Have recent evolutions in European governance brought harmonisation in the field of illicit drugs any closer?

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Abstract

With the long awaited ratification of the Lisbon Treaty on 1 December 2009, it appears that plans within Europe to achieve an 'ever closer union' are back on track, yet, in the field of illicit drug policy, harmonisation remains as elusive a goal as ever. Sweden and the Netherlands have long provided examples of the different paradigms of drug policy operating within Europe and this article seeks to examine whether, as European Union harmonisation moves forward, recent developments bring the two any closer to convergence on this contentious issue. In addition to changes in Swedish and Dutch drug policy, the progress of the drug policy of other European countries has been evaluated. The article concludes that the Swedes and the Dutch remain ultimately wedded to their national policies and that movement both towards increased repression of drug use and increased liberalisation of drug use can be observed among other European countries. Harmonisation of European drug policy therefore remains in a state of stalemate.

Key words

European Union, harmonisation, illicit drug policy

Introduction

With the long awaited ratification of the Lisbon Treaty on 1 December 2009, it appears that plans within Europe to achieve an '*ever closer union*' are back on track. The brief stumbling block presented by the failure of the constitutional treaty and then, more recently, the refusal of the Irish to ratify the Lisbon Treaty itself, has been overcome and commentators are beginning again to look to an increasingly federalist Europe. Does this reaffirmation of European Union, however, accurately reflect developments in terms of policy making and shaping at the national level? This article examines the contentious, at least from a harmonising point of view, area of illicit drug policy and questions whether it is an area in which any significant developments in terms of policy harmonisation have been made.

Background to integration of European drug policy

At a relatively early stage in the development of European integration, the illicit drug problem was investigated as an area for potential closer co-operation between national governments. European commissions launched into drug problems in the 1980s and early 1990s failed to achieve any consensus on the best approach to combating the problem, being divided on whether a Dutch style of tolerance or a more traditional

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control-oriented policy was the right direction for Europe as a whole (Blom & van Mastrigt, 1994). The European Union (EU) itself retired from attempts to judge the desirability of one method of drug control over another and, instead, drug policy has been defined as an area of subsidiarity, ie. one more suited to national control. Nevertheless, evidence exists to support the idea that the EU continues to prioritise illicit drug policy. Extensive numbers of working bodies and groups have been created to monitor the problem and the European Parliament, the Commission and the Council of Europe have all become involved with the issue. The abundance of activity within the EU in this area is indicative of the fact that the underlying aim is far from having been abandoned (Boekhout van Solinge, 2002). What, then, have been the effects of all this prioritising and activity; are we seeing any real convergence in European drug policy?

Before answering this question, it is important to establish the existence of two different paradigms of drug policy that exist at the European level (Chatwin, 2003; 2007). Each EU member state has developed a highly nationalised response to the illicit drug problem, sometimes involving fundamentally different basic principles that are in almost direct opposition to each other in terms of finding and implementing different solutions, which has, of course, made attempts at harmonisation difficult. In the areas of drug dealing and drug trafficking, European consensus has been less difficult to achieve, with all member states avowedly against both behaviours. Considerable headway, in terms of harmonisation, has already been made in this area, as evidenced by the implementation of agreed minimum penalties across Europe for these offences, although agreement on the actual terms of these penalties was not straightforward. It is in the areas of drug use and drug users, however, that accord has generally been much more difficult to reach. The drug policies of the Netherlands and Sweden offer good examples of the two different extremes of drug policy operating within Europe and thus deserve a brief exploration here. Other European member states differ along the continuum between them.

In Sweden, drug policy is strictly control-oriented and moralistic, operating as a cross-political party issue where policy is endorsed by wider society in its entirety (Boekhout van Solinge, 1997; Goldberg, 2004; Lenke & Olsson, 2002). The ultimate aim, realistic or not, is to achieve a drug-free society, which has resulted in a policy that is stricter than that operated in many other European countries. Policies disallow the consumption of drugs (as compared to many European countries that only criminalise their possession), recognise no difference between soft and hard drugs, ensure that users are targeted with as much vigour as dealers and primarily invest in abstention-based or coercive treatment programmes. Tham (1995) describes the Swedish drug problem as having become entwined with national identity, with the life of the drug abuser being held up as the antithesis of the life of a good citizen. Drugs are seen as a problem that has come from outside Sweden and, as such, constitute a threat to the Swedish lifestyle (Gould, 1994); it is therefore an issue that supercedes party political interest and that requires the participation of all if it is to be overcome.

In the Netherlands, meanwhile, drug policy has been based on the principle of normalising the drug problem as far as possible (van Vliet, 1990). Rather than seeking to stigmatise and marginalise drug users, pushing them to the outskirts of society, policy seeks to normalise their experience and include them within society as far as possible. Where they are treated as 'different', it is as patients in need of cure rather than as criminals in need of punishment. Pragmatic policy initiatives such as the 'separation of the markets' have been implemented whereby, in an effort to keep cannabis users away from potentially more damaging drugs, semi-legal environments (coffee shops) have been established where cannabis can be bought and consumed under some form of regulation. The overall aim, which has become as important a part of national identity to the Dutch as the pursuit of a drug-free society is to the Swedes, is to minimise the harm done to society by the use of drugs and, therefore, the principle of harm reduction has gained much ground here.

Recent developments in Swedish and Dutch drug policy

Sweden and the Netherlands have been often-invoked examples of the different paradigms of drug policy in operation in Europe and it might therefore be expected that if European policy on this issue is to converge, some signs of that convergence would be observed within the recent policy developments of these two countries. Indeed, on a first perusal, evidence does suggest that some changes are being made to the policies of each country that indicate a dilution of their national positions on the drug policy issue. In Sweden, for

example, academics have noted two recent policy initiatives that suggest the Swedish government may be loosening its grip on illicit drug control policy (Goldberg, 2005; Johnson, 2006). Firstly, the Drugs Commissioner has recommended that the needle exchange programmes in southern Sweden, which have only ever been tolerated on a temporary basis, albeit an ongoing one, should be made permanent. Secondly, he has recommended that a greater number and a greater variety of substitution treatment programmes should be made available to problem drug users. Taken together, Goldberg (2005) and Johnson (2006), among others, have reflected that these aims may represent a shift towards the acceptance of the principles of harm reduction not previously seen in Sweden, as harm reduction does not sit well within the framework of a drug-free society. This new consideration for improving the lives of drug users may indicate a fundamental shift in the '*foundations on which the strategy of the drug free society is built*' (Hallam, 2010, p9).

Similarly, in the Netherlands, academics have begun to notice a shift in drug policy, this time towards repression (Uitermark, 2004; Lemmens, 2003). Since 2003, a centre-right cabinet has been in power within the Netherlands, resulting in an increasing tendency for politicians to appear tough on drugs. This has combined with a decreasing willingness from the general public to tolerate drug-related public nuisance (Garretsen, 2003), resulting in a number of policy changes. Since 1995, local authorities in Holland have been granted the power to ban coffee shops completely from their confines or to close them where regulations are clearly being contravened (Boekhaut van Solinge, 1999) and current figures (Intraval, 2007) show that there has been a recent decrease in both the overall number of coffee shops and the number of towns/cities with any coffee shops at all. This example illustrates how external pressure to normalise cannabis policy has coincided with internal pressure to reduce drug-related public nuisance to effect concrete policy changes, which, interestingly, have been implemented here at the local rather than national level. There is also evidence of an increasingly law-enforcement-based policy towards ecstasy use and users, probably as a result of the rising role of the Netherlands as a producer of this drug (Uitermark & Cohen, 2005). Finally, the alarming rise in prison numbers for drug-related crimes (Goldberg, 2005, p53) is an indication that '*power in the drug field is moving from the Ministry of Health to the Ministry of Justice*'.

So, at face value, if Swedish drug policy is becoming more liberal and Dutch drug policy is becoming more repressive, then there are some signs of convergence of drug policy ideals at a European level. However, while the changes described above are certainly noteworthy, there is plenty of evidence to suggest that, despite them, national drug policy in both Sweden and the Netherlands is mainly one of continuation of past policy goals. While public perception of the drug problem and the centre right government of the Netherlands have certainly had some impact on policy implementations, many liberal elements of Dutch drug policy remain, suggesting it still has a place at the forefront of European harm reduction and tolerant drug policy practice. The heroin trials that began in 1998 were extended in 2001 after an overwhelmingly positive evaluation (van Kolfschooten, 2002). Additionally, the last decade has seen the Dutch become increasingly involved in promoting the potential use of cannabis as a medicine in its own right, particularly in treating multiple sclerosis (Sheldon, 2002). At the end of 2007, despite relatively disappointing take-up of this treatment option, the Minister of Health, Welfare and Sport announced that development of the medicinal use of cannabis would be extended for a further five years (de Jong, 2009).

In Sweden, while the new policy instructions regarding needle exchange programmes and substitution treatment do promise a new attitude towards harm reduction measures, the overwhelming message of drug policy remains strictly control oriented. The report of the drug commission appointed in 1998 to examine the drug problem in light of rising levels of drug use, demands stronger leadership in drug policy and a more active role from the government in a new offensive against the drug problem. The strict policy of control with regard to drugs is reiterated and enforced: '*In its choice of direction, the Drugs Commission has found that Sweden's restrictive policy on drugs must be sustained and reinforced*' (Swedish Commission on Narcotic Drugs, 2000, p2). Furthermore, since the implementation of this report via national action plans in 2002 and 2006, Sweden has seen a decrease in levels of drug use since the highs of the 1990s (CAN – Council for Information on Alcohol and Other Drugs, 2009). The United Nations Office for Drug Control has seized on this, while ignoring Sweden's high proportion of heavy drug users and drug-related deaths (Cohen, 2006; Ramstedt, 2006), and published a report

entitled *Sweden's Successful Drug Policy* (United Nations Office on Drugs and Crime, 2007). This endorsement of Sweden's drug policy is further likely to ensure that no significant changes in terms of operating a less restrictive policy are to be expected.

Seeds of change in European drug policy?

It can thus be observed that, while both Sweden and the Netherlands have made minor concessions in their national drug policies, possibly as a nod to differing styles of drug policy operating in Europe, in the main they have remained unchanged, despite a focus on harmonisation in this area. If we now turn to look at drug policy in a greater variety of European member states, we can further observe no overall coherent direction for the recent changes that have been made. With Sweden overwhelmingly in favour of a continuation of its strict drug policy, and the impact of a centre right government and a decrease in public tolerance of drug related nuisance in the Netherlands, evidence so far suggests a trend towards repression in European drug policy. Such a trend can be further evidenced by the legitimacy of increasingly severe penalties towards drug traffickers seen in Europe, which is '*deepening the culture of prohibition …* [and ensures] *the dichotomy at the heart of European drug policy remains as strong as ever: harmonisation and toughening of enforcement measures*' (Elvins, 2003, p182). Cohen (2000, p4) suggests that drug policy is still operating as an '*arena*' for politicians across Europe, who are more interested in vote-winning rhetoric focused on control measures than implementing real changes. To further emphasise this point, if we consider a country such as Denmark, which has long been accepted as operating a policy that is caught between a desire to be liberal and a reality of being heavily influenced by other repressive Nordic policies, Laursen and Jepsen (2002, p22) observe that the recent closure of the free cannabis market in Christiania and the general toughening of measures against cannabis users means '*the battle between repression and welfare seems likely to give priority to repression in actual practice*'.

Taking the rest of Europe, however, this trend towards repression is not upheld. For example, Belgium and Luxembourg have recently effectively removed criminal sanctions for the possession of cannabis for personal use. Germany, Estonia and Lithuania, meanwhile, have written into their penal codes the possibility of waiving prosecution in the case of small amounts for personal use of any drug; and Spain, the Czech Republic and Latvia have gone one step further, making administrative sanctions the norm for possession of small amounts of illegal drugs for personal use. Furthermore, in France – a traditional supporter of a control-oriented, Swedish style of drug policy – a reduction in both the number and length of sentences for drug use has been observed since 1998 (Bergeron & Kopp, 2002). Perhaps the most convincing example of this alternative trend towards liberalisation of drug policy, however, is provided by recent efforts to decriminalise all drugs in Portugal in 2001. The latest evaluations of this policy initiative have declared it a '*resounding success*' (Greenwald, 2009, p1), resulting in a reduction in drug trafficking, drug-related deaths and heroin use while maintaining a relatively low lifetime usage rate for cannabis (*Economist*, 2009). Furthermore, Hedrich and colleagues (2008, p512) have noted a '*clear trend across Europe towards recognition of harm reduction as an important component of mainstream public health and social policies towards problem drug use*'. MacGregor & Whiting (2010) have noted that this is a trend that has permeated the powerhouses of the EU itself, as evidenced by the latest *EU Drugs Action Plan 2009–2012* (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2008), which refers explicitly to harm reduction as a guiding principle in reducing drug-related death and disease. Even here, however, policy consensus is not absolute, as a lack of appropriate funding has made it difficult for the further expansion of harm reduction in central and eastern European countries (World Health Organization Department of Mental Health and Substance Abuse, 2004).

Conclusion

Based on the evidence presented above, it is very difficult to argue that any real signs of convergence can yet be seen in European drug policy. Despite cosmetic changes, neither Sweden nor the Netherlands have committed to any change in their respective underlying principles of drug control. Change in other countries cannot be said to show any convincing direction or cohesion, either. This is a somewhat surprising turn of events, particularly if we consider what has happened in similar policy areas at the European level. For example, in the area of alcohol policy, convergence can clearly be seen. Prior to entrance to the EU, Nordic countries had uniquely control-orientated alcohol policies in comparison with

the rest of Europe. Since Sweden and Finland joined the EU, changes have been swift and have encompassed abolishing restrictions on travellers' allowances and the monopolies on import, export and wholesale, lowering taxes on alcohol and generally liberalising their restrictive anti-drinking measures (Cisneros Ornberg, 2008; Andreasson *et al*, 2006).

Indeed, despite obvious European interest in harmonising illegal drug policy, it is clear that opinion on the issue within the EU itself remains relatively divided. In 2004, for example, the European Parliament accepted the radical *Catania Report* (European Parliament, 2004), which labelled current policies inadequate and called for a new policy to be fundamentally built on health concerns. Yet, at the same time, the *EU Drugs Strategy 2005–2012* (EMCDDA, 2005) fundamentally committed to the same old principles of prohibition and control, albeit tempered by the inclusion of increased prioritisation of the principle of harm reduction. Ultimately, it is this lack of decision that appears to be stymieing further efforts to harmonise. Cross-national data comparisons in this area, for example on prevalence of lifetime drug use or numbers of drug related deaths, are subject to data scarcity, poor data quality and comparability, weak causal inference and unknown generalisability (MacCoun & Reuter, 2002; Chatwin, 2007), making it impossible to reliably correlate drug policy direction and the prevalence of drug use across EU member states (Boekhout van Solinge, 2004). With this stalemate over which style of drug policy is better suited to addressing the problem, individual countries are able to promote their own success and '*Ironically, both Swedish and Dutch policy makers think they are on the right track*' (Boekhout van Solinge, 2004).

This lack of agreement and preference for national tradition is not problematic in itself. Indeed, evidence suggests that the drive for European harmonisation of drug policy has thus far only resulted in an increase in law enforcement measures as practiced against drug traffickers and drug suppliers. The relatively tough minimum penalties introduced by the European Union in this area, ever-rising European prison rates for drug offenders and the continual preoccupation with drug control by institutions such as Europol vouch for this. A continual increase in 'war on drugs' style policy control measures is not desirable when its harms are so well documented (Beyers *et al*, 2004; Greene, 1999; Rhodes *et al*, 2005; Shiner, 2003; Small *et al*, 2005). Klein (2008) cautions against further harmonisation: '*Global recipes of failure…have only served to spread drug related problems across ever wider parts of the globe*'. Dorn (1996a), however, postulates that if drug policy remains ultimately in the hands of individual countries, it will converge more because decisions will continue to be made by those in power for each country. Both he and Klein (2008, p3) call instead for a policy that is based on decision-making at the local rather than the national level. Dorn (1996b) further links the development of a local-level response to the drug problem to a system of sharing incidences of best practice in similar areas at the European level. As there exists no policy that could so far be called successful in eradicating the drug problem, it therefore makes sense for as many different policy options to be in operation as possible and for these to be implemented at the local level, independent of national policy. The real issue here is whether individual countries have become so locked into their own paradigms that they are unable to learn from other countries or from identifiable policies of best practice, for example for urban areas. While, ultimately, it does not matter whether or not Europe achieves unity of policy style in this area, it does make sense to work together on the issue and for individual nation states to be able to pick and choose from a variety of drug policy implementations developed at the local level to best suit their own drug problem.

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