



A Background Paper for an Australia21 Roundtable Melbourne, Friday 6th July 2012

Addressing the question:

"What can Australia learn from different approaches to drugs in Europe including especially Portugal, Switzerland, the Netherlands and Sweden?"

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"Incomplete scientific knowledge does not confer upon us a freedom to ignore the knowledge that we already have, or to postpone the action that it appears to demand"

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Executive summary

This is a background paper for the Australia21 Roundtable, to be held in Melbourne, on 6th July 2012, at which national opinion leaders familiar with Australian and international public policy, and drug policy experts, will discuss the question “What can Australia learn from different approaches to drugs in Europe including especially Portugal, Switzerland, the Netherlands and Sweden?”

Context

This will be the second of two roundtables organised by Australia21. The first was held in January 2012 with 24 former senior politicians, law enforcement officers, public health officials and experts on drug policy, and concluded that the international and Australian prohibition of the use of certain “illicit” drugs has failed comprehensively and that Australia must have an informed national debate about the prohibition of drug use, and alternatives to its regulation and control.

This discussion paper draws attention to the drug policies of four European nations. Each country has been selected because of its particular approach and the evidence about that approach that has accumulated. For each nation we consider three central questions:

- 1 What is this country's approach to drugs?
- 2 Why did this country approach drugs in this way?
- 3 What have been the positive and negative outcomes of this approach?

We conclude by considering the lessons and quandaries for Australia.

Summary of the drug policy approaches

Nation	Goal	Legal approach	Main policy options
Portugal	<ul style="list-style-type: none">• Reduce the use of drugs among the population and their negative social and health consequences	<ul style="list-style-type: none">• <i>De jure</i> decriminalisation of use, acquisition and possession – of all drugs• Criminalisation of trafficking-consumption and trafficking	<ul style="list-style-type: none">• Prevention• Treatment• Harm reduction• Supply reduction• Social reintegration
Switzerland	<ul style="list-style-type: none">• Reduce drug-related harm	<ul style="list-style-type: none">• Criminalisation of use, possession and trafficking• Punishment is often waived for user offences	<ul style="list-style-type: none">• Harm reduction• Prevention• Treatment• Law enforcement
Netherlands	<ul style="list-style-type: none">• Normalisation of use• Separation of cannabis and other illicit markets	<ul style="list-style-type: none">• <i>De facto</i> decriminalisation of cannabis and coffee shop system• Criminalisation of possession of other illicit drugs (not use) and trafficking	<ul style="list-style-type: none">• Harm reduction• Prevention• Treatment• Law enforcement
Sweden	<ul style="list-style-type: none">• Drug-free society	<ul style="list-style-type: none">• Criminalisation of use, possession and trafficking. NB: use and trafficking subject to same penalties	<ul style="list-style-type: none">• Health promotion• Prevention• Treatment• Law enforcement

Summary of key observed outcomes

Nation	Youth drug use	Problematic drug use	Drug-induced overdose	Drug-related HIV/AIDS	No. drug offences
Portugal	↑↓	↓	↓	↓	↓
Switzerland	↑↓	↓	↓	↓	↑
Netherlands	↑↓	↓	↓	↓	↔
Sweden	↓	↑	↑	↔	↑

Conclusion

A number of conclusions can be drawn from the comparison of these four countries:

- There is more cross over between these approaches than is often recognised in popular debate. For example, Sweden also has some harm reduction approaches. Nevertheless there are also important differences.
- The different objectives and philosophies can be seen to have affected what is and is not possible, and the policy mix adopted. For example, the approach of Sweden to have the same criminal sanctions for traffickers and users is clearly at odds with the approaches of the other countries, yet is consistent with the Swedish view of curtailing or even eliminating all drug use.

Winners and losers of reform?

- There is no evidence that any of the policy approaches led to the feared policy disasters, such as a drug epidemic.
- Instead, all nations, largely perceive their policy objectives to have been attained.
- Nevertheless, many policies had some arguably negative consequences. The question is to what extent these could have been avoided or reduced?

Optimal approach?

- While mindful of the need to remain cautious about drawing direct links between the policies and outcomes the different objectives can be seen to be associated with different trends in use, problematic drug use and offending.
- The policies that placed greatest emphasis upon a public health and social approach appear to have been more effective at reducing problematic drug use, overdose and HIV.
- Yet, it is policies that combine a public health and social approach, with reduced criminal penalties that were associated with the greatest gains, across the domains of health and criminal justice.

In terms of future directions:

- There is no such thing as a perfect drug policy.
- Within the current International Conventions on drugs, multiple reform options are possible that offer the opportunity to reduce drug related harms for users and/or society and to also reduce the burden on the criminal justice system.
- It is likely that any of the specific policy models outlined would require modification and adaptation if implemented in the Australian context. But equally importantly, the central messages can inform discussion now about what an alternate version could look like: the framing, the policy mix, and the priorities.
- From all four nations the most important message is that 'fortune favours the brave'.

Introduction

In January 2012, following the release of the Global Commission on Drug Policy Report (1) which concluded that the 40 year 'war on drugs' had failed, a high level Roundtable was held in Australia to address the question "What are the likely costs and benefits of a change in Australia's current policy on illicit drugs?" The Roundtable agreed with the Commission that the international and Australian prohibition of the use of certain "illicit" drugs had failed comprehensively (2) and called for a national debate about the prohibition of drug use and consideration of alternative forms of regulation and control.

One often noted frustration is that morality, values and political priorities usually dominates discussion of drug policy to the detriment of good public policy (see for example 3). Since the release of the Australia21 report, public and media debate about the prohibition of illicit drugs has increased considerably. For example, the number of media mentions about drugs and prohibition increased from an average of 23 hits per month to 208 hits in April 2012 in Australian print media alone. Fairfax media moreover took the historic decision to devote two weeks of media coverage to illicit drugs policy (4). Public engagement is undoubtedly a good thing, yet so to is inserting evidence in the debate to highlight alternatives to the status quo, consideration of the feasibility of drug policy reform and the possible consequences, both intended and unintended, of such reforms.

The International Conventions on Drug Control (1961 Single Convention on Narcotic Drugs; 1971 Convention on Psychotropic Substances; and the 1988 Convention Against Illicit Trafficking in Narcotics and Psychotropic Substances) are regarded as a huge constraint on experimentation with policy options, especially due to the requirement that all signatories criminalise non-medical drug use (3). Nevertheless, there are viable options from which lessons can be drawn (5). The most well recognised and studied site of innovation is Europe, which has been frequently identified as a patchwork quilt of experimentation with innovative drug policy approaches (6). In this discussion paper we outline the approaches of four diverse European nations: Portugal, Switzerland, the Netherlands and Sweden. This will form the basis for an Australia21 Roundtable on 6th July to address the question: "What can Australia learn from different approaches to drugs in Europe including especially Portugal, Switzerland, the Netherlands and Sweden?" The four nations have been purposefully selected, due to the diversity of approaches adopted and the evaluation evidence that has accumulated.

For each nation we seek to examine:

- 1 What is this country's approach to drugs?
- 2 Why did this country approach drugs in this way?
- 3 What have been the positive and negative outcomes of this approach?

We conclude by considering the lessons and quandaries for Australia.

Key concepts

Illicit drug policy can be conceptualised in multiple ways: legislation, policy documents e.g. national or local strategies, funding decisions etc (7). There can be important distinctions between these. There can be further distinctions between documented policy and the ways it is implemented in practice. For example, as noted by McDonald (8) there can be important distinctions between *de jure* and *de facto* reforms to drug policy and drug law. *De jure* approaches involve changing legislation while *de facto* approaches involve changing practice, rather than laws. When comparing approaches of federated systems of government, there are further challenges in that national policies can differ across and between and even within states.

Yet, even with a thorough understanding of 'national drug policy' the link between drug policy and outcomes is far from easy. As noted by MacCoun and Reuter (9) "even with a complete and accurate database, there are daunting obstacles to a rigorous assessment of the policy-outcome link". This is because drug policies and drug outcomes are influenced by a host of factors, including but not limited to international treaties, the criminal justice, health and welfare policies of each nation, socio-demographics, economic context and even geographical situation (10). Finally, policy is not 'fixed' but rather an ongoing process, and perception of problems and outcomes can influence the way subsequent policy decisions are conceptualised and made.

National willingness to adopt different policy approaches is further affected by a host of factors, including public opinion, political factors (including the level of politicisation of the drug problem and political cycles), social values, legal and constitutional systems (beyond drugs), the status of drug research within the nation (e.g. level, quality and openness) and the strength and nature of key interest groups (9, 11).

The challenges in defining policies, and examining policy outcomes and rationales for different policy approaches are even greater when moving from one country to multiple countries. Nevertheless, comparisons are possible and indeed can be very instructive when conducted with caution. One key hazard is direct comparisons of rates. For example, the lower prevalence of drug use in Sweden is often cited as evidence of policy success (see for example 12). Yet, this may be much more reflective of other non-drug policy factors, such as absence of trafficking routes, low income inequalities, large proportion of the population living in rural areas and high expenditure on health and social welfare policies, than the specific drug policy adopted. For this reason, it is trends within a nation, rather than absolute rates across nations that are much more instructive, as they control for much of the unique influences within each national context.

Approach

This discussion paper describes the drug policy approaches and rationales based on a combination of examination of national drug strategies, national evaluations, peer reviewed published literature and major reports by reputable bodies (e.g. the European Monitoring Centre for Drugs and Drug Addiction - EMCDDA). Blogs or discussion on web sites have not been considered. Data was sourced for key outcome variables including: prevalence and nature of drug use, prevalence of problematic drug use, prevalence of drug-induced deaths, HIV and drug offences.

Trend data was sourced wherever possible data from national reports produced for the EMCDDA. This increases the comparability of the data. And as noted above, wherever possible we focused on comparing trends within nations, rather than absolute rates across nations.

Finally, a range of indicators are now available on phenomena. Not all are equally valid for reporting on changes. We highlight two of particular note:

- The **prevalence of drug use** can be reported using lifetime use or recent use (last year). The World Health Organisation, EMCDDA and United Nations Office on Drugs and Crime all concur that lifetime prevalence is useful for examining trends in youth, but for trends in adults, recent use is essential, as the former will capture *historical* rather than *current* market situations (13). For this reason we prioritise data on recent use over lifetime use.

Moreover, the prevalence of drug use in a country is often cited, on its own, as an outcome of drug policy. This is problematic as increasing drug consumption may have an indirect relationship with the level of drug-related deaths, disease and

crime. For this reason we have examined data on drug consumption in concert with data on drug-related deaths, disease and crime.

- **Drug-related deaths and drug-induced deaths** are sometimes used interchangeably. However, identifying the number of people who died due to drug intoxication has much greater policy significance than the number of people who took drugs but died due to unrelated events. It is for this reason that European nations are increasingly moving towards coding all deaths in terms of the international Classification of Diseases (ICD) protocol, which require determination by a physician that "deaths are directly attributable to drug intoxication". Where nations report multiple indicators, we thus utilise this definition.

Limitations

One key policy domain that might have been useful to examine is government expenditure. While there have been huge improvements in the gathering of such data, estimates remains unavailable for all four nations and/or are inconsistently reported for others. To avoid potentially erroneous comparisons we omitted comparisons of relative allocation of funding. Many output and outcome domains also could not be examined as there is no data available e.g. corruption, organised crime involvement. Finally, in spite of efforts to streamline counting system (particularly by the EMCDDA) methods of collecting data still differ across national boundaries. Key areas of note are how drug crimes are recorded.

Key population statistics in 2010

Country	Population	Age – 15-24	Age – 25-49	Age – 50-64	Unemployment rate	Expenditure on social protection (% of GDP)
Portugal	10 637 713	11.1 %	37.2 %	18.6 %	11.0 %	24.3 %
Switzerland	7 785 806	11.9 %	37.0 %	19.1 %	3.9%	26.4%*
Netherlands	16 574 989	12.2 %	34.8 %	20.1 %	4.5%	28.4 %
Sweden	9 340 682	13.3 %	32.9 %	19.1 %	8.4 %	29.4 %

Source: Eurostat. *2009 figure.

Portugal

1 What is this country's approach to drugs?

The Portuguese drug policy is characterised by both decriminalisation and a comprehensive national drug strategy based on prevention, treatment, harm reduction, social reintegration and supply reduction (14). Portugal historically criminalised all drug offences. But since 1 July 2001 use, possession and acquisition of all illicit drugs, including cannabis, heroin, amphetamines and ecstasy, when deemed for personal use have been made administrative rather than criminal offences. The decriminalisation is a *de jure* reform, enacted through Law no. 30/2000. Persons found to have been in possession of illicit drugs but below specified threshold levels are referred to specially devised commissions for the dissuasion of drug addiction (CDTs), which are regional panels comprised of a treatment professional, social worker and lawyer. The CDTs provide a number of purposes. They assess the treatment needs of any referred offenders and explore the cause and circumstances of drug use. They also provide a range of sanctions including community service, suspended sentences and bans on attending designated places. But their primary goal is to refer dependent offenders to drug treatment. However the vast majority have been found to be non-dependent persons who are provided with education about the potential harms from drug use and

given a simple suspension on proceedings (15). All other drug offences, including trafficking-consumption, trafficking, manufacturing and cultivation continue to be criminal offences sanctionable with up to 12 years imprisonment (Decreto-Lei n. 15/93, de 22 de janeiro 1993).

The decriminalisation is supported by a national drug strategy and action plan, which has as its central goals (i) to reduce use and (ii) to reduce the health and social consequences of use. The first iteration of these documents was adopted in May 1999 (National Strategy in the Fight Against Drugs) and led to a mass expansion in policies across multiple domains, including a range of harm reduction measures (such as needle syringe programs, outreach teams, free hepatitis B vaccinations, and social reintegration of drug users through subsidies for employers to hire drug-dependent individuals). Estimates of government expenditure suggest 48% of labeled public expenditure was allocated to health programmes, compared to 33% to law and public order activities (16). More detailed estimates are ongoing.

2 Why did this country approach drugs in this way?

The law reform and national strategy emerged following a period of national debate. As noted at the time the new approach was based on a number of core principles, the most important of which were humanism and pragmatism:

Humanism takes into account the complexity of the human dramas that so often lead to the use of drugs and drug addiction. It essentially considers the drug addict to be someone who is ill, and demands guaranteed access to forms of treatment for all drug addicts who seek treatment, including those who may for any reason be in prison. It also implies the promotion of conditions for effective social reintegration, as well as the adoption of an appropriate, fair and balanced, legal framework, respecting the humanistic principles on which our legal system is grounded (Resolução do Conselho de Ministros n.o 46/99 de 26 de Maio 17).

Pragmatism reflected the notion that the dogmatic policies of the past, based on tougher laws and abstinence oriented prevention had not worked, and that there was need for more effective, evidence-informed policies, including the adoption of proven harm reduction policies (11).

Decriminalisation formed one core aspect of the policy, due to a number of reasons. First, it was recognised that criminalisation was making the drug problem worse: increasing the marginalisation of users, neglecting their human rights, particularly the most marginalised at the time – heroin users. Second, decriminalisation offered the means to send an important signal to society, to say that drug users are not criminals and ought not be treated as such. Finally and most importantly, the reform offered a means for a more effective response to drug use, one that included the possibility of a more health oriented response.

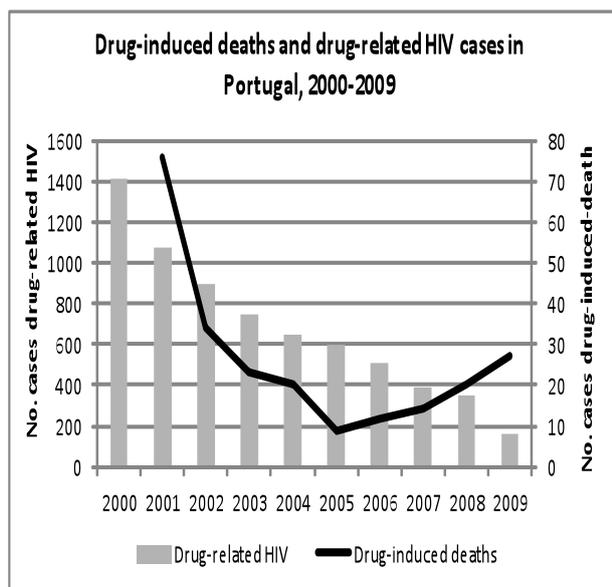
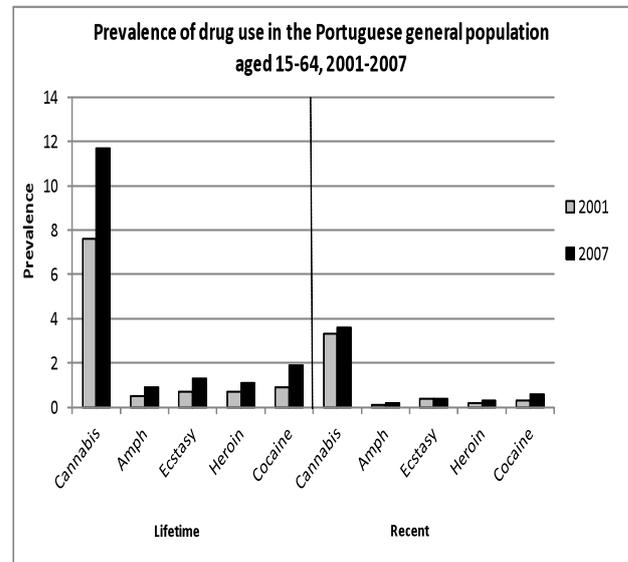
One unusual facet of this approach is that decriminalisation was deliberately linked to an expanded drug strategy approach. The decriminalisation sought to provide a more humane legal framework, and by expanding policies and resources across the areas of prevention, harm reduction, treatment, social reintegration and supply reduction, the strategy sought to open up new ways for the field to respond, such as through channelling minor drug offenders through to the drug treatment system. As was argued at the time – Portugal could not expand harm reduction services while saying use was a crime – but nor could it decriminalise without expanding services for drug users (11).

Multiple factors were involved including the increasingly serious Portuguese drug problem, growing numbers of intravenous drug users and worsening social marginalisation and the establishment of an expert commission (18). Other important factors at the time included increasing advocacy from the drug treatment and law enforcement systems for new and more effective responses, changes in the political

arena, and the increasing perception that existing approaches were so ineffective that even if these critics could not be certain of the consequences of alternative policies, they were clear that 'something new had to be tried' (11).

3 What have been the positive and negative outcomes of this approach?

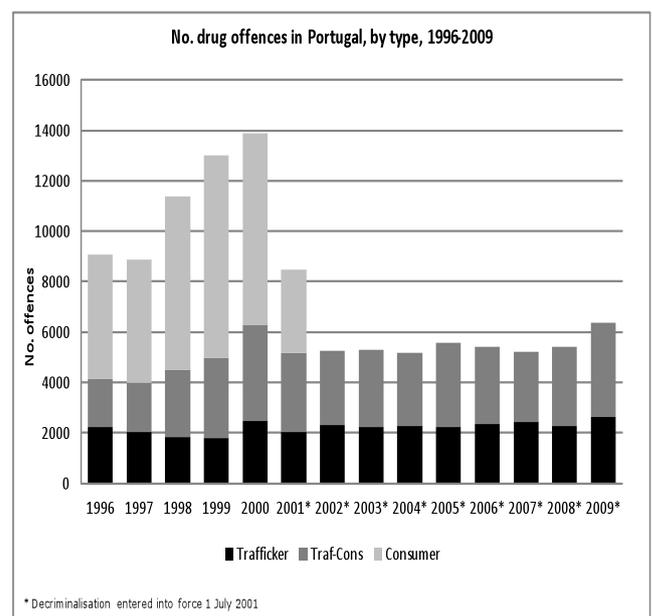
At the general population level between 2001 and 2007, the reported prevalence of lifetime drug use increased in Portugal for almost all illicit substances, however looking specifically at the trends in recent use (the more policy significant indicator) there were only negligible increases (between 0.1 and 0.3%). Trends differed somewhat across different age groups, with recent use increasing most among those aged 25-34 years. Yet, recent use declined among those aged 15-24 years. Looking at school students permits a longer term view, and indicates cannabis use appeared to increase at the time of reform and then subsequently declined (13).



Trends regarding drug-related problems were more significant. The prevalence of injecting drug use declined (15). The number of drug-induced deaths in Portugal (defined according to ICD protocols) also decreased from the time of reform (19). Following a large drop from 2001 to 2005, there has been a subsequent increase, albeit to levels that remain much lower than at the time of reform. Yet the biggest change was in regards to drug-related new HIV infections, which decreased significantly between 2000 and 2009 from 1400 to fewer than 200 cases per year.

The number of drug offences in Portugal resulting in criminal action declined at the time of reform, and subsequently remained stable. Even taking into account the numbers now sanctioned through the CDTs, there seems to have been a reduction in the number receiving some form of police action than at the time of reform. Moreover, of all actions taken, 55% were directed at traffickers and trafficker users (i.e. only 45% were directed at users).

There has been considerable debate about Portugal's law reform, most notably exemplified by the accounts of Greenwald of a 'resounding success' (20) and Pinto of a



* Decriminalisation entered into force 1 July 2001

'failure' (21). However, between these Hughes and Stevens (13) argue that the reality falls between the two extremes.

For example, there does appear to have been some increased drug use, which some have attributed to unsatisfactory communication about the nature of the legal reform. Nevertheless, the levels of problematic drug use, HIV and offending all reduced. Coupled with evidence of reductions in the number of drug-related offenders imprisoned, increases in the quantity of drugs seized by law enforcement authorities, and reductions in retail prices and evidence that many trends were counter to that observed in Spain or Italy (15) increases the probability that the reforms contributed to largely positive outcomes. The key unknown is discerning to what extent the trends were attributable to the decriminalisation, the drug strategy or the combination of both.

Switzerland

1 What is this country's approach to drugs?

The central objective of the Swiss drug policy is a 'reduction in drug-related problems'. The most recent strategy notes that non-use of drugs is the norm, but also recognises the need for a pragmatic, public health focus:

To a certain extent drug use constitutes an undeniable reality... it should occur in such a way that users expose themselves to the least possible risk (e. g. HIV infection) and their quality of life be affected as little as possible. One aspect of this is that they should remain integrated in society or become better integrated (22).

To reach this objective Switzerland pioneered a four-pillared approach: prevention, treatment, law enforcement and most critically harm reduction. Indeed, while prevention and treatment have long been emphasised¹ Switzerland has become a fore-runner in trialing and expanding harm reduction services. They were the first nation to trial heroin assisted treatment (HAT) (from 1994-1996), and following the passing of the *Ordinance governing the medical prescription of heroin in 1999* HAT has become a mainstream policy, applied in 2007 to approximately 5% of the total opiate dependent population (more than in any other nation) (23). Switzerland have also placed a strong emphasis upon provision of needle syringe programs and consumption rooms.

The federal initiative "MaPaDro" has been central to the public health approach, and particularly to enabling the Swiss cantons, communes and private agencies (all of whom have a much stronger role in implementation than the federal government) to expand approaches (22). Since adoption in 1991 this has enabled approximately 300 projects and programs crossing the domains of prevention, treatment and harm reduction to be initiated and/or supported. Equally importantly, it has also fostered the evaluation of these programs, to inform future MaPaDro initiatives.

Drug use, possession for personal use, trafficking and cultivation are all criminal offences. For example, the intentional consumption of narcotics is punishable by detention or a fine (*Narcotics Act*, s. 19a). However, for petty offences, the appropriate authority may stay the proceedings or waive punishment and may issue a reprimand. Interestingly, on June 5 2012 the Swiss parliament agreed 'in principle' to impose a fine on consumers with a small quantity of cannabis, instead of opening a mandatory criminal proceedings (24). This is still subject to both houses of parliament agreeing to a suitable fine.

¹ The Narcotics Act first stipulated in 1975 that cantons had to carry out prevention work and offer therapy to dependent drug users (Federal Office of Public Health 2006).

2 Why did this country approach drugs in this way?

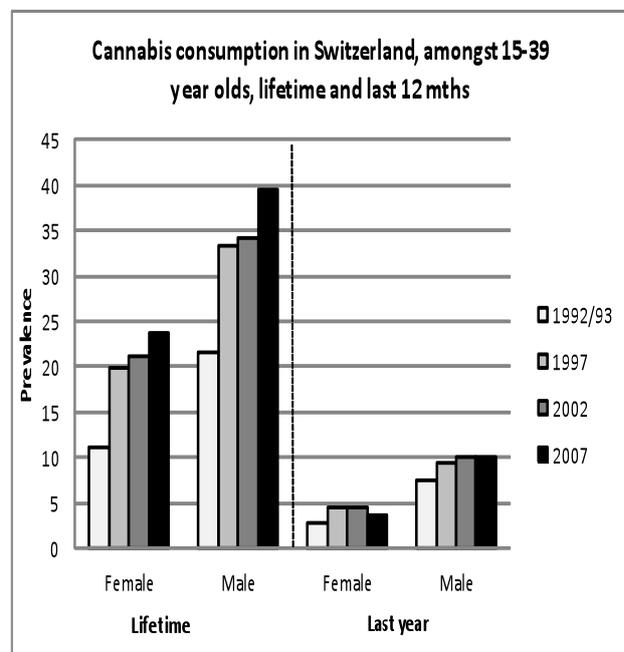
The Swiss approach of a very public health oriented approach can be attributed to a number of factors. The first was the 1980s growth in injecting drug use, injecting related problems and the emergence of open air drug scenes (including the infamous Platzspitz park or 'needle park' in Zurich), and subsequent increase in new HIV infections among people who inject drugs. This increasingly called into question the effectiveness of a repressive policing approach. The second was local experimentation with harm reduction approaches, including drug consumption rooms. One such example was a number of Zurich physicians and social service providers who set up a local agreement to trial public health approaches in Platzspitz park (25). Between 1988 and early 1992 this enabled a number of initiatives including needle and syringe provision to be trialled and studied, even though they went against federal policy at the time. The third key reason was the Swiss system of open and direct democracy, whereby all levels of government and even ordinary members of the public can create ballot initiatives or overturn government acts of Parliament with as few as 50,000 votes (23). This has played a critical role in both ensuring public input into policies, and in requiring governments at all levels, to be able to justify their adopted approach. i.e. an evidence-informed public health approach.

Interestingly, initiatives for 'zero tolerance' and legalisation were put to the popular vote in 1997 and 1998 respectively, and both were rejected (by 71% and 73% voters respectively). As argued by the drug strategy, through rejecting these "voters indirectly came out in favour of the four pillar model as a pragmatic middle way" (22).

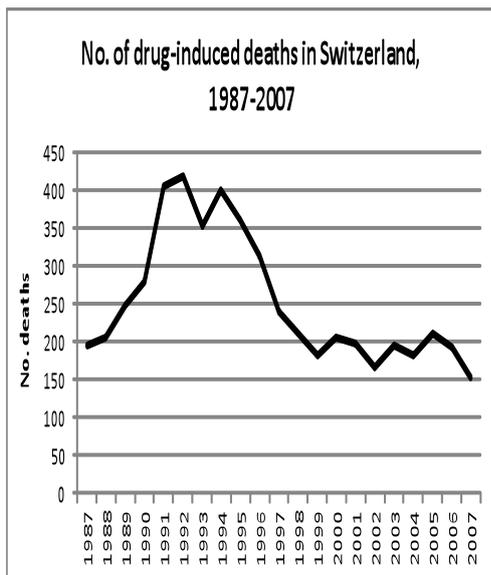
3 What have been the benefits and costs of this approach?

Fears were raised at the time of the reform that the provision of low threshold methadone and harm reduction services may increase the attractiveness of heroin. Nevertheless, at the general population use of any illicit substance other than cannabis has remained low. For example in 2007 only 4.3% of females aged 15-39 and 8.1% of males reporting lifetime use of any drug other than cannabis (23).

Significantly, the number of heroin dependent users in Switzerland is estimated to have declined by approximately 30% (from 29,000 in 1994 to 23,000 in 2002).² Impressive evidence of the change in the pattern of regular heroin use comes from a study of a Zurich treatment population. Nordt and Stohler (26) used the case register of substitution treatments for 7256 patients (covering 76% of those treated between 1991 and 2005). They noted how the number of clients reporting beginning regular use of heroin in Zurich rose steeply, from 80 people in 1975, to 850 in 1990, before declining substantially to about 150 users in 2002. The number of drug-induced deaths and prevalence of IDU-related HIV in Zurich followed a similar pattern. In the country as a whole, in contrast to the earlier expansion, drug-related deaths decreased in Switzerland from 350-400 per annum in the 1990s to 150-200 per annum in the 2000s.

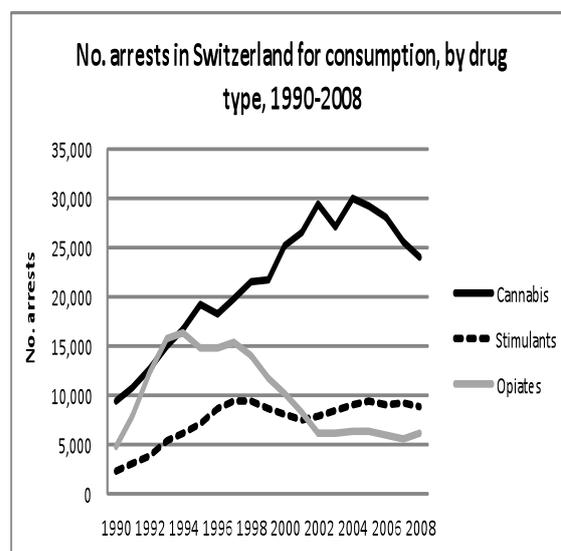
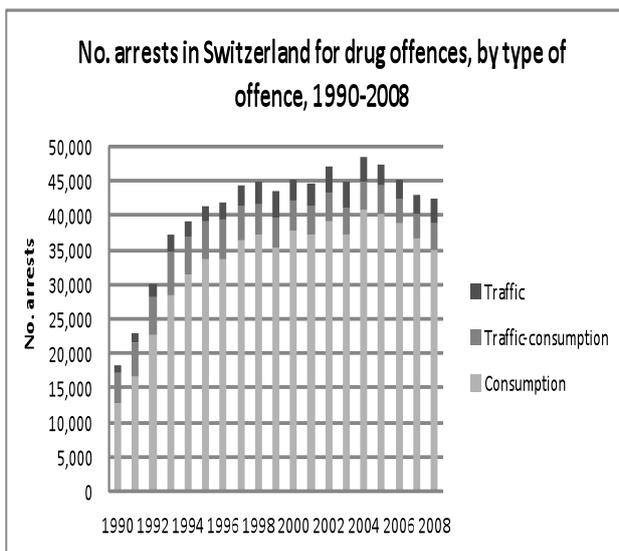


² More recent figures could not be attained.



However, at the same time there has been an apparent increase in the prevalence of cannabis use in Switzerland, particularly among young populations. For example, between 1992/93 and 2007 the reported incidence of lifetime cannabis consumption almost doubled (from 11.1% to 23.7% in females and from 21.5% to 39.5% in males in the population aged 15-29 years). Increases in reported cannabis consumption in the previous year were however much more moderate, and suggest that across the population as a whole there was only a slight increase from 1992/93 to 1997 with a stabilisation or decline in more recent years (23). Data amongst school students specifically indicate an increase from 1986 to 2002 specifically, followed by a drop (27).

The number of arrests for drug offences in Switzerland increased significantly from 1990 to a peak of 48,563 in 2004 (with a slight subsequent decline). This has been driven largely by arrests of consumers, who since 1994 have constituted 80-86% of all persons arrested for drug possession (28). Moreover, most consumer arrests are for cannabis. Indeed, Switzerland had even more arrests (per capita) for simple possession of cannabis than the United States. But, equally importantly, the number of recorded convictions each year are only about one sixth as high as the number of arrests and a maximum of 2150 individuals (5% of those arrested) received prison sentences in any one year.



The challenge is to determine to what extent the changes, particularly the declines in heroin-related problems, are attributable to the Swiss drug policy. On the one hand there are many, such as Buechi and Minder (29), who have directly credited the reforms with the declines:

The "Fourfold drug policy" has proven to be very successful and has put a stop to the increase in new users of hard drugs among young people; it has helped a multitude of drug-dependent individuals escape the vicious cycle of addiction and protects the physical and mental wellbeing of drug-dependent individuals.

Yet, others have been more circumspect. For example, Reuter and Schnoz (23) noted that similar reductions in dependent heroin use and related problems had been seen in other countries with different policies. They thus argued it could not be concluded that the observed reductions were directly attributable to the Swiss harm reduction policies. They nevertheless noted that even if the harm reduction policies did not affect the timing of the decline (as the start of the decline preceded many programs), they may well have affected the speed of decline. At the very least, concerns voiced by some of an increase in heroin use and dependence did not occur. Another question that remains unanswered is the extent to which changes in cannabis use were unique to Switzerland and/or an unintended consequence of the Swiss approach. Reuter and Schnoz (23) suggest not, as the trend mirrors that in neighbouring countries, but others have questioned whether for this particular drug a more socially oriented approach may have better curtailed drug consumption (see for example 25).

Netherlands

1 What is this country's approach to drugs?

The Netherlands are best known for their *de facto* decriminalisation and the establishment of a coffee shop cannabis distribution system (30). At the coffee shops different strains and strengths of cannabis can be bought or consumed through a quasi legal system. The possession, sale, import/export, cultivation or manufacturing of drugs, but not drug use are and remain criminal offences in the Netherlands. Penalties range from up to four years imprisonment for possession of 'hard drugs', to up to 12 years for import/export or one month for possession of small quantities of cannabis. Nevertheless, since the decision in 1976 to not enforce minor violations of cannabis possession, such offences rarely result in prosecution.

The details of this approach have often been changed over time. From 1976-1984 cannabis possession was not subject to any penalties, however there was very limited legal access. In 1984 municipalities were allowed to license coffee shops to sell small amounts of cannabis subject to conditions that are laid down in the national guidelines of the Public Prosecutor (the AHOJ-G criteria). In 1995 following the 1995 Drugs Policy Paper there were increased controls over coffee shops: e.g. instilling mandatory minimum distances from schools, reduced amount of cannabis that could be sold (from 30 grams to 5 grams), increased monitoring of compliance and expanded administrative measures and decentralisation of coffee shop policy – giving increased rights to local governments e.g. to reduce hours or close coffee shops. Finally, in 2012 coffee shops have been restricted to 'private clubs', accessible only to residents of the Netherlands, aged over 18, upon display of a valid membership pass (the number of members will be capped to 2000 per club). The initial restrictions commenced on 1 May in three provinces, with national roll out expected by the end of 2012.

Coupled with the decriminalisation and coffee shop approach the Dutch drug policy prioritises the protection of public health, through a combination of prevention, treatment, harm reduction and law enforcement policies. The Dutch have been leaders in harm reduction, being the first to pioneer needle syringe programs (in 1984), pill testing and rapid adopters of other harm reduction policies such as heroin-assisted treatment (30). Yet, while maintaining these core elements since the 1995 Drugs Policy Paper, the Dutch drug policy has also included an intensified focus on public nuisance and organised crime and funding efforts, which has increased the role of law enforcement, among other players.

2 Why did this country approach drugs in this way?

The *de facto* decriminalisation in the Netherlands followed recommendations in the 1970s by the Hulsman Commission and the Baan Commission (Boekhout van Solinge 1999; Cohen, P. 1994; Leuw & Marshall 1994; Uitermark 2004). Key underpinnings were normalisation and separation of the markets. 'Normalisation', reflected the realisation

that drugs are here to stay, hence the optimal approach for society is to minimise rather than just ameliorate the harms, through for example use of harm reduction and treatment options and avoiding the provision of criminal records. Separation of the markets reflected the notion that cannabis use was more prevalent than the use of other illicit drugs hence the best way to reduce the likelihood of exposure to and/or engagement with hard drug markets was to keep the two markets apart. This approach has been characterised as a tolerant yet pragmatic pragmatic.

Dutch drug policy was influenced by a number of other factors. First, as Boekhout van Solinge (1999) noted, during the development of the Dutch drug policy advocates from a sociological perspective dominated the debate. They framed cannabis use as a deviant but acceptable behavior. Second, as noted by MacCoun and Reuter (2001), cultural interpretation was also important. The recommendation to “separate the markets” was remarkably different to the US conclusion to stamp out use early, yet both followed the observation that cannabis use was more prevalent than the use of other illicit drugs. Thirdly, and in line with this, Uitermark (2004) argues that the Dutch *de facto* decriminalisation was aided by Dutch preference for decision making through consultation and compromise, rather than dogma and a preference for “gedogen” or a pragmatic and minimalistic approach to difficult social problems. Finally, the acceptance of decriminalisation was also facilitated by the context of non-problematic drug use and support from criminal justice officials for reform (Cohen, 1994).

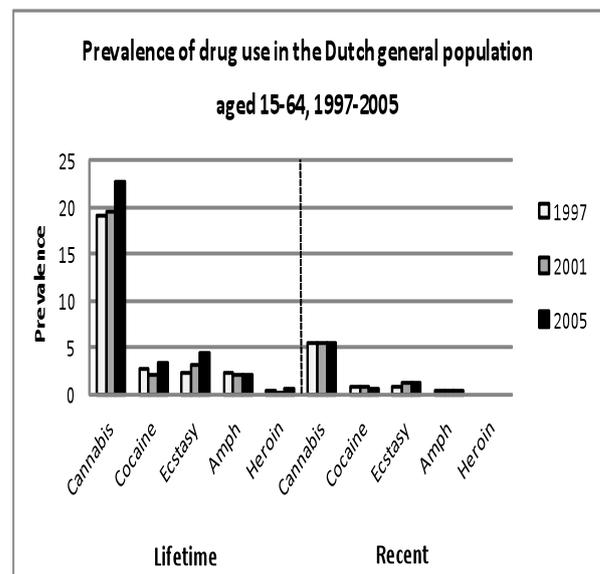
The progressive tightening of responses to coffee shops appears to have been influenced by a number of factors. Some argue they have been driven by costs and unintended consequences e.g. increasingly large scale and professional illegal cannabis cultivation and a rise in drug tourism (31). Others argue that the perceived costs have been over-emphasised and that political rationales, particularly a more conservative political environment with increased emphasis upon crime control has been a more important factor (30). Whatever the cause it is clear that the 1995 Drugs Policy Paper facilitated a 28% decline in coffee shops: from 1179 in 1997 to 846 in 1999, with still further declines to the current day: 666 in 2009 (32).

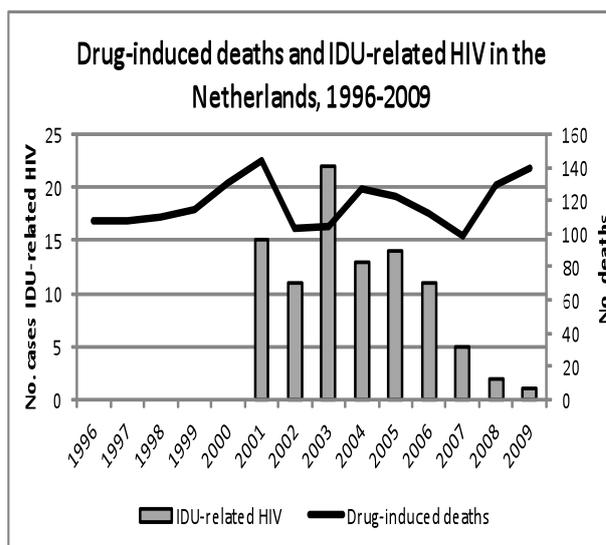
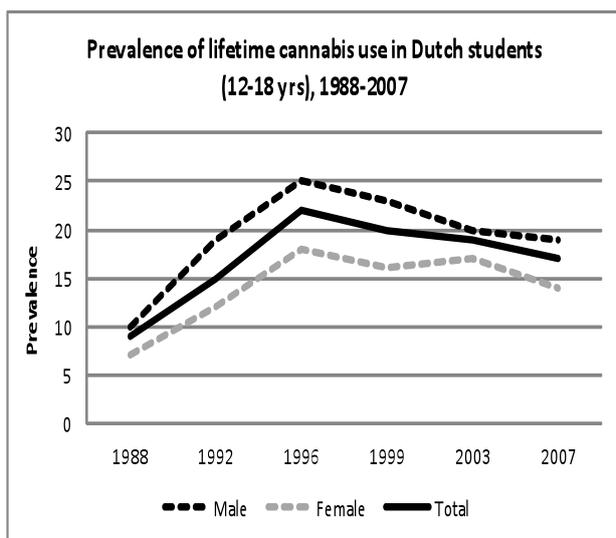
3 What have been the positive and negative outcomes of this approach?

At the general population level, the Netherlands has reported increases in reported lifetime use for most substances, however trends in recent use have been stable. For all drugs, with the exception of ecstasy, the Netherlands scores below the European average (33).

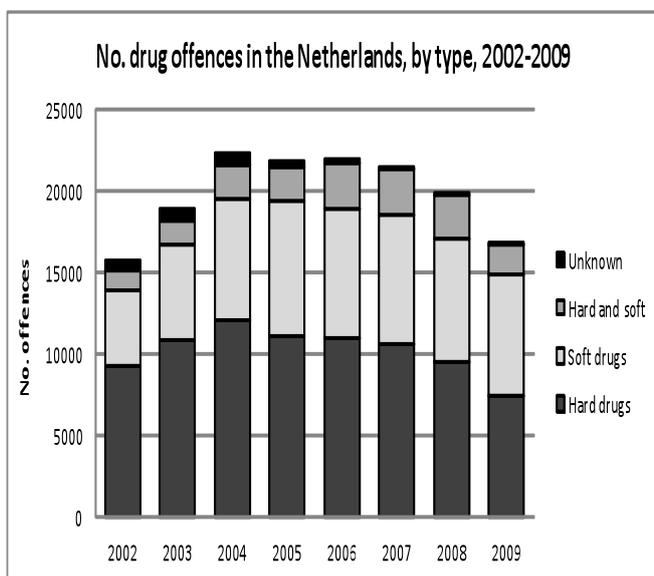
The Netherlands fares less well for students. Cannabis use increased from 1985 until 1999, and in spite of a levelling off it remains higher than the European average.

From the mid 1980s the Netherlands has reported declines in a number of drug related problems. The number of dependent opiate users declined, drug treatment expanded, and the number of new IDU-related HIV infections reached a peak of 77 cases in 1995. There have been further reductions in IDU-related HIV infections in recent years. In contrast, drug-induced deaths in the Netherlands have remained fairly stable, at about 110 per year. This is higher than during the mid 1980s (approximately 40 per year).





At the adoption of the Dutch policy the major drug offences were for so-called 'hard' drugs. While the split has narrowed slightly, this has remained a core observation today. However, the number of offences has change. Between 1985 and 1993 the number of drug offences in the Netherlands decreased (from 6000 to under 4000 offences per year) (34). Following the 1995 drugs paper offences more than doubled and have remained higher still since 2002 (32). Data on sentencing indicate increases in both the use of imprisonment and community based orders for drug offenders. However, more are imprisoned for trafficking than for possession, as reflects the data from the prosecutors that only 40% of all cases (or 30% of soft cases) pertain to possession (32).



Coupled with data showing that where available most Dutch cannabis consumers report buying their cannabis from coffee shops, this suggests that that the core objectives of the Dutch approach have been largely attained. Whether or not the increases in cannabis among students were a consequence of the cannabis reforms remains unclear (9, 33). One challenge is the data only commenced in 1985, not in 1975 when the reforms first commenced, or more preferably prior to this point. Another challenge remains whether or not there have been real changes in the levels of organised crime associated with coffee shops, a very difficult entity to measure and monitor.

Sweden

1 What is this country's approach to drugs?

The primary goal of Swedish drug policy is "a narcotics-free Sweden" (35). Sweden uses a combination of health promotion, prevention, law enforcement and compulsory and non-compulsory treatment. Most drug treatment emphasises abstinence. The most recent strategy covers the period 2011-2015. The long-term objectives are: (1) to reduce the supply of drugs, (2) to protect children from the harmful effects of drugs, (3) to reduce the recruitment of new 'drug abusers', (4) to reduce the development of high-risk drug

use behaviours, (5) to increase access to high quality healthcare and social support services, (6) to reduce direct and indirect harmful health consequences of drug use, (7) to promote the Swedish drug policy internationally.

A notable difference to the approaches of Portugal and Switzerland is the absence of explicit 'harm reduction' policies. Moreover, even though the Drugs Commission in Sweden states that drug users can be offered help without the requirement of an immediate and/or long-lasting drug-free life, the Commission advises against legal prescription of heroin, safe injection rooms and other low-threshold programmes. There is also a preference against needle and syringe programs. For example, only two counties initiated needle and syringe provision in 1986 and 1987 (Lund and Malmö respectively). In 2006, the Swedish government introduced a law which in effect allowed other regions to introduce needle exchange programmes. However, by 2010 no new programmes have been established. Moreover, any that were to be established would have to demonstrate need and availability of resources and be further obliged to provide referrals to drug free treatment.

Sweden places a strong emphasis upon criminalisation and enforcement. Possession has been a criminal offence under the Narcotic Drugs Punishment Act since 1967, and drug use since 1988 (36). One point of distinction between Sweden and most European nations is that Sweden does not distinguish penalties for use versus trafficking (37). Drug trafficking offences, sanctionable under the Law on Penalties for Smuggling, thus carry the same penalty range as for users. For all drug offences, offenders are punished according to three degrees of severity. Penalties range from fines or up to six months' imprisonment (minor offence) to 2-10 years imprisonment (serious offence). However, those offenders deemed to be 'recidivists' are liable with up to 18 years imprisonment. Sweden also has adopted laws enabling additional police powers, most notably the 1993 law for coerced drug testing for any suspected user.

2 Why did this country approach drugs in this way?

The emergence of Swedish drug policy is the source of some conflict. Official accounts often portray Swedish drug policy, particularly the emphasis upon a restrictive policy, as having arisen post a period of amphetamines prescription in 1965-67, during which a police doctor (Nils Bejerot) theorised that the level of liberalisation or restrictiveness of drug policy had a direct impact on the level of use in society. Specifically he argued that if drug users could be prevented from taking drugs, the whole system of drug taking would eventually collapse.³ However, many have argued that the real story is much more complex. For example throughout much of the late 1960s and 1970s there was public debate about the merits of improving social policies for drug offenders, rather than combating use and sales (36). Moreover, the first drug law avoided the criminalisation of use and provided prosecutorial options to avoid sanctioning possession. Policies to control drug use particularly in the late 1980s, with the criminalisation in 1988 then subsequent decision that drug use ought be punished with equal severity to other drug crimes. From this perspective, while the precursors for a 'drug-free society' were set early on, there has not been a straight-forward road to this. Factors including mass mobilization, a moral panic over drug use, and the election of a conservative government in 1977 were thus central to the drug-free society objective becoming mainstream (36).

Regardless of the exact trajectory it is clear that Swedish drug policy is steeped in philosophies of Bejerot and the belief that problematic consumption is primarily the result of biochemical rather than psychosocial processes, and that any drug use is problematic as it can give rise to dependency and/or spread further use (38). This underpins policy approaches of criminalising not only drug trafficking but also drug use,

³ As noted by Boekhout van Solinge (1997: 45) "Bejerot's assumptions and conclusions have been thoroughly analysed and criticised."

targeting cannabis as the gateway drug and having a strong emphasis upon prevention. It is also why for users there is an emphasis upon abstinence-oriented (and often compulsory) treatment, rather than harm reduction.

3 What have been the benefits and costs of this approach?

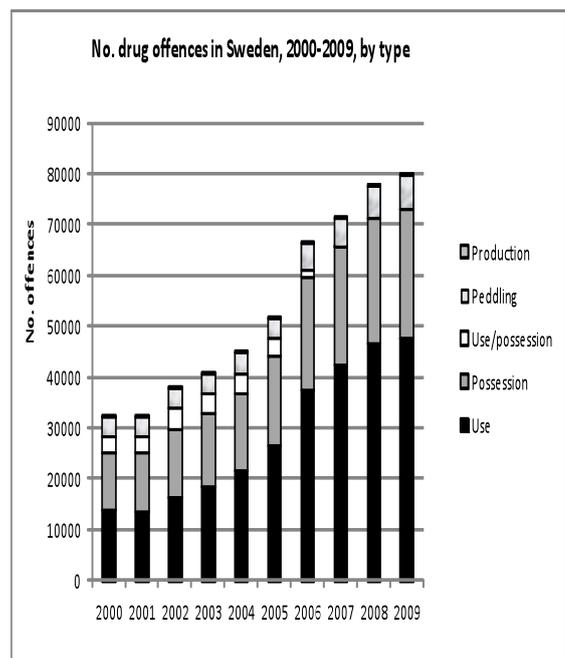
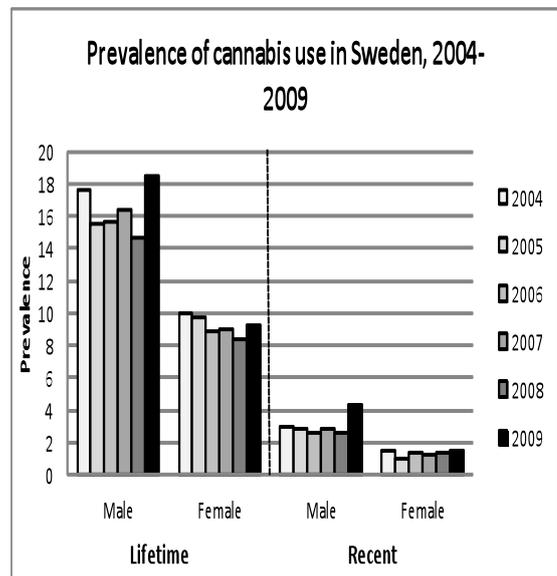
The most noted trend relevant to the Swedish approach is that among youth the prevalence of drug use is lower now than in the 1970s (from 15% to 6-7%). Yet general population data only started to become available in 2004. Such data points to a stabilisation in cannabis use and/or an increase in 2009. The apparent increase was greatest for males, particularly for males aged 16-24, among whom recent use was reported to have more than doubled (from 4.8% to 11.1%) (39).

The level of problem drug use specifically increased. For example there were an estimated 15,000 users in 1979, 19,000 users in 1992 and 26,000 in 1998 (from 1.8 PDUs per 1000 inhabitants to 2.9 per 1000 inhabitants) (39). There was a further increase to 28,000 PDU in 2001. Moreover, drug-induced deaths in Sweden have increased significantly. Indeed, even examining the deaths coded using ICD protocols (the more conservative estimate) deaths have more than doubled between 1993 and 2008, to a new peak of 241 cases in 2008 along.

Finally, while the prevalence of IDU-related HIV cases has remained low, particularly after a decline between 1989 and 2000, there was a worrying HIV outbreak in 2006 in the domestic IDU population in Stockholm (39). As a response, intensified testing and other activities resulted in more HIV infected IDUs being detected. A subsequent regional study in Stockholm identified further cases of HIV as well as high rates of other infections (including 82% of IDUs being HCV positive).

There has been a steady increase in drug offences in Sweden, to a peak of 80,256 offences in 2009 (39). Of these, use and possession offences accounted for the vast majority of offences. Indeed, they accounted for 87% offences in 2000 and 91% in 2009. Mirroring this trend the number of offenders convicted for drug offences has more than doubled in Sweden from 2000 to 2009 and the utilisation of imprisonment, while infrequent, has also increased. Of note is that in 2009 those aged 21-24 are at greatest risk of drug conviction: 840 drug convictions per 100,000 population, compared to 100 drug convictions per 100,000 population for those aged 50 and over (39).

There is much contention about the outcomes of the Swedish approach. For example, the United Nations Office on Drugs and Crime (UNODC) (12) issued a report titled "Sweden's successful drug policy: A review of the evidence" which concluded, as per the title, that the approach has been one of the most successful in Europe. "Drug use levels



among students are lower than in the early 1970s. Life-time prevalence and regular drug use among students and among the general population are considerably lower than in the rest of Europe. In addition, bucking the general trend in Europe, drug abuse has actually declined in Sweden over the last five years." But many of the UNODC's conclusions have been challenged (40).

Six years on, while the prevalence of use remains low relative to most European nations, the Swedish trends in relation to problematic drug use are of increasing concern. Indeed, while the 2010 evaluation of the Swedish action plan noted achievements in the development of a solid knowledge base for prevention of drug use, it also highlighted the increase in observed harmful consequences of the drug use phenomenon, such as drug-related morbidity, mortality and crime in Sweden (39). Whether or through what means these will be addressed is not known.

Discussion and conclusions

The four different approaches highlight a number of lessons and quandaries.

- The Portuguese drug policy illustrates that even decriminalisation of all personal illicit drug use will not inevitably lead to a mass rise in use. To the contrary, this suggests that drug policy can target the most negative consequences of drug use (initiation to injecting, deaths and HIV), with only minor apparent costs (a rise in recent use). This raises questions of to what extent drug law reform ought be targeted at all illicit drugs, and to what extent it ought be undertaken alone versus as part of one element of broader strategic reform?
- The Swiss approach both highlights the potential benefits of local rather than national strategies and of fostering conditions for experimentation. Yet given the combination of the most harm reductionist approach combined with high numbers of arrests of people for drug consumption, Swiss drug policy shows the risks of classifying countries as either 'liberal' or 'conservative' in the continuing debate about drug policy.
- The Dutch drug policy indicates that the separation of markets appears to be largely feasible. Yet it also indicates the clear challenges of supplying coffee shops via 'the back door'. The policy is also a clear example of how no drug policy is static, and how changes, particularly in the political arena, can impact on observed outcomes.
- Finally, the Swedish drug policy, while clearly demonstrating apparent preventative benefits, also raises the query of to what extent negative effects from such a policy are undetected, rather than absent?

A number of conclusions can be drawn from the comparison of these four countries:

- There is more cross over between these approaches than is often recognised in popular debate, for example Sweden has some harm reduction approaches. Nevertheless there are also important differences.
- The different objectives and philosophies can be seen to have affected what is and is not possible, and the policy mix adopted. For example, the approach of Sweden to have the same criminal sanctions for traffickers and users is clearly at odds with approaches of most other countries, yet it is consistent with the Swedish view of curtailing all drug use.

Winners and losers of reform?

- There is no evidence that any of the policy approaches led to drug disasters, such as a severe drug epidemic.
- Instead, all nations, largely perceive their policy objectives to have been attained.

- Nevertheless, many had some arguably negative consequences. Of note is the increases in problematic drug use and HIV in Sweden. Yet, both the Dutch and Portuguese policy reforms were followed by some apparent increases in use. To what extent could these have been avoided or reduced by swift action remains unclear.

Optimal approach?

- While we are cautious about inferring direct links between policies and outcomes, different drug policy objectives can be seen to be associated with different trends in outcomes.
- For example, many more drug users are arrested in the Netherlands than Portugal for use of drugs such as ecstasy or cocaine: this difference reflects the extent to which the arrest of 'hard drug users' is deemed to be acceptable.
- The largest increases and highest levels of arrests of drug users occur in Sweden and Switzerland, and reflect the national policy in both countries of criminalising use and possession. Nevertheless, the differences between these two remain equally pertinent: Switzerland convicts few of those arrested. In contrast, Sweden convicts the majority of those arrested.
- A particularly striking trend is in the levels of problematic drug use, overdose and HIV, with the nations of Portugal, Switzerland and the Netherlands all having seen reducing (or low stable) trends, and Sweden the reverse.
- Yet, the trends in drug offending and levels of consumer arrests clearly place Switzerland at odds with Portugal and the Netherlands.
- These observations provide grounds for arguing that the policies that place greatest emphasis upon a public health and social approach appear best at reducing problematic drug use, overdose and HIV. Yet, it is policies that combine a public health and social approach, with reduced criminal penalties that appear associated with the greatest gains, across both health and criminal justice domains.
- It is also clear that optimal policies and implementation can aid a comprehensive evidence based assessment to understand the context before implementing any reform and establishing effective systems for monitoring and early adjustment should unforeseen consequences occur.

Future directions:

- There is no such thing as a perfect policy. Discussion of drug policy has been made more difficult and unrealistic by the search for solutions. There are no 'solutions'. Countries can choose between which kinds and what level of adverse consequences they are prepared to accept. As 'The Economist' noted 'there are no wins in the war on drugs, only Pyrrhic victories'.
- While the current International Conventions are often viewed as a constraint, these examples have demonstrated multiple reform options that offer the opportunity to reduce drug related harms are possible.
- Transferring any policy models, whether it be from Europe to Australia or from another context, would inevitably require adaptation to the different conditions seen in the Australian context. Each reform must take into account the unique local social, political and economic conditions, timing and specific policy goals of a nation. Nevertheless the central messages and experiences can inform discussion about what an alternate version of Australian drug policy could look like: the framing, the policy mix, the priorities, what is within and outside scope and the benefits of reform.
- Equally importantly debates about drug policy are far too often envisaged narrowly around legislative approaches or how much relative emphasis is given to drug law enforcement, prevention, treatment and harm reduction. While these aspects are undoubtedly important, drug related deaths, disease and crime are affected by a

number of other factors including the broader social, health and economic policies, including the level of support provided to community members most at risk.

- The evidence base on drug policy and drug law reform has expanded considerably in recent years. While this discussion paper examined four European models here, there are many other approaches from which lessons could have been drawn, including the United States. For a comprehensive review on the outcomes from this policy see 41. Indeed, relative to when all four nations here considered their reforms, we are in an evidence-rich environment, that is more and more demonstrating the erroneousness of much of the common assumptions underpinning drug policy, such as that less punitive approaches will inevitably increase availability or consumption of drugs (see for example 42).
- Perhaps the most important message from all four nations is that there will always be reasons why not to reform e.g. evidence-gaps, potentially erroneous assumptions, vocal critics, but fortune favours the brave. In the words of the Portuguese former drug strategy coordinator Vitalino Canas:

“We only knew about the past and in the past the policies were not positive, were not good. Past policies were not solving the problems, and were in some instances, in some areas, counterproductive.” (11)

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