence known in European countries; the aim was to increase the quality and effectiveness of programmes,

widen the spectrum of services provided and increase the evaluation of impacts of the interventions.

The newest document, "National Drug Policy Strategy for 2005-2009", is based on the principles of previous strategic documents, that is, a balanced approach between reducing drug demand and drug supply, and four pillars: prevention, treatment, harm reduction and supply reduction. The drug policy is formulated in the context of co-ordination, financing, international co-operation and research, information and evaluation (see Figure 3.1). The main objectives of the National Strategy are defined as: (1) to combat organised crime and enforce observance of laws in respect to the distribution of licit drugs, (2) to reduce the use of all types of drugs and the potential harm to individuals and society (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2005b). Specific objectives include:

- to stabilise or reduce the number of problem drug users,
- to stop the increase in experimental and recreational use of licit and illicit drugs,
- to stabilise or reduce the consumption of licit and illicit substances in society, especially among young people,
- to reduce the potential risks of use of all types of drugs and the economic, health and social impacts of their use, on the individual and society,
- to improve the quality of life of drug users, their parents and relatives by ensuring the accessibility of good-quality treatment and rehabilitation services,
- to reduce the availability of licit and illicit substances for the general population, and especially for young people, through the effective use of existing legislation and institutional instruments.

Figure 3.1: The context and four pillars of drug policy in the Czech Republic

<table>
<tr><td colspan="4">Co-ordination
Funding</td></tr>
<tr><td>Primary prevention</td><td>Treatment and re-socialisation</td><td>Risk reduction</td><td>Reduction of availability</td></tr>
<tr><td>Activities aimed at preventing drug use or postponing first experience of drugs to a more mature age</td><td>A range of services related to abstinence therapy for drug users who make a conscious choice to live without drugs</td><td>Activities to reduce the potential health and social risks and impacts of drug use in relation to users not yet ready to give up drugs and in relation to society</td><td>Activities to enforce the law in combating the supply of drugs</td></tr>
<tr><td colspan="2">Reducing demand</td><td>Reducing harm</td><td>Reducing supply</td></tr>
<tr><td colspan="4">Research, information, evaluation</td></tr>
<tr><td colspan="4">International commitments and co-operation</td></tr>
</table>

Source: Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2005b

Other objectives include an effective system of funding drug policy implementation, effective co-ordination of specialisms at all levels with clearly defined competencies and duties, information provided to the public (complex, objective, reliable and evidence-based information), international co-operation and evaluation of activities. The specific and organisational objectives and actual activities are then described in more detail in the Action Plan for Implementation of National Drug Policy Strategy for 2005-2006 and the Action Plan for 2007-2009.[4]

4. The text of the National Drug Strategy can be downloaded in pdf format from: http://www.drogy-info.cz/index.php/english/publications/national_drug_policy_strategy_for_the_period_2005_to_2009.

3.3. Licit drugs

3.3.1. Policies on licit drugs

In parallel with the development of drug policy, policies on licit substances (alcohol and tobacco) were formulated as a part of health policy. From the beginning of the 1990s, several documents aiming to improve the health of the population were prepared and approved by the government: the National Programme for Health Promotion in 1992, the National Health Programme in 1994 and the Action Plan on Health and Environment in 1998 (Institut zdravotní politiky a ekonomiky, 2004). These documents defined several objectives in the reduction of alcohol consumption and smoking, especially among young people, as there was increasing consciousness about the risks of smoking and alcohol consumption. Interventions included restricting availability of alcohol and tobacco, promoting non-smoking and monitoring the extent of smoking and alcohol consumption and the consequences.

In 2000, a new Law on the Protection of Public Health (No. 258/2000 of the Collection) was adopted, defining the responsibilities of different institutions in the field of public health. In 2002, the government approved a long-term strategy for improvement of the health of the population "Health 21 – Health for All in the 21st Century", which is the Czech version of the WHO concept Health 21 (with the main objectives adjusted to the specific Czech situation). One part of Health 21 was dedicated to alcohol, tobacco and illicit drugs (Objective 12): to reduce damage caused by alcohol, drugs and tobacco, that is, to reduce the negative effects of the use of addictive substances (Ministerstvo zdravotnictví ČR, 2002). Interventions to reach this objective included legislative and tax measures, restrictions on advertising, prevention programmes in schools, media campaigns, establishing a minimum network of treatment facilities and establishment of a co-ordinating, monitoring and research centre for alcohol and tobacco. The Czech Republic has also joined the 2000-05 European Action Plan on Alcohol, which defines objectives to prevent and reduce the harm caused by alcohol, and the Framework Convention on Tobacco Control of the WHO, which has a similar objective in the field of tobacco smoking; objectives defined in these documents are in line with the above-mentioned Health 21 document.

Responsibility for implementing interventions promoting public health was delegated to the Ministry of Health. So far only small improvements have been achieved in implementation. This is especially caused

by the fact that the Ministry of Health has been permanently facing problems in the sustainability of the system of health care (with lack of financing for primary health care and health facilities, and increasing debts of health insurance companies); at the moment, these areas are of much higher priority than the area of proactive health promotion (Institut zdravotní politiky a ekonomiky, 2004). This is combined with low attractiveness of the topic for policy makers and underestimation of the risks related to alcohol consumption and smoking (Nešpor and Csémy, 2004; Lejčková et al. 2005).

The laws adopted in the 1990s and 2000 have been updated several times, the last update being done in 2006 (Law No. 76/2006 of the Collection, which modifies the content of laws No. 167/1998 on addictive substances and No. 258/2000 on protection of public health). In 2005, the Law on interventions for protection against harm caused by tobacco products, alcohol and other addictive substances (No. 379/2005 of the Collection) was adopted. The new law defines restrictions on the availability of tobacco products, smoking bans in specific areas (such as public buildings, schools and health facilities), restrictions on the availability of alcohol and sanctions for violation of the law. At the same time, this law defines organisation and implementation of drug policy on national and regional levels.

3.3.2. Licit drugs as part of a national policy

For the first time, issues related to licit drugs (in particular, tobacco and alcohol) were incorporated in the National Drug Policy Strategy for 2005-09. Already during the preparation of the previous strategy (for the period 2001-04) several experts had been calling attention to correlations between the use of licit and illicit drugs. However, issues related to licit drugs failed to be incorporated in the previous strategy – mainly because there was no political support or will, because alcohol consumption and tobacco smoking are accepted across society and action to reduce their availability or accessibility would generally (and politically) be perceived as unpopular measures.

The reasons behind the decision to incorporate tobacco and alcohol into the drug policy were as follows:[5]

– Both tobacco and alcohol are addictive substances and, like illicit drugs, they cause addiction and changes of perception,

5. Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2005b, Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2005a.

mood, thinking and/or motor functions, as well as serious health and social problems;

- The risks of alcohol consumption and tobacco smoking are still underestimated, even though they have repeatedly been mentioned in strategies on the protection and promotion of public health;
- The prevalence of smoking and alcohol drinking in the population of the Czech Republic is high, both among adults and among children and young people. At the same time, sales of cigarettes and alcohol to under-age persons are prohibited (the legal age for buying alcohol and tobacco products in the Czech Republic is 18 years);
- Current (school) prevention does not differentiate between licit and illicit drugs.

The expert working group on Alcohol and Tobacco prepared background documentation and formulated three key objectives in this field: (1) to reduce alcohol and tobacco consumption, especially among young people; (2) to reduce the unfavourable impacts for individuals and society, and (3) to reduce the availability of alcohol and tobacco products. Four fields were selected and specific activities were formulated for each of them, covering the fields of data collection, legislation, prevention and treatment, and information.

A specific chapter on licit drugs was to be included in the Action Plan on Implementation of National Drug Policy Strategy for 2005-2006, to point out the inclusion of this topic in the strategy; however, in the final document, the interventions on tobacco and alcohol were scattered into the chapters on treatment, supply reduction, information and so on, and thus the original intention of pointing out the topic disappeared.

For details of the formulation of specific activities and interventions on tobacco and alcohol, see the Action Plan on Implementation of National Drug Policy Strategy for 2005-2006 (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2005a) or the Selected issue of the Annual Report on the State of Drugs in the Czech Republic in 2004.[6]

6. The Annual Report on the State of Drugs in the Czech Republic in 2004 can be downloaded in pdf format from: http://www.drogy-info.cz/index.php/english/publications/czech_annual_report_on_the_2004_drug_situation.

3.3.3. Including licit drugs in the strategy – was it a success?

The Action Plan for 2005-06 was evaluated at the beginning of 2007. Altogether, 14 activities included in the Action Plan were to be realised by the end of 2006; out of these, nine were reported as successfully fulfilled while five were not. Those accomplished include implementation of short interventions regarding tobacco and alcohol use in practice, training for health professionals, proposed draft of a new law, implementation of restrictions on availability of tobacco products and alcohol, sanctions for violation of the law, and establishment of a monitoring centre for tobacco and alcohol use (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2007b). However, there are doubts about the real state of their implementation because the outcomes are often unclear, frivolous or even unknown; there are suspicions that their implementation was only formally reported as fulfilled.

Some of the activities that were not realised (or were only partly realised) were included in the new Action Plan for Implementation of the National Drug Policy Strategy for 2007-09. The Action Plan now contains specific action to reduce the availability of alcohol and tobacco products for under-aged children (analysis of the effectiveness of implementation of the restrictions) and action on data collection on the extent of smoking and alcohol consumption and the consequences: launch of a website of the monitoring centre for tobacco and alcohol, preparation of an annual report on the situation, formulation of a list of indicators for data collection and analysis, and situation analysis of existing network of services providing prevention and treatment (Sekretariát Rady vlády pro koordinaci protidrogové politiky, 2007a). Several activities, especially in the field of prevention or training/education, do not distinguish between licit and illicit substances and refer to addictive substances in general. However, the scope of action related specifically to alcohol consumption and smoking has diminished; in fact, there was no aim to broaden its scope across different fields and no aim to focus a specific chapter on licit substances. One activity regarding restrictions on the availability of volatile substances was specified in the new Action Plan.

At the same time, there is increasing pressure to open services targeted at (illicit) drug users to users of alcohol and tobacco, especially those types of service that are not currently available to users of licit drugs (e.g. therapeutic communities, aftercare programmes or low-threshold services). Extending access like this would interfere with the system of financing these services, since they are financed from grants assigned to drug policy. However, these grants are not raised in proportion to the number of users, and existing finances are very limited and

thus cannot cover treatment and aftercare for users of alcohol and tobacco.

So far, a general perception has persisted in society that "alcohol and tobacco are not drugs" and thus they do not need to be addressed through drug policy. Thanks to the high tolerance and acceptability of smoking and alcohol consumption in society generally, any restrictions on their availability and use (e.g. smoking bans, increased taxation or restrictions regarding selling places) are not popular among policy makers and are not welcomed by society, even though professionals constantly report on the risks and harm caused by alcohol and drugs. The only interventions accepted by society so far are in the field of alcohol and driving (zero tolerance for alcohol content exists) and restrictions on selling alcohol and tobacco products to children and teenagers (the legal age for buying alcohol and tobacco is 18 years).

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4. Alcohol and drug policies and prevention strategies in Estonia

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4.1. Before 1991

The history of Estonia is long and interesting, from the time over 10 000 years ago when the first people came to the area until today when it is an independent nation state. After many centuries of independence, the country was occupied by Germans, Danes, Swedes and Russians between the 12th and 19th centuries. It achieved independence in 1918, but then was occupied by the Soviet Union from 1940 to 1991. The end of the 20th century brought the opportunity to re-establish an independent republic of Estonia.

Different drinks have been consumed here through history. Unlike southern countries, where wine has been always one of the most popular alcohol drinks, in Estonia beer was the main drink over the centuries. The popularity of vodka came later, in the 17th and 18th centuries.[7] As with the history of Estonia, the legislation has been very diverse and influenced by different politics. The concern about public health has been created by different risk factors: in the 19th and 20th centuries by alcohol; at the end of the 20th and the beginning of the 21st century by illicit drug use.

4.1.1. Legislation, 1918-40

At the beginning of the 20th century, alcohol problems were mainly regulated by limiting availability. In 1918 the punishments for producing and selling illegal alcohol were increased – they could bring 3-5 years in prison, confiscation of the property or a fine. In 1920, the sale of vodka was declared to be a state monopoly and it was sold by registered cheques.

7. See http://www.virumaateataja.ee/200405/esileht/15023848.php.

In 1926 the cheque system was repealed and in 1927 local authorities got the rights to decide when and where alcohol sale is permitted and they got also the rights to arrange referendums for the residents of their area.

The first Alcohol Act was adopted in 1934 and revised in 1935. By this, the state took away the right to sell alcohol from local authorities. When alcohol use increased, in 1937 the state limited the amount of licences for alcohol sale and in 1939 the opening hours of bars were shortened and the number of bars reduced.

4.1.2. Legislation, 1940-91

In 1940 the Soviet Union occupied the Republic of Estonia and its legislation came into force. Alcohol and drug addiction policy in Soviet Union was based on a Criminal Code and involuntary treatment.

The Criminal Code of the Soviet Republic of Estonia was adopted in 1961. That stated that all drug and alcohol addicts must receive medical and work-treatment whether they wanted it or not. There were also several penalties for having, producing or selling illegal alcohol and drugs and for persuading adolescents to use drugs and alcohol.

In 1970 several acts were adopted to promote involuntary medical and work treatment for alcohol and drug dependency. Also, government registries for addicts were set up. Despite all the measures taken to fight addiction, especially alcohol use in the Soviet Union, it increased rapidly in the 1980s. In 1985 more severe measures were decided upon – abstinence was declared to be the only correct way of living, sale and production of liquors were limited, and penalties for selling alcohol to people under 21 were adopted. Penalties were quite strict: for example, involving people under the age of 21 in using alcohol could bring five years' imprisonment, and disregarding the alcohol sale rules could bring three to five years' imprisonment.

Until 1988 there was no Act dealing only with drug addiction. That year the list of narcotic and psychotropic substances was adopted, and fundamental rules for the treatment strategy of drug addicts were published.

4.2. Since 1991

4.2.1. Legislation

Estonia regained its independence in 1991. Since that year, a new legislation system has been built up and harmonised with European Union

law. One of the first Acts that was changed was the Criminal Code and the biggest change affecting addicts was the repeal of involuntary treatment in Estonia. On the other hand, punishments for illegal drug use were much more accurately recorded and strictly enforced.

Since sale limitations and involuntary treatment had not been very effective, newly liberated Estonia decided to take another direction. The Alcohol Excise Act (1997) was an attempt to reduce alcohol consumption by raising the price with taxes; with the Advertisement Act (2003), advertisements of alcohol, drugs and tobacco in the media were prohibited.

From the second half of the 1990s, illegal drug use in Estonia started to increase rapidly. Therefore in 1997 the first Narcotic and Psychotropic Substances Act in Estonian history was adopted. That Act regulated all legal and illegal drug use – the list of narcotic drugs was established, the control system for handling drugs was created, and measures were put in place to prevent illicit drug use and to organise treatment and rehabilitation. The Act has been amended twice, in 2005 and 2006. With this amendment, the National Drug Treatment Database was established and all necessary European Union directives were taken into account. In 2000 Estonia also joined with the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

The Estonian Alcohol Act was adopted in 2001. Despite other Acts already regulating this area, the Alcohol Act codified several aspects: the registry of spirits was established, and requirements for the sale and production of alcohol were written down. An important point for public health was that alcohol use before age 18 was prohibited by this Act.

In the same year the Estonian Penal Act made the sentences much more severe for all crimes related to illegal drugs – having or selling drugs could now carry 15 years in prison, enticing an adolescent to use drugs could bring life imprisonment, and several other alcohol-related crimes could also end with imprisonment.

The latest addiction-related law is the Tobacco Act, adopted in 2005. It regulates production and sale, sponsorship restrictions and requirements for cigarettes and their packages. An important point for public health is the complete ban on tobacco products being sold to, or used by, adolescents under age 18 and prohibition of smoking by adults in public places.

4.2.2. Prevention of alcoholism and illicit drug use

Preventing alcoholism has been a frequent topic in Estonia since the end of the 19th century. Temperance unions played a very big role in this work.[8] Nowadays, concern about alcohol abuse has reached most parts of society. Since 1997, the Estonian Government, with the co-operation of other organisations, has established political programmes to prevent alcohol and drug abuse. In 1997 the first prevention programme – Prevention Programme for Alcoholism and Drug Addiction 1997-2007 – was adopted. That programme was based on the UN Convention, and its main aim was reduction of the harm caused by alcohol abuse and illicit drug use. At the same time the government adopted "Principles for Drug Prevention and Harm Reduction for Years 1997-2007", listing direct actions for achieving the goals.

With the change in society and increasing drug problems in Estonia, it became necessary to focus on drug prevention. In 2004 the government adopted a new National Strategy for Drug Prevention up to the year 2012, which is fully in compliance with European Union drug directives. The strategy came into force in 2005 and invalidated the earlier prevention programme. The new strategy has six main areas which need to be raised and resolved for the year 2012 – prevention, harm reduction, demand reduction, drug treatment and rehabilitation, drugs in prison and drug monitoring. The most important target groups in this strategy are children and adolescents.

Besides the National Drug Prevention Strategy, the HIV/AIDS prevention programmes and strategies are also included. The first HIV prevention programme was adopted in 1992, the second in 1997, and in 2002 the National Strategy for Preventing HIV/AIDS was adopted. All these programmes have had results against illicit drug addiction, and almost all local authorities have their own drug-prevention programmes to help resolve the addiction problems in their areas. At the moment there are no tobacco-prevention programmes and unfortunately, since the adoption of National Drug Prevention Strategy, there is also no alcohol-prevention programme or strategy in Estonia.

For now, in Estonia there is an established and strong legislative background to prevent the prevalence of illicit drug and alcohol use, with quite a large budget for developing good treatment, rehabilitation systems and prevention programmes. Only time can show if we can realise all these opportunities in a proper way.

8. See http://www.ave.ee/mis.php?page_id=7.

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5. French public policy on drugs, both legal and illegal

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5.1. The MILDT

In the early 1980s, France set up a central body to co-ordinate action by the authorities to combat the use of, and trafficking in, illegal drugs (including heroin, cocaine and synthetic drugs). It was initially called a Standing Task Force, but is now known as the Joint Ministerial Task Force for combating drugs and drug addiction (MILDT).

Establishing this co-ordinating body was in keeping with France's tradition of a centralised state. It was presented at the time as a political response to the concerns engendered in France by the significant increase in the use of heroin in the country during the 1970s and the fact that the problem was increasingly conspicuous. The use of injected heroin spread to all social classes during this period and began to affect disadvantaged social groups. It was at this point that the problem of street dealing emerged, along with all its clearly harmful side effects (crime carried out in order to purchase drugs, public disorder and other results).

Until the mid-1990s, the co-ordinating body suffered from chronic instability resulting from successive reorganisations, being moved to and fro between the Ministry of Health and the Ministry of Justice and, above all, a high turnover among those in charge. As a result it did not really guide and co-ordinate public policy as it was expected to do, and the real impetus for public policy continued to come from the ministries responsible for law enforcement (Justice and the Interior), with regard to combating drug use and trafficking, and the Ministry of Health, in respect of the health and welfare facets (prevention, care and rehabilitation).

The extremely rapid spread of the AIDS epidemic among injecting opiate users between 1985 and the early 1990s undermined this

approach in France, as was the case elsewhere. It pushed into the background the law and order aims of the ministries of Justice and the Interior (to punish drug-use offences and prevent recidivism by promoting abstinence through detoxification), shifting the emphasis to a health-related strategy based on risk reduction (designed to contain a deadly epidemic liable to spread to the entire population). In this new context, the French government decided in 1995, as a matter of some urgency, to set up a large-scale programme of opiate substitution therapy, which had been practically non-existent previously. The task was assigned to the Ministry of Health, but it was expected to call on the active support of the MILDT. To ensure that the Task Force had institutional status that placed it above the relevant ministries (Health, Justice and the Interior) and acquired true legitimacy, it was made permanently responsible to the Prime Minister, under a decree passed in 1996.

From that point on, the MILDT began to play a real part in co-ordinating government policy on drugs, even though the Ministry of Health was directly responsible for the main aspects of the new risk-reduction policy, as was only natural. However, it was not until three years later, in 1999, that the MILDT's sphere of competence was extended to include legal drugs, in other words alcohol and tobacco, and the misuse of psychotropic medicines and doping substances (under a decree of 15 September 1999), and that a fully-fledged, integrated addiction-prevention policy was drawn up and implemented within this new framework.

5.2. A change of attitude

What factors made it possible in France, at the time, to bring legal psychotropic substances within the scope of policy on drugs? The first factor was the rapid advance from the mid-1980s onwards of knowledge in the field of the neurobiology of addictions. This showed that in all addictions, whether to alcohol, heroin, tobacco or cannabis, there were common molecular mechanisms which brought the same reward-and-pleasure pathways into play. It so happens that French neuroscience teams were very active in this research field and they were able to raise awareness of these new data among politicians and the general public. As a result, the idea that the means of treating different types of addiction could, in part, have a shared pharmacological basis began to be increasingly accepted.

5.2.1. The Roques report

Reference should also be made to the impact of an expert report, which caused a considerable stir in France and other French-speaking countries, namely the Roques report.[9] It was commissioned in 1997 by the then Minister of Health, Bernard Kouchner, from Professor Bernard Roques, an internationally renowned neuropharmacologist. The conclusions of the report were made public in January 1999 and came as a bombshell to all those involved in this area. Firstly, the report highlighted the fact that legal psychotropic substances have all the defining features of a drug: they modify people's state of consciousness, activate reward pathways in the brain, have major and often underestimated addictive potential and cause partly irreversible changes to brain functioning among abusive or dependent users. Secondly, it showed clearly that misuse of some legal drugs, particularly alcohol, was much more dangerous (not just to health, but also in economic and social damage) than the consumption of certain illegal drugs such as cannabis.

In other words, the report pinpointed the inconsistencies of France's legislation on drugs, pointing out that illegal drugs were not necessarily more dangerous for individuals and the community than legal psychotropic substances and that it was therefore somewhat unreasonable to punish the use of the former severely while being very tolerant about the misuse of the latter. Although they gave rise to a heated debate, these conclusions had a major influence on the thinking of France's political leaders. Firstly, they revealed the extent to which beliefs and ideologies affected the legislative basis for drug policy. Secondly, they opened up new avenues for the general approach to drugs, centring on the notion of risk rather than on legislation and prohibition.

5.2.2. The wider picture

At the same time, a third factor played a major role in this far-reaching change in outlook, namely the establishment of durable arrangements for epidemiological surveys conducted among the general public. Until the early 1990s there was a complete lack of epidemiological knowledge of the consumption of drugs in France, apart from the results of a few ad hoc, piecemeal surveys, often conducted using somewhat unsound methods. The situation was radically altered by the establishment in 1994-95 of a French Observatory of Drugs and Drug Addiction (the OFDT), which coincided with the opening of the European Observ-

9. Bernard Roques (1999), *La dangerosité des drogues: rapport au Secrétariat d'Etat à la Santé*, Odile Jacob/La Documentation Française, 316 pp.

atory in Lisbon. The OFDT's first surveys highlighted two things: the extent, and indeed omnipresence in everyday life, of the consumption of "legal" drugs, which had millions of users (14 million people who regularly drank alcohol and 13 million smokers in 2002), as opposed to the consumption of illegal drugs, which in fact concerned a much lower number of people (1.7 million regular users of cannabis and about 200 000 heroin users); and the frequency among teenagers and young adults of multiple drug use, in which cannabis was combined with alcohol and tobacco – a situation that called into question the traditional distinction between public policies on illegal drugs and those on alcohol and tobacco.

Two final factors have also significantly contributed to the emergence of an integrated approach to drug policy. For one thing, the authorities now have a clearer picture of the extent of the social damage caused by alcohol consumption, whether in terms of accidents (on the road, at work and in the home) or crime, and this calls for a shift in the balance of government action and hence a review of the resources allotted to combating narcotic-related crime. Secondly, the various health professionals in contact with dependent users (specialising in areas such as alcohol, tobacco or opiates) have expressed a desire to stop working in isolation and share clinical practices because of the growing number of people with multiple addictions coming to consult them.

In short, a number of more or less unrelated and contingent factors all came to a head at the end of the 1990s, resulting in a change in approach to policy on drugs in France. Having been based on the legal status of the substances concerned and the concept of prohibition, policy came to rely more on the concept of addictive behaviour and the risks associated with this behaviour, regardless of the substances being consumed and their legal status.

There was, however, one major obstacle that had to be surmounted, and this was by no means a formality: it was necessary to gain acceptance, in what is a country with a very strong wine-making tradition, for the idea that alcohol is just as dangerous as illegal drugs and that, accordingly, all alcoholic drinks should be included in the scope of government drug policies. Rather than triggering a head-on confrontation with the representatives of the wine-making industry and their numerous and powerful backers in parliament and government (particularly in the Ministry of Agriculture), the advisers to the Prime Minister, the MILDT and the Ministry of Health cleverly opted to word the legislation indirectly, in such a way as to avoid equating alcohol with a drug. The famous decree of 15 September 1999, which broadens the scope of MILDT activities to include all legal drugs, merely states

that the MILDT is responsible "for all addictions that endanger health and public safety". At no point in the text are the various legal drugs concerned directly named, and this allows the various wine-making professions to save face.

5.3. The integrated approach

It was in devising and implementing its three-year plan for 1999 to 2001 that the French government inaugurated its new "integrated" approach to drugs policy. The plan marked a clear break with previous strategies. It favoured an approach based on consumption patterns (referred to as "the global approach"), on the grounds that addiction was not so much the automatic consequence of a substance's pharmacological properties as a behavioural disorder. As a result, it called for decompartmentalisation of the system of care, which had formerly been divided into specialised care centres for drug addicts (CSSTs), focusing on the treatment of users of illegal drugs, and food hygiene centres (CHAs), specialising in treatment for alcoholics. This development was confirmed by the 2002 Public Health Act, which set up centres for the treatment, supervision and prevention of addictions (CSAPAs), bringing together the previous bodies. These centres should ultimately offer a whole range of care, covering all forms of drug addiction.

The current government plan (2004-08), which is due to end shortly, does not take a radically different approach from the previous one, though it does stress the need to take account of the specific nature of the substances concerned in some care situations (for example, the special problems posed by crack users) or in certain prevention scenarios (calling, for instance, for specific messages to prevent the spread of cannabis use among teenagers, given that it is particularly popular among this age group).

Some backtracking could still occur in the future as the political majority changes, but it is unlikely, given that the field workers who implement drug policy (for example, members of associations, health professionals and administrative experts) have now taken this change of policy on board and regard it as a new core ingredient of their approach.

6. Towards a policy on psychoactive substances: Germany

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6.1. The German context

Germany, lying in the centre of Europe and bordering Denmark, the Netherlands, Belgium, Luxembourg, France, Switzerland, Austria, the Czech Republic and Poland, has a total frontier of 3 757 km. It is one of the founding members of the EU and its most populous country, with a population of 82 351 000 inhabitants, less than 10% of them foreigners (7 289 000). The political and administrative system is of a strongly federalist character, the 16 *Bundesländer* representing the regional distinctions (*Statistisches Bundesamt*, 2007).

The responsibility for drugs and addiction policy is shared between the Federal Government and the *Länder*. According to the Basic Constitutional Law, the Federal Parliament has legislative authority – over the narcotic drugs law, the penal law and the social welfare law. On this basis, it has defined a legal framework for its drugs policy and has formulated specific standards. However, the implementation and execution of the federal laws mainly fall under the responsibility of the *Länder*. The *Länder* also have their own legislative authority in areas that are relevant to drugs and addiction policy, including school, health and education systems. The actual implementation of drugs and addiction policy – in particular, the treatment system – mainly lies in the hands of the *Länder* and municipalities, which may very well have a different focus within the framework of legal guidelines and common goals.

Several competencies, in counselling, care and general prevention, are joint responsibilities of the *Länder* and the municipalities. Accordingly any attempt to improve integration, for example between youth welfare and addiction support systems, has to follow the principle of subsidiarity. This tends to render supra-regional exchange of information and surveys of the overall situation more difficult (Pfeiffer-Gerschel et al., 2007).

6.2. Empirical data on drug use

6.2.1. Alcohol and tobacco

From an epidemiological point of view, the consumption of legal psychotropic substances, namely tobacco and alcohol, is the greatest preventable danger to public health (Batra et al., 2003). Ezzati et al. (2002) estimated 59 million disability-adjusted life years (DALYs) lost worldwide due to the use of tobacco (representing 4.1% of all DALYs) and 58 million DALYs due to the use of alcohol (4.0%).

Alcoholism as a global problem has been well known since the middle of the 19th century (Aßfalg, 2007). In Germany, while current trend analyses among the 18- to 64-year-olds have revealed that beverage-specific amounts of consumed alcohol remained stable over the last ten years (based on the last 30 days) as well as the prevalence of alcohol abuse (3.8%) and alcohol dependence (2.4%), the prevalence of risky single occasion drinking (RSOD) in the last 30 days among 18- to 24-year-olds increased significantly from 33.0% in 1995 to 45.4% in 2006 (Pabst and Kraus, 2008).

Smoking prevalence in the last 30 days among 18- to 24-year-olds decreased from 57.4% in 1980 to 39.4% in 2006. Also, prevalence of heavy smoking (at least 20 cigarettes per day) among 18- to 59-year-olds fell significantly between 1995 (14.7%) and 2006 (9.6%) (Baumeister et al., 2008).

6.2.2. Illegal drugs

Since the late 1960s, in Germany, as in other European countries, the use of illegal drugs, such as cannabis or LSD, started to increase and began to play a more important role. Obviously opiates and cocaine had been used by specific groups before that, though use had not been widespread at that time. After an initial increase, cannabis use was more or less stable in the decade between the mid-1970s and the mid-1980s (Briesen, 2005). However, prevalence rates increased considerably between 1986, when lifetime prevalence (LTP) among 18- to 24-year-olds was 13.3%, and 2003, when LTP was 43.6% (Kraus et al., 2008). Today cannabis use is spread all over the country and over quite different social groups (LTP among 18- to 64-year-olds: 23.0%). In contrast to cannabis consumption, the use of LSD dropped sharply after the 1970s and remained only a minor problem until the middle of the 1980s; today the prevalence rates are extremely low (Briesen, 2005).

Heroin was already starting to be used more in the 1970s in Germany. To date, heroin use is primarily found in metropolitan areas; whereas prevalence rates and seizures in rural areas are much lower. Prevalence estimates of problem opiate use in Germany for 2000 varied according to the data selection source: from 166 000-198 000 (treatment data) and 153 000-190 000 (police data) to 127 000-169 000 (mortality data) addicts (Kraus et al., 2003). Until 2006, the prevalence estimates based on the aforementioned sources slightly declined (Pfeiffer-Gerschel et al., 2007).

Even if the number of heroin users in Germany has always been much lower than, for example, the number of cannabis users, yet social and health problems rose sharply with the increase in heroin use. The increase in drug-related deaths (DRD) until 1991, along with the sharp increase in drug-related crime, underlined this negative development. Between 1980 and 1987, fewer than 500 DRDs were reported per year. In the 1990s the number of DRDs fluctuated around 2 000 per year and peaked in 1991, when 2 125 drug-related deaths were reported. In the 21st century the number has decreased; according to recent data (2006), 1 296 DRDs were reported (Bundeskriminalamt, 2007).

Cocaine consumption became more visible about 1980, with very small figures at first (LTP among 18- to 24-year-olds: 0.6%). It then increased continuously until 1990 (LTP among 18- to 24-year-olds: 5.1%) and remained at this level until 2006 (LTP among 18- to 24-year-olds: 4.4%) (Kraus et al., 2008).

While amphetamines played some role in drug use in Germany already in the 1980s, MDMA and other relevant substances became more popular after the end of the 1980s and had their peak in 1995 (LTP 18- to 24-year-olds: 6.2%). From 1997 to 2006 the LTP was quite stable, at about 5.5% (Kraus et al., 2008). Unlike heroin and cocaine, ecstasy use can be found all over the country and there seems to be only a small difference in prevalence rates from urban and rural areas. The differences in the prevalence of ecstasy use between Eastern and Western Germany are smaller compared to other drugs.

6.3. German drugs policy

The Opium Law was introduced in 1920 and brought German legislation in line with the International Opium Convention of 1912. In 1972 the Opium Law was replaced by the Narcotics Act, which has been continually revised to adapt the law to actual requirements.

On 23 January 2008, the Narcotics Act got its 21st update since its introduction.

In autumn 1998, the office of the Federal Drug Commissioner moved from the Federal Ministry of the Interior (BMI) to the Federal Ministry for Health (BMG). This political step showed that health and social aspects had become more prominent in national drugs policy than they used to be. In general, actual drugs policy follows the principle "help comes before law enforcement". In 2003, in the agreement of the coalition of the Federal Government (the agreement was confirmed after the new constitution in 2005), education, prevention, help for drug addicts and law enforcement were explicitly fixed as four major pillars of drugs policy. The responsibility to implement these elements of German drugs policy is shared between federal, regional (*Länder*) and municipal authorities, as well as among the different institutions and ministries involved.

Prevention is stressed as a main focus of the national drugs policy: preventive interventions should focus on the use of psychotropic substances, and there is increasing interest in abuse of alcohol and tobacco. "Health promotion" and "strengthening of life skills" are concepts placed in the foreground. A further aim of the Federal Government is to support addiction treatment orientated to efficiency and quality. In accordance with their psychological, physical and social condition, addicts are to be offered individualised help, with access facilitated by a differentiated drugs help system. As a general principle, all types of interventions and therapies should finally target the individual client's abstinence from addictive substances (at least as a long-term perspective). Against this background, low-threshold services aiming at survival and harm reduction are as important as facilities providing counselling, out-patient treatment, detoxification, substitution treatment or specialised in-patient treatment.

6.3.1. The Board of Drugs and Addiction

In October 2004, the national Board of Drugs and Addiction (Drogen- und Suchtrat) had its first meeting. It replaced the Drugs and Addiction Commission (Drogen- und Suchtkommission), which had existed from 1999 to 2004. The Board of Drugs and Addiction is composed of representatives of the respective government and *Länder* departments as well as funding organisations, associations, and research and self-help organisations. The function of the board is to give professional advice and support the Federal Drug Commissioner. Its votes have a consultative character.

One of the last tasks of the Drugs and Addiction Commission was to develop an overall "drugs and addiction concept" in order to improve prevention; this was taken as a basis for the development of the new national action plan. In 2003, the Action Plan for Fighting Drugs and Addiction (*Die Drogenbeauftragte der Bundesregierung*, 2003) replaced the Anti-Drugs Action Plan of 1990, which had one-sidedly focused on illegal drugs and served as a framework for addiction policy until then. The focus of German drugs and addiction policy since its inception has above all been on the reduction of tobacco and alcohol consumption. The Board of Drugs and Addiction (after its re-formation in 2006) supports implementation of the Action Plan for Fighting Drugs and Addiction, which has the following key aspects:

- The prevalence of smokers among teenagers (12-17 years) should fall below 17% by 2008 (it had already sunk from 28% to 18% between 2001 and 2005).
- The prevalence of teenage consumers of alcoholic beverages should be reduced from 20% to below 18% by 2008.
- The prevalence of experimental cannabis users among 12- to 25-year-olds should be brought down from 31%, as reported in 2004, to below 28% by 2008.
- The prevalence of regular cannabis users among 12- to 25-year-olds should fall below 3% by the year 2008.

In order to implement these goals, a wide range of support offers provided by the *Länder* and service providers is considered imperative.

6.3.2. Drugs policy

In Germany, the term 'drugs policy' is undergoing a gradual change of meaning. Until the end of the 20th century, it related exclusively to illegal drugs, which were at the centre of political interest. There was no comparable concept of a policy dealing with alcohol or tobacco, nor for an 'addiction policy' covering the whole range of addictive substances. Since the turn of the century, however, the focus of political interest has increasingly moved to (1) disorders resulting from legal psychotropic substances and (2) common aspects of all substances (e.g. in universal prevention or in patients with multiple abuse). This is why the terms 'drugs and addiction policy' or 'addiction policy' are used more frequently, gradually replacing the term 'drugs policy'. As a result of the changes in policy aims pursued and strategies deployed in the area of legal and illegal substances, the use of the term 'drugs and addiction policy' has become more and more prevalent in the German language.

Moreover, the range of vision is expanding from the original main focus on substance-related addiction to risky and harmful use, and thus to a comprehensive understanding of health policy for substance-related disorders and risks. However, the German language has no appropriate term reflecting this expansion of the concept, so that the (unsatisfactory) term of 'addiction policy' continues to be used (Pfeiffer-Gerschel et al., 2007).

6.4. Legal foundations of drugs policy

The latest national developments correspond with these changes in the drugs policy. The main aim is still to differentiate the way drug trafficking and drug consumption are dealt with. For trafficking, a stronger punishment is envisaged, whereas for use an alternative solution is encouraged. Also the expanded focus on legal drugs has resulted in new laws. The following examples corroborate the changes in the legal foundations concerning legal and illegal drug consumption, and the effects:

In 1994 the Federal Constitutional Court adjudicated that the criminal prosecution has to differentiate between seizures of large amounts (an indicator for trafficking) and seizures of small amounts (presumed to be for own needs) (Hettenbach, 2002). Hence the *Länder* have set individual boundaries for cannabis possession. These boundaries varied a lot among the *Länder*, but they are becoming more and more aligned.

To protect especially youngsters against the danger and consequences of alcohol drinking, additional taxes on alcopops were introduced on 1 July 2004 (Deutscher Bundestag, 2004) as well as a ban for novice drivers (under age of 21 or having a driving licence less than two years) against drinking any alcohol (Bundesministerium für Verkehr, Bau und Stadtentwicklung, 2007).

On 20 July 2007, a non-smoker protection law at federal level was ratified, which bans smoking in public federal government facilities and public transport (Bundesministerium für Gesundheit, 2007). Moreover, almost all federal *Länder* have meanwhile ratified laws to protect citizens from the dangers of environmental tobacco smoke. In Germany, the *Länder* are responsible for any regulations affecting all kinds of (public) schools, universities, bars and restaurants. In most of the *Länder*, tobacco has been completely banned in public schools (Bundeszentrale für gesundheitliche Aufklärung, 2008).

6.5. International context

German drugs policy is bound to the 1961 United Nations Single Convention on Narcotic Drugs as amended by the 1972 Protocol, the 1971 Convention on Psychotropic Drugs and the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

Germany is an active partner of international institutions in the field of drugs and addiction. As a member of the United Nations, Germany co-operates with the UN Office on Drugs and Crime (UNODC) and the World Health Organization (WHO). The main focus of the WHO is on demand and harm reduction, but the UNODC contributes to reducing demand and supply.

The most important partners of Germany at European level are the European Commission, the Horizontal Drugs Group (HDG), the European Monitoring Centre for Drugs and Addiction (EMCDDA) and the Pompidou Group at the Council of Europe. Bilateral co-operation on drugs and addiction has taken place with numerous countries. Germany participates in and co-ordinates several international projects, including the International Cannabis Need of Treatment Study (INCANT) and the Driving under the Influence of Drugs, Alcohol and Medicines (DRUID) study.

6.6. Conclusions

An overall addiction policy that increasingly focuses on common aspects of the whole range of psychotropic substances has replaced isolated "drug" concepts. The current Action Plan for Fighting Drugs and Addiction is the mainstay of the overall policy concept. It is based on the new concept of public health, which integrates both individual specialised addiction care and universal health care with the goal to create the conditions in which people could be and remain healthy. Within this framework, it is emphasised that individually targeted prevention and therapy are fundamental, though they can contribute only to a small extent in reducing the substance addiction problems in society. Specific goals are the reduction of smoking and consumption of alcohol or cannabis. Recent focal points of national policy-making in the field of illegal substances are the improvement of care offered to persons with cannabis problems and research on the effects of cannabis abuse.

To achieve the written aims, individual specialised addiction care is combined with a structural framework. Parts of the structural frame-

work are bans and law enforcement for supply reduction, as well as laws on protection of consumers and third parties against the negative consequences of substance (ab)use. The prohibition of substances lying under the Narcotics Act and the law enforcement of contraventions are examples, as well as the alcohol ban for novice drivers and the law for protection against the danger of passive smoking.

The German treatment system for individuals suffering from drug-related problems can be seen as a comprehensive, professionally driven and complex one. This system could be illustrated as a continuum ranging from low-threshold offers, counselling and acute treatment (e.g. detoxification), through specialised in- and out-patient treatment, to substitution treatment for opiate addicts and rehabilitation services. Generally, professional help can be provided at each stage of the development of an individual's drug career and many interfaces do exist between different treatment modalities (such as in-/out-patient, social treatment or medically assisted treatment). Usually, treatment of drug-related problems in specialised treatment centres tries to account for as many aspects of the individual's problems as possible, resulting in comprehensive offers to get back to a working life or to stabilise or even improve physical conditions.

Prevention as written down in the Addiction Plan is the main pillar of the German drugs and addiction policy. The aim is to reduce demand especially among youngsters. Educational advertising plays an important role as well as nationwide programmes like FreD, INCANT, DRUID, *Hart am Limit* (HALT) and multitudinous local projects.

Although the prevalence rates of most psychoactive substances have remained quite stable, there is growing evidence that there was a decrease in the prevalence of tobacco and cannabis use among adolescents from 2004 to 2007 (Bundeszentrale für gesundheitliche Aufklärung, 2007a, b). Nonetheless, the smoking prevalence among male adolescents is still at the level of 1994. Settertobulte and Richter (2007) attribute the decrease in the number of young smokers in 2002-07 to the social climate, which has become more and more non-smoker friendly, the rigorously increased tobacco tax and the extension of tobacco bans especially in schools. On the other hand, data from the Health Behaviour in School-aged Children study (HBSC, Settertobulte and Richter, 2007) also indicate a shift towards smoking initiation at a younger age; and the Epidemiological Survey on Addiction (ESA) 2006 showed an increase in heavy episodic drinking among young adults (Pabst and Kraus, 2008).

In summary, the epidemiological data may indicate that the macro-level social policy does not always have the expected positive effects, at least to the extent it was supposed to. Overall, despite the progress that has been already made in the field of policy on psychoactive substances, the effectiveness of the measures taken regarding supply and demand reduction should be constantly evaluated, whereas efforts could be intensified so that the impact of these policies is also shown in empirical data.

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7. Drug and alcohol policy in Hungary

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7.1. Epidemiology

The drug situation has significantly changed in Hungary since the 1980s. In the 1970s and 1980s, the epidemiological picture was dominated by the use of various legal substances, such as inhalants, benzodiazepines (also combined with alcohol) and other medications containing opiates (mainly codeine). The misuse of Parkan, an antiparkinsonic medicine, was also common. (The use of the dopamine releaser Parkan leads to hallucinations.) Cannabis was used only in small intellectual circles, while other illegal substances were practically unavailable in this period (Bácskai and Gerevich, 1994; Demetrovics, 2001).

The growth in the use of opiates, already recognised by the health-care system, started during the 1980s. Besides codeine, the use of harsh opium, extracted from poppies, also became popular. This meant the intravenous use of poppy cuttings during summertime, while during the winter period poppy tea was used. Both codeine and poppy use were combined with the use of glutethimide (Paksi and Demetrovics, 1999).

A quantitative and qualitative change in drug use occurred at the beginning of the 1990s. All illegal substances became available almost overnight. All indicators showed a growing prevalence of drug use, though this trend had slowed down by the end of the 1990s (Elekes and Paksi, 2000; National Focal Point, 2007; Paksi, 2003).

7.2. The Hungarian National Strategy[10]

Until 1985, the political leadership denied the presence of drug use in Hungarian society. It became a topic of debate only after a decision

10. Part of this section is taken from the 2005 National Report (2004 data) to the EMCDDA, by the Reitox National Focal Point, entitled "Hungary: New development, trends and in-depth information on selected issues".

by the Central Committee of the Hungarian Communist Party in this regard. This decision made it possible to start real professional work. An important development was in 1992, when a new specialisation – addictology – was first offered to psychiatrists; since 2001, clinical psychologists also can undergo special training to become addiction psychologists. The most important drug policy development since 1990, however, has been the acceptance of the *National Strategy to Combat the Drug Problem* by the Hungarian Parliament in December 2000.

The Hungarian National Strategy to Combat the Drug Problem (Ministry of Youth and Sport, 2000) does not set aims for alcohol and tobacco use. The National Strategy deals principally with illegal drugs, but in several fields the tasks are inseparable from the problems of alcohol use, smoking, inhalant use and abuse of pharmaceuticals without a doctor's prescription. Such a field is at the level of local communities, where these problems are often interwoven and appear together in the same family or individual; another such field is prevention, where successful programmes can be implemented only if unambiguous messages are transmitted in relation to substance use; and there is the field of therapy and help, where several substance-use problems are interlinked and the treatment network helps both drug and alcohol users. The National Strategy takes in the experiences of action plans against alcoholism and smoking, and strives for co-operation with experts, state and professional institutions, civil and church organisations and local communities in the fields mentioned.

The National Strategy mentions, among the risk factors enhancing drug use, certain cases of alcohol use and smoking. Alcohol use and smoking of parents and peers, as well as their attitudes, are among the risk factors since they can have great effect on children and young adults. Cultural aspects – such as the relation of society to licit drugs and the appearance of the need in announcements and mass communication – might also influence people. Alcohol use and smoking also appear in the prevention section of the National Strategy.

In schools, prevention of abuse of illicit drugs cannot be separated from the prevention of abuse of licit drugs (alcohol, nicotine, use of pharmaceuticals without a doctor's prescription). According to the Strategy, workplaces should play a major role, primarily still in preventing licit drug abuse (alcohol use and smoking), but the need for prevention of illicit drug use at workplaces has also already arisen.

7.3. Public Health Programme[11]

7.3.1. Aims

Aims for alcohol use and smoking in Hungary are set out in the Public Health Programme adopted by parliamentary decision No. 46/2003 (IV.16.). There is a short summary here of the aims in its subprogrammes related to alcohol and smoking.

7.3.1.1. Reducing smoking

The subprogramme aims at reducing cigarette consumption by 8% yearly and decreasing the prevalence of regular smokers by 6% (35% for men) by 2010. The essential features are:

- prevention of addiction: community programmes, health communication, health policy measures (regulation);
- enhancement of giving up smoking: development of system of care provision;
- ensuring the option of a smoke-free environment for every person;
- getting acquainted with and investigating the reasons for, and motivations of, smoking.

7.3.1.2. Reducing alcoholism

The essence of the subprogramme lies in:

- "Minimal intervention programmes" in the basic service;
- Programmes protecting children of alcoholic persons;
- Development of treatment centres (low-threshold services, civil organisations, self-help groups);
- Enhancement of social response skills (civil organisations, youth prevention programmes, media programmes);
- Observation of changes in patterns of alcohol use.

The Hungarian Drug Strategy does not include aims for licit drugs, which are managed in a different strategy and health programme; thus they are separated from the drug issue. A separate alcohol or tobacco policy does not exist.

11. See ibid.

7.3.2. Treatment

The first drug outpatient centre in Hungary was opened in 1987, to be followed by many similar clinics. At the moment some twenty such institutes are operating nationwide. Psychiatric wards are also more ready for detoxification. However, the rejection of drug-addicted patients is still common. Residential treatment centres (separate, drug-free inpatient units for long-term – typically, around one year – treatment) have been available since the early 1990s. Some of these centres work with adapted professional models (such as the Minnesota model or the Therapeutic Community model), while others are less theoretically based. At most centres, both alcohol and drug patients are accepted.

7.3.3. Harm reduction

Not unlike other central and eastern European countries, Hungary has found that the harm-reduction approach has generated widespread professional and public discussion and argument in recent years. We can conclude that these disputes, and especially the role of those policy makers and professionals who were against introducing harm-reduction facilities, continually hindered the spread of these services.

As a result, though opiate agonist substitution treatment has existed in Hungary since 1989 – in the first years using codeine, but since 1993 adopting methadone as the dominantly used opiate agonist for substitution – the legal status of this treatment was not clarified until 2001 (Demetrovics, Honti, Csorba and Szemelyácz, 2001). Consequently, many drug outpatient centres have not taken the risk of starting such a programme. Recently some 700 opiate addicts received methadone in Hungary in a year (National Focal Point, 2007). Needle exchange has been available in Budapest and other big cities since the early 1990s. It has been found that those programmes that are combined with outreach work are much more effective than those settled at one given place.

It must be emphasised that the harm-reduction approach is also present in the party culture (Demetrovics and Pelle, 2000; Demetrovics and Rácz, 2008). There are other services too that, apart from counselling, also distribute water, vitamins, condoms and information leaflets at parties and discos in order to make entertainment venues safer. However, co-operation between party organisers, civil services, local authorities, police and other bodies involved in the problem is still lacking in many cases.

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8. Irish drug policy and its link with alcohol and tobacco policies

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There is a growing convergence of perceptions and approaches within the domains of illicit drugs and alcohol policy, though the political will to combine the domains has not been so strong, unless within a wider substance-misuse policy domain. Tobacco control remains a separate and distinct policy domain.

Five inter-related factors have influenced the way these developments have occurred:

- cultural attitudes,
- research-based evidence,
- harm-reduction principles,
- structural and resourcing arrangements,
- political considerations.

8.1. Context[12]

Situated off the north-west coast of Europe, Ireland is a 69 000 sq. km island, lying some 30 km west of the island of England, Scotland and Wales. It has a 1 500 km-long coastline and controls some 16% of the EU's territorial waters. It also has a 360 km-long land border with Northern Ireland, part of the United Kingdom, which is in the north-east corner of the island and occupies one sixth of the island's land mass.

12. This section is based on Central Statistics Office (2006), *Census 2006: preliminary report*, Dublin: Stationery Office; Central Statistics Office (2007), *EU survey on income and living conditions (SILC) 2006*, Dublin: Stationery Office; Institute of Public Administration (2007), *Administration yearbook and diary 2008*, Dublin: Institute of Public Administration.

In the 2006 Census, Ireland recorded a population of 4.234 million. Since 1996, the population has increased at an annual average rate of 1.6% – the largest population growth rate in the EU. Since the last population census in 2002 there has been net inward migration of, on average, 46 000 per annum. English is the language used by the majority of the population, and Roman Catholicism is the religion of 88%. The Irish economy is an open, mostly export-based economy that has experienced unprecedented growth since the latter half of the 1990s. In 2006, 17.0% of the population of Ireland was at risk of poverty, and 6.9% were living in consistent poverty.

Ireland is a parliamentary democracy. Its law is based on common law and legislation enacted by Parliament. The Constitution sets out the form of government, defining the powers and functions of the President (Head of State), the two Houses of the Oireachtas (Parliament), including a lower House of Representatives (Dáil Éireann), which is the main legislative body, and an upper Senate (Seanad), and the composition and functions of the government, including a Prime Minister (Taoiseach) and ministers. It also defines the structure and powers of the courts and outlines the fundamental rights of citizens. Local authorities, directly elected by the people, oversee the provision of local services.

Social partnership provides for ongoing dialogue on social and economic issues between the Irish Government and the trade union, employer and business organisation, farm organisation, and community and voluntary sectors. Since 1987, multi-annual national social partnership agreements have been adopted, and the social partners and government sit on a variety of national, regional and local bodies to help shape strategies for local economic, social and cultural development and plans to counter disadvantage and social exclusion.

8.2. Data on drug use

In late 2002 and early 2003 the first-ever illicit drug use prevalence survey of households on the island of Ireland was undertaken.[13] Using face-to-face interviews, it investigated drug prevalence on a lifetime, last year (recent) and last month (current) basis among people aged 15

13. National Advisory Committee on Drugs (NACD) and Drug and Alcohol Information and Research Unit (DAIRU) (2005), *Drug use in Ireland and Northern Ireland – first results (revised) from the 2002/2003 Drug Prevalence Survey.* Dublin and Belfast: NACD and DAIRU.

to 64. Listed below are the key findings for Ireland, excluding Northern Ireland:

- One in five people surveyed reported ever using an illegal drug: one in eighteen reported use within the previous year, while one in thirty-four reported use in the previous month;
- Cannabis was the most widely used illegal drug;
- Prevalence of other illegal drugs was lower and largely confined to younger age groups;
- More men used illegal drugs than women;
- Women and older people reported higher rates of sedative, tranquilliser and antidepressant use.

In 2008 the first results of the second iteration of the same survey were published.[14] In Ireland, it was found that lifetime use of any illegal drugs among all adults increased between 2002/3 and 2006/7 from 19% to 24%. Increases were observed for the lifetime use of the following drugs: cannabis (from 17% to 22%) cocaine (from 3% to 5%) and magic mushrooms (from 4% to 6%). Overall, the gender and age differences observed in lifetime use of drugs in the 2002/3 survey were also observed in the 2006/7 survey. Men and younger age groups generally reported higher lifetime prevalence rates for any illegal drugs.

8.3. Perceptions by the public and policy-makers

A nationwide survey of drug-related knowledge, attitudes and beliefs was conducted in 1998, and repeated in 2000, but then discontinued.[15] Subsequently, there have been only sporadic and unrelated nationwide surveys regarding aspects of the illicit drugs issue. The following account draws on nationwide surveys conducted since 2005.

Drug-related crime is considered a serious problem, by the public and policy-makers alike. Based on fieldwork done in May/June 2005, *Eurobarometer 63* reported that, when asked to select the three actions that the EU should follow, in order of priority, from a list of 16 possible

14. NACD and DAIRU (2008), *Drugs use in Ireland and Northern Ireland – first results from the 2006/2007 Drug Prevalence Survey Bulletin 1*. Dublin and Belfast: NACD and DAIRU.
15. Bryan, A., Moran, R., Farrell, E., O'Brien, M. (2000), *Drug-related knowledge, attitudes and beliefs in Ireland: report of a nation-wide survey*. Dublin: Health Research Board.

actions, respondents in Ireland ranked "fighting organised crime and drug trafficking" second, after "fighting poverty and social exclusion".[16] A year later, in a survey by the market research company TNS mrbi, commissioned by the Minister for Justice, Equality and Law Reform to enquire into the Irish public's attitude to crime and law enforcement issues in Ireland, "drug abuse" was seen by respondents as the most serious crime problem in Ireland.

In 2007 a study by the Irish Penal Reform Trust into public reaction to a range of issues relating to the prison system, using face-to-face interviews with a nationally representative sample of adults aged 18+, revealed that less punitive measures, such as drug programmes, are preferred for non-violent offenders, and there is a persistent preference to see more treatment programmes available for those with drug problems.[17] Also, 44% agreed that criminalising drug use causes more problems than it prevents, while 28% disagreed, but it was noted that this question attracted the highest level of uncertainty, with 19% answering "neither agree nor disagree" and a further 9% answering "don't know".

The legalisation of cannabis is a subject of continuing debate. Recent surveys show public support for legalising the medical use of cannabis and, to a lesser extent, "personal consumption" of cannabis.[18] However, in the most recent political debates on the subject, in 2001-2, the government stated it would not alter the controlled status of cannabis until conclusive scientifically-based evidence emerged to support the change.[19] In her foreword to a report on cannabis by the Joint Oireachtas Committee in 2006, the Chair noted:

> Members of the Joint Committee are convinced that the only attitude to cannabis should be *noli tangere* – or 'do not touch' as the Romans used to say – and that there should be no movement towards the liberalisation of the legal sanctions which attach to the possession of, use and dealing in this truly noxious weed. Finally the Joint Committee wish to

16. European Commission (2005), *Eurobarometer 63: public opinion in the European Union.* Brussels: European Commission.
17. TNS mrbi (2007), *Public attitudes to prison.* Irish Penal Reform Trust.
18. Lansdowne Market Research Omnibus Survey (September 2001), *Public opinion of cannabis in Ireland.* Dublin: Lansdowne Market Research; National Advisory Committee on Drugs (NACD) and Drug and Alcohol Information and Research Unit (DAIRU) (2005), *Drug use in Ireland and Northern Ireland – first results (revised) from the 2002/2003 Drug Prevalence Survey.* Dublin and Belfast: NACD and DAIRU.
19. Martin, M. (26 February 2002), *Parliamentary Debate.* Vol. 549, col. 817; Ahern, N. (15 July 2002), "UK cannabis laws eased, but we don't have to follow suit". *Irish Times*; National Advisory Committee on Drugs (2004), *An overview of scientific and other information on cannabis.* Dublin: Stationery Office.

> see the full rigours of the law applied to those who benefit financially from trading in cannabis.[20]

A consensus has not yet been reached on harm reduction. The National Drugs Strategy provides for substitution treatment, needle-exchange facilities and outreach services. Inclusion of heroin prescription and/or injecting rooms was considered unwarranted, given Ireland's international obligations under the UN drug conventions and the need for further evaluation and research "to establish objectively the benefits of such treatment". A recent study on the introduction of safer injecting facilities in Ireland, in which service users and providers and policy-makers were interviewed, concluded: "it is perhaps a bridge too far in the current political climate and any change will be incremental, and may well arise from service providers attempting to initiate change from the ground up."[21]

In the 2007 general election, the political manifestos of the main political parties all addressed the issue of illicit drugs.[22] They indicated a broad consensus in line with public opinion (insofar as it is understood): they endorsed the measures contained in the National Drugs Strategy 2001-08 to, on the one hand, reduce the availability of illicit drugs through a variety of law-enforcement interventions, and, on the other hand, enable people with drug-misuse problems to access treatment and other support, and re-integrate into society, while reducing the risk behaviour associated with drug misuse and the harm caused by drug misuse to individuals, families and communities.

8.4. Irish drug policy

8.4.1. Development

Official concern about illicit drugs in Ireland began in the late 1960s, when the government established a working party on drug abuse. Cannabis, LSD and amphetamines were identified as the main problem

20. Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs (2006), *What everyone should know about cannabis.* Dublin: Houses of the Oireachtas.
21. O'Shea, M. (2007), "Introducing safer injecting facilities (SIFs) in the republic of Ireland: 'chipping away' at policy change". *Drugs: Education, Prevention and Policy*, 14(1): 75-88.
22. Fianna Fáil (2007), *Now, the next steps: Fianna Fáil manifesto 2007.* Dublin: Fianna Fáil; Fine Gael (2007), *General election manifesto 2007*. Dublin: Fine Gael; Labour Party (2007), *The fair society – Labour manifesto 2007*. Dublin: Labour Party; Sinn Fein (2007), *Sinn Fein general election manifesto 2007*. Dublin: Sinn Fein.

drugs.[23] In the 1980s, concern shifted to opiates, specifically heroin, and to the spread of blood-borne infectious diseases through drug injecting.[24] The association between heroin and socio-economic disadvantage was officially recognised in the mid-1990s.[25] Recreational drugs, including cannabis and ecstasy, became a concern in the later 1990s. In the first decade of the new century, cocaine and polydrug use, including alcohol, have become new causes for concern.[26] Over the forty-odd years since the late 1960s, five reports/strategies, including the current National Drugs Strategy, have been adopted as government policy on illicit drugs. All five documents have reflected a prohibitionist perspective and adopted a "balanced approach", addressing the reduction of both supply of and demand for illicit drugs.

Beginning in the early 1990s, when the public health dangers associated with intravenous drug use began to be recognised, harm-reduction practices were introduced, including substitution treatment and needle-exchange facilities, albeit still with the ultimate aim of achieving a drug-free society. Centralised treatment services were gradually superseded, with a more active role assigned to general practitioners in treating drug users, and the encouragement of community-based prevention, treatment and rehabilitation responses. Satellite clinics providing both medically assisted treatment and counselling are now located in communities affected by illicit drug use.

In 1998, 13 local drugs task forces (LDTFs) were established in the areas worst affected by problem drug use; these areas also experienced serious socio-economic deprivation, crime and poor 'quality of life'. Representatives of government departments, statutory agencies, local voluntary organisations and community groups were brought together on these LDTFs to provide co-ordinated and integrated responses to the drugs issue at local level. In 2000, the number of LDTFs increased

23. Working Party on Drug Abuse (1971), *Report of working party on drug abuse*. Dublin: Stationery Office.
24. National Co-ordinating Committee on Drug Abuse (1991), *Government strategy to prevent drug abuse*. Dublin: Department of Health.
25. Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996), *First report of the ministerial task force on measures to reduce the demand for drugs*. Dublin: Stationery Office; Ministerial Task Force on Measures to Reduce the Demand for Drugs (1997), *Second report of the ministerial task force on measures to reduce the demand for drugs*. Dublin: Stationery Office.
26. Department of Tourism, Sport and Recreation (2001), *Building on experience: national drugs strategy 2001-2008*. Dublin: Stationery Office; Steering group for the mid-term review of the National Drugs Strategy (2005), *Mid-term review of the National Drugs Strategy 2001-2008*. Dublin: Department of Community, Rural and Gaeltacht Affairs.

to 14. In 2004, 10 regional drugs task forces (RDTFs) were established to serve a similar purpose across the rest of the country. In 2005 the government decided to establish rehabilitation as a new pillar of the National Drugs Strategy, separate from treatment.[27]

8.4.2. Legal foundations of drug policy

The classification of drugs and precursors in Ireland is made in accordance with the three United Nations conventions of 1961, 1971 and 1988, which introduced controls on legitimate scientific or medical use of drugs and precursors that also take into account the particular risks to public or individual health. Irish legislation defines as criminal offences the import, manufacture, trading and possession, other than by prescription, of most psychoactive substances. The principal criminal legislative framework is laid out in the Misuse of Drugs Acts (MDA) 1977 and 1984 and the Misuse of Drugs Regulations 1988. The offences of drug possession (s.3 MDA) and possession for the purpose of supply (s.15 MDA) are the principal criminal charges used in the prosecution of drug offences in Ireland. The Misuse of Drugs Regulations 1988 list, under five schedules, the various substances to which the laws apply.

Tackling drug trafficking was the focus of new legislation introduced in the mid to late 1990s, following the murder in 1996 of the journalist Veronica Guerin, who had been investigating drug-related organised crime in Ireland. These laws provide for increased powers to detain and interrogate suspects, harsher sentencing for offences relating to the possession of drugs for supply, with powers to confiscate illegally-acquired assets and tackle money-laundering. More recently, stronger statutory powers to tackle organised criminal activity and to combat drug dealing in communities and in prisons have been introduced.[28]

Intoxication, owing to consumption of either alcohol or drugs, or both, has been the subject of a separate range of legislative measures. The purpose of these measures is to reduce the incidence of disorder in public places,[29] and/or to reduce the danger of harm to the individual

27. Steering group for the mid-term review of the National Drugs Strategy (2005), *Mid-term review of the National Drugs Strategy 2001-2008*. Dublin: Department of Community, Rural and Gaeltacht Affairs.

28. See, for example, the Criminal Justice (Drug Trafficking) Act 1996, the Criminal Assets Bureau Act 1996, the Europol Act 1997, Criminal Justice Act 1999 (Sections 4, 5 and 6) and the Criminal Justice (Theft and Fraud Offences) Act 2000. See also Criminal Justice Act 2006, and the Criminal Justice Act 2007.

29. See Criminal Justice (Public Order) Acts 1994 and 2002.

or to others as a result of being intoxicated.[30] Intoxication by alcohol or other substances was explicitly excluded from the scope of the definition of "mental disorder" in the Criminal Law (Insanity) Act 2006, and cannot be used as a ground for either pleading unfitness to stand trial or a defence in a criminal trial.

Harm-reduction practices receive "very limited validation in Irish laws and policies generally". Organisations providing drug-related harm-reduction services in Ireland have been advised to obtain legal advice when planning the content of their drug policies, confidentiality policies and working methods, and to identify and work co-operatively with local police personnel who are aware and supportive of organisational policies and working methods.[31]

8.4.3. International context

Ireland has either ratified or acceded to the three United Nations drug conventions of 1961, 1971 and 1988. Ireland also supports EU-level drug initiatives such as the EU drugs strategy and action plan, and participates in the drug-related special agencies of the EU – Europol and the EMCDDA. With reference to the proposed EU Reform Treaty, as the only members of the EU operating under common law, Britain and Ireland have secured an opt-in/opt-out arrangement on judicial co-operation in criminal matters and police co-operation. Notwithstanding, Ireland has made a firm declaration that it will endeavour to be part of EU co-operation except where it could cause legal complications, and that it will opt into future police co-operation measures.[32]

Ireland participates in other international organisations engaged in tackling crime and drug trafficking,[33] and maintains an interest in general drug policy developments in other jurisdictions by participating in international fora.[34] The Review Group that drafted the

30. See, for example, the Maritime Safety Act 2005, the Safety, Health and Welfare at Work Act 2005 and the Railway Safety Act 2005.
31. Kiely, E. and Egan, E. (eds) (2000), *Harm reduction: an information and resource booklet for agencies engaged in drug education.* Cork: Department of Applied Social Sciences, NUIC.
32. Ahern, B. (16 October 2007), *Parliamentary Debate.* Vol. *639*, col. 1054.
33. For example, the Financial Action Task Force on Money Laundering, Interpol, the World Customs Organization and, as of September 2007, the Maritime Analysis and Operations Centre (Narcotics) (MAOC-N) based in Lisbon, together with the United Kingdom, the Netherlands, France, Spain, Portugal and Italy.
34. For example, the Pompidou Group of the Council of Europe and the informal Dublin Group.

current National Drugs Strategy benchmarked the proposed strategy against those of the Netherlands, Portugal, England, Scotland, Spain, Sweden and Australia, which were deemed to have "modern drugs strategies". A "modern drugs strategy" was defined as one that focused on the needs of drug misusers, as well as attempting through various enforcement measures and agencies to cut off the supply of drugs. The Review Group concluded that the new strategy stood up well to the comparison.

In the last decade Ireland and the United Kingdom have developed closer links in, *inter alia*, the drugs area, both through formal information-sharing via the British-Irish Council and through increased co-operation in police matters.

8.4.4. Relationship with alcohol/tobacco policy

Policies on illicit drugs, alcohol and tobacco have evolved independently of one another. During the current millennium, however, the need for organisational support and resources has seen a convergence between the alcohol and illicit drug policy domains.

The *National Alcohol Strategy*, published in 1996, aimed to reduce the prevalence of alcohol-related problems by promoting moderation among those choosing to drink. It was based on current research from the World Health Organization and was in keeping with the European Charter on Alcohol, which Ireland had endorsed. It identified broad strategies and called for stakeholders across different sectors to commit themselves to the successful implementation of the strategy, but it did not propose any proper strategies or structures to support implementation and was largely ignored.[35]

In its first report, also published in 1996, the Ministerial Task Force on Measures to Reduce the Demand for Drugs acknowledged the linkages between illicit drugs and alcohol, and also tobacco. It argued that, in the long term, a coherent, integrated response to all forms of substance abuse, including alcohol, was needed. However, noting that it was only mandated to look at the abuse of illicit substances, and that a national strategy on alcohol had already been published, the Ministerial Task Force restricted its recommendations to illicit drugs. Unlike the National Alcohol Policy, the Ministerial Task Force made detailed recommendations regarding structural arrangements to address the

35. Department of Health and Children (1996), *National alcohol policy*. Dublin: Stationery Office.

illicit drugs issue. These structural arrangements, to ensure co-ordination and implementation of drug policies and programmes at national and local level, have persisted to the current day.[36]

In 2002 the Strategic Task Force on Alcohol was established.[37] Its main remit was to recommend specific evidence-based measures to prevent and reduce alcohol-related harm in Ireland. With respect to structural arrangements and resourcing, the Strategic Task Force recommended the integration of alcohol into the work of the drugs task forces (if regional task forces on alcohol were not established), and an increase in the level and strategic focus of funding to capital funding mechanisms such as the Young People's Facilities and Services Fund, which then only targeted young people at risk of drug abuse. With regard to prevention and treatment, the Strategic Task Force referred jointly to alcohol and drugs.

8.4.4.1. The Steering Group

In 2005 the Steering Group's mid-term review of the National Drugs Strategy viewed the Strategic Task Force's recommendations positively, but cautioned that they should be developed only if the capacity were available and the funding for drug-related projects was not diluted as a result.[38] The Steering Group took the view that the formation of closer synergies between the two policies at a strategic level had been hindered by the lack of equivalent managerial structures on the alcohol side. The Steering Group recommended that a working group involving key stakeholders of alcohol and drugs be established to explore the opportunities for "better co-ordination" and "closer synergies" between drugs and alcohol policies, including the question of a combined strategy. This working group was convened in late 2006 under the auspices of the Department of Health and Children and has yet to report.

While noting that there were separate alcohol and drug policies, the Steering Group also noted that services addressing drug and alcohol

36. Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996), *First report of the ministerial task force on measures to reduce the demand for drugs*. Dublin: Stationery Office.

37. Strategic Task Force on Alcohol (2002), *Interim Report*. Dublin: Department of Health and Children; Strategic Task Force on Alcohol (2004), *Second Report*. Dublin: Department of Health and Children.

38. Steering group for the mid-term review of the National Drugs Strategy (2005), *Mid-term review of the National Drugs Strategy 2001-2008*. Dublin: Department of Community, Rural and Gaeltacht Affairs.

misuse were far from separate. Although it was difficult to build linkages in the area of supply reduction, because of the different legal status of the substances, the Steering Group argued that, given the acknowledged linkage between early use of alcohol and illicit drug use, the laws regarding the sale and supply of alcohol should be rigorously enforced. The Gardaí (Police) were also tasked under the National Drugs Strategy with actions seeking to divert young people from drug and alcohol misuse. With regard to prevention, the Steering Group noted that most education programmes cover substance misuse in general, including alcohol, tobacco and illicit drugs. It took the view, however, that awareness-raising and campaign messages should be separate, to keep them "focused and credible".

With respect to treatment, the Steering Group recognised that, owing to the increase in polydrug use, many drug services were also treating clients with problem alcohol use; it recommended that the availability and range of treatment options needed to be increased. In a separate development, in 2006, the new mental health policy report stated that "individuals whose primary problem is substance abuse and who do not have mental health problems will not fall within the remit of mental health services".[39] This marked a departure from the World Health Organization's (WHO's) international classification system, where substance abuse (dependence) is included among the categories of mental health problems.[40] According to the mental health policy report, the major responsibility for the care of those with substance abuse (dependence) would now lie with separately funded services within the Health Service Executive (HSE). In its National Service Plan for 2007, the HSE stated that work would begin during 2007 on scoping the transition of the management of alcohol services from mental health to social inclusion services, which already include drug-addiction services, and that a review of how drug and alcohol services could have a better fit would be completed.[41]

8.4.4.2. The Tobacco-Free Policy Review Group

In 2000, the year that the Review Group was convened to prepare the current National Drugs Strategy, the Tobacco-Free Policy Review Group, set up by the Irish Government to carry out a fundamental

39. Expert Group on Mental Health Policy (2006), *A vision for change*. Dublin: Stationery Office.

40. Long, J. (2006), "New mental health policy distances its links with the addiction services". *Drugnet Ireland* 18: 9.

41. Pike, B. (2007), "HSE outlines plans for drug-related services in 2007". *Drugnet Ireland* 22: 5-7.

review of health and tobacco, published its report.[42] The Review Group argued that the then current policy response – comprising statutory and voluntary environmental controls, controls on industry behaviour and health education – which had been in place since the 1960s, was unlikely to yield further progress in reducing the prevalence of smoking. The Review Group identified four key strategic objectives and an action plan, with the ultimate aims of reducing dramatically the level of smoking in Irish society and preventing Irish children from starting to smoke. An adequately resourced management system was necessary to ensure success and the Tobacco-Free Policy Review Group recommended that this cost should be internalised to the tobacco sector.

In 2001, following endorsement of the idea in the Tobacco-Free Policy Review Group's report, the Research Institute for a Tobacco-Free Society was established in Ireland. Its aim is to form a multi-disciplinary academic community researching all aspects of tobacco from a public health perspective, including the disciplines of chemistry, biochemistry (including toxicology), economics, law, behavioural sciences (including marketing and advertising), education, actuarial science, epidemiology, medicine and health care. In 2002, to support implementation of the policy recommendations in the Tobacco-Free Policy Review Group's report, the government passed the Public Health (Tobacco) Act. Among other things, the Act established the Office of Tobacco Control as an independent statutory body, to support the Minister for Health and Children, to organise a national inspection programme, enforce the tobacco-control laws, conduct research into tobacco and communicate the findings.

8.5. Ideology versus evidence

In a comparative study of the development of alcohol and drug policy in Ireland between the mid-1940s and the mid-1990s, Shane Butler has shown how cultural attitudes influenced policy choices.[43] Despite the fact that the health-promotion approach put forward by the WHO was embraced by the health authorities in Ireland, policy in the drugs and alcohol domains did not converge to form "a unitary, rational or research-based substance abuse policy"; rather, the two policy domains

42. Tobacco Free Policy Review Group (2000), *Towards a tobacco free society.*

43. Butler, S. (1991), "Drug problems and drug policies in Ireland: a quarter of century reviewed". *Administration* 39/3: 210-33; Butler, S. (2002), *Alcohol, drugs and health promotion in modern Ireland.* Dublin: Institute of Public Administration.

moved forward as "parallel activities, involving different actors pursuing different agendas, with science or research making, at best, a modest contribution in each of these two related arenas".

Butler argued that cultural attitudes kept the two policy domains apart: alcohol was regarded as a familiar part of everyday life in Ireland and "essentially benign", while illicit drugs were regarded as "unspeakably evil". Butler argued that politicians, rather than any of the other policy actors, were the final arbiters. He concluded that by 1996 it was the politicians' view that the Irish were not ready to accept what would have been "a paradoxical change: that is, the simultaneous introduction of tougher and more paternalistic alcohol policies alongside more liberalised, or at least more pragmatic, drug policies – all in the name of health promotion".

8.5.1. Research data

From the mid-1990s onwards, the systematic generation of research data and information began to change the basis on which policy decisions in relation to drugs and alcohol were made. In its 1997 report, the Ministerial Task Force called for the establishment of an advisory body that would conduct research into causes, effects, trends and international developments in respect of illicit drugs, conduct reviews of responses, offer advice and make recommendations to government.[44] In 2000, following a two-year developmental phase, the National Advisory Committee on Drugs (NACD) was set up to undertake this role in the areas of prevalence, prevention, treatment, rehabilitation and consequences of drug use. To date, it has published over forty reports.

In 1990 the Health Research Board (HRB) set up a drug-treatment reporting system, which was extended nationwide in 1995. In 1996, data from this National Drug Treatment Reporting System (NDTRS) was used to identify the 13 LDTF areas.[45] Since 2004, the NDTRS has been expanded to include alcohol, alongside illicit and licit drugs, as one of the main problem drugs. In 2005, the HRB launched the National Drug-Related Deaths Index (NDRDI), which included alcohol-related deaths from 2004. In 2006, the HRB changed the name of the Drug Misuse Research Division (DMRD), which managed the two epidemiological

44. Ministerial Task Force on Measures to Reduce the Demand for Drugs (1997), *Second report of the ministerial task force on measures to reduce the demand for drugs*. Dublin: Stationery Office.

45. Sinclair, H. (2006), *Drug treatment demand data: influence on policy and practice*. Strasbourg: Council of Europe.

databases. It became the Alcohol and Drug Research Unit (ADRU), and an Alcohol Research Officer was recruited. Within a year the HRB published its first research report on alcohol – *Health-related consequences of problem alcohol use*.[46] Among the report's conclusions was a call for greater integration of alcohol- and drug-treatment services.

Starting in 1995, a series of national surveys of lifestyle choices and health status began in Ireland – their coverage including alcohol, tobacco and illegal drug use, among both the general and the school-going populations.[47] Now into their second or third iterations, these surveys are beginning to yield accurate information on the nature and direction of trends in substance-use prevalence.

8.5.2. Evidence-based policy

8.5.2.1. Alcohol

On the basis of this growing body of data and research, Irish policy makers have become increasingly confident about building closer links between drug and alcohol policies. For example, completed in the course of 2005, the majority of the first round of regional drugs task force (RDTF) strategies and action plans include alcohol along with drugs.[48]

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46. Mongan, D., Reynolds, S., Fanagan, S. and Long, J. (2007), *Health-related consequences of problem alcohol use*. Overview 6. Dublin: Health Research Board.

47. Friel, S. *et al.* (1999), *The national health and lifestyle surveys: survey of lifestyle, attitudes and nutrition (SLAN) and the Irish health behaviour in school-aged children survey (HBSC)*. Galway: National University of Ireland; Hibell, B. *et al.* (1997), *The 1995 ESPAD report: alcohol and other drug use among students in 26 countries*. Stockholm: Swedish Council for Information on Alcohol and Other Drugs (CAN) and Council of Europe Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group); Hibell, B. *et al.* (2000), *The 1999 ESPAD report: alcohol and other drug use among students in 30 countries*. Stockholm: Swedish Council for Information on Alcohol and Other Drugs (CAN) and Council of Europe Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group); Hibell, B. *et al.* (2004), *The 2003 ESPAD report: alcohol and other drug use among students in 35 countries*. Stockholm: Swedish Council for Information on Alcohol and Other Drugs (CAN) and Council of Europe Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group); Kelleher, C. *et al.* (2003), *National health and lifestyle surveys: survey of lifestyle, attitudes and nutrition (SLÁN) and the Irish health behaviour in school-aged children survey (HBSC)*. Department of Health and Children: Dublin; Nic Gabhainn, S. *et al.* (2007), *The Irish health behaviour in school-aged children (HBSC) study 2006*. Dublin: Department of Health and Children.

48. Pike, B. (2006), "RDTF strategies push out the boundaries". *Drugnet Ireland* 20: 11-12.

In July 2006, a Joint Oireachtas Committee (comprising members of the upper and lower houses of Parliament) published a report on whether and how the national alcohol and illicit drugs policies should be combined.[49] The report acknowledged, but did not describe in detail, the research and information available on the extent and nature of the alcohol problem in Ireland, commenting simply: "The arguments have been rehearsed *ad nauseam*, yet it would appear that to date no sustained, evidence-based policy response has been set in place in this sphere." The report highlighted a disparity between alcohol policies that were popular (including education, diversion and treatment for those with alcohol dependence) and those that were effective (including fiscal measures to increase prices, restrictions on outlets and hours of sale, and restrictions on advertising and promotion).

Regarding the reluctance of Irish politicians to introduce these "effective" responses, the report commented that there had, in the past, been two main reasons. Firstly, the measures were seen as a threat to the drinks industry, "which not only contributes to the economic well-being of the country but also has well-established links to Irish political life"; and secondly, they targeted the drinking population as a whole, rather than subgroups "such as 'alcoholics', alcohol 'abusers' or young drinkers", which would be electoral suicide.

The report went on to note that public support for alcohol control measures was growing, citing an attitudinal survey conducted in 2006 by the lobby group Alcohol Action Ireland, which showed that most people were aware of Ireland's problem with alcohol, and accepted that tackling the problem would involve a change in Ireland's cultural attitude towards and acceptance of alcohol misuse and drunkenness. Only a small minority (26%) of respondents believed that the government was doing enough to tackle the problem.[50]

The report concluded by suggesting that the failure to introduce the proven preventive measures was due not so much to a lack of political will as to "a somewhat more mundane reason": there were no management structures in place to give effect to the recommendations made in the plethora of reports and policies drafted since 1996. While the ideal would be "an integrated national alcohol policy, such as has been advocated by WHO for several decades", a less ambitious, more

49. Joint Committee on Arts, Sport, Tourism, Community, Rural and Community Affairs (2006), *The inclusion of alcohol in a national substance misuse strategy*. Ninth Report. Dublin: Houses of the Oireachtas.

50. Sinclair, H. (2006), "Public attitudes to alcohol in Ireland: a recent survey". *Drugnet Ireland* 18: 10.

practicable solution was put forward. The report called for alcohol to be added to the agenda of the existing National Drugs Strategy. This option would have the advantages that it could be implemented quickly, there would be economies of scale, and the five-pillar model (supply reduction, prevention, treatment, rehabilitation and research) would offer an ideal framework for addressing alcohol issues.

The Joint Oireachtas Committee did not recommend including alcohol in the National Drugs Strategy. Instead, they urged "that alcohol should be included in a new national substance misuse strategy. This will have the effect of cementing alcohol policy at the Governmental level, satisfying growing public demand for an integrated policy response to alcohol-related problems." In her foreword to the report, Cecilia Keaveney TD, the Chair of the Oireachtas Committee, explained that they had changed "drug" to "substance" because "they were loath to have alcohol classified alongside heroin and cocaine etc., and all that that entails".

On 5 October 2007 the Minister of State with responsibility for the National Drugs Strategy, Pat Carey TD, made the following statement regarding drugs and alcohol policy:

> As I set out now on the consideration of a new National Drugs Strategy [due in 2009] … I am very conscious of the alcohol problem in terms of overall addiction. I have an open mind on how the details of a new Strategy will pan out, but certainly there is at least room for increased synergies between the approach to illicit drugs and the approach to alcohol. While there are differences in the problems, in terms of legality, attitudes, and degree of pervasiveness, there can, I think, be similarities in the approach to prevention, research and aspects of treatment.[51]

8.5.2.2. Tobacco

Established in 1997, the Joint Oireachtas Committee on Health and Children decided to undertake a comprehensive overview of tobacco/health policy and legislative issues.[52] Not only was it ten years since tobacco legislation had last been debated in the Oireachtas, but in the interim "voluminous documentation stretching back over decades

51. Carey, P. (2007), Speech by Minister of State Pat Carey TD at the opening of the "Getting a Grip Conference – Winning or Losing", held in Killarney, Co. Kerry, 5 October 2007.
52. Joint Committee on Health and Children (1999), *A national anti-smoking strategy – a report on health and smoking.* Dublin: Houses of the Oireachtas; Joint Committee on Health and Children (2001), *Second interim report of the sub-committee on health and smoking.* Dublin: Houses of the Oireachtas.

which forms part of the records of, reports by and research of various major tobacco companies has been disclosed in the United States." With regard to ongoing research and information, the Committee called for "reliable and up-to-date information and data be available to assess the impact and effectiveness of the various initiatives proposed", and for the extension of its powers to compel documentary disclosure in order to "have access to all research either funded by or relied upon by those tobacco companies which sell cigarettes in the State and all relevant internal documentation of these companies relating to such research".

Having assessed the research-based evidence on the content of cigarettes, the health effects of smoking, the tobacco industry, tobacco use and tobacco-related diseases in Ireland, the Tobacco-Free Policy Review Group, established following the tabling of the Joint Oireachtas Committee's report in 1999, assessed tobacco-related harm as follows: "Tobacco products are not just another consumer product with regrettable adverse products. These products, when used in the manner intended by the manufacturer, cause addiction followed by illness and premature death." The Review Group recommended a "tobacco-free society" as the most appropriate objective; prohibition was not an option:

> If tobacco were to appear for the first time today its sale would not be permitted. … However, tobacco usage has been established for many centuries in Ireland …. There have been understandable calls for an outright ban on tobacco but this is not achievable at present because of the high numbers of people who are addicted to the product and because of the ready availability of tobacco products in neighbouring jurisdictions. A complete ban would, in our opinion, lead to the emergence of a substantial black market in smuggled products with its associated criminality.[53]

53. Tobacco-Free Policy Review Group (2000), *Towards a tobacco-free society*.

9. From policies on alcohol, tobacco and other drugs to a policy on psychoactive substances: Luxembourg

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9.1. Context

Luxembourg is one of Europe's smallest countries with an area of 2 586 sq. km, covering a maximum of 82 km from north to south and 57 km from east to west. It is situated between Belgium, Germany and France, and the languages spoken are Luxembourgish, French and German. Teaching is in all three languages. Luxembourgish and French are the official languages, French being the administrative and judicial language. German is the language mainly used in the written media. Administratively the country is divided into three districts, 12 cantons, 118 municipalities and four electoral constituencies.

The country is a "democratic, free, independent and indivisible state". It is a parliamentary democracy in the form of a constitutional monarchy. Under such a system, a hereditary monarch is recognised as head of state, but his or her powers are limited by a higher legal authority, the Constitution, to which the head of state, like the other powers, is subject. The Grand Duke plays a central and key role, and he abides to the letter by the maxim that "the sovereign rules but does not govern".

Luxembourg has a unicameral legislature. Parliament is the 60-seat Chamber of Deputies. Its members are elected by universal suffrage for a five-year term. Following parliamentary elections, the leader of the majority party or coalition is appointed Prime Minister by the sovereign for a five-year term. The Prime Minister is the head of government[54] and has executive power, which includes execution of

54. Following the parliamentary elections of June 2004, Jean-Claude Juncker became Prime Minister, heading a coalition between the Christian-Social Party (CSV) and the Luxembourg Socialist Workers' Party (LSAP). On 31 July 2004, the Grand Duke signed the decrees to form the new government, and its 15 members – including the Prime Minister, Deputy Prime Minister, 11 ministers, a deputy minister and a state secretary – were sworn in.

the law and direction of the country's current affairs. A second body, the Council of State, is appointed by the Grand Duke. It comprises 21 citizens recommended by the Prime Minister and advises the Chamber of Deputies on the drafting of legislation. The Grand Duke has constitutional authority to dissolve parliament and establish a new one. The Prime Minister can only recommend its dissolution to the Grand Duke. Parliament and the government exercise legislative power. Each year the government issues a statement on the country's economic, social and financial situation and a statement on foreign policy. The income and expenditure budget is voted annually.[55]

9.1.1. Population[56]

This small country has about 480 000 inhabitants. Since the 1970s the resident population has grown by 120 000. Compared with nearby countries, this demographic growth rate is quite exceptional and is mainly the consequence of immigration. On average, Luxembourg's migratory balance was more than 10‰ per year over the decade 1990-2000, whereas in the Europe of the Fifteen the corresponding figure was about 2.3‰. Fewer than two thirds of the population are Luxembourgers. The population is a remarkable coming together of different nationalities, mainly from Europe, in particular Portuguese, Italians, French, Belgians and Germans.

Domestic employment has grown consistently since 1983, particularly with the contribution of a large number of cross-border workers, who make up a third of the country's work force. Unemployment was for long a marginal phenomenon, with rates of under 3%, but it rose sharply in the second half of 2002. In 2007 it was over 4%.

9.2. Data on drugs

Science and the scientific approach form a rather young discipline in Luxembourg. The first public research centres (Centres de Recherche Publics) were created in 1987 and financed by different ministries, in areas such as health, technology and innovation. The University of Luxembourg has existed only since 2003, although post-secondary studies were organised in restricted areas in the form of academic courses before that. The lack of information in the field of drugs was filled by a monitoring centre first implemented in the Ministry

55. See http://www.gouvernement.lu/.
56. See http://www.statec.public.lu/fr/index.html/.

of Health, and later integrated into the public health research centre (CRP-Santé).

This evolution has been leading to a national drugs and drug-addiction monitoring and information network called RELIS (Réseau Luxembourgeois d'information sur les sutpéfiants, les substances psychotropes et les toxicomanies), which was established in 1993 and has since been developed by the national focal point to provide the EMCDDA with reliable data on drugs. RELIS is based on a multi-sectoral information network that includes national out-patient and residential specialist treatment centres, consultation centres, general hospitals and the relevant judicial and criminal authorities. This national database is updated annually and enables those concerned to:

- estimate the prevalence, incidence and trends in problem drug use at national level,
- determine the institutional patterns of those seeking care,
- provide scientific support and data for research,
- assess emerging trends and the impact of certain forms of intervention on the behaviour and characteristics of problem drug users, and inform the decision-making process when policies are being developed for anti-drug action plans and intervention strategies.[57]

RELIS is mainly an information network, but it is above all a human network consisting of practitioners dealing with drug problems and experts from specialised governmental and non-governmental organisations.

So far, no representative survey of legal and illegal drug use among the general population has been conducted. However, a multi-method study on the prevalence of problem drug use was carried out in 2000[58] (Origer, 2001) and revealed a prevalence rate of 8.42 problem drug users per 1 000 inhabitants aged between 15 and 64.

Besides that, several targeted surveys of specific sub-groups (mostly of schoolchildren) have been carried out. Selected larger studies are listed in the table below; for full information, see the National Report on the

57. Origer, A. (2006), *L'état du phénomène de la drogue au Grand-Duché de Luxembourg (RELIS)*, Point focal OEDT Luxembourg – CRP-Santé, Luxembourg.

58. Origer, A. (2001), *Estimation de la prévalence nationale de l'usage problématique de drogues à risque élevé et d'acquisition illicite – Etude comparative multi-méthodes 1997-2000*, Séries de recherche No. 2, Point focal OEDT Luxembourg – CRP-Santé, Luxembourg.

state of the Drugs Phenomenon (RELIS report), online at http://www.relis.lu/. Luxembourg has joined the HBSC network and the results from the latest study (the second one) will be available soon.

There have been other studies since the early 1990s, and recently research was carried out by the national focal point to assess the prevalence of HIV, HCH HAV and HBV among problematic (injecting) users of illicitly acquired drugs. The aim of this study was to increase national vaccination coverage and refer infected users and appropriate treatment centres.

Table 9.1: Some studies of drug use in Luxembourg, 1995-2003

Year	Authors	Study	Description
1995	Matheis, J. et al.	*Schüler an Drogen/ Students and drugs*	Self-administered questionnaires about drug use in national schools, targeting 16- to 20-year-old students
1996	Dickes, P., Houssemand, C.L. and Martin, R.	*La consommation de drogues légales et illégales des élèves des 6es de l'enseignement secondaire et des 8es de l'enseignement professionnel et technique*	Self-administered questionnaires about the use of licit and illicit drugs by students of 13-16 years
1998	Fischer, U. and Krieger, W.	*Suchtpräventioun an der Gemeng/Drug prevention at communal level*	Self-administered questionnaires: 12- to 60-year-olds
2000	Fischer, U.	*Cannabis in Luxembourg – Eine Analyse der aktuellen Situation/Cannabis in Luxembourg – analysis of the current situation*	15- to 64-year-olds
2001	Origer, A.	*Estimation de la prévalence nationale de l'usage problématique de drogues à risque élevé et d'acquisition illicite*	
2003		HBSC Study	

9.3. National drug policy

Several ministries are involved in drugs policies, including health, justice, education and training, the family and integration, social solidarity, and foreign affairs and immigration.

The interministerial commission on drugs (ICD) – the Groupe Interministériel Drogues or GID – co-ordinates policy, in consultation with the national drugs co-ordinator (who is also chair of the ICD) and representatives of the prosecution service, the police, customs and excise, the national youth service and the drug prevention centre. The national drugs co-ordinator, appointed by the Minister of Health in 2000 for his long-term experience and knowledge in the drugs domain, is responsible for co-ordinating work on drug-related demand and harm reduction. He is the official contact and spokesperson at national and international level. The ICD meets four to six times a year to follow up the implementation of national drugs strategies and action plans, to supervise field activities and to operate as a consultative body with the power to issue opinions and recommendations.

National policy is based on a strategy and action plan developed jointly by the health ministry, the health directorate and the drugs co-ordination unit. The current action plan (2005-09) follows a first plan (2000-04).[59] The aim is to reduce demand by developing primary prevention measures, care and treatment facilities and also reintegration measures based on previous experience and scientific observation, in accordance with the principles laid down in the EU's 2005-12 drug strategy.[60]

9.4. International co-operation and changes in legislation

As explained above, a national focal point was created in 1993 to provide information to the European monitoring centre for drugs and drug addictions. The country is a founder member of the Council of Europe and has been part of the Pompidou Group since its inception.

The Anti-Drugs Trafficking Fund (see below) co-operates with the United Nations Office on Drugs and Crime and systematically finances the UN Office's projects. The sole UN convention of 30 March 1961

59. See Table 9.3 at the end of this chapter.
60. Cordrogue 53: the draft EU Drugs Strategy (2005-12).

was adopted by Luxembourg on 3 July 1972 and was embodied in the anti-drugs law of 19 February 1973. This law made no distinction between the different types of drugs as far as penalties were concerned. In other words, the use, sale, possession and cultivation of drugs were prohibited and carried heavy criminal penalties.

The first debates on decriminalisation of cannabis and illicit substances took place in 1993, but all the various parliamentary bills were rejected. Even though there have been modifications to the so-called basic law of 2001, since then a distinction has been made between different products, and between simple drug use and trafficking. The prison sentences and fines imposed differ according to the nature of the offence and the type of drug. Before 2001, the simple possession of an illicit substance was punished severely, and no distinction was made between a consumer and a dealer.

In 1992, Luxembourg adopted the 1988 Vienna Convention and established the Anti-Drugs Trafficking Fund (FLTS – Fonds de lutte contre le trafic des stupéfiants). All money seized in connection with drug trafficking is transferred to the Fund, which finances several therapeutic treatment centres and the prevention centre.

The Council of Europe Convention on Laundering, Search, Seizure and Confiscation of the Proceeds from Crime, adopted in Strasbourg on 8 November 1990, entered into national law under legislation of 14 June 2001.

9.5. Treatment and prevention

In Luxembourg, as in most European countries, drug use expanded rapidly in the late 1960s. Twenty years later, in the early 1980s, the first specialist drug advisory and treatment bodies made their appearance. The first such institution, Jugend an Drogenhëllef (Drug assistance for young people), was established in 1983 and clearly reflected the philosophy of the time. The centre was targeting young persons and the focus was essentially on the mono-consumption of hard *or* soft drugs – heroin *or* cannabis. Today the target population is older and the nature of the problem has greatly altered. Multiple consumption of legal and illegal drugs is increasingly systematic. Treatment is no longer focused on the product as such, but rather on the addictive behaviour and form of use. Therapeutic treatment programmes concentrate very much on socialisation and mobilising individuals' own capacities.

At the same time, as existing therapeutic facilities became unable to cope with the situation on the ground – and following implementation of the national drugs plans, first for 2000-04 and then for 2005-09 – a number of low-threshold centres have been opened, coupled in 2005 with the first drug-consumption room not far from the capital's railway station, a major centre and transit point for drug users.[61] In view of the demand for treatment of multiple addictions (or multiple products), the more holistic concept of "dependence" or "addiction" is increasingly used in the care provided. Moreover, the perception of the problem is now less focused on particular drugs. There are groups and associations concerned with dependence on medicines or on gambling. Anonym Glécksspiller (Gamblers Anonymous),[62] a non-profit organisation created in 2003 by a former pathological gambler, is an illustration of the evolution of treatment facilities, but also of the "addiction" concept in Luxembourg.

This change in the care offered (low-threshold facilities, consumption rooms) is evidence of how the whole drugs problem and national drugs policy have altered. Treatment was once based on total abstinence, a policy all too often doomed to failure; it is now moving towards a more diversified and accessible range of services.

The national prevention strategy is no longer exclusively concerned with illegal drugs, but tries to cover all forms of addictive behaviour, and it includes alcohol and tobacco. There are prevention projects for each type of dependence, organised by different bodies, such as the Drug Prevention Centre (unlawful drugs), Road Safety (drink-driving) and the Anti-Cancer League (smoking). They also offer separate treatment for alcohol and tobacco dependence.

9.6. New legislation

The law distinguishes clearly between different psychotropic substances, or groups of substances. In recent years, though, there have been more fundamental changes, sometimes affecting several drugs simultaneously.

The most recent changes concern the road traffic code. From 18 September 2007, the maximum blood alcohol concentration was

61. This closed unit, supervised by health professionals, offers users sterile and single-use syringes and enables them to prepare and inject their drugs away from the public gaze and in total security. The staff are also trained in first aid and can intervene in the event of accidents, in particular overdoses.
62. For more information, see http://www.anonym-gleckssspiller.net/.

reduced from 0.8‰ to 0.5‰ – to 0.2‰ for young drivers. All drivers and pedestrians involved in accidents are tested by the police for unlawful drugs. These measures are a response to the finding that speed and alcohol are responsible for over half of all fatal road accidents, and 45% of convictions in the courts are for drink-driving offences. Drink-driving is the main cause of problems on the roads in Luxembourg. Alcohol consumption reaches very high levels (though the official consumption figures do not reflect reality, being biased by the high number of cross-border travellers who buy alcohol and cigarettes because of the cheaper prices and lower taxes in Luxembourg).

It must be stressed that no alcohol action plan has been implemented in Luxembourg as it has in other European countries. Even so, some measures were taken after public concern and a government statement in 2004 about the risks of consuming mixed alcoholic drinks – 'alcopops' – and their increased consumption among the young. A special health ministry working party proposed new measures to reduce consumption of alcohol and alcopops. These measures include a significant rise in the tax on alcopops (from 1 January 2006) and a ban on the supply or sale of alcohol to persons under 16 (from 22 December 2006).

The anti-smoking law of 11 August 2006 restricts the advertising of tobacco and tobacco products, bans smoking in certain places and also bans the sale of tobaccos for oral use.

Table 9.2: Psychotropic substance legislation in Luxembourg, 1973-2007

Date	Substance	Law
19.02.1973	Medicines	Basic law on the sale of medicines and combating drug abuse
27.04.2001	Cannabis Medicines	Amends the basic law of 19.02.1973 by decriminalising the use of cannabis and introducing wider variation of penalties linked to the various offences and the nature of the controlled substances concerned
01.01.2006	Alcohol	Higher taxes on alcopops
11.08.2006	Tobacco	Ban on all direct or indirect tobacco advertising or sponsorship
11.08.2006	Tobacco	Ban on smoking in public places, including hospitals, public establishments, restaurants, cafés and bars serving meals (in the latter, only during meal times: 12.00-14.00 and 19.00-21.00)

Date	Substance	Law
11.08.2006	Tobacco	Ban on sale from/free access to cigarette vending machines for persons under 16
22.12.2006	Alcohol	Ban on sale or supply of alcoholic drinks to all young persons under 16
18.09.2007	Alcohol	Reduction in the maximum blood alcohol concentration for drivers from 0.8‰ to 0.5‰, and 0.2‰ for young drivers and professional drives
18.09.2007	THC Amphetamines Cocaine Opiates	Screening for illegal drugs of any driver or pedestrian involved in an accident. Maximum limits: – 2 ng/ml of tetrahydrocannabinol (THC) – 50 ng/ml of amphetamines – 50 ng/ml of cocaine – 20 ng/ml of opiates

Table 9.3: Basis of drugs/drug addiction strategies and action plans in Luxembourg

2000-04	Drugs and drug addiction	Action plan based on: low-threshold centres care and treatment network post-therapeutic arrangements: social and occupational reintegration epidemiological research and monitoring primary prevention
2005-09	Drugs and drug addiction	Action plan based on: reducing demand reducing supply plus four transversal elements: reducing risks, harm and disturbance research and information international relations co-ordination arrangements

9.7. Conclusion

Even if a more holistic concept of addiction is intellectually accepted by most actors and by public opinion, prevention, treatment and legislation still quite obviously separate alcohol, tobacco and illicit drugs, and a distinction will probably remain in law, but also in treatment and prevention.

In the last few years, political leaders and the population at large have grown considerably more aware of the need for practical measures to deal with problems of dependence. The national action plans that have been implemented have contributed greatly to this and will assist the various bodies concerned to consolidate their efforts in the future.

10. From policies on alcohol, tobacco and other drugs to a policy on psychoactive substances: The Netherlands

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10.1. Drugs policies

The Netherlands has separate policies on alcohol, tobacco and drugs. Dutch national policy distinguishes these psychoactive substances and defines different major aims. In this way, differences in health risk and social acceptance of the substances are taken into account.

The main goals and measures for each substance are:

- Alcohol: to stimulate the decrease of alcohol use and limit the risk of alcohol-related problems in specific situations;
- Drugs: to prevent or limit the risks of drug use for individuals, their direct environment and society;
- Tobacco: to discourage smoking and protect the non-smoker.

Prevention – of health risks and negative consequences for society – is the prime aim of Dutch policy on alcohol, drugs and tobacco. In its policy the Dutch Government focuses mainly on public health, but there is also special attention to criminality, civil order, traffic safety, absence through illness and inability to work.

10.2. Context: The Netherlands

To understand Dutch drug policy, it is important to be aware of some typical features of Dutch society. The Netherlands is one of the most densely populated and urbanised countries in the world. The country has almost 16.5 million inhabitants – that is, almost 400 people per square kilometre. The Netherlands has long been a trading country,

with Rotterdam as the biggest port in the world and a strong transport sector.

Dutch people attach much value to the freedom of the individual. The government is expected to act in a reserved way on issues like religion and moral questions. Open discussion of issues like drug use is characteristic of Dutch society. Its citizens also attach much value to protecting the public good. The Netherlands has therefore an extensive system of social care, along with public access to health care and the education system.

10.3. Drugs

To quote the NDM report for 2006:[63]

The national drug policy in the Netherlands has four major objectives:

- To prevent drug use and to treat and rehabilitate drug users;
- To reduce harm to users;
- To combat the production and trafficking of drugs;
- To diminish public nuisance by drug users (the disturbance of public order and safety in the neighbourhood).

Dutch drug policy is primarily focused on health protection and health risk reduction.

Unlike the production, trafficking and possession of drugs, the use of drugs is not penalised in the Netherlands. The framework for prosecuting unlawful activities, especially the production and trafficking of drugs, and for sentencing criminal drug users has been gradually expanded in the past decade and now involves an extensive set of laws and other legal instruments. The most important law on drugs is the Dutch Opium Act (1928), or Narcotics Act, which is a penal law. It was fundamentally changed in 1976. A distinction was made between drugs presenting unacceptable risks (hard drugs) and drugs like cannabis (soft drugs), which were seen as less dangerous.

Several departments are responsible for drug policy. It is co-ordinated by the Ministry of Health, Welfare and Sports, which is also respon-

63. National Drugs Monitor, *The Netherlands drug situation, 2006*. Trimbos Instituut, Utrecht (2007).

sible for policy on prevention and care. The Ministry of Justice implements and oversees criminal law, and the Ministry of Internal Affairs is responsible for local government and police. Local authorities discuss their drug policy in "triangle meetings" of the mayor, head of the local police and deputy public prosecutor.

10.3.1. Hard drugs

In its hard drugs policy, the Dutch Government focuses mainly on prevention and harm reduction. Several projects set up by government bodies contribute to this prevention policy. In high schools and primary schools, educational programmes about drug use are offered. Special attention is given to night-time drug use by adolescents. This campaign, started by the Trimbos Institute, aims at the use of drugs in night life like cocaine and ecstasy.

Besides prevention, the government pays attention to harm reduction among drug addicts. The Dutch Government counts it their duty to limit the problems of and those caused by addicted individuals, and co-operation with other sectors has led to an integrated drug policy. For example, in several communities (but not yet at national level) there is special housing counselling for drug addicts. In recent years, the policy on hard drugs more often goes together with policy on other marginal groups in society, like homeless people.

When prevention and educative information are no solution, and individual counselling or relief centres do not suit the situation any more, the government tries to find other solutions. An example of a solution for extreme cases is the 'Heroin Experiment'. In this project, the most serious addicted are offered heroin on the basis of medical advice.

10.3.2. Soft drugs

Again quoting from the NDM report, *The Netherlands drug situation, 2006*:

> The sale of cannabis is illegal in the Netherlands, yet coffee shops are allowed to sell cannabis if they adhere to certain criteria (AHOJ-G criteria). These criteria are: no advertising, no sale of hard drugs, no selling to persons under the age of 18, no causing public nuisance and no selling more than 5 grams per transaction. Three extra criteria are: no alcohol vendor, no more than 500 grams in stock and – in some cities – a minimum distance to a school or to the Dutch border. In recent years, the government policy has aimed to reduce the number of

coffee shops. However, the decision whether or not to tolerate a coffee shop lies with the local authorities.

The cultivation and possession of cannabis is always a penal act, even when it concerns small amounts. Actual practice is different: there is no active criminal investigation if someone cultivates up to five cannabis plants or is in possession of less than 30 grams of hash or cannabis (and coffee shops are banned from selling more than 5 grams of cannabis to one person in one day). This policy of no active investigation is called *gedoogbeleid* (appeasement policy). Police and justice give priority to discouraging cultivation, trafficking and possession of large amounts. Sharp penalties are inflicted on these crimes.

10.3.3. Alcohol

In its national alcohol policy, the Dutch Government focuses on decreasing the number of individuals who use alcohol problematically. The main goal of the alcohol prevention policy is not to discourage the moderate use of alcohol or to prohibit it – it is a socially accepted stimulant, which (if used moderately) will not cause any harm for most people. A second focus of the policy is to minimise the risk of alcohol-related problems in specific situations: family, work, traffic and night life.

Research has shown that the most effective way to decrease alcohol use is an alcohol policy that contains a mix of different measures: an integral alcohol policy. The most effective measures reduce the availability of alcohol: buying alcohol is made more difficult. Financial availability can be narrowed down by price rises, by means of excise/tax. In the Netherlands an excise of 6 eurocents is paid on beer and wine, and 22 cents on spirits.

Physical availability of alcohol can be reduced by age limits: no selling of low-alcohol drinks to persons under 16 and no selling of strong drinks or spirits to persons under 18. Another way to set boundaries to the availability of alcohol is by limiting its sale – for instance, by selling spirits only at liquor stores, no alcohol in sports canteens, closing times in bars – and banning the sale of alcohol at certain places, like filling stations and shops that sell no food.

Limitations on alcohol advertising and giving out information about alcohol use are also an important support of other measures. Information and education have always been primary in Dutch alcohol policy. National campaigns and regional activities are organised by different bodies. In high schools and primary schools, special programmes about

alcohol use are offered. On line there are several informative websites for adolescents, sites for children with addicted parents and sites for problematic users.

10.3.4. Tobacco

The primary aims of Dutch tobacco policy are to discourage the smoker and protect the non-smoker. Several laws contribute to tobacco policy. It is prohibited to sell tobacco products in government agencies, to sell tobacco products to children under 16 or to provide free tobacco products. Besides that, there is a ban on advertising tobacco products. Advertisements on television or billboards and in newspapers or magazines are not allowed.

For a couple of years, a prohibition of smoking remains in several (public) places. In public traffic (trains included), it is prohibited to smoke. An employer has to make sure his employees have a non-smoking workplace. Employees may not have any discomfort by cigarette smoke. From 1 July 2008, the catering industry (restaurants, bars, and cafés) has to be smoke free as well. Employers can create a closed space where smoking is allowed. The main goal of this prohibition of smoking is the protection of non-smokers.

Besides these laws, other measures are taken. Several campaigns and activities are established to make people aware of the consequences of smoking. The main goal in these campaigns is to help people stop smoking rather then to prevent people from starting. The use of tobacco can also be narrowed down by rises in excise/tax. The excise is seen as the most effective measure in tobacco policy; the price of tobacco has a strong and direct influence on its consumption. In 2004 an excise rise of 55 eurocents was implemented.

10.4. Conclusion

The Ministry of Health, Welfare and Sports co-ordinates policy on drugs, alcohol and tobacco. The Ministry of Justice is responsible for the criminal law on drugs. Although different ministries (and departments within the Ministry of Health, Welfare and Sports) work together, there is no integrated policy for all legal and illegal psychotropic substances.

11. Norway: alcohol and drug policy

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11.1. A coherent policy

In Norway alcohol and drug policy is in principle seen together as one coherent policy. This means that the two kinds of substances are handled together as far as possible. In Norwegian a term like "policy on substance use and misuse" is used to underline that problems concerning alcohol and narcotic drugs are related. Both at national and local level, the issues of alcohol and illegal drugs are dealt with in the same agencies. This means that prevention measures aim to address problems related to alcohol as well as problems related to narcotic drugs.

Treatment for alcohol and drug problems is also organised within the same treatment centres, even if you will find some centres specialising more in the treatment of alcohol abuse, and others specialising in treatment for the abuse of narcotic drugs (such as substitution treatment).

To underline that it is a coherent policy, action plans (national and local) normally address both alcohol and drug problems. Thus action plans normally aim to provide the basis for broad-based strategies with measures that cover the entire alcohol and drug field.

11.2. Legislation

As a consequence of the difference in legal status of the substances, the two groups are separate when it comes to legislation: alcohol policy is regulated by the Act on Alcohol; and illicit drugs are regulated by the penal law.

12. Polish alcohol and drug policies

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12.1. The Polish context

Polish responses to drug problems and to alcohol problems have developed separately. There are two parallel administrative structures, separate laws, separate treatment systems and mostly different NGOs dealing with these problems. The background to these separate approaches is historical and cultural. The different legal status of the substances also contributes to different approaches.

Alcohol drinking has belonged to our tradition for thousands of years; the response to it also has a long history. Alcohol abuse and related problems have been identified for centuries. The organised temperance movement in Poland can be dated from the second half of the 19th century, and a state alcohol policy was developed after the First World War, when Poland was restored as an independent state. So alcohol and related problems are traditional elements of our life, and alcohol policy is a well-known and obvious part of our social and health policy.

The drug problem as a social problem started in Poland in the late 1960s. The first response was formulated in the 1970s and it was limited to strengthening controls on psychoactive pharmaceuticals. At first the drug problem was hidden by officials for ideological reasons. According to the official ideology of the Polish communist party, the drug problem was attributed to capitalist, imperialist countries only, like unemployment, poverty and other social problems. A more extended response to the drug problem in Poland was formulated at the beginning of 1980s in the Solidarity period, mostly by newly established NGOs. Specialist treatment was first offered and the first prevention measures were developed and implemented at that time.

In the beginning, the drug problem developed only among youth, in contrast to the alcohol problem. Therefore alcohol-treatment facilities were not relevant for drug-dependent patients. There were different profiles for drug-dependent and alcohol-dependent patients in terms

of socio-demographic characteristics, life experiences and cultural backgrounds. Drug addicts were not accepted by other patients and found the existing treatment methods insufficient. As the drug problem was a new one, it was totally unaccepted by society. Drug addicts also faced negative attitudes from the staff of existing psychiatric services, including those helping the alcohol-dependent.

Therefore, specialised drug-treatment facilities were established. At the start of the 1980s, the drug-use pattern was based on home-made opiates, called *kompot*, made from poppy straw by drug addicts themselves to satisfy their own needs. The drug-treatment system developed at that time tried to meet the therapeutic needs of such patients. It consisted of out-patient clinics or counselling centres as an entry to the system, then detoxification units in hospitals and then rehabilitation centres run mostly by NGOs and based on a therapeutic community concept.

12.2. Alcohol policy

The Polish model of solving alcohol-related problems is based on the state administration, the local self-government administration and non-governmental organisations. The legal base for alcohol policy is provided by the Act on Upbringing in Sobriety and Counteracting Alcoholism. Based on this Act, the National Programme of Preventing and Resolving Alcohol-Related Problems is designed for the state administration (ministries and central agencies). The State Agency for the Prevention of Alcohol-Related Problems prepares the project, and co-ordinates and supports the National Programme.

Regional Programmes of Preventing and Resolving Alcohol-Related Problems are then implemented in the 16 regions, funded by the fees from regional permits for wholesale beer and wine sales. The Marshal of the Region appoints a Plenipotentiary who is in charge of execution of this programme.

12.2.1. Local programmes

Local Community Programmes of Preventing and Resolving Alcohol-Related Problems are developed and implemented in all local communities, funded by the fees from permits to sell beer, wine and vodka at retail outlets. The Community President/Mayor calls together the Local Commission for Resolving Alcohol-related Problems, which represents

the local administration's alcohol policy, and may also appoint a Plenipotentiary for preventing and resolving alcohol problems.

The tasks of local programmes for preventing and resolving alcohol-related problems are:

- increasing availability of therapeutic and recovery help for alcohol-dependent persons,
- providing support for families with alcohol-related problems, and especially protecting them against domestic violence,
- running preventive educational and informative activities about alcohol and drug abuse, especially for children and youth, including afternoon sport lessons and providing food for poor children in the frame of social care and social therapeutic programmes,
- supporting the activities of associations, institutions and individuals who deal with alcohol-related problems in the community,
- responding to violations of the bans on advertising and alcohol sales to under-aged and drunken buyers, and appearing in court as public prosecutors,
- supporting social work, and organising and financing social integration centres.

The tasks of local programmes that are most commonly supported by local communities are:

- socio-therapeutic club rooms, care/educational centres for children and young people,
- consultation desks for alcohol-dependent persons and members of their families,
- special help centres for victims of domestic violence (with hostels and crisis-intervention centres for victims, intervention-consultation stations, support groups and help lines),
- additional therapeutic programmes and training for medical personnel in dependence-treatment centres, which are financed by the Health Fund,
- school and other preventive programmes,
- professional training for workers who may observe alcohol-related problems and family violence in their work – psychologists, social workers, school workers, police officers, priests, judges, court workers and some professions connected with health care,

– local sobriety coalitions – clubs that in many local communities are actively involved in realising some tasks of the local programme and have become an important partner in solving alcohol problems.

The Polish system of solving alcohol-related problems is local in orientation. Year by year it is becoming more stable and effective for local communities, which systematically modernise and actively develop their work in preventing and solving alcohol-related problems. It is gradually becoming an important element of social politics.

12.2.2. The State Agency

Co-ordination of alcohol policy is in the hands of the State Agency for the Prevention of Alcohol-Related Problems. It is a professional, government-supported body set up to construct the foundations of state health-care policy on the improvement of alcohol abuse prevention, treatment and public education. It was founded as a result of the Act on Upbringing in Sobriety and Counteracting Alcoholism. Its goals and tasks are outlined in this Act and in the National Programme of Preventing and Resolving Alcohol-Related Problems for the years 2000-05.

The Agency co-operates with experts and scientific centres to diagnose the health of society, its lifestyle and model of consumption, and brings prevention and therapeutic programmes up to date. It supports institutions for the treatment and prevention of alcohol problems. It co-ordinates provision with state and local government representatives and offers professional help to many institutions and associations working to implement the National Programme.

The tasks of the State Agency for the Prevention of Alcohol-Related Problems are:

– preparing a draft of the National Programme of Preventing and Resolving Alcohol-Related Problems for coming years and a budget for its implementation,
– giving its expert opinion and preparing drafts of legislative acts and agendas for policy on alcohol and alcohol-related problems,
– providing information and education, preparing expert opinions, and preparing and executing new methods of preventing and resolving alcohol-related problems,

- providing professional support to local governments, institutions, associations and individuals that perform tasks connected with prevention and resolution of alcohol-related problems, commissioning these tasks and financing their implementation,
- co-operation with representative bodies of provinces and representatives of local government councils in charge of alcohol-abuse prevention,
- initiation and co-ordination of activities that make substance-abuse therapy more efficient and more available,
- commissioning and financing tasks connected with the prevention and resolution of alcohol-related problems,
- co-operation with international organisations and institutions in the field of alcohol-abuse prevention.

12.3. Drug policy

On 4 October 2006 a new Act on Counteracting Drug Addiction came into force. The laws of 1997 had to be modified in order to harmonise Polish legislation with the EU *acquis* and to bridge gaps in the existing regulations. Such gaps were an especial concern of drug-treatment specialists. Work on the new law was accompanied by a selective approach to public opinion and the media. The 'hot potato' was the possession of small amounts of drugs for private use. This issue was the focal point of the media coverage and of participants in 'social listening', which is a form of social consultation organised by the Minister of Health. However – apart from penal provisions, which eventually did not undergo major changes – the Act introduced a number of vital changes in the field of counteracting drug addiction.

New provisions of the Act on counteracting drug addiction significantly influenced the National Programme for Counteracting Drug Addiction (NPCDA). The NPCDA remained the basis for activities in counteracting drug addiction, but there were changes to the general aims of the document and its status. The NPCDA would now define only courses of action for local authorities, leaving it to them to decide on specific problems and ways of solving them.

12.3.1. The National Bureau

The National Bureau for Drug Prevention (the NBDP, established in 1993 by the Minister of Health) is a body conducting and supervising

implementation of tasks in the prevention, treatment, rehabilitation and re-adaptation of drug-dependent individuals. The bureau works out the basic policy, strategy and methods of drug prevention, and contracts NGOs operating in the field to perform relevant tasks, funded from government resources.

The most significant task of the bureau is organising studies, especially in epidemiology and hazards related to drugs (with studies in schools). Epidemiological studies are performed mainly by the Institute of Psychiatry and Neurology, which also prepares yearly reports on the situation regarding drugs and psychotropic-substance dependency. The epidemiological data serve as the basis for developing the strategy of drug prevention. The bureau also carries into effect training activities in the area of drug prevention, utilising, among others, the experiences of international organisations – the World Health Organization, the Council of Europe and its Pompidou Group, the United Nations Drug Control Programme and the European Union PHARE Programme. The bureau conducts wide editorial activities as well.

In 2001, as a result of changes in the issue of counteracting drug addiction, the Bureau on Drug Addiction became the National Bureau for Drug Prevention. The Drug Information Centre was established as a branch of the bureau.[64]

12.3.2 The Council for Counteracting Drug Addiction

The Council for Counteracting Drug Addiction was established on 6 March 2001 by the Prime Minister, its legal basis being Article 5.6 of the Law of 24 April 1997 on Counteracting Drug Addiction. The tasks of the Council include:

- presenting the Prime Minister with opinions on the draft of the National Programme for Counteracting Drug Addiction
- moving issues connected with changes or complements to the programme to a minister competent in the scope of public health for consideration
- passing opinions on the reports on the execution of the programme

64. Ustawa z dnia 6 września 2001, Dz.U. z 2001, No. 125, poz. 1367.

- passing opinions on the legislative acts related to drug prevention
- moving proposals for changes in binding legislative acts in the field of drug prevention to competent ministers
- co-operating with organs of government administration and units of territorial self-government in the scope of problems which the Council deals with.

12.3.3. National strategy

In Poland anti-drug strategy is defined in the National Programme for Counteracting Drug Addiction adopted by the Council of Ministers. The bodies and institutions responsible for implementing the programme are mainly in the central administration and local authorities in communes, counties and provinces. Non-governmental organisations should play an important role in implementing particular activities in the field of prevention and rehabilitation.

The National Bureau for Drug Prevention draws up an annual Monitoring Report on NBDP tasks performed by institutions and local government. The latest report states that provincial governments mainly performed tasks related to prevention. Drug-addiction issues formed part of provincial strategies for solving social problems using educational campaigns, training courses for those running prevention programmes, and dissemination of information on drug-prevention programmes and centres. Local authorities at all levels mainly got involved in supporting primary, upper primary and secondary schools in developing preventive actions.

12.4. New development – tendency to integration

Since the 1990s we observe a tendency of integration of alcohol and drug response. The tendency to an integrated approach is visible in the following areas:

- treatment,
- prevention,
- local and regional policy,
- NGOs.

The integrated approach is increasingly popular due to the following factors:

- Drug problems are more and more common and less and less shocking and similarities to alcohol problems are more and more visible for society;
- The profile of alcohol-dependent patients is more and more similar to the profile of drug-dependent patients;
- Drug-dependent people usually drink too much alcohol, and alcohol-dependent people more and more often have experiences with drugs;
- The prevention measures are more or less the same, at least, as far as universal prevention is concerned;
- Alcohol and drug use are common especially among youth, and this group is being considered as the priority target group for prevention;
- Problematic drug use is often substituted by alcohol consumption;
- The mechanisms of addiction and risk groups are similar;
- Alcohol and drug dependency are considered to be illnesses, not only by professionals but also by society – alcohol and drug problems are more and more considered by public opinion in the same way;
- A common treatment offer is more efficient;
- Common management structures for co-ordinating policy at the local and regional levels are more economical.

The factors against integration could be identified as follows:

- The different legal status of alcohol and drugs – some effective alcohol-control measures cannot be applied to drugs;
- The international context – different concerns, interests, management structures, and policies, at European level and on a world scale;
- The costs of integration – changing the law, national management structures and so on;
- The interests of particular professional groups, which could be lost with integration.

13. From policies on alcohol, tobacco and other drugs to a policy on psychoactive substances in Portugal

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Ministry of Health, with contributions from L. Dias and M. Moreira

13.1. Context

Portugal is the most western country in Europe, with about 10 million inhabitants and a territory of almost 90 000 sq. km, surrounded by the Atlantic Ocean and Spain, apart from two archipelagos, the Azores (nine islands) and Madeira (two islands), in the Atlantic.

It has been a republic since 1910. After about four decades of being ruled by a dictatorship that progressively left Portugal closed in on itself and isolated from the world, the democratic revolution of 1974 (the Carnation Revolution) brought the country back into the international community, and gave birth to a long process of changes aimed at recovering from the developmental gap from other European countries.

During the dictatorship period, conditions were very basic at all levels. Portugal was a rural country, where wine production was one of the most important economic activities. At the time, with many people living in extreme poverty and wine not being expensive and easily available, over-consumption was common. As a result, alcohol abuse was very frequent.

Among the big changes introduced by the democratic revolution was the end of the large Portuguese colonial empire, when its colonies gained independence.[65] After independence, either because of the unstable situation that followed it or because the colonial war ended

65. Angola, Mozambique, Cabo Verde, Guinea-Bissau, São Tomé and East Timor (this last, after independence in 1975, came under the rule of Indonesia until 2000, when its independence really began).

and military troops finished their mission, thousands of people returned to Portugal bringing with them, among other things, familiarity with cannabis and, in some cases, even the experience of smoking it.

With democracy, development first reached the main urban areas around the cities of Lisbon and Oporto, where large numbers of people converged. The rapid influx of people with different origins, created large neighbourhoods, often without the necessary basic conditions to promote healthy lifestyles. From the 1970s onwards, there were clear improvements in general social indicators. Universal, compulsory and free schooling, until the 9th grade or 16 years of age, and universal, free health care are among the most relevant of those improvements. Despite that, an economic gap still remains: in 2005, the GDP per capita in Portugal was about US$18 500, while it ranged between US$35 000 and US$50 000 in most other western European countries.

Portugal joined the European Economic Community (EEC) in 1986, together with Spain, and the country's structural modernisation was accelerated: all the regions were drawn closer either by new highways or by "routes" based on the new communication technologies (TV, computers, Internet, etc.), promoting the economic development of the interior of the country. With the Schengen Agreement in 1997, and the consequent abolition of borders, conditions were in place for Portugal to become a full part of Europe, open to all the diverse influences of trends developing worldwide.

It is within this framework that the development of policies concerning alcohol, drug use and tobacco, should be addressed. An overview of the situation concerning these three types of consumption shows there have been changes in opposite directions since the 1970s: the prevalence and patterns of alcohol use decreasing, but the prevalence and patterns of illicit drug use increasing until the end of the century, then becoming stable or even decreasing since. More or less the same pattern seems to be found in teenagers' tobacco use.

13.2. Alcohol use

Alcohol consumption per capita decreased from 14.3 litres in 1971 to 9.4 litres in 2003.[66] According to this indicator, Portugal was the third highest consumer in the world in 2001, and in 2003 dropped to the 8th place in the ranking. Among people aged 15 to 65, lifetime preva-

66. *World Drinking Trends*, 2005.

lence was 75.6% and last-30-day prevalence was 73.6%;[67] however, the pattern of consumption during the week shows a decrease in percentage of daily consumers and an increase of occasional consumers; at the same time the traditional wine use is decreasing while beer consumption increased by more than 14 times between 1961 (4.9 litres) and 2000 (65.3 litres), which means a less harmful pattern of use.[68]

According to other studies,[69] one third of the population never drink alcohol or have stopped, one third regularly consumes it and the other third drink some alcohol daily, at all or almost all meals. This data points to a high level of alcohol dependence and excessive drinkers.

On the other hand, among the school-age population, data from the national school surveys[70] [71] show that prevalence rates are not increasing and seem to have become stable or even begun to decrease since 2001. Among 16-year-old students, data from the ESPAD[72] [73] [74] [75] show that for Portugal, like some other countries (most of them Latin countries), even when lifetime prevalence of use is a high value, the indicators related to more intensive use show that the patterns of use are much less problematic than in countries of northern Europe, where rules for alcohol use are very prohibitionist. For example, in 2003, "lifetime prevalence for drunkenness" was 32% for Portugal and 85% for Denmark, and "last-30-day prevalence for drunkenness" was 14% for Portugal and 61% for Denmark.

The relation between alcohol use and driving or road-traffic accidents shows that Portugal has the highest rate of mortality related to alcohol

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67. Balsa, C. (2003), *Inquérito nacional ao consumo de substâncias psicoactivas na população portuguesa 2001*. Lisboa: IPDT.
68. Matias, C., Silva, A., Neto, A. (2003), *O consumo de bebidas alcoólicas em Portugal Continental segundo os dados dos Inquéritos Nacionais de Saúde de 1996 a 1999*. Lisboa: INSA.
69. Gameiro, A. (1998), *Hábitos de consumo de bebidas alcoólicas em Portugal: 1985, 1991 e 1997*. Lisboa: Ed. Hospitalidade.
70. Feijão, F. (2006), "Os adolescentes e o consumo de substâncias psicoactivas: O tempo e o espaço enquanto factores subjacentes às dinâmicas de consumo em Portugal e na Europa". *Toxicodependências* 13 (1): 59-75.
71. Feijão, F. (2007), "Consumo de substâncias psicoactivas pelos adolescentes portugueses. Que evolução de 2001 para 2006?" *Toxicodependências* 13 (3).
72. Feijão, F. (2006), "Os adolescentes e o consumo de substâncias psicoactivas: O tempo e o espaço enquanto factores subjacentes às dinâmicas de consumo em Portugal e na Europa". *Toxicodependências* 13 (1): 59-75.
73. Hibell, B., Anderson, B., et al. (1997), *The 1995 ESPAD Report*. Stockholm: CAN/GP.
74. Hibell, B., Anderson, B., et al. (2000), *The 1999 ESPAD Report*. Stockholm: CAN/GP.
75. Hibell, B., Anderson, B., et al. (2004), *The 2003 ESPAD Report*. Stockholm: CAN/GP.

in Europe: about 40% of those killed in road-traffic accidents have traces of alcohol in the blood.[76] On the other hand, the mortality rate from chronic liver disease and cirrhosis has significantly decreased since the 1970s, being in 2004 responsible for 1.6% of all deaths in the country, a value that was the 13th highest in the European region of the WHO, and corresponds to less than half of the average value in this region. Another aspect, which is more difficult to quantify, is that the family (relationships and communication, particularly with children, etc.) and social problems (particularly those of work accidents and absenteeism) related to alcohol abuse.

Portugal being a producer of alcoholic beverages, mainly of wine, despite the relevance of those problems, the first political action trying to reduce alcohol abuse appeared only in 1977, when a Commission to Fight Alcohol Abuse[77] was created; two years later, the first regulation on alcohol supply – by a ban on ambulatory trade[78] – was published. Following the WHO interest and call for attention on the problems on alcohol and health policies in 1982, Portugal participated in the Collaborative Study on Community Responses to Alcohol related Problems promoted by WHO-Europe. In 1988, three facilities specifically to treat alcohol dependence[79] were created. Legal norms on the presence of alcohol in the blood of motor vehicle drivers were published in 1982, and have been updated from time to time since; the last update fixed at 0.5mg/ml the highest level permitted. Rules to control the advertising and promotion of alcohol use appeared for the first time in 1990 and were updated in 1995.[80]

In 1993 the Council for Alcoholism was created, but it was the work of the Interministerial Commission created in 1999[81] that led to the first Action Plan against Alcohol Dependence.[82] This was based on guidelines of the WHO-Europe and it pointed to the need to build a National Network to Treat Alcohol Dependence. This network was created[83] (on the basis of the three already existing treatment centres), but few improvements at national level seem to have been implemented.

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76. Marinho, R. T. (2001), "Perspectiva médica sobre a taxa de alcoolémia de 0.2mg/ml". *Revista Portuguesa de Clínica Geral* 17: 471-85.
77. Normative Decree No. 176/77.
78. Decree-Law No. 122/79.
79. Centros Regionais de Alcoologia, in Lisbon, Oporto and Coimbra, created by the Regulamentar-Decree No. 41/88.
80. Decree-Law No. 330/90, and Decree-Law No. 6/95.
81. Resolution of Council of Ministers No. 40/99.
82. Resolution of Council of Ministers No. 166/2000.
83. Decree-Law No. 318/2000.

However, the change in orientation clearly pointed to the need for more integrated prevention, health education, treatment and research, and the urgent introduction of rules to control the alcohol trade and the availability of alcohol to teenagers. Two years later, selling alcohol to children under 16 was forbidden.[84] At the same time, the conditions for availability and sale in public places (facilities belonging to the National Public Administration, highways zones with food trade, etc.) were also regulated.

Recently, as part of the investment being made by the current government to modernise and downsize public administration, all the alcohol health-related issues were integrated in the mandate of the Institute for Drugs and Drug Addiction. Previously it dealt only with domains related to illicit drug-use demand. It is expected that, progressively, the two services will be integrated in order to make alcohol-dependence prevention, treatment and social reinsertion available all over the country, in a more effective and efficient way.

13.3. Drug use

Policy before 1983

Contrary to what happened with alcohol use, illicit drug use was not part of the country's traditional culture and habits. Until 1983 legislation was concerned only with questions related to international trade: import and sale were regulated only on the basis of fiscal law. Drug use was not forbidden, and had no social relevance until the end of the 1970s.

It was after the political changes in 1974 and after Portuguese decolonisation, when soldiers and civilians came back from the former colonies, that the country was opened up to the rest of the world, and instances of the consumption of cannabis appeared. Until then, drug use was found only in some specific groups (intellectuals, health professionals and artists) and raised few health or criminal problems.

As drug circulation increased, the first responses at institutional level appeared, first in 1976 within the scope of the Presidency of the Council of Ministers, moving later to the Ministry of Justice. Three institutions were created to control traffic, to deal with prevention and to monitor the situation. It was in this context that the first reliable data and

84. Decree-Law No. 9/2002.

actions related either to supply or to demand begun to be available. By that time Portugal had already ratified, in 1971, the United Nations Convention of 1961, and in 1979 ratified that of 1971.

The 1980s and 1990s

In the 1980s, with the demographic explosion in urban areas and the subsequent degradation of some neighbourhoods, the consumption and abuse of psychoactive substances increased. Heroin appeared as the most common drug abused in problematic areas, at the same time that cannabis use also spread. It was in 1983 that consumption of the substances included in the United Nations Convention of 1961 and 1971 schedules, usually named "drugs" in the European context, became criminalised.[85] Drug users were seen as delinquents, serving prison sentences in many cases. According to what was then considered the right way to do prevention, there were campaigns based on "Say No To Drugs" and "Drugs–Violence–Death". Treatment was based mainly on psychotherapies, and therapeutic communities began to appear.

By the end of the 1980s, the National Plan to Fight against Drugs, named Projecto Vida[86] was created to co-ordinate action on supply (international traffic, and trade at national level) as well as demand (prevention, treatment, etc.) areas. By that time, under the Ministry of Health, the first specialised treatment centre for drug dependants[87] was set up, with the mission not only to treat users but also to rehabilitate and reintegrate them back into society.

At the beginning of the 1990s, Portugal ratified[88] the United Nation Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. During the decade, cocaine use became more frequent, and hashish and heroin consumption spread to urban areas in the interior of the country. In 1993 a new law addressed the majority of issues related to the control of illicit drug use, supply and demand.[89] It remains the reference law today, despite updates in some aspects. By that time, prevention programmes were being implemented in some public schools,[90] providing information on the negative effects of drug use and policies targeted at reintegrating drug users in work and soci-

85. Decree-Law No. 430/83.
86. Resolution of Council of Ministers No. 23/87.
87. CAT das Taipas, created by the Decree No. 20-A/87.
88. Decree from the President of the Republic No. 45/91.
89. Decree-Law No. 15/93.
90. Viva a Escola, a prevention programme implemented by the Ministry of Education.

ety.[91] An increased need for prevention programmes and treatment facilities led to implementation of the SPTT – Service for Prevention and Treatment of Drug Addiction – integrating all the existing services in the main urban areas,[92] adding new facilities over almost all main cities in the country's districts, and diversifying the answer to treatment with the introduction of new treatment programmes.

Since the 1990s

During the later 1990s the spread of infectious diseases (AIDS, HIV, hepatitis, etc.), particularly among injecting drug users, the dimension of drug-related crime (prisons were overcrowded), the visibility of the deprived conditions of problematic drug users and the public nuisance associated with illicit drug use led to calls for reflection and discussion of the different dimensions and implications of the global situation. As a result a National Strategy to Fight against Drugs and Drug Addiction was drafted. This strategy, driven by a public health concern, pointed to the need to regulate in a pragmatic way the legal status of prevention, use, harm reduction, social reintegration, traffic and money laundering in order to obtain effective gains in health and a decrease in the public nuisance associated with illegal drug use and traffic. Integrated legislation appeared concerning these aspects, and structural changes took place in order to adapt institutions to the needs of the new legal framework.

The law regulating use of narcotic and psychotropic substances without medical prescription, and the health and social protection for drugs[93] (the so-called Law of Decriminalisation of Drug Use), the 30 Goals to Combat Drugs and Drug Addiction,[94] the National Action Plan – Horizonte 2004,[95] the framework to implement risk-prevention and harm-reduction policies[96] – were all issued at this time. The Portuguese Institute for Drugs and Drug Addiction – IPDT, Instituto Português da Droga e da Toxicodependência[97] – was created to help the National Co-ordinator of the Fight against Drug and Drug Addiction to implement the Strategy. All these changes were designed at the same

91. Resolution of Council of Ministers Nos. 104/96 and 44/97.
92. Decree-Law No. 83/90.
93. Law 30/2000.
94. Resolution of Council of Ministers No. 30/2001.
95. Resolution of Council of Ministers No. 39/2001.
96. Decree-Law No. 183/2001.
97. Decree-Law No. 43/99.

time that, at European level, the European Strategy[98] and the European Action Plan[99] were prepared.

The more visible of the measures mentioned above was the decriminalisation of drug use, which became treatable by either administrative penalties or treatment. This process was undertaken and controlled by the Commission for the Discouragement of Drug Abuse.[100]

All these measures correspond to a change in the paradigm addressing drug use. Drug abuse was increasingly perceived as a health problem, and not as criminal behaviour; a drug addict was more and more seen as a patient requiring health care and social reinsertion, and not as a criminal or a delinquent. Implementation of these public policies between 1999 and 2004 was followed by internal and external evaluations that were a landmark at national and international level. In response to their conclusions, and in order to promote increasingly co-ordinated policy and the concentration of resources, an integration of agencies took place, giving birth to the Institute for Drugs and Drug Addiction – IDT,[101] whose mandate included all areas related to demand reduction, until then divided between IPDT and SPTT.

Meanwhile, a new National Plan against Drugs and Drug Addiction until 2012,[102] an update of the National Strategy against Drugs, and an Action Plan against Drugs and Drug Addiction – Horizonte 2008[103] – were approved and implemented. In 2008 an internal evaluation of this Action Plan was already being prepared, to improve the actions to be developed under the next Action Plan (Horizonte 2012) in order to attain the goals of the National Strategy.

Data on drug use

All these legal and institutional developments in the Portuguese drug field took place against a background of drug use that, compared to other European countries, shows indicators of prevalence and patterns of use that are under the average, in all cases except problematic drug

98. The European Council endorsed the EU drugs strategy (2005-2012) in December 2004.
99. The European Council endorsed the EU drugs action plan (2005-2008) in June 2005.
100. Decree-Law No. 130-A/2001.
101. Decree-Law No. 269-A/2002.
102. Resolution of Council of Ministers No. 115/2006, rectified by the Declaration of Rectification No. 79/2006.
103. Annex to Resolution of Council of Ministers No. 115/2006.

use. The National Population Survey – 2001[104] shows that lifetime prevalence of cannabis use among people aged 15-64 was about 8%, whereas in England, for example, it was about 25%; for cocaine use, it was about 1%, while for England it was 3%; for ecstasy use, it was less than 1%, when in England it was 4%; but for heroin use it was almost 1%, and for England it was almost the same, 1%.

Data from school surveys on drug use show that the Portuguese 16-year-olds surveyed by the European School Survey on Alcohol and other Drugs – ESPAD in 1995,[105] 1999[106] and 2003[107] – had prevalences under the European average. Since 2001, however, data from National School Surveys 2001,[108] preliminary data from 2006[109] and data from HBSC-WHO for Portugal[110] show a trend toward a decrease in most prevalence of use for all drugs.

In contrast, results from the National Estimates on Problematic Drug Use – 2001[111] pointed to values that placed Portugal at the highest level in Europe: estimates for problematic drug use were 10/1000 inhabitants for Luxembourg, 7/1000 for Portugal and the United Kingdom, while for injecting drug use the estimates were 6/1000 for Luxembourg and 4/1000 for Portugal and the UK. Another study is being carried out, to update the national estimates, and next year it will be possible to know how the situation has changed.

Analysis of the Annual Reports on the Situation of the Drug Problem – that are presented either to the National Parliament or to EMCDDA, the European Monitoring Centre for Drugs and Drug Addiction – show an

104. Balsa, C. (2003), *Inquérito nacional ao consumo de substâncias psicoactivas na população portuguesa 2001*. Lisboa: IPDT.
105. Hibell, B., Anderson, B., et al. (1997). *The 1995 ESPAD Report*. Stockholm: CAN/GP.
106. Hibell, B., Anderson, B., et al. (2000). *The 1999 ESPAD Report*. Stockholm: CAN/GP.
107. Hibell, B., Anderson, B., et al. (2004). *The 2003 ESPAD Report*. Stockholm: CAN/GP.
108. Feijão, F. (2006), "Os adolescentes e o consumo de substâncias psicoactivas: O tempo e o espaço enquanto factores subjacentes às dinâmicas de consumo em Portugal e na Europa". *Toxicodependências* 13 (1): 59-75.
109. Feijão, F. (2007), "Consumo de substâncias psicoactivas pelos adolescentes portugueses. Que evolução de 2001 para 2006?" *Toxicodependências* 13 (3).
110. Matos, M. et al. (2006), *Aventura Social e Saúde. O consumo de substâncias pelos adolescentes portugueses. Relatório preliminar*. Lisboa: FMH/UTL and IDT.
111. Negreiros, J. (2003), *A national estimate on problematic drug use*. Lisboa: IDT.

improvement in many indicators related to drug treatment: decreases in drug-related deaths, infectious diseases and so on.[112]

13.4. Tobacco use

Issues of tobacco use had always been addressed separately from alcohol or drug use, in all areas but epidemiological research. In fact, school surveys, at national or international level, and general population surveys have always included all psychoactive substances.

Portugal adopted the Framework Convention for Tobacco Control promoted by the World Health Organization, and implemented prevention measures following the best evidence-based public health models[113] (for example, increasing the price of cigarettes and banning cigarette advertising). Smoking prevalence in the Portuguese population is one of the lowest among EU countries and is decreasing among teenagers, according to the school surveys.[114]

13.5. Integration

As mentioned before, following the global reorganisation target to downsize public administration, it was decided to include alcohol services in the existing national network for illicit drug use, merging them in the IDT (Institute for Drug Addiction).[115]

In Portugal, the issues of tobacco, alcohol and drug abuse are health problems to be addressed in the global framework of the health strategies underlying the National Health Plan 2004-10 developed by the Ministry of Health.[116] The strategic goals identified are:

– Achieving health gains, by raising the level of health in different stages of the lifecycle and reducing the burden of disease;

112. IDT (2006), The 2006 Annual Report (2005 data) to the EMCDDA – Portugal. New developments, trends and in-depth information on selected issues. Lisbon: IDT.
113. WHO-Europe (2005), *The European health report 2005. Public health action, for healthier children and populations*. Copenhagen: WHO-Europe
114. Directorate General of Health (2007), *Health in Portugal: 2007*. Lisbon: Directorate General of Health – Ministry of Health.
115. Decree-Law No. 221/2007, and Portaria No. 648/2007.
116. High Commissariat of Health (2007), *Health Strategies in Portugal. The National Health Plan 2004-2010*. Lisbon: High Commissariat of Health – Ministry of Health.

- Using the necessary tools in an appropriate organisational context – focusing change on the citizen, empowering innovation in the health system and reorienting health care;
- Ensuring the right mechanisms for fulfilment of the Plan, by adequately securing resources, promoting inter-sectoral dialogue, adapting the legal framework and creating follow-up and updating mechanisms for the Plan.

In this context, it is possible that – at first by sharing approaches based on "evidence-based public health models" and later by sharing institutional dependence – all areas of dependency (psychoactive substances, gambling, sex, internet, etc.) – will be progressively integrated. In the near future, sharing facilities, human resources, prevention programmes and so on will probably be a common procedure at health organisation level, in order to allow everyone facing a dependence to get help easily from the health system, wherever they are.

14. From policies on alcohol, tobacco and other drugs to a policy on psychoactive substances: Romania

Andrei Botescu, Researcher at the Romanian National Anti-drug Agency

14.1. Introduction

The Romanian drug policy framework now integrates policies on alcohol and tobacco use as well as illicit drugs and precursors. The main criterion distinguishing the category of alcohol and tobacco from other kind of drugs is the licit/illicit divide, which mirrors the legal/illegal character of possession for certain substances. Although the law places restrictions on alcohol and tobacco, regarding their use in public places or commercialisation for minors, for example, in the case of the illicit substances possession is strictly forbidden.

The first measures to co-ordinate policies on licit and illicit drugs in Romania were taken in 1998. With the aim of achieving the goal of drug use prevention, spelt out in the National Programme for Preventing and Combating Drug Use, the Inter-ministerial Commission for the Prevention of Illegal Drugs Use (CIPCID) came into being by a Common Order, formed of representatives of the ministries of the Interior, Health and Family, Public Administration, Education and Research, and Youth and Sport. The Commission's work was also open to civil society, with the participation of the most significant NGOs in activities related to preventing drug use and addiction.

In order to co-ordinate activities carried out at local level, a national network was created; it consists of 47 anti-drug prevention and counselling centres at county level and also for each district of Bucharest. The effect of these programmes is hard to judge, because the lack of appropriate evaluation and studies covering the entire population makes it very difficult to monitor changes in behaviour and attitude towards drug use and addiction.

14.2. Institutions and projects

14.2.1. International projects

The PHARE 2000 international twinning project led to the institutionalising and extension of the National Focal Point on Drugs. In 2003 this became a public body, set up to co-ordinate and enforce anti-drug policies, the National Anti-drug Agency (NAA). Also in 2003, the first harmonised document on the misuse of illicit and licit drugs (the NAS or National Anti-drug Strategy 2003-05) was published.

In 2004 the Institutional Twinning RO/2003/IB-JH-05 – Fighting against Drug Trafficking and Abuse began its activities. This project, developed in partnership with Spain and France, was a sequel to PHARE 2000. The budget of the project amounted to €700 000, of which €650 000 came from the European Union, and the remaining €50 000 from the Government of Romania. The overall aim of the project was to strengthen the capacity of Romanian institutions to fight the drug phenomenon, within a comprehensive and integrated approach.

14.2.2. The National Anti-drug Agency (NAA)

Based on a national strategy, the NAA determines the general approach and the integrated co-ordination of the fight against illicit drug trafficking and abuse developed by the competent authorities, by other state institutions and non-governmental organisations; the NAA also consolidates and monitors the results of co-operation between qualified Romanian institutions and the foreign organisations involved in the field.

The Ministry of the Interior in Romania hosts the National Anti-drug Agency (NAA). The National Focal Point, an independent department within the NAA, compiles data on drug epidemiology data on a yearly basis and these are forwarded to the EMCDDA, European Commission and the national bodies involved in the co-ordination of drug-related activities (the ministries of Health, Education and Labour, the Parliament and so on). Studies of the prevalence of drug use are becoming more and more common, like the General Population Survey conducted in 2004. ESPAD studies that look at prevalence in the 15- to 16-year-old cohort were conducted in 1999, 2003 and 2007. A national study of the *Prevalence of drug use in the prison system in Romania* was been carried out in 2006. All these epidemiological studies are designed to keep track of substance use and abuse

by monitoring both alcohol and illicit drugs. Therefore, comparative analysis of the correlations between alcohol abuse and other types of drug abuse is facilitated.

For better local co-ordination of drugs demand-reduction activities, the personnel of NAA were augmented at central and regional level. By Government Decision No. 1093/2004, the 47 drug prevention, evaluation and counselling centres (six in Bucharest and one in each county) became the regional structure of the National Anti-drug Agency. Each centre is planned to have five employees (an education specialist, a prevention specialist, a physician, a psychologist/sociologist and a social worker).

14.2.3. Background to the National Anti-drug Strategy (NAS)

The National Anti-drug Strategy was based on studies by government and non-government institutions, national and international studies, statistics and practice in the field. Reflecting this document's integrative vision, among the main concerns of the NAS 2003-05 were the increasing number of alcohol and tobacco users in the 15-24 age range, especially among women, the increasing of indigenous alcohol and tobacco production, the growing number of advertising campaigns for imported tobacco and alcohol, the increase of cocaine and heroin use and traffic, and the use of amphetamines and stimulants among youngsters in clubs, discotheques, entertainment areas, abandoned houses and university campuses.

A key determinant factor of drug use and addiction, according to the NAS 2003-05, was society's acceptance of tobacco and alcohol. The strategy aimed to make qualitative and quantitative changes in society's acceptance of these substances, using information, prevention and restrictions on the commercialisation and use of alcohol and tobacco.

In 2004, a new National Anti-drug Strategy was drafted for 2005-12, along with the National Action Plan for 2005-08. The main principles of the NAS were underpinned by revision of the legislative framework, relying on inter-agency co-ordination to reach the general targets set in the strategy. The legislation was updated by revising existing regulatory acts, drafting enforcement regulations for some drugs laws and ratifying European laws. Thus, 11 regulatory acts of both superior and inferior level were formulated and approved, tailoring the response policies to the needs identified at legislative level.

With ratification of the EU Accession Treaty,[117] Romania adopted European drug framework regulations. In the public health field, Romania ratified the Framework Convention of the WHO for tobacco control,[118] adopted in Geneva on 21 May 2003. The Convention defines the specific terminology and refers to taxes as a means to reduce tobacco demand, and to other measures such as:

- packaging, labelling and supplying tobacco products;
- protection measures against passive smoking;
- education, communication and raising the awareness of the public;
- advertising and sponsoring tobacco products;
- other measures referring to tobacco addiction.

The National Anti-drug Strategy 2005 was adopted in 2005 together with its Action Plan, in line with the provisions of the European strategy in the field.

14.3. The National Anti-drug Strategy

In line with the objectives of the drugs strategy, provisions targeting drug supply and demand reduction were included in the working and operational regulations or in internal orders of the institutions active in the drug field. Thus, responsibilities regarding drug-use prevention were specified for social care institutions (organisation and operations),[119] while the basic medical services provide medical-sanitary education and drug counselling in line with enforcement of the framework contract on the provision of medical care.[120.] Additionally, the aim of the health programmes run by the Ministry of Health[121] was to detect and quantify the specific risk posed to health by risk behaviours (drug, alcohol and tobacco use) and to assess knowledge of and attitudes to these behaviours. The annual task of informing of the negative effects of drug, alcohol and tobacco use is shared by the National Health Insurance Office.

117. Law No. 157/24 (May 2005), issued by Parliament, *Official Gazette* (OG) No. 465/ 1 June 2005.
118. Law No. 332/15.11.2005, issued by Parliament, OG: 1088/2 December 2005.
119. Framework regulation of 1 September 2005, issued by Government, OG. 822/ September 2005.
120. Order 56/3 of February 2005, issued by the Ministry of Health and National Health Insurance House, OG. 134/ 14 February 2005.
121. Order No. 728/7 July 2005, Ministry of Health, OG. 651/22 July 2005.

The psychological-pedagogic centres and units in the Ministry of Education and Research monitor cases at risk for drug use, behaviour disorders or school drop-out in lower education learning units, based on their working and organising regulation.[122]

In the last two years NAA (the National Anti-drug Agency) has developed a nationwide network of counselling, treatment and prevention centres (CPECA), each of which offers integrated services to illicit and licit drug addicts. The network is in the course of developing and adapting its range of services to clients' demands. In 2008 an evaluation project assessed the quality and accessibility of the services offered by the national CPECA network. The main recommendation of this assessment was to point out the need to widen the range and the focus of the specialised treatment and counselling services for the alcohol-addicted population.

As for countering illicit drugs trafficking and use, competence training was introduced for all police structures, to better manage the drugs phenomenon at street level.[123] In the field of the fight against licit and illicit drug and precursor trafficking, Romania has continued to develop co-operation, ratifying agreements in the field with the Kingdom of Sweden, the Islamic Republic of Pakistan and the Republic of Chile. Additionally, in 2005, Romania became a full member of the Pompidou Group (the Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs) of the Council of Europe.[124]

As was mentioned in the NAS 2003-05, the alcohol-misuse problem became, because of its social acceptance, one of the most alarming medical and social problems in Romania. Moreover, alcohol use is one of the main factors in severe associated effects like accidents, crimes, violence, cancer and hepatic cirrhosis.

14.4. The situation and the future

Since 1995 there has been a series of documents, like the European Charter, on alcohol use. The European Action Plan 2000-05 sets out ethical principles and strategies of intervention for decreasing alcohol use and the Youth Declaration on alcohol use, adopted in September

122. Order No. 5.418/8 November 2005, issued by the Ministry of Education and Research, OG. 1.158/21 December 2005.

123. Directive of the General Inspector of the Romanian Police No. 135/09.02.2005.

124. Law No. 64/23.03.2005, issued by Parliament, OG: 251/25 March 2005.

2001 in Madrid, was the foundation of the objectives formulated in the Romanian NAS 2005 for protecting youth from the harmful consequences of alcohol abuse.

According to an EMCDDA report (in 2003) on the candidate countries to EU accession, 90% of youngsters aged under 16 have tried alcoholic products at least once (in Romania 83%), and 60% (in Romania 43%) have been drunk at least once in their life. The ESPAD survey offers comparable data to sustain the above estimates and also indicates increasing levels of alcohol use combined with marijuana smoking – 50% more in 2003 than in 1999. A survey by the NAA in 2004 of the prevalence of alcohol, tobacco and illicit drug use in the general population (ages 15 to 64) concluded that the lifetime prevalence of alcohol use in general population is 87.1%, and 62.1% in the case of tobacco.[125]

For tobacco use, the stipulations of Directive 72/464 EEC, Directive 92/79 EEC and Directive 92/80 EEC on special taxation measures have been integrated into national legislation since 1999. However, the level of excise for tobacco products is still below general European levels, because Romania requested a five-year transition period.

At the same time, the NAS 2005-12 spelt out clear objectives and activities for informing public opinion of the risks of tobacco and alcohol use and abuse, such as:

- implementing risk assessments and national and local surveys by the Anti-drug Prevention, Evaluation and Counselling Centres (APECC) in areas at risk, for tobacco, alcohol and illicit drug use, and setting up an early-warning and monitoring system for tobacco, alcohol and illicit drug use among the school population,
- conducting information, educational and communication projects on the associated harmful effects of tobacco and alcohol use, through the territorial network of the APECC,
- running annual information and educational campaigns at local and national level by the APECC to enhance the importance of Tobacco Free International Day and Tobacco Free National Day.

125. More data available at www.ana.gov.ro/.

15. Slovene drug policy

Jože Hren, Ministry of Health, with Dušan Nolimal and Vito Flaker

15.1. Drug policy before 1991

In Yugoslavia before 1991, Slovenian alcohol and drug policy was the responsibility of the health, social-welfare, education and labour agencies and their decentralised authorities, as well as those individuals and groups concerned with alcohol and drugs. At the level of individual Yugoslav republics, which included Slovenia, policy implementation was entrusted to co-ordinated bodies dealing with alcohol and other drugs policy. These bodies were representative of their area and had some political power. On the federal level there was the Federal Commission for Mental Health. Although the roles of civil society and NGOs were not as prominent as today, the Red Cross agencies assumed substantial responsibility for prevention of alcohol and other drugs problems. All these bodies had a relatively wide variety of preventive measures aimed at improving alcohol and other drug information and education, and at limiting the abuse of drugs.

Acceptance of the World Health Organization recommendations on the problems related to psychoactive substances formed an important part of the activities of these bodies. There were approaches aimed at the individual, family, community and society as a whole. Three basic preventive strategies were recognised:

- Health education as an integral part of general education and as part of the treatment of addicts;
- Control of alcohol, controlling the availability of drugs and legal sanctions;
- Economic and political approaches aimed at social change and development, including prevention of poverty, unemployment and discrimination, and promotion of a better quality of life.

These strategies were seen as the main elements in a comprehensive policy for alcohol and other drugs control and to prevent related problems. They also complemented one another.

Following independence in 1991, the main policy priority became illicit drugs, and a single policy for alcohol, tobacco and illicit drugs became an issue. At present, the separate policies for tobacco and alcohol are the priorities. However, we can still learn from these past experiences, in particular from the economic and political approaches aimed at social change and development, including approaches to preventing poverty, unemployment, discrimination and to promote quality of life.

The first Slovenian national drug programme goes back to 1992. At the beginning of the 1990s, there was a marked increase in drug misuse among young people. In parallel with the increasing trend of drug use, the government recognised the need to establish effective methods to protect society from the serious social, health and security problems that can be caused by drug use.

15.2. Users' impact on policy, treatment and research

At the outset of the new wave of drug use in the 1990s, users had an important impact on the development of treatment programmes, research and policy in Slovenia. Being denied access to methadone treatment (closing a pilot programme run by a psychiatrist), users launched a campaign as early as 1990, mobilising the general public as well as some professionals to protect their rights. Besides that, they linked up with the international harm-reduction organisation and WHO, and initiated the first needle-exchange programme in 1991. Hence the ground was set for a relatively progressive drug policy that established a good network of methadone clinics and low-threshold activities.

The users' movement in Slovenia was very strong in the early 1990s, but somehow withered in following years. However, users were always involved in decision making and discussion of important issues, and still run some services (such as shelter and outreach).

The beginning of the drug research in Slovenia is also connected to this episode, since the users wanted to legitimise their claims by collecting data to prove the necessity of the new treatment programmes. The first research performed in Slovenia (Flaker et al., 1993) had users participating in the research team as well as in data collection and analysis. This tradition has remained to this day, because users participate in research as consultants, interviewers and members of boards.

15.3. Drug policy since 1991

National policy on drugs depends on a number of variables, such as political and economic stability, availability of various services, extent of drug use, the social characteristics of this phenomenon, the legal framework and the location of an individual country. In relation to the last, it can be said that Slovenia lies on an important transit route (east–west – the 'Balkan' route), which is used by producers and traffickers of illicit drugs in both directions.

The priority that a country gives to drug policy depends on the 'visibility' of the drug problem in society, the social groups that are most threatened, and the blurred ideas that drug use triggers in the public. It depends at the same time on historical, criminological, social and cultural factors of the space and time in which we live.

Problems associated with drug abuse must also be understood from the aspect of wider social questions, such as poverty, employment and unemployment, homelessness and the effects of social exclusion. Improving the social position of the individual and supporting threatened groups and others living in the most difficult circumstances strengthens protection from drug use and abuse. In highlighting these issues in Slovenia, the research that transcended the evaluation of services and shed light on the social contingencies of drug use (e.g. Flaker et al., 1999) was instrumental in formulating these issues in Slovene drug policy.

All the aforementioned factors influence the prevailing social understanding of the phenomenon of drug use and abuse, and the method of remedying the harmful effects, which are inevitably integral with drug use. The remedies require a large measure of mutual co-operation across various fields, experts, civil society and the administration, from local level to the state.

Together with legislation on drugs, adopted in 1999 and 2000, the first national strategy was until the year 2004 the basic document for implementing various activities in this field. Important changes in the legal field and developments in other professional fields occurred in this period. Since 2000, the supply of drugs has increased and become more varied, and simultaneously the availability of drugs has increased and new drugs have come into use. This has caused an increase in drug use among the population, thus increasing the need to develop new programmes for reducing supply of and demand for drugs, and programmes for reducing the harm caused by drug use.

Because of these changes, a new national programme was urgently required, so in compliance with the Prevention of Use of Illicit Drugs and Treatment of Addicts Act, the Government Office for Drugs prepared, together with all relevant ministries and civil society, a new national programme. The National Programme in the Field of Drugs (ReNPPD) is a result of recent social developments and signifies a harmonisation of various sectoral approaches to aims, priority tasks, sources and costs. The ReNPPD is therefore explicitly based on the principle of balanced intersectoral co-operation and establishing partner relations between the state and civil society on the basis of needs and effects.

Slovenia's accession to the European Union and adoption of the *acquis communautaire* have created in the area of drugs numerous new opportunities for taking measures, and challenges for various activities in the spheres of health protection, social policy, education, the police, customs and judicial system. Slovenia has harmonised its legislation with UN conventions and other international regulations. The ReNPPD takes into account the international legal framework, UN conventions, the provisions of the Council of Europe and European Union, and other international treaties and recommendations in various professional fields.

15.4. National drug strategy

The basic legal background of the ReNPPD in Slovenia derives from the Constitution, legislation, UN Conventions, EU regulations, provisions of the Council of Europe and the specific aims that our society wishes to achieve in the period 2004-09. The main objectives of Slovene drug policy are prevention of drug use and reduction of the social and health-related problems caused by substance misuse. Drug policy should also include better ways of preventing drug- and alcohol-related problems from arising, effective treatment, good rehabilitation and adequate harm reduction.

The new Slovene Drug Strategy was approved by the National Assembly. The key points of the drug strategy are:

- establishment of a functional information system;
- drug-demand reduction (prevention, and programmes of harm reduction, health treatment and resolution of social problems);
- involvement of civil society, by establishing better co-operation between governmental and non-governmental programmes;

- activities in the field of drug-supply reduction;
- activities orientated to reducing illegal production and trafficking of synthetic drugs;
- research, evaluation and education.

15.4.1. Strategic objectives

The National Programme in the Field of Drugs (ReNPPD) is marked by a holistic approach. It constitutes a basic understanding of the drug problem in Slovenian society, and gives equal attention to demand- and supply-reduction measures. The only missing part of the document is the action plan, specifying tasks for actors, the time framework, identifiable results and the financial resources needed. Reorganisation of government in 2004 prevented the main co-ordinating body for drafting and implementing drug strategy, the Office for Drugs, from preparing this document. The main responsibility for national drug policy now lies with the Ministry of Health.

Co-operation, co-ordination and quality assurance of measures are perceived as necessary for effective fulfilment of drug policy. All efforts in the field of drug and alcohol misuse (by community, parents, voluntary organisations, municipalities and national bodies) must complement each other, forming a comprehensive and dynamic chain of measures. The government supports the work of voluntary organisations in the field of drugs. The most important instruments in reducing the drug supply are regulations and controls. Supply-reduction responsibilities are divided between three ministries: Interior, Justice and Finance.

The main demand-reduction measures are information, prevention, attitude-changing, local campaigns and monitoring of the drug problem. Effective preventive measures have to target individuals, risk groups and larger groups of the population: children, young people, adult groups – for instance, at the workplace or in recreational settings, as well as individuals in the process of developing a drug or alcohol problem.

The existing low-threshold health measures have been strengthened by increased support from the state in the last few years. Increased international co-operation and increased local mobilisation are considered crucial in reducing the availability of drugs in the coming years. A debate has been going on about the use of synthetic substances, the effectiveness of treatment and the question of safe injecting facilities.

15.4.2. Policy challenges

In some cases, the prevention and treatment of disorders related to alcohol and drug use overlap; in other cases they require special methods and expertise. The main challenges include:

- pursuing a policy that reduces the substance-misuse problem;
- tightening up control of illegal trafficking and production;
- strengthening preventive efforts at local and national level;
- ensuring that users receive effective help and care.

15.5. The drug situation in Slovenia

Alcohol remains the most common drug in the general population and in youth culture. Other drug use among young people has been to a considerable extent stabilised since 2000. The number of deaths from overdoses is low and stable, but with a slight increase in 2007. In 2000-02 the rise in the use of illegal substances flattened out. The number of seizures of the most common substances and the number of individuals who have been in front of the court system has increased. Slovenia is a "low-level" HIV/AIDS epidemic country, with less than one individual per 1 000 inhabitants living with HIV/AIDS. As yet, there is no evidence of a rapid spread of HIV among the population of injecting drug users and their partners.

Drug-prevention work emphasises local measures, focusing on the interplay between home life, schools, the social and health sectors, the cultural sector and law enforcement agencies. Local Action Groups were established for this purpose and are playing now an important role. There are almost fifty of them, each co-operating with municipalities to develop competence, innovative working methods and programmes for prevention. Together they form a network with regular national conferences and trainings. A number of prevention programmes exist for schools, but only a small number of them are scientifically evaluated.

Since the mid-1990s, emphasis has been given to developing various social and health-assistance programmes. The government has contributed substantial funds to organisations for prevention and treatment, therapeutic communities, communes and day centres, substitution programmes, needle-distribution programmes and outreach work. In contrast to some countries, Slovenia still provides rather good coverage of methadone-assisted treatment. The criteria for admission to the

methadone programme are not restrictive. In Slovenia, since 2007, six vans have been operating around the country providing information, counselling, clean needles, syringes and condoms.

Different treatment and rehabilitation services have been developed in Slovenia with different professional and ideological approaches: professional psychotherapeutic approaches, therapeutic communities and approaches based on Christian principles. Research and evaluation of treatment takes place in research institutions and at faculties.

Aftercare seems to be the weakest link in the rehabilitation chain. Follow-up and building up a network around individual clients is often poorly organised and has too short a time horizon. Some institutions run their own systematic aftercare regime.

During and after a term in prison, inmates with a drug-addiction problem are offered opportunities to take part in a number of programmes such as education, leisure activities, labour activities within the prison and a psychosocial support programme during and after release. The National Prison Administration requires that prisons make antiseptics available, but there is no needle-distribution programme in Slovenian prisons. The law gives inmates with a drug problem the opportunity to receive the appropriate treatment, including a methadone maintenance programme. Usually the opportunity to serve a sentence in a treatment facility is not granted.

15.6. Conclusions

In the formation of Slovene drug policy, besides international development and treaties, it was the dialogue and activities of those most closely involved, researchers as well as users, that created the most vital parts of the policy, such as the methadone centres and harm-reduction programmes. The knowledge and professionalism of all key actors in the field, including politicians, was instrumental in the development of the drug policy. The positive involvement of politicians can be observed in the fact that relatively substantial funds have been devoted to the drugs field.

The existence since the early 1990s of low-threshold projects – in particular, its needle-exchange programme, where users were included as important actors in research – have, according to many researchers and politicians in Slovenia, made an important contribution to early awareness-raising among drug users and the general public of the

need for HIV prevention. They have created favourable conditions for keeping HIV prevalence low in a country with a relatively high prevalence of injecting heroin use.

One lesson learned from both practice and research is that there should be a nuanced understanding of drug use and its prevention, of the beginning, course and ending of drug addiction. Drug use is a complex phenomenon, which cannot be explained solely on the basis of pharmacological, psychological, physical, social or political conditions. All its dynamics and the inter-relations between different aspects must be considered for a full understanding of drug use. This understanding, however, is no use if it is not shared by the actors and if the experience of users is not valued and included in general thinking.

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16. From policies on alcohol, tobacco and illicit drugs to an addiction policy: Switzerland

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16.1. The Swiss context

Switzerland, lying at the centre of western Europe and bordering on Germany, France, Italy, Austria and Liechtenstein, is one of the continent's smaller nations. It has a population of 7 million, with four different local linguistic cultures (German, French, Italian and Romansh). Foreigners account for 20% of the population, and just under half of this total are native speakers of a non-Swiss language.

Switzerland's political and administrative system is of a strongly federalist character, with responsibility for many state tasks being shared by the federal authorities, 26 cantons and more than 2 500 communes. In particular, the cantons are primarily responsible for health and education policy. Popular initiative and referendum rights mean that the public influences the country's political constitution to a considerable extent. Any amendments to the constitution and numerous laws have to be approved by a popular vote before they come into effect. The government – a collegiate body of seven ministers – is made up of representatives of the country's four main parties, collectively representing about 80% of the electorate.

16.2. Empirical data on drug use

Drug problems – in the sense of consequences of the use of illegal psychoactive substances, as perceived by the public – have existed in Switzerland, as in many other European countries, since the social upheavals of the late 1960s and early 1970s. For a long time, popular and expert perceptions centred on heroin use and the associated multiplicity of health, psychosocial, economic and social problems, and on the use of cannabis products.

However, as shown by the following epidemiological data (lifetime prevalence among people aged 15-39 from 1992 to 2002), consump-

tion patterns and the associated problems have undergone significant changes over this period:

- The proportion using any illegal drugs rose from 16.7% to 28.2%.
- This rise was mainly due to the spread of cannabis use (up from 16.3% to 27.7%).
- Over the same period, there was also a slight increase in cocaine use (from 2.7% to 2.9%); experts have observed a substantial further rise since 2002.
- In contrast, there was a clear decline in heroin use, from 1.3% to 0.9%; over the same period, the number of dependent heroin users, as estimated by the FOPH, fell by about 25%.

16.3. Drug problems as perceived by the public and policymakers

Since 1988, the Swiss public has been surveyed each year on the issues considered to be most serious. Until 1994, the proportion of respondents indicating drugs as an important problem varied between 62% and 76%. Since then, this figure has declined steadily and sharply, and it now stands at only 14%. Thus, in the public mind, the drugs issue – formerly a highly pressing problem – has become a barely perceived marginal phenomenon.

Surveys conducted as part of the Drogenmonitor programme in the 1990s provide an indication of the areas relating to illegal drugs where the public sees a need for action by the state. For example, almost the entire population (over 90%) favoured criminal prosecution of trafficking, preventive measures in schools, therapy and survival aid, and needle-exchange programmes to prevent transmission of HIV. A somewhat lower but still substantial proportion – about 65% – supported medical prescription of heroin and the establishment of drug-injection rooms. Proposals for toleration of the (still prohibited) use and sale of cannabis and for the free sale of cannabis and marijuana were supported by a considerable percentage, albeit not a majority, as were calls for forced detoxification for all dependent drug users. A large majority was opposed to the idea of tolerating the sale and use of small quantities of heroin and cocaine for personal use, and to calls for imprisonment and fines for all users of illegal drugs.

With regard to state action, the Drogenmonitor also revealed that in 1997, while a substantial majority supported all four pillars of federal

drug policy – prevention, law enforcement, therapy and harm reduction – a large proportion of the population considered federal efforts to be inadequate in the areas of prevention (52%) and combating the drug trade and money laundering (71%). About half of all respondents favoured a combination of instruments of state action including both tolerant and restrictive elements; about a fifth supported an exclusively tolerant regime, and another fifth an exclusively restrictive approach.

Attitudes to drug issues varied substantially according to age and cultural background. Younger people supported liberalisation measures to a much greater extent, and more frequently favoured a tolerant or mixed policy approach, whereas older people tended to prefer a restrictive approach. Although a mixed approach was required in all language regions, French speakers tended to favour restrictive elements, while German speakers were more supportive of liberal components.

A survey conducted in 2000 indicated that opinions on cannabis policy were highly polarised. Half the respondents favoured a liberal policy, involving the legalisation or at least toleration of cannabis cultivation, trade and use, while the other half were firmly opposed to this type of policy, preferring prohibitions and law enforcement. Here, too, it was the younger generation and inhabitants of German-speaking Switzerland who supported the liberal model, while the older generation and French-speaking Swiss tended to approve of repressive measures.

These attitudes found among the general public are reflected by the policy positions adopted by political parties. Among the parties, there is a strong consensus that prevention, law enforcement and treatment should be key elements of the state's drug policy. By contrast, party political views are highly polarised about harm reduction (the most important measures being medical prescription of heroin and the provision of injection rooms) and the question whether cannabis production, trade and use should be legalised. On both these issues, there are two rival groupings, roughly equal in strength: the liberal camp, consisting of the leftist and green parties and liberal non-socialists, and the law-and-order camp, consisting of conservatives and right-wingers.

In the late 1990s, the public's nuanced attitudes to various aspects of drug use, as previously revealed by opinion polls, were confirmed by the outcomes of votes on two popular initiatives and a federal decree: proposals for an abstinence-orientated drug policy and for extensive legalisation of drugs were both rejected by a large majority (with more than 70% "No" votes in each case), while a narrow majority approved heroin-assisted treatment as a new therapeutic option. To this day,

these referendums are generally regarded as providing broad-based political legitimation for the government's fourfold drug policy.

16.4. The development of Swiss drug policy

Up until the mid-1970s, Swiss legislation on illegal drugs was largely based on obligations arising from international treaties. The Narcotics Act of 1924, which imposed licensing requirements on the production, processing and commercialisation of opium, morphine and cocaine, brought Swiss regulations into line with the International Opium Convention of 1912. In 1951, in the wake of a number of international treaties, heroin – which had previously been merely controlled – was completely prohibited, and the cultivation of hemp for cannabis production became subject to licensing. In 1968, as a result of new international commitments, the cultivation of hemp for the production of narcotics was also banned. The provisions and definitions contained in all this legislation were adopted unchanged from international treaties, since Switzerland had yet to experience any significant drug problems.

Swiss drug policy in fact was established in the 1970s. It was essentially shaped by three developments:

- From the late 1960s, non-medical narcotics use and the associated problems were a rapidly growing social phenomenon, both epidemiologically and as perceived by the public. Narcotics use, not hitherto expressly defined as an offence, was initially addressed through more restrictive judicial practice and later made punishable under amended legislation. Efforts were made to secure compliance with this prohibition through rigorous, but largely unsuccessful, law-enforcement activities. In addition, out-patient and in-patient treatment facilities were gradually established.
- In the 1980s, the drugs issue became more acute in Switzerland. There were sharp rises in the numbers of dependent users, drug-related deaths and (especially) in HIV infection rates, and open drug scenes emerged in major cities. These developments led to two key changes in drug policy. Firstly, policymakers, criminal justice authorities and treatment programmes focused closely on users of injectable drugs and their problems. The relevant treatment services were professionalised, methadone maintenance programmes were widely introduced in outpatient management, and harm-reduction programmes (needle exchange, injecting rooms and various low-threshold services)

were set up for dependent users unwilling or unable to pursue the goal of abstinence. Secondly, in German-speaking Switzerland, law-enforcement measures were scaled down. Retail trade in and use of soft drugs – and, in certain open scenes, also hard drugs – was no longer prosecuted and was thus de facto tolerated. In French-speaking Switzerland, a policy focusing primarily on rigorous law enforcement was pursued, and harm-reduction measures were largely rejected.

– In 1994, there was a sharp increase in violence in various cities, open drug scenes and a concentration of visible drug-related misery. Images from the city of Zurich were diffused worldwide, under the heading of "Needle Park". The intolerability of these woeful images for the Swiss public and the concerns expressed by many politicians about Switzerland's international reputation finally triggered another wave of drug policy innovations. The open drug scenes were closed down by the police, and any emerging scenes were quickly suppressed. Low-threshold services were strengthened, substitution programmes involving methadone were expanded and began to include additional substances, and heroin-assisted treatment was added to the range of existing options.

Since then, Switzerland's drugs problem has abated considerably. The open scenes have disappeared, and the numbers of drug-related deaths, HIV and hepatitis infections, and severely dependent users have stabilised at a low level.

Over the same period, federal drug policy has been consolidated. In 1994, the government officially endorsed the fourfold approach (prevention, therapy, harm reduction and law enforcement) as the basis of its drug policy. In 1991 and then again in 2002 and 2006, the government approved packages of measures, each running for several years, to reduce drug-related problems in Switzerland. Each package contained a large number of individual measures whereby the federal authorities proposed to fulfil their drug policy responsibilities while supporting the cantons, which bear primary responsibility for drug policy and its implementation in Switzerland.

16.5. Legal basis

All the above-mentioned measures were based on the Narcotics Act, last revised in 1975. Especially in the first half of the 1990s, numerous political motions – with widely varying aims – were submitted to

Parliament. In 1994, three of the four governing parties called for the decriminalisation of drug use, expansion of heroin-assisted treatment, increased prevention efforts and a clampdown on drug trafficking.

After lengthy preparation, the government finally submitted a revision of the Narcotics Act to Parliament in 2001. The proposed amendments included defining drug policy as a matter of public health policy, incorporating into the law the fourfold approach that had already been applied for a number of years, decriminalising cannabis use and providing firm legal foundations for heroin-assisted treatment. The Council of States – the first chamber to consider the revision – approved the introduction of the bill and voted in favour of the key amendments proposed. However, because of their opposition to the decriminalisation of cannabis use, a majority of the National Council rejected the bill.

The revision was thus defeated and the 1975 Act for the time remains the legal basis of the government's drug policy measures. The failure of the bill was widely seen in political and expert circles as a sign of the limited room for political manoeuvre in the area of illegal drugs. Nonetheless, a further popular initiative "For a rational hemp policy with effective protection of young people" was finally submitted at the end of 2006. This calls for the legalisation of hemp use and of cultivation for personal use; in addition, the federal authorities are to issue regulations on the cultivation, production, import, export and trade in psychoactive substances from the hemp plant; lastly, the popular initiative also calls for measures to protect young people. This initiative is currently the subject of preliminary deliberations in Parliament, and it will be put to the popular vote in the future.

16.6. International context

At the international level, Switzerland was very active during the years when its illegal drug problems were increasing. Switzerland has participated in the work of the Council of Europe's Pompidou Group and its expert committees since the 1970s, as well as the United Nations Commission on narcotic drugs.

Switzerland ratified the UN 1961 Single Convention on Narcotic Drugs, as amended by the 1972 Protocol and the 1971 Convention on psychotropic substances. After having de facto applied the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances long before, Switzerland ratified the 1988 convention in

September 2005, after the completion of an internal political process leading to the Convention's approval.

At the Swiss annual ambassadors' conference in Bern in September 2001, the Federal Councillor for Home Affairs presented the newly shaped drug policy, the proposed draft for the revision of the Narcotics Act and a corresponding package of measures to reduce drug-related problems (MaPaDro).

Hosting the International Network Conference on new directions in substitution treatment with a special focus on heroin in February 2001 gave Switzerland an international forum to review and comment on five years of experience with heroin-assisted treatment.

At the ministerial conference on cannabis in February 2002, Switzerland agreed to participate in INCANT (INternational CAnnabis Need of Treatment), an international project on the efficacy of multidimensional family therapy for outpatients, compared to conventional outpatient treatment for adolescents with problematic cannabis use.

In co-operation with Germany, Switzerland also launched the Realise It project (developing and introducing a brief intervention programme for young people at risk of dependence) following a March 2002 international conference, where Switzerland presented its ideas on the management of cannabis-related problems in the light of the decriminalisation of cannabis use, which was still envisaged at that time.

As Switzerland is not a member of the European Union, there is no close involvement with or orientation towards the latter's drug-policy efforts.

16.7. Drug policy and alcohol/tobacco policy

The Swiss public and policymakers concentrate primarily on the use of illegal drugs and only to a lesser extent on tobacco- and alcohol-related problems. At the same time, problems arising from the use of other psychoactive substances (medicines) or attributable to non-substance-related dependence are barely perceived. Equally, connections are rarely made between shared features of the use of illegal drugs, alcohol and tobacco, or the associated problems.

A similar segmentation can also be observed in professional circles. Three cultures exist, differing widely in values and norms, and each offering separate programmes for prevention, counselling and treat-

ment. Although these three segments are scarcely interconnected and only limited exchanges occur between them, a growing tendency towards an integrated perspective has been detectable in recent years. This change is due, firstly, to an increase in multiple dependence across the three segments (simultaneous use of various illegal drugs, alcohol and tobacco) and addiction transfer (from illegal drugs to alcohol). There is also a growing awareness that the non-dependence-specific prevention efforts pursued by all three segments (especially in the area of protecting young people) are largely identical. Recently, commonalities have also been identified in counselling and treatment, and it is becoming increasingly evident that the WHO definition of dependence (ICD system) underlying work in the various segments is shared by all of them. Against this background, various specialist circles have called in recent years for an integrated view of all dependence problems and a more coherent addiction policy.

The segmentation found in the professional arena can also be observed within the Federal Office of Public Health (FOPH), where for many years different and largely unco-ordinated administrative sections have existed – with separate programmes and budgets – for illegal drugs and for alcohol and tobacco. However, in 2002, the FOPH responded to growing calls from specialists for an integrated view by commissioning a report from an external expert, in which foundations and materials were presented to support greater integration of federal activities in the area of addiction policy. The report[126] employs a broadly defined concept of addiction, including both substance-related and non-substance-related forms of dependence, together with eating disorders. It contains an empirically based account of the need for action on addiction policy, provides an overview of current federal practice in this area and sets forth requirements and recommendations for a new addiction policy in Switzerland.

Around the same time, the question of greater integration of federal drug policy activities was also addressed by the Federal Commission for Drug Issues (EKDF), which advises the government on drug-related matters. In its report,[127] the EKDF analyses the past and present state of Switzerland's drug policy and calls on the government to increase the

126. M. Spinatsch (2004), *Eine neue Suchtpolitik für die Schweiz? Grundlagen und Materialien für eine verstärkte Integration der suchtpolitischen Aktivitäten des Bundes/Une nouvelle politique en matière de dépendances pour la Suisse? Bases et prémisses pour une politique fédérale plus intégrée en matière de dépendances.* Bern. http://www.m-spinatsch.ch/d/DetailsPublikationen/BAG.html/.

127. Swiss Federal Commission for Drug Issues (EKDF), *Von der Politik der illegalen Drogen zur Politik der psychoaktiven Substanzen.* Verlag Hans Huber, Bern, 2006.

coherence and credibility of its addiction policy for the future. Taking the fourfold drug-policy approach as a starting point, the Commission proposes a new, three-dimensional model as a basis for the reorientation of addiction policy. As well as the various illegal drugs, this model encompasses alcohol, tobacco and medicines with psychoactive effects. It declares the four pillars of prevention, therapy, harm reduction and law enforcement to be a valid model for all these substances, and it distinguishes in each case between low-risk use, problematic use and dependence. The FOPH has taken up the recommendations from both these reports, and it plans to draft an addiction-policy framework in the coming months. It is also planned that the three expert commissions advising the government on drug, alcohol and tobacco issues should be dissolved and replaced by a newly established commission for addiction issues.

16.8. Ideology versus evidence

Particularly in the early years, the public and political debate on the use of illegal drugs in Switzerland was mainly concerned with questions of lifestyle, conformity and protest among the rising generation, and less with the problems and harm arising from drug use. These arguments about social policy also left their mark on professionals, influencing the behaviour of many people dealing directly with drug-related problems. From the outset, the FOPH sought to expand the empirical knowledge base through research programmes and by monitoring and evaluating drug policy interventions, to promote an evidence-based learning culture, and thus to introduce an element of objectivity into ideology-laden controversies. Meanwhile it can be assumed that, to a much greater extent than in the past, professionals' behaviour is guided by the available empirical evidence; the public debate, however, remains heavily influenced by social conceptions of acceptable and unacceptable ways of life.

17. Turkey's strategy

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17.1. Context

As a consequence of globalisation and the blurring of borders around the world, trafficking of illicit addictive substances is no longer a problem of one country but has evolved into a regional and international crime.

Increasing numbers of users and addicts, a high profit margin, terrorist acts and the changing political structure of the world have directly influenced the production of illegal addictive substances and trafficking routes, thereby making addictive substances a global problem.

Turkey is directly or indirectly influenced by more than one drug-trafficking route. The Balkan route, the Eastern Mediterranean route and the North Black Sea route are all used in trafficking heroin from Afghanistan to European markets. Turkey is also affected by being a transit country for trafficking of amphetamine-type synthetic drugs produced in Europe to be consumed in Arabic countries, and of chemical precursors used in substance production to south-west Asian countries, which are the producer countries of heroin. Being on the Balkan Route, Turkey attaches great importance to international co-operation in supply and demand reduction, since it is severely affected in two-way from substance trafficking.

These new trends in drug trafficking and abuse require dynamic structures to counteract them. National and international success is possible only by integrating and conducting the efforts of counteracting addictive substances. Strategies that transform national development and joint action policies into international ones are the most important tools for fighting the spread of addictive substances.

17.2. The basis of drugs policy

17.2.1. Documents

Turkey considers that a policy and a strategy covering all dimensions of the problem is the essential element in an efficient fight against drugs. Turkey revised recently its 1997 National Policy and Strategy Document on Drug Addiction Prevention, Monitoring and Control, and agreed to harmonise it with the EU Strategy and Action Plan on Drugs in the short term.

Under the scope of evaluation works, the criteria of the European Union Strategy and Action Plan on Drugs were taken as a basis for the development of National Policy and Strategy Document. Within the framework of harmonisation and improvement efforts, the following items in the European Union Action Plan on Drugs have been taken into consideration:

- the most recent trends in substance abuse and trafficking in the EU,
- the EU's approach to counteracting addictive substances,
- evaluation,
- new challenges,
- the new legal framework laid down by the Treaty of Amsterdam,
- fundamental objectives and targets under the sections of special objectives,
- Turkey's own efforts,
- historical experiences,
- the legislation.

The document put forward initiatives to guide national efforts by taking into account the unique position of Turkey in trafficking and abuse of addictive substances, structural aspects and views of the problem, and the qualities of requirements. The content and quality of the document were prepared in conformity with the requirement of meeting national and international needs of the country.

With the motivation of an understanding of a broad and balanced approach to the fight against addictive substances, joint activities by non-governmental organisations and scientific centres should be supported and improved. The strategy attaches special importance to the options created by the Treaty on Mutual Legal Assistance in

Criminal Matters finalised in 2000, taking them into account for related crimes.

17.2.2. The international aspect

In this field, the chief aims are to increase the opportunities for working together – primarily with neighbouring countries and EU member states, but also with other countries experiencing the same problems – on joint projects, with the aim of finding solutions and making full use of the opportunities offered by UNODC, INTERPOL, EUROPOL, EUROJUST, CEPOL and similar organisations.

17.2.3. The Turkish situation

Alcohol and cigarettes are the most commonly used psychoactive substances in Turkey. The values, attitudes and behaviours in alcohol consumption are driven by socio-cultural structures. There is still a general tendency towards alcohol consumption and towards falling into the habit of using alcohol at a young age.

Smoking is the most significant public health problem in Turkey. An increasing tendency to start smoking at an early age poses an important risk factor for substance addiction in general.

Monopolistic structures under state control for the sale of alcohol and cigarettes have recently been opened to the international market as a result of privatisation. Newly emerging production and a consumers' market have brought structural risks that will increase an addiction tendency.

Passing through a process of transition from a traditional agricultural society to an industrial and knowledge society, Turkey is experiencing general problems brought by social and economic crises, increasing migration, urbanisation and the effects of becoming urbanised. Thus there are a number of problems based on structural risks to the growth, development and participation of children and young people beside the general population. The above-mentioned problems cause homeless, unprotected children working and living in the streets to emerge as a sub-category. This segment of the society is now more likely to commit a crime and use addictive substances (volatile substances, cigarette, alcohol).

17.3. Early experiences of drugs

Examining the drugs used according to the order of initial use, one can see that these data reveal the transitions experienced specifically in drug use. In the ranking made by drug users according to initial use of various drugs, it seems that the first drug used is cigarettes, by 89%, the second drug used is hashish, by 5%, and the third one is alcohol, by 4%. Heroin and volatile substances fall below the 1% category.

The data from the survey demonstrate that most drug users start smoking before they start using narcotic drugs. It is possible say that cigarettes and alcohol are precursors to the initial use of other addictive and illegal drugs: those who do not smoke or drink alcohol are isolated from addiction, when compared with those who do smoke or drink, and the two social environments and shared acquaintances are thus separated from each other.

The survey was based on the European School Survey Project on Alcohol and Other Drugs (ESPAD), done by the UNODC Turkey representative in six cities (Adana, Ankara, Diyarbakır, İstanbul, İzmir and Samsun) in 2003, at the same time as a survey of the general population. The survey team visited 88 schools.

Where drug use among young people is indicated, this section examines the data regarding the use of drugs, alcohol and smoking over three periods: lifelong, in the last 12 months and in the last 30 days, as stated by those taking part in the survey.

More than half the students answering the questions about the use of alcohol, tobacco and other substances stated they had experience of smoking. Two end results were obtained in terms of the experience of smoking: 18% of the students stated they tried smoking once or twice, whereas 13% stated they had experienced smoking over 40 cigarettes. Fewer than half the students stated they had had experience of drinking alcoholic beverages.

17.4 Aims and approaches

The chief aim is to achieve a measurable decrease in substance abuse, addiction and substance-related health and social risks. Within this scope, another aim is to fight demand in all aspects and to adopt a balanced approach to fighting supply, in terms of law enforcement and other means.

The national policy requires efficient links with all media and press agencies so as to assign an effective role to the mass media within the national and international prevention network. By continually informing policymakers of the general situation and new trends in addictive substance abuse, the aim is to draw their attention and have their support by increasing their willingness to report and support policies.

Great importance is attached to increasing the opportunities for working together on joint projects with other countries, primarily EU member states and other countries experiencing the same problems, with the aim of finding solutions and making full use of the opportunities offered by institutions and organisations established for this purpose.

All institutions and organisations are responsible for fulfilling the aims and goals stipulated by the policy document and for abiding by the document. Each and every institution and organisation must provide the necessary support to the department of the ministry in charge of enforcing the document, in carrying out the works stipulated by the document.

18. Policies on alcohol, tobacco and illicit drugs in the UK

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18.1. The UK context

The United Kingdom's population is about 60.6 million, of which 83.8% (50.8 million) live in England, 8.4% (5.1 million) in Scotland, 4.9% (3.0 million) in Wales and 2.9% (1.7 million) in Northern Ireland. England comprises the central and southern two thirds of the island of Great Britain. It is bordered to the north by Scotland and to the west by Wales. Northern Ireland is also part of the UK. France is separated from the UK by a 38 km sea gap, the Channel Tunnel directly linking the two countries. Its other nearest neighbour is Ireland (until 1922 part of the UK).

Many of the functions of government have been devolved in Northern Ireland, Scotland and Wales. The Scottish Government has responsibility in most areas of policy. In Wales the Home Office retains responsibility for the criminal justice system. The UK parliament is responsible for setting out the overall drug strategy and for delivery in the devolved administrations only for the areas where it has reserved power. Each devolved administration exercises its delegated powers to shape strategy to match local circumstances. The Serious Organised Crime Agency (SOCA) and HM Revenue and Customs, both with responsibility for addressing drug supply, cover the whole of the UK.

18.2. The UK drug problem

In England and Wales 10% (3 186 000) of adults have used drugs in the last year, and 5.9% (1 891 000) use them currently. This probably represents the UK average, with prevalence being higher in Scotland and lower in Northern Ireland. Young people are more likely to use drugs: in England and Wales, 24.1% (1 597 000) of 16- to 24-year-olds had used drugs in the last year. Prevalence amongst schoolchildren is about 16.5%

(526 356). Cannabis (8.2% recent use) is the most commonly used drug, followed by powder cocaine and ecstasy (for last-month use). There are indications of a fall in drug use, particularly of cannabis, though cocaine use, while still low (2.6% recent use), is rising.

Latest estimates suggest there are 398 845 problem drug users in the UK, a rate of 10.15 per 1 000 population; again, the estimated rate is higher in Scotland (15.39) and lowest in Northern Ireland (1.28). There are an estimated 281 320 opiate users (8.53) and 192 999 (5.85) crack users. The estimate for injecting users is 137 141 (4.16 per 1 000).

18.2.1. Alcohol

Alcohol use has grown considerably since the 1990s; in 2007 the majority (90%) of adults consumed it. In England 74% of men and 59% of women drink alcohol at least once a week, and 15% of men and 8% of women report daily consumption, but 39% of men and 22% of women drink more than the recommended number of units per day at least once a week. Older people are more likely to drink regularly; younger people are more likely to drink heavily.

18.2.2. Smoking

There has been a large decrease in smoking since 1980, most marked among older people. At present, 24% of adults smoke. In England, 9% of schoolchildren report smoking at least once a week; girls are more likely to smoke than boys. There are concerns that there may be an upward trend in smoking among young people.

18.2.3. Public opinion

Research suggests that most people perceive alcohol (78%) and tobacco (60%) to be more damaging to health than illegal drugs. The prime issue with alcohol is one of under-age drinking and binge drinking by young adults, the latter associated with public disorder. Seven people in 10 think the UK would be a "healthier and better place to live" if the amount of alcohol consumed was reduced. The main issue with tobacco is health, in particular, concerns about passive smoking. Drug misuse, particularly dealing, is seen as a public nuisance issue.

18.2.4. The policy context

The alcohol industry has had a strong and powerful influence on policy. Revenue from taxation on spirits, wine and other products in

2006-07 was £7.9 billion. Alcohol consumption is not seen as problematic *per se* by the government: its latest policy statement suggests that "Most of us do drink sensibly". The main issues for government, as with the population, are public nuisance (associated with binge drinking), health issues and the effect on work.

Alcohol-related illness or injury accounts for 180 000 hospital admissions per year, of particular concern being the number of young people with alcohol-related health problems. In 2005, there were 4 160 deaths associated with alcohol consumption; this has doubled in the past two decades, with more people dying younger. Deaths associated with drink-driving also remain an issue, though there has been a huge reduction in the number of drink-driving deaths, from more than 1 600 per annum at the end of the 1970s to 560 in 2005. During the past ten years, the rate of decline in all drink-driving casualties has slowed significantly.

Smoking has been seen as a matter of personal choice by government for a long time. Even with acceptance in the 1960s of the relationship between smoking and premature death, and concerted lobbying by the medical establishment, policy barely changed until very recently. As with alcohol, the tobacco industry has in the past proved a huge and powerful lobby; this, coupled with the perceived economic benefit of the tobacco industry to the UK, has been an obstacle to change. Until recently, its huge sponsorship of sport was another obstacle. However, with the public accepting the health risks of smoking, including passive smoking, and many giving the habit up or not starting to smoke, the government's stance has become more proactive. Also, the economic position of tobacco has changed considerably. The number of jobs related to tobacco has fallen substantially, as has tobacco tax revenue as a proportion of total revenue, helped by a rise in imported (and illegally imported) products. There has also been a recognition by the Treasury of the broader costs to productivity and health of tobacco consumption.

Since the mid-1990s, illegal drug use has had a particularly high profile politically. There are clearly no economic benefits associated with illegal drug use and there is no industry to consider. The use of certain drugs has long been a concern, but until the large rise in prevalence in the 1960s, addiction was seen as an issue for the medical profession – though there had been laws to curb the sale of certain drugs, particularly opiates, cocaine and cannabis. This health care approach still dominates, and treatment remains the key to policy initiatives. However, seminal research in the 1990s showed the effectiveness of treatment in reducing the use of illegal drugs, and also the strong

link between drug use and crime. This has meant that government has become more proactive in increasing users' access to treatment. A further concern has been to disrupt the drugs market, made much more difficult in an illegal situation. The threat of HIV in the 1980s and the rise in drug-related infection has also been influential in policy.

18.3. The development of policy

18.3.1. Alcohol

In England the first strategy document on alcohol was the Alcohol Harm Reduction Strategy for England of 2004, which was concerned to educate the public about the dangers of harmful and binge drinking. It also aimed to combat alcohol-related crime and disorder by the use of new enforcement powers in the Licensing Act 2003 and, later, the Violent Crime Reduction Act 2006. In 2007, *Safe, Sensible, Social: The next steps in the National Alcohol Strategy* reviewed progress since 2004 and aimed to encourage those who drink alcohol to do so in a safe, sensible and social way. Again it focused on harmful and binge drinking, and the association with violence, pointing not only to the legal penalties, but also to a strong element of harm reduction, using interventions where appropriate to help bring about changes in behaviour.

The Licensing Act 2003 sharpened the response of the criminal justice system to those committing crime and anti-social behaviour when drunk. Also, somewhat controversially, it allowed 24-hour opening of pubs and clubs – something not seen since the Intoxicating Liquor (Licensing) Bill of 1872, which introduced restrictions on opening hours and at the time was universally reviled. The Licensing Act 2003 is premised on eliminating the need to drink heavily before pub closing time.

There has long been a recognition that alcohol can be a problem, not only to health, but in terms of anti-social behaviour, violence and the impact on the economy through lost work, with laws as early as the 16th century designed to curtail drunken behaviour. However, until the late 1990s, policy was mostly concerned with the sale of alcohol: preventing its sale to children and young people, curtailing the hours when it could be sold and licensing the premises where it could be sold and/or consumed. Taxation has also been important, to discourage people from buying large quantities of alcohol; in the early 18th century, taxation was used for social and health purposes to quell the large consumption of cheap gin.

There has, however, never been any real consideration of complete prohibition, despite a fairly vociferous Temperance Movement in the 19th and early 20th century. Rather, there have long been voluntary agreements with a very powerful industry, in acknowledgment of the potential problems associated with use. Major policy developments in the last decades have centred around the effects of alcohol in the workplace and in driving machines, not least cars, for which legislation defines the amount it is safe to drink before driving.

18.3.2. Tobacco

As with alcohol, there have been a number of policy initiatives on smoking in recent years. The 1998 White Paper, *Smoking kills*, announced a plan of action to reduce smoking. The Tobacco Products (Manufacture, Presentation and Sale) (Safety) Regulations 2002 regulated the contents and labelling of tobacco products (this legislation was necessary to comply with a 2001 European Directive on tobacco products and labelling). The 2003 White Paper, *Choosing health: making healthier choices easier*, set out further steps to reduce smoking through media/education campaigns, price increases, Stop Smoking Services, Nicotine Replacement Therapy and reduced tobacco advertising and promotion. On 1 July 2007, legislation came into force prohibiting smoking in virtually all enclosed public places and workplaces in England, including all pubs, clubs, cafés and restaurants. Such legislation had been introduced in Scotland in 2005, and in Wales and Northern Ireland in April 2007.

These policy initiatives had been slow in coming, despite lobbying by the medical profession since the 1960s, apart from information campaigns and the labelling of tobacco products by voluntary agreement with the industry; and taxation, until fairly recently, was perhaps less of a public health response and more of a revenue benefit. Smoking was banned on some public transport in the 1980s, but only as a fire hazard. However, tobacco is now very much seen as harmful to health, not just to those who smoke, but those around them – and recent policy reflects this. It has been argued that current policy has depended on a series of events that came together at the right time: a rapid shift of public opinion, strong pressure from lobbying groups such as Action on Smoking and Health, and lobbying from the medical establishment.

18.3.3. Drug policy in the UK

Current drug policy is premised on reducing the harm caused by drugs, by means of

- preventive action, based on information and education,
- treatment, seen as key to reducing the many harms associated with problematic use, including drug-related infectious disease and drug-related death,
- reducing the availability of drugs,
- reducing the harm to the community, particularly drug-related crime.

A major aspect of policy in England and Wales since 2000 has been the Drug Interventions Programme (DIP), established in 2003: when drug users are identified in the criminal justice system, this programme gives them access to treatment, including maintenance treatment. The Drugs Act 2005 amended sections of the Misuse of Drugs Act 1971 and the Police and Criminal Evidence Act 1984, strengthened police and court powers in relation to drugs, and increased the effectiveness of DIP by getting more drug-using offenders into treatment. In addition to DIP (and working with it), there are projects specifically designed to help drug-free or stabilised drug users find appropriate housing and employment.

Drug policy before 1971

Such an all-encompassing approach to drug misuse and the role of treatment, particularly maintenance treatment, has not always been accepted by policymakers. Although illicit drug use has never been condoned, and there were a number of laws regulating the use and sale of psychoactive substances, particularly opiates, cocaine and cannabis, nonetheless a disease model of addiction predominated for much of the 20th century in the treatment of those addicted. Treatment, not punishment, has long been the UK's response to the problem, and this remains the case. However, there has been a shift in focus between maintenance- and abstinence-based treatments (the latter predominant in the later 20th century), and there is concern to find the right balance between these approaches.

The 1926, the Rolleston Committee, meeting to review the drug problem in response to international concerns, found that there were few addicts (and most were middle-class and professional, often addicted following treatment or with ready access to addictive drugs). Rather than bow to international pressure to criminalise drug users, the committee argued that the problem should be addressed by offering medical help, recommending that the treatment of choice should be gradual withdrawal from the drug of dependence (mainly heroin), but also advocating maintenance prescribing as a legitimate treatment

that enabled addicts to continue to lead 'normal' lives. What became known as the "British system" was therefore established, premised on the disease concept of addiction: it confirmed the status of addicts as ill, and established the right of medical practitioners to use their discretion in the choice of treatment offered to their patients. In essence, what underlay the British response was the principle that treatment decisions are a matter between doctor and patient, based around the Hippocratic oath. Addiction was largely an issue for doctors, not for legislators; and this is still the case.

In 1962, again in response to international concerns about drug misuse, the Brain Committee met to consider the problem, endorsing the findings of Rolleston forty years earlier. However, there was by then a recognition that the problem had changed; drug misuse was no longer confined to a few among the middle classes, but becoming increasingly prevalent among young people. In 1964 the Brain Committee reconvened and this time recommended that the treatment goal shift from seeking to normalise the life of addicts, including maintaining them on the drug to which they were addicted, to containing the problem. Abstinence was recommended and greater stress placed on preventing access to drugs. In an attempt to reduce 'leakage', the committee recommended that drugs of abuse be banned from prescription by general practitioners for the management of drug addiction. This was accepted and, with the Dangerous Drugs Act 1967, diamorphine and cocaine (and, at that time, methadone) could no longer be prescribed by general practitioners for the treatment of addiction unless they applied for a licence to do so, which some did (general practitioners were still able to prescribe these drugs for other conditions). In response to this change, clinics (Drug Dependency Units) were established, predominantly in London, led by consultant psychiatrists. This established drug misuse firmly as a mental health issue, and treatment was largely restricted to these centres.

The 1970s and 1980s

During the 1970s and 1980s there were varying opinions about the place of longer-term opiate substitution and the balance between it and abstinence treatment (most commonly short-term detoxification). This discussion has continued, to a lesser degree, to the present day – but now, it may be argued, with an increased evidence base to inform practice.

The Misuse of Drugs Act 1971 established the system classifying drugs according to their perceived harmfulness and fixing sanctions in relation to this. The Act also established the Advisory Council on the

Misuse of Drugs (ACMD) to "keep under review the situation in the United Kingdom with respect to drugs which are being, or appear likely to be, misused and the misuse of which is having, or appears capable of having, harmful effects sufficient to constitute a social problem".

Despite these actions, misuse of drugs was not contained. By the 1980s, use of opiates had increased significantly, particularly among males, in areas of high unemployment and social deprivation. In 1982, ACMD, in their report, *The treatment and rehabilitation of drug users*, suggested that one problem was the lack of provision outside London. It recommended multi-disciplinary regional problem drug teams be established, along with more counselling services and a much wider range of residential detoxification and rehabilitation facilities, and that local authorities and the voluntary sector be involved in providing services. In addition, it recommended community drug teams be established to provide information and advice to drug misusers and their families, and to act as gatekeepers to appropriate services.

These recommendations were accepted and, over the rest of the 1980s, central funding was allocated to health authorities, local authorities and the voluntary sector for drugs services, creating the structure of community-based treatment services now staffed by social workers, probation officers, mental health nurses and others, with the voluntary sector also playing a role. The aim was to help drug users become and remain drug-free.

In the 1980s, AIDS proved to be a catalyst for change in the provision of services, with the risk to injecting drug users highlighted in 1985. Combating AIDS was given priority. The public were to be informed through national publicity campaigns and provision was to be made for counselling for those at risk, establishing HIV testing and planning HIV-treatment initiatives. In 1988, the ACMD, asked to consider the issue of AIDS and injecting drug use, suggested that "The spread of HIV is a greater danger to individual and public health than drug misuse. Accordingly services which aim to minimise HIV risk by all means should take precedence in development plans" (ACMD 1988).

The new approach on Merseyside

In 1986 Mersey Regional Health Authority, given the high number of drug users in the region, recognised the need to plan services to prevent the spread of HIV. Their approach was based on what was called the "New Public Health", developing services on a population-based model of harm reduction, targeting the whole population at risk, and not simply those already attracted to established drug-treatment

services. Famously, a syringe exchange was opened in a toilet in the Regional Drug Training Centre offering clean injecting equipment to all users. The service attracted large numbers of users, many of whom were found to be unwell, with injecting sites often infected.

The next step in the harm-reduction response was through the Drug Dependency Unit (DDU) in Liverpool. This service was already slightly outside the more typical detoxification services in its rationale; short-term detoxification was rejected in favour of gradual withdrawal from prescribed substitute drugs over a period of weeks, rather than days. However, with the recognition that most patients failed to complete the regime and returned to street drugs it was decided to offer services to attract and maintain users in treatment – including longer-term maintenance prescribing, mainly methadone, but also heroin to a few patients. In part, the idea was that if contact could be maintained with drug users it was easier to influence behaviour change, particularly sharing of injecting equipment. Over a thousand drug users were attracted to the services.

In addition, a third type of service was opened, offering not only syringe exchange, but basic health care for those suffering from the physical complications of injecting, confidential HIV testing, treatment for minor infection and injuries, advice on safe injecting and, recognising sexual transmission of HIV to sexual partners, safe sex. This approach was not fully endorsed by government though, given the position of doctors in being responsible for treating their patients, nor was it rejected. Eventually, syringe-exchange schemes were endorsed by government, along with funding that to ensure clean injecting equipment was available, free of charge, to all drug misusers. All treatment was, and is, also free of charge as part of the National Health Service.

In time, the concept of harm reduction became associated with a criticism of the medical model of treatment. This was not what the original Mersey model sought; there was no criticism of doctors and their role in treatment, only a suggestion that, if HIV was to be prevented and the health care needs of users met, there should be a much wider approach than that suggested by the one-to-one doctor–patient relationship that Rolleston endorsed. Instead there should be a public health approach targeting all. This misinterpretation led to a mistrust of the concept of harm reduction among many, and the term "harm reduction" was rejected in the first UK drug strategy which was much more strongly abstinence-based. Abstinence-based treatment remained the norm across much of the UK until after 2000. Reducing harm, not only to health, has now become part of government policy; and the role of treatment services, in this, is also firmly accepted.

Since the 1990s

In the 1990s a review of drug treatment was commissioned by government, which suggested that *Treatment works*. A further report, *Tackling drugs together*, emphasised the need for a partnership approach, laying the foundations for multi-agency local drug action teams to ensure the delivery of drug strategy. In 1997 the UK Anti-Drug Co-ordination Unit (UKADCU), with a "drugs tsar", was established, followed in 1998 by the first UK drug strategy, *Tackling drugs together to build a better Britain*. This strategy was premised on the idea that initial spend would be concentrated on reacting to the drug problem, but that in time, because treatment and other initiatives would be able to address the problem by helping users to become drug-free, money would become more and more focused on prevention. The aims were: to help young people resist drug misuse in order to achieve their full potential; to protect communities from drug-related anti-social and criminal behaviour; to enable people with drug problems to overcome them and live healthy and crime-free lives; and to stifle the availability of illegal drugs.

In 2001 overall responsibility for the Drug Strategy moved to the Home Office, and in 2002 the strategy was updated. This update reiterated the four original strands, but prioritised Class A drugs, the most damaged communities and problematic drug users, though prevention also remained a priority. Reducing harm to health was also given importance with a strategy for reducing drug-related death published in 2001 and an action plan on hepatitis C in 2004 (both since updated). The Drug Interventions Programme in 2003, established for users who commit crime to give them access to treatment, also set up teams to help with social reintegration through providing help with access to education, employment and housing.

As noted earlier, each devolved administration has its own drug strategy tailored to the needs of each country, but all reflecting wider UK strategy.

At the time of writing, a new strategy is being developed which aims to make further progress on tackling dealing, reducing the harm caused to young people and families by drug misuse, reducing the impact on communities, and reducing the health harm to drug misusers.

18.4. Drug policy and alcohol/tobacco policy

In UK there is little policy linkage between these three areas, though in every case action consists of population-based prevention/harm-

reduction campaigns, education, treatment and control of supply. The use of alcohol by problem drug users is only lately being addressed, through drug policy; and, while there is concern about the use of drugs in settings licensed for the sale and consumption of alcohol, the response remains within the relevant, but separate, policy. While there are integrated strategies for substance misuse in Wales and Northern Ireland, responses tend to be separated except in terms of treatment service provision. As noted above, drug policy developed around a disease model of addiction with the medical profession taking responsibility to help addicts to cope with or quit their addiction, known as the British system.

A shift in practice towards abstinence-based treatment came with the rise in numbers addicted, though the medical professional retained responsibility for the treatment of addicts and there was widespread recognition of the difficulty of sustaining abstinence. HIV/AIDS provided a catalyst for a wider public health approach to the problem, though in policy terms this public-health approach remained associated with infectious disease. Neither the link between drug misuse and crime, nor the role of treatment in reducing drug-related crime was really a central concern until the 1990s. Once recognised, it was this that to a large extent drove policy from the late 1990s. In the last few years the role of treatment in reducing health harms has become firmly established, and substitution prescribing is once again endorsed as a harm-reduction intervention.

In contrast, tobacco and alcohol policy have been dominated by economic issues, with public health interests being less powerful. Policy in both areas has focused on voluntary regulation and fiscal policies, with only recently a pronounced public health interest. Although the evidence linking smoking to illness had been increasingly accepted within government, the policy response was minimal. Government acceptance of smoking as an issue of choice and a once-powerful tobacco lobby ensured that voluntary agreements with the industry were chosen over legislation. However, in the last few years the decline in the power of the tobacco industry and public concern over health issues associated with smoking have brought about a more interventionist response from government. There is now information and education, treatment for those who smoke and legislation, to curtail the damage to non-smokers and to reduce the influence of the tobacco industry by banning advertising.

It has, however, been argued that it is smoking that has been a pioneer of new styles of public health since 1945, involving a sea-change from the traditional assumption that lifestyles were a matter of personal

choice to an acceptance that government should intervene to protect the public. It has also been suggested that it has been smoking that has been responsible for a change in the role of doctors, from being concerned with individual patients (as has been the case with drug misuse and the British system) to one of lobbying about issues of public health. In addition, it required a shift in the nature of public health from local information giving to central publicity campaigning; and also, as importantly, it required politicians to modify their early dislike of the "nanny state" and show a willingness to be more interventionist in health matters.

The response to alcohol has likewise been one of information and education about the problems associated with its use, as well as legal restrictions on the sale and consumption of it. There has long been treatment for those who have problems in using alcohol. Like tobacco duty, alcohol taxation has been a mechanism for control – though, as with tobacco, such taxation has also contributed to the public purse. Voluntary agreement with the industry has been, and remains, a key aspect of policy, with legal sanctions focused on public nuisance rather than public health.

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ID 6852

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