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A review and assessment of EU drug policy

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POLICY DEPARTMENT C: CITIZENS' RIGHTS AND CONSTITUTIONAL AFFAIRS

CIVIL LIBERTIES, JUSTICE AND HOME AFFAIRS

A review and assessment of EU drug policy

STUDY

Abstract

This study, commissioned by the European Parliament's Policy Department for Citizens' Rights and Constitutional Affairs at the request of the LIBE Committee, provides an overview of the drug policies in international fora, at EU level, in seven Member States and in three non-EU countries. The study highlights the very different approaches taken and their varying level of effectiveness.

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To contact the Policy Department for Citizen's Rights and Constitutional Affairs or to subscribe to its newsletter please write to:
poldep-citizens@europarl.europa.eu

Research Administrator Responsible

Kristiina MILT
Policy Department C: Citizens' Rights and Constitutional Affairs
European Parliament
B-1047 Brussels
E-mail: Poldep-citizens@ep.europa.eu

AUTHORS

Mirja GUTHEIL, Optimity Advisors
Quentin LIGER, Optimity Advisors
Aurelie HEETMAN, Optimity Advisors
James EAGER, Optimity Advisors
Solveig BOURGEON, Optimity Advisors

With the support of Dr Axel KLEIN, Global Drug Policy Observatory (GDPO), Dr Martin ELVINS, lecturer in Politics and International Relations University of Dundee; Dr Caroline CHATWIN, Senior lecturer in criminology, University of Kent; Martin JELSMA, Transnational Institute (TNI); Mariana DATES, Optimity Advisors, and Clive PRITCHARD, Optimity Advisors.

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CONTENTS

LIST OF ABBREVIATIONS

ANDT	alcohol, narcotics, doping and tobacco
CADAP	Central Asia Drug Action Programme
CDT	Commission for the Dissuasion of Drug Abuse (PT)
CELAC	Community of Latin American and Caribbean States
CEPOL	European Union Agency for Law Enforcement Training
CND	The Commission on Narcotic Drugs
COPOLAD	Cooperation Programme on Drugs Policies between Latin America and the EU
COREPER	Committee of the Permanent Representatives of the Governments of the Member States to the European Union
COSI	Standing Committee on Operational Cooperation on Internal Security
DIMS	Drug Information and Monitoring System (NL)
DRDs	drug-related deaths
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EMPACT	European Multidisciplinary Platform against Criminal Threats
EWS	early warning system
GCDP	Global Commission on Drug Policy
GHB	Gamma hydroxybutyrate
GDPO	Global Drug Policy Observatory
INCB	International Narcotics Control Board
HAT	heroin-assisted treatment
HCV	hepatitis C virus
IDPC	International Drug Policy Consortium
LIBE Committee	European Parliament's Committee on Civil Liberties, Justice and Home Affairs
MAOC-N	Maritime Analysis and Operations Centre – Narcotics
MDMA	Methylenedioxy-methamphetamine
MEP	Member of the European Parliament

NPS	new psychoactive substances
PWID	people who inject drugs
REITOX	Réseau Européen d´Information sur les Drogues et les Toxicomanies (European Information Network on Drugs and Drug Addiction)
TEU	Treaty on European Union
TFEU	Treaty on the Functioning of the European Union
THC	Tetrahydrocannabinol (the active ingredient in cannabis)
UNAIDS	United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
WCO	World Customs Organisation
WHO	World Health Organization

Two-letter country codes

AT	Austria
BE	Belgium
BG	Bulgaria
CH	Switzerland
CY	Cyprus
CZ	Czech Republic
DE	Germany
DK	Denmark
EE	Estonia
EL	Greece
ES	Spain
FI	Finland
FR	France
HR	Croatia
HU	Hungary
IE	Ireland
IT	Italy

LT Lithuania
LU Luxembourg
LV Latvia
MT Malta
NL Netherlands
PL Poland
PT Portugal
RO Romania
SE Sweden
SI Slovenia
SK Slovakia
UK United Kingdom
US United States of America
UY Uruguay

LIST OF BOXES

LIST OF FIGURES

LIST OF TABLES

EXECUTIVE SUMMARY

The challenges facing Europe in the field of drugs are still significant and have increased in complexity in recent years. In addition to the key issue of mortality and morbidity as a result of opioid use, new and emerging problems are being experienced across the EU. These include the creation of new psychoactive substances and the increasing dynamism of illicit drug markets. This study aims to provide evidence on international and EU approaches to drug policy, including these challenges and focusing on several case study countries. This evidence has been used to identify and develop policy proposals.

Drug policy at the UN and EU levels

The main tenets of the **UN's approach to drugs** are the 1961 UN Single Convention on Narcotic Drugs, the 1971 UN Convention on Psychotropic Substances and the 1988 UN Convention against illicit traffic in Narcotic Drugs and Psychotropic Substances. A key UN policy document is the **2009 'Political Declaration and Plan of Action** on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem'. This document details a set of goals to be achieved by 2019, including significant and measurable progress in eliminating the illicit cultivation of opium poppy, coca bush and cannabis plant, as well as actions to be implemented by countries across three main pillars. In April 2016, the **UNGASS on the World Drug Problem** was convened; a UN General Assembly special session seen as an important milestone in achieving the goals set out in the 2009 policy document. The UNGASS resulted in the adoption of the outcome document 'Our joint commitment to effectively addressing and countering the world drug problem'. This document provided a range of operational recommendations and **broadened the original pillar structure to 7 pillars** (see chapter 2). Several new themes were added including drugs and health, drugs and human rights, new drug related challenges such as NPS and use of the internet, and international and development related cooperation.

At the **EU level**, although the primary onus for developing drug policy and legislation remains with the Member States, there are a **several legal bases for EU action**, as stipulated in the Treaty of Lisbon. These cover the context of adopting minimum rules on the definition of criminal offences and sanctions on serious organised crime (Article 83 TFEU), public health (Article 168 TFEU), the internal market (Article 114 TFEU) and judicial cooperation in criminal matters (Articles 82-86 TFEU).

In terms of EU policy, the most prominent current instrument is the **EU Drugs Strategy 2013-2020**. The Strategy provides the overarching political framework and priorities for EU drug policy. The EU Drugs Strategy has 5 main objectives, namely to reduce demand and harm, disrupt the drugs market, discourse and analysis, cooperation, and research and monitoring.

The implementation of the Strategy's long-term objectives have been operationalised in 4-year Action Plans. In November 2015, the Commission adopted a report on the progress of the implementation of the EU Drugs Strategy and Action Plan.[1] The **mid-term evaluation of the first Action Plan (2013-2016)** is due to be completed by the end of 2016 or, at the latest, early 2017. The findings from the mid-term evaluation and the Public Consultation[2], which was launched by the European Commission in March 2016, will inform the Commission's decision to propose a new Action Plan for 2017-2020.

[1] European Commission, Report on progress in the EU's 2013-2020 Drugs Strategy and 2013-2016 Action Plan on Drugs, COM(2015) 584 final, Brussels, 27 November 2015.

[2] European Commission, Public consultation for the 2016 evaluation of the EU Drugs Strategy and Action Plan on Drugs, May 2016.

Recent EU legislative developments relate to a package of two proposals regarding new psychoactive substances.[3] These proposals were put forward by the European Commission is 2013. As Member States expressed doubts in the Council concerning the choice of Article 114 TFEU as the legal basis for the proposed Regulation, inter-institutional negotiations of this legislative package were ongoing for more than two years. As a result, the Commission withdrew its proposal on 29 August 2016 and tabled a **proposal amending the founding Regulation of the EMCDDA** (Regulation (EC) No 1920/2006 on the EMCDDA).[4] Under this proposal, deadlines for decision-making on NPS will be significantly reduced and Europol will take on a more active role in the risk assessment procedure and the Early Warning System (EWS), with a view to quicker identification and assessment of the involvement of criminal groups. The new proposal was welcomed by all Member States and was **backed by the European Parliament's** LIBE Committee on 17 November 2016.

Observations

Observations on the effectiveness of drug policy at the MS level

The drug policy approaches implemented by the Member States selected for case studies vary in their objectives, focus and doctrine. In every Member State policy-makers and the public have become habituated to government drug policy, but the actual implementation and design stem from the cultural and historical context of each country. The objectives of drug policies are therefore very difficult or impossible to harmonise.

Member States fit along an ideological spectrum from a more restrictive approach, characterised by a primary focus on law enforcement and criminal justice activities, to a more liberal approach, characterised by a primary focus on reducing the health and social harms experienced as a consequence of drug use. Regarding the selected case study countries, SE is consistently reported to be the most restrictive Member State in terms of its approach to drug policy, with a policy focused on achieving a drug-free society based on an ideology of drug addiction as a biochemical dependency. DE also employs a policy based on the idea of law enforcement as a deterrent to drug use but, as a result of Germany's federal system, approaches vary by Länder. At the other end of the spectrum, CZ, PT and the NL employ primarily harm reduction approaches, viewing drug misuse more as a psychosocial challenge. However, even with these differences, all seven Member States examined refer to the two major types of approaches in their drug policy objectives: i) drug demand reduction; and ii) drug supply reduction. Moreover, all the Member States examined implement activities in all of the traditional four 'pillars' of drug policy: i) prevention; ii) harm reduction; iii) treatment / therapy; and iv) law enforcement. Furthermore, the majority of examined Member States implement activities aimed at social reintegration and stakeholder cooperation.

There are a number **of impediments to assessing the effectiveness** of the EU's drugs policy. These relate to: (i) the data limitations; (ii) the varying objectives of policies at Member State level; and (iii) the limited impact of policies on drug demand and supply. For instance, a policy evaluated as effective in one country may not be replicable in another as the specific history, culture and nature of the drug problem play important roles. Moreover, policies are only one of the many factors that influence the drugs market (both in terms of use and supply). Any assessment must therefore take into account the limited impact that these policies can have on patterns of use or the supply of drugs.

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[3] European Commission, Proposal for a directive of the European Parliament and of the Council amending Council Framework Decision 2004/757/JHA of 25 October 2004 laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking, as regards the definition of drug, COM(2013)0618; and the Proposal for a Regulation on new psychoactive substances COM(2013)0619.

[4] https://ec.europa.eu/transparency/regdoc/rep/1/2016/EN/1-2016-547-EN-F1-1.PDFn

However, what can be said is that, despite very different approaches, **no Member State that formed part of this assessment appears to be exceptionally successful** in achieving their stated objectives or significantly reducing drug consumption. To take the example of two often cited 'successful' policies:

- PT has seen significant reductions in HIV notifications amongst drug users and drug-induced deaths, but still faces many issues that need to be addressed; and
- In NL, the introduction of the "gedoog"-policy for coffee-shops has reduced the number of street dealers offering cannabis alongside more harmful drugs and appears to have reduced prevalence of use for most drugs. However, ecstasy is an exception with high prevalence levels seen.

The work undertaken for this study highlights the need for further research in order to assess the effectiveness of drug policies and associated interventions. While the EMCDDA provides a source of robust and (partly) comparable data (see Appendix D), which represents an added-value compared to other regions, there is still a clear lack of robust empirical research on the effectiveness of the different policies in achieving their objectives. There is also a lack of understanding on the scope and size of the wider (societal) impacts of drug policies in the medium and long term.

Observations on policies addressing the demand side

In most Member States (with the notable exception of SE) there has been a move away from the goal of a drug-free society to the goal proposed by the European Parliament recommendation of 15 December 2004 to the Council and the European Council on the EU drugs strategy (2005-2012) – i.e. policies focusing on harm reduction. Consensus appears to be building around this approach, as illustrated by the EU Drugs Strategy's inclusion of the "reduction of the health and social risks and harms caused by drugs" as a policy objective.

Coordinated harm reduction policies have had a tremendous effect in reducing the number of drug-induced deaths, as well as the number of HIV notifications amongst drug users, as evidenced by PT's drug policy. This is primarily due to a coordinated approach between law enforcement and public health. The success of this approach is based on: i) a strong public health system with related investments; ii) the early identification of users (i.e. before they become addicts); and iii) public buy-in to the policy.

The effectiveness of harm reduction policies, with regard to reducing HIV infections among drug users and reducing drug-related deaths, has been abundantly and consistently proven. This is probably the most intensively researched area in this field, and all UN agencies have now accepted these conclusions. There is a solid evidence base suggesting that opposition to this has become an ideological viewpoint.

Increased quality and availability of information on drugs used, including their quality, purity and provenance, is important. A number of health consequences are linked to opiates of a low purity that are cut with adulterants. Cannabis users in the NL and ES appear to seek more information on the provenance and quality of the cannabis they use, as well as seeking to procure it from more "ethical" sources (i.e. away from organised criminal groups). More generally, safer injection interventions, such as needle exchanges and supervised injection sites, protect users with no evidence of their numbers increasing.

Pill and powder testing facilities have also proven to be effective; for example, NL was able to send out national warnings when dangerous PCP superman pills were being sold as ecstasy due to their testing facilities. Meanwhile, people were killed taking these pills in the UK, where such facilities were not in use.

Observations on policies addressing the supply side

As for all illegal activities, it is extremely difficult to assess the size of the supply side of the drugs market both in terms of imports and production. The only tangible indicator available is that of seizures, which, as highlighted in this report, may be impacted by external factors, such as increased law enforcement activity or a large catch. However, despite large amounts of resource being aimed at reducing the supply of drugs, very few tangible results are available on their impact. Moreover, where the sale of cannabis is tolerated, there are clear issues related to the "backdoor problem".

The distinction between illicit and non-illicit drugs makes issues relating to supply unclear. According to the international treaties, all substances can have both licit and illicit purposes. The increase in the number of countries and territories regulating or legalising the production of cannabis, coupled with the growing acceptance of cannabis derivates in the pharmacological industry, legal or regulated cannabis production is evolving into an agri-tech industry in the US and Israel.

Observations on cooperation

The EMCDDA's role in developing and compiling more comparative data is hugely important for the understanding of the drug scene in the EU and the effectiveness of drug policies. Furthermore, the EWS and information exchange overseen by the Centre has clearly been beneficial to the Union's response to NPS in the absence of a legislative instrument.

The EU Drugs Strategy, built upon three pillars, is being challenged by the new, more modular 7 pillar approach raised at UNGASS. This more granular approach provides more scope for action. For instance, the first pillar – demand reduction and related measures – is divided into two elements. The first covers prevention and treatment, as well as other health-related issues, and the second relates to the availability of and access to controlled substances exclusively for medical and scientific purposes, while preventing their diversion to illicit use.

Recommendations and policy proposals

Encourage further research and strengthen evidence based policy making

Given the need for drug policies to be seen in a holistic manner as part of a wider public policy debate, what works in one country may not be successful in another. The legal bases of EU intervention are tenuous and intervention would not be welcomed by most Member States. More empirical research is necessary to assess the effectiveness of different policy approaches and the factors which affect their impact. Consequently, the European Parliament could refrain from trying to develop a unified drug policy through the EU.

Policy Proposal 1 (PP1) *- The European Parliament should commission more research or encourage the Commission or other bodies to undertake more evidence-based research on the effectiveness of different drug policy approaches.*

Countries covered by this study, such as CH, emphasise the use of evidence-based practices. Swiss authorities have initiated and supported significant research which has determined the viability of systems they use and evidenced the benefits to drug users; in particular, those who had failed to respond to other treatment types. In IE, the Health Research Board has set up a "National Drugs Library", an information resource that supports researchers, policy makers, educators and practitioners working to develop the knowledge base around drug, alcohol and tobacco use in the country.

PP2 *- The European Parliament should encourage the development of an evidence-base on existing policies. This could be done through an extended role for the EMCDDA. Independent evaluation and monitoring of drug policies and interventions should also be encouraged. A report on the wider impacts of different drug policies should be commissioned in order to: i)*

scope the range of their (societal) effects; ii) provide more robust and holistic cost-effectiveness analyses; and iii) consider qualitative elements, such as the improvement in the quality of the life of users and their families, and the wider impacts related to changes in the prison population, the presence of criminal groups etc.

***PP3** - The European Parliament should call for and encourage the creation of a pan-European clearinghouse on the model of the What Works? Centres aiming to: i) review research on practices and interventions relating to drugs; ii) label the evidence on interventions in terms of quality, cost, impact, mechanism (why it works), context (where it works) and implementation issues; and iii) provide stakeholders with the knowledge, tools and guidance to help them target their resources more effectively.*

Strengthen the evidence base around decriminalisation and harm reduction

Where decriminalisation is encouraged, it must be accompanied by a strong public health response. Positive experiences of decriminalisation have been the result of coordinated and concerted effort on the part of all public authorities in charge of drugs policy. It is therefore key to build on the experience of these successes if they are to be replicated in countries that wish to do so.

***PP4** - The European Parliament should encourage Member States that have experienced a positive decriminalisation effort to share their experiences through lessons learnt workshops and robust evidence-based impact analyses in order to highlight the key success factors of these experiences.*

One side effect of drug use (and in particular the use of opiates) is the impact of other substances in the product injected, as well as the risk of infection from used needles and using in non-safe places.

***PP5** - The European Parliament should encourage evidence-based research specifically on harm reduction mechanisms for users and, if they are proven to be effective, support their development on a Public Health basis.*

Strengthen the evidence base around effectiveness of law enforcement interventions

While law enforcement interventions can clearly play a role in the short term disruption of drug markets, their long-term impact is unclear. More research should be undertaken to understand the effectiveness of these responses and their impacts on the drug markets and the patterns of use.

***PP3** –see above*

The production of cannabis for medical purposes should be explored on the basis of what is currently being done in Israel and the US.

***PP6** –The European Parliament should encourage the development of market analyses based on potential demand for, and pharmacological and therapeutic benefits of cannabis, to ensure that Europe does not fall behind in this area of bio-technology, where other countries are quickly establishing a lead.*

Support to the EMCDDA and EU alignment with the UN 7 pillar approach

The EMCDDA is a vital component of the EU's response to drugs and drug addiction. It has developed into a key player in the exchange of information between Member States.

***PP7** – The European Parliament should encourage the EMCDDA to continue playing an important role in the development of information exchange, including the EWS on NPS. The new Regulation on the EMCDDA should retain the proposed elements relating to NPS.*

The EU should continue to align its strategy to the UNGASS structure. It is recommended that the new Strategy (beyond 2020) follows the 7 pillar approach.

***PP8** – The European Parliament should encourage the adoption of the 7 pillar approach in the future EU Drugs Strategy.*

1. INTRODUCTION AND METHODOLOGY

1.1. Aim and structure of the study

The aim of the study was to:

- Provide evidence on the global approach to drugs including three non-EU case studies (Switzerland, Uruguay and the USA);
- Provide evidence on drug policy and legislation at the EU level;
- Provide evidence on the approach to drug policy in selected Member States based on seven case studies;
- Provide an analysis of drug policies and the interactions between the international, EU and Member State levels; and
- Identify and develop policy proposals based on the finding of the study.

1.2. Adopted methodology

The methodology used for this assessment builds upon comparative and legal analysis techniques and relies on **qualitative** and **quantitative research,** as well as expert opinion consisting of:

- **Country case studies,** covering seven Member States (DE, PT, PL, ES, CZ, SE, NL) and thee non-EU countries: Uruguay, Switzerland and the USA;
- **Desk research,** assessing information published at the EU level, internationally and in the case study countries;
- **Interviews** with European institutions, as well as national authorities and academics in the case study countries (a full list of interviewees can be found in Appendix C);
- **Expert workshop**, held in London in October 2016 with the study experts, Dr Martin Elvins, Dr Caroline Chatwin, Martin Jelsma from TNI, Dr Axel Klein from the GDPO and a representative from the EMCDDA.

1.3. Limitations to the quantification and assessment of the policy impacts

There are strong limitations associated with the data used for assessing and evaluating drug policies across the European Union. Despite the work of the EMCDDA, data on drugs are not always accurate and the availability of some indicators is limited or inexistent. The limitation of the current indicators used for assessing drugs-related health issues, drug consumption and drug markets are detailed in Appendix D.

1.4. Structure of the report

This report is structured as follows:

- This chapter sets out the aims and methodology of the study;
- Chapter 2 sets the scene of the international drugs policy, including the UN fora and other types of international cooperation;

- Chapter 3 looks at the EU drug policy framework, including the EU Drug Strategy, institutional arrangements and the proposed legislative instrument on new psychoactive substance (NPS);
- Chapter 4 focuses on policies at Member State level, based mainly on the EU case studies;
- Chapter 5 looks at the impact and effectiveness of the various measures adopted at EU and national level;
- Chapter 6 builds on all the above-mentioned chapters and provides observations, recommendations and policy proposals.

2. INTERNATIONAL DRUG POLICY OVERVIEW

The World Drug Report 2016 estimated that 1 in 20 adults, which amounts to a quarter of a billion people between 15 and 64 years old, used at least one drug in 2014.[5] The report further estimated that the number of drug-related deaths has remained stable worldwide (207 400 drug-related deaths in 2014). Over 29 million people who use drugs are estimated to suffer from drug use disorders, and of those 12 million inject drugs, of whom 14% are living with HIV.[6]

This section provides an overview of the UN drug Conventions adopted at the international level, the international organisations and bodies involved in drug policy at the international level, as well as examples of forms of (regional) cooperation under the auspices of the UN.

2.1. UN drug Conventions

Inter-state policy aimed at tackling drug-related challenges was first initiated at the international level under the 1913 Shanghai conference and then under the auspices of the UN League of Nations. The following three drug-related treaties, as presented in Figure 1, adopted between 1961 and 1988, are key tenets of the UN's approach:

Figure 1: Timeline presenting the key UN Conventions on drugs and their objectives

[5] UNODC, World Drug Report 2016.

[6] UNODC, World Drug Report 2016.

The first convention, the 1961 Convention on Narcotic Drugs, was adopted to establish a single instrument for multiple existing treaties on controlling narcotic drugs. It includes provisions on the prevention of drug abuse and drug trafficking, as well as on the availability of drugs for medicinal and scientific purposes. The Convention requires Parties to make illicit production, possession and supply of drugs punishable offences and establishes that serious offences 'shall be liable to adequate punishment particularly by imprisonment or other penalties of deprivation of liberty.' However, the Single Convention includes an escape clause that the obligation of Parties to criminalise such acts is 'Subject to its constitutional limitations'. The treaty's language is ambiguous on whether or not it requires criminalisation of drug possession for personal use. The Convention requires that 'the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes'. The Convention also categorises drugs in four 'schedules' of controlled substances: Schedule I (includes for example cannabis, cocaine and opium), Schedule 2 (includes for example codeine and some opioids), Schedule 3 (which is a light subset of Schedules I and II) and Schedule 4 (stricter subset of Schedule I).

In 1988, the Convention was supplemented by the Convention on Psychotropic Substances, which controls LSD, MDMA, and other psychoactive pharmaceuticals, as well as the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, which strengthens provisions against money laundering and other drug-related offences.

2.2. International organisations and bodies involved in drug policy

The UN organisations involved in drug policy are listed in Table 2. It should be noted that these are successor organisations to the Opium Control Board at the League of Nations – an international organisation created by the Versailles Treaty of 1919 that can be seen as a precursor to the UN.

Table 1: UN organisations and bodies involved in drug policy

UN office/body	Description
UN Office on Drugs and Crime (UNODC)	The UNODC accounts for more than 90% of the UN resources dedicated to drug control. UNODC supports Member States in addressing drugs by[7]: • Providing legislative support (model legislation); • Capacity building (e.g. law enforcement training); • Implementing drug use prevention interventions; • Providing drug dependence treatment and care services. The UNODC has, for example, published the International Standards on Drug Use Prevention[8]
Commission on Narcotic and Drugs (CND)	The CND is the governing body of the UNODC and was established by the Economic and Social Council of the UN in 1946 (Resolution 9(I)). All matters pertaining to the objectives of the UN drug control treaties and their implementation form a key element of CND mandate, as well as ensuring that countries have access to essential medicines.

[7] https://www.unodc.org/unodc/en/drug-prevention-and-treatment/index.html

[8] UN, International Standards on Drug Use Prevention, Vienna, February 2015.

UN office/body	Description
World Health Organization (WHO)	The WHO is responsible for conducting the medical, scientific and public health evaluation of substances, and it assesses controlled drugs for public health risks. The evaluations are conducted through the WHO Expert Committee on Drug Dependence (ECDD), which also makes recommendations to the UN Secretary-General, on the need for and level of international control of substances.
International Narcotics Control Board (INCB)	The INCB is an independent, quasi-judicial expert body established by the Single Convention on Narcotic Drugs made up of 13 experts elected by the Economic and Social Council for a period of five years. Its tasks include the monitoring of countries' compliance with the UN international drug control treaties. The INCB mandate under the 1988 Convention is very limited.
International Drug Policy Consortium (IDPC)	The IDPC is a global network of NGOs and professional networks that supports evidence-based policies that are effective in reducing drug-related harm. It promotes objective and open debate on the effectiveness of drug policies at national and international level.

In several initiatives, the above organisations work together, for example:

- The **UNDCP/WHO Global Initiative on Primary Prevention of Substance Abuse** was a collaborative project between the United Nations Office on Drugs and Crime (UNODC, formerly the United Nations International Drug Control Programme or UNDCP) and the World Health Organization (WHO). It was fully funded by the Government of Norway.[9]
- The UNODC is leading the **Joint Global Programme** on 'Access to Controlled Drugs for Medical Purposes While Preventing Diversion and Abuse' (also known as GLOK67), in which the World Health Organization (WHO) and the Union for International Cancer Control (UICC) also participate.

2.3. UN Policy Framework

A key policy document of the UN is the 2009 'Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem'. The policy document details a set of goals to be achieved by 2019, including significant and measurable progress in eliminating the illicit cultivation of opium poppy, coca bush and cannabis plant; as well as actions to be implemented by Member States across three main pillars (see Table 3).

In 2012, the Presidents of Colombia, Guatemala and Mexico called on the UN to host an international conference on drug policy reform. As a result, an annual omnibus resolution on drug policy was developed, led by Mexico, and co-sponsored by 95 other countries, which included a provision to hold this global drug policy meeting already in 2016. In March 2014, a high-level review of the progress made in the implementation of the Political

[9] https://www.unodc.org/globalinitiative/index.html

Declaration and Plan of Action was conducted by the CND,[10] which identified achievements, challenges and priorities for further action for 2019.

Building on the above, in April 2016 the UN General Assembly convened a special session **(UNGASS) on the world drug problem**, which was seen as an important milestone in achieving the goals set out in the 2009 policy document. The UNGASS resulted in the adoption of the outcome document 'Our joint commitment to effectively addressing and countering the world drug problem'. This document provided a range of operational recommendations covering the above-mentioned areas, and **broadened the original pillar structure to 7 pillars** (see Table 3), adding several themes such as drugs & health (new pillar 2), drugs & human rights (new pillar 3), new drug-related challenges such as NPS and use of the internet (new pillar 5), and international cooperation and development-related cooperation (new pillar 6 and 7).

With regard to the latter, it is important to note the integration of the Sustainable Development Goals (SDGs) into the UN drug policy: 'Efforts to achieve the Sustainable Development Goals and to effectively address the world drug problem are complementary and mutually reinforcing'.[11] Interesting with regard to Pillar 1 is the lack of explicit reference to the term 'harm reduction'. This is in part due to the *modus operandi* of the CND, where decisions are made by consensus and where a number of countries are still opposed to 'harm reduction', including the USA, Saudi Arabia, Egypt and Russia. On the other hand, some resolutions of the General Assembly (and its third Committee: Social, Cultural, and Humanitarian – SOCHUM) are adopted through majority voting, which means the committee has adopted positions on the abolition of the death penalty and harm reduction.[12] The inclusion of the human rights pillar is the result of the presence and involvement of a group of UN human rights experts from the Office of the UN High Commissioner for Human Rights (OHCHR) in the UNGASS.[13]

Table 2: Change in pillar structure from 2009 to UNGASS 2016

Three pillars 2009 Political Declaration	Seven-pillar UNGASS 2016
Pillar 1: Demand reduction and related measures;	**Pillar 1:** Demand reduction and related measures, including prevention and treatment, as well as other health-related issues.
	Pillar 2: Ensuring the availability of and access to controlled substances exclusively for medical and scientific purposes, while preventing their diversion.
Pillar 2: Supply reduction and related measures; **Pillar 3:** Countering money-laundering and promoting judicial cooperation to	**Pillar 3:** Supply reduction and related measures; effective law enforcement; responses to drug-related crime; and countering money-laundering and promoting judicial cooperation.

[10] UNODC, Joint Ministerial Statement 2014: High-Level Review by the Commission on Narcotic Drugs of the Implementation By Member States of the Political Declaration and Plan of Action on International Cooperation Towards an Integrated and Balanced Strategy to Counter the World Drug Problem, 2014.

[11] Outcome document UNGASS 2016.

[12] See: UNGASS 2016: A Broken or B-r-o-a-d Consensus?, Transnational Institute (TNI) and Global Drug Policy Observatory (GDPO), July 2016. https://www.tni.org/files/publication-downloads/dpb_45_04072016_web.pdf

[13] OHCHR, Tackling the world drug problem: UN experts urge States to adopt human rights approach, Geneva, April 2016.

Three pillars 2009 Political Declaration	Seven-pillar UNGASS 2016
enhance international cooperation.	
	Pillar 4: Drugs and human rights, youth, children, women and communities.
	Pillar 5: Evolving reality, trends and existing circumstances, emerging and persistent challenges and threats, including new psychoactive substances, in conformity with the three international drug control conventions and other relevant international instruments.
	Pillar 6: International cooperation based on the principle of common and shared responsibility.
	Pillar 7: Alternative development; regional, interregional and international cooperation on development-oriented balanced drug control policy; addressing socioeconomic issues

However, the outcome document for UNGASS was not well received on all fronts. For example, the Global Commission on Drug Policy (GCDP), a key international stakeholder, announced its profound disappointment with the outcome document. The GCDP deemed the current drug control regime to have been a comprehensive failure with 'critical flaws'.[14] The identified flaws were (i) the basic aims of the policy in terms of demand and supply reduction have failed; (ii) the collateral damage of pursuing those aims has been dramatic: overcrowded prisons, less effective HIV policies, inadequate access to these controlled drugs for essential medicinal purposes, etcetera; (iii) human rights have been violated on a major scale under the banner of a war on drugs (see Philippines now); (iv) instead of reducing harms, harms for users as well as society have been multiplied: risky adulterated substances on the illicit market, much more drug-related violence and so on. Furthermore, the GCDP reported that support for progressive legislation and new approaches was not recognised by the UNGASS outcome document, an outcome due to the consensus method of decision-making detailed above.[15]

2.4. International and regional cooperation

Apart from the special sessions on drugs from the General Assembly mentioned above, countries exchange information on drugs policy during the **annual and the inter-sessional meetings of the UN Commission of Narcotic Drugs (CND)** in Vienna. Following the UNGASS 2016, the CND is convening seven special thematic sessions in Vienna to discuss the follow-up and implementation of the UNGASS 2016 outcome document.

The UNODC organises annual **Heads of National Drug Law Enforcement (HONLEA) meetings** for Africa, Latin America and the Caribbean, as well as Asia and the Pacific, to

[14] Global Commission on Drug Policy (2016) Public statement by the Global Commission on Drug Policy on UNGASS 2016.

[15] Global Commission on Drug Policy (2016) Public statement by the Global Commission on Drug Policy on UNGASS 2016.

allow participants to discuss major regional drug trafficking trends and countermeasures and to exchange expertise, share best practices and information on drug-related matters and to develop a coordinated response.

Moreover, some states meet and coordinate their views on drug policy outside the framework of the UN. At the regional levels discussions to define common positions take place within the EU, CICAD, CARICOM, ASEAN, CIS, UNASUR, CELAC, etc. And more informally, groups of like-minded states have gathered in the core group of countries on drug and human rights in Geneva, the Cartagena group coordinated by Colombia, Switzerland and Ghana; the Brandenburg forum under German and Dutch auspices, and a series of informal drug policy dialogues organised by influential NGOs in the drug policy arena – in collaboration with reform-orientated countries – such as the Transnational Institute (TNI), the Washington Office on Latin America (WOLA), the International Drug Policy Consortium (IDPC) and the Open Society Foundations (OSF).

More information on international and regional coordination and cooperation is provided in Chapter 5.4.

3. EU LEGAL AND POLICY FRAMEWORK

This section firstly provides some contextual information on the problems faced at EU level. Secondly, it gives an overview of the EU institutions and agencies involved in EU drug policy, the legal basis for the EU to work in the area of drugs, as well as the EU legislation adopted in this area, including recent legislative developments. Thirdly this section discusses the policies adopted at EU level addressing drugs.

3.1. Background

The problems faced by Europe in the field of illicit drugs have increased in complexity in recent years.[16] The key challenges facing the EU with regard to drug policy include the increasing trends towards non-opioid drug use, the emergence of new psychoactive substances (NPS)[17] and the continuing high prevalence of drug-related deaths (DRDs) within the EU, especially as a result of the use of opiates.[18] It appears as though the use of illicit psychoactives has become entrenched in the EU, and that, while there are fluctuations between Member States, the use of NPS is often cultural in nature and the related policy interventions only partly influence drug consumption.

Cannabis remains the most commonly used drug in the EU, with a 'last year' prevalence rate of 6.6% in the EU (against 7% in 2006), followed by cocaine (1.1%), MDM (0.8%) and amphetamines (0.5%).[19] In addition, there are currently 1.3 million high-risk opioid users, with opioids found in 82% of fatal overdoses, and 3% of young adults (15–24) used new psychoactive substances in 2015.[20] Moreover, the use of the different types of drugs differs considerably between the EU Member States. With regard to cannabis, for example, there are countries with a last year prevalence rate of 0–1% (e.g. HU and LT), while in other countries this is as high as 11% (e.g. FR and CZ).[21] These data demonstrate that drug use in the EU is a dynamic phenomenon which is not going away and is different across different countries.

In 2014, for the first time 101 NPS were reported in the EU, compared to 41 in 2010, of which the production is increasingly taking place within the EU.[22] Moreover, the EMCDDA estimated that in 2014 at least 6,800 deaths occurred due to overdose alone.[23] Furthermore, the trend has reversed in some countries such as the UK, where after years of improvement there has been a sharp increase in DRDs for a number of years. Nowhere in the EU are drug deaths as alarming as in the US, however, where prescription drugs are responsible for most fatalities.

In addition to changes to drug use, drug trafficking has also seen substantial developments. The EU drug strategy 2013–2020,[24] for example, highlights the dynamics of illicit drug markets as an emerging challenge, citing shifting drug trafficking routes, cross-border organised crime and the use of new communication technologies as key facilitators of drug distribution. Driving these developments is the fact that the illicit drug markets offer significant financial rewards: the EMCDDA recently estimated that, in 2013,

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[16] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), European Drug Report: Trends and Developments, 2016.

[17] Interview European Commission, DG Home, Unit D.3. Organised Crime and Drugs Policy, 14 September 2016 and Interview representative EMCDDA, 7 September 2016.

[18] Interview representative EMCDDA, 7 September 2016.

[19] EMCDDA, European Drug Report, Trends and Developments, 2016.

[20] Ibid, p.13.

[21] See http://www.emcdda.europa.eu/countries/prevalence-maps

[22] European Commission, Roadmap for EU Drugs Strategy 2013–2020.

[23] EMCDDA, European Drug Report, Trends and Developments, 2016.

[24] EU Drugs Strategy (2013–2020).

the retail market for illicit drugs was between EUR 21 billion and EUR 31 billion.[25] This estimate was considered to be conservative, aptly demonstrating the scale of the challenge facing Europe. In terms of trafficking, two main trends have emerged. The first one is the emergence of organised criminal groups operating cross-border. The second is a gradual shift in cannabis imports, with European markets becoming self-sufficient under the double impulse of increased demand for higher-quality drugs and the wish for users to avoid interaction with the criminal groups mentioned above. Additional information on trafficking routes is presented in section 4.1 when discussing the structure of the drug markets across the case study countries.

3.2. Institutional and legal framework

This section provides an overview of the EU institutions and agencies involved in EU drug policy, the legal basis for the EU to work in the area of drugs, as well as the EU legislation adopted in this area, including recent legislative developments.

3.2.1. EU institutions and agencies involved in drug policy

A number of entities within the EU feed into the EU drug policy, with the **European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)** being the most high-profile. Set up in 1993, the EMCDDA's objective is to provide factual, objective, reliable and comparable information on drugs and drug addiction and their consequences at EU level.[26] Its tasks include: the collection and analysis of existing data; improvement of data-comparison methods; dissemination of data; and cooperation with European and international bodies and organisations and with third countries.[27] In this regard, the EMCDDA **monitors** the state of the drugs problem and emerging trends, as well as the solutions applied in Member States, and developing tools for Member States to evaluate their drug policies.[28] Over the last few years the EMCDDA has become responsible for assessing the risks of NPS within the early warning system; however, this is only a small part of the work of the Agency.[29] The agency also publishes reports, including the annual 'European Drug Report' (now in its 21st year), as well as thematic reports such as the 'EU Drug Markets Report' and the recent 'Internet and drug markets' report. It had a budget of EUR 15.14 million for 2016.

The Regulation governing the EMCDDA's work (regulation (EC) No 1920/2006) requires each participating country to appoint one national focal point (NFP). As a result the **European Information Network on Drugs and Drug Addiction (REITOX)** was set up. The REITOX network allows for the collection and exchange of data between 31 members (EU28, Norway, Turkey and the Commission). It is important to note that the EMCDDA does not have a political or executive role but one of information gathering, sharing and the promotion of scientific excellence.

Within the **European Commission**, drug policy used to fall within the remit of DG Justice and Consumers, but has since 2015 been part of **DG Migration and Home Affairs'** portfolio. Within DG Home, Unit D.3. (Organised Crime and Drugs Policy, part of the Directorate on Security) is responsible for the development of the Drugs Policy. Its tasks include the coordination with different Commission services of the EU drug policy, and the unit chairs the inter-service group on drugs. In addition, the unit is responsible for the

[25] EMCDDA – Europol : EU Drug Market Report,2016.

[26] Article 1 (2) Regulation (EC) No 1920/2006 on the European Monitoring Centre for Drugs and Drug Addiction (recast), 12 December 2006.

[27] Article 2 Regulation (EC) No 1920/2006.

[28] Annex I (priority areas) to the Regulation (EC) No 1920/2006.

[29] Interview representative EMCDDA, 7 September 2016.

implementation of the **EU Drugs Strategy** and **Action Plan**, and the negotiation of legislative proposals in the area of drugs. It is part of the management board of the EMCDDA (together with DG Health and Food Safety) and represents the Commission in the Council's Horizontal Working Party on Drugs, the United Nations Commission on Narcotic Drugs in Vienna, in other UN meetings (such as the 2016 UNGASS), as well as in all dialogues on drug policies with third countries. Finally, it is responsible for the administration of EU budget on drugs issues, including the commissioning of projects under the drugs policy strand of the Justice Programme (2013-2020),[30] in relation to illicit drug trafficking, under the Internal Security Fund-Police,[31] the Health Programme and the Horizon 2020 programme on research.

Other relevant institutions include the Council. Its **Standing Committee on Operational Cooperation on Internal Security (COSI)** has a mandate concerning operational actions relating to internal security, which includes drug trafficking. COSI's focus on illicit drugs is implemented through the EU policy cycle's European Multidisciplinary Platform against Criminal Threats (EMPACT), which includes activity against trafficking and production of synthetic drugs, cocaine and heroin. Moreover, the Council has a **Horizontal Working Party on Drugs**, which is composed of representatives of Member States, the EEAS, the Commission, the EMCDDA and EUROPOL. It is mainly focused on coordination, international cooperation, research, monitoring and evaluation in the field of drug supply and drug demand reduction. The HDG has a horizontal role in adopting and overseeing the EU Drugs Strategy and AP; it deals with all drug-related legislative files; the Chair of the HDG chairs dialogues with third countries on drugs; it prepares common positions for international events such as the CND sessions or UNGASS. The Working Party prepares and negotiates EU drug strategies and action plans and carries out correspondence with third countries. Within the **European Parliament, the LIBE Committee** is involved in the adoption of legislative proposals in the field of drugs.

Other relevant agencies include **Europol and Eurojust**: Europol supports cross-border coordination in law enforcement and provides expertise with regard to drug trafficking. Combating drug trafficking remains one of the main activities of Europol. Eurojust supports cross-border coordination for investigations and prosecutions of drug law offences.

3.2.2. Legal basis

Although the primary onus for developing drug policy and legislation remains on the Member States, there is a legal basis for EU action on the basis of several articles of the Treaty of Lisbon, namely in the context of[32]:

- Adopting **minimum rules** concerning the definition of criminal offences and sanctions on serious organised crime, including illicit drugs trafficking (Article 83 TFEU);
- **Public health** (Article 168 TFEU), where the EU has a complementary competence (focusing on drug demand reduction, including prevention and harm reduction);
- **Internal market** (Article 114 TFEU), including trade in drug precursors within the Union, and external trade in drug precursors (Art. 207 TFEU); and
- **Judicial cooperation** in criminal matters (Articles 82-86 TFEU), where the EU has a shared competence (focusing on drug supply reduction).

[30] http://ec.europa.eu/justice/grants1/programmes-2014-2020/justice/index_en.htm

[31] http://ec.europa.eu/dgs/home-affairs/financing/fundings/security-and-safeguarding-liberties/internal-security-fund-police/index_en.htm

[32] European Commission, Roadmap on EU drug policy.

Under Article 83 TFEU the EU may establish minimum rules regarding the definition of criminal offences and sanctions of particularly serious crimes with a cross border dimension, including illicit drug trafficking. This means the EU has the legal basis to adopt Directives which approximate the definition of drug trafficking offences and the related sanctions thereof. Article 84 TFEU (judicial cooperation) further allows the EU to adopt measures to promote and support the action of Member States in the field of crime prevention, including the prevention of drug trafficking. The Commission can, for example, in close contact with the Member States, undertake initiatives aimed at establishing guidelines and indicators, organise exchange of best practice and prepare periodic monitoring and evaluation. It may not, however, adopt any legislation aimed at the harmonisation of the laws and regulations of the Member States. The EU competence in the area of crime remains a sensitive issue for the Member States, therefore the legal base is quite narrow.[33]

Moreover, drug demand reduction is part of EU health policy, where the EU has complementary competence. Pursuant to Article 168 TFEU, the EU can complement the EU Member States' efforts in reducing drugs-related health damage, including through information and prevention. The Article also provides scope for the EU to encourage cooperation between the Member States in this regard and, if necessary, lend support to their actions.

Finally, the EU has a competence in drugs policy in the context of the internal market (Article 114 TFEU) and judicial cooperation (Articles 82-86 TFEU). For example, the 2013 proposal for a Regulation on new psychoactive substances was initially based on Article 114 TFEU, given the European Commission's aims of ensuring the trade of new psychoactive substances (and related precursors) for industrial and commercial purposes while ensuring a high level of health, safety and consumer protection. In this instance, Member States expressed doubts on the robustness of the legal basis and the legal basis for this proposal has since been changed to Article 168 TFEU (see section 3.2.3 for more detail).[34] Nevertheless, the potential for a legal basis under Article 114 TFEU exists.

3.2.3. EU legislation of drugs

As a result of the limited legal basis for EU action around drugs policy, the EU has consequently adopted only a limited amount of legislation in this area in addition to the decisions to ban substances.[35]

Table 3: Overview of current EU legal framework and legislative developments in the field of drugs.

Current legal framework			Legislative developments
Year	**Type of legislation**	**Content**	
2001	Council Decision 2001/419/JHA	On the transmission of samples of controlled substances: sets up a procedure at EU level for the	N/A

[33] Interview representative EMCDDA, 7 September 2016.

[34] European Commission, Proposal for a Regulation amending Regulation (EC) No 1920/2006 as regards information exchange, early warning system and risk assessment procedure on new psychoactive substances, Explanatory Memorandum, COM(2016) 547 final, Brussels, 29 August 2016.

[35] http://ec.europa.eu/dgs/home-affairs/e-library/documents/policies/organized-crime-and-human-trafficking/drug-control/index_en.htm

Current legal framework			Legislative developments
Year	**Type of legislation**	**Content**	
		exchange of samples of seized drugs[36]	
2004	Framework Decision 2004/757/JHA	Establishing minimum rules on the constituent elements of the offences of illicit drug trafficking, in terms of the definition of drug trafficking offences and their sanctions.	Proposal to amend this Framework Decision through a Directive (latest proposal is COM(2013)0618)
2005	Council Decision 2005/387/JHA	On the information exchange, risk assessment and control of new psychoactive substances.	Proposal to replace this Council Decision with amended 2004/757/JHA and amended Regulation No 1920/2006
2006	Regulation (EC) No 1920/2006	On the European Monitoring Centre for Drugs and Drug Addiction	Proposal to amend this Regulation (COM(2016) 547 final)

Council Decision 2005/387/JHA established the **early warning system (EWS)**, which is currently being carried out by the EMCDDA. Under the early warning system, the EU (the EMCDDA and Europol) and its Member States can swiftly exchange information on new narcotic and psychoactive substances that appear on the drug market. When required the EWS can include a risk assessment and eventually could involve the control of the new substance.

In 2009, the European Commission reported that the implementation of the 2004 Framework Decision had not been completely satisfactory.[37] Moreover, the provisions apply to substances covered by the UN Conventions and to synthetic drugs, but not to NPS which were spreading rapidly across the EU driven by the phenomenon of adaptive chemists staying ahead of the legislator in developing new formulas and the continuous demand for psychoactive substance. As a result, in 2013 the Commission put forward a package of two **proposals, including:**[38]

- A **Directive amending the 2004 Framework Decision** to include new psychoactive substances posing severe health, social and safety risks within its scope of application; and
- A **Proposal for a Regulation on new psychoactive substances**,[39] which aimed to subject these new psychoactive substances to permanent market restriction measures.

[36] Council Recommendation of 30 March 2004 (2004/C 86/04) provides guidelines for taking samples of seized drugs.

[37] European Commission, Report on the implementation of Framework Decision 2004/757/JHA, Brussels, 10 December 2009.

[38] European Commission, Proposal for a directive of the European Parliament and of the Council amending Council Framework Decision 2004/757/JHA of 25 October 2004 laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking, as regards the definition of drug, COM(2013)0618.

[39] COM(2013)0619.

This package of two legislative proposals on new psychoactive substances intended to subject new psychoactive substances to criminal law provisions on illicit drug trafficking (as per the proposed amended Framework Decision), as well as to permanent market restriction (as per the proposed Regulation).

However, inter-institutional negotiations of this legislative package were ongoing for more than two years, as Member States expressed doubts in the Council concerning the choice of Article 114 TFEU as the legal basis for the proposed Regulation. As a result, the Council refused to adopt a general approach.

Subsequently, the Dutch presidency proposed a new approach which would achieve the same objective as proposed in the 2013 package. This approach was agreed on in the Committee of Permanent Representatives (COREPER) in April 2016 and consists of the follow elements:

- Amend the proposed Directive in terms of its legal basis (Article 83 TFEU instead of 114 TFEU) and for it to include a definition of NPS and provisions that would allow for rapid EU decision-making on the criminalisation of harmful NPS in the Member States;
- For the Commission to present a proposal amending Regulation (EC) No 1920/2006, the founding Regulation of the EMCDDA, to include the provisions on early warning system and risk assessment procedure (which were in the previous proposed Regulation). The proposed Regulation on new psychoactive substances would be withdrawn.

As a result, on 29 August 2016, the Commission withdrew its proposal and tabled a proposal amending **Regulation (EC) No 1920/2006 on the EMCDDA** as regards information exchange, early warning system and risk assessment procedure on new psychoactive substances. The new proposal was presented at the first meeting of the Slovak presidency in September 2016 and was welcomed by all Member States, as well as the European Parliament in a recent LIBE meeting.[40]

On 17 November 2016 the European Parliament's LIBE Committee backed the proposed amendments to the founding Regulation of the EMCDDA. Under this proposal, deadlines for decision-making on NPS will be significantly reduced and Europol will take on a more active role in the risk assessment procedure and the EWS to quickly identify and assess the involvement of criminal groups. The MEPs also voted in support of the negotiating team and the mandate to open negotiations with the Council. In the meantime, the EMCDDA will work to finalise amended working arrangements with key partners, such as Europol, the European Medicines Agency and the European Food Safety Authority, due to their important roles in data collection for the risk assessment and EWA procedures.[41]

3.3. EU drug policy framework

With regard to the debate on approaches to drug policy, the EU is broadly seen as progressive in its aim of providing a balanced, evidence-based and humane approach.[42] While this is not an approach accepted by all countries, there are other countries such as Uruguay, and some of the US states, that already have moved considerably further (as shown in the non-EU case studies in Appendix B), with more such as Canada likely to

[40] Interview European Commission, DG Home, Unit D.3. Anti-Drugs Policy, 14 September 2016.

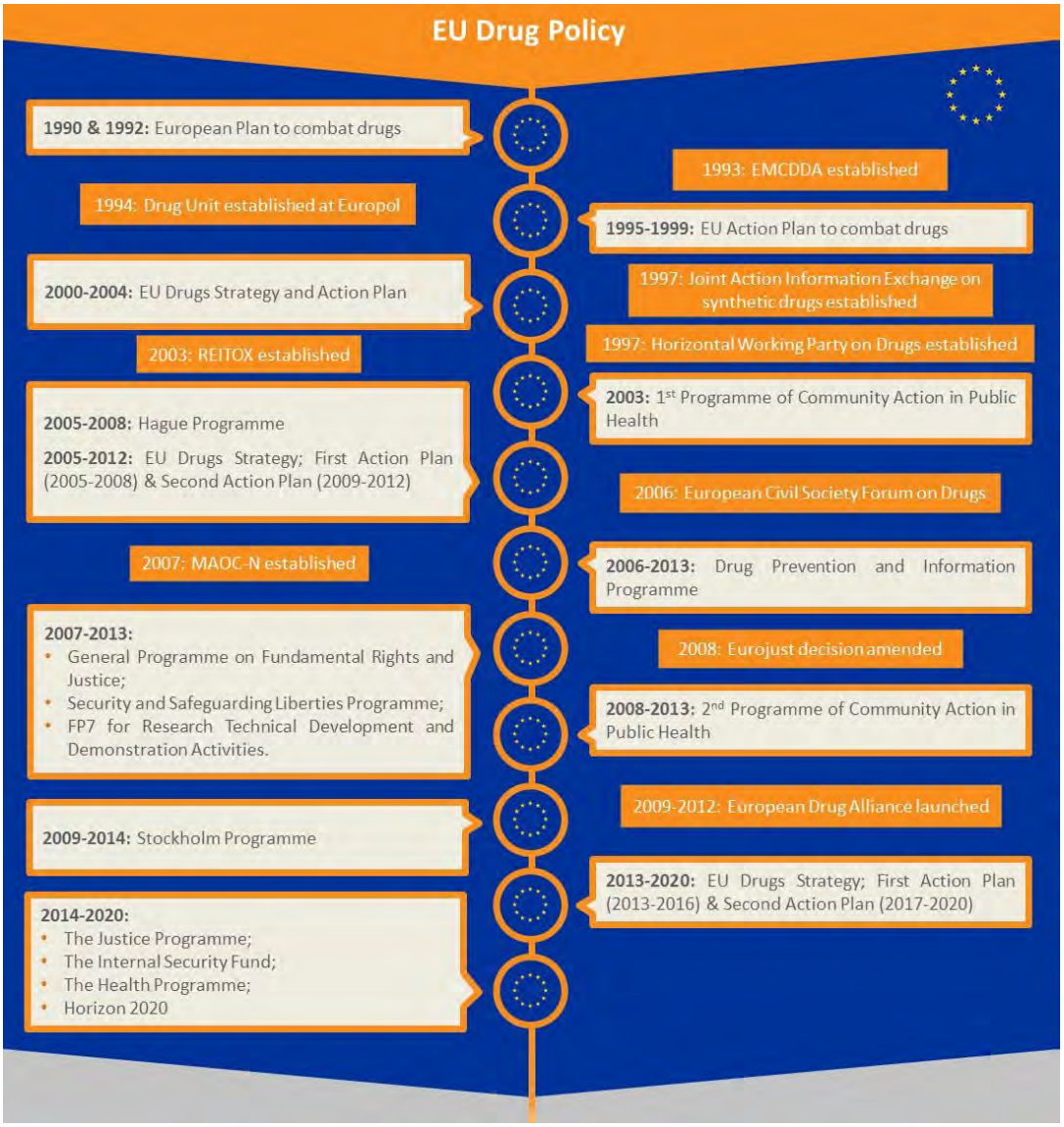
[41] European Parliament Press Release (2016) Drugs: MEPs back changes to ensure quicker action against new substances, 17-11-2016

[42] Jelsma, M. (2016) UNGASS 2016: Prospects for Treaty Reform and UN System-Wide Coherence on Drug Policy. Washington DC: Brookings Institute.

follow. Neither the EU nor any of its Member States are therefore currently drug policy innovators or leaders.

Figure 2 provides an overview of the drugs policies, programmes and action plans adopted by the EU since 1990. The key types of action at the EU level include funding programmes, policy initiatives and coordination with civil society, as well as national and international actors. Coordination with the Council is also vital to the adoption of drug policy at the EU level.

Figure 2: Timeline presenting key EU drug policies and establishment of relevant entities



EU Drugs Strategy 2013–2020

As can be in Figure 2, the most prominent current policy instrument is the EU Drugs Strategy 2013–2020. The Strategy provides the overarching political framework and priorities for the EU drugs policy. The EU Drugs Strategy has five main objectives:

1 **Reduce demand and harm**: To contribute to a measurable reduction of the demand for drugs, of drug dependence and of drug-related health and social risks and harms;

2 **Disrupt drugs market:** To contribute to a disruption of the illicit drugs market and a measurable reduction of the availability of illicit drugs;
3 **Discourse and analysis**: To encourage coordination through active discourse and analysis of developments and challenges in the field of drugs at EU and international level;
4 **Cooperation:** To further strengthen dialogue and cooperation between the EU and third countries and international organisations on drug issues;
5 **Research and monitoring**: To contribute to a better dissemination of monitoring, research and evaluation results and a better understanding of all aspects of the drugs phenomenon and of the impact of interventions in order to provide a sound and comprehensive evidence base for policies and actions.

The Strategy's objectives represent five themes, which include two policy fields – drug demand reduction and drug supply reduction – and three cross-cutting themes, which are described further below.

According to the Strategy, **drug demand reduction** includes 'prevention (environmental, universal, selective and indicated), early detection and intervention, risk and harm reduction, treatment, rehabilitation, social reintegration and recovery'. In this regard, the main objectives are to prevent and reduce (problem) drug use, drug dependence and drug-related health and social risks and harms, and to delay the age of people first using drugs. It identifies 10 priorities with regard to drug demand reduction including improving the availability of prevention programmes and effective and diversified drug treatment.

According to the Strategy, **drug supply reduction** includes 'prevention and dissuasion and disruption of drug-related, in particular organised, crime, through judicial and law enforcement cooperation, interdiction, confiscation of criminal assets, investigations and border management'. Here the focus lies on the criminal justice system, with the main objective to reducing the availability of illicit drugs, by disrupting the market, focusing on large-scale, cross-border organised crime. It identifies 11 priorities with regard to drug supply reduction, including intelligence-led law enforcement, increased cooperation, the use of arrest referral and appropriate alternatives to coercive sanction.

In addition, the Strategy identifies three cross-cutting themes:

- **Coordination:** 'to ensure synergies, communication and an effective exchange of information and views in support of the policy objectives, while at the same time encouraging an active political discourse and analysis of developments and challenges in the field of drugs at EU and international levels';
- **International cooperation:** 'to further strengthen dialogue and cooperation between the EU and third countries and international organisations on drug issues in a comprehensive and balanced manner'. There is a growing emphasis on international cooperation, with actions such as the EU-CELAC dialogue on drugs and programmes to combat drug trafficking;
- **Information, research, monitoring and evaluation:** 'to contribute to a better understanding of all aspects of the drugs phenomenon and of the impact of measures in order to provide sound and comprehensive evidence for policies and actions'.

Furthermore, the Strategy has three focus points, namely:[43]

- To **respond to new challenges in the drugs market**, including communication technologies and the combined use of illicit drugs and alcohol and the misuse of

[43] EMCDDA, Perspectives on drugs: The EU drugs strategy (2013–20) and its action plan (2013–16), May 2015.

prescription medicines as well as those highlighted by EMPACT (namely crypto markets, postal delivery systems and biker gangs);

- **Addressing health and social issues**: this is the first time an EU strategy includes the policy objective of reducing health and social risks and harms caused by drugs as a policy objective, alongside the two traditional drug policy aims of reducing supply and demand;
- **Supporting evidence-based decision-making**: the strategy focuses on the need for an empirical and evidence-based approach to drugs policy, expanding the main principles on which international drugs policies are based (as enshrined in the 2009 UN political declaration on drugs).

First Action Plan (2013–2016)

The implementation of the Strategy's long-term objectives has been operationalised in four-year Action Plans. Targeted actions are developed for inclusion in the Action Plan around the Strategy's two policy areas of focus (drug demand reduction and drug supply reduction), as well as around three cross-cutting themes mentioned above. The Strategy has developed criteria for the selection of these actions, such as the requirements for the actions to be evidence-based and to have a clear EU added value.

The first Action Plan (2013–2016) includes 54 actions, including timelines, indicators and data collection and assessment mechanisms, assigning a responsible party for each action. According to the EMCDDA, the action plan addresses in particular the need to ensure the quality of policy interventions, enhances the role of civil society in the drug policy-making process, with an increased emphasis on drug use in prisons and the social reintegration and recovery of all drug users.[44]

The findings of an ongoing mid-term evaluation are due to be completed by the end of 2016 or at the latest early 2017. This will help the Commission to decide whether to propose a new Action Plan for 2017–2020.

In addition, the EU financial programmes provide funding for **drug-related projects** between 2014 and 2020, to help implement the objectives set by the EU Drugs Strategy 2013–2020 and to foster cross-border cooperation and research on drug issues:[45]

- Justice Programme (2014–2020) of EUR 378 million;
- The Internal Security Fund (2014–2020) of around EUR 1 billion;
- The Health Programme (2014–2020) of EUR 449.4 million;
- Horizon 2020 of nearly EUR 80 billion overall.

3.4. Implementation of EU drug policies

In November 2015, the Commission adopted **a report on the progress of the implementation of the EU Drug Strategy and Action Plan**.[46] Key findings, highlighted by the Commission, included that half of Member States had implemented anti-drugs campaigns in recreational settings; more than half targeted drug-related crime over the internet; and that half of the EU28 had entered into cooperative arrangements with non-EU countries. Another outcome was the reduction of heroin and cocaine consumption at an EU level. Further aspects of EU drug policy implementation which were highlighted by the Commission as working well included:[47]

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[44] EMCDDA, Perspectives on drugs: The EU drugs strategy (2013-20) and its action plan (2013-16), May 2015.

[45] http://ec.europa.eu/dgs/home-affairs/financing/fundings/drug-policy-initiatives/index_en.htm

[46] European Commission, Report on progress in the EU's 2013-2020 Drugs Strategy and 2013-2016 Action Plan on Drugs, COM(2015) 584 final, Brussels, 27 November 2015.

[47] Interview European Commission, DG Home, Unit D.3, 14 September 2016.

- The ongoing work on the development and implementation of **indicators on drug supply reduction**, as a result of the 2013 Council Conclusions on improving the monitoring of drug supply in the EU;
- The **coordination** between the different services involved in drug policy at EU level, including the Council's Horizontal Working Party on Drugs;
- For the EU to be able to speak with **one voice at the international level**: for example the EU adopted a common position on UNGASS 2016,[48] supported by all Member States. In this respect, EU drug policy can be considered a model area compared to other EU policy areas.

The Commission also reported on the effectiveness of the early warning system: 98 new substances were detected for the first time in 2015 and reported through the EWS.[49] A representative of the EMCCDA noted more generally that the EU Drugs Strategy was set up in a broad way, which allowed it to be flexible to respond to the changing needs over time.[50]

DG Home's Unit D3 noted the following **current challenges** in the area of EU drug policy:[51]

- The ongoing drug problem which is becoming more and more **complex**: such as the increase of poly-drug use, the increasing availability and accessibility of new psychoactive substances, the increased potency of drugs and related health risks, the increased use of the internet as the market place for drugs, as well as the specialised needs of the older generation of drug users;
- The need for engagement at **political level** of drug policy: Other policy areas such as migration and economic issues are considered more urgent at the political level and overshadow the importance of drug problems;
- The effect of the **economic crisis**: The economic crisis seems to have reduced the capacity of Member States to fund activities related to drug policy. This is also the case for third countries, which have an increased need for capacity building.

The EMCDDA also noted as a challenge the innovation in chemistry, which allows for the production of very potent substances which are very small in terms of volume, and therefore very easy to transport for the purpose of drug trafficking.[52]

However, some organisations have been more critical on the EU action in the area of drugs. The **Global Commission on Drug Policy (GCDP)** has publicly called for greater intervention by the EU, as well as Member States, on the international stage. The **International Drug Policy Consortium (IDPC)** published a report in 2013 on the effectiveness of the Strategy and Action Plan. It welcomed the fact that objectives were clearly stated in the Strategy, which would make evaluation easier, and the reference to human rights standards and obligations. However, the IDPC criticised the way in which the strategy was conceptually structured, categorising activities either under demand or supply reduction. With respect to the current EU Action Plan, the IDPC argued that the actions

[48] European Union, Common Position on UNGASS 2016, April 2016.
[49] EMCDDA Database.
[50] Interview representative EMCDDA, 7 September 2016.
[51] Interview European Commission, DG Home, Unit D.3, 14 September 2016.
[52] Interview representative EMCDDA, 7 September 2016.

included in the Action Plan were too broad in nature and it criticised the lack of information on whether the resources to be used for each of the priorities of the Strategy.[53]

The EU Drugs Strategy 2013−2020 and the Action Plan on Drugs 2013−2016 have not been evaluated yet. The **mid-term evaluation** is planned to be completed by the beginning of 2017.[54] In addition, upon conclusion of the Drugs Strategy and its Action Plans by 2020, the Commission is requested to initiate an overall **external evaluation** of their implementation. The evaluations will measure the overall effectiveness of implementation through the REITOX/EMCDDA over-arching indicators set up in the 2013−2016 Action Plan.

The second Action-Plan (2016-−2020)

The findings from the mid-term evaluation, as well as the findings from the **Public Consultation**,[55] launched by the European Commission in March 2016, will inform the decision of the Commission to present a new Action Plan, as well as its preparation. As a second Action Plan would fall within the framework of the current EU Drugs Strategy, it would still follow the same structure around drug demand reduction, drug supply reduction and the three cross-cutting themes.[56] The Commission noted the following issues which could be an area of focus in the future:[57]

- **The increasing role of the internet for the sale of drugs:** In June 2016 an Expert Meeting on Internet and Drugs took place in Brussels, which indicated some options/priorities for future action[58];
- The need to review the range of **dialogues with third countries** on drug policy: for example there is a lack of dialogue with China, which is an important country as it is a key producer of NPS;
- Further information on risks and dangers of the use of cannabis, as well as on the different national approaches taken in this area.

The EMCDDA also noted the importance of the next Action Plan to be focused on coordination and cooperation, in addition to the topic of NPS and synthetic drugs that already dominated the debate in recent years.[59]

3.5. Cooperation

EU−international cooperation activities focus on specific drug trafficking routes and cover a wide range of regions and types of cooperation. A flagship EU cooperation programme is the Cooperation Programme on Drugs Policies between Latin America and the EU (COPOLAD). The EU funds two main transnational programmes on drug-related cooperation, namely the cocaine route programme including the countries of Latin America and the Caribbean (through the Community of Latin American and Caribbean States (CELAC) and West Africa, and the heroin route programme (from Asia through the Balkans).[60] Expert dialogues take place with Central Asia, the Eastern Partnership and the Western Balkans and with partners like the US and Russia.

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[53] IDPC, Advocacy note: The European Drugs Strategy 2013−2020, July 2013.

[54] Interview European Commission, DG Home, Unit D.4. Anti-Drugs Policy, 14 September 2016.

[55] European Commission, Public consultation for the 2016 evaluation of the EU Drugs Strategy and Action Plan on Drugs, May 2016.

[56] Interview representative EMCDDA, 7 September 2016 and Interview European Commission, DG Home, Unit D.4. Anti-Drugs Policy, 14 September 2016.

[57] Interview European Commission, DG Home, Unit D.4. Anti-Drugs Policy, 14 September 2016.

[58] See: http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/organized-crime-and-human-trafficking/drug-control/docs/background_document_en.pdf

[59] Interview representative EMCDDA, 7 September 2016.

[60] Interview European Commission, DG Home, Unit D.4. Anti-Drugs Policy, 14 September 2016.

According to the Commission, it would be in the EU's interest to increase cooperation and EU and Member State interaction with countries in Asia and Africa, including for example through the Commission on Narcotic Drugs (CND) in Vienna.

The EU also cooperates extensively with international stakeholders, including the UNODC, the International Narcotics Control Board (INCB), UNAIDS, the World Health Organization (WHO), the Council of Europe and the World Customs Organisation. At policy-making level, cooperation between the EU and the UN was noted as particularly strong, especially through the CND, as the EU has a strong presence there and is supported by the 12 Member States that also have a seat in the CND (AT, BE, CZ, HR, FR, DE, HU, IT, NL, SK, ES, UK).[61] The EU also has strong operational cooperation with the UNODC. The EU is the biggest donor to the UNODC, accounting for one-third of its budget: in the area of drugs the EU funded 24 capacity building projects worldwide which amounted to EUR 184 million.[62]

Finally, the European Commission has created a consultative body on drugs, the **European Civil Society Forum on Drugs.** The forum is made up of EU-wide and national NGOs working on drug prevention, harm reduction and treatment, which give the Commission advice on drug policy.[63]

More information on coordination and cooperation between the EU and international organisations and third countries is provided in Chapter 5.4.

[61] Interview European Commission, DG Home, Unit D.3, 14 September 2016.
[62] Interview European Commission, DG Home, Unit D.3, 14 September 2016.
[63] Interview European Commission, DG Home, Unit D.3, 14 September 2016.

4. MEMBER STATE DRUG POLICIES

This section presents an assessment of Member State legal frameworks and approaches to drug policy based on the data collected in seven EU case study countries (see Appendix A). The case studies present country-specific data on the drug scene, the legislative and policy framework and the associated drug-related activities.

The following section first provides the context in which the assessment of Member State legislative and policy frameworks should be understood – this context includes the rationale by which the case study countries were selected and a comparative analysis noting the similarities and differences of the drug scenes in the case study countries. After the context is established, a comparative analysis of the legislative and policy frameworks is presented.

4.1. Setting the scene

The selected seven case study countries and the rationale for their selection are presented in Table 5. The selection was conducted in collaboration with the study experts and the European Parliament and seeks to cover a range of approaches to drug policy across the EU.

Table 4: Rationale for selected EU case study countries

Czech Republic (CZ)
 The Czech drug-related legislation is quite extensive and includes laws as well as various by-laws. The most important feature of the Czech legislative system is that criminal law does not consider drug use to be a criminal offence. Additionally, Czech drug policy, historically, has shifted from a fairly liberal policy to a quite repressive one and back again due to detailed evaluations which reported on the negative impact of the repressive policies.
Germany (DE)
 Germany's Federal system presents an interesting element for exploration as there are considerable differences in state-level approaches to drug policy.
Netherlands (NL)
 The Netherlands has a drug policy focused on the reduction of harm to users and public nuisance by drug users as well as to prevent recreational drug use and the criminalisation of drug users. The key objectives of the policy were to prevent the criminalisation of drug users and to separate drug markets.
Poland (PL)
 Focusing on Poland brings an important insight into a central-eastern European approach to drug policy, and will act as an interesting comparator to the Czech approach. Poland also has a long tradition of therapeutic communities for drug abuse rehabilitation.
Portugal (PT)
 Since 2001, Portugal has adopted an approach focused on harm reduction. One aspect of this approach was the decriminalisation of the use and possession of controlled drugs. The possession of controlled drugs is only an administrative offence if the quantity held is equivalent to (or less than) 10 days' consumption. Additionally, the use of 'dissuasion panels' to assess drug offenders is similar to drug courts but led by health professionals.

Spain (ES)

Presence of cannabis social clubs is of interest, offering a not-for-profit way in which to distribute cannabis in opposition to the commercialisation approach that might happen elsewhere.

Sweden (SE)

Sweden has a zero tolerance approach to controlled drugs, governed by the primary aim of a 'drug-free society'. Achieving this aim is driven primarily by law enforcement and a repressive and restrictive approach.

Building on the above rationales, and in preparation for the analysis of Member State drug policies and legal frameworks, it is important to understand the needs related to drug use and misuse in each of the seven Member States. As documented in the European Commission's Better Regulation Guidelines[64], high quality policies are built on a clear assessment of the needs which the policy should address. Therefore, in the case of drug policy, Member States should base policy decisions on evidence of the use and misuse of drugs. Thus, a comparison of the drug scenes that are driving drug policy across the EU are presented below through an examination of the Member State similarities and differences with regard to three elements: **i) drug use; ii) health consequences of drug use; and iii) drug markets.**

Drug use

There are two important similarities in the use of drugs across the examined Member States. The first key trend is the position of **cannabis as the dominant drug** being consumed across all Member States examined, without exception. According to EMCDDA estimates, approximately 16.6 million young Europeans (ages 15–34) used cannabis within the last year (i.e. last year users).[65] This represents significantly more last year users than for cocaine, MDMA and amphetamines combined (around 5.8 million) and nearly seven times more last year users than cocaine, the second most commonly consumed drug with approximately 2.4 million last year users.

The second key similarity is the **decrease in opiate use** across the majority of case study countries in the recent past. Given the hidden nature of opioid use and the very low figures reported, general population prevalence surveys are not considered to be robust.[66] This means that researchers are required to draw on indirect statistical extrapolations in order to understand this phenomenon. One example of this is examining the number of treatment entrants as a result of opioid use – a figure which is reported to be declining or stable across the EU.[67] Furthermore, EU-wide heroin possession / use and supply offences have decreased in the past 10 years – heroin is the most commonly used opioid.[68] In the case

[64] European Commission (2015) Commission Staff Working Document: Better Regulation Guidelines {SWD(2015) 110 final}, p.49.

[65] European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg.

[66] European Monitoring Centre for Drugs and Drug Addiction (2016), Heroin drug profile: Prevalence data. Accessed on 01.11.16 at: http://www.emcdda.europa.eu/publications/drug-profiles/heroin

[67] European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg.

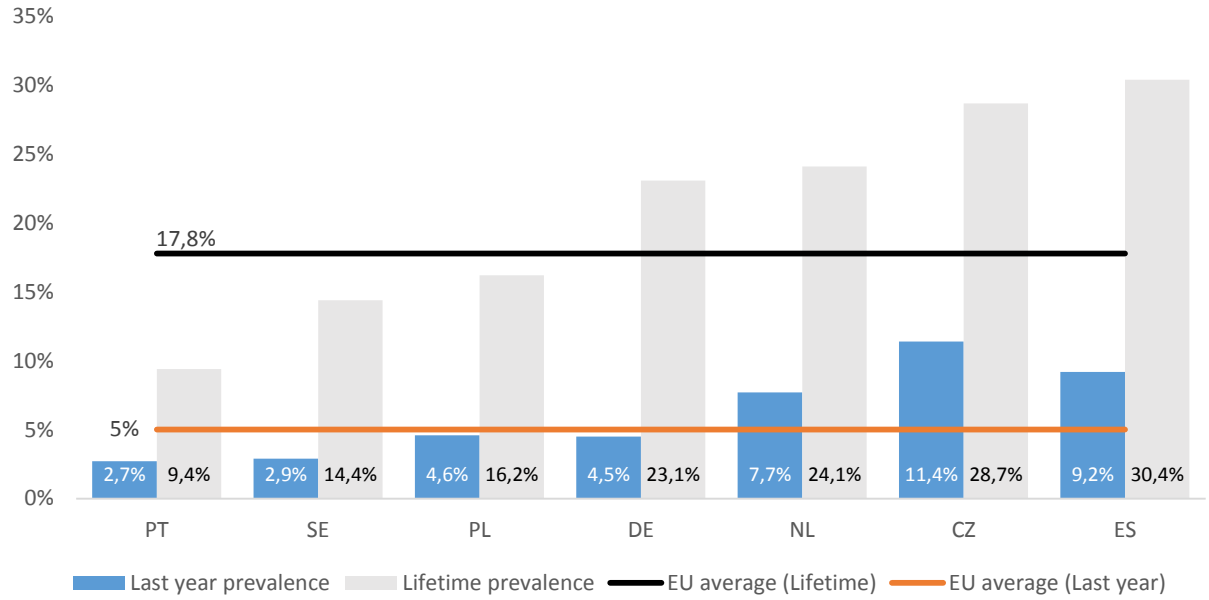
[68] Ibid, p.34.

study countries, for instance, the available data on the number of heroin-related supply and use offences reported a decrease of approximately 41% between 2005 and 2014.[69,70]

However, beyond the similarities noted above, there is also significant variance in drug use across the spectrum of controlled drugs. For example, although cannabis is the most used drug across all countries, the prevalence data across those countries experience significant variance, according to available data and taking into account the caveats that accompany these data (see section 1). In the seven case study countries studied (see Figure 3), last year cannabis prevalence figures range from 2.7% (PT) and 11.4% (CZ), and lifetime prevalence figures range from 9.4% (PT) to 30.4% (ES).

Furthermore, cannabis trend data suggest differences across the case study countries. In its 2016 European Drug Report,[71] the EMCDDA reported statistically significant decreasing trends in last year cannabis prevalence in DE and ES (2000−2014). Over the same period (2000−2014), the CZ and SE were reported to have experienced statistically significant increases in last year cannabis prevalence.

Figure 3: Lifetime and last year prevalence rates for cannabis in seven MS



Source: EMCDDA, Statistical Bulletin 2016

Beyond cannabis, drug use varies by country, with local trends identified for specific drugs (see Figure 4). The Netherlands, for example, has comparatively high lifetime use figures for cocaine (1.5%), amphetamines (1.3%) and ecstasy (2.4%).[72] It is posited that this is related to the increase in recreational drug use by younger age cohorts at festivals, clubs and parties. As reported in the NL case study, the last year prevalence rates for 15−35-year-old party-goers were much higher, when compared with the general population, for cannabis (by 3x), cocaine (by 10x), and ecstasy / MDMA (by 20x).[73]

[69] No data are available for NL and SE for these data categories.

[70] European Monitoring Centre for Drugs and Drug Addiction (2016), Statistical Bulletin 2016

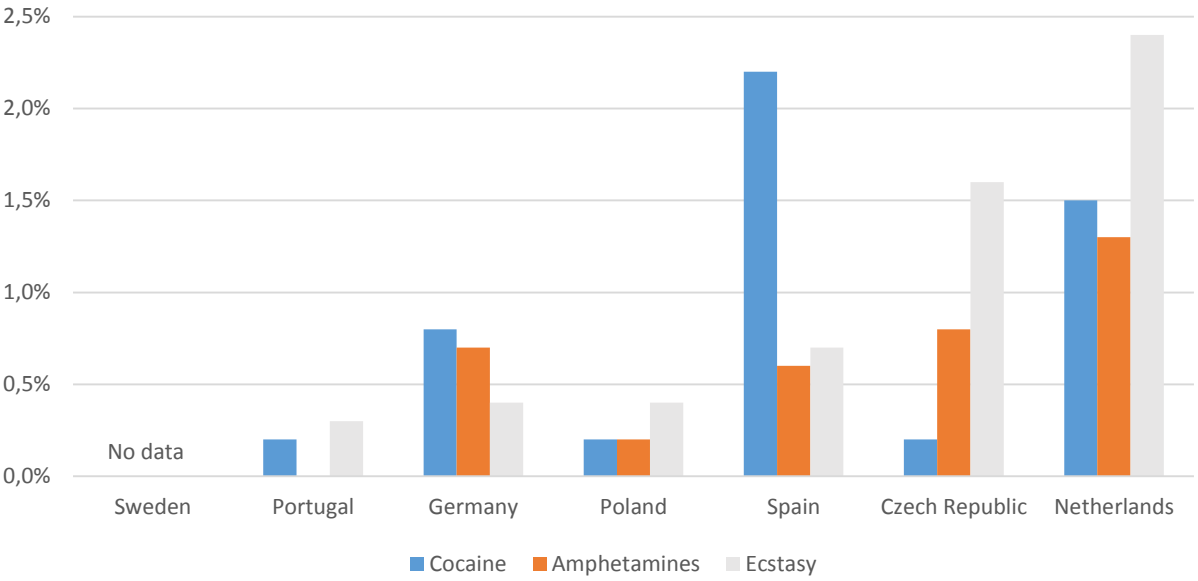
[71] European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg.

[72] European Monitoring Centre for Drugs and Drug Addiction (2016), Statistical Bulletin 2016.

[73] Nabben T., Benschop m A. & Korf D. J. (2014) Antenne 2013. Trends in alcohol, tabak en drugs bij jonge Amsterdammers. Amsterdam: Rozenberg Publishers.

The variety in drug use across the EU is also demonstrated by the comparatively low lifetime prevalence rates across all drug types in some countries (e.g. PT and PL) and the high lifetime use figures for cocaine in ES (2.2%) and ecstasy in CZ (1.6%). Drug use data are not collected in SE.

Figure 4: Lifetime prevalence for cocaine, amphetamines and ecstasy in seven MS



Source: EMCDDA, Statistical Bulletin 2016

Health consequences of drug use

Drug use and misuse can impact the health of drug users in a variety of ways; these health consequences of drug use, as will be highlighted in subsequent sections, are significant drivers of Member State drug policy. The most pertinent health consequences include the transmission of infectious diseases – most notably, the hepatitis C virus (HCV) and the human immunodeficiency virus (HIV); and drug-related deaths.

In order to examine the situation related to these health impacts across the case study countries, it is important to understand the extent to which injecting drug use and opiate use exist.

Injecting drug users, for example, are a key population affected by HCV and HIV infections due to transmission primarily through sharing needles and syringes. In fact, it has previously been found that estimates for the prevalence of HCV antibodies – a proxy for HCV infection – were on average nearly 50 times higher for injecting drug users compared with the general population.[74]

As can be seen in Figure 5, estimates of injecting drug use are generally low (between 0 and 10 individuals per 1,000 population). Of the case study countries examined for this study, NL and ES have significantly lower levels of injecting drug use when compared with CZ. However, 14 countries within the EMCDDA's remit[75] do not have recent estimates available; a 'significant information gap'.[76]

[74] Hahné, S. J., Veldhuijzen, I. K., Wiessing, L., Lim, T. A., Salminen, M. and Laar, M. (2013), 'Infection with hepatitis B and C virus in Europe: a systematic review of prevalence and cost-effectiveness of screening', BMC Infectious Diseases 13, p. 181.

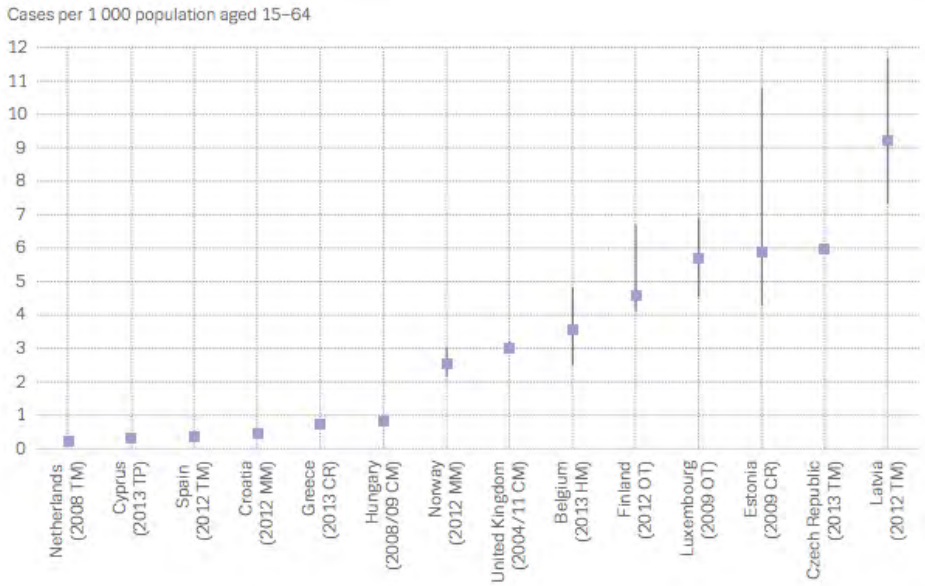
[75] Covers the EU28, Norway and Turkey.

[76] EMCDDA (2015) Drug-related infectious diseases in Europe: Update from the EMCDDA expert network.

Trend data have also been analysed by the EMCDDA,[77] demonstrating that injecting drug use has declined in Europe in recent years (2000–2011).

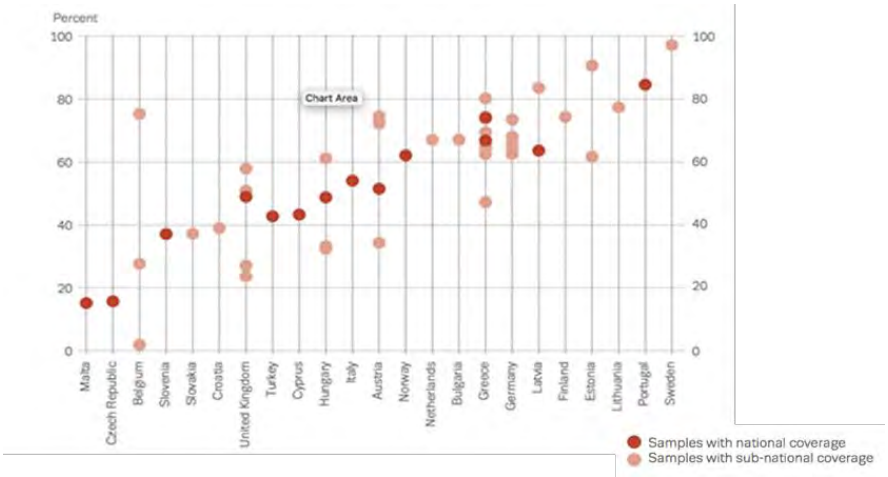
With regard to **HCV infections**, it has been found that anti-HCV prevalence varies significantly across the EU, from 15% to 84% (Figure 6). Across the examined case study countries, these data also vary. The Czech Republic, for instance, reports comparatively low levels of HCV infection, whereas SE and PT report high levels of HCV infection when compared with the other countries.[78]

Figure 5: Prevalence estimates of injecting drug use (2008–2013 data)[79]



Methods: CR, capture-recapture; CM, combined method; TM, treatment multiplier; TP, truncated Poisson; OT, other; HM, HIV multiplier; MM, mortality multiplier. See also citation.
Source: Table PDU-1-2 in the 2015 EMCDDA Statistical Bulletin

Figure 6: Anti-HCV prevalence (%) among people who inject drugs in the European Union, Norway and Turkey, 2013–14[80]



[77] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2015a), Estimating trends in injecting drug use in Europe using national data on drug treatment admissions, technical report, EMCDDA, Lisbon.

[78] EMCDDA (2016) Hepatitis C among drug users in Europe: Epidemiology, treatment and prevention, p.23.

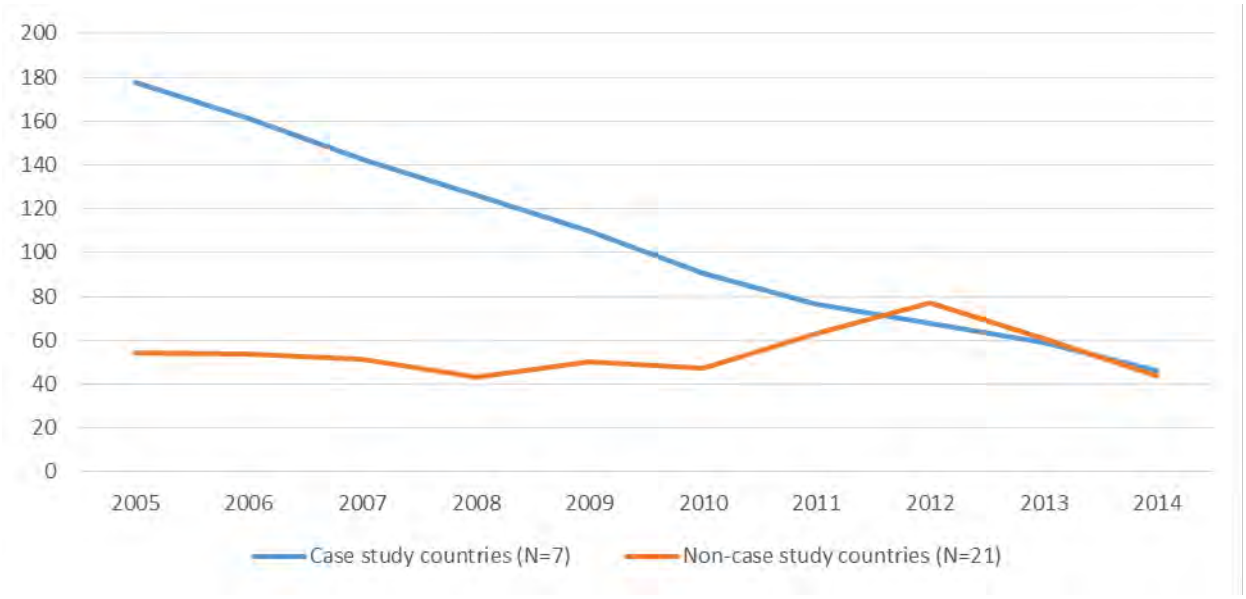
[79] EMCDDA (2015) Drug-related infectious diseases in Europe: Update from the EMCDDA expert network, p.5.

[80] EMCDDA (2016) Hepatitis C among drug users in Europe: Epidemiology, treatment and prevention, p.23.

Source: Studies with national and subnational coverage covering the period 2013-14, reported to the EMCDDA by REITOX national focal points.

In terms of **HIV infections**, new diagnoses are reported to have fallen in recent years. When reviewing new notifications across the EMCDDA's remit, a clear decline (48%) can be seen from 2005 (2 379) to 2014 (1 236). Among the selected case study countries, this trend is even more pronounced. A reduction of 74% has been recorded over the 10 years, although the starting point was much higher as a result of significant numbers of HIV diagnoses in PT, ES and PL (Figure 7).

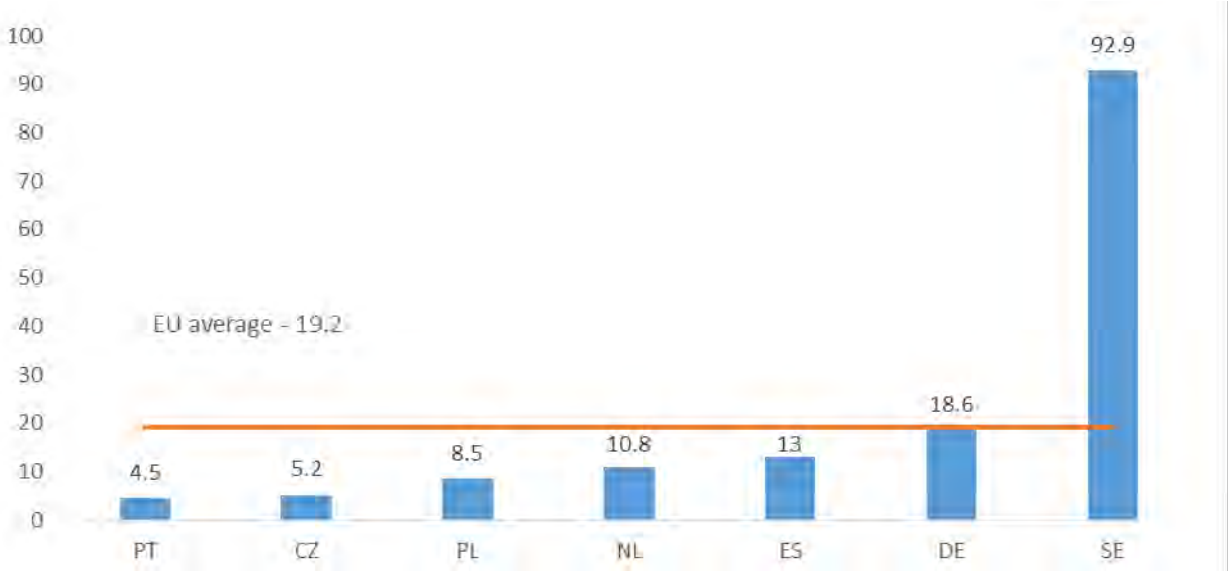
Figure 7: Average number of HIV notifications per year (2005–2014): Case study countries vs non-case study countries



With regard to **drug-induced deaths**, data are generally low across the case study countries but do vary significantly. As can be seen in Figure 8, PT, CZ and PL all have drug-induced mortality figures below 10 individuals per million. In contrast, however, SE has a drug-induced mortality figure of almost five times the EU average. A key trend related to drug-induced deaths is their close association with opiate use. In fact, opioids are found in 82% of fatal overdoses across the EU.[81]

[81] European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg.

Figure 8: Drug-induced mortality among adults aged 15–64 (per million) for seven MS



Further trends within the EU drug scene that are likely to have health consequences include the **high and/or increasing purity and potency of most drugs; the high rate of polydrug use; and the fact that high-risk drug user cohorts are ageing**.

Both cannabis resin and herb have seen significant increases in potency since 2006; and heroin and cocaine purity have seen a resurgence in the last few years after experiencing declining purity between 2006 and 2012. However, the biggest changes have been seen in the purity of amphetamine and MDMA. In fact, MDMA has doubled its purity since 2006 and amphetamine has seen a significant increase in the last few years. Furthermore, the purity of methamphetamine is as high as 73%, with a range of 28% to 67%.[82]

Polydrug use patterns are reported to be the norm among individuals with drug problems[83] and the cohort of high-risk drug users is increasing in age, resulting in increased health impacts among this group.[84] In fact, the median age of clients entering treatment for opioid use increased by five years between 2006 and 2013, while the ages of users of other drugs remained stable. In the same time period, the average age of drug-induced deaths increased from 33 to 37 years.[85]

Drug markets

Conservative estimates for 2013 place the EU retail market for illicit drugs between EUR 21 billion and EUR 31 billion. Mirroring the drug use data presented above, cannabis products represent the primary EU drug market, with an estimated retail value of around between EUR 8.4 billion and EUR 12.9 billion. However, even taking into account the significant differences in use, the higher costs of other drugs place them relatively close to cannabis in terms of market value. The heroin market, for example, is estimated to be worth between EUR 6 billion and 7.8 billion and the cocaine market is valued at around

[82] European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg.

[83] *Ibid.*

[84] EMCDDA (2015), Drugnet Europe: Newsletter of the European Monitoring Centre for Drugs and Drug Addiction, April-June 2015.

[85] European Monitoring Centre for Drugs and Drug Addiction (2015), European Drug Report 2015: Trends and Developments, Publications Office of the European Union, Luxembourg.

EUR 4.5−7 billion.[86] Although these data tell the story of a significant market, it is important to take them in the context of the very limited data on which they are based, and they should therefore be viewed as initial minimum estimates.

Other key indicators to examine with regard to drug markets are trends in **price and purity**. As detailed above, purity and potency are trending upwards for the majority of drugs. For both cannabis resin and herb, prices have greatly increased, with the 2014 value sitting at nearly double the value in 2006. However, MDMA, amphetamine, cocaine and heroin have seen slight decreases in price over the same time period.[87]

As is the case for drug use, drug markets vary across the EU. One example is the level of domestic cultivation. A selection of the countries examined have prominent domestic cultivation, although the drugs being produced vary. Poland, for instance, has experienced increasing cultivation of amphetamines and methamphetamines, whereas cannabis is the main drug cultivated domestically in DE and NL. In addition, CZ is reporting increases in domestic production of cannabis and the subsequent establishment of organised crime groups.

Furthermore, a range of indicators suggest increasing domestic cannabis cultivation within the EU. It is reported that the increased availability of cultivation equipment, coupled with increasing knowledge of the technical elements of cultivation, has resulted in an increase in indoor cultivation.[88]

Although domestic production for domestic use is becoming more prominent for select drugs in certain Member States, there is still significant trafficking of illicit drugs into and within the EU. Box 1 details the key characteristics in this regard by drug types.

Box 1: Drug trafficking into and within the EU by drug type

Cannabis: As described above, domestic cannabis cultivation has become increasingly common in recent years. Data on the movement of illicit drugs within the EU appear to corroborate this finding. For instance, cannabis entering PL is trafficked primarily from NL, BE, DE and CZ, and cannabis entering SE reportedly originates in NL, BE and CZ.

The main non-EU source of cannabis entering the EU is Morocco − with ES and PT found to be both destination and transit countries. In recent years, new routes are reported to have emerged through Libya and Egypt.

Cocaine: The Netherlands appears to be a key transit country for cocaine coming to the EU from South America (primarily Colombia, Bolivia and Peru) via Africa − CZ and PL both report cocaine trafficking through NL. In addition, PT experiences direct trafficking of cocaine from Brazil.

Heroin: Afghanistan is the key country of origin for heroin entering the selected case study countries (as noted by DE, ES, NL, PL and SE). However, there are a variety of trafficking routes in use. The primary route is through the Balkans, as reported in CZ, ES, NL, PL and SE. Prior to entering the EU, heroin can move through Iran and Turkey.

Synthetic drugs: As detailed above, synthetic drugs are experiencing growth in terms of domestic cultivation in the case study countries examined for this study. The Netherlands is reported as a key source for synthetic drugs (including amphetamines, methamphetamines and ecstasy) entering CZ, DE, ES and SE. It is also found that PL is an

[86] European Monitoring Centre for Drugs and Drug Addiction (2016), European Drug Report 2016: Trends and Developments, Publications Office of the European Union, Luxembourg.

[87] Ibid, p.19−29.

[88] EMCDDA (2016), New developments in Europe's cannabis market. Accessed on 01.11.16 at: http://www.emcdda.europa.eu/topics/pods/cannabis-markets-developments

important country of origin for methamphetamines and ecstasy entering CZ, DE, FR, SE, the UK and IE.

As a result of this extensive EU-based production, only PT reports the importation of synthetic drugs from outside the EU – ecstasy from Israel.

New psychoactive substances: Sweden is the only case study country to report on trafficking of NPS, simply stating that these substances are mainly trafficked from China. This finding is in line with the EMCDDA's findings on NPS – i.e. that the majority are shipped from China to the EU.[89]

Another key emerging element impacting on the drug scenes of the Member States examined is the role of the internet in facilitating drug retail practices. Since 2009, the internet, in particular with the dark net and the emergence of cryptocurrencies, has seen a proliferation of illicit drug stores, the prime example being Silk Road. These 'hidden' drug markets are predicted to experience exponential growth.[90]

The drug scenes presented in the case studies comprise a set of complex and interactive elements related to the profiles of drug use and users, the health consequences of drug use and the workings of the drug markets. Although some similarities can be demonstrated and some EU-level trends can be presented, it is clear that the available data illustrate that each Member State has its own specific drug scene.

4.2. Approaches to drug policy in the case study countries

A comparative analysis of Member State approaches to drug policy, as explored through the case studies, is included in this section. It first outlines the ideologies encountered that impact drug policy before discussing the stated objectives, aims and activities being delivered under the different approaches to drug policy. In addition, Box 2 presents an analysis of the organisations involved in drug policy.

Box 2: Analysis of the organisations involved in drug policy across the seven MS

Organisations involved

All case study countries recognise that coordinating drug policy requires engagement of stakeholders from a range of traditionally divided ministries / departments, covering health and social care and the justice system.

In terms of the organisations involved in each case study country, two different models are employed. A range of Member States, for instance, incorporate the responsibility for drug policy in a single dedicated organisation, with the presence of stakeholders from all groups (e.g. SICAD in PT and the National Bureau for Drug Prevention in PL), whereas other Member States keep these separate (e.g. SE, NL).

In all the non-EU case study countries it was found that effective cooperation and coordination were important factors in their perceived success. For instance, a key role of the federal entities responsible for drug policy in Switzerland is to facilitate cooperation between law enforcement actors and primarily those implementing harm reduction measures – two groups of stakeholders that, historically, have held significantly disparate views. Although these entities are not led via a central body, they have a clear mandate to facilitate cooperation and coordination.

[89] EMCDDA-Europol (2015) Annual Report on the implementation of Council Decision 2005/387/JHA.

[90] Buxton, J. and Bingham, T. (2015) The Rise and Challenge of Dark Net Drug Markets: Policy Brief 7. Global Drug Policy Observatory (GDPO) and Swansea University.

In the US, stakeholders from both Washington and Colorado highlighted the value of, and need for, collaboration across a broad range of stakeholders, supported and led by a central body. In this instance, Washington did not establish a central body and recognised this as a gap in their policy development in hindsight.

Uruguayan stakeholders reported that cooperation across a range of stakeholder groups was a highly valued input to the policy development process. As a result, Uruguay undertook an extensive consultation process in the development of its cannabis regulation bill, which received input from a wide-range of stakeholders including academic contributors, world-renowned drug policy experts, and multiple government institutions.

One of the key differences in the policy approaches of the case study countries relates to their underpinning ideologies. It is found that Member States fit along an ideological spectrum from a restrictive approach, characterised by a primary focus on law enforcement and criminal justice activities, to a more liberal approach, characterised by a primary focus on reducing the health and social harms experienced as a consequence of drug use.

In terms of the case studies discussed here, SE is consistently reported to be the most restrictive Member State in terms of its approach to drug policy, with an ideology based on drug addiction as a biochemical dependency and a policy focused on achieving a drug-free society. DE also employs a policy based on the idea of law enforcement as a deterrent to drug use but, as a result of Germany's federal system, approaches vary by Länder. At the other end of the scale, CZ (as evidenced by the below quote), PT and the NL employ primarily harm reduction approaches, viewing drug misuse more as a psychosocial challenge.

'The Czech Republic is a devoted supporter of the principles of a rational and effective drug policy oriented towards human rights and public health'

Dr Svatopluk Němeček, Minister of Health (CZ)
Vienna, 14 March 2016

It is reported that this spectrum reflects long-held cultural views on 'drugs' in the broader sense, including alcohol for instance. In SE, alcohol was viewed as problematic; for example, until 1955 beer with an alcohol content above 4% could only be purchased in a pharmacy with a doctor's prescription, and households were rationed until 1955. Furthermore, SE has a retail monopoly in place – Systembolaget[91] – in order to control alcohol sales and taxes alcohol heavily.[92] In contrast, it was noted in the expert workshop that southern European countries have historically considered wine as a food item.

However, even with these differences, all seven Member States examined refer to the two major types of approaches in their drug policy objectives: i) drug demand reduction; and ii) drug supply reduction. For example, in SE, where the approach to drug policy is focused on restricting access and use, the drug strategy's key objectives focus on improving the situation with regard to the potential harms of drug use, as documented in Box 3 below.

[91] https://www.systembolaget.se/

[92] Swedish Retail Institute (2009) Swedish Alcohol Policy: An effective policy?

Box 3: Aims and objectives of Sweden's drug strategy

The Swedish current approach to drug policy is primarily outlined in the 2016–2020 strategy for alcohol, narcotics, doping and tobacco (ANDT). This strategy is working towards achieving the following overarching objective:

'A society free from narcotic drugs and doping, with reduced alcohol-related medical and social harm and reduced tobacco use'

In order to achieve this objective, the following six objectives are detailed:

1. *Access to alcohol, narcotics, doping substances and tobacco must be reduced.*
2. *The number of children and young people who start to use narcotics, doping substances and tobacco or who have an early alcohol debut must be progressively reduced.*
3. *The number of women and men, as well as girls and boys, who become involved in the harmful use or abuse of or dependence on alcohol, narcotics, doping substances or tobacco must be progressively reduced.*
4. *Women and men, as well as girls and boys, with abuse or addiction problems must be given greater access to good-quality care and support on the basis of their circumstances and needs.*
5. *The number of women and men, as well as girls and boys, who die or are injured as a result of their own or others' use of alcohol, narcotics, doping substances or tobacco must be reduced.*
6. *An EU and international approach to ANDT that is based on public health.*

It is clear that reduction of access is a key driver, but many of the objectives (including 3–6) also engage the policy with reducing the potential harms associated with drug use and misuse.

For PT, at the other end of the spectrum, objectives focusing on prevention of drug use through the provision of information and investing resources in treatment and social integration for drug addicts are complemented by an objective of repressing the illicit traffic of drugs.

This trend is also true of the countries in between the ideological extremes. The four 'pillars' of the CZ policy, for example, range from reduction of availability to implementing harm reduction initiatives. These objectives are detailed in Box 4.

Box 4: Aims and objectives of the Czech Republic's drug strategy

The **Czech Republic** reports on a comprehensive, multidisciplinary and well-balanced approach that includes drug supply reduction, drug demand reduction and reduction of the harms associated with drug use. The four main pillars of the policy plan are:

1. *Reducing the level of occasional and experimental drug use through primary intervention;*
2. *Reducing the level of problems linked to intensive drug use by offering treatment and social reintegration;*
3. *Reducing drug-related risks to individual through harm reduction initiative. The 2013–15 Action Plan also introduced a number of new tasks, including facilitating harm reduction treatments for hard-to-reach and socially excluded communities;*
4. *Reducing the availability and supply of drugs.*

Furthermore, three supporting domains are identified: coordination and funding; monitoring, research and evaluation; and international cooperation.

Further trends with regard to the policies of the selected Member States are the integration of drug policy with other addiction policies such as alcohol and gambling (e.g. SE, PT, CZ) and the increased focus on targeting younger age groups (e.g. NL, PT, SE).

With regard to the consolidation of addiction policies, PT is a key example. The current direction for PT's drug policy was initially outlined in the Portuguese Drug Strategy (1999).[93] This sole focus on drugs continued until the conclusion of the 2005-2012 National Plan on Drugs and Drug Addiction, which was enacted alongside a similar policy for alcohol-related problems – the National Plan for Reducing Alcohol-Related Problems 2010–2012.[94] Since the publication of the current policy document in 2013, drugs, alcohol and gambling-related problems are tackled together in the same policy document – the National Plan for the Reduction of Addictive Behaviours and Dependencies 2013–2020.[95]

The trends related to targeting younger age cohorts can be demonstrated through the Dutch approach to drug policy. In fact, in November 2015, the Dutch Government (Ministry of Health, Wellbeing and Sport) established a new policy document specific to drug prevention (entitled Drug Prevention Policy Vision – 'Beleidsvisie drugspreventie'[96]). A primary objective of this new policy was to address the so-called normalisation of drug use among young adults in nightlife settings; a list of six measures were announced (see Box 5).[97]

Box 5: Specific measures to address drug use among young adults (NL)[98]

Drug Prevention Policy Vision ('Beleidsvisie drugspreventie')

Six measures announced to prevent the normalisation and harm of drug use by young adults in nightlife settings:

i Supporting parents in talking to their adolescent children about drugs by informing them of drugs use and its dangers (awareness raising);
ii Informing young people about the risks of drug use by modernising the drug education programme for schools;
iii Supporting municipalities in their drug prevention policies;
iv Cooperating with the events and nightlife industry;
v Cooperating with health sector professionals; and
vi Increasing monitoring of the drugs market and provide warnings in case of high risk drugs.

Although Member State policy statements echo one another, covering the major policy focuses, variations can be ascertained in certain areas from the terminology in use – e.g. SE is the only country to refer to drug addicts as abusers – but primarily the variations in approach to drug policy are more evident when the activities implemented under the Member State policy documents are analysed.

As mentioned above, all the Member States examined implement activities in the traditional four 'pillars' of drug policy: i) prevention; ii) harm reduction; iii) treatment /

[93] Portuguese Drug Strategy. (1999). Retrieved from http://www.emcdda.europa.eu/system/files/att_119431_EN_Portugal%20Drug%20strategy%201999.pdf.

[94] REITOX National Focal Point, Portugal (2012). 2012 National Report to the EMCDDA: Portugal – New Developments, Trends and in-depth information on selected issues.

[95] General-Directorate for Intervention on Addictive Behaviours and Dependencies, Portuguese Ministry of Health (2014). National Plan for Reducing Addictive Behaviours and Dependencies 2013–2020: Executive Summary.

[96] Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie, 3 November 2015, p. 1.

[97] *Ibid.*

[98] Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie, 3 November 2015.

therapy; and iv) law enforcement. Furthermore, the majority of Member States examined implement activities aimed at social reintegration and stakeholder cooperation.

However, the extent to which these activities exist, and the balance between these activities, differ greatly across the case study countries. In order to illustrate this, Box 6 presents contrasting examples from SE and PT.

Box 6: Balance of drug policy-related activities in SE and PT (see Appendix A)

Sweden

Sweden's primary objective is a completely drug-free society. Their activities reflect this, primarily focusing on law enforcement action to remove drug supply and demand.

Although the availability of treatment and harm reduction interventions is increasing, Sweden currently has low availability and significant restrictions when compared with other Member States – e.g. treatment options are primarily high threshold programmes with a focus on abstinence.

Portugal

The primary focus of Portugal's activities in the field is reducing the individual and societal harms associated with drug use. This translates into extensive harm reduction and therapy options, including needle and syringe exchange programmes, and low threshold substitution programmes through three levels of outpatient care.

Furthermore, the criminal justice system supports this approach by focusing solely on organised crime groups and presenting any apprehended drug users to harm reduction interventions.

As can be seen above, the drug policy approaches of Sweden and Portugal differ significantly in practice, particularly with SE focusing on the role of criminal justice actors and PT focusing on the harm reduction / treatment programmes.

Factors that influence this balance of activities include the prevailing ideologies, as discussed above, including the historical development of the policy approach, and the Member State specific drug scene (see section 4.1).

Conclusion

Section 4.1 found that the drug scene in each case study country is the sum of a range of complex and interrelated elements – including drug use, the health consequences of drug use and the retail market for drugs – which contribute to significant variance across those countries. In the same way, although the Member State policy documents are similarly termed, the approaches to drug policy analysed in this section vary significantly in practice. Historical approaches and prevailing ideologies play an important role in some Member States – for example, SE and DE retain prevailing restrictive ideologies – whereas other Member States rely more strongly on analyses of the drug scene – for example, CZ has recently changed the focus of its drug policy based on policy evaluations and PT famously overhauled its approach to drug policy based on challenges posed by the nation's drug scene.

4.3. Legal framework in the case study countries

Most of the case study countries have criminalised drug offences in their national law. This section will outline the national legal framework on drugs in the case study countries, distinguishing between four types of behaviours, namely the production of drugs, the supply of drugs, the possession of drugs and drug use. For each of these behaviours, the section will clarify whether it is a criminal or administrative drug law offence, the existence of a personal use exception, the maximum penalties and whether or not the penalty depends on the quantity or the drug type.

4.3.1. Distinctions of types of drugs in national law

The Czech Republic, ES, NL and PT distinguish between different types of drugs in their national law, which they use as a criterion to define the criminalisation of drug offences. The Netherlands and PT classify drugs into different 'lists', as shown in Table 6. In NL since 1976, the Dutch Opium Act distinguishes between hard drugs (List I) and soft drugs (List II), while PT classified the drugs in four lists.

Table 5: Distinctions of types of drugs in the national law

CZ	ES	NL	PT
Only for possession offences	**Only for supply offences**	**All drug-law offences**	**All drug-law offences**
Cannabis and other substances containing THC: 1 year	Drugs causing serious damage to health	List II (e.g. cannabis or hallucinogenic mushrooms)	List I: Cannabis and derivatives, Opiates, Coca derivative
Other substances: 2 years	Other drugs	List I (e.g. heroin, cocaine, ecstasy, amphetamines and GHB)	List II: Hallucinogens, Amphetamines, Barbiturates
			List III: Preparations with controlled substance
			List IV: Tranquilisers and analgesics

Source: Case study country reports – see Appendix A

4.3.2. Production

In CZ, DE, NL, PL, PT and SE the production of drugs is generally criminalised in law. In ES, drugs production is considered as a drug trafficking (i.e. supply) offence. In CZ, ES, NL and PT an exception to criminalisation is made for small-scale production of cannabis for personal use, while in PL and SE this is still a criminal offence. In CZ, small-scale production of cannabis for personal use is still an administrative offence. In ES, the producers can, however, be punished by a fine if the production is seen from outside.

In NL, PL and SE the penalties depend on the quantity of the drugs produced. In NL and SE, the penalty for drug production also depends on the type of drugs. In NL, for instance, higher penalties are given for drugs in 'List I' (hard drugs) than in 'List II' (soft drugs). Finally, in practice, in SE the level of the penalty is also dependent on other circumstances, such as whether the offender was involved in large-scale or professional production activities.

Maximum penalties vary among the case study countries: from six months in PL and SE to 15 years in case of aggravating circumstances in DE. In DE, aggravating circumstances include supplying narcotic substance to a minor, being part of a gang, and carrying a weapon when committing a serious drug-related offence.

Table 6: Drug law offences related to production

	Criminalisation of Drug Supply	Personal use exception for cannabis?	Penalties depend on:		Maximum penalty
			Quantity	Drug type	
CZ	**Yes**	**Yes:** Small-scale production for personal use 'tolerated' and is an administrative offence	N/A	N/A	N/A
DE	**Yes**	N/A	N/A	N/A	5 years. 15 years in case of aggravating circumstances
ES	**Not applicable** This would be considered as a criminal offence of supply / drug trafficking.	**Yes:** production for personal use is not a crime and is not punished. However, punished by a fine if the production is seen from outside	**Not applicable**, see under supply	**Not applicable** see under supply	
NL	**Yes**	**Yes:** if 5g or less plants and not for profit considered for personal use, unless two or more professional criteria are satisfied.[99]	✔	✔	12 years prison
PL	**Yes**	**No**	✔		6 months to 8 years (if large quantity)
PT	**Yes:** is a crime, no matter the amount.	**Yes:** very low amount for personal use, the offender could be directly referred to the CDT	N/A	N/A	N/A
SE	**Yes**	**No**	✔	✔	6 months to 10 years.

Source: Case study country reports – see Appendix A

4.3.3. Supply

Supply refers to the sale and trafficking (including import and export) of drugs. In all seven case study countries, drug supply is a criminal offence, with the penalty depending on the quantity of the drugs supplied. Moreover, in the NL as well as PT and SE, the penalty also depends on the type of drugs being sold. In ES, the type of drugs, in terms of the seriousness of the health damages associated with it, define the penalty. In PT, additional criteria such as the addiction of the trafficker and whether the trafficker sell drugs to finance their own consumption are also taken into account.

Maximum penalties for the drug supply vary among the case study countries from eight years in NL and 10 years in SE, to 18 years in CZ and 20 years in ES (both in case of aggravating circumstances).

[99] Aanwijzing Opiumwet (2015A003). Available here: https://www.om.nl/onderwerpen/drugs/@88338/aanwijzing-opiumwet-0/

Table 7: Drug law offences related to drug supply

	Criminalisation of Drug Supply	Penalties depend on:		Maximum penalty
		Quantity	Drug type	
CZ	Yes	✔		5 years. Up to **18 years** prison in aggravating circumstances (e.g. larger-scale offences)
DE	Yes	✔		5 years. **15 years** in case of aggravating circumstances such as supplying narcotic substance to a minor, being part of a gang or carrying a weapon when committing a serious drug-related offence.
ES	Yes	✔	✔ 100	Supply of drugs causing serious damages to health is punishable by 3–6 years imprisonment; other drugs are punishable by 1–3 years imprisonment. Aggravating circumstances: up **to 20 years and 3 months** (i.e., belong to any organised crime group)
NL	Yes	✔	✔	Sale: **8 years.** mport: up to 12 years for hard drugs (List I); up to 2 years for soft drugs (List II); up to 6 years for importing if a large quantity of soft drugs (List II).
PL	Yes	✔		6 months to **12 years**.
PT	Yes	✔	✔	**12 years** for Lists 1-III and 5 years for List IV In case of aggravating circumstances, the minimum and maximum penalties can be increased by one quarter. Financing a criminal group could lead to 10–**25 years** imprisonment and leading a criminal group is punished by 12–25 years imprisonment.
SE	Yes	✔	✔	6 months to **10 years**.

Source: Case study country reports – see Appendix A

In NL, a **special policy exists for the sale of cannabis**, called the '*gedoogbeleid*', under which coffee shops can sell cannabis without being prosecuted. This policy is described in the 'Aanwijzing Opiumwet', which states that coffee shops need to adhere to certain strict requirements, also called the AHOJGI criteria:[101]

- A: no Advertising;
- H: no sale of Hard drugs;
- O: no public nuisance (Overlast) in and around the coffee shop;
- J: no sale to minors (Jong);
- G: no sale of large (Groot) quantities:
  - per transaction (maximum 5 g)
  - maximum stock for selling of 500 gram;
- I: entry into coffee shops and sales are limited to residents (Ingezetenen) of the Netherlands.

In ES, if the offender was drug-dependent at the time of the crime, then the prison sentence may be reduced when the offender successfully completes a detoxification treatment. Similarly, in CZ, alternatives to imprisonment such as suspended sentences, community service and probation with treatment are available for drug addicts committing drug-related crime.

[100] Differentiation made between drugs causing serious damages to health and other drugs.

[101] EMCDDA, Netherlands Country overview, last updated 20 May 2016.

4.3.4. Possession

In all case study countries, except for ES, the possession of drugs is generally a criminal offence. In ES, the possession of drugs is considered as a drug supply offence. However, in CZ, ES and PT, an exception to criminalisation is made for the possession of a small quantity for personal use, which is considered an administrative offence. In some other countries possession of small quantities for personal use is criminalised, but not investigated or prosecuted in practice (NL) or prosecution is left to the discretion of the judge (DE and PL). For example, in the NL, the possession of small quantities of drugs for personal use is not subject to targeted investigation by the police and the possession of less than 0.5 g of List I drugs (hard drugs) and up to 5 g of List II drugs (soft drugs) will generally not be prosecuted. Polish law includes an option to discontinue criminal proceeding for individuals who possess a small amount of drugs for personal use. Similarly in DE, there are various possibilities within the law to refrain from prosecution depending on the substance possessed, the quantity and whether the drug is for personal use. In SE, no such exception of criminalisation or penalisation for small quantities for personal use exists.

In CZ, NL, PL and SE, the penalty for drug possession will depend on the quantity of the drugs possessed. Moreover, in NL, PT and SE, the penalty also depends on the type of drugs the person possesses. Maximum penalties for possession in countries where it is a criminal offence vary from 1 year in PT to 10 years in PL and SE.

Table 8: Drug law offences related to drug possession

	Criminalisation of Drug possession	Personal use exception?	Penalties depend on:		Maximum sentence
			Quantity	Drug type	
CZ	Yes	**Yes,** small quantity for personal use is an **administrative offence**.[102]		✔	**Criminal offence:** 6 months to 8 years **Administrative offence:** punishable by a fine up to EUR 550.
DE	Yes	**Optional:** There are various possibilities within the law to refrain from prosecution depending on the substance possessed, the quantity and whether the drug is for personal use.			up to 5 years
ES	**N/A** Possession for trafficking would be considered as a drug supply offence (see under supply)	**Yes:** possession for personal use is an **administrative offence.**[103]	**Not applicable** see under supply		**Criminal offence: Not applicable** see under supply **Administrative offence:** fine from EUR 601 to EUR 30,000
NL	Yes	**Yes:** the possession of small quantities of drugs for personal use is not subject to targeted	✔	✔	1 month (soft drugs) to 6 years (large amount of hard drugs)

[102] The Supreme Court developed a table which defines the quantities considered an administrative or criminal offences

[103] Judge may consider quantity among other factors to determine if the drug possessed is for personal use or trafficking

	Criminalisation of Drug possession	Personal use exception?	Penalties depend on:		Maximum sentence
			Quantity	Drug type	
		investigation by the police and the possession of less than 0.5 g of List I drugs and soft drugs (List II) up to 5 g will generally not be prosecuted.			
PL	Yes	**Optional:** option to discontinue criminal proceeding for individuals who possess a small amount of drugs for personal use	✔		Up to 10 years
PT	Yes	**Yes:** small quantity for personal use (lower than 10 daily doses) is an **administrative offence**.		✔	**Criminal offence**: Up to 1 year imprisonment or 120 day-fines (i.e. over 10 daily doses). **Administrative offence**: referral to a local Commission for the Dissuasion of Drug Abuse (CDT) where the offence is likely to be settled with treatment and counselling.

Source: Case study country reports – see Appendix A

In ES, the fine for the administrative offence can be suspended if the offender is a minor and willing to undergo treatment. The PL drug law implements the 'treat rather than punish principle', in which proceeding can be suspended and breaks in serving the sentence can be allowed when an individual is in treatment. Moreover, in PL, in minor cases the offenders can be fined or ordered to serve a sentence involving limitation/deprivation of liberty for up to one year.

4.3.5. Use

In none of the case study countries, except for SE, is drug use criminalised. In ES, drug use in public spaces is an administrative offence which can be subject to fines of EUR 601 to EUR 30 000. Similarly, in NL, drug use can be prohibited at the local level in certain circumstances (e.g. at schools or on public transport for reasons of public order or to protect the health of young people).

Moreover, in ES, in the case of drug users or supply offenders who are considered to be addicted, it is for the judge to evaluate the situation, working together with medical experts, to put drug users in a safe environment where they are not considered criminals but as persons with an illness having the right to be treated.

Table 9: Drug law offences related to drug use

	Criminalisation of Drug use	Maximum sentence
CZ	No	N/A
DE	No	N/A
ES	No, but use in public space is an administrative offence.	N/A
NL	No: Drug use is not criminalised as such, but can be prohibited at the local level in certain circumstances.	N/A
PL	No	N/A
PT	No, a small amount of drugs (lower than 10 daily doses) is considered as an administrative offence and cases are referred to the Commission for the Dissuasion of Drug Abuse (CDT).	N/A
SE	Yes	3 years

Source: Case study country reports – see Appendix A

5. EFFECTIVENESS AND ADDED VALUE OF DRUG POLICY

The tug-of-war between official drug control community and reform advocates stops evaluation from playing a constructive role in helping policy-makers to devise more effective and legitimate interventions to tackle problems associated with the production, trade and use of drugs, as well as with the policies that are commonly pursued to tackle them.

GDPO Policy Brief[104]

There are a number of impediments in assessing the effectiveness of the EU drugs policy, relating to: (i) the data limitations discussed in Chapter 1, (ii) the varying objectives of policies at Member State level (see Appendix D) and (iii) the limited impact of policies on drug demand and supply. The strong positions taken by proponents and critics of various policies make it very challenging to undertake impact evaluations of policies as a whole. Both sides are interested in protecting the health and welfare of individuals and societies.

Due to data limitation detailed in Appendix D, specific data indicators are not used to compare the approach of different Member States. A good practice when using data is to always look at trends. Despite the limitations in the comparing data between Member States, assuming that the comparative bias remains constant, one can infer the general trend of an indicator by looking at historical data. Due to issues of comparability between countries' data, it is not possible to compare the effectiveness of one policy with another. Furthermore, policy approaches differ between the countries studied, which would lead to different outcomes and evaluation methodology. For instance, the Dutch approach is one of harm reduction for users, while the Swedish approach aims at reducing the number of drug users. Therefore, the efficiency of SE's drug policy would be assessed by looking at its low drug use prevalence rate, while NL's policies would be assessed by looking at its low number of HIV infections and drug-related deaths. Bearing these limitations in mind, the data can still provide some indication of the evolution of the drug market.

This Chapter addresses:

- the **correlation between the EU strategy and Member States'** legal and policy framework and the added value of actions at EU level;
- the effectiveness of **demand-focused** measures;
- the effectiveness of **supply-focused** measures;
- the effectiveness of **coordination, cooperation and monitoring activities.**

5.1. Correlations between the EU Strategy and MS Legal and Policy Framework

The impact of policies is relatively limited on the drugs market, in terms of reducing both demand and supply, although it has had an impact on shaping the market. The impact of policies related to drugs at the EU level is further limited by the very different approaches adopted by Member States. Drug laws had existed in all Member States before the advent of a coordinated EU approach on drugs. As such, the most significant impact of the EU drug policy has been on newer Member States who had no previous national drug strategy or policy. Opinions expressed during the expert workshop carried out as part of this study highlighted how Member States having joined the EU in 2005 and later avoided the worse consequences and cycles experiences by other Member States by benefiting from a modern

[104] Schultze-Kraft, Markus and Befani, Barbara, *Getting high on impact: the challenge of evaluating drug policy*, GDPO policy brief 3, June 2014.

existing policy framework on which to base their national legislation. There is evidence that countries that have not had existing national policies have adopted EU policies wholesale, but these policies are so vague they can be interpreted in very different ways, casting doubt on the meaningfulness of these aspects.[105]

A number of Member States see themselves as leading or influencing the EU rather than being led by it; the UK, for instance, which has been nationally at the forefront of the development of new legislation on NPS. These factors, added to the relatively unclear legal basis, means that there is therefore relatively little influence from the Union on national legal frameworks.

Chapter 4 highlighted the different approaches Member States have towards drugs and indeed, their objectives, ranging from the goal of a drug-free society in Sweden to a 'pure' harm reduction one such as in PT, where all drugs were decriminalised in 2001. These different approaches are deeply ingrained in the national psyche and influenced by cultural, historical and societal factors. Drug policies are very sensitive for Member States and for public opinion in these states. The lack of consensus among Member States on whether or not to criminalise drugs, and the difficulties in agreeing the new legislative instrument on NPS, are examples of how difficult and potentially ineffective harmonisation of the EU drugs policies would be.

An effective policy might not be replicable in another country as it depends on the history, the culture and the nature of the drug problem. For example, Poland and Portugal adopted different strategies in the 1990s. On one hand, in Poland, after the fall of communism there was a violent black market which contributed to shift the public debate from perceiving drug policy as a health issue, to view it as a justice and order issue.

In Poland, law enforcement and supply reduction activities were directed at tackling black market associated violence. Portugal, by contrast responded to the high level of injecting heroin use in the 1990s with a health-orientated strategy. A bottom-up movement led the government to decriminalise the use of drugs and develop a harm reduction response.[106]

Despite these shortcomings, the value-added and effectiveness of drug policy at the EU level is clear in two instances: (i) information gathering and information exchange, and (ii) the EU speaking as one block in international fora (as discussed below).

Box 7: Best practice: Importance of context (CH)

The Swiss approach developed in response to a specific set of circumstances, including rising HIV infections and the emergence of open drug scenes in Swiss parks. This elicited an equally unique response, with the emergence of 'street workers', the pressure of the population and the implementation of HAT. Therefore, Switzerland's approach to drug policy had to account for this specific context. Experts support this view, stating the importance of ensuring that local, regional and national contexts are taken into account when drafting drug policy and implementing interventions.[107] Furthermore, the trends related to drug use are always shifting, requiring the development of new solutions – for example, one of the biggest challenges Switzerland is reported to be facing is related to the proliferation of drug use in nightclubs. Thus, cooperation is required with different stakeholders in order to tackle the challenge.

[105] Chatwin, C. (2011). Drug Policy Harmonization and the European Union, Palgrave Macmillan.

[106] Based on research and interview with the REITOX focal points of Portugal and Poland.

[107] Interviews with Diane Steber, Swiss Federal Office of Public Health, and Christian Schneider, Swiss Federal Office of Police.

5.2. Effectiveness of demand-focused policies

As highlighted above, there is little evidence on the effectiveness of policies in terms of demand reduction given the lack of coherent and comparable data as well as the difficulties in establishing a causal link between policy and impact. Despite these shortcomings, it is possible to assess the effectiveness of certain policies based on historical trends within a country or through qualitative and anecdotal evidence. According to the EU Strategy, which serves as the conceptual framework for this section, **demand reduction** includes *prevention*, *early detection and intervention*, *risk and harm reduction*, as well as treatment, rehabilitation, social reintegration and recovery.

In order to measure the effectiveness of **policies which aim to stop, prevent or reduce drug use**, prevalence rates are a useful indicator. However, given the different ways of measuring prevalence and other methodological caveats, while prevalence rates provide an interesting benchmark, it is misleading to compare them between Member States. It is interesting to see that those countries allowing/legalising the sale of cannabis (NL and PT) do not have the highest prevalence rates. Furthermore, there is no understanding of why some phenomena happen; cannabis consumption has been fluctuating throughout the western world without any clear cause. This is illustrated best in the case of the UK, where cannabis consumption started declining when it was considered a Class B drug and continued declining while the categorisation of the drugs switched to C and back to B again. This example appears to underline the lack of correlation between policies and use and how no policy has been particularly effective at stopping, preventing or significantly reducing drug use.[108]

While all policies and measures are intended to prevent drug use, the drug policy sector of **prevention** refers to education and information, usually through school and public media. The research conducted has not uncovered any evidence of these programme being effective in reducing demand for drugs. Furthermore, research carried out in Scotland has not been conclusive of the effectiveness of drug education programmes. In some cases, education programmes can even be harmful, especially if the curriculum is based on 'fear information'.[109] Here again, the importance of interventions such as education programmes should be qualified. Popular culture can have a far larger audience and arguably more impact than a school programme. In the words of one expert participating in the workshop organised during the course of the study, the film *Trainspotting* has had more influence on the ways in which drug use is viewed in the UK than most information policy campaigns. Hence, the conclusion of the evaluation of the 2005–12 EU Drugs strategy stating that 'prevention approaches are still not grounded in scientific evidence that they can prevent drug use' still appears valid.[110]

Box 8: Best Practice – Drug Information and Monitoring System (NL)

A well-known drug prevention (and harm reduction) service available in the Netherlands is **the Drug Information and Monitoring System (DIMS**), which is part of the Trimbos Institute. Drug users can bring their drug to the DIMS to have it tested for adulterants in a DIMS laboratory. If a substance is found with adulterants which pose a direct risk to public health, regional and/or national warning activities are set up. DIMS will also start a national **warning campaign (Red Alert**), if the risk is an acute one to public health, together with the Ministry of Health, Wellbeing and Sports, and the public health inspectorate (Inspectie voor de

[108] Expert validation Workshop

[109] Social Research, Literature Review into the Effectiveness of School Drug Education – Scottish Executive, 2004.

[110] EMCDDA trend report for the evaluation of the 2005–12 EU drugs strategy.

Gezondheidszorg).[111] According to a representative of the Trimbos Institute, the DIMS works well as a monitor of the drug market, as well as a prevention tool, and has allowed them to be in good contact with the user population.[112] An expert in Dutch drug policy noted that the Netherlands is quite good at developing information campaigns that are credible sources of information for users, as the campaigns do not overstate the risk of drug use. Instead, they put the risks into the context of a range of other risks.[113]

As demonstrated in Chapter 4, there is very little evidence of effective measures to reduce drug use; in other words, it appears as though the objective of a drug-free society is unlikely to be achieved. This was recognised by the European Parliament in 2004 with the adoption of the Catania Report which called for Member States to adopt a '**harm reduction**' approach. This assessment will distinguish between the harm reduction for the user and for society as whole. These aims are interlinked as measures designed to protect individual uses from contracting infectious diseases are also serving a public health goal of reducing the spread through society.

Drug use prevalence provides limited information on the actual effectiveness of individual drug policies beyond the fact that no policy has been effective in stopping, preventing or significantly reducing drug use. One has to keep in mind that there is also substitution between different types of drugs, both legal and illegal. A low or declining prevalence of one drug (amphetamine) might be correlated to higher use of another one (cocaine). For example, the prevalence of the NPS 'spice', a synthetic cannabis substitute, is extremely low in the Netherland because good-quality cannabis is easily available and quasi-legal.

Cultural factors, which are difficult to quantify, strongly determine drug use patterns and complicate any analysis of the impact of policy changes. For instance, the introduction of regulated cannabis use in Colorado and Washington State resulted in significant increases in half month prevalence (by 43% and 25% respectively). Looking only at these data, one could assume that the law led to a huge increase in cannabis consumption. However, in the same period, 12 other US states (not affected by cannabis law) saw an increase in half month prevalence of 25% or higher. The increase in cannabis consumption in Colorado and Washington State cannot be associated (or cannot only be associated) with the new regulation, as other factors seem to have impacted on cannabis consumption.[114]

For all indicators related to demand reduction, it is often complicated to demonstrate causality between an indicator and a policy. Causality is even harder to demonstrate when evaluating the long-term impact of an intervention (in particular prevention programmes).

Prevalence data on drug use, however facilitates the interpretation of other indicators. HIV prevalence among people who inject drugs (PWID) and overdose deaths has always to be considered with the population at risk. The population most at risk of overdose or HIV infection are the overlapping cohorts of injectors and opiate users. By knowing this population (estimated from prevalence) and the main health indicators, one can broadly assess the benefit of harm reduction programmes within a country. Ideally, overdose data need also to be compared with the age of the population at risk. Holding everything else constant, an older population of problematic drug users would have a higher probability of dying from an overdose than a younger population.

[111] http://www.drugs-test.nl/dims

[112] Interview Trimbos Instituut, 19 September 2016.

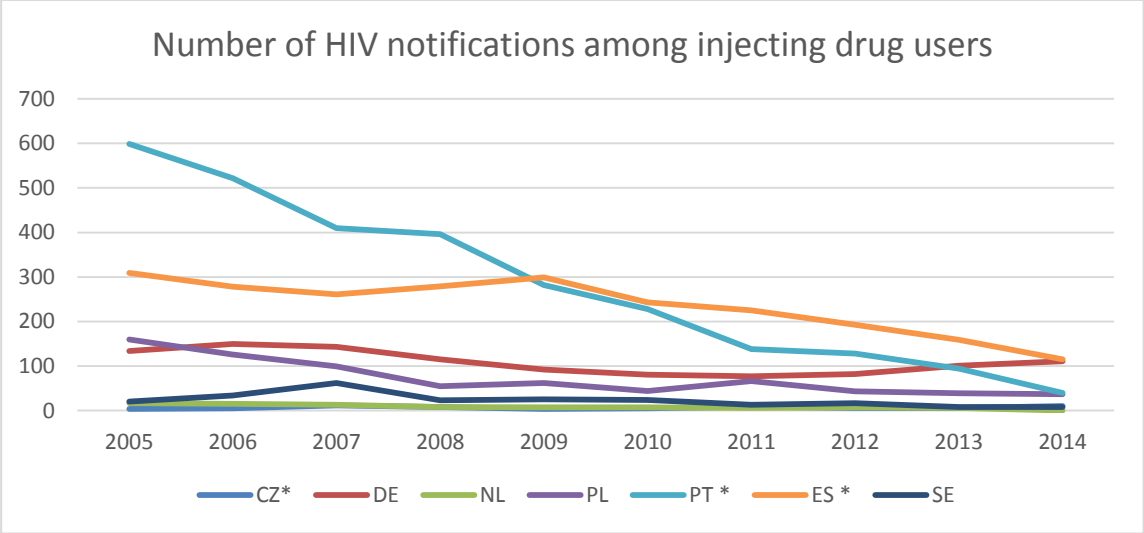
[113] Interview Freek Polak, Stichting Drugsbeleid, Netherlands, 9 September 2016.

[114] Expert in research on drug policy in the US.

In terms of harm reduction for the user, all case study countries provide basic treatment or user-focused harm reduction services (such as syringe exchange programmes, opioid substitution programmes and low threshold services); going beyond, a few Member States have also introduced drug consumption rooms (FR being the latest to do so), although those remain limited. SE is a notable exception. While the country offers limited access to harm reduction programmes, the situation has started to evolve in recent years with the government allowing 21 counties to introduce needle exchange programmes, leading to five needle and syringe programmes being opened by 2013.[115]

The most useful indicator of harm reduction effectiveness is that of HIV infections amongst people who inject drugs (PWID). While estimation methods vary between countries,[116] Figure 9 shows that ES and PT are the two case study countries that have experienced the highest decline in the number of HIV notification amongst PWID.

Figure 9: Number of HIV notifications among injecting drug users



Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016

Box 9: Best Practice – decriminalisation, harm reduction and integration between justice and health (PT) [117]

The legal framework in Portugal is seen by proponents of liberal approach to drug policy as a model of best practice because health and welfare of citizens are at the centre of the PT drug policy. The decriminalisation of drug use related offences contributed to reducing drug users' stigmatisation. Drug users would then be more likely to seek help through harm reduction services as they would not fear being referred to the drug justice system. Decriminalisation has been successful in PT because large amounts of resources have been spent on health and harm reduction activities. There is a very good integration between the justice and health system. Even though drug use is not criminalised, it is still an administrative offence and people intercepted by the police while using drugs are referred to a health-oriented organisation, the CDT (Commission for the Dissuasion of Drug Abuse) that will encourage the citizen to seek help if necessary.

[115] EMCDDA website.

[116] For example in CZ, foreigners with short-time stays in the country are not included in reported data.

[117] Based on research and interview with the Portuguese National REITOX Focal point.

Programmes targeted at particular populations appear to be more effective than others. Segmentation can be based on the type of drug used or on personal characteristics such as age. A key feature of the Dutch drug policy is its success of outreach / harm reduction policies and activities targeted at opiate users, evidenced by the fall in deaths of these drug users and the fall in the number of opiate-injecting drug users. In PL and DE, a treatment programme for cannabis users is based on modular cognitive-behavioural intervention for treating adolescents and adults with problematic patterns of cannabis use. Other related harm reduction strategies include targeting by mode of administration or type of use (such as injection) or specific settings (such as in and around party settings). A typical example of a harm reduction strategy targeting a type of use is syringe vending machines. Germany is the country with the highest number of such machines in the world, yet is a country with a high level of HIV prevalence, owing possibly to large gaps in service provision. The 160 machines are installed in only six of the country's 16 Länder. A WHO study found that such schemes 'substantially and cost effectively reduce the spread of HIV' among PWID without increasing drug use at the individual or societal level.[118]

Programmes targeting users by personal characteristics (e.g. age and social environment) include treatment for people with multiple condition or dual diagnosis (e.g. addiction and mental health) or homeless drug users in NL. In ES, interventions are targeted by personal characteristics rather than type of drug used (e.g. women, minors, dual pathology) as the country considers targeting by personal characteristics to be more effective than by type of drugs.

Box 10: Best Practice – targeting specific population groups rather than drug users (ES)[119]

In Spain, prevention and harm reduction activities notably tend to target specific groups of population (e.g. by age, gender or for instance the working population) rather than targeting a type of drug used. This is perceived as a good practice; as population-based programmes are resource intense, it makes more sense to target and communicate effectively with the population at risk.

A number of initiatives and policies can be considered as part of harm reduction for society overall. The definition of 'harm reduction' for society is difficult to establish as it varies between Member States. In PT, the decriminalisation of possession of all drugs coupled with a strong public health response in 2001 led to a significant fall in the number of death by OD and HIV prevalence. Beyond these rare quantifiable examples, the PT policy, where young offenders and users are referred to the health system, provides a way to identify potential problematic future users through early detection and intervention, which is therefore more effective as it reaches people who are not addicts.

The importance of a strong public health system and reintegration programmes have been highlighted by interviewees in countries with a more liberal attitude to drug policies. In CZ, flexible legislation and easy-to-access programmes were designed to give confidence for substance users to reach the health system. There is increasing availability of **reintegration programmes** (notably support for housing, employment and debts), which has a positive impact on society more widely. Similarly, in ES intervention covers the

[118] WHO, Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users, 2004

[119] Based on research and the interview with the Spanish REITOX National Focal Point.

overall drug user pathway to ensure that programmes support social integration, such as occupational integration programmes that are mainly performed in outpatient assistance facilities.

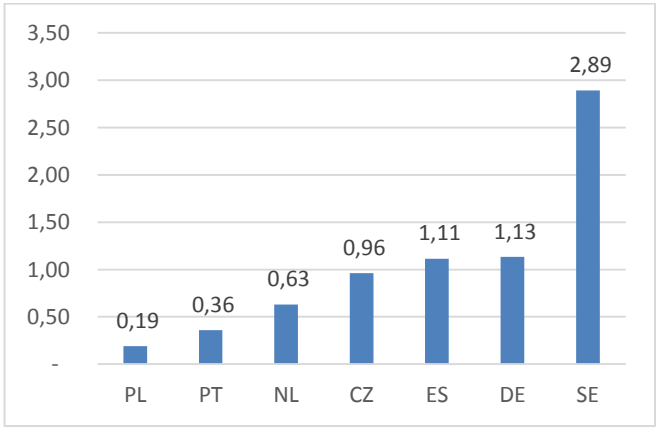
Box 11: Best practice – Reintegration programmes[120]

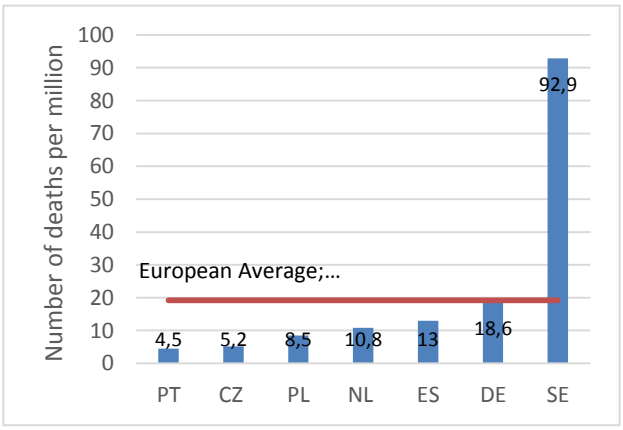
ES, notably, intervenes in the overall drug user pathway to ensure that many support programmes for social integration are available, such as occupational integration programmes that are mainly performed in outpatient assistance facilities. Efforts made across the countries tend to focus more on harm reduction activities rather than social reintegration. Social reintegration is, however, an important part of the drug user pathway as it would prevent drug users, suppliers and traffickers from reoffending.

There is also widespread evidence of the effectiveness of coerced drug treatment in helping 'individuals to reduce their drug use and offending and to improve their health, but it is unlikely to have large effects on population levels of drug use and crime', although there are clear ethical issues relating to it.[121] There is also evidence that incarceration had positive health outcomes for some users. However, in addition to the ethical problem mentioned above, this is neutralised by the high rate of overdose risk at the point of release, as some drug users tend to revert to pre-detention injecting habits without factoring in their loss of tolerance. In addition, prison spells create an additional obstacle to reintegration and are a predictor for re-offending. It therefore appears to be more effective to avoid incarceration and the inherent difficulties with reintegration into society after a prison spell.

While there appears to be a higher number of people entering treatment in countries focusing more on law enforcement activities, the chart indicating drug-induced mortality is very similar (see Figure 10).

Figure 10: Proportion of people entering treatment (per '000 population) and Number of deaths per million of PWID





Treatment programmes are offered in all case study countries, but there is a variation between the 'drug-free' model (SE, PL) and the pharmacological and stabilisation

[120] Based on research and interview with the Spanish National focal point and some expert opinion.

[121] See for instance Stevens, Alex (2012) The ethics and effectiveness of coerced treatment of people who use drugs. Human Rights and Drugs, 2 , (1) , pp.7-15.

treatments used on other Member States. In SE, there are high threshold programmes, as well as abstinence ones, and a general limitation in the availability of substitution programmes, accompanied by the quasi-forced institutionalisation of users in some cases. In PL, abstinence-oriented treatments are the dominant model. On the other hand, pharmacological treatment and treatments that do not necessitate abstinence are adopted in the other case study countries (DE, CZ, PT, NL, ES). In NL for instance, a large variety of treatments is available, with large number of patients treated. Increasing effort is given to developing outpatient services, GP services, e-health, empowerment and self-regulation efforts. Again, the effectiveness of the treatment depends to a large extent on the objective of the intervention. Substitution therapies will not be considered effective in countries striving for a drug-free society.

5.3. Effectiveness of supply-related policies

This sub-section addresses the issue of supply-related policies, starting with legal channels for the distribution of drugs, before moving on to illegal (or para-legal) channels of distribution and the issues of production and import.

The main aim of supply reduction is to reduce drug availability, with drug prices often used as an indicator and the raising of price a stated objective. Law enforcement operationalises this goal, with significant variation between and within countries, by reducing public consumption of drugs, closing open drug markets and disrupting organised crime groups. Particularly in mature drug markets like the UK, NL, DK, law enforcement is more concerned with tackling organised criminal groups involved in trafficking or production than the elimination of drug use per se. Beyond the immediate impact on availability, price, and purity levels, the potential consequences of reducing the supply of one drugs include:

- **Displacement** (substitution effects); reducing the availability of one drug can lead to an increase in consumption and supply of other drugs. For example, the EU ban on Ephedra appears to have led to an increase in consumption of more dangerous substances.
- The seizure of drugs and subsequent shortage could lead to market distortion, including local shortages and price increases that attract new people to the drugs market. High levels of law enforcement control coupled with severe penalties leads to the professionalisation of the drug market, which would potentially increase the level of market violence as described in more detail below.
- A reduction in the risk of terrorist financing – the 2016 Drugs market report highlighted the increased risk of terrorist finance. While the report highlighted a risk rather than a direct link between the two, an international investigation uncovered direct links between the proceeds of drugs trafficking (cocaine in Latin American and Cannabis in Lebanon) and the Hezbollah through providing "a revenue and weapons stream" to the organisation[122].

Assessing the impact of supply reduction policies is therefore very challenging. The overall market dynamics need to be monitored in order to assess whether an increase in the number of seizures of one drug led to another black market of the same drugs or an increase in the supply of a substitute drug. Number of arrests, notably per types of drugs, however, gives an indication on where police resources are concentrated.

[122] DEA, https://www.dea.gov/divisions/hq/2016/hq020116.shtml

Coffee shops and cannabis social clubs are two of the most interesting and often talked about distribution channels that have started organically and are now either legal or tolerated in some Member States. In NL, coffee shops need to adhere to strict requirements, but there is no regulation for supply, leading to what is referred to the 'backdoor problem'. The NL experience appears to show that decriminalising cannabis at retail / consumption level does not lead to an increase in medical problems or social problems. However, it still has to resolve the problem of the drug supply side being in the hands of criminal groups – which could provide a strong case for regulating cannabis supply. In ES, there has been an explosion in the number of cannabis social clubs with significant consequences for drug consumption, social perception and the development of the drugs scene and economy. Run on a not-for-profit basis, the Cannabis Club model takes out the commercial motives and cuts out the criminal markets. It has since been emulated in other countries like BE and the UK.

While it is not part of the national drug strategy, this demand for cannabis sourced and produced outside of the traditional criminal groups allows members to get more information about what they use and reduces the spectrum of the types of drugs sold by one outlet. In NL for instance, 14% of cannabis users reported that other drugs were available through their 'usual cannabis source', compared to 52% in SE.[123]

One of the main criticisms of the NL policy is the 'backdoor problem', given that the sale of cannabis is legal but production is criminalised (except for a small personal use exemption). There is therefore a paradox where it is legal for coffee shops to supply cannabis but illegal to supply cannabis to coffee shops. This problem relates to the production of drugs which essentially stem from two sources: domestic production and imports of foreign production. The share of imports in relation to national production varies between Member States and between types of drugs. Poland, for instance, has extensive production of amphetamines and methamphetamines, whereas DE and NL have extensive domestic cannabis production. In addition, CZ is reporting increases in domestic production and the subsequent establishment of organised crime groups. Overall, domestic cannabis production is increasing in the EU (see Chapter 4). While drugs production is a crime in all Member States covered by this study, personal use exemptions exist in CZ, ES, NL and PT. One of the drivers of this increasing trend for domestic production is a growing demand by users of higher-quality cannabis and procurement of the drugs outside of the criminal system. Recent developments in Colorado and Uruguay regulating the cannabis market (including its production) have re-ignited the debate about the regulated production of cannabis.

The effectiveness of policy responses to the supply of drugs stemming from imports of illegal drugs is notoriously difficult to assess. While the EMCDDA now collects and compiles data on the price and purity of drugs, it is almost impossible to gain an adequate picture of the size of the illicit drug supply in the EU and consequently the effectiveness of policies targeting it. Increased police and judicial cooperation mechanisms set up in the EU (such as Joint Investigation Teams – JITs) and intelligence sharing platforms such as the Maritime Analysis and Operations Centre have improved law enforcement capacity in tackling trafficking groups and criminal organisations.[124] This is demonstrated by the regular reporting of spectacular seizures such as the international *Operation Ciconia Alba* in 2016,[125] or, from a purely EU perspective, a recent seizure of over three tonnes of

[123] European Monitoring Centre on Drugs and Drug Addiction (2013) Further insights into aspects of the EU illicit drugs market: summaries and key findings, p. 18.

[124] http://maoc.eu/

[125] https://www.europol.europa.eu/content/global-operation-ciconia-alba-delivers-major-blow-organised-crime

hashish.[126] Despite these seizures, there is no evidence that these policies or supply reduction have led to any significant reduction in the availability of drugs in the EU, beyond some short-term and highly localised 'heroin droughts'.[127] Furthermore, these heroin droughts may be counter-effective.

Box 12: Heroine Drought – UK experience 2010–11

A UK Home Office report on the 2010–11 'heroin drought' experienced by the country highlighted a number of interesting findings.[128]

While the reduction in supply led to increased wholesale prices, sellers on the street elected to reduce the purity of the drug sold rather than raise their prices.

There were no significant falls in the number of fatal and non-fatal overdoses during the reported period of reduction in heroin supply. There were local reports of increased numbers of overdoses as well as other side effects, due to the additional adulterants contained in the heroin and/or replacement substances which individuals were using.

Indicators currently used to assess the effectiveness of supply-reduction measures only measure what is being done by law enforcement authorities rather than what is effective, making it very difficult to measure the impact of these policies. While seizures and law enforcement authorities play a role in removing both drugs and criminal groups, the most critical factor is what this actually achieves in the longer term. That is, a community that is less burdened by the impact of drugs, such as crime, illness, injury and death[129] (in other words, harm reduction to users and society).

5.4. Effectiveness of coordination, cooperation and monitoring and evaluation

As stated in Chapter 3, the EU Drug Strategy identifies **three cross-cutting themes**, namely coordination, international cooperation, and information, research, monitoring and evaluation.

5.4.1. Coordination

At an EU-wide level, communication and exchange of information and views in support of the policy objectives is happening through different EU fora, such as the Standing Committee on Operational Cooperation on Internal Security (COSI), the Horizontal Working Party on Drugs, the European Parliament (LIBE Committee), through the work of DG Migration and Home Affairs of the European Commission, and the EMCDDA. A good example with regard to the latter is the early warning system on NPS offered by the EMCDDA in cooperation with Europol (see Chapter 3 for more information).

With regard to operational (law enforcement) actions related to heroin and cocaine, several interviewees mentioned the Europol-led European Multidisciplinary Platform against Criminal Threats (EMPACT) as the main coordination platform for the EU Member States (i.e. NL and SE). EU Member States also cooperate through EU-funded projects, such as

[126] https://www.europol.europa.eu/content/over-3-tonnes-hashish-seized-international-police-operation

[127] EMCDDA, Annual report 2011, p 77.

[128] Ahmad, Amryam and Richardson, Anna, *Impact of the reduction in heroin supply between 2010 and 2011*, January 2016.

[129] Willis, K., Andreson, J. and Homel, P., *Measuring the effectiveness of drug law enforcement*, February 2011.

the Maritime Analysis and Operations Centre (MAOC),[130] which is an anti-drug trafficking action by several EU Member States with financial support from the Prevention against Crime Programme of the European Commission, and the CHOPIN project implemented in PL that aims to reduce the illicit distribution of drugs in the EU and involved experienced law enforcement agencies from NL, BE, DE, LT, CZ as associates.

Some countries cooperate outside the framework of the EU. For example, the Swedish customs and police cooperate on drug issues in the framework of the Nordic Customs and Police Co-operation (PTN), and have strategically located liaison officers in, inter alia, Germany, Russia, Turkey, Colombia, Serbia and China. The Czech Republic is also reported to cooperate bilaterally with all countries across the Balkan route, and PL is reported to cooperate with all its neighbouring countries.

5.4.2. International cooperation

In terms of international cooperation, the EU Member States and third countries discuss drug issues and cooperate effectively with each other through international organisations. The main international organisation is the UN, which has several fora that discuss drug matters such as **the UNODC, the Commission on Narcotic drugs (CND) and the UNGASS**. The latest UNGASS on the World Drug Problem took place in April 2016 and resulted in the adoption of the outcome document 'Our joint commitment to effectively addressing and countering the world drug problem'. This UNGASS provided a range of operational recommendations and broadened the original UN pillars (see for further information Chapter 2). Other relevant international organisations through which EU Member States cooperate with third countries on drug issues are **Interpol,** the **World Health Organization (WHO) and the International Narcotics Control Board**.

The EU also cooperates with particular groups of countries or regions, to work on more specific drug issues which are relevant to a specific geographical area. The EU cooperates with Latin America through, for example, **COPOLAD,** which is a cooperation programme on drug policies. Through this programme, the Polish government aims to reduce the illicit supply of cocaine and synthetic drugs in Poland. The EU cooperates with Asia through the Central Asia Drug Action Programme (**CADAP**), in which the EU and its Member States inform and support countries in developing their drug policies from a more punitive to a more progressive policy approach.[131]

There are also EU programmes supporting the capacity and institutional development in drug producer or transit countries. These are either delivered at regional or inter-regional basis such as the Heroin Route Programme (HRP) and the Cocaine Route Programme (CRP). The CRP, for example supports law enforcement agencies and judicial authorities in 38 countries in West Africa, Latin America and the Caribbean to combat organised crime and cocaine trafficking. Since 2009, the EU has committed almost EUR 50 million to the programme through the Instrument contributing to Peace and Stability.

One project which was mentioned by interviewees and which is part of the CRP, is the **AMERIPOL-EU project**, which was focused on enhancing the capacity of law enforcement and judicial cooperation to tackle transnational organised criminal drug networks. According to the European Commission, this programme was particularly effective in fostering cooperation between different European and Latin American countries and contributed to the seizure of drugs and assets in several countries over 2011–2013.[132]

[130] See case studies PT, ES, NL

[131] Case study Poland.

[132] http://europa.eu/rapid/press-release_IP-14-914_en.htm

Another cooperation mechanism is dialogues on drugs, such as **annual dialogues on drugs** between the EU and other countries and regions, such as CELAC, the USA, Brazil, the Russian Federation, CARICOM and Central America. Some Member States organise and host international drug-related conferences too; for example PL organises the Urban drug policy conference,[133] which is one of the largest international events dedicated to urban drug policies and is aimed at facilitating integration and cooperation between local government authorities, politicians and policy-makers, police officials, prosecutors, penitentiary staff, NGOs and researchers and to transfer knowledge and promote the dissemination of effective drug policies based on scientific evidence.

5.4.3. Information, research, monitoring and evaluation

At the EU level, the **EMCDDA** is the agency responsible for the data collection, research, monitoring and evaluation on drugs and drug addiction to contribute to a better understanding of all aspects of the drugs phenomenon. As stated in Chapter 3, its tasks include: the collection and analysis of existing data; improvement of data-comparison methods; dissemination of data; monitoring the state of the drugs problem and emerging trends; developing tools for Member States to evaluate their drug policies, and assessing the risks of NPS within the early warning system. In this capacity, the EMCDDA was generally perceived as effective by national authorities and experts interviewed for this study.

Also relevant to mention here is the **European Information Network on Drugs and Drug Addiction (REITOX)**, which allows for the collection and exchange of data between 31 members (EU28, Norway, Turkey and the Commission).

In addition, several **EU-wide research networks** exist in the field of drugs, which some Member States are part of. For example, PT is involved in two networks: the European research Area Network on illicit drugs (ERANID), a four-year project aiming at developing long-term cooperation in the field of scientific research on illicit drugs, as well as the European Harm Reduction Network, which aims to advocate knowledge on harm reduction within Europe.[134]

Moreover, some Member States have set up a **specific national research institutes on drugs**, such as the Trimbos Institute in the Netherlands. In the CZ, the National Monitoring Centre for Drugs and Addiction coordinates the collaboration and exchange of information between research institutions, service providers and public administration bodies. In PL, the National Bureau for Drug Prevention (NBDP) remains the main body commissioning and financing the implementation of research in the field of drugs and drug addiction, although Poland's global Scientific Research Committee also represents a funding source for drug-related research. These research and monitoring bodies often also function as the REITOX national focal point.

However, such national research institutes do not exist in all EU Member States. For example in DE, the exchange of information in the research community is to a large extent organised by researchers themselves, networks and professional companies, and takes place primarily through research conferences and scientific journals addressing the drugs field, clinical guidelines and transfer processes. Similarly in ES, university departments and research networks are the main actors undertaking drug-related research.

[133] Urban Drugs Policy Conferences,. About – Urban Drug Policies Conference. Urbandrugpolicies.com. Retrieved 26 September 2016, from http://urbandrugpolicies.com/about/

[134] Case study Portugal

Box 13: Best practice: Information, research, monitoring and evaluation in non-EU countries

The practice of building monitoring and evaluation practices into drug policies is highly valued, and perceived as key success factor, in the drug policy approaches of all the non-EU countries examined. For instance, Uruguay demonstrated a strong commitment to consulting international drug policy experts on its drug policy, in particular the 2013 cannabis regulation bill. Furthermore, the bill includes an evaluation strategy, with five sets of indicators selected for the monitoring of the bill's implementation and regular reporting on progress.

This practice is echoed by the US states of Washington and Colorado in their respective cannabis regulation bills. Both states are dedicated to ensuring the ongoing monitoring and evaluation of the bill's implementation, with an early findings report already published by the Colorado Department of Public Safety (2016).

Switzerland also emphasises the use of evidence-based practices and conducts significant research alongside its policy implementation. For example, when Switzerland first implemented heroin-assisted treatment (HAT) it was extremely controversial and faced significant opposition. However, the government ensured that research was conducted alongside its implementation, evidencing its benefits to drug users who had failed to respond to other types of treatment. It is now an intervention that is accepted by all stakeholder groups.

6. OBSERVATIONS, RECOMMENDATIONS AND POLICY PROPOSALS

This chapter provides observations, recommendations and policy proposals based on the findings of the sections above as well as the case studies in the appendices.

6.1. General comments

6.1.1. Observations

This first observation resulting from this assessment of EU drug policy is that despite the best efforts of policy-makers and regardless of their approach, policies are only one of the many factors that influence the drugs market (both in terms of use and supply). Any assessment must therefore take into account the limited impacts that policies can have on changes to patterns of use or on the supply of drugs.

A second key observation is that despite very different approaches, no Member State that formed part of this assessment appears to be exceptionally successful in achieving the stated objective or significantly reducing drug consumption. To take the example of two often-cited examples of successful policies, while PT is significant in the reduction of HIV notification amongst drug users and the number of drug-induced deaths, there are still many issues that need to be addressed. In NL, the introduction of coffee shops has reduced the number of street dealers offering cannabis as well as other more harmful drugs and appears to have reduced prevalence of use for most drugs. Ecstasy is an exception, although its prevalence is greater in 'party settings', as is the case in other Member States.

The approaches taken by the Member States selected in the case studies vary in their objectives, focus and doctrine. In every Member State, policy-makers and the public have become habituated to government drug policy, but the actual implementation and design stem from the cultural and historical context of each country. The objectives of drug policies are therefore very difficult or impossible to harmonise.

The work undertaken for this study highlights the need for further research in order to assess the effectiveness of drug policies and interventions. While the EMCDDA provides a source of robust and (partly) comparable data (see Appendix D), which is an added-value compared to other regions, there is still a clear lack of robust empirical research on the effectiveness of the different policies in achieving their objectives. There is also a lack of detail on the clear scope and size of the wider (societal) impacts of drug policies in the medium and long term.

6.1.2. Recommendation and policy proposal

Given the need for drug policies to be seen in a holistic manner as part of a wider public policy debate, what works in one country might not be successful in another. The legal basis of EU intervention is tenuous and intervention would not be welcomed by most Member States. More empirical research is necessary to assess the effectiveness of different policy approaches and the factors which affect their impact. Consequently, the European Parliament could refrain from trying to develop a unified drug policy through the EU.

Policy Proposal 1 (PP1) *– The European Parliament should commission more research or encourage the Commission or other bodies to undertake more evidence-based research on the effectiveness of different approaches.*

Countries covered by this study, such as CH, emphasise the use of evidence-based practices. Swiss authorities have initiated and supported significant research which has determined the viability of systems they use and evidenced its benefits to drug users who

had failed to respond to other treatment types. In IE, the Health Research Board has set up a 'National Drugs Library', an information resource that supports researchers, policy-makers, educators and practitioners working to develop the knowledge base around drug, alcohol and tobacco use in the country.

PP2 *– The European Parliament should encourage the development of an evidence base on existing policies. This could be done through an extended role for the EMCDDA. Independent evaluation and monitoring of drug policies and interventions should also be encouraged. A wider-ranging report on the wider impacts of different drug policies should be commissioned in order to (i) scope the range of their (societal) effects, (ii) provide more robust and holistic cost-effectiveness analyses, and (iii) take into account qualitative elements such as the improvement in the quality of life of users, their families and the wider impacts related to changes in the prison population, the presence of criminal groups, etc.*

PP3 *– The European Parliament should call for and encourage the creation of a pan-European clearinghouse on the model of the What Works? Centres aiming to (i) review research on practices and interventions relating to drugs; (ii) label the evidence on interventions in terms of quality, cost, impact, mechanism (why it works), context (where it works) and implementation issues; and (iii) provide stakeholders with the knowledge, tools and guidance to help them target their resources more effectively.*

6.2. Demand side

6.2.1. Observations

In most Member States (with the notable exception of SE) there has been a move away from the goal of a drug-free society to that proposed by the Catania report of policies focusing on harm reduction. Consensus appears to be building around this approach, as illustrated by the EU Drugs Strategy setting the 'reduction of the health and social risks and harms caused by drugs' as a policy objective.

Coordinated harm reduction policies have had a tremendous effect in reducing the number of drug-induced deaths as well as the level of HIV notification amongst drug users in PT. This is mainly thanks to a coordinated approach between law enforcement and public health. The success of this approach is based on (i) a strong public health system with related investments, (ii) the early identification of users before they become addicts, and (iii) public buy-in to the policy.

The effectiveness of harm reduction policies with regard to reducing HIV infection among drug users and reducing drug-related deaths has been abundantly and consistently proven. This is probably the most intensively researched area in this field, and all UN agencies have now accepted these conclusions. There is a solid evidence base, suggesting that opposition to this has become an ideological viewpoint.

Increased quality and availability of information of drugs used, including their quality, purity and provenance, is important. A number of health consequences are linked to opiates of a low purity and cut with adulterants. Cannabis users in NL and ES appear to seek more information on the provenance and quality of the cannabis they use, as well as seeking to procure it from more 'ethical' sources away from organised criminal groups. More generally, safer injection interventions such as needle exchanges and supervised injection sites protect the users, with no evidence of it leading to an increase in their number.

Pill and powder testing facilities have proven to be effective; for example, NL has such facilities and when dangerous PCP superman pills were being sold as ecstasy, they were

able to send out national warnings. Meanwhile, people were killed in the UK by taking these pills.

6.2.2. Recommendation and policy proposal

Where decriminalisation is encouraged, it must be accompanied by a strong public health response. Experiences of decriminalisation have been the result of coordinated efforts on the part of all the public authorities in charge of drugs policy. It is therefore key to build on the experience of these successes if they are to be replicated in countries that wish to do so.

PP4 *– The European Parliament should encourage Member States having experienced a positive decriminalisation effort to share their experiences through lessons learnt workshops and robust evidence-based impact analyses in order to highlight the key success factors of these experiences.*

One side effect of drugs use (and in particular the use of opiates) is the impact of other substances in the product injected, as well as the risk of infection from used needles and using in non-safe places.

PP5 *– The European Parliament should encourage evidence-based research specifically of harm deduction mechanisms for users and, if they are proven to be effective, support their development of a Public Health basis.*

6.3. Supply side

6.3.1. Observations

As for all illegal activities, it is extremely difficult to assess the size of the supply side of the drugs market both in terms of imports and production. The only tangible indicator available is that of seizures, which, as highlighted in this report, may be a factor of increased law enforcement activity, or skewed by a large catch. However, despite large amounts of resources invested in attempts to reduce the supply of drugs, very little tangible evidence is available on their impact on the availability of drugs.

Where the sale of cannabis is tolerated, there are clear issues related to the 'backdoor problem'.

The distinction between illicit and non-illicit drugs (i.e. pharmaceutical and illicitly produced products) makes issues relating to supply unclear. According to the international treaties, all substances can have both licit and illicit purposes. The increase in the number of countries and territories regulating or legalising the production of cannabis, coupled with the growing acceptance of cannabis derivate in the pharmacological industry has led to an increase in legal or regulated cannabis production. This sector is becoming an increasingly important agri-tech industry in the US and Israel.

6.3.2. Recommendation and policy proposal

While law enforcement interventions can clearly play a role in the short-term disruption of drug markets, their long-term impact is unclear. More research should be undertaken to understand the effectiveness of these responses and their impacts on the drug markets and the patterns of use.

PP3 *– see above*

The production of cannabis for medical purposes should be explored on the basis of what is currently being done in Israel and the US.

PP6 *– The European Parliament should encourage the development of market analysis based on potential demand for, and pharmacological and therapeutic benefits of, cannabis, to ensure that Europe does not fall behind in this area of bio-technology, where other countries are quickly establishing a lead.*

6.4. Cooperation

6.4.1. Observations

The EMCDDA's role in developing and compiling more comparative data is hugely important for the understanding of the drug scene in the EU and the effectiveness of policies. Furthermore, the early warning system and information exchange overseen by the Centre has clearly been beneficial in the Union's response to NPS in the absence of a legislative instrument.

The EU Drugs Strategy, built upon three pillars, is being challenged by the new more modular 7-pillar approach taken by UNGASS, adding several themes such as drugs & health (new pillar 2), drugs & human rights (new pillar 3), new drug-related challenges such as NPS and use of the internet (new pillar 5) and international cooperation and development-related cooperation (new pillar 6 and 7). This more granular approach provides more scope of actions. For instance the first pillar (demand reduction and related measures) is divided into two parts, the first including prevention and treatment, as well as other health-related issues, the second relating to the availability of and access to controlled substances exclusively for medical and scientific purposes, while preventing their diversion.

6.4.2. Recommendation and policy proposal

The EMCDDA is a pillar of the EU's response to drugs and drug additions and has developed into a key player in the exchange of information between Member States.

PP7 *– The European Parliament should encourage the EMCDDA to continue playing an important role in the development of information exchange including the EWS on NPS. The new Regulation on the EMCDDA should retain the prosed elements relating to NPS.*

The EU should continue to align its strategy to UNGASS' structure. It is recommended that the new Strategy (beyond 2020) follows the 7-pillar approach.

PP8 *– The European Parliament should encourage the adoption of the 7-pillar approach in the future EU Drugs Strategy.*

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APPENDIX A: EU CASE STUDIES

Providing insight into the approach to drug policy of seven Member States is an important criterion for this study. It can provide a broader understanding of the policy debate in this complex field, given the varied approaches to drug policy between Member States, as well as present examples of good practices that may be replicable at EU and/or Member State level. The selected seven case study countries and the rationale for their selection are presented in Table 10.

Table 10: Rationale for selected EU case study countries

	**Czech Republic (CZ)** The Czech drug-related legislation is quite extensive and includes laws as well as various by-laws. The most important feature of the Czech legislative system is that criminal law does not consider drug use to be a criminal offence. Additionally, Czech drug policy, historically, has shifted from a fairly liberal policy to a quite repressive one and back again due to detailed evaluations which reported on the negative impact of the repressive policies.
	**Germany (DE)** Germany's Federal system presents an interesting element for exploration as there are considerable differences in state-level approaches.
	**Netherlands (NL)** The Netherlands has a drug policy focused on the reduction of harm to users and public nuisance by drug users as well as to prevent recreational drug use and the criminalisation of drug users. The key objectives of the policy were to prevent the criminalisation of drug users and to separate drug markets
	**Poland (PL)** Focusing on Poland brings an important insight into a central-eastern European approach to drug policy, and will act as an interesting comparator to the Czech approach. Poland also has a long tradition of therapeutic communities for drug abuse rehabilitation.
	**Portugal (PT)** Since 2001, Portugal has adopted an approach focused on harm reduction. One aspect of this approach was the decriminalisation of the use and possession of controlled drugs. The possession of controlled drugs is only an administrative offence if the quantity held is equivalent (or less) than 10 days' consumption. Additionally, the use of 'dissuasion panels' to assess drug offenders are similar to drug courts but led by health professionals.
	**Spain (ES)** Presence of cannabis social clubs is of interest, offering a not-for-profit way in which to distribute cannabis in opposition to the commercialisation approach that might happen elsewhere.
	**Sweden (SE)** Sweden has a zero tolerance approach to controlled drugs governed by the primary aim of a 'drug-free society'. Achieving this aim is driven primarily by law enforcement and a repressive and restrictive approach.

Appendix A1: Case Study – Czech Republic

Introduction

Drug policies in Czech Republic are liberal and centred on harm reduction. Because drug use is not considered as an offence, the REITOX focal point believes that drug users are more confident to seek for help without feeling stigmatised and without worrying to be arrested. This liberal policy has impacted positively drug-related health issues and drug-related crime violence in the country. There are still, however, some inequalities in the availability of harm reduction and treatment offers, leaving apart hard-to-reach and socially excluded communities. Prevention programmes have also not been very successful in engaging teachers and pupils at school due to a fragmented system. Also, because of the limiting budget and because drugs are not seen as a problematic health and security issue, resources are concentrated in more problematic areas, such as alcohol and gambling.

Needs

Drug use among population

Overall, in the last ten years the mean estimate of the number of high-risk drug users has risen by more than half. The highest drug use prevalence was the prevalence of cannabis use that was 11.4 per 1 000 in 2014. According to the 2012 National Survey on Substance Use, the estimated number of high-risk cannabis users is around 79 000, while another 116 000 are estimated to be at moderate risk of cannabis use[135].

The number of injecting drug users was estimated at 45 600, that is 6.4 per 1 000[136]. Hard core drug users who have been using drugs for a long period of time are a main challenge for Czech Republic and for the mental and public health services[137]. The biggest problems encountered in terms of drug use in the Czech Republic are those related to the use of amphetamine and heroin, and inhalant is also a problem in certain groups, notably in school settings[138].

Besides substances presented in Table 11, there was also a peak in New Psychoactive substances (NPSs) in 2011 and its use was stabilised at 1.3% of adults in 2014.[139] The outbreak of NPSs and synthetic cannabis is not considered as a major problem but the entire impacts and consumption of these new substance are still unclear and that is why they are carefully monitored and under surveillance[140].

[135] Czech Republic country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/czech-republic .

[136] *Ibid*.

[137] Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy

[138] Interview with Mgr. Voboril, National Drug Coordinator from Czech Republic.

[139] Czech Republic country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/czech-republic.

[140] Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy.

Table 11: Prevalence rates among adults 15–64 (2014).

Title (%)	Life time prevalence EU average	Life time prevalence (2014)	Last year prevalence (2014)
Cannabis	17.8	28.7	11.4
Opioids			
All Opioids drug use problems	Average of annual prevalence at the most recent year available: 0.35	N/A	0.16
Stimulants			
Cocaine	3.0	0.9	0.2
Amphetamine	2.5	2.6	0.8
Hallucinogens			
Ecstasy	2.9	6	1.6
LSD	1.4	7	0.1
All drugs			
Total	19.1	31.1	12.6

Source: *Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016*

[i] *Average EU data have been calculated according to the most recent data available per country in EMCDDA statistical bulletin. Latest year available for all types of drugs except opioids are as following: 1998 for LU; 2004 for EL; 2007 for HU; 2008 for AT and EE; 2010 for SK; 2011 for IE and LV; 2012 for BG, HR, CY, DE, LT, PT, SI; 2013 for BE, DK, MT, RO and ES; 2014 for CZ, FI, FR, IT, NL, PL, SE and UK. Data from SE, BE and EE were not broken down by drugs and were only available for the overall drug prevalence. There were not any available data on all drug prevalence for LU and NL and no amphetamine use prevalence were available for LU;*

[ii] *Latest year for Opioids use prevalence estimations used for calculating EU average data are as follow: 2007 for LT and LU; 2008 for SK, 2009 for PL, 2010 for HR, 2012 for FI, NL and PT; 2013 for AR, DE, SI and ES; 2014 for CY, CZ, EL, IT, LV and MT; 2010-11 for HU and UK; 2013-14 for FR. There were no available data on opioids prevalence for BE, BG, DK, EE, IE, RO and SE;*

[iii] *Recurrent drug use that is causing actual harms to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high risk of suffering such harms'. Prevalence data for Portugal have been estimated with capture recapture method and based on treatment data and criminal justice data.*

Health impact of drug use in the Czech Republic

Prevalence rates of human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HBC) are partly attributable to injecting drug use. The rate of infection

of HIV, HBV and HBC has remained relatively stable in recent years and is usually higher among clients of opioid substitution treatment programmes and prisoners[141].

The number of new HIV cases reported has been stable, amounting to 232 in 2014 and among these cases, 10 were attributed to injecting drug use. HIV prevalence rates among injecting drugs has consistently been below 1.0 % since 1996 and ranged between 0.2 and 0.3% in 2014. Since 2009, there is a downward trend in HCV prevalence among injecting drug users; diagnostic testing of clients in low-threshold services was 22.4% in 2009 and 15.7% in 2014[142].

The drug-induced mortality rate among adults aged 15–64 was 5.2 deaths per million, which is below the European average of 19.2 deaths per million[143].

Table 12: Drug induced mortality and epidemiology (2014)

	Number of people who inject drugs[i]	Prevalence of new HIV among people who inject drug (%)[ii]	Prevalence of new Hepatitis C among people who inject drugs (%)[ii]	Prevalence of hepatitis B antibodies among people who inject drug (%)[ii]	Drug induced mortality among adult 15-64 (per million)[iii]
Czech Republic	38 700	0%	7.95%	2%	5.2
European average					19.2

Source: [i]Harm Reduction International,. (2014). The Global State of harm reduction 2014. London: Harm Reduction International. Retrieved from https://www.hri.global/files/2015/02/16/GSHR2014.pdf ; [ii] Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016; [iii] Czech Republic country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/czech-republic

Drug production, import and export

Cannabis (most frequently seized drug) and methamphetamine (pervitin) are the major drugs produced for the domestic market. Low-volume home-based cannabis cultivation sites (6–49 plants) account for 40 % of all cultivation sites. Large-scale cannabis cultivation and distribution has become more specialised in recent years, it has contributed to the establishment of highly organised criminal groups. 735 kg of cannabis were seized by the Czech law enforcement agencies in 2013 and 570 kg were seized in 2014. The quantity of pervitin seized is significantly lower but it has increased considerably from around 4 kg in 2008 to 50 kg in 2014.[144]

Main drugs imported are Heroin, Cocaine and Ecstasy. Heroin enters the Czech Republic mainly through the Balkan route and a total of 65 heroin seizures (157kg) were reported in 2014, representing 157kg. 144 seizures of cocaine (5.4kg) were reported in 2014; the

[141] Czech Republic country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/czech-republic.

[142] *Ibid*.

[143] *Ibid.*

[144] *Ibid*.

substance mainly reaches the Czech Republic from the Netherlands. Ecstasy is mainly imported from the Netherlands, Poland and Slovakia and the seizures of this substance.[145]

LEGAL FRAMEWORK

After the fall of communism, there were not any clear drug laws in Czech Republic, notably about drug use offences. After years of debates, the Czech Republic adopted a liberal approach for tackling drug-related problems and in 2010, a national legislation has been approved and is now part of the Penal Code (Act No. 40/2009). The Penal Code regulates several aspects such as drug trafficking, unauthorised possession of drugs, conditions of prosecution, diversion of prosecution, types of penalties, etc. Possession of small quantity of drugs is not a criminal offence but an administrative offence and is penalised with a fine. The definition of a low quantity of drugs had to be defined by the highest court and there is now, since 2012, a clear table reporting quantities cut off values between administrative and criminal offences.[146]

Table 13 below provides an overview of how drugs are penalised in the Czech Republic. Using drugs is not considered as an offence and possessing small quantities of drugs is a non-criminal offence. Penalties for possession depends on quantities and the definition of 'small', 'greater than small' and 'significant' is defined by the Supreme Court of the Czech Republic. Penalties for drugs supply goes up to 18 years of prison, depending on the circumstances. Alternative to imprisonment such as suspended sentences, community service and probation with treatment is available for drug addicts committing drug-related crime. Secure detention with compulsory treatment is a possible response to addicts who are deemed to be socially dangerous, and is also an option for juvenile delinquents. In terms of production, law enforcement agencies focus mainly on large scale production. Even though small-scale drugs production and manufacturing should be an administrative offence they are not the priority of law enforcement agencies.[147]

Table 13: Criminalisation of drugs and penalties

Produce	Supply	Possess		Use
Penalty	**Penalty**	**Penalty**	**Depending on Quantity?**	**Penalty**
- Small scale production for personal use: Administrative offence but in practice, it is 'tolerated'	- From 1–5 years to 10–18 years of imprisonment, depending on various aggravating circumstances (e.g. larger scale offences and involvement in	- Small quantity for personal use: non-criminal offence punishable by a fine up to EUR 550. - 'Greater than small quantity' for	- Penalties vary by quantity: small quantity, greater than small and significant.	Use of drugs is not mentioned as an offence and not regulated by law.

[145] *Ibid*.

[146] Interview with Mgr. Voboril, National Drug Coordinator from Czech Republic; Czech Republic country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/czech-republic .

[147] Belackova, V., Maalsté, N., Zabransky, T., & Grund, J. (2015). 'Should I Buy or Should I Grow?' How drug policy institutions and drug market transaction costs shape the decision to self-supply with cannabis in the Netherlands and the Czech Republic. International Journal Of Drug Policy, 26(3), 296-310.; Interview with Mgr. Voboril, National Drug Coordinator from Czech Republic; interview with Pavel Bem.

Produce	Supply	Possess		Use
Penalty	**Penalty**	**Penalty**	**Depending on Quantity?**	**Penalty**
- Large scale production: Criminal offence	criminal organisation lead to higher penalties). - In the case of addicts committing a drug-related crime, a range of alternatives to imprisonment is available to the court. - Penalty not influenced by the substance of addiction - Punishment range extends to 2-10 years when there is recidivism.	personal use: up to one year imprisonment for cannabis or other substances containing THC and two years for other substance. - 'Larger quantity': 6 months to 5 years imprisonment. - 'Significant quantity': up to 2–8 years. - Penalty not influenced by the substance of addiction		

Source: http://www.emcdda.europa.eu/countries/czech-republic#pdu

AIMS AND OBJECTIVES OF THE NATIONAL APPROACH TO DRUG POLICY

Objectives and overview of the current strategy(ies)

Originally focused solely on illicit drugs, the May 2010 National Drug Policy Strategy for 2010–2018 was revised in December 2014 in order to integrate alcohol and gambling in the new policy strategy[148]. This Strategy is the key document for tackling the problem of drug use and it presents the intensions and procedures to be followed by the government. The National Drug Policy Strategy encompasses 4 action plans focusing on each topic (drug, alcohol and tobacco and gambling).

The Czech Republic favours a comprehensive, multidisciplinary, and well-balanced approach that includes drug supply reduction, drug demand reduction and reduction of the harm associated with drug use. The 4 main pillars of the policy plan is as follow[149]:

[148] Government Council for Drug Policy Coordination. (2010). National Drug Policy Strategy for the Period 2010 – 2018. Retrieved from http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf; Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy.

[149] Government Council for Drug Policy Coordination. (2010). National Drug Policy Strategy for the Period 2010 – 2018. Retrieved from http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf.

- Reducing the level of occasional and experimental drug use through primary intervention;
- Reducing the level of problems linked to intensive drug use by offering treatment and social reintegration;
- Reducing drug-related risks to individual through harm reduction initiative. The 2013–15 Action Plan also introduced a number of new tasks, including facilitating harm reduction treatments for hard-to-reach and socially excluded communities;
- Reducing the availability and supply of drug.

The 2010-2018 policy strategy is complemented by three supporting domains: coordination and funding; monitoring, research and evaluation; and international cooperation.

Tackling problems about addictive substance use is also reported from a public health perspective in the 2020 National Strategy for Health Protection and Promotion and Disease Prevention[150]. The 2020 health strategy aims to stabilise the system of measures to protect and promote health. It is not drug specific, but one of the objectives is to tackle dependencies (alcohol, drugs and cigarettes) especially through prevention and educational programmes[151]. There is some cooperation at the strategic level between the departments of justice, Education and Health as they all sit on the national commission where policies development is discussed. At the practical level, however, there is no coordination between the 3 departments[152].

With the growing issues related to new psychoactive substances, controlled new psychoactive substances have been listed in a recent legislation in 2013 and early warning systems have been put in place. These initiatives undertaken in the Czech Republic go beyond what is recommended by the proposal for a regulation of the European Parliament and of the Council on new psychoactive substances.[153]

Table 14: Main current policies and actions plans in Czech Republic

Policies, actions plans	Description
National Drug Policy Strategy for 2010–2018	The National Strategy is the key document designing policy directions. It aims at dealing with drug problems and, since 2014, with addictive behaviour in general). The four cornerstone features are primary prevention, treatment and social rehabilitation, harm reduction, and a reduction of the availability of drugs.

[150] Ministry of health of Czech Republic, (2014). Health 2020 – National Strategy for Health Protection and Promotion and Disease Prevention (1st ed.).

[151] Ministry of health of Czech Republic, (2014). Health 2020 – National Strategy for Health Protection and Promotion and Disease Prevention (1st ed.).

[152] Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy.

[153] Interview with Mgr. Voboril, National Drug Coordinator from Czech Republic.

Policies, actions plans	Description
2020 National Strategy for Health Protection and Promotion and Disease Prevention	One of the priority area of the national public health strategy is to create resilient communities living in supportive environments. One of the targets in this area is to reduce harm from addictive substance (i.e. alcohol, drugs, tobacco)
National Strategy for the Primary Prevention of Risk Behaviour for 2013–18	Key policy document presenting school-based prevention-related activities that are under the responsibility of the Ministry of education, youth and sport.

Organisations involved

The government of the Czech Republic and more precisely the Government Council for Drug Policy Coordination (GCDPC) is responsible for developing and enforcing national drug policy. The GCDPC includes all Ministries involved in the delivery of the national drug policy, a representative from the Czech Association of Addictologists, and three representatives of civil society including a representative of the regions (the Association for Addictive Diseases of the Czech Medical Association; an association of NGOs dealing with drug prevention and treatment; and the Association of the Regions). The scope of the GCDPC's has been expanded recently following the revision of the drugs strategy and it now addresses alcohol and gambling issues alongside illicit drug issues.

Most of the regions in the Czech Republic have developed their own strategies based on national policies, and drug coordinators have been established in most of the municipalities.

The National Monitoring Centre for Drugs and Drug Addiction is the EMCDDA national focal point. It was established in 2002 within the structure of the Office of the Government of the Czech Republic and the Secretariat of the Council of the Government for Drug Policy Coordination[154].

INPUTS (I.E. MONETARY COST OF DRUG POLICIES)

In 2010, the total drug-related public expenditures (at both, national and local level) represented 0.06 % of gross domestic product (GDP).[162] Total expenditure amounted to 88 775 000 EUR in 2010 and among these, around a fifth were 'labelled expenditure' (i.e. planned and identifiable expenditure earmarked for drug policy programmes). 'Unlabelled expenditure' are expenditure contributing to drug policies without being identified as such and are usually estimated through modelling approaches (i.e. a demand reduction activity could be included in general health expenditure and supply reduction activities could fall under general crime reduction activities). Total labelled expenditure were 24 807 000 EUR in 2010 and non-labelled expenditure were 63 968 000 EUR. Most of the labelled budget is spent on demand reduction programmes (18 901 000 EUR) and the unlabelled budget is mainly spent on supply reduction programmes (45 800 000 EUR). Drug-related labelled

[154] Interview with Mgr. Voboril, National Drug Coordinator from Czech Republic; Czech Republic country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/czech-republic.

public expenditure seems to have decreased in the recent year moving from 24 807 000 EUR in 2018 to 18 078 000 in 2013. There are no data available on the evolution of non-labelled expenditure.[155] Table 15 below breaks down labelled public expenditure per type of expenditure and reveals that most of the drug-dedicated budget are spent on harm reduction programmes, treatments and sobering up stations.

Considering labelled and unlabelled expenditure together, the share of budget spent on law enforcement activities and demand reduction activities is approximatively 70%, 30% respectively[156].

Table 15: Drug-related labelled public expenditure in 2013, per types of expenditure (in thousand EUR)

Proportion spent on each activities would be different with the inclusion of unlabelled expenditure as 75% of such expenditure are spent in supply reduction activities.

Type of expenditure	Amount (thousand EUR)	Proportion (%)
Prevention	1 756	9.7
Harm reduction *Outreach programmes, drop in centres, integrated programmes.*	6 710	37.1
Treatment *-Outpatient services: health, social and unspecified services;* *-Prison-based services;* *-Residential services: inpatient health services, therapeutic communities and other unspecified residential services.*	4 563	25.2
Sobering up station	3 072	17.0
Aftercare services	1 353	7.5
Coordination, research and evaluation	299	1.7
Law enforcement	119	0.7
Others, unspecified	206	1.1
Total	**18 078**	**100**

[155] Czech Republic country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 26 August 2016, from http://www.emcdda.europa.eu/countries/czech-republic; Mravčík, V., Chomynová, P., Grohmannová, K., Nečas, V., Grolmusová, L., & Kiššová, L. et al. (2014). National Report: The Czech Republic – 2013 Drug Situation. Prague: Office of the Government of the Czech Republic. Retrieved from http://www.emcdda.europa.eu/attachements.cfm/att_239732_EN_VZ_2013_EN_final.pdf.

[156] Interview with Pavel Bem.

Source: Mravčík, V., Chomynová, P., Grohmannová, K., Nečas, V., Grolmusová, L., & Kiššová, L. et al. (2014). National Report: The Czech Republic – 2013 Drug Situation. Prague: Office of the Government of the Czech Republic. Retrieved from http://www.emcdda.europa.eu/attachements.cfm/att_239732_EN_VZ_2013_EN_final.pdf.

ACTIVITIES (DRUG POLICIES, PROGRAMMES, STRATEGIES ETC)

Prevention activities

Prevention activities come in the form of universal programmes dedicated to children and adolescent no matter their socio demographic characteristics (30 certified programmes in 2014) and selective and indicated programmes for population with higher level of risk factors (23 certified programme in 2014; and, national and local media campaign)[157]. Czech Republic has notably developed good prevention programmes that target restricted group of population such as ethnic minorities[158].

In terms of school programmes, the recent Czech Republic initiative was to learn from the UK prevention system and to include prevention within the education curriculum in primary and secondary schools. The practical implementation varies from one school to another and depends on the schools methodology. There are obligations to have a drug coordinator in each school; the coordinator is usually a teacher who has received training from specialised centres.[159] Extra activities can also be provided by NGOs, notably in large cities. There are, however, an insufficient capacity and a lack of commitment for implementing school based interventions[160].

Treatment and Harm reduction activities

As per the National Drug Policy Strategy for 2010–18, harm reduction is the key area of the drug strategy and addiction treatments related to drug abuse have been implemented in the country:

- Low-threshold drop-in centres and outreach programmes across the Czech Republic form the basis of the network of harm reduction services. There are, however, unevenly distributed across the Czech Republic and not available in 21 districts. The network of low-threshold facilities exists since 1992 and the number of drug users participating to the programme has been increasing over the last 11 years. There were in 2013 a total of 111 low-threshold programmes[161]. In 2014 these centres reached around 40 300 individual drug users, mainly those who inject heroin, buprenorphine or methamphetamine, while an increase in the number of cannabis users seeking help from low-threshold services has also been noticed in recent years[162].
- The number of syringes distributed through needle and syringe programmes continues to increase, and reached more than 6.6 million in 2014. Besides needle and syringe programmes (drop-in and outreach work), pharmacy syringe sales are the main sources of sterile injecting material for people who inject drugs.

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[157] Mravčík, V., Chomynová, P., Grohmannová, K., Nečas, V., Grolmusová, L., & Kiššová, L. et al. (2014). National Report: The Czech Republic – 2013 Drug Situation. Prague: Office of the Government of the Czech Republic.

[158] Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy.

[159] Interview with Mgr. Voboril, National Drug Coordinator from Czech Republic and Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy.

[160] Interview with Mgr. Voboril, National Drug Coordinator from Czech Republic.

[161] Mravčík, V., Chomynová, P., Grohmannová, K., Nečas, V., Grolmusová, L., & Kiššová, L. et al. (2014). National Report: The Czech Republic – 2013 Drug Situation. Prague: Office of the Government of the Czech Republic.

[162] Czech Republic country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 17 August 2016, from http://www.emcdda.europa.eu/countries/czech-republic#pdu.

- It is estimated that substitution treatment was provided for approximately 4 000 clients in 2014, of which 17 % were on methadone and almost 83 % on buprenorphine-based medication. It is also delivered, to a lesser extent, by private institutions, which provide three main treatment services: detoxification, outpatient care and inpatient care. Substitution centre are not equally available across Czech Republic and is not available in 25 districts.
- There are also more and more reintegration programmes for drug users providing assistance with housing employment and debts.

Table 16: Example of activities and interventions tackling drugs supply and demand in place in the Czech Republic

The table represents an overview of type of activities available and is not exhaustive.

Activity name	Year	Short description	Type of interventions (Prevention, treatment and harm reduction, criminal justice response)
Media campaigns targeting heavy cannabis users or users of counterfeit legal drugs in 2013.	2013	N/A	Prevention
Prevention programmes	2013	The Government Council for Drug Policy Coordination supported five prevention projects, costing EUR 61 000. These projects offered universal, selective, and indicated prevention; three also pursued information and educational activities. The prevention programmes included blocks of lectures, interactive seminars, and individual consultations. Telephone and online counselling were the most frequently used services within the indicated prevention programmes.[163]	Prevention
Opioid Substitution Treatment (OST) with methadone	1998-Current	OST is delivered in specialised psychiatric facilities, and has also been available in prisons since 2009. In addition, any medical doctor, regardless of his/her speciality, may initiate buprenorphine-based OST.	Treatment and harm reduction
Network of low-threshold facilities offering counselling, infection testing	1992-Current	It includes low-threshold centres (drop-in) and outreach programmes providing needle exchange in 105	Treatment and harm reduction

[163] Mravčík, V., Chomynová, P., Grohmannová, K., Nečas, V., Grolmusová, L., & Kiššová, L. et al. (2014). National Report: The Czech Republic – 2013 Drug Situation. Prague: Office of the Government of the Czech Republic. Retrieved from http://www.emcdda.europa.eu/attachements.cfm/att_239732_EN_VZ_2013_EN_final.pdf.

and syringe exchange programmes.		units, three vending machines, and special street bins for the safe disposal of used needles. Needle and syringe programmes operate in all regions, providing a wide range of services: clean needles and syringes, condoms, voluntary counselling and testing for infectious diseases, risk reduction information, aluminium foil for heroin smoking and other services. 72 programmes offered HIV testing, 78 HCV testing, and 52 HBV testing, and 51 programmes offered testing for syphilis in 2013	
Restrictions on the sale of pseudoephedrine-containing medication. (Medicines containing pseudoephedrine are the main precursor of methamphetamine)	2009-Current	N/A	criminal justice response
Routine vaccination of HBV	2001-Current	The number of newly reported cases of acute HBV infection continued a declining trend, which is attributed to the routine vaccination introduced in 2001.	Treatment and harm reduction
Social reintegration programmes	N/A	Provided by addiction treatment programmes; social reintegration assistance includes support for housing, employment, and debts.	Treatment and harm reduction
Prison based addiction treatments	N/A	8 out of the 35 prisons provided in 2013 addiction treatments for their inmates. Mandatory court-ordered treatment could be completed in 4 prisons; 7 prisons offered substitution treatments; 23 worked with NGOs on the implementation of drug policy activities.	Treatment and harm reduction

Source: authors based on Mravčík, V., Chomynová, P., Grohmannová, K., Nečas, V., Grolmusová, L., & Kiššová, L. et al. (2014). National Report: The Czech Republic – 2013 Drug Situation. Prague: Office of the Government of the Czech Republic. Retrieved from http://www.emcdda.europa.eu/attachements.cfm/att_239732_EN_VZ_2013_EN_final.pdf .

Criminal justice response

Criminal justice response activities represent an important part of the drug-related activities performed by the public authorities; around 70% of the drug resources are spent

on criminal justice response. It mainly covers activities performed under the legal framework discussed in section 0. It is worth noting that penalties for drug offences are at the discretion of law enforcement agencies and therefore the penalties described in Table 13 might differ from actual practices. For example, one expert suggested that even if not explicit in the law, a court judgement would be less tough for offenders who shifted from hard core use to more moderate use. Also determining whether someone in possession of small quantity of drug should be arrested for drug use or drug trafficking is usually complicated. Offenders would always affirm that the drugs they possess are for personal use rather than sale and that is why, undercover operations are often necessary to get some evidence of drug trafficking[164].

Cooperation at the international and EU level

Being part of the Balkan route, Czech Republic is a place of transit for drug trafficking activities and it exists some cooperation with law enforcement agencies in the neighbouring countries and countries that are part of the Balkan route. Cooperation exist notably between the Czech Republic and Slovakia, Germany and Austria)[165].

There are also some cooperation at the international level. The Ministry of health, as part of the national drug commission is very active at the UN level and has notably been very active during the delegation UNGASS in April 2016[166]

In the Czech Republic, drug demand reduction is mainly achieved through harm reduction and prevention programmes while supply reduction activities are in the hand of law enforcement agencies. Most of the offences reported from the criminal justice system are related to drug supply crime with an approximate ratio of one demand related offence for two supply related offences. (See Table 17). Table 16 above provides some example of activities aiming at tackling drug supply and demand.

EFFECTS

The effects of liberal drug laws and policies officially implemented in 2010 have been very promising[167].

Impact on drug market violence and drug supply

As a result of the liberalisation of drugs, there is a very low existence of organised crime. Even if there is an increasing number of small productions of drugs, they are mainly used for personal use and the number is too small to have any influence and consequences on the drug market. Transnational cooperation have been effective in reducing drug-supply related crime; there is not, however a dramatic change in supply[168]. In 2014, a total of 7 438 drug-law offences were reported, including criminal and administrative offences. The highest number of people were arrested in connection with methamphetamine, followed by those who were arrested in connection with cannabis (see Table 17). Although supply-related offences exceed those related to use, data from 2004−14 show that the proportion of use-related offences (both criminal and administrative offences) has increased (see Figure 11).

[164] Interview with Pavel Bem.

[165] Interview with Mgr. Voboril, National Drug Coordinator from Czech Republic; Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy.

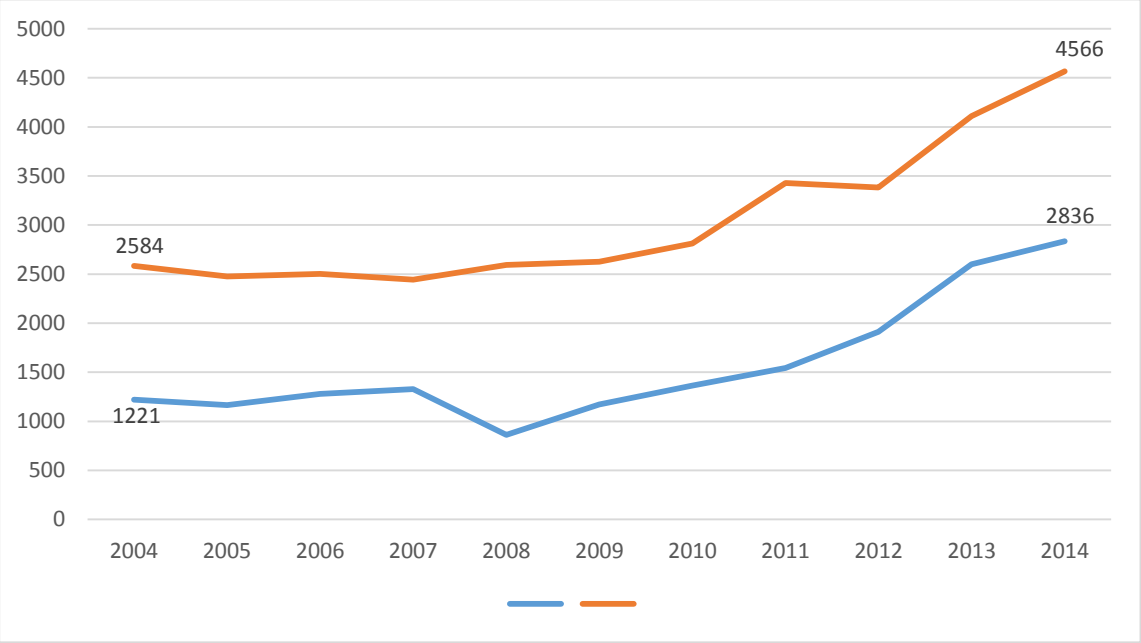
[166] Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy.

[167] *Ibid*.

[168] *Ibid*.

Production is now performed by hard to reach format organised group (notably through the Vietnamese drug crime groups) which set another challenges for law enforcement agencies in the Czech Republic[169]. Also, the Methadone Substitution programme led to unintended consequences in the drug market with the development of a black market of methadone across the Czech Republic. [170]

Figure 11: Number of drug law offences in Czech Republic



Note: Drug use offences includes use and possession for personal use; and drug supply offences includes production and trafficking.

Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016

Table 17: Number of offences in criminal justice system per type of drugs (2014)

The stage within the criminal justice system at which data have been reported and recorded, vary sometimes across countries. i.e. Data might be recorded at an initial stage when a first report is made by law enforcement agencies, or after investigation by the Judicial Police, or even following a decision for a charge to be issued by the Prosecutor.

Drugs	Drug-use related offence	Drug-supply related offences	Total
Cannabis	500	1 052	1 580
Opioids/Opiates			
Heroin	3	29	32
Stimulants			
Cocaine	12	36	48

[169] *Ibid*.
[170] *Ibid*.

Drugs	Drug-use related offence	Drug-supply related offences	Total
Amphetamine [i]	1	4	5
Methamphetamine	138	1 852	1 995
Hallucinogen			
Ecstasy	12	21	33
LSD	N/A	2	2
All drugs			
Total	2 836	4 566	N/A

Note: Drug use offences includes use and possession for personal use; and drug supply offences includes production and trafficking. The sum of drug use and supply offences does not necessarily add up to the total because some offences are not distinguished when reported.

Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016; [i] Data from 2013

Injecting drug use, infectious disease and impact of harm reduction programmes

The health effects are also perceived positively[171] with:

- A general low overdose rate (Figure 15);
- A HIV prevalence under 1% (Figure 14);
- A huge decrease in general hepatitis C prevalence from around 60% to approximatively 18%[172].

The positive effects are partly due to the flexible legislation and the easy to access programmes. The flexible law gives confidence to drug users in looking for help in treatment and harm reduction facilities. In recent years there has been an increase in the number of early detection of drug users and addicts, notably thanks to the low threshold facilities and supportive local communities which contributed in preventing HIV and Hepatitis B infections.[173]

In terms of prevention, however, school based prevention, in place since 1998, has not been very efficient due to an absence of budget and a fragmented system with not enough informed teachers[174]. Prevention is good at the strategic level but fail in the implementation[175]. The flexibility in the implementation of the educational programme managed by the school director led to a lack of involvement and efficiency. Some schools might have developed a good prevention programme but other could simply consider prevention as an administrative task[176]. Also, school coordinators were not paid, which led

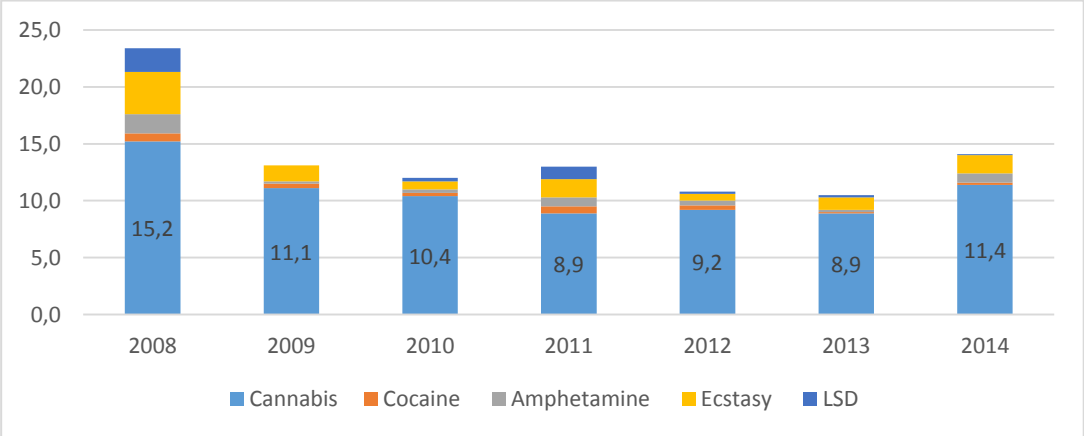
[171] *Ibid.*
[172] *Ibid.*
[173] *Ibid*.
[174] *Ibid.*
[175] *Ibid.*
[176] Interview with Pavel Bem.

to a lack of engagement. Even though the intervention was cheap to implement, its effectiveness was very low and did not provide the same results as in the UK. [177]

There has been, however, a slight increase in drug prevalence and in the number of high risk users (Figure 12 and Figure 13). This increase has mainly been attributed to outbreaks in localised minority groups in excluded area. The 2013-2015 action plan discussed the importance to enhance harm reduction programme in hard-to-reach and socially excluded communities. However, because of the limiting budget and because drugs are not seen as a problematic health and security issue, resources are concentrated in more problematic areas, such as alcohol and gambling.[178]

Even if there exist some very good programmes in Czech Republic, there are often not widespread across the country. For example, harm reduction programmes in prison exist but are not widely available. There are also very good social reintegration programme that are not widespread and cannot be accessed by everyone. There are around 25 000 injecting drug users in Czech Republic but there are approximatively 150 beds available for social reintegration programmes in Prague and there is only 1 job assistance programme in Prague that could only welcome 20 persons per day. Harm reduction is prioritised over aftercare programme and an Expert from Czech Republic suggests that more effort should be spent on reintegration as it could contribute in decreasing the black market for demand.[179]

Figure 12: Last year drug use prevalence (%)



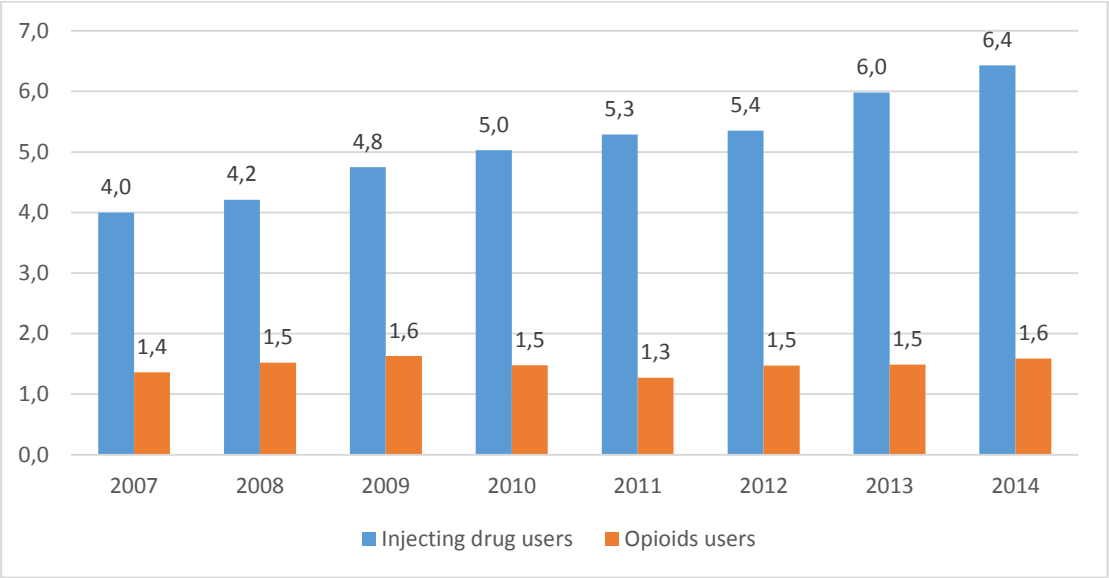
Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from ***http://www.emcdda.europa.eu/data/stats2016***

[177] Interview with Mgr. Voboril, National Drug Coordinator from Czech Republic.

[178] Interview with Mgr. Voboril, National Drug Coordinator from Czech Republic and Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy.

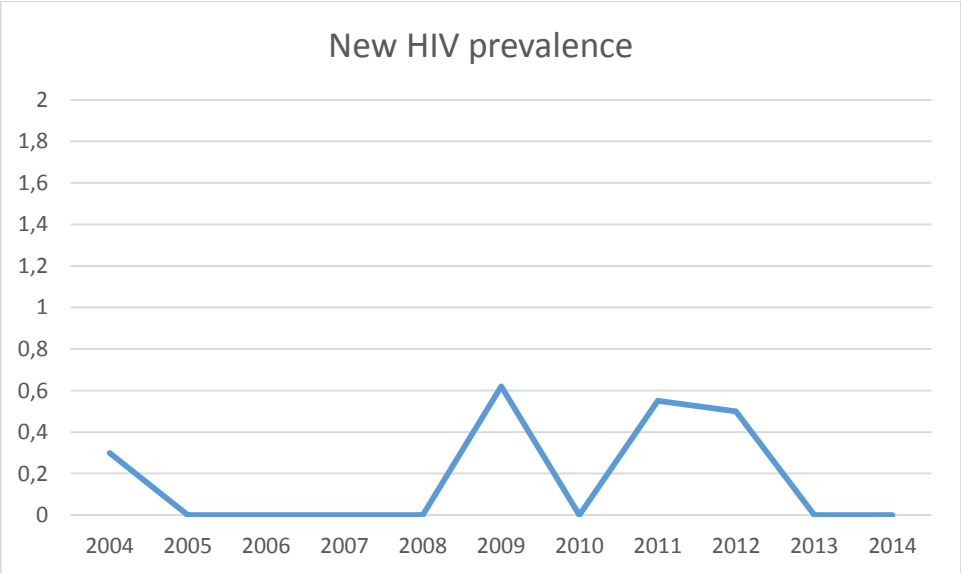
[179] Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy.

Figure 13: Last year prevalence of high risk drug users (using injecting drugs or Opioids) (per thousand)



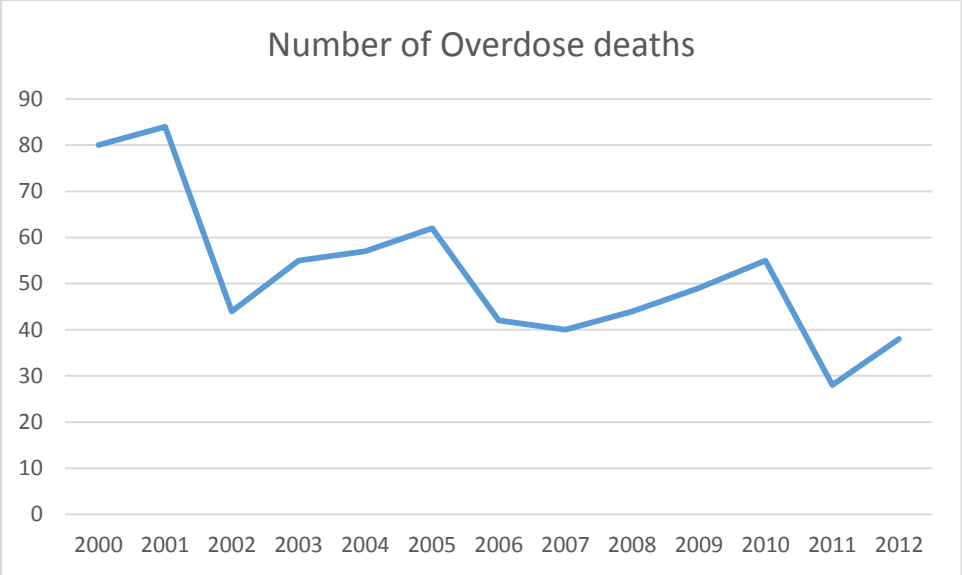
Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016

Figure 14: New HIV prevalence among people who inject drugs (%)



Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016

Figure 15: Number of overdose deaths in Czech Republic



Note: According to national definition of overdose that is acute deaths directly related to drug consumption. It does not include death that are linked to drug abuse but not caused by them (e.g. mental health issues)

Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016

CONCLUSIONS

Future strategy

The Czech Republic has done fairly well in terms of drug's liberalisation and harm reduction and for this reason drug is not the main priority in terms of addictive behaviours related issues. There are still however some area of improvement around prevention and coordination across different Czech institutions. Some research work is also done in other countries such as Canada and Uruguay and the Czech Republic in order to pick up best practices and challenges around decriminalisation. The Czech Republic is currently in the process of decriminalising drug possession for personal use and the next legislation period aims to eliminate contradictions that exist currently between laws and practices. For example, even though production of Cannabis for personal use should be considered as an offence, law enforcement agencies do not investigate on small production but only on large scale productions.[180]

It is also worth mentioning that budget attributed to drug-related issues decreased recently which led the Czech Republic to reduce the number of interventions they offer and to refocus on social work.[181] There have been some discussion around psychiatric care reforms led by the Ministry of Health, that aim to further shift the treatment system towards community-type care. A new illicit drug action plan, covering the years 2016–2018, is currently pending approval by the Government.[182] Due to the limited budget, an expert also suggested that balance between resources spent on criminal justice system and health system should be reviewed. The expert suggested to a 60%-40% budget

[180] Interview with Mgr. Voboril, National Drug Coordinator from Czech Republic.

[181] Interview with Mgr. Voboril, National Drug Coordinator from Czech Republic.

[182] Czech Republic country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 26 August 2016, from http://www.emcdda.europa.eu/countries/czech-republic; Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy.

allocated to supply and demand reduction respectively compared to an actual balance of 70%-30%.[183]

Also due to the change in market and the emergence of hard to reach format organised crime, Czech Republic is currently shifting its priorities to investigate and combat newly emerged technologies on production (i.e. new technologies enable to produce stronger substances that take less spaces to smuggle from one place to another.)[184]

STAKEHOLDERS AND DOCUMENTS CONSULTED

Table 18: Czech Republic case study – Sources

Stakeholders interviewed	• Mgr. Voboril, National Drug Coordinator from Czech Republic, [06/09/2016] • Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy, [13/09/2016]
Documents / websites reviewed	• Czech Republic country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved from http://www.emcdda.europa.eu/countries/czech-republic • Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved from http://www.emcdda.europa.eu/data/stats2016; • Harm Reduction International,. (2014). The Global State of harm reduction 2014. London: Harm Reduction International. Retrieved from https://www.hri.global/files/2015/02/16/GSHR2014.pdf; • Belackova, V., Maalsté, N., Zabransky, T., & Grund, J. (2015). 'Should I Buy or Should I Grow?' How drug policy institutions and drug market transaction costs shape the decision to self-supply with cannabis in the Netherlands and the Czech Republic. International Journal Of Drug Policy, 26(3), 296-310. • Government Council for Drug Policy Coordination. (2010). National Drug Policy Strategy for the Period 2010 − 2018. Retrieved from http://www.emcdda.europa.eu/system/files/Czech%20Strategy%202010-2018%20English.pdf . • Ministry of health of Czech Republic,. (2014). Health 2020 − National Strategy for Health Protection and Promotion and Disease Prevention (1st ed.). Retrieved from http://www.mzcr.cz/unie/Soubor.ashx?souborID=21944&typ=application/pdf&nazev=Health%202020%20%E2%80%93%20National%20Strategy%20for%20Health%20Protection%20and%20Promotion%20and%20Disease%20Prevention.pdf • Mravčík, V., Chomynová, P., Grohmannová, K., Nečas, V., Grolmusová, L., & Kiššová, L. et al. (2014). National Report: The Czech Republic − 2013 Drug Situation. Prague: Office of the Government of the Czech Republic. Retrieved from

[183] Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy.
[184] Interview with Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy.

	http://www.emcdda.europa.eu/attachements.cfm/att_239732_EN_VZ_2013_EN_final.pdf.

Appendix A2: Case Study – Germany

Introduction

Germany places at the federal level a strong focus on law enforcement that is used as a deterrent for preventing drug use. Even if there are some innovative preventions programmes, an important number of prevention activities emphasises to their target population the illegality of drug use rather than having a more open discussion about drug use and the negative health effects associated. However, the approach to implementing the federal drug policy differs by Länder that may set different focuses within the policy framework. The need for harm reduction activities are highlighted by the relatively high number of overdose deaths in the country and there has been at the regional level, an increasing focus on health-oriented activities, including expanding treatment options and harm reduction programmes.

Needs

Drug use among population

Cannabis is the most used drug with an annual prevalence of 4.5% followed by cocaine and amphetamine. According to an estimate based on a 2012 general population survey in Germany, 0.6 % of adults aged 15-64, used cannabis daily or almost daily. The estimated number of high-risk drug users ranges between 70 840 and 84 122, that is between 4.04 and 4.80 per 1 000 inhabitants[185].

Table 19: Prevalence rates for Germany among adults 15–64 (2012)[186]

Title	Life time prevalence EU average	Life time prevalence Germany (2012)	Last year prevalence (2012)
Cannabis (%)	17.8	23.1	4.5
Opioids			
All Opioid drug use problems (per thousand)[i]	Average of annual prevalence at the most recent year available: 0.35	2.95	
Stimulants			
Cocaine (%)	3.0	3.4	0.8
Amphetamines (%)	2.5	2.7	0.7

[185] Germany country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/germany.

[186] Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016 ; [i] 2013 based figure based on average between the lower and upper bound of prevalence estimate.

Title	Life time prevalence EU average	Life time prevalence Germany (2012)	Last year prevalence (2012)
Hallucinogens			
Ecstasy (%)	2.9	2.7	0.4
LSD (%)	1.4	2.2	0.3
All drugs			
Total (%)	19.1	23.9	4.9

Source: Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016;

[i] Average EU data have been calculated according to the most recent data available per country in EMCDDA statistical bulletin. Latest year available for all types of drugs except opioids are as following: 1998 for LU; 2004 for EL; 2007 for HU; 2008 for AT and EE; 2010 for SK; 2011 for IE and LV; 2012 for BG, HR, CY, DE, LT, PT, SI; 2013 for BE, DK, MT, RO and ES; 2014 for CZ, FI, FR, IT, NL, PL, SE and UK. Data from SE, BE and EE were not broken down by drugs and were only available for the overall drug prevalence. There were not any available data on all drug prevalence for LU and NL and no amphetamine use prevalence were available for LU;

[ii] Latest year for Opioids use prevalence estimations used for calculating EU average data are as follow: 2007 for LT and LU; 2008 for SK, 2009 for PL, 2010 for HR, 2012 for FI, NL and PT; 2013 for AR, DE, SI and ES; 2014 for CY, CZ, EL, IT, LV and MT; 2010-11 for HU and UK; 2013-14 for FR. There were no available data on opioids prevalence for BE, BG, DK, EE, IE, RO and SE;

[iii] Recurrent drug use that is causing actual harms to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high risk of suffering such harms'. Prevalence data for Portugal have been estimated with capture recapture method and based on treatment data and criminal justice data.

Health impact of drug use in Germany

There was a 7.2% increase in the number of newly diagnosed HIV cases between 2013 and 2014 with 3 525 cases in 2013. The trend however of the incidence of HIV among injecting drug users is decreasing as 3.9% of the cases with a known transmission route were people who inject drugs in 2013, compared to 12.4% in 2000. The number of reported cases of hepatitis B virus (HBV) has been stable in recent years and the incidence among general population in 2014 was 0.9 per 100 000 habitant. There were in 2014, 7.2 per 100 000 of newly diagnosis of hepatitis C virus (HCV) and among those with a known transmission route (1 555), 82% were cases of injecting drug use.[187]

A study from 2012 on drugs and chronic infectious diseases reported prevalence results among people who inject drugs in 8 different German cities. All cities with available data show a new HIV prevalence below 1% (in Berlin, 2011; Cologne, 2013; Essen, 2011; Frankfurt, 2013; Hannover 2013; Leipzig, 2012; Munich, 2013) except for Hamburg when it has been reported 9% prevalence new HIV in 2014[188].

[187] Germany country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/germany.

[188] Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016.

Prevalence of HCV antibodies ranged from 37% to 73% and the HBV prevalence ranged from 5% to 33% in 2012[189].

The most recent national data from 2010 – 2014 shows an increase in the number of people who die because of the use of illicit drugs. Drug-related deaths increased from 944 in 2012 to 1 032 in 2014. The drug-induced mortality rate among adults (age 15-64) was 18.6 deaths per million in 2014, which is slightly lower than the European average of 19.2 deaths[190].

Table 20: Drug induced mortality and epidemiology (2014)[191] [192]

	Number of people who inject drug[i]	HIV prevalence among people who inject drug (%)[ii]	Hepatitis C prevalence among people who inject drugs (%)[ii]	Hepatitis B prevalence among people who inject drug (%)[ii]	Drug induced mortality among adult 15-64 (per million) [iii]
Year		**2014**- based on subnational data	**2014**- based on subnational data	Old estimates from 1992-1994	**2014**
Germany	94,250 (78,000–110,500)	3.9–5.6	56.0–71.6	7.2	18.6
European average	N/A	N/A	N/A	N/A	19.2

Source: [i]Harm Reduction International,. (2014). The Global State of harm reduction 2014. London: Harm Reduction International. Retrieved from https://www.hri.global/files/2015/02/16/GSHR2014.pdf; [ii] Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016; [iii] Portugal country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/Portugal

Drug production, import and export

Domestic market

Cannabis is extensively cultivated in Germany. There has been a considerable increase in large and professional plantation. In 2014 the total number of plantations seized amounted

[189] Germany country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/germany .

[190] *Opt.Cit*.

[191] Harm Reduction International,. (2014). The Global State of harm reduction 2014. London: Harm Reduction International. Retrieved from https://www.hri.global/files/2015/02/16/GSHR2014.pdf.

[192] Germany country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/germany .

873. Also, 20 illegal laboratories have been dismantled in 2014 and 13 of them were producing amphetamine and/or methamphetamine.[193]

Import and export market

Heroin is mainly trafficked to Germany from South East Asia (notably Afghanistan) and the quantity of heroin seized in 2013 was 780 kg. That is three times more than the quantity seized in 2012. Cocaine seized in Germany mainly originates from South America and the quantity seized in 2014 increased compared to 2013 from 1 315 kg to 1 568 kg. Synthetic drugs, such as amphetamine, imported from the Netherland and Czech Republic are in expansion. There were 3 905 seizures of methamphetamine and 73 kg of substance seized in 2014, which is triple the amounts reported in 2010 and the quantity of amphetamine seized in 2014 was 1 411 kg. There has been a massive drop in ecstasy seizures, when compared to the period 1999-2007, however an increasing tendency is notable since 2011; the quantity of seizure in 2014 was 3 122 compared to 2 233 in 2013.[194]

Supply and demand

Among the 282 177 drug-law offences reported in 2014, more than half of them were related to cannabis, followed by amphetamine. Around 74% of the offences were related to personal use of drug[195]. The General Statistical Office estimated that the total price paid for consumption of the 5 main types of drugs in Germany (i.e. heroin, cannabis, cocaine, ecstasy and amphetamine) was EUR 1.9 billion. A quarter of this drug was exported from abroad which leads to a Gross value added from drug trafficking of EUR 1.2 billion for Germany[196].

LEGAL FRAMEWORK

The national legislation criminalising drug-offences in Germany is the Federal Narcotics Act. It provides a legal framework for the prescription of Narcotic, the criminal and administrative liabilities regarding drug law offences and the possibilities to refrain from prosecution in certain condition. Table 21 below provides an overview of how drugs are penalised in Germany.[197]

The use of drug is not considered as an offence and penalty range for possession and supply of drugs does not depend on the type of drugs. Possession of drugs is a criminal offence that can be punished by imprisonment up to 5 years or a fine. There are various possibilities within the law to refrain from prosecution depending on the substance possessed, the quantity and whether the drug is for personal use. At the regional level, Länder are responsible for prison legislation and law enforcement in the areas that are relevant for drug and addiction policies. Most of the Länder have established a value for 'small amounts' of cannabis and few have defined such value for heroin, cocaine, amphetamine and ecstasy. The Federal Government however has defined a national limit for the maximum quantity of methamphetamine that can be considered as small amount. The law also encourages the justice system to favour treatment over punishment and a

[193] *Opt.Cit.*

[194] *Opt.Cit.*

[195] Germany, 2015 National Report (2014 data). (2015). Retrieved from http://www.dhs.de/fileadmin/user_upload/pdf/Reitox_Jahresberichte/WB01_Policy_2015_Germany_EN.pdf .

[196] Germany, 2015 National Report (2014 data). (2015). Retrieved from http://www.dhs.de/fileadmin/user_upload/pdf/Reitox_Jahresberichte/WB01_Policy_2015_Germany_EN.pdf .

[197] Germany country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/germany .

postponement or remission of the punishment can be offered if the offender undergoes treatment.[198]

The illicit supply and production of narcotic drugs can lead up to 5 years' imprisonment. The sentence can increase to 15 years in case of aggravating circumstances of which there are two type: (i) those ruled by law: eg. committed in a gang, with weapons or involving minors, and (ii) those ruled by the courts: measuring the punishment, eg. very high amounts, individual aspects of the situation or perpetrator.[199]

Table 21: Criminalisation of drugs and penalties[200]

Produce	supply	possess		use
Penalty	**Penalty**	**Penalty**	**Depending on Quantity?**	**Penalty**
Production brings the same legal sentencing as supply: i.e. up to 5 years imprisonment for standard cases; up to 15 years imprisonment if aggravating circumstances.	- Standard case: up to 5 years imprisonment - Aggravating circumstances: up to 15 years imprisonment – these can include links to a gang (which can be formed of 2 individuals in this instance) or the use of weapons.201 - Punishment does not differ depending on the drugs. - There are higher penalties for trade of significant quantities	- Standard case: up to 5 years imprisonment	- Prosecution may be refrained if the offender's guilt is minor	Not mentioned as an offence

Table 22: Number of offences in criminal justice system per type of drugs (2014)[202]

Drugs	Drug-use related offence	Drug-supply related offences	Total
Cannabis	131 130	34 774	165 904

[198] Germany country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/germany .

[199] *Ibid.*

[200] European Legal database on drugs: http://www.emcdda.europa.eu/topics/law/penalties-at-a-glance

[201] Interview with Lorenz Böllinger, Emeritus Professor of Criminal Law and Criminology at the University of Bremen.

[202] Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016; [i]: data from 2013.

Drugs	Drug-use related offence	Drug-supply related offences	Total
Opioids/Opiates			
Heroin	8 806	3 218	12 024
Stimulants			
Cocaine	10 933	4 045	14 978
Amphetamine [i]	34 679	7 915	42 594
Methamphetamine	N/A	N/A	N/A
Hallucinogen			
Ecstasy[i]	4 479	1 424	5 903
LSD	377	102	479
All drugs			
Total	209 514	54 323	282 177

The stage within the criminal justice system at which data have been reported and recorded, vary sometimes across countries. i.e. Data might be recorded at an initial stage when a first report is made by law enforcement agencies, or after investigation by the Judicial Police, or even following a decision for a charge to be issued by the Prosecutor.

AIMS AND OBJECTIVES OF THE NATIONAL APPROACH TO DRUG POLICY

Objectives and overview of the current strategy(ies)

Germany uses an integrative approach for tackling addiction; both legal and illegal substance are addressed together. This approach is said to give particular consideration to the widespread use of addictive substances, such as alcohol, tobacco and psychotropic substances.

The National Strategy on Drug and Addiction Policy originates from 2012 and does not have a definitive end date. The strategy stresses the importance of prevention in health policy and health promotion and is based on the new challenges in drug and addiction policy arising notably from demographic change, societal changes, emergence of new addictive substance. The policy focuses on dependence but also on risk use behaviours that are harmful to health even if they do not lead to a dependence. The main pillars of the strategy are built on prevention, counselling and treatment, cessation assistance, measures for harm reduction and repression. Policies can then be redefined and adapted according to the local needs by the lander. Both, the Federal Government and the Länder are increasingly setting their focus on young population as well as addiction with legal substance.[203]

[203] National Strategy on Drug and Addiction Policy (2012) Berlin.

Table 23: Main current policies and action plans in Germany[204]

Policies, actions plans	Description
National strategy on Drug and Addiction Policy, 2012	Adopted in 2012 by the Federal cabinet, the strategy's primary aim is to help individuals to avoid and reduce their consumption of licit and illicit addictive substances and addictive behaviour. It is the main document shaping drug policies at the national level in Germany.

Organisations involved

Responsibilities for drug and addiction policies are shared between the Federal Government, Länder and municipalities.

Policy strategy

The federal government has the legislative authority for narcotic drugs law, criminal law and social welfare law. The Federal Government Commissioner on Narcotic Drugs is attached to the Federal Ministry of Health since 1998 and is responsible for coordinating drugs and action policy. His main responsibility is to develop policies that promote and support initiatives for addiction and drug prevention and to develop new methods and areas of focus in addiction and drug help policies with the aim of alleviating health, social and mental problems. The German Monitoring Centre for Drugs and Drug Addiction (DBDD), acting as a national focal point of the EMCDDA, regroups the federal centre for health education, the German centre for addiction issue and the IFT Institute for Therapy Research. The Federal Centre for Health Education is responsible for planning and executing prevention campaigns, the German Centre for Drugs and Drug Addiction manages addiction treatment and harm reduction policies and the Institute for Therapy Research administers the overall scientific coordination and management of the German National Focal Point.

Policy implementation

The actual implementation of policies mainly lies in the hands of the Länder and municipalities. Lander and municipalities may set different focuses within the policy framework and they are the main bodies funding and developing activities that reflect their drug policy strategy.

INPUTS (I.E. MONETARY COST OF DRUG POLICIES)

The funding of drug-related measure is complex and shared between Federal, Länder and municipal organisation, along with social insurance providers. The aggregation of expenditure on drug-related issues can therefore not be exhaustively estimated.

However, one study by Mostardt et. al (2010) estimated the public expenditures related to illicit drugs using 2006 data, according to which an amount of EUR 5.2−6.1 billion were spent on the task of tackling illicit drugs[205]. Table 24 below reports public expenditure on drug-related policies per government functions.

[204] National Strategy on Drug and Addiction Policy (2012) Berlin.

[205] Mostardt, S., Flöter, S., Neumann, A., Wasem, J., & Pfeiffer-Gerschel, T. (2010). Schätzung der Ausgaben der öffentlichen Hand durch den Konsum illegaler Drogen in Deutschland. *Das Gesundheitswesen*, *72*(12), 886-894.

Table 24: Total drug-related public expenditure in 2006[206]

Expenditure per government function	Expenditure (billion EUR)	% of total
Public order and safety	3.37–4.22	64–69
Health and social protection	1.79 –1.81	30–34
General public services	0.04	1
Total	**5.19–6.07**	**100**
% of GDP	**0.23–0.26**	

ACTIVITIES (DRUG POLICIES, PROGRAMMES, STRATEGIES ETC)

This section will provide an overview of the different activities undertaken by the German government under its drug policy, including in the field of prevention, treatment and harm reduction, its criminal justice response and in terms of cooperation with other international and EU institutions and bodies. Table 25 below provides some example of activities aiming at tackling drug supply and demand.

Prevention policies

Prevention is widely emphasised in the National Strategy on Drug and Addiction Policy and the activities for addiction prevention fall within the competence of the ministries at federal and Land level. The Centre for Health and Education, the Länder, municipalities, and the self-governmental bodies of the social insurance scheme are in charge of implementing the drug prevention activities. More than half of the prevention activities for illicit substance mainly focus on the prevention of cannabis and they are available universally mainly in schools but also in other recreational settings, such as sport clubs. There are, however, other community and family oriented interventions that are also available such as the Strengthening Families Program, Family Outreach Therapy for Risky Drug Using Adolescents and their Families and counselling programmes[207]. Germany is also at the origin of an early intervention programme for drug users, FReD Goes net[208], which has now been implemented in 11 European countries. It consist of detecting early on drugs and alcohol consumption at school and to offer students a health education course. This free intervention gives a chance to young people to think about their drug use before they get addicted.

Treatment and harm reduction activities

In Germany, the Länder and municipalities are responsible for implementing drug treatments.

[206] Estimates from EMCDDA, based on Mostardt et al calculation; Government function as per Eurostat definition: http://unstats.un.org/unsd/cr/registry/regcst.asp?Cl=4.

[207] Germany country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/germany .

[208] EMCDDA | Best practice portal: EDDRA project description. (2016). Emcdda.europa.eu.

Family doctors play a special role in drug treatment because they are often the first point of contact for drug addicts and individuals at risk. Additionally, the primary support system for drug addiction is provided by 1 300 addiction counselling and treatment centres, 300 psychiatric outpatient institutes, around 800 facilities for integration support and approximately 500 outpatient and 320 inpatient therapy facilities[209].

There are also some complementary services such as low threshold facilities, day care facilities, job programmes and employment projects, assisted living, youth housing, socio therapeutic transitional residential facilities, hostels for the homeless, and self-help initiatives. Opioid substitution treatments (OST) are offered by the primary healthcare system where 2 650 have the licence for providing OST[210].

Concerning harm reduction, the primary aim is to reduce mortality and morbidity of drug users. The main activities aiming at reducing drug use related harm are the needle and syringe programme, the low threshold and counselling facilities and the open drug consumption rooms. Data on the number of syringes distributed are not available in Germany but the number of syringe and vending machines are the highest in the world. There are 160 vending machines across nine of its 16 Lander and there is one programme available in prison. There are about 300 low-threshold services and counselling facilities, which are, for the most part, funded by public funds. 6 Länder passed a special regulation on the basis of a national law which enabled them to open drug consumption rooms. There are currently 23 drug consumption rooms in Germany and there is also one drug consumption vehicle in circulation.[211]

Furthermore, stakeholders consider the treatment and harm reduction programmes being undertaken in Germany to be very effective.[212]

Criminal justice response

It has been reported by experts in the field that the German strategy promotes a primarily law enforcement-led approach to illicit drugs based on the idea that these authorities, and criminal law more generally, deters individuals. An unofficial analysis presented by an expert in the field suggested that up to 80% of expenditure is allocated to law enforcement, with only 20% set aside for prevention, harm reduction and treatment programmes.[213]

It has also been noted that, in the German Federal system, the proactivity of law enforcement differs by state, particularly given the lack of legal provisions guiding prosecution (e.g. regarding quantity and type of drugs). For example, Bavaria is said to be much tougher on drug use than Bremen. This is reflected in the different amounts linked to the sentencing. In Bavaria, 5g of cannabis is enough to ensure criminal prosecution compared with 15g in Bremen.[214]

It has been reported that the role of law enforcement as a deterrent has had little effect.[215]

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[209] Germany country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/germany .

[210] *Ibid.*

[211] *Ibid.*

[212] Interview with Lorenz Böllinger, Emeritus Professor of Criminal Law and Criminology at the University of Bremen.

[213] *Ibid.*

[214] *Ibid.*

[215] Interview with Lorenz Böllinger, Emeritus Professor of Criminal Law and Criminology at the University of Bremen.

Cooperation at the EU and International level

Because Germany is one of the main consumers country of illegal drugs produced in developing countries, the government believes that it has a role to play for finding a sustainable way of dealing with the drug problem. Germany supports, notably projects in Columbia that aims at finding alternative source of income for household whose incomes depend on drug cultivation (e.g. cultivation of coffee and rubber instead of coca)[216]. It also contributes in the Global Partnership on Drug Policies and Development, a project that aims to find effective ways to tackle the global drug issue by refining evidence-based development and public health oriented approaches to drug policy in close collaboration with interested governments.[217]

From the data available, it is difficult to establish what are the main activities dedicated for supply and demand reduction. As described above, prevention seems to play an important role in demand reduction and there are also some resources allocated for treatment and harm reduction programme. However, it seems that the majority of the drug-related budget is dedicated for public order and safety (see Table 24). Interestingly, assuming that the order and safety budget represents mainly criminal justice response according to the law described in Table 21, it can then be assessed the role of the criminal justice response by looking at number of offences due to drug use or supply related offences (Table 17). 80% of the offences were related to drug use and 20% to drug supply. This leads to suggest that most of the action undertaken (from prevention, health and criminal perspective) are mainly focused on demand-reduction rather than supply-reduction.

Table 25: Example of drug activities and intervention in place in Germany

Activity name	year	Short description	**Type of intervention** (Prevention, treatment and harm reduction, criminal justice response)
Initiatives for preventing and consuming the consumption of crystal meth and methamphetamine	N/A	Few Länder have implemented some activities for tackling the growing consumption of methamphetamine.	Treatment and harm reduction
Opioid substitution treatment	1992 - Current	Substitution treatment exists since 2012 and are originally provided with methadone. There now other substitution substances such as Buprenorphine and diamorphine	Treatment and harm reduction

[216] Rural development instead of drug cultivation – Minister Müller and German Drug Commissioner Marlene Mortler issue statements on World Drug Day. (2016). Federal Ministry for Economic Cooperation and Development.

[217] Global Partnership on Drug Policies and Development (GPDPD). Thai-german-cooperation.info.

Activity name	year	Short description	**Type of intervention** (Prevention, treatment and harm reduction, criminal justice response)
Cannabis for medicinal purpose	2011 - current	Cannabis-containing proprietary medicinal products can be manufactured since 2011 and prescribed, after clinical testing and licensing by the Federal Institute for Drugs and Medical Devices (BfArM).	Prevention
School based preventions	N/A	School based intervention activities are primarily focused on cannabis, alcohol and tobacco. The prevention activities includes information on the health damages of addictive substances but promote also life skills and encourage student to think critically about drug use. Klasse2000, KlasseKinderSpiel (developed in the US as the good behaviour game), Prev@WORK, Unpluged, REBOUND My Decision are the most widespread programmes. They target students/children of different ages in standard training and vocational training.	Prevention
Strengthening Families Programme	2013-2014	Family skills training program that aims to increase resilience and reduce risk factors for behavioural, emotional, academic and social problems. It has been originally designed specifically for 6 to 12 year old high-risk children who have substance abusing parents.	Prevention
FReD Goes net	N/A	This intervention programmes targeting young offenders originated in Germany and is now implemented in 11 countries. FReD Goes net aims to enable cooperation between institutions such as police, judicial authorities, and governmental and non-governmental organisations active in the field of drug treatment. The 8 hours course offered to the young offenders aims to encourage them to reflect their drug use behaviour and stop them from drifting into dependency.	Prevention
Family Outreach Therapy for Risky Drug Using Adolescents and their Families	N/A	This is a federal pilot programme which assists the parents of drug using children. It aims to facilitate intra-family communication and to enable early detection and intervention	Prevention
www.quit-the-shit.net	N/A	Evaluated online counselling programme for cannabis users	Prevention

Activity name	year	Short description	Type of intervention (Prevention, treatment and harm reduction, criminal justice response)
Needle and syringe programmes	1992-2014	Needle and syringe programmes have existed unofficially in some cities since 1984 and were legalised in 1992	Treatment and harm reduction
Drug consumption room	-	6 Länder passed a special regulation on the basis of a national law which enabled them to open drug consumption rooms. There are currently 23 drug consumption rooms in Germany and there is also one drug consumption vehicle in circulation.	Treatment and harm reduction
Take-home naloxone programmes	2014-current	To prevent opioid overdose deaths, take-home naloxone programmes have been developed in 2014-2015. Two programmes are currently operational and two are in the planning stage.	Treatment and harm reduction

Source: Authors based on the EMCDDA website and national reports.

EFFECTS

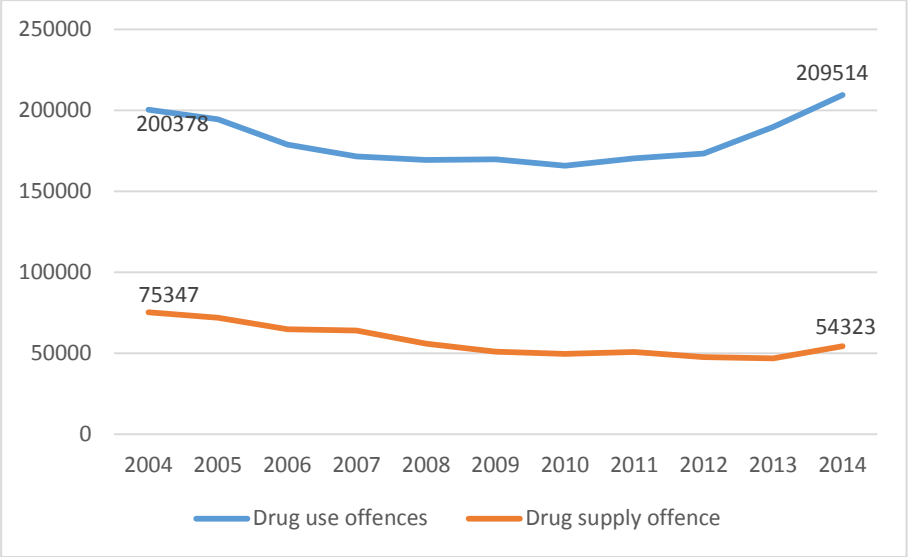
In general, drug policies in Germany have not been perceived as very effective. As reported in section 0, more than 60% of the budget is dedicated for public order and safety issues.. However, an expert on drug policy in Germany pointed out that the police focuses on arresting drug users rather than on tackling drug supply or organised crime[218]. Figure 16 confirms the observation made by the expert; the number of drug law offences have been relatively constant overtime, with a high number of drug use offences compared to drug supply offences. There has also been between 2004 and 2014 a slight increase in drug use offences and a slight decrease in supply offences. Because of the police focus on drug users, supply reduction strategy is not perceived effective and not enough attention is drawn on demand reduction and on drug users' health. Limited resources are notably spent on harm reduction activities. There has been, however, a decrease of number of overdose deaths (Figure 19) with a relatively constant population at risk with the proportion of opioids users oscillating around 3 per thousand of the population (see: Figure 18). Prevalence data have been relatively constant overtime (Figure 17, Figure 18). There has been a slight decrease in cannabis consumption that seems however to have been replaced by LSD consumption. Concerning prevention, innovative projects are constantly being developed and the effectiveness of prevention programmes has gained a lot of importance among policy makers. Germany has compiled a list of prevention programmes that have shown positive outcomes in Germany. This list, called the Green List Prevention[219] is not limited to drug prevention but includes prevention of violence, crime, behaviour, and other problems of children and adolescent. Even though the approach undertaken for prevention seems positive, it has been reported, that prevention programmes suffer from the 'illegality' of drugs, meaning that all prevention activities talk to the aim of stressing the

[218] Interview with Lorenz Böllinger, Emeritus Professor of Criminal Law and Criminology at the University of Bremen.

[219] Gruene-liste-praevention.de. Retrieved 3 November 2016, from http://www.gruene-liste-praevention.de/nano.cms/datenbank/information

illegality of the drugs. It was said that these programmes would benefit from more open discussions.[220]

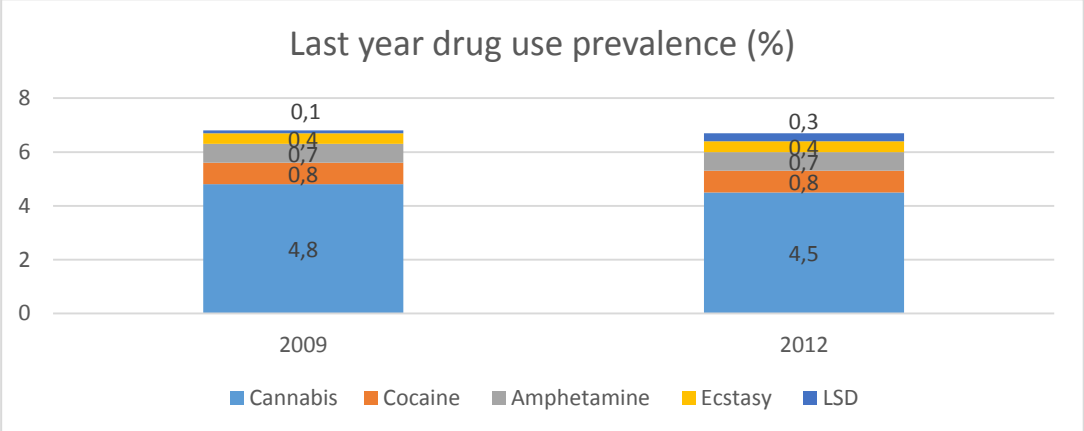
Figure 16: Number of drug law offences in Germany



Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016

Trend in drug prevalence and impacts of prevention activities

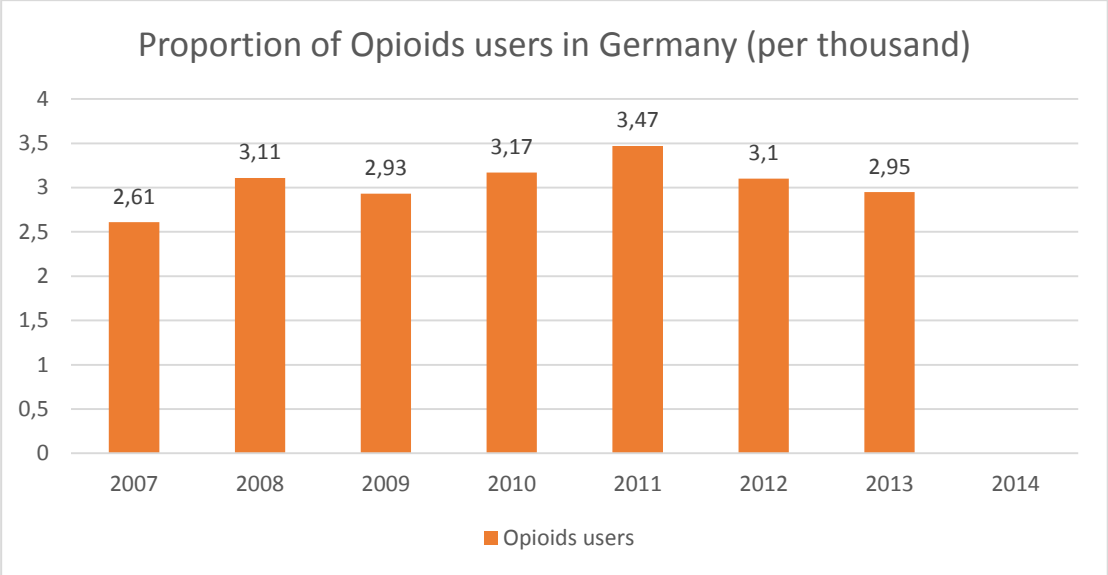
Figure 17: Last year drug use prevalence in Germany



Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016

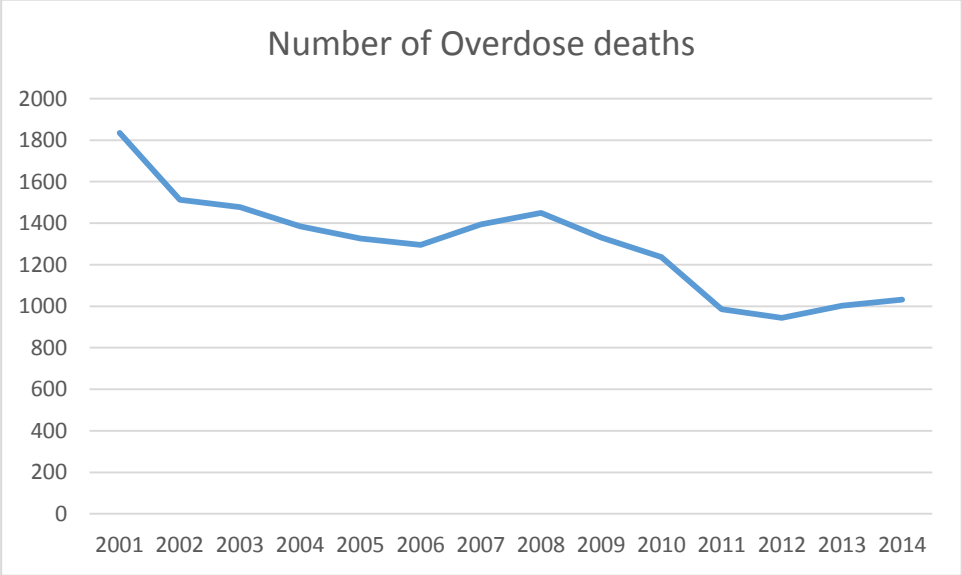
[220] Interview with Lorenz Böllinger, Emeritus Professor of Criminal Law and Criminology at the University of Bremen.

Figure 18: Proportion of Opioids users in Germany



Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016

Figure 19: Number of overdose deaths



CONCLUSIONS

As demonstrated in this case study, at the federal level Germany places a strong focus on law enforcement as a deterrent. However, the approach to implementing the federal drug policy differs by Länder and there is an increasing focus on health-oriented activities, including expanding treatment options and harm reduction programmes (such as the consumption rooms authorised in 6 Länder).

Regarding good practice examples, it has been reported that the increase in health-focused options, including heroin substitution programmes and consumption rooms, is considered to be positive, particularly with regard to removing drug users from sub-cultures where drug use is prevalent. Furthermore, one stakeholder referred to the possible use of tobacco

as a good practice blueprint for cannabis, particularly in light of the impact of the law prohibiting smoking in public places.[221]

STAKEHOLDERS AND DOCUMENTS

Table 26: Germany case study – Sources.

Stakeholders interviewed	• Lorenz Böllinger, Emeritus Professor of Criminal Law and Criminology at the University of Bremen
Documents / websites reviewed	• Mostardt, S., Flöter, S., Neumann, A., Wasem, J., & Pfeiffer-Gerschel, T. (2010). Schätzung der Ausgaben der öffentlichen Hand durch den Konsum illegaler Drogen in Deutschland. Das Gesundheitswesen, 72(12), 886-894 • National Strategy on Drug and Addiction Policy. (2012). Berlin. Retrieved from http://www.emcdda.europa.eu/system/files/att_229612_EN_DE_2012_National%20strategy%20on%20drugs%20%26%20addiction%20policy% • 20%28EN%20version%29.pdf • Germany country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved from http://www.emcdda.europa.eu/countries/germany. • Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved from http://www.emcdda.europa.eu/data/stats2016 ; • Harm Reduction International,. (2014). The Global State of harm reduction 2014. London: Harm Reduction International. Retrieved from https://www.hri.global/files/2015/02/16/GSHR2014.pdf • European Legal database on drugs: http://www.emcdda.europa.eu/topics/law/penalties-at-a-glance • Rural development instead of drug cultivation – Minister Müller and German Drug Commissioner Marlene Mortler issue statements on World Drug Day. (2016). Federal Ministry for Economic Cooperation and Development. Retrieved from https://www.bmz.de/en/press/aktuelleMeldungen/2015/juni/20150626_pm_050_Rural-development-instead-of-drug-cultivation-Minister-Mueller-and-German-Drug-Commissioner-Marlene-Mortler-issue-statements-on-World-Drug-Day/index.html • Global Partnership on Drug Policies and Development (GPDPD). Thai-german-cooperation.info. Retrieved from

[221] Interview with Lorenz Böllinger, Emeritus Professor of Criminal Law and Criminology at the University of Bremen.

	http://www.thai-german-cooperation.info/project/content/117. • Gruene-liste-praevention.de. Retrieved from http://www.gruene-liste-praevention.de/nano.cms/datenbank/information

Appendix A3: Case Study – Spain

Introduction

Spain drug policies are relatively progressive and use of drugs in private place is not considered as an offence, although administrative. The spread of cannabis social clubs particularly in Catalonia and the Basque country has opened a social supply route outside of criminal markets. The main aim of the Spanish drug policy is to offer support to general population and Spain has a balanced approach between demand and supply reduction activities[222]. Notably, Spain provides programmes for targeted population such as minors or people with dual diagnosis. Also, prevention activities are very well developed and many of them are recommended as best practices by the EMCDDA; it is the leading country in terms of prevention interventions targeting family groups and leisure activities Law enforcement agencies have also done an important work in arresting drug offenders and notably through operational plans targeting entertainment and educational centres.

Health indicators show improvements with regard to mortality and morbidity and Spain remains committed to supporting drug users with a wide range of interventions.[223]

NEEDS

Drug use among population

In the EDADES 2013 survey on a general population of adults aged 15-64, the highest prevalence of drug consumption in the last 12 months after alcohol and tobacco were hypno-sedatives (12.2%), cannabis (9.2%) and cocaine (2.2%). The use of most drugs had declined compared to 2011, except for the use of ecstasy and amphetamines that remained stable and the use of hypno-sedatives has increased recently[224].

There is also a decline in the number of high-risk drug users and injecting drug users in Spain. High-risk heroin users were estimated to be 65 684 in 2013 that is 2.04 per 1 000 inhabitants and the number of injecting drug users ranged from 7 971 to 11 786[225].

Table 27: Prevalence rates among adults 15–64.

Title	Life time prevalence EU average	Life time prevalence Country (2013)	Last year prevalence (2013)
Cannabis (%)	17.8	30.4	9.2
Opioids/Opiates			
Heroin (%)		0.7	0.1
Problem drug use: all opioids	Average of annual prevalence at the most		0.21

[222] Interview with REITOX Focal point.

[223] Interview with REITOX Focal point.

[224] Spain country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 23 August 2016, from http://www.emcdda.europa.eu/countries/spain.

[225] Spain country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 23 August 2016, from http://www.emcdda.europa.eu/countries/spain.

Title	Life time prevalence EU average	Life time prevalence Country (2013)	Last year prevalence (2013)
	recent year available: 0.35		
Stimulants			
Cocaine (%)	3.0	10.3	2.2
Amphetamines/Speed (%)	2.5	3.8	0.6
Hallucinogens			
Ecstasy (%)	2.9	4.3	0.7
LSD (%)	1.4	N/A	N/A
Volatile inhalants (%)	N/A	0.6	0.1
All drugs			
Total	19.1	31.3	9.9

Source: Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016;

[i] Average EU data have been calculated according to the most recent data available per country in EMCDDA statistical bulletin. Latest year available for all types of drugs except opioids are as following: 1998 for LU; 2004 for EL; 2007 for HU; 2008 for AT and EE; 2010 for SK; 2011 for IE and LV; 2012 for BG, HR, CY, DE, LT, PT, SI; 2013 for BE, DK, MT, RO and ES; 2014 for CZ, FI, FR, IT, NL, PL, SE and UK. Data from SE, BE and EE were not broken down by drugs and were only available for the overall drug prevalence. There were not any available data on all drug prevalence for LU and NL and no amphetamine use prevalence were available for LU;

[ii] Latest year for Opioids use prevalence estimations used for calculating EU average data are as follow: 2007 for LT and LU; 2008 for SK, 2009 for PL, 2010 for HR, 2012 for FI, NL and PT; 2013 for AR, DE, SI and ES; 2014 for CY, CZ, EL, IT, LV and MT; 2010-11 for HU and UK; 2013-14 for FR. There were no available data on opioids prevalence for BE, BG, DK, EE, IE, RO and SE;

[iii] Recurrent drug use that is causing actual harms to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high risk of suffering such harms'. Prevalence data for Portugal have been estimated with capture recapture method and based on treatment data and criminal justice data.

Health impact of drug use in Spain

The special *Registry of Mortality due to Acute Reaction to Drug* reported that in 2013 there were 437 drug-related deaths. Opioids are the main identified substances responsible for death, however, the Opioid-related acute death has been reduced between 1983 and 2008. In 2013, the drug-induced mortality rate of 13 per million was lower than the European average.

There is a slight downward trend in HIV prevalence since 2006 and the 2013 prevalence of HIV infection among injecting drugs users, was 30.6 %. There were, however, only 2.5 per million cases of HIV infections newly diagnosed in 2014[226]. Hepatitis B virus (HBV) and hepatitis C virus (HCV) have not been systematically monitored among drug users; Harm reduction International, however, estimated that the total prevalence of Hepatitis C and Hepatitis B in 2003 among drugs users was 79.6% and 3.6% respectively. [227]

Drug production, import and export

Due to its geographical situation, Spain is most affected by international drug traffickers and acts as a transit for reaching other European countries. Spain is not a drug producing country, however, small-scale production of cannabis became generalised in the country and covers part of the local demand; 270 741 Cannabis plants were seized in 2014[228]. Because, there is not a huge domestic production. The 'Cannabis club' phenomenon is partly responsible for this increase as they grow a certain number of plants. It is important to note that cannabis clubs are not condoned by the state.

The most trafficked drugs are Cannabis (both resin/hashish or leaf/marijuana), and cocaine. A large amount of South American cocaine enters the European market through Spain. Cannabis resin come directly Morocco and has more recently been routed via Egypt and Libya.

LEGAL FRAMEWORK

Table 28 below provides an overview of how drugs are penalised in Spain. The Law on the Protection of Citizens' Security (2015) (Art. 36) establishes that drug use in public space and personal possession are serious administrative offences that could be fined from EUR 601 to EUR 30 000. Drug use in private space is not punished by the law[229]. When the drug offenders for drug use in public space are minor, the fine can be suspended if the offenders are voluntary willing to attend treatment, rehabilitation or counselling activities.

Why not: Penalties for drug trafficking vary according to drug type and quantity, as well as mitigating or aggravating circumstances, such as drug dependence or drug addiction. Penalties raise from 1 to 20 years imprisonment.

For drug use offences or drug supply offenders who are considered as drug addicts, it is for the judge to evaluate all the situation and the condition of the offence and the health of the offenders. The judges work with medical experts to find the appropriate answer. The objective of this law is to put drug users in a safe environment where there are not considered as criminal but as persons with an illness having the right to be treated[230].

Table 28: Drug law offences and penalties

Produce	supply	possess		use
Penalty	**Penalty**	**Penalty**	**Depending on Quantity?**	**Penalty**

[226] Spain country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/spain.

[227] Harm Reduction International,. (2014). The Global State of harm reduction 2014. London: Harm Reduction International.

[228] Spain country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 23 August 2016, from http://www.emcdda.europa.eu/countries/spain.

[229] Interview with Dr Babín Vich and Mª. Aragón Sánchez , REITOX Focal point.

[230] Interview with REITOX Focal point.

Produce	supply	possess		use
- For personal use: production for personal use is not a crime and is not punished. The producers can, however, be punished by a fine if the production is seen from outside - For organising trafficking: This would be considered as a drug trafficking and supply offence	- Supply of drug is a criminal offence: Supply of drugs causing serious damages to health is punishable by 3-6 years imprisonment; other drugs are punishable by 1-3 years imprisonment. - When aggravating circumstances exists, imprisonment can go up to 20 years and 3 months - Prison sentence could be partially suspended if the offender is willing to undergo a detoxification treatment	- Possession for personal use in public places: Provided no criminal offences, possession for personal use is an administrative offence that is penalised by a fine from EUR 601 to EUR 30 000 that can be suspended if the offender is a minor and willing to undergo treatment - Possession for trafficking: Possession for trafficking would be considered as a drug supply offence F	Penalty does not vary with quantity possessed. The judge may, however, consider quantity among other factors to determine if the drug possessed is for personal use or trafficking	- Use in public places is an administrative offence penalised by a fine from EUR 601 to EUR 30 000. The fine can be suspended if the offender is a minor and willing to undergo treatment. - Use in private places is not defined as an offence

Source: European Legal database on drugs / http://www.emcdda.europa.eu/topics/law/penalties-at-a-glance

AIMS AND OBJECTIVES OF THE NATIONAL APPROACH TO DRUG POLICY

Objectives and overview of current strategy (ies)

Each of the 17 autonomous communities and 2 autonomous cities developed their own drug strategies. Major Spanish cities (with the cooperation of the autonomous communities) are also in charge, for the financing, planning and management of drug treatment resources and programmes within their territory. They follow and adapt to their community the National Drug Strategy and the 2013-2016 action plan.

Reduction of risk and harm, prevention, treatment and social reintegration and supply reduction are the main objectives of the National Drug Strategy for 2009-16. The strategy recommends achieving these objectives through transversal activities such as improving scientific knowledge, training, international cooperation, coordination and evaluation.

From the National Drug strategy, it has been drafted 2 four-year Action Plans. The Government Delegation for the National Plan on Drugs has designed the implementation of the 2013-2016 Action Plan that consists of 36 actions grouped under 5 different goals[231]:

- 13 actions are related with demand reduction;
- 8 actions are related to supply reduction;
- 6 actions are related to information systems;
- 4 actions are of transversal nature;
- 3 actions are related to coordination at the international level.

Table 29: Main current policies and actions plan in Spain

Policies, actions plans	Description
2013-2016 Action Plan	The 2013-2016 Action Plan based on the National strategy on Drugs presents the actions in matters of drug dependencies which will be carried out by the Ministry of Health, Social Services and Equality within 2013-2016. In addition to the other ministries involved (Interior and Education) of the Autonomous Communities and the local entities, other bodies which participated in drafting the Plan are NGOs, scientific societies and trade unions concerned with the problems of addictions.
2009 – 2016 National Strategy on Drugs	Approved by an Agreement of the Council of Ministers on 23 January 2009, this strategy established the drafting of two consecutive four-year Action Plans during its period of life. It is built around 4 pillars: prevention, risk and harm reduction, treatment and social reintegration and supply reduction

Organisations involved

The government Delegation for the National Plan on Drugs is under the management of the Ministry of Health, Social Policy and Equality. The delegation is responsible for coordinating different aspects of drug policy and is in charge of designing the implementation of National Action Plans on drug-related issues ranging from drug trafficking to response to the drug problem. However, Spain is a decentralised state consisting of 17 autonomous communities/cities and they have substantial competencies in the development and implementation of drug policies in their respective territories. Each autonomous communities and cities have their own organisational structure and their own drug plan and strategy for implementing drug policies in their respective territories. The implementation of drug policies is supported by budget from the central government, for the autonomous communities and cities and by some municipalities (usually big cities) The Spanish EMCDDA focal point is located within the Government Delegation for the National Plan on Drugs[232].

[231] National report: Spain, New development, trends. (2014). Retrieved from http://www.emcdda.europa.eu/publications/national-reports/spain-2014.

[232] Spain country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 23 August 2016, from http://www.emcdda.europa.eu/countries/spain.

INPUTS

Programmes and activities which come under the competence of Autonomous communities/cities are funded by both, their own budget and from money transferred by the Central administration (General State Administration). Spanish local entities also have a budget to invest in drug policies however no approximate figure can be offered on the amount they invest in drugs policies.

The total amount invested by the Central Government and the Autonomous Communities and Cities in the execution of drug policies amounted in 2012 to EUR 363 million [233] and to EUR 337 million in 2013.

- EUR 140 million was provided in 2012 by the central government (including EUR 15 million which the Central Government transferred to the Autonomous Communities and Cities).
- EUR 223 million was provided in 2012 by the Autonomous Communities and Cities.

Table 30 below breaks down the expenditure against each type of intervention. Most of the budget was dedicated to harm reduction such as sanitary assistance and social rehabilitation.

One has to bear in mind that data presented in drug policy budget from the EMCDDA are not exhaustive as an important part of the drug-related interventions are funded by budgets that are not specifically dedicated to drug activities. Therefore an important amount of the budget, notably for tackling drug trafficking and organised crime come from other departments (i.e. the Ministry of Justice and Ministry of interior)[234].

Table 30: Total drug-related expenditure in 2012 of autonomous communities and cities per type of intervention

This budget simply represents the expenditure from the autonomous communities and not the central government and it represents only the budget officially dedicated to drug activities. It does not include expenditure from other budgets such as budget spent by the ministry of justice to fight organised crime.

Type of intervention	Expenditure (million EUR)	Proportion of the total Autonomous communities and cities budget
Prevention	30.6	13%
Social and sanitary assistance and social rehabilitation	201.0	84%
Research, documentation and publications	1.4	1%
Institutional coordination	5.0	2%

[233] National report: Spain, New development, trends. (2014). Retrieved from http://www.emcdda.europa.eu/publications/national-reports/spain-2014.

[234] Interview with REITOX Focal point.

Sources: Spain country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 23 August 2016, from http://www.emcdda.europa.eu/countries/spain.

ACTIVITIES (DRUG POLICIES, PROGRAMMES, STRATEGIES ETC)

This section will provide an overview of the different activities undertaken by the Spanish government under its drug policy, including in the field of prevention, treatment and harm reduction, its criminal justice response and in terms of cooperation with other international and EU institutions and bodies.

Prevention activities

Most classic activities recommended by the good practices in drug policies have been introduced in Spain. Spain is notably a leading country in terms of prevention interventions targeting family groups and leisure activities. The delegation for the National Plan on Drugs ensure quality and homogeneity of prevention activities across the country but the implementation decision are made by the autonomous communities and cities[235].

Prevention activities start at an early age as some programmes target children who are less than 10-year-old such as 'the hole in the Fence' programme. The programme helps children aged between 5 and 9-year-old in their psycho-social development and tries to incorporate healthy habits in their life. It intends to enhance protective factors that get children the ability to reject drug use offers that they may have during adolescence and young age. The programme intends to develop the children's coping and problem-solving skills and to improve their self-image[236] Some programmes also include early interventions. The 'Madrid Municipal Government Intervention Programme for Adolescents' targets children and teenager aged between 13 and 18-year-old in high-risk situations for developing drug addiction but also provides specialised advising and guidance for the families of minors who take drugs. Other programmes such as Hirusta focuses on agents in contact with teenagers at risk such as the family, teachers and social mediators in order to encourage them in acting preventatively. Hirusta also supports families and teenagers who experience behaviour problems (i.e. conflicting relationship within the families and notably conflicts related to drug use). [237]

The REITOX focal point is well aware that drug use could potentially be a problem in the workplace and there exist a specific survey for drug use in the workplace which provides the basis for developing early interventions about drug use in the workplace[238].

Finally, intervention activities are also provided in prisons and most of them would have an education unit. The training of health mediators among the prison population has been one of the most effective and efficient means of communication in prisons[239].

Treatment and harm reduction

Treatment

A specific drug dependence care network provides outpatient and inpatient treatment across the countries. In 2012, 98 247 persons received treatment for illicit drug use in one of the 527 outpatient centres; 7 632 persons visited one of the 129 therapeutic

[235] Interview with REITOX Focal point.
[236] EMCDDA, The Hole In The Fence. Early Prevention of Drug Abuse in the Region of Madrid (1st ed.).
[237] EMCDDA | Best practice portal: Hirusta project description. Emcdda.europa.eu.
[238] Interview with REITOX Focal point.
[239] National report: Spain, New development, trends. (2014).

communities and 3 290 patients received treatment in one of the 60 hospitalised detoxification units.[240]

Substitution treatment with methadone was introduced in 1990 and is provided for free. In 2013, 59 059 patients received a substitution treatment. The other substances used for substitution programme is a combination of buprenorphine and naloxone. It is offered by the National Health Service for patients who were stabilised first with Methadone. 2 895 patients received this treatment in 2013. There is a declining trend of patients receiving OST which is consistent with other data indicating a decrease in Heroin users.

Harm reduction

The National Drug Strategy 2009-2016 included among its principal objectives the reduction of risk and harm. The policy aims to prevent emergencies and deaths related to drug use among the population at risk by facilitating contact with drug injectors.

Most harm reduction programmes offer *preventive educational interventions*, overdose prevention activities, sterile injection material (through the syringe exchange programme), infection tests and vaccination. They are provided by a large public network of facilities such as mobile units (the 36 units have been visited 4 547 drug users in 2012); social emergency centres (17 519 drug users seek for support in one of the 52 centres in 2012); pharmacies (in 2012, 1 076 pharmacies had a harm reduction programme that enabled them to offer methadone treatment and syringe exchange programmes). Spain is also developing supervised drug use facilities that enable drug users to use drugs in a safe environment to be in contact with other sanitary resources and to receive information about existing programmes for drugs dependence.[241] Besides health-related programmes, there exist many support programs for social integration, such as occupational integration programme that are mainly performed in outpatient assistance facilities.

It is also worth noting that there is a misperception of the role of cannabis social club in Spain. To exist, these clubs commits illegal action and there are not at all part of the National Strategy. If smoking in a private environment per se is not a crime, the cannabis social clubs usually contribute in supplying drugs to the people going to the club which is as explained in Table 28 a criminal offence[242].

Criminal justice response

As part of the national policy, there are some operative plans such as the Operative Plans of Police Response to Drug Use and Trafficking in Leisure and Entertainment Zones, Places and Establishment and the Steering Plan for Coexistence and Improvement of Security in Educational Centres and their Surroundings where law agencies provide preventive services to leisure places and educational centres and their surrounding in order to dissuade drug use and trafficking[243].

Regional cooperation

There is an important level of cooperation within the European Union, between the Spanish authorities and its member states as well as between Spain and the countries exporting drugs in Spain (i.e. South American countries)[244].

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[240] National report: Spain, New development, trends. (2014). Retrieved from http://www.emcdda.europa.eu/publications/national-reports/spain-2014.

[241] *Ibid*.

[242] Interview with REITOX Focal point.

[243] National report: Spain, New development, trends. (2014). Retrieved from http://www.emcdda.europa.eu/publications/national-reports/spain-2014.

[244] Interview with REITOX Focal point.

Through the International and Ibero-American Foundation for Administration (FIIAP), Spain has participated in a number of European Commission funded international cooperation activities in the field of drug demand reduction and law enforcement cooperation (COPOLAD, Ameripol-EU; SEACOP). The implementing agency is also responsible for organising the bi-annual EU-CELAC dialogue on drugs.

In summary, Spain's drug policy activities seem well balanced between drug demand reduction (mainly through prevention and harm reduction activities) and supply reduction activities (mainly through law enforcement agencies and cooperation). Also, drug interventions notably in the area prevention and harm reduction are not designed according to the substance of addiction but intervention focuses on the persons they are targeting. There exist many tailored programmes that focus on a specific target of the population. For example, 5 431 persons joined a specific module of attention for women, 6 013 persons joined an attention programme for minor and 8 4900 joined an attention programme for dual pathology in 2012. [245]

Table 31: Drug policies in place in country Spain

Policy name	year	Short description	Type of interventions (Prevention, treatment and harm reduction, criminal justice response)
Harm reduction programmes	N/A	Harms reduction programmes are performed by mobile units, social emergency centres and pharmacies. These organisations aim at supporting drug users with the greatest risk of marginalisation and to provide them social and health services.	Treatment and harm reduction
Supervised drug use facilities	N/A	The facilities are designed to provide a safe environment for individual to consume illicit drugs and they also provide drug users with an access to the community and health services.	Treatment and harm reduction
Opioids substitution programme	Started in 1990	The legal framework of treatment programmes with opioids substitutes is regulated by the Royal Decree of 19 January 1990 and Royal Decree nº 5/1996. There exist methadone and buprenorphine/naloxone substitution programmes.	Treatment and harm reduction
Prevention and health education activities in prisons	N/A	Prevention programmes have been developed in prisons. In 2013, 26,930 inmates took part in this type programmes. Training of health mediators among the prison population has been one of the most effective and efficient means of communication in prisons. Prisons also developed some harm reduction programmes by providing	Prevention, Treatment and harm reduction

[245] National report: Spain, New development, trends. (2014). Retrieved from http://www.emcdda.europa.eu/publications/national-reports/spain-2014.

Policy name	year	Short description	Type of interventions (Prevention, treatment and harm reduction, criminal justice response)
		syringes and methadone substitution treatment, detoxification programme, reintegration programmes.[246]	
The Hole in the Fence. Early prevention of Drug Abuse in the Region of Madrid	1999	Based on the Canadian programme, 'the Hole in the Fence', this preventions programme intends to contribute to the psychological and emotional maturity of 5 to 9-year-old children and to the acquisition of healthy habit	Prevention
Madrid Municipal Government Intervention Programme for Adolescents	1992	This programme intends to avoid drug consumption and addiction in adolescents who are at risk. It also offers specialised treatment to those addicted to drug and their families	Prevention
Hirusta: Preventive Support Programme For Teenagers And Their Families	1996	This programme offers guidance and support to teenagers their families and any community service that has to do with teenagers that present numerous conflicts, among which may appear drug use.	Prevention

EFFECTS

Impact of the criminal justice system

Cannabis accounts for over half (14 510 in 2013) of all drug trafficking arrests, followed by cocaine, 29.3%, hallucinogens/psychotropics representing 8.7% and opiates 5.6%.

Among law enforcement activities, it has been discussed in section 0 operative plans for improving security in educational and leisure centres. It is indicated in Table 32 the main outputs of these plans. Specifically, in 2013, the State Security Forces brought 143,045 criminal charges within the framework of the implementation of these Plans, representing 35.65% of the total[247].

[246] National report: Spain, New development, trends. (2014). Retrieved from http://www.emcdda.europa.eu/publications/national-reports/spain-2014.

[247] National report: Spain, New development, trends. (2014). Retrieved from http://www.emcdda.europa.eu/publications/national-reports/spain-2014.

Table 32: Number of arrests, offences and seizure as a result of the operational plans (2013)

	Steering Plan for Coexistence and Improvement of Security in Educational Centres and their Surroundings	Operative Plan of Police Response to Use and Retail Traffic of Drugs in Leisure and Entertainment Zones, Places and Establishments
Arrest for drug trafficking	98	1 345
Deactivation of drug sales point	341	1 197
Criminal charges for use and possession	4 721	138 324
Total drug seizures	4 953	145 586
Quantity of Heroin seized (g)	111	5 028
Quantity of Cocaine seized (g)	948	108 647
Quantity of Hashish seized (g)	5 765	1 495 424
Quantity of Marihuana seized (g)	25 552	387 115
Quantity of Amphetamine Sulphate - Speed seized (g)	553	9 949
Quantity of Ecstasy seized (units)	21	10 565
Quantity of psychotropic drugs seized (units)	257	10 953
Quantity of LSD seized (g)	N/A	183

Source: Organised Crime Intelligence Centre (CICO), Ministry of the Interior. Retrieved from http://www.emcdda.europa.eu/publications/national-reports/spain-2014

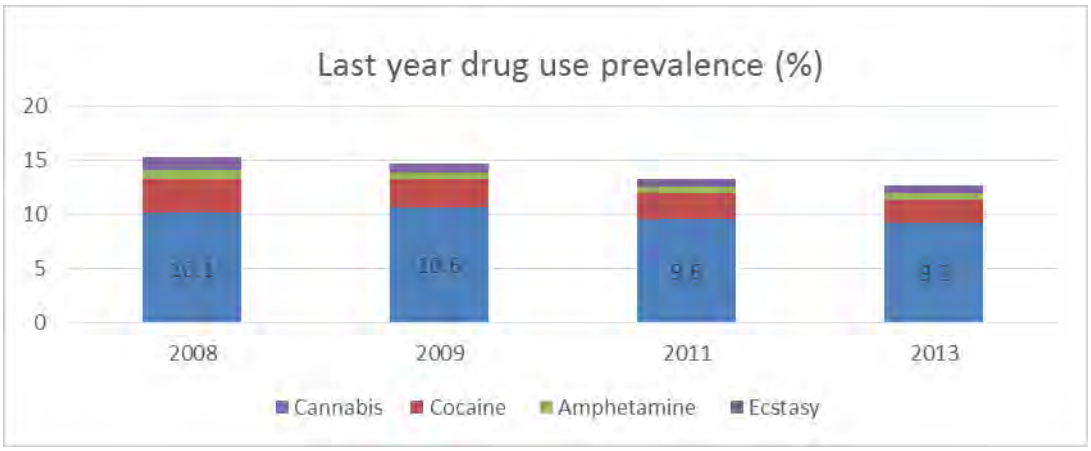
Spain accounts for more than half of the cocaine and 74% of hashish (not herbal cannabis) seized in Europe

Trend in drug prevalence and impacts of prevention activities

Drug prevalence data presented in Figure 20 seem quite stable over time with a slight decrease in 2011 and 2013. These data give an indication of the trend but cannot tell much about the efficiency of a specific drug policy. However, prevention activities in Spain have been perceived positively by international organisation and notably evaluation of

prevention activities targeting very young children achieved their objective by improving children self-image [248]

Figure 20: Last year drug use prevalence in Spain



Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016

Injecting drug use, infectious disease and impact of harm reduction programmes

Concerning HIV prevalence, the accuracy of data has been highly contested by the REITOX national focal point as it only rated to data which has not been collected throughout the country; data presented in Figure 22 are likely to have been collected from a small sample size. They are likely to be overestimated and need therefore to be considered carefully[249]. Ignoring, the magnitude of HIV prevalence and considering that the data have been collected in a similar way every year, we could comment on the trend of HIV prevalence presented in Figure 22. There is a decreasing trend in HIV infection and this could be interpreted as a decrease in the number of drug users with HIV infection.

This decrease could partially be attributed to the syringe exchange programme. There were 2.7 million syringes distributed in Spain in 2013 but the number of syringes distributed has been decreasing since 2005. This decrease could partially be attributed to a reduction in injecting drug users as illustrated in Figure 21 250.

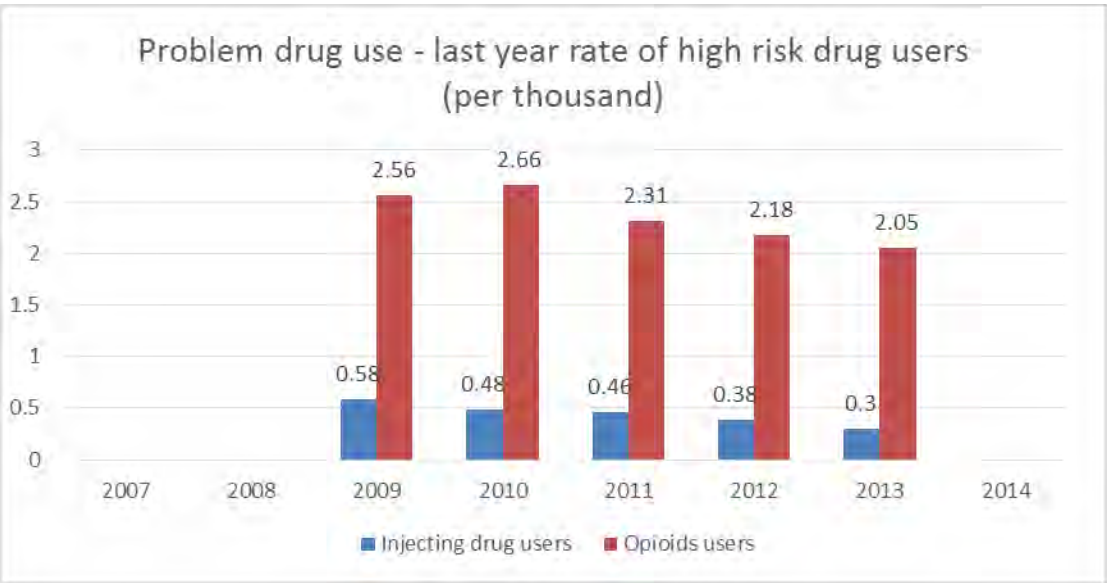
In general, health indicators show a decrease in HIV infection (Figure 22), a slight decrease in drug use prevalence (Figure 20) and a decrease in overdose deaths (Figure 23).

[248] EMCDDA, The Hole In The Fence. Early Prevention of Drug Abuse in the Region of Madrid.

[249] Interview with REITOX Focal point.

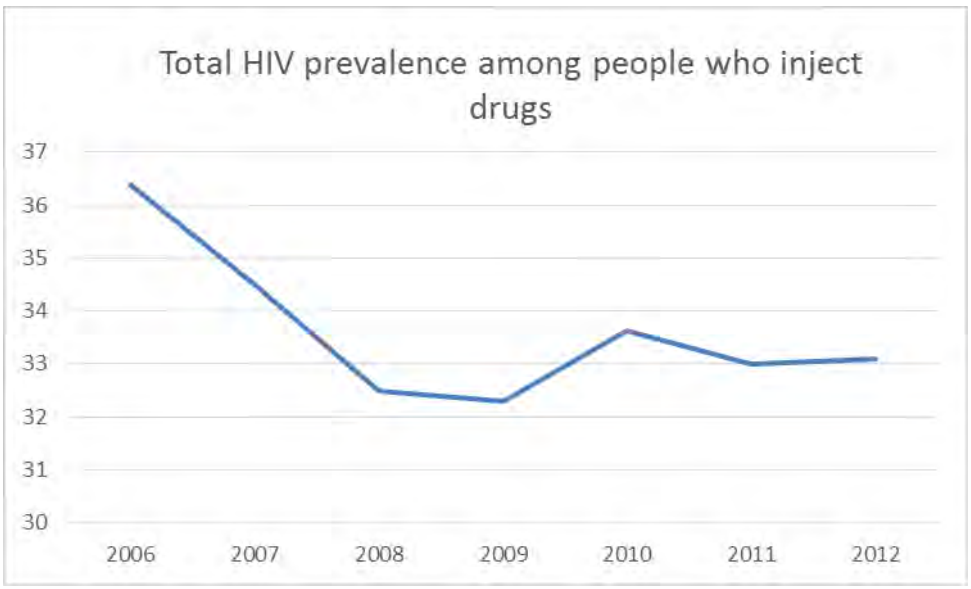
[250] Spain country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 23 August 2016, from http://www.emcdda.europa.eu/countries/spain.

Figure 21: Last year rate of high-risk drug users in Spain



Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016

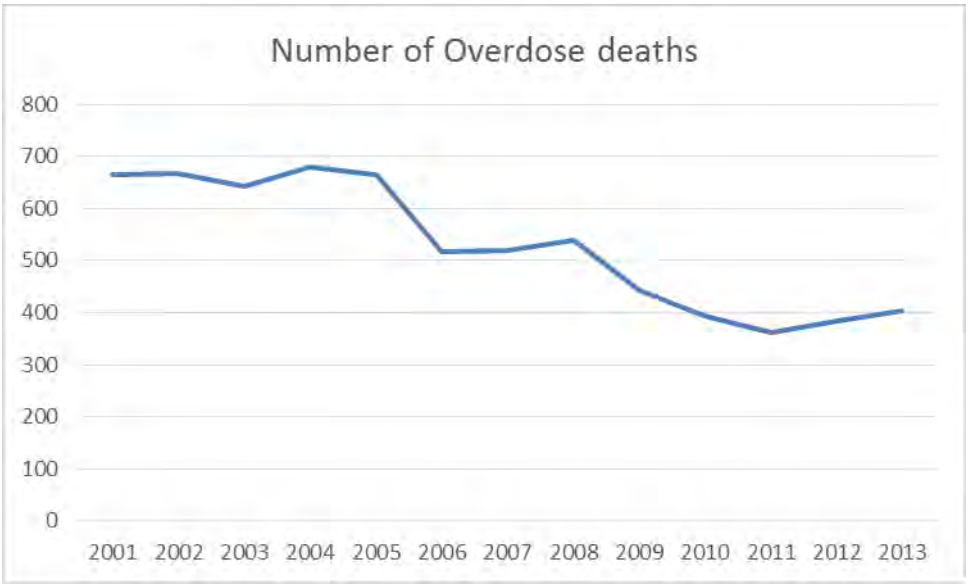
Figure 22: Total HIV prevalence among people who inject drugs in Spain



Note: data based on a small sample size; they might not be representative of the entire population

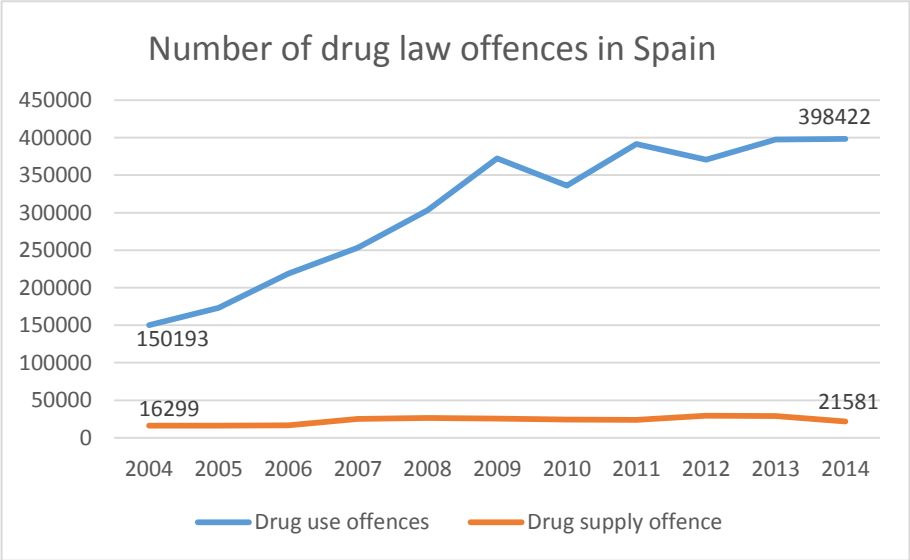
Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016

Figure 23: Number of overdose deaths in Spain



Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016;

Figure 24: Number of drug law offences (administrative and criminal) in Spain



Note: Administrative offences are also reported here (e.g. number of offences related to drug use and drug possession for personal use have been included in drug-use related offences)

Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016;

Conclusions

The drug policies in Spain are progressive and key indicators concerning healthcare seem to move in the right direction. Law enforcement agencies have also been active in arresting drug offenders and notably through operational plans targeting entertainment and educational centres. One good practice is related to prevention activities delivered in Spain. These activities target a specific group of population (e.g. minors, women) which is considered as a reason for their success.

In the future, Spain will keep a balanced strategy between law enforcement and health activities and will further work on its holistic approach, providing support to drug users at any stage of the drug addiction by offering activities from prevention to rehabilitation[251].

STAKEHOLDERS AND DOCUMENTS

Table 33: Spain case study- Sources

Stakeholders interviewed	• Dr Francisco de Asís Babín Vich and María-Sofía ARAGÓN SÁNCHEZ , REITOX Focal point [08/09/2016]
Documents / websites reviewed	• National report: Spain, New development, trends. (2014). Retrieved from http://www.emcdda.europa.eu/publications/national-reports/spain-2014 • Spain country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 23 August 2016, from http://www.emcdda.europa.eu/countries/spain • Statistical Bulletin 2016 | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 7 September 2016, from http://www.emcdda.europa.eu/data/stats2016 • Harm Reduction International,. (2014). The Global State of harm reduction 2014. London: Harm Reduction International. Retrieved from https://www.hri.global/files/2015/02/16/GSHR2014.pdf • European Legal database on drugs / http://www.emcdda.europa.eu/topics/law/penalties-at-a-glance • EMCDDA | Search results. Emcdda.europa.eu. Retrieved 30 September 2016, from http://www.emcdda.europa.eu/html.cfm/index52006EN.html • EMCDDA,. The Hole In The Fence. Early Prevention of Drug Abuse in the Region of Madrid (1st ed.). Retrieved from http://www.emcdda.europa.eu/modules/wbs/dsp_print_project_description.cfm?project_id=2119 • EMCDDA | Best practice portal: Hirusta project description. Emcdda.europa.eu. Retrieved 30 September 2016, from http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=2916&tab=overview • Fiiapp What we do ?. Fiiapp. Retrieved 30 September 2016, from http://www.fiiapp.org/en/que-hacemos/; • Cooperation: fight against cocaine trafficking. Fiiapp. Retrieved 30 September 2016, from http://www.fiiapp.org/en/proyectos_fiiapp/lucha-contra-el-trafico-de-cocaina/#ancla-contenido-proyectos • Cooperation: fight against heroin trafficking. Fiiapp. Retrieved 30 September 2016, from

[251] Interview with Dr Babín Vich and Mª. Aragón Sánchez , REITOX Focal point.

	http://www.fiiapp.org/en/proyectos_fiiapp/lucha-contra-el-trafico-de-heroina/#ancla-contenido-proyectos

Appendix A4: Case Study – Netherlands

Introduction

At the international level, the Netherlands is most well-known for its cannabis policies and coffee shops, the distinction it makes in law between soft drugs and hard drugs, and its harm reduction policies. Its cannabis policy is based on the intention of the law makers to avoid the criminalisation of drug consumers and the separation of markets (for soft & hard drugs). The Dutch drugs policies are comprehensive, in that they have a criminal justice response, as well as covering prevention, harm reduction and treatment.

NEEDS

Drug use among population

As can be seen in the table below, the most popular "ever used" drug among adults (15-64 year olds) in the Netherlands is cannabis (life time prevalence rate of 24.3%), followed by ecstasy (7.4%), cocaine (5.1%) and amphetamine (4.4%). Even though the Netherlands has a special policy for cannabis (see further section 1.4), the life time prevalence rate for cannabis is not the highest of the EU Member States[252]. The Netherlands has the highest last year prevalence rate of ecstasy of all EU countries.[253]

Table 34: Prevalence rates among adults 15–64 (2014).

Type of drug	Life time prevalence EU average %	Life time prevalence %(2015)[254]	Last year prevalence % (2015[255])
Cannabis	17.8	25.6	8.7
Opioids			
All Opioids drug use problems	0.35	N/A	0.126 (2012)
Stimulants			
Cocaine	3.0	5.1	1.9
Amphetamine	2.5	4.7	1.6
Hallucinogens			
Ecstasy	2.9	8.4	3.4

[252] In CZ, DK, FR, IE, IT, ES and UK the life time prevalence rate for cannabis is higher.
[253] Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2015, 2015, p. 153.
[254] Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2016, 2016.
[255] Unless mentioned otherwise.

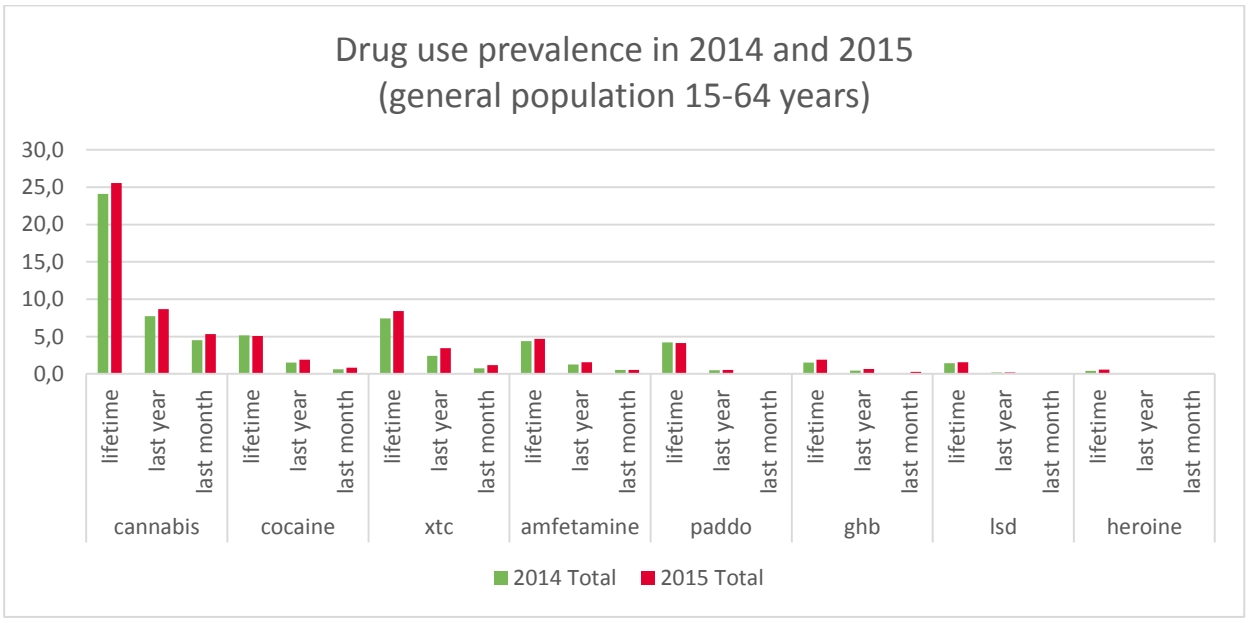
Type of drug	Life time prevalence EU average %	Life time prevalence %(2015)[254]	Last year prevalence % (2015[255])
LSD	1.4	1.6	0.2
All drugs			
Total (%)	19.1%	N/A	N/A

Source: Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016 and Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2015, 2015

Another drug that is reportedly being used in the Netherlands is **GHB**[256]. In 2015, 1.9% of the population (15-64) had ever used GHB, and 0.6% had used it in the past year. It is estimated 0.5% of the population (15-64) had ever used **heroin**. [257]

The prevalence of (last year) ecstasy use (2.4% in 2014 and 3.4% in 2015) and (last month) cannabis use (4.5% in 2014 and 5.3% in 2015). However, among secondary school pupils of 12-16 years the prevalence of cannabis use has steadily declined over the years.[258]

Figure 25: Last year drug use prevalence Netherlands 2014-2015 (%)

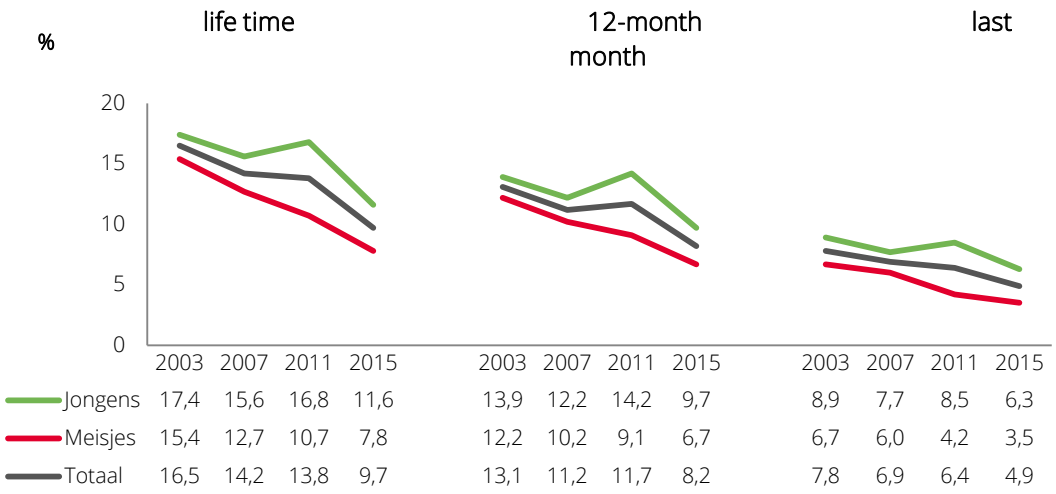


[256] It should be noted that there may be different products with different chemical compositions all masquerading as GHB.

[257] Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2015, 2015, p. 132 and 201.

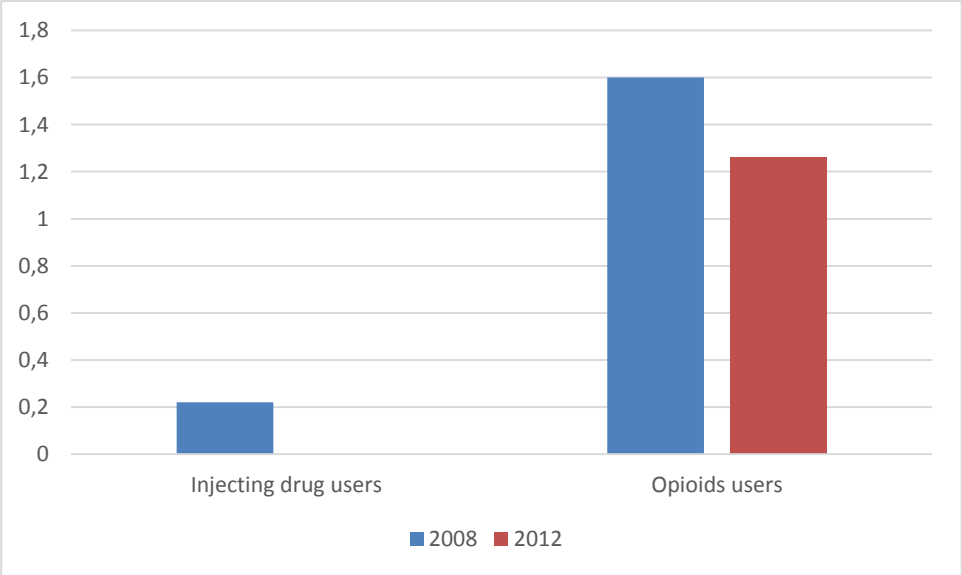
[258] Peilstationsonderzoek Scholieren/Leefstijlmonitor, Trimbos-instituut i.s.m. RIVM, 2015.

Source: Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2016, 2016



In terms of high risk users, as can be seen in the figure below, the number of high risk opioids users has decreased between 2008 and 2012. In addition, according to the last estimate in 2012, the number of addicted **heroin** users has decreased more than 20% compared to previous estimates of 2008/2009.[259] There is not data available on the prevalence of injecting drug users for 2012.

Figure 26: Last year prevalence of high risk drug users (using injecting drugs or Opioids) (per thousand)



Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016

Prevalence rates a higher for people aged 15-35, and especially amongst a specific select high risk group of young highly educated Dutch people that frequent nightlife and use

[259] Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie, 3 November 2015.

drugs in a recreational manner at parties and events.[260] A web survey undertaken in 2016[261] among a sample of **4 905 people aged 15–35 who had frequently visited parties, festivals and clubs** in the past year found that last year prevalence of drug use in the last year among this group was very different from the general population:

- Prevalence rate of **cannabis**: about three times higher**;**
- Prevalence rate of **cocaine**: about seven times higher;
- Prevalence rate of **ecstasy/MDMA**: about seven times.

The online survey also showed that about 50% of this surveyed group of young people had used ecstasy. Interestingly, the Dutch Drugs Information and Monitoring System (DIMS), which tests drugs for users, reported that the average dose of active ingredient in ecstasy has doubled in recent years, from an average of 66 mg in 2009 to more than 150 mg in 2015.[262] In 2015, 57% of the sampled pills contained more than 140 mg of MDMA[263].

The drugs reported to Dutch Drugs Information and Monitoring System (DIMS) can also provide a good indication of the drug use in the Netherlands.[264] After ecstasy/MDMA (60%) and cocaine (13%), the most supplied drug to the DIMS in 2015 was **speed** (6%) and **4-Fa** (4-fluoramfetamine). The latter drug is a new psychoactive substance known as "ecstasy light", for which DIMS has seen a strong increase (from 29 cases in 2011 to 708 in 2015).[265] Another fast growing drug used at parties, seems to be **ketamine**: DIMS was supplied with 16 samples in 2005, and 362 samples in 2015.[266] Moreover, there have been reports of a revival of the use of laughing gas (N2O).[267]

In terms of **high risk users**, 1.5% of adults (15-64 year olds) had used cannabis daily or almost daily in the last 30 days.[268]

Health impact of drug use

Due to the successful harm reduction policies in the Netherlands, as well as the low number of injecting drug users[269], the incidence of human immunodeficiency virus (HIV), hepatitis B virus (HBV) and hepatitis C virus (HCV) has remained at a low level for many years in the Netherlands. Of all the newly registered HIV infections in the Netherlands, less than 1% is attributable to injecting drugs (0 in 2014 and 2015).[270] Of the 28100 HCV patients in the Netherlands, 27.5% was infected because of injecting drug use, however new infections are rarely recorded.[271]

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[260] Interview Trimbos Instituut, 19 September 2016. See also Monshouwer, K., Van der Pol, P., Van Laar, M. (2016). Het Grote Uitgaansonderzoek 2016. Trimbosinstituut:Utrecht.

[261] Nabben T., Benschop m A. & Korf D.J. (2014) Antenne 2013. Trends in alcohol, tabak en drugs bij jonge Amsterdammers. Amsterdam: Rozenberg Publishers. See also: F.X. Goossens, T. Frijns, N.E. van Hasselt, M.W. van Laar, Het Grote Uitgaansonderzoek 2013, Uitgaanspatronen, middelengebruik en risicogedrag onder uitgaande jongeren en jongvolwassenen. https://assets.trimbos.nl/docs/02d0f9a3-1227-4f88-8cfe-e90e360201a5.pdf

[262] Drugs Informatie en Monitoring Systeem (DIMS), Jaarbericht 2015.

[263] Drugs Informatie en Monitoring Systeem (DIMS), Jaarbericht 2015.

[264] However it an increase in the reporting of a certain drugs at a DIMS test centre could also be attributable to a belief among drug users that a certain drug is risky and therefore it more likely to be taken to the dims for testing.

[265] Drugs Informatie en Monitoring Systeem (DIMS), Jaarbericht 2015.

[266] Drugs Informatie en Monitoring Systeem (DIMS), Jaarbericht 2015.

[267] EMCDDA, Netherlands country overview, last updated 20 May 2016.

[268] Jaarbericht 2016.

[269] Interview Trimbos Instituut, 19 September 2016.

[270] Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2016, 2016, p. 147.

[271] Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2016, 2016, p. 151.

In 2014 a total of 123 toxicologically confirmed drug-induced deaths were registered, of which 30% of the cases had used Opiates. The drug-induced mortality rate among adults aged 15–64 was 10.8 deaths per million, which is below the European average of 19.2 deaths per million.

Table 35: Drug induced mortality and epidemiology

	Number of people who inject drug[1]	Prevalence of HIV among people who inject drug (%)[2]	Prevalence of Hepatitis C among people who inject drugs (%)[2]	Prevalence of hepatitis B antibodies among people who inject drug (%)[2]	Drug induced mortality among adult 15-64 (per million)[3]
Year	**2008**	**2012**	**2008**	**2000**	**2014**
Netherlands	2390	0.0–3.7	86.2	3.0	10.8
European average					19.2

Source: [I] Statistical Bulletin | www.emcdda.europa.eu. (2016). Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016 under Problem drug use > Injecting > Most recent estimates ; [ii] The Global State of harm reduction 2014. London: Harm Reduction International. Retrieved from https://www.hri.global/files/2015/02/16/GSHR2014.pdf, HIV prevalence among people who inject drugs (%) - Figure is based on sub-national data.; [iii] Netherlands country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 08 September 2016, from http://www.emcdda.europa.eu/countries/netherlands.

Drug production, import and export

The Netherlands has **domestic production of cannabis**, which is illegal (see next section), of which the majority is cultivated indoors. The Netherlands also produced synthetic drugs such as amphetamine and MDMA: the increasing detection and destruction of synthetic drug production locations between 2011 and 2013[272], could indicate an increase in the production in synthetic drugs in recent years.

The Netherlands is an exporter of cannabis to the United Kingdom, Germany, Italy and Scandinavian countries. It is also an exporter of synthetic drugs, with the primary destination countries being the UK and Scandinavian countries for amphetamines and Australia for MDMA.

The Netherlands is also a transit country for heroin and cocaine, with heroin mainly originating from Afghanistan. In terms of import, cocaine is supplied from South American countries (Colombia, Peru and Bolivia) via African countries.[273]

[272] EMCDDA, Netherlands country overview, last updated 20 May 2016.
[273] EMCDDA, Netherlands country overview, last updated 20 May 2016.

LEGAL FRAMEWORK

The national legislation criminalising drug-offences in the Netherlands is the Opium Act[274] and the Opium Acts Directives[275]. Since 1976, the Act distinguishes between hard drugs as defined in List I[276] (e.g. heroin, cocaine, ecstasy, amphetamines and GHB) and soft drugs as defined in List II[277] (e.g. cannabis). New psychoactive substances are regulated through amendments to relevant Schedules of the Opium Act.

In March 2015 the amended "**Aanwijzing Opiumwet**[278]" entered into force, which has legal effect and outlines the approach to be taken by the Public Prosecutor in the investigation and prosecution of drug law offences. Moreover a new "**strafvorderingsrichtlijn**" entered into force in March 2015[279], which states the penalties for each of the drug offences.

Drug use is not criminalised as such, but can be prohibited at the local level in certain circumstances (e.g. at schools or on public transport). As confirmed in recent jurisdiction such prohibitions are compatible with the Opium Act, if for reasons of public order.

The **possession** does constitute a crime under the Opium Act. However, the possession of small quantities of drugs for personal use is not subject to targeted investigation by the police and the possession of less than 0.5 g of List I drugs and soft drugs (List II) up to 5 grams will generally not be prosecuted. In such circumstances the police will confiscate the drugs and – in the case of hard drugs - refer the person to a care agency. Possession of larger amounts can be sanctioned with fines, community service or prison sentences (see table below).

Producing and supplying drugs on List I and List II is punishable according to the Opium Act. According to the quantity and type of drug being supplied penalties reach up to 12 years' imprisonment. In 2014 the Opium Act was amended, to include as an offence the acts of preparation or facilitation of large-scale and professional production of cannabis (see Article 11a in the Opium Act), which entered into force in March 2015.

Although the use of drugs is not a criminal offence, the selling of it is. However in the Netherlands a **special policy exists for the sale of cannabis**, called the "gedoogbeleid", under which coffee shops can sell cannabis without being prosecuted. This policy is described in the previously mentioned "Aanwijzing Opiumwet", which states that the coffee shops needs to adhere to certain strict requirements, also called the AHOJGI criteria:[280]

- A: no Advertising,
- H: no sale of Hard drugs,
- O: no public nuisance (Overlast) in and around the coffee shop,
- J: no sale to minors (Jong);
- G: no sale of large (Groot) quantities:
    - per transaction (maximum 5 g),
    - maximum stock for selling of 500 gram;
- I: entry into coffee shops and sales are limited to residents (Ingezetenen) of the Netherlands.

[274] Opiumwet, available here: http://wetten.overheid.nl/BWBR0001941/2016-08-01

[275] Richtlijn voor strafvordering Opiumwet, harddrugs, 2015 and Richtlijn voor strafvordering Opiumwet, softdrugs, 2016.

[276] Available here: http://wetten.overheid.nl/BWBR0001941/2016-08-01#BijlageI

[277] Available here: http://wetten.overheid.nl/BWBR0001941/2016-08-01#BijlageII

[278] Aanwijzing 2015A003; Stcrt-5391, 2015).

[279] Stc-4953 en 4954, 2015.

[280] EMCDDA, Netherlands Country overview, last updated 20 May 2016.

The enforcement of the coffee shop policy lies primarily with the mayor: coffee shop owners need a permit from the mayor and under article 13 of the Opium Act, the mayor may close a coffee shop if it does not adhere to the above mentioned criteria. The Public Prosecutor can decide to prosecute coffee shop owners that don't keep to these rules.[281]

However, this policy does not de facto decriminalise the production of cannabis, to be sold to the coffee shop, or the sale of cannabis to coffee shops. This double standard issues has been called the "backdoor problem".

Table 36: Drug law offences and penalties

Produce	Supply	Possess		Use
Penalty	**Penalty**	**Penalty**	**Depending on Quantity?**	**Penalty**
Hard drugs: 12 years **Cannabis:** if 5 or less plants and not for profit considered for personal use, unless two or more professional criteria are satisfied.[282]	**Supply:** up to 8 years prison **Import:** • up to 12 years a hard drugs (List I), • up to 2 for importing soft drugs (List II) • -up to 6 years for importing if a large quantity of soft drugs (List II).	**Hard drugs (List I):** • Large amount: up to 6 years or a fine • Small amount: up to 1 year prison or fine **Soft drugs (List II):** • up to 1 month prison • Cannabis: no investigation in quantity less than 5g, no prosecution if less than 30g	Yes for hard drugs	Use of drugs is not mentioned as an offence.

Source: European Legal database on drugs / http://www.emcdda.europa.eu/topics/law/penalties-at-a-glance

AIMS AND OBJECTIVES OF THE NATIONAL APPROACH TO DRUG POLICY

Objectives of current strategy(ies)

In the current Opium Act Directive the objective of the drug policy is described as: 'to discourage and reduce drug use, certainly in so far as it causes damage to health and to society, and to prevent and reduce the damage associated with drug use, drug production and the drugs trade' [283]

[281] Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2015, 2015.

[282] Aanwijzing Opiumwet (2015A003). Available here: https://www.om.nl/onderwerpen/drugs/@88338/aanwijzing-opiumwet-0/

[283] Report to the EMCDDA by the REITOX National Focal Point: The Netherlands, Drug situation 2013, p. 17.

For years, Dutch Drug policy has had five main objectives[284]:

1. to prevent drug use;
2. to prevent damage to health caused by drug use;
3. early detection and interventions of short duration;
4. to provide adequate treatment for addicts;
5. harm reduction.

In November 2015 the Government (Ministry of Health, Wellbeing and Sports) formulated a new policy view on drug prevention, intending among other things to curb the normalisation of drug use among young adults in nightlife settings[285]. In order to stop this normalisation and to prevent harm, the following six measures were announced:

- supporting parents in talking to their adolescent children about drugs by informing them of drugs use and its dangers (awareness raising);
- informing young people about the risks of drug use by modernising the drug education programme for schools;
- supporting municipalities in their drug prevention policies;
- cooperating with the events and nightlife industry;
- cooperating with health sector professionals;
- Increase monitoring of the drugs market and provide warnings in case of high risk drugs.

Table 37: Main current policies and actions plans in the Netherlands [286]

Policies, actions plans	Description
2015 policy vision on drug prevention & its Annex (principles of current drug policy)	Sets out general drugs policy for 2015 going forward, focussing on drug use by young people in nightlife setting. The Annex (principles of current drug policy) summarised the approach as follows: preventing is better than treating, treatment is better than harm reduction, harm reduction is better than doing nothing.
Police and the Public Prosecution Office policy letter for 2008–12 and again for 2012–16.	Priority areas targeted: Organised crime in relation to synthetic drugs, heroin, cocaine and the large-scale cultivation of cannabis
National white paper on Healthcare[287]	Includes policy on harm reduction, including early detection

[284] Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie, 3 November 2015, p. 1.
[285] Ibid.
[286] This list is not exhaustive.
[287] https://www.rijksoverheid.nl/onderwerpen/drugs/documenten/beleidsnota-s/2011/05/25/landelijke-nota-gezondheidsbeleid

Policies, actions plans	Description
2011 Drugs Letter[288]	Government letter amending the coffeeshop policy, to be only open to Dutch citizens.
2009 policy letter to the Parliament, 'Letter outlining the new Dutch policy'[289]	Placed an increased emphasis on prevention and the reduction of drug use. It also adjusted the 'coffee shop' policy to make the establishments small, and principally for local users, and with the number of shops restricted to reflect the local situation, and established an integrated approach for fighting organised crime.
1995 White paper: 'Drug policy: continuity and change'[290]	Set out some of the basic principles of the Dutch drug policy on illicit drugs. These included a continuation of the distinction between 'soft' (List II) and 'hard' (List I) drugs.

In addition, different policies were adopted for specific types of drugs. The policies adopted in relation to cannabis have already been described in the Legal Framework section. With regards to ecstasy, the Dutch Government adopted policy papers in 2001[291], and again in 2007[292] which proposed the strengthening of law enforcement in tackling the production and trafficking of ecstasy. With regards to cocaine, the Government adopted a specific action plan in 2002 on combatting drug trafficking of cocaine at Schiphol airport.

Organisations involved

In the Netherlands, the responsibility for Dutch drug policy is shared between the following two Ministries:

- the **Ministry of Health, Welfare and Sport**: tasked with coordinating the Dutch Drugs policy; it is responsible in particular for the public health, addiction prevention and addiction care (treatment and harm reduction). The Ministry is responsible for ensuring the availability of reliable information, and has the task of innovation in the area of awareness raising, prevention and care and to ensure research and monitoring
  is carried out;[293]
- the **Ministry of Security and Justice**: responsible for law enforcement and matters relating to local government with regard to drugs and the police.

Another key organisation in the Netherlands is the national research institute for mental health and addiction called the **Trimbos Institute** conducts research on issues related to mental health and addiction. The experts at the Trimbos Institute put research findings

[288] Tweede Kamerstukken 24 077, Vergaderjaar 2010-2011, nr. 259. van mei 2011.

[289] https://www.rijksoverheid.nl/documenten/kamerstukken/2009/09/14/hoofdlijnenbrief-drugsbeleid

[290] Tweede-Kamer der Staten-Generaal, Drugsbeleid: continuiteit en verandering, 1995. Available here: https://zoek.officielebekendmakingen.nl/dossier/24077/kst-24077-3?resultIndex=288&sorttype=1&sortorder=4

[291] Tweede Kamer der Staten-Generaal, Beleid inzake XTC, The Hague, 9 May 2001.

[292] Kabinetsnotitie 'Voortzetting aanpak synthetische drugs vanaf 2007'.

[293] Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie – Bijlage 1: Uitgangspunten huidig drugsbeleid, 3 November 2015.

into practice to support policymakers, educators, and professionals who provide mental health and addiction services. Its Drug Monitoring and Policy Department is responsible for publishing the National Drugs Monitor report[294], and also functions as the EMCDDA REITOX national focal point for the Netherlands.

Finally, there is also a role for the mayor in terms of the enforcement of the coffee shop policy, namely though its competences of closing coffee shops under Article 13b of the Opium Act.[295]

INPUTS

There are no data on the expenditure of the Dutch government on the implementation of the drug policies. The Dutch policy documents on drugs do not earmark a budget allocated for the implementation of the policies. Moreover there is no publically available evaluations of executed expenditures.[296]

The drug monitor (2015)[297] estimated that with regards to law enforcement, most money was spent on the enforcement of penalties for hard drugs offenses and very little was spent on prevention, investigation and prosecution and the trial.

Moreover, one 2006 study has estimated the drug-related public expenditure, which estimated that in 2003 this represented 0.5 % of gross domestic product, according to the proportions as shown in the table below.[298] However the findings of this study has been disputed, and outdated.[299]

Table 38: Drug related labelled public expenditure, per types of expenditure (in thousand EUR)

Proportion spent on each activities would be different with the inclusion of unlabelled expenditure as 75% of such expenditure are spent in supply reduction activities.

Type of expenditure	Amount (thousand EUR)	Proportion (%)
Prevention	N/A	2%
Harm reduction *Outreach programmes, drop in centres, integrated programmes.*	N/A	10%
Treatment *-Outpatient services: health, social and unspecified services;* *-Prison-based services;*	N/A	13%

[294] Available here: https://www.trimbos.nl/themas/monitoring-middelengebruik/ndm-monitoring-drugsgebruik-in-nederland

[295] Aanwijzing Opiumwet (2015A003).

[296] EMCDDA, Netherlands Country overview, last updated 20 May 2016.

[297] Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2015, 2015, p. 68.

[298] H. Rigter (2006), 'What drug policies cost: Drug policy spending in the Netherlands in 2003', Addiction 101, pp. 323–329.

[299] Interview Trimbos Instituut, 19 September 2016.

Type of expenditure	Amount (thousand EUR)	Proportion (%)
-Residential services: inpatient health services, therapeutic communities and other unspecified residential services.		
Sobering up station	N/A	N/A
Aftercare services	N/A	N/A
Coordination, research and evaluation	N/A	N/A
Law enforcement	N/A	75%
Others, unspecified	N/A	N/A
Total		**100%**

Source: EMCDDA, Netherlands Country overview, last updated 20 May 2016.

ACTIVITIES

This section will provide an overview of the different activities undertaken by the Dutch government under its drug policy, including in the field of prevention, treatment and harm reduction, its criminal justice response and in terms of cooperation with other international and EU institutions and bodies.

Prevention activities

An important task of prevention rests with local authorities, supported by centres for addiction care and municipal health services (GGD). They for example provide **schools educational programmes** and provide assistance in its implementation. The Ministry of Health, Wellbeing and Sports ensures that reliable information is available, as providing national awareness and prevention activities, which are then carried out by local municipalities in cooperation with schools and local care services. An example is the Healthy School and Drugs Programme (*De Gezonde School en Genotmiddelen*[300]) developed by the Trimbos Institute, which is used by more than three quarters of Dutch schools.[301] However, in 2014 an evaluation reported that the programme was ineffective in preventing the onset of alcohol, tobacco and cannabis use. It has been suggested the awareness on drugs at a too young age can have the opposite effect.[302] As a result the Programme was discontinued for primary schools and revised for the secondary schools.[303] The evaluation of the revised programme is still ongoing. [304]

[300] See http://www.dgsg.nl/professionals

[301] Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie – Bijlage 1: Uitgangspunten huidig drugsbeleid, 3 November 2015.

[302] Interview Trimbos Instituut, 19 September 2016.

[303] EMCDDA, Netherlands Country overview, last updated 20 May 2016.

[304] Interview Trimbos Instituut, 19 September 2016.

In addition, there are information brochures and websites (such drugsinfo.nl). Trimbos Institute, in collaboration with other addiction care centres, also established a **Drugs Infoline[305],** which allows people to call over the phone or chat and ask questions on alcohol and drugs through e-mail or chat. Although the infoline has been used a lot over the years, the effectiveness of the info line is difficult to measure, and has not been evaluated. [306]

Since 2014, the Trimbos Institute is implementing the **Safe and Healthy Catering and Events Programme** (*Veilige en Gezonde Horeca en Evenementen*), which aims to reduce drug use and related problems of youth (16-24 years old). The programme includes the supporting and working together with municipalities to develop safe and healthy local catering and event policies. The programme also includes awareness raising and providing information to young people and their parents, as well as offering training for professionals in the events/nightlife scene.[307]

In recent years prevention activities haven become more and more focussed on certain types of groups, such as young people from socio-economically deprived backgrounds or focussed on certain settings. For example , the Ministry of Health, Welfare and Sport has commissioned different projects focussing on the drug use at parties and in **recreational settings**, including on the implementation of safe clubbing regulations and the testing of substances at addiction care organisations. With regards to the latter, the most well-known drug prevention service available is **the Drug Information and Monitoring System (DIMS**). The DIMS is part of the Trimbos Institute, drug users can bring their drug to have the drug tested for adulterants in a DIMS laboratory. If a substance is found with adulterants which pose a direct risk to the public health regional and/or national warning activities are set up. DIMS will also start a national **warning campaign (Red Alert**)[308], of the risk is an acute one to public health, together with the Ministry of Health of Health, Wellbeing and Sports, The Inspection of Public Health Care (Inspectie voor de Gezondheidszorg).[309] According to a representative of the Trimbos Institute, the DIMS works well as a monitor of the drug market, as well as a prevention tool, and has allowed them to be in good contact with the user population[310]. An expert in Dutch drug policy noted that the Netherland is quite good in developing credible information campaigns that are credible sources of information for users, as the campaigns don't overstate the risk of drug use. Instead it puts the risks into the context of a range of other risks.[311]

In addition, the Drug Incidents Monitor (MDI) of the Trimbos Institute collects data with medical institutions in eight regions, such as the departments of Emergency First Aid at hospitals, first aid stations of large-scale dance events, ambulance services and forensic doctors. By linking the DIMS data with that of the MDI, risky developments can be quickly passed on to the health institutions.[312]

In the Netherlands, the municipality is the body issuing licenses to parties and events, and can require the organisers to have a first aid service on the party, or for the organisers to follow EHBDu[313] training. Moreover, many municipalities fund the project "Unity", which

[305] Available at: https://www.drugsinfo.nl/publiek.

306 Interview Trimbos Instituut, 19 September 2016.

[307] Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie – Bijlage 1: Uitgangspunten huidig drugsbeleid, 3 November 2015.

[308] https://www.trimbos.nl/actueel/nieuws/bericht/?bericht=2141

[309] http://www.drugs-test.nl/dims

[310] Interview Trimbos Instituut, 19 September 2016.

[311] Interview Freek Polak, Stichting Drugsbeleid, Netherlands, 9 September 2016.

[312] Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie – Bijlage 1: Uitgangspunten huidig drugsbeleid, 3 November 2015.

[313] Eerste Hulp bij Drank- en Drugsincidenten in het Uitgaanscircuit.

provides peer to peer awareness raising and information on parties and events on the drugs and risks of alcohol and drugs use.[314]

Finally, a national database of evaluated prevention projects is hosted by the Centre for Healthy Living of the National Institute of Public Health and the Environment, in order to support municipalities and promote evidence-based prevention interventions.[315]

Treatment and Harm reduction activities

As per the National Drug Policy Strategy, harm reduction and treatment are two key areas of the drug policy in the Netherlands. The Netherlands spends most resources on the **treatment** aspect of drugs policy, as this is a much larger and more resource intensive area than for example Prevention. [316]

In terms of **treatment**, there has been a general review and change in the way mental health care is provided in the Netherlands.[317] As drugs treatment is part of that, it was affected as well. There has been a reduction of the number of addiction service providers in the past decade and an expansion to outpatient services, services through general practitioners and e-health interventions, supporting an overall vision of empowerment and self-regulation, and that addiction clients are in charge of their own addiction treatment.[318]

The following **treatments** are available in the Netherlands:[319]

- Methadone substitution treatment (OST) is dominant for opiate dependence: available since 1968 and often complemented by psychosocial interventions, most commonly prescribed - 7 569 clients in 2014;
- High-dosage buprenorphine treatment (introduced in 1999);
- Heroin-assisted treatment[320] (HAT, introduced in 1998) – 697 in 2014;
- Regular' (outpatient and inpatient) addiction treatment:
- Treatment for: Treatment therapies include motivational interviewing, relapse prevention techniques, cognitive behavioural therapies, and family, community and home-based treatment therapies.
    - young cannabis users;
    - people with multiple (addiction and mental health) problems;
    - for crack and GHB users
    - homeless drug users in several municipalities.

The National Alcohol and Drugs Information System (LADIS)[321] showed that in 2015 a total of 64821 clients entered treatment (including for alcohol and gambling), of which 36% related to drug addiction:

- 17% for a cannabis;
- 14% for opiates;
- 11% for a cocaine;
- 3% for amphetamine;
- 1 % for GHB.

[314] Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie – Bijlage 1: Uitgangspunten huidig drugsbeleid, 3 November 2015.

[315] EMCDDA, Netherlands Country overview, last updated 20 May 2016.

[316] Interview Freek Polak, Stichting Drugsbeleid, Netherlands, 9 September 2016.

[317] Interview Trimbos Instituut, 19 September 2016.

[318] EMCDDA, Netherlands Country overview, last updated 20 May 2016.

[319] EMCDDA, Netherlands Country overview, last updated 20 May 2016.

[320] It should be noted this treatment is only available to a restricted and controlled group of treatment-resistant opiate users.

[321] IVZ,LADIS - Kerncijfers verslavingszorg 2015, July 2016.

In addition to treatment, the Netherlands has over 30 years of experience in the area of **harm reduction**, as well as widespread availability of (maintenance) methadone. For example needle and syringe programmes have been established for more than 20 years. Harm Reduction responses in the Netherlands include:

- **Outreach work** carried out by low-threshold services in outpatient care facilities such as daytime shelter in drop-in centres for street-based problem drug users;
- **Needle and syringe programmes** are available in all major Dutch cities: in 2014, 92 400 syringes were exchanged in Amsterdam and 48 800 in Rotterdam.
- 31 **drug consumption rooms** in 25 cities targeting people who inject drugs and those who smoke or inhale drugs.

Table 39: Example of drugs activities and intervention in place in he Netherlands

Activity name	Year introduced	Short description	Type of interventions (Prevention, treatment and harm reduction, criminal justice response)
Campaign Celebrate Safe[322]		A platform providing reliable information on the risks of the use of drugs at parties and other events	Prevention / Harm reduction
Healthy School and Drugs (De Gezonde School en Genotmiddelen)	N/A	As discussed above	Prevention
the Safe and Healthy Catering and Events Programme	2014	Programme aiming to reduce drug use and related problems of 16-24 years old.	Prevention
PAS	N/A	A Swedish programme, Preventing Heavy Alcohol Use in Adolescents (the Örebro programme), implemented in the Netherlands under the name PAS.	Prevention
Alcohol and Drug Prevention at Clubs and Pubs	N/A	Aims to create a healthy and safe nightlife environment using a healthy settings approach, focussing on reducing the high-risk use of substances among young people and its related problems.	Prevention
Medical prescription of Heroin	2009	The medical prescription of heroin to treat chronic and treatment-resistant opiate addicts was established as a regular part of the treatment system in 2009.	Treatment

[322] See http://celebratesafe.nl/

Activity name	Year introduced	Short description	Type of interventions (Prevention, treatment and harm reduction, criminal justice response)
The Placement in an Institution for Prolific Offenders (ISD)	2004	Introduced in 2004 for the treatment of mainly problematic drug users, including imprisonment and behavioural interventions and treatment, mostly carried out in care institutions outside prison.	Treatment
National HBV vaccination programme	N/A	Programme including screening for HBV infection and vaccination for vulnerable people, targeted at behavioural risk groups. In 2015 HCV treatment availability was expanded and has become reimbursable.	Harm Reduction
Infolijn	1998-present	Allows people to call over the phone or chat and ask questions on alcohol and drugs through e-mail/ chat	Prevention
Drugs Informatie en Monitoring systeem DIMS)	1992- present	Monitoring of the drug market and surveillance to signal new risky drugs at an early stage.	Prevention & Harm reduction

Source: authors. The table represents and overview of type of activities available and is not exhaustive.

Criminal justice response

The police work closely with the customs and police forces in other (European) countries to combat drug trafficking. In terms of prosecution, the focus also lies on the production and trafficking of drugs. The detection of possession of small amounts of drugs for personal use has been granted a much lower priority.[323] In 2011 a special task force was set up to counter cannabis criminality. Among other things, this Task Force undertook raids of so called "stashes", the places outside the coffee shops where coffee shops hold their stock (as they are not allowed more than 500 gr stock in the coffee shop).[324] In a number of cases, judges have not sanctioned coffee shop owners for having such "stashes" or cannabis producers which sell to coffee shops, as their activities are considered a necessary part of the coffee shop system.. In some cases judges have sentenced coffeeshop owners, but without any penalty[325].

Cooperation at the international and EU level

The Netherlands are working with Europol in the framework of EMPACT on the priority 'Cocaine' and 'Heroin'.

[323] https://www.om.nl/onderwerpen/drugs/

[324] http://www.trouw.nl/tr/nl/4492/Nederland/article/detail/2892270/2011/09/06/Coffeeshops-vrezen-aanpak-van-voorraad.dhtml

[325] http://www.nu.nl/binnenland/3905054/rechter-geeft-twee-principiele-wietkwekers-geen-straf.html

EFFECTS

The comprehensive evaluation of the overall drug policy in 2009 undertaken by the Trimbos Institute and the WODC has shown that the implementation of the Dutch Drugs policies have had good results in the field of public health.[326] According to the Dutch government, the prevention activities, addiction treatment and research and monitoring carried out in the area of drug use in the Netherlands are at a high level. The government further noted that the Netherlands plays a leading role in the area of harm reduction, because of its use of evidence-based interventions.[327]

Overall, "last year prevalence rates" were higher in 2014 for all types of drugs compared to 2009, but due to methodological differences, the data in these years cannot be compared. However, inasmuch as the indicators below can be used as indicators of the effectiveness of drug policies, the following positive effects on public health can be noted:

- Decrease in cannabis use among youth and problematic heroin use;
- Decrease in the number of high risk opioids users (Figure 4);
- A low HIV prevalence (Figure 15);
- Limited use of new psychoactive substances.

More negative effects seems to be:

- Unstable overdose rate (Figure 11),

The expert also noted how certain drugs, like methamphetamine, are a very small problem in the Netherlands compared to other countries like the US. According to the expert, this may be due to the fact that in the Netherlands, a clear distinction is made between soft drugs and hard drugs: people are aware of the risks associated with both and therefore are more likely to consume drugs with lower risks. This is very different to the US, where all drugs are seen as carrying the same risk, and same penalty, which may cause people to choose the drug with the most effect. [328]

Another well known issue in the Netherlands, is the "**front door / back door problem**", which relates to the dilemma of having on the one hand de facto decriminalised retail and consumption of drugs, and quite successfully avoided criminalising large numbers of users, but at the same time having created an opportunity for organised crime groups to supply drugs to the coffee shops (even if this is this illegal).[329] Another issue related to the border regions of the Netherlands, to which measures have been taken, is drug tourism: the success of the Dutch coffee shops have led to other countries, like Germany and France, to export their drug problems to the Netherlands as a result of un-met demand of quality cannabis in those countries.[330]

Key indicators related to health

- **Number of people entering treatment**

The number of clients registered for treatment on account of a primary cannabis problem duplicated between 2005 and 2011 and has stabilised since (around 11,000 cannabis

[326] Trimbos Instituut/WODC, Evaluatie van het Nederlandse drugsbeleid, 2009. Available here: https://assets.trimbos.nl/docs/cf089eb0-b227-47f5-8904-2de21eada502.pdf

[327] Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie, 3 November 2015

[328] Interview Freek Polak, Stichting Drugsbeleid, Netherlands, 9 September 2016.

[329] Additional information provided by study expert Axel Klein on 21 September 2016.

[330] Additional information provided by study expert Axel Klein on 21 September 2016.

clients in 2014). The increase could be attributable to an increase in the number of problematic cannabis users, however other possible explanations could be the increase in the number of available treatment centres, as well as an increase in the awareness of the addictive nature of cannabis which made people look for help more timely.[331] Another reason noted by the study expert was the fall in number of problematic opiate users and therefore a fall in demand of this type of treatment, allowing treatment centres to provide treatment to cannabis users instead.[332]

The number of clients with cocaine as primary problem rose between 2005 and 2008 by 13%, but decreased between 2008 and 2014, again by 20%.

Even though the Netherlands has the highest prevalence rate of ecstasy use among all EU countries, the number of people registering to treatment for ecstasy use is very low. Since 2005 this number decreased and has been stable since. Less than 1% of the problematic drug users in 2014 had ecstasy use as its primary problem. The number of amphetamine clients in treatment increased between 2005 and 2014, but their share of all drug clients remains relatively limited (5% in 2014). [333]

- **Admissions to general hospitals**

The National Medical Registration (LMR) registered almost 2 million admissions in 2012, of which in 538 cases drug abuse and drug addiction was the primary diagnosis. Of these admissions, 14% these were related to cannabis and 16% to cocaine.

The National Medical Registration (LMR) registered 2938 cases in which drug abuse and drug addiction the secondary diagnosis, of which 26% was related to cocaine and 25% is related to cannabis. The most common primary diagnoses in these secondary diagnoses were: accidents; intoxication; heart-disease; abuse or dependence on alcohol; diseases of the respiratory tract; abuse or dependence on drugs; psychosis.

The LMR registered few annual admissions to general hospitals with psychostimulants as the diagnosis: 67 in 2012 as primary diagnosis and 196 admissions in 2012 as secondary diagnosis.

- **Number of incidents at events**

In 2014, the Monitor Drugsincidenten (drug-related emergencies) (MDI) of the Trimbos Institute reported 3797 drugs incidents. In 47% of these cases ecstasy was used, in 19% of the cases cannabis was used and in 11% cocaine-HCL was used.[334] The number of ecstasy related incidents has not increased since 2012, however the severity of ecstasy incidents reported by First Aid Posts at major events continues to increase in 2014.[335] Moreover, an increase of health incidents has been registered between 2009 and 2014 at major events with regards to GHB: the number of GHB users requesting aid at first aid stations under moderate to heavy influence has risen from 34% in 2009 to 70% in 2014.[336]

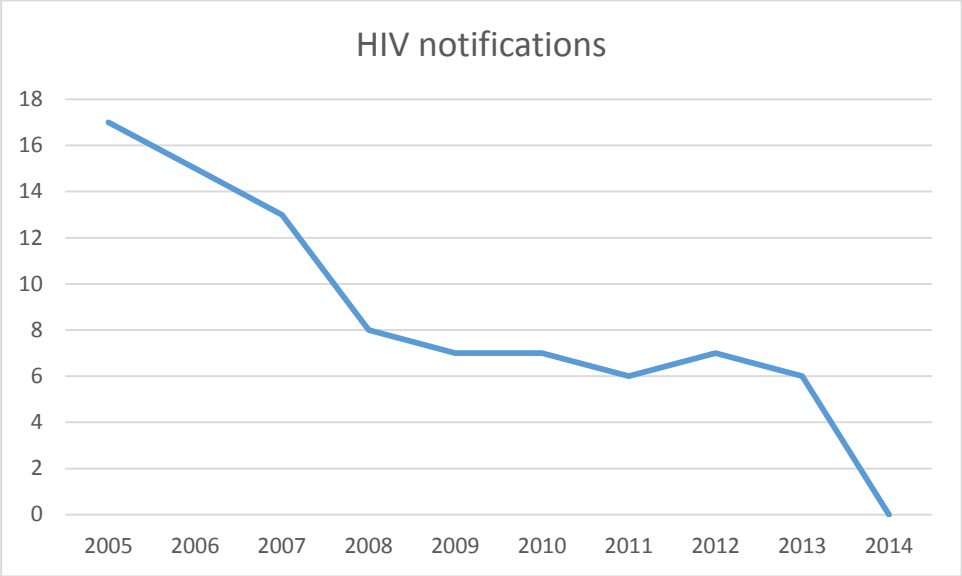
- **HIV Prevalence**

The number of newly reported cases of HIV related to injecting drug use has been low for years and this number is the lowest in Europe. New infections related to drug use are

[331] Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2015, 2015, p. 95.
[332] Additional information provided by study expert Axel Klein on 21 September 2016.
[333] Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2015, 2015, p. 154.
[334] Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2015, 2015, p. 98, 123 and 172.
[335] Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2015, 2015, p. 154.
[336] Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie, 3 November 2015.

hardly found.[337] The main reason for this is the effective Dutch harm reduction policies, which provide clean syringes and needles to heroin addicts for years.[338]

Figure 27: HIV notifications

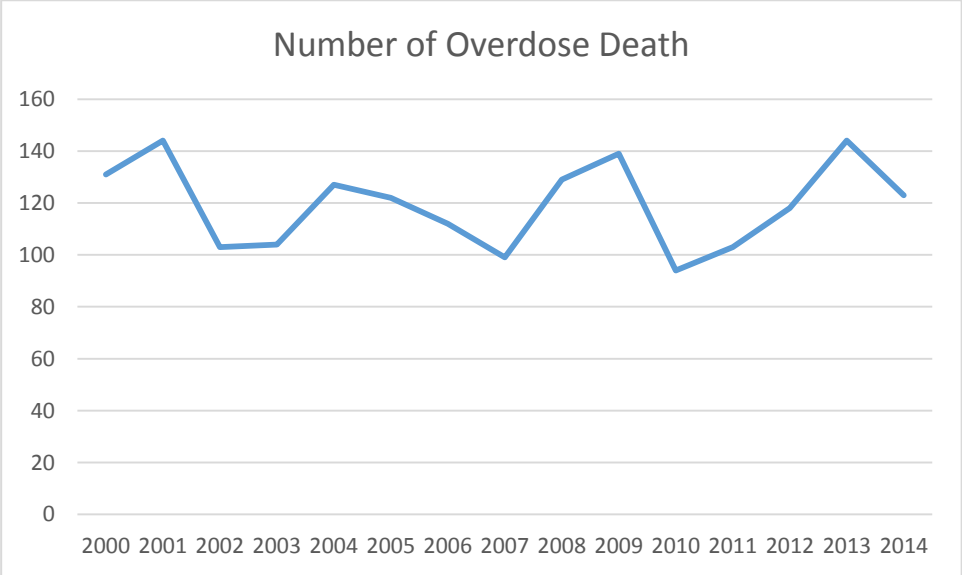


Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016 - ECDC data.Retrieved from TESSy database

- **Death indicators:**

As can be seen in the table below, the number of overdose death has on average been around 120 deaths, with a decrease in 2002/2003 and 2007 and 2010 and a peak in 2001, 2009 and 2013. However, the overall number of drug related death per million population is low in the Netherlands compared to other EU member states.

Figure 28: Number of overdose deaths in the Netherlands



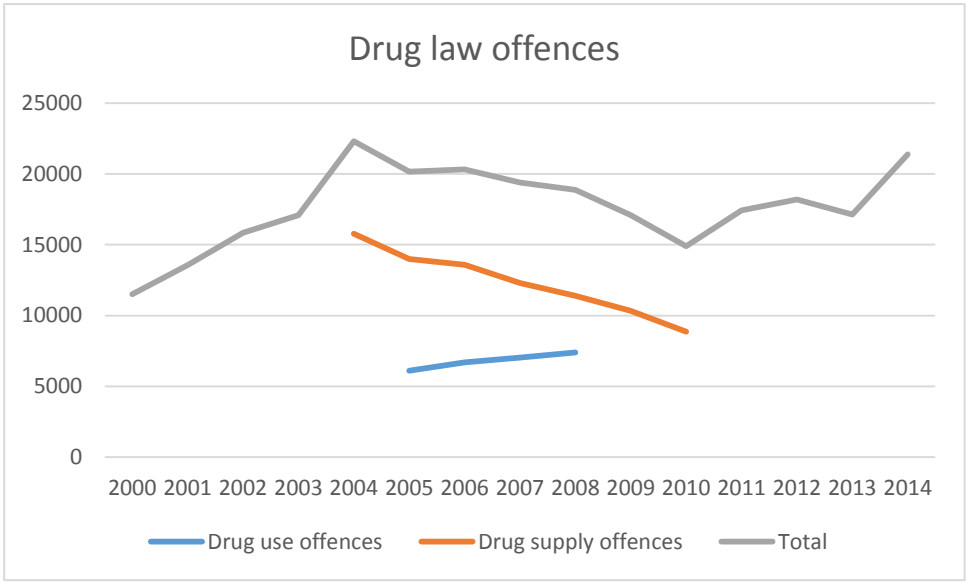
Note: According to national definition of overdose that is acute deaths directly related to drug consumption. It does not include death that are linked to drug abuse but not caused by them (e.g. mental health issues)

[337] Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie, 3 November 2015.

[338] Interview Freek Polak, Stichting Drugsbeleid, Netherlands, 9 September 2016.

Key indicators related to criminal justice system

Figure 29: Number of drug law offences in the Netherlands



Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016 - Drug law offences > Number of Offences > Offences

The number of drug law offences in the criminal justice system seems to be decreasing in the Netherlands.[339] The number of suspects against whom a report was made as a result of a drug law offense by the police or Royal Military Constabulary (KMar) decreased from 19.000 in 2012/2013 to around 18.000 in 2014.

It should be noted that data on the number of drug law offences are not available per type of drug (see table below), instead the Netherlands distinguished between List I and List II drugs.[340] In 2014, Slightly more than half of all reports have been linked to 'soft drugs' (List II), while 42% related to hard drugs (List I). The majority of offences related to 'hard drugs' are linked to their possession.[341]

Moreover, since 2011 the number of cannabis **plantations being dismantled** is more or less stable: with some 6 006 cannabis plantations dismantled in 2014. Similarly the number of synthetic drugs production locations being dismantled is increasing as well: from 30 in 2011 and 2012 to 50 in 2013 and 2014.[342]

In terms of investigations of organised crime in relation to drugs, most investigations relate to cocaine

[339] Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2015, 2015, p. 306.
[340] Interview Trimbos Instituut, 19 September 2016.
[341] EMCDDA, Netherlands country overview, last updated 20 May 2016.
[342] EMCDDA, Netherlands country overview, last updated 20 May 2016.

CONCLUSIONS

In the Netherlands, drug demand reduction is mainly achieved through prevention activities, as well as treatment and harm reduction activities, and drug supply reduction activities are in the hand of law enforcement agencies who cooperate closely with other agencies and local authorities.

Another key feature of the Dutch drug policy is its success of outreach / harm reduction policies and activities for opiate users, evidenced by the fall in deaths of these drug users and the fall in the number of opiate injecting drug users.

Moreover, the Netherlands has made good use of non-statuary agencies, i.e. NGOs and third sector institutes like the Trimbos Institute – they have credibility, they don't carry stigma, and they are closer to drug using scenes – resulting in high quality information.

The Netherlands still has to resolve the problem of the drug supply side being in the hands of criminal groups.

STAKEHOLDERS AND DOCUMENTS

Table 40: Persons interviewed and document retrieved.

Stakeholders interviewed	• Trimbos Institute, REITOX Focal Point Netherlands. • Freek Polak, retired psychiatrist and doctor, Founding Director of the Stichting Drugsbeleid and member of the MDHG and VOC.
Documents / websites reviewed	• Aanwijzing Opiumwet (2015A003). • Drugs Informatie en Monitoring Systeem (DIMS), Jaarbericht 2015. • Eerste Hulp bij Drank- en Drugsincidenten in het Uitgaanscircuit • EMCDDA, Netherlands country overview, last updated 20 May 2016 • H. Rigter (2006), 'What drug policies cost: Drug policy spending in the Netherlands in 2003', Addiction 101, pp. 323–329. • Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie, 3 November 2015. • Ministerie van Volksgezondheid, Welzijn en Sport, Beleidsvisie drugspreventie – Bijlage 1: Uitgangspunten huidig drugsbeleid, 3 November 2015 • Nabben T., Benschop m A. & Korf D.J. (2014) Antenne 2013. Trends in alcohol, tabak en drugs bij jonge Amsterdammers. Amsterdam: Rozenberg Publishers. • Opiumwet, available here: http://wetten.overheid.nl/BWBR0001941/2016-08-01 • Peilstationsonderzoek Scholieren/Leefstijlmonitor, Trimbos-instituut i.s.m. RIVM, 2015. • Richtlijn voor strafvordering Opiumwet, harddrugs, 2015 and Richtlijn voor strafvordering Opiumwet, softdrugs, 2016 • Trimbos Instituut/WODC, Evaluatie van het Nederlandse drugsbeleid, 2009. • Trimbos Instituut/WODC, Nationale Drug Monitor-Jaarbericht 2015, 2015. • Tweede-Kamer der Staten-Generaal, Drugsbeleid: continuiteit en verandering, 1995. • Tweede Kamer der Staten-Generaal, Beleid inzake XTC, The Hague, 9 May 2001.

	• IVZ,LADIS - Kerncijfers verslavingszorg 2015, July 2016. • Kabinetsnotitie 'Voortzetting aanpak synthetische drugs vanaf 2007' • http://www.drugs-test.nl/dims • http://www.nu.nl/binnenland/3905054/rechter-geeft-twee-principiele-wietkwekers-geen-straf.html • http://www.trouw.nl/tr/nl/4492/Nederland/article/detail/2892270/2011/09/06/Coffeeshops-vrezen-aanpak-van-voorraad.dhtml • http://celebratesafe.nl/

Appendix A5: Case Study – Poland

Introduction

Poland's drug policies have been oscillating in the last 15 years, since a change of perception of drug-related problems from a health to a criminal issue in 1997. After having a strict criminalisation system put in place 2001, an amendment to the drug law in 2011 smoothed the penalties received by drug offenders. The amendment enables prosecutors and judges to discontinue the criminal procedure for individuals caught in possession of small quantities of psychotropic substances and narcotic drugs for private use. Poland had also started to integrate the health and justice system together. Under article 70a of the criminal code, prosecutors and judges need to set up an interview between the offender and a therapist specialist for all offenders suspected to be a drug user.

The health indicators seem to be improving, but it is complex to assess the extent to which the improvement in health is due to drug policies. Poland has invested in prevention activities but not in harm reduction strong prevention activities based on European quality standard but the efficiency of harm reduction policies seem to be more mitigated. Notably opioid substitution programmes are not as widespread as they could be due to a high level of public regulation. Poland is actively looking at improving its harm reduction programme and it notably promotes the European Quality standard on demand reduction among its local communities.

NEEDS

Drug use among population

There was a sharp rise in drug use prevalence in Poland between 2006 and 2010. The prevalence has since them stabilised. In 2014, any illegal drug use prevalence was 4.7%. The highest lifetime prevalence is for cannabis with a rate of 16.2%, followed after by amphetamine, ecstasy and cocaine with a prevalence of 1.7%, 1.6% and 1.4% respectively. The most recent estimates of the number of high-risk drug users were calculated in Poland based on 2009 data. 79 500 high-risk drug users have been identified, that is 2.93 per 1 000 inhabitants[343].

Table 41: Prevalence rates among adults 15–64 (2014)

Title (%)	Lifetime prevalence EU average [i, ii]	Lifetime prevalence Country	Last year prevalence 2014
Cannabis	17.8	16.2	4.6
Opioids			
Problem drug use: all opioids [iii]	Average of annual prevalence at the most recent year available: 0.35	N/A	Prevalence in 2009: 0.06
Stimulants			

[343] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland .

Title (%)	Lifetime prevalence EU average [i, ii]	Lifetime prevalence Country	Last year prevalence 2014
Cocaine	3.0	1.3	0.2
Amphetamines	2.5	1.7	0.2
Hallucinogens			
Ecstasy	2.9	1.6	0.4
LSD	1.4	1.3	0.1
All drugs			
Total	19.1	16.4	4.7

Source: Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016;

[i] Average EU data have been calculated according to the most recent data available per country in EMCDDA statistical bulletin. Latest year available for all types of drugs except opioids are as following: 1998 for LU; 2004 for EL; 2007 for HU; 2008 for AT and EE; 2010 for SK; 2011 for IE and LV; 2012 for BG, HR, CY, DE, LT, PT, SI; 2013 for BE, DK, MT, RO and ES; 2014 for CZ, FI, FR, IT, NL, PL, SE and UK. Data from SE, BE and EE were not broken down by drugs and were only available for the overall drug prevalence. There were not any available data on all drug prevalence for LU and NL and no amphetamine use prevalence data were available for LU;

[ii] Latest year for Opioids use prevalence estimations used for calculating EU average data are as follow: 2007 for LT and LU; 2008 for SK, 2009 for PL, 2010 for HR, 2012 for FI, NL and PT; 2013 for AR, DE, SI and ES; 2014 for CY, CZ, EL, IT, LV and MT; 2010-11 for HU and UK; 2013-14 for FR. There were no available data on opioids prevalence for BE, BG, DK, EE, IE, RO and SE;

[iii] Recurrent drug use that is causing actual harms to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high risk of suffering such harms'. Prevalence data for Portugal have been estimated with capture-recapture method and based on treatment data and criminal justice data.

Health impact of drug use in Poland

Up to the end of 2014, a total of 18 757 HIV infections have been reported and a third of these were among people who inject drugs. There is a downward trend in HIV infection among drug users, and only 37 cases were reported in 2014. However, there is potentially an underestimation of the cases reported because the transmission route is often not indicated in HIV data. Other prevalence data have been estimated based on a sample of 505 people who injected drugs in 2014. Among the 505 people tested, 3.0% had an HIV infection. As presented in Table 42, the prevalence of drug-related new HIV is relatively low and below 1% which is quite positive considering that new HIV prevalence reflects the proportion of drug users who have been infected recently. Regarding acute hepatitis B virus (HBV) and hepatitis C virus (HCV), one out of 68 cases of HBV was an injecting drug user in 2014, and 158 of 2 173 chronic HCV infections cases were reported as being transmitted through drugs injections.

There is a downward trend in the number of deaths among drug users. There were 324 drugs induced deaths in 2002 compared to 227 in 2012 and 247 in 2013. Compared to the

European average of 19.2 deaths per million in 2014, the drug-induced mortality in Poland was relatively low and reached 8.5 deaths per million.[344].

Table 42: Drug-induced mortality and epidemiology

	Number of people who inject drug[s]	Prevalence of drug related-new HIV (%)[ii]	Prevalence of new Hepatitis C among people who inject drugs (%)[ii]	Prevalence of hepatitis B antibodies among people who inject drug (%)[ii]	Drug-induced mortality among adult 15-64 (per million)[ii]
Year		**2014**	**2014**	**2014**	**2014**
Poland	15 119	1.0 cases per million	N/A	3.0	8.5
European average	N/A	N/A	N/A	N/A	19.2

Source: [i]Harm Reduction International, (2014). The Global State of harm reduction 2014. London: Harm Reduction International. Retrieved from https://www.hri.global/files/2015/02/16/GSHR2014.pdf; [ii] Poland country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/poland

Drug production, import and export

Amphetamines and methamphetamine are illegally produced in Poland to be then either exported or consumed in the country. In total, 19 laboratories producing amphetamines and other drugs (mephedrone, GHB) were dismantled in 2013 and 17 in 2014. The quantity seized of amphetamine and methamphetamine increased considerably in the last decade reaching in 2014 the quantity of 783 kg of and 1 kg respectively. Besides being a country of transit for Heroin, Poland produces its own type of Heroin, called 'kompot', a product made from poppy straw that retain many of the impurities and high content of codeine and thebaine make it dangerous to inject. Kompot has been used in the country in Communist times, but with the government then denying the problem, there is no data on the health impact of its use. The country has seen the opening of its first 'smart shops' in 2008 which sells new psychoactive substance (or legal high). These substances have been firmly established in Poland; the number of smart shops reached 1 400 in 2010[345] and 28 000 products were temporally seized in 2013[346]. Cannabis is also increasingly produced domestically and in 2014, 95 214 cannabis plants were seized[347].

[344] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland.

[345] European Monitoring Centre for Drugs and Drug Addiction,. (2014). Drug policy profile: Poland. Luxembourg: Publication Office of the European Union. Retrieved from http://www.emcdda.europa.eu/attachements.cfm/att_227226_EN_TDAU14003ENN.pdf.

[346] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland.

[347] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland.

Poland is both the producer of synthetic drugs for Western European markets and a transit country for drug trafficking from east to west. Amphetamines and methamphetamine are smuggled to Western and Scandinavian countries. Heroin is smuggled via the Balkan and the silk routes from Afghanistan to Germany and the UK. Cocaine reaches the country from the Netherlands, France and Belgium and via Turkey and Greece. Non-grown domestically cannabis is trafficked primarily from the Netherlands, Belgium, Germany and the Czech Republic on to other eastern European markets and Russia. Cannabis (domestic and non-domestic) is still involved in the vast majority of seizure; the total quantity of herbal and resin cannabis seized was 270 kg (2014) and 208 kg (2014) respectively[348].

LEGAL FRAMEWORK

In the post-communist Poland, a violent black market developed and contributed to a gradual shift in the public debate from perceiving drug policy as a health issue, to view it as a justice and order issue. The act on Countering Drug Addiction (1997) is the first act criminalising any possession of drugs; before drug use was considered as an administrative offence. There were, however, some provisions in the 1997 law stipulating that possession of small amount for personal use could not be subject to punishment other than the confiscation of the drug.

Another act from 2001 increased penalties for drug use or possession without any exception. The government, however, realised that the law did not provide the intended effect and instead used an excessive amount of police resources on minor rather than serious drug offences. Therefore, an amendment to the law in 2011 (article 62a) provided the option to discontinue criminal proceeding for individuals who possess a small amount of drugs for personal use which represented an important proportion of the drug-related offences.

The national legislation criminalising drug offences in Poland is the Act on Counteracting Drug Addiction of 29 July 2005 and Table 43 below provides an overview of how drugs are penalised in Poland. Possession of drugs is sentenced to up to 3-years imprisonment and in minor cases, the offenders can be fined or ordered to serve a sentence involving limitation/deprivation of liberty for up to one year. The amendment from 2011 enables the prosecutors and judges to discontinue the criminal procedure for individuals caught in possession of small quantities of psychotropic substances and narcotic drugs for private use. Article 72 and 73a of the Polish drug law implement the 'treat rather than punish principle'; proceeding can be suspended and breaks in serving the sentence can be allowed when an individual is in treatment. Sentences for the supply are more important and depend notably on whether the offenders make a profit from the drug trafficking. Penalties range do not vary by type of drugs.[349]

Table 43: Criminalisation of drugs and penalties

Production	supply	possess		use
Penalty	**Penalty**	**Penalty**	**Depending on Quantity?**	**Penalty**

[348] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland.

[349] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland. European Legal database on drugs. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/topics/law/penalties-at-a-glance

Production	supply	possess		use
Criminal offence: Cultivation or drug production, is punishable by up to 3 years. - Cultivation in large quantities can be penalised from 6 months to 8 years imprisonment. - If a production offence involves a substantial amount of drugs or was committed in order to receive benefits, there is a minimum 3 years imprisonment. Penalty varies by quantity and penalty range does not vary with drug type	- Drug supply is a criminal offence - Standard offence: Fine and imprisonment of between six months and eight years - Minor offence: perpetrator may be fined, subjected to limitation of liberty, or imprisoned for a maximum of one year. - substantial case (involving a considerable quantity): the perpetuator may be imprisoned for up to 12 years Penalty range does not vary with drug type but varies by quantity	- Possession is a criminal offence punished by up to three years' imprisonment. - Penalty for minor offences: the offender can be fined and be deprived of liberty for up to one year. Also, for a small amount of narcotic drugs and psychotics for personal use, a judge can decide to discontinue the criminal procedure but can oblige a sentenced drug user to undergo treatment. - Penalty for major offences: If possession of a considerable quantity of drugs, the punishment can go up to 10 years imprisonment	Punishment depends on quantity. In case of lesser gravity, maximum punishment is 1 year Possession of a considerable amount of drugs can lead up to 10 years imprisonment	Use of drugs is not mentioned as an offence

Source: European Legal database on drugs / http://www.emcdda.europa.eu/topics/law/penalties-at-a-glance

AIMS AND OBJECTIVES OF THE NATIONAL APPROACH TO DRUG POLICY

Objectives and overview of current strategy (ies)

Poland's drug policy shifted from being perceived as a health issue to a security and order issue but after having a strict law criminalising any drug use or possession, the government reduced penalties set out in law by the 2011 amendment that provides the option to discontinue criminal proceeding for individuals who possess a small amount of drug for personal use. Poland's drug policy is nowadays a combination of criminalisation and drug-related harm reduction; the country is still in the process of finding its equilibrium.

In 2011, the fourth National Programme for Counteracting Drug Addiction (2011–16) was adopted. Primarily concerned with illicit drugs, the Programme's general aim was to reduce drug use and drug-related social and health problems. The programme was constructed around prevention, treatment rehabilitation, harm reduction and social reintegration,

supply reduction, international cooperation and research and monitoring. For the years 2011−16, there was a greater emphasis on improving the quality of drug prevention programmes and the quality of life of those undergoing treatment, harm reduction and social reintegration activities. The Programme also took account of changes in the drugs market and addressed domestic cannabis cultivation, the online sale of new psychoactive substances (NPS) and the illicit trade in chemical precursors[350]. With the emergence of the NPS, Poland has undertaken many actions and it was a strong supporter of the EU proposal on NPS. However, even though Poland still requires European support, it has now developed a long national legislation that it will try to protect over the European laws on NPS[351].

Table 44: Main current policies and action plans in Poland

Policies, actions plans	Description
National Programme for Counteracting Drug Addiction 2011−16	The National programme assigned 113 actions to 10 ministries, 24 institutions, provincial pharmaceuticals, and communal governments. The programme is constructed around the 5 following pillars: prevention, treatment, rehabilitation, harm reduction and social integration, supply reduction, international cooperation and research and monitoring.
Anti-drug Action Plan	This was adopted to improve the quality of drug prevention in schools and educational facilities.
Response to the legal highs Phenomenon	Following the development of the smart shops selling psychoactive substances, the government prepared a series of amendments to the drug law.

Organisations involved

The National Bureau for Drug Prevention (NBDP) is a state institution in charge of implementing Poland's drug policies, notably in the drug demand reduction field. Policies are highly influenced by Non-governmental organisations (NGO's) that provide treatment, rehabilitation and counselling services for drug addicts. After being decided at the national level drugs policies are implemented by the local governments.

The most important NGO, MONAR, has been created in the 1980s and it created the first therapeutic community. Besides its role in establishing treatment/health support centres, MONAR plays a role notably in developing international cooperation, improving mass media prevention activities and developing post-rehabilitation services[352]. Another organisation that contributes in shaping drug policies is the Polish drug policy network.[353] The Polish

[350] European Monitoring Centre for Drugs and Drug Addiction,. (2014). Drug policy profile: Poland. Luxembourg: Publication Office of the European Union.

[351] Interview with Artur Malczewski, REITOX focal point .

[352] Stowarzyszenie MONAR. Monar.org. Retrieved 27 September 2016, from http://www.monar.org/history#!

[353] O nas | www.PolitykaNarkotykowa.pl. (2011). Politykanarkotykowa.pl. Retrieved 26 September 2016, from http://www.politykanarkotykowa.pl/o-nas

drug policy network emanated from a citizens' initiative that started in 2008 by a group of professional working with drug users (i.e. therapist, doctors, lawyers, prison staff, social workers, educators, representatives of NGOs, users of psychoactive substances). It aims to have an impact on drug laws in Poland in order to make them less restrictive and to increase the availability of substitution treatment. The network has also been working on prevention projects and law enforcement training.

Located within the NBDP, the Information Centre for Drugs and Drug addiction is the EMCDDA national focal point and it has been established in 2001.

INPUTS

Poland started in 2012 to estimate the funding of all NGOs dealing with drug demand reduction. They added in 2013 the spending of communal government on drug reduction initiatives. Based on these data, drug-related expenditure represented 0.01% of the GDP in 2014 which represents around EUR 25 million. Some qualitative information is also reported on the EMCDDA website which suggests that the funds allocated to drug initiatives might have diminished in 2014 compared to 2013[354].

However, the discussion with the REITOX national focal point[355] suggested that more is spent on drugs-related activities. It has been roughly suggested that:

- Around EUR 100 million are dedicated to NGOs activities and another EUR 100 million is spent at the national level.
- Approximatively EUR 40 million is dedicated to national health substitution programmes
- Around EUR 120 million are spent by local communities for investing in drugs and alcohol related programmes (around 8-9 million is spent for drugs-related activities). In the budget spent by local communities, 80% is dedicated to prevention activities and 20% for harm reduction and rehabilitation activities.

ACTIVITIES (DRUG POLICIES, PROGRAMMES, STRATEGIES ETC)

This section will provide an overview of the different activities undertaken by the Polish government under its drug policy, including in the field of prevention, treatment and harm reduction, its criminal justice response and in terms of cooperation with other international and EU institutions and bodies.

Prevention activities

Steps have been taken to improve the quality of prevention activities in Poland. In 2010, the National Bureau for Drug Prevention (NBDP), in cooperation with key institutions in this field, introduced a system of recommendations for drug prevention. The NBDP contributed in developing European drug prevention quality standards (EDPQS) that are promoted across Poland[356]. There exist in total 100 different prevention programmes in Poland that have all been certified. The EDPQS outlines the necessary steps to be taken when planning, conducting or evaluating drug prevention programmes. The NBDP, together with local governments, also provides funding for the implementation of

[354] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland .

[355] Interview with Artur Malczewski, REITOX focal point.

[356] Poland | European drug prevention quality standards. Prevention-standards.eu. Retrieved 26 September 2016, from http://prevention-standards.eu/poland/

prevention activities and encourage local authorities to follow the European quality standard recommendations[357].

Schools are obliged to implement prevention programmes, and health education is part of the core curricula. In cooperation with the NBDP, the Ministry of National Education is responsible for developing a number of activities for informing parents, teachers, and students about the risks of using new psychoactive substances. Notably, they promoted the international programme called 'Unplugged[358]' which has been implemented in 2014 in 352 schools[359]. Unplugged is an internationally renowned programme delivered to both parents and pupils. It consists in improving awareness of issues related to addiction and developing interpersonal and intrapersonal skills of the children. As part of the programme, parents are also encouraged to participate in some discussion around the following topics: How to better understand a teenager and how parents can develop a good relationship with a child by setting up rules and limits[360].

Besides school prevention, prevention programmes have also been implemented in more than 200 companies (e.g. project on the Prevention of psychoactive substances in workplaces). There is also a lot of support available online[361]. Some of the prevention programmes are selective and target specific risk groups, and for example, the 'Fred goes net' early intervention programme targets occasional drug users and aims to prevent them from becoming dependent. The 'Fred goes net' programme is listed among best practices for intervention in the EMCDDA best practices portal and provides early intervention for first-time drug offenders. As part of the programme, police, judicial authorities, governmental and non-governmental organisations work in cooperation in the field of drug treatment in order to establish and maintain a long-term support to occasional drug users. The young offenders receive a course to reflect on their consumptive behaviour and the course aims at preventing them from drifting into dependency[362].

Finally, with the emergence of new psychoactive substances, Poland responded by actions that go beyond prevention activities. They started monitoring NPS in 2008 and established some population survey in 2009 in order to monitor the evolution of the NPS use and to develop prevention activities accordingly[363].

Treatment and Harm reduction activities

The implementation of drug treatment is the responsibility of communities and provinces who receive most of their funding from the National Health Fund. Treatment services include detoxification units, rehabilitation centres, outpatient clinics and counselling centres and are free of charge for the patients.

The treatment system in Poland has two approaches: 'drug-free' treatment (psycho-social models) and pharmacological treatment (e.g opioid substitution treatment). Of these two, the 'drug-free' model is still recognised as the dominant treatment model. NGOs created in the 1980s are major players for offering these drug-free, abstinence-oriented treatment

[357] Interview with Artur Malczewski, REITOX focal point and Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland; and EMCDDA,. (2011). European drug prevention quality standards.

[358] *UNPLUGGED Area: Education Material. Eudap.net. Retrieved 19 August 2016, from* http://www.eudap.net/Unplugged_HomePage.aspx

[359] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland.

[360] EMCDDA | Best practice portal: EDDRA project description. (2016). Emcdda.europa.eu.

[361] Internetowa poradnia dla osób zagrożonych uzależnieniem, uzależnionych i ich bliskich | Poradnia internetowa. Poradnia internetowa. Retrieved 19 August 2016, from http://www.narkomania.org.pl/ .

[362] EMCDDA | Best practice portal: EDDRA project description. Emcdda.europa.eu.

[363] Interview with Artur Malczewski, REITOX focal point.

within therapeutic communities. The therapeutic communities superseded the overriding role given to psychiatric institutions in other neighbouring countries. In recent years, taking into account the changing profile of the drug users seeking for help, a new treatment programme, CANDIS[364], has been developed and targets cannabis users. In 2016, there are around 85 inpatient treatments centres and 200 outpatient treatment centre[365].

Harm reduction activities programmes reflected in the Drug Act and in the National Programme for Counteracting Drug Addiction 2011-2016 have been carried out in Poland since 1989. They consist predominantly of needle and syringe programmes, prevention-related educational programmes, and opioid substitution treatment (OST). Regular harm reduction programmes have also been conducted in large cities since 1996 and are mostly run by NGOs. Because of the importance of the non-medical sector in providing support for drug users, the National Bureau for Drug Prevention started to provide in the early 2000s guidelines training and certifications for non-medical staff working with drug users.

- Opioid substitution programmes initiated in 1992, but their development has been very slow with only 2 200 patients undergoing OST in 2011. The legal recognition of OST in 1997 facilitated its expansion with at least one new programme opening every year in a different city. However, because OST could only be provided by the public services under specific conditions, the underfinancing of the Polish healthcare system limited the expansion. The 2005 legal change which allowed OST to be run by new players did not reverse trend due to complicated procedures and funding provisions.
- Needle and Syringe exchange programmes have started after the first case of HIV infection in the late 1980s and there were in 2014 around 25 non-prison OST programme; they mainly offer methadone as substituting substances but buprenorphine-based medications are also available.[366]

Table 45: Drug policies in place in Poland

Activities	Year of implementation	Short description	Type of interventions (Prevention, treatment and harm reduction, criminal justice response)
Syringe exchange programmes	1988-89	The syringe exchange programmes started after the first case of HIV infection was reported. There were first offered in the NGO MONAR, counselling centres and were provided then in public outpatient clinics.	Treatment and arm reduction

[364] Candis - indywidualny program terapii dla użytkowników konopi. Candisprogram.pl. Retrieved 19 August 2016, from http://www.candisprogram.pl/

[365] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland and Interview with Artur Malczewski.

[366] European Monitoring Centre for Drugs and Drug Addiction,. (2014). Drug policy profile: Poland. Luxembourg: Publication Office of the European Union. Retrieved from http://www.emcdda.europa.eu/attachements.cfm/att_227226_EN_TDAU14003ENN.pdf; Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland; interview with Artur Malczewski.

Activities	Year of implementation	Short description	Type of interventions (Prevention, treatment and harm reduction, criminal justice response)
Methadone prescription programme/ High threshold Opioids substitution programme	1993	Poland was the first among the former communist countries to introduce a methadone prescription programme. In 1997 methadone maintenance treatment was recognised as a legitimate treatment to be financed by the public money. However, this programme could only be run by public healthcare institution under a special permit until 2005. This limited the development of substitution treatment.	Treatment and harm reduction
Professionalisation of the non-medical drug treatment sector	2002	A related development during the early 2000s was the professionalisation of the non-medical drug treatment sector via a system of training and certification. The director of the National Bureau for Drug Prevention requested a team of experts to develop guidelines that could serve as the basis for such a certification system, while an amendment to the drug law mentioned the compulsory certification for drug therapists	Treatment and harm reduction
FreD goes net	2007	An early intervention programme for young drug users that has been implemented since 2007 in 50 cities in Poland. The programme relies on brief interventions and motivational interviewing and intends to prevent young drug and alcohol users aged 14 to 21 from becoming drug dependent.	Prevention
CANDIS	2011	An evidence-based treatment programme for cannabis-related disorders, which has been implemented since 2011.	Prevention
Therapeutic communities	1980s	The NGOs created in the 1980s are still major players in drug policy today and their model of intervention, abstinence-	Demand reduction

Activities	Year of implementation	Short description	Type of interventions (Prevention, treatment and harm reduction, criminal justice response)
		oriented treatment within therapeutic communities, is still recognised as the dominant treatment model	
Unplugged	N/A	An internationally renowned prevention programme that provides teaching material for teacher and that targets pupils and parents. It is based on a life skills education and social influences approach to promote positive health behaviours. It is built on drug health related issues awareness, and the development of interpersonal and intrapersonal skills	Prevention
Prevention of psychoactive substances in workplaces	2013-14	This project supported by the Swiss Contribution Programme aims to prevent psychoactive substance use in workplaces.	Prevention
'Taking medication or high on drugs? Prescription drugs are for treatment, not for getting high'	2013-14	A nationwide campaign to raise awareness about the non-medical use of prescription medications among adolescents	prevention

Criminal Justice Response

A person caught in possession of drugs is always arrested by the police, the drug is confiscated and the individual is sent to court. At the court level, besides activities performed under the legal framework (see section 0), prosecutors and judges are obliged by law (Article 70a of the criminal code) to set up an interview with a therapist specialist if the person caught with possession of drugs is suspected to be a user. In practice, the therapy specialist can help the court to determine whether a person needs treatment rather than imprisonment. If the drugs offenders undergo drug treatment with positive results, then the judges and prosecutors can decide to suspend proceedings. There is also some alternative to imprisonment for convicts who want to receive treatments; some convicts can access therapy out of prison under conditional release[367].

Cooperation at the international and EU level

A number of cooperation mechanisms have been established at national, regional and international levels to tackle illicit drug supply. Cooperation is considered according to the

[367] Drug Policy Dialogue on South East Europe,. (2013). Informal Drug Policy Dialogue Report (1st ed.).

Polish government as being essential to combatting drug-related organised crime and to tackle trafficking close to production areas.[368]

Poland has contributed and keep contributing to the development and application of European Quality Standards such as the European Drug prevention Quality Standards and the minimum quality standards in demand reduction[369]. It organises and hosts international drug-related conferences such as the Urban drug policy conference [370] which is one of the largest international event dedicated to Urban drug policies. The conference arose out the desire to facilitate integration and cooperation between local government authorities, politicians and policy-makers, police officials, prosecutors, penitentiary staff, NGOs activists and researchers. The main objectives are to transfer knowledge between European cities and to promote the dissemination of urban drug policies based on scientific evidence.

In addition, the Polish law enforcement agencies organise advanced level training on the dismantling of illicit laboratories. This training is open to law enforcement officers and forensic experts with particular focus on synthetic drugs from all EU Member States. It is provided under the banner of the EU Agency for Law Enforcement Training (CEPOL). The course comprises of three steps and aims to train participants on how to safely and securely dismantle an illicit drug laboratory and how to properly conduct a crime scene investigation in this context. It is delivered at the Legionowo / Serock Police Training Centre.

At the International level, Polish Police headquarter and the Ministries of Foreign and of Internal Affair collaborate with UN agencies notably with the Commission on Narcotic Drugs (CND) to negotiate resolutions on drug policy. Poland is also involved in a number of transnational cooperation projects with neighbouring countries such as Ukraine, Moldova, Belarus and Georgia. [371]

Poland is also involved in EU programmes facilitating cooperation with non-EU countries. It is notably involved in the following projects:

- The cooperation programme between Latin America and the EU on Drug Policies (COPOLAD). Poland aims through this project to reduce the illicit supply of cocaine and synthetic drugs.[372]
- Cooperation projects with China. Poland contributes in an EU-China police training on precursors used for synthetic drugs.[373]
- The 'Reduction of Production and Distribution of Drugs in the EU' (CHOPIN project) that aims to reduce the illicit distribution of drugs in the EU.[374]
- The Central Asia Drug Action Programme (CADAP).[375] EU and members state provide support for transitioning drug policies in central Asia from a rather punitive policy inherited from the Soviet era to a modern more progressive approach. It intends to inform political decision-making with proven methods of treatment for addiction, prevention, and cooperation measures. The Polish National Bureau for Drug Prevention is at the head of the Media and dissemination strategies (MEDISSA) which is one of the four components of the CADAP programme. As part of MEDISSA, the National

[368] Ibid

[369] Interview with Artur Malczewski.

[370] Urban Drugs Policy Conferences,. About − Urban Drug Policies Conference. Urbandrugpolicies.com. Retrieved 26 September 2016, from http://urbandrugpolicies.com/about/

[371] Drug Policy Dialogue on South East Europe,. (2013). Informal Drug Policy Dialogue Report (1st ed.).

[372] *Ibid.*

[373] *Ibid.*

[374] *Ibid.*

[375] Central Asia Drug Action Programme (CADAP). Giz.de. Retrieved 26 September 2016, from https://www.giz.de/en/worldwide/14393.html

Bureau, supports national information and prevention campaign against drug abuse and infectious disease. It is in charge to develop in central Asia group-specific information material and communication strategies for journalists, teachers and local opinion leaders, to support local prevention and education network and to facilitate the establishment of a drug abuse information service.

EFFECTS

Impact on the criminal justice system

The number of drug law offences increased considerably during the 1990s and notably after the new law that criminalised drug use for personal consumption (1997). The increase in offences could partially be due to the law but also to the improvement in policing as modern techniques of crime investigation were introduced at the same time. The government, however, realised that the law did not provide the intended effect and instead used an excessive amount of police resources on minor rather than serious drug offences (most offences were due to drug possession for personal consumption). The extra public expenditure spent were estimated at about EUR 20 million[376]. In 2012, the total number of law offences related to consumption reached 50 614 compared to 36 166 in 2004 (see Figure 30)[377]. The change in the law in 2011 which enabled proceeding discontinuation for small drug-use related offences led to savings that have then been reinvested in drug prevention and harm reduction. Since January 2012, criminal proceedings have been discontinued for 1 094 persons; this led to a decrease in the number of people sent to prison for drug possession from 6,226 people in 2011 to 5,650 in 2012. This freed approximatively PLN 5 million (around 1.16 million with 2016 exchange rate) of savings from public expenditure. [378]

Table 46: Number of offences in criminal justice system per type of drugs (2014)

The stage within the criminal justice system at which data have been reported and recorded vary sometimes across countries. i.e. Data might be recorded at an initial stage when a first report is made by law enforcement agencies, or after an investigation by the Judicial Police, or even following a decision for a charge to be issued by the Prosecutor.

Drugs	Drug-use related offence	Drug-supply related offences	Total
Cannabis	40949	16575	57524
Opioids/Opiates			
Heroin	625	439	1064
Stimulants			
Cocaine	241	183	424
Amphetamine	7581	5163	12744

[376] European Monitoring Centre for Drugs and Drug Addiction,. (2014). Drug policy profile: Poland. Luxembourg: Publication Office of the European Union.

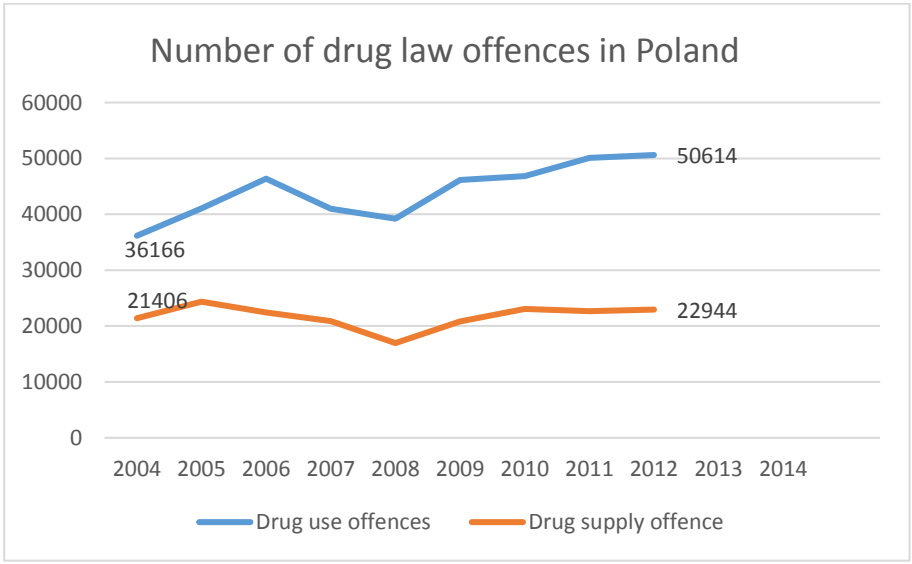
[377] *Ibid.*

[378] Drug Policy Dialogue on South East Europe. (2013). Informal Drug Policy Dialogue Report (1st ed.).

Methamphetamine	N/A	N/A	N/A
Hallucinogen			
Ecstasy	152	99	251
LSD	21	5	26
All drugs			
Total	25274	3715	N/A

Note: Drug use offences include use and possession for personal use and drug supply offences includes production and trafficking. The sum of drug use and supply offences does not necessarily add up to the total because some offences are not distinguished when reported.
Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016; [i] Data from 2013

Figure 30: Number of drug law offences in Poland



Note: data after 2012 are not reported because they cannot be compared with previous years due to a change in collection method
Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016;

Trend in drug prevalence and impacts of prevention activities

Drug use prevalence and notably Cannabis use seems to have decreased since 2010 for the 16 to 64 age range. Last year cannabis prevalence was 9.6% in 2010 compared to 4.6 in 2014. This drop in prevalence could partially be due to the implementation of prevention activities.

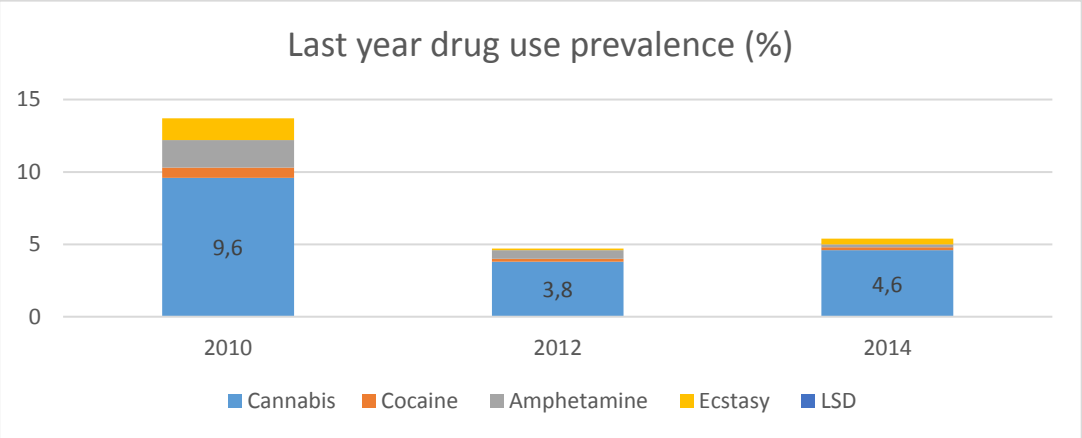
In the whole prevention programme aiming at improving the functioning of families are growing and developing in Poland. Notably, the 'Unplugged' programme discussed in section 0 was implemented in 2014 in 352 schools. The evaluation of the programme highlights some positive impacts on the reduction of Cannabis use and the risk of alcohol consumption. It has contributed to the change in perception of addictive substances (i.e. less positive beliefs regarding addictive substances) and has increased the knowledge and competence of parents. The programme has also been perceived positively by the teacher who found the training seminars very useful.

However, the programme could have potentially achieved higher results if more time would have been available within school timetables to complete the whole syllabus and participations among parents was relatively low[379].

Early intervention programmes also attracted the attention. For instance, the 'Fred Goes net' intervention targeting young drug users, have been implemented in 86 facilities in 2014.[380]

In the whole, prevention activities have received positive critics, however, an internal implementation review after the first year of the National Programme for Counteracting Drug Addiction 2011–16 showed strong disparities in the implementation of prevention activities between urban and rural municipalities and a strong focus on universal rather than selective and indicated prevention.[381]

Figure 31: Last year drug use prevalence in Poland



Injecting drug use, infectious disease and impact of harm reduction programmes

In terms of harm reduction, the efficiency of demand reduction activities seems mitigated. Health indicators appear to move in the right direction but the impact of policies could probably have been bigger with a more efficient implementation and notably concerning the implementation of the OST programmes.

There has been a downward trend in HIV infection among drug users; 127 cases have been reported in 2006 compared to 37 in 2014.[382] The needle and syringe exchange programmes are likely to have contributed to this decreasing trend. In 2002, 21 needle and syringe exchange programmes (NSPs) were operational in 23 Polish cities and they distributed an estimated 668 000 needles and syringes, a 10-fold increase compared to 1998[383]. In 2014, there were 24 NSPs at fixed sites and 10 sites with outreach work operated in 12 Polish cities. More than 1 465 injecting drug users attended these specialised programmes and around 106 000 syringes were distributed in 2014. The number of people using this programme, however, has continued to decline. This decline can be attributed to a change in priorities of harm reduction programmes towards recreational drug users, a lack of funding and a possible decline in the number of injecting drug users in Poland.

[379] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu.

[380] *Ibid.*

[381] European Monitoring Centre for Drugs and Drug Addiction,. (2014). Drug policy profile: Poland. Luxembourg: Publication Office of the European Union.

[382] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu.

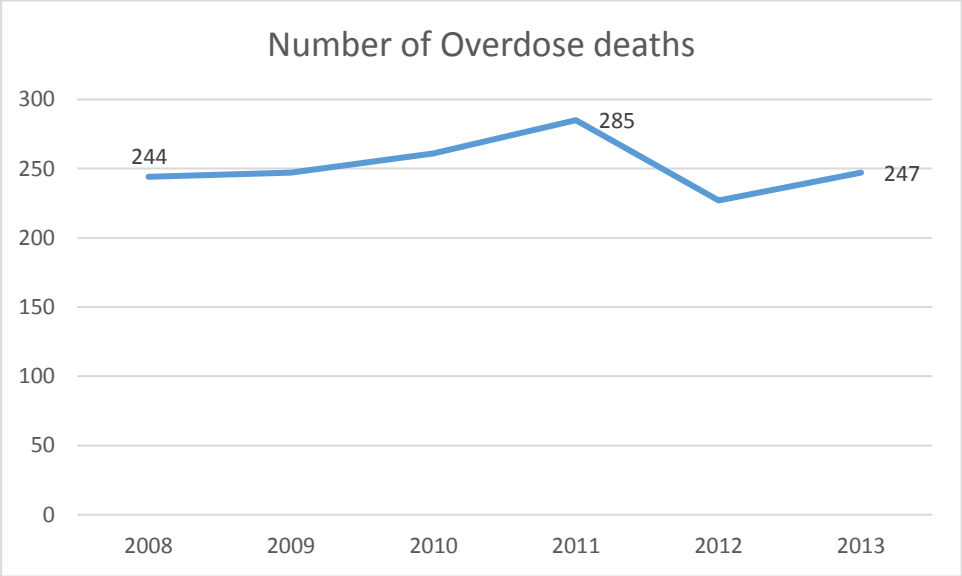
[383] European Monitoring Centre for Drugs and Drug Addiction, (2014). Drug policy profile: Poland. Luxembourg: Publication Office of the European Union.

Concerning the OST, the effects have been quite limited because the programme reached a very small portion of problematic drug users.

In 2014, some 25 non-prison OST programmes provided services to about 2 586 clients, the majority of whom received methadone as the substituting substance, while buprenorphine-based medications are also available. In addition, 140 clients received OST within seven programmes in 23 prison units. In general, the coverage of problem opioid users receiving OST in Poland remains sub-optimal according to international recommendations; there are approximatively 50 000 problematic opioids users but only 2 500 clients are on substitution treatment with methadone[384]. The programme did not develop as extensively as expected certainly because of the over-regulation of services providing OST by the government.[385]

Finally, regarding deaths, overdose deaths have been more or less constant over time, with a small increasing trend until 2011 (see Figure 32). There was then a slight drop in 2011 from 285 in 2011 to 247 deaths in 2013. This drop coincides with the 2011 amendment to the law and notably with the Article 70a obligating the prosecutors and judges to set up an interview between drug offenders and therapy specialists for all cases where there is suspected use of drugs. One cannot infer that there is causation between the law and the decrease in the number of deaths but decreasing trends in overdose death and HIV but Figure 32 could suggest that the health system in place for tackling problematic drug use (prevention, treatment, and harm reduction) have had a positive effect on health.

Figure 32: Number of overdose deaths in Poland



[384] Interview with Artur Malczewski.

[385] European Monitoring Centre for Drugs and Drug Addiction. (2014). Drug policy profile: Poland. Luxembourg: Publication Office of the European Union. Retrieved from http://www.emcdda.europa.eu/attachements.cfm/att_227226_EN_TDAU14003ENN.pdf; Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland; interview with Artur Malczewski.

Evolution of drug market, organised crime and violence

Drug-related crimes were problematic after the collapse of the Soviet Union; there was an important and violent black market of illicit drugs that were notably trafficked by Vietnamese organised crime groups. The inclusion of new restrictive laws started in 1997 and the emergence of the new psychoactive substances impacted and changed the way the drug market is operating. The dynamic changed in the last 15 years, the number of small production for personal use have been increasing and NPS are accessible in 170 retail shops and are a very profitable market. The perception of drugs in the society have changed; the population attitude strengthens against drug-related crime. The drug issues, however, remain important nowadays; the market simply has a different structure[386].

Conclusion and good practices

Poland is still finding its equilibrium between health and criminal law enforcement activities. It has spent some efforts developing quality standards of drug prevention activities and drug demand reduction activities and promoting European standards (such as the European drug prevention quality standard and the minimum quality standards in drug demand reduction) to its local communities in charge of implementing drug demand reduction activities.

Poland has considerably developed its prevention activities based on adopting internationally recognised good practice models' such as the 'Unplugged' programme and the 'freD goes net' programme discussed in section 0. It has also developed its own programmes, notably at the school level and few of them are reported in the EMCDDA portal best practices.

Harm reduction programmes have not produced, however, as good results as the prevention activities but Poland is actively trying to improve their efficiency. Notably, Opioids substitution programmes reach a limited number of injecting drug users because there is a high level of regulation for an organisation to be able to offer a substitution service. The national Bureau for Drug prevention is currently discussing ways of smoothing the regulation in order to expand the opioid substitution treatment offering. Poland has notably started to deliver substitution programme through psychiatric doctors[387]. In the next few years, the National Health Fund also aims to considerably increase the availability and reach of programmes that aim to decrease and treat infectious diseases (e.g. through contracting antiretroviral treatment services, providing vaccination against HBV, counselling and testing for HCV and HIV)[388].

STAKEHOLDERS AND DOCUMENTS

Table 47: Poland case study - Sources.

Stakeholders interviewed	• Artur Malczewski, head of Polish focal point [09/09/2016]
Documents / websites reviewed	• European Monitoring Centre for Drugs and Drug Addiction,. (2014). Drug policy profile: Poland. Luxembourg: Publication Office of the European Union. Retrieved from

[386] Interview with Artur Malczewski, REITOX focal point.

[387] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland; interview with Artur Malczewski.

[388] Poland country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 August 2016, from http://www.emcdda.europa.eu/countries/poland.

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- *UNPLUGGED Area: Education Material. Eudap.net. Retrieved 19 August 2016, from* http://www.eudap.net/Unplugged_HomePage.aspx
- Internetowa poradnia dla osób zagrożonych uzależnieniem, uzależnionych i ich bliskich | Poradnia internetowa. Poradnia internetowa. Retrieved 19 August 2016, from http://www.narkomania.org.pl/.
- EMCDDA | Best practice portal: EDDRA project description. Emcdda.europa.eu. Retrieved 23 September 2016, from http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=01DE11&tab=overview
- Stowarzyszenie MONAR. Monar.org. Retrieved 27 September 2016, from http://www.monar.org/history#!
- O nas | www.PolitykaNarkotykowa.pl. (2011). Politykanarkotykowa.pl. Retrieved 26 September 2016, from http://www.politykanarkotykowa.pl/o-nas

	• Harm Reduction International, (2014). The Global State of harm reduction 2014. London: Harm Reduction International. Retrieved from https://www.hri.global/files/2015/02/16/GSHR2014.pdf

Appendix A6: Case Study – Portugal

Introduction

Historically Portugal was a country relatively free of drugs-related issues. Drug use problems exploded after the revolution in all social classes and by 1990, around 1% of the entire population were hooked on heroin. The growing concern of the population about drug use issues led to a bottom-up movement for decriminalisation in the late 1990. In this particular context, decriminalisation with the adequate health response seemed to be the most appropriate approach for the National drug policy[389]. Portugal's drug policies have been focused on destigmatising drug addiction and on offering a support-focused health intervention to the people. This encompasses harm reduction and early intervention programmes. The objective of the policies seems to have been achieved as there has been a decrease in main indicators such as drug-related deaths, HIV prevalence and drug consumption among the youngest population. This achievement is due to the combination of decriminalisation and health response. This case study reviews the drug situation in Portugal following the intervention logic presented in **Error! Reference source not found.**. It first establishes the drug scene and present key indicators of drug use prevalence, of health-issues associated with drug use and of the drug market. It then reviews the legal framework associated with drug offences and presents the main policy objectives and activities performed for tackling drug-related issues in Portugal. The case study finally discusses on the potential impact of the Portuguese drug policy.

Drug scene

Drug use among population

In Portugal, drug use prevalence data for all types of drugs have been estimated below EU average data (Table 48). Cannabis remains the most frequently used illicit substance with a prevalence in 2012 of 2.7%, followed by ecstasy and cocaine. However since 2007, the use of illicit substances among adults has declined from 12% life time prevalence of any illicit drug use to 9.5% in 2012. The number of injecting drug users in 2012 was estimated at 0.22% and the prevalence of high risk drug users is 0.62% for cocaine and in the range of 0.42%–0.55% for opioids[390].

Table 48: Prevalence rates among adults 15–64

Title (%)	Life time prevalence EU average [i, ii]	Life time prevalence (2012)	Last year prevalence (2012)
Cannabis	17.8	9.4	2.7
Opioids			
Problem drug use: all opioids [iii]	Average of annual prevalence at the most recent		Prevalence in 2012: 0.49

[389] Interview with SICAD.

[390] Portugal country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 18 August 2016, from http://www.emcdda.europa.eu/countries/portugal.

Title (%)	Life time prevalence EU average [i, ii]	Life time prevalence (2012)	Last year prevalence (2012)
	year available: 0.35		
Stimulants			
Cocaine	3.0	1.2	0.2
Amphetamines	2.5	0.5	0
Hallucinogens			
Ecstasy	2.9	1.3	0.3
LSD	1.4	0.6	0.2
All drugs			
Total	19.1	9.5	2.7

Epidemiological studies on which these figures are based vary enormously in quality between the different MS
Source: Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016;

[i] Average EU data have been calculated according to the most recent data available per country in EMCDDA statistical bulletin. Latest year available for all types of drugs except opioids are as following: 1998 for LU; 2004 for EL; 2007 for HU; 2008 for AT and EE; 2010 for SK; 2011 for IE and LV; 2012 for BG, HR, CY, DE, LT, PT, SI; 2013 for BE, DK, MT, RO and ES; 2014 for CZ, FI, FR, IT, NL, PL, SE and UK. Data from SE, BE and EE were not broken down by drugs and were only available for the overall drug prevalence. There were not any available data on all drug prevalence for LU and NL and no amphetamine use prevalence were available for LU;

[ii] Latest year for Opioids use prevalence estimations used for calculating EU average data are as follow: 2007 for LT and LU; 2008 for SK, 2009 for PL, 2010 for HR, 2012 for FI, NL and PT; 2013 for AR, DE, SI and ES; 2014 for CY, CZ, EL, IT, LV and MT; 2010-11 for HU and UK; 2013-14 for FR. There were no available data on opioids prevalence for BE, BG, DK, EE, IE, RO and SE;

[iii] Recurrent drug use that is causing actual harms to the person (including dependence, but also other health, psychological or social problems) or is placing the person at a high risk of suffering such harms'. Prevalence data for Portugal have been estimated with capture recapture method and based on treatment data and criminal justice data.

Health impact of drug use in Portugal

As a whole, there is in Portugal a low level of drug mortality and HIV infections. According to the statistical bulletin from the EMCDDA, infectious disease among drug users seem problematic for Hepatitis C (HCV) and Hepatitis B (HBV); there was in 2014 more than 50% prevalence of HBV and new HCV. However, new HIV prevalence is quite low and below 1 % in 2014. (Table 49).

In terms of mortality, 28 cases of drug-related deaths were registered in 2013 by the General Mortality Registry (GMR) which is the largest number reported since 2001 when 34 deaths were reported. Even though there was a slight increase in the number of deaths in 2013, it is estimated that there is around 4.5 deaths per million among adults which is still far below the European average[391].

[391] *Portugal country overview | www.emcdda.europa.eu*. (2016). *Emcdda.europa.eu*.

Table 49: Drug induced mortality and epidemiology (2014)

	Number of people who inject drug[i]	Prevalence of new HIV among people who inject drug (%)[ii]	Prevalence of new Hepatitis C among people who inject drugs (%)[ii]	Prevalence of hepatitis B antibodies among people who inject drug (%)[ii]	Drug induced mortality among adult 15-64 (per million)[iii]
Portugal	N/A	0%	50%	53.6%	4.5
EU average	N/A	N/A	N/A	N/A	19.2

Source: [i]Harm Reduction International,. (2014). The Global State of harm reduction 2014. London: Harm Reduction International. Retrieved from https://www.hri.global/files/2015/02/16/GSHR2014.pdf; [ii] Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016; [iii] Portugal country overview | www.emcdda.europa.eu. Emcdda.europa.eu. Retrieved 25 August 2016, from http://www.emcdda.europa.eu/countries/Portugal

Drug production, import and export

- Domestic Market

Except for a small (non-significant) number of cannabis plantations, drugs used in Portugal come primarily from importation.[392]

- Imports/Export Market

Because there is not a significant drug domestic market, efforts for tackling drug supply related crimes should be focused on transnational drug trafficking. Portugal is indeed a significant transit point for international drug trafficking. In 2014 most cocaine was trafficked from Brazil, heroin comes mainly from the Netherlands, cannabis products come from Morocco or Spain and ecstasy arrives from Israel or Germany. The highest number of seizures in 2014 involved cannabis resin (3 472 seizures), followed by cocaine and heroin (1 042 and 690 seizures respectively). Although the number of Cannabis seizures has been in decline since 2005, the quantity of cannabis seized increased considerably from 8.5 tonnes in 2013 to 32.9 tonnes in 2014. Quantity of cocaine seized also increased from 2.5 tonnes in 2013 to 3.7 in 2014. The seizures of Amphetamines and Ecstasy is lower than any other drugs substance and the number of heroin seizure has steadily declined for the last 10 years[393]. A lower number of seizures and a higher quantity seized of Cocaine and Cannabis might suggest that drug trafficking is more professionalised and performed by a smaller number of people than before. A more sophisticated transnational traffic requires more cooperation by law enforcement agencies across countries.

LEGAL FRAMEWORK

The legal framework on drugs changed with the adoption of Law 30/2000, which has been in place since July 2001. Before 2001, the use and possession of illicit drugs could trigger a sentence of 3 to 12 months and the penalty could be waived for occasional users or

[392] Interview with Maria Moreira.

[393] Portugal country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 18 August 2016, from http://www.emcdda.europa.eu/countries/portugal.

suspended for drug addicts that attend treatment. Since 2001, the use or possession of drugs is an administrative rather than a criminal offence, thus decriminalising illicit drugs, and it is the Ministry of Health's responsibility to provide drug treatment.

Table 50 summarises the legal sanctions and outcomes as a result of drug-related offences. The use and possession of small amount of drugs (calculated as less than 10 daily doses) is dealt with as an administrative offence and managed by the Commission for the Dissuasion of Drug Abuse (CDT).

If a citizen is intercepted by the police for possession of drugs, he is taken to the police station where the drug is weighed and confiscated. Any case where the quantity of drugs is greater than 10 daily doses, as defined by the law, is referred to court. Otherwise, the citizen is invited to attend the CDT. Once in contact with the CDT, a technical team would evaluate the citizen to assess if drugs are used for recreational purposes or if the person is addicted. The CDT is then in charge of orienting the citizen for rehabilitation, by using the most appropriate response. If the citizen is considered as an addict then, he would be invited to join a treatment. Although it is not mandatory for the citizens to undertake any actions advised by the CDT, most of them initiate a first contact with the appropriate health authority.

If a person has already been intercepted in possession of drugs, the CDT can refer to treatment or apply other sanctions, such as a warning, referring the individual to health and social care, banning the individual from certain places, financial sanctions, banning the individual from meeting certain people, the obligation of periodic visits, and the removal of firearm licenses. However, financial sanctions cannot be given to drug addicts[394].

If the quantity possessed is higher than the maximum amount allowed (10 daily doses), then the offence is considered a crime. All crimes go through the criminal justice system but the outcomes differ according to the setting (e.g. user or trafficker setting) and small crime (e.g. very low production of cannabis) could then be referred back to the CDT[395].

For drug trafficking and supply, the law offers some penalty scales depending on circumstances; the quantity of drug trafficked, the addiction of the trafficker and whether the traffickers sell drugs to finance their own consumption are taken into account. The maximum penalty for trafficking is usually 12 years for list I, II and III drugs (see Table 50) and five years for list IV drugs[396]. Minor trafficking offences are punishable by 1 to 5 years imprisonment for list I, II and III drugs and up to two years imprisonment for list IV drugs. In case of aggravating circumstances, the minimum and maximum penalties can be increased by one quarter. Financing a criminal group could lead to 10-25 years imprisonment and leading a criminal group is punished by 12-25 years imprisonment[397].

Table 50: Drug law offences and penalties

Produce	Supply	Possess		Use
Penalty	***Penalty***	***Penalty***	***Depending on Quantity?***	***Penalty***
No matter the amount, production is	Supply of drugs is a criminal offence.	**- Limited quantity:** The offender is	Small quantity (up to 10 days the average	If no suspicion of drug

[394] Interview with SICAD.
[395] Interview with Maria Moreira.
[396] Portugal country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu.
[397] European Legal database on drugs / http://www.emcdda.europa.eu/topics/law/penalties-at-a-glance

Produce	Supply	Possess		Use
Penalty	***Penalty***	***Penalty***	***Depending on Quantity?***	***Penalty***
always a crime and offenders would go to the criminal justice system. However, if this is a production of a very low amount for personal use, the offender could be directly referred to the CDT. Penalties vary depending on which Table of Decree-Law 15/93 the drug is listed in. (Law 30/2000, Art 16)	Trafficking in substances included in Lists I to III attracts a prison sentence of four to 12 years, while substances in List IV may be punished by a prison sentence of one to five years. Years of imprisonment can be reduced or increased in case of mitigating or aggravating circumstances	referred to a local Commission for the Dissuasion of Drug Addiction where the offence is likely to be settled with treatment and counselling. - **High quantity**: punished up to 1 year imprisonment or 120 day-fines Penalties vary depending on which Table of Decree-Law 15/93 the drug is listed in. (Law 30/2000, Art 16)	consumption is an administrative offence	trafficking, the offenders is referred to the local Commission for the Dissuasion of Drug Addiction. If suspicion of drug trafficking, the case would be treated as a supply offence. Penalties vary depending on which Table of Decree-Law 15/93 the drug is listed in. (Law 30/2000, Art 16)
***List I drugs**: Cannabis and derivative, Opiate, Coca derivative* ***List II drugs**: Hallucinogens, Amphetamine, Barbiturate* ***List III drugs**: Preparation with controlled substance* ***List IV drugs**: Tranquiliser and analgesic*				

Source: European Legal database on drugs / http://www.emcdda.europa.eu/topics/law/penalties-at-a-glance

AIMS AND OBJECTIVES OF THE NATIONAL APPROACH TO DRUG POLICY

Main objective of the current strategy

The policy reforms about decriminalisation that occurred between 1999 and 2001 were the result of 20 years of drug policy debates. Portugal moved progressively towards a model that prioritises treatment and early intervention over criminal sanctions. This approach resulted from a growing consensus in the Portuguese Parliament on the need to address drug use as a health, rather than a criminal, matter. In parallel with decriminalisation, the aim of the national drugs policies were to expand and improve the care network[398].

[398] Portugal country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu.

The initial Portuguese Drug Strategy[399] was launched in 1999 and is built around six objectives:

- Contributing to the European and international strategy for tackling drug policy;
- Preventing drug use and informing people on danger of drugs and addition;
- Reducing demand for drugs, notably among the younger member of the population;
- Investing resources in treatment and social integration of drug addicts;
- Insuring public health and people security;
- Repressing the illicit traffic of drugs.

The current plan, the National Plan for the Reduction of Addictive Behaviours and Dependences 2013-20[400] is built on the 1999 strategy and promotes an integrated approach on tackling any addiction problems, not just drugs (e.g. alcohol and gambling). The plan is built around a demand and supply reduction pillar.

- The citizen is at the centre of the demand reduction pillar and aims to answer individual needs along the lifecycle of an individual based on 11 age groups. The plan takes a comprehensive approach and aims to develop intervention on health promotion, prevention, dissuasion, risk and harm reduction, treatment and social reintegration. It particularly emphasises the importance of regional initiatives through the Operational Plan of Integrated Responses (PORI). Within PORI, the most vulnerable territories have been mapped in order to prioritise them for resources and intervention allocation. In each region, a diagnosis is made on the local need of the population and from there a call for tenders for NGOs is launched. This tender process enables NGOs to better identify the needs in their region. There are also continuous efforts made for standardising best practices and promoting new treatment approaches. In this respect, new guidelines were published in 2011 for defining early treatment for at-risk teenagers and treatment/rehabilitation in therapeutic communities.[401]
- The supply reduction pillar focuses on national and international cooperation. The main objectives are to reduce the availability and access of traditional illicit substances and new psychoactive substances and to regulate the market of licit substances[402].
- There are also some cross cutting themes to demand and supply fields that enable to ensure a continuous improvement process. The Portugal National Strategy therefore highlights the importance of information and research, training and communication and international cooperation[403].

[399] Portuguese Drug Strategy. (1999). Retrieved from http://www.emcdda.europa.eu/system/files/att_119431_EN_Portugal%20Drug%20strategy%201999.pdf.

[400] General-Directorate for Intervention on Addictive Behaviours and Dependencies,. (2014). National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020.

[401] *Ibid,* Interview with REITOX National Focal Point Portugal; Interview with Maria Moreira

[402] General-Directorate for Intervention on Addictive Behaviours and Dependencies. (2014). National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020.

[403] General-Directorate for Intervention on Addictive Behaviours and Dependencies. (2014). National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020.

Table 51: Main current policies and actions plan in Portugal

Policies, actions plans	Description
National Plan for the Reduction of Addictive Behaviours and Dependencies 2013–20[404]	The current plan focuses on primary prevention; treatment access; harm reduction; social reintegration; treatment and harm reduction in prisons and alternatives to prison; research and training; research in policy evaluation; regional coordination; the reinforcement on the fight against drug trafficking and money laundering. It consists of two structural measures (The Operational Plan of Integrated Responses and the referral network) and four transversal themes (information and research; training and communication; international relation and cooperation; and quality).
Portugal Drug Strategy 1999[405]	It is the first National drug strategy that has been established by the government and one of its proposals was the decriminalisation policy.

Organisations involved

Even though drug policy decisions are centralised in Portugal, there are around 200 partners who work in collaboration and who contribute in shaping the national policy.[406] There is also a high level of integration between the health and justice system that further increased with the creation of the General-Directorate for intervention on Addictive Behaviours and Dependencies (SICAD) and the implementation of the last national programme[407]. SICAD is the EMCDDA national focal point. It is attached to the Ministry of Health and is responsible for implementing the National Plan for the Reduction of Addictive Behaviours and Dependencies 2013-2020. SICAD's objectives are to reduce the use of psychoactive substances, prevent addictive behaviour and decrease dependencies.

The main body in charge of drug-related offences (except for drug trafficking offences) is the Commissions for the Dissuasion of Drug Abuse (CDT) and is managed primarily by the Ministry of Health. Healthcare for drug users, reorganised in 2013–14, is now provided through the Referral Network for Addictive Behaviours and Dependencies. The Network ensures wide access to quality-controlled health services that are in integration with non-health services. The public services are available for all users seeking treatment and they are free of charge. The Network encompasses public specialised services that are under the authority of Regional Health Administrations of the Ministry of Health; non-governmental organisations (NGOs); and other treatment services (public and private) competent in the provision of care.

INPUTS (I.E. MONETARY COST OF DRUG POLICIES)

There are many public institutions (e.g. education, health, justice) working in the area of drugs. However, the resources spent are not necessarily registered as drug-related expenditure making it complicated to estimate the budget spent on drug policies. This is

[404] General-Directorate for Intervention on Addictive Behaviours and Dependencies, (2014). National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020.

[405] Portuguese Drug Strategy. (1999).

[406] Interview with SICAD.

[407] Interview with Maria Moreira.

especially true since the national policy targets addictive behaviours in general (i.e. illicit and licit substances/behaviours)[408].

There is not any quantitative information on drug policy budget in the most recent plan but in the overall national Plan 2005-2012, the allocated drug-related public expenditure was anticipated to grow annually by 3% and to represent around 0.05% of GDP. However there are no available information on the actual expenditure. The new Action Plan against Drugs and Drug Addiction 2009-2012 presents the actions of creating a subcommittee on Public expenditure to better monitor and assess drug-related public expenditure.[409]

The REITOX National Focal Point suggested, however, that before the crisis, the budget for the Institute for Drugs and Drug Addictions (the previous organisation acting as a focal point) was around EUR 75 million. The crisis negatively impacted the budget resulting in a reduction of about 10%. This cut in budget make it difficult to keep financing for some activities, namely research. Financing health responses remains the priority of the Portuguese strategy and finances in the health system have recently seen slight increases.

ACTIVITIES (DRUG POLICIES, PROGRAMMES, STRATEGIES ETC)

This section will provide an overview of the different activities undertaken by the Portuguese government under its drug policy, including in the field of prevention, treatment and harm reduction, its criminal justice response and in terms of cooperation with other international and EU institutions and bodies.

Prevention activities

Prevention activities play an important role in the Portuguese Action Plan. These activities are delivered at the national level through education as part of the school curriculum (see Table 52.for a list of main prevention activities). The activities focus on health-related issues and are delivered through training sessions, awareness-raising activities and dissemination of printed information. The most important programme at the national level is 'Eu es os outros' (Me and the other's) and has been reported as an example of best practice by the EMCDDA. This programme is an interactive game where young people between 10 and 18 years old can learn about the effects of drugs and psychoactive substances through discussing problems of the everyday life around the themes of growing up, friendship, school family, relationship interaction, drugs and law, recreational setting and the future[410]. Prevention activities are also provided by law enforcement services who share drug-related information to pupils.

Besides national programmes, local and regional authorities have also developed standardised school-based prevention programmes as well as selective intervention programmes that target the most vulnerable people (Searching for the Family Treasure) and people who have greater exposure to drugs in their environment (Kosmicare). Local prevention activities are facilitated by PORI, which recognise that interventions should be designed based on local needs; local communities use a customised approach and perform a risk assessment to build a package for what they need[411].

[408] Interview with Maria Moreira.

[409] Portugal country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 18 August 2016, from http://www.emcdda.europa.eu/countries/portugal.

[410] EMCDDA | Evaluated examples of best practice in Europe: EDDRA. Emcdda.europa.eu. Retrieved 9 September 2016, from http://www.emcdda.europa.eu/themes/best-practice/examples.

[411] Interview with REITOX National Focal Point Portugal and Maria Moreira.

Treatment and harm reduction

Health protection is the main focus of the National Plan for the Reduction of Addictive Behaviours and Dependencies 2013−20. There are 3 levels of care providing outpatient services and referencing patients to the right interventions: (1) primary healthcare service; (2) specialised care services that are mainly in outpatients settings; and (3) alternative care services such as detoxification units, therapeutic communities, and specialised mental or somatic healthcare. The main interventions enabling harm reduction include:

- Needle and syringe exchange programmes.
- Low threshold substitution programme.
- Mobile centres for the prevention of infectious diseases.

Criminal justice response

As discussed in section 0 on the legal framework, even if drug use is not considered as a criminal offence, person who are caught by the Portuguese police for using or possessing a small amount of drugs would be referred to the CDT. The CDT would decide the appropriate response for the offenders who would often be encouraged to receive some health and social support. As health and social organisations providing services to problem drug users are well developed in Portugal, it is assumed that problem drug users have many ways to reach the health system. The users less likely to reach the health system are the non-problematic drug users and this group of users is the main target of the Portuguese police. The police therefore enable drug users (and mainly the non-problematic drug users) to reach the health system before the drug use gets problematics.[412] Health and Justice System is well integrated in Portugal which facilitate early detection of potential future problem drug users. Also, in the Safe School Programme, police patrols aim to protect the school environment by patrolling around the school and preventing drug use and drug trafficking.

For criminal offences (i.e. drug production, supply and possession of more than 10 daily doses), offenders would be penalised with imprisonment and fine. The length of imprisonment would depend on circumstances and the court can suspend the execution of a punishment if the offender is considered as drug dependent and is willing to undertake treatment.

Cooperation at the international and EU level

As a country of transit, regional cooperation is an important aspect to prevent transnational crime. Notably, a lot of cooperation work is done between Portugal and Spain. For example, it is reported that they often implement controlled delivery interventions. This happens when a consignment of drugs is detected at one border but the enforcement agencies of both countries cooperate and decide to let the drug cross the border in order to try and identify the point of origin of the drug trafficking[413].

At the European level, Portugal is notably highly involved in the European Research Area Network on Illicit Drugs (ERANID)[414] which is a 4 year project aiming at developing a long term cooperation in the field of scientific research on illicit drugs[415]. Portugal is also part

[412] SICAD Portugal.
[413] Interview with Maria Moreira.
[414] Interview with Maria Moreira.
[415] ERANID - About. Eranid.eu. Retrieved 22 September 2016, from http://www.eranid.eu/about/

of the European Harm Reduction Network which aims to advocate and share knowledge on harm reduction within Europe[416]. Beside research and knowledge sharing, Portugal also contributes in the coordination of law enforcement agencies. It is involved in the Maritime analysis and Operation centre (MAOC) that aims to enhance criminal intelligence and coordinate law enforcement agencies in the high seas and Portugal participates in the different cocaine route programmes such as SEACOP, AIRCOP and AML[417].

At an international level, Portugal also engages with UNODC projects, particularly in Portuguese speaking countries such as Cap Verde and Guinea Bissau; the ministry of justice of Portugal, in cooperation with the UNODC provide some advisory services and technical assistance missions for Portuguese speaking countries in order to translate United Nations conventions against crime, terrorism, and corruption.[418]

In summary, to facilitate the drug demand reduction, there is an important integration between the health and law enforcement systems. Most of the activities are dedicated to reduce harm and focuses on the health of the citizen rather than criminal sanctions. The main role of the Portuguese Police is to refer drug users to the health system through the CDT. Beside surveillance in schools' area, they also undertake prevention activities in the classrooms. Table 52 below provides some example of activities impacting drug demand. Because there is not a huge drugs domestic market, activities for reducing drug supply are concentrated on transnational and international cooperation.

Table 52: Drug activities in place in country Portugal

Activity/intervention name	year	Short description	Type of interventions (Prevention, treatment and harm reduction, criminal justice response)
Syringe-exchange and HIV-testing programme	1993-present	The programme mainly involve health centres, NGOs and pharmacies. Approximately 53 million syringes have been given out under this programme between its launch in October 1993 and December 2013.	Treatment and harm reduction
Mobile centres for the prevention of infectious diseases	N/A	N/A	Treatment and harm reduction
Low-threshold substitution programmes	N/A	Substitution treatment is widely available in Portugal and can be delivered by specialised treatment centres, health centres, health centres, hospital and pharmacies as	Treatment and harm reduction

[416] About Us||What is EuroHRN?. Eurohrn.eu. Retrieved 22 September 2016, from http://eurohrn.eu/index.php/aboutus.

[417] Discussion with experts.

[418] Interview with Maria Moreira; UN, PORTUGAL COOPERATE IN PROMOTING CONVENTIONS AGAINST CRIME, TERRORISM AND CORRUPTION | Meetings Coverage and Press Releases. Un.org. Retrieved 22 September 2016, from http://www.un.org/press/en/2003/soccp256.doc.htm.

		well as NGOs and non-profit organisation.	
Integrated response prevention projects	N/A	16 integrated response prevention projects (out of a total of 77 projects) were implemented in the framework of the Operational Plan, covering nearly 21 200 people, mainly through awareness raising, information activities and educational interventions.	Prevention
Safe school programme	N/A	In the Safe School programme law enforcement agents patrol the areas surrounding schools to prevent and protect the school from criminal activities in the surrounding area, such as drug trafficking.	Supply reduction
Searching for the Family Treasure	N/A	Selective programme for vulnerable families	Prevention
Kosmicare	N/A	New intervention to tackle crisis events related to the use of psychoactive substances at music festivals.	Prevention
'Eu es os outros' (Me and the other's)	2006-current	'Eu es os outros' is the most important prevention programme in school at the national level. It promotes knowledge on psychoactive substances related problems. Many tools are available to explore in an interactive way topics related to adolescence and the use of psychoactive substances. This programme is integrated with problems of the everyday life such as sexuality, violence, eating habit.	Prevention

EFFECTS

According to SICAD, the Portugal drug policy had a positive impact and positive trends have been observed for the last 15 year. The positive impacts are attributable to decriminalisation and also to the extensive harm reduction services implemented, notably the access to sterile syringes, low threshold methadone maintenance therapy and other medication-assisted treatments[419]. It is reviewed below the potential effects of Portugal drugs policies on the criminal justice system, drug prevalence and infectious diseases.

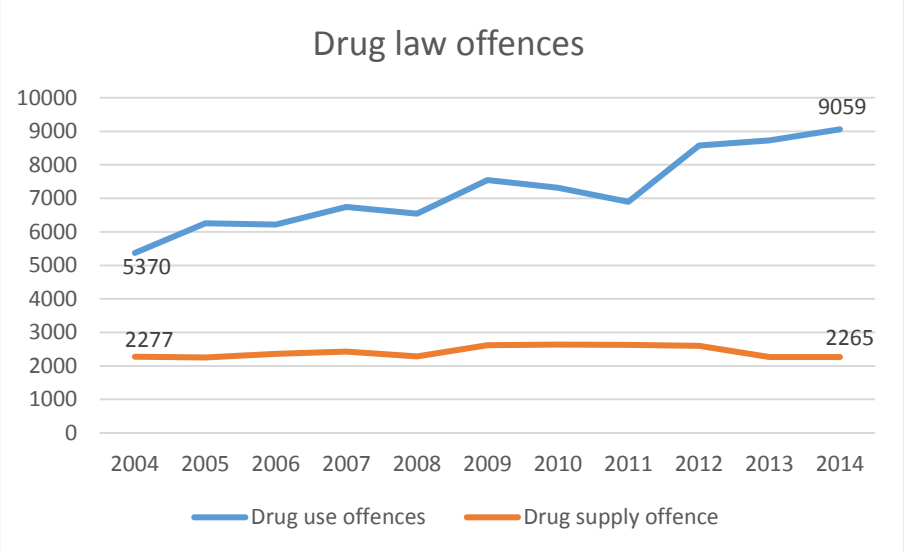
[419] REITOX National Focal Point Portugal and Hughes, C. & Stevens, A. (2012). A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs. Drug And Alcohol Review, 31(1), 101-113. http://dx.doi.org/10.1111/j.1465-3362.2011.00383.x.

Impact on the Criminal justice system

A total of 14 733 people were reported to be involved in drug-law offences in 2014. Among them, 5 674 were involved in 5 046 offences related to drug supply. The majority of drug-law offenders (9 059) were involved in non-criminal offences related to use and possession of drugs for personal use. It has been reported that fewer people have been arrested and incarcerated for drugs related issues and the number of people referred for administrative offences under the new decriminalisation law has been relatively stable overtime[420]. The increase in drug use offences presented in Figure 33 is likely to indicate that there has been an increase in the number of people who have been assessed by the CDT and referred to health authorities when necessary[421]. In 2009, the CDT provided a warning to the offender in 68% of the cases for drug use/possession; 15% of cases were suspended with an agreement to undergo treatment and 14% of cases required punitive rule (4% fines and 10% non-pecuniary sanctions)[422].

The new criminal system and the CDT as well as the strong harm reduction offers have certainly played an important role in increasing the number of people receiving drug treatment from approximately 23,600 in 1998 to 38,000 in 2011[423]. Because a significant part of the drug use offences are managed by the CDT instead of a justice court, decriminalisation, enabled to reduce the burden on the criminal justice system.[424] The resources invested in the justice system, however, has remained stable which enabled to invest differently and to increase the quality of life of the population living in prisons.

Figure 33: Number of drug law offences in Portugal



Note: Administrative offences are also reported here (e.g. number of drugs users who have been referred to CDT have been included in drug-use related offences)

Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016;

[420] Drug Policy Alliance,. (2015). Drug Decriminalization in Portugal: A Health-Centered Approach.
[421] Ibid.
[422] Portugal country overview | www.emcdda.europa.eu. (2016). Emcdda.europa.eu.
[423] Drug Policy Alliance. (2015). Drug Decriminalization in Portugal: A Health-Centered Approach.
[424] SICAD, Portugal.

Table 53: Number of offences (administrative and criminal) per type of drugs (2014)

The stage within the criminal justice system at which data have been reported and recorded, vary sometimes across countries. i.e. Data might be recorded at an initial stage when a first report is made by law enforcement agencies, or after investigation by the Judicial Police, or even following a decision for a charge to be issued by the Prosecutor.

Drugs	Drug-use related offences	Drug-supply related offences	Total
Cannabis	7 417	4 419	11 836
Opioids/Opiates			
Heroin	677	690	1 367
Stimulants			
Cocaine	709	1 046	1 755
Amphetamine	60	77	137
Methamphetamine	0	0	0
Hallucinogens			
Ecstasy	77	138	215
LSD	16	49	65
All drugs			
Total	9 059	2 265	N/A

Note: Administrative offences are also reported here (e.g. number of drugs users who have been referred to CDT have been included in drug-use related offences)

Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016;

Trend in drug prevalence and impacts of prevention activities

Even though there was an increase in recent and current drug use (last year and last month use) in selected cohorts, particularly those aged 25 to 34, it has also been reported that recent and current drug use has declined among individuals aged 15-24. The decline of use among the 15-24 is perceived by Hughes and Steven (2012) and by the REITOX national focal point as a success given that this is the cohort group most at risk of initiation and long term engagement.[425] This improvement in prevalence could be partially due to early interventions facilitated by the CDT as well as prevention activities performed in schools. For example, the 'Me and others' programme have been implemented in 247 schools/institutions and around 758 young people have been involved in training sessions.

[425] Hughes, C. & Stevens, A. (2012). A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs. Drug And Alcohol Review, 31(1), 101-113. http://dx.doi.org/10.1111/j.1465-3362.2011.00383.x .

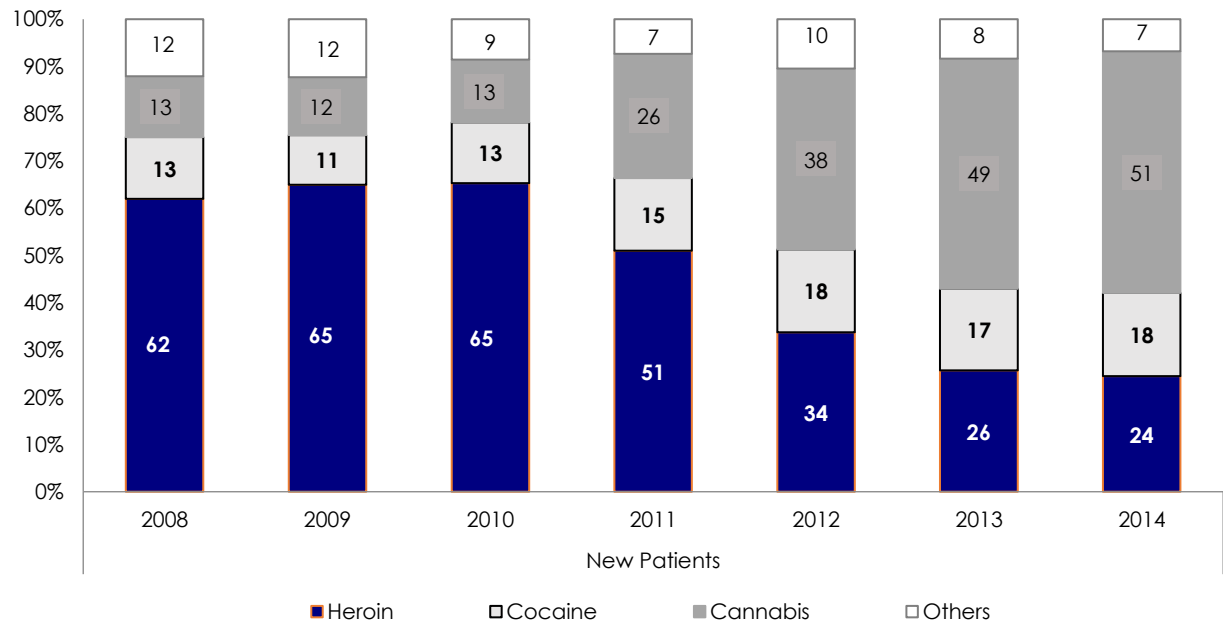
In an evaluation of this programme, there was not a direct assessment between drug consumption and participation in the programme but the evaluation assessed the overall wellbeing and confidence of the young people. It has been shown that the 'Me and others' programme improved notably social Competence, Intellectual Flexibility emotional control and self-confidence. These indicators are considered protective factors that can help young people to develop the 'resilience 'needed to resist alcohol and other drug use[426].

Injecting drug use, infectious disease and impact of harm reduction programmes

As discussed in previous section on the criminal justice system, there have been an increase in treatment demand from 23,600 in 1998 to 38,000 in 2011[427]. This increase in demand has been facilitated by the numerous harm reduction and treatment activities put in place in Portugal. For example, 16 587 clients were registered in 2014 for opioid substitution programmes (OST). Among them, 67% were in Methadone maintenance treatment and 35% were high-dosage buprenorphine treatment. OST is also now available in prison settings.

Among patients receiving treatment, the REITOX national focal point identified a decreasing trend in the number of people injecting drugs in the last 12 months, from 21% in 2012 to 12% in 2014.[428] Treatment demands have shifted from highly problematic drugs such as heroin to less problematic ones such as cannabis (see Figure 34).

Figure 34: Treatment demand per type of drugs used



Source: REITOX National Focal point

Beside the decreasing trend in proportion of injecting drug users, the harm reduction activities undertaken through the syringe-exchange and HIV-testing programmes contributed probably in the decreasing trend in new HIV prevalence illustrated in

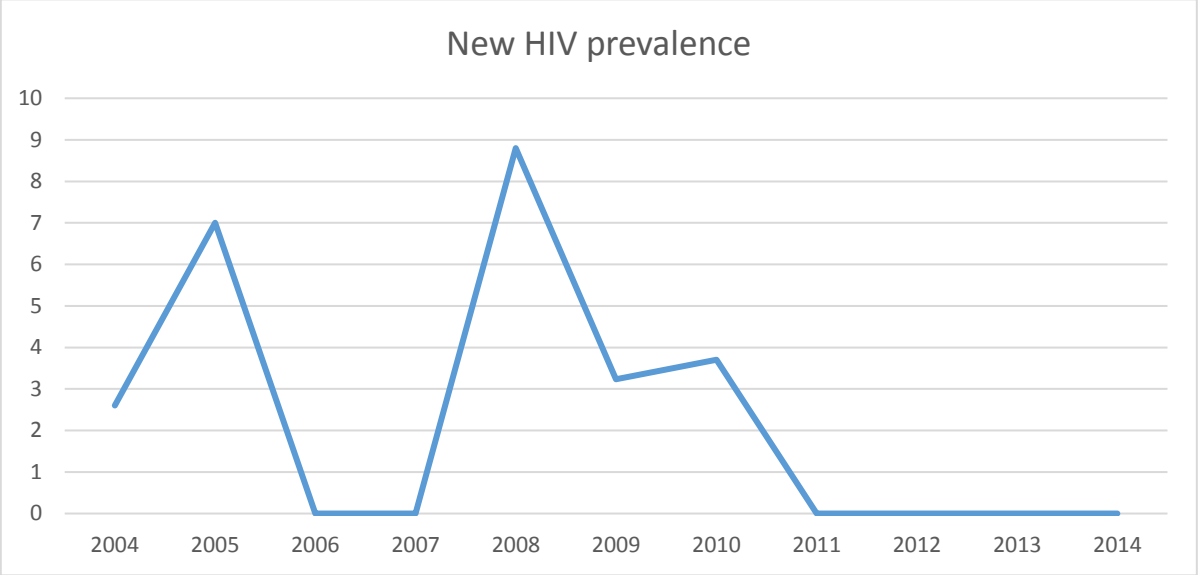
[426] EMCDDA | Best practice portal: EDDRA project description. Emcdda.europa.eu. Retrieved 22 September 2016, from http://www.emcdda.europa.eu/html.cfm/index52035EN.html?project_id=08PT05&tab=results; Overview Me and the others: Executive summary.

[427] Drug Policy Alliance, (2015). Drug Decriminalization in Portugal: A Health-Centered Approach.

[428] SICAD.

Figure 35. Primary health centres distributed around 1.7 million syringes in 2014 and there were in 2014, only 40 HIV diagnosis among drug users compared to 1206 in 2001.[429]

Figure 35: New HIV prevalence in Portugal



Note: No data available in 2013

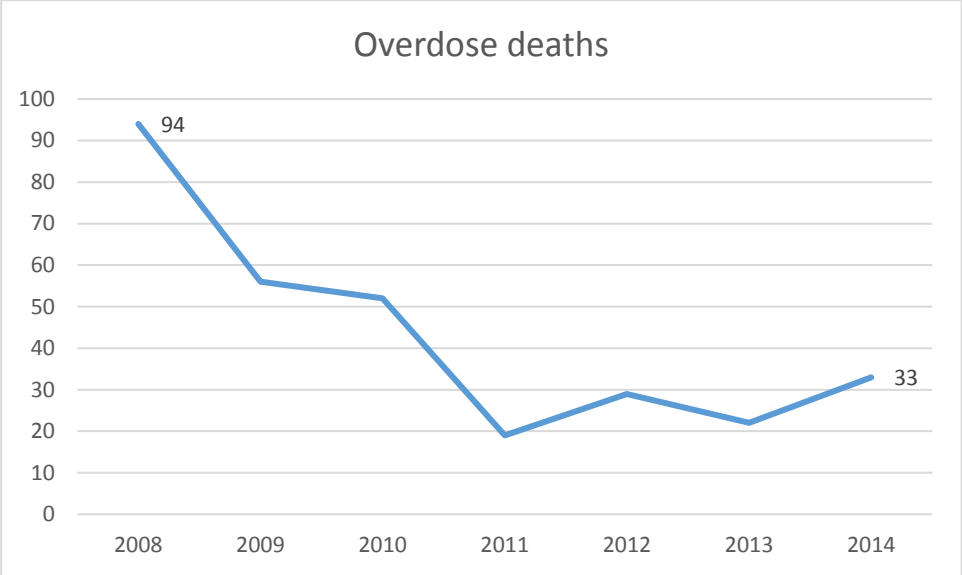
Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016;

Concerning drug-related death, National statistics data (INE) suggest that the decriminalisation policy had a positive impact on drug-induced deaths. This dataset is to be contrasted with the one from the National Institute of Forensic Medicine (INML) that reports the post mortem toxicological tests for presence of illicit substance, no matter if the substance is responsible or not for the death and that does not take into account the change in recording practices (i.e. number of toxicological autopsies performed).[430] The INE dataset is considered to be more accurate for measuring the number of drug of related deaths; Hughes and Stevens (2012), the REITOX National focal point and the EMCDDA statistical bulletin seems to all agree on a reduction drug-related deaths. As shown in Figure 36, overdose reduced from 94 in 2008 to 33 in 2014.

[429] Instituto Nacional de Saúde Doutor Ricardo Jorge, IP (INSA, IP): DDI-URVE / SICAD.

[430] Hughes, C. & Stevens, A. (2012). A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs. Drug And Alcohol Review, 31(1), 101-113. http://dx.doi.org/10.1111/j.1465-3362.2011.00383.x .

Figure 36: Number of overdose deaths in Portugal



Note: According to national definition of overdose

Source: Statistical Bulletin 2016 | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016;

Essentially, the drug policies in Portugal aims at reducing drug-related harm across the population and the current trends and evaluation are very positive to support the success of these policies. This conclusion is further supported by a study from 2015. The study found that that the social cost of drug misuse (including treatment, prevention, harm reduction, health cost, social rehabilitation, legal system costs and indirect cost such as lost income) decreased by 12% and 18% in the five and 11 years respectively following the Portugal National drug strategy of 1999[431].

CONCLUSIONS / Good PRACTICE

The legal framework in Portugal is seen as a model of best practices because health and welfare of citizens are at the centre of the Portugal drug policy. The decriminalisation contributed in reducing drug users' stigmatisation and facilitated the access of drug-related health support because drug users won't fear to be referred to the drug justice system. According to the REITOX National Focal Point, decriminalisation is not sufficient and in Portugal the drug addiction is perceived as a disease that needs to be tackled by the health system. Decriminalisation success is mainly due a strong overall response in the health and social education system[432]. Many of its prevention activities mainly provided through the education system are highlighted as best practices by the EMCDDA. The activities, such as those provided by the 'Eu es os outros' programme, tend to tackle life problems of young population as a whole rather than being limited to drug prevention.

The REITOX national focal point highlights that the system put in place in Portugal works very well in the country because drugs are primarily approached / managed / dealt with as a use and not a supply issue. There is no strong violent criminality because drugs trafficking is mainly a white collar type of crime. It has been emphasised that it is not because the system works very well in Portugal that it could be replicated in other countries

[431] Gonçalves, R., Lourenço, A., & Silva, S. (2015). A social cost perspective in the wake of the Portuguese strategy for the fight against drugs. International Journal Of Drug Policy, 26(2), 199-209. http://dx.doi.org/10.1016/j.drugpo.2014.08.017 .

[432] Interview with SICAD.

with different culture, different resources for providing health support, different social welfare benefits and different level of drug crime violence. Decriminalisation was led by a bottom-up movement in 1990s when 1% of the entire population was hooked on heroin. In this particular context, decriminalisation with the adequate health response seemed to be the most appropriate approach for the National drug policy. It enabled to change the perception of drug addiction as disease rather than a stigma and the result have been very positive[433].

In summary, decriminalisation, has immediate benefits for the majority of people who are saved from criminalisation; it takes the pressure of the criminal justice system and can allow for transfers from criminal justice to the health sectors. As only 15% of cases that came before the CDTs required treatment and the majority were dealt with a verbal warning, the extra resource required in the treatment service is relatively small, while the savings from police, court and prison costs are considerable. The challenge lies in achieving cross – departmental value transfers[434].

STAKEHOLDERS AND DOCUMENTS

Table 54: Portugal case study - Sources.

Stakeholders interviewed	• João Goulão, General-Director of SICAD (General Directorate on Addictive Behaviours and Dependencies • Maria Moreira, Data Quality Officer, EMCDDA; previously a programme manager for drugs strategy for the Portuguese government
Documents / websites reviewed	• EMCDDA (2011) Drug Policy Profile: Portugal. Luxembourg: Publications Office of the European Union. Retrieved from http://www.emcdda.europa.eu/system/files/publications/642/PolicyProfile_Portugal_WEB_Final_289201.pdf • Portugal country overview. Retrieved from http://www.emcdda.europa.eu/countries/portugal. • Statistical Bulletin. Retrieved from http://www.emcdda.europa.eu/data/stats2016; • Harm Reduction International,. (2014). The Global State of harm reduction 2014. London: Harm Reduction International. Retrieved from https://www.hri.global/files/2015/02/16/GSHR2014.pdf • European Legal database on drugs. Retrieved from http://www.emcdda.europa.eu/topics/law/penalties-at-a-glance • Portuguese Drug Strategy. (1999). Retrieved from http://www.emcdda.europa.eu/system/files/att_119431_EN_Portugal%20Drug%20strategy%201999.pdf. • General-Directorate for Intervention on Addictive Behaviours and Dependencies,. (2014). National Plan for Reducing Addictive Behaviours and Dependencies 2013-2020. Retrieved from http://www.emcdda.europa.eu/system/files/Portugal%20National%20Plan%20for%20the%20Reduction%20of%20Addictive%20Be

[433] Interview with REITOX National Focal Point Portugal.

[434] Discussion with experts.

haviours%20and%20Dependencies%202013%E2%80%9320_EN.pdf.

- EMCDDA | Evaluated examples of best practice in Europe: EDDRA. Retrieved from http://www.emcdda.europa.eu /themes/best-practice/examples.
- ERANID - About. Retrieved from http://www.eranid.eu /about/
- About Us What is EuroHRN?.Retrieved from http://eurohrn.eu/index.php/aboutus.
- UN, PORTUGAL COOPERATE IN PROMOTING CONVENTIONS AGAINST CRIME, TERRORISM AND CORRUPTION Meetings Coverage and Press Releases. Retrieved from http://www.un.org/press/en/2003/soccp256.doc.htm.
- Hughes, C. & Stevens, A. (2012). A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs. Drug And Alcohol Review, 31(1), 101-113. http://dx.doi.org/10.1111/j.1465-3362.2011.00383.x.
- Drug Policy Alliance,. (2015). Drug Decriminalization in Portugal: A Health-Centered Approach. Retrieved from https://www.drugpolicy.org/sites/default/files/DPA_Fact_Sheet_Portugal_Decriminalization_Feb2015.pdf
- Gonçalves, R., Lourenço, A., & Silva, S. (2015). A social cost perspective in the wake of the Portuguese strategy for the fight against drugs. International Journal Of Drug Policy, 26(2), 199-209. http://dx.doi.org/10.1016/j.drugpo.2014.08.017 .

APPENDIX A7: CASE STUDY – SWEDEN

INTRODUCTION

Since 1977, the primary objective of Sweden's approach to drug policy has been achieving 'A society free from narcotic drugs'.[435] This zero tolerance objective is reflected in the country's restrictive and hard-line approach to drug policy.[436] It is reported that this approach is driven by the assumption that drug misuse is a biochemical dependency, putting it at odds with the psychosocial model currently driving drug policy elsewhere in the EU and internationally.[437] In light of this assumption, the dominant approach to tackling the use and misuse of illicit drugs in Sweden is through law enforcement and the criminal justice system. In this respect, Sweden's legal framework does not demand heavy sentences[438] when compared to the rest of the EU and a wide range of alternative sanctions exist.[439]

Sweden also implements other approaches to tackling drug use, including harm reduction, prevention and treatment programmes. However, prevention programmes are reported to be primarily fear-based interventions in schools[440], harm reduction programmes (such as needle and syringe exchange programmes) are limited in number[441], and treatment programmes are almost exclusively high-threshold[442].

Although it is not possible to attribute the following indicators to Sweden's policy, prevalence levels for drug use are low in comparison to the rest of the EU and drug-related offence data are high. This potentially reflects the role of the criminal justice system, the focus on creating a drug-free society and the availability of recreational alternatives for young people. However, a key challenge faced by Sweden is that the number of drug-related deaths is significantly higher than in the rest of the EU, potentially reflecting the limited availability of treatment and harm reduction programmes.

NEEDS

Drug use as a driver of drug policy

Cannabis is the focus of the majority of Swedish analyses and reporting of drug use. It is the most commonly used drug in Sweden, with a lifetime prevalence figure of 14.4% of the population sample; this is generally an indication of experimental use. As is to be expected, 'last 12 months' and 'last 30 days' prevalence figures are much lower, and all three indicators have remained stable in recent years. All three indicators are lower than the EU average for cannabis use.

There are only a few academic studies looking at the use of other drug types. A 2013 study found that the most common substances after cannabis in terms of lifetime prevalence are cocaine (3.3%), amphetamine (3.0%), ecstasy (2.4%), opioids (2.2%), and hallucinogens (2.1%).

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[435] Chatwin, C (2011) Drug Policy Harmonization and the European Union.

[436] Ibid, p.10.

[437] Interview with Ted Goldberg, Professor of Sociology, University of Gävle.

[438] EMCDDA (2016) Illicit Drugs Law, Penalties at a glance.

[439] Interview with Per Ole Träskman, Emeritus Professor at Lunds Universitet.

[440] Interview with Ted Goldberg, Professor of Sociology, University of Gävle.

[441] Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 September 2016, from http://www.emcdda.europa.eu/data/stats2016.

[442] Chatwin, C (2016) Mixed Messages from Europe on Drug Policy Reform: The Cases of Sweden and the Netherlands, Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016.

As can be seen in the below table, however, official statistics are only recorded for cannabis prevalence.

Table 55: Prevalence rates among adults 15–64 (2014)[443]

Title	Life time prevalence EU average	Life time prevalence (2014)	Last year prevalence (2014)
Cannabis (%)	17.8%	14.4%	2.9%
Opioids			
All Opioids drug use problems (per thousand)	0.35	N/A	N/A
Stimulants			
Cocaine (%)	3.0%	N/A	N/A
Amphetamine (%)	2.5%	N/A	N/A
Hallucinogens			
Ecstasy (%)	2.9%	N/A	N/A
LSD (%)	1.4%	N/A	N/A
All drugs			
Total (%)	19.1%	14.8%	3.2%

Health as a driver of drug policy

It is reported the **Hepatitis C virus** (HCV) is the infection that most commonly affects people who inject drugs. Sweden reported 1 786 new cases of HCV to the European Centre for Disease Prevention and Control in 2014; 757 were related to injecting drugs. Furthermore, as shown in the table above, the most recent available estimates report that a high proportion (75.1%) of injecting drug users are infected with Hepatitis C. Expert opinion confirms that the proportion of injecting drug users infected with HCV is still high[444].

In 2014, Sweden reported only 8 new **human immunodeficiency virus** (HIV) cases among people who inject drugs. This was Sweden's lowest figure since the ECDC started collecting these data in 2004 and a reduction of 9 cases compared with 2012.[445] However, it is reported that public awareness of HIV and its transmission is high in Sweden[446], potentially contributing to the low number of new cases[447].

[443] Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 2 September 2016, from http://www.emcdda.europa.eu/data/stats2016.

[444] Interview with Ted Goldberg, Professor of Sociology, University of Gävle.

[445] European Centre for Disease Prevention and Control (2013) HIV/AIDS surveillance in Europe. Available at: http://ecdc.europa.eu/en/publications/Publications/hiv-aids-surveillance-report-Europe-2013.pdf. Accessed on 08.09.2016.

[446] Plantin, L., Wallander, L. and Mannheimer, L. (2016) Public knowledge and attitudes to HIV – Research from three decades in Sweden. International Journal of Sexual Health

[447] Interview with Ted Goldberg, Professor of Sociology, University of Gävle.

The number of notified cases of **hepatitis B virus** (HBV) infection related to injecting drug use was 38, representing a small increase from 2013.

In 2014, 609 **drug-induced deaths** were reported in Sweden. This figure represents a significant increase when compared with the 460 drug-induced deaths in 2013. Sweden has seen this indicator increase significantly since 2003, when only 211 drug-induced deaths were reported. The majority of these cases were related to opiates (507), and many were characterised by poly-drug use or other substances. Additionally, as can be seen in the below table, the drug-induced mortality rate is almost four times that of the European average. This is a particular challenge facing the Sweden and its government's approach to drug policy.[448]

Table 56: Drug induced mortality and epidemiology

	Number of people who inject drugs (/1000 inhabitants)[449]	Prevalence of new HIV among people who inject drug (%)[450]	Prevalence of Hepatitis C among people who inject drugs (%)	Prevalence of hepatitis B antibodies among people who inject drug (%)	Drug induced mortality among adult 15-64 (per million)[451]
Year	2008-2011	2014	2007	2014	2014
Sweden	1.31	4.4%	75.1%	2.3%	92.9
EU average	2.98[452]				19.2

Drug Production, import and export as a driver of drug policy

As referred to above, cannabis and its derivatives are the most commonly used and most freely available illicit drugs on the Swedish market, and **domestic production** of these drugs is reported to be increasing[453]. It is reported that this domestic production is primarily tied to transnational organised crime, although it is reported the amount linked to local crime groups has increased in recent years. Cannabis is said to be available in all areas of Sweden.

It is reported that amphetamine and methamphetamine, as well as cocaine and other stimulants, are also available throughout Sweden, although use is concentrated in urban areas. Heroin use is also concentrated to urban areas. Kath and opium use is currently

[448] Public Health Agency of Sweden (2014) 2014 National Report to the EMCDDA: Sweden, new developments and trends (2013 data). Available at: http://www.emcdda.europa.eu/system/files/publications/1003/2014%20National%20Report%20-%20Sweden.pdf. Accessed on 08.09.2016.

[449] Statistical Bulletin | www.emcdda.europa.eu. (2016). Emcdda.europa.eu. Retrieved 19 September 2016, from http://www.emcdda.europa.eu/data/stats2016.

[450] Harm Reduction International (2014) The Global State of Harm Reduction 2014.

[451] Sweden country overview | www.emcdda.europa.eu. Emcdda.europa.eu.

[452] EU average based on the following countries and most recent estamite year: BE, CY, CZ, EL (2014), ES (2013), PT, LV, FI, HR (2012), LU, EE (2009), NL (2008), HU (2008-2009), UK (2004-2011) & SE (2008-2011).

[453] Public Health Agency of Sweden (2014) 2014 National Report to the EMCDDA: Sweden, new developments and trends (2013 data). Available at: http://www.emcdda.europa.eu/system/files/publications/1003/2014%20National%20Report%20-%20Sweden.pdf. Accessed on 08.09.2016.

confined to ethnic minority communities. There is little domestic cultivation of drugs other than cannabis.

Key *modus operandi* for the **importation** of illicit drugs include entry from Denmark via the Öresund Bridge in Malmö and the ferry port of Helsingborg, most likely due to the speed and availability of these transport routes. Another important *modus operandi* for accessing illicit drugs, reported to be rapidly increasing, is the use of physical mail services to deliver drug orders placed over the internet. More than 50% of all drug seizures currently relate to postal deliveries.[454]

EU countries are the primary origin of Sweden's drugs imports. Approximately 90% of drugs seized by Swedish authorities are smuggled from another country within the European Union. The most important sources, as reported by the Public Health Agency of Sweden, are Lithuania (for amphetamine and methamphetamine); the Netherlands (for amphetamine, cannabis resin and marijuana); and Poland (for amphetamine).

It is also noted that heroin and cocaine are imported from both Central Asia and South America.

LEGAL FRAMEWORK

The key legislation in the field of illicit drugs include:

- **Penal Law on Narcotics** (SFS 1968:64) – aims to regulate drugs and other products that can cause harm to the life and health of individuals;
- **Act on the Prohibition of Certain Goods Dangerous to Health** (SFS 1999:42) – stipulates that substances defined as 'goods dangerous to health' may not be imported, transferred, produced, acquired, sold or possessed and lists those substances.
- **Narcotic Drugs Control Act** (SFS 1992:860) – concerns the control of precursor chemicals, including their use in certain industrial purposes.
- **Act on the Destruction of Certain Substances of Abuse Dangerous to Health** (SFS 2011:111) – sets out the means for the regulation of substances that are dangerous to health but are yet to be defined in law.

As can be seen above, Sweden has three levels of penalty which are the same for production, supply, possession, and use. The level of penalty is dependent on the nature and quantity of the drugs, and can be aggravated further by an individual's involvement in large-scale or professional activities. The outcomes brought by these aggravating factors are not prescribed in the legal framework but dealt with on a case-by-case basis.

In 2006, Sweden also established legislation in the field of harm reduction. The Act on Exchange on Syringes and Needles (SFS 2006:323) aims to positively impact the spread of HIV and other blood-borne infections through needle and syringe exchange programmes. It stipulates that these measures should be implemented by healthcare entities alongside interventions aimed at promoting care and treatment. These programmes should also include the social services and the National Board of Health and Welfare.

Furthermore, Sweden's legal framework distinguishes between different types of drugs but only in relation to their medical use. As defined in the Medical Products Agency Regulation 2000:7 there are five lists:

[454] Public Health Agency of Sweden (2014) 2014 National Report to the EMCDDA: Sweden, new developments and trends (2013 data). Available at: http://www.emcdda.europa.eu/system/files/publications/1003/2014%20National%20Report%20-%20Sweden.pdf. Accessed on 08.09.2016.

I. drugs without medicinal use (cannabis, heroin, MDMA, LSD);
II. drugs with a limited medicinal use and a high risk of addiction (amphetamines, cocaine, methadone);
III. drugs with medicinal use and a risk of addiction (codeine);
IV. drugs with medicinal use and a low risk of addiction (barbiturates, benzodiazepines, buprenorphine).
V. drugs prohibited in Sweden but not internationally.

Government support for service user involvement either in service provision or policy is very limited.

Table 57: Criminalisation of drugs and penalties[455]

Produce	Supply	Possess	Use
Penalty			
• **Minor:** Fines or up to 6 months' imprisonment; • **Ordinary:** Up to 3 years' imprisonment; • **Serious:** 2-10 years' imprisonment. Dependent on type and quantity of drugs and other circumstances, such as involvement in large-scale or professional activities			Dealt with as an 'ordinary' or 'minor' offence depending on the type and quantity of drug and other circumstances (see produce, supply and possess penalties).

AIMS AND OBJECTIVES OF THE SWEDISH APPROACH TO DRUG POLICY

Objectives and overview of the current drugs strategies

The Swedish Government's current approach to drug policy is primarily outlined in the 2016-2020 strategy for alcohol, narcotics, doping and tobacco (ANDT). This strategy builds on the 2011-2015 strategy of the same name and works to the same overarching objective, set by the Riksdag: 'A society free from narcotic drugs and doping, with reduced alcohol-related medical and social harm and reduced tobacco use'.

Both general measures and targeted measures are documented in the strategy for the purpose of ensuring all Swedish citizens have the chance of maintaining good health. Six objectives have been defined which are intended to contribute to achieving the overarching objective:

1. Access to alcohol, narcotics, doping substances and tobacco must be reduced.
2. The number of children and young people who start to use narcotics, doping substances and tobacco or who have an early alcohol debut must be progressively reduced.
3. The number of women and men, as well as girls and boys, who become involved in the harmful use or abuse of or dependence on alcohol, narcotics, doping substances or tobacco must be progressively reduced.
4. Women and men, as well as girls and boys, with abuse or addiction problems must be given greater access to good-quality care and support on the basis of their circumstances and needs.

[455] EMCDDA (2016) Illicit Drugs Law, Penalties at a glance.

5. The number of women and men, as well as girls and boys, who die or are injured as a result of their own or others' use of alcohol, narcotics, doping substances or tobacco must be reduced.
6. An EU and international approach to ANDT that is based on public health.

Table 58: Main current policies and actions plans in Sweden

Policies, actions plans	Description
2016-2020 Strategy for alcohol, narcotics, doping and tobacco (ANDT)	Sets out the key overarching objective of Swedish drug policy (a drug free society), the six sub-objectives that are intended to contribute to achieving the overarching objective, and the general and targeted actions to be taken in order to achieve these objectives.

Organisations involved

The Swedish Ministry of Health and Social Affairs is the Government's coordinating function for the 2016-20 Strategy for Alcohol, Narcotics, Doping and Tobacco (ANDT). It is supported in implementation by a number of national agencies, including the Public Health Agency of Sweden and the National Board of Health and Welfare, and three additional government ministries:

- Ministry of Justice, regarding correctional treatment, penal law, and police work;
- Ministry of Finance, regarding customs issues and legislation on smuggling; and
- Ministry of Foreign Affairs, regarding foreign affairs and drugs-related development assistance.

There is a national council for ANDT issues, the participants of which include relevant agencies, researchers, civil society representatives, and the Swedish Association of Local Authorities and Regions.

Furthermore, each county supports the implementation of the ANDT strategy by ensuring the national strategy is applicable locally. The 21 counties coordinate with each other and the state through a regional organisation consisting of county-level administrative boards.

The ANDT strategy also highlights roles for the following organisations: the National Council for Crime Prevention; the Swedish Consumer Agency; the Swedish Prison and Probation Service; the Swedish Coast Guard; the Medical Products Agency; the Agency for Family Law and Parenthood Support; the Swedish Police Authority; the National Board for Health and Welfare; the National Board of Institutional Care; the Swedish National Agency for Education; the Swedish Transport Administration; the Swedish Transport Agency; and Swedish Customs.[456]

The Public Health Agency of Sweden also contributes to the EMCDDA's core tasks by acting as the REITOX national focal point.

[456] Ministry of Health and Social Affairs (2015) A comprehensive strategy for alcohol, narcotics, doping and tobacco policy, 20160-2020. Available at: http://www.emcdda.europa.eu/system/files/Sweden%20ANDT-strategy-2016-2020.EN_.summary.pdf. Accessed on 08.09.2016.

INPUTS

The government allocates funds annually for work relevant to the ANDT strategy. In 2014, the amount allocated was around SEK 300mn (EUR 31.54mn[457]). However, the funding includes activities related to alcohol, doping and tobacco, as well as gambling.

Furthermore, funding from other policy areas and related bodies that are involved in activities in the field of drugs policy is not included in this figure.

Beyond this allocated budget, various estimates have been developed since 1991 aiming to estimate the total drug-related public expenditure in Sweden. The most recent study, in 2011, estimates the cost to be around EUR 2.62 billion[458].

ACTIVITIES

The detailed 2016-2020 ANDT strategy is yet to be published in English so the following section presents activities stipulated in the 2011-2015 ANDT policy and discussed in the REITOX national focal point's 2014 report to the EMCDDA.

Prevention activities

Prevention was the main component of the 2011-2015 ANDT strategy. Drug prevention activities have been increasing for many years with the major focuses including research, development and dissemination of preventative methods, regional coordination efforts, and local activities.

Although the Public Health Agency of Sweden and the National Board of Health and Welfare are responsible for monitoring the ANDT strategy, as well as public health more generally, the municipal governments play a vital role in implementing the strategy. All 21 Swedish counties have a county coordinator promoting evidence-based prevention measures at the regional and local levels. 81% of the municipalities have appointed a full-time or part-time drug coordinator for drug and alcohol prevention work at the community level.

Sweden implements a range of prevention activities in the school, family and community domains and most municipalities report the implementation of activities across all three domains.

Furthermore, social services and the Swedish Police Authority cooperate to deliver prevention activities to at-risk groups, at-risk families and in recreational settings.

Treatment and Harm reduction

Treatment

Social services in the local community, hospitals and therapeutic communities organise and deliver Sweden's drug treatment activities. In specific cases, the National Board of Institutional Care provides **compulsory** treatment. Drug treatment is also offered to individuals on probation and in prison.

Outpatient services are primarily provided by the state, county councils or municipalities and just over half of inpatient services are provided by private and non-governmental organisations (NGOs). Drug treatment programmes are generally combined with treatment

[457] Exchange rate of 1 SEK = 0.11 EUR as of 08.09.2016. Available at: http://www.xe.com/currencyconverter/convert/?Amount=1&From=SEK&To=EUR.

[458] Statens Offentliga Utredningar (2011) Missbruket, Kunskapen, Varden: Missbruksutredningens forskningsbilaga.

for alcohol and other addictions. County councils provide opioid substitution treatment (OST), detoxification and psychiatric co-morbidities treatment. Municipalities are responsible for long-term rehabilitation through social services.

Social reintegration interventions are reported to be limited in both coverage and availability.

Methadone and buprenorphine-based medications are the only available opioid substitution treatments (OST). As of 2013, there were 110 OST units in Sweden. In 2014, it was reported that 3 502 individuals were involved in OST in Sweden.

Harm reduction

In 2006, a law was passed by the Swedish government allowing the counties to establish needle and syringe exchange programmes. These programmes are required to inform individuals using their services about the risks of injecting and other available services, including vaccinations and infectious disease testing. However, by the end of 2014 there were only six needle and syringe exchange programmes in place in Sweden. They served a reported 2 266 individuals in 2014.

Criminal justice response

Restricting drug use through law enforcement activity in the area of drug control is the primary focus of Sweden's drug policy. In this respect, significant resources have been devoted to narcotics cases since the 1990s and an increase in seizures has been experienced. The Swedish police aim to tackle drug-related crime, in cooperation with a range of organisations, such as the Swedish National Bureau of Investigation.

In terms of sentencing, it is noted that Sweden's maximum sentences are generally lower than those in central and southern European countries, and this is true for sentencing in drug cases. However, it is stated by experts that the maximum of 3 years for minor offences (see legal framework section) is high when viewed in line with the rest of Sweden's legal system. Furthermore, it is reported that many drug-related cases in Sweden are deemed 'serious' by the courts, with the majority of these cases yielding sentences of 6 or more years imprisonment – significantly higher than the minimum for 'serious' offences (2 years).[459]

However, a range of drug-related interventions are also available in the criminal justice system. Upon conviction, a range of sanctions can be implemented including imprisonment, supervision with electronic monitoring, community service, probation, probation with community service, and probation with contract treatment. This provides a range of alternatives to imprisonment, depending on a range of case-specific factors. It is reported that almost three times as many individuals are returned to society than placed in prison based on this programme of alternative sanctions. However, it is further reported by the Swedish Public Health Authority that three quarters of prisoners have an alcohol and/or drugs problem, a figure that has remained stable over the past 5 years.[460]

Individuals that are imprisoned receive special measures before release. These measures aim to reduce the risk of reoffending and facilitate reintegration into society. The measures include:

- **Activity release:** a prisoner might undertake work, participate in an educational setting or receive treatment.

[459] Interview with Per Ole Träskman, Emeritus Professor at Lunds Universitet.

[460] Folkhälsomyndigheten (2016) The Drug Situation in Sweden – An Overview of the Reporting to the EMCDDA. Accessed on 30.09.2016 at: https://www.folkhalsomyndigheten.se/publicerat-material/publikationsarkiv/t/The-Drug-Situation-in-Sweden---An-Overview-of-the-Reporting-to-the-EMCDDA/

- **Stay in care:** a prisoner is able to leave the prison to participate in treatments, such as treatment for substance use, at a treatment centre or in a family care home.
- **Half-way house:** a prisoner lives in a home under the control of the Prison and Probation Service, with the provision of additional support.
- **Extended activity release:** a prisoner may serve his/her sentence under intensive supervision, with electronic tagging, at home.

The Swedish Prison and Probation Service (SPPS) also implements a range of activities through its action plan against alcohol misuse, illicit drug use, use of anabolic steroids and tobacco. It encourages all prison inmates to receive help. To achieve this, 22,000 motivational interviews were held with people in custody between 2010 and 2012.

The SPPS also implements treatment programmes, such as the 12-Step and Dare to Choose programmes.

Cooperation at EU and International level

Swedish Customs cooperates with domestic and international authorities. Swedish customs and Swedish police share responsibility for Sweden's involvement in the EMPACT Cocanie, Heroin and Synthetic Drugs projects. These are conducted within the framework of the Europol-led EU Policy Cycle on Serious and Organised Crime. For example, Sweden recently led the Costalot project focused on seizing postal delivery orders coming from Costa Rica.

Swedish customs and police also report cooperation in the framework of the Nordic Customs and Police Co-operation (PTN), and have strategically located liaison officers in, *inter alia*, Germany, Russia, Turkey, Colombia, Serbia, and China.

On the EU stage at least, it is reported that Sweden has come to feel at odds with other Member States. Their restrictive policy approach is said to put them in a different place to most EU level discussions on the subject.[461]

EFFECTS

There a number of drug-related indicators which can provide a picture of how Swedish drug policy, practice and the legislative framework may have had an impact. It is very difficult, however, to link the approach to drug policy undertaken by the Swedish authorities to any changes in these drug-related indicators. This section will therefore focus on presenting the relevant trends in drug-related indicators across: i) drug use; ii) health effects of drug use; and: iii) drug-related offences.

With regard to **drug use**, Sweden consistently reports low levels of illicit drug use. In 2014, for instance the life-time prevalence rate for cannabis was 14.4% compared with an EU average of 17.8%. For young adults (15-34), a key population group regarding drug use, Sweden's average lifetime prevalence of 21.4% is also well below the average for the eight other European countries with available data (35%). This figure has stayed stable over the past 10 years. It is not possible, however, to track these rates across other illicit drugs as these data are not reported to the EMCDDA by the Swedish Public Health Agency. These figures are perceived to be fairly low.[462]

[461] Interview with Per Ole Träskman, Emeritus Professor at Lunds Universitet.

[462] Chatwin, C (2016) Mixed Messages from Europe on Drug Policy Reform: The Cases of Sweden and the Netherlands, Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016.

Additionally, drug users face significant stigmatisation in Sweden[463]. It is reported that this is likely to hinder accurate representation of the situation in drug use surveys.[464]

It is reported that the number of dependent drug users, at last estimates, is around 30 000 individuals and the number of injecting drug users (2008-2011) was just above 8 000. Given the small proportions of the population reported to have tried illicit drugs, it can be assumed that a fairly high proportion of individuals who try drugs such as heroin and amphetamines become problematic in their use of these drugs.[465]

Regarding the **health effects of drug use**, the Hepatitis C virus (HCV) is the most common infection that affects injecting drug users. In Sweden, the proportion of drug users that are infected with HCV is high. A 2009 study examining Hepatitis C infections in injecting drug users in Stockholm found that 86.5% of its participants tested positive for HCV antibodies[466], and in Harm Reduction International reported an HCV prevalence rate of 75% in 2007 in Sweden[467].

Further infections that commonly impact injecting drug users include HIV and HBV. For both viruses, the number of new cases in recent years has been small. However, it is said that, particularly for HIV cases, external factors, such as the level of awareness of HIV transmission, might also contribute to these low figures.

One of the largest challenges facing Sweden, however, relates to the number of drug-related deaths. In 2014, 609 drug-induced deaths were reported in Sweden. This figure represents a significant increase when compared to 2013 (460) and 2003 (211). Additionally, the drug-induced mortality rate is almost four times that of the European average.

Sweden has experienced a steady rise in **drug-law offences** in the years up to 2013 culminating in a peak of 99 175 reported drug-law offences. In 2014, however, a slight reduction was seen, with 95 324 drug-law offences reported.[468]

Production-related offences have seen the largest increase in this time period. This type of drug-law offence increased by 22% from 697 in 2012 to 850 in 2013. However, these production statistics do not distinguish between production for personal use and production with intent to supply.

In the ten-year period 2003-2013 the number of individuals convicted of a drug-related offence as the primary crime has more than doubled (10 106 in 2003 to 20 765 in 2013).

These increases in crime statistics is reported to be a result of the drug control efforts of the Swedish police; these efforts are said to be characterised by an increasing focus on targeting drug users[469].

CONCLUSIONS

The Swedish position on drug policy has, since the 1960s, been one of restriction characterised by a high reliance on the criminal justice system and law enforcement to

[463] Interview with Per Ole Träskman, Professor Emeritus at Lunds Universitet.

[464] Chatwin, C (2016) Mixed Messages from Europe on Drug Policy Reform: The Cases of Sweden and the Netherlands, Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016.

[465] Chatwin, C (2016) Mixed Messages from Europe on Drug Policy Reform: The Cases of Sweden and the Netherlands, Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016.

[466] Lidman, C et al. (2009) Hepatitis C infection among injection drug users in Stockholm Sweden: prevalence and gender. Scand J Infect Dis. 2009;41(9):684

[467] Harm Reduction International (2014) The Global State of Harm Reduction 2014.

[468] EMCDDA (2016) Statistical Bulletin 2016, Sweden. Available at: http://www.emcdda.europa.eu/data/stats2016. Accessed on 15.09.2016

[469] Interview with Per Ole Träskman, Professor Emeritus at the Department of Law, Lunds Universitet.

achieve the Riksdag's overarching objective. However, the aspiration of a completely drug-free society is considered unachievable by stakeholders[470,471] and, although prevalence rates are low in Sweden, the country is facing difficulties reducing the health effects of drug use.

Treatment options, prevention activities and harm reduction strategies are being increasingly implemented in Sweden but there existence is still relatively low and the primary focus of the country's illicit drug policy is the work carried out by the criminal justice system, including the Swedish police and customs authorities.

To date, there has been no coherent challenge to this paternalist approach, which has cross-party consensus and considerable professional support.

STAKEHOLDERS AND DOCUMENTS

Table 59: Sweden case study - Sources.

Stakeholders interviewed	• Per Ole Träskman, Emeritus Professor of Criminal Law, Lunds Universitet • Ted Goldberg, Professor of Sociology, University of Gävle
Documents / websites reviewed	• EMCDDA Statistical Bulletin, 2016 • EMCDDA Country Overview: Sweden • Chatwin, C (2016) Mixed Messages from Europe on Drug Policy Reform: The Cases of Sweden and the Netherlands • Ministry of Health and Social Affairs (2015) A comprehensive strategy for alcohol, narcotics, doping and tobacco policy, 20160-2020 • Statens Offentliga Utredningar (2011) Missbruket, Kunskapen, Varden: Missbruksutredningens forskningsbilaga • Harm Reduction International. (2014). The Global State of harm reduction 2014. London: Harm Reduction International • Public Health Agency of Sweden (2014) 2014 National Report to the EMCDDA: Sweden, new developments and trends (2013 data) • European Centre for Disease Prevention and Control (2013) HIV/AIDS surveillance in Europe. • Folkhälsomyndigheten (2016) The Drug Situation in Sweden – An Overview of the Reporting to the EMCDDA. Accessed on 30.09.2016 at: https://www.folkhalsomyndigheten.se/publicerat-material/publikationsarkiv/t/The-Drug-Situation-in-Sweden---An-Overview-of-the-Reporting-to-the-EMCDDA/

[470] Interview with Per Ole Träskman, Professor Emeritus at the Department of Law, Lunds Universitet. Interview with Ted Goldberg, Professory of Sociology, University of Gävle.

[471] Boekhout van Solinge, *Supra* note 1, p. 53.

APPENDIX B: NON-EU CASE STUDIES

Providing insight into international approaches to drug policy is an important criterion for this study. It can provide a broader understanding of the policy debate in this complex field, given the varied approaches to drug policy found outside the EU, as well as present examples of good practices that may be replicable at EU and/or Member State level.

Building on section 2 of this research paper, which outlines the debates and discussions within UN and other international fora, this section will detail the approaches to drug policy in three selected non-EU countries: Switzerland, the US and Uruguay. As the primary focus of these case studies is to identify positive and innovative practices in the area of drug policy, the countries were chosen accordingly. More detailed rationales for these non-EU countries are presented below:

Table 60: Rationale for selected non-EU case study countries

Switzerland (CH)
Exhibit a strong public health based approach to drug policy, with extremely interesting contextual drivers, including the development of open drug scenes and the role played by the general population.

United States of America (US)
Complex interactions exist between federal and state approaches to drug policy, which is epitomised by the development of cannabis regulation in several US states, most notably Colorado and Washington.

Uruguay (UY)
The recent legalisation of cannabis in Uruguay drives its inclusion. The drivers for that decision and the challenges being faced in terms of implementation make this an interesting country to examine.

The approaches within these three countries will be detailed below, alongside an exploration of a particular policy of interest (e.g. HAT in CH). Furthermore, these case studies will present good practices examples and success factors for these practices.

APPENDIX B1: CASE STUDY – SWITZERLAND

This case study will first outline Switzerland's approach to drug policy, including the necessary historical context, before discussing the implementation of HAT treatment in the country and the success factors and good practice elements of Switzerland's approach.

In order to understand Switzerland's current approach to drug policy – first realised in 1991 – it is necessary to present context on the drivers of this policy approach.

1970s-1990s: Prohibition

Prior to 1991, Switzerland's drug policy was characterised by strict prohibition, primarily governed by the 1975 revision of the Swiss *Narcotics Act*.[472] This legal framework was complemented by a drug policy consisting of three pillars – law enforcement, treatment and prevention – with no place for the concept of harm reduction.[473] It is widely considered that this prohibitionist approach was not effective[474], as demonstrated by the following government-produced analyses.

Table 61: 'Drug Issues' in Switzerland – Summaries of government publications

Sub-commission for Drug Issues, Swiss Federal Narcotics Commission (1989)

In 1989, the Sub-commission published a report concluding that the 'most problematic aspects related to drug use had worsened'[475] since the sub-commission's inception in 1983.[476] This Report primarily noted that HIV infections among drug users had increased and law enforcement were concentrating resources on cases of little significance, while activities tackling large-scale drug trafficking were receiving insufficient support.[477]

Schild Commission, Federal Department of Home Affairs (1996)[478]

In 1996, the Schild Commission published a report on the revision of the Swiss *Narcotics Act.* This report concluded that HIV infections had increased, as had the presence of open drug scenes, characterised by 'needle parks'[479] such as 'Platzspitz' and 'Letten'[480]. It further highlighted the increasing poverty levels and declining health status of addicts.

This evidence is supported by statistical data and perceptions of experts. As can be seen below, it is estimated that the incidence of heroin use (per 1 000 population) increased by

[472] Federal Act on Narcotics and Psychotropic Substances of 3 October 1951 (Status as of 1 October 2013), *The Federal Assembly of the Swiss Confederation,* 812.121. Accessed on 20.10.16 at: https://www.admin.ch/opc/en/classified-compilation/19981989/index.html#fn1

[473] Koeppel, H (2011) The Four Pillar Policy in Switzerland – 20 years after, Journal of Global Drug Policy and Practice

[474] Interview with Diane Steber, Swiss Federal Office of Public Health

[475] Collin, C (2002) Switzerland's Drug Policy, Prepared for the Senate Special Committee on Illegal Drugs, Parliament of Canada

[476] Subcommission for Drug Issues of the Federal Narcotics Commission (1989) Aspects de la situation et de la politique en matière de drogue en Suisse: Rapport de la Sous-commission drogue de la Commission fédérale des stupéfiants [Aspects of the drug situation and policy in Switzerland: Report of the Subcommission for Drug Issues of the Federal Narcotics Commission], Swiss Federal Office of Public Health [unofficial translation]

[477] Collin, C (2002) Switzerland's Drug Policy, Prepared for the Senate Special Committee on Illegal Drugs, Parliament of Canada

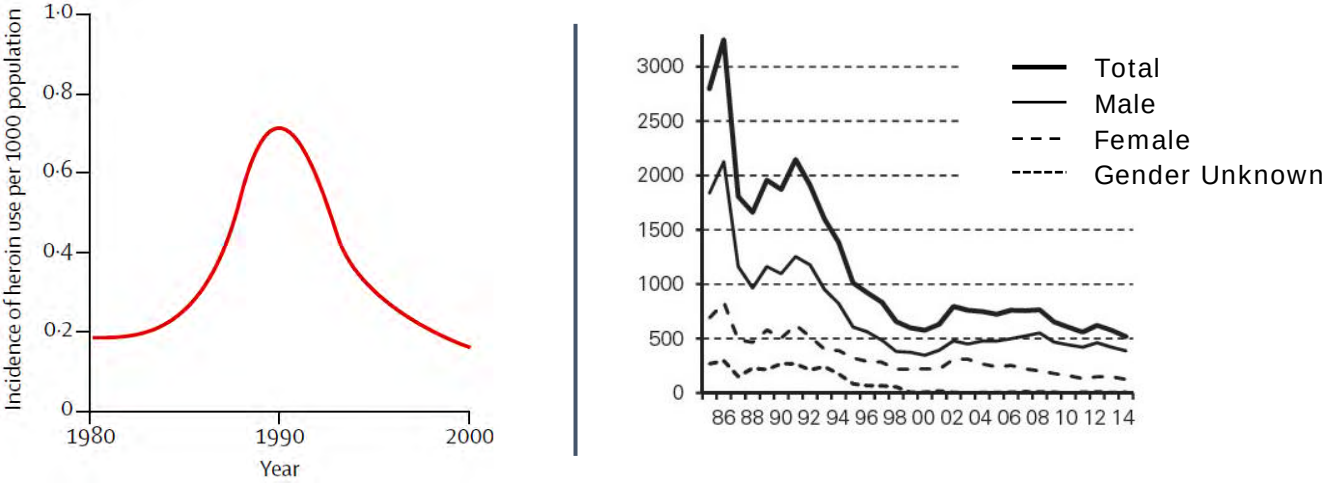
[478] Commission of experts for revision of the federal Narcotics Act of October 3, 1951, (1996) Rapport de la Commission d'experts pour la révision de la loi fédérale du 3 octobre 1951 sur les stupéfiants à l'attention de la chef du Département fédéral de l'intérieur [Report of the Commission of Experts for Revision of the federal Narcotics Act of october 3, 1951, submitted to the Head of the Federal Department of Home Affairs], Federal Office of Public Health [unofficial translation]

[479] Forsythe-Yorke, W (2015) Permit or Prohibit: An enquiry into the morality of illegal drugs and into their legalisation and decriminalisation.

[480] Koeppel, H (2011) The Four Pillar Policy in Switzerland – 20 years after, Journal of Global Drug Policy and Practice

more than three times in the 1980s[481] and the number of HIV notifications per year peaked in the late 1980s at over 3 000[482]. Although these HIV notifications are not necessarily related to heroin use, experts consulted for this research paper reported a big increase in heroin-related HIV cases in the late 1980s, alongside an increase in drug-related deaths and heroin-related crime.[483] Furthermore, it is reported that the law enforcement tactic of repression did not prevent drug use but simply displaced the open drug scenes to different locations.[484]

Figure 37: Left – Estimates of the incidence of heroin use in CH (1980-2000)[485]; Right – HIV notifications by year and gender in CH (1985-2014)[486]



1990s-2016: Change of approach

Based on the increasing drug-related challenges being experienced in Switzerland (presented above), it was determined that a new approach was required. Given the importance of direct democracy in Switzerland, this process was partly driven by the public. The general population saw the open drug scenes, including the poverty and health issues being experienced by drug addicts. This influenced the public debate as well as the outcomes of two national votes on the topic. Furthermore, it resulted in public support for new approaches, particularly what is now known as harm reduction.[487]

Switzerland's Annual Worry Barometer (1988-1995)[488]

The Swiss population consistently considered 'drug issues' as a major problem between 1988 and 1995. In each year, more than 60% of the population selected 'drug issues' as one of the top five major national problems in the annual survey of concerns.

[481] Nordt, C., Stohler, R. (2006). Incidence of heroin use in Zurich, Switzerland: a treatment case register analysis. *Lancet*, 367 (9525): 1830-1834.

[482] Federal Office of Public Health, HIV-Labormeldungen seit Beginn der Testungen nach Geschlecht und Testjar, 1985-2014.

[483] Interviews with Diane Steber, Swiss Federal Office of Public Health, and Christian Schneider, Swiss Federal Office of Police.

[484] Interview with Diane Steber, Swiss Federal Office of Public Health

[485] Nordt, C., Stohler, R. (2006). Incidence of heroin use in Zurich, Switzerland: a treatment case register analysis. *Lancet*, 367 (9525): 1830-1834.

[486] Federal Office of Public Health, HIV-Labormeldungen seit Beginn der Testungen nach Geschlecht und Testjar, 1985-2014.

[487] Interview with Diane Steber Buechli, Swiss Federal Office of Public Health

[488] Schumacher, J (2016) The Swiss four pillar drug policy: Prevention, therapy, harm reduction and law enforcement, Presentation accessed on 21.10.16 at: http://www.just.ee/sites/www.just.ee/files/jann_schumacher.pdf

As a result, public and private social services began offering support to drug addicts through 'street workers'.[489] These 'street workers' initiated Switzerland's first harm reduction measures, distributing clean syringes and needles, setting up emergency shelters and providing advice to drug addicts.[490]

Although public and private services were being dedicated to supporting drug addicts, the Federal Council initially decided against revising the *Narcotics Act*, following extensive and controversial political debates.[491] In the absence of legislative changes, the harm reduction approach still received significant political backing. In 1991 the Swiss Government approved a new national drugs programme – the Package of Measures regarding Illicit Drugs or 'MaPaDro'. This programme introduced harm reduction into the country's drug policy and led to the Swiss Federal Office of Public Health supporting over 300 projects between 1991 and 1993.[492]

This approach was further advocated at the political level through the 1990s. Although the political debates were reported to be 'passionate', a consensus for this 'pro-progressive'[493] approach was achieved in 1994 through the reconciliation of the Christian Democratic Party (PDC), the Free Democratic Party (PRD) and the Social Democrats (PS).[494] Furthermore, two initiatives – 'Youth Without Drugs' and 'Droleg' – which called for completely contrary changes to drug policy were rejected by more than 70% of the Swiss electorate in two referendums (1997 and 1998) – this was interpreted as an indirect statement of public approval for the four pillar approach.[495]

The four pillar approach to drug policy has continued to the present day, with continuous improvement implemented through the recommendations of audits conducted in 1989, 1996 and 1999[496].

Furthermore, the four pillar approach is now cemented in the Swiss legal framework. In fact, the Swiss *Narcotics Act* has been revised twenty times since the prohibitionist legal framework, established in 1975.[497] The key revision, however, is the 2008 amendment which provided a statutory basis for the four pillar approach and the inclusion of 'harm reduction and survival support' (Art. 1a)[498].

The current version of the Swiss drug policy, as summarised below, is MaPaDro III and its 2012-2016 action plan.

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[489] Swiss Federal Office of Public Health (2000) Swiss Drugs Policy

[490] *Ibid, p.7-8*

[491] Swiss Federal Office of Public Health (2000) Swiss Drugs Policy

[492] *Ibid, p.9*

[493] Cattaneo M, Dubois-Arber F, Leuthold A, Paccaud F. (1993) Evaluation des mesures de la Confédération destinées à réduire les problèmes liés à la toxicomanie: phase I. Bilan initial 1991-1992. Lausanne: Institut universitaire de médecine sociale et préventive; 1993 (Cah Rech Doc IUMSP, no 81). *[unofficial translation]*

[494] Cattaneo M, Dubois-Arber F, Leuthold A, Paccaud F. (1993) Evaluation des mesures de la Confédération destinées à réduire les problèmes liés à la toxicomanie: phase I. Bilan initial 1991-1992. Lausanne: Institut universitaire de médecine sociale et préventive; 1993 (Cah Rech Doc IUMSP, no 81). *[unofficial translation]*

[495] Khan, R et al. (2014) Understanding Swiss drug policy change and the introduction of heroin maintenance treatment. European Addiction Research, 20(4):200-207. DOI: 10.1159/000357234

[496] Forsythe-Yorke, W (2015) Permit or Prohibit: An enquiry into the morality of illegal drugs and into their legalisation and decriminalisation.

[497] Federal Act on Narcotics and Psychotropic Substances of 3 October 1951 (Status as of 1 October 2013), *The Federal Assembly of the Swiss Confederation,* 812.121. Accessed on 20.10.16 at: https://www.admin.ch/opc/en/classified-compilation/19981989/index.html#fn1

[498] *Ibid, Art. 1a*

Swiss National Drug Policy[499]

Switzerland's drug policy has three overarching aims: **i) reduce drug consumption; ii) reduce the negative consequences for drug users; and iii) reduce the negative consequences for society.**

As referred to above, achieving these aims is attempted through the combination of four 'pillars': **i) prevention; ii) therapy; iii) harm reduction; and iv) law enforcement.**

Prevention activities aim to stop people from starting to use drugs as well as developing dependencies on drugs. Public sector prevention activities are targeted at children and young people and the environments in which they interact through conditional prevention (i.e. targeting the structures and general conditions in which these individuals live as well as directly impacting behaviours). Prevention activities generally take place in 'school and commune' through the provision of factual information.

Therapy is targeted at those individuals that already have a drug dependency and aims to help them reduce their drug use and overcome their dependency, as well as supporting their social integration and improving their physical and psychological health. The Swiss target is to diversify and personalise treatment programmes based on the person's individual capacities and scientific evidence. An initially controversial element of Switzerland's catalogue of treatment options is the use of heroin-assisted treatment (HAT). However, it is reported that the use and benefits of HAT are now accepted by all Swiss stakeholders.

Harm reduction interventions aim to reduce the negative consequences of drug consumption directly on the user as well as indirectly on society by reducing the individual and societal risks related to consumption. As detailed above, harm reduction interventions are the most recent addition to Switzerland's drug policy, and include initially controversial interventions such as drug consumption rooms and needle and syringe exchange programmes.

Law enforcement aims to lower the negative impact of drug use on wider society. At federal level, law enforcement efforts (through the Federal Office of Police, fedpol) are focused on the political interactions around drug policy and ensuring effective cooperation between stakeholders – primarily supporting collarboation with representatives of the harm reduction pillar.[500] Additionally, fedpol investigates organised crime and the federal government exercises a coordinating function in the area of prosecution when cases have inter-cantonal or international dimensions.

For all of the four pillars, the **onus is the local government** (i.e. cantons, cities) to develop locally relevant interventions that support the Federally-derived aims.

Good practices

Stakeholders embedded in the Swiss approach to drug policy believe there are a number of good practice elements being employed, as described below:

Importance of context: The Swiss approach developed in response to a specific set of circumstances, including rising HIV/Hepatitis-C infections, one of the highest overdose rates in Europe and the emergence of open drug scenes. This elicited the development of a selection of support options, with the emergence of 'street workers', the pressure of the population and the implementation of HAT. Therefore, Switzerland's approach to drug policy

[499] Federal Office of Public Health (FOPH) (2006) Switzerland's National Drugs Policy: The federal government's third package of measures to reduce drug-related problems (MaPaDro III) 2006-2011

[500] Interview with Christian Schneider, Swiss Federal Office of Police (Fedpol)

had to account for this specific context. Experts support this view, stating the importance of ensuring that local, regional and national contexts are taken into account when drafting drug policy and implementing interventions.[501] Furthermore, many trends related to drug use shift, requiring adaption – for example, an important current challenge is the variability of MDMA content in recreationally used ecstasy pills, which puts consumers at risk of overdoses. Cooperation is required with different stakeholders in order to identify, better understand and tackle such challenges.

Cooperation and coordination: Drug policy requires the involvement of a range of different stakeholders, ranging from health and social care to law enforcement and the justice system. These stakeholder groups have, in the past, had difficult relationships given their differing objectives – law enforcement strive for public order and supporting society as a whole whereas health and social care authorities aim to support the individual. It has been reported, for example, that in the early days of needle and syringe exchange programmes, police would confiscate the clean needles and syringes. With this in mind, Switzerland has developed a range of cooperation and coordination mechanisms, which have improved relations between these authorities and initiated cooperation with regard to solution development and information exchange.[502]

Evidence-based policy: Switzerland emphasises the use of evidence-based practices whenever possible. In the case of HAT, for example, although the evidence-base was not robust before HAT was established, the Swiss authorities have initiated and supported significant research which has determined the viability of HAT and evidenced its benefits to drug users who had failed to respond to other treatment types.[503,504]

[501] Interviews with Diane Steber Buechli, Swiss Federal Office of Public Health, and Christian Schneider, Swiss Federal Office of Police.

[502] Interview with Christian Schneider, Swiss Federal Office of Police

[503] Swiss Federal Office of Public Health (2000) Swiss Drugs Policy

[504] Khan, R et al. (2014) Understanding Swiss drug policy change and the introduction of heroin maintenance treatment. European Addiction Research, 20(4):200-207. DOI: 10.1159/000357234

APPENDIX B2: CASE STUDY – UNITED STATES OF AMERICA

This case study will first outline the U.S. approach to drug policy at the federal level, including the necessary historical context, with specific focus on the advances in cannabis regulation at state level before discussing the success factors and good practice elements of the U.S. approach.

Federal approach to drug policy

Traditionally, the U.S. has implemented a prohibitionist approach to drug policy at the federal level. The roots of this approach can be found in the rising drug use at the end of the 19th century, which contributed to an increase in public concern.[505] At this time the federal government was not involved in regulating or restricting the medical or recreational use of drugs such as cocaine and opium. Scholars identified this lack of intervention as a primary reason for the unregulated market.[506]

As a result, federal control of drugs began in the early 20th century, initially through the Harrison Narcotics Act 1914 (see Box 14) and later through the Marihuana Tax Act 1937 – in fact, the growth and use of Marijuana was legal, both federally and at state level, until 1937. In the 1930s, due primarily to the Great Depression, the U.S. drug enforcement agency of the time – the Federal Bureau of Narcotics (FBN) – had limited human resources. In lieu of feet on the ground, the FBN increased its use of fear-based prevention campaigns.[507]

Box 14: U.S. Harrison Narcotics Act 1914 – first drug regulation.

The **Harrison Narcotics Act** regulated the market for cocaine and opium, such that medical prescription and use was permitted under the law. However, the law was subject to interpretation and the Treasury viewed 'maintenance prescriptions' to habitual users as beyond the medical scope.[508] Thus, many physicians and users were arrested, clinics were closed and most physicians halted the prescription of these drugs.[509,510] This, to a certain extent, negated the Act and left users purchasing from the black market.[511]

Although the U.S. law enforcement response to illicit drugs was developed through the 1950s – including the 1951 Boggs Act and the 1956 Narcotic Control Act – there was also a significant increase in the opposition to strict law enforcement approaches and the support for harm reduction-focused interventions. The American Bar Association, for example, was outspoken in its opposition to the extensive punishments for drug offences; federal support for a health-focused approach increased;[512] and methadone treatment for heroin addicts became increasingly common and accepted[513]. This period culminated in a 1963 report published by the President John F. Kennedy's Advisory Commission on Narcotic and Drug Abuse which made four key recommendations: i) reduced punishment for drug offenders,

[505] Courtwright, D.T. (2001). Dark Paradise: A History of Opiate Addiction in America (Harvard University Press); Musto, D.F. (2013). 'The American Experience with Stimulants and Opiates,' in Drugs, Crime, & Justice, ed. Larry Gaines and Janine Kremling, 3rd ed. (Waveland Press, Inc.).

[506] Sacco, L.N. (2014) Drug Enforcement in the United States: History, Policy and Trends, Congressional Research Service.

[507] Musto, D.F. (1999). The American Disease: Origins of Narcotic Control, 3rd ed. (New York: Oxford University Press), pp. 183-200.

[508] *Ibid, pp. 183-200.*

[509] *Ibid, pp. 183-200.*

[510] Levinthal, C.F. (2012). Drugs, Society and Criminal Justice, 3rd ed. (Boston: Prentice Hall), p. 56.

[511] *Ibid, p.56.*

[512] Musto, D.F. (1999). The American Disease: Origins of Narcotic Control, 3rd ed. (New York: Oxford University Press), pp. 183-200.

[513] Sacco, L.N. (2014) Drug Enforcement in the United States: History, Policy and Trends, Congressional Research Service.

including the possibility of parole and probation for some offenders; ii) increased funds for narcotic research; iii) stop the FBN's operations; and iv) provide the public with accurate knowledge through educational material.[514]

However, emphasis on the law enforcement response to drug abuse also stayed strong through this time period.[515] For example, 1968 saw the responsibility for drug abuse control transferred from the U.S. Treasury Department to the Department of Justice[516] and 1969 saw President Nixon place the reduction of drug use as one of his main priorities – the beginning of his path to declaring a war on drugs[517].

War on Drugs

As a result of rising drug misuse[518], the Controlled Substances Act (CSA) was established in 1970 as Title II of the Comprehensive Drug Abuse Prevention and Control Act. The CSA replaced all, previously fragmented, drug laws with a single statute and ensured that the control of illicit drugs was under federal jurisdiction. This legal basis was, in 1971, complemented by President Nixon's declaration of a 'war on drugs'[519] which initiated a strengthened role for law enforcement in the country's prohibitionist drugs policy and enhanced foreign policy efforts, such as those enacted in Turkey and South America.[520]

One key development in this regard was the creation of the Drug Enforcement Administration (DEA) in 1973.[521] The commitment to the war on drugs over the years can be characterised by resource data on the DEA (Box 15).

Box 15: U.S. Drug Enforcement Agency – Resources 1973-2016.

Development of DEA resources (1973-2016)[522,523]

1973: In its first year, the DEA employed 1,470 special agents with an annual budget to USD 74.9 million.

1975: Within two years, this had risen to 2,135 special agents and an almost doubled annual budget of USD 140.9 million (1975).

2016: Fast-forward to the present day and the DEA anticipates 10,968 employees with a requested budget of USD 3,008 million. Even within the last 5 years, the DEA's budget has increased by around USD 200 million (budget for 2011 was USD 2,814).

[514] President's Advisory Commission on Narcotics and Drug Abuse (1963). Interim Report of President's Advisory Commission on Narcotics and Drug Abuse, 3 April 1963.

[515] Sacco, L.N. (2014) Drug Enforcement in the United States: History, Policy and Trends, Congressional Research Service.

[516] Musto, D.F. (1999). The American Disease: Origins of Narcotic Control, 3rd ed. (New York: Oxford University Press), pp. 183-200.

[517] Boyum, D. and Reuter, P. (2005). An Analytic Assessment of U.S. Drug Policy (Washington, DC: The AEI Press), p. 6;

[518] Levinthal, C.F. (2012). Drugs, Society and Criminal Justice, 3rd ed. (Boston: Prentice Hall), p. 56.

[519] Sacco, L.N. (2014) Drug Enforcement in the United States: History, Policy and Trends, Congressional Research Service.

[520] Musto, D.F. (1999). The American Disease: Origins of Narcotic Control, 3rd ed. (New York: Oxford University Press), pp. 183-200.

[521] Executive Order 11727, 'Drug law enforcement,' July 6, 1973.

[522] Sacco, L.N. (2014) Drug Enforcement in the United States: History, Policy and Trends, Congressional Research Service.

[523] U.S. Department of Justice, Drug Enforcement Agency (2015). Drug Enforcement Agency: FY 2016 Performance Budget, Congressional Submission.

As a result, the 1980s saw rising enforcement, with the number of federal convictions for drug offences more than doubling between 1980 (5,244 offences) and 1986 (12,285).[524] This law enforcement focused approach was further cemented with amendments to the legal framework, including the introduction of the Comprehensive Crime Control Act 1984 and the Anti-Drug Abuse Acts of 1986 and 1988. These developments have been complemented in the 1990s by a range of measures primarily targeting synthetic drugs.[525]

Current approach

The federal government's current position is still strictly prohibitionist, but, as will be expanded on below, its commitment to harm reduction measures has increased significantly in recent years and it has offered limited challenge to the cannabis regulation being established at state level.[526]

Box 16: U.S. federal approach to harm reduction.

Harm reduction in the U.S.

Based on evidence collated by the National Institute on Drug Abuse (NIDA), a government body aiming to 'advance science on the causes and consequences of drug use and addiction'[527], the federal government has recognised that drug addiction treatment is effective.[528]

In this respect, it supports the implementation of programmes for early intervention; the integration of treatment in healthcare settings; speciality treatment; and medication assisted treatment.[529]

The Substance Abuse and Mental Health Services Administration (SAMHSA) – an agency within the U.S. Department of Health and Human Services – keeps track of a significant number of these programmes and campaigns related to substance abuse treatment. Furthermore, SAMHSA's National Registry of Evidence-Based Practices (NREPP) promotes the adoption of scientifically verified health interventions through the provision of evidence on specific programmes to individuals as well as policy-makers.

However, it is reported that law enforcement is to a certain extent still opposed to the use of harm reduction interventions, given that it permits the use of illegal substances.[530]

Furthermore, the war on drugs initiated in the 1970s has received significant criticism in recent years. A number of high-profile global NGOs, including the Global Commission on Drug Policy and the Drug Policy Alliance, as well as foreign politicians, such as Uruguay's José 'Pepe' Mujica and Colombia's Juan Manuel Santos, have stated that the war on drugs has failed. The Drug Policy Alliance, for instance, have famously presented statistics on the war on drugs which claim that the U.S. spends more than USD 51 billion per year on the war.[531]

[524] U.S. Department of Justice, Bureau of Justice Statistics, Drug Law Violators, 1980-86, June 1988, p. 3, http://www.bjs.gov/content/pub/pdf/dlv80-86.pdf.

[525] Sacco, L.N. (2014) Drug Enforcement in the United States: History, Policy and Trends, Congressional Research Service.

[526] Interviews with academic experts in the U.S. approach to drug policy.

[527] National Institute on Drug Abuse (2016). About NIDA. Accessed on 03.11.16 at: https://www.drugabuse.gov/about-nida.

[528] Office of National Drug Control Policy (2016). Treatment and Recovery: Understanding Treatment. Accessed on 03.11.16 at: https://www.whitehouse.gov/ondcp/treatment-and-recovery.

[529] *Ibid*

[530] Interviews with academic experts in the U.S. approach to drug policy.

[531] Drug Policy Alliance (2016). Drug War Statistics. Accessed on 03.11.16 at: http://www.drugpolicy.org/drug-war-statistics.

Although the federal government retains its prohibitionist stance, recent years have seen significant support for pro-cannabis movements across the U.S. and subsequently the regulation of cannabis by certain states. These state level initiatives have met minimal federal opposition.[532] In fact, five states voted on the introduction of cannabis regulation in November 2016 (Arizona, California, Maine, Massachusetts and Nevada). Three states (California, Nevada and Massachusetts) approved their respective cannabis regulation initiatives, bringing the number of states to seven; Colorado, Washington, Alaska and Oregon were already regulating cannabis prior to the November 2016 ballots[533]. In addition, the ballot in Maine approved the regulation of cannabis but, due to the small margin of victory (50.17% to 49.83%), its current status is too close to call with a recount pending. Arizona became the first and only state to reject the proposition to regulate cannabis.A recent study reported that cannabis use has increased in the U.S. over the period 2002-2014. Over the same time period, the perceptions of the risks / harms of using cannabis 1-2 times a week has decreased. Thus, as mentioned above, pro-cannabis support has grown and four states have regulated cannabis.[534] The key characteristics of the approaches in two states, Colorado

Cannabis regulation

and Washington, are detailed in Box 17.

Box 17: U.S. state cannabis regulations – Key characteristics.

Colorado and Washington State cannabis regulation: Key characteristics[535,536]

Similarities: both regulations place the minimum purchasing age at 21, in line with alcohol regulation; establish a ban on use in public places; levy excise tax upon sales of cannabis; and require businesses involved in any elements related to the supply of cannabis to hold a valid license.

Differences: Washington State bans home cultivation whereas Colorado permits up to six plants per household. Furthermore, where the medical marijuana industry had already equipped Colorado with a well-established medical distribution system, Washington had no existing production / supply channels.

In addition, both states have implemented a means by which the new cannabis regulation will be monitored an evaluated. In Colorado, this will be conducted by a public authority (the Department of Public Safety pursuant to Senate Bill 13-283) whereas Washington State's evaluations will be conducted by an independent research body.[537]

As both regulations are in the early stages of implementation it is not yet possible to assess the full results and impacts. However, experts consulted for this study reported that initial youth surveys in Washington State had not resulted in an significant increase in cannabis use[538], while Colorado reported post-commercialisation increases in 18-25 year olds (21% in 2006 to 31% in 2014) and 26 years and older (5% in 2006 to 12% in 2014).[539] However, it

[532] Interviews with academic experts in the U.S. approach to drug policy.

[533] Drug Policy Alliance (2016). Marijuana Legalization and Regulation. Accessed on 03.11.16 at: http://www.drugpolicy.org/marijuana-legalization-and-regulation.

[534] Correct as of 03.11.16. As mentioned, 5 states will vote on regulating cannabis on 09.11.16.

[535] Canadian Centre on Substance Abuse (2015). Cannabis Regulation: Lessons Learned in Colorado and Washington State. ISBN 978-1-77178-293-7.

[536] Initiative Measure No. 502 filed in Washington State on July 8, 2011; Amendment 64 to the Colorado constitution on the Use and Regulation of Marijuana.

[537] Interviews with academic experts in the U.S. approach to drug policy.

[538] Interviews with academic experts in the U.S. approach to drug policy.

[539] Colorado Department of Public Safety (2016). Marijuana Legalisation in Colorado: Early Findings – A report Pursuant to Senate Bill 13-283.

is not possible to link these potential impacts with the regulatory changes (as evidenced by the Box 18).

Box 18: Impact of cannabis regulation on use: US-wide perspective[540]

The impact of cannabis regulation on cannabis use

It has been reported that half month prevalence figures for cannabis use in Colorado and Washington increased after the regulation of cannabis in these states – by 43% and 25%, respectively.

However, what these data do not demonstrate is the US-wide trend in cannabis use – in the same period, it is reported that 12 other US states (which were not impacted by the introduction of cannabis regulation) experienced increases in half month prevalence of 25% or higher.

In this light, it is clear that the prevalence increases in Colorado and Washington cannot be associated directly with the introduction of cannabis regulation.

Furthermore, significant financial benefits have been reaped in both states. Colorado, for example, reported revenue, from taxation, licensing and fees, of USD 76,152,468 in 2014 and USD 135,100,465 in 2015. As written into the legislative amendment, USD 35,060,590 of this revenue was dedicated to school capital construction assistance (2015).[541] Similarly, Washington State has documented significant tax revenue of USD 350,174,043 since the legislation was enacted.[542]

Good practices

Stakeholders embedded in the U.S. approach to drug policy believe there are a number of good practice elements being employed, particularly with regard to the implementation of novel cannabis regulation in Colorado and Washington State, as described below:

Evidence-based policy. Public authorities in both Colorado and Washington are dedicated to ensuring the changes in cannabis regulation are monitored and evaluated. These evaluations will be used as a basis for future cannabis policy developments. In the case of Washington State, these analyses will be carried out by an independent research body.[543] Linked to this, U.S. based researchers are particularly innovative in tackling the difficulties around measuring the impacts of drug policy (see Appendix D for more information on these difficulties). For example, the Colorado Behavioural Risk Factor Surveillance System (BRFSS), a state-wide telephone survey, has been expanded to include questions around frequency of cannabis use.[544]

Effective consumer education. Colorado and Washington State have both aimed to ensure that their populations are accurately educated, in a non-politicised way, about cannabis use prior to and throughout the implementation of the regulations. More specifically, the policy approach should be detailed, such that the public and other stakeholders are fully informed

[540] Interviews with academic experts in the U.S. approach to drug policy.

[541] Colorado Department of Public Safety (2016). Marijuana Legalisation in Colorado: Early Findings – A report Pursuant to Senate Bill 13-283.

[542] http://www.502data.com/

[543] Interviews with academic experts in the U.S. approach to drug policy.

[544] Interviews with academic experts in the U.S. approach to drug policy.

on the measures to be implemented as well as the risks and harms associated with drug use.[545,546]

Strong collaboration. Stakeholders in both Washington State and Colorado have highlighted the value of and need for collaboration across a broad range of stakeholders, supported and led by a central body. In Colorado, for instance, the Office of Marijuana Coordination was established with this exact mandate, facilitating a valuable cross-sectoral working approach in order to benefit from a wide diversity of perspectives. Furthermore, Washington State noted that as a gap in their policy development.[547]

[545] Interviews with academic experts in the U.S. approach to drug policy.

[546] Canadian Centre on Substance Abuse (2015). Cannabis Regulation: Lessons Learned in Colorado and Washington State. ISBN 978-1-77178-293-7.

[547] Canadian Centre on Substance Abuse (2015). Cannabis Regulation: Lessons Learned in Colorado and Washington State. ISBN 978-1-77178-293-7.

APPENDIX B3: CASE STUDY – URUGUAY

This case study will first outline Uruguay's approach to drug policy, including the necessary historical context, with specific focus on the regulation of cannabis in the country before discussing the success factors and good practice elements of Uruguay's approach.

Historically liberal

Although small in size compared to its neighbours, Uruguay, with a population of just under 3.5 million, has a history of being a vanguard of social reform in Latin America[548]. For instance, it was the first Latin American country in which women exercised the right to vote (in 1927)[549] and, more recently (2008), Uruguay became the first South American country to legalise same-sex civil unions[550].

This trend also extends to Uruguay's approach to drug policy, which has historically been relatively liberal even under the 1973-1985 military regime characterised as 'one of the most repressive authoritarian regimes ever seen in the hemisphere'[551]. In fact, 1974 saw the passing of Decree Law 14294, which removed penal sanctions for individuals that possess less than 'a minimum quantity [of illicit substances], intended solely for personal use'[552].

However, strict sentences (3-15 years) were still attributed to the cultivation and supply of illicit drugs giving rise to a strong pro-cannabis movement. Since Uruguay's return to democracy in 1985, these pro-cannabis activists have been able to openly state their case for legalisation with support increasing over the years. Furthermore, Uruguay's implementation of harm reduction approaches has increased. In the 1999 amendment of Uruguay's drug policy[553], for example, low-risk (production and supply) offenders were permitted to serve their sentences in rehabilitation centres. In addition, this amendment reduced the mandatory minimum sentences to from 3 years to 20 months.[554] In the mid-2000s, further harm reduction measures were introduced – including the provision of clean needles to injecting drug users – with explicit references in national policy documents.[555]

Meanwhile, cannabis use is reported to have increased significantly – between 1998 and 2006, for example, the proportion of Uruguayans that reported having tried cannabis increased from 3%[556] to 12.2%[557]. It is reported that, due to Uruguay's legal contradiction (i.e. essentially legal cannabis consumption, heavy penalties for cannabis cultivation), Uruguayans increasingly resorted to purchasing low-quality cannabis from Paraguay.[558]

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[548] Walsh, J. and Ramsey, G. (2015) Uruguay's Drug Policy: Major Innovations, Major Challenges. Policy brief for 'Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016'.

[549] Miller, F (1991) Latin American Women and the Search for Social Justice, University Press of New England / Hanover & London.

[550] Ley Nº 18.246, Union Concubinaria, Regulacion, Pub. D.O. 10 ene/008-Nº 27402.

[551] Gillespie, C.G. (1985) Uruguay's Return to Democracy, *Bull. Latin Am. Res.*, Vol. 4, No. 2, pp.99-107, 1985.

[552] Decreto Ley N° 14.294, Pub. Registro Nacional de Leyes y Decretos, No. 19396 (1974) (Uruguay), http://www.infodrogas.gub.uy/html/marco_legal/documentos/02-DecretoLey14294.pdf.

[553] Ley N° 17.016, Pub. Registro Nacional de Leyes y Decretos, No. 25142 (1998) (Uruguay), http://www.parlamento.gub.uy/leyes/AccesoTextoLey.asp?Ley=17016&Anchor.

[554] *Ibid.*

[555] Junta Nacional de Drogas, 'Se pliegan así a campaña de lucha nacional,' news release, June 1, 2004, http://www.infodrogas.gub.uy/html/prensa/unoticias/20040601-prevencion_programa_farmacias-u-noticias.htm.

[556] Guillermo Garat, Marihuana y otras yerbas: prohibición, regulación y uso de drogas en Uruguay (Montevideo, Uruguay: Random House Mondadori, Editorial Sudamericana Uruguaya, 2012), 175.

[557] Junta Nacional de Drogas, Informe Anual: Situación y tendencias del consumo de drogas en Uruguay (Montevideo, Uruguay: Dirección Nacional de Impresiones y Publicaciones Oficiales, 2007), http://infodrogas.gub.uy/html/informes-documentos/docs/anuario_final__2007.pdf.

[558] Walsh, J. and Ramsey, G. (2015) Uruguay's Drug Policy: Major Innovations, Major Challenges. Policy brief for 'Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016'.

Moreover, the majority of these transactions were made with criminal actors who pushed the sale of more dangerous drugs, including pasta base and cocaine paste.[559]

Initiating change

Upselling of illicit drugs, in particular past base, was one of the key drivers identified by President José 'Pepe' Mujica for his administration's 2012 'Strategy for Life and Coexistence'[560]. The headline element of the strategy was that Uruguay would be the first country to legalise and regulate all levels of the cannabis market, including cultivation, distribution and consumption.[561] Additionally, the strategy expanded treatment options for problematic drug users and increased the state's repression tactics against corruption and narcotics trafficking.[562]

Following the 2012 strategy document, which had already received criticisms for its lack of specifics, Mujica's administration proposed a bill with one article dealing with the proposal's implementation; it called for the government to undertake all production and commercialisation of cannabis under the bill.[563] This proposal received significant criticism[564] and was shortly followed by a public poll that found 66% Uruguayans were in opposition to the proposal.[565] Subsequently, the initiative underwent a period of iterative development. A selection of amendments were made – most notably the introduction of home cultivation, the creation of a federal regulatory organisation and an upper limit for monthly retail purchases. Furthermore, the 'Responsible Regulation' coalition was formed by Uruguayan human rights and drug policy NGOs; this coalition focused on improving the government's initial arguments. The amended arguments moved the focus from a security focus to a strong public health focus, stating that the cannabis regulation law would:[566]

1. Address insecurity and reduce users' exposure to more harmful drugs;
2. Fix hypocrisy in the existing legal framework to enable users to grow the drug;
3. Improve public health by increasing access to medical cannabis.

Despite low public support for the initiative (seven CIFRA polls from 2012-2014 placed opposition to the bill between 61-66% of Uruguayans[567]) the bill passed Uruguay's lower house in July 2013; it was signed into law on December 24, 2013; and the regulations accompanying the law were published in May, 2014.[568]

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[559] Walsh, J. and Ramsey, G. (2015) Uruguay's Drug Policy: Major Innovations, Major Challenges. Policy brief for 'Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016'.

[560] 'Vea el documento completo: 'Estrategia por la vida y la convivencia',' El País, June 21, 2012, http://www3.elpais.com.uy/120620/ultmo-647381/ultimomomento/Vea-el-documento-completo-Estrategia-por-la-vida-y-la-convivencia-/.

[561] *Ibid.*

[562] *Ibid.*

[563] Presidencia de la República Oriental del Uruguay, 'Proyecto de Ley,' CM/534, August 8, 2012. http://archivo.presidencia.gub.uy/sci/proyectos/2012/08/cons_min_534.pdf.

[564] Walsh, J. and Ramsey, G. (2015) Uruguay's Drug Policy: Major Innovations, Major Challenges. Policy brief for 'Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016'.

[565] 'Los Uruguayos y la Marihuana,' CIFRA Consultoría Privada.

[566] Walsh, J. and Ramsey, G. (2015) Uruguay's Drug Policy: Major Innovations, Major Challenges. Policy brief for 'Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016'.

[567] 'Los Uruguayos y la Regulacion de la Produccion, la Venta y el Consumo de Marihuana,' CIFRA Consultoría Privada, http://www.cifra.com.uy/novedades.php?idNoticia=233; and 'Dos de cada tres uruguayos en contra de la regulación de la marihuana,' Equipos MORI, November 23, 2013, http://www.equipos.com.uy/noticias_despliegue.php?i=135.

[568] Walsh, J. and Ramsey, G. (2015) Uruguay's Drug Policy: Major Innovations, Major Challenges. Policy brief for 'Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016'.

Regulating cannabis

The cannabis regulation bill presents three legal methods of accessing cannabis (see the Figure below). These three methods are open to all permanent residents, as well as Uruguayan citizens, over the age of 18.

Figure 38: Uruguayan cannabis regulation bill in practice.[569]

State produced & commercialised
Individuals can purchase cannabis produced by state-approved commercial growers in licensed pharmacies.

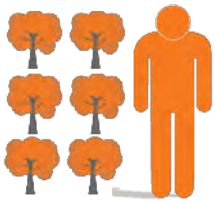
Monthly: up to 40 grams
Weekly: 10 grams

Users must be registered with the Institute for Regulation and Control of Cannabis (IRCCA).

Cannabis cooperatives
Individuals can join cooperatives comprising 15-45 members and collectively grow cannabis.

Up to 99 plants in the same space and a member may not receive more than 480 grams per year.

Cooperatives must be registered with the IRCCA, who receive any surplus cannabis.



Home cultivation
Individuals can grow cannabis at home.

Up to six female flowering cannabis plants per household for their own consumption; no more than 480 grams per year.

Plants must be registered with the IRCCA.

Key differentiators of Uruguay's cannabis regulation bill, particularly when compared with similar initiatives in the US states of Colorado and Washington, include the heavy state involvement in production and commercialisation; restricted commercial benefits driven by bans on advertising and cannabis tourism; minimal taxes in order to compete on price with the black market; explicit public health aims; the requirement for registration with the IRCCA in order to consume; the permittance of home cultivation; and restrictions on public use through a ban on smoking in public locations and a zero tolerance policy towards driving under the influence.[570]

Given that pharmacies are only now (late 2016) able to register as dispensers of cannabis[571], it is not possible to present a detailed assessment of the impact of the cannabis regulation bill. A preliminary assessment of the impact, however, has been conducted. This assessment found that the reform had not significantly increased cannabis prevalence rates but it has increased visibility and acceptance of cannabis.[572]

[569] Walsh, J. and Ramsey, G. (2015) Uruguay's Drug Policy: Major Innovations, Major Challenges. Policy brief for 'Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016'.

[570] *Ibid, p.9-10.*

[571] El Observador, Marihuana legal sin puntos de venta en ocho departmentos: Roballo dijo que eso impide hacer um 'cumplimento homogeneo' de la ley, Agosto 18 2016.

[572] von Hoffman, J (2015) Assessment of the first year of the legally regulated cannabis market in Uruguay, GDPO Situation Analysis: January 2015.

Good practices

Stakeholders embedded in the Uruguayan approach to drug policy believe there are a number of good practice elements being employed, as described below:

Evidence-based policy. Throughout the development of its cannabis regulation bill, as well as in its approach to drug policy more generally, Uruguay emphasised the use of evidence-based practices. For example, there was a strong commitment under the Mujica administration to invite and consult international drug policy experts, particularly with regard to the cannabis regulation bill.[573] Furthermore, it is reported that a strategy by which to evaluate the bill has been developed from the outset, with agreed sets of indicators selected for the monitoring of the cannabis bill's implementation.[574]

Cooperation across multiple stakeholder groups. Alongside the extensive expert and academic consultation, Uruguayan drug policy, with a particular focus on the cannabis regulation bill, is developed in collaboration with multiple government institutions, as well as significant civil society actors.[575]

Transparency and legitimacy. The Uruguayan authorities aims for complete transparency throughout the development of its drug policy, in particular the cannabis regulation bill. For instance, all relevant documentation and information is available across the websites of the relevant bodies (e.g. IRCCA, Junta Nacional de Drogas, Observatorio de drogas). In addition, all government discussions on the topic are covered by the media ensuring the Uruguayan population are well informed and familiar with the bill. Furthermore, the expert consultations and the evidence-base described above provide for the legitimacy of the bill.[576]

[573] Walsh, J. and Ramsey, G. (2015) Uruguay's Drug Policy: Major Innovations, Major Challenges. Policy brief for 'Improving Global Drug Policy: Comparative Perspectives and UNGASS 2016'.

[574] Interview with Augusto Vitale, President of the Board of Directors, IRCCA.

[575] Interview with Augusto Vitale, President of the Board of Directors, IRCCA.

[576] Interview with Augusto Vitale, President of the Board of Directors, IRCCA.

APPENDIX C: LIST OF CONTACTS

Table 62: List of contacts.

Country	Contacts
EU institutions	
EMCDDA	• Paul Griffiths (Scientific Director) • Maria Moreira (Principal Quality Officer, Scientific Committee)
European Commission	• Alina Radu DG HOME D3
Non-EU Countries	
Uruguay	• Lic. Augusto Vitale (Instituto de Regulación y Control del Cannabis)
Switzerland	• Diane Steber Buechli (Swiss Federal Office of Public Health) • Christian Schneider (Swiss Federal Office of Police)
USA	• Alison Holcombe (Director, ACLU Campaign for Smart Justice and lead drafter of Washington Initiative 502) • Annonyous
Member States	
Czech Republic	• Mgr. Voboril, National Drug Coordinator from Czech Republic • Pavel Bem, former mayor of Prague and member of the Global Commission on Drug policy
Germany	• Lorenz Böllinger (University of Bremen)
Spain	• Dr Francisco de Asís Babín Vich, REITOX Focal point • Mª. Sofía ARAGÓN SÁNCHEZ, REITOX Focal point
Netherlands	• Margriet van der Laar, Trimbos Instituut, REITOX Focal Point Netherlands. • Freek Polak, retired psychiatrist and doctor, Founding Director of the Stichting Drugsbeleid and member of the MDHG and VOC.
Poland	• Artur Malczewski, head of Polish focal point
Portugal	• Maria Moreira (Formerly of the Portuguese Ministry of Health, now at EMCDDA) • João Goulão, General-Director of SICAD (General Directorate on Addictive Behaviours and Dependencies
Sweden	• Per Ole Träskman (Professor Emeritus of Criminal Law, Lunds Universitet) • Ted Goldberg (Professor of Sociology, University of Gävle)

APPENDIX D: DATA LIMITATIONS

There are strong limitations associated with the data used for assessing and evaluating drug policies across the European Union. Despite the work of the EMCDDA, data on drugs are not always accurate and the availability of some indicators is limited or inexistent. The limitation of the current indicators used for assessing drugs-related health issues, drug consumption and drug markets are detailed in this section.

a. Indicators for drug-related health issues

A common way of measuring drug-related health issues is to consider the number of drug users with an infectious disease (i.e. HIV, HCV and HBC) and the number of overdose deaths. The sample size and methodology for collecting this type of data limits the reliability of health indicators.

- Infectious disease and sample size

Prevalence among drug users of infectious diseases tends to be estimated from a small sample size. The prevalence is usually inferred by testing a population of injecting drug users in contact with services. This approach excludes all users who are not in contact with services. Depending on the settings chosen for estimating the prevalence (e.g. users in drug treatment, in low threshold services, in prison), there would be a bias in the prevalence figure compared to the total population of injecting drug users. Also, some methodologies for assessing the HIV prevalence are based on registers of HIV notifications which report the route of infection. However, the route of infections is not always known, reported or broken down by type of injections. Therefore HIV prevalence estimated from HIV registers might be underestimated due to unknown and uncertain cases.[577]

- Methodology for estimating overdose deaths

The methodology for estimating overdose and drug-related deaths varies across countries. In some countries such as SE, an after-death drug test (testing for the presence of a wide range of substances) is systematically performed. Due to the comprehensive approach used for identifying drugs' presence after death, SE reports a higher number of deaths than in countries such as PT that do not perform a systematic and complete after-death drugs test.

b. Indicators for drug consumption

Drug use prevalence is the most common way of estimating drug consumption in a country. These data have to be interpreted carefully as their method of collection is not fully reliable and they do not reveal the full pattern of drug consumption in a country.

- Reliability of self-reported data

Drug use prevalence data are most of the time estimated from population surveys on drug use. Because prevalence is calculated from self-reported data, the number of drug users is likely to be underestimated (i.e. the users might lie about their consumption). The self-reporting bias would vary from one country to another depending on the country's culture and on how stigmatised drug users are. The more stigmatised drug use is perceived in a country, the less likely drug users would report their drug consumption in a survey. Moreover, according to the size and population of the sample surveyed, different datasets could potentially contradict themselves. It is well illustrated on an example retrieved by Hughes and Steven (2012); the authors compared two evaluations of the impact of decriminalisation

[577] Discussion of expert at the workshop and EMCDDA | European Drug Report 2015: Data and statistics: Methods and definitions for drug-related infectious diseases. Emcdda.europa.eu. Retrieved 17 October 2016, from http://www.emcdda.europa.eu/data/stats2015/methods-drid

in PT. Based on prevalence data, one evaluation concluded that decriminalisation was a success in reducing drug-use prevalence whilst the other evaluation (that used another prevalence dataset) concluded opposite results.

- Differentiation between problematic and non-problematic drug users

Beside the reliability issues, drug use prevalence data fail to disentangle problematic and non-problematic drug consumption. Disaggregating data by last year, last month and lifetime prevalence gives an indication of the frequency of consumption but not in the quantity consumed. In a paper discussing the effects of the drug decriminalisation in PT, Hughes and Steven (2012) explain that a distinction needs to be made between lifetime and last month prevalence[578]. The decriminalisation is likely to have increased the number of experimental users (who would not become regular users). So one could expect an increase in lifetime prevalence (because more experimental users) and potentially an increase in last month prevalence just after the introduction of the law. Over the longer term, however (and if the policy has been efficient at reducing problematic drug consumption), last month prevalence would be expected to decrease. Adding an information on quantity would enable to differentiate between experimental, recreational and frequent drug users.

c. Indictors of the size of the drug market and supply reduction

Common indicators used for estimating the size of the drug market are drug offences, seizures, price and purity of drugs.

- Absence of supply reduction indicators

These indicators enable to have an overview of the drug market but say little about the potential impact of a supply reduction policy. Drugs arrests are often used as a proxy for supply reduction. However, the number of arrests tells us where law enforcement resources are used but not if the overall supply of drugs decreased. It has been highlighted in the workshop that there is currently an absence of indicators for supply reduction in the 15 recommended indicators from the Action Plan on Drugs 2013-2016[579].

- Absence of drug market violence indicators.

Arresting drug-related offences can lead to a reduction in drug supply but drugs arrests are also likely to disrupt the market. By making drug supply more complicated to operate without being arrested, it could potentially create a more professionalised and more violent drug market. Alongside drug supply indicators, it would be crucial to have an indicator measuring the violence of a drug market.

d. Good indicators for assessing a drug market

A quick brainstorming was performed during the expert workshop on the ideal data that should be collected consistently across the different countries in order to have an accurate picture of the current drug situation in the EU. The table below summarises the current metrics used to assess the current drug scene of a country and how they could be improved and completed by extra data.

[578] Hughes, C. & Stevens, A. (2012). A resounding success or a disastrous failure: Re-examining the interpretation of evidence on the Portuguese decriminalisation of illicit drugs. Drug and Alcohol Review, 31(1), 101-113. http://dx.doi.org/10.1111/j.1465-3362.2011.00383.x .

[579] EU action plan on drugs. 2013-2016. (2013) (1st ed.). Retrieved from http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52013XG1130(01)&from=EN

Table 63: Current data used for assessing a drug market and ways of improvement

Variable	Current indicators	Missing indicators
Drug consumption	• Lifetime, last year, last month drug use prevalence	• **Quantity consumed per day/month** would give a better picture of experimental, occasional and frequent drug users.
Drug users satisfaction	• Currently no indicators	• **Users' perception of drug quality, criminality and attitude of law enforcement agency.** Current policy approach problematizes the drug use. However, problems for the drug user are around information, quality and safety and avoid criminal markets. Drug users, notably in countries where drug use is decriminalised should have a voice in presenting their needs. • **Quality of drugs consumed** should also be considered in order to satisfy/protect the user.
Drugs-related health issue	• Overdose deaths • HIV infection	• **Emergency hospital admission.** Drugs related health issues cannot just be summarised by overdose deaths. Acute drug poisoning not leading to death should be monitored and potentially recorded through hospital admission data. The EMCDDA has started stimulating collection of this type of data and encountered some difficulties. Users do not always know what they have taken. There is not enough forensic testing in hospital and national countries usually do not separate drug-related admission per type of drugs.
Drug Market	• Number of seizures • Quantity seized • Price, purity and potency	• **Violence of drug market.** No data available but indicators that will be useful. It is the social harm that needs to be fought • **Data on the cyber market.** High restriction on drug in a country could potentially lead to more activities performed online. It would be interesting to have a measurement of the cyber drug market.
Supply reduction	• There is no clear indicators measuring supply reduction. Number of drug law offences is often used as proxy.	• **Number of arrests of high level organised crime group** Have law enforcement agencies been efficient at reducing drug supply? There is a lack of evidence and that is why, indicators related to supply reduction need to be included in the EU Action Plan on Drugs.
Effect of drug use on performance	• Currently no indicators	• **Number of high school drop outs and unemployment compared between drug users and non-users.** Drugs use is often perceived as an adverse behaviour leading to negative consequences for the user's life

Variable	Current indicators	Missing indicators
		performances. It would be important to establish what these consequences are; and to estimate how negative they are in the short and long term. These consequences are likely to vary by the quantity used.
Criminal adverse consequences	• Currently no indicators	• **Drugs related homicide** Some work is currently done on estimating drug-related homicides. Complicated however to disentangle the reasons of homicide.

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