Drug Laws in Europe:
main features and comparisons

editors
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UniversItalia

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PREFACE

This book presents works conducted within the framework of the project "New methodological tools for policy and programme evaluation", financed by the EU Commission DG Justice and coordinated by the Centre for Biostatistics and Bioinformatics of the University of Rome "Tor Vergata".

The book is divided into two parts and a guest contribution: part one is a comparison between the laws of most European countries regarding illegal drug use; part two is a more in depth comparison between Italian and Portuguese laws aimed at highlighting how apparently similar regulations are in fact quite different and have completely different outcomes. The guest contribution presents a comparison, conducted by Brendan Hughes, of penalties for trafficking in some legislations of EU countries based on data from the European Monitoring Centre for Drugs and Drug Addiction.

The study of the various laws that are applied in different countries has allowed us to identify their strengths and weaknesses and verify their effectiveness.

This analysis, in fact, has demonstrated that some regulations are more efficient than others because they employ a comprehensive approach to the problem of illegal drug use and are not limited to only one aspect, such as sanctions or merely procedural aspects.

The debate about drug policy is often represented as a polarized choice between two options, "prohibition" and "legalization". The reality is that

there are multiple options that are in no way reducible to a simple dichotomy between these two extremes.

After having analysed advantages and disadvantages connected with each national legislation, we have attempted to identify the elements contained in the so-called *best practices* in order to propose a homogeneous legislative framework.

The point of view is not ideological, and the choice is not between a right or wrong system, but is an analysis based on the laws and facts. To ascertain *best practices,* it is necessary to start analysing the positive results (the facts) of legislation.

INTERNATIONAL COMPARISON ABOUT DRUGS LEGISLATIONS

Elena Ventura

INTRODUCTION

A comparative analysis of European legislation highlights how different the approach taken by States to resolve the problem "drug" (from production to consumption) is. Each of the choices made has visibly different consequences and it is necessary to analyze the methods that have produced positive results and see whether those can be exported and developed in contexts different to those in which they were generated.
Many national laws are geared to a highly restrictive regime (just think of France, which does not distinguish between personal use and trafficking, or Italy, which equates hard drugs with soft drugs). Some States instead have made specific choices and approaches differing only in levels of repression.
There have been various UN Conventions on this problem, which have certainly helped to stimulate a comparative analysis of different policies and to address the choices within an homogeneous approach. Examples are:

a) The UN Convention of 1961, which obliges signatory states to take all practicable measures to prevent drug abuse and early diagnosis, treatment, rehabilitation and social reintegration of the persons concerned;
b) The UN Convention of 1998, which requires persecution and punishment for serious drug trafficking understood in all its forms.

As in any analysis of law enforcement, one critical difficulty is that there are numerous discrepancies between the "*law on the books"* and the "*law in action*". It is possible to reform and improve easily the first one, but this

does not mean that the final effects of the change in law will be in conformity with initial objectives, because the law has a "social dimension", and the "making of crime" is a process influenced by subjective factors.

The enforcement of existing law, in fact, often occurs selectively or arbitrarily, or even under the dynamics of systematic bias. "*Law in the books*" sometimes has a political purpose, which is often not focused on the consequences of decision making. So it is necessary to pay attention to the "*law in action*" in order to find real solutions. Concretely, the moment in which the law on the books enters in contact with the real world and produces some specific effects is important.

For example, the different approaches to cannabis and the way to control it are very interesting. One important analytic distinction between different types of alternative cannabis use control regimes is thus the differentiation between *de jure* and *de facto* reforms, with the former referring to reforms being written into and stipulated by the letter of the law, and the latter being realized by the way the law is used or applied in the various stages of the criminal justice system.[1]

So it is very important to analyse and compare differing national legislation regulating the consumption and the trafficking of illicit drugs, in order to derive their effects on the economy and society, and assess the *best practices*.

Each national team in fact has the role of providing a complete framework of national legislation. A comparative analysis will be built up in order to analyse advantages and disadvantages connected with each national legislation and, therefore, to propose a homogeneous legislative framework containing the best practices found in each national legislation.

The point of view is not ideological, and the choice is not between a right or wrong system, but is an analysis based on the laws and facts. To individuate the *best practices* it is in fact is necessary to start analysing the positive results (the facts) of some legislation.

Moreover it is fundamental to consider that the critical division in the world of drug policy is between, on the one hand, those who continue to believe that the priority should be eradication - or, at least, substantial reduction - of drug use and availability, whatever the costs; and, on the other hand, those who argue that widespread drug misuse will continue for the foreseeable future and that the challenge is to manage this

[1] *Global Cannabis Commission Report*, CANNABIS POLICY: MOVING BEYOND STALEMATE pagg.97-98.

problem as effectively as possible. This fundamental divide is a source of tensions within and between countries and the aim is to understand which policy is most efficient.

Elimination of illegal drug markets in fact is a laudable objective. But the experience of the last four decades provides no grounds for optimism. By contrast, there are grounds for optimism that drug-related harm can be reduced.

1. NATIONAL DRUG LAWS

A comparative analysis necessarily must start from the law, intended as a forecast made by the legislator to regulate a particular sector. We refer to "law on the books", which was mentioned earlier. The legislative aspect allows us to understand the underlying strategy with which it was decided to fight against the phenomenon. The more consistent and complete the law is, the greater is the chance that it will produce the desired effects.

1.1. CZECH REPUBLIC

The legislation of the Czech Republic was changed on 1 January 2010, when an amendment to the Criminal Code decriminalized the possession of a number of drugs, heavy and light, in small quantities.
The substances vary greatly, from marijuana to cocaine, heroin, ecstasy, and it is the inclusion of hard drugs in the list of decriminalized drugs that has aroused the most controversy.
Prior to this change (and, in particular, until the end of 1999) the Criminal Code stated that possession of narcotic drugs and psychotropic substances in **greater than small quantities was a criminal offence.** The sentences provided in such offenses could reach 2 years imprisonment, growing from 1 to 5 in the case of aggravating circumstances. In cases of the **possession of small quantities without intention to supply**, the Act on Misdemeanours imposed **administrative sanctions**.
The new Code fixed binding limit quantities with which to determine whether an offence was administrative or criminal (these had previously been set by non-binding prosecutor and police directives).
When the quantity (or, better, the quantity seized) of the possessed drug(s) exceeds the so-called "small quantity", criminal prosecution commences and the case is forwarded to the court.
The "quantity greater than small" for different types of drugs is as follows[2]:

1. Heroin – 10 doses (100 mg each)
2. Cocaine – 10 doses (50 mg each)
3. Amphetamine/Metamphetamine (pervitin) – 10 doses (50 mg each)
4. MDMA (ecstasy) – 10 doses (100 mg each)
5. LSD – 10 doses (trips, 50 micrograms each)

[2] http://www.drogy-info.cz/index.php/english/changes_in_the_czech_drug_related_legislation_2010

6. Marijuana – 20 cigarettes with 1.5 % of delta 9 THC

If anyone is caught with a small quantity of drugs on him/her without intention to supply, the police/prosecutors will deliver the case to the specialised local Police units that are competent to impose a non–criminal (administrative) sanction to the offender (a fine or warning) under the Act on Violations[3].

Penalties for drug trafficking can be up to 10–18 years of imprisonment, depending on aggravating circumstances. In the case of addicts committing a drug-related crime, a range of alternatives to imprisonment is available to the court (e.g. suspended sentences, community service and probation with treatment). Since January 2009, security detention with compulsory treatment is a possible option for dangerous addicts[4].

In 2009, a new category of medicines was created to restrict sales of non-prescription medicines, such as those containing pseudoephedrine (a precursor for producing methamphetamine).

So, what it is possible to infer from the recent amendments to the Czech penal law is that they have given the **judges** more opportunities to consider the drug addiction of the offenders as well as other circumstances around a committed crime. According to these amendments judges are empowered to impose other sentences as alternatives to the sentence of imprisonment in the cases where circumstances allow for such approach.

The aim of the new rules is to streamline the workload of the judiciary and the economic resources invested in pursuit of the consumers, and divert those funds towards prevention and public information according to the pattern already seen in Holland.

Below we analyze in detail a number of provisions of the Criminal Code (Act 40/2009, date of Entry into Force of this version 01 January 2010**) that examine "**Unauthorized Production and Other Handling Of Narcotic And Psychotropic Substances And Poisons" and "Possession Of Narcotic And Psychotropic Substances And Poisons".

Regarding **"***Unauthorized Production and Other Handling Of Narcotic And Psychotropic Substances And Poisons*" it establishes that:

1)**Whoever** without authorization **produces, imports, exports, transports** through the country, **offers, traffics in, sells, or otherwise procures or holds in its possession for another** a narcotic or psychotropic substance, a

[3] http://www.emcdda.europa.eu/html.cfm/index5174EN.html#

[4] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/cz;

preparation containing a narcotic or psychotropic substance, a drug precursor or a poison, **shall be punished by imprisonment for a term of between one and five years,** or by a fine.

2) There are aggravating circumstances:
2.1.with an expected sentence of imprisonment for a **term of between** t**wo and ten years** if they committed such a crime

a) as a member of an organized group,
b) despite having been convicted of or punished for such a crime in the three years preceding,
c) on a substantial scale, or
d) on a significant scale in relation to a child, or involving a quantity greater than small in relation to a child of below the age of fifteen.

2.2.with an expected sentence of imprisonment for a **term of between eight and twelve years** if

a) they caused by a crime under subsection 1 severe injury to health,
b) they committed such a crime with the intention of obtaining substantial benefit for themselves or for another,
c) they committed such a crime on a large scale, or
d) they committed such a crime on a significant scale in relation to a child of below the age of fifteen.

Instead Regarding the "*Possession Of Narcotic And Psychotropic Substances And Poisons"*, it establishes that:

1) **Whoever** without authorisation **possesses for their own use in a quantity greater than small** the narcotic substance cannabis, cannabis resin (hashish), or a psychotropic substance containing in any form tetrahydrocannabinol, or an isomer or a stereochemical variant thereof (THC), shall be punished by **imprisonment for a term of up to one year, by prohibition of business activity, or by forfeiture of an item of property or asset.**
2) **Whoever** without authorization **possesses for their own use** a narcotic or psychotropic substance other than that stated in subsection 1 or a poison in a **quantity greater than small shall be punished by imprisonment for a term of up to two years, by prohibition of business activity, or by forfeiture of an item of property or asset.**

3) **Offenders under subsections 1 or 2 above shall be punished by imprisonment for a term of between six months and five years**, or by a fine, if they committed such a crime on a significant scale.
4) **Offenders under subsections 1 or 2 above shall be punished by imprisonment for a term of between two and eight years** if they committed such a crime on a substantial scale.

We point out that it would seem that the Czech Republic is preparing a law that considers marijuana a medicine that can be safely consumed by people affected by serious diseases (cancer, multiple sclerosis and terminally ill). The newspapers of the Czech Republic, speaking on the bill, say that the drug will be cultivated directly by the State in private establishments with a government license or imported from abroad, more particularly the Netherlands. The new type of medical cannabis will then be distributed in pharmacies and medical practices in order to avoid the black market.
Therefore, the Czech Republic has the most liberal legislation in terms of variety and quantity of substances allowed, in Europe
The logic behind decriminalizing drug possession is to treat drug addiction as a public health problem rather than a criminal one.

1.2. NETHERLANDS

The basic legislative document of Dutch legislation is the **Netherlands' 1995 white paper Drug policy.**
This white paper, which addresses only illegal drugs, includes **several specific strategies**: dismantling ecstasy production locations (2001); stopping cocaine trafficking by drug couriers using airplanes (2002); and dismantling large-scale cannabis cultivation (2004); on a national level, police and prosecutors set priorities for law enforcement, which involve the fight against organized crime with regard to heroin, cocaine, synthetic drugs and cannabis (2008).
Regarding the Netherlands' 1995 white paper Drug policy, it states the basic principles of Dutch drug policy: a distinction between soft and hard drugs; a balanced and integrated approach; and four major objectives (to prevent drug use and to treat and rehabilitate drug users; to reduce harm

to users; to diminish public nuisance by drug users, and to combat the production and trafficking of drugs)[5].
Moreover is interesting to note that in the Netherlands only a few laws and regulations are primarily directed towards drugs, but many other laws with a broader scope are important in relation to illegal drugs[6]:

1) Drug laws and regulations:

-Opium Act (Opiumwet) – (criminal law)**.** The Dutch Opium Act (1928), or Narcotics Act, is a partly criminal law. It was fundamentally changed in 1976, when a distinction was made between drugs presenting unacceptable risks (hard drugs) and drugs like cannabis (soft drugs), which were seen as less dangerous. Since then, the Opium Act has been amended on various occasions (in particular we will shortly analyze an amendment of 2006) but its basic structure has been maintained.
-Opium Act Decision (Opiumwetbesluit) (Royal Decree)
-Opium Act Directives (Directive of Public Prosecution Service)
-Victor Act (Wet Victor) – (criminal law/administrative law)
-Regulation Heroin Treatment – (ministerial regulation)

2) Laws and regulations with indirect importance for illegal drugs:

-Prisons Act (Penitentiaire Beginselenwet) - (criminal law)
-Conditional Release Act – (criminal law)
-Placement in an Institution for Prolific Offenders Act (Plaatsing in een inrichting voor stelsel-matige daders – ISD) - (criminal law)
-Abuse of Chemical Substances Prevention Act (Wet Voorkoming Misbruik Chemicaliën) - (chemical precursors – administrative law).
-Public Administration Probity Screening Act (Wet bevordering integriteitsbeoordelingen door het openbaar bestuur or Wet Bibob) - (money laundering – administrative law)
-Health Insurance Act (Zorgverzekeringswet) (health law)
-Medicines Act (Geneesmiddelenwet) (health law)
-Collective Prevention Public Health Act (Wet collectieve preventie volksgezondheid) (health law)

[5] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/nl
[6] REPORT TO THE EMCDDA, by the Reitox National Focal Point, THE NETHERLANDS DRUG SITUATION 2009 FINAL VERSION , As approved on 18-12-2009 by the Scientific Committee of the Netherlands National Drug Monitor (NDM).

-Community Support Act (Wet Maatschappelijke Ondersteuning - WMO) (health law)
-Plan of approach for social relief (Plan van aanpak maatschappelijke opvang) (policy letter)
- Combatting organized crime (Bestrijding Georganiseerde Misdaad) (policy letters)

In 2006, an amendment to the Opium Act was proposed. Until then, article 13b of the Opium Act combined with article 174a of the Local Government Act could only be used to close premises used for the sale of illegal drugs, if *disturbance of public order* could be proved. In April 2006, a proposal was sent to Parliament, in which *only the sale* of illegal drugs has to be proved. The scope of this bill includes the sale of hard drugs as well as the illegal sale of cannabis. The tolerated sale of cannabis in coffee shops falls outside the scope of this bill. In practice, in these cases law enforcement will be used proportionately. That means that the closing of premises will be the ultimate sanction in a chain of sanctions. In November 2007 this law came into effect. It falls within the jurisdiction of the local authorities to use this new instrument of administrative coercion[7].
An evaluation and revision process for Dutch drug policy was conducted throughout 2009 and 2010 to create a new policy document. Recently we could assist at a change in strategy: it was proposed a law that was intended to prohibit the sale of cannabis in the Netherlands and other soft drugs to foreigners. From 1 May 2012, three Dutch provinces in the south, Zealand, North Brabant and Limburg (on the border with Belgium and Germany) have applied the ban, with the expectation that it would be extended by the end of 2012 to all the provinces of the country. The new law, among other things, provides that customers of the seven hundred Dutch coffee shop should prove to be resident in the Netherlands showing a specific card issued only to Dutch and foreign residents in order to prevent access to coffee shops to foreigners. However, on November 2012 the Justice Minister, Ivo Opstelten, informed the Parliament that the measure will be modified and that it is up to each local authority to decide whether to keep or not free access to soft drugs offered by the "coffee shop" inside their territories. It is necessary, therefore, to monitor regulatory changes in the Netherlands.

[7] REPORT TO THE EMCDDA, by the Reitox National Focal Point, THE NETHERLANDS DRUG SITUATION 2009 FINAL VERSION , As approved on 18-12-2009 by the Scientific Committee of the Netherlands National Drug Monitor (NDM).

1.3.SPAIN

In June 2010 Spain modified its Penal Code for drug-related offences.

1.The most significant change was the creation of a separate penal category for **drug offenses committed by organized criminals**.

a) For **drugs causing serious physical harm** (a distinction made under Spanish law), prison sentences range from 9-12 years with fines up to four times the value of the confiscated drugs.
b) For **all other drugs**, 4.5-10 years and fines of double the drug value may be imposed.

2. For those not connected with organized crime, Spain actually

(a) shortened the maximum incarceration period from 3-9 years (serious harm drugs) to 3-6 years for drugs causing serious physical harm and
(b) to 1-3 for other drugs.

Judges now also have the option to deport foreign non-resident aliens sentenced to less than six years. Shorter sentences and deportation are designed to deal with Spain's "drug mule" phenomenon. Today, non-resident aliens account for 28 percent of the Spanish prison population[8].
In any case, the **Law on protection of citizens' security (1992) considers drug consumption in public, as well as illicit possession, as a serious order offence punishable by administrative sanctions.** Fines are the usual punishment, but the law foresees that the execution of the fine can be suspended if the person freely attends an official drug treatment program[9].
The approval of **the Law 1/2008 of December 4** for executing resolutions in the European Union that impose pecuniary sanctions and by virtue of which *the Marco Decision 2005/214/JA1, of the Council, February 24 2005, relating to the application of the principle of the mutual recognition of pecuniary sanctions* was incorporated into the Spanish, has been very important.

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[8] *The 2011 International Narcotics Control Strategy Report (INCSR),* http://fulltextreports.com/2011/03/04/2011-international-narcotics-control-strategy-report-incsr/

[9] European Monitoring Centre for Drugs and Drug Addiction, http://www.emcdda.europa.eu/publications/country-overviews/es

In the sphere of control of narcotics the approval of the *order SCO/1870/2008 of June 17 by which the substance oripavina is included in the list I annex of the Unique Convention of 1961 on drugs* must be noted.
Within the same sphere, the approval of the *Order ITC/426/2008 February 13, concerning the regime of control of importation of cannabis seeds not destined for planting* is also notable.
In the matter of drug dependency prevention *Order ESD/1729/2008 June 11 by which the Law is regulated and the curriculum of secondary education ("bachillerato") qualification is established* must be mentioned.
Insofar as the prevention of laundering capital in general is concerned, including, therefore that which comes from illegal drug trafficking, it is necessary to refer to *the Law EHA/114/2008 January 29 the regulator of the observance by specific notary obligations in the field of the prevention of laundering capital.*
Finally in the paragraph of Administrative Organization note the *Royal Decree 185/2008 February 8 by which the Statute of the State Agency of Anti-doping is approved*[10] is noteworthy.
For trafficking, the Spanish law lays down penalties in line with the seriousness of the health damages associated with specific drugs and any aggravating and mitigating circumstances that may exist. **Penalties can reach up to 20 years and three months in prison,** with such long terms reserved for cases with aggravating circumstances such as sale to minors under 18, or the sale of large quantities (over 500 doses).

1.4. UNITED KINGDOM

The main law regulating drug control in the UK is **The Misuse of Drugs Act 1971,** with amendments. It is an Act of Parliament which represents UK action in line with treaty commitments under the Single Convention on Narcotic Drugs, the Convention on Psychotropic Substances, and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. No such Treaty is however in any way binding on the UK Courts or Parliament and these have not been incorporated into UK law.

[10] 2009 NATIONAL REPORT (2008 data) TO THE EMCDDA by the Reitox National Focal Point "SPAIN" New Development, Trends and in-depth information on selected issues.

The Misuse of Drugs Act 1971 divides controlled substances into **3 Classes (A, B, C) based on harm, with Class A being the most harmful.** These Classes provide a basis for attributing penalties for offences.
Substances may be removed and added to different parts of the schedule by statutory instrument, provided a report of the Advisory Council on the Misuse of Drugs has been commissioned and has reached a conclusion, although the Secretary of State is not bound by the council's findings.
Maximum penalties vary not only according to the Class of substance but also whether the conviction is a summary one made at the Magistrate's Court or one made on indictment following a trial at the Crown Court[11].
Offences under the Act include:

1. Possession of a controlled drug unlawfully;
2. Possession of a controlled drug with intent to supply it (this latter is effectively for drug trafficking offences);
3. Supplying or offering to supply a controlled drug (even where no charge is made for the drug);
4. Allowing premises you occupy or manage to be used unlawfully for the purpose of producing or supplying controlled drugs;

The important point to understand is that **personal drug use is not an offence under the Misuse of Drugs Act 1971: it is the possession of the drug which constitutes an offence.**
The penalties for drug offences depend on the class of drug involved. These penalties are enforced against those who do not have a **valid prescription or licence to possess** the drug in question. Thus it is not illegal for someone to possess heroin, a class A drug, so long as it was administered to them legally (by prescription). Class A drugs attract the highest penalty, and imprisonment is both "proper and expedient". The maximum penalties possible are as follows[12]:

[11] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://webarchive.nationalarchives.gov.uk
[12]Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://webarchive.nationalarchives.gov.uk

	POSSESSION	DEALING	
Class A	Ecstasy, LSD, heroin, cocaine, crack, magic mushrooms, amphetamines (if prepared for injection).	Up to seven years in prison or an unlimited fine or both.	Up to life in prison or an unlimited fine or both.
Class B	Amphetamines, Cannabis, Methylphenidate (Ritalin), Pholcodine.	Up to five years in prison or an unlimited fine or both.	Up to 14 years in prison or an unlimited fine or both.
Class C	Tranquilisers, some painkillers, Gamma hydroxybutyrate (GHB), Ketamine.	Up to two years in prison or an unlimited fine or both.	Up to 14 years in prison or an unlimited fine or both.

So for the unlawful possession of Class A drugs such as heroin or cocaine involve penalties of up to six months' imprisonment or a fine; on indictment penalties may reach seven years' imprisonment.
Class B drugs such as cannabis and amphetamines attract penalties at magistrate level of up to three months' imprisonment and/or a fine; on indictment up to five years' imprisonment and/or an unlimited fine.
Possession of most Class C drugs, such as barbiturates attracts penalties of up to three months' imprisonment and/or a fine at magistrate level, or up to two years' imprisonment and/or an unlimited fine on indictment. There are also a number of alternative responses such as cannabis warnings and cautions from the police, who have considerable powers of discretion.
The act makes it a crime to **assist in, incite, or induce**, the commission of an offence, outside the UK, against another nation's corresponding law on drugs. A corresponding law is defined as another country's law "providing for the control and regulation in that country of the production, supply, use, export and import of drugs and other substances in accordance with the provisions of the Single Convention on Narcotic Drugs" or another drug control treaty to which the UK and the other country are parties. An example might be lending money to a United States drug dealer for the purpose of violating that country's Controlled Substances Act.
Additionally, really the **Drug Trafficking Act 1994,** that is an Act of the Parliament of the United Kingdom is very important. It largely replaced the Drug Trafficking Offences Act 1986. The Drug Trafficking Act 1994 **defines drug trafficking as transporting or storing; importing or exporting;**

manufacturing or supplying drugs covered by the Misuse of Drugs Act 1971.

Where the defendant is convicted of a drug trafficking offence and the prosecutor applies to the Crown Court for a confiscation order, the court must determine whether the defendant has benefited from drug trafficking.

If at any time the defendant has received any payment or other reward in connection with drug trafficking carried out by him or another he will be deemed to have benefited from drug trafficking and the court must make a confiscation order.

The **penalties applied depend again on the classification of the drug and on the penal procedure** (Magistrate level or Crown Court level). For trafficking in Class A drugs, the maximum penalty on indictment is life imprisonment, while trafficking of Class B and C drugs can attract a penalty of up to 14 years in prison. In 2000, a minimum sentence of seven years was introduced for a third conviction for trafficking in Class A drugs. Two drug court pilots were opened in Scotland in 2002 and England in 2005, and four more were announced in April 2008 after an evaluation indicated they could have a positive impact on reoffending, court attendance and compliance by offenders.

The Drug Trafficking Act 1994 came into force on 3 February 1995 and any benefit received by the defendant in connection with drug trafficking prior to that date must be included when calculating the defendant's benefit.

Finally, the **Response to Consultation about Drug Offence of the Sentencing Council** is very interesting. The Sentencing Council, set up in April 2010, is the independent body responsible for developing sentencing guidelines and promoting greater transparency and consistency in sentencing, whilst maintaining the independence of the judiciary[13].

In March 2011, in accordance with section 120 of the Coroners and Justice Act 2009, the Sentencing Council published a consultation on draft guidelines on the sentencing of drug offences.

As the guideline will be the principal point of reference in all drug offence cases in both the Crown Court and the magistrates' courts, the Council sought views on the draft guideline from as wide an audience as possible, including members of the judiciary, legal practitioners and organisations involved in the criminal justice system.

Final guidelines include:

[13] http://sentencingcouncil.judiciary.gov.uk/docs/Drug_Offences_Response-(web).pdf

a) In relation to *Drug mules*: they are defined as *"poor, foreign people who have imported drugs in circumstances falling short of legal defense of duress but which have elements of coercion and in which personal profits are minimal".* The starting point for sentencing is reduced from 10 years to 6 years in most cases. On this point there are conflicting arguments: the principal considers the given range of 5-7 years to be a disproportionate punishment for this type of offence; with regard to this there are conflicting opinions.

b) Possession offences: the initial proposal was that both the quantity and class involved should determine the sentence; instead the final guideline establishes that possession offenses are to be sentenced based only on the Class of drug.

1.5. ALBANIA

The Republic of Albania **has adopted and implemented a complete and contemporary national legislation**, which is summarized in the following laws[14]:

a. **Law No 7975, dated 21 July 1995** 'On narcotic and psychotropic substances' (*Official Gazette of the Republic of Albania No 20*, 25 August 1995, p. 853), amended by Laws: No 9271 dated 9 September 2004; No 9559 dated 8 July 2006. This law contains the list of psychotropic drugs and defines the rules of production, manufacturing, import and export of psychotropic substances.

b. **Law No 7895, dated 27 January 1995** 'On the Penal Code of the Republic of Albania' (*Official Gazette of the Republic of Albania No 2*, 16 March 1995, p. 23), amended by Laws: No 8279 date 15 January 1998; No 8733, date 24 January 2001; No 9275, date 16 September 2004.

c. **Law No 8750, dated 26 March 2001** 'On the prevention and combating of illicit trafficking of narcotic drugs and psychotropic substances' (*Official Gazette of the Republic of Albania No 14*, 13 April 2001, p. 391), defines the standards for the prevention and combating of illicit trafficking of drugs and their precursors. The creation and functioning of the National Committee for Coordination of the Fight against Drugs is foreseen in this law.

[14] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/al

d. **Law No 8874, dated 29 March 2002** 'On the control of substances that can be used for illicit manufacturing of narcotic and psychotropic substances' (*Official Gazette of the Republic of Albania No 12*, 29 April 2002, p. 359), defines the rules for the control of substances that are often used for the illicit manufacturing of narcotic and psychotropic drugs, with the aim of preventing the supply or deviation from legal destination of such substances.

e. Important improvements were made to the **Albanian Penal Code since 2004,** such as changes regarding criminal organizations (Article 333) and structured criminal groups (Article 333/a). **Law No 7905, dated 21 March 1995 'Penal Procedural Code of the Republic of Albania'** (*Official Gazette of the Republic of Albania No 5*, 24 April 1995, p. 159). Important changes were also made to laws: No 8813, dated 13 June 2002; No 9187, dated 12 February 2004 with regard to the use of special investigation means, such as surveillance and interceptions (Articles 221, 222, 223, 224), simulation actions and infiltration (Article 294/a, 294/b).

With regard to international legislation, Albania has **adhered to the three UN Drug Conventions by adopting the following laws**[15]**:**

a. **Law No 8722, dated 26 December 2000** 'On the adherence of the Republic of Albania to the ''United Nations Convention against illicit traffic in narcotic drugs and psychotropic substances, 1988'(*Official Gazette of the Republic of Albania No 50*, 29 January 2001, p. 2156);

b. **Law No 8723, dated 26 December 2000** 'On the adherence of the Republic of Albania to the Single Convention on narcotic drugs of 1961, and that Convention as amended by the 1972 Protocol' (*Official Gazette of the Republic of Albania No 50*, 29 January 2001, p. 2190);

c. **Law No 8965, dated 7 November 2002** 'On the adherence of the Republic of Albania to the Convention on drug and psychotropic substances, 1971' (*Official Gazette of the Republic of Albania No 79*, 8 December 2002, p. 2254);

[15] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/al

The main elements of the Albanian legislation are:

1)Sanctions for persons committing drug related crimes:

a) 5–10 years of imprisonment for production, selling, distribution and possession of drugs;

b) 7–15 years for trafficking.

2)There is an **aggravating** situation: these sanctions are more severe if offences were committed in cooperation or by criminal organizations.

3)Penal sanctions are defined for illicit cultivation of narcotic plants (3-7 years of imprisonment) and trafficking or deviation of precursors (3–7 years of imprisonment).

4)Possession of a "daily dosage" of drugs for personal use is not punishable.

1.6. BELGIUM

In Belgium the major existing changes in the legal framework are the **modifications to the Narcotic Drug Act**. These changes have been mentioned in **two laws** (of 4 April and 3 May 2003) and **one Royal Decision** or 'Koninklijk Besluit' (KB) of May 16th 2003 (which is needed for the implementation of the law and to make the law operational in Belgium)[16].
The KB specifies three categories of criminal offences concerning drugs: 1) import, manufacturing, transport, buying and possession of narcotics and cultivating cannabis plants; 2) the same offences as under 1) but with aggravating circumstances; 3) other infractions of the Belgian Drug Law.
The two laws and the KB constitute the foundations of the Belgian legal framework on drugs and determine the illegal nature of drug possession and other infractions.
The legislative reform concerning the *use of drugs* and their possession for use took effect in June 2003 following the adoption of four new texts.
Two more minor changes have been applied to the Drug Law in 2006 but these changes did not alter the law significantly[17].

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[16] Sandrine, Sleiman, "Belgium National Report on Drugs 2003," Scientific Institute of Public Health, Epidemiology Unit (Brussels, Belgium: European Monitoring Center on Drugs and Drug Addiction, October 2003), p. 19.

[17] Sander de Bruijn*, European drug policy: the EU Drug Action Plan 2009 – 2012 and the Belgian drug policy,* Ghent University 2009 – 2010, p.11.

The underlying principle of this legislative reform is that the *application of the criminal* law as a response to illegal drug use should now constitute only a *last resort*.

Cannabis was differentiated from other illicit substances. Cannabis use (possession of a quantity of cannabis that can be used on a single occasion or at most within 24 hours – i.e. 3 grams) will thus involve a police registration. Therefore **not even a police report**, by the police forces is required when: 1) the **possession of cannabis doesn't exceed the amount for personal use**; 2) this possession is **not accompanied by public nuisance** and 3) the possession is not accompanied by **problematic (ab)use of the drug**.

This means there will be no prosecution, no treatment or settlement when these conditions are respected because the police will not submit the case to the prosecutor. Though in theory the act remains a criminal offence although there will be no punishment of any kind which *de facto* depenalises cannabis possession[18].

The two concepts of 'problem drug use' and 'public nuisance' were introduced. In the case of 'public nuisance' or 'problem use', a standard record (of the place, date and time of the relevant facts, type of substance and form of use) is drawn up and the substance is confiscated. For public nuisance stricter measures may also be imposed, such as three months' to one year's imprisonment and a fine of €5 000 to €500 000, or only one of these penalties. The law confirms that the possession and cultivation of cannabis remain offences, and provides for increased penalties for illicit production or trafficking. The law is based on the *principle of deterrence from all drug use*, including recreational use by adults. It is expressly stated that use by adults in the presence of minors will be treated more severely, with custodial penalties[19].

For drugs other than cannabis, Belgian law punishes possession, production, import, export, or sale by imprisonment for between three months and five years and/or a fine. There is no separate offence of 'trafficking', but the term of imprisonment may be increased to 15 or even 20 years in the event of specific aggravating circumstances.

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[18] Sander de Bruijn*, European drug policy: the EU Drug Action Plan 2009 – 2012 and the Belgian drug policy,* Ghent University 2009 – 2010, p.12.

[19] European Monitoring Center on Drugs and Drug Addiction, "Illicit drug use in the EU: legislative approaches" Lisbon, Portugal: (EMCDDA, 2005), p. 15.

1.7. GERMANY

The key disciplinary procedure in the field of illegal drugs is contained in the **Law of 10 January 1972** (Gesetz ueber mit den Verkher Betaubungsmitteln - Betäubungsmittelgesetz Bt MG), that makes a clear distinction between hard drugs (Hart) and soft drugs (Weiche).
This law was the subject of **two major revisions in 1981 and 1994**. Most of its provisions are based on the principles enshrined in International Conventions such as those adopted by the UN in 1961 and 1971 (Single Convention on Narcotic Drugs, NY 3 / 1961 - Convention on Psychotropic Substances, Vienna, 21.2.1971 - Convention against Illicit Traffic in Narcotic Drugs and psychotropic Substances, Vienna 20.12.1988 (ratified by Germany on 30.11.1993).
The **primary objective** of the German legislation is the **protection of human health** since all drugs can be addictive and pose a serious health hazard.
On **25 June 2003**, the federal government has launched a new action plan (**Action Plan on Drugs and Addiction**) to combat drugs for a period of 10 years, based on four fundamental principles: 1) Prevention - 2) Advice and assistance - 3) Therapy and harm reduction to health - 4) Repression and supply reduction of illicit drugs.
Under German law**, unauthorised possession of drugs is a criminal offence.** Nevertheless, there are various possibilities within the law to **abstain from prosecution if only small quantities of narcotic drugs for personal use** are involved. Important criteria for such a decision are the **amount and type** of drugs, **involvement of others, personal history, and public interest in prosecution**. When a sentence is given, the principle 'treatment instead of punishment' still allows a reduction or remission of the punishment if the offender undergoes treatment instead of imprisonment.
Since 1981, the increasing number of drug addicts and drug-dependent offenders has led to the inclusion of detailed provisions on activities in the Narcotics Act to reduce the demand for narcotics and to reduce drug-related harm. These include the legal bases for 'therapy instead of punishment' (1981), substitution-based treatment and distribution of sterile disposable syringes (1992), the prerequisites for the establishment of drug injecting rooms at the discretion of the Federal Länder (2000) and diamorphine-assisted substitution treatment in 2009. The illicit trafficking, cultivation and manufacture of narcotic drugs carry penalties of 1–15 years' imprisonment. Aggravating circumstances include 'not insignificant'

quantities of narcotic drugs; an adult supplying narcotics to a person under the age of 18 years; someone trafficking narcotics 'professionally' or as a member of a gang; or, when committing a serious drug-related offence, carrying a weapon.
The Act on diamorphine-assisted substitution therapy entered into force on 21 June 2009. It created the legal preconditions for a transfer of the diamorphine-assisted therapy into regular care by changing the Narcotics Act, the Medical Products Act and the Regulation on the Prescription of Narcotic Drugs.
In 2010, additional legal provisions were passed to regulate availability of therapy through the statutory health insurance and promote appropriate training among medical professionals[20].

1.8. FRANCE

The regulatory framework of the French policy on drugs is established in **Law No. 70-1320 of 31 December 1970**.
At the time of its adoption the three goals that the legislature had set itself were:

1. strict enforcement of traffic,
2. prohibition of drug use and an alternative proposal for the repression of drug use,
3. free medical care to needy consumers and anonymous of treatment.

The main point is that "use" or "**possession"** of illegal drugs is a **criminal offence**. The law itself **does not distinguish between possession for personal use or for trafficking, nor by type of substance**. However, judicial authorities may take into consideration the nature of the substance, the quantity and any prior criminal records in their decision to prosecute, reduce the charges or not prosecute an offender. An offender charged with personal use only faces a maximum prison sentence of one year and a fine of up to EUR 3 750, though prosecution may be waived[21].
The Act of 1970 has not so far been substantially altered even if in the meantime the Ministry of Justice has undertaken a **number of directives to**

[20] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/de#nlaws
[21] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/fr#nlaws

harmonize its practical application: in particular, very important is **the Circular of 17 June 1999**, because the Ministry of Justice, in that Circular, asked prosecutors to prioritize treatment over incarceration for small-time offenders and problematic drug users. Practice has shown that therapeutic alternatives are used mainly for simple users and that most cases of simple drug use receive a warning with the recommendation that a social or health service is contacted. When legal proceedings are undertaken, the magistrate may also force, and not simply order, the accused to undertake a detoxification program but in this case, judicial authorities take charge of the case rather than health authorities. In these cases, if the user completes the treatment, no penalties may be imposed on the individual but the use of such measures are extremely rare.

The next **Law 99-515 of 23 June 1999** proposing alternatives to prosecution through a so-called "settlement" which provides the possibility of not resorting to criminal proceedings for a number of minor offences.

Voluntary payment of a fine or non-remunerated work useful to society may be alternatives to prosecution, but there are more complex circumstances, such as those involving drivers or those in educational establishments, as well as recidivists, where prison might be considered. Users in simple cases may receive a caution, but this should usually be accompanied by a request for a compulsory drug awareness course.

Prosecutors may also prioritise **treatment approaches** for small-time offenders, both those related to personal drug use or other minor crimes.

A circular to prosecutors in 2005 stated that any legal action before the magistrates' courts must remain exceptional, but a new circular of 9 May 2008 defined a new "rapid and graduated" policy. Addicts would continue to receive the therapeutic injunction, directing them to treatment.

Drug trafficking is punishable with imprisonment of up to 10 years, or up to life in prison in the case of particularly serious offences, and a fine of up to EUR 7 600 000.

1.9. POLAND

The Polish legislation has always been considered one of the strictest regarding drugs. However, **on 9 December 2011 an important change in national** drug policy **has been introduced**: an amendment to the law on illegal possession of drugs has come into force.

Previous situation: Drug addiction in Poland is regulated by the **Act of Law of 29 July 2005** on counteracting drug addiction. The act generally has a preventive and treatment-oriented character, and the stipulated sanctions

should not be used against problem drug users. **This is in contrast to the previous formulation of drug law, wherein any possession of drugs - even a small amount for personal use - was penalized.**
In minor cases, the offender was fined or ordered to serve a sentence involving limitation of liberty or deprivation of liberty of up to one year. The court could, however, also decide to oblige a sentenced drug user to undergo treatment.
Following the amendment, however, there are important innovations. The amendment, in fact, **would allow lawyers to give the commencement of criminal proceedings against those who possess illegal drugs**.
This is possible in the presence of **three conditions:**

1. if the defendant is in **possession of small amounts of drugs**;
2. if the drug is held for **personal use only**, and
3. if the **punishment would be useless** for the harmless nature of the offense.

Possession of drugs is illegal, but from now on it will be for the lawyer to decide depending on the particular case whether it is to be treated as a crime or offence.
This is definitely a very important step, but the new amendment will certainly be reviewed because of the lack of a definition of "small quantities of drugs."
Trafficking of drugs is penalized by a fine and deprivation of liberty of between 6 months and 8 years. In the case of a minor offence, the perpetrator may be fined, subjected to limitation of liberty, or imprisoned for a maximum of one year. In cases where the amount of drugs is substantial, the perpetrator may be subjected of a fine and the penalty of deprivation of liberty for a term up to 10 years[22].

[22] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/pl

1.10. SWEDEN

The first official narcotics law came with the **Edict on Narcotic Drugs**, or *Narkotikakungörelsen*, in 1923 when Sweden joined the International Opium Convention. The law regulated the import and export of some opiates and cocaine. In 1930 the law was extended to include more opium derivatives, coca leaves and cannabis, and possession was restricted as well. Initially, the punishments consisted of fines.

In the 50s there were signs of emerging drug use among criminals in Stockholm. On the 27th of April in 1954 the first debate was held in the Riksdag, the Swedish Parliament. The center-right opposition had filed a interpellation regarding the drug problem. The issue discussed was whether the government considered that drug use justified an increased vigilance by society and, if so, if a change in the laws to rectify the problem was necessary. The Riksdag believed that further debate was unnecessary since information, collected from The Medicinal Board and The Police, stated that drug abuse was not a serious problem in Sweden.

In 1958 the punishments became more repressive, setting a minimum fine and introducing up to 6 months imprisonment as a possible penalty. **In 1962 the law was superseded by the Decree on Narcotic Drugs, *Narkotikaförordningen*, which increased the maximum prison term to two years.**

In 1965, the maximum term was reduced to one year. There were signs that drug use were increasing, and the Social Welfare Agency argued that police should have more resources, with the hope that a stricter enforcement would have a preventative effect[23].

Today the use and possession of illegal drugs are criminal offences under the **Narcotic Drugs Punishment Act.**

The Drug policy of Sweden is one of zero tolerance, including cannabis, focusing on prevention, treatment, and control, aiming to reduce both the supply of and demand for illegal drugs[24].

The term *narcotic drugs* refers to all pharmaceutical substances controlled under the provisions of the Narcotic Drugs Act and listed on the Narcotic Drug Schedules issued by the Swedish Medical Products Agency. These schedules contain all internationally controlled substances and some

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[23] Boekhout van Solinge, Tim (1997), *The Swedish drug control policy. An in-depth review and analysis.* Amsterdam, Uitgeverij Jan Mets/CEDROv

[24] Welcome speech by Ms Maria Larsson at the opening ceremony of The World Forum Against Drugs, http://www.sweden.gov.se/sb/d/8018/a/110658

additional substances, such as KHAT (leaves and branches from *Catha edulis*). The use of Schedule I drugs (*Cannabis*, LSD, HEROIN, MDMA, khat etc.) is prohibited, even for medical purposes.

Use and possession are punished according to **three degrees of severity for drug offences: minor, ordinary and serious.**

1. Petty offenses involving possession of small amounts of the drug punishable with a fine or imprisonment for a maximum of six months.
2. Narcotic offenses, which might entail selling ("pushing") drugs on the streets, carry a maximum of three years imprisonment.
3. Grave (serious) narcotic offenses, such as the import of large amounts of illicit drugs or the production and sale of narcotics. These offenses are punishable by imprisonment for two to ten years[25].

The degree of offence takes into consideration the nature and quantity of drugs and other circumstances.

The penalties for drug trafficking offences regulated in the **Law on Penalties for Smuggling** are identical with the penalties provided in the Narcotic Drugs Punishment Act.

Sweden also operates a system of classifying substances as “Goods dangerous to health”, which may be used to control goods that, by reason of their innate characteristics, entail a danger to human life or health and are being used, or can be assumed to be used, for the purpose of intoxication or other influence. The import of such goods is punished in the same way as for drugs offences, whereas their possession and transfer will be punished by up to one year imprisonment. A new bill was introduced in 2010 to enable confiscation and destruction of so-called ‘new psychoactive substances’. In addition, turnover of a number of new psychoactive substances was put under the control of the Swedish drug laws (classified us narcotic drugs and/or goods dangerous for health) in 2009–10[26].

[25] http://www.enotes.com/sweden-drug-use-reference/sweden-drug-use

[26] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/se#nlaws

REFLECTIONS

Analyzing 10 countries in the sample and excluding momentarily Portugal and Italy, which are discussed below, it can be seen that these states, territorial neighbors, provide very different regulations in the fight against drugs: just think on the one hand of the Czech Republic, which does not punish the possession of a quantity of drugs, regardless of the type (if intended for personal use) as opposed to countries such as France, which by contrast, do not distinguish between personal use and trafficking.

Based only on the legislative provisions, however, it is not possible to determine whether a law is or is not better than another, as it is necessary to analyze the strategy as a whole in order to understand how the rule is applied and which aspects are supported (preventive, treatment, rehabilitation).

In fact it is important to assess how prevention, treatment and rehabilitation are structured, by which body they are managed and check as the abstract rule is supported by them in its implementation phase.

Just think of the different effects produced by the Italian and Portuguese legislations, which, starting from common assumptions (to punish personal use with administrative sanctions) produce totally different effects because they have a different overall approach (very structured in the case of Portugal and totally lacking in the case Italy).

2. NATIONAL DRUG STRATEGIES

A drug policy, or drug strategy, is a comprehensive and coordinated body of preventive, educational, therapeutic, social, regulatory, control, and other measures, including law enforcement, carried out at the international, national, regional, and local levels.
Usually its purpose is to secure health and the protection and safety of individuals, society, and property from health, social, and economic harm and the consequences of drug-related crime.
To achieve that purpose each nation chooses a strategy that in its opinion will succeed.

2.1. CZECH REPUBLIC

The **National Drug Policy Strategy for the Period 2010 to 2018** was adopted by virtue of Government Resolution No. 340 on 10 May 2010. It is the fifth strategic document on Czech drug policy since 1993, the year when the first drug policy programme, for the period 1993 to 1996, was conceived.
It updates the previous strategies in accordance with the latest scientific knowledge on the phenomenon of drug use, its consequences, and efficient solutions to the problems related to drug use. The 2010-2018 National Strategy, moreover, defines the basic starting points for and directions of the measures aimed at dealing with the drug problem and the principles and approaches which the drug policy is based on.
In addition, the strategy includes a set of measures designed to accomplish the objectives which is further elaborated in the action plans for the implementation of the 2010-2018 National Strategy, including the quantification/identification of resources necessary for putting it into practice.

The strategy is comprehensive and is based on four pillars:

1. **prevention,**
2. **treatment and resocialisation,**
3. **risk reduction,**
4. **supply reduction.**

The focus is mainly on illegal drugs but with some scope to address other drugs (alcohol, prescription drug misuse), if necessary. The strategy has **two main goals**[27]**:**

a. to **combat organized crime associated** with the unauthorised handling of drugs and to enforce the observance of laws in connection with the distribution of licit drugs;
b. to **reduce the use of all types of drugs** and potential risks and damage that may affect individuals and society as a consequence of drug use.

The action plan covers seven policy fields (primary prevention, treatment and aftercare, harm reduction, drug supply reduction and law enforcement, information/research/evaluation, coordination and funding, international collaboration) and contains 172 different objectives.
Finally, it is interesting to note that the Czech Republic's drug policy is underpinned by two central concepts, which complement each other rather than being contradictory:

a. **Protection of public health.**
b. **Protection of the safety of individuals and society.**

2.2. NETHERLANDS

As previously mentioned, the Netherlands' 1995 white paper Drug policy had formulated the basic principles of Dutch drug policy: a distinction between "soft" and "hard" drugs; a balanced and integrated approach; and four major objectives, that are:

a. to prevent drug use and to treat and rehabilitate drug users;
b. to reduce harm to users;
c. to diminish public nuisance caused by drug users;
d. and to combat the production and trafficking of drugs.

So, the Dutch policy emphasizes compassion and treatment for those who develop drug use problems, because public health is the overriding concern. Using this pragmatic approach, the government sets clear priorities based on the perceived risks of particular drugs.
One can perhaps better understand the entire system if we focus on one aspect that is not present in every system, but that is perhaps the best key

[27] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/cz;

to understanding the legal system of the Netherlands[28]. This is the **"concept of opportunity"** in the criminal law of the Netherlands, according to which, for reasons that concern the public interest can desist from prosecuting a crime. In practice, when a behavior that violates the law (a crime) does not undermine public order, the prosecutor may decide not to pursue it. The guidelines on when and when not to punish such crimes are published in a public document of the Public Ministry.

This explains why, despite the production and sale of drugs being prohibited, coffee shops - which comply with the strict conditions that minimize the risk to the community - have the opportunity to sell cannabis.

The existence of a **liberal, but still rigorous**, **regime,** for the controlled sale of cannabis use is justified by the objective of achieving a division of markets, aimed at preventing cannabis users coming into contact with environments in which you use hard drugs. It is, therefore, addressed towards the alleged link between soft drugs and hard drugs, under which the former would lead to use of the latter.

A key aspect of Dutch drug policy, in fact, is the notion of **market separation.** By classifying drugs according to the risks posed and then pursuing policies that serve to isolate each market, it is felt that users of soft drugs are less likely to come into contact with users of hard drugs. Thus, the theory goes, users of soft drugs are less likely to try hard drugs. Possession of small amounts of cannabis for personal use has been decriminalized in the Netherlands. The sale of cannabis is technically an offence under the Opium Act, but prosecutorial guidelines provide that proceedings will only be instituted in certain situations.

An operator or owner of a coffee shop (which is not permitted to sell alcohol) **will avoid prosecution if he/she meets the following criteri**a:

1. no more than 5 grams per person may be sold in any one transaction;
2. no hard drugs may be sold;
3. drugs may not be advertised;
4. the coffee shop must not cause any nuisance;
5. no drugs can be sold to minors (under age 18), nor may minors enter the premises;

[28] See for an extensive analysis of the beginning of modern Dutch drug policy Ed Leuw: "Initial construction and development of the official Dutch drug Policy". In Ed Leuw and I. Haen Marshall (Eds.) *"Between Prohibition and Legalization. The Dutch Experiment in Drug Policy".* Kugler Publications Amsterdam / New York 1994.

6. the municipality has not ordered the establishment closed.

Separating the markets by allowing people to purchase soft drugs in a setting where they are not exposed to the criminal subculture surrounding hard drugs is intended to create a social barrier that prevents people experimenting with drugs like heroin, cocaine and methamphetamine; drugs deemed an "unacceptable risk."

2.3. SPAIN

A new **Spanish National Drug Strategy (2009–16)** was adopted in early 2009 and it was complemented in October of that year by a new drugs action plan 2009–12. It starts from an institutional framework established since the creation of the National Plan on Drugs in 1985. Coordination and collaboration between the national civil service (in Spanish, Administración General del Estado) and the regional administrations (in Spanish, Administraciones Autonómicas) play a fundamental role at the heart of the framework.

The Spanish National Drug Strategy (2009–16) rejects the socially accepted image of drug use as associated with leisure. It also demands the regulation of professional assistance to the users as well as the guarantee of health services. The Strategy also proposes to create a **therapeutic circuit** in direct connection with social and work services by including drug abuse prevention in the health programs, the improvement of risk and harm reduction programs, the improvement of specific attention to dual pathology programs, prioritization in sensitive scenarios such as prisons as well as populations at risk. Finally the National Strategy supports the culture of program evaluation, research and development as well as the immediate transference of scientific findings to the field of clinical practice[29].

The strategy, which is comprehensive and focuses on illicit drugs, alcohol and other substance, has **five fields of action**:

1. demand reduction (The area of action for demand reduction ranges from health promotion to strategies for prevention of use and associated problems and encompasses risk and harm reduction, and social care insertion).

[29] Spanish National Drug Strategy (2009–16), Edita: Delegación del Gobierno para el Plan Nacional sobre Drogas, NIPO.: 351-09-046-7 , Depósito legal: M-27343-2009

2. supply reduction;
3. improvement of basic and applied scientific knowledge;
4. training;
5. and international cooperation.

Two specific chapters of the strategy are also devoted to its coordination and to its evaluation. The strategy has **several objectives**, including diminishing the use of legal and illegal drugs, to delay the age of initiation of contact with drugs, to guarantee quality assistance, adapted to the needs of all people affected by drug use, to reduce or limit the harm caused to drug users health and to facilitate their social integration.
The complementary action plan includes **68 actions to be implemented until 2012** with a mention, for each action, of the responsible party as well as the indicator for evaluation and the corresponding data source.
Spain has also developed a **specific Action programme against cocaine 2007–10**.

2.4. UNITED KINGDOM

In early 2008, the UK Government published **a 10-year drug strategy** called "**Drugs: protecting families and communities".** The strategy focused mainly on illicit drugs and covered four broad fields: law enforcement; prevention; treatment and social re-integration; and communication[30].
A series of boards have been put in place to ensure that Cabinet Ministers, Junior Ministers and senior officials have oversight of the development, and delivery of the strategy.
At Cabinet level, the Home Affairs Cabinet Committee, chaired by the Deputy Prime Minister maintains oversight of drug treatment and enforcement.
In addition, the Social Justice Cabinet Committee, chaired by the Secretary of State for Work and Pensions also considers developments in relation to drugs and their impact on the wider issues of poverty and social justice.
Beneath this is the Public Health sub-committee, chaired by the Secretary of State for Health. At senior official level, there is a strategic board, led by the Home Office and made up of all relevant government departments.

[30] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://webarchive.nationalarchives.gov.uk

A number of powers are devolved to Northern Ireland, Scotland and Wales, and each of these countries has its own strategy based upon the UK strategy.

2.5. ALBANIA

During 2001, a technical working group of the Ministry of Health (namely the Institute of Public Health and the Clinical Toxicology Service of TUHC), with the technical support of Czech experts (under the Catching-up Czech Republic–Albania Project of the Technical Assistance Phase of the Drug Demand Reduction Programme), drafted the **first National Drug Demand Reduction Strategy for 2001–04**, which was approved by the Ministry of Health[31].

This strategy was incorporated in the subsequent **National Strategy Against Drugs 2004–10**, approved by the Decision of the Council of Ministers No 292 of 7 May 2004. The strategy is comprehensive and covers both drug demand reduction and drug supply reduction.

The strategy is drafted in such a way as to identify the goals and objectives. The experience of other European countries is analysed and referred. There is no doubt that drugs cannot be fought if they are considered a responsibility of only one institution.

The strategy recognises the serious nature of the drug problem at national and international level and admits that success might be achieved only by coordinating the efforts of all acting parties, namely the government, civil society and international partners. Furthermore, with the aim of implementing this strategy, the Prime Minister via Order No 156 of 23 September 2004 approved an **inter-institutional action** plan where all the relevant institutions/agencies/actors have taken their responsibilities and concrete duties for the period 2004–10[32].

There are four main pillars upon which this strategy is built:

1. **A balanced drug policy**
2. **Strategic coordination**
3. **Exchange of information**
4. **Delivery of services for the reduction in drug demand**

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[31] European Monitoring Centre for Drugs and Drug addiction, Albania, Country Overview 2009, (http://europa.eu).

[32] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/al

The action plan will be linked with other important national strategies such as health reform, National AIDS Strategy, amendment to the Criminal and Criminal Procedures Laws, anti corruption, juridical reform etc.

Overall objectives of the strategy include: reducing the supply of illegal drugs through improving the efficiency of law enforcement bodies; preventing drug abuse through the increase of public awareness on the risks of using drugs and the negative consequences of the use of psycho-active substances, as well as offering efficient and preventive services; reducing the volume of illegal trade in chemical substances used for illegal production of drugs; providing effective drugs policy coordination and management and establishing efficient information systems.

There is no clear information about the new National Strategy from 2011 onwards.

Nevertheless, 2010 is the last year covered by the strategy, and an interinstitutional working group is created by the Order of the Prime Minister No 125 from 9 June 2010 to draft a new strategy from 2011 onwards.

The **National Committee for Coordination of the Fight against Drugs**, under the Council of Ministers of the Republic of Albania and chaired by the Prime Minister, was established by Law No 8750 of 26 March 2001, 'For the prevention and combating against illicit trafficking of narcotic drugs and psychotropic substances' aiming at (a) implementing drug prevention and drug control policy; (b) organising implementation of drug prevention and drug control measures; (c) coordinating the activities of all governmental institutions and non-governmental organisations in the sphere of drug prevention and drug control. The Committee has met on several occasions to assess the drug situation in Albania. Following the instructions of 7 May 2003 of its Chairman, the Prime Minister, the Committee set up an inter-ministerial working group to compile a long-term national anti-drug strategy and an action plan for its implementation, which was drafted and approved during 2004 as indicated earlier in this overview[33].

[33] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/al

2.6. BELGIUM

In **January 2001**, the Government of Belgium released a **Political Note** in which it expressed the intention to modify the main drug law in order to make non-problematic use of cannabis non-punishable.
This policy document considers the drug problem as a public health matter and therefore as a health related issue.
The Note in fact stated the intention that "The criminal judge will no longer interfere in the lives of people who use cannabis on a personal basis and who do not create harm or do not show dependence." The production, supply, sale and ownership of larger quantities will remain actively prosecuted, as will the use of cannabis which leads to "unsociable behavior". Use and possession will still be prosecuted in cases involving minors, public nuisance, use in school premises, or in any place where the public order will be threatened[34].
The Belgian federal "Drug policy note" so forms the structure of Belgian drug policy and covers both illicit and licit drugs (i.e. alcohol, tobacco and some medicines). The strategy's main goal is to prevent and limit risks for drug users, their environment and for society as a whole.
The Drug policy note takes a **comprehensive approach** and is based on three pillars: (1) prevention of drug consumption, (2) harm reduction, assistance and re-integration and (3) enforcement. What is clear is that the main goal is to prevent and limit risks for drug users, their environment and for society as a whole[35].
It also envisages a system of coordination units on drugs at federal level represented by communities, regions and the federal state.
Moreover it is interesting to note that Belgium is a major supporter for Comprehensive **Operational Strategic Planning for the Police (COSPOL)**, which is a new methodology for multinational police cooperation. This program was created by the Police Chiefs Task Force functioning under direction of the European Union. Belgian and other EU police officials have discussed plans to share information in order to create a database of places indicating where illicit lab equipment and drug producing chemicals

[34] "Decriminalisation in Europe? Recent Developments in Legal Approaches to Drug use" (Lisbon, Portugal: European Monitoring Centre on Drugs and Drug Addiction, November 2001), pp. 3-4.
[35] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/be;

are shipped and manufactured. The database also includes information on the trade in drug related chemicals and laboratory materials.
Belgium also participates in "**Drugwatch**", a non-profit information network and advocacy organization that provides policymakers, media and the public with current narcotics information. In cooperation with "Drugwatch", Belgium is participating in a program focused on monitoring the internet to identify narcotic sale and production in Belgium[36].

2.7. GERMANY

Germany's Action Plan on Drugs and Addiction was adopted in June 2003 and replaced the plan to combat drugs, developed in 1990. The current action plan is comprehensive and covers four pillars: prevention, counselling and treatment; survival aid and harm reduction; controls (repression); and supply reduction[37].
It focuses on all psychotropic substances and on some special groups (children of addicted parents, high-risk groups, car drivers, consumers of different drugs) which have been identified and should be targeted specifically.
The Action plan is based on a **'balanced approach'** between law enforcement strategies and interventions to prevent, treat and reduce to a minimum the harm caused by drugs to the individual and to society.
The three main goals concerning drug consumers are:

1. to delay the start of consumption
2. to reduce high-risk use patterns early
3. to treat dependence with all available means

The focus on illicit drugs is placed on

1. avoiding or reducing consumption (demand reduction)
2. reducing the availability of illicit drugs and making access difficult (supply reduction)

[36] International Narcotics Control Strategy Report: Volume I Drug and Chemical Control," *Bureau for International Narcotics and Law Enforcement Affairs (Washington, DC: United States Department of State, March 2011), p. 132, http://www.state.gov/documents/organization/156575.pdf*
[37] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/html.cfm/index33533EN.html

In 2010, the Federal Government Commissioner on Narcotic Drugs called for development of a new national strategy on drug and addiction policy.

2.8. FRANCE

French drug policy is closely controlled by the government to achieve two main objectives: to ensure therapeutic efficacy and safety, and to control pricing. For a long time, these objectives are the objectives that France is aiming to achieve[38].

The French **"Action plan on drugs, tobacco and alcohol" (2008–11)** was adopted in July 2008. The plan includes measures covering many aspects of drug addiction.

The current plan is based on the evaluation of the plan 2004-2008 and is comprised of 193 measures: 38 measures on prevention and communication, 41 on law enforcement, 69 on treatment and reduction of risks associated with drug abuse, 30 on training and research and 15 at the international level[39].

A key theme of the plan is the prevention on the onset of illicit drug use and on alcohol abuse. The emphasis is placed on:

1. **prevention** and, in particular, the interest attached to reminding individuals of drug-related laws and the central role played by parents;
2. **awareness-building messages** aimed at avoiding or at least delaying experimentation, including with alcohol (Example of measures: a ban on selling alcohol to minors, a ban on consuming alcohol on the public highway around educational establishments)[40].

The plan discusses interesting strategies aimed at dismantling the sources of supply, such as stronger cooperation between the European Union Member States and the nations on the Mediterranean south; an

[38] Lucien Steru and Pierre Simon (1986). French Drug Policy. International Journal of Technology Assessment in Health Care, 2, pp 637-642 doi:10.1017/S0266462300003470;

[39] Report of the International Narcotics Control Board for 2008, United Nations Publications (COR),United Nations;

[40] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/fr#nlaws

intensification of the fight against cannabis and the misuse of psychotropic medicines; tougher economic penalties for traffickers.

2.9. POLAND

Poland's latest "National programme for counteracting drug addiction 2011–16", was adopted in March 2011 (the previous programme was implemented between 2006 and 2010). The general aim of the programme is to reduce drug use and more effectively address drug-related health and social consequences. It contains actions intended to combat new drugs and substitute substances and includes an evaluation of these actions[41].

The programme is divided into five pillars:

1. **prevention;**
2. **treatment, rehabilitation, harm reduction and social reintegration;**
3. **supply reduction;**
4. **international cooperation;**
5. **research and monitoring.**

In particular, the last two areas appear interesting and innovative with respect to the drug strategies of other states. They support the implementation of the first three: prevention, treatment and supply reduction. It must be stressed the NPCDA is fully integrated with the EU Drugs Strategy and Action Plan. Under the National Programme for Counteracting Drug Addiction 60 actions were formulated to be implemented by 10 ministries and 23 central level institutions, Provincial Pharmaceutical Inspectorates, and provincial and communal governments[42].

[41] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/pl

[42] 2010 NATIONAL REPORT (2009 data) TO THE EMCDDA by the Reitox National Focal Point, "POLAND" New Development, Trends and in-depth information on selected issues, p.16, www.kbpn.gov.pl/portal?id=15&res_id.

2.10. SWEDEN

Two separate action plans in relation to drugs, one for alcohol and the other for drugs, namely **"National alcohol and drug action plans 2006–10"** came to an end in 2010.

The previous National Alcohol and Drug Action Plan was approved in 2002 by Parliament for the years 2002–2006 with a specific objective: "The objective of the Swedish drug policy should continue to be a drug-free society. The main focus of drug policy is focused on concerted efforts to limit both supply and demand of drugs. Strengthened efforts are needed to strengthen the political priority on drugs, to improve cooperation between different authorities and between authorities and organisations, to improve the preventive work among other things through method and skills development, development of care through, inter alia, methodology and skills development and research, develop of treatment in prison, streamlining operations in the field of control, improving methods to comply with drug development and society's efforts, and to increase international cooperation..."[43]

The drug action plan was comprehensive, focused on illegal drugs and covered prevention, treatment, rehabilitation, and supply reduction. Each year, the Government developed an action programme to support the implementation of the action plans.

In 2010, an evaluation of the action plan was carried out. **The new strategy covers 2011–15** and is similar to the previous one. It continues to endorse the overall goal for Swedish drug policy: a drug-free society. The strategy covers drugs, alcohol, doping and tobacco.

From 1 April 2011, the police and customs may seize synthetic drugs that are not on the list of drugs covered by the anti-drug laws if the police suspect that the purpose of the holding is related to drug abuse. It's about synthetic drugs that manufacturers changed a bit in the recipe so that the drug therefore become lawful. Following a decision by a prosecutor, the police may destroy the seized. The reason for this change in the law are a number of deaths due to ingestion of unclassified synthetic drugs, often sold in online stores.[44]

[43] http://en.wikipedia.org/wiki/Drug_policy_of_Sweden#cite_note-larsson-0
[44] http://en.wikipedia.org/wiki/Drug_policy_of_Sweden#cite_note-37

REFLECTIONS

Analyzing "drug policy" it is already easier to get an idea of what the real strategy of each State is. The more comprehensive and global the strategy is, in fact, the greater the chance that it will obtain really good results.
From this point of view it is known that the Netherlands and Portugal are complete and efficient systems, although indeed, as noted above, all States are trying to deal with the phases of prevention, treatment and rehabilitation.
The real problem, however, is in understanding how the State intervenes to concretely implement the general principles of a drug policy
So what factors should be used to get a true picture of the situation? We have identified at least one that is discussed subsequently: the composition and nature of the “body in charge of procedure”.

3. THE STRONG CONNECTION BETWEEN THE FIELDS OF LAW AND HEALTH IN RELATION TO DRUG POLICY

3.1. THE SPECIAL CASE OF PORTUGAL[45]

The debate about drug policy is often represented as a polarized choice between two options, 'prohibition' and 'legalization'. In this atmosphere, any criticism of existing policy is regarded as a call for a radical change of direction.

The reality, as shown before, is that there are multiple options that are in no way reducible to a simple dichotomy between these two extremes. Liberalization of laws on drug use in countries such as Portugal have not been steps on the road to drug legalization.

With decriminalization the state can maintain the rule of prohibition but take sanctions for drug use outside the framework of criminal law. Decriminalization, in fact, differs depenalization because the purchase, possession, and consumption of illicit drugs remain criminal offences and carry criminal sanctions[46].

The new law of 2000 **maintained the status of illegality for using or possessing any drug** for personal use without authorisation. **However, the offence changed from a criminal one, with prison being a possible punishment, to an administrative one**.

Moreover, Portugal's reforms have not been limited to treating drug possession as an administrative offence; they also **include a wide range of measures** such as prevention and social education, discouraging people from further use of controlled substances, harm reduction, treatment for drug dependent people, and assistance in reintegrating them into society.

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[45] For further information see also " *Comparison Between Italian and Portuguese Legislation*", E. VENTURA, http://www.drugpolicyevaluation.eu/

[46] According to the EMCDDA: "Decriminalization" comprises the removal of a conduct or activity from the sphere of criminal law. Prohibition remains the rule, but sanctions for use (and its preparatory acts) no longer fall within the framework of criminal law. [By contrast], "depenalization"relates to the penal sanction provided for by law. In the case of drugs, and cannabis in particular, depenalization generally signifies the elimination of custodial penalties. For a fuller discussion of the differences between decriminalization and depenalization, see Greenwald, G. (2009), *Drug Decriminalization in Portugal*; *Lessons for Creating Fair and Successful Drug Policies,* The Cato Institute, p. 2.

This law established a system of "**Dissuasion Commissions**" that is unique in Europe and managed by the Ministry of Health, rather than the Ministries of Justice or the Interior[47], and this was an important symbolic step that reflected a new approach to drug policy[48].

The commissions seek to inform people and dissuade them from drug use and also have the power to impose civil sanctions for non compliance and to refer consenting persons to treatment.

When a person is caught **in possession of no more than 10 daily doses of drugs** (their corresponding gram limits had already been established in a regulation: (the law stipulates the permissible amount in detail—in grams or pills—of each drug: cannabis, 25 grams; hashish, 5 grams; cocaine, 2 grams; heroin, 1 gram; LSD or ecstasy, 10 pills), and the police have no suspicions or evidence that supply offences are involved, the drug will be seized. The case will then be transmitted to **the Commission for the Dissuasion of Drug Abuse (CDT),** of which there is one in each of Portugal's 18 districts.

The CDT is composed of **three members** appointed by the Ministries of Justice and Health (the member appointed by the Ministry of Justice has to be **a legal expert**, the other two usually being a **health professional and a social worker**). These Commissions evaluate each case with the help of a technical team to assess whether the person is an occasional or a dependent user, or a dealer.

Several options are available to the CDT when ruling on drug use offences, including **warnings**, **banning from certain places**, **banning from meeting certain people**, obligation of periodic **visits to a defined place, removal of professional licence or firearms licence**[49]**.** Sanctioning by fine, which may vary by drug involved, is an available option (though not for addicts) but it is not the main objective in this phase.

When the quantity of controlled substances in possession is **larger than 10 daily doses or if a person is charged with selling drugs (also in cases when it is less than the maximum quantity for personal possession), he/she will be sent to the criminal court.**

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[47] Drug Policy Profiles, Portugal, European Monitoring Centre for Drugs and Drug Addiction.

[48] Prior to this two different structures coexisted: the Portuguese Institute on Drugs and Drug Addiction, under the Council of Ministers, and the Cabinet for Planning, Coordination and Fighting Against Drugs under the Ministry of Justice.

[49] For a full list of available sanctions, see Law 30/2000.

Behind the change of approach toward drug consumption there was a recognition of the need to respect human dignity, understand the life choices and social circumstances of others, and uphold the constitutional right to health[50].

3.2. ITALY: THE FAILURE OF THE "ZERO TOLERANCE" APPROACH [51]

On the subject of drugs, as previously shown, there is a strong connection between the fields of law and health. So it is necessary to create a strong relationship between the legal and health systems, which have to work together in finding a real solution to the drug problem.
In fact if we imagine that a drug user is not a "criminal" but a "patient" it is easier to find concrete solutions.
In **Italy** for example, the "zero tolerance" drug bill, punishing with the same penalty any kind of drug infringement, without any distinction based on danger or harm to people, looks unable to obtain its initial objectives and expectations.
The reason is that a policy that considerers a drug user to be a criminal, cannot succeed in making positive effects in terms of successive steps of intervention, dedicated to prevention, treatment and, above all, rehabilitation programs.
Italian legislation, as with other Countries that are using the same policy of zero tolerance, does not pay attention to the "*ex ante*" and "*ex post*" phases of prevention, treatment and rehabilitation.
One example of this is given in a new version of article 75 of D.P.R 9 October 1990, n. 309, changed by law 49 of 21th of February 2006 (which converted into law the Decree of 30th of December 2005, n.272). It could be strongly criticized for the strange union it creates between administrative and criminal matters.

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[50] The Portuguese Drug Strategy, 1999, provides that: "The guarantee of access to treatment for all drug addicts who seek treatment is an absolute priority of this national drug strategy. The humanistic principle on which the national strategy is based, the awareness that drug addiction is an illness and respect for the State's responsibility to satisfy all citizen's constitutional right to health, justify this fundamental strategic option and the consequent mobilization of resources to comply with this right."

[51] For further information see also " *Comparison Between Italian and Portuguese Legislation*", E. VENTURA, http://www.drugpolicyevaluation.eu/

Administrative sanctions are identical to the preceding text of article 75, but changes the period of the sanctions, that can be imposed from one month to one year, without any discrimination between “soft” and “heavy” drugs.
The principal sanctions are the confiscation of a person’s driving licence, passport, gun licence, or, in case of non-EU nationals, the prohibition from obtaining a visa to stay in Italy.
As in the past, there is the formal invitation of the Prefect to follow a specific rehabilitation program, created specifically for the particular situation and person.
The main concern is that with the new law, the rehabilitation program is no longer an alternative to sanctions, that are in any case inflicted. This makes treatment an option rather than an obligation, and as such is an ineffective policy. It is not easy to find the rationale behind this strategy: people who must serve sanctions anyway are unlikely to opt for rehabilitation.
The procedure of art. 75 is the following: the Police reports immediately or in not more than 10 days, to the Prefect. With the limit of 40 days, from signaling the fact and person involved, the Prefect, if he think that the verification is well founded, assumes appropriate writ, calling the subject in order to value, through the interview, administrative sanctions and their duration, and *eventually* to formulate the general invitation for a rehabilitation program.
Analyzing Italian legislation about drugs, it is clear that it is lacking a precise and specific strategy for the rehabilitation of drugs addicts.
Therapeutic programs are considered only insofar as they reduce penalties. To have positive results, instead, we have to create a complete system that intervenes in every aspect of the drugs phenomenon: from war to drug consumption to the complete rehabilitation of the drug addict and his or her reintegration in the society.

4. THE IMPORTANCE OF THE COMPOSITION OF THE BODY IN CHARGE

An element of great differentiation among disciplines is surely represented by those who have been placed in charge of the procedure, because, as can be seen, the composition and nature of the procedure that follows reveals the real settings and strategies of the state.

4.1. CZECH REPUBLIC

The **Council of the Government for Drug Policy Coordination** is the authority responsible at the political level for the overall implementation of the national drug strategy. This Council is the main coordinating body of the government for drug issues[52].

It is presided over by the Prime Minister and includes all ministries involved in the delivery of the national drug policy and three representatives of civil society in respective areas (Czech Medical Association — Association for Addictive Diseases, Association of NGOs dealing with drug prevention and treatment, and Association of the Regions).

Moreover, the Secretariat, that ensures on a permanent basis the day-to-day implementation of the strategy and the coordination of the respective ministries' activities, is very important.

A peculiarity of the Czech Republic is that many ministers are involved, each within its zone of competence, in the fight against drugs. This is a winning strategy because it presents a comprehensive approach.

a) **Ministry of Health** is responsible for legislation concerning the legal handling of addictive substances, products, precursors, and adjuvants.

b) **Ministry of Labour and Social Affairs** is responsible for tackling social problems associated with the use of all types of drugs.

c) **Ministry of Education, Youth, and Sport** is mainly responsible for primary prevention of the use of all types of drugs by children and young people, which is based on evidence-based measures and activities.

d) **Ministry of the Interior** is responsible for the protection of public order and safety and for fighting crime committed in relation to all types of drugs.

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[52] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/cz;

d) **Ministry of Justice** is responsible for drawing up legislative proposals in the field of criminal law. It creates conditions for the activities of courts and public prosecutor's offices in matters related to drug crime.
e) **Ministry of Defence** ensures the protection of the safety and sovereignty of the Czech Republic. It allocates forces and resources to be deployed in operations to support and maintain peace and in rescue and humanitarian missions outside the Czech Republic.
f) **Ministry of Foreign Affairs** coordinates the fulfilment of tasks ensuing from the international treaties by which the Czech Republic is bound and from the membership of the Czech Republic in the United Nations Organisation (UN).
g) **Ministry of Finance** participates in the setting of rules for the funding of the non-profit-making sphere and supervises their accordance with Act No. 218/2000 Coll., on budgetary rules. It provides methodological guidance and consulting in relation to the granting of subsidies from the state budget and with regard to audits of the corresponding financial flows.
h) **Ministry of Industry and Trade** is responsible for the control of advertising pertaining to legal drugs – alcohol and tobacco.
i) **Ministry of Agriculture** maintains technical collaboration with the General Customs Headquarters concerning the keeping of records relating to the legal production of opium poppies and industrial hemp, i.e. crops containing narcotic or psychotropic substances.

At the **local level**, a network of 14 regional coordinators provide coordination of activities (including the implementation of the national drug policy) at the regional and local levels. However, their competencies vary from region to region. Each region draws up and implements their own strategies and plans on drug-related measures and the extent of such plans and strategies also varies between regions. At the local level, local drug coordinators are installed in 205 municipalities (so-called 'municipalities with extended competency').

4.2. NETHERLANDS

The first drug commission was set up in 1968 by the National Federation of Mental Health Organizations. In the Netherlands, Mental Health used to be organized in a myriad of private and public-private settings along the lines

of the different religious and political denominations[53]. The previous year the National Federation of Mental Health Organizations had commissioned extensive research among drug users in the Netherlands. It also set up a drug policy commission of which the broadly defined task was "to clarify factors that are associated with the use of drugs, to give insight into the phenomenon as a whole, and to suggest proposals for a rational policy..." (Hulsman, 1971)[54].

The members of the commission included law enforcement officials, alcohol treatment experts, psychiatrists, a drug use researcher and a sociologist.

Also in 1968 the Undersecretary of Health, a medical man himself who was worried about the use of marijuana, set up a State Commission. After an unsuccessful chairmanship of the Inspector of Mental Health, it was chaired from 1970 by Pieter Baan, a Chief Inspector of Mental Health. The final report of the Baan commission was presented to the Minister of Health in February 1972. Four years later, in 1976 the new Opium Law was adopted, including the articles that made decriminalization of cannabis use possible, as advocated by the Baan Commission.

Now the responsibility for Dutch drug policy is shared between **several ministries**. **The Minister of Health, Welfare and Sport** is responsible for coordinating the drug policy, and the **Ministry of Security and Justice** is charged with law enforcement and matters relating to local government and the police.

This is an important element, and probably key to winning the whole system, as three ministries are responsible simultaneously for drug policy, each by virtue of its functions:

1. The Ministry of Justice is responsible for compliance with the law and the conduct of investigations and prosecution.
2. The Ministry of Health, Welfare and Sport is responsible for the policy of prevention and care.
3. Further aspects are managed by local administration and police, under the Ministry of Internal Affairs and Relations.

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[53] Cohen, Peter (1994), *The case of the two Dutch drug policy commissions. An exercise in harm reduction 1968-1976*. Paper presented at the 5th International Conference on the Reduction of Drug related Harm, 7-11 March 1994, Addiction Research Foundation, Toronto. Revised in 1996.

[54] Louk Hulsman, "*Ruimte in het drugbeleid".* Boom Meppel, 1971, page 5.

A common policy on drugs is coordinated by the "**triangle of power",** consisting of the mayor, the chief prosecutor and the police chief (who, among other powers, has the power to determine the extent of the directive of the prosecutor's policy to be followed in respect of the coffee shop).

This cooperation between Ministries is a novelty that is really interesting. In particular, the involvement of the Ministry of Health, Welfare and Sport, which has been given a major role in coordinating policy on drugs, highlights how problems relating to drugs in the Netherlands are mainly associated with risks to health.

Under the Directive, the "triangle of power" may decide:

1. who can have coffee shops in a particular town; they may choose to have none.
2. the maximum amount of stocks of drugs for sale in the coffee shop (although to a lesser extent than that laid down in the directive of the prosecutor).
3. The mayor also has the power to decide to close coffee shops.

4.3. SPAIN

In Spain the drug policy is coordinated by an **Inter-ministerial Group,** a body which ensures coordination between the different departments of the national civil service. It is **chaired by the Minister for Health and Social Policy, and includes the Ministers for Justice, Education, the Interior, Work and Immigration, Territorial Policy and Foreign Affairs and Cooperation as well as the Secretaries of State for Treasury, for Economy, for Security and for Relations with the Spanish Parliament and the General Secretary of Health.** The Secretary of this Inter-ministerial Group is the Government Delegate for the National Plan on Drugs.

The Government Delegation for the National Plan on Drugs carries out the function of coordinating the different institutions included in the national drug plan. It has the status of a Directorate-General and reports to the General Secretary for Social Policy of the Ministry of Health and Social Policy. The Government Delegate for the national drug plan is the national drug coordinator.

The National Plan on Drugs (PNSD) is a government initiative designed to coordinate and strengthen the policies which are carried out by the different Public Administrations and social entities in Spain with regard to drugs.

It is the responsibility of the Government Delegation for the National Plan on Drugs as the principle organ in charge of executing the Plan to define a global strategic policy which, based on consensus, enables the stability of preventive programmes and actions, their constant evaluation and progressive improvement. The Autonomous Communities, in collaboration with local Administrations, have the function of planning and executing appropriate autonomous and local policies in this matter, as well as the corresponding financial and technical support[55].

The 'Sector conference' of the National Plan on Drugs is the governing body for coordination between the General State Administration and the administrations of the autonomous communities. It is made up of the Inter-ministerial Group and the regional ministers of the departments of the autonomous regions, which have been assigned responsibility for the area of prevention and assistance for people with drug dependency problems.

The **Inter-Regional Committee**, (in Spanish, la Comisión Interautonómica de la Conferencia Sectorial del Plan Nacional sobre Drogas), which acts as the delegate body of the Conference, is chaired by the Government Delegate for the National Plan on Drugs and reports to the Sector Conference and is made up of all the Deputy Director-Generals of the Government Delegation, as well as those responsible for the regional drug plans.

Finally, there is a **Drug Commissioner in each of the 17 autonomous communities and in the two autonomous cities (Ceuta and Melilla).** They communicate with the Government Delegation through their participation in the Inter-regional Committee and the Sector conference.

4.4. UNITED KINGDOM

UK Drugs Strategy is governed by the Home Affairs, Public Health and Social Justice Committees. On 8 December 2010, the government launched its drug strategy, "Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life".[56]

Implementation of the strategy is governed by three overarching groups:

a. The Inter-Ministerial Group on Drugs (IMG)
b. The Drug Strategy Group (DSG)

[55] National Plan on Drugs, MINISTERIO DEL INTERIOR, Delegación del Gobierno para el Plan Nacional sobre Drogas

[56] http://www.homeoffice.gov.uk/drugs/drug-strategy-2010/

c. The Drug Strategy Implementation Group (DSIG).

The strategy has recovery at its heart. It:

1. puts more responsibility on individuals to seek help and overcome dependency
2. places emphasis on providing a more holistic approach, by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing
3. aims to reduce demand
4. takes an uncompromising approach to crack down on those involved in the drug supply both at home and abroad
5. puts power and accountability in the hands of local communities to tackle drugs and the harms they cause

With regards to devolved powers, the coverage of the new strategy is as follows:

1. health, education, housing and social care – confined to England;
2. policing and the criminal justice system – England and Wales
3. the work of the Department for Work and Pensions – England, Wales and Scotland

The **Scottish Government** has devolved responsibility for health and education and much of the justice agenda in Scotland.
The Scottish Drug Strategy Delivery Commission consists of experts with a wide range of expertise who provide independent expert advice to Scottish Ministers on the delivery of the national drug strategy.
Consequently, the Scottish Government launched its Drug Strategy in 2008, the 'Road to Recovery'. This strategy focuses on person-centred care, treatment and recovery, prevention, enforcement and children affected by parental drug misuse.
In **Wales**, the National Substance Misuse Strategy Implementation Board oversees the implementation of the 10-year Welsh substance misuse strategy 'Working Together to Reduce Harm' and an associated implementation plan. Seven Substance Misuse Area Planning Boards have been established to support the planning, commissioning and performance management of substance misuse services in Wales. These Boards are co-terminous with Local Health Boards and bring existing members of Community Safety Partnerships together with Probation services, the Drug Interventions Programme, Public Health Wales and the voluntary service.

In **Northern Ireland**, the Drugs and Alcohol Implementation Steering Group coordinates implementation of the Northern Ireland Substance Misuse Strategy at the governmental level. In addition, several working groups have been established to support the development of action in specific areas[57].

4.5. ALBANIA

On March 2001 the **National Committee for Coordination of the Fight against Drugs, under the Council of Ministers of the Republic of Albania and chaired by the Prime Minister** was established by Law No 8750.

The Committee:

a. Approves the internal regulation of the National Committee for Coordinating the Fight against Drugs,
b. Approves the Strategy of the Fight against Drugs
c. Approves the Plan of Actions on the implementation of strategy
d. Provides for the functioning of specialist staff that represent member institutions of the National Committee for Coordinating the fight against Drugs
e. Provides for the functioning of a National System Office that administrates data for drugs
f. Coordinates activities among institutions that attend a National Committee for Coordinating the fight against Drugs

National agencies engaged in efforts for diminishing the drugs supply:

1. **The Ministry of Public Order, MoPO, and General Directorate of Customs as part of the Ministry of Finance** are the institutions in charge of fighting illegal trafficking, distribution, cultivation and production of drugs.
2. **The General Prosecution Office** is responsible for the investigation of drug trafficking and assets that originate from this illegal activity, the investigation of money laundering and any other financial activity that relates to illegal drugs, enforcement of penal procedures, dispositions of drug related assets forfeiture, and the exchange of information with MoPO and SHISH.
3. **The National Intelligence Service** is responsible for: collecting information on national and international criminal drug

[57] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://webarchive.nationalarchives.gov.uk

organizations that use Albania as a base and transit country; the strengthening of detection actions by means of infiltration of information sources, and technical means; detection, documentation and prevention of criminal drug activity; participation together with specialized state police drug units in drug operations, working together with the General Directorate of Customs and the Ministry of Finance in identifying criminals and traffickers and assets and property that derive from criminal activity and money laundering mechanisms.

4. **The Ministry of Health** provides sufficient and continual information to the specialized drug-combat Unit in the General Directorate of Police.

4.6. BELGIUM

In Belgium, **three levels of coordination units** are under development:

1. a **general drug policy unit (or general coordination unit**), headed by a drug coordinator, to be placed under one of the federal ministries. This unit should include actors from different sectors/ministries (health, security, international affairs, other), regions and communities. Its task will be to develop and follow up on the national drug policy (for the federal government);
2. **sub-coordination of units in the health, control and international affairs sectors.** Each of these units will include representatives from relevant ministries at the federal, regional and community level. Their task is to develop and follow-up on the national drug policy in their field (for the relevant inter-ministerial committees on health, security, etc.); and
3. **a national (federal and community) inter-ministerial conference on drugs** to monitor the evolution of the drug problem and the responses developed to reduce it[58].

In 2006, a single 'Drugs Health Policy Unit' was implemented to oversee the other bodies. In particular the general drug policy with its drug coordinator, and the inter-ministerial conference,will be implemented in the very near future.

[58] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/be;

4.7. GERMANY

The **Federal Ministry of Health** continues to be the lead agency in developing, coordinating, and implementing Germany‘s drug policies and programs. The National Drug Commissioner at the Federal Ministry of Health coordinates Germany‘s national drug policy. Drug consumption is treated as a health and social issue. Policies stress prevention through education. The Ministry funds numerous research and prevention programs, as do the Federal states[59].

The **Federal Drug Commissioner** is responsible for the addiction policy of the Federal Ministry for Health (BMG) and coordinates the drug and addiction policy of the whole Federal Government. Drug consumption is treated as a health and social issue. Policies stress prevention through education. The Ministry funds numerous research and prevention programs, as do the Federal states[60].

The **Drugs and Addiction Council** is an advisory body which accompanies federal actions and evaluates them. It is composed of representatives of the respective government and Länder departments as well as funding organs, associations, research and self-help organisations. The Federal Länder and the local authorities are to a large extent responsible for the implementation of the national policy on drugs, and some Länder may have a different list of priorities concerning some elements of the plan.

Coordination between the Federal Government and the Länder takes place in the conferences of government departments and their working groups[61].

[59] International Narcotics Control Strategy Report: Volume I Drug and Chemical Control," Bureau for International Narcotics and Law Enforcement Affairs (Washington, DC: United States Department of State, March 2011), p. 264, http://www.state.gov/documents/organization/156575.pdf

[60] International Narcotics Control Strategy Report: Volume I Drug and Chemical Control," Bureau for International Narcotics and Law Enforcement Affairs (Washington, DC: United States Department of State, March 2011), p. 264, http://www.state.gov/documents/organization/156575.pdf

[61] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/de

4.8. FRANCE

The authority in France designated to prepare the decisions of the government in all domains related to the drug problem is the **Inter-ministerial Committee on Drugs.** Moreover**,** this committee approves the national plan on drugs. It is placed under the authority of the Prime Minister and is composed of ministers and state secretaries.
The Mission Interministerielle de la Lutte Contre la Drogue et la Toxicomanie (**MILDT, or the Interministerial Mission for the Fight Against Drugs and Drug Addiction**), is the focal point for French national drug control policy. The MILDT (which received its current name in 1996) coordinates the 19 ministerial departments that have direct roles in establishing, implementing, and enforcing France's domestic and international drug control strategy. The MILDT is primarily a policy organ, but it cooperates closely with law enforcement officials[62].
There are also regional, local and territorial project managers.
The **national police force** under the supervision of the Ministry of the Interior and the **national gendarmerie** under the supervision of the Ministry for Defence are two key players in law enforcement. With respect to drug trafficking, the Ministry of the Interior is also home to the Central Office for Illegal Drug Trafficking (L'office central pour la répression du trafic illicite des stupéfiants – OCRTIS), the agency responsible for centralizing relevant information from the police, the criminal investigation department, and social and medical services. Criminal justice is rendered according to the nature of the offence by the police court (contraventions), the "Tribunal Correctionnel" (délits) or the "Cour d'Assises" (crimes).

4.9. POLAND

The coordination and advisory body in the field of counteracting drug addiction is the **Council for Counteracting Drug Addiction**.
The Council operates at the Prime Minister's office and functions as a coordination and advisory body for counteracting drug addiction. The legal basis for The Council for Counteracting Drug Addiction are articles 12 to 18

[62] "International Narcotics Control Strategy Report: Volume I Drug and Chemical Control," Bureau for International Narcotics and Law Enforcement Affairs (Washington, DC: United States Department of State, March 2011), p. 250.http://www.state.gov/documents/organization/156575.pdf

of the Act of 29 July 2005 on Counteracting Drug Addiction (Polish Journal of Laws: Dz.U. No. 179, item 1485 as further amended)[63].
The members of the Council are appointed by the Prime Minister. They are:

1. **Council Chairman**: the Secretary or the Undersecretary of State in the office where a minister competent for health matters operates (Which is Adam Fronczak, Undersecretary of State in the Ministry of Health);
2. **Deputy Chairman of the Council:** the Secretary or the Undersecretary of State in the office where a minister competent for interior affairs operates (Which is Adam Rapacki, Undersecretary of State in the Ministry of Interior and Administration) ;
3. **Council Secretary**: the Director of the National Bureau for Drug Prevention (Piotr Jabłoński - Director of the National Bureau for Drug Prevention);
4. **Members of the Council:** the Secretaries or the Undersecretaries of State in the offices where the following ministers operate: minister of Justice; National Defence; the ministers competent for matters of: education, agriculture, social security, public finances — the Head of the Customs Service, foreign affairs, science (Who are, respectively: Bożena Malik- Representative of local government in the Joint Central and Local Government Committee; Jarosław Duda- Secretary of State in the Ministry of Labour and Social Policy; Jacek Kapica- Undersecretary of State in the Ministry of Finance; Artur Ławniczak- Undersecretary of State in the Ministry of Agriculture and Rural Development; Czesław Piątas - Secretary of State in the Ministry of National Defence; Stanisław Chmielewski - Secretary of State in the Ministry of Justice; Zbigniew Włodkowski - Undersecretary of State in the Ministry of Education)[64].

The **National Bureau for Drug Prevention** is responsible for coordinating the implementation of the National Program for Counteracting Drug Addiction and the preparation of an annual report on the state of its implementation. Its activities also include setting priorities in the field of

[63] http://www.kbpn.gov.pl/portal?id=763224
[64] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/pl

drug prevention. The secretariat of the Council for Counteracting Drug Addiction is located in the Bureau. Among its activities we can remember that on 2009, under selective prevention, the National Bureau took part in an international "FreD goes net" project co-financed by the EU under the Public Health Programme. The project aims at promoting a selective prevention model based on short-term intervention for young drug users across European countries.

At the provincial level, **provincial drug coordinators** are responsible for the coordination of regional drug policy and for the implementation of regional strategy which by law is in line with the national strategy and action plan. Additionally, at the provincial level, there are **provincial experts** on drugs and drug addiction who collect and exchange information, data and documentation concerning the drug problem. The provincial drug coordinators and experts are often the same person. Every year, provincial experts prepare reports on the situation of drugs and drug addiction.

4.10. SWEDEN

Four ministries share the primary responsibility for drug policy:

1. the Ministry of Health and Social Affairs,
2. the Ministry of Justice,
3. the Ministry of Finance and
4. the Ministry for Foreign Affairs.

Together, officials from these ministries form an independent working group. Its title is **The Governments Coordination Body in Drug Related Issues**[65]. The Ministry of Health and Social Affairs is responsible for drug coordination.

Moreover there are:

a) **The Swedish National Institute of Public Health (SNIPH):** a state agency under the Ministry of Health and Social Affairs. The Institute works to promote health and prevent ill health and injury, especially for population groups most vulnerable to health risks. The three main tasks of the Institute are: to monitor and coordinate the implementation of the national public health policy; to be a national expert agency for the development and dissemination of methods and strategies in the field of public

[65] http://www.sweden.gov.se/sb/d/2943

health, based on scientific evidence; to exercise supervision in the areas of alcohol and tobacco[66].

b) **The National Board of Health and Welfare (NBHW):** (Socialstyrelsen) is a government agency under the Ministry of Health and Social Affairs. The agency was the result of a merger between the Swedish Royal Medical Board and the Swedish Royal Board of Social Affairs in 1968. The Board is the central national authority for the social services, public health, the prevention of infectious diseases, and health services. The Board establishes norms by issuing provisions and general advice. It evaluates legislation and activities conducted by municipalities, county councils and local authorities.[67]

c) **The County Administrative Board** (***Länsstyrelse***) is a Government appointed board at County level. It is responsible for the supervision and the distribution of financial support for drug policy interventions in the municipalities.

Regional drug coordinators are located at the regional level, most often in the County Administrations or the County Councils. The regional drug coordinators' tasks are to coordinate the regional activities in the drug area and to support local activities in the municipalities[68].

[66] http://www.fhi.se/en/About-FHI/

[67] http://en.wikipedia.org/wiki/National_Board_of_Health_and_Welfare_(Sweden);

[68] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/se#nlaws

REFLECTIONS

By examining the composition and powers of the body in charge of drugs policy one can find useful information. The phenomenon of drugs and drug addictions, in fact, includes a wide range of determinants and dimensions. Coordination facilitates both better planning of interventions executed by the agents involved in drug policy, as well as a more rational and efficient use of all resources, both human and material, in order to reach common goals[69].

In the field of demand reduction, the greatest involvement and commitment basically corresponds to the administrations with responsibility and competences in health, social and educational areas. Actions in this field must necessarily be of a transversal character to enable the set objectives to be achieved. Therefore they will have to involve the public administrations in different territorial spheres with jurisdiction in the field itself –including work and employment, immigration, justice, and promotion of road safety among others. The area of supply reduction is a special jurisdiction of the national police force and civil guard and their counterparts in the autonomous communities, the different inspection bodies of the public administrations at national, regional and local levels, and the specialist legal bodies. The activity in this area of supply control also benefits from the cooperation of the local (municipal) police forces.

The composition of these forces can determine whether the strategy is intended merely to sanction or for the rehabilitation of the subject. In this sense, countries like Portugal or the Czech Republic, which include the composition of members belonging to the sphere of health will surely have a different approach compared to countries like Italy or France in which the role is given respectively to the Prefect and a committee that reports directly to the Prime Minister.

Of course, after viewing the composition of the bodies in charge of drug policy it is necessary to consider whether the powers are sufficient to achieve their objectives.

Finally, it is necessary to consider the overall picture of the predictions made by the State in order to 1) prevent the abuse of drugs, 2) ensure interventions related to the treatment phase and the means provided for a complete rehabilitation and 3) allow the integration into society.

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[69] *National Drug Strategy 2009-2012, Edita: Delegación del Gobierno para el Plan Nacional sobre Drogas NIPO.: 351-09-046-7 Depósito legal: M-27343-2009*

5. PREVENTION, THERAPEUTIC APPROACH AND OBJECTIVES OF REHABILITATION.

5.1. CZECH REPUBLIC

Primary prevention. Prevention involves the implementation of specific preventive activities to reduce the level of experimental and occasional drug use, particularly among young people**.** Prevention activities in the Czech Republic are coordinated by the Ministry of Education and are mainly implemented by schools and NGOs that provide services in the field of treatment and help to drug users.

Since 2007, a ministerial guideline introduces prevention into the school curriculum, describes the individual institutions involved in the system of prevention and the role of the teacher, defines the Minimum Preventive Programme, and recommends specific practices for schools and school facilities if they detect specific risk behavior among children and young people[70].

Treatment and social rehabilitation. The main objective is reducing the level of problem and intensive drug use. Interventions carried out in the domain of treatment and social reintegration.

A nationwide system for reporting treatment demand has been operating in the Czech Republic within the framework of the Hygiene Service since 1995.

The Council of the Government for Drug Policy Coordination is the main coordinating and initiating body on drug-related issues. The Secretariat of the Council organises the distribution of subsidies to service providers (mainly NGOs) in the sphere of the treatment of drug addiction and reintegration. Furthermore, the Secretariat is also responsible for accreditation, monitoring, evaluation and coordination of delivery of drug treatments, and medical and inpatient facilities at the regional/local levels.

Harm reduction. The main objective is reducing potential drug-related risks to individuals and society. Harm reduction interventions seek to minimize the adverse health and social consequences of drug use for both society and current drug users.

A reduction of the availability of drugs. To reduce the availability of drugs, particularly to young people. Particularly on the basis of the more efficient

[70] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/cz;

use of the existing legislative and institutional instruments and law enforcement interventions.
Finally, it is important to remember that in the Czech Republic, drug treatment is primarily delivered by public organisations and NGOs. To a lesser extent, private institutions and office-based medical doctors are also involved in treatment delivery. These organisations provide three main treatment services: detoxification, outpatient care and institutional care. Treatment and inpatient services are also divided into short-term (4–8 weeks); medium-term (3–6 months) and long-term (seven or more months) services. Out and inpatient medical drug treatment is mainly financed through health insurance, whereas outpatient and inpatient psychosocial treatment is primarily funded by public budgets at national and regional/local levels.

5.2. NETHERLANDS

Prevention. In the Netherlands schools are highly active in the fight against all types of drugs. This shows that in the Netherlands drug use is not a phenomenon nor encouraged nor accepted: it is discouraged by educational activities taking place in schools and campaigns to raise awareness of the risks associated with the use of substances that are addictive.
Treatment. If prevention can intervene *ex ante* on the issue, it should be noted that the legislation of the Netherlands is occupied alsowith the *ex post* stage, providing specific forms of intervention in the case of drug addicts who commit crimes. Assuming that dependence is not a mitigating factor, drug addicts who commit a crime, however, are given the opportunity to choose between treatment or detention. If the subject opts for the treatment program, the penalty imposed by the judge may be suspended temporarily or permanently. Obviously, drug addicts who choose to follow a treatment plan must meet a number of conditions. Failure to comply with these conditions triggers detention.
The idea underpinning the ability to choose between treatment or jail is that, for drug users who commit a crime, the treatment is more effective than a prison sentence. Conditions for treatment are, among other things, the motivation to tackle the problems of addiction and readiness to undergo checks on the use of drugs. With this system, the Netherlands has seen sustained positive results.
On 1 April 2001 the **Legal Detention of Addicts** (SOV) became operational. It has thus been possible, since that time, to impose compulsory detention

on drug addicts for a maximum duration of 2 years,calculated as from the day the court decision was made. The target group comprises hard drug addicts who have usually committed a series of offences, and have thereby become a serious "nuisance element" in the society around them. The judge can take account of the period of time the accused has been held on remand, although he is not bound to do so (art. 38n, Stat.). What is new here is that the judge can impose the sentence on the instruction of the Department of Public Prosecutions (art. 38m, para 1, Penal Code, hereinafter PC)[71].

Another structure of particular interest is the **Forensic Clinic for treatment of drug addiction** (FVK), which is designed for people subject to severe drug addiction, the nature of which is located halfway between an institution and judicial community for recovering drug addicts. The target of people who may be included in clinical FVK are those who are able to support a salvage therapy, but whose type of addiction, severity of crimes committed, personality structure and history of treatment incurred do not allow their inclusion in a common structure recovery.

5.3. SPAIN

The National Drug Strategy 2009-2016 covers the objectives to be achieved in the field of demand reduction as included within the European Union anti-drug action plans. In order to ensure such objectives are operative, actions on prevention of use, and on risk and harm reduction are included, as well as those of health care and social integration.

Prevention of use focuses primarily on promoting social awareness of the significance of the problem, the damage and the personal and social costs related to drugs, on the genuine possibility of avoiding them, and on the importance of society at large becoming an active part of the solution.

Secondly, it aims to increase the personal capacity to resist the offer of drugs and the problematic behaviour associated with them.

Universal prevention in schools continues to be the preferential setting for actions in every autonomous community in Spain.

Additionally, the new ARGOS programme (community-based prevention organised from health centres) aims to increase the engagement of the health centre sector as points of reference in school and community-based

[71] http://scielo.isciii.es/scielo.php?pid=S0213-61632005000200001&script=sci_arttext

prevention. It has a strong informative character through a range of support materials[72].

Selective prevention with vulnerable groups is a priority in the action plan on drugs and a large part of the preventive efforts in this area are focused on at-risk minors.

The main features of prevention policy in Spain are strong cooperation with the educational system, are full coverage of the school population with school-based prevention programmes, and important interventions in prevention. Mass media campaigns continue to play a major role while less effort is put into environmental strategies.

The care and **treatment** context for detoxification and habit-breaking in relation to addictive behavior is of importance, and there is growing support for the conclusion that there is a directly proportionate relationship between health and social service actions in the natural framework of the patient's environment and the success of the therapy concerned.

Drug treatment at national level is coordinated by the Government Delegation for the National Plan on Drugs, based within the Ministry of Health and Social Policy, which is responsible for the promotion, monitoring and evaluation of drug treatment. The public sector is mostly involved in the delivery of treatment, followed by NGOs and private organisations. In Spain, funding of drug treatment is provided mostly by the public budget of the state and autonomous regions.

There is a specific drug dependence care network which is widely distributed throughout the country. The majority of services in Spain are outpatient facilities, which are publicly owned. Healthcare and treatment are provided by the Autonomous Communities both for drug abuse disorders and for other diseases.

National priorities in the prevention of infectious diseases among drug users include needle and syringe programmes, voluntary counselling and testing of infections and hepatitis vaccination programmes. These services are provided by a large public network of facilities, including social emergency centres, mobile units and pharmacies.

Most specialist harm reduction programmes include a socio-sanitary service that offers preventive educational interventions, sterile material, emergency care and assistance for injecting drug users who are not usually in contact with any assistance intervention.

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[72] European Monitoring Centre for Drugs and Drug Addiction, http://www.emcdda.europa.eu/publications/country-overviews/es

Supply reduction. Spanish National Police, the Civil Guard, and Customs Services, along with autonomous regional police forces, increased their operational tempo in 2010. By June 2010, seizures of cocaine, heroin, ecstasy and "Speed" were on track to exceed 2009 figures. In addition security forces conducted a number of major operations against synthetic drug suppliers. Spain continues to account for 70 percent the hashish seizures in Western and Central Europe and is the world's fourth largest seizer of cocaine.

With regard to illegal drugs, the national law enforcement agents, vigilant customs authorities (in Spanish, Vigilancia Aduanera), the judiciary and especially the Anti-drugs Public Prosecutor, are all active in this part of the generic supply-demand process, affecting four large areas vulnerable to criminal organizations:

1. The process of the production of drugs from raw materials and precursors.
2. The process of the wholesale distribution of substances, including international trafficking and internal trafficking in every State.
3. The process of retail distribution; in other words, distribution of the substance to the end users.
4. The process of the transformation of profits into economically quantifiable assets.

5.4. UNITED KINGDOM

The prevention of drug use among young people is a key element of drug strategy in the United Kingdom.

Acting early, particularly with young people, can help stop drug and alcohol problems from developing. However there are many different factors that can lead people to misuse drugs or alcohol and a range of different approaches to prevention.

The reasons that people come to misuse drugs or alcohol are complex, influenced by personal, community and societal factors. The government has already set out some proposals for tackling the supply of drugs or alcohol to young people including a system of temporary bans on so called 'legal highs' and licensing measures to increase the penalties for those selling alcohol to underage young people.

Universal drug prevention initiatives are an important area of policy in the field of prevention. Communication programmes such as 'FRANK' in England and 'Know the Score' in Scotland, provide information and advice to young people and their families.

All UK drug strategies give priority to the provision of better access to effective **treatment**, particularly for vulnerable or excluded groups, and to encourage client retention.

Drug addiction in fact is a complex disorder that has serious health costs and causes serious harm to the community. Whilst reducing harm is an important component of treatment, promoting and supporting recovery and a drug free lifestyle is the ultimate aim.

Delivery of drug treatment is through local multi-agency partnerships, representing health, criminal justice agencies and social care services. In recent years, increased attention is given to measuring health and social outcomes associated with treatment.

In most parts of the United Kingdom, particularly in England, there is a **four-tier system of treatment** providing a conceptual framework for treatment provision[73].

-Tier 1 refers to **generic interventions** such as information and advice, screening and referral to more specialist services.

-Tier 2 refers to **open-access interventions**, such as drop-in services providing advice, information and some harm reduction services such as syringe exchange.

-Tier 3 services are **specialist community services** and include prescribing services, structured day programmes and structured psychosocial interventions, such as counselling and therapy and community-based detoxification.

-Tier 4 services are **inpatient services**, including detoxification and residential rehabilitation. The majority of structured treatment is delivered at Tier 3, predominantly through community-based specialist drug treatment services.

Recovery and social reintegration are key elements of drug strategies in the United Kingdom. In England and Wales, the Drug Interventions Programme targeting drug users in the criminal justice system offers a range of treatment and social reintegration responses through Criminal Justice Intervention Teams, based in the community and in the prison system[74].

[73] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://webarchive.nationalarchives.gov.uk

[74] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://webarchive.nationalarchives.gov.uk

5.5. ALBANIA

Objectives and actions oriented toward both drug demand reduction and supply control are included in the National Strategy Against Drugs.
The Strategy is based on a balanced approach combining measures in the area of prevention, treatment, rehabilitation as well as harm minimisation including prevention of HIV and other communicable diseases. Particular respect is given to co-operation with law enforcement agencies in order to assure a balance between drug demand reduction and drug supply reduction initiatives.
The following principles are key targets of the strategy:

1. Early beginning of prevention initiatives in order to ensure the influence of healthy lifestyle attitudes in the formative age of the target population of children and youth;
2. Complex and comprehensive drug demand reduction activities planning and management to maximise preventive effects;
3. Specific interventions targeted at identified risk groups.

It is interesting to note that nevertheless, the activities in the field of **prevention** have been spontaneous and uncoordinated.
Early activities in the drug prevention field started in the late 1990s, being supported mostly by foreign donors, including the Council of Europe, the United Nations Population Fund (UNFPA), UNICEF, the Soros Foundation, etc. The interventions have developed lifestyle skills through providing extracurricular materials for schools, and training for teachers, media representatives and peers. Community awareness about the risks drugs pose for individuals and families has also been raised through TV programmes, adverts, posters, leaflets and other activities[75].
So today prevention programmes cover a wide range of activities, typically involving:

1. School-based programmes
2. Mass media campaigns
3. Community-based programmes

There is still only one specialised public drug **treatment** centre in Albania, namely the Clinical Toxicology Service of Tirana University Hospital Centre

[75] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/al and European Monitoring Centre for Drugs and Drug addiction, Albania, Country Overview 2009, (http://europa.eu)

"Mother Theresa" (TUHC). This is a public centre, responsible for the whole country, and deals mainly with detoxifications and overdose treatment. It serves both as a hospital inpatient and as an outpatient unit, and is the main source of treatment demand data.

There are two other treatment centres, both of which are non-public and non-profit organisations: the Emanuel, an NGO therapeutic treatment centre that offers residential treatment, and Aksion Plus, an NGO offering methadone maintenance treatment. Clients come from, or are referred to, the above TUHC Clinical Toxicology Service. A proper data exchange between them doesn't take place because the National Centre for Drug Information System at the Institute of Public Health, which should provide the systems needed to log the data, has not done so, and the Ministry of Health has not built any coordination mechanisms between the three organisations.

Harm reduction programmes began in Albania in 1995. They are currently offered by four NGOs (Aksion Plus, APRAD, Stop AIDS and UKPR) operating in the field of drug demand and HIV/AIDS reduction with a clear focus on harm reduction activities, as well as by the public Voluntary Counselling Testing Centres for the HIV/AIDS/STIs National Programme. Harm reduction responses are focused on needle/syringe exchange, peer education, information and counselling, basic medical support and psychosocial support.

The needle and syringe exchange services are offered only in the capital Tirana, and there is still an insufficient distribution across the country as a whole.

5.6. BELGIUM

Strategies for **drug prevention** in Belgium differ significantly across the three language communities and differences even exist at the level of planning. The interventions have to be organised in different settings (youth centres, schools, prison) in order to delay or postpone a first drug use. The action should focus also on poly drug use and the combination of drug use and driving.

Major investments to develop drug policies in schools have been encouraged in the French community, whereas such policies have already been implemented in the Flemish community. A common main objective adopted is to better involve all actors: parents, students, teachers and directors in prevention matters resulting in a comprehensive, integrated approach.

Differences between the three communities also exist in selective prevention programmes targeted at families-at-risk. The Flemish community developed a number of prevention programmes, such as 'Broeders Alexianen' in Tienen, a programme that helps children of alcoholics to understand and deal with the addiction of the parent, and the programme 'Bubbels & Babbels', a prevention project focusing on the problems of children of ex-drug-dependent parents.

The French community **treatment services** provide assistance to drug-addicted mothers by improving the mother–child relationship as well as the children's living conditions. In the French community, in a particular neighbourhood, special means are granted as a "priority action zone" (socially/economically deprived). A "Parent's house" was created, aiming to support parenthood, and a "homework school" project, where children can be helped after school with their homework, before going home. This support goes beyond homework help, and also targets problems such as the respect of limits, or risky behaviours that children might experiment with. It is difficult to report on indicated drug prevention as no strategies or services specifically exist in this area. Special characteristics of the prevention culture in Belgium within the European context are: heterogeneous objectives and strategies across the federal entities; a common focus on strengthening the network of fieldworkers available for young people; innovative programmes addressing - for example - children, and strong efforts in environmental strategies in recreational settings.

The national drug strategy document, the 'Federal drug policy note of 2001', specifies that the treatment offer should be based on a multidisciplinary approach adapted to the complex bio-psychosocial problem of addiction. In Belgium, different levels of decision-making provide funding for treatment, including the regional and federal governments. For example, at the federal level, the Federal Public Service for Public Health, Food Chain Safety and Environment provides the financing for a number of therapeutic communities, crisis centres and day centres which were set up in the 1970s and have expanded their capacities in recent years. Meanwhile, mental health centres, for example, are financed by the Walloon Region or by the Flemish community.

Different services for treatment and/or healthcare for drug users are available in a large part of the country, except in the German community where specialised treatment centres for drug users are not implemented. Overall, treatment offerings encompass specialised inpatient treatment centres, outpatient centres, low threshold services, units in psychiatric hospitals or psychiatric units in general hospitals, general welfare centres

in general health services and specialised self-help groups. Eight social reception centres are located in the major cities and provide a low threshold access to treatment, counselling and outreach. Most after-care and re-integration programmes are delivered in outpatient and inpatient structures. For example, there are halfway houses in therapeutic communities, day treatment in drug centres and also employment rehabilitation programmes.
The EU emphasizes the importance of health care provisions for drug users in prevention. The underlying aim is once again to prevent and reduce health-related harm associated with drug (ab)use. The emphasis here lies upon the vulnerable prison population. This is why prevention, treatment, harm reduction and rehabilitation services should be provided within the prison equivalent to the services organised outside of prison. There should also be attention paid to development after a release from prison. It is important to monitor the drug problem and drug use in the prisons[76].

5.7. GERMANY

Addiction prevention aims to promote health as far as possible and to maintain abstinence and to prevent abuse. Addiction prevention can only be effective and sustainable if it follows its overall conceptual strategy, and if the various complementary measures of the Federation, the Länder and the local authorities interlink and complement one another[77].
The school environment still remains the most important setting for universal drug prevention in Germany, followed by the family, community and youth sports settings. Prevention activities are primarily focused on three areas; alcohol, tobacco and cannabis. Several large-scale school-based prevention interventions have been implemented[78].
As with the Federal Centre for Health Education campaign, addiction prevention must therefore be orientated towards making children strong. A selective prevention project (FReD goes net) targeting young offenders is now being implemented in 17 Member States.
In Germany, the implementation of **drug treatment** falls under the responsibility of the Federal States and municipalities.

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[76] Sander de Bruijn, European drug policy: the EU Drug Action Plan 2009 – 2012 and the Belgian drug policy, Ghent University 2009 – 2010, p.28.
[77] Key points for the Action Plan on Drugs and Addiction, Drug Commissioner of the Federal Government, June 2002.
[78] http://www.emcdda.europa.eu/publications/country-overviews/de#nlaws

Experts in Germany are calling for more funding for drug prevention and education, so that more can be done than just reacting with hindsight. Victims of illegal drugs in particular, such as heroin, cocaine or hashish, face an alarming situation.
The model "Therapy Instead of Penalty" has also been developed. A drug addict convicted with a prison sentence of less than two years for a criminal offense can go into withdrawal treatment instead of going to jail. The therapy's duration is then deducted from the sentence. Most of the drug treatment takes place in centres and institutions which deal with addiction in general, although there are also treatment units for illicit drug users only.
In Germany, funding of treatment is provided by many actors: the Federal Länder, the German pension and health insurance bodies, municipalities, communities, charities, private institutions and companies.
On 1st April 2000, the Third Narcotics Amendment Act legitimised the operation of drug consumption rooms in Germany. Today, 25 consumption rooms have been opened in 16 cities and six Landers[79].

5.8. FRANCE

The Inter-ministerial Mission for the Fight against Drugs and Drug Addiction (MILDT) is responsible for coordinating France's **demand reduction programs**. Drug education efforts focus on government officials, counselors, teachers, and medical personnel, with the objective of giving these opinion leaders the information they need to assist those endangered by drug abuse in the community.
At a decentralised level (region, department, city), prevention actors enjoy considerable independence in terms of organisation and the implementation of interventions.
So in France, universal **prevention** is mostly carried out in the school environment, with the educational community being largely involved in the coordination and implementation of prevention activities. As part of the 2003–08 drug prevention and education plan, the MILDT and the Ministry of Education, assisted by several institutional partners, have drawn up an intervention guide for school environments, aimed at preventing addictive behavior[80].

[79] International Drug Policy Consortium, http://www.idpc.net/it/node/2116
[80] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/fr#nlaws

Moreover the MILDT is responsible for defining, setting up, and coordinating drug-related policy on illicit and licit drugs. **Three systems are concerned with drug treatment**: a specialised addiction treatment system operating within medico-social establishments, a general care system comprising hospitals and GPs and a risk-reduction system. The provision of treatment to drug users falls under the responsibility of the regional and local authorities. Since 2003, drug treatment has been financed by the French social security system.

France is comparable to the United States in its ability to match its programs to the size of the addiction population. French rehabilitation facilities use similar treatment methods to those used in the United States for treating addictions. Subutex (a trade name for Buprenorphine) and methadone are used to treat heroin addiction[81].

Almost all of the 100 sub-regional administrative areas across France have at least one specialised drug addiction treatment centre, that provide three types of services: outpatient care (medical care or treatment that does not require an overnight stay in a hospital or medical facility. Outpatient care may be administered in a medical office or a hospital, but most commonly, it is provided in a medical office or outpatient surgery center), inpatient care (the care of patients whose condition requires admission to a hospital), and treatment for prison inmates.

Regarding **harm reduction (**officially defined as intended to prevent transmission of infections, death from overdose by intravenous injection of drugs and social and psychological damage linked to drug addiction by substances classified as drugs**)**, the Governmental Plan to fight drugs and drug addiction (2008–11) makes it one of the five axes on which the strategy is built. Since 2004, a harm reduction policy has been incorporated into public health regulations and state jurisdiction.

It is very interesting that in August 2010, the Health Minister Roselyn Bachelot sparked a nationwide debate when she proposed creating "shooting galleries", which would have allowed illegal users to inject and smoke illegal drugs in a medically controlled environment, but Prime Minister François Fillon opposed the experiment – arguing that the priority is to "reduce drug consumption in France, not to support it or organize it".

[81] International Narcotics Control Strategy Report: Volume I Drug and Chemical Control, Bureau for International Narcotics and Law Enforcement Affairs (Washington, DC: United States Department of State, March 2011), p. 259, http://www.state.gov/documents/organization/156575.pdf

In September 2010, a parliamentary committee was set up to investigate drug addiction and to reflect on the shooting galleries proposal[82].

5.9. POLAND

The National Programme for Counteracting Drug Addiction, years 2011-2016, will be implemented in the following fields:

1)Prevention: The primary objective will be the reduction of drug demand. Although survey results show stabilization of the trend or even a drop in drug use prevalence among the young there are still a lot of young people who decide to use drugs for the first time in their lives.
Central governmental agencies established to coordinate activities aiming at drug and alcohol prevention include the National Bureau for Drug Prevention (NBDP) and the State Agency for Prevention of Alcohol-Related Problems.
The Ministry of National Education is responsible for universal drug prevention in schools. Schools and other units in the framework of the education system are **obliged to implement a school prevention programme** for children's and young people's problems which are coherent with a school socialising programme. Such activities include, inter alia, the promotion of mental well-being, the promotion of a healthy lifestyle, information on the dangers of narcotic drugs and psychotropic substances, as well as interventions[83].
In 2008, by way of a Resolution of the Council of Ministers of 19 August 2008, the "Safe and Friendly School" governmental programme for 2008-2013 was approved. The programme aims at building a school which is both supportive and demanding for students. On 23 November 2009, a

[82] International Narcotics Control Strategy Report: Volume I Drug and Chemical Control, Bureau for International Narcotics and Law Enforcement Affairs (Washington, DC: United States Department of State, March 2011), p. 260, http://www.state.gov/documents/organization/156575.pdf

[83] *Act of 29 July 2005 on Counteracting Drug Addiction* (Polish Journal of Laws: Dz.U.2005.179.1485 as further amended); *Regulation of the Minister of Education of 31 January 2003 on specific forms of educational and preventive actions among children and adolescents prone to addiction* (Polish Journal of Laws: Dz.U. of 2003, No. 26, item 226); *Regulation of the Minister of Education and Sport of 11 December 2002 on detailed methods of operation of public psychological and pedagogical counselling centres, including specialised public counselling centres* (Polish Journal of Laws: Dz.U. of 2002, No.5, item 46).

Memorandum of Understanding was signed between the Minister of National Education, Minister of Health and Minister of Sport and Tourism for the promotion of health in children and young people[84].

2)Treatment, rehabilitation, harm reduction and social reintegration. In treatment the main objective will be the improvement of the quality of life of harmful drug users and drug dependent individuals. One of the major tasks will be the professionalization of drug treatment programmes, better access to treatment, development of harm reduction programmes, reducing homelessness and unemployment among harmful drug users and drug dependent individuals. The programme also involves local governments in these actions: communes and Marshal Offices.

Pursuant to Article 26, section 1 of the Act of 29 July 2005 on Counteracting Drug Addiction, treatment of addicts can be provided by public or non-public healthcare centres, as well as practicing medical doctors including doctors practicing within organised medical centres. Health services for drug addicts are provided by an extensive system of outpatient and inpatient health centres, as well as several other means of indirect care, such as day wards and post-rehabilitation programmes. Another type of service, usually linked with outpatient care are substitution programmes. As part of therapeutic programmes, health services are provided both for addicts and their families, i.e. diagnosis, individual and group counselling, psychotherapy, individual and group psychological therapy and critical interventions.

Poland has a long tradition of therapeutic communities aimed at rehabilitation and prolonged abstinence. The first centre was established in 1978.

The implementation of drug treatment falls under the responsibility of communities and provinces, while drug treatment is delivered by different providers. Funding for drug treatment is primarily covered by health insurance, yet also by the public budget of local communities. However, there is also an option to receive treatment at private clinics or from private practitioners, but for an additional fee paid by a client/patient.

Drug treatment services are provided through the network of inpatient and outpatient treatment centres, detoxification wards, day-care centres, drug treatment wards in hospitals, mid-term and long-term drug rehabilitation

[84] 2010 NATIONAL REPORT (2009 data) TO THE EMCDDA by the Reitox National Focal Point, "POLAND, "New Development, Trends and in-depth information on selected issues, p.6, www.kbpn.gov.pl/portal?id=15&res_id...

facilities and drug wards in prisons, and also post-rehabilitation programmes.
In line with the public health perspective of drug treatment, the treatment system in Poland can be differentiated into two approaches: 'drug-free' treatment and pharmacological treatment (i.e. substitution treatment).
Treatment is provided in two modes: outpatient and residential treatment.
a) Outpatient interventions for users of illicit psychoactive substances are provided through addiction counselling centres, mental health counselling centres and day-care centres located in large cities.
b) Residential treatment is dominated by long-term and mid-term residential treatment lasting more than one year. Detoxification which is not a treatment in itself but is the first step to treatment is provided in detoxification wards and usually lasts 8 to 14 days. Outpatient and inpatient drug treatment is mainly delivered by NGOs, followed by public services and private providers. Detoxification is mainly provided by public services, as well as by private clinics and physicians. Polish post-rehabilitation programmes are also implemented, mainly by non-governmental organisations. These are subsidised from the state budgets and with resources from local authorities[85].

3)**Supply reduction:** The primary objective will be the reduction of manufacture, trade and availability of narcotic drugs and psychotropic substances. Poland is one of the chief manufacturers of amphetamines. IT is also crisscrossed by major drug trafficking routes. The Programme will aim at detecting illegal cannabis plantations grown by organized crime groups and combating money laundering. Actions will be taken to reduce drug-related crime on the Internet.

4)**International cooperation**: Strengthening the position of Poland on the international arena will serve domestic actions. Poland will participate in the works of EU institutions concerned with the reduction of drug supply and demand. It also plans bilateral cooperation with other countries. Poland will provide support for Russia, the Ukraine and Belarus so that their actions to combat drug supply and demand will be more effective.

5)**Research and monitoring:** The main aim is support for the implementation of the programme. The Programme includes monitoring

[85] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/pl

the epidemiological situation; assessment of institutional and social attitudes towards drugs and drug addiction; development and consolidation of the information system on psychoactive substances and substitute drugs. The implementation of these tasks will provide room for planning effective and rational actions, e.g. social campaigns and modification of existing policy. It will also be possible to evaluate the effectiveness of spending. Monitoring will also cover the market of new psychoactive substances, including legal highs.

5.10. SWEDEN

The organisation of **national drug prevention efforts** changed somewhat in 2008. The commission, Mobilisation Against Narcotics, which coordinated narcotics policy efforts, and the Alcohol Committee, which had the corresponding task in the alcohol area, were disbanded at the end of 2007 and their activities were transferred to SNIPH and the Swedish National Board of Health and Welfare. To coordinate national policy concerning efforts against alcohol, narcotics, doping and tobacco, a special workgroup with representatives from all ministries involved was established at the Government Offices (SAMANT) and a special ANDT Secretariat was established[86].

School-based prevention programmes have played an important role in municipalities and schools. Training in motivational interviewing for school healthcare staff has been carried out in a third of the municipalities and many interventions aim to improve the psychosocial climate in schools. Social and emotional training, which aims to develop children's social and emotional capacity is widespread in Sweden. Selective prevention in recreational settings is carried out by municipalities and the entertainment industry, with a focus on norm-setting and controlling approaches. Special characteristics of the prevention culture in Sweden within the European context are, besides the importance given to checking individuals for signs of drug use, a strong local community-based delivery of prevention which comprehensively tackles alcohol alongside illicit drugs, and provides much research into new prevention approaches[87].

According to the Social Welfare Act of 1980, "The Social Welfare Committee shall actively ensure that the individual addict receives the help

[86] http://www.fhi.se/en/Publications/Summaries/Drug-prevention-work-in-Sweden-2008/

[87] Country Overview, European Monitoring Centre for Drugs and Drug addiction, http://www.emcdda.europa.eu/publications/country-overviews/se#prev

and care that he or she needs to escape from addiction."[88] The **treatment system** is closely tied to the notion of a drug free society and to the enforcement of abstinence; abstinence-based interventions form the greater part of Sweden's treatment provision.

Treatment is mainly delivered by public institutions, followed by private and non-governmental organisations. Funding of substance treatment, including treatment delivered by NGOs, is provided by the public budget of the municipalities, which are also subsidised by state funds. In the case of NGOs, public funding is handled by the National Board of Health and Welfare and is based on applications from the NGOs.

The role of social workers is very important in the Swedish treatment system, as these professionals provide links within the "care chain". Composed of outreach, detoxification, institutional facilities, aftercare and rehabilitation, the care chain is an important concept that ties together the various elements of the drug control regime. Thus, working in close cooperation with the police, social workers play a key role in the initial identification of drug users on the streets; if the police locate a drug user, they bring him or her to the attention of a social worker who will decide upon the proper course of action. Social workers as a profession have also played a significant political role, which will be discussed below.

As regards social reintegration, there are reports of social reintegration interventions, although they seem to be modest in availability and coverage.

[88] RFHL & Swedish Association of Local Authorities and Regions (2008) "*Your Rights and Options in Treatment and Care of Drug Addicts*" P.2 Available at: http://www.socialstyrelsen.se/Lists/Artikelkatalog/Attachments/8707/2008-124-9_20081249.pdf

6. CONCLUSIONS: INDIVIDUATION OF BEST PRACTICES.

Many of the problems the drug war purports to resolve are caused by the drug war itself. So-called "drug-related" crime is a direct result of drug prohibition's distortion of immutable laws of supply and demand. Public health problems like HIV and Hepatitis C are all exacerbated by zero tolerance laws that restrict access to clean needles.
In the Report of the Global Commission on Drug Policy, we can read "The global war on drugs has failed, with devastating consequences for individuals and societies around the world…. Vast expenditures on criminalization and repressive measures directed at producers, traffickers and consumers of illegal drugs have clearly failed to effectively curtail supply or consumption. Apparent victories in eliminating one source or trafficking organization are negated almost instantly by the emergence of other sources and traffickers. Repressive efforts directed at consumers impede public health measures to reduce HIV/AIDS, overdose fatalities and other harmful consequences of drug use.[89]"
The Commissioners in that Report gives some **principles and recommendations,** useful in changing the national laws**:**

1. End the criminalization, marginalization and stigmatization of people who use drugs but who do no harm to others.
2. Encourage experimentation by governments with models of legal regulation of drugs to undermine the power of organized crime and safeguard the health and security of their citizens.
3. Offer health and treatment services to those in need.
4. Invest in activities that can both prevent young people from taking drugs in the first place and also prevent those who do use drugs from developing more serious problems.
5. Focus repressive actions on violent criminal organizations, but do so in ways that undermine their power and reach while prioritizing the reduction of violence and intimidation.

So, if the "war on drugs" has failed, it is interesting to analyze some of the legislation that has followed a pragmatic approach, based on the idea that drug addiction is an illness, not a crime.

[89] War on Drugs, Report of Global Commission on Drug Policy , June 2011, www.globalcommissionondrugs.org

What we can understand by making international comparisons is that the zero tolerance approach does not work and that for an **approach** to be **effective** and lead to a solution to drug-related problems, it needs to be **comprehensive, multidisciplinary, and well balanced.**

Such an approach must be based on robust nationwide, interdepartmental, interdisciplinary, and inter-agency collaboration at all levels.

The phenomenon of drugs and drug addiction has many determinants and dimensions. In order to facilitate the development of a consistent policy in relation to the phenomenon and its derived manifestations, it is not only necessary to consider the different perspectives, but also to have the vital collaboration of all agents with responsibility in the sectors of activity concerned. In this dual sense, coordination is the basic principle which needs to be followed in order to develop the Strategy correctly.

In conclusion, following an analysis of the various legislations and in particular of the best practices, we can identify the elements necessary for a good legislation:

1. composition of the body in charge of the procedure so that at least one member belongs to the sphere of Health,
2. drug supply reduction (controlling the sale and distribution of legal drugs and clamping down on the illicit manufacturing and supply of illegal drugs),
3. drug demand reduction (primary prevention, treatment, and social reintegration of users),
4. reduction of the harm associated with drug use.

COMPARISON BETWEEN ITALIAN AND PORTUGUESE DRUG LEGISLATION

Elena Ventura

INTRODUCTION

The debate about drug policy is often represented as a polarized choice between two options, "prohibition" and "legalization". The reality is that there are multiple options that are in no way reducible to a simple dichotomy between these two extremes.
Moreover, the choice of taking one path rather than another one, could produce a lot of different and unexpected effects. So a comparative analysis will be built up in order to analyze advantages and disadvantages connected to the respective national legislation of Italy and Portugal.
We want to demonstrate that prohibition alone is not a solution. The main purpose of such a law, in fact, appears to be penalization, whilst frightening and repressing young consumers of drugs; such a policy does not give enough attention to rehabilitation.
The evidence that a zero tolerance approach has failed on its own terms is overwhelming: drug use and drug markets continue to expand.
For this reason, it is very important to analyze and compare the different national legislation regulating the consumption and the trafficking of illicit drugs, in order to ascertain their effects on the economy and on society, and assess the best practices.
In particular it is interesting to analyze the legislation of Portugal. Surprisingly, in fact, Portugal, a small country known for its conservative values, strong Catholic tradition, and recent emergence as a democracy, has become an international model for drug policy reform[90].

[90]Drug Policy in Portugal: The Benefits of Decriminalizing Drug Use; Artur Domosławski, June 2011

What makes the Portuguese case special is that decriminalization was not, as in other countries, associated with an increasing prevalence of cannabis use among young people and the consequent difficulties for law enforcement bodies in coping with it. In Portugal, problem drug users, mainly heroin users, were the focus of the policy discussions and it was with them (and their problems) in mind that it was decided to change the law in 2000. It is understood that behind the use or abuse of drugs there is a discomfort and health problem to treat rather than a crime to be punished.

The second aspect that can be clarified from this policy profile is that the decriminalization of drug use should be understood as only one element of a larger policy change that has:

• progressively removed responsibilities from the Ministry of Justice to give them to the Ministry of Health;

• led to more integrated and detailed plans;

• highlighted the importance of evaluation as a policy management tool; and

• brought alcohol and drug policy closer together.

These changes have a strong public health orientation and this might be the best way to characterize the Portuguese drug policy today.

The positive effects of Portugal's experiment with drug policy have been corroborated by research, and the Portuguese people's reactions to it have been verified by reliable surveys; this experience can and should be a lesson for a world caught up in a failed "war on drugs." The innovative nature of the Portuguese approach proves that it is not generals, police officers, or criminal court judges, but rather doctors, social workers, and researchers who need to address drug-related issues.

1. HISTORY

1.1. ITALIAN LEGISLATION:

The history of Italian drug legislation can be divided into these steps:

1. **The overture of Italian legislation is represented by Laws prior to the reform of 1975.**

This step is characterized by a very repressive attitude. Not only were drug dealers were punished but consumers were imprisoned.
Penalization and the repression impeded the therapeutic and social approaches.

2. **The second step is represented by Law 685 of the 22nd of December 1975.**

This phase covers the period from 1975 to 1990.
According to this law the drug user, who is not at the same time a drug dealer and doesn't possess a large quantity of drugs, was considered a patient that needed to be cured and to rehabilitated. The punishment was given to people in possession of drugs up to a certain threshold. This threshold was determined by the expression, a "modest quantity". The problem was that this threshold was not precisely and a priori determined.

3. **The third step is represented by Law n.162 of the 26th of June 1990.**

This law was coordinated with the " Testo unico delle Leggi in materia di stupefacenti- decreto Presidenza Repubblica 9 ottobre 1990 n.309".
This legislation inverted the previous logic and expressed a negative judgment about trafficking, dealing and, moreover, the consumption of drugs , that was sanctioned with an administrative penalty. Although the possession of drugs does not exceed the "daily dose", was punished with administrative sanctions.

Reasons for this reform were:

a) The gravity of the phenomenon of drug use;
b) Penalization had not succeeded in downsizing consumption;

c) The large proliferation of AIDS, which made health services and diseases prevention relevant to drug policy.

4. **The fourth steps started with the Referendum to repeal the Law of 18-19th of April 1993.**

Through that Referendum decisive articles of Law 162/1990 have been repealed.
The consequences were that :

a) personal use of drugs without therapeutic reason, before forbidden by art. 72, were not sanctioned by criminal law.
b) Instead any activities concerning drugs not destined for personal use, were sanctioned by art.73.
c) The import, purchase and possession of drugs for personal use were given an administrative sanction by the Prefect, that is an organ, representative of the government subordinate to Minister of the Interior, who was uniquely authorized to intervene; but the reform has the consequence of depriving him of a concrete dissuasive power.

5. **Finally the fifth steps started with Decree-Law n.272 of 30th December of 2005, transformed into law, with amendments, by Law n.49 of 21th of February of 2006., that amended the DPR of 9th of December 1990 n.309.**

Law 49 of February 2006, known as the Fini-Giovanardi Law has a lot of critical aspects. Just think about the procedure by which the law was passed: as a result of the transformation of the Decree-Law of 30 December 2005, n. 272, devoted to urgent measures to ensure the safety and funding for the Winter Olympics and not providing a Decree Law specifically dedicated to drug problems). Moreover, also from the point of view of content there are many unclear aspects, as will be demonstrated below.

1.2. PORTUGUESE LEGISLATION[91]:

1. The origin of Portuguese legislation: the1920s.
In the 1920s Portugal adapted its own national legal framework to the recommendations of the International Opium Convention of 1912, but for almost 40 years after that (until the treatment of "drug addiction" was mentioned in the 1963 mental health law) no other legislation was passed on illicit drugs.

2. Drug use became visible as a health problem: the 1970s

a)The first law to regulate the production, traffic and use of narcotics (Decree-Law 420/70) was approved in 1970, providing the legal framework for the criminalization of drug use.

Main aspects:
-The concept of **narcotic drugs** was legally defined;
-**Personal possession offences** would be punished with up to two years' imprisonment or a fine of PTE 5 000 to 50 000 (EUR 25 to 250).
-**Traffickers**: could be punished by **two to eight years in prison**.
-**Consumption** causing danger or encouraging others to consume: would be punished **by six months to two years in prison or by a fine.**

b)One year later, Portugal ratified the 1961 UN Single Convention on Narcotic Drugs and a first addiction treatment service was opened in 1973.
Political debates at that time focused on the moral aspects of drug use.
It was considered the source and cause of crime and of the increasing social opposition to the political regime.
The main purpose was stopping the phenomenon from spreading, because it was seen necessary to keep Portuguese young people out of "physical and moral degradation".

c)The first changes were made to Portuguese drug policy following the democratic revolution of 1974, when there was a sudden increase in experimentation with drugs, which was associated with the idea of new-found freedoms.

[91]Drug Policy Profiles, Portugal, European Monitoring Centre for Drugs and Drug Addiction, June 2011.

In reaction to this, **two governmental bodies** were established under the Council of Ministers:
-the ***Centro de Estudos da Juventude*** (Youth Studies Centre) for developing prevention and treatment research;
-the ***Centro de Investigação Judiciária da Droga*** (Drug Criminal Investigation Centre), concerned with law enforcement and supply reduction.

d)In 1976, the notion of drug use decriminalization was introduced for the first time within the national legal framework.
The foreword to a legal text that enlarged the mandate of the Youth Studies Centre suggests that the "concept of drug use as a criminal act" should be revised and replaced 'when justified, by a set of norms' to bring it under an administrative offence framework. The response to drug use would thus move from a criminal penalty model towards 'clinical treatment and the qualification of the drug user as a patient and not as a criminal'[92].

3. In the 1982 with the growing visibility of drug problems, services created during the previous decade were re-structured and responsibility for them was moved, for budgetary and operational reasons, to the Ministry of Justice. This brought the whole area, including treatment and prevention, closer to the criminal justice system.

4. In 1983: Decree-law 430/83.
Main Aspect:
-The new law adapted the national legal framework to the 1971 UN Convention on Psychotropic Substances (which Portugal had ratified in 1979);
- increased the repressive focus on drug trafficking;
- maintained that the use of illicit drugs was 'socially condemnable', thus retaining its status as a crime;
-the law recognized the drug user as a patient in need of medical care, stating that the priority was to treat and not to punish. This brought the Ministry of Health into the drug policy area and allowed for the opening of its first treatment centers. Most treatment centers and prevention services, however, were still under the auspices of the Ministry of Justice.

[92]Rather Treat Than Punish, The Portuguese Decriminalization Model, Fátima Trigueiros, Paula Vitória and Lúcia Dias, 2010

5. In 1987, following increases in heroin problems and in drug trafficking operations, a first National Programme to Fight Against Drugs, Project VIDA, was adopted.
The programme, overseen by the Council of Ministers, was a major drug policy development, being the first indication of a comprehensive and integrated drug policy in Portugal, covering both demand and supply reduction. It also reflected a stronger and increasing political commitment to addressing drug problems.

6. In 1993, a new drug law was adopted and remains today the primary Portuguese law on supply reduction.
This law transposed the recommendations of the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, focusing on drug money laundering and control of drug precursors. It maintained the criminalization of drug use but developed a specific approach to it.

7. In 1998, the government appointed the Commission for the National Strategy to Fight against Drugs, with the mandate to produce a report with guidelines for the 'fight against drugs and drug addiction', namely on the topics of prevention, treatment, social reinsertion, training, research, risk reduction and supply control. The Commission had nine members, including five recognized (legal or health) experts/researchers in the drugs area, two from the relevant public bodies in the Health and Justice Ministries. The Commission made use of its broad mandate and delivered its report to Parliament the same year, recommending the decriminalization of drug possession and use for both "hard" and "soft" drugs as the most effective way of limiting drug consumption and reducing the number of drug dependent persons[93]. The committee recommended that, along with the legal changes, the government should concentrate on prevention and education, harm reduction, broadening and improving treatment programs for drug dependent persons, and activities that helped at-risk groups and current drug users maintain or restore their connections to family, work, and society.

[93] Results were presented in the content of the "Portuguese Drug Strategy," 1999.

8. The Parliamentary Committee on Drugs unanimously approved the report and, one year later, the Council of Ministers formally approved its content, which became the 1999 National Strategy for the Fight Against Drugs (Portuguese Government, 1999).

9. One important proposal of the new drug strategy was the decriminalisation of drug use that was discussed and approved by Parliament and implemented with Law 30/2000, which entered into force on 1 July 2001.
This law established a system of 'dissuasion commissions' that is unique in Europe and managed by the Ministry of Health, rather than the Ministries of Justice or the Interior

10. A new legal basis for harm reduction measures was also adopted, in the form of Decree-law 183/2001, on 21 June 2001. This comprehensive law regulates harm reduction interventions overall, as well as drop-in centres for drug addicts, refuges and shelters, mobile centres for the prevention of infectious diseases, low-threshold substitution programmes (methadone and buprenorphine), syringe and needles for heroin-injecting exchange schemes[94], programmes for supervised drug use (though none were set up), contact and information units and street workers.

Even if you only compare the historical excursus we find the first differences between Italy, which has continually changed its strategy, often going backwards, and Portugal which has had a much more consistent path.

[94] Needle exchange is a well-documented intervention and is supported by major health institutions, such as the World Health Organization and the National Institutes for Health (United States). In a recent review of needle exchange in Australia between 2000 and 2009, it was estimated that around 27–31 million needles were given out, avoiding an estimated 32,050 HIV infections. For every dollar spent, the government saved four dollars in short-term health care costs. See: National Centre in HIV Epidemiology and Clinical Research, *Evaluating the Cost Effectiveness of Needle and Syringe Programs in Australia*, 2009.

2. ACTUAL ITALIAN DRUG POLICY

The main aspects of **Law 49 of 21st of February 2006, that has emended the DPR of 9th of December 1990 n.309** are:

1) The tightening of sanctions relative to behaviours of productions, traffic, illicit detention and use of drugs.
2) All drugs received the same treatment by Law with abolition of any distinction between soft drugs (as Cannabis) and hard ones (as Heroin and Cocaine).
3) There are 2 tables of substances and not 4.
4) The concept of "quantity" to distinguish between personal use and drug pushing has been introduced again.
5) Possession of Cannabis is punished in the same way as Cocaine and Heroin: imprisonment from 6 to 20 years.
6) Still there are mitigating circumstances (circumstances which, if present, allow to reduce the sentence) for no serious facts: imprisonment from 1 to 6 years
7) Art.73, as amended by Law, establishes that in case of sentence for minor crimes, if there is not the possibility of making use of a suspended sentence, it could be possible to ask for the offender to work for a period correspondent to the punishment inflicted. There is an appropriate Local Office that has the duty of verifying that work of public utility is carried out. In case of violation the Judge could revoke his decision and impose another penalty. Work for Public utility can substitute the original penalty not more than twice.
8) For personal use administrative sanction are always established that could last up to 1 year.
9) For consumers that are at the same time considered to be a danger to society safety measures are established, such as: a) the obligation of presentation to Police; b) the prohibition of going to public places; c) the prohibition of driving vehicles.
10) The form of arrest known as "*House arrest*" (which allow the offender to serve a sentence in their own homes, or in another private house or in a public place of care and treatment) has become the norm, instead of custody, for the drug addict who is following a treatment programme (or who has the intention of starting it) in Public or authorized Private centres.

11) The certification of the state of a drug addiction can be given not only by public services but also by private agencies in order to obtain punishments that are alternative to prison or to suspend punishment.

Consequences of this changes:

d. Harm reduction and therapeutic programmes are weakened.
e. The main purpose is to penalize , frighten and repress young consumers of drugs.
f. The Government does not appear to really be interested in rehabilitation.

The last point is particularly evident when analyzing the new version of article 75 of Italian law, especially if compared with the old text. The most critical aspect of the new version of Article. 75, in fact, consists in the fact that it preferred a purely punitive-repressive punishment in comparison to the educational and rehabilitation option.

Article 75 is included in Title VIII, entitled "THE REPRESSION OF ILLICIT ACTIVITIES". To better understand the innovations of the reform it is appropriate to compare the old and the new text of art. 75 amended by the Decree-Law n.272 of 30th December of 2005, transformed into law, with amendments, by Law n.49 of 21st of February 2006.

	PREVIOUS VERSION OF ARTICLE 75	NEW VERSION OF ARTICLE 75	MAIN ASPECTS
CONDUCT HELD TO BE ILLEGAL	Personal use, illicit import, purchase or holding of psychotropic drugs.	Illicit import, export, buying, receiving or holding at any drugs or psychotropic substances.	
ADMINISTRATIVE SANCTIONS	a) suspension of driver's license, b) a license to carry firearms, c) passport and any other document or equivalent, d) for foreigners, a residence permit for tourism or the prohibition to obtain these documents, (1) for a period of two to four months, when it comes to drugs or psychotropic substances included in Tables I and III referred to in Article 14, and (2) for a period of one to three months, when it comes to drugs or psychotropic substances included in Tables II and IV under the same Article 14.	a) suspension of driver's license or prohibition of achieving it; b) suspension of a license to carry firearms or prohibition on obtaining one; c) suspension of passport and any other equivalent document or prohibition on obtaining them; d) Suspension of the permit for tourism or ban get it if non-EU citizen.	Administrative penalties are identical to those of the previous Article 75, but the period of sanctions changes ranging from one month to one year, without any discrimination between soft and hard drugs.

	PREVIOUS VERSION OF ARTICLE 75	NEW VERSION OF ARTICLE 75	MAIN ASPECTS
POWER TO APPLY ADMINISTRATIVE SANCTIONS	Prefect of the place where the act was committed.	The Prefect responsible for the area in relation to 1) place of residence or, 2) place of domicile and, 3) where these are unknown, in relation to the place where the crime was committed.	
PROCEDURE	a) If the acts provided for in paragraph 1 shall cover the substances listed in Tables II and IV and it is believed that the person will abstain for the future from committing an offence again, instead of punishment, and for once the Prefect terminates the procedure with the formal invitation not to use more drugs. b) Make sure the facts, the judicial police without delay report to the Prefect. c) Within five days from the report before, the Prefect or his delegate meets the subject to clarify the	a) The person concerned if they have prerequisites, are invited to follow the treatment program and social rehabilitation of Article 122 or another educational program, prepared by the Public Service Addiction responsible for the area similar to the provisions of paragraph 13 or by a private facility authorized under Article 116. b) Make sure the Police report without delay and no later than ten days, to the	As before, there is the formal invitation from the Prefect to follow a specific program of rehabilitation, designed specifically in relation to the case and the person. The critical aspect, however, is that the new law with the rehabilitation program is no longer an alternative to sanctions that are imposed in all cases. Moreover there is just a general invitation to the

	reasons of the violation, and to find useful measures to prevent further violations. In this activity, the Prefect is assisted by a staff consisting of an operative system, that exists in each prefecture. d) The judicial police may ask the person against whom the complaint is made, to report immediately, if possible, to the Prefect or his representative. e) Where the person concerned voluntarily requested to undergo counseling and social rehabilitation as provided for under Article 122, the Prefect, if they think fit, may suspend the proceedings and provide that the applicant is sent to the public service for Addiction for the preparation of the program, setting a deadline for the acquisition and taking care of the necessary data to assess the overall behavior during the execution of the program, subject to the confidentiality required by the regulations for the purposes of	competent Prefect with the results of toxicological testing carried out on substances seized. c) Within forty days after receipt of the alert, the prefect, meets the subject or his delegate: - To assess, as a result of the interview, the administrative sanctions to be imposed and their duration; - And, where appropriate, to formulate the invitation referred to in paragraph 2. e) If it appears that the person concerned has successfully completed the program referred to in paragraph 2, the Prefect can revoke sanctions, by giving notice to the Chief Justice and the competent authority.	person. Consequently, it is not easy to identify the rationale behind this strategy, because they will be subject to sanction in any case and are unlikely to opt for rehabilitation. Compared to the previous procedure it seems almost as if the moments of promoting rehabilitation and recovery, managed as part of the interview referred to the Prefecture and overseen by the department for drug addiction, are overshadowed by the repressive function attributed to the sanction.

	PREVIOUS VERSION OF ARTICLE 75	NEW VERSION OF ARTICLE 75	MAIN ASPECTS
	any provision of the Law. f) The Prefect makes use of local health units and any other structures located in the province that carries out activities of prevention and recovery. Can obtain information at the same structures, in order to assess the appropriateness of treatment. g) If it appears that the subject has implemented the program, with a positive result, the Prefect prepares the filing of documents. h) If the applicant does not submit to the public service for drug addiction within the time indicated and the program does not start according to the requirements laid down or is interrupted without justification, the Prefect meets them again and invites them to participate in the program.	f) In the violation is tenuous in nature, and if there are conditions such as to suggest that the person will abstain from committing the offence again, instead of a punishment the Prefect can make a formal invitation to the subject to take no more substances.	

3. DRUG STRATEGY OF PORTUGAL

a. New drug strategy of Portugal

One important proposal of the new drug strategy of Portugal is the decriminalisation of drug use that was discussed and approved by Parliament and implemented with Law 30/2000, which entered into force on 1 July 2001.

With decriminalization the state would maintain the rule of prohibition but take sanctions for drug use outside the framework of criminal law. Decriminalization, in fact, differs from depenalization because the purchase, possession, and consumption of illicit drugs remain criminal offences and carry criminal sanctions[95].

The new law of 2000 **maintained the status of illegality for using or possessing any drug** for personal use without authorization. **However, the offence changed from a criminal one, with prison a possible punishment, to an administrative one**.

Moreover, Portugal's reforms have not been limited to treating drug possession as an administrative offence; they also **include a wide range of measures** such as prevention and social education, discouraging people from further use of controlled substances, harm reduction, treatment for drug dependent people, and assistance in reintegrating them into society.

This law established a system of "**Dissuasion Commissions**" that is unique in Europe and managed by the Ministry of Health, rather than the Ministries of Justice or the Interior[96], and this was an important symbolic step that reflected the new approach to drug policy[97].

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[95]According to the EMCDDA: "Decriminalization" comprises removal of a conduct or activity from the sphere of criminal law. Prohibition remains the rule, but sanctions for use (and its preparatory acts) no longer fall within the framework of the criminal law. [By contrast], "depenalization" means relation of the penal sanction provided for by law. In the case of drugs, and cannabis in particular, depenalization generally signifies the elimination of custodial penalties. For a fuller discussion of the differences between decriminalization and depenalization, see Greenwald, G. (2009), *Drug Decriminalization in Portugal*; *Lessons for Creating Fair and Successful Drug Policies,*The Cato Institute, p. 2.

[96] Drug Policy Profiles, Portugal, European Monitoring Centre for Drugs and Drug Addiction.

[97]Prior to this two different structures coexisted: the Portuguese Institute on Drugs and Drug Addiction, under the Council of Ministers Presidency, and the Cabinet for Planning, Coordination and Fighting Against Drugs under the Ministry of Justice.

The commissions seek to inform people and dissuade them from drug use and also have the power to impose civil sanctions for non compliance and to refer consenting persons to treatment.

When a person is caught **in possession of no more than 10 daily doses of drugs** (their corresponding gram limits had already been established in a regulation: the law stipulates the permissible amount in detail—in grams or pills—of each drug: cannabis, 25 grams; hashish, 5 grams; cocaine, 2 grams; heroin, 1 gram; LSD or ecstasy, 10 pills), and the police have no suspicions or evidence that supply offences are involved, the drug will be seized. The case will then be transmitted to **the Commission for the Dissuasion of Drug Abuse (CDT),** of which there is one in each of Portugal's 18 districts.

The CDT is composed of **three members** appointed by the Ministries of Justice and Health (the member appointed by the Ministry of Justice has to be **a legal expert**, the other two usually being a **health professional and a social worker**).

These Commissions, evaluate each case with the help of a technical team to assess whether the person is an occasional or a dependent user, or a dealer.

Several options are available to the CDT when ruling on the drug use offence, including **warnings**, **banning from certain places**, **banning from meeting certain people**, obligation of periodic **visits to a defined place, removal of a professional licence or firearms licence**[98]**.** Sanctioning by fine, which may vary by drug involved, is an available option (though not for addicts) but it is not the main objective in this phase.

When the quantity of controlled substances in possession is **larger than 10 daily doses or if a person is charged with selling drugs (also in case it is less than max. quantity for personal possession), he/she will be send to the criminal court.**

Behind the change of approach toward drug consumption there was a recognition of the need to respect human dignity, understand the life choices and social circumstances of others, and uphold the constitutional right to health[99].

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[98] For a full list of available sanctions, see Law 30/2000.

[99] The Portuguese Drug Strategy, 1999, provides that: "The guarantee of access to treatment for all drug addicts who seek treatment is an absolute priority of this national drug strategy. The humanistic principle on which the national strategy is based, the awareness that drug addiction is an illness and respect for the State's responsibility to satisfy all citizen's constitutional right to health, justify this

From the viewpoint of Portuguese policymakers, drug dependence was a disease that society must take efforts to prevent, and drug dependent persons were patients needing help, not dangerous criminals needing to be locked away from society.

A policy was formed which could, it was thought, bring positive results only when all its elements worked well and there were no "gaps." It had to be comprehensive and include all the issues directly and indirectly related to drug use. These main issues could be divided as follows: prevention; Dissuasion Commissions; risk and harm reduction; treatment; and return toa healthy life in society[100].

The **overall responsibility for drug policy coordination lies with the Inter-ministerial Council**, a coordinating body chaired by the Prime Minister and comprising the National Drug Coordinator and 10 ministers (Assistant Minister of the Prime Minister and the Ministers of Justice, Health, Education, Welfare and Employment, Home Affairs, Foreign Affairs, National Defence, Finance and Cities and Environment. This list could vary slightly according to government restructuring). The Inter-ministerial Council set up an Inter-ministerial Committee, chaired by the National Coordinator and comprising representatives designated by the Ministers themselves.

The **Institute on Drugs and Drug Addiction (IDT)** is located under the Ministry of Health and is in charge of implementing the National Strategy and the Action Plan. The President of the IDT is the National Drug Coordinator for both demand and supply issues, although the Criminal Police *(Polícia Judiciária)* at the Ministry of Justice coordinates interventions and information on supply reduction.

In 2010, the coordination mechanisms' arrangements were revised to include a mandate on the definition and implementation of policies on alcohol misuse. The Ministries of the Economy, Labour and Agriculture were added to the newly renamed Inter-ministerial Council for Drug-related Problems, Drug Abuse and the Harmful Use of Alcohol, and the national drugs coordinator is now also the national coordinator for the harmful use of alcohol. The coordination mechanisms now have an explicit responsibility to promote the integration of drug- and alcohol-related policies.

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fundamental strategic option and the consequent mobilisation of resources to comply with this right."

[100]Drug Policy in Portugal: The Benefits of Decriminalizing Drug Use; Artur Domosławski, June 2011

The National Council for the Fight Against Drugs, Drug Addiction and the Harmful Use of Alcohol is an advisory body, chaired by the Minister of Health. It is composed of representatives of the regional governments of Madeira and the Azores, the Judiciary, the General Prosecutor and civil society, as well as five personalities designated by the government. It advises the government on national strategies and action plans, and follows reports of their implementation.

b. Positive results[101]

So far, the Portuguese system has yielded positive results.
According to a study from 2001, 7.8 percent of the Portuguese population had tried an illicit drug in their lifetime, whereas according to a study from 2007 the number has increased to 12 percent[102].
Drug consumption, especially cocaine, has increased in all age groups, but there is an exception and it has a special meaning. According to the analysis of the 15–24 age group, drug consumption from 2001 to 2007 has risen from 12.4 percent to 15.4 percent with a substantial increase among 20- to 24-year-olds. However, the level of drug use in the most "sensitive" group (15–19) has decreased from 10.8 percent to 8.6 percent. Moreover, studies conducted among two age groups of school pupils (13–15 and 16–18) have also shown that drug consumption decreased after 2001.
While the spread of the HIV epidemic among injecting drug users (IDUs) had largely increased up to 1997, the numbers of infections caused by drug injection have subsequently consistently gone down.
The number of individuals accused and convicted for crimes against the drug law has also significantly reduced between 2003 and 2009, hence removing a heavy burden on the criminal justice and prison systems. Since the fear of arrest and incarceration has disappeared and the levels of stigma attached to drug use have decreased, more drug users agree to access the health care services they need. Currently, over 38,000 people follow a drug dependence treatment programme. With regards to law enforcement activities, as police and customs forces have more time and resources at their disposal, they are able to target high level traffickers more efficiently, and increase the number of annual drug seizures.

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[101] Informal Drug Policy Dialogue, Lisbon 21-22 January 2011, IDT.
[102] IDT study (Nucleo de Estudos e Investigacao), Portugal—Drug Research and Trends in DrugUse since 2001.

In terms of impact, it took almost a decade for the Portuguese model to attract international attention.

It is the 2008 report from the Cato Institute that put the Portuguese model at the forefront of the drug policy reform debates. In Australia, for example, the report captured the interest of policy makers, after years of inability from the central right government to discuss drug policy issues. However, some scepticism was expressed as to the message of the report – some participants felt that the report put too much importance on decriminalisation and tended to ignore the fact that **decriminalisation in Portugal is part of a more complex policy** aimed at providing health and social services to those in need.

According to Portuguese and international experts, these positive trends are rooted in a drug policy that offers treatment to people who are drug-dependent, instead of treating them like criminals. Levels of drug consumption in Portugal are currently among the lowest in the European Union[103].

As far as cannabis consumption is concerned, Portugal is "behind" Belgium, Denmark, Finland, France, Germany, Great Britain, Greece, Ireland, Luxembourg, the Netherlands, Norway, Spain, and Sweden, according to a study covering the years 2001–2005. In the case of cocaine consumption, Portugal is only "ahead" of Greece, Lithuania, Luxembourg, Poland, and Romania; other EU countries have a higher or much greater consumption of this drug.[104]

This trend did not decrease in subsequent years as the studies published by EMCDDA confirm. The 2010 statistical bulletin shows that only 8 out of 28 European countries studied have a lower cannabis consumption than Portugal, 10 of 27 countries studied have a lower cocaine consumption, 4 of 27 a lower amphetamine consumption, 4 of 27 a lower ecstasy consumption, and 5 of 23 a lower LSD consumption[105].

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[103]The European Monitoring Centre for Drugs and Drug Addiction (hereafter, EMCDDA), *Statistical Bulletin 2010,* "Lifetime prevalence of drug use in nationwide surveys among the general population." Only 8 out of 28 surveyed countries have a lower cannabis consumption than Portugal, 10 out of 27–cocaine, 4 out of 27–amphetamine, 4 out of 27–ecstasy, 5 out of 23–LSD.

[104] IDT, *Annual Report 2007*, as quoted in: Greenwald, G. (2009), *Drug Decriminalization in Portugal*, Cato Institute.

[105]EMCDDA, 2010, *Statistical Bulletin 2010, Lifetime Prevalence of Drug Dse in Nationwide Surveys among the General Population*, available at: http://www.emcdda.europa.eu/stats10/gpstab1b.

Finally, the success of the Portuguese model has been recognized at the international level. At first concerns were raised by the International Narcotics Control Board[106] and others (e.g., the United States) that Portugal was in breach of UN drug conventions in adopting the decriminalization policy.

[106]See INCB, 2001, *Report of the International Narcotics Control Board for 2001*, pp. 167–169, E/INCB/2001/1.

4. SIMILARITIES AND DIFFERENCES BETWEEN ITALIAN AND PORTUGUESE DRUG POLICY.

As seen above, the Italian law on drugs is very different from Portuguese one. However, it is interesting to compare them in order to find possible similarities and differences and to verify the possibility of importing to our advantage the efficient aspects of Portuguese law.

4.1. Conducts that constitute administrative offenses.

1.a) Art. 75 of Italian Law n.49 of 21 February 2006, which amends the DPR of 9th of December 1990 n.309, considers the following behaviors as administrative offenses: it is unlawful to import, export, buy, receive or hold drugs or psychotropic substances outside of the assumptions referred to in Article 73, paragraph 1, and medicines containing narcotic or psychotropic substances listed in Table II, sections B and C outside the conditions laid down in Article 72, paragraph 2.
The premise for their application, therefore, is that the conduct is outside the assumptions referred to in Article 73, paragraph 1-bis (Import, export, buying, receiving or otherwise in any way illegally stocking) and that the person holds psychotropic drugs that are not exclusively intended for personal use or medicinal products containing narcotic or psychotropic substances listed in Table II, section A, which exceed the quantity prescribed. In this latter case, these sentences have declined by a third to a half) and outside the conditions laid down in Article 72, paragraph 2 (which allows the therapeutic use of medicinal preparations with a basis of narcotic or psychotropic substances, properly prescribed according to the needs of care in relation to particular pathological conditions of the subject).
The threshold of criminality is established only with the concept of "personal use", without further specification. The absence of indicative elements creates, therefore, a lot of uncertainty in the determination of quantity for personal use.
The decision on this element (whether a quantity of drugs in possession by an individual is or is not intended for personal use) must be conducted on the basis of all of the criteria mentioned in regulation (relative, however, to the quantity of the active ingredient and not the weight itself); so taking into account not only if the limits indicated are exceeded but also all other circumstances.

There may, indeed, be cases where, although the quantity exceeds the maximum permitted quantity of an active ingredient there are other circumstances indicating that the substance is intended for personal use only, implying the need for the application of only one administrative penalty.

It is also possible that, although percentage limits are not exceeded, other factors demonstrate that the use of a substance is not for personal use, with a criminal punishment being subsequently applied.

1.b) Article 2 of Portuguese Law no. 30/2000, of 29 November establishes that the **consumption, acquisition and possession for own consumption** of plants, substances or preparations listed in the tables referred to in article 1 (plants, substances and preparations subject to the framework established here are those listed in tables I to IV attached to Decree-Law no. 15/93 of 22 January.) constitute **an administrative offence**.

It follows, therefore, that our right, as the Portuguese, respectively, provides in Article 75 Law 309/2006 and Art. 2 of Portuguese Law no. 30/2000 that certain conducts do not constitute a crime administrative offence. The premise is personal use.

However, differences are detectable immediately because while in Italian law the practical definition of "personal use only", is delegated to the Courts[107], art. 2 of the Portuguese legislation continues providing a specification and providing that “For the purposes of this law, the acquisition and possession for personal use of the substances referred to in the preceding paragraph shall not exceed the quantity required for an average individual consumption during a period of 10 days (their corresponding gram limits had already been established in a regulation; the law stipulates the permissible amount in detail—in grams or pills—of each drug: cannabis, 25 grams; hashish, 5 grams; cocaine, 2 grams; heroin, 1 gram; LSD or ecstasy, 10 pills).

[107] The judgment of the Court of Verona n.1339/06 July 24, 2006, ruled that the system introduced by the reform, which aims to establish the rules for identifying personal use, it still has a value that is purely circumstantial. This means that it is necessary to take into account other elements and that the rules specified in the regulations are not binding, leading to disagreements between the judges in making their decisions. Even the Supreme Court-Sixth Criminal Chamber, Judgment n.17899/2008 has ruled on the matter, stating that possession for personal use only is not punishable, even if exceeding the limit of the small amount set by law .The reform was therefore criticized because of the absence of clear and defined parameters in order to easily detect "personal use".

4.2. Penalties.

2.a. Article 75 provides the following sanctions for a period not less than one month and not exceeding one year:

a) suspension of driver's license or prohibition of achieving it;
b) suspension of a license to carry firearms or prohibition of pursuing it;
c) suspension of passport and any other equivalent document or prohibition of achieving them;
d) Suspension of a residence permit for reasons of tourism or ban non-EU citizens if they have a permit.

2.b) Portuguese Law no. 30/2000, of 29 November establishes s**everal options** available to the CDT when ruling on the drug use offence, including **warnings**, **banning from certain places**, **banning from meeting certain people**, obligation of periodic **visits to a defined place, removal of professional licence or firearms licence** (For a full list of available sanctions, see Law 30/2000.**).**
Art 15 in fact establishes that "Non-addicted consumers may be sentenced to payment of a fine or, alternatively, to a non-pecuniary penalty". Non-pecuniary penalties, instead, shall be applied to addicted consumers. Moreover, it is specified that the Commission shall set the penalty in accordance with the need to prevent the consumption of narcotics and psychotropic substances and that in applying penalties, the Commission shall take into account the consumer's circumstances and the nature and circumstances of consumption, weighing up namely:

a) The seriousness of the act;
b) The degree of fault;
c) The type of plants, substances or preparations consumed;
d) The public or private nature of consumption;
e) In the case of public consumption, the place of consumption;
f) In the case of a non-addicted consumer, the occasional or habitual nature of his drug use;
g) The personal circumstances, namely economic and financial, of the consumer.

Art.16, instead, determines the amount of the penalty:
1. In the case of plants, substances or preparations contained in tables I-A, I-B, II-A, II-B and II-C, the fine shall be fixed between a lower limit of PTE

5.000$00 and an upper limit equivalent to the national minimum monthly wage.
2. In the case of substances or preparations contained in tables I-C, III and IV, the fine shall be fixed between PTE 5.000$00 and PTE 30.000$00.
Also peculiar is the way in which the penalty is distributed: "The proceeds of fines shall be distributed as follows:

a) 60% to the State;
b) 20% to the SPTT (Drug Addiction Treatment and Prevention Service);
c) 10% to the Governo Civil;
d) 10% to the IPDT".

4.3. The Portuguese Dissuasion Commission and the Italian Prefect.

An element of great differentiation between the two disciplines is surely represented by those who have been placed in charge of the procedure.
3.1 In the Italian administrative system, the Prefect is an organ, representative of the government in the province.
The Prefect is subordinate to Minister of the Interior, but the President of the Council of Ministers and other Ministers, in exercise of the power of political-administrative, may issue special directives to the Prefects.
According to Art. 11 D. Decree N. 300/1999 the prefecture-Local Government, without prejudice to their duties, ensures the coordinated operation of the administrative offices of the local state and ensures the sincere cooperation of these offices local authorities.
As the provincial public security authority, the Prefect has overall responsibility for public order and security in the province, and supervises the implementation of directives issued in this area. They ensure unity of direction and the coordination the of tasks and activities of officers and agents, and public safety. They have the police and other forces eventually placed at their disposal.
Therefore the management of the proceedings relating to Article 75 of Italian law is just one of many functions and duties of the Prefect.
This distinguishes the role of the Prefect significantly from that of the Dissuasion Commission, a body created specifically for the purpose of administrating Portuguese policy.
3.2 Dissuasion Commissions, as previously mentioned, are composed of three members, one of which is the Chairman. It is mandatory that one of its members be a jurist. Each Commission is assisted by a multidisciplinary team provided by the Institute on Drugs and Drug Addiction. The

multidisciplinary team is composed of psychologists, sociologists, social workers and lawyers as well as administrative assistants who prepare and support decision making and monitor the implementation of measures, be they therapeutic or administrative.
The multidisciplinary team is responsible for analyzing presumed offender assessments, which are sent by police and/or courts, supporting decision making and monitoring the implementation of therapeutic and administrative oriented measures.
Moreover, the Dissuasion Commission is managed by the Ministry of Health, rather than the Ministries of Justice or the Interior (as in Italy), and this was an important symbolic step that reflected the new approach to drug policy.

4.4. Phase of treatment and rehabilitation

On this point the Italian legislation and the Portuguese are poles apart.

3.a) Article 75, paragraph 2 provides that "The interested party is **invited** to follow the treatment program and social rehabilitation of Article 122 or other educational programs and information customized according to his specific needs, prepared by the public service for drug addicts responsible for the area similar to the provisions of paragraph 13 or by a private facility authorized under Article 116 ".
In light of the legislation, therefore, the rehabilitation program is no longer an alternative to sanctions that are imposed in all cases. And it is only the subject of a general invitation to the person.
Moreover, article 122 gives a “Definition of the therapeutic program and social rehabilitation” and establishes the necessary inquiries and consultations assisted by a doctor authorized to attend also to the necessary investigations, defines a customized treatment program that **can provide for initiatives aimed at social inclusion** through a full orientation and training, activities “public utility” or of “solidarity ”. As part of treatment programs that require it, may adopt methods of cessation, as well as' psychosocial and pharmacological treatments appropriate. The service for drug addiction monitor the implementation of the program by the addict. Also it says that the program is formulated in respect of the dignity of the person, in each case taking into account the needs of work and study and the familiar and social living conditions family of the user.

The program is implemented at facilities of public service or in private structures authorized under Article 116 or, alternatively, with the assistance of the medical officer.

3.b) As shown above, Portuguese law established a system of "**Dissuasion Commissions**" that is unique in Europe and managed by the Ministry of Health, rather than the Ministries of Justice or the Interior.

Offences shall be processed and the respective penalties applied by a commission referred to as the "Commission for the dissuasion of drug addiction", especially created for this purpose, operating under the premises of the civil governments (Art.5)

- Art.10, moreover, establishes that:

1 The commission shall hear the consumer and gather the information needed in order to reach a judgement as to whether he or she is an addict or not, what substances were consumed, the circumstances in which he was consuming drugs when summoned, the place of consumption and his economic situation.

2 The consumer may request that a therapist of his or her choice takes part in the proceedings, and the commission shall establish the rules for such participation.

3 In order to formulate the judgement referred to in paragraph 1, the commission or the consumer may propose or request that appropriate medical examinations be conducted, including blood or urine tests or any other tests as may be deemed appropriate.

4 If the commission does not base its definition of the nature of consumption on the findings of a medical examination with the characteristics set out in the preceding paragraph, the consumer may request such examination, and the findings shall be analysed with a view to a possible reconsideration of the initial judgement reached by the commission.

5 The commission shall have the examination conducted by a duly licensed health service, the costs being borne by the consumer if he or she chooses a private service, and the tests shall be carried out within a period of no more than 30 days.

If an addicted consumer agrees to undergo treatment, the commission shall notify the public or private health service chosen by the consumer, who shall be notified of the alternatives available Art.12). If the consumer opts for a private health service he or she shall bear the respective costs of treatment. The organization shall notify the commission every three months of whether treatment is continuing or not.

Proceedings may be suspended for up to two years, which may be extended by one additional year by means of a decision with due grounds made by the commission(Art.13).
The commission shall file proceedings, which may not be reopened, if:

a) in the case of a non-addicted consumer, there is no repeated offence;
b) an addicted consumer undergoes treatment and does not interrupt it unduly.

Other than as provided for in the preceding paragraph, the proceedings shall continue.
Moreover, it is important to consider the Decree-law no. 183/2001, of 21st June. The objective of this decree-law is to create programmes and social and health structures designed to raise awareness amongst drug users and to guide them towards treatment, as well as to prevent and reduce risk attitudes and to minimise the damage caused to individuals and society by drug addiction (Article 1).
It establishes that "with a view to the **protection of public health and the health of drug users**, and in compliance with international obligations, the State is duty bound to make available gradually to all drug users with attitudes or behaviour of risk such **programmes and structures,** as provided for in this decree-law, and as may constitute a priority in each particular case"(Article 2).
For that purpose (article 3) the decree-law governs the following social and health programmes and structures: a) Drop-in centres for drug addicts without social or family support; b) Refuges; c) Shelters; d) Contact and information units; e) Mobile centres for the prevention of infectious diseases; f) Low threshold substitution programmes; g) Syringe exchange schemes; h) Street teams; i) Programmes for supervised drug use.
The combination of the 2 above laws makes Portuguese law efficient and successful.

5. CONCLUSIONS

This analysis highlights how laws which are apparently similar, produce different effects, depending on the importance given to some aspects such as rehabilitation and medical treatment, over others, such as penalisation.
The law of Portugal in this respect is more efficient than Italian law because of the overall approach used to tackle the problems associated with drugs: in addition to not punishing the personal use of drugs, Portuguese law provides a detailed and specific procedure for the recovery and rehabilitation of the subject, who is treated as a patient and not as a criminal.
In analyzing Italian drug legislation it becomes clear that it lacks a precise and specific strategy for the rehabilitation of drugs addicts.
Therapeutic programs are considered only insofar as they reduce penalties.
To achieve positive results we have to create a complete system which intervenes in every aspect of the drugs phenomenon, up to the full rehabilitation of the addict and his reintegration into society.

Comparing drug trafficking penalties across Europe using EMCDDA data

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EMCDDA has monitored penalties for drug trafficking offences established in national legislations across the European Union since 1997, but in many cases these only consist of maximum penalties and are often not linked to the type of drug involved, limiting clarity of what might really be handed down for a particular offender [108].

In 2004, the European Council passed Framework Decision 2004/757/JHA calling for minimum standards in the definition of offences, requesting maximum penalties within a certain range.[109] Article 4(2) instructed Member States to establish higher maximum penalties when "(a) the offence involves large quantities of drugs; (b) the offence either involves those drugs which cause the most harm to health, or has resulted in significant damage to the health of a number of persons." However, the definition of these criteria was left fully to Member States when implementing the Framework Decision, and subsequently few made changes to their legislation. In 2009, the European Commission assessed the implementation of this Framework Decision and concluded that it had

[108] http://www.emcdda.europa.eu/html.cfm/index146646EN.html#countries

[109] Council Framework Decision 2004/757/JHA of 25 October 2004 laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking http://eur-lex.europa.eu/LexUriServ/LexUriServ.do? uri=CELEX:32004F0757:EN:HTML

only had a very limited impact; "the Commission notes that … it has not brought about a substantial approximation of national laws." [110]

In order to obtain more precise comparative data on the penalties likely to be handed down, EMCDDA carried out a quantitative study of Member States' sentencing and other outcome statistics in 2009.[111] This was able to compare information about the frequency of types of penalties given (immediate or suspended prison, fine, community service), but found that few countries recorded the type of drug or the quantity seized that led to those penalties. The resulting aggregate sentences for "drug supply" were therefore of little use in that respect; a sentence for sharing a cannabis cigarette with friends should not be compared with one for transporting many kilograms of cocaine or heroin.

However, sentences for drug offences may also be delineated using threshold quantities established for the different drugs in laws or decrees, prosecutor or sentencing guidelines, or judicial practice. These thresholds may define a quantity of a certain drug by total weight of material seized, weight of active principle within that material, number of doses, monetary value etc, and these may be used to distinguish a minor, normal or aggravated trafficking offence.[112] EMCDDA has also been monitoring these thresholds, originally concentrating on their existence and the particular criteria used for definition, but more recently by converting any quantity defined to gram weight to aid comparison.[113] Therefore, when a country establishes a narrower penalty range for supply of 'a large amount' of drugs, and separately defines that "large amount" for each drug in grams (directly or indirectly, eg when interpreting value using retail price per gram), it is possible to combine the two datasets. This starts to provide a basis for cross-country comparison of possible sentencing for each drug.

Nevertheless, these ranges across various European countries still show great variation in both dimensions of quantity and sentence length. Therefore, to further limit the variation, we chose to fix one of those dimensions by establishing scenario quantities for the most common substances. In this way, for those countries that clearly differentiate

[110] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0669:FIN:EN:PDF
[111] http://www.emcdda.europa.eu/publications/selected-issues/sentencing-statistics
[112] http://www.emcdda.europa.eu/html.cfm/index34041EN.html
[113] http://www.emcdda.europa.eu/html.cfm/index99321EN.html

penalty ranges by quantity of drug, we can directly compare the ranges of prison penalties set out in some countries for supply of 1kg or 10kg of cannabis resin, or 100g or 1kg of other common drugs. These are easily comparable at a glance when represented on bar charts per substance (Figures 1, 2, 3 and 4).

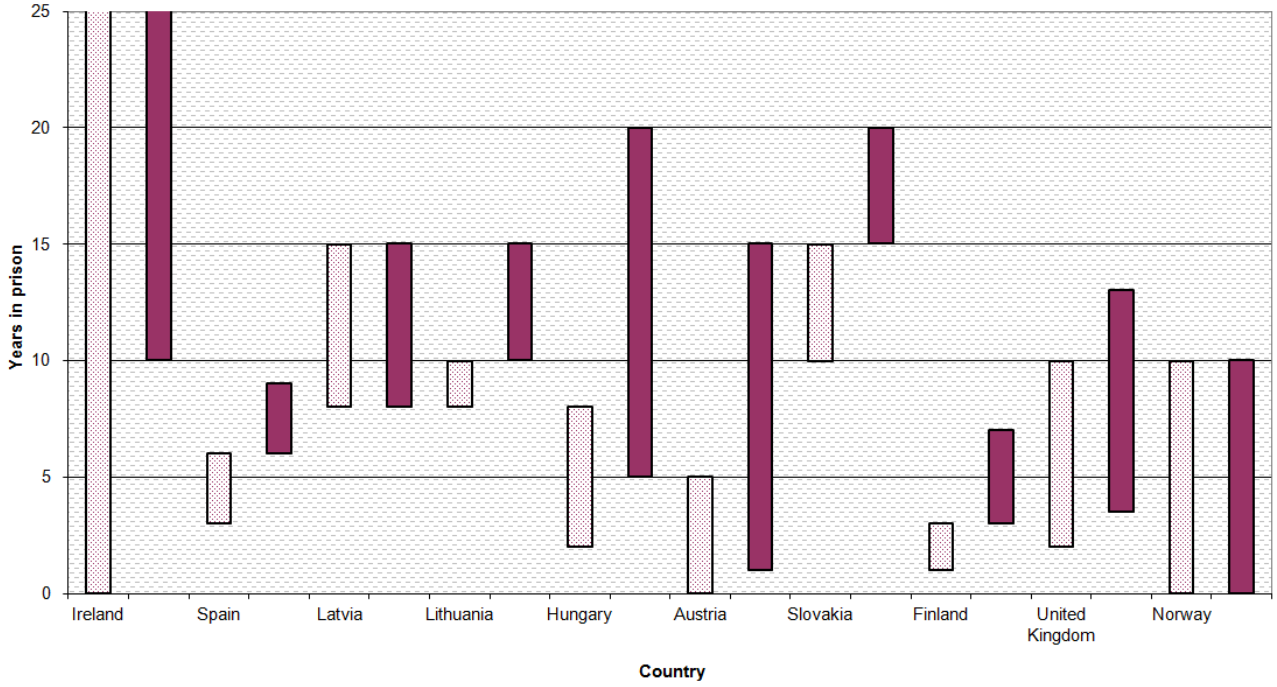

Figure 1. Prescribed sentencing ranges for supply of 100g and 1kg of cocaine

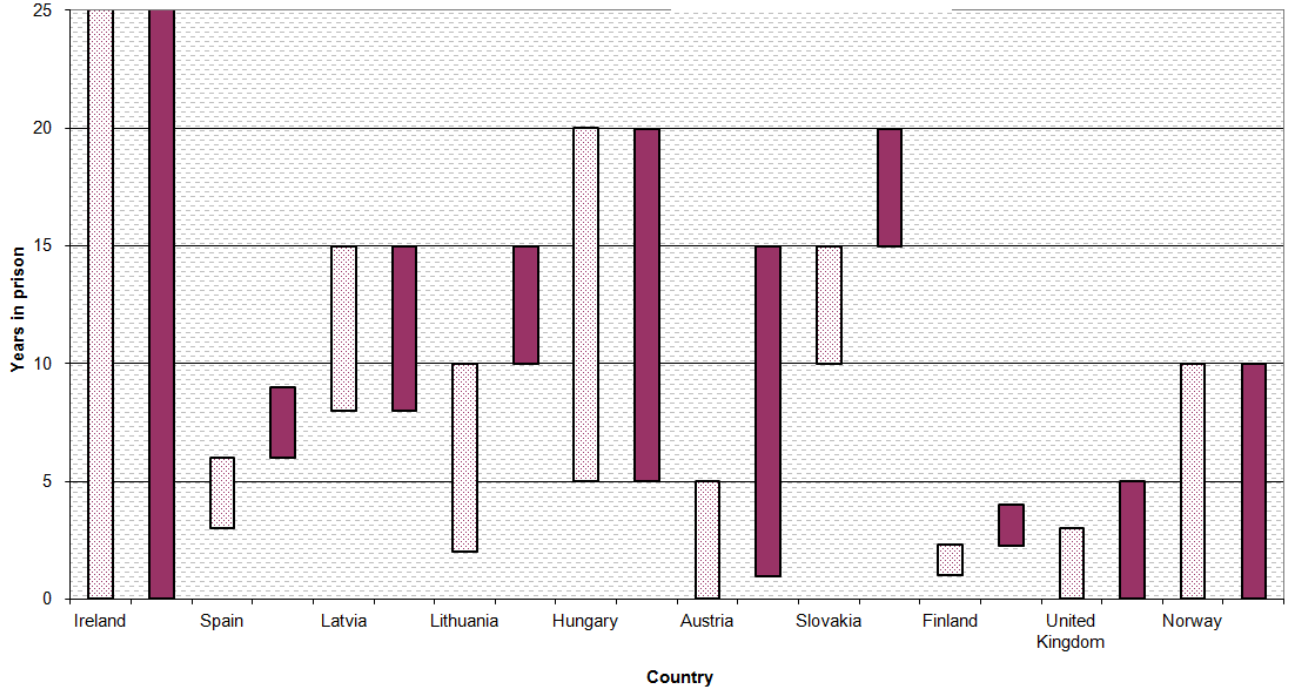

Figure 2. Prescribed sentencing ranges for supply of 100g and 1kg of amphetamine

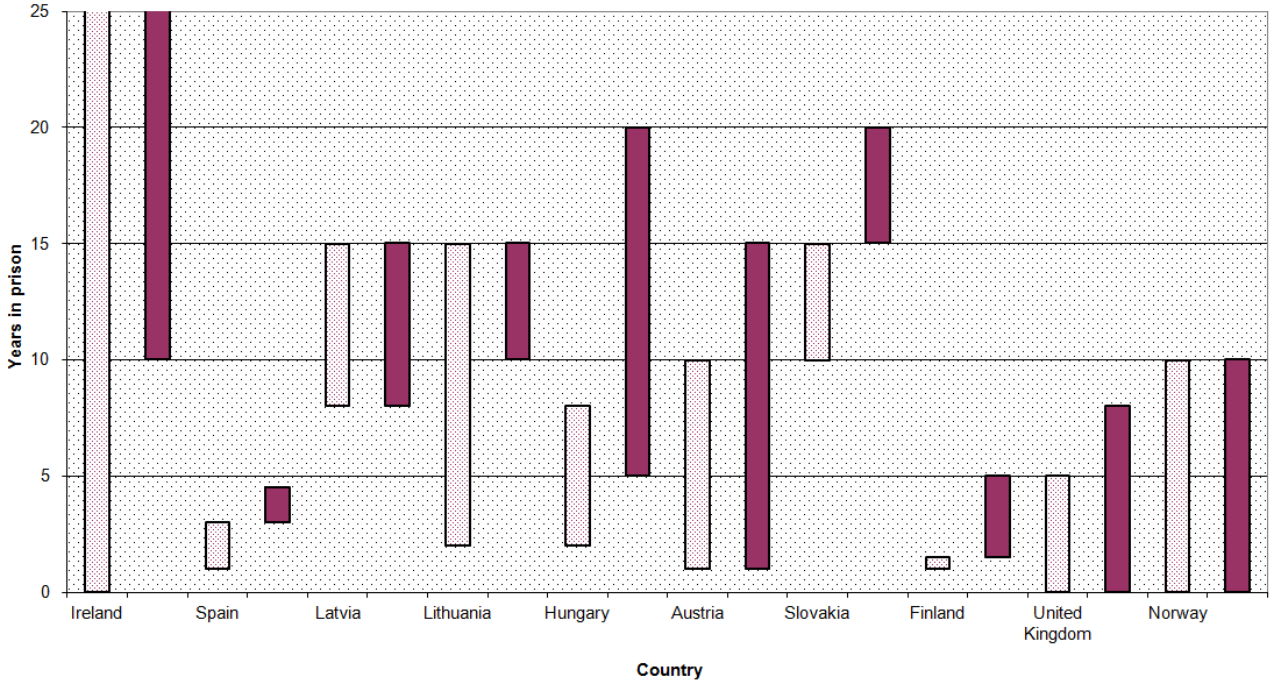

Figure 3 . Prescribed sentencing ranges for supply of 1kg and 10kg of cannabis resin

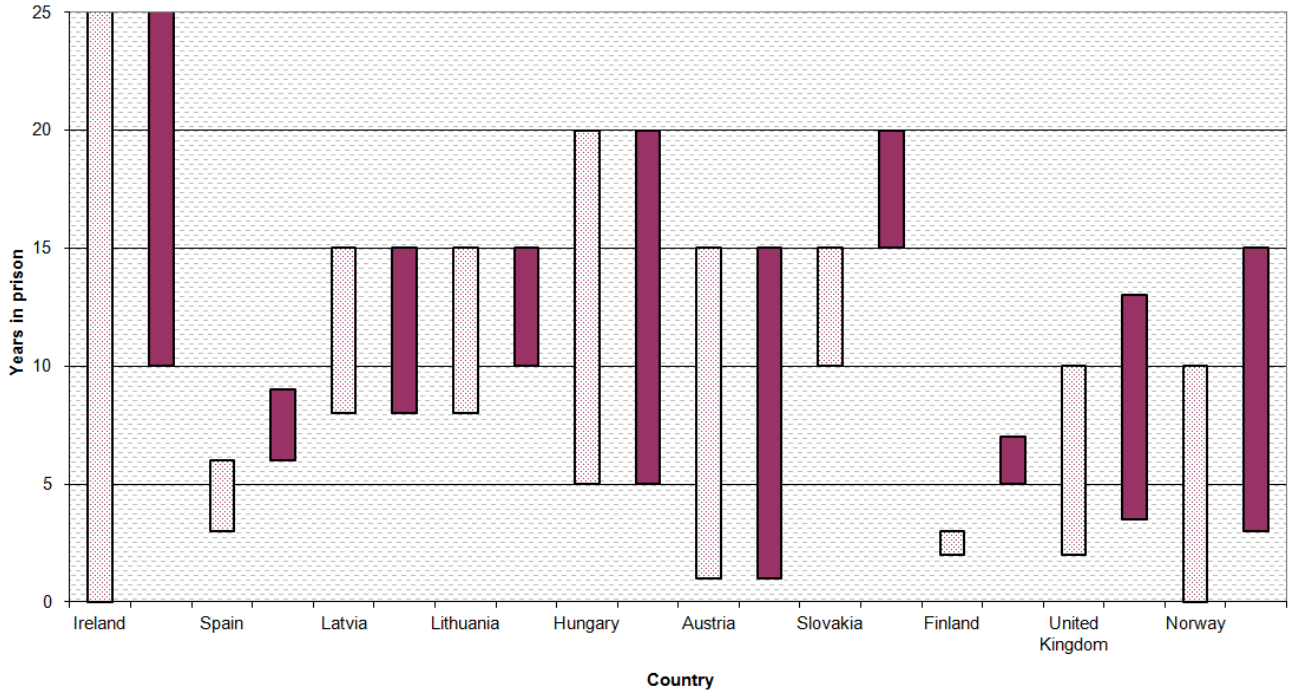

Figure 4.Prescribed sentencing ranges for supply of 100g and 1kg of heroin

There are various limitations to this method, both technical and empirical. In those countries where a threshold quantity is applied to the active principle rather than total weight of the material seized, assumptions had to be made regarding purity or potency, in order to ensure the consequent penalty ranges were comparable. Similarly, where quantity is defined using monetary value of the drug, this had to be converted into grams using an estimation of price per gram. Both of these conversions were facilitated using different EMCDDA datasets on price and purity, but the assumptions remain only that.[114] Empirically, there is no guarantee that these penalty ranges will be applied by the judiciary; to quote only one example of various reported in the EMCDDA's Selected Issue on sentencing statistics, above, "a 2003 study in Ireland found that the minimum sentence of 10 years' imprisonment for trafficking over EUR 12 700 of drugs had only been applied in three of 55 eligible cases between 1999 and 2001." Penalties applied by the judiciary will depend on other aggravating or mitigating factors such as membership of a criminal organisation, previous convictions, guilty pleas or assisting law enforcement during the investigations. Finally there is no factor considered that might indicate whether the offender will stay in prison for that length of time; in some countries, it is accepted practice to allow offenders out of prison after a proportion of the sentence has been served, while in others offenders are expected to serve the full time of the sentence in incarceration. Nevertheless, the Commission's conclusion that the Framework Decision "has not brought about a substantial approximation of national laws" is brought into sharp focus when using the above combinations of datasets.

The Commission's impact assessment noted "maximum sentences are meaningful only in the context of proceedings actually initiated and penalties actually imposed by the courts. A comparison of judicial practice in each Member State would enable an assessment of the extent to which the objective of aligning national systems has been achieved in practice." For this reason EMCDDA aims to check more scenarios against both the national legal frameworks and any rules on probation or early release, whilst also obtaining expert opinion on how the judiciary commonly sentence such individuals.

[114] http://www.emcdda.europa.eu/stats12#ppp:displayTables

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