

## Reflections on the concept of coherency for a policy on psychoactive substances and beyond

Richard Muscat, Brigid Pike  
and members of the Coherent Policy Expert Group

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# **Reflections on the concept of coherency for a policy on psychoactive substances and beyond**

*Richard Muscat*

*Brigid Pike*

*and members of the Coherent Policy Expert Group*

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*Politique sur les substances psychoactives et autres – Réflexions sur le concept de cohérence*  
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Austria  
Belgium  
Ireland  
Israel  
The Netherlands  
Norway  
Portugal  
Switzerland

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## **The Pompidou Group**

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

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

In 2004, the Research Platform superseded the group of experts in epidemiology. There was also a change of function, from developing data collection and monitoring methodologies to assessing the impact of research on policy. This started with the holding in 2004 of the Strategic Conference on Linking Research, Policy and Practice – Lessons learned, challenges ahead – which identified as a major gap the lack of exchange of knowledge.

The Research Platform's prime role was to support better the use of research evidence in policy and practice, thus facilitating the development of evidence-based policy. Moreover, it also signalled the latest issues arising from drug research in the social and biomedical fields and promoted interaction between research disciplines such as these and psychological drug research. Reports on these subjects have been published and are listed in the appendix.

Following the mandate given by ministers at the ministerial conference in November 2010, for the 2011-14 Pompidou Group work programme, the Research Platform has now been superseded by expert groups on specific topics. Coherent policies in the area of psychoactive substances were selected

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1. See the appendix for a list of Pompidou Group publications.

as one such topic and hence the expert group was formed at the end of 2010 and met four times in 2011 to produce this, the third publication in the series.

The activities of the Coherent Policy Expert Group follow on from an initial request and funding from the Federal Office of Public Health in Switzerland to acquire information on the ways in which drug policy is formulated/applied by other countries. This information provided the basis for the first publication – *From a policy on illegal drugs to a policy on psychoactive substances* – a retrospective analysis of drug policy in the 17 member countries, taking into account the social and cultural context. These contributions were aided by an overall synopsis that reflected on the change from single policies on alcohol, tobacco and drugs to one which incorporates all substances.

The second publication was a further attempt to understand the scientific basis for the choice of a single policy for each substance or one that incorporates all substances; in addition it provided empirical information on how such a choice is currently put into practice. Seven countries – Germany, Ireland, the Netherlands, Norway, Portugal, Switzerland and the United Kingdom – provided the means to address this issue.

Thus, this third publication in this area attempts to make headway in the area of coherent policies for psychoactive substances. The opinions expressed in this publication are those of the authors and do not necessarily reflect those of the Council of Europe or of the Pompidou Group.

# 1. Policy coherence framework: context, systems, measurement

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As a follow-up to the publications *From a policy on illegal drugs to a policy on psychoactive substances* in 2008 and *Towards an integrated policy on psychoactive substances: a theoretical and empirical analysis* in 2010, the objective of the present project is to arrive at a better understanding of what structures better suit integrated and coherent drug policies, and what models/indicators may be developed to give better information about the outcome of such policies. The funds for this follow-up study have been provided by the Swiss authorities and the Pompidou Group is grateful to them for their continued support in this area of policy development.

The Pompidou Group's major objective is to better support the use of research evidence in policy and practice, thus facilitating the development of evidence-based policy.

The participating countries in this third phase of the project were Austria, Belgium, Ireland, Israel, the Netherlands, Norway, Portugal and Switzerland.

I was assigned the role of "primary investigator" while Brigid Pike researched the concept of "policy coherence", which provided a framework for the country reviews in this volume. All participants were involved in the discussions held at the four meetings and the outcome is a result of their dedicated input, as seen in this publication.

The project has been organised in three parts to take into account these three aspects:

- Context: understanding the factors that influence the particular politics/policy interface in individual jurisdictions, in order to accommodate differences between countries in the analysis, such as historical/cultural/economical factors; governance arrangements; underlying beliefs and assumptions: in other words, the ideology that has provided the basis for the policy as it stands today;
- Systems: structures and processes in place to enable the achievement of the desired policy outcomes: in other words, how does one translate ideas into political goals?



- Measurement: the means of evaluating effectiveness and efficiency of systems: in other words, if goals can be measured, then the coherence of these goals can also be measured too.

As a result of these three considerations, the following framework was prepared after much discussion to provide the basis on which the participants may attempt to review policy in their respective countries, keeping these attributes in mind.

## **1.1. Context**

With regard to the first item – context – it was agreed that the résumé should reflect the development of drug policy in the member countries based on historical/cultural factors and political ideology.

The résumé for each country should include the development of drug policy there, taking into account on a national level the ratification of any United Nations conventions, the adoption of European Union drug strategies and any major changes that may have influenced the path taken by the country concerned and thus resulted in the actual state of play within that country today.

In addition, this development should be framed in the context of each particular country, taking into account its size, geographical position, its relation to its neighbours, the state of the drug problem and public opinion. This in turn must also be supported by the political context of the time, that is the political ideology.

Each country's résumé must also record the impact of drug research on policy development, though this will probably refer mainly to drug epidemiology.

It also needs to be stressed that this account of the development of drug policy is strictly at national level, and not local level, though some insight should also be given into whether national drug policy has been followed at local level or whether it first developed at local level and then provided the impetus for national policy.

In the end it may be possible to reflect on the type of influences that have shaped drug policy over the period in question. In certain periods policy may have developed incrementally but, when problems arose, radical changes may have been sought and implemented to deal with the problems in hand. Moreover, political interest groups, civil society groups and public opinion may have had some say in shaping policy as we know it today. Advocacy groups, or networks in which alliances are formed around beliefs, also have a place in some countries and may have influenced drug policy. Finally, policy today and for the future seems to be increasingly under the influence of what can be termed evidence-based medicine, in that the question more frequently asked is "What works?" To answer such a question and inform policy, one needs evidence of what works and what does not. This policy model is sometimes

referred to as the rational and/or technical model, which has been adapted in public policy for a number of years in different spheres.

The first publication from the project, *From a policy on illegal drugs to a policy on psychoactive substances* (2008), was just such an attempt to contextualise drug, alcohol and tobacco policies in each of the 17 participating countries. In writing up the findings, I reported that the common denominator among all the national policies was an over-arching concern with health: this was the prime factor guiding most policy choices. To help analysis and understanding of the policy options, I suggested that, in future, it might be appropriate to frame substance-use policy within this context, and that the Council of Europe should take a lead in developing such a global policy framework.

I proposed a model based on the assumption that policy formulation in the area of substance use is influenced by three “proximal” factors – civil society, science and practice – which impact directly on the shape and direction of policy. These in turn may be modified by six “distal” factors – public opinion and political ideology inform civil society, theory and experiment inform science, and the evidence base and outcomes inform practice. The impact of these distal factors is less tangible but no less important.

## 1.2. Systems

By “systems” we mean the structures and processes in place in a country to enable achievement of the desired policy outcomes. In other words, how does one translate ideas into political goals? In the second phase of the project, to explore further the relationship between policy outcomes and “integration”, Dike van de Mheen and Cas Barendregt of the Addiction Research Institute in Rotterdam, undertook an empirical investigation in the seven countries participating, enquiring (1) what the term “integrated policy” meant in each of the seven countries, and (2) how “integrated policy” had been operationalised in these countries.

In the report *Towards an integrated policy on psychoactive substances* (2010), van de Mheen and Barendregt concluded that integration might refer to the combination of a variety of psychoactive substances in the one substance-misuse policy. Alternatively, it might refer to the co-ordination of policies and actions in different government departments through a formal co-ordinating mechanism. Underlying these two structural forms of integration, the researchers also discerned an integrating process of a more intangible and fluid nature – integration of ideas (politics) and action (policy). They explained:

If the idea is that the consumption of psychoactive substances, other than tobacco or alcohol, is sinful or bad [i.e. the political view] it may lead to prohibition of these substances [i.e. policy response]. If the dominant idea is that legal and illegal substances can be viewed as potentially damaging to health, a health approach

to psychoactive substances comes into focus. Co-ordination of health-oriented interventions requires a different policy infrastructure from a merely prohibitionist approach.<sup>2</sup>

### **1.3. Measurement**

Measurement refers to the means of evaluating effectiveness and efficiency of systems. In other words, if goals can be measured, the coherence of these goals can also be measured too.

It is crucial that ideas be translated into tangible political goals if they are ever to see the light of day, and the drug issue is no exception. A drug policy per se, whether it takes into account all psychoactive substances or not, still must acknowledge this fundamental premise. Moreover, in the future drug policy will – depending on circumstances – have to decide which route it is to follow: independent policies for each substance or one policy that incorporates all substances. This in itself may become resolved when considering the systems and measures in place to monitor such policies.

However, all policies need to be goal-directed: they need to provide a valid outcome as a result of their implementation. Thus, a clear and concise goal needs to be formulated in the form of a mission statement, which now is commonplace among corporate organisations.

The discussions within the expert group during the third phase of the project have resulted in two formidable goals for drug policy: first, that the policy should provide for the “well-being” of the population targeted; and second, that the policy should prevent the harm caused by substance use. With regard to the first goal, that of well-being, this usually relates to three factors, namely the physical, mental and social state of an individual that enable him/her to be a full, active member of society. In defining the second goal, that of preventing harm from substance use, a scientific attempt has been made to define these harms using three categories, namely, physical, mental and social, to better inform policy makers and the public at large. It is (to say the least) odd that both sets of goals, well-being and the prevention of harm, use the same factors to define what it is they aim to do, and thus appear as two sides of the same coin. In effect, one may see the policy goal as providing the policy framework for health and social well-being, whereas the goal of harm prevention provides the safety net.

What needs to be considered to ensure that such policy outcomes can be realised in any meaningful way? The analogy that came to the fore in the 2010 publication was that structure sub-serves function; thus this would appear to be the foundation on which a systems approach might be considered. “Systems” implies that the whole is made up of a number of parts and these

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2. R. Muscat, D. van de Mheen, C. Barendregt et al. (2010), *Towards an integrated policy on psychoactive substances: a theoretical and empirical analysis*. Strasbourg: Council of Europe, p. 57.

in turn need to function in a coherent manner to produce the desired outcome. One may then also talk of the different levels of analysis within the system, describing matters in an ideological fashion and at the same time on a different level referring to the services on offer. A systems approach assumes that all the components are to an extent integrated to produce the coherent response.

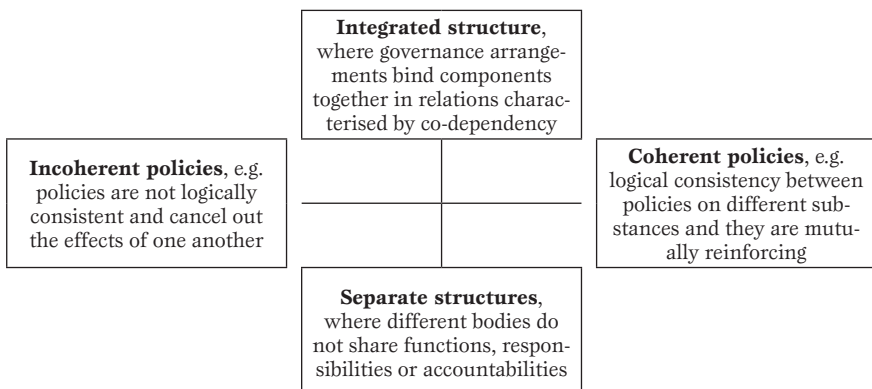
During the third phase of the project, the expert group focused increasingly on the relationship between integration and coherence, and how this might assist in developing a means of measuring the achievement of policy outcomes. In the discussion that follows, an attempt is made to define what “integration” and “coherence” mean and so provide concepts that might form the basis for devising a framework of benchmarking criteria.

Searching online for definitions of integration and coherence suggests there is a fundamental difference in meaning:

- Integration is about combining parts into a single, unified whole.
- Coherence is about sticking a number of parts together in a logically consistent manner.

Integration is like a chemical process: it is irreversible and the whole is greater than the parts, whereas coherence is more like a physical process that is reversible, and in which the elements can be separated out again.

An attempt is made to combine integration and coherence as two dimensions indicating the extent of fusion of policies (coherence) and of structures (integration) – see Figure 1 below. The term “integration” refers to structures insofar as they are either integrated, with the different parts interlinked and sharing some systems, or they are not integrated and function independently of one another. The term “coherence” refers to policies, and the extent to which they align with each other and are mutually supportive while retaining their individual and separate characters.



**Figure 1: Coherence and integration as two dimensions, indicating how far policies have fused (coherence) and how far structures have fused (integration).**

Gauging the extent of integration is useful for getting a broad-brush understanding of a particular set of policy and structural arrangements, of their character. Gauging the degree of coherence yields a more detailed, more fine-grained picture, which may increase the capacity of policy makers to respond flexibly as a policy domain changes over time; that is, the framework may be a tool for policy makers to both understand the overall nature of their policy approach and manage their policies in a timely and responsive manner.

This framework is explored in more detail in the next chapter and in the country reports that follow.

## **2. Policy coherence: notes towards a concept**

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### **2.1. Definitions**

According to the *Oxford English Dictionary*, coherence means “the action or fact of cleaving or sticking together”, while coherency means “the quality of being coherent or hanging together in any respect” – one is an action; the other is a quality. In this chapter, “coherence” is used when referring to policy coherence as a policy tool, because it connotes a process of becoming more, or less, coherent; “coherency” is used for the goal, the final state to be achieved by implementing the policy coherence instrument, a set of fully coherent policies.

Following the characterisation of “policy coherence” given in the previous chapter, a more formal definition of the concept is now proposed. Policy coherence refers to the extent to which different public policies complement or support each other. At best, policy coherence creates synergies between different public policies; it leverages capacity to realise a common policy goal. At a minimum, it ensures that different policies do not undermine one another or cancel each other out.

A consequence of this layered definition (layered in that there are gradations, namely, ever greater degrees of coherence) is that policy coherence depends on alignment and consistency not only across policies directly related to a specific goal or set of goals, but also across other unrelated policies that may have an impact on directly related policies. A further consequence is that coherence at different levels, from international to local, also needs to be considered.

### **2.2. Measuring policy coherence**

Six possible indicators of the degree of coherence between different policies are proposed.

- Conceptualisation of the problem: how are problems associated with different psychoactive substances (illicit drugs, alcohol and tobacco) described, and how do research evidence, media coverage, cultural mores or social, economic and political considerations shape the nature of the “problem”? To what extent do these elements converge? (This indicator is comparable to mapping the profile of policy influencers outlined in phase 1 of the project.)

- Policy context: where are psychoactive substance policies located within the overall policy environment, e.g. in criminal justice, in the medical context or within the context of a value set such as social inclusion, human rights or equality? To what extent is there a consistent approach across different psychoactive substances?
- Legislative/regulatory framework: how are various psychoactive substances controlled and regulated? To what extent are the controls and regulations complementary and supportive of the desired outcomes?
- Strategic framework: what are the goals and aspirations, the objectives, of drug, alcohol and tobacco policies? How far do they overlap with one another?
- Responses/interventions: are interventions logically consistent and mutually supportive, in line with over-arching policy goals and aspirations?
- Structures and resources: to what extent does the organisation of structures and resourcing support the co-ordination and/or integration of drug, alcohol and tobacco policies? (The structural aspect of this indicator was explored in phase 2 of the project.)

In Chapter 5, Ireland’s national policies on illicit drugs, alcohol and tobacco are assessed against these six indicators. The outcome of this pilot test suggests that, though the assessment may not lead to precise measurement of the various policies against an external benchmark, the process does facilitate identification of options for strengthening the impact of different policies relating to the misuse of psychoactive substances.

## **2.3. Making policies coherent**

Some questions need to be answered in order to test the validity of this conceptual model and to translate it into a practical policy tool.

- How sensible or useful is it to spend time wondering about abstract concepts such as “policy coherence”? Does it add value? Does it ensure our policies on psychoactive substances are more relevant and effective?
- How feasible is it for different countries, each with their own unique set of policy priorities, to agree a common policy goal or goals?
- How possible is it to devise systems, structures and processes to support the adoption of a policy coherence model?

### **2.3.1. Reality check**

How relevant is the concept of policy coherence? Will it contribute to desired policy outcomes? Has “policy coherence” been used in any other policy areas? To answer the last question first, yes, the concept of policy coherence has been tried elsewhere. With leadership from the Organisation for Economic Co-operation and Development (OECD), in conjunction with the United

Nations (UN), the concept has been applied to the formulation of policy on international development aid and to assist in managing the diverse policies that come together in this area, including agriculture, environment, transport, energy, finance, fisheries, migration, science, technology, intellectual property rights, security and trade.<sup>3</sup>

The International Labour Organization has also made use of the concept to assist countries in formulating and adopting policy portfolios that support coherence between the objectives of economic growth and the generation of decent work for all. Elements of this approach are (a) a better balance between objectives such as sustainable growth, equity, employment and “decent work”, (b) a more comprehensive policy mix and better sequencing to obtain these objectives, and (c) the creation of more policy space to implement national policy.<sup>4</sup>

So far, so good, but how relevant and viable is the concept of policy coherence in psychoactive-substances policy? There are notable parallels between the psychoactive-substances policy domain and these other policy domains, which suggest the concept is both relevant and viable: a global market, a global problem, close links with other policy domains and the complication of different models, cultures and ideologies.

Psychoactive substances are deeply implicated in the political economy of globalisation. The markets for them comprise suppliers and consumers spread around the world, who are part of a complex web of trade relationships and interdependencies.

The global markets in psychoactive substances encompass under-developed, developing and developed regions of the world. In 2008, the Latin American Commission on Drugs and Democracy published the conclusions of its year-long deliberations on the problems associated with illicit drugs on the South American continent. The authors made a plea for a global policy on drugs controlled under the UN conventions to ensure coherence between the policies of these different global regions:<sup>5</sup>

The question is not to find guilty countries and allocate blame for this or that action or inaction, but to reiterate that the United States and the European Union share responsibility for the problems faced by our countries, insofar as their domestic markets are the main consumers of the drugs produced in Latin America. It is, thus, pertinent for us, Latin Americans, to ask them as partners to design and implement policies leading to an effective reduction in their levels of drug consumption and, as a consequence, in the overall scope of the narcotics criminal activities.

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3. For full details visit [www.oecd.org/department/0,3355,en\\_2649\\_18532957\\_1\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/department/0,3355,en_2649_18532957_1_1_1_1_1,00.html).

4. For more information, visit [www.ilo.org/integration/themes/pci/lang--en/index.htm](http://www.ilo.org/integration/themes/pci/lang--en/index.htm).

5. The report was downloaded on 16 August 2011 from [www.drogasedemocracia.org](http://www.drogasedemocracia.org).



In 2011, in Recommendation 10 of its final report, the Global Commission on Drug Policy similarly called for coherence in what is a global problem:<sup>6</sup>

The United Nations system must provide leadership in the reform of global drug policy. This means promoting an effective approach based on evidence, supporting countries to develop drug policies that suit their context and meet their needs, and ensuring coherence among various UN agencies, policies and conventions.

As in the case of policy on international development aid, policy on psychoactive substances is closely interlinked with a number of policy domains – health, education, social inclusion, regulation and law enforcement. To integrate such disparate policy domains would be a huge challenge; ensuring that they complement and support one another appears to be a more easily achieved solution.

Finally, policies on psychoactive substances are often infused with conflicting ideological, moral and cultural assumptions and attitudes, which result in different policy preferences; but, if policy coherence is the objective, this need not be a stumbling block in the search for a common outcome.

These parallels suggest that the concept of policy coherence is as relevant in the area of psychoactive substances as in the area of international development aid. Although I have not explored such parallels in the areas of alcohol and tobacco, I expect that similar parallels exist there.

Regarding viability, the policy coherence framework and tools developed in the past 10 to 15 years in the domains of international development and international labour policy appear capable of being used to find workable and useful solutions in the face of conflicting and competing interests, which are unlikely ever to be fully resolved. It would seem reasonable to suggest that similar approaches may also be useful in developing tools to build greater coherency in the psychoactive-substances policy domain, where differences are also not readily amenable to compromise.

### **2.3.2. Common goals**

The adoption of health as an over-arching policy goal, within which policy on a variety of licit and illicit psychoactive substances can be combined, was identified in phase 1 of the project, and confirmed in phase 2. In the final phase, the need for a common over-arching goal, to provide the focal point around which policies can cohere and to justify investment in seeking greater coherency, was agreed – and again health was identified as the likely goal.

So just where could common goals acceptable to a wide variety of countries come from? The answer we arrived at is the goals and aspirations of the international organisations established in the wake of the Second World War

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6. The report was downloaded on 16 August 2011 from [www.globalcommissionondrugs.org](http://www.globalcommissionondrugs.org).

and afterwards, such as the United Nations, the Council of Europe and the European Economic Community, precursor to the European Union. Many countries belong to these various bodies. Given that the Pompidou Group, which set up the expert group on policy coherence, is a constituent part of the Council of Europe, the expert group adopted a pragmatic approach: the health-related goals articulated by the Council of Europe provide the necessary and sufficient objectives; the expert group did not undertake any a priori investigation or justification of the choice of goals.<sup>7</sup>

The primary aim of the Council of Europe is to create a common democratic and legal area over the whole continent, ensuring respect for fundamental values like human rights, democracy and the rule of law. These values are regarded as the foundations of a tolerant and civilised society, and indispensable for European stability, economic growth and social cohesion. On the basis of these fundamental values, members of the Council of Europe try to find shared solutions to major problems like terrorism, organised crime, corruption, cyber crime, bioethics, cloning, violence against children and women, and trafficking in human beings.

More specifically relevant to promoting a public health approach to the issues associated with psychoactive substances is Article 11 of the Council of Europe's European Social Charter. Article 11 provides for the right to protection of health and stipulates that, with a view to ensuring the effective exercise of the right to protection of health, the parties to the social charter undertake to take appropriate measures designed, *inter alia*, to remove as far as possible the causes of ill-health, to provide advisory and educational facilities to promote health and encourage individual responsibility in matters of health, and to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

Even though the right to health has been included in a considerable number of human rights treaties at the international, regional and national levels, it has been found difficult to pinpoint exactly what it entails. Jurisprudence dealing with the right to health, even though limited, has helped to clarify and define the right, and has demonstrated that it is a right closely related and dependent on other human rights, such as the rights to life, non-discrimination, privacy, access to information and freedom from torture or inhuman and degrading treatment.

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7. The following account of the Council of Europe's articulation of health-related goals has been taken from an unpublished survey by the Pompidou Group Secretariat, led by Thomas Kattau. Acknowledging the important role of jurisprudence in clarifying and defining the right to health, and demonstrating its close association with and dependence on other human rights, the Secretariat also listed the Council of Europe instruments in which these rights are set out, including the Convention for the Protection of Human Rights and Fundamental Freedoms, the Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data and the Convention on Human Rights and Biomedicine.

### **2.3.3. Systems, structures and processes**

Not only has the OECD published guidelines on how to strengthen policy coherency, but the EU and national bodies have also taken up the challenge. In 2005 the European Council adopted the European Policy Coherence on Development (PCD), which provides for strengthening PCD procedures, instruments and mechanisms at all levels in the EU. The European Commission has since published two progress reports on PCD in the EU.<sup>8</sup> At national level, in the Netherlands the government has established a dedicated Policy Coherence Unit. In Ireland the Institute for International Integration Studies in Trinity College Dublin (TCD) has set up a Policy Coherence Unit which manages a website devoted to exploring the many dimensions of Irish policy coherence for development. In the following brief overview I draw on the work of the OECD and the TCD-based unit.

Operationalising policy coherence (that is, turning the concept into a set of tangible objectives, in relation to which actions can be identified) might focus on four main objectives and related action areas.<sup>9</sup>

1. Seek to eliminate policy inconsistencies – the elimination of inconsistencies is the starting point for policy coherence. The ideal end point for this stage is for all policies to be at least neutral in their effect on the supply of and demand for psychoactive substances.
2. Identify opportunities for policy enhancement – which involves a deliberate decision to make policies unrelated to psychoactive substances also work for objectives in the psychoactive-substances policy domain. This includes taking opportunities to tweak policies not related to psychoactive substances to achieve pay-offs at relatively little cost, or using resources to leverage the positive impact of policies on psychoactive substances policy.
3. Develop mitigation policies to overcome the adverse effects of policies not related to psychoactive substances – by developing alternative policies and programmes, by which the adverse effects, whether intentional or otherwise, of non-psychoactive-substances-related policies may be offset.
4. Ensure consistency in advocacy – use the national voice at international forums to put forward arguments and policy options consistent with the objective of a coherent policy on psychoactive substances.

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8. EU 2009 Report on Policy Coherence for Development, Brussels, 17 September 2009. COM(2009) 461 final, SEC(2009) 1137 final. Downloaded on 17 August 2011 from [http://ec.europa.eu/europeaid/what/development-policies/policy-coherence/index\\_en.htm](http://ec.europa.eu/europeaid/what/development-policies/policy-coherence/index_en.htm).

9. This operationalisation model is based on a typology outlined in F. Barry, M. King and A. Matthews (2009), Policy coherence for development: the state of play in Ireland. A scoping report commissioned by the Advisory Board for Irish Aid. Dublin: Institute for International Integration Studies, TCD, pp. 21-3. Downloaded on 17 August 2011 at [www.tcd.ie/iis/policycoherence/](http://www.tcd.ie/iis/policycoherence/).

Implementing policy coherence might depend on carrying out four related tasks, forming part of a continuous cycle.<sup>10</sup>

1. Set and prioritise objectives: determine which policy objectives take priority in pursuit of the overall policy aim, either annually or over a longer period. Impact assessments can help to prioritise competing options. Political commitment and policy statements are other key tools in this stage of the cycle.
2. Co-ordinate policy and its implementation: work out how policies and implementing them can be modified to maximise synergies and minimise incoherence. As well as departmental and other statutory policy co-ordination mechanisms, parliamentary oversight by committee (Oireachtas committees in Ireland) and an annual parliamentary debate could be considered. Non-governmental organisations (NGOs) could be encouraged to assess coherence issues and contribute to the knowledge base on policy coherence in relation to psychoactive substance policies.
3. Monitor, analyse and report: the impacts of policies, separately and in combination, need to be monitored and analysed, and the findings fed back to policy makers and those with the task of holding policy makers and their political masters accountable. Policy coherence indicators should be independently published bi-annually to ensure legitimacy.
4. Build capacity and capability: training (explicitly on policy coherence) officials and others working in the area of psychoactive substances and initiating a research programme (within the context of overall aims and short-term policy priorities) to assess a range of coherence issues, will help to build capacity (resources) and capability (knowledge).

## 2.4. Conclusion

One other issue, beyond the remit of the expert group, but which policy makers need to bear in mind, is the need to maintain a historical perspective on policy coherence and/or integration, and on the dynamics of the system whereby the building blocks (the underlying beliefs, principles and assumptions) continue to alter and shift over time, upsetting any balance that may have been temporarily achieved between competing policy demands.<sup>11</sup>

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10. This implementation framework is based on the “policy coherence cycle” outlined in *Understanding policy coherence for development: building blocks for policy coherence for development*, OECD 2009, Chapter 2 (downloaded 17 August 2011 from [www.oecd.org/department/0,3355,en\\_2649\\_18532957\\_1\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/department/0,3355,en_2649_18532957_1_1_1_1_1,00.html)) and on the “Model of PCD Support for Ireland” outlined in Barry, King and Matthews (2009), *Policy coherence for development: the state of play in Ireland*, op. cit. Dublin: TCD, pp. 28-31 (downloaded 17 August 2011 from [www.tcd.ie/iis/policycoherence/](http://www.tcd.ie/iis/policycoherence/)).

11. These final remarks are based on observations by a member of the expert group, Irmgard Eisenbach-Stangl.

When an appropriate mix of policy initiatives has been achieved, when an acceptable degree of coherency between policies has been realised, policy makers cannot relax. Policy makers need to be constantly vigilant and continuously monitor developments – in international regulatory frameworks, in national cultural and social reactions, and in the evidence base and notions of good practice in relation to addressing the issues associated with psychoactive substances – and reflect on how such developments, however insignificant, may impact on the overall balance and coherence between policies.

The goal of policy coherency is a never-ending quest.

### **3. Integration and coherence of policies for alcohol, illicit drugs and tobacco in Austria: the past 100 years**

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#### **3.1. Introduction**

An assessment of the available literature and other documents prompted the decision to present the Austrian case in historical phases defined by the degree of “coherence” of national alcohol, drug and tobacco policies, that is, of selected addiction or dependency policies. Policies here are considered to be coherent if they coincide in their evaluation of relevant objects and acts, and are consistent with each other in their regulations and measures. Coherence is thus a way to look at policies on addictions or dependencies in a comparative way, but it does not touch on the internal structure of policies (Muscat 2011). The consistency of single policies is referred to under the concept of integration, looking at frictions and contradictions in evaluations of objects and acts as well as in reactions to them. But, though integration is not of less interest, the focus of the following discussion is on coherence.

Coherence was assumed to be given if national policies on alcohol, illicit drugs and tobacco coincided in three crucial areas: (1) leading definitions of behaviour and problems related to alcohol, drugs and nicotine, (2) the main organisations in the alcohol, drug and tobacco field that intervene by organising or providing controls and services, and (3) national policy goals (imprinting legislation) and the degree of their enforcement.

This concept allows one to distinguish periods of higher and lower coherence of the three addiction policies. The qualitative approach used to distinguish them is in need of further development and systematisation. This analysis mostly considers manifest interventions and neglects policy concepts and programmes; as a result, it does not systematically shed light on the difference and interplay between “action” and “discourse”. And (as well as integration) it ignores how far national policies are worked out – in terms of putting the policy across orally or in writing – and how far state programmes, plans, strategies and actions are matched by enforcement and public opinion. Policies that are fully worked out are more often likely to be integrated than patchy ones consisting of various competing, hidden or even unconscious concepts and interventions contradicting each other. But patchy policies are not necessarily

unintegrated or harder to reconcile with other policies. In Austria as in many other European countries alcohol interventions by the state are not understood as “alcohol policy” – a term hardly known and hardly used – and such documented concepts and programmes are missing. Nevertheless, it is not difficult to identify a consistent underlying concept that to a high degree is coherent with worked-out drug and tobacco policies.

Finally, the discussion below concentrates on alcohol, tobacco and illicit drug policy, and ignores the regulation of psycho-pharmaceutical drugs, which are partly identical with illicit substances, but marketed and used in different societal contexts under different labels. This means that, for a wide variety of substances, only half of the policies were observed and the most incoherent and unintegrated policies were ignored.

### **3.2. Coherent legislative tolerance: prelude in the Austro-Hungarian Empire**

The degree of coherence of alcohol and drug policy under the sign of tolerance was very high in the 19th century, unlike earlier centuries (Lehner 1996). Since special organisations providing controls and services were hardly developed, coherence must be assessed by policy and legislation.

Tolerance of alcohol consumption, intoxication and alcohol-related problems in the time of the monarchy is indicated by a unique law on “full intoxication”, part of the penal code of 1803. Full intoxication, according to this law, had a mitigating effect that can be summarised as follows: offenders who had committed a crime when fully intoxicated were sentenced for a misdemeanour; those who had committed a misdemeanour were not sentenced at all. In a restricted version, the law is still valid today, though it is rarely applied.

There was also tolerance of public intoxication. When temperance movements grew in the second part of the 19th century and there were increasing demands to criminalise public inebriety, the Austrian Parliament (Zisleithanien) refused to pass such a law at Austrian level and agreed only to a restricted local regulation (“public intoxication causing annoyance”) in Galicia, where the strongest request came from (Eisenbach-Stangl 1993).

In line with the rejection of penal responses to the alcohol question, Austrian politicians with backgrounds in law or medicine agreed on the disease concept of inebriety and argued against arresting drunkards, as practised in Germany, and in favour of voluntary and compulsory treatment in special sanatoria – which never got established during the monarchy.

Opiate addicts, whose numbers increased after the wars in the second half of the 19th century, were also considered to be ill, and prohibitive responses to drug problems were rejected. The monarchy was represented at the First Opium Conference in Shanghai in 1909, which had no results, because it did

not sign the 1912 the International Opium Convention of The Hague. But, like other European countries (among them Germany and the United Kingdom), the republic had to sign the treaty eight years later, as part of the Treaty of Saint Germain-en-Laye (Pilgram 1992).

The coherence of dependency concepts and related interventions is most visible in the Incapacity Law of 1916, which legislated for the total incapacity of the mentally ill and for the limited capacity of three groups: “drunkards, those dedicated to nerve poisons [drugs] and wasters”. Limited capacity reduced their civil rights to those of adolescents (7 to 14 years old) and allowed for the development and modulation of pressure put upon people to undergo treatment. Limited incapacity was, so to say, a sophisticated precursor of the regulations allowing “therapy instead of punishment” developed 60 years later in the frame of the Drug Law. The courts in control of enforcing incapacitation interpreted the regulations in favour of any dependants and prevented compulsory admissions and treatment (Eisenbach-Stangl 1991: 234; Lehner 1983).

### **3.3. Imported policies and a step towards discrepancy: the First Republic, 1918-1934/8**

During the First Republic, the Austrian temperance movement imported numerous alcohol policy concepts from countries such as Switzerland, Sweden and the United States, where temperance forces were stronger or had a longer tradition. Among them were the reduction of availability by restriction of outlets; the right of communities to decide on the prohibition of retail sales (with the hope of eventually achieving national prohibition by these measures) and earmarking a part of alcohol taxes for alcoholism treatment and prevention. But none of these concepts none was seriously considered by Parliament.

What remained from the movement, which was losing influence already after 1923, accorded with local traditions: a law prohibiting the supply of alcoholic beverages to young people in a public place (already being discussed at the end of the 19th century) and a well-structured professional system of voluntary treatment in the framework of the mental asylum and social administration in Vienna, whose outpatient departments were closed down after the Austrian Civil War in 1934, whereas the inpatient departments remained active until the *Anschluss* in 1938. The outpatient services in all nine states (the Bundesländer) run by abstinence organisations and churches after 1938 remained active only underground. They tried to help their clients avoid sterilisation and detention in work camps (Eisenbach-Stangl 2003).

Signing the peace treaty signed in St Germain in 1920 meant that Austria had to import certain foreign policy concepts, but the First Republic fulfilled the obligations hesitantly and reluctantly. In 1921 the opium convention was acknowledged by a decree which, roughly speaking, submitted to restrictions all those who processed opiates and cocaine. A first law only followed in 1928:



it did not regulate only narcotics but poisons in general and was accordingly called the *Giftgesetz* (Federal Law on Poisons). Although the penalties contained in this law still were mild, they heralded stricter drug policies, even penal sanctions – a novelty in Austria with regard to drugs – and they criminalised not only acquisition but also possession. But, since drug users at this time – especially cocaine users – were mostly upper-class, the *Giftgesetz* was hardly enforced.

### **3.4. Alcohol and drug policy depart further: the Second Republic 1945-1968**

In 1946 the Law on Poisons became the *Suchtgiftgesetz* – the first law concentrating on drugs with much stricter sanctions (minimum sentences were 50 times higher, maximum sentences 20 times). Only two years later the law was amended to criminalise possession for personal use. These legal innovations did not respond to new drug problems. But Austria at this time was an occupied country and the United States, one of the four occupying forces and a main agent of tight international drug controls, may have exerted its position.

This escalation of restrictions was only at the legal level – and the new Drug Law was seldom enforced. An analysis of court records shows an average of 16 convictions per year between 1948 and 1968; most of them had started drug use in a medical context, either as patients who had been prescribed narcotic substances as painkillers, or as nurses and medical doctors and their wives, who had easy access to controlled substances. The convicted were middle-aged and a remarkable percentage were female (Graßberger 1969). It must remain an open question to what extent the small numbers of drug offenders mirror a small iatrogenic drug scene and to what extent drug problems had secondary priority for criminal policy. However, few were convicted and criminalised.

Alcohol policy and controls in this period developed in opposite directions. To some extent alcohol policy was conceived of as a policy cutting across many policy fields and accordingly was “normalised” and “representative”. This is indicated by the establishment in 1955 of the alcohol advisory board at the ministry of social affairs (at this time responsible for health), which was comprised of honorary representatives from the temperance movement, specialists in the treatment of alcoholism, wine and spirit producers, but also employees and employers (the *Sozialpartner*). The advisory board at first committed itself to the re-establishment and extension of professional voluntary treatment for alcoholics – soon called alcohol-sickness, to counteract stigmatisation. Already in 1953 insurance companies had acknowledged alcoholism as a disease and paid for cures. At the same time, calls for a law on compulsory admission, retention and treatment of alcoholics, which had been raised since the First Republic, were finally rejected. And, at the end of the period, the limited incapacitation of alcoholics dropped to zero – a sign not only of enduring tolerance for alcoholics but also of the successful establishment of

special voluntary treatment (Eisenbach-Stangl 1991). In 1984 the Law on Trustees, without special regulations for addicts and users, replaced the Law on Incapacity.

But the advisory board was also influential in establishing repressive measures against alcohol consumption in a well-circumscribed area. A blood alcohol limit of 0.8 per mille for drivers was introduced by the traffic law of 1960. The regulation built on an amendment to the penal code in 1952, which considered intoxication as an aggravating circumstance when the safety of others had been endangered or violated (Eisenbach-Stangl 1991). The regulation of intoxication in road traffic law, the penal code and their administrative and penal sanctions has been continually tightened up ever since. Thus, tolerance of alcohol consumption and intoxication has endured in general, but tolerance changed to strictness in the road traffic context. Whether this strictness should be considered as a sign of the disintegration of alcohol policy under the pressure of new problems originating in new social contexts (and, if so, to what extent) has to remain an open question.

### **3.5. Rapprochement with legal and social limits: 1968 and 1995**

The so-called international drug wave, carried forward by young people, some of whom were well-educated, stimulated a controversial public debate and gave reason to diversify drug policy, though it is better seen not as diversification, but as an ever-widening split. Since the amendment to the Drug Law in 1970, drug users are urged to submit to medical and therapeutic controls “instead of punishment” whereas drug dealers are often imprisoned. Sentences for dealing have been continually raised since 1970, whereas diminishing percentages of other drug offenders have been imprisoned (at most about 10%). And, due to extended regulations but also to extended services, increasing numbers and percentages of drug users have been given “therapy instead of punishment”. The divide is artificial and a sign of disintegration, but has proved useful to legitimise the increasing replacement of penal by medical controls for users – who, because of their continually growing numbers, otherwise would overcrowd prisons. The divide has also allowed a rapprochement between drug and alcohol services, and between drug (treatment) and alcohol (treatment) policy, with the result that at the end of the period drug services and treatment became more innovative and took the lead.

The introduction of “therapy instead of punishment” in 1970 involved the drug services in the enforcement of drug law, so thereafter the law governed their development and the state subsidised them. The few services available in the 1970s mainly offered long-term residential treatment and most of the beds were within the prison system 10 years later, the extended drug services mostly provided outpatient care on a voluntary basis comparable to alcohol services. With the appearance of HIV and AIDS in the mid-1980s, the extension

and diversification of services accelerated. Substitution treatment – never prohibited in Austria but not considered to be a medically adequate cure – was officially introduced in 1987 and a few years later syringe exchange was established. Harm reduction thus fell in step with the abstinence cure and overtook it in the 1990s – especially in Vienna, the only metropolitan city of Austria. Another major innovation was low-threshold services.

If the extension and diversification of drug services was meant to enlarge their coverage, to reach HIV- and AIDS-infected drug users and to protect the health of all, it also compensated drug users for the – more or less overt – exclusion of general medical and social services. The new standards set by innovations in the voluntary drug-service sector a few years later were partly adopted by the drug services in prisons. And, in a rudimentary form, they were also taken over by the alcohol services, which – apart from an increase of capacity, mainly in the 1970s and 1980s – had not changed much since the inter-war period. In addition, common services for alcoholics and drug addicts were established during this period – mainly shelters and day centres – but were not accepted by the clientele, reinforcing a limit to integration that was already known (Gratz and Werdenich 1980). According to their mirror-image hierarchy, alcoholics despise drug addicts, and drug addicts despise alcoholics.

In prevention, too, drugs became the leading substance area in policy innovation under the sign of coherence. In 1980 an amendment to the Drug Law called for the establishment of prevention services on a state basis, which – after long public and professional debate – was realised in the early 1990s. “Addiction prevention institutes” (*Suchtpräventionsinstitute*) were established, mainly dealing with drugs but also with alcohol and other addictions (Fellöcker and Franke 2000). For the first time alcoholism prevention was institutionalised and professionalised, though it remained (and still is) subordinate to drug prevention.

Last but not least, the administration of alcohol policy also profited from political innovations in the field of drugs. During the 1990s, drug co-ordinators and their bureaus were established as part of the state administrations, which decide on and finance most health, social and educational matters. Many of the new state-employed drug professionals were also made responsible for alcohol and other addictions. The drug co-ordination bureaus – conceived as “policy enforcement units cutting across policy fields” – were given considerable power: initiative in decisions and a budget. This was far more than the alcohol advisory board had ever been granted. They operated at the level of the federal state (weak in health, social and educational matters) without contract or budget.

The advisory board was dissolved in the early 1990s. Already in 1971 it had taken over drugs and “other addictive substances” which, as anticipated, dominated discussions and activities from then on. It became dispensable not only

because of the establishment of powerful addiction structures at state level, but also because of new structures at European level, as discussed in the next chapter. What remains to be mentioned here is that with the advisory board, the last organisation disappeared that in an operational context at federal level, where decisions on laws were taken could broach the disparate legal status of the addictive substances in question. Another insight inherent to its operational context was ignored in the increasing discrepancy in legal status of different substances in contrast to the increasing coherence of definitions and services for drug and alcohol problems.

### **3.6. Discrepancy and coherence: Austria as an EU member state since 1995**

Austria joined the European Economic Area in 1993 and became a member of the EU in 1995. Membership required adaptation to EU drug policy in legislation and administration. Adaptation of laws took place in the first half of the 1990s, adaptation of administration in the second half. In 1997, a few years after the demise of the alcohol advisory board, federal drug co-ordination was established at the Ministry of Health, responsible for the enforcement of drug law. The co-ordination panel consists of three drug co-ordinators, representing the ministries of health, justice and the interior; it is chaired by the first-named. The federal drug co-ordination panel co-operates with drug co-ordination at state level via administrative directives, but also via an advisory structure, the so-called *Bundesdrogenforum* (Federal Drug Forum), besides the drug co-ordinators of the states, who are drug professionals and experts (Pietsch 2011).

The federal drug structure differs from that developed for alcohol a few years later, again at the request of the EU. The alcohol structure too – still nameless (this is no accident) – is chaired by a representative of the Ministry of Health, responsible for alcohol matters at federal level, and advised by a forum of stakeholders and experts – the *Alkoholforum* – established in 2007. But, because it is poorly developed, the alcohol structure lacks partners at state level. In other words, the national alcohol and drug structures built up at the request of the EU differ strongly from those previously built up on national traditions.

Independently of this drifting apart of national alcohol and drug policy structures, a new merging of controls has come about since the turn of the millennium in a circumscribed area of selected urban public places (Schmidt-Semisch and Wehrheim 2005). Irrespective of the substances being used, the police, prevention and addiction professionals all take action to settle conflicts and maintain order in central areas of cities. Professions partly co-operate and partly compete: for instance, the police occasionally take care of intoxicated persons and prevention professionals may settle violent conflicts. In Vienna the merger reached the level of services: the police established a drug

service providing advice and care to drug users, whereas the drug services were enriched by a facility providing mediation of conflicts in selected public areas. It remains an open question as to whether this local development is to be considered as a precursor of a merger of controls and policy structures at higher level.

### **3.7. Coherence of repressive controls: when Austria joins the EU, tobacco comes under national substance policies**

Treatment for smokers was established in 1980 as outpatient therapy, and from 1997 also as residential therapy in a few special facilities (Schoberberger and Rieder 2005). As with alcohol and drugs, treatment/therapy for smoking is covered by insurance though with restrictions, most prominently of (expensive) substitution therapy. The awakening interest in tobacco-related problems was possibly also expressed by anti-smoking campaigns, but since campaigns on national level are neither co-ordinated by nor assigned to a special ministry or organisation, they may have been launched later. What is certain is that the political interest in health aspects of smoking developed years after the establishment of treatment, and it came with the relevant EU recommendations, becoming stringent with accession to the EU in 1995.

The first milestone of tobacco policy was the Tobacco Law of 1995, which for the first time in Austria regulated the quality of tobacco products for health reasons, introduced obligatory warning labels on tobacco products and restricted advertising in regard to quantity, number of products and target groups, variety of messages and forms of advertising. Following further EU recommendations and an international World Health Organization convention, the law was rigorously tightened up in 2004.

The amendment of 2004 that can be considered as a second milestone was one that changed the paradigm of tobacco controls because smoking became defined as deviant behaviour and non-smoking the norm. The prohibition of smoking in public places and of advertising protected the non-smoker as potential victim. In 2008 the prohibition of smoking was extended to restaurants, and penalties were defined for violators of the regulations – fines for those responsible for the enforcement of prohibition and smaller ones for smokers themselves.

The protection of victims of behaviour related to psychoactive substance consumption under the sign of health is also a goal governing the development of (repressive) controls related to alcohol and drugs: the early established and continually tightened drunk-driving regulations and the continually increasing penalties for drug dealers. But unifying victim protection takes place within regulatory systems with different consequences for violators: drug dealers are criminalised and often imprisoned, whereas drunk drivers can expect such

penalties only if the health of their victims was severely diminished. Smokers only have to pay an administrative fine. These discrepancies partly express the degree of problematisation of the different behaviours and issues within the country; they are partly a product of the period when the regulations were established and of the international bodies in charge of the conventions.

Within health administration and prevention, tobacco joined alcohol and drugs as a minor latecomer. Like the alcohol agenda and enforcement of the Drug Law, the Tobacco Law is the responsibility of the federal Ministry of Health, where all three are organised in one department. But, unlike alcohol and drug administration, tobacco administration seems to be best developed at national level; at state and local level it seldom attracts attention.

### **3.8. Conclusions**

This broad assessment of the development of alcohol, drug and tobacco policy in Austria during the past 100 years indicates that coherence was promoted by various factors, some effective only in restricted periods. Those that seem most important are summarised below, though it must be kept in mind that they may differ from the main factors effective in other countries.

In the Austrian case, coherence seems to be rooted in tolerance of substance use, intoxication and other effects, because of the local production of most substances and traditionally high consumption levels. In contrast, substance-related problems are met with ambivalence: partly with support, but partly also with stigmatisation and exclusion.

But the medicalisation of alcohol, drug and tobacco problems – their definition as disease and dependence or addiction – contributed to the coherence of alcohol, drug and tobacco policy. It would be of interest to study the changing concepts of disease referred to in debates, laws and discussions, and their political consequences. But all concepts used in the period under analysis seem to have promoted a scientific view of the behaviour and problems in question – at the expense of a moral view – and all of them put the emphasis on internal processes, such as compulsion instead of external ones (e.g. drug profit).

Seen from another angle, disease and addiction concepts and the medical view gained importance in parallel with the process of individualisation speeding up in the period under analysis, and each promoted the other. Psychoactive substances lost their social significance, and the individual meaning of consumption and its effects became more important, which furthered the coherence of “addiction” policy, especially of treatment and prevention interventions.

Coherence of Austrian policy on the substances in question has especially developed with “addiction” administration and preventive “addiction” interventions at state level. The professional, practice-oriented and local responses,

irrespective of interesting differences between the states, seem to have emphasised the normal, everyday character of the problems, instead of their uniqueness, and directed attention to specific individual problems, rather than societal problems such as low productivity, poor morals or poverty.

Discrepancies were mostly promoted by external influences and partly by the compulsory import of foreign (repressive) policies, which – as mainly moral policies – drove a wedge between Austrian alcohol and drug policies. The imported policies came from international drug treaties, American drug laws and EU recommendations inspired by other European cultures. Imported measures in the long run became better integrated in Austrian policies, but they still impair coherence.

Moral views lost importance but found a refuge in the protection of non-users, where the penalties for violations express the weighting of the substances: according to the sentences given, alcoholic beverages – the substances most familiar in the country – are best because least dangerous for non-users, whereas foreign illicit drugs are the worst/most dangerous, and tobacco is in between. Moral views thus seem to work equally against coherence and integration in that prevailing policies are tolerant, medicalised and aimed at local reactions.

Coherence of substance policy seems to have two main limits, to some extent linked: a limit at policy level determined by the legal status of the substance (criminalisation of illicit drugs in international convention) and a limit set by the users (alcohol and drug users despise and discriminate against each other, which impairs the establishment of services for both).

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## **4. The long road to an integral and integrated policy in Belgium**

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### **4.1. The drug phenomenon in Belgium: a late discovery**

In Belgium, the drug phenomenon became apparent rather late. By the late 1980s and early 1990s, some of the major cities faced a steep increase in frequent crime, so-called “petty crime”, which caused a great deal of discontent and seriously affected livability in a number of impoverished neighbourhoods. The idea spread (though not backed up by data) that problem drug users, and in particular the acquisitive crimes they committed, were causing the rise in crime and nuisance. An extreme right-wing political party used these feelings of insecurity in their election campaign in 1991, resulting in their breakthrough in November of that year. The traditional political parties were suddenly confronted by a serious political problem, one that was augmented by a societal phenomenon they were for the most part unfamiliar with; not only that, there was hardly a hint of a drug policy at the time.

In Belgium, as in many other European countries, a drug law was in force. This law was passed in 1921 to fulfil Belgium’s international obligations under the International Opium Convention of the Hague of 1912. In 1975, this Drug Law was amended, again partly to fulfil international obligations (namely the United Nations Single Convention of 1961 and the UN Drug Convention of Vienna of 1971). The minister of justice at the time, acting as a moral crusader, overzealously endorsed the prohibitionist philosophy of the UN treaties. On the upside, the 1975 amendment did expand the options for probation measures for drug users, enabling faster diversion into drug treatment, though the prevention and treatment offer was scarce. The few initiatives that did exist were private clinics that based their treatment methods on the ones used in the Netherlands.

It was only after the societal and political changes of the early 1990s that the Belgian Government took numerous initiatives. At that time, they were not targeted at any particular problem, though they proved to be necessary later on. Firstly, the government tried to gain insights into the nature and extent of the drug phenomenon through (limited) scientific research. Then, in 1992, the government set up safety and prevention contracts to sustain local authorities in their response to crime and nuisance. In 1993, subsidies – for drug

prevention, street-corner work, drug treatment and local drug co-ordinators – focused on specifics of the drug phenomenon. In 1994, a conference involving all relevant actors in the field (doctors, drug treatment and justice) established guidelines for good practice in methadone substitution.

In 1995, socio-medical treatment centres were established in all nine provinces of the country. These low-threshold centres worked with a multidisciplinary team and were aimed at the most problematic drug users. These centres were based on the way low-threshold drug treatment was organised in the Dutch city of Amsterdam. Indeed, quite a lot of methods adopted in Belgium – in drug prevention, drug treatment, co-operation between justice and treatment, and local drug co-ordination – were based on good practice established in the Netherlands.

In retrospect, Belgium's late discovery of the drug phenomenon proved to be an important advantage since it was possible to learn from Dutch experience, negative as well as positive. In the Netherlands, it had become clear by the mid-1990s that the system of tolerated distribution of cannabis through coffee shops was not a successful strategy. The flood of foreign drug tourists resulted in more coffee shops and their development into commercial enterprises that did not respect the tolerance criteria. This also resulted in increased nuisance in major Dutch cities and border towns, explosive growth in illegal cannabis production and the spread of illegal sales points for drug tourists. In fact, these changes resulted in a failure of the planned division of the markets. Learning from this Dutch experience, consensus grew in Belgium that coffee shops were not an option.

## **4.2. The development of Belgian drug policy: a bottom-up story**

In the first half of the 1990s, Belgium did not pursue a coherent drug policy at all. Belgian Government initiatives were unco-ordinated and unlinked. With the increased visibility of the drug problem in Belgian society, every competent minister “discovered” the drug phenomenon separately and announced separate initiatives without any discussion with other members of the government, let alone with those at other policy levels. Indeed, 24 ministers in federal and regional government had drugs within their competence, so several policy initiatives (both specific measures and policy plans) were begun for different policy levels (federal, regional, local) and domains (justice department, internal affairs, public health, social affairs, federal urban policy, welfare).

According to the conclusions of the parliamentary working group on drugs, these initiatives were perceived as extremely chaotic by the relevant sectors. The policy measures issued in this period were entirely incoherent, not tuned to one another and absolutely not embedded in public health or social policies. Even worse, certain policy measures counterbalanced one another. For

instance, the minister of justice issued a circular in 1993 demanding that the public prosecutor act upon every violation of the Drug Law. This demand was at odds with several prevention initiatives aimed at applying a preventive health approach to experimental users. Another striking example was the Ten Points plan of 1995, when the government issued 10 measures that were completely divergent from each other. Thus one could not speak of an univocal approach to the drug phenomenon. Despite this lack of co-ordination these initiatives were strongly appreciated by those working in the field. One must remember that at the time there was no Belgian drug policy, and politicians hardly had any experience of the drug phenomenon.

This situation changed when in 1996 the Chamber of Representatives decided to establish a parliamentary working group on drugs with the clear mission to inform itself about every aspect of the drug phenomenon and, based on this information, to give clear recommendations to the federal government. The group chose a brave working method: they asked national and international experts, working in all domains of drug policy (epidemiology, prevention, treatment, the social sector, repression) to convey their analysis and their recommendations. The working group followed most of these recommendations. Across the different domains there was a striking consensus about the need for a multidisciplinary and coherent approach to the multi-dimensional drug phenomenon. The conclusion from this appears to be that there was no integrated policy in the past and that we were still dealing with separate structures. According to the parliamentary working group, policy harmonisation was a necessary condition for any future Belgian drug policy. The final report of the working group mirrored the needs and expectations of the different domains in the field and in the academic world. These would become the pillars of Belgian drug policy.

The report recommended developing an integrated and integral drug policy, with both vertical policy co-ordination between different policy levels (federal, regional, provincial and local) in the domains of prevention, treatment and social policy, and horizontal co-ordination between the various policy domains and at the various levels. Remarkably, only at the local level was there a fully-fledged consultative structure available in that period. In some communities and cities, a local drug co-ordinator acted as president/supervisor/facilitator to chair these local steering groups or committees on drugs. It is striking that the security (justice and police) and education sectors also participated in these local steering groups on drugs. It is not an exaggeration to state that in this case a bottom-up approach was followed, in order to develop the structures needed to make a coherent drug policy possible. Epidemiology, which hardly existed before that time in Belgium, would provide the facts and figures for drug policy. Structural and person-orientated prevention was to become the priority. For drug users experiencing problems, a wide variety of drug-treatment services and general treatment services (from low-threshold

to high-threshold) had to be established. As for highly problematic drug users, a harm-reduction approach was chosen, with the provision of substitution treatment aimed at protecting the individual as well as society, in particular from drug-related crime and nuisance.

The working group proposed to limit repression to drug producers and traffickers striving for profit. The criminal justice system had to try, when possible, to divert problem drug users to (drug) treatment (based on the philosophy of the last resort). Furthermore, priorities were set for investigation and prosecution policy: possession of a consumer quantity of cannabis by a non-problem drug user was to receive the lowest priority. This recommendation led to the comment by some observers that Belgian policy would resemble Dutch policy (apart from the tolerated coffee shops). Despite these objections, the conclusions and recommendations of the working group were almost unanimously approved by the Chamber of Representatives. The foundations of Belgian drug policy were laid on a firm political basis.

### **4.3. The federal policy note on drugs (2001): a clear answer**

The response from the federal government took more time than anticipated because of the Dutroux crisis in the summer of 1996 and the political attention it received in its aftermath. Following a parliamentary inquiry, this crisis led to the biggest reform of the police and of justice that Belgium had ever seen. In January 2001 the Verhofstadt government approved the first federal policy note on drugs in Belgian political history. Since the federal note, for the most part, copied the recommendations of the parliamentary working group on drugs, political support for these recommendations continued.

The starting point of the federal policy note was that drug use is a matter of public health. Therefore the federal minister for public health is in charge of the integrated and integral drug policy and chairs the inter-ministerial conference of the 24 competent ministers in order to develop the necessary vertical policy co-ordination. The General Drugs Policy Cell was created, under the chairmanship of the national drug co-ordinator. This cell prepares the decisions of the inter-ministerial conference and guards the integrated character of the policy measures.

The drug phenomenon is considered to be a permanent social reality and thus drug policy is aimed at rational risk-control. From this starting point, the note follows the recommendations of the parliamentary working group on epidemiology, prevention, treatment and repression. The federal note is in accordance with European Union drug policy and respects United Nations drugs treaties. For 10 years now, the diverse elements of the federal note have been implemented.

At epidemiological level, an early warning system was set up, at first for ATS (amphetamine-type stimulants) and later on for new synthetic drugs and psychotropic substances. This stimulated evaluation research, which contributed to the development of an evidence-based policy. Nonetheless, we have to admit that for epidemiology Belgium remains a weak partner within the EU, as becomes abundantly clear in the annual reports of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

At prevention level (which is strictly speaking the competence of the communities), although the number of prevention workers has increased, prevention is still far from achieving its priorities. Public expenditure research demonstrates that the means available for prevention represent but a fraction of the means for treatment and repression.

At treatment level, the most pressing needs were answered. Following pilot projects, there was increased capacity in crisis centres and for double-diagnosis patients. Treatment circuits were installed to counter shopping around for treatment and especially to optimise use of the diverse treatment offer. Ten years after the methadone conference, a legal framework was established for substitution treatment (following a law on needle exchange). Funding for drug treatment increased (more treatment centres and focus on drug-using parents and minors).

Criminal policy on drugs was provided with a clear framework. This policy is anchored in an adaptation of the Drug Law and a number of ministerial circulars. The starting points formulated by the parliamentary working group on drugs were maintained to the full: the criminal justice response is primarily aimed at drug production and drug trade. Problem drug users who come in contact with the criminal justice system because of drug-related crime need to be promptly diverted to (drug) treatment, making use of the existing legal provisions on different levels of the criminal justice system (prosecution, sentencing and execution of sentence). The possession of less than three grams of cannabis or one female cannabis plant has the lowest prosecution priority except in the case of nuisance, the presence of minors or indications of problem drug use.

Prioritising drug production and trade proved necessary because the Netherlands increased the pressure on professional cannabis cultivators and synthetic drug laboratories from about 2000, leading Dutch organisers to shift their activities to Germany and (particularly) Belgium.

Co-operation between the criminal justice system and treatment services increased in the first decade of the 21st century, not least because of the success of the “Test care” and “Drug treatment court” pilot projects, both in the judicial district of Ghent. The criminal justice system in particular is willing to extend these projects to all judicial districts. The problem is the limited capacity of drug-treatment services and the differences in geographical spread of drug treatment. Some Belgian regions lack the capacity even to respond to

treatment demands from criminal justice clients, and the limited number of regions that do have sufficient treatment capacity still cannot respond fully to all treatment requests.

#### **4.4. The current state of affairs in Belgium**

Belgium has clearly chosen an integral and integrated drug policy (as described above). To what extent has this approach been implemented? The structures to develop and monitor an integral and integrated drug policy are present, both at federal and at local level. Evaluation research has indicated that local steering groups or committees on drugs, supervised by a local drug co-ordinator, can be considered as good practice. These co-ordination structures, including all domains and actors, enable co-operation that increases the efficiency of interventions in the domains involved. The extra value of developing a policy at local level is that the policy is based on the drug phenomena that are most frequently manifested. Furthermore, evaluation research has indicated that pilot projects on co-operation between the criminal justice system and treatment services (described above) can also be labelled as good practice. However, the planned and desired generalisation of these projects faces capacity and financial obstacles.

Research into co-operation between criminal justice and treatment has demonstrated that better results can be obtained when several life domains (such as housing and employment) are included and improved. For problem drug users, this involves the homeless sector, social housing, social economy and general social services, all of which lack sufficient funds. It is clear that the success of a drug policy is determined by the financial means it can use. Public expenditure studies conducted in Belgium clearly demonstrate increased financial means over recent decades. Nonetheless it is also clear that public expenditure in Belgium is still far from the level of expenditure in Sweden and the Netherlands.

The development of a coherent, integrated drug policy is an ongoing process. On 25 January 2010, the Inter-Ministerial Conference on Drugs approved a joint declaration, which carries on the principles adopted in the Federal Drug Policy Note of 2001. The General Drugs Policy Cell and the inter-ministerial conference are entitled to develop policy on illegal drugs, alcohol, tobacco and psychoactive medication. Use of the first three substances is primarily considered to be a public health issue. However, this phenomenon should be seen in its global context, including the different domains by which it is being influenced and affected: welfare, social integration, education, security, justice and the economy. With regard to the latter, there is a permanent area of tension between the economic imperatives of the pharmaceutical industry and the consequent public health policy on psychoactive medication.

#### **4.4.1. The alcohol policy**

At both international and national levels, growing awareness of the detrimental effects of alcohol use has resulted in several policy documents and strategies. On the European level, the European Charter on Alcohol from the WHO can serve as an example. In Belgium, the Inter-Ministerial Conference on Public Health fulfilled the need for an integral and integrated approach in tackling the alcohol problem by adopting a “Joint declaration on future alcohol policy in Belgium” (2008). The objectives of this new policy are: (1) preventing and reducing alcohol-related harm, (2) tackling the problematic use of alcohol (not only the dependency problem) and (3) pursuing a policy addressed to high-risk groups and risky situations. In implementation of this declaration, several measures and actions were executed concerning availability, legislation, advertising, alcohol in traffic and prices policy, with young people and pregnant women as specific target groups that require extra attention.

For instance, the Law of 10 December 2009 (on various conditions on the subject of health) stated a clear health message by lowering the age limits for selling and serving alcohol to young people with a ban on selling and serving alcoholic beverages to younger minors (under-16s), and liquors to minors (under-18s). Another example is the institutionalising of the Belgian Covenant on Behaviour and Advertising on the subject of Alcoholic Beverages (2005), an agreement between the federal minister for public health, the catering industry and consumer organisations, on the limitations of alcohol advertising (particularly restrictions in advertising to young people). The Law of 12 July 2009 introduced alcohol as a possible aggravating factor when committing a traffic offence.

#### **4.4.2. The tobacco policy**

In the first decade of the 21st century, Belgium moved towards a more restrictive policy on tobacco, which received a lot of attention from the legislator. The Federal Drug Policy Note of 2001 recommended working-out an anti-tobacco policy in order to reduce tobacco use and its health-related consequences. Restrictions on the use and supply of tobacco were meant to be accompanied by awareness campaigns.

In order to obtain these objectives through a global approach, the federal government adopted a plan to combat the use of tobacco, which was executed in 2003-7. As part of this plan several royal decrees were implemented, helping the evolution towards the criminalisation of smoking in public places. In 2005, some protective measures on minors were issued, whereby selling tobacco to persons under the age of 16 was prohibited. Alongside this restriction, cigarette vending machines were equipped with a secure system. Furthermore, the cost of counselling to quit smoking was refunded to pregnant women and their partners. Since 2007, a pack of cigarettes has had to show a combined



warning: an illustration with a small text to inform the smoker about the possible consequences of smoking.

In 2006, the principles of courtesy, which had informally regulated smoking in the working environment since 1993, were superseded by legal restrictions giving employees the right to a smokeless area to protect their health. Also, there was a complete ban on smoking in closed public spaces. Both regulations were taken into account in a new law of 22 September 2009 that also restricted smoking in restaurants. From 1 January 2010, smoking was prohibited in closed public spaces, working environments and restaurants. It was, however, still allowed in bars that did not serve food. This last exception has since been annulled and, from 30 June 2011, smoking in bars is only allowed in separated smoking rooms.

## **4.5. Conclusion**

Since the early 1990s, Belgium has continued to develop a coherent drug policy. A lot of effort through the years has established the core principles in the approach to the multi-dimensional drug phenomenon. A global and integrated policy requires prevention, early detection and intervention, treatment including risk-reduction and repression. Repression towards the users, however, remains a last resort (*ultimum remedium*). The drug policy currently being pursued relies on objective and scientific data, which have a sufficient basis and are subject to validation of good practices in the different sectors of the work field. Belgian drug policy is part of international treaties and European policy plans, to ensure consistency with international and European policy. The General Drugs Policy Cell (and its three working cells: Drug Health Policy Cell, Control and International Co-operation) and the Inter-Ministerial Conference on Drugs are the fora for co-ordination and consultation in putting the global and integrated drug policy and the joint declaration into practice.

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## **5. Coherency of Irish policies on illicit drugs, alcohol and tobacco**

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### **5.1. Introduction**

This chapter seeks to assess the coherency of Ireland’s policies on alcohol, tobacco and those psychoactive substances controlled under the United Nations drug conventions (referred to as “illicit drugs” in this chapter) in relation to an over-arching health objective. Following the approach outlined in Chapter 2, each policy is assessed against the following six indicators:

- problem conceptualisation,
- policy context,
- legislative/regulatory framework,
- strategies,
- responses,
- structures and resources.

The definition of health in this chapter is that used by the World Health Organization (WHO) in its founding charter and adopted in Ireland’s current national health strategy: “a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity” (Department of Health and Children 2001). In pursuit of this over-arching health objective, the Irish Government has developed a “population health” approach, defined as “one which promotes and protects the health of the whole population or sub-groups, with particular emphasis on reducing inequalities” (Health Service Executive 2008).

Ireland’s policies on illicit drugs, alcohol and tobacco, all included in Ireland’s national health strategy, are here assessed in terms of whether and how they contribute to realising this over-arching population health objective. Particular attention is paid to how the three policy areas make use of prevention measures, based on the health promotion model, which seek to elicit

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12. The author wishes to acknowledge comments by Cliona Murphy of Alcohol Action Ireland (<http://alcoholireland.ie>), a national charity for alcohol-related issues, on an earlier version of this chapter. All errors and omissions are the author’s.

individualistic responses (behavioural and lifestyle choices to prevent illness) and structural responses (strengthening environmental factors to maintain good health) (Butler 2002).

For an account of the context and development of Ireland's drug policy since the 1970s and its links with alcohol and tobacco policies, readers are referred to the chapter on Ireland in the first report from this project, published in 2008 (Muscat 2008). The main substantive change in Ireland's policy environment since then has been the political decision to combine illegal drugs and alcohol in one policy domain. The first action listed in the National Drugs Strategy 2009-16 was to "establish a Steering Group in autumn 2009 to develop proposals for an overall Substance Misuse Strategy" (Department of Community, Rural and Gaeltacht Affairs 2009). The recommendations of the Steering Group were presented to the Minister of State, Ms Róisín Shortall TD, on the 7th February 2012. A consultation process will now commence with an action plan being presented to Government during 2012. Tobacco still constitutes a separate and distinct policy domain.

In 2011, the new government transferred responsibility for co-ordinating illicit drugs policy to the Department of Health, where responsibility for alcohol policy also resides. The department has not had responsibility for drugs since the mid-1990s, when the link between illicit drug use and social and economic disadvantage was officially recognised. As a result, lead responsibility was transferred to government departments with responsibility in the areas of local and community development (Ministerial Task Force on measures to reduce the demand for drugs 1996). This shift back to health may foreshadow a shift in policy emphasis, but this had not been articulated at the time this report went to press, so it is not taken into account in assessing the degree of coherency among the different policies.

## **5.2. Problem conceptualisation**

How are the problems associated with the three categories of psychoactive substances described? How do research evidence, media coverage, cultural expressions, social, economic and political considerations shape the nature of the problem?

A notable feature of problem conceptualisation is how perceptions of the toxicity associated with each of the three categories of psychoactive substance, be that toxicity physiological or behavioural (see Table 1), are mediated by various factors including scientific evidence, expert opinion, media coverage, public debate and cultural attitudes. In this section, the

interplay between toxicity and mediating factors is not discussed, only the mediating factors.<sup>13</sup>

**Table 1: Prevalence of illicit drug, alcohol and tobacco use and associated problems in Ireland**

	<b>Illicit drugs</b>	<b>Alcohol</b>	<b>Tobacco</b>
<b>Prevalence in adult population</b>	7 % of Irish adults reported using an illegal drug in the past year (2010/11). <sup>14</sup>	About 81 % of adults reported drinking alcohol in 2007. <sup>15</sup>	The smoking rate for Irish adults in 2007 was 29 %. <sup>16</sup>
<b>Related deaths</b>	There were 293 deaths per annum by poisoning (deaths directly due to the toxic effect of the presence in the body of one or more illicit drugs) in 2008. <sup>17</sup>	Every seven hours, someone in Ireland dies from an alcohol-related illness (about 1 251 people each year). <sup>18</sup>	Each year over 6 500 Irish people die prematurely from the effects of tobacco. <sup>19</sup>
<b>Other costs</b>	To date, no study of the social costs associated with illicit drug use in Ireland has been conducted.	Alcohol-related problems were estimated to cost Ireland €3.7 billion in 2007 – or €3 318 on each person paying income tax – including costs associated with health, absenteeism, workplace accidents, crime, vandalism and alcohol-related road collisions. <sup>20</sup>	No data available.

13. For a more detailed account of how the problems linked to the various categories have been conceptualised, see Muscat R. et al. (2008).

14. National Advisory Committee on Drugs and Public Health Information and Research Branch (2011), *Drug use in Ireland and Northern Ireland: first results from the 2010/2011 drug prevalence survey*, Bulletin 1, National Advisory Committee on Drugs, Dublin.

15. Morgan K. et al. (2009), *SLÁN 2007: Survey of lifestyle, attitudes and nutrition in Ireland. Alcohol use in Ireland: a profile of drinking patterns and alcohol-related harm from SLAN 2007*. Dept of Health and Children. Dublin: The Stationery Office.

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18. <http://alcoholireland.ie/alcohol-facts/alcohol-related-harm-facts-and-statistics/>. Accessed on 24 October 2011.

19. Tobacco Control Unit (2010), Tobacco control fact sheet January 2010, [www.dohc.ie/fact\\_sheets/tobacco\\_control\\_sept2011.pdf?direct=1](http://www.dohc.ie/fact_sheets/tobacco_control_sept2011.pdf?direct=1). Accessed on 24 November 2011.

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### **5.2.1. Illicit drugs**

The “heroin epidemic” in Dublin in the mid- to late 1980s coincided with the emergence of HIV/AIDS as a public health issue. This led to the development in 1991 of a government drugs strategy that addressed the public health risk and the need to reduce harms associated with intravenous drug use (Department of Health 1991). In 1996, the Ministerial Task Force on Measures to reduce the demand for drugs used epidemiological data on problem drug use to highlight the association between problem drug use, especially of opiates, and social exclusion and poverty. This framing of the drug problem has continued to underpin government policy on illicit drugs.

### **5.2.2. Alcohol**

Although the problems associated with alcohol consumption in Ireland were already recognised in the mid-1990s, it has been difficult to reach a consensus on how these problems should be addressed. To this day, there is no national alcohol strategy and no coherent approach to the problems associated with alcohol use. This difficulty has been attributed to divergent cultural attitudes: alcohol has been regarded as part of everyday life in Ireland and “essentially benign”, while illicit drugs have been regarded as “unspeakably evil” (Butler 2002).

Ten years after the first report of the ministerial task force on measures to reduce the demand for drugs, which suggested that a “coherent, integrated” drug and alcohol strategy should be developed, a joint Oireachtas committee (comprising members of the upper and lower houses of Parliament) published a report on whether and how such a strategy might be developed (Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs 2006). The report noted that public support for alcohol-control measures was growing, citing a recent survey which showed that most people were aware of Ireland’s problem with alcohol, but that only about a quarter believed that the government was doing enough to tackle the problem. Treatment data also showed a growing problem of polydrug use, involving consumption of both alcohol and illicit drugs.

Notwithstanding the growing call for combining strategies, the different perceptions of alcohol and illicit drugs persisted. In her foreword to the 2006 parliamentary report, the chair explained that the committee believed the combined strategy should be called a “substance-misuse” strategy rather than a “drug and alcohol” strategy because they were “loath to have alcohol classified alongside heroin and cocaine etc., and all that entails”. As noted in Section 5.1 above, in 2009 the government took the political decision to include both illicit drugs and alcohol in a “substance-misuse strategy”. Following the presentation of the recommendations of the Steering Group to the minister in February 2012, a consultation process will now commence and an action plan will be presented to the government in 2012.

### 5.2.3. Tobacco

Following a comprehensive review of the international evidence, in 2000 a Tobacco-Free Policy Review Group assessed tobacco-related risks as follows: “Tobacco products are not just another consumer product with regrettable adverse products. These products, when used in the manner intended by the manufacturer, cause addiction followed by illness and premature death.” (Tobacco-Free Policy Review Group 2000). However, the review group did not see prohibition as an option because: “A complete ban would, in our opinion, lead to the emergence of a substantial black market in smuggled products with its associated criminality” (ibid: 42).

Dr Tony Holohan, Chief Medical Officer at the Department of Health, has highlighted the need for an integrated approach to tobacco and alcohol control. Noting that Ireland was at an advanced stage in reviewing its tobacco policy, he said at a forum on obesity that they needed to look at relationships between lifestyle factors – including tobacco use, alcohol consumption and obesity – and their effects on health: “There is no way these complex, societal challenges which face all of us can be confronted unless we can find a way of working together.” (Gartland 2011).

## 5.3. Policy context

Where are drug and alcohol policies located in the overall policy environment? Are they in criminal justice or medicine, or in a value set like social inclusion, human rights or equality?

Ireland has tended to be a policy taker in relation to policies on the three categories of psychoactive substances: it has followed the policy priorities agreed internationally.<sup>21</sup> Policy may also be influenced by the “political rationalities” of the day, which bring different political values and aspirations to the fore, such as welfarist, neo-conservative or neo-liberal (McKeganey 2011; Houbourg and Bjerge 2011). All these influences can be seen at work in the Irish policy arena at various times.

### 5.3.1. Illicit drugs

Following ratification of the UN conventions on drugs, Ireland translated the provisions into law. As a consequence, Irish drug policy is partly located in a criminal justice context, in which the customs and police authorities work to reduce the supply of, and demand for, drugs through law enforcement. Since the first recognition of a drug problem in Ireland, the national response has also been partly health-based. Initially, this meant treatment

21. For example, UN drug conventions; the WHO European Charter on Alcohol; its Framework Convention on Tobacco Control; EU directives on alcohol and tobacco policy; EU strategies/action plans on illicit drugs and alcohol-related harm.



for individual drug users. From the late 1980s, following acknowledgement of the links between the spread of infectious diseases and injecting drug use, harm-reduction measures were also introduced, but at local level, being only gradually absorbed into mainstream policy (Butler and Mayock 2005).

As noted earlier, the 1996 report of the ministerial task force on measures to reduce the demand for drugs recognised the link between problem drug use and socio-economic deprivation, and Ireland's first national drugs strategy was positioned within the broader domain of social inclusion policy. The review group that drafted the strategy commented:

The review group fully recognises that, notwithstanding the obvious benefits for communities affected by the drugs problem of having a specific drugs strategy, the best prospects for these communities, in the longer term, rest with a social inclusion strategy which delivers much improved living standards to areas of disadvantage throughout the country.<sup>22</sup>

### **5.3.2. Alcohol**

As noted in Section 5.2 above, there has so far been no national alcohol strategy and no coherent approach to problems associated with alcohol use. Although responsibility for alcohol policy resides in the Department of Health, this has not resulted in a policy approach noticeably rooted in a public health philosophy. For example, there has been no over-arching policy objective stating that the aim of alcohol policy is to lower alcohol use; furthermore, in recent years, the government has enacted policies and legislation that have countered a public health approach by increasing availability of alcohol products and access to them.

### **5.3.3. Tobacco**

Ireland's tobacco policy is located entirely in a population health context, which includes both the health of tobacco users themselves and the wider environmental health risks created by tobacco smoke. The overall objective is to achieve a "tobacco-free society" (Tobacco-Free Policy Review Group 2000).

## **5.4. Legislative/regulatory framework**

How are the various psychoactive substances controlled and regulated?

Legislative provisions are in place to (1) control the supply and quality of the three categories of psychoactive substances, (2) regulate the markets in those substances, and (3) reduce the external costs associated with trade in the substances and their consumption.

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22. Department of Tourism, Sport and Recreation (2001), *Building on experience: National Drugs Strategy 2001–2008*. Dublin: Stationery Office, paragraph 6.1.9.

The Irish Medicines Board, a statutory body, licenses the manufacture, preparation, importation, distribution and sale of medicinal products, including all drugs, in Ireland. The Misuse of Drugs Regulations 1988, drafted on foot of the Misuse of Drugs Acts (MDA) 1977 and 1984, include schedules of the substances controlled under the UN conventions. The quality of alcohol and tobacco products available in Ireland is also controlled in line with Ireland's international agreements and commitments.

Trade in illicit psychoactive substances is prohibited in Ireland: under the MDA, the importation, manufacture, trade in and possession, other than by prescription, of the scheduled substances are all criminal offences. In response to the emergence of head shops<sup>23</sup> selling "legal highs", the Criminal Justice (Psychoactive Substances) Act 2010 was enacted, making it a criminal offence to sell or supply substances which might not be specifically controlled under the MDA but which have psychoactive effects. As a consequence of prohibition, there are no measures controlling the quality of the substances traded in this illegal market or regulating the market itself. With regard to the legality or otherwise of harm-reduction measures, a review of Irish legislation governing the production, possession and supply of controlled drugs found that methadone treatment by medical practitioners and pharmacists is provided for under the MDA but it is not permissible to legally operate a drug-consumption facility in Ireland (Moore et al. 2004). Given the residual uncertainty surrounding the legality of other harm-reduction measures, such as advice on safe drug use or needle exchange, organisations providing these types of service in Ireland have been advised to seek legal advice and to communicate and work co-operatively with local police personnel (Moore et al. 2004; Kiely and Egan 2000). In Dublin needle exchange services are provided through HSE clinics and through voluntary sector providers. The HSE is in the process of rolling out a needle exchange service through community pharmacies at various locations outside Dublin to facilitate broad national coverage.

The markets in tobacco and alcohol in Ireland are controlled, increasingly strictly, under the Public Health (Tobacco) Acts 2002, 2004 and 2009, and the Intoxicating Liquor Acts 2000, 2003 and 2008. A key objective behind this growing body of legislation is to ensure that young people are neither exposed to nor able to have access to tobacco or alcohol products. The legal minimum age for purchasing tobacco and alcohol is 18 years.

By law, the advertising and display of tobacco products is prohibited on television, in shops and around cigarette vending machines, and access to tobacco products in retail outlets and licensed premises is strictly controlled. Health warnings on tobacco products occupy 32% of the front of each packet and 45% of the back. Legislation has recently been introduced in Ireland to provide for combined text and photo warnings on tobacco products. Given the

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23. A head shop sells goods related to illicit drugs or of interest to the drug culture.

finding that tobacco price elasticity is comparatively high among low income groups and young people, pricing of tobacco products is used in Ireland as a policy tool to discourage people, including children, from purchasing tobacco; tax represents about 80 % of the retail price of cigarettes. It is illegal to sell cigarettes in packs of less than 20, again to deter people, especially children, from buying them.

The alcohol market is not as tightly controlled. Legislation specifies the opening hours for licensed premises and off-licences, and prohibits a “happy hour”, a limited period in any day when alcohol is sold at reduced prices, but there is little control of alcohol marketing at point of sale, such as product promotions or placements in mixed retail outlets like supermarkets. By law, it is an offence to supply alcohol to a drunken person or to admit a drunken person to a bar.<sup>24</sup> Moreover, children under the age of 18 are only allowed in licensed premises if they are with a parent or guardian, subject to certain time and other restrictions, and may not drink there;<sup>25</sup> similarly, children may not enter an off-licence premises unless accompanied by an adult.

Voluntary codes on alcohol advertising and sponsorship are negotiated between the Department of Health and representatives of the Irish alcohol and advertising industries. The codes aim to reduce the exposure of young people to alcohol advertising and marketing, and limit the volume and placement of alcohol advertisements across all media in Ireland. The effectiveness of the codes in discouraging inappropriate consumption of alcohol has never been evaluated. The Department of Health is currently engaged in a review of the need for legislative measures in relation to alcohol advertising, promotions and sponsorships.

Ireland has used pricing as a policy tool to reduce tobacco use, but not to cut alcohol intake.<sup>26</sup> According to an EU report, in 2004 Ireland was one of six countries in the EU where alcohol had become 50 % more affordable than eight years earlier, primarily because of increased disposable income in Ireland (Rabinovich et al. 2009). Furthermore, alcohol prices in Ireland have recently fallen while average prices have risen: according to the Central Statistics Office Consumer Price Index, average prices rose by 2.6 % in the year to September 2011, while alcohol prices fell by 1 % in the same period. And finally, in 2010 excise rates on alcohol in Ireland were cut by around 20 % with a resulting rise in alcohol consumption, from 11.3 litres per capita in 2009 to 11.9 in 2010. In the public debate ahead of the development of a National Substance Misuse Strategy, the policy option of a minimum price for alcohol products is being widely debated. It is argued that, as minimum pricing affects people directly in relation to how much they drink, it will primarily affect those

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24. Intoxicating Liquor Act 2003, s. 4.

25. Children may only drink alcohol in a private residence and only with the permission of their parents.

26. This paragraph uses information from Alcohol Action Ireland (2011).

who drink most, and also children and young people who tend to consume low-cost alcohol. The legality of minimum pricing under Irish law has yet to be established.

Regarding external costs, the prohibition of the market in illicit drugs led in the 1990s and 2000s to a surge in drug-related criminal activity. In response, successive Irish governments have enacted a large body of criminal justice legislation to tackle drug trafficking/smuggling and money laundering, giving powers to detain and interrogate suspects, to impose harsher sentencing for offences relating to possession of drugs for supply, to confiscate illegally-acquired assets, to tackle organised crime and to combat drug dealing in communities and in prisons.<sup>27</sup> The consequences of intoxication by alcohol and/or drugs are also addressed jointly in a range of laws dealing with public order, anti-social behaviour and dangerous driving.<sup>28</sup>

With regard to the public “bads” associated with tobacco, in line with the WHO Framework Convention on Tobacco Control, Ireland enacted legislation in 2005 to protect third parties, such as workers, from the ill-effects of exposure to second-hand smoke. Compliance with this legislation is reported to be as high as 95 % across all sectors (Tobacco Control Unit 2010). At the same time, Europol recently reported that, on account of its comparatively high tax on tobacco, Ireland is becoming one of several preferred destinations for organised crime groups who are increasingly active in cigarette smuggling, which is seen as “an attractive alternative to drug smuggling because of the lower penalties and larger profits” (Europol 2011).

## 5.5. Strategies

What are the goals and aspirations, and the objectives of illicit drug, alcohol and tobacco policies?

Since 2001 Ireland’s strategic approach to the challenges of illicit drugs and tobacco has been set out in national strategy documents. They reflect the population-health aims and objectives set out in the national health strategy and population-health strategy, as described in section 5.1. In line with the previous eight-year national drugs strategy, the *National Drugs Strategy 2009-2016* has this over-arching strategic objective – “to continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research” – and its strategic aims include a safer, healthier

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27. See, for example, Criminal Justice (Drug Trafficking) Act 1996; Criminal Assets Bureau Act 1996; Europol Act 1997; Criminal Justice (Theft and Fraud Offences) Act 2000; Criminal Justice Acts 1999 (sections 4-6), 2006 and 2007.

28. See, for example, Road Traffic Act 1994; Criminal Justice (Public Order) Acts 1994 and 2002; Maritime Safety Act 2005; Safety, Health and Welfare at Work Act 2005; Railway Safety Act 2005; Intoxicating Liquor Act 2008.

society, comprehensive treatment and rehabilitation services for individual problem drug users, and sound and relevant data on the extent and nature of problem substance use, to help inform future policy decisions (Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs 2006).

Since 2000, *Towards a Tobacco-free Society* (Tobacco-Free Policy Review Group 2000) has provided the basis for government policy on tackling the tobacco problem. The mission is to “promote a tobacco-free society” and four “key strategic objectives” seek to change attitudes, help people give up smoking, protect people from passive smoke and focus on children.

With regard to alcohol, as already noted, the recommendations of the Steering Group of the “national substance misuse strategy” were presented to the Minister in February 2012, a consultation process will now commence with an action plan being presented to Government during 2012. It is expected to set out strategic aims and objectives for alcohol within a population health context.

## 5.6. Responses

Are interventions logically consistent and mutually supportive?

The *National Drugs Strategy 2009-2016* contains operational objectives and 63 actions, which are designed to ensure that the strategic objective and aims (noted in section 5.5) are met. The objectives and related actions align with the population-health approach already indicated by the overall strategic aims and objectives (see Table 2).

**Table 2: Responses to drug-related problems: *National Drugs Strategy 2009-2016***<sup>29</sup>

Policy approach	Operational objectives
Supply-reduction actions focus on tackling and reducing community drug problems as well as closing down the market in illicit drugs	<ul style="list-style-type: none"> <li>– Significantly reduce the volume of illicit drugs available in Ireland</li> <li>– Prevent the emergence of new markets and the expansion of existing markets for illicit drugs</li> <li>– Disrupt the activities of organised criminal networks involved in the illicit drugs trade in Ireland and internationally, and undermine the structures supporting such networks</li> <li>– Target the income generated through illicit drug trafficking and the wealth generated by individuals involved in the illicit drugs trade</li> <li>– Tackle and reduce community drug problems through a co-ordinated, inter-agency approach</li> </ul>

29. Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs (2006).

Policy approach	Operational objectives
Prevention actions focus on the general population and on communities at particular risk	<ul style="list-style-type: none"> <li>– Develop a greater understanding of the dangers of problem drug/alcohol use among the general population</li> <li>– Promote healthier lifestyle choices among society generally</li> <li>– Prioritise prevention interventions on those in communities who are at particular risk of problem drug/alcohol use</li> </ul>
Treatment and rehabilitation are focused not only on medical interventions, but also on reintegration, including education, accommodation and employment measures	<ul style="list-style-type: none"> <li>– Develop a national integrated treatment and rehabilitation service that provides drug-free and harm-reduction approaches for problem substance users</li> <li>– Encourage problem substance users to engage with, and avail of, such services</li> </ul>
Research aims to generate information that can inform policy and practice	<ul style="list-style-type: none"> <li>– Ensure the availability of data to accurately inform decisions on initiatives to counteract problem substance use</li> <li>– Provide appropriate research to fulfil the information needs of government in formulating policies to address problem substance use</li> </ul>

Building on the *Towards a Tobacco-free Society* strategy document, in February 2010 Ireland's Health Service Executive (HSE) published a Tobacco Control Framework to provide an evidence-based approach to its work in addressing tobacco-related harm within the population as a whole and in particularly vulnerable groups such as children, adolescents and those at the margins of society. The framework is modelled on the MPOWER package of evidence-based tobacco-control policies promoted by the World Health Organization and the nine elements of the HSE's Population Health Strategy (see Table 3, below).

The Tobacco Policy Review Group was established in 2010 with the following terms of reference: (i) to examine Irish and international evidence and experience of effective measures and programmes to reduce smoking prevalence; (ii) to arrange a workshop of relevant stakeholders to identify what additional measures are feasible to reduce smoking prevalence rates in Ireland; (iii) to make policy proposals to the Minister aimed at reducing smoking initiation and prevalence. The report will be published in 2012.

Following the publication of the recommendations of the Steering Group, a consultation process will commence with an action plan being presented to Government during 2012. This is also expected to be framed with a population health context.

**Table 3: Responses to tobacco-related problems: HSE’s Tobacco Control Framework, 2010<sup>30</sup>**

<b>WHO MPOWER principles</b>	<b>HSE Population Health Strategy – nine principles</b>
<p><b>M</b>onitoring of tobacco use and prevention policies</p> <p><b>P</b>rotecting people from second-hand smoke</p> <p><b>O</b>ffering help to people who want to quit</p> <p><b>W</b>arning of the dangers of tobacco</p> <p><b>E</b>nforcing bans on advertising, promotion and sponsorship</p> <p><b>R</b>aising taxes on tobacco</p>	<ol style="list-style-type: none"> <li>1. Addressing the wider determinants of health and tackling health inequalities</li> <li>2. Planning for health and social well-being, not just health and social care services</li> <li>3. Developing and employing reliable evidence to improve health and social care outcomes</li> <li>4. Making choices for health investment</li> <li>5. Measuring and demonstrating the return for investment in health and social care services</li> <li>6. Shifting the balance from hospital to primary care and health promotion</li> <li>7. Integrating services across the continuum of care</li> <li>8. Proactively engaging and working with other sectors to improve health</li> <li>9. Engaging the population on the issue of their own health</li> </ol>

### 5.7. Structures and resources

To what extent does the organisation of structures and resourcing support the co-ordination and/or integration of drug, alcohol and tobacco policies?

In their empirical study of the extent to which drug and alcohol policies were integrated in various jurisdictions, van de Mheen and Barendregt found that Ireland was unique in having separate policies on illicit drugs, alcohol and tobacco and only loose co-ordination mechanisms supporting dialogue between government departments in relation to policy (Muscat et al. 2010).

The structures and resources supporting the development and implementation of Ireland’s tobacco policy are quite separate and distinct from those supporting illicit drugs and alcohol policies. Until 2011, the Office of Tobacco Control (OTC), a statutory body established under the 2002 Public Health (Tobacco) Act, had responsibility, on behalf of the responsible minister, for developing and implementing policies and objectives to control and regulate tobacco products. It also organised research and disseminated the results, co-ordinated a national inspection programme and advised the minister on the manufacturing and marketing activities of the tobacco industry.

As of 1 January 2011, the Office of Tobacco Control was dissolved and its staff and functions were transferred to a National Tobacco Control Office within the Health Service Executive. The National Tobacco Control Office continue

30. HSE (2010), *Tobacco Control Framework*, www.hse.ie. Accessed on 24 November 2011.

to have all of the functions of the dissolved Office of Tobacco Control. Within the Department of Health the Tobacco Control Office responsibilities include: maintaining appropriate arrangements and structures for the implementation of tobacco-control policy and legislation; drafting legislation to implement EU directives/decisions on tobacco; monitoring enforcement of legislation; working with the HSE to build compliance; and representing Ireland on tobacco-related EU and WHO groups. The HSE's environmental health officers are responsible for enforcing, among other things, tobacco-control legislation, including the restriction of advertising and marketing of tobacco products, under-age sales and enforcing the prohibition of the smoking of tobacco products in certain places.

The current structures supporting the development and implementation of illicit drug policy were put in place on foot of recommendations contained in the mid-1990s reports of the ministerial task force on measures to reduce the demand for drugs (whose work is discussed above under 5.2. Problem conceptualisation and 5.3. Policy context). A strong emphasis is placed on social partnership, providing for ongoing dialogue on social and economic issues between government and the trade union, employer and business, farming, community and voluntary sectors. Fourteen local drugs task forces (LDTFs) have been established in areas experiencing the greatest level of problematic drug use, with representatives from government, statutory bodies, and voluntary and community organisations involved in service provision locally. These task forces ensure the development of co-ordinated and integrated responses to tackling the drugs problem. In 2004-5, 10 regional drugs task forces (RDTFs) were established, covering all the country not included in the LDTF areas. All these DTFs are funded by and report to the government department with responsibility for developing drug policy and co-ordinating implementation of the national drugs strategy. Every quarter, an Oversight Forum on Drugs, with representatives of all relevant government, statutory, voluntary and community bodies, meets to review progress and to address any bottlenecks.

Between 1997 and 2011, responsibility for drug policy and co-ordination lay with government departments that also had responsibility for local and/or community development. In March 2011, when the newly elected government abolished the Department for Community, Equality and Gaeltacht Affairs, responsibility for illicit drugs was transferred back to the Department of Health, which had had lead responsibility until the mid-1990s. This department is now tasked with implementing both the national drugs strategy and the new substance-misuse strategy, which will include both drugs and alcohol.

The Department of Health has had continuous responsibility for alcohol policy. Although its health promotion unit developed the National Alcohol Strategy in 1996, this document lacked teeth and was largely ignored; subsequently, the department preferred to develop alcohol policy via temporary



groups – a strategic task force on alcohol, which reported in 2002 and 2004, and a government alcohol advisory group, which reported in 2008. Alcohol-related services have tended to be provided in tandem with drug-related services; for example, educational activities in relation to prevention include illicit drugs, alcohol and tobacco, and treatment services provided by the Health Service Executive, and those funded through DTFs, address problems associated with both illicit drug and alcohol use.

That these ad hoc arrangements may not always have had beneficial results is suggested by the findings of an epidemiological study, which has found that while policy in Ireland on the treatment of alcohol disorders shifted from the disease to the public health model as long ago as the mid-1980s, change on the ground was slow and some of the main tenets of the disease model still remained in place in some regions as late as 2007 (Cullen 2011).

From 2005 onwards, calls increased for combining alcohol and drug strategies in order to ensure that the structures and resources available for tackling the illicit drugs problem could also be applied to tackling the nation's alcohol problem.<sup>31</sup> It remains to be seen how structures and resources will be organised in the forthcoming national substance-misuse strategy.

## **5.8. Discussion**

The foregoing assessment indicates that tobacco is the policy area most consistently aligned with a population-based approach to health. Defined as a public health problem, and causing a substantial number of deaths, Ireland's tobacco policy focuses on prevention, of both individual use and environmental exposure to tobacco smoke. Research and monitoring are also designed and undertaken to support effective prevention efforts.

A population-based health approach has also been used in planning responses to problematic illicit drug use. However, in view of the criminal activities, public disorder, anti-social behaviour and violence that may be associated with illicit drugs, criminal justice responses have also been adopted. While these responses may achieve the desired criminal justice outcomes, such as a lower incidence of violent crime or safer communities, they may also serve to undermine the population-health ethos by criminalising and/or stigmatising problem drug users. The authors of a study of the impact of the Criminal Justice (Psychoactive Substances) Act 2010, introduced to target the proliferation of head shops in Ireland, argue that while the Act may have resulted in “effective cross-cutting activity between the health and criminal justice sectors”, it has also had a deleterious effect on efforts to reduce the harms associated with illicit drug use (Ryall and Butler 2011).

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31. Steering Group (2005); and Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs (2006). For a full account of the issues associated with policy co-ordination, see Pike (2008), Ch. 4.

With regard to alcohol policy, there has been considerable ambivalence. With no overall strategy to guide decisions, responses have included self-regulation, licensing and criminal justice responses. Moreover, implementation has been inconsistent. Authors of a recent study on alcohol-related violence in Ireland reported research showing a decline in the number of cases taken under the liquor licensing laws and an increase in the number of public order offences, suggesting a preference for controls in the public arena (street) rather than in the drinking environment (Hope and Mongan 2011).

This lack of coherence among policies on various psychoactive substances, in relation to an over-arching population-health objective, may be expected to have adverse effects in terms of realising “a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity” among the Irish population, as different measures undermine or cancel the effects of other initiatives.

One reason for this lack of coherence may be the different international conventions, charters, frameworks and directives to which Ireland is a party, which favour different approaches to achieving different outcomes. One means of tackling this source of incoherence is to challenge the conflicting approaches at the international level.

For example, in 2011, in order to support UNAIDS’ strategic target of “zero new infections, zero AIDS-related deaths and zero discrimination”, the UN’s Commission on Narcotic Drugs (CND) adopted a resolution supporting this target among injecting and other drug users. Addressing the CND session, a representative of UNAIDS explained why greater coherence between different policy domains was the way to go forward. Some of these reasons are outlined below.

Effective HIV responses among drug users can be quickly undone by counter-productive policing or criminal procedures. For example, if drug users face criminal penalties because they are carrying a clean needle, then needle and syringe programmes are rapidly undermined. Programmes which have carefully and over years built up trust among drug users, and which may be able to reduce problematic drug use and avoid HIV and related health threats, can be devastated within weeks if legal or policing authorities demand names and addresses of clients with a view to prosecuting them. All too often, drug control and AIDS authorities seem to inhabit different worlds. UNAIDS mechanisms for a joint country programme of work at national level create a common UN system platform for joint action. The UNAIDS family looks to the United Nations Office on Drugs and Crime (UNODC) to ensure that this platform is also able to translate into effective support for co-ordinated, mutually supportive national programmes addressing drug users and the threat of HIV (Bartos 2011).

Policy researchers have also begun to explore approaches at national level that can bypass the negative impacts of the law-enforcement approach on public health objectives. Thus, while complying with the abstentionist approach of the UN drug conventions and operating within a legislative framework that respects these international commitments, policy makers might prefer to design and implement policy initiatives that emphasise harm reduction, rather than a coercive law-enforcement response (MacCoun and Reuter 2001; Kleiman et al. 2011). Alternatively, policy makers might shift the goalposts: for example, in place of a legislative framework to address the drugs problem, they might adopt a pyramid of regulatory interventions, from “persuasion” at the base to “licence revocation” at the top (Seddon 2011), or drug policy might be placed within the context of a country’s equality policy, on the grounds that the distribution of drug-related harm is determined as much by how welfare policy distributes risks and benefits, as by the degree of “strictness” of drug policy (Stevens 2011).

The review of strategies and responses in sections 5.5 and 5.6 indicated a high level of coherence between illicit drug and tobacco policies in relation to the overall population-health objective, and the forthcoming national substance-misuse strategy, incorporating policies for alcohol and illicit drugs, is expected similarly to reflect a population-health ethos and approach. However, Section 5.7 revealed tensions at the level of structures and resources, especially in the co-ordination of efforts, differing expectations at national and local level and between statutory and voluntary, and the allocation of resources.

On a theoretical level, having compared US and Canadian institutions engaged in developing and implementing North American drug policy, and finding that the institutional dynamics of state structure, administrative capacity and policy legacies shaped the policy choices available within a polity, Benoit argued that these dynamics are a more useful means of explaining policy changes than a narrow focus on social control (Benoit 2003). Similarly, Seddon proposed that governance structures could be used as a way of mapping the distribution of power within a drug policy system and thereby gaining an understanding of its dynamics (Seddon 2011).

An empirical study at EU level demonstrated how allocation of responsibilities can significantly influence the shape of policy (Elvins 2003). Elvins described how law-enforcement agencies across the EU, including Ireland, led the development of EU-level illicit drug policy, and how, as a result, drug policy has developed on the basis of notions of “protection”, and anti-drugs trafficking policies have converged across all member states, while harm-reduction strategies have been left to the discretion of individual states. The outcome, according to the author, is a much more heterogeneous range of harm-reduction policies in different countries, as opposed to the increased similarity of anti-drug trafficking policies across the EU.

In Ireland, the need to achieve a balance between competing departments was recognised as long ago as 2000, when the Review Group that drafted the first national drugs strategy explained why it was recommending that responsibility for co-ordination of the strategy should be left with a small government department rather than with the Department of Health and Children: “in the case of the Department of Health and Children – as it is a service provider – if it were to be accorded overall responsibility, its ability to drive issues surrounding supply control and education and awareness issues would be limited. The Department of Tourism, Sport and Recreation can, however, be objective in relation to all the thematic areas covered by the national policy.”<sup>32</sup>

Discussion of structures and resourcing brings the discussion full circle, to the conceptualisation of the policy problem, and, in particular, to the question of how different stakeholder groups conceive and shape the definition of the problem. With regard to alcohol policy, the authors of a recent study on alcohol-related violence in Ireland posed the question fairly and squarely: “Will the cultural ambivalence in Ireland towards alcohol and its problems be changed? Will political leadership lead the change with an integrated alcohol strategy, and will communities take action to make their communities a safer place? Only time will tell. To adapt a well-known phrase in Ireland, alcohol’s problems haven’t gone away, you know”. (Hope and Mongan 2011).

It has been beyond the scope of this chapter to explore the historical development of policy positions in Ireland. However, the importance of the historical perspective, and the potential for rapid change, are demonstrated by looking at the changes in 2011 alone – the Office of the Minister for Drugs has been abolished and its functions absorbed into the Department of Health; the statutorily-based Office of Tobacco Control has been dissolved and its functions taken over by the Health Service Executive. How these changes will affect the conceptualisation of the problems associated with the three categories of psychoactive substances is difficult to predict, but change it they will.

## 5.9. Conclusions

This assessment has been selective, choosing certain items of evidence principally because they illustrate how the various indicators (or perspectives) can highlight matters relevant to thinking about the degree of coherency between policies. This approach is justified on the assumption that assessing policy coherence is not a means for measuring policies – for example, against an external benchmark such as an over-arching health objective – which would require rigour to ensure accuracy and comprehensiveness, but is rather a tool to facilitate discussion on how to strengthen the impact of policies relating to misuse of psychoactive substances.

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32. Department of Tourism, Sport and Recreation (2001), paragraph 6.6.2.

In line with the framework of possible objectives and related action areas outlined in Chapter 2, the following measures might be proposed to help make the different policies more coherent:

- eliminate policy inconsistencies, for example ensure that coercive drug policies do not cancel out the benefits of harm-reduction measures; or ensure that taxes to disincentivise the purchase of legal psychoactive substances does not inadvertently incentivise participation in black markets in those substances;
- identify opportunities for policy enhancement, for example seek widespread acceptance of a “whole population” approach to reducing consumption of various substances, rather than targeting problem or under-age users; design organisational structures and co-ordination and integration mechanisms in order to ensure a balanced approach to the over-arching population-health objective; or use research-based evidence to tackle the use of substances from the different categories, for example reducing the incidence of polydrug use involving both illicit drugs and alcohol;
- develop mitigation policies to overcome the adverse effects of non-psychoactive-substances policies, for example consider alternative regulatory or governance arrangements; set policies on psychoactive substances within a broader policy context such as equality or social inclusion; or review strategies in areas such as mental health, suicide prevention, education, training, employment and housing, to ensure they do not undermine policy initiatives in the psychoactive substances policy area;
- ensure consistency in advocacy, for example use the national voice at international forums to put forward arguments and policy options which may help to resolve the contradictions between agreements at international level which have an adverse impact on a health-related outcomes.

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## **6. The evolution of an integrated and coherent policy on drugs and alcohol in Israel**

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### **6.1. Background**

The Israel Anti-Drug Authority (IADA), a statutory government agency set up in 1988, is the central body in Israel charged with leading the struggle against the plague of drugs and alcohol.

The vision of IADA is to lead the State of Israel in its efforts to fight the plague of drugs and the adverse consequences of alcohol abuse, and to ensure a healthy and ethical society in order to promote welfare and a high standard of living for its citizens.

The establishment of IADA was the culmination of a long process that began in the late 1970s, a consequence of the rising number of drug addicts lacking adequate care and demanding solutions to their problems. Until then, drug control efforts were sporadic and unco-ordinated. Not enough treatment facilities were available. Different ministries and non-governmental organisations (NGOs) attempted to offer solutions to the best of their abilities, but there was a lack of co-ordination among the various organisations involved, as well as a lack of adequate and secured funding.

It became obvious that there was an immediate need to implement a uniform national policy to provide a co-ordinated, balanced approach to prevention, training, treatment, rehabilitation and adequate law enforcement. Consequently, an inter-ministerial committee drafted the Israel Drug Control Authority Law 5748 in 1988. The law was approved by Parliament, leading to the establishment of the IADA in December of 1988. In addition to addressing internal needs, the creation of IADA was part of Israel's efforts to comply with Article 6 of the 1971 UN Convention on Psychotropic Substances, which calls for a national anti-drug authority. Israel is signatory to all three international UN drug conventions (1961, 1971, 1988).

Because of the complex, multi-faceted nature of the drug problem, which touches on many areas and demands the involvement of various government agencies, the Prime Minister of Israel is the minister responsible for implementing the Drug Control Authority Law. However, in 2009, Parliament

approved the government's decision to grant the Minister for Internal Security responsibility over the IADA.

Between 2000 and 2010, there was an alarming increase in alcohol problem drinking among adolescent and young-adult populations in Israel. Concerned with this trend, the government decided, in 2005, to extend IADA's mandate to include alcohol abuse. The comprehensive approach to drug prevention, treatment and law enforcement was expanded to include alcohol abuse. National surveys, such as the Health Behaviour in School-aged Children (HBSC) and the national epidemiology survey on drugs and alcohol, have shown that drug use in Israel has remained relatively low and fairly stable among youth and young adults in recent years, placing Israel very low compared to most countries in Europe and North America. The fact that IADA was charged with combating alcohol abuse meant it could apply its successful experience from the field of drugs to the war against alcohol abuse, in an attempt to contain the rising trend.

Under IADA's umbrella, professionals in government and non-governmental agencies work together to rid Israel of the plague of drugs and alcohol. This inter-ministerial and inter-institutional co-operation and co-ordination in prevention, treatment and law enforcement enables IADA to fulfil its main duty, as defined by law: "to formulate all national supply- and demand-reduction policies on drugs and alcohol abuse".

For example, the policy and goals related to the prevention of drugs and alcohol use among youth and young adults are carried out collaboratively by a coalition of partners that include the ministries of education, health, welfare and internal security, and are implemented throughout the formal education system and local municipalities in a integrated and co-ordinated effort using intervention strategies and programmes developed collaboratively. By doing so we can ensure the ongoing implementation of an integrated and coherent intervention strategy across the country.

In addition, IADA is charged with:

- initiating and developing educational and prevention programmes nationwide;
- promoting public awareness materials, organising communal awareness and leading community work in order to create a social climate which rejects substance use;
- treating and rehabilitating victims of substance abuse, and their families;
- supervising all areas related to law enforcement, and all institutions' roles in this area;
- implementing monitoring and research systems to ensure that policy and intervention strategies are evidence-based and evaluated;

- 
- recruiting and training qualified professionals and volunteers to lead the war on drugs from the bottom up;
  - providing national informational services in many formats, through many vehicles and across the spectrum of Israeli society;
  - developing and maintaining contact with national and international bodies active in matters of drug abuse.

## **6.2. National alcohol strategy**

The national alcohol strategy seeks to cover all areas related to the excessive use of alcohol, paying particular attention to youth and young adults, focusing on areas of prevention, awareness and change in youth culture. Nevertheless, it is a comprehensive strategy that takes into account the four pillars: prevention, treatment, law enforcement and harm reduction.

Mediators, such as parents, teachers, mentors, social workers, doctors and counsellors, play a key role in the prevention and treatment of alcohol abuse among youth. In view of this, special attention is given to interventions and training aimed at providing significant adults with tools to enable more effective mentoring to facilitate effective prevention interactions with youth.

The main aim of the strategy is to significantly decrease the excessive consumption and abuse of alcohol, reducing the physical and mental health outcomes of alcohol use, influencing the social well-being of youth by influencing a youth culture that will be free of alcohol (and drugs) and addressing other social and economic hazards to society related to alcohol use.

The recommendations by the World Health Organization (WHO) and the target areas put forward in the: “Strategies to reduce the harmful use of alcohol: global strategy” were easily incorporated and adapted into the parallel key target area of Israel’s national strategy, owing to the high degree of correspondence between these two strategies. The key target areas of the national strategy are: (1) leadership and awareness; (2) health services’ response; (3) community action; (4) drinking and driving; (5) law enforcement and legislation; (6) reducing the negative consequences of drinking and alcohol intoxication among youth; (7) protection of high-risk groups; (8) development of professional human resources; (9) research, monitoring and evaluation.

## **6.3. Evaluation of the national alcohol strategy**

An evaluation study of the national alcohol strategy is planned for the beginning of 2012. Among other things, this will map out current programmes and activities, rates of alcohol use in municipalities where the programme is being implemented, the extent of exposure to the awareness campaign and the efficacy of developments in law enforcement and legislation.

## **6.4. Demand reduction**

Israel devotes much effort to implementing a comprehensive demand-reduction strategy. Co-ordinated by the IADA (in co-operation with relevant ministries such as health, education, social affairs and social services and other governmental agencies and NGOs), evidence-based prevention and treatment programmes are implemented throughout the country, targeting the general and at-risk populations. IADA also addresses addiction as a chronic health disorder, and aims to provide adequate and accessible treatment and rehabilitation solutions to all drug and alcohol abuse victims.

A well co-ordinated and integrated infrastructure allows us to provide a continuum of prevention and treatment services to drug-abuse victims and their families. The comprehensive system of pharmacological and psychosocial interventions provides a wide array of treatment solutions addressing the different needs of individuals based on gender, age, and cultural and religious background, in order to ensure accessibility to all. Addicts and substance abusers who seek treatment are referred to the type of programme which they will be most compatible with, based on personality, cultural considerations, substance abuse situation and prior treatment experiences. Among the solutions are physical detoxification, therapeutic communities, day-care centres, individual and group treatment sessions, family intervention and rehabilitation, which includes legal counselling, help with housing and studies, vocational rehabilitation and follow-up counselling. Facilities for women patients have all women staffs and a treatment centre for mothers with children. A special treatment centre addresses the needs of young adults, particularly those returning from backpacking excursions, suffering from mental imbalance from hallucinogenic or mind-altering drugs. The village is internationally recognised as a unique centre specifically dedicated to the recovery and rehabilitation of non-addict young people.

Seeking to minimise the adverse consequences of drug abuse for society at large, Israel also developed a harm-reduction approach to reduce illicit drug use, beginning with methadone-substitution programmes in 1975. Today, other drug substitutes are available for addicts who are unable to undergo complete drug detoxification, affording these individuals a chance to lead normative lives. As part of this approach, needle-exchange programmes are available in several locations and walk-in clinics assist addicts with rapid admission into treatment programmes. These efforts have led to a significant decrease in the number of cases where individuals contract HIV/AIDS due to drug use. Special attention is given to drug-abuse victims suffering from co-morbidity. Treatment is offered as an alternative to incarceration, and in prison settings.

In co-operation with the Ministry of Education, IADA is involved in developing and evaluating a host of comprehensive school-based health education

programmes aimed at preventing alcohol and drug use. These programmes are age- and culture-specific and focus on children from kindergarten to 12th grade. In addition to health education programmes aimed at all schoolchildren, there are specific programmes for schoolchildren identified as being at risk. They are usually followed up after school in the community in an integrated manner. All new programmes undergo evaluation. The psychological counselling services of the Ministry for Education ensure comprehensive and integrated implementation of school-based programmes throughout the country.

A new national strategy being implemented by IADA is aimed at students in colleges and universities across the country. In co-operation with the academic leaders of higher education institutions, IADA is training and funding the activity of campus co-ordinators, who help to organise implementation of a host of awareness campaigns, peer education programmes and other drugs and alcohol prevention activities on campus. We believe that more than just reducing rates of substance use by college students is at stake here; this target population is important because they are future decision makers and can have an impact on the development of population attitudes and social norms that do not tolerate substance abuse.

Community action is an essential part of our strategy, and the national policy is implemented and adapted to the needs and requirements of individual municipalities at the local level. The community action framework is a multi-disciplinary and integral structure that offers local responses in the areas of education, prevention and awareness; treatment and rehabilitation; and law enforcement. Action is led by IADA local co-ordinators, who are trained and skilled individuals in charge of bringing together all drug-related issues and social initiatives in the municipality, integrating activities carried out at the community level with regional and national action.

In 100 out of 250 municipalities, voluntary parent patrols are active at weekends, visiting local pubs and youth hang-out settings, engaging teens in conversation and offering advice and help, such as a ride home. Workshops and seminars on prevention of substance use and abuse are offered to parents, youth instructors and community leaders. Special programmes are aimed at engaging parents and youth, in order to enhance communication between parents and their children.

Other volunteers, particularly students of education, undergo special training at IADA and are active in school vacations at popular hang-outs, outdoor events and concerts, offering youth a listening ear, advice and assistance when needed.

The IADA community and prevention divisions, and the IADA local authority co-ordinators who manage implementation of local drugs and alcohol policy and programmes, work closely with representatives of local education,

health and welfare professionals, the police and other organisations to ensure a well-integrated and coherent local strategy. For example, the Ministry for Internal Security has put into action a national strategy named Violence-Free Cities, but this programme is also implemented in municipalities across the country using local co-ordinators. The close proximity between the problems of alcohol and drugs, and the causes and consequences of youth violence, for example, points to a vital need to develop and implement an integrated strategy in each municipality so that the target population is exposed to a coherent and consistent set of messages and activities. This is achieved by structuring close collaboration between the two programmes at both national and local level, thus increasing the synergy between the policy and programmes being implemented.

## **6.5. Law enforcement**

Even though it is not in itself a law-enforcement body like the police or DEA, IADA is by law the body responsible for co-ordinating effective collaboration between the various law-enforcement bodies in Israel: the Ministry for Public Security (responsible for the Israel National Police and Israel Prison Services); the Israel Defence Force Police; the National Anti-Drug Money Laundering Unit (which belongs to the Israel Tax Authority); Ministry of Finance; Ministry of Justice and other ministries and law-enforcement bodies in the community.

## **6.6. International co-operation**

Israel takes an integral part in international efforts to combat the global plague of drugs. In recent years, delegations have visited a number of countries, establishing solid platforms for bilateral and multilateral co-operation and mutual learning. IADA has been honoured to host foreign delegations and experts who came to Israel to learn and share best practice and experiences in the field. IADA works closely with MASHAV – the Centre for International Co-operation of the Israeli Ministry for Foreign Affairs, organising courses for participants from developing countries around the world in Israel, and on-the-spot, short-term courses, given in the participants' home countries.

On the multilateral front, Israel has strong working relations with international organisations working to fight substance abuse, among them the UN Office for Drugs and Crime (UNODC), the International Narcotics Board (INCB) and WHO. Co-operation with European bodies, such as the Council of Europe and the European Union, has also risen to a new level, in particular collaboration with the Pompidou Group and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

At a regional level, co-operation between neighbouring countries is essential to control the flow of illicit drugs and crime. A Memorandum of Understanding

agreed upon by Israel and the Palestinian Authority in Cairo in 2005 paved the way for information exchange on reducing drug demand and supply. Mutual study visits also took place with our Jordanian counterpart.

## **6.7. Measurement**

The Office of the Chief Scientist at the IADA is responsible for the development, implementation, dissemination and use of scientifically sound research and monitoring systems that provide comprehensive and coherent information to enable evidence-based policy and intervention strategies in the fight against drugs and alcohol. To do so, IADA implements a host of research systems. Those include national epidemiology surveys, monitoring systems, comprehensive and targeted evaluation studies and an extramural funded research programme supporting academic scientific studies ranging from laboratory experiments to psycho-social determinants research.

Ongoing national surveys include WHO-HBSC (ages 11-18), the Israeli Defence Forces (IDF) drug and alcohol survey (ages 18-21), the national epidemiology survey on drugs and alcohol (ages 18-60) and a finger-on-the-pulse Internet survey that provides ad hoc information on a sample of about 1 500 respondents ages 12-40 every three months. In addition, IADA is planning to conduct the ESPAD survey (ages 11-18) in 2012, thus having ESPAD and HBSC alternate every two years.

Since 1994, Israel has been collecting drug and alcohol information on representative samples of school children aged 11-18, as part of the WHO-HBSC cross-national survey. In addition, IADA conducts periodical national epidemiological surveys on the age groups 12-18 and 19-40.

The HBSC survey is funded jointly by the ministries of education and health, and IADA. The HBSC findings include complete information on smoking (cigarettes and nargila “water-pipes”), alcohol, drugs and related behaviours such as involvement in youth violence or truancy. It also includes an array of information on psycho-social determinants of risk behaviours covering most social settings such as home, community, school, peer group and the Internet. The comprehensive nature of the survey, and the way the findings are disseminated, contribute to an ongoing synergy between all government agencies involved in policy and programmes related to youth smoking, alcohol, drugs and violent behaviours.

The most recent data are from the 2011 HBSC survey. After 15 years in which the trend was an increase in alcohol problematic drinking, in 2011, for the first time, the data show declining rates (compared to 2007) of binge drinking and getting drunk – especially in the younger age group of 11-13. This is a good sign, since for the past two years most intervention efforts in the educational system countrywide have focused on the 5th-9th grades (ages 9-14). Learning from this success, we have extended the focus to include



older youth, a focus that will probably be reflected in the findings of the next survey in two years' time.

Despite the increase in alcohol problematic drinking in Israel during the past decade, Israel is still ranked among the countries with the lowest rates of drinking problems among the 47 HBSC countries.

IADA's national epidemiology survey, representing the different sectors in Israeli society, was last conducted in 2009, but is planned again for 2012. The younger age group in the survey included 7 700 students (ages 12-18) in 175 schools around the country. About half of the students reported consuming alcohol. These figures are similar to the previous survey (2005), but there was an increased intake of alcoholic spirits, compared to the previous survey (in the last year, month and week). About 30 % of respondents reported they got drunk at least once in the past year. About 10.7 % of students reported using an illegal drug of some kind; rates were similar to those of the previous survey. However, about 5.7% had used cannabis in the previous 30 days, an increase compared to previous surveys. The 2011 HBSC findings show a continued increase in cannabis use among schoolchildren, parallel to a drop in youth perceptions regarding the level of danger its use can cause.

Among the adult population (18-40), 11.4 % reported using some kind of illegal substance, 8.9 % reported using cannabis and 1.91 % reported using "other drugs". In general, the findings were similar to the previous survey. Even so, there was a decrease in drinking wine (other than for religious ceremonies) and a minor increase in the rate of drinking beer. In addition, there was a minor increase in the number of people who reported getting drunk.

Since its beginning, IADA has striven to implement evidence- and science-based policy and intervention strategies. It recognises the importance of research as a means to achieving this end, and promotes national research in all areas related to drugs and alcohol.

As part of our collaboration with the EMCDDA in Europe, IADA has recently embarked on the development of the Israeli Monitoring Centre for Drugs and Alcohol. This has involved mobilising representatives from over 20 governmental agencies to co-operate in providing information on the drug-related data they obtain and developing a structured mechanism to pool these data, together with a national observatory, which will be used by all agencies. This will provide a broad and updated picture on all aspects of drug and alcohol demand, supply and treatment across the country. We hope to produce the first national indicators to be sent for inclusion in the international European EMCDDA during the first half of 2012.

In sum, over the past couple of decades, the IADA has been developing, coordinating and leading the implementation of an integrated national policy and intervention strategy aimed at the reduction of drugs and alcohol use

and their consequences. These policies and programmes are orchestrated on a national level in collaboration with all relevant ministries and national agencies, and on the local level, in close synergy and co-operation with local leadership and all relevant municipality agencies and organisations. This integrated approach uses round-table steering committees, both nationally and locally, to oversee activities and ensure a well-integrated and coherent implementation of policy and strategies aimed at reducing the drugs and alcohol problem in Israel.



## 7. Some contextual aspects of Dutch policy on psychoactive substances

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The Netherlands has separate policies on alcohol, tobacco and drugs: they are based on different laws and there is no policy document that includes all psychoactive substances and addictive behaviours. Unlike most EU countries, the Netherlands has not developed a comprehensive “national drug strategy” and a subsequent “action plan”. The latest comprehensive national drug policy document was issued in 1995 (Ministerie van Volksgezondheid Welzijn en Sport 1995). With respect to health-related issues, the co-ordination of these different policies is executed by one ministry, namely the Ministry of Health, Welfare and Sport. The ministries of justice and internal affairs and security focus on the public order aspects of psychoactive substances.

The fact that substance policy in the Netherlands is not integrated does not necessarily imply that it is incoherent. Coherence means that policy actions mutually reinforce one another, or at least are not counteractive.<sup>33</sup> One problem with the term “coherent” is that proponents of a certain policy option will support this option by invoking arguments that make the option coherent. Parties that challenge a certain policy option will do so by trying to demonstrate that the prevailing policy is incoherent. In other words, it is virtually impossible to make any statements about coherence without taking a (normative) position. In the context of the Council of Europe, health and human rights are important values from which norms regarding substance policies may be derived. Nevertheless, in the arena of politics, shared values may still lead to other political standpoints and, thus, other ideas on what a coherent policy entails.

In this chapter we highlight some aspects of coherence within and between substance policies in the Netherlands.

The Netherlands borders on the North Sea in the west, Germany in the east and Belgium in the south. The rivers Rhine and Maas debouch into the North Sea, forming the Dutch delta and historically important trade routes to the hinterland. The fact that part of the Netherlands is a delta, and that a large part of the country is below sea level gave rise to the popular idea that the Dutch

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33. See [www.oecd.org/about/0,3347,en\\_2649\\_18532957\\_1\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/about/0,3347,en_2649_18532957_1_1_1_1_1,00.html) (accessed 8 October 2011).

are a pragmatic people. Since dikes had to be built to protect land from flooding, people had to overcome their religious disagreements and collaborate to protect themselves. Historically speaking this might be too simple a view, yet people tend to cling to this idea. Pragmatism rules over dogmatism. Analogous to this is our self-image that the Netherlands is a country of tradespeople and reverends, based on the observation that, from the 17th century to the present, decisions of national significance have been a trade-off between (Calvinistic) principles and the interests of trade. Principles and pragmatism go hand in hand (Min. BZK 2010).

In 2009 the ministry of health commissioned a report from the National Institute for Public Health and the Environment on the harmfulness of psychoactive substances. In this report, the harmfulness of a substance was assessed on toxicology (short- and long-term), individual harm and social harm. Evaluation of harmfulness was deliberately asked for as an aid to evaluating Dutch drug policy on a rational basis (Amsterdam et al. 2009). If we were to match prevailing policies with the ranking of drugs based on harmfulness, the level of incoherence would be striking, especially if we compare one substance with another. This implies that current policies on substances are not based on the rationale of harmfulness alone, but also on other norms, interests and traditions.

## **7.1. Illegal drugs**

To get an idea of how in the Netherlands illegal drugs are conceptualised, we could have a look at prevailing policies. However, policy documents often lack explicit statements on how the phenomena are viewed. It is only by justifications and other indirect statements on closely related issues that we can see how the substances are seen. It goes without saying that, in a domain like the drug field, policies do not go un-debated. Conceptualisation or framing of the subject is constantly at stake in a politicised debate.

## **7.2. Dutch policy on illegal drugs**

In the case of illegal drugs, international treaties limit the latitude of governments to develop national policies. The three main international treaties on illegal drugs are the UN Single Convention on Narcotic Drugs, 1961; the UN Convention on Psychotropic Substances, 1971; and the UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988. The Dutch Government has made a reservation to the 1988 treaty concerning enforcement of the law that penalises psychoactive substances (Article 3, paragraph 6). The Opium Act of 1976 makes a distinction between cannabis and other drugs, in that the possession of small quantities of cannabis is considered as a minor offence. The reservation to the 1971 treaty expresses this distinction in the national legislation, and led the way to further development

of the appeasement policy on the use and sale of cannabis, ultimately resulting in the coffee-shop system.

The legislative rationale behind the distinction between drugs with an “unacceptable risk” and drugs with a “less serious” risk rests upon a notion of public health. So if we speak about the conceptualisation of illegal drugs, possible health consequences are part of the concept. On the other hand, illegal drugs, by definition, include aspects of criminal law, and thus also policies and practices in this domain have developed.

In 2009 the Trimbos Institute issued a brochure on Dutch drug policy. Its key messages are that drugs are illegal; drug use is not punishable; the law distinguishes between soft and hard drugs for reasons of different health risks; that coffee shops are tolerated because of public health; and that information and prevention are an essential part of public health policy that mainly focuses on young people. This brochure (Gouwe 2009) can be found on the website of the ministry of health (March 2011).

In 2009 the last-year prevalence<sup>34</sup> of cannabis use among the general population (ages 15-64) was 7%. Among schoolchildren aged 12-16, last-year prevalence of cannabis use was 9.3%. An increase was observed in the number of cannabis users that applied for treatment. Last-year prevalence of cocaine use among the general population (ages 15-64) was 1.2%. In 2007 the prevalence of last-month cocaine use among schoolchildren aged 12-18 was 0.8%. Prevalence of opioid use is low among both the general population and schoolchildren. It is estimated that 1.6 persons per thousand inhabitants can be defined as problematic opioid users (2008). A relatively new trend is the use of gamma hydroxybutyrate (GHB). In 2009 the lifetime prevalence among the general population was 1.3%. It was highest among visitors to national and regional rave parties.

Over the past few years the Dutch Government has taken action to evaluate and update its drug policy. In 2008 an extensive policy evaluation was co-ordinated by WODC<sup>35</sup> and the Trimbos Institute<sup>36</sup> (Van Laar et al. 2009), and in 2009 the government installed an Advisory Committee in Drugs Policy that “diagnosed” the situation and made recommendations for improvement (Donk et al. 2009). The committee underlined the successes achieved and critically examined the negative side effects of drug policy, notably cannabis policy. The execution of policy on substances like heroin and cocaine was not criticised by this committee.

The Ministry of Health set up the Co-ordination point Assessment and Monitoring new drugs (CAM) in 2000. Its task is to do risk assessments

34. The prevalence figures in this paragraph are based on the National Drug Monitor 2010 (Van Laar 2011).

35. WODC: Scientific Bureau of the Ministry of Justice.

36. Trimbos Institute: a centre of expertise on mental health and addiction.

(Amsterdam et al. 2004) of new drugs and inform the minister for health. CAM is a partner in the European early warning system for new psychoactive substances. Since then, assessments have been made on various substances, among them cannabis (2008), ketamine (2001), mushrooms containing psilocybin and psilocibine (2000, 2007) and GHB (1999, 2011).

### **7.2.1. Heroin and crack cocaine**

Policy on hard drugs has been mainly focused on heroin and crack cocaine, as substances that have the most damaging effect on the user, their social network and society (Amsterdam et al. 2009). In the mid-1980s the threat of AIDS sparked the innovation of harm-reduction policy related to injecting drug use. In the same decade, crack cocaine made its appearance on the hard drug scene and its use became associated with marginalisation and public nuisance (Coumans 2005). In 1995 the government issued an action plan that explicitly included the fight against drug-related nuisance (Ministerie van Volksgezondheid Welzijn en Sport 1995).

Until the first years of the new century, the use of heroin and crack cocaine was the topic that ruled the local political agenda in many big cities in the Netherlands – partly because of the negative effects on many users, partly because of the negative effects on society. “Drugs-related nuisance” caused a major problem for the liveability of deprived urban areas. In the course of years, there was less and less tolerance for the marginalised drug user as a phenomenon of the city landscape. Marginalised drug users became almost a symbol of failing urban policy, feeding the growing dissatisfaction with traditional middle-of-the-road politics. As a result, increased policing of public nuisance was implemented, in parallel with a targeted approach to individuals identified as causing a public nuisance. In addition, in the mid-2000s the national government set up collaboration with the four big cities to fight homelessness, and explicitly targeted homeless drug users. The joint action of policing and caring has led to a situation where many problematic users of heroin and cocaine are housed, treated and employed in work training projects. A general tendency in Dutch society, which has contributed to the success of this approach, is that citizens are increasingly held responsible for their own lives. Social and economic participation in society has become an obligation rather than a right. Although the government continues to support vulnerable people, they are encouraged to take responsibility and participate in society. Labour training for drug users is not a right but an obligatory part of a trajectory towards “the highest level possible of self sufficiency”.

Dependent heroin users who have proved to be “treatment resistant” are now entitled to enrol in heroin-prescription treatment. After extensive scientific evaluation, prescribed heroin has now become a regular treatment option under strict clinical conditions, and 17 treatment centres in 15 cities are operational (2010), treating about 700 patients.

### 7.2.2. MDMA and similar substances

In the case of ecstasy or XTC (MDMA), a shift can be observed from concerns over the quality of pills on the black market and the short- and long-term effects on the brain, to concerns about XTC production. In the early 1990s, concerns with pill quality led to pill-testing services in recreational settings. This practice came to an end after intervention by Parliament (1999), though the quality of XTC on the black market continues to be monitored, basically as a tool to warn the public in case of dangerous adulterations.

A second concern over XTC was an awareness that the Netherlands had developed into a country that produced and exported the substance. Taking into account international criticism on the Dutch cannabis policy, in the mid-1990s the government decided to scale up action to control production and trafficking of ecstasy (and other hard drugs) in the framework of international collaboration (Neve et al. 2005).

### 7.2.3. Magic mushrooms

The case in 2007 of a deadly accident to a French tourist, who supposedly had used magic mushrooms, fuelled discussion on scheduling the substance. A majority of conservative parties in Parliament demanded a total ban on magic mushrooms, ignoring the advice of a committee (CAM 2000) that there was not enough rationale for prohibition. The Minister of Health commissioned new advice. The committee's advice was, though more comprehensive, basically the same as that given earlier. Nevertheless, the minister proposed to put magic mushrooms under the restrictions of the Opium Act. In 2008 his proposal was accepted by Parliament.

### 7.2.4. Cannabis

The Netherlands is internationally known for its tolerant policy on cannabis. In 1976 the Opium Act was amended and cannabis was classified as a substance that poses "less of a threat" to public health. The rationale behind this re-classification was a public health approach. The legislators wanted to keep the markets for hard drugs ("with unacceptable health risks") separate from the cannabis market. After some years a policy of appeasement developed, resulting, among other things, in the emergence of the "coffee shops". In the framework of appeasement, criteria<sup>37</sup> were defined to which coffee shops should adhere to avoid prosecution. Over the years these criteria were tightened and will probably become more strict in the future. An example of tightened regulation was the introduction of the distance criterion (2008), by which coffee shops less than 250 metres from a school should be closed.

37. The so called AHOJ-g + criteria include: no advertising, no alcohol, no minors, no hard drugs, no nuisance, no sales of more than 5 grams, no stocks of more than 500 grams.



The Opium Act, and the subsequent system of appeasement, only regulates sales of cannabis to the consumer; it does not regulate the wholesale purchase of cannabis by the coffee-shop owner and supplying the coffee shop remains illegal. This is clearly an incoherent aspect of Dutch cannabis policy. When coffee shops started to emerge, most of the cannabis offered was imported from traditional cannabis-growing countries. International drug trafficking is a high-risk activity and these risks stimulated the development of home-grown cannabis. Initially amateurs grew their own supply, the rest being shared with friends or sold to coffee shops. This practice was gradually taken over by commercial cannabis cultivators, increasingly coming from criminal networks. Enhanced law enforcement scared the amateurs away, leaving the business to criminals who are willing to take risks and use violence. The increased level of THC (tetrahydrocannabinol) in cannabis has been attributed to the criminalisation of cannabis cultivation. Profit-driven cultivators are said to have no “love” for the hemp plant and solely focus on growing crops with high THC percentages.

Under the system of appeasement this back-door issue has been addressed by several observers, including the police, several mayors of big cities and the co-ordination point assessment and monitoring new drugs (CAM 2008). However, international treaties and relations do not allow the government much space to move toward relaxation of legislation. Also, conservative political parties, which have always been critical of cannabis policy, have opposed any solution to the back-door problem. To them, closing coffee shops altogether is the best solution.

Another unforeseen effect of the tolerant attitude to cannabis has been the increasing quality of domestically grown cannabis. Crop-improvement techniques have led to THC levels in marijuana equalling those in imported hashish. The increased THC levels fuelled the debate on whether or not the perception of cannabis as a soft drug should be re-evaluated. Although THC levels in domestic cannabis seem to have stabilised (Niesink and Rigter 2011), there is still worry about the effects on (young) people. In recent years an increasing number of requests for treatment related to cannabis use has been observed (IVZ 2011). The explanation for this trend is unclear: it could be related to increased cannabis potency; it could be related to lower barriers to asking for help. A government advisory board has suggested putting cannabis with more than 15 % THC on the list of drugs with “unacceptable risks” (Garretsen 2011). In October 2011 a majority of Parliament voted in favour of this.

The appeased cannabis policy in the Netherlands has led to tourism from all over the world, a phenomenon of which Amsterdam is the best known example. Coffee shops in southern and south-eastern border cities, however, also

developed as well-known destinations for cannabis consumers from Belgium, France and Germany. In those cities, the large numbers of “cannabis visitors” in those cities caused considerable nuisance for the citizens, and coffee shops became a serious public order issue, resulting in dislocation and closure of coffee shops. The ongoing problems and subsequent debates on acceptable solutions led, along with other reasons, to the establishment of the earlier mentioned Advisory Committee in Drugs Policy.

The current government (2011) intends to limit access to coffee shops through the introduction of a mandatory consumer’s pass (“weed pass”), to be issued only to Dutch citizens. This plan goes much further than the advice of the Advisory Committee on Drugs Policy, which advised an experiment with the pass in certain border cities. The minister of interior and security has taken this advice further and insists, despite opposition from many big cities because of the fear of increased street dealing, on a “weed pass” for all coffee-shop visitors. Parliament had still to vote on this proposal in September 2011.

In sum, the current cannabis policy is subject to national debate. The government, supported by a majority in Parliament, inclines towards a repressive standpoint by attributing negative characteristics to the substance and related phenomena. More liberal stakeholders do not praise the substance but argue that the health risks are limited and most adverse effects could be viewed as (undesired) side effects of a repressive approach.

### **7.3. Tobacco**

In line with international developments, there is growing awareness that inhaling tobacco smoke is a serious threat to the health of the individual and subsequently to those who inhale second-hand smoke. Tobacco smoking is viewed as a public health concern because tobacco smoking is seen as the most important avoidable cause of death. The public health concern includes the high costs of medical care related to smoking (Ministerie van Volksgezondheid Welzijn en Sport 2006).

The prevalence of tobacco smoking is 28 % among men and 26 % among women (Stivoro 2010a). Among teenagers (ages 10-19) 21 % reported they had smoked tobacco in the past four weeks (Stivoro 2010b).

The primary aims of Dutch tobacco policy are to discourage smoking and to protect the non-smoker. Several laws contribute to tobacco policy, of which the Tobacco Act is the most important. It is prohibited to sell tobacco products in government agencies, to children under 16 or provide free tobacco products. Besides that, there is a ban on advertising tobacco products. Advertisements on television or billboards and in newspapers or magazines are not allowed. Since May 2002, packets of cigarettes and tobacco have health warnings written on them. These measures are in conformity with the European Union guidelines on the presentation and sales of tobacco products (Directive 2001/37/EG).

So far, the government has delegated the prevention of tobacco smoking to an expert organisation, Stivoro, which is the Dutch centre specialising in tobacco control. Its mission is to promote the health of smokers and non-smokers, by developing and applying knowledge about tobacco use and addiction. Stivoro plays a role in informing stakeholders on the execution of the Tobacco Act. The new government's ministry of health has issued a policy document on health in which the use of tobacco is viewed as part of a lifestyle for which citizens themselves are responsible (Ministerie van Volksgezondheid Welzijn en Sport 2011). One of the consequences of this view is that financial support for Stivoro will terminate as of 2013. Another consequence is that medically assisted abstinence treatment (for tobacco) will no longer be part of statutory health insurance. From a liberal point of view these decisions could be viewed as coherent; from a public health point of view the decisions might be seen as incoherent.

In an increasing number of public places the smoking of tobacco is prohibited. Most of these restrictions go without much debate. An exception to this is the ban on smoking in bars. As of July 2008 the catering industry is smoke-free. The main goal of this prohibition is the protection of non-smokers, especially staff that work in the cafés. From the very beginning this measure was contested by café proprietors and visitors. The proprietors claimed that many of their clients were tobacco smokers and they would lose them because of the ban. Another argument put forward was that, in small cafés, proprietors are behind the bar themselves and do not hire staff. Although the legislation allowed the creation of ventilated smoking compartments in cafés, it was claimed that this would be unrealistic in small-area venues. Debate on this subject came to an end with an amendment of the Tobacco Act (2008) that relaxes the ban for small cafés (up to 70 sq.m.) without employees.<sup>38</sup> This relaxation could be interpreted as a pragmatic solution to the tension between public health principles and the interests of small entrepreneurs. It is unclear what the influence of the tobacco industry lobby has been in this case.

## **7.4. Alcohol**

The ministry of health puts emphasis on the undesirable consequences of “too much” alcohol consumption among adults and young people. Excessive alcohol use is related to adverse health effects, aggression and dangerous driving. These negative side effects should be reduced as much as possible. In its national alcohol policy the government focuses on minimising the number of individuals who use alcohol problematically. The goal of the alcohol prevention policy is not to discourage the moderate use of alcohol or to prohibit it – it is seen as a socially accepted stimulant, which (if used moderately) will not cause harm for most people. The focus is on lifestyle education of young

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38. This relaxation is not applicable to cannabis coffee shops.

people and on detecting and referring (young) people with risky consumption patterns to treatment. A second focus of the policy is to minimise the risk of alcohol-related problems in specific situations: family, work, traffic and night life. The prevention of problematic alcohol use is targeted at specific contexts rather than on general prevention.

The prevalence of recent (last-year) alcohol consumption among the general population is 84 %; for current use, 76 % report having consumed alcoholic drinks in the past month (Van Rooij, 2011).

Research has shown that the most effective way to decrease alcohol use is an alcohol policy that contains a mix of different measures. An integral alcohol policy includes limitation of access to alcohol (e.g., an age threshold) and targeted prevention aimed at alcohol users at risk (e.g., driving or at work). The most effective measures reduce the availability of alcohol: buying alcohol is made more difficult. Financial availability can be narrowed down by price rises, by means of excise/tax (Anderson and Baumberg 2006).

The European guidelines on alcohol focus on regulation of taxation of alcoholic beverages. The guideline, dating from 1992, was modified in 2006 when minimum tax rates were introduced. The rationale for this guideline is regulation of the internal market rather than the minimisation of health risks.

In 2001 the Council of the European Union issued a recommendation “on the drinking of alcohol by young people, in particular children and adolescents” (Council Recommendation 2001/458/EC). The recommendation explicitly took the interests of the alcohol industry into account. It addressed the form and content of alcohol marketing, but not its volume or timing. In the Netherlands alcohol marketing was left to self-regulation by the industry till 2008. In that year Parliament adopted, after lengthy debate, the proposal of a complete ban on alcohol commercials between 06:00 and 21:00 on radio and television. As said, alcohol marketing is mostly shaped by self-regulation which, in turn, is shaped by negotiations between industry, government and health interest groups.

In 2006 the European Commission issued “an EU strategy to support Member States in reducing alcohol-related harm”, with goals to be attained by 2012 (COM (2006) 625). The Alcohol Strategy could be viewed as important because it was the first time the commission had put alcohol-related harm on the European agenda. The strategy does not insist that national legislation be amended. Individual member states remain responsible for their national alcohol policies.

The current debate on alcohol focuses on (excessive) alcohol consumption by young people. There is increasing evidence that alcohol use could have a negative influence on their brain development (Brown et al. 2000). About the turn of the century, this notion coincided with the emergence of “booze barracks”

(*zuipketen*) and binge drinking (*coma zuipen*). These phenomena received a lot of media coverage and thus alerted politicians and health professionals.

Two important lobby groups operate in the field of alcohol policy. One group, Stiva,<sup>39</sup> represents the interest of the alcohol industry and contributes to the reduction of “alcohol misuse”. This lobby group promotes responsible and moderate drinking at various websites. In doing so, they also protect and promote the image of alcohol as a sociable substance. The participation of this lobby group in the national campaign to promote the age limit of 16 years could be seen as an expression of its position as a reliable and respectable partner.

The other lobby group, STAP,<sup>40</sup> takes a health approach and basically communicates the message that “less is better”. This lobby group is critical to the message that moderate alcohol use is part of a healthy lifestyle. They closely and critically monitor commercial expressions of the alcohol industry. They have lobbied strongly, in collaboration with some major health organisations, to raise the legal age to buy soft alcoholic beverage from 16 to 18 years, a proposition that was voted against by a majority in Parliament (2010).

The issue of binge drinking by young people has successfully been addressed by a medical doctor. In the hospital where he works, he opened an alcohol clinic for young people who have drunk themselves to unconsciousness. Over the years the topic has raised a lot of media attention and at the beginning of 2011 Parliament agreed on a proposal to open similar alcohol departments in other hospitals throughout the country.

## **7.5. Reflection**

Although Dutch policy on psychoactive substance is a non-integrated policy (different policy papers on different substances), the over-arching approach could be defined as pragmatic. All policies take into account a mix of public health and public order interests. But if we look a bit closer we discover that economic interests also play a role, notably the economic interest of the alcohol industry and to a lesser extent the interests of small entrepreneurs in the catering industry.

In the case of alcohol, it could be seen as ironic (but not incoherent) that there is no political majority to raise the legal age to buy alcoholic beverages to 18 years, and at the same time there is political support for alcohol clinics for young people.

With respect to scheduled drugs the approach is slightly different. Public health and public order arguments are the most important rationales in developing policies on psychoactive substances. However, normative arguments also seem to play a role in this field. The case of magic mushrooms illustrates

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39. Stiva: Stichting Verantwoord Alcoholgebruik (Foundation for Responsible Alcohol Use).

40. STAP: Dutch Institute for Alcohol Policy.

the weakening influence of health arguments on drug policy and the direct influence of the political power balance. Political decisions do not take into account only health arguments, but also normative and electoral arguments. With the desire to update drug policy, notably cannabis policy, the government has commissioned an evaluation study and has appointed several advisory committees (van de Donk, Garretsen), alongside existing consulting structures (CAM). The extent to which the government follows up on advice seems to depend on prevailing political configurations. The rationality of weighing out substance-related risks remains subordinate to weighing out political stakes.

Both advisory committees (Donk et al. 2009, Garretsen 2011) recommended that alcohol use should be considered in designing drug policy, because alcohol use brings substantial harm to society and many individuals. This is a call for an integrated approach, coherent with a view that puts substance-related harm in a central position of the policy debate.

Although the policy on tobacco and alcohol are subject to competing interests, the political disagreements raise moderate media attention. The approach to cannabis, however, seems to be controversial. The debate on cannabis policy is partly rooted in the incoherent appeasement policy that allows sales to consumers and prohibits wholesale supply to retail distributors. Although the scheduling of cannabis with a high THC level (> 15%) as a “hard drug” is motivated by health arguments, it is also a result of the unforeseen and unwanted side effects of an incoherent cannabis policy. It fits well into a general tendency to a strict approach to cannabis and reflects the shift to a more conservative political landscape.

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## **8. Coherence of Norwegian policy for alcohol, narcotic drugs and tobacco**

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### **8.1. Introduction**

Norway's alcohol and drug policy has traditionally been based on regulations/controls (alcohol) and prohibition (narcotic drugs), combined with help/treatment services, and has been regarded by other countries as restrictive. The Norwegian alcohol and drugs policies are integrated and in principle seen as a coherent substance policy. This can be illustrated by the fact that in most official documents the terms “substance-related problems, abuse, addiction” and “treatment” are widely used instead of “alcohol problems, drug problems” and so on. The target groups, both with regard to prevention and treatment, are seen as much the same. So are the actors, interventions and methods. To emphasise that it is a coherent policy, action plans, both at national and local level, will normally address both alcohol and drug problems. Thus action plans will normally aim at providing the basis for broad-based strategies for measures that cover the entire alcohol and drug field. In general the Norwegian substance policy is deeply anchored in a public health perspective: life skills, health promotion and preventing behavioural risk factors.

Doping (drugs in sport) will be included in such plans from 2012, but tobacco has not been included so far. For tobacco there are separate action plans and strategies, but since people who start smoking at an early age are assumed to be more likely to use drugs than those who do not start smoking, tobacco is included/integrated in the broad prevention strategies.

Both at national and local level, the issues of alcohol and narcotic drugs are dealt with by the same agencies. This means that most prevention measures aim to address problems related to alcohol as well as problems related to narcotic drugs. As early detection and intervention have been more emphasised, there is now more focus on predictors for problematic substance use than on the substances themselves.

In the same way, treatment for alcohol and drug problems is organised within the same treatment centres, even if some centres specialise more in treatment

of alcohol abuse and others in treatment for the abuse of narcotic drugs (such as substitution treatment).

The use of all the substances (alcohol, legal and illegal drugs, doping and tobacco) is considered to be a health risk and to cause harms both to the individual user and to society, in different ways or at different “levels”. Thus narcotic drugs are more strongly regulated than alcohol and tobacco, alcohol more strongly than tobacco, and doping cannot legally be distributed, though possession and use are not illegal. As a consequence of the differences in legal status of alcohol and narcotic drugs, they are separated when it come to legislation for the substances as such. Alcohol policy is regulated by the Alcohol Act and illicit drugs by the Medicinal Product Act and the General Civil Penal Code.

## **8.2. Intra-coherency**

### **8.2.1. Alcohol**

Compared to most other countries, alcohol consumption in Norway is low even if there has been a rather big increase since the mid-1990s. The main instruments of Norway’s alcohol policy are: the licensing system; the alcohol retail monopoly system (Vinmonopolet) for the sale of strong beer, wine and spirits; limited retail and serving times; specific orders and prohibitions such as advertising bans, statutory age limits; and restrictive tax policies. Under the Alcohol Act, beverages containing higher alcohol content than 2.5 % by volume may only be sold and served by persons in possession of an appropriate licence. The authority to grant licences lies in general with the municipal authorities.

The number of Vinmonopolet retail stores grew steadily between 1990 (106 outlets) and 2010 (259 outlets). There used to be a limit determined by the Parliament of how many outlets the country should have, but that system was discontinued in 2005. Today, Vinmonopolet itself decides whether to apply for a licence, and the relevant municipal authorities decide whether to issue one. Municipal authorities are increasingly likely to grant such licences.

Licences to sell medium-strength beer/alcopops (up to 4.7% alcohol by volume) are generally issued to grocery stores and supermarkets. A major 20-year-long restructuring process left the retail sector without many of the traditional grocery stores. As a result the number of retail outlets selling medium-strength beer fell, though municipal authorities are now increasingly likely to grant such licences. In 2003, for the first time it was possible to buy beer/alcopops in every municipality in Norway.

When it comes to bars and restaurants, the number of establishments with a licence to serve alcohol today is nearly three times what it was in 1980, an increase from 2 439 in 1980 to 7 376 in 2010.

As can be seen, even if Norway still has a restrictive alcohol policy as such, in practice the policy is balanced and increasingly liberal and pragmatic – at the “sacrifice” of coherency. One challenge is the fact that commercial interests are often in conflict with public health interests; indeed, in many cases, commercial interests are given precedence over public health, though what is profitable for individual companies is not always best for society. Another challenge is the need to get sufficient support in public opinion and strong political support for measures shown by research to be most effective in reducing the supply of alcohol (high prices and low availability). Still, in terms of alcohol policy the Norwegian Government wants to take steps to ensure that the balance between public health considerations and commercial considerations globally, nationally and locally tips in favour of public health. Norway has to ensure that international trade agreements attach sufficient importance to public health, and that commercial interests do not sway the local authorities’ licensing policy. Although alcohol is a legal substance that the majority of the population consumes in a controlled manner, it is seen as important to stress that alcohol is not an ordinary commodity.

### **8.2.2. Narcotic drugs**

While alcohol has been a part of the Norwegian culture for hundreds of years, real drug problems are a relatively young phenomenon. It all started on a relatively small scale in the late 1960s/early 1970s, and heroin was seized for the first time in 1976. Since then it has developed and changed, and we are still learning. Norway has traditionally shown a rather restricted approach to narcotic drugs, and all non-medical use of such drugs is illegal. Nevertheless, the Norwegian drugs policy has progressively changed over the years.

All non-medical use, possession, dealing and other forms of illegal handling of narcotic substances and prescription drugs may render offenders liable to prosecution. Illegal import and dealing can, in the most serious cases, carry the strongest penalties of the law. The intention is to control legal use and to combat illegal use of narcotic drugs.

Because of the HIV epidemic in the mid-1980s, drug use – and especially injecting drug use – became part of social and health workers’ agenda in a new way. As a result, harm-reduction measures were carefully introduced. One had to reconsider the fundamentals and assumptions on which the drugs policy was based. This can be illustrated by the fact that in 1988 free needles were handed out for the first time. Thus 1988 became a kind of turning point, and Norwegian drugs policy lost its virtue – though not overnight, and not without painful discussions and controversies. Today more than 3 million needles and syringes are handed out every year.

In 1994 a trial methadone programme was introduced, with 50 patients. In 1998, substitution treatment was introduced on a permanent basis. At the turn

of 2011 about 6 500 patients were in substitution treatment. Furthermore a lot of low-threshold programmes (health care centres, day centres, etc.) have been built up.

One other important change in Norwegian drug policy took place in December 2004 when a temporary Drug Injection Rooms Act was passed by Parliament (Stortinget). In 2009, the Storting decided to make the temporary act permanent, which means that municipalities that wish to establish injection rooms have a legal basis for doing so. So far only the municipality of Oslo has established an injection room facility.

Drug policy is hampered by many difficult trade-offs between legal and social-political considerations. In Norway, narcotic drugs are, and will in all likelihood remain, illegal. Nevertheless it is seen as a duty to look after people who get into substance abuse problems, because everyone is entitled to a worthy life and to be treated with respect by society and the treatment system. This dilemma can be illustrated by the work on substitution treatment. This involves treating people with strong addictive medicine. At the same time we want as many people as possible to manage without addictive medicines. However, at present, pharmacotherapy appears to be the best option for many opioid addicts. Use of methadone/buprenorphine must, however, be recommended only after a thorough, comprehensive assessment of the individual's condition. One has to ensure that substitution treatment goes hand-in-hand with good psycho-social follow-up, which is not always the case.

Opponents to harm-reduction measures such as needle exchange and drug injecting rooms claim lack of consistency because on the one hand all use of narcotic drugs is illegal, while on the other hand such harm-reduction efforts can be seen as legalising it and thus giving inconsistent messages. Is this a lack of coherency?

### **8.2.3. Tobacco**

Massive tobacco consumption started in Norway at the same time as the tobacco industry was automated about 100 years ago. The increase in the first half of the 20th century coincided with extensive commercial pressure that linked cigarette smoking with modernism, a refined lifestyle and elegance. After the Second World War, the authorities assigned a necessity status to tobacco and supplied it to people through Marshall Plan aid. As in other western countries, smoking was deeply rooted in social life; it was common among doctors and top athletes, and was projected visually through television programmes, films, newspaper pictures and commercials.

The pro-tobacco social climate in the 1950s and 1960s made it difficult to disseminate information on the adverse health effects of smoking in an effective way. Commercials became more aggressive when final evidence of the health risks of smoking became available. Up to 1970, doctors and authorities had a

very low profile and did not inform people about the dangers of tobacco nor engage themselves in preventive work. The first Norwegian publicly financed information campaign on tobacco was launched in 1975.

From 1975 there was a total ban on all tobacco commercials. Health warnings on cigarette and tobacco packs were introduced and an age limit of 16 was set for the buying and selling of tobacco products. The law was later expanded to protect people against passive smoking in the work place, on means of transportation (1989), and in places where food was served (2004). New nicotine products were banned (1989), more and larger health warnings were introduced (2003) and the age limit for buying and selling tobacco was set at 18 years (1995). The real price of tobacco increased several times after 1975, systematic preventive measures were instigated and campaign activity was intensified.

### **8.3. Momentous changes**

Altogether since the 1980s there have been momentous changes in policy and approaches to substance abuse and substance abusers. This also goes for ideas on the best way of organising and delivering care and treatment for substance abusers. After a centralist approach was discarded in favour of decentralising treatment in the 1980s, in the early 2000s policy reverted to a centralised treatment model. From being classified as patients, in the 1980s substance abusers became clients, only to end up as patients again. In 2004 treatment of substance abuse became part of the specialised health care services provided by the state through four regional health enterprises. This meant that what is called interdisciplinary specialised treatment for substance abuse was in line with specialised somatic and psychiatric health care. At the same time, substance abusers were given the same patients' rights as any other patient in the specialised health care system. Thus there has been a shift in recent years from understanding and treating substance abuse problems as a social issue to seeing them more as a health issue.

With the exception of substitution treatment for opioid dependency, interdisciplinary specialised treatment does not in general discriminate between substances. It is all a matter of substance abuse problem/addiction and is treated as such. For historical reasons, however, there are also institutions originally established for treating alcohol problems or narcotic problems, and some of these still remain in this traditional form.

As already mentioned, the public health perspective is a key element of Norwegian drugs and alcohol (and tobacco) policy, based on the assumption that there is a clear relationship between the amounts of drugs or alcohol used and the extent of harms. The extent of negative social and health-related consequences, including illness and accidents, increases in step with the use of drugs and alcohol. Whereas alcohol causes most harm, both socially and in

terms of health, the use of narcotic drugs is associated with considerable morbidity and high mortality rates. Norway has a population of nearly 5 million and it is estimated that  $\pm 100\ 000$  people are high-risk consumers of alcohol; the number of injecting drug users is estimated at  $\pm 10\ 000$ . The number of drug-related deaths is higher than in most European countries, even if there are problems comparing overdose statistics due to differences in registration. On the other hand, prevalence rates of drug use among young people are lower in Norway than in most other European countries.

The goal for Norwegian alcohol and drug policy is to reduce the population's use of the substances overall, with a view to reducing the total amount of harm caused. Efforts will be aimed at reducing the availability of alcohol and narcotic drugs, and limiting demand for them. Supply reduction and law enforcement are, as already mentioned, different for each substance, and are in part differently organised. The legislation regulating licences for alcohol as a legal substance is within the ministry of health and care services; the authority to grant licences is in general delegated and lies with municipal authorities. Illicit drugs are partly regulated by the Medicinal Product Act, which also lies with the ministry of health and care services, and partly by the General Civil Penal Code, which is the ministry of justice's responsibility. The ministries of foreign affairs and finance (Customs) are also involved. Tobacco legislation lies within the ministry of health and care services.

Demand-reduction efforts do in most cases include alcohol as well as narcotic drugs, especially when it comes to young people. Early intervention, targeting potential drug and/or alcohol problems, is emphasised as well as services for people suffering from substance use/abuse. Treatment is the state's responsibility, care services and prevention the responsibility of the municipalities.

#### **8.4. International collaboration**

One of Norway's goals is to limit harms related to alcohol and narcotic drugs. Norway aims to contribute to improving the health situation in Norway's immediate area as well as in other parts of the world. It is the goal of Norway's international health collaboration to meet challenges by developing schemes for effective prevention and combating illness.

Norway's international commitment occurs chiefly through the United Nations (Norway has ratified the three UN control conventions on the prohibition and control of narcotic substances), the Council of Europe, the European Union/European Economic Area, the Emus Northern Dimension, the Nordic Council of Ministers and other Nordic collaboration.

#### **8.5. NGOs**

Non-governmental organisations NGOs play an important role in the alcohol and drug field in Norway. They do invaluable work in preventing alcohol and

drug use and helping people with substance abuse problems. Furthermore, NGOs are important collaboration partners for local authorities and the specialist health services in providing treatment and for the government's work in developing alcohol and drug policy.

## **8.6. National action plan on alcohol and drugs**

Norway's alcohol and drugs policy is set out in an action plan for the drugs and alcohol field. This plan, introduced in 2008, was intended to run until 2010. However, the government has decided to extend the plan period until the end of 2012. The plan covers a broad range of measures, from universal and early prevention to treatment, rehabilitation and harm reduction, as well as addressing problem drug and alcohol users' need for complex and coherent services over time. The over-riding goal is to reduce the negative consequences of drug and alcohol use for individuals and for society as a whole. As the action plan says, Norway's alcohol and drug policy is about solidarity and society's capacity for solidarity. Substance-use problems are seen as a matter of social inequality, social trends, exclusion of social misfits and overcoming challenges, at school and in the workplace. The action plan lays out the government's areas of priority in the field of alcohol and drug problems. In the action plan the government is looking at the entire field of alcohol and drug problems in context, and work in this area is based on the government's general policy. The goal is to offer good services that focus on the user of the services.

It is said that there is still no clear-cut solution for how to deal with the negative consequences of substance use for individuals and society as a whole. One must learn to live with the dilemmas and trade-offs. It is also said that it is impossible to come up with a successful alcohol and drug policy through organisation, funding or regulations alone. It is just as much a matter of attitudes and conduct, of feelings, and of wanting to help people who, for some reason or other, have ended up in a difficult situation. All in all, the national action plan covers 147 specific and rather wide-ranging measures that address the challenges in the drugs and alcohol field.

The action plan has five main objectives, as follows.

### **8.6.1. A clear public health perspective**

Norway has the ambitious goal of reducing consumption of alcohol. Alcohol is under pressure, from international bodies and business interests. Norway wants to improve support for the general Norwegian alcohol policy. With a view to reinforcing the work to combat narcotic drugs and illicit use of medicines, the government is going to increase efforts, both internationally to limit availability of drugs and nationally to ensure that fewer people start using illicit substances. The government wants to focus more on targeted information and greater participation from young people and parents. Knowledge



must be generated and attitudes must be changed to reduce the harmful side effects. There is a widespread consensus that the workplace should be an alcohol- and drug-free arena. As it is worrying that alcohol is increasingly being used in work-related situations, at seminars and courses for example, workplace alcohol and drug prevention will be bolstered. Norway has a tradition of taking international collaboration on alcohol and drug seriously. This will be continued and strengthened.

### **8.6.2. Better quality and increased competence**

The government is investing in research on substance use: it has established a special research programme and a research centre aimed at clinical substance abuse research to supplement existing research institutes in the field. The result of the research is to be communicated outside the field, to be invested in more and better teaching in basic and further education. To improve expertise in the alcohol and drug field, more people must be given the opportunity to qualify and undertake further education. Recruiting people with the right academic knowledge and training is a long-term priority. The quality and content of services are going to be improved.

The work requires a systematic approach and long-term investment, and is going to be done within the framework of “the National Strategy for Quality Improvement in the Health and Social Services for People with Substance Dependence Problems”. Existing alcohol- and drug-related data do not provide enough information about the scope of the problem, causes, input of resources and results. Better systems for reporting, statistics and documentation will be developed and implemented. NGOs play an important role in prevention, treatment and care. The government will continue supporting voluntary work and will take steps to ensure that NGOs are also involved in the quality improvement work in the substance-use area.

### **8.6.3. More accessible services**

Services must be accessible to children and young people, who are especially at risk of developing alcohol- or drug-related problems. We must ensure that everyone at risk of becoming alcohol- or drug-dependent, and people in the early stages of developing alcohol and drug problems, receive appropriate help at the earliest possible opportunity. People with substance-use disorders must be given far better individual follow-up at municipal level. Services are to be made more accessible and more flexible. Greater priority will be given to social inclusion, rehabilitation and networking, and closer follow-up after discharge from a treatment institution or release from prison. Low-threshold schemes, outreach activities and ambulatory services will be strengthened in order to reach people who do not make use of ordinary services. Good, comprehensive services in the municipalities are critical for the success of our efforts in the alcohol and drug field. A good living situation is important

for rehabilitation, health and dignity. In recent years, many different models have been developed for housing and services.

Regional health authorities have achieved significant increases in capacity in interdisciplinary specialised treatment for substance abuse (though the number of referrals for treatment has also risen), and services are largely organised in such a way that people with substance abuse problems receive varied, comprehensive treatment. Input and capacity will be increased to meet the need for treatment. Over half the people serving a prison sentence are estimated to have substance abuse problems. They are just as entitled as anyone else to have their need for help assessed and to receive adapted treatment and follow-up, but the evidence is that they have poorer access to help services than other people. The government intends to change this.

#### **8.6.4. More binding co-operation**

Priority will be given to measures that guarantee good co-ordination for children and young people; they are particularly vulnerable, and co-ordination often involves more people and agencies than services for adults. The treatment and follow-up of people with substance abuse problems often entails a number of measures being implemented at once or consecutively, and many people experience the services as fragmented and poorly co-ordinated. The government wants to ensure better quality and use of resources by improving collaboration and continuity.

People who need long-term and co-ordinated social and health services are entitled to have an individual plan drawn up for their treatment and follow-up, if they wish. Nevertheless, many reports show that few people with substance abuse problems have an individual plan. Changes have to be made that promote use of individual plans, which are tools to achieve collaboration on the individual level. On the system level too, we must ensure that systematic and target-oriented work is done to resolve collaboration challenges. Prevention requires measures that reduce both availability of intoxicants and demand for them. In many places, local authorities and NGOs separately run a range of preventive measures aimed at the same target groups. The government wants to facilitate the local authorities' preventive measures being seen in an overall perspective and that they are considered in light of follow-up of people with substance abuse problems.

#### **8.6.5. Increased user influence and attention to the interests of children and family members**

Children and young people whose parents have an excessive or hazardous use of alcohol and/or drugs are more frequently subject to parental neglect, abuse and violence than others. They must be identified and helped at the earliest possible opportunity. Planning and design of services in collaboration with service-users is a statutory requirement and a necessary condition for

good quality. Services must be arranged in such a way that the users are given real influence and relatives are well looked after. Work in this area must be based on the Directorate of Health's quality strategy for the social and health services. Systematic gathering of experiences from users and their relatives is important to be able to develop good, effective services. These experiences are necessary correctives and help stimulate continual improvement. The government wants to make sure that user experiences are used more systematically in the work to improve quality.

## **8.7. Systems and structures**

There is a high degree on the overall objectives, values and means of Norwegian alcohol, drugs and tobacco policy and thus it is long-term. Every fourth year there are parliamentary elections. Each political party states its goals for the alcohol and drugs policy in its manifesto though this is usually not among the top 10 issues. For some years the government has been a coalition of certain political parties, which negotiate to end up with a common programme, usually expressed in a declaration where the final political goals are set. These goals, as a result of party political processes, set the agenda for ministries and directorates, and set the direction for policy, usually stated in action plans, sometimes in white papers; most often they adjust policy and do not draw up totally new policy. The minister for health and care services is responsible for co-ordinating the policy area.

Ideas forming and translating to political goals are both formal and informal in character. The media plays a central role in drawing attention to what are often more acute issues; and responsible politicians are expected to give immediate answers. To a certain extent this contributes to day-to-day adjustments of policy, not always in accordance with long-term goals. Civil society, NGOs and more professional actors are well aware of (and take advantage of) the role the media plays in influencing policy. Several actors, professional as well, seek influence by lobbying via the media, Parliament and the opposition.

Public engagement and involvement is a general political goal, and several initiatives have been taken and channels opened to facilitate this. Now and then public meetings to discuss alcohol and drug policy are arranged, people are invited to write letters and ministers have regular meetings with different groups and individuals. Every ministry has a secretariat responsible for receiving and interpreting all these kinds of ideas and initiatives, and transforming them into political and operational goals.

Formally there are several processes, actors and levels in formulating and transforming ideas into political goals. This is a dynamic process. When the government draws up action plans or white papers, it accepts input from a wide range of actors: relevant directorates, councils, research institutions, regional health authorities, municipalities, counties, NGOs and user

organisations. Challenges, suggestions, recommendations and good examples are requested. This dialogue ends up in a final plan worked out by the ministry, with a political stamp. The same actors as mentioned above are then given responsibility to implement and carry out the policy. For the duration of the plan, there is a dialogue between these actors and the ministries and every year new initiatives and actions are launched in state budgets.

### **8.8. Selected reading**

Edland-Gryt M. (2011), *Alcohol and drugs in Norway*. Norwegian Institute for Alcohol and Drug Research

Norwegian Ministry of Health and Care Services (2008), *Norwegian National Action Plan on Alcohol and Drugs*



## 9. A Portuguese insight into coherent policy

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### 9.1. Historic overview of the Portuguese context for drugs

The first Portuguese drug laws, dating back to 1924 and 1926, remained unaltered until 1962. They aimed to regulate the import and export of drugs and associated drug addiction with mental illness treatment.

Until the end of the 1960s, drug use and abuse was not seen in Portugal, remaining confined to very close knit circles, such as artistic and *beaux arts* people, with the exception of Macao, a Chinese territory under Portuguese administration until 1999, where the use of opium was forbidden in 1946 (Foreword of Law Decree 5/91/M). In view of Macao's geographical situation and cultural environment – Macao is on the western side of the Pearl River Delta, just across from Hong Kong – drug use was seen as a problem confined to an overseas territory under Portuguese administration.

Following Portugal's ratification of the United Nations Single Convention on Narcotic Drugs of 1961, in 1970 a piece of legislation was approved introducing a legal framework that illegalised and criminalised traffic in narcotic drugs.

Drug use in the Portuguese African colonies, which until the end of the 1960s had been confined to ethnic groups, spread through the contingent of men sent from Portugal to fight guerrilla movements and thus to people associated with their economy, namely recreation during breaks from jungle fighting. "The increase in the abuse of psychotropic and narcotic substances worldwide from the beginning of the 1970s has also been seen in Portugal in ever greater proportions" (SPTT 2001: 4). According to Poiares, "During the 1960s and 1970s, war mobilisation ... of a large percentage of male youngsters caused the initiation of many of them into drug worlds, a process made easier by the environment and the culture in which they found themselves, as well as by the typical psychological conditions of a war scenario"<sup>41</sup> (Poiares 1998: 239).

It was around 1970 in this context of profound political, institutional, economic, social and cultural changes that the first public campaign in Portugal was launched to alert people about the use and abuse of drugs (Dias 2007: 41). According to Poiares, the campaign, whose slogan was "Drug, madness and

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41. Free translation by the author.

death”, was the expression of the relationship between drugs and a very specific political fact, the war overseas (Poiares, 1998: 242).

With the independence of the colonies, one million people returned to Portugal and the colonial army was dismantled. The 25 April 1974 Revolution fostered freedom and the loosening of social morality, so a desire for experimentation and therefore drug consumption rose. Portuguese institutions were not ready to respond to this outbreak, since law-enforcement agencies had been based on a repressive model and there were no specifically targeted health structures. Heroin injection in particular became problematic.

The treatment of addictions was targeted for the first time under Portuguese legislation in 1963, when it was incorporated in the Mental Health Law, which established the treatment framework for mental illnesses. However, drug addiction treatment as such was never regulated within this framework. The 1963 law was replaced in 1998 by the current Mental Illness Law, which no longer includes drug addiction treatment.

In view of the emergence of an alarming drug-consumption pattern, a specialised government structure, the Centre for the Study of Drug Prophylaxis (CEDP), was created in November 1976 to address the problem specificities and the difficulties faced by care-and-treatment institutions (Trigueiros et al. 2010: 28-35).

After the 25 April 1974 Carnation Revolution, democratic governments pursued, with the agreement of Parliament, policies to address the issues related to drug use and abuse.

## **9.2. Signature and ratification of UN drug conventions**

After the ratification by Portugal of the UN Single Convention on Narcotic Drugs of 1961, it entered into force in 1970.

The newly democratic regime established in Portugal after 1974 opened up the country’s diplomatic relations. No longer subject to the stigma attached to being a colonial power in an era of self-determination by former colonies worldwide, the Portuguese authorities picked up multilateral ties.

Portugal adhered to the 1972 Protocol to the Single Convention on Narcotic Drugs of 1961 in December 1978 and in January 1979 to the UN Convention on Psychotropic Substances of 1971.

In June 1991 the Portuguese Parliament ratified the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, which Portugal had signed in December 1989.

With this framework of conventions in place, Portugal proceeded to adapt its internal legal and institutional framework.

### **9.3. Evolution of the institutional framework for illicit drugs**

In view of the need to address the growing problem of drug addiction, following the exposure to drugs of a large contingent of men in the military, in 1973 Lisbon's Hospital Santa Maria started an outpatient clinic specialising in consultation for drug addicts, who were transferred from other medical services. Hospital Santa Maria was, and still is, a medical school as well as the central hospital for metropolitan Lisbon (Dias 2007: 77).

However, the most remarkable result of the evolving institutional framework for illicit drugs in Portugal was that the first dedicated treatment units as such were created within the ministry of justice structure, rather than under the ministry of health.

The criminalisation of personal drug use and possession, in accordance with the United Nations conventions, was transcribed into the Portuguese legal framework from 1970, raising an urgent need to address the concern of growing numbers of young people approaching the criminal system due to drug use and abuse. Both they and their parents used the services in the ministry of justice structures according a biopsychosocial model.

Following the 25 April 1974 Carnation Revolution, "faced with the increasing scale and enormous complexity of the problem, the democratic governments" approved legislation "to counteract the trend", having youngsters in mind, in particular (SPTT 2001: 4). Thus, in 1975 the CEJ (Youth Study Centre) and the CIJD (Judicial Investigation Centre on Drugs) were created. The CEJ's purpose was to study problems associated with drug use, particularly those related to medical treatment and social support for addicts. The CIJD was responsible for investigating, monitoring and tackling crime related to drug use and abuse and trafficking (SPTT 2001: 5).

The CEJ was restructured in November 1976, to be replaced by the CEPD, whose purpose was to address the prevention, treatment and social reintegration of drug addicts. The law decree that created the CEPD laid down that it would have regional services. They operated in Lisbon, the capital, Oporto, Portugal's second largest city, and Coimbra, a university town and third largest city at the time. The Preamble of Law Decree No. 792/76 that created the CEPD clearly stated that ideally the criminal model should be replaced by clinical treatment, with the drug user qualifying as a patient rather than a criminal, because drug use leads to "a weakening, and even an enslavement of the will and, therefore should be immune to an ... imputation of guilt" (Trigueiros et al. 2010: 28).

The Co-ordination Office for the Fight against Drugs (GPCCD) was created at the same time (1976) to co-ordinate the CEJ and the CIJD activity and to



study and propose legislative proposals, to focus on bilateral and multilateral co-operation, namely at the United Nations, and to pursue research and data.

The first dedicated specialised hospital unit under the ministry of health was created in 1987. The Taipas Centre's mission was to prevent and treat drug addiction; it was the basis of the later SPTT, the Service for Drug Addiction Prevention and Treatment. The Taipas Centre started as an outpatient clinic that included detoxification and emergency services. Most of its medical people had previously worked at Hospital Santa Maria outpatient consultation (Dias 2007: 77).

The next year, in 1988, the Faro health centre in Algarve opened an extension for the prevention and treatment of drug addiction, SPAT (Drug Addiction Prevention and Treatment Service). Algarve, at the southern point of Portugal, was, as it still is, a well-known holiday resort. All-year, all-weather amenities, the affluence of foreign and Portuguese tourists, closeness to traffic routes, a natural coastline that fostered illegal landings and a holiday mood favoured a leisure environment for drug addiction and led local health authorities to open SPAT.

The illegality and criminalisation of drug consumption naturally posed a problem to medical and nursing personnel, since they were bound to report drug addicts to the criminal justice system. This duty was overruled by professional secrecy, which they had pledged to uphold.

The year 1990 was pivotal. Apart from the existing GPCCD, the Co-ordination Office for the Fight against Drugs, the presidency of the Council of Ministers reformulated Projecto VIDA, headed by a high commissioner with the position of Under Secretary of State for Prevention Issues, who acted as national co-ordinator. SPTT, the Service for Drug Addiction Prevention and Treatment, was created in 1990. From then on, the treatment centres within the ministry of justice were absorbed by SPTT and the ministry of health regained sole competence for the treatment of drug addiction. That same year, a National Directory for the Investigation of Drug Trafficking was created at the Judiciary Police.

The institutional design would be reformulated over the years, but in substance it remained very close to the 1990 framework.

In 2000 the GPCCD was restructured as the IPDT, the Portuguese Institute for Drugs and Drug Addiction, which one year later absorbed Projecto VIDA; in 2003 the IPDT absorbed the SPTT to become the IDT, the Institute for Drugs and Drug Addiction. This, the current government institution, depends on the ministry of health and encompasses transversal areas such as international co-operation, research, training, data, communication and demand reduction. Since the president of the executive board is the national co-ordinator, IDT also carries out national co-ordination tasks.

## 9.4. The illicit drugs situation

Using data from the internal evaluation report on the Action Plan on Drugs and Drug Addiction 2008, along with data from the 2009 Annual Report on Drugs and Drug Addiction as presented to Parliament (data for 2010 not being released until November 2011), we find the illicit drugs situation is as follows.

The Portuguese General Population Surveys, conducted in 2001 and 2007 for the 15-64 age group, evidenced an increase for every age group of lifetime prevalence of consumption of any drug, except for a decrease of lifetime prevalence in the 15-19 age group, from 10.8% to 8.6% (Balsa et al. 2008).

Lifetime prevalence of illicit drug use among Portuguese school students aged 16 in 1995 and 2007 showed a decrease in all illicit drugs taken together, as well as for cannabis, ecstasy, amphetamines, cocaine and heroin.

A study conducted by the IDT found a decrease in the lifetime prevalence of illicit drug use among Portuguese secondary school students of all ages. Illicit drug use was 14.2% (under 16) and 27.9% (16 and over) in 2001, and 8.4% (under 16) and 19.9% (16 and over) in 2007 (Feijão 2008).

Within the public network the number of patients has steadily grown, from 30 266 in 2004, when an external evaluation to the Portuguese National Strategy was conducted, up to 38 875 in 2010. First treatment demands grew from 5 023 in 2004 to 7 643 in 2010. Follow-up treatment episodes grew from 374 149 in 2004 to 614 213 in 2010, this being the only indicator with a decrease from the year before: it was 616 658 in 2009 (IDT 2010). However, new patients' intravenous consumption in the 30 days before first consultation had decreased from 36% in 2000 to 7% in 2010 (IDT 2010).

The prevalence estimates among problematic drug users (estimated prevalence rates per 1 000 inhabitants aged 15-64) decreased from 6.4-10.7 in 2000 for opiates, cocaine and/or amphetamine consumption to 6.2-7.4 in 2005. As for intravenous consumption (current or recent) it was 2.3-4.7 in 2000 and 1.5-3.0 in 2005 (Negreiros et al. 2009).

In 2010, outreach teams, support teams and low-threshold treatment programmes contacted 15 263 users, with an average of 7 032 contacts monthly. The harm-reduction network works with hospitals, day centres, tuberculosis and HIV attendance units, treatment structures, therapeutic communities, detoxification units, shelters and social security services in providing care to users and signalling their need for treatment.

HIV transmission notifications among drug users had fallen from 1 430 in 2000 to 164 in 2009, whereas HIV transmission among heterosexual partners decreased much more slowly, from 1 032 in 2000 to 677 in 2009, and among homosexual partners it went up from 214 in 2000 to 218 in 2009 (transmissions reported until 31 December 2009).

The proportion of inmates sentenced for drug and other offences reporting the use of heroin before confinement fell from 44.1 % in 2001 to 29.9 % in 2007, while those acknowledging intravenous consumption fell from 27 % to 18.21 %; the proportion of inmates sentenced for drug and other offences reporting the use of heroin during confinement fell from 20.1 % in 2001 to 13.5 % in 2007, while those acknowledging intravenous consumption fell from 11.4 % to 3.1 % (Torres et al. 2009).

The proportion of inmates convicted under the Drug Law (production, possession of more than 10 days' average doses, trafficking, money laundering) relative to the total decreased substantially between 2003 and 2009, from 3 558 in 2003 to 2 026 in 2009 (IDT 2010). However, illicit substances seized between 2003 and 2009 rose; it is believed that, after drug decriminalisation on 1 July 2001, law-enforcement agencies no longer concentrated on charging drug users.

Within the Drug Addiction Dissuasion Commissions (DADC) 7 870 files were instructed in 2010, from a mere 2 246 in 2001. From 2001 to 2010 a total of 66 378 processes were filed. Between 2007 and 2009 there was an increase of 39 % in indicters (that is, persons due to be presented to the DADC) assessed as drug addicts who pursued voluntary treatment.

In 2010 indicters were 93.9 % male and 36.38 % employed, whereas 27.4 % of the indicters were unemployed and 19.59 % were students. The most common illicit drug in indictment applications was cannabis, 60.98 %, followed by heroin, 16.71 %, and cocaine, 10.68 %.

## **9.5. The alcohol situation**

The first Portuguese Action Plan against Alcoholism was published in 2000 as a Council of Ministers resolution, but due to the lack of regulation it was not enforced properly.

Three facilities were established in Oporto, Coimbra and Lisbon, dedicated to the treatment of alcoholism, receiving patients from a referral network of public hospitals and health centres. In 2007 the three alcohol centres were merged in the structure of the Institute of Drugs and Drug Addiction, which was granted an enlarged mandate “to promote the reduction of licit and illicit drugs, as well as the decrease of toxic addictions”.

With the restructuring of the Institute of Drugs and Drug Addiction the treatment of alcoholic patients was integrated into the treatment centres already addressing drug treatment. Patients are now sent to IDT treatment structures, including for detoxification, through a reference network, which is also being redesigned.

In support of the design of the new National Plan on Alcohol Related Problems, a study was conducted on behalf of the IDT (Lourenço 2008) that compiled best practice on alcohol.

The prevalence of alcohol consumption, as shown by general population surveys for the 15-64 age group, was 75.6 % in 2001 and 79.1 % in 2007. Last-year prevalence was 66 % in 2001 and 70.6 % in 2007; last-month prevalence was 59.1 % in 2001 and 50.6 % in 2007 (Balsa et al., 2008).

According to *World Drink Trends 2005*, Portuguese consumption of wine, beer and distilled drinks in 2003 amounted to 42.8, 58.71 and 1.4 litres per capita, respectively. Portugal was then the fourth world consumer of wine.

According to the 1995/6 INS study, the age groups with highest consumption of alcoholic drinks were 25-44 and 45-64. The 1998/9 INS study showed that the 25-44 age group had increased its consumption of alcoholic drinks, whereas last-year prevalence had increased in the over-75 age group. In the 15-24 age group, the most common drink was beer, several times a week.

Still according to the 1995/96 INS study, men's last-year prevalence was twice that of women, last-month prevalence was three times that of women, and men consumed more wine. The prevalence of male consumers was higher in northern Portugal and there was increased consumption among women and young people from the southern area of Alentejo.

According to the 2005/6 INS study, there was an increase of last-year prevalence, with women's consumption increasing 5 % and men's increasing 2.4 %.

Eurobarometer 2007 reported that 15 % of the Portuguese population showed a binge pattern, with 11 % reporting having three to four units and 4 % drinking more than four units.

Gameiro estimated (Gameiro, 1997) that there were 750 000 excessive consumers (9.4 % of the general population over 15 years old) of which 580 000 were alcohol-dependent (7 % of the general population over 15).

Among young people (16 to 18) 44 % did not agree that alcohol is harmful to health, with only 11 % agreeing that alcohol is a "very dangerous" substance (Eurobarometer, 2004). Lifetime prevalence of alcohol among secondary students (under and over 16) in 2003 was 47 % (16+) and 94 % (under 16), and in 2006 it was 59 % (16+) and 88 % (under 16) (Feijão and Lavado 2006, Aníbal 2006).

In 2006 nearly 44.9 % of children and youngsters under 16 who were under the scrutiny of the Children's and Youngsters Protection Commissions had one or both parents with alcoholic dependence (Aníbal 2006). Also in 2006, 1 876 (15.3 %) children and youngsters who were institutionalised had been withdrawn from their families for reasons of alcoholic dependence (ISS 2006).

According to APAV, the Portuguese Association for Victim Support, 24 % of the perpetrators of violent crimes are alcohol-dependent and 25 % of violence-related situations reported are related to alcohol dependence.

In 2006, in the 503 900 alcohol tests conducted by road enforcement agencies, 7.3 % of drivers (37 011) presented rates of blood alcohol of more than 0.5 grams/litre, with 54 % (19 986) committing a criminal offence, that is, having more than 1.2 grams/litre blood rate.

In 2007 the road enforcement agencies registered 1 584 (1.6 %) out of 99 835 accidents were probably due to alcohol (GNR), with 6 031 people involved in driving accidents monitored by the National Institute on Legal Medicine (INML). Of those, 3 574 (60 %) reported rates of blood alcohol of more than 0.5 grams/litre. Out of the 3 546 drivers involved in car accidents and monitored, 2 091 (59 %) had rates of blood alcohol of more than 0.5 grams/litre and 43.3 % had rates of more than 1.2 grams/litre, classed as a crime. Out of the 970 victims of car accidents with autopsies conducted by INML, 35.4 % had rates of blood alcohol of more than 0.5 grams/litre.

In 2006 a total of 6 454 people were diagnosed with cirrhosis and alcoholic hepatitis, which corresponds to a total of 67 565 hospital inpatient days. They represented 6.7 % of all patients admitted in 2006.

Currently alcohol-related problems intervention is addressed through the National Plan for the Decrease of Alcohol Related Problems 2010-12, which is the backbone of Portuguese intervention. It was designed as a result of a debate with much participation by public administration, industry, marketing and NGO representatives. Ideally, the National Plan for Drugs and Drug Addiction and the National Plan for the Decrease of Alcohol Related Problems 2010-12 should have been one single document, but the time frames were different, so it was agreed that the two plans might become one in the strategic framework of 2013-20. The National Plan for the Decrease of Alcohol Related Problems 2010-12 was approved by the Inter-ministerial Council on Drugs, Drug Addiction and Alcohol Related Problems in May 2010, though it was enforced from 2009.

The National Plan for the Decrease of Alcohol Related Problems 2010-12 sets strategic objectives and operational goals for seven priority areas: youngsters, children and pregnant women; road accidents; adults and workplace; prevention, training, communication and education; data collecting and information systems; treatment; reintegration. Quantitative goals have been set for the seven priority areas, namely:

1. To reverse the growing trend of consumption prevalence and:
  - a. To decrease from 20.7 % (2007) to 18 % the prevalence of drunkenness in the past year within the general population;
  - b. To decrease from 34.6 % (2007) to 30 % the prevalence of drunkenness in the past year among young people aged 15-19;
  - c. To decrease from 48.3 % (2007) to 43 % the prevalence of binge drinking (more than three or four drinks on one occasion) at least once a year among young people aged 15-24.

2. To decrease from 305 (2007) to 250 the number of deaths in car accidents associated with a rate of blood alcohol equal to or higher than 0.5 grams/litre.
3. To decrease from 18.8% (2006) to 14% the random pattern rate for sicknesses assigned to alcohol for people under the age of 65.
4. To decrease from 9.6 litres (2003) to 8 litres the per capita annual consumption.

The National Plan for the Decrease of Alcohol Related Problems 2010-12 has also assigned special goals for national co-ordination, international co-operation and information, research, training and evaluation.

Other than the existing three levels of the National Co-ordination for Drugs, Drug Addiction and Alcohol Related Problems – that is, inter-ministerial (the Inter-ministerial Council), between ministries (the Inter-ministerial Council's Technical Commission) and with the main constitutional organs and civil society (the National Council) – a fourth level was created for alcohol-related problems composed of parties representing the interest groups that participated in drafting the National Plan on Alcohol, namely public administration, industry production, retail and NGOs, which are part of the newly created Alcohol Forum.

## 9.6. The tobacco situation

Tobacco-related problems are addressed in the technical-normative guidance of the General Directorate on Health. Hospitals and health centres provide outpatient anti-smoking consultations.

In 2007 a bill of law that prohibited smoking indoors in any collective place, be it public or private, was approved. Law 37/2007 was published in 14 August, approving norms for the protection of the population involuntarily exposed to tobacco smoke and regulations to reduce demand for tobacco and foster consumption cessation or non-dependence. Enclosed areas for smokers in areas of collective use can be provided only when separate air renewal is assured. Penalties vary from €50 to €750 for smokers and €50 to €250 000 for owners of public and private facilities. The bill establishing tobacco standards to protect citizens from exposure to involuntary tobacco smoke entered into force on 1 January 2008. Its implementation marked a turning point in tackling this issue at national level.

The main conclusions of the report covering the years 2008 to 2010, to be delivered to the state minister responsible for health with a view to its subsequent submission to the National Assembly<sup>42</sup> (INFOTABAC 2011), are as follows. Portugal was the European country with the highest prevalence of

42. [www.min-saude.pt/portugal/conteudos/a+saude+em+portugal/noticias/arquivo/2011/5/relatorio++tabaco.htm](http://www.min-saude.pt/portugal/conteudos/a+saude+em+portugal/noticias/arquivo/2011/5/relatorio++tabaco.htm), accessed on 20 October 2011.

smoking-decreased liabilities in the workplace from 2005 to 2010, ranking 6th in Europe out of 27. There is evidence of reduced tobacco consumption in the home after the entry into force of the law. There was a clear change of smoking patterns among smokers, both in reducing active smoke as well in reducing exposure to second-hand smoke. In 2009 the number of episodes of hospital admittances for ischemic heart disease decreased for the first time in 16 years; the rate of episodes of hospitalisation for chronic obstructive pulmonary disease observed a slight decrease. There is technical incompatibility between the enforcement of legislation on indoor air quality and the current law on tobacco.

The law is perceived very positively by the population, with room for improvement in the reduction of second-hand smoke. There is a majority in favour of banning smoking in public places and supporting policies on tobacco control. The population recognises that the law has helped to change habits, improve health, protect non-smokers and improve air quality in public indoor spaces.

Studies are not conclusive about changes in the prevalence of smoking in Portugal. There is a sustained decrease of tobacco consumption in pupils of 6th to 8th grades (mandatory school is from 1st to 12th grades), with one of the series pointing to a downward trend in consumption tobacco estimated at 5 % decrease. None of the series studied showed a trend of increasing prevalence of smoking among women, and smoking cessation consultations increased 62 % between 2007 and 2009. However, there is some evidence that tobacco advertising is still in place in Portugal.

### **9.7. National co-ordination structure for drugs, drug addiction and alcohol-related problems**

In April 2010 the National Co-ordination Structure for Drugs and Drug Addiction was enlarged by Law Decree 40/2011 to include alcohol-related problems. The national structure is composed of: an Inter-ministerial Council of the competent ministers; an Inter-ministerial Council's Technical Committee, composed of ministers' representatives; a member of government responsible for Drugs, Drug Addiction and Alcohol Related Problems, who is the minister for health; a national co-ordinator, who is the president of the IDT's executive board; and a national council composed of representatives of other sovereign organs; the Azores and Madeira autonomous regions' governments; the public prosecutor; and an array of institutions from civil society, including representatives of alcohol production, trade and marketing.

The national co-ordination structure is in charge of designing, monitoring and evaluating the national strategy on drugs and drug addiction and alcohol-related problems. At the top level, the Inter-ministerial Council approves the national strategy, national plans and action plans. Ten sub-commissions were created within the framework of the Inter-ministerial Council's Technical

Committee, with representatives of public institutions and general directorates that are in charge of implementing the National Plan on Drugs and Drug Addiction 2005-12 and the National Plan for the Decrease of Alcohol Related Problems 2010-12.

These sub-commissions are: monitoring and evaluation; international co-operation; public expenses; data and research; communication, information and training; prevention, harm reduction, treatment and reintegration; drug addiction dissuasion; intervention in school, university, work, recreation and road contexts; illicit substances supply reduction; and regulation and monitoring of licit substances.

In spite of having two different national plans for licit and illicit substances, that is the national plans on alcohol and drugs, the fact that either organ of the national co-ordination structure (and in particular the sub-commissions) can monitor and evaluate the two national plans within the same structure allows for a growing commonality and integration of policies on alcohol and drugs. These organs are also in charge, at different levels, of proposing and adopting the national strategy on drugs, drug addiction and alcohol-related problems and its operationalisation. It is expected that for the next strategic cycle, 2013-20, there may be a single plan for drugs, drug addiction and alcohol-related problems.

## **9.8. Conclusions**

Drug, drug addiction, alcohol and tobacco public policies in Portugal have evolved differently in line with international and national contexts. These contexts may vary from international convention law, issued from the United Nations drug conventions framework, World Health Organization guidelines or European Union common policies and supranational agreements. In all cases, national circumstances as well as actual needs have shaped policies and determined their evolution.

Policies in drugs, drug addiction and alcohol-related problems are at present organised under national plans and action plans co-ordinated by the same office, though (owing to different time frames) policy is conducted under two separate strategic plans. It is expected that from 2013 a common plan may address drugs, drug addiction and alcohol-related problems.

Drug addiction and alcoholic issues are already addressed by a common social and health structure. The National Plan on Drugs and Drug Addiction 2005-12 has introduced a change of paradigm regarding intervention in the demand-reduction area. The widening of the Institute on Drugs and Drug Addiction's mission provides for inclusion of alcohol-related problems, with an integrated approach to prevention, harm reduction, treatment and reintegration, though patients' referral may vary.



As for tobacco, the policy pathway has been different and was chosen to protect non-smokers and prohibit passive smoking by enforcing severe prohibitions.

## **9.9. Acronyms**

- APAV Associação Portuguesa de Apoio à Vítima (Portuguese Association for Victim Support)
- CEJ Centro de Estudos da Juventude (Youth Study Centre)
- CEPD Centro para o Estudo da Profilaxia da Droga (Centre for the Study of Drug Prophylaxis)
- CIJD Centro de Investigação Judiciária da Droga (Judicial Drugs Investigation Centre)
- CSDP Centre for the Study of Drug Prophylaxis
- DADC Drug Addiction Dissuasion Commissions (Comissões para a Dissuasão da Toxicodependência)
- GNR Guarda Nacional Republicana (National Republican Guard)
- GPCCD Gabinete de Planeamento de Coordenação e Controlo de Droga (Co-ordination Office for the Fight against Drugs)
- IDT Instituto da Droga e da Toxicodependência (Institute of Drugs and Drug Addiction)
- IPDT Instituto Português da droga e da Toxicodependência (Portuguese Institute of Drugs and Drug Addiction)
- INME Inquérito Nacional em Meio Escolar (National School Inquiry)
- INML National Institute of Legal Medicine
- SPAT Serviço de Prevenção e Atendimento de Toxicodependentes (Drug Addiction Prevention and Treatment Service)
- SPTT Serviço de Prevenção e Tratamento da Toxicodependência (Service for Drug Addiction Prevention and Treatment)

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## **10. From policies on alcohol, tobacco and illicit drugs to a Swiss addiction policy**

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### **10.1. Introduction**

#### **10.1.1. The Swiss political system**

Switzerland, lying at the centre of western Europe and bordering on Germany, France, Italy, Austria and Liechtenstein, is one of the continent's smaller nations. It has a population of 7.5 million, with four different local linguistic cultures (German, French, Italian and Romansh). Foreigners account for 20 % of the population, and about half of them are native speakers of a non-Swiss language.

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

#### **10.1.2. Substance use/misuse: some data on consumption, demand and supply reduction**

Drug problems – in the sense of consequences of the use of illegal psychoactive substances, as perceived by the public – have existed in Switzerland, as in many other European countries, since the social upheavals of the late 1960s and early 1970s. For a long time, popular and expert perceptions centred on heroin use and the associated multiplicity of health, psycho-social, economic and social problems, as well as the use of cannabis products. As will be shown, the consumption of tobacco and alcohol became a subject of Swiss public health strategies only at the end of the last century.

However, the epidemiological data (for lifetime prevalence among people aged 15-39, 1992 to 2002) show that consumption patterns and associated problems have undergone significant changes over this period.

The quantity of pure alcohol consumed per person per year has been steadily decreasing since 1990 (8.5l in 2010, down from 10.3l in 1990). In parallel, the number of persons consuming alcohol in a non-risky way increased between 1997 and 2007 (from 94.2 % to 95.5 %). In contrast, the number of young people between 15 and 24 years old consuming alcohol riskily slightly increased.

In 2001, 33 % of the population (ages 14 to 65) smoked. Since then, this number has steadily decreased until, in 2010, only 27 % of those aged 14 to 65 smoked (poll on the consumption of tobacco, yearly).

In 2007, 19.7 % of all persons over 15 had consumed illegal drugs at least once in their life. Among persons aged 15-39, the proportion using any illegal drug had risen from 16.7 % in 1992 to 28.2 % in 2002. This was mainly due to the strong rise in the number of people consuming cannabis. From 1997 to 2007, the proportion of persons over 15 having ever used cannabis rose from 14.2 % to 19.4 %. Over the same period, there was also a considerable increase in cocaine use in the same population, from 1.6 % to 2.8 % (Swiss Health Survey). In contrast, there was almost no increase in heroin use, up from 0.5 % to 0.7 %, and the number of dependent heroin users, as estimated by the Federal Office of Public Health, fell by about 25 %. We can judge that heroin use has stabilised by looking at the statistics for heroin and methadone substitution treatment, which show that now only a few patients each year begin a substance-based treatment, while most such patients have been in one of these programmes for years. The average age of people in treatment is rising by about one year every year (methadone statistics).

Statistics on treatment show an important decrease in persons aged 16 to 29 coming into contact with any kind of help structure (ambulant or stationary) because of heroin since 1997, but they show a continued increase in persons in need of help or counselling due to cannabis. The reasons for this increase are increased prevalencies for cannabis and continuing co-operation by justice and police with the addiction aid system for (mainly) very young users. The same tendency, though less marked, can be shown for cocaine until 2006 (statistics on the addiction aid system).

Data collected during prevention actions in night-life settings (surveys carried out at the same time as drugs are being checked by qualitative laboratory analysis) show a very high rated prevalence of tobacco and alcohol as well as cannabis, ecstasy, amphetamines and cocaine (all more than 74 %, up to 98 %). This shows that at least in certain settings, the use of substances does not depend on their legal status, but on the effects the substances might have.

The data above, from the Swiss Health Survey, Health Behaviour in School-aged Children (HBSC) studies and other polls by social and health institutions, must be complemented by data on drug seizures by police and customs, by waste water tests and other data on disposables.

## **10.2. The political and legal context, and perceptions of addiction issues**

### **10.2.1. The development of Swiss addiction policy**

#### *Alcohol policy*

The oldest domain treated by politics in the whole prevention and addiction field is alcohol. The federal state started the taxation of alcoholic products in the 1880s. The first national Alcohol Act was passed in 1887 and was expected to stop the increase in numbers of alcoholic citizens by raising the prices of beer and wine. Nevertheless, prevention aims were always less central than a possibly liberal taxation system. Only after 2005 did the Swiss federal state start to define a national alcohol programme with the focus on public health, not least because of the experience of increasing numbers of young people consuming alcoholic drinks to excess. However, this first programme under a public health umbrella was partly pre-set to fail, since no structural measures were designated.

The antagonism between public health issues/prevention and a liberal taxation system is illustrated in the actual debates on revision of the national Alcohol Act. Whereas addiction professionals favour an extended catalogue of structural measures like minimum prices or a ban on “happy hours”, producers and the economy hold up all of these recommendations and fight for the status quo or even liberalisation of charges and restrictions.

#### *Drug policy*

Current Swiss drug policy has its origins in the 1970s. During this decade, drug use was still considered as a criminal act. The partial revision of the federal Narcotic Drugs Act in 1973 penalised every use of illicit substances. The punishment was at that time explicitly extended to personal use and was as strict as that for production and dealing. Drug consumers were still considered as delinquents who must be prosecuted. The principle was, through punishment, to achieve abstinence.

In the 1980s the incursion of HIV marked a very important moment in Swiss drug policies. The fast propagation of the virus within drug consumer groups and the misery of the heroin consumers caused law-enforcement measures to fail. The open drug scenes challenged not only the law-enforcement side, but also the social and public health side. Due to this situation several bigger towns established the first harm-reduction offers such as needle exchange,

consumption rooms and emergency overnight accommodation. At the same time, specific therapy and caring offers were developed, for example opioid maintenance or heroin-based treatment programmes. In addition, the open drug scenes were closed down by the police. This marked the most important turnaround in Swiss drug policy.

During the early 1990s, federal drug policy was consolidated. In 1994, the government officially endorsed the fourfold approach (prevention, therapy, harm reduction and law enforcement) as the basis of its drug policy. In 1991 and then again in 2002 and 2006, the government approved packages of measures, each running for several years, to reduce drug-related problems in Switzerland. Each package contained a large number of individual measures whereby the federal authorities proposed to fulfil their drug policy responsibilities while supporting the cantons, which bear primary responsibility for drug policy and its implementation in Switzerland. In 2011, the third package of measures – originally planned to run for a five years from 2006 to 2011 – was extended by another four years to give time to develop alternative strategic approaches (see below).

Until a few years ago, the focus of the policy makers and federal administration was on illegal substances. This pattern is gradually changing. Illegal drugs are losing public attention while tobacco and, to a lesser extent, alcohol are gaining importance in public perception as well as in political actions and regulations.<sup>43</sup>

### *Tobacco policy*

The Swiss Government took its first steps in the 1990s. The Federal Office of Public Health launched campaigns spreading the message of smoking harm. But it was only at the beginning of the new century, when strategies were changed and campaigns started focusing on passive smoking, that there were also influences on cantonal and federal legislation. Within a few years a federal act and cantonal acts – in all cantons – were passed or amended to accomplish smoke-free public spheres.

Tobacco policy is much more than drug policy, where thinking is defined under the umbrella of the public health approach, focusing in this case on the defence of the people (potentially) harmed by smokers. Since NGOs as well as policy makers have to confront a powerful tobacco industry, it is quite difficult to put in place well functioning structural measures to regulate more heavily the production of and trade in tobacco products. Therefore, tobacco policies stress complete abstinence and smoking cessation rather than less harmful forms of consuming tobacco.

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43. For a good overview of drug policy making in Switzerland, see Joanne Csete (2010), *From the mountaintops: What the world can learn from drug policy change in Switzerland*, Open Society Foundations, Lessons for Drug Policy Series, Warsaw/New York.

### 10.2.2. Comparisons

If we compare the three sectors – alcohol, drug, and tobacco – some points attract attention.

Drug policy is noticeably affected by a black market that undermines every interest of the consumer as well as being completely free of every form of active regulation. This leads to various specific problems for consumers (access to prevention messages, social disintegration and squalidness) and for the state (substance control, taxation and market supervision are all impossible). In contrast, tobacco and alcohol policies are – or at least can be – determined in co-operation between the interests of prevention and production.

Within the whole domain of illegal substances, nothing is more fixed than the acceptance that the persons concerned are already consuming and are therefore ready to take risks (health, life, social disintegration and criminal prosecution). With a little less certainty, this accepted point of view is also true for alcohol consumers. Nevertheless, an important branch of the alcohol prevention field is that followed by the temperance movement. In tobacco policy, by contrast, abstinence is set as a norm, following the credo that every cigarette is harmful, and tobacco industries should not be allowed to propagandise a “healthy form of smoking”. Therefore the drug policy pillar of harm reduction is often excluded as an effective approach to users.

After 1995, professionals from the demand- and supply-reduction sides drafted models of co-operation between the police and harm-reduction professionals. This happened predominantly at municipal level, starting from the assumption that all agencies were working on the same problem and pursuing similar goals, with the aim of getting more co-ordination in measures by police and the aid system. This led to a common understanding of what had to be done by professionals of the two pillars, harm reduction and repression. These models now have new interest because of increasing numbers of people consuming alcohol (and other psychoactive substances) in public and because of major problems with clandestine drug traffic that nevertheless invades the public sphere. Whereas police intervention in drug use was mostly aimed at criminality, today’s police interventions are much more linked to the duty of public order. This has set new challenges to the co-operation models for police and aid services.

Drug policy was, for a time, a response to a specific problem, namely the huge number of socially disintegrated heroin users and open scenes of drug use. Since the public considered the “drug problem” a high priority, politics had to propose strategies urgently. Since the problem was mainly located in the bigger cities, and since it was in the national interest to close down “needle parks”, it was at the beginning communes and the confederation who jointly started finding new solutions to the problem. The confederation took over at first a lot of local initiatives, for example, the prescription of heroin, which was



first practised in Zurich and Bern. At that time, the Federal Office of Public Health (FOPH) judged this plan as promising and a practical component of a wider answer to these major problems. It found a scientific umbrella that allowed it to offer this new therapy legally. Because of this very field-oriented approach, Swiss drug policy is still quite close to the institutions offering therapy or harm-reduction measures.

Unlike this fieldwork approach, alcohol and tobacco policies were always focused on public health issues (if that, since alcohol policy was for 100 years determined by fiscal policies). The co-operation between confederation and cantons is notable in this different approach. The actions of FOPH, for example, are mainly concentrated on promoting projects by financing them or by promoting networks. In tobacco and alcohol policies, it is hard to imagine FOPH creating a quality-assessment instrument or a catalogue of recommended products for (substitution) treatment. On the other hand, it is hardly imaginable that FOPH could lead a campaign on illegal drugs like those it has led on smoking or problematic alcohol use.

Drug policy always stresses addiction, whereas alcohol and tobacco policies also emphasise chronic or non-communicable diseases (NCDs). Therefore we must say that tobacco policies focus largely on the prevention of NCDs and less on the treatment of tobacco consumers.

### *Rethinking policy*

In view of all that, and having talked about addiction policies, we are close to thinking about addiction policies by starting to rethink drug policies. Since drug policy has been, from the start, regularly confronted by use, by important changes in behaviour, by central social questions like disintegration and squalidness, its instruments are hardly restricted to the drug policy field, apart from specific instruments like the prescription of heroin which cannot find any use with tobacco or alcohol users. Drug policy is characterised by an openness between the four pillars – prevention, therapy, harm reduction and repression – but it is also open to measures on illegal and legal substances. A last point to mention is the fact that drug policy has never been considered as uniquely a matter of public health and an instrument to prevent non-communicable diseases. In the case of addiction, this approach is urgently needed, since therapy or harm reduction cannot deal only with health questions, but also with social, integrative, criminal and other matters.

This thinking had its effects also on the legal situation in Switzerland. At the end of the 1990s, the federal Parliament was willing to anchor the four pillars in the federal Narcotic Drugs Act. Since liberalisation of cannabis was included, amendment of the act was refused by the low chamber (Nationalrat) in 2004. In 2006, the parliamentary commission for social security and health adopted a new proposal for partial revision of the federal act.

The aims were to set aside the cannabis question, but to:

- adapt the law of 1951 to recent societal and political changes;
- fix four-pillar politics in the federal Narcotic Drugs Act and improve government measures on prevention, therapy and harm reduction;
- anchor heroin-based treatment (heroin prescription);
- strengthen youth protection measures with a focus on early intervention;
- find answers to the increasing phenomenon of drug consumption, as well as to the more and more prevalent mixed consumption of alcohol and illicit drugs;
- give a legal framework to the medical use of cannabis.

In its report, the commission declared (on the purpose clause of the project): “It is about to improve efficacy and efficiency by promoting a more coherent, more co-ordinated view of the measures and of the stakeholders. Complete abstinence may be an aim of these. Yet Article 1a enumerates explicitly the four pillars. To achieve these objectives, the Confederation and the Cantons will take measures over all four pillars. All of these measures are applicable, independently of the substance. In other words, they are intended not only for illicit substances but for all substances with addiction potential. This disposition embodies the will to follow integral policies on addiction matters.”<sup>44</sup>

Thus the legislative authority, in revising the federal Narcotic Drugs Act, clearly wishes to focus on real and potential addiction problems due to substance use and abuse, integrating all psychoactive substances. Whereas the act itself only refers to psychotropic substances, the report mentioned above, the popular vote provoked later and the resulting legal ordinance (on narcotic addictions and other addictive disorders) clearly refer to all psychoactive substances.

### **10.2.3. Different conceptual approaches to a more integral addiction policy**

The segmentation found in the professional arena can also be observed in the Federal Office of Public Health (FOPH), which for many years has had largely unco-ordinated administrative sections – with separate programmes and budgets – for illegal drugs, alcohol and tobacco. However, in 2002, the FOPH responded to growing calls from specialists for an integrated view by commissioning a report from an external expert, in which foundations and materials were presented to support greater integration of federal activities in

44. Initiative parlementaire: Révision partielle de la loi sur les stupéfiants. Rapport de la Commission de la sécurité sociale et de la santé publique du Conseil national, Bern, 4 May 2006, pp. 8155-6 (report by the commission on social security and public health of the lower chamber on partial revision of the federal Narcotic Act).

the area of addiction policy. The report<sup>45</sup> employs a broadly defined concept of addiction, including both substance-related and non-substance-related forms of dependence, together with eating disorders. It contains an empirically based account of the need for action on addiction policy, provides an overview of current federal practice in this area and sets forth requirements and recommendations for a new addiction policy in Switzerland.

Around the same time, the question of greater integration of federal drug policy activities was also addressed by the Federal Commission for Drug Issues (Eidgenössische Kommission für Drogenfragen; EKDF), which advises the government on drug-related matters. In its report<sup>46</sup> the EKDF analysed the past and present state of Switzerland's drug policy and called on the government to increase the coherence and credibility of its addiction policy for the future. Taking the fourfold drug-policy approach as a starting point, the commission proposed a new, three-dimensional model as a basis for the reorientation of addiction policy. As well as the various illegal drugs, this model encompasses alcohol, tobacco and medicines with psychoactive effects. It declares the four pillars – prevention, therapy, harm reduction and law enforcement – to be a valid model for all these substances, and it distinguishes in each case between low-risk use, problematic use and dependence.

Taking up the recommendations from both reports, the FOPH requested the three federal commissions – on drug issues, on alcohol issues and on tobacco control – to jointly develop a coherent addiction policy framework based on a public health approach. From 2008 to 2010, a steering group of members of all three commissions assessed what had been achieved and identified the present and future need for action. In their report, *The challenge of addiction*,<sup>47</sup> they widened the scope of the framework of addiction policy by stating that addiction is more than dependence, more than a question of legal status and more than substances.

Subsequently the steering group presented their policy framework for the challenge of addiction, based on three new strategic directions. Beyond personal responsibility, they saw a need to develop structural measures and to promote skills; beyond youth protection, there was a need for appropriate approaches for different sections of society; and, beyond health policy measures, they found a need for an inter-sectoral addiction policy. Finally, the steering group defined 10 principles that should guide implementation of this new policy,

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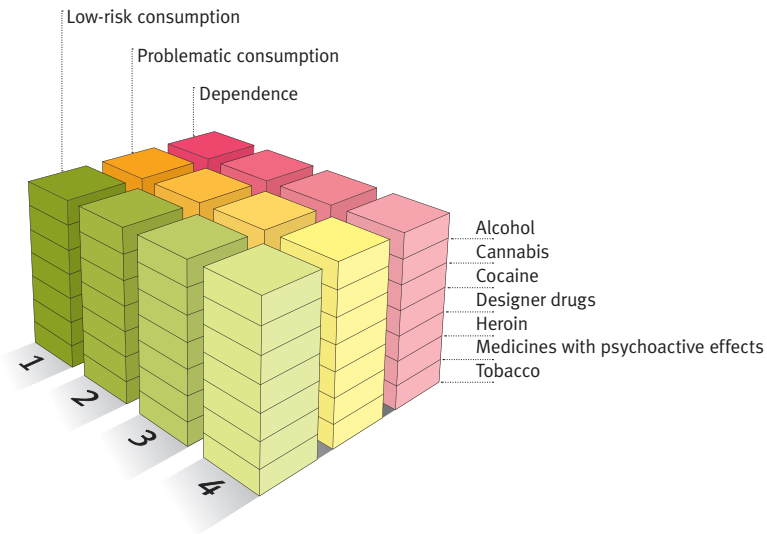
45. Markus Spinatsch (2004), *Eine neue Suchtpolitik für die Schweiz? Grundlagen und Materialien für eine verstärkte Integration der suchtpolitischen Aktivitäten des Bundes/Une nouvelle politique en matière de dépendances pour la Suisse? Bases et prémisses pour une politique fédérale plus intégrée en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

46. Swiss Federal Commission for Drug Issues (EKDF), *Von der Politik der illegalen Drogen zur Politik der psychoaktiven Substanzen*. Verlag Hans Huber, Bern, 2006 ([www.psychoaktiv.ch](http://www.psychoaktiv.ch)).

47. Challenge of Addiction Steering Group, *The challenge of addiction – foundations for a future oriented policy on addiction in Switzerland*. Bern, Federal Office of Public Health. [www.challengeaddiction.ch](http://www.challengeaddiction.ch).

including the prevention of problematic consumption and behaviours, and reduction of the harmful effects on health and the impact they have on individuals, their environment and society.

**Figure 1: The Cube, Federal Commission for Drug Issues (EKDF), 2006**



- 1 **Comprehensive prevention:** Health protection, health promotion and early recognition
- 2 **Therapy:** Therapy with various treatment options; social integration
- 3 **Harm reduction:** Individuals and for society
- 4 **Law enforcement:** Market regulation and youth protection

### 10.3. Structures, measures and stakeholders

As policies on alcohol, drugs, and tobacco are separated, we see the structures of these three policies also differ. Within the Federal Office of Public Health all prevention and addiction measures are integrated in the sense that it is the same administration unit. However, the responsibilities of the three substance specific units are very different.

FOPH is the leading body of Swiss federal drug policy, and its drugs section is charged with the development and operational realisation of measures defined by FOPH. The Federal Office of Police (Fedpol) and the Federal Office of Justice are associated with FOPH, since all three agreed to and support the current measures on drugs (Massnahmepaket Drogen; MaPaDro). Similarly, FOPH is charged with all prevention matters of tobacco consumption and passive smoking. Its tobacco section is responsible for the development and operational realisation of the National Tobacco Programme (Nationales Programm Tabak NPA), but is not the executing body for the tobacco prevention pool

which funds federal, cantonal and prevention projects of NGOs and communes to prevent tobacco consumption. For that purpose, a separate administrative unit, the Tobacco Control Fund, is led by an expert commission. Only in 2011 did the strategic direction of the national programme and the fund converge to co-ordinate and adjust the strategies and measures undertaken or promoted by each. As already mentioned, FOPH has been charged with a national alcohol programme only since 2008. Although the Federal Council (government) charged FOPH with developing and realising the programme, it is the Swiss Alcohol Board that administers alcohol taxation and the resulting fund. This unit is part of the financial administration, the leading body for all kinds of alcohol policies and as such also a member of the strategic guidance of the programme.

### **10.3.1. Stakeholders of Swiss addiction policy, and their competences**

In Switzerland, drug policy is a joint venture between the federal state, the cantons, the municipalities and private actors, mainly non-profit NGOs. Co-operation between these actors is guided by the principles of subsidiarity and federal policy implementation. The principle of subsidiarity states that, as long as a lower level of the political-administrative organisation is in a position to accomplish a public task, it should not be allocated to a higher level. The principle of federal policy implementation attributes major legislative enactments to the federal state, whereas the cantons are primarily responsible for implementation of these laws. These two principles delimit the range of action of the federal state and make the cantons the most important actor in Swiss drug policy.

As presented above, the main legal basis of Swiss drug policy is the Narcotics Act and its “four pillars” model of prevention, therapy, harm reduction and law enforcement. Within this frame, the various actors have different and complementary responsibilities.

At the federal level, in the fields of prevention, therapy and harm reduction, the Federal Office of Public Health is the main actor. Its responsibilities include:

- developing national programmes of prevention as an umbrella programme for cantonal, regional and communal measures;
- supporting the cantons, communes and relevant NGOs in their implementation work, and co-ordinating their activities;
- promoting quality control, further education and programme evaluation;
- documenting and informing the nation about drug problems, and promoting scientific research on illegal drug problems;
- participating in international conferences and representing Switzerland on international bodies.

At another level, Swissmedic, the Swiss Agency for Therapeutic Products, is in charge of the authorisation and supervision of therapeutic products, including narcotics and other psychotropic substances and controlled precursors. The Federal Roads Office is responsible for problems related to driving and drug consumption, and the State Secretariat for Economic Affairs is the body in charge of addiction problems at the workplace.

In the field of law enforcement, the Federal Office of Police supports and co-ordinates the cantons in enforcing drug laws. It is also responsible for international police co-operation and arrangements for law enforcement. The Federal Criminal Police investigate cases of serious organised crime and money laundering. Fedpol also publishes police bulletins on the drug situation, acts in precursor control, and co-operates with international police organisations and the UN Office on Drugs and Crime (UNODC). The Federal Office of Justice plays an important role in drug-related legislative enactment, in international judicial assistance and in promoting model experiments in prison and penal regimes. Finally, the Federal Customs Administration is in charge of drug smuggling control and of preventing the illegal import of prohibited substances.

The cantons are responsible for the implementing most drug-related regulations and programmes, including programmes in primary and secondary prevention, inpatient and outpatient treatment, medical prescription of heroin, substitution therapy, injection rooms and law enforcement of the ban on producing, trading, possessing and consuming illegal substances. The cantons have a high degree of autonomy in how they shape and implement their drug policies.

The drug-related administrative settings for prevention, therapy and harm reduction in the cantons are very heterogeneous. In some cantons, the unit in charge is the health department, in others it is the social department. Some follow an integrated philosophy concentrating all addiction related activities (except tobacco) in the same unit; others have a sector oriented approach with separate units for each addiction form.

Although the Narcotics Act does not delegate any drug-related tasks directly to the communes, many cantons do transfer many such tasks to their communes. This is particularly the case with medium and big cities that are most immediately concerned by drug problems.

Law enforcement is in all cantons exclusively a police task. Responsibility for enforcing national drug laws lies almost entirely with the cantonal and municipal police forces of Switzerland.

Besides these public authorities, there are many NGOs which are mandated and financed by cantons or communes to fulfil tasks in the fields of prevention, therapy and harm reduction. These institutions have been playing a

vital role in the definition and implementation of Swiss drug policy for a long time. In some cantons, they are in charge of (almost) all implementation of non-repressive drug-related measures.

Besides these actors in charge of defining and implementing drug-related regulations, there exist many co-ordination and consulting bodies, among them:

- the Federal Commission for Drug Issues (EKDF), composed of 14 experts from various scientific disciplines who advise the government and its administration on all aspects of the Narcotics Act;
- the Conference of the Commissioners of the Cantons in Addiction Affairs, composed of the responsible civil servants of all 26 cantons, which is in charge of co-ordinating policies and programmes between the cantons as well as between the cantons and the federal state;
- the Conference of the Commissioners of the Cities in Addiction Affairs, which consists of representatives of the addiction departments and the police of 26 cities, its task being to promote exchange and co-operation between the administrative units of social affairs, health and police concerning drug and other addiction problems at city level;
- the National Committee on Drug Affairs, composed of representatives of the federal administration, the cantons and the cities, is in charge of co-ordination and exchange between the three administrative levels of the state; and
- the National Co-ordination Committee on Addictions, which is a platform for exchange and co-ordination of NGOs involved in drug-related activities.

Most of these committees and commissions are co-ordinated by, and are part of, the Co-ordination and Service Platform in Addiction Related Matters. The platform includes most of the relevant bodies of the federal state, cantons, communes and NGOs dealing with addiction matters. This platform was convened in the 1990s, when communes and the confederation recognised an important need for co-ordination work. Until 2011 the platform was constituted via a government enactment. Both the platform and co-ordination itself came into effect by a specific article of the amended national act on illicit drugs.

Co-ordination on a federal level is all the more important since the federal Narcotic Drugs Act assigns some important duties and responsibilities to the cantons, whereas the confederation is charged with co-ordination. Also, politics in Switzerland are always realised by co-operation between cantonal, municipal and civil society. Therefore co-ordination assures at least a minimal common standard of approaches. Experiences of recent years have led to the expectation that the whole addiction and drug field will sample another catalogue of important changes, such as concentration and specification in the whole treatment offer, an approximation between the different substance policies or even abolition of the differentiation corresponding to substances.

## 10.4. Measurement and evidence

From the beginning of its drug-related measurement packages in the early 1990s, the FOPH tried to base the shaping of its activities on relevant data. What began with a rather pragmatic use of available statistical data and incidental research materials developed over the years into a more and more sophisticated information system for steering and evaluating programmes and projects. This development was a consequence of fundamental changes in the organisation and management of the public sector in Switzerland. By making effectiveness and efficiency part of the focus of state action, concepts like “taking informed decisions” and “evidence-based decision making” required accurate and timely information. Some of this information has been collected for a long time and is continually updated. Other data sources had to be newly developed and produced for the specific management and accountability needs of the policy.

### 10.4.1. Statistical and epidemiological data

Statistical and epidemiological data are collected and published regularly. They are generally produced for multiple users and purposes including monitoring and evaluation. In Switzerland, there are three such databases (discussed below) that play an important role in the shaping, steering and evaluation of drug programmes.

The Swiss Health Survey (SHS), conducted by the Federal Office of Statistics, provides information about the health status and health behaviour of the adult population, and includes data about drug consumption. The survey has been conducted every five years since 1992, covering a random sample of 12 000 persons with telephone interviews and postal questionnaires. On demand, this sample can be increased to serve the particular needs of single cantons. In 2012, the Swiss Health Survey will for the first time include questions of the Minimum European Health Module (MEHM) and the European Health Information System (EHIS). This will allow for future international comparisons on some central indicators.

Health Behaviour in School-age Children (HBSC) is a World Health Organization cross-national collaborative study which is conducted every four years. It is carried out by the NGO Addiction Info Switzerland (formerly the Swiss Institute for the Prevention of Alcohol and Drug Problems, or SIPA) and financed by the FOPH and the cantons. Health behaviour being the focus of the study, it includes a number of questions related to drug consumption as well as other addictive behaviour. Switzerland has participated in this study since its beginnings in 1986. The survey covers a sample of about 10 000 11- to 15-year-old pupils who complete a questionnaire in their classroom. The international character of this study allows cross-national comparisons with 43 countries.



The Swiss Statistics on Narcotics, published by the Federal Office of Statistics, has provided each year since 1975 statistics on police arrests for dealing, consumption, smuggling and seizures of drugs. Numbers of drug-related deaths were reported until 2008. These statistics are based on data provided by the cantons.

## **10.5. Monitoring**

Since 2004, FOPH in co-operation with three NGOs has been running a monitoring system called Act-Info on consultations for and treatment of addictions. This monitoring system was created by integration and harmonisation of five separate statistical systems covering different aspects of addiction treatment. The information is collected from all clients (about 9 000 per year) in specialised inpatient and outpatient treatment centres in Switzerland at the beginning and end of the treatment process. The data collected come from five different sources: the Treatment Demand Indicator Standard Protocol of the EMCDDA, the Documentation Standards III of the Deutsche Gesellschaft für Suchtforschung und Suchttherapie, the Addiction Severity Index, former questionnaires of the integrated statistical systems and selected standardised screening tests.

This monitoring system provides data on treatment conditions, socio-demographic variables and substance consumption before and after treatment. These data are intended to serve the following objectives: general knowledge about the clients and their addiction problems, early detection of trends, documentation of treatment system structures, feedback to practitioners, international comparability and exchange, and data for further research.

A more comprehensive Addiction Monitoring System in Switzerland (AMIS) is currently under construction. It aims to integrate data from ongoing population surveys (SHS, HBSC, Study in low-threshold centres) with specific modules of yearly surveys as well as regularly collected data on mortality, treatment and repression. The system is planned to be functional by 2012.

### **10.5.1. Evaluation**

Again following the definition of the OECD, “evaluation is the systematic and objective assessment of an ongoing or completed project, programme, or policy, including its design, implementation, and results. The aim is to determine the relevance and fulfilment of objectives, development efficiency, effectiveness, impact, and sustainability. An evaluation should provide information that is credible and useful, enabling the incorporation of lessons learned into the decision-making process of both recipients and donors”.

From the start of its first package of measures, FOPH began also an external evaluation programme that was intended to continually provide relevant

information about the basic essentials of current activities. Since 1991, four global evaluations and several other evaluation studies have been conducted.

The first global evaluation covered the years 1990-92. This preliminary step was intended to show up the various indicators (needed or available) for the consumption of drugs. Based on this study, the first global evaluation report contained a statement about the general drug-related situation in Switzerland as well as a methodological frame for future evaluations. Major criteria included in this frame were that the evaluation should be global (in the sense of including all relevant aspects of the activities) and primarily goal-based, but it should at the same time include information about decision making and implementation of measures.

The second global evaluation covered the period 1990-96. It was based on the reframed results of the first evaluation and included an assessment of the measures taken by FOPH and by cantons. Like the first evaluation, it contained also an analysis of epidemiological data on drug consumption.

The third global evaluation (1996-9) was methodologically based on action theory and logic modelling in order to assess the objectives of the singular measures of the package. The analysis was particularly focused on the conceptualisation and planning of the programme and on the relation between objectives and implementation.

Covering the period from 1999-2002, the fourth global evaluation was particularly focused on implementation of the package. Simultaneously, a team of political scientists was mandated to evaluate the political anchorage of the measure package.

These global evaluations covered the first two packages of measures and a time period from 1990 to 2003. They consisted of several partial studies focusing on selected aspects. Besides, additional singular evaluations of institutions, measures and instruments were commissioned by FOPH, among them the upskilling programme of MaPaDro, the function of consulting centres for harm reduction, the role of police and juvenile courts in prevention and many others.

After 2003, FOPH continued to regularly commission evaluations on particular aspects of drug policy, for example, an international comparison of drug-related state interventions, an assessment of the Act-Info monitoring system and an analysis of a nationwide information platform on drug-related matters.

Before starting with the activities of the third package of measures in 2006, FOPH initiated an *ex ante* evaluation to survey the state of the central success indicators of the package before intervention. In 2011, a second survey of these indicators was conducted to identify the net effects of the package. Simultaneously, a comprehensive evaluation of ongoing programmes (drugs, alcohol, tobacco, nutrition and movement) was commissioned. This evaluation

should provide inputs to develop integrated programmes including all relevant addiction fields, as suggested by the report *The challenge of addiction* mentioned above.

## **10.6. Conclusions**

When talking of coherence of policies, it is not enough to define the meaning of coherence as such. We should take a look at its practicability or its realisable character. Therefore addiction policies cannot be judged as coherent only when they are self-consistent. Coherence means then to adjust measures so they are more consistent, or – with a view on systemic theories – to attune the objectives of different subsystems by formulating them as common objectives. In addition coherence can mean to promote exchange of good practice, of experience and of concepts to more easily develop measures answering similar problems. Let us give some examples.

We can adjust objectives of subsystems, for instance in models of co-operation between demand and supply reduction. When looking at the mission of the police and harm reduction, measures against demand and supply stand in the way of each other, because the offers of harm reduction create consumption rooms and offer needle exchange, whereas the police should, in a traditional understanding, be taking substances and needles away from the arrested users. Thanks to adaptation of the missions and objectives on both sides, it has been possible in Switzerland since the 1990s, to offer a set of harm-reduction institutions in bigger cities with the acceptance of the supply-reduction side. Actually, due to the initiative of FOPH, Fedpol and the Swiss association of police constables, it was possible, co-ordinated by Infodrog, the Swiss co-ordination body in addiction matters, to agree on an offer of continued training and conferences advocating co-operation and actions common to both sides.

We can also broaden concepts to other substances by analysing experience. For instance, after the turn of the century, in several Swiss towns discussions were held on neglected people similar to the drug users in earlier years, but now for their alcohol abuse. To guarantee a minimal protective offer by channelling their appearance in public space, the City of Bern developed for the first time a low-threshold recreation room for alcoholics. The main idea was borrowed from the harm-reduction offers for illegal drug users. As to promoting the health of this new group, the offer was slightly adapted, because there is no separation of habitable and consumption rooms. Even though since then only four low-threshold offers have been established for neglected alcohol users, enlargement of the concept has shown that experiences within one field can be adapted to others.

Thus, Swiss addiction policy cannot be judged as coherent or consistent. But there are initiatives to attempt a more coherent policy by adjusting measures and enlarging concepts. Nor is Swiss addiction policy integral, in the sense

that structures correspond to the responsibilities of the different involved state bodies. Whereas a more coherent direction is – relatively – easy to arrange by adjusting subsystems, the alignment of state structures is more difficult and risks being fought by different stakeholders. If the people responsible within the separate structures do succeed in adjusting subsystems, or objectives, there is little need for integral structures. Coherency in this sense can then be understood as the readiness of all stakeholders to co-ordinate their strategies and actions.

Concerning the Swiss experience, the initial position is quite comfortable. There is a long tradition of not only developing measures focusing on one form of addiction, but of considering similar needs within different fields as a reason to develop instruments and measures integrating several fields, for example concerning quality-control instruments for therapy and harm-reduction institutions. These were developed not only for institutions focusing on illegal drugs, but for every addiction. This choice is all the more justified by having a look at the changes in the therapy institution field.

Last but not least, Switzerland has, as remarked before, a legal basis not within the federal Narcotic Drugs Act itself but in the will of the legal authorities and in the regulations of the act.



## **11. Summary and conclusion**

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The eight contributions herein attempt to provide an overview of the development of policy in the area of psychoactive substances and the current state of affairs with regard to integration and coherence of such policies using the six indicators developed by the group.

The salient feature from all the eight contributions is the fact that health seems to be the main prerequisite for having a policy in place that addresses the issue of substance use and possibly beyond.

A second attribute seems to be the move from considering individual substances on their own within their specific domain – and hence the respective government ministries that over the years have been responsible for policy on their respective substances. In turn this follows on from above in that the main ministry responsible for policy on substance use is health, irrespective of whether there is a single document that encompasses more than one substance or a single document for each of the substances.

Thirdly it would appear that there is a move afoot to consider better integration of policies related to substance use and hence better co-ordination of actions resulting from those policies.

Finally, at last, it is also being acknowledged that a policy for psychoactive substances and possibly beyond – for example, addictions in general – does not stand alone among a number of national policies in place, and thus the question of coherency seems to be surfacing. In the wider picture this also has implications with regard to international organisations such as the European Union (EU), the World Health Organization (WHO), Council of Europe and the United Nations (UN) who also have their own agendas and conventions that need to be transposed by their respective member countries.

In light of above, each of the four points will now be considered in the framework developed in the course of the project and outlined at the start of this text.

### **11.1. Context**

The context in which drug policy has evolved over the past century provides one with an eye opener in explaining what that policy has come to look like today. In most countries drug policy came into being in the 1960s and 1970s

but it really came into focus during the HIV epidemic of the 1980s. Possibly with the exception of Austria, the Netherlands and Portugal, where the drug issue was to some extent addressed in the legal sphere at the start of the 20th century, in Belgium, Ireland, Israel, Norway and Switzerland drug policy came much later, only after the 1960s. This scenario may be similar to that of alcohol, which became a major social issue at the start of the 20th century, whereas drugs became an issue in the latter half of the 20th century and the start of the 21st century. So the use of substances and their social impact would seem to be the prime driving force in the arena of policy development. The introduction of harm-reduction measures would appear to be a good example of this particular aspect, in that actions were put in place to remedy a major social/health issue, that of the spread of HIV through the use of shared paraphernalia.

This in turn raises two issues in relation to the object of this exercise. The first is that of bottom-up activities – harm-reduction measures such as needle exchange and substitution treatment – that were introduced by the services on the ground and then at a later stage made “formal” in that they were ingrained in later drug policies of the said country. Consequently, the issue of top-down/bottom-up approach to the development of policy has now become more acknowledged with the presence of interest groups and NGOs on national councils, for example, the National Co-ordination Committee on Addictions (NCCA) in Switzerland, .

The second issue is the introduction of top-down policy making in the wider sphere, notably to differentiate the hard drug and soft drug markets, which resulted in the problem of the back-door sales of cannabis to coffee-shop owners in the Netherlands. The appeasement policy can be in turn considered to be a consequence of the introduction of the 1998 UN convention in which all psychoactive substance use was deemed to be punishable by law, and not a minor offence, whereas the Opium Act of 1976 had considered use of cannabis to be a minor offence. Without entering into the merits or not of the appeasement policy, the fact of the matter is that international bodies have influence over the development of policy in individual countries, but this is an example of the top-down approach that has resulted in problems of coherency with respect to national policy in relation to implementation.

Also of interest is the development of policy in Portugal in 2001, by which use of minor amounts of substances was deemed to be an administrative offence and not a criminal offence and so was handled by a specific body, namely the Drug Addiction Dissuasion Commission. Once again, whether or not this development in policy can be considered counter to international norms is not the point, but what may be highlighted is that activity by international organisations does have some impact on the way a country addresses the issue and at times may be thought to be counter to international norms.

So all in all on the issue of context, policy development today in the field of psychoactive substances, mainly drugs, alcohol and tobacco, is influenced by background factors, be they internal or external, that have shaped the type of policies we see today.

## **11.2. Integrated and coherent policy for psychoactive substances**

As described in Chapter 1, the issue of integrated and coherent policies for psychoactive substances is one that needs to be tackled if a major leap in policy development is to occur.

At the start of this work, we described how the concepts “integrated” and “coherent” mean different things to different people. So much so that, in the discussion on the framework it was noted that using the first notion of these ideas resulted in a two-dimensional scale – that of integrated/not integrated versus coherent/incoherent – which did not work. Thus the need arose to clarify these terms and as a result the following was suggested, namely that integration implies how well the pieces fit together and coherence, how different policies complement or support each other. It is also interesting that, in some chapters herein, coherence and consistency are used interchangeably, and thus another factor seems to have slipped in to the equation.

Taking the three terms, “integrated”, “consistent” and “coherent”, it would seem from a hierarchical perspective that they take the following order: coherent at the top of the tree and integrated at the bottom, with consistent somewhere in between. If we now adopt the definition used in the coherency chapter, and cited above, then this would suggest that the term “coherency” is used, both within a policy and across policies, to signify the positive aspect of the said policy both nationally and internationally. However, “consistent” would be used where there are no negative connotations within the policy per se or within different policies across government. The term “integrated” has been used within policy mainly to suggest that different aspects of the same policy are held together to make a neat whole – in other words the different shapes that make up a jigsaw fit neatly into each other.

Using this type of analogy it emerges that it is imperative to be clear about the level of analysis one is referring to. For example, at the topmost level it is the overall objective of international organisations and government to provide the necessary policies to achieve a particular goal. Following on from this, the next level may be how government per se draws up policies to achieve these and then the next level of analysis how each policy per se fulfils its functions in striving to reach the over-arching goal. In effect, it is like those lovely Fabergé gold eggs, where each fits neatly into the next but each has its own design and therefore identity. Each egg may stand on its own as an object of art, but that is not the whole picture: the concept of the artist was



to render all and consequently the art work can be appreciated in full only with the presence of all the eggs.

In turn, therefore, an overall objective/goal may be considered that indeed goes beyond psychoactive substances. It was expressed by WHO in the preamble to its 1946 constitution: “Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity”.

Moreover, well-being is thought to comprise the following elements: (Seligman, 2011)

- positive emotion;
- engagement with the people you care about;
- maintenance of good relationships;
- achieving work goals;
- having a meaning in life.

In addition, since the Council of Europe also upholds democracy and human rights, and has in place a Social Charter that provides for the right to health, it may be appropriate that the Council of Europe now consider the addition of social well-being as exemplified above.

The eight contributions in this publication have demonstrated that, at least at national level, the issue of psychoactive substances is currently the domain of health. This in turn would suggest that at least two of the criteria, those of physical and mental health, are being addressed by the countries participating in this exercise. Some further examination may show that some countries are doing more and possibly entertaining the factor of social well-being, and doing it in a coherent manner.

In Austria, for example, all substances fall under the responsibility of the ministry of health and the approach is one of protection, but this is managed in tandem with regulatory controls and it would appear that these are increasing, mostly as result of international obligations. At the level below government, the local level, prevention and treatment of the problem is based on the individual level and apparently works well, except for the fact that there are some problems relating to the type of substance used which prevents having one service for all.

In Belgium the problem of “coherency” seems to have struck a chord in 1996, following a parliamentary working group report that resulted in 2001 in the first government policy notice on drugs. The problem was put in the domain of public health and, more to the point, the minister for health was to chair the inter-ministerial group of 24 ministers that was to tackle the problem in the areas of prevention, treatment and social policy. Consequently over the years there has been better co-operation between the criminal justice system and the treatment providers, following pilot projects such as the drug-treatment

courts. This is not only due to the projects per se but also due to the fact that structures for monitoring and evaluation have been put in place, at federal and local level, and at present seem to be working well. However, it is not clear that these are the only critical factors in view of the findings that better results may be obtained by including the means to house and employ former users following treatment. It is stressed that the funds for these fall short of what is required, but the direction seems to be the right one in that it upholds the Belgian philosophy of “repression towards the users as a last resort”. A final comment is the fact that both alcohol and smoking are also at federal level, being the responsibility of the ministry of health, and it is the inter-ministerial group that provides direction such as the joint declaration on alcohol policy of 2008.

In Ireland also it was the joint parliamentary committee in 2006 that cleared the way for government to consider substance use from the health perspective and thus provide the basis for a substance-misuse policy that also addresses well-being. At present there is an interim strategy that combines drugs and alcohol; previously, separate strategies for each substance were in place and these had evolved to different degrees. However, when a substance-misuse strategy is finally drawn up, it is envisaged that drugs, alcohol and tobacco will be included since now the Office of Tobacco Control, an independent statutory body, is to be merged into the Health Service Executive. This at least will “integrate drug and alcohol abuse strategies at local level”. A major issue is that of co-ordination and this is reflected in the tensions between health and justice, which may be counter-productive in the pursuit of coherence.

In Israel, the main player in the field is the Anti-Drug Authority (IADA), which has evolved since 1988 to include both drugs and alcohol (from 2005). One other development is the move of the authority from the office of the Prime Minister to that of the ministry of internal security. This is the only such case among all the countries in this exercise and could be viewed, at first glance, as a move to a more repressive policy. In effect, this is not so at all, as IADA’s mission is to foster a “healthy and ethical society in to order to promote welfare and a high standard of living for its citizens”. Consequently this has provided for better coherence between the ministries of internal security, health and education; thus, what may appear to work in one country may not be the case in another in with respect to structures.

The Netherlands, as described in this and the previous publication, has separate policy papers for each substance but, as in other countries, it is the ministry of health, welfare and sport that co-ordinates the activities related to these policies. With the advent of a number of advisory committees, notably the one for drugs and evaluation, it has now been recommended that drugs and alcohol be considered in one policy document that takes its central theme as “substance-related harm”. It is argued that such substances produce substantial harm to both the individual and society and that to address this in a

coherent manner a more integrated approach is required. In relation to drugs, joint action on policing and caring is an example of both reducing negative effects of problem drug use in deprived city areas and helping users confront their problem, together with the provision of housing and better prospects of employment. In essence it is an attempt to provide the basis to achieve physical, mental and social well-being.

Norway is said to have a coherent substance policy on alcohol and drugs, centred around the public health domain. It is exemplified by the action plan on alcohol and drugs which was introduced in 2008 and has been extended to run on to 2012. It has five main objectives: a clear public health perspective, better quality of service and increased competence, more accessible services, better binding co-operation, and greater attention to the interests of children and family members. The ministry of health and care services is responsible for co-ordination of policy, with the ultimate goal of reducing substance use by the whole population and thus “reducing the total amount of harm caused”. Although tobacco has not been included in the action plan, it is treated in the same way as other substances in the broad prevention strategies. The biggest changes to date concern the organisation and delivery of treatment and care, which includes housing and other social services, for substance users.

As in Ireland, Portugal has decided to wait a little longer to have a single strategy for both drugs and alcohol. There are currently in operation single strategies for each, and the ideal time to integrate them into one has been set for 2013. As in other countries, the ministry responsible is the one related to health, and over the years the different bodies operating in the field have now been amalgamated into one, namely the Institute for Drugs and Drug Addiction within the said ministry of health. The inter-ministerial council is responsible for national co-ordination for drugs, drug addiction and alcohol-related problems; it is served within the ministries by technical commissions and from the outside by what is known as the National Council, which is made up of constitutional bodies and members of civil society. Tobacco, however, as in Norway, does not feature and is addressed separately but still under the auspices of the general Directorate of Health.

Switzerland is undergoing a major reform in the area, started by actors in the addiction aid system, in the communes and in the cantons. A major recurring criticism was the fact that for each substance there was a separate body, strategy and budget. This need for reform provided the opportunity to go beyond psychoactive substances per se by promoting an addiction policy that includes other forms of addiction not related to substances, such as gambling, Internet misuse and other behavioural addictions. At federal level, this development was taken into account, and at the turn of the century a phase of conceptual work was begun, along with a review of the federal Narcotic Drugs Act. Again, from a policy perspective, all fall under the Federal Office for Public Health and as in other countries it would seem that the perspective

prior to and beyond this phase was and is one of health. But it is the local level (communes and cantons) that is responsible for implementation of policy and thus the ways in which policy is actuated in the forms of programmes and the like. The key here is that Switzerland is attempting to go beyond what was customary and introduce an addiction policy that has in place the relevant structures at federal level to respond to needs and developments at regional and local level, all to provide for a coherent policy in this area. However, for this to mature into a coherent policy, the overall objective will need to give credence to the construct of social well-being – which, in part, it has by stating that an addiction policy is more than just personal responsibility, youth protection or for that matter health measures.

The foregoing overview has been an attempt to put into perspective the salient points of what may be termed a coherent policy on psychoactive substances and beyond. It is now time to remind ourselves of the six indicators suggested in Chapter 2, namely:

- Conceptualisation: how are the problems associated with different psychoactive substances, illicit drugs, alcohol and tobacco, described? How do research evidence, media coverage, cultural mores and social, economic and political considerations shape the nature of the “problem”? To what extent do these elements converge? (This dimension is comparable to the model of policy influencers outlined in phase 1 of the project.)
- Policy context: where are psychoactive-substances policies located within the overall policy document? In criminal justice, in the medical context or within a value set such as social inclusion, human rights or equality? To what extent is there a consistent approach across different psychoactive substances?
- Legislative/regulatory framework: how are various psychoactive substances controlled and regulated? How far are controls complementary and supportive of the desired outcomes?
- Strategic framework: what are the goals and aspirations, the objectives, of drug, alcohol and tobacco policies? To what degree do they overlap with one another?
- Responses/interventions: are interventions logically consistent and mutually supportive?
- Structures and resources: to what extent does the organisation of structures and resourcing support the co-ordination and/or integration of drug, alcohol and tobacco policies?

It would appear that all the countries discussed herein have taken into account these six indicators of coherency and that the development of policy in this field is leading to one in which most substances are incorporated. This analysis, however, is a first attempt and possibly needs further work to better focus

on the defining features that may lead to a better measure of efficiency and effectiveness of coherency.

### **11.3. Conclusion**

The results herein may be a surprise to some in the field in that in all eight participant countries are putting the issue of a psychoactive substance policy (and beyond) under the spotlight at present, together with the issue of whether how this may be achieved in a coherent manner. It is to the greater good that the issue of coherency is currently at the forefront of policy making at national level because this is also a matter of international urgency, as can be seen in the attempts by the EU and OECD in the sphere of policy coherence for development. It is also to say the least timely that coherence has been brought to the fore by this group in light of the fact that a number of current issues in the EU, like foreign policy and monetary union, imply coherency. It has been argued elsewhere that such an attempt is not possible in that national governments tend to compromise because of different interests. However, as suggested in Chapter 2, the over-arching goal of coherency and the tools developed over the past 15 years or so to achieve it may over-ride “conflicting and competing interests”.

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The issue of psychoactive substance policies (and beyond) is currently at the forefront of policy making in a number of countries, including those participating in this study, together with the issue of how such a policy may be implemented in a coherent manner. Continuing the work carried out in two previous publications, *From a policy on illegal drugs to a policy on psychoactive substances* (2008) and *Towards an integrated policy on psychoactive substances: a theoretical and empirical analysis* (2010), this work attempts to put into perspective the salient points of what may be termed a coherent policy on psychoactive substances and beyond. It proposes six indicators, around which the concept of coherency is articulated: conceptualisation, policy context, legislative and regulatory framework, strategic framework, responses/interventions, and structures and resources.

The results of this study may be a surprise to some in the field, and tie in with broader efforts by the European Union and the Organisation for Economic Co-operation and Development in the sphere of policy coherence for development.



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