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DUTCH DRUG POLICY IN A EUROPEAN CONTEXT

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The increased cooperation between European Union member states in many policy areas has made it increasingly difficult for individual countries to pursue national policies on issues like drugs. The drug policies of the Netherlands, which center squarely on harm reduction, were under severe attack in recent years. Yet a good look at the actual practices in many other countries leaves no doubt that the predominant tendency is towards a harm reduction approach. Debates are also underway in many countries on drug policy reform, and everything from the decriminalization or legalization of cannabis to the legal prescription of heroin have been advocated. Although it is not yet clear just what future policies will look like, the current wave of pragmatism in many European countries has made the liberal Dutch approach less of an isolated case than it was a decade or more ago.

Introduction

For many years, Dutch drug policy has been one of the most widely discussed approaches to the drug problem. Outside the Netherlands, the "Dutch system" has won both praise and condemnation, the latter sometimes in a emotional or even violent way. The most vociferous critics have those from the USA, France and Sweden. A number of the misunderstandings and myths that have circulated in other countries have astonished the Dutch. If the wildly exaggerated stories disseminated by the press, politicians and government officials were true, one might rightly wonder whether the Netherlands is really that 'pragmatic country', a country concerned with the practical results of its policy.

A key determining factor in Europe today is the continuing development of the European Union (EU). Since 1993, cooperation between the 15 member States has expanded from economic matters to other policy areas, changes which have a direct bearing on national drug policies. This article describes some recent European developments relating to drug policy. It situates the Dutch policies in a European context – mainly by contrasting them with the policies of Sweden and France – and examines some general trends in other EU countries.

Some Principles of Dutch Drug Policy

Public health is the starting point of drug policy in the Netherlands. Its primary aim is to protect the health of individual users and their environments by reducing the harms associated with drug use. Experimental drug use, although discouraged, is not necessarily considered a problem. Perhaps Dutch drug policy is best known for its tolerant approach to cannabis use. The Dutch "coffeeshops," or cannabis cafes, which sell hashish and marijuana in small quantities for personal use, have become something of an international symbol for the nation's policy. It is not solely with respect to cannabis, though, that Dutch policy is tolerant. Users of hard drugs, such as heroin and cocaine, are also treated with relative lenience by the police. Even street dealing is tolerated to some extent, provided it does not lead to public nuisance

In 1976 the Dutch parliament revised the Opium Act, creating a formal distinction between cannabis and other drugs. Grapendaal et al. (1995: 6) summarized the major elements of national drug policy as established by the 1976 parliamentary debate (see also Leuw and Haen Marshall 1994; Korf 1995; van de Wijngaart 1991):

- The central aim is the prevention or alleviation of social and individual risks caused by drug use;
- A rational relation between those risks and policy measures;
- A differentiation of policy measures which will also take into the risks of legal recreational and medical drugs;
- A priority in repressive measures against (other than cannabis) drug trafficking
- The inadequacy of criminal law with regard to any other aspect of the drug problem (hence except the trafficking of drugs).

These general principles have remained unchanged ever since. One key word used in setting out drug policy is "normalization." Drug use is treated according tot a normalization model of social control, aiming at depolarization and integration of deviance, as opposed to a deterrence model of social control, aiming at isolation and removal of deviance (Grapendaal et al. 1995: 5). The normalization para-

digm also implies that drug problems should be regarded as "normal social problems" rather than as specific, individual problems requiring special treatment.

Another principle is that criminal law should be used as little as possible to solve these types of social problems. Since the policy's central aim is the reduction of risks associated with drug use, both to the individual and society, drug use is not per se considered a problem in itself. The revised opium law of 1976 created a legal distinction between drug with an unacceptable health risk (such as amphetamines, cocaine, heroine, and LSD) listed on schedule I, and cannabis products (hash and marihuana) on schedule II. This led to the implementation of different policies for these two categories of drugs, an approach that came to be known as the "separation of the markets" for soft and hard drugs. By nurturing an environment (coffeeshops) where cannabis could be bought and consumed without threat, authorities believed consumers would be less likely to graduate to hard drug experimentation and use. Possession of 30 or more grams of cannabis (about one ounce) was defined as a serious offense. Possession of lesser amounts was deemed a misdemeanor and assigned a low priority for prosecution. This principle of discretionary power – which meant that possession of up to 30 grams was "allowed" in practice – led, in turn, to the toleration of "house dealers" in youth centers. These were later succeeded by the phenomenon of coffeeshops, outlets where the selling of cannabis is an important, if not the main reason for existence.

This method for handling cannabis makes Dutch drug policy seem very different from other national policies. Although many other countries are tolerant of cannabis, the Dutch are unique in the openness with which the policy is carried out. Currently, an estimated 1,200 coffeeshops are operating in the Netherlands (Trimbos Institute 1997). Certain rules have been set out for coffeeshops by the College of Procurators-General, the board that monitors the Public Prosecutions Service and establishes standards for the criminal enforcement. The rules are no advertising, no nuisance, no sales to minors (under 18) and no use or sales of hard drugs. If these rules are violated, the coffeeshop can be closed down by the municipal authorities; the seriousness of the violation (e.g. the sale of hard drugs is considered very serious) determines the duration of the closure, ranging from a few days to a permanent shutdown.

Beside these formal rules there are also informal norms about the use of cannabis. As in most European countries, drug use is not against the law in the Netherlands. As we have seen, the Dutch rules allow people to possess small amounts of cannabis for personal use. Tolerance does not mean that cannabis smokers can just light up a joint anywhere they like outside a coffeeshop. Although no formal rules prohibit cannabis smoking in public places, bars or restaurants, very few people do so. If they do, no sanctions are applied; but the person is likely to be asked by the personnel of a shop, bar or restaurant to put out the cigarette. The absence of formal regulations for the use of cannabis has opened the way for these informal norms, and their existence and importance is an aspect of Dutch drug policy that is often underestimated and difficult to grasp by foreigners. For example, young tourists who visit Amsterdam have made the mistake of thinking they can smoke cannabis 'everywhere'.

The Dutch policy on hard drugs is generally quite different, although some aspects of it are based on the same principles as the cannabis policy. One basic assumption is that users of hard drugs should not be punished for that behavior alone. Just as a small quantity of cannabis is defined as being for personal use, the possession of heroin or cocaine in quantities not exceeding 0.5 grams is defined as a petty offense with a low prosecution priority. Depending on the circumstances, such a small quantity of hard drugs, if found on a person, may actually be returned to them later by the police. Consistent with the normalization model, the police leave drug addicts in relative peace unless they cause a public. In a practical sense, this means that marginalized drug addicts are likely to be more readily visible than in countries with more restrictive policies. Rather than retreating into less visible parts of town, Dutch drug addicts are often seen in the main shopping and entertainment areas of the cities. One result of the public presence of these unsightly drug addicts has been to give heroin a very negative public image. For most young people, there is nothing glamorous or attractive about heroin. As pointed out by the Dutch vice-PM and minister of foreign affairs at the UN drug summit UNGASS in June 98: "For young people in the Netherlands now, heroine is for losers. Very few of them would think of trying it." (Van Mierlo 1998). In this sense, the visibility of drug addicts may have contributed to this, and in that respect, seems to have been an effective prevention measure. As appears from the 'panel studies' that are held every year among young people in the city of Amsterdam, even for susceptible young people heroin has a negative image, as they associate the use of this drug with addiction (Korf et.al. 1996).

Since problematic drug use is considered a social and medical issue, rather than a criminal one, interventions with drug users are non-punitive, with particular emphasis on care and treatment. Because the extensive care system is diversified and offers many low-threshold programs without too many conditions to enter, it is estimated that the services now reach about 65-85% of all addicts (Gageldonk et al. 1997; Schreuder and Broex 1998). Methadone and needle exchange programs are designed for addicts who are not yet "ready" to quit the habit. Because of the low-threshold nature of such programs, they are a good way of establishing and maintaining contact with the addict population.

The low-threshold availability of methadone has also served to turn heroin addicts into critical consumers. The relative stability of both the heroin user population, and in the demand for the drug has caused heroin prices to drop to as low as $30 a gram (30% purity). The availability of this cheap heroin has created the possibility that a majority of heroin users addicts use "chasing the dragon" rather than

injection, as their route of administration. If the prices were to be (much) higher, some of the heroin smokers would, after a longer period of use and heroin toleration, probably have turned to injection, as this is more 'effective' way of administration (because no heroin goes up into the air like is the case with chasing the dragon), and hence less expensive. The low heroin prices in the Netherlands, however, makes it easier to continue chasing the dragon and not shifting to injection. Because smoking heroin carries a far lower risk of contracting infectious disease than does injection, this method of administration has been encouraged by local Dutch health authorities. A further advantage of the availability of cheap heroin, in combination with the easy availability of methadone supplements has made it possible for drug users to maintain an addiction while earning a low income or subsisting on welfare and without resorting to property crime or prostitution.

Recent Modifications to Dutch Drug Policy

In 1995, the government published a paper entitled Drugs Policy in the Netherlands: Continuity and Change. A major public debate ensued among politicians, government officials and drug specialists, and drug policy regularly made front-page news. Following the parliamentary debate, the government implemented a number of measures derived from the policy paper.

This particular policy debate also received wide attention abroad. Several foreign newspapers reported that the policy review was in response to international criticism, particularly from neighboring countries that claimed to have been adversely affected by the liberal Dutch approach. Another claim by both politicians and press outside the Netherlands was that the liberal experiment there had failed. One can not escape the impression that many of these foreign commentators were only responding to their own prejudices. They were convinced that toleration "could not work," that it "inevitably had to lead" to more drug use and abuse, and that the Dutch reconsideration of its policy could only mean that it had been an utter failure.

The policy review was actually prompted by a series of different concerns. To begin with, a new three-party coalition had gained political power one year earlier. This coalition was made up of the social democrats (PvdA), conservative liberals (VVD) and progressive democrats (D66), a new and highly unusual combination in Dutch politics. It came as a surprise to many that the left-of-center PvdA had now joined forces with the right-of-center VVD. Moreover, for the first time since the 1920s, the Christian-democratic CDA had been excluded from playing a role in a national government coalition. Long at the center of the political spectrum and the pivot of almost every earlier coalition, the CDA was now being relegated to the opposition. Although it had been a stable factor in many previous governments, it had also been a conservative force that resisted change in many areas. With regard to the impact of these political shifts on drug policy, many people expected moves toward more liberal policies, especially with respect to cannabis, since two of the three coalition parties had clearly advocated its legalization in their party platforms. The PvdA had adopted this position at its annual party congress before the 1994 elections, while D66 had supported it for a long time and was the most outspoken Dutch political party in this respect. Expectations of an impending move to drug policy liberalization were reinforced by the fact that the two cabinet members most directly responsible for drug policy, the health and the justice ministers, both belonged to D66. Once in office, moreover, both ministers indicated that they felt "committed" to the drug section of their party platform and that they would do their best to implement it.

In addition to these political motives, there was also a practical reason to review the drug policy. As we have seen, most of the principles underlying it dated back to the mid-1970s. During this twenty year period, various elements of the policy had been reviewed, although it had never been evaluated in its entirety. The new government, absent the Christian democrats and with two parties favoring an innovative approach, seemed likely to undertake such an evaluation. Since most experts seemed convinced that the greater formal acceptance of drugs had not led to higher rates of drug use than were found in neighboring countries, analysts expected this evaluation to turn out positive. That could then mean further liberalization and an end to some troublesome incongruities, such as the quasi-legal situation of the coffeeshops.

Besides the confusion on the nature of the drug policy paper, as noted earlier, there was also some confusion with regard to the measures that were implemented following the paper's passing in Parliament. Some of these measures meant a sharpening up of Dutch drug policy, which led several commentators and journalists to the conclusion that these measures had been taken as a response to the criticism coming from other European countries, France in particular. As a result, in several non-Dutch newspapers one could read that Dutch had changed to become more in line with the policy of other countries. However, the simultaneous relaxation of other restrictions attracted far less attention, as they amounted to a restatement of policies already in place, or even moves toward further liberalization. But ultimately, the policy paper proposed only minor changes on the practical level in the existing situation. (For a fuller account of this debate, see the article by De Kort in this issue.)

One of the changes widely reported in the foreign media was the lowering of the maximum acceptable cannabis purchase in coffeeshops from 30 to 5 grams, which should be interpreted as a symbolic measure. This was one of the new guidelines issued by the College of Procurators-General, the board that monitors the Public Prosecutions Service and establishes standards for the criminal enforcement of drug policy (See College of Procurators-General 1996). The same guidelines, however, increased the quantities of cannabis that coffeeshops were allowed to have in stock from 30 to 500 grams. This measure gives coffeeshops a

more solid and practical basis, as before they could be closed down if the police wanted so, in the case the coffeeshop had more than 30 grams in stock. The internationally provocative political position of Dutch drug policy ultimately deterred the government from taking more decisive steps (as was its original intention, as stated by the ministers of health and justice when in office) to regulate the supply lines of the coffeeshops. It arrived at a compromise instead: by assigning a high priority to a crackdown on the importation of cannabis and on the large-scale commercial cultivation of domestic cannabis, and by formally assigning low priority to the control of small-scale, non-professional cultivation, it now favors the latter without actually saying so. The penalties for importation or large-scale cultivation were increased, while small crops not exceeding five plants would be ignored. This small-scale production is permitted in order to supply the coffeeshops with marijuana.

Municipal governments are free to decide whether they will allow coffeeshops within their boundaries. Some have chosen a zero option, which does not, however, mean that individuals can be arrested or prosecuted for possession of small amounts or public consumption. The more common viewpoint in Dutch municipal government, however, is that some people are going to use cannabis anyway, and that it is better to have this happen in a relatively open setting, rather than underground in criminal environments. They believe that this makes it easier to exercise social and political control over the problem. In this way, coffeeshops have gradually become an accepted policy option for many middle-sized and larger cities. Some municipalities have even actively assisted in, or organized themselves, the establishment of a coffeeshop in their community.

The new guidelines prescribe higher enforcement priority and harsher penalties for the production and trafficking in hard drugs, with an additional focus on synthetic drugs (ecstasy, amphetamine, LSD), which the Netherlands has gradually become major producers of. A special team, the Synthetic Drugs Unit, was created to coordinate the efforts of police, public prosecutors, the Economic Investigation Service (ECD), and tax, customs and even intelligence officials. A number of policy innovations were also implemented in the wake of the policy paper, such as an experiment with the legal prescription of heroin to long-term, 'incurable' addicts. After a 50-person pilot study (the result of a compromise with reluctant conservative parliamentary factions) proved successful, the program was expanded to include the 750 people originally intended (see article by van den Brink et al. in this volume).

A unique paradox has arisen since the mid-1990s. On the one hand, the Dutch drug policy is becoming more firmly established, and its guiding premises have remained generally constant over the years. On the other hand, there is no longer broad political agreement about how to approach the drug problem. In the 1980s, a cross-party consensus existed on drug policy, and it was hardly a political item at all. In the course of the 1990s, the coalition party VVD has stepped up its criticism, and the opposition CDA has abruptly withdrawn its support. This has caused some eyebrows to be raised, since the CDA was one of the parties that shaped the tolerant drug policy in the first place. At any rate, its revised stance did not appear to yield the CDA any electoral gain in the 1998 parliamentary elections. It is unlikely that drugs will become an moral issue during the Dutch elections, as they are in, for example, the U.S.

The International Predicament of Dutch Drug Policy

In recent years Dutch drug policies have come under increasing political pressure from several other countries. The most negative epithets have been coined in the United States. It has almost become a common thing that every now and then the Dutch approach is being castigated by a senator or a drug czar. With the appointment of the latest czar, General McCaffrey, these attacks have not only intensified, but now seem even further removed from the facts than those made earlier, such as his statement that the homicide rate in the Netherlands would be twice as high as in the US (in reality it is four times as low). This new American offensive has both irked and flabbergasted many people in the Netherlands. Whereas the Dutch authorities previously believed that many stories from abroad were based on simple misunderstandings, McCaffrey left no doubt during his 1998 European "fact-finding tour" that he was less interested in facts than in political maneuvering. His predecessor once remarked that the Dutch youth in the Vondelpark were "stoned zombies," and another American drug czar had proclaimed that "you can't walk down the street in Amsterdam without tripping over junkies" (Reinarman 1998).

A more diffuse picture emerges when we assess the attitudes of European governments to the Dutch drug policies. When they were first approved, these policies were criticized by some countries, but the matter was not put on the European agenda because it was regarded as a domestic issue. Occasionally, a country has openly criticized the policies, as in the 1980s when some 2,000 foreign heroin users per month, almost half of them from Germany, were discovered "hanging out" in Amsterdam (Korf 1987: 43) This led to a diplomatic stir, with the German government alleging that the liberal policies had caused a steady stream of Germans to travel to Amsterdam to buy cheap heroin. But it became clear that the Netherlands was not so much the 'cause' of this problem, but that the more repressive climate vis-à-vis drug users in Germany, combined with a few of care and treatment facilities, were more important. In other words, the German 'push factors' were actually more important than the Dutch 'pull factors'. Besides that, few Amsterdam citizens were contented with the large number of foreigners (especially Germans) in their city, many of no fixed abode, and responsible for a part of the petty crimes, such as the theft of car radios. Since the Germans realized the flow of drug addicts to the Netherlands had more to do with their policy, instead of the Dutch, which was followed by the implementation of more treatment fa-

cilities and less emphasis on law enforcement, later in the decade the inflow of Germans faded away.

In 1995, new diplomatic problems arose, this time with the French. France accused the Netherlands of being the chief supplier of drugs to the French market. The coffeeshops were discussed as a particular source of annoyance. In just a few hours' drive, French people could openly buy cannabis in Holland and then bring it home with them. President Chirac in particular seized every opportunity to lash out against the Dutch "laxity." It soon was learned that France's hardening stance was motivated primarily by personal considerations on the part of Chirac alone. From the moment of his election in 1995, he put Dutch drug policy high on his political agenda. He persisted in these criticisms even after it was convincingly demonstrated that only a tiny proportion (less than 2%) of the cannabis in France had come from the Netherlands (Boekhout van Solinge 1997a).

Chirac also placed drugs on the agendas of almost every European summit, where he usually managed to win some support from German Chancellor Kohl and the British Prime Minister Major. At one point, Chirac scheduled a visit with Dutch Prime Minister Kok in order to attempt to "resolve" the drug question, and he persuaded his ally Kohl to attend as well. Ironically, shortly before the visit was to take place, the health ministers of eight of the fourteen German federal states (who are responsible for drug policy), wrote to their Dutch counterpart, Borst, expressing their support for Dutch policy and implicitly urging her not to give in to foreign criticism. This put Kohl into an embarrassing predicament, since he obviously could no longer speak on behalf of Germany. This was one reason why the meeting was ultimately cancelled. Of course it would have been highly unusual for foreign leaders to fly to the Netherlands to press for changes in Dutch domestic policies. Many observers regarded these announced plans as interference in Dutch internal affairs, and those concerns would have made it difficult for Kok to make any concessions. The three leaders finally agreed to call off the meeting. In 1997 France's criticism suddenly died down after Chirac called for earlier elections, which he to unexpectedly lost. Besides losing some of his political credibility, he now had to face the task of forming a new government with his political adversaries, the socialists, some of whom favored a liberalization of French drug policy.

A second development occurred in 1995 and led to sharper criticism of Dutch drug policy within the European Union. With the entry of Sweden into that body, drug policy liberalization acquired its fiercest opponent to date. Before that, a slow trend toward the evolution of a more pragmatic approach to drug use had been noted. Sweden frequently condemned the Dutch attitude on moral grounds, arguing that liberalizing drugs is, in essence, "giving up" on the problem. Another concern was that the Dutch approach undermines the credibility of the Swedish anti-drug campaign, which emphasizes the dangers of cannabis. Sweden argues that, after trying more liberal approaches in the past, it now has settled on a restrictive drug policy that works. Although the Swedish drug policy has been severely criticized both in and outside Sweden because of the far-reaching measures by which one tries to pursue the drug-free society (such as by forcing people to undergo a urine or blood test if the police suspects them to be under the influence of drugs), the Swedish statement that it is possible to have a society free of drugs, sounds attracting to some European politicians (Boekhout van Solinge 1997c).

Principles, Paradigms and Politics

As we have seen, Dutch drug policy has at times been vilified in some countries. One might ask why these negative conclusions have been reached when the same policy has been positively evaluated by the large majority of Dutch officials and specialists, and is generally judged to be achieving its objectives? Why does such a radically different picture prevail in these other countries than exist in the Netherlands itself?

A partial explanation may be found in the perception that foreign visitors sometimes form of the drug situation in the Netherlands. Many of them only visit Amsterdam, the most popular Dutch tourist attraction. Amsterdam is little representative of the Netherlands, however, as it has a relatively young population, is home to many artists and other cultural professionals and people with a (slightly) alternative lifestyle and its attractions and services range from bars, clubs and cinemas to brothels and cannabis coffeeshops. Historically, too, the old city has long been the site of many marginal activities. The red-light district, situated near the central railway station and former harbor is perhaps the clearest example of this. In addition, because Dutch policy avoids ostracizing drug users, addicts need not hide from the police in outlying districts. Consequently, tourists visiting Amsterdam are far more likely to encounter them face-to-face than they would be in many other cities. Finally, the largest concentration of coffeeshops in Amsterdam occur in tourist locales, adding to the potential impression that "drugs are everywhere."

Yet these "selective" impressions cannot serve as the only explanation for the perceived magnitude of the drug problem in the Netherlands. Another possibility is that the Dutch drug policy, despite many attempts to explain it, remains profoundly misunderstood outside Dutch borders. This indeed seems to be partly the case, because national drug policies are closely related to other policy concerns as well as to social and cultural traditions that have developed over time. Together these have produced different national "drug control systems".

People generally perceive reality by filtering it through some preconceived model, which serves as a construction of reality. Appraisals of the drug problem also involve such constructions, and it seems that the ways of viewing drugs and of defining the underlying causes of the drug problem often differ sharply from one country to another. Of course it is true that not everyone is aware of these paradigms.

One clue as to why they are so different may be found in the contrast between Dutch and French perspectives; in the Netherlands sociologists have been instrumental in defining the drug problem, while in France the psychiatrists have played a predominant role.

In the Dutch "sociological" view, the use of drugs was originally interpreted as a form of deviant behavior that was part of a youth culture (de Kort 1995). After it was discovered in the late 1960s that most cannabis users were "normal people," the implication for policy was that such behavior should not aggressively stigmatized. Attacking deviant behaviors with punitive measures would be likely to intensify them, initiating a spiral that would make a return of the individual to a socially accepted life style increasingly difficult (Cohen 1994). This is the source of the Dutch normalization paradigm, which proposes to consider drug problems as normal social problems, rather than specific, individual ones. It is part of a more general attitude toward deviance, and a tradition of not using criminal law any more than is necessary to deal with social problems. One relevant issue in this context is public nuisance, which is now becoming an increasingly important factor leading to police action (Ministry of Health, Welfare and Sports, Ministry of Justice, and Ministry of the Interior 1995). Another strong feature of Dutch society is the acknowledgement of individual freedom, provided one does not disturb others. The Netherlands also has a strong public health tradition, reflected in the ministry of health's status as one of the most important government ministries.

French society rests on an entirely different set of traditions. There, it is not individual freedom, but the notion of citizenship that is crucial: people are expected to respect rules, and law is seen as having an important symbolic value (Ehrenberg 1995). Related to this is a tradition of a strong, influential police force, which is very visible in the streets – in stark contrast to the Dutch police. The ministry of the interior stands high in the ranks of every French government, with public health occupying a much lower status. The politician now directly responsible for public health, Bernard Kouchner, is not a minister, but a state secretary. Another crucial difference is in the way drug use is conceived. French psychiatrists have interpreted drug taking as a transgression, an expression of an inner desire to violate laws and norms. If people take drugs, that is interpreted as a sign that their lives are not sufficiently "structured." The law can then be used to "restructure" the law-breakers' lives. The French drug act passed in 1970 was exceptionally severe in comparison to many other French laws. That was partly because it was adopted only two years after the dramatic events of May, 1968, which led to the resignation of President De Gaulle, the most prominent postwar French statesman. At the time, some of the revolting students had used drugs, not in private but as a group activity, and that was interpreted as a threat to the establishment and to law and order generally. With the drug act on the books, the state then granted the psychiatrists a "monopoly" on care and treatment. Psychiatrists already enjoyed great influence in French society, and were now in a position to define drug use without any "competition" from the social sciences or other disciplines. This also explains why French drug specialists have long opposed harm reduction measures. In their view, that is just treating the symptoms and not the underlying cause of the deviant behavior (Boekhout van Solinge 1997b).

In Sweden, drugs and drug use are conceived in yet another way, and this forms the basis of the Swedish drug policy paradigm. First, Sweden is a "temperance culture," a country where the temperance movement gained a strong foothold in the 19th century. The principle aim of the Swedish temperance movement was to achieve a total ban on alcohol. Between 1917 and 1955 Sweden had an alcohol rationing system, and even today embraces a comparatively restrictive alcohol policy. This tradition makes a restrictive drug policy a logical option. The current alcohol policy is based on the "total consumption" model, which holds that the more people use alcohol, the more they will abuse it and the greater the total harm caused by alcohol will be. The implication for policy, then, is to limit alcohol use through the instruments of price and availability. The total consumption model is assumed to be valid for drugs as well: the more people use drugs, the more they will abuse them, the more people that will become addicted, and the greater the damage to society. For policy, it is further assumed, this means preventing the use of any drug, and cannabis in particular, since it is the most widely used illicit drug. Of course, a premise of this model is the accuracy of the stepping stone hypothesis.

A further influence on Swedish policy were the theories of the physician Nils Bejerot, who defined drug use as a contagious disease in which one drug user can contaminate another person (Boekhout van Solinge 1997c). This makes the drug epidemic particularly difficult to combat. Drug users are considered irreplaceable elements in the "drug chain." Drug dealers can and will be replaced by others, but the users are the ones who keep the engine going. Thus, the implication for policy is to target the drug users at the street level.

The strict Swedish drug policy is clearly linked to the way Swedish society deals with deviance in general. Sweden is a homogeneous country where social values are oriented toward conformity, without much allowance for deviance (Daun 1996). Unlike the Netherlands, Sweden does not have a strong tradition of liberalism and individual freedom. In fact, liberalism is viewed very negatively (Tham 1995). In 1977 the Swedish parliament proclaimed a drug-free society as the official policy aim. Since that time, the policy has grown more repressive, fueled to a high degree by a moral panic in which people have viewed drugs as posing a major threat to society. The decline of the Swedish welfare state in the 1980s and 1990s created an atmosphere in which drugs could be defined as an "ideal" social problem and singled out as a scapegoat on which other social problems could be blamed (Christie and Bruun 1991). The fight against drugs has become the symbol for the protec-

tion of that which is "typically Swedish" (Tham 1995). This specific exorcising function indicates why, since joining the EU, Sweden has been the most vehement opponent of drug liberalization and harm reduction initiatives.

In the Swedish model, prevalence figures, and especially incidence rates, are seen as the prime indicators for policy evaluation. The emphasis is on keeping the incidence rate as low as possible. This explains the apprehension of Swedish policy makers exhibit toward the Dutch model, which regards experimental drug use as not a serious problem. Although drug experimentation among teenagers is certainly discouraged in Holland, it is also seen as an inevitable phenomenon of youth culture. The implication for policy is to steer the inevitable experiments in the right direction by giving information that is credible and not only emphasizing the negative effects of drugs. The clear distinction made in the Netherlands between soft and hard drugs is thought to deter young people from moving on to addictive drugs. In the eyes of the Swedes, this must have resulted from an out-of-control situation, where the authorities simply gave up and adopted laissez-faire attitudes. Ironically, both Swedish and Dutch policy makers are convinced they are on the right track, and that their policies have kept the numbers of drug addicts relatively low. More specifically, the Swedes believe their restrictive policies (particularly those with regard to cannabis) are the basis of their success, while the Dutch think their tolerant cannabis policy accounts in part for the country's lower numbers of hard drug addicts. A more convincing explanation for why the two countries both appear to have relatively low numbers of drug addicts is that they are rich welfare states with good social policies and relatively few people living in the gutter.

The existence of various drug policy paradigms in different countries, and the consequences these have for their respective practices, offer one clue as to why Dutch drug policy is frequently misunderstood. People living in countries with paradigms very different from the Dutch normalization approach may have difficulty comprehending the principles of the Dutch approach, let alone believing that it is successful. Exploring these distinctive national drug policy paradigms will help us understand how drugs are perceived in different countries, why certain policy decisions are made on the basis of these perceptions, how those decisions are implemented, and what effect they have on the actual drug situation there. This should remind us that it is naive to pass judgment on drug policies without first looking at their underlying paradigms, and taking into account their primary objectives. Many observers and even drug experts, however, are finding it hard to step outside their belief systems. This may explain some of the ideological intractability that now prevails.

Sometimes myths are deliberately disseminated in the service of domestic political ends. The clearest example of this is the distorted portrayals of Dutch policy that have been presented by U.S. government officials. In Europe, too, drugs are sometimes enlisted in the service of political aims. Politicians often play on people's sentiments and fears in discourses on tougher law enforcement. "Security" is a popular theme in French politics, especially among populist politicians. One source of this is the tradition of strong, omnipresent police and military forces. Another is the popularity (15%) of the extreme right National Front, which plays on people's feelings of insecurity and tempts other right-wing parties to embrace this political theme. An underlying aspect of the French drug problem seems to be what is called "the social fracture", the socioeconomic division of French society and the existence of many disadvantaged suburban neighborhoods. These depressed areas harbor many hard-core drug addicts, among whom ethnic minority groups are over-represented, as well as an underground drug economy. Most French politicians prefer to speak of drugs as the main problem, rather than addressing the social conditions that give rise to the drug problems in the first place. In this respect the situation in France has some similarities with the drug problem in the U.S.

Toward a European Drug Policy?

European nations are now working collaboratively in the development of drug policy, both at the national (between governments and their departments) and local levels (between municipalities). In the 1990s, two European city networks were established to deal with drug issues: European Cities on Drug Policy (ECDP) and European Cities Against Drugs (ECAD) (Kaplan and Leuw 1996).

In 1990, Amsterdam, Frankfurt, Hamburg, and Zürich signed the Frankfurt Resolution, which launched European Cities on Drug Policy (ECDP). Other cities soon joined, including Basel, Charleroi, Dortmund, Hamburg, Hanover, Rotterdam and Zagreb. The signatories committed themselves to implement a more pragmatic, less prohibitionist drug policy, which would include the decriminalization of cannabis. As a reaction to the Frankfurt Resolution, the Stockholm Declaration was drawn up in 1994. With their imminent EU membership, many Swedes were wary of the "European tendency" toward harm reduction and decriminalization, and they formed a group called European Cities Against Drugs (ECAD). The ECAD advocates restrictive drug policies and opposes moves toward either the decriminalization of cannabis or the legal prescription of heroin. In the early years of its existence, ECAD received its funding from Swedish state institutions; it now depends on contributions from its members (Boekhout van Solinge 1997c: 82). ECAD incorporates a number of European capitals among its members, including Berlin, London and Paris. The organization is particularly well received in Scandinavia, Greece and in the non-German-speaking regions of Switzerland.

In addition to cooperating on the local level, both city networks also try to exert influence over EU policy development. In view of their widely divergent approaches, it will be a challenge for the EU to find a way to strengthen the interaction between the two city networks (Kaplan and Leuw 1996: 88). What will eventually be more important

and decisive for the future European drug policies is the what will happen in the EU and the way the 15 member states will work together on the drug question.

The Treaty of Maastricht (1993) of the EU extended cooperation between the 15 member States to non-economic areas. Since that date, the EU is organized on the basis of three pillars. The first involves the "traditional", mainly economic cooperation of the European Community. One responsibility of the Community (Article 129) is the "prevention of diseases, in particular the major health scourges, including drug dependence," although it is left up to the member states to coordinate their own policies and programs. The European Commission can stimulate such coordination with due regard for the "principle of subsidiarity", which means "only if and so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States." The second and third pillars represent new post-Maastricht policy areas. The second pillar covers cooperation in external relations (foreign and security policy). Drugs come under the second pillar in terms of supply reduction and the fight against drug trafficking. The topic is also systematically included in political dialogue with non-member countries, which can mean urging them to ratify the UN drug conventions. Another activity involves the promotion of crop substitution programs in drug-producing countries. Special conventions have been signed between the EU and African, Caribbean and Pacific countries in order to reduce the supply of drugs. The third pillar regulates cooperation in justice and home affairs. As we shall see below, this is where the most important decisions are now being made that impact the drug issue.

The three-pillar structure has not improved the transparency (openness) of drug-related decision-making, since drugs are targeted by all three pillars. Hence, a special "cross-pillar" Horizontal Drug Group has been established to coordinate drug policies. It includes representatives of the various national ministries concerned with drug issues. Since the EU is still in the process of constructing further cooperation, the various responsibilities within the EU bureaucracy on aspects of the drug issue are not fully clear. This has led to a degree of competition between different components of the EU bureaucracy over the drug tasks.

The most important decisions in the EU are not made by the European Commission (as many people believe), but by the Council – a meeting of the 15 ministers of all member States in a particular policy field. With regard to the drug question, many of the relevant decisions are made by the ministers in the Council of Home Affairs and Justice.

Since the 1995 Cannes European Council, which adopted the EU Action Plan to Combat Drugs (1995-99), drugs have been a recurrent topic on the European political agenda. The action plan addresses demand reduction, drug trafficking, money laundering and trafficking in precursor chemicals. A new plan is expected in 1999. Some countries have wanted to reach a harmonization of national drug legislation and practices. The issue of harmonization has repeatedly returned to the political agenda, promoted largely by France. However, the drug issue remains too sensitive to be shifted to the EU level. The main opponents of such harmonization are the Netherlands and Sweden, both of which staunchly guard their unique national approaches. Other countries are reluctant about harmonization as well, and for a variety of reasons. One might speculate about whether harmonization would have much effect, however. The situation in Germany, for example, illustrates the difficulty of harmonizing even on a national level. Although there is a single national drug law, drug policy falls under the jurisdiction of the federal states, and the policy gulf between northern and southern states is very wide. Most of the northern states have adopted tolerant, pragmatic policies —some of them even more liberal than the Dutch ones when looked at the quantities of drugs allowed for personal use—whereas in the southern states the policy is more restrictive and one is only allowed to have tiny quantities in possession.

In 1996 a EU study was presented with a comparative study of national drug legislation. It showed that differences between nations were relatively minor and that national drug policies already had a great deal in common. Ultimately the EU decided not to make harmonization of national drug legislation an immediate objective. An alternative approach was adopted whereby EU countries would work together more intensively on common problems and try to find pragmatic solutions to them.

Drugs are also a recurring item in the European Parliament. The committee that usually discusses drug issues is the Committee of Civil Liberties, responsible for justice and home affairs. However, the European Parliament only has any real say on the health aspects of drugs; for the justice and home matters it is merely consulted. Before 1995, the parliament was leaning toward a pragmatic approach to drugs, including support for harm reduction measures. That climate changed with Sweden's entry into the EU, since all Swedish members, irrespective of their political affiliation, opposed both liberalization and harm reduction. The ensuing debates have become increasingly ideological, and it is now much more difficult for them to achieve a consensus.

Recent Changes in the European Drug Policy Landscape

In the course of the 1990s, a number of European countries made changes in the way they approach the drug question. Most national drug policies consist of a combination of law enforcement with care and treatment. In the 1980s drugs were primarily considered a criminal problem in most countries, and law enforcement concerns predominated over those of public health. With the onset of AIDS in the second half of the decade, however, many countries began implementing harm reduction measures to curb the further spread of HIV. Thus, public health arguments slowly found their way into drug policy. The threat of HIV was the factor that forced countries to define drugs as a public health problem, rather than solely as a criminal justice one. This trend continued

throughout the 1990s, when HIV and intravenous drug use posed major threats to public health, especially in southern European countries, which did not have strong public health traditions or prevention policies.

Among the harm reduction measures introduced were methadone and needle exchange programs. Care and treatment systems for drug addicts were also gradually extended. Since priority was given to the users of hard drugs and to ways of limiting the risks associated with their drug use, some countries eased their attitudes to other drugs such as cannabis. By the mid-1990s, most EU countries had seemingly accepted a harm reduction approach to the drug problem. The only one that still resists this approach is Sweden, and even there some small harm reduction projects have been initiated (e.g. in Malmö, Lund and Stockholm).

Since the mid-1990s, debates have been underway in several countries about further steps such as decriminalizing cannabis, permitting the medical use of marijuana, or legally prescribing heroin. There are several possible explanations for these developments. One of them is the public health threat posed by HIV which forced some countries to adopt a more pragmatic policy and to experiment with alternative approaches. Another probable reason is that experimental drug use has been on the rise in many European countries throughout the 1990s. In fact, no country has truly managed to curb drug use in the past decade. Even in countries that have intensified their law enforcement and prevention measures, such as France and Sweden, experimental drug use has been on the rise in the 1990s. Growing numbers of policymakers now seem convinced that drug use is influenced not so much by which drug policy is in place, as by international sociocultural factors. An increasing number of politicians, national personalities and media have spoken out against punishing citizens solely for taking drugs. A third explanation for the revived debate on liberalization may be found in the many favorable experiences with innovative drug policies. The Dutch experience has shown that the greater availability of cannabis has not resulted in a significantly higher rate of cannabis use than is found in neighboring countries. The Swiss experience has shown that good results can be achieved with the legal prescription of heroin for a select group of problematic addicts.

Debates in the various countries about alternative drug policies reached a crescendo in 1998. Ironically, this was in the same year that the United Nations convened a special session of the General Assembly, UNGASS, to address the world drug problem. That body's stated intention was to intensify the repressive measures against drugs – an approach that was questioned by hundreds of prominent specialists and politicians in an open letter to UN Secretary General Kofi Annan (see the Lindesmith Center 1998).

Following the initiation of projects in Switzerland and the Netherlands with the legal prescription of heroin, initiatives are now under discussion in Belgium, Denmark, the UK, France, Germany and Ireland. Drug users' rooms for heroin or cocaine have been created in a number of countries.[1] Austria, Denmark, Italy and Portugal now also seem to favor more pragmatic, liberalized drug policies. For many years now, the use and sale of cannabis has been tolerated in Denmark, in particular in Copenhagen. Since 1994, the possession of cannabis in small quantities and for private use is no longer being prosecuted in Germany, and the present government has announced it will study the case for legalizing cannabis. An official Belgian guideline has assigned cannabis use the lowest law enforcement priority. The UK newspaper The Independent has begun a cannabis legalization campaign, and so has a group of Spanish lawyers. A committee of British Lords has declared itself in favor of the use of marijuana for medical purposes, and Portugal has urged a renewed drug policy debate. Another trend is the adoption of a public health approach that deals with all drugs, whether legal or not.

Conclusion

The reality in many European countries today is that drug use is increasingly seen as an inevitable fact of life. Rather than persisting in the idea of creating a drug-free society, many European countries are now seeking to manage drugs in workable, pragmatic ways. Many now place strong emphasis on a public health approach. By 1998, sweeping changes had also occurred in the European political landscape, and social democratic parties now govern a large majority of EU countries. For the oft-beleaguered Dutch approach to drugs, this has meant a passage into smoother political waters. The social democratic governments will most likely accelerate the trend toward pragmatism and liberalization on the level of practice.

Whether this tendency will find expression in the official national policies of the European countries or of the European Union itself remains to be seen. It appears that drug issues are increasingly assigned to the Justice and Home Affairs pillar. On the other hand, the EU has made a clear decision that drug policy is to remain the responsibility of the member states. The uncompromising Swedish position may make it difficult for the EU to ever officially promote harm reduction policies, however, although the Treaty of Amsterdam, which took effect on May 1st, 1999, does create more room for harm reduction measures. Although the term itself is usually avoided in policy documents, harm reduction is increasingly a part of EU policy in practice. It is unlikely that any drugs will be legalized in the years to come. Such a step could only be taken in an EU context, but the bureaucratic character of the EU, and the fact that EU cooperation in the field of drugs is partially based on UN drug treaties, creates a whole series of obstacles.

What position do the drug policies of the Netherlands now occupy within this general European picture? On the one hand, the increased cooperation with other EU countries might make it harder for the Dutch government to maintain its traditional liberal approach, or at least to deviate too far from the center. All EU countries have committed themselves in international treaties to fight drugs (not

only the Treaty of the EU, known as the Maastricht Treaty, but also the UN Drug Conventions). On the other hand, in many European countries one sees that on the national level, and especially on the local level, measures are increasingly being implemented that more or less resemble the Dutch policies. Within the European context, the Swedes have now become more of a maverick than the Dutch. All around Europe, approaches to drugs have become more pragmatic and tolerant, a trend that is especially apparent at the local level. Since the EU has instructed member states to work together in their practical efforts on drugs, it will probably be the developments on the local and practical level that will eventually determine future European drug policies.

Notes

1 Drug user rooms are places installed by the municipality where hard core drug users are allowed to use drugs such as heroin and cocaine.

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