



# **Addiction and Lifestyles in Contemporary Europe: Reframing Addictions Project (ALICE RAP)**

## **Description and analysis of addiction governance practices Understanding changes in governance practice**

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### **Deliverable D14.2, Work Package 14**

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## Summary

In this study we analyse a number of current major trends in drug and gambling policy in the EU. The focus is on identifying important factors that influence policy decision making and policy implementation.

## Methods

We decided to work with case studies, exploring the development of the selected trends and involving a selected number of EU Member States to identify and better understand forces and factors operating in governance of policies targeting drug use and gambling.

## Trends

One overarching key trend in the EU is convergence of drug policies. We selected three specific trends which can be viewed as examples of this convergence:

1. The wider acceptance of harm reduction, both for illicit and licit drugs.
2. The decriminalisation of drug use (and possession of small quantities for personal use), accompanied by a tougher, more punitive approach to the production and trafficking of illicit drugs.
3. The growing interest in exploring the feasibility of regulation as a drug control instrument.

For these three trends we looked into processes, driving forces, stakeholders involved, the different interests / arguments that play a role and interfering factors and principles.

## *Sample of Member States and substances / behaviour*

We chose a purposive sample of five EU Member States (France, the Netherlands, Slovenia, Spain and UK), representing different geographical regions and different governance approaches, which will enrich our description and analysis of governance practice. We also decided to limit the scope of our study to heroin, cannabis, tobacco and gambling. Tobacco is one of the most widely used legal drugs, causing serious health harm. Cannabis is the most widely used illicit drug, scoring rather low on drug harm scales and playing a prominent role in discussions about drug policy innovation. Heroin is a far less widely used illicit drug, classified as one of the most harmful drugs. Heroin use also played a prominent role in introducing the concept of harm reduction. Gambling is the best researched and monitored non-substance related compulsive behaviour.

## *Matching countries, substances and trends*

As a final step we matched the selected Member States, substances / behaviours and trends. Taking into account the time frame and available resources for this research it was impossible to analyse all three trends for the four selected addictions in all five sample Member States.

**Decriminalisation** only applies to illicit drugs, in our sample to cannabis and heroin. Regarding **harm reduction** we decided to focus on heroin and tobacco, two fields where harm reduction measures play a role. We analysed **regulation** measures for cannabis, where one can observe a move from prohibition to regulation, and for tobacco and gambling, where the policy is travelling in the opposite direction: from a pretty unregulated regime to rather restrictive regulations.

Within each trend-addiction combination we decided to focus on one or two selected cases of governance practice. For **heroin use** we selected **opioid substitution treatment (OST)** as a harm reduction measure and the **decriminalisation of use**. For **cannabis use** we chose the **decriminalisation of use** and, as an example of regulation replacing prohibition, the introduction of **regulated selling**.

For **tobacco use** we focused on **legislation and regulations regarding smoke free hospitality venues** as an example of regulation policies and **e-cigarettes** as an example of harm reduction. Finally, for **gambling** we analysed **control and regulation** measures.

To divide these trend-addiction combinations over the five sample Member States we used a purposive approach. For each of the selected trend-addiction combinations we chose countries which serve interesting elements in the respective governance / policy field and provide rich examples for our analysis, resulting in the following schedule:

- Concerning harm reduction, for heroin we concentrated on The Netherlands, Slovenia and Spain, whereas for tobacco on the Netherlands and France.
- For the decriminalisation case study we focused on the Netherlands, Slovenia and Spain for heroin, and on the Netherlands, Spain and the UK for cannabis.
- For the case study on regulation we looked into cannabis, tobacco and gambling policy. For cannabis we drew on the policy in the Netherlands, Spain and the UK, for tobacco on France and the Netherlands and for gambling on France, Slovenia and the UK.

Putting this selection in one table results in the following overview:

	Harm reduction	Decriminalisation	Regulation
Heroin	NL, E, SI	NL, E, SI	
Cannabis		NL, E, UK	NL, E, UK
Tobacco	NL, F		NL, F
Gambling			UK, F, SI

### ***Research focus / theoretical framework***

In our case studies we focus on identifying important factors that influence policy decision making and shape the implementation of policy. We aim to explore the development of a number of policy trends, to identify forces and factors operating in governance of policies targeting drug use and gambling. We chose for a rather eclectic approach, combining elements of Kingdon's Multiple Streams Model and Walt and Gilson's Health Policy Triangle. This combination fitted best with our research purposes.

Kingdon distinguishes in the process of policymaking three separate streams – problems, politics and policy. The 'problem stream' covers conditions that become noted and defined as important problems. The 'policy stream' is characterised by Kingdon as 'primeval soup', where many ideas or proposals for change float around. Through a kind of natural selection some policy proposals survive and are considered for implementation. Finally, the 'political stream' relates to the political environment of policy making. It consists of organised political processes, different forms of consensus building and decision making, public opinion, national mood, election results, changes in administration, and partisan or ideological distribution in administrations. Within policy areas the streams operate rather independently from one another until there is a change that causes two or more streams to meet, creating a 'policy window', offering an opportunity for policy change.

This Multiple Streams Model is clearly the most dynamic model of policy making, reflecting the complex character of the decision making process, which in fact consists of different concurrent processes which can go different directions. However, it has one major weakness: it is rather unspecific and therefore less useful for analysing and explaining specific governance developments or policy decisions, as we intend to do in this study.

To get a better grip on the factors influencing decision making processes we were in need of a simpler but sharp conceptual framework. We found this in Walt and Gilson's Health Policy Triangle.



This model tries to capture the comprehensiveness of health policy analysis by focusing on the interaction between **policy content, actors, context** and **process** and their impact on policy making:

- The content of policy ('what'), covering the objectives, measures and underlying reasons;
- The process, how policy is made and implemented, the issue of governance of policy ('how')
- The actors and stakeholders, who are involved in, who have influence on policy making and implementation, in governance of policy ('who');
- The context of policy making and implementation, of governance of policy ('where' and 'when'), the historical, political, economic and social-cultural factors influencing policymaking.

The clear-cut separation of these elements is somewhat static and artificial but useful for analytical purposes. It helps to have a clearer view of the different factors influencing policy making and to better understand the 'force field' in which policy making and governance take place. But it misses the dynamic of the Multiple Streams Model.

Combining elements of both models enabled us to capture the complexity and dynamic of the drug policy trends we focus on and serves as heuristics to analyse and understand the factors that have an impact on drug policy decisions and developments.

### ***Methodology***

In order to better understand the factors and mechanisms influencing policy regarding heroin, cannabis, tobacco and gambling, we use qualitative, exploratory case studies. We started with a stocktaking exercise looking at how policy in the four fields is implemented in the five sample EU Member States.

Based on the structure and elements of the Health Policy Triangle we produced a **topic guide** for the systematic collection of relevant information about policy content, context, stakeholders and process. We used this topic guide for selecting, reviewing and analysing relevant information from the sample Member States. Based on the topic guide we developed a detailed format for so-called country reports per selected substance and gambling to collect relevant information from the Member States. The country report format followed the structure of the Health Policy Triangle. The country reports and the reviewed literature formed the basis material for the three case studies: one per selected trend, i.e. the wider acceptance of harm reduction, the trend towards a decriminalisation of use of illicit drugs and thirdly the growing interest in exploring the feasibility of regulation as drug control instrument.

### **The case studies**

#### ***Convergence and divergence in EU drug policy***

Our point of departure is a short analysis of the general convergence trend in EU drug policy. In earlier studies of the developments of the drugs problem and drug policy we found that there is a worldwide trend of harmonisation of drug policy, driven by two forces: A bottom-up force to gain support for wider acceptance of an innovative approach and a top-down force pushing towards wider implementation of innovations. Most innovations in drug policy started bottom-up as criticism on and alternatives for established paradigms. The three trends covered in our case studies are examples of this convergence trend. However, in recent years one can see divergence tendencies in EU drug policies. There is for example a decreasing support for harm reduction by some governments (including the Netherlands).

## ***The wider acceptance of harm reduction***

### *The response to the heroin epidemic*

Harm reduction services, targeting users of illicit drugs, mainly heroin injectors, started to develop in the Netherlands and the UK from the 1970s onwards. The socio-political developments in those years were an important contextual factor. The emerging drug use 'epidemic', inadequate treatment and policy responses, protest movements in the Netherlands and fundamental societal changes in Slovenia and Spain were important contextual factors for developing alternatives to the existing abstinence oriented drug services. Harm reduction started bottom-up as a countermovement, as criticism on established norms and rules and initiating a change from the abstinence to the harm reduction paradigm. The development of opioid substitution treatment (OST) is one example of the process from an alternative treatment option starting as opposition in the margins and turning through a top-down driven process into mainstream spreading over Europe.

Besides counter movements local policymakers, politicians, health professionals, charity and, particularly in the Netherlands, researchers and scientists were important stakeholders. Drug use was a new problem, for which no appropriate solutions were available. The approach to this challenge was, at least in the Netherlands, a surprisingly rational one. Scientists were asked to explore and explain the nature and extent of the problem and come up with recommendations on how to tackle the problem. It was their views which shaped an important part of the policy response to this new problem and marked the shift from a bottom-up process to a top-down driven process.

On EU level the change from a bottom-up to a top-down driven development became clearly visible in 2003 with the recommendation of the Council of the European Union, encouraging all EU Member States to implement harm reduction measures including substitution treatment (Council of the European Union 2003) and later with the EU Drug Strategy 2005-2012, which stressed the inclusion of harm reduction measures as an element of demand reduction (Council of the European Union 2004a).

This growing acceptance of OST and other harm reduction services is an illustration of the processes described by Kingdon in his Multiple Stream Model. It can be understood as a combined working of the policy and the political stream: policymakers (and politicians) started to see particularly heroin use as a serious problem (the problem stream) requiring a response going beyond the services offered by the available drug treatment programmes. On the political level one could see then increasing consensus that OST and other harm reduction services are appropriate responses to reduce harm to the user but also harm to society resulting in what Kingdon calls a policy window: a coming together of the problem, policy and political streams, serving as an opportunity for fundamental drug policy changes. Other important factors contributing to this policy window were the combination of different interests (health and public order), and a growing stakeholders' consensus in support of harm reduction.

### *Harm reduction strategies for other drugs*

Harm reduction strategies also started to find their way into approaches towards other substances than heroin. One example are programmes targeting health risks related to nightlife, which started to emerge in the late 1990s, involving the use of both illicit and licit drugs, from ecstasy and other Amphetamine Type Stimulants, to cocaine and alcohol. In different EU Member States approaches have been implemented to reduce substance use related health risks involved in nightlife.

Harm reduction has also been adopted in the field of licit drugs in particular targeting problem alcohol use. Some approaches can be seen as copying the substitution treatment approach, like alcohol dispensation programmes that provide limited, mainly low-alcohol drinks to chronic alcoholics. There are various options of moderation management. Finally, there are also strategies

addressing harms caused by the user to his / her surroundings as various strategies to reduce drink driving.

#### *Reducing tobacco smoking related harm*

In the field of tobacco harm reduction options seem to be limited. The e-cigarette may be an interesting option here.

However, experts disagree whether this product is just a recreational smoking product that may be less harmful than regular cigarettes, or a device that can be helpful in reducing conventional smoking or even an aid in quitting, or a gateway to smoking for non-smoking youth. The relative novelty of the e-cigarette, (it has been available on the European market for less than ten years), means that there is not much evidence-based information on the e-cigarette (its toxicological aspects, its potential to support cessation, the possible gateway to smoking). This limits policymakers' ability to evaluate the potential public health consequences of e-cigarette smoking and also limits the ability to decide on appropriate regulation policies. This uncertainty can also be found in the discussions on EU level.

#### ***The decriminalisation of drug use***

Decriminalisation of drug use is an approach which is widely applied in the field of illicit drugs. Usually cannabis use and possession are treated more lenient than the use of other drugs.

#### *The paradigm shift from crime to health*

Basically decriminalisation has the same origins as the wider acceptance of harm reduction, starting bottom-up as critique on the appropriateness of criminalising the use of illicit drugs. The criminalisation of drug users was criticised for having detrimental effects on the social and health situation of the user.

Like in the case of harm reduction social unrest or changes seem to have worked as powerful contextual factors supporting decriminalisation. This holds for the protest movements in Western European countries like the Netherlands but even more for countries like Slovenia and Spain, which underwent fundamental societal changes. In all three countries liberalisation was a key trend, and cannabis was the drug in focus. The policy response to the AIDS epidemic formed another important contextual element.

#### *Key stakeholders*

A wide variety of stakeholders supported the choice for the health paradigm. We decided to focus on three stakeholder groups which had a major impact in the countries we studied: social movements, scientists and politicians. Social movements played an important role in the Netherlands and, particularly, in Spain, where the 'cannabis social movement' was one of the most important stakeholders, campaigning for a radical change of the existing prohibitionist drug policy.

Like in the case of harm reduction, scientists played a decisive role in the paradigm change from crime to health, particularly in the Netherlands. They stressed the fact that criminalising drugs is ineffective to control or reduce drug use. Their contribution also mark the change from a bottom-up countermovement to a top-down driven reform. The health paradigm was embraced as a leading concept in Dutch drug policy

Also in the UK science played a key role in the (de)criminalisation debate. Here the debate centred mainly around the classification of drugs according to their actual harmfulness, which traditionally was based on recommendations of an expert committee. The 'tumultuous' developments around the re-classification of cannabis to a class C drug, the category for the least harmful drugs, present an interesting case, which shows that it is not anymore a matter of course that political decisions follow the evidence presented by science. This case illustrates the tension between two key stakeholders:

scientists and politicians. It shows how science is overruled by political agendas. It also shows that there is in fact no uncontested evidence base for drug policy decisions.

#### *Different options*

Many countries chose for a de facto depenalisation by formally maintaining possession of drugs as a criminal offence but not prosecuting possession of small quantities. Portugal and Spain went for a more formal decriminalisation. Other widely implemented approaches are the so-called diversion schemes: courts offer drug users the option to choose treatment as an alternative for imprisonment and so-called alternative sanctions.

#### *The other side of the coin: a harsher approach to producers and sellers*

In many countries decriminalisation of use is accompanied by a tougher, more punitive approach to the supply of illicit drugs. These two trends seem to be two sides of the same coin. The view of a drugs user as a patient is mirrored by the picture of the producer and seller of drugs as criminal, causing harms to the user and the society.

#### ***The growing interest in regulation approaches***

Regulation policies are applied increasingly in the field of illicit and licit drugs and gambling. For illicit drugs and in particular for cannabis one can observe a cautious trend from prohibition to regulation. At the same time the policy response to alcohol, tobacco and gambling is moving in the opposite direction: from a rather unregulated state to an increasingly strict regulation regime.

#### *From prohibition to regulation: cannabis policy in the Netherlands and Spain*

The coffee shops in the Netherlands, where the sale of cannabis products is condoned, and the cannabis social clubs in Spain, a condoned cooperative approach for growing and distributing marijuana, are the two best known examples of (partial) cannabis regulation in the EU. The coffee shops have the same roots as harm reduction and decriminalisation. They can be traced back to the changes initiated by the countermovement in the 1960s and 1970s and supported by scientists. Unintended consequences of the coffee shop policy contributed to a 'mood change'. Coffee shops developed from small-scale, alternative establishments into commercial 'big' business. Production and wholesale of cannabis increased significantly, attracting, due to its illegal character, organised crime. 'Drug tourism', foreigners coming to buy cannabis in Dutch coffee shops, flooded in, triggering public order problems, particularly in the border regions. From the 1980s the regulations for coffee shops became increasingly stricter. Rising political conservatism, supported by the economic crisis and an increasingly negative view on producers and sellers, supported a more restrictive drug policy in general. However, after nearly thirty years of tightening the rules for coffee shops there are signs of a growing opposition against the increasingly restrictive coffee shop policy.

In Spain the cannabis social movement, which dates back to the early 1960s and has a clear anti-prohibitionist agenda, has been the breeding ground for the cannabis social clubs (CSC), which started to emerge in 2002. Possession of small quantities of cannabis was formally decriminalised in 1982. The 1992 Public Security Law brought about a tightening of the policy regarding drug use and possession. An individual using or carrying an illicit drug in public places risked an administrative sanction (a fine). This led in the subsequent years to an enormous rise of proceedings against users, in the majority cannabis users. As a consequence home growing became increasingly popular. And from home growing it proved to be just a small step to the CSC model, a collective form of home growing. In recent years one can observe a substantial growth and commercialisation of CSC market which resulted in increasing control efforts of municipalities.

#### *From unregulated to regulated: tobacco policies in France and the Netherlands*

The history of tobacco use and policy in Europe reveals some interesting features of the complex process of how a new substance appears at one point out of nowhere, meets strong refusal, then

gets widely accepted and then is increasingly under attack again.

From the early 20<sup>th</sup> century onwards the mounting research evidence for the serious health damage caused by tobacco smoking was the most powerful contextual factor contributing to increasingly strict tobacco control policies. Passive smoking was one of the most convincing elements in the change towards a ban on smoking in public places like hospitality venues. Widely supported stricter tobacco control efforts only started to emerge as late as the 1960s. Key elements in shaping national tobacco control policies were the International initiatives to support and guide national responses like WHO's Framework Convention on Tobacco Control (FCTC) and the EU Tobacco Products Directive.

National tobacco control policies like smoke-free hospitality venues generally met with substantial opposition of lobbies, resulting in the Netherlands in a messy process from lenient to more strict and back again. Establishing a smoke-free hospitality sector has been a process characterised by a fierce clash between the proponents and opponents. The most outspoken and powerful opposing stakeholders were the tobacco industry and the organisations representing the interests of hospitality entrepreneurs. The most influential stakeholders in support of more restrictive regulations were researchers, health services and anti-smoking pressure groups. Conflicting interests could also be found on the political level, among others between the Ministry of Health (reducing health harms) and the Ministry of Finances (securing tax incomes).

All efforts to come to a more strict tobacco regulation policy seem to have had some effect on the extent of smoking. Over the last decades one can observe a drop in tobacco (cigarette) sales and in the smoking prevalence in the EU, an increase of the number of ex-smokers and of people who never smoked, and a change towards a more negative attitude towards smoking.

#### *From unregulated to regulated: gambling policy*

Also gambling policy has developed from a rather unregulated state to an increasingly restrictive control regime. However, compared with smoking, gambling is a much less prominent issue in the public debate. Much less research has been done in the field of gambling than in the field of smoking. We therefore decided to regularly focus on the commonalities and differences of gambling control efforts with tobacco control policy.

Unlike tobacco smoking 'compulsive' gambling does not cause any physical health damage. This seems to make the case for a stricter control approach less strong. However, problem gambling may have a serious and broad health and social impact. Unlike the concept of tobacco addiction it has been taken less seriously by health experts, policymakers and politicians.

The available data show that in recent years the gambling market is growing rapidly in the EU. Unlike the tobacco market, which is dominated by one product, namely cigarettes, the gambling market is much more fragmented and varied. It is divided in different segments, many of which have a substantial market share.

A shared feature of tobacco and gambling control policies are economic interests working against more restrictive control policies. The substantial revenues from gambling explain an ambiguous attitude of governments: while the Ministries of Health and Social Affairs generally support more strict control policies, the Ministries of Finance and Economic Affairs are usually against strict control policies aimed at limiting or reducing (certain forms of) gambling. Still, in most EU Member States a trend towards privatisation and further regulation of gambling can be observed. State monopolies tend to be abandoned.

There is another difference between gambling and tobacco policies. While in the case of tobacco we

saw a fierce conflict between proponents and opponents of stricter regulations, a comparable open and heavily polarised conflict cannot be observed in the field of gambling. There are no powerful alliances of proponents, as is the case with smoking.

Still, gambling has been taken on board of the European Commission's agenda, be it in moderate steps. The focus of the European Commission is mainly on online gambling as response to its strong growth.

The diversity of the gambling market is reflected in a fragmentation of the gambling lobby. Still it is an influential lobby, divided over different branches for different types of gambling, which sometimes have conflicting interests. These lobby efforts have not been able to prevent the emergence of a trend towards stricter gambling regulation policies, both on national level and EU-wide.

### **Concluding discussions**

In our case studies we identified forces and factors influencing the development of the three drug policy trends we selected:

- The wider acceptance of harm reduction;
- The decriminalisation of drug use, accompanied by a tougher, more punitive approach to the production and trafficking of illicit drugs;
- The growing interest in exploring the feasibility of regulation as drug control instrument.

In the concluding discussions we concentrate on a selection of prominent issues in the case studies, following the structure of the Health Policy Triangle:

- The process: convergence of policies in the EU;
- The content: the paradigm changes, well-being as possible alternative for the health (illness) paradigm and the irrational elements in (governance of) drug policy;
- The stakeholders: factors contributing to the influence of stakeholders, taking a closer look into the role of three selected stakeholders: science and research, the supply lobby and social movements;
- The context: the impact of societal mood and societal changes and opportunities created by uncertainties.

#### *The process: convergence of policies*

Convergence seems to be an overarching key trend, which can be observed in the EU for all drug control policies. Still, the process and outcomes of convergence differ substantially between policy fields and between countries. All three trends in the illicit drugs field show in the early stages a primarily bottom-up driven process, which – in case of the wider implementation of harm reduction and decriminalisation of use – later turned into a process where top-down forces played a dominant role.

There seems to be a cautious trend away from prohibition towards regulation. Cannabis policy is the most striking example of such a move away from prohibition. Regulation is also an issue in the field of licit drugs. The policy response to alcohol, tobacco and gambling is moving in the opposite direction, from a rather unregulated state to increasingly stricter regulation.

#### *The content: changing of views, changing of paradigms*

A helpful concept to better understand this process of convergence can be found in the work of Thomas Kuhn (2012) and Ludwig Fleck (1979) on paradigm changes. Both argue that science is necessarily based on expert consensus on how phenomena have to be explained. Science is

therefore not fact based but grounded on the prevailing perceptions of facts, on a set of beliefs that are shared by a scientific community. This set of beliefs or assumptions are paradigms which are supported by research findings. A paradigm change is therefore a socio-psychological process rather than rooted in scientific or research facts.

This theory of paradigm change is a useful heuristic for better understanding the developments of the trends we focus on. Translated into the field of our studies it means that a change of the majority of stakeholders in support of a new view plays a decisive role in a paradigm change.

All three convergence trends we analysed can be understood as paradigm changes, as the emergence of a new consensus among influential stakeholders, a prevailing perception of how elements of the 'drugs problem' have to be explained. It is the result of socio-psychological processes in the policymaking and governance arena.

#### *- Alternative: the well-being paradigm*

The health and disease paradigm prove to have serious shortcomings. Not all forms of drug use can be well understood as pathology. Not all drug use can be fully understood from the perspective of the health paradigm, as for example experimental use or use for recreational or spiritual purposes.

A key element in the research work of ALICE RAP is to reframe the general understanding of addiction. The aim is to use the input from the different research areas and disciplines brought together in the project to come to a new understanding, which can contribute to a more effective approach of addictions. The discussions among the researchers involved centre on the usefulness of the well-being concept for this reframing exercise. Compared with the health paradigm, well-being might indeed be a more appropriate paradigm to explain the drug use and addiction phenomenon. It covers a broader spectrum than the health paradigm. It helps to grasp the negative impact of (problem) drug use, reducing well-being, but is also useful in understanding the positive sides.

#### *- Content: irrational elements in (governance of) drug policy*

A complicating factor in drug policymaking and governance is the influence of moral judgments or beliefs and other irrational perceptions. Drugs are seen as evil or demonic, drug use as depraved behaviour or paving the way to immorality. These moralist views and ideological connotations are an influential 'content' factor in the developments of the trends we covered in our case studies. They work as barriers as well as facilitators for the wider implementation of harm reduction and decriminalisation of use.

#### *Selected stakeholders*

Our case studies show that various stakeholders have influenced the development of the three trends covered in this study. Though politicians and policymakers played, of course, a decisive role in the decision making process, we decided to focus in these concluding discussions on three stakeholder groups, because of their importance in the development of these trends: science and research, the supply lobby and the social movements. Social movements and science played a key role in challenging dominant paradigms, functioning as facilitators of changes.

#### *- Influence of science and research*

Despite the highly politicised and ideologically charged character of drug policy and the strong influence of economic interests of the producers (lobby), the influence of science has been substantial and – at least from time to time – decisive. Evidence has played an important role in many policy decisions. The radical change in Dutch drug policy may be one of the few examples of a drug policy change which for an important part was guided by evidence.

#### *- The supply lobby*

There are different lobbies active in the drugs and gambling market. There are lobbies pro and con

stricter control policies. We decided to focus on the most powerful lobby: the supply lobby which has a decisive influence on the making of stricter regulation policies.

#### *- Social movements*

From the 1960s onwards a – relatively – new stakeholder appears on the scene in different EU Member States, claiming a say in drug policy debates. Social movements of mainly young people emerged all over Europe, opposing the established social order, which – in the view of the protesters – was predominantly conservative and restrictive.

In four of our five sample Member States social movements popped up, opposing the generally repressive drug policies. They were an important element in the bottom-up forces pushing for new approaches, setting the trends which we covered in our case studies: the introduction of harm reduction, the push for decriminalisation of use and regulation instead of a prohibition regime.

#### *Key contextual factors*

In our case studies numerous examples of contextual factors influencing policymaking and governance passed in review: historical, economic, political and social-cultural factors. Contextual factors have proven decisive in determining the influence of a certain stakeholder or specific policy content in the decision making process. In our concluding discussions we discuss contextual factors that had a major impact on the drug policy changes in the past decades: the social mood, the societal environment and changes, and closely linked to the latter: ‘uncertainties’ in a changing policy and governance environment.

#### *- Important contextual factors: social mood, societal environment and changes*

At different points in our case studies we came across references to the societal mood as explanation for drug policy changes. In the Netherlands the predominant conservative and restrictive mood, characteristic for the post-war reconstruction era, was for instance the breeding ground for the protest movement resulting in the 1970s ‘mood for a change’. Societal changes were another significant contextual factor helping to create a policy window for drug policy changes in Slovenia and Spain.

#### *- Some specifics: uncertainties create opportunities*

These societal changes were coupled with uncertainties. The transformation in Slovenia and Spain from a totalitarian to a democratic political system implied the breaking down of old structures and rules and the absence of well-established positions regarding new policies. This may have been particularly true for policies addressing relatively new social phenomena such as the then emerging ‘drug problem’. The societal changes in the Netherlands, Slovenia and Spain had a major impact on various areas, among others on drug policy issues. In all three countries the ownership of the drug problem was not yet clearly defined. There was no consensus on a leading paradigm: was the drug issue a health, crime or social problem? There was no consensus how to define the problem and how to deal with it. The territory was not yet divided, allocating clear responsibilities to different stakeholders. These uncertainties contributed to a window of opportunity for developing the three approaches discussed in this study: harm reduction, decriminalisation and regulation.

#### *From government to governance*

The drug policy changes starting in the 1970s show a growing involvement of various stakeholders, both in the policy making process and the implementation of policy measures. This increased stakeholders involvement is seen as one important element of a general change of the ways policy is made and implemented in contemporary ‘Western’ societies. In the UK and other English speaking countries it is framed as a change from government to governance.

#### *Concluding remarks*

In this last part we shortly reflect on practical implications of our case studies. Are there any lessons



to be learnt from these analyses? We limit ourselves to pointing out some practical conclusions how to – more effectively – influence drug policy making.

## 1 Introduction

In this study, based on research undertaken as part of the ALICE-RAP project, we analyse a number of current trends in drug policy in the EU. We include in our analysis policy targeting licit and illicit addictive substances but also gambling, which is one example of non-substance related addictive or compulsive behaviour. The focus is on identifying important factors that influence policy decision making and on the implementation of policy. This means we also address governance of policy.

We decided to work with comparative case studies exploring the development of selected policy trends, involving a selected number of EU Member States to identify and better understand forces and factors operating in governance of policies targeting drug use and gambling. Comparing the drug policy governance processes in different countries helps to understand the factors that influence or shape the actual governance processes. It illustrates the differences in the developments of these general trends in different EU Member States, showing that different factors have resulted in different policy implementation processes. Many factors play a role here: changes in the political and economic situation, changes in the political 'mood', changes in prevalent views of a problem, changes in the weighing of certain arguments and interests and changes of power or influence of specific stakeholders, to name a few.

In the discussions during the preparation of this research the clarification of concepts, in particular of the concept of 'governance' and the commonalities and differences between 'governance' and 'policy' proved to be a challenge. One complicating factor in this clarification exercise was the notion that 'governance' is in many countries an emerging concept for which there is not (yet) one generally agreed definition. This concept has brought new ideas of public or social administration in contemporary discussions on politics and policy. This draws attention to new processes of governing in increasingly complex societies.

Within the ALICE RAP project we used the following rather general definition: "Governance is the way in which a society or organisation steers itself, including the response to outbreaks and the course of events, something which involves many players, multiple agencies and sites, with action on many levels, from global to local". There are definitions of governance that focus more on the implementation aspects of policy: "Governance refers to the processes and mechanisms by which policy is directed, controlled and held to account". (Hughes et al. 2010) Others focus more on the ways a problem is managed.

We also learned from our discussions that working with experts from different European countries makes things even more complex. While the meaning of the English word 'policy' is relatively similar to the meaning of its translations in other languages, finding an accurate translation of 'governance' in other languages proved much more difficult. This has partly to do with the absence of a clear concept in English. Governance is a concept which only recently has gained importance in the discourse about the making and implementation of drug policy, in particular in the UK and Australia. It emphasizes the complexity of managing a societal problem and the involvement of various stakeholders on different levels in these management processes. We found that in some European languages there simply seems to be no word for governance, covering the riches of connotations of the English word. German and Dutch can be taken as examples for this. The Dutch word 'bestuur' and the German word 'Verwaltung', that come closest to the concept of governance are more focussed on aspects of 'administration' and 'government'.

Although the understanding of the concept and the definitions of the term may differ, the issues raised are similar and include: the role of networks and policy communities; the influence of different stakeholders and interests regarding the design and implementation of policy; the shape of the new public management – such as forms of contracting and compliance procedures;

new styles of governing in multi-level arrangements, such as those of the European Union; and links between the public and private sectors and with civil society. One key assumption is that new modes of coordination are required, involving linkages between actors beyond the traditional forms of government. Complexity and change are major themes in current literature on this subject (MacGregor et al. 2014).

We chose for a rather pragmatic demarcation of governance and policy, leaning on the definition used by the UK Drug Policy Commission (UKDPC). Governance is how policy is made and implemented rather than what policy is, following the definition that governance refers to the processes how a problem is managed in a society (UK Drug Policy Commission 2012). Policy refers to the formal decisions about the direction that problem is managed in a society, as summarised by Reuter and Stevens: "By drug policy, we mean the pattern of legislation and government action that aims to affect the use of drugs and the related problems." (Reuter and Stevens 2007).

## **2 Methods**

### **2.1 Research focus**

We focus on identifying important factors that influence policy decision making and shape the implementation of policy. In our case studies we aim to explore the development of a number of policy trends, to identify forces and factors operating in governance of policies targeting drug use and gambling. Our aim is to better understand the basic issues of policy making:

- The content of policy ('what'), covering the objectives, measures and underlying reasons;
- The process, how policy is made and implemented, the issue of governance of policy ('how')
- The actors and stakeholders, who are involved in, who have influence on policy making and implementation, in governance of policy ('who');
- The context of policy making and implementation, of governance of policy ('where' and 'when'), the historical, political, economic and social-cultural factors influencing policymaking.

For feasibility reasons we decided to restrict the scope of our study to:

- focusing on a number of selected Member States;
- concentrating on a limited number of addictions;
- selecting a number of key trends in addiction policy and governance in the EU;
- combining these three choices by matching the selected Member States, addictions and trends.

#### **2.1.1 Geographical scope**

We chose for a purposive sample of Member States participating in ALICE RAP. These Member States represent different geographical regions and different governance approaches, which will enrich our description and analysis of governance practice.

Regarding the geographical demarcation we focused on a sample of five EU Member States:

- France
- the Netherlands
- Slovenia
- Spain
- UK.

#### **2.1.2 Selected substances / gambling**

The second demarcation was to focus in our research on a number of selected substances and compulsive behaviour. Our purposive sample entails:

- Heroin
- Cannabis
- Tobacco
- Gambling.

Tobacco is besides alcohol the most widely used legal drugs, causing serious health harm on a large scale. Cannabis is the most widely used illicit drug, scoring rather low with regards to harms associated with its use. Cannabis also plays a major role in discussions about drug policy innovation.

Heroin is a far less widely used illicit drug, classified as one of the most harmful drugs (Nutt et al. 2007; Nutt et al. 2010; Van Amsterdam et al. 2010; EMCDDA 2012a; WHO 2013a).

Heroin also played a prominent role in initiating substantial change in governance views and practice by introducing the concept of harm reduction. Gambling is the best researched and monitored non-substance related compulsive behaviour.

Where appropriate we will include elements of policy and governance regarding the use of other substances which can be taken as illustrative for or add to the understanding of certain specifics or features of policy and governance in the field of addictions.

### **2.1.3 Selected trends**

We decided to focus on a selection of current major trends in drug policy in the EU. One overarching key trend which can be observed in the EU as well as in other parts of the world is convergence of drug policies in the EU Member States. The promotion of the concept of a 'balanced and comprehensive' drug policy approach is an illustration of the formal drive towards convergence. It is a core element in the EU Drug Strategy 2005-2012, emphasizing that demand and supply reduction should be taken as the two constituting elements of drug policy (Council of the European Union 2004a). The promotion of this concept can be regarded as formalisation of a growing consensus among Member States and as the onset of introducing this concept in policy papers in all EU Member States. We will briefly analyse the driving forces towards this harmonisation of drug policy, building on the analysis we made in the 'Report on Global Illicit Drug Markets 1998-2007' (Reuter and Trautmann 2009; Trautmann 2013).

We selected three specific trends which can be viewed as examples of the overarching general trend towards convergence of drug policy (Reuter and Trautmann 2009; Trautmann 2013). We will use these trends to analyse and describe key features of drug and gambling policy making and implementation in the EU.

1. The first trend **wider acceptance of harm reduction**, can be observed both for illicit and licit drugs. Harm reduction became widely accepted in the past twenty years in all EU Member States. It started to emerge in the late 1970s as response to the heroin epidemic in the Netherlands and the UK. After years of vigorous debates and against the stand of powerful stakeholders, harm reduction developed into mainstream policy in the EU and in many other countries. Also in the field of licit drugs, harm reduction started to play a more prominent role. Examples are 'alcohol dispensation programmes' for chronic alcohol addicts and the production of light products, like low-alcohol and alcohol-free beer.
2. The second trend we selected is **decriminalisation of drug use** (and possession of small quantities for personal use). Considering drug use as a health issue rather than a crime, is a major trend in drug policy governance aimed at illicit drugs like heroin and cannabis. All EU Member States – as well as many other countries – have shown in the past two decades a trend towards a less punitive, health-oriented approach towards the use and possession of small quantities for personal use. At the same time one can see another trend: **a tougher, more punitive approach to the production and trafficking of illicit drugs**, apparently the other side of the same coin.
3. The third trend we identified in our studies of the illicit drugs market (Reuter and Trautmann 2009; Trautmann et al. 2013) is **the growing interest in exploring the feasibility of regulation as an instrument to control the drug and gambling market**.

These three trends represent different realms. There are, however, junctions between these realms. In some countries they were introduced as separate strategies, while in others, as for instance in the Netherlands, they were launched as a package deal of drug policy change. Harm reduction refers to a

set of health measures aiming at reducing health harms related to substance use (and gambling). Decriminalisation of the use of illicit drugs as such is just a change of the legal status of drug use. Regulations are rules, sometimes formulated as laws, specifying 'how the game has to be played'. Regulations in drug (or gambling) policy generally refer to measures aiming to control supply.

However, decriminalisation is linked with regulation of the demand side when it also allows the possession of small quantities for personal use. This can be seen as a measure regulating the demand side. Decriminalisation of use can also contribute to reduce health harms related to the illicit status of, among others, heroin. Regulation policies are measures that are (also) meant to reduce health harms of licit and illicit drugs and gambling. Regarding illicit drugs regulation is meant to replace prohibition. This decriminalisation of drug supply can also help to reduce specific health harms related to prohibition, as for instance health damage by drugs which are diluted due to black market conditions.

For these three trends we will look into processes, driving forces, stakeholders involved, different interests / arguments that play a role and interfering factors and principles.

#### **2.1.4 Matching countries, substances and trends**

The final step in this focussing exercise was to match selected Member States, substances / behaviours and trends. Taking into account the time frame and available budget for this research it was impossible to analyse all three trends for the four selected addictions in all five sample Member States.

It was easy to match trends and substances / behaviours, as not all trends apply to the four selected addictions. **Decriminalisation** only applies to illicit drugs, in our sample to cannabis and heroin. The other two trends apply to all three substances and gambling.

The concept of **harm reduction** finds its origins in the attempts to tackle health problems related to heroin use, in particular to heroin injecting. It was also applied in measures addressing health harm caused by alcohol and tobacco use (see under 4.4). Applications in the field of cannabis and gambling are rather rare. Therefore we decided to limit our work to harm reduction regarding heroin and tobacco.

**Regulation** policies can be found for the three selected substances and gambling. Decriminalisation or depenalisation of the use of illicit drugs and the possession of small quantities for personal use is one measure targeting the demand side containing regulatory elements (see 2.1.3). Cannabis policy in different countries serves examples of regulation replacing criminalisation at the supply side (see 6.1). The approach to legal substances and gambling also shows the growing importance of regulation. Here there is a move from the other end: from a more or less unregulated situation to a highly regulated one. The tobacco and gambling policy are good examples of this. On this basis we selected cannabis, tobacco and gambling for an analysis of the trend towards control through regulation policies. Within each trend-addiction combination we decided to focus on one or two selected cases of governance practice.

For **heroin use** we selected the introduction of **opioid substitution treatment (OST)** as example of a harm reduction measure and the **decriminalisation of use** and possession of small quantities for personal use as an example of decriminalisation.

For **cannabis use** we chose the **decriminalisation of use** and possession of small quantities for personal use as an example of decriminalisation and the introduction of **regulated selling** (such as social clubs or coffee shops) as example of regulation replacing prohibition.

For **tobacco use** we focused on **legislation and regulations regarding smoke free hospitality venues** as example of regulation policies and **e-cigarettes** as example of harm reduction.

Finally, for **gambling** we limited ourselves to one case, i.e. aspects of **control and regulation**, e.g. licensing.

For dividing these trend–addiction combinations over the five sample Member States we again used a purposive approach. For each of the selected trend-addiction combination we chose countries which serve interesting elements in the respective governance / policy field and provide rich examples for our analysis, resulting in the following schedule:

- In the case study on the harm reduction trend we analysed the developments in heroin and tobacco policy. For heroin we looked into processes of policy implementation in The Netherlands, Slovenia and Spain. For the tobacco policy we concentrated on the Netherlands and France.
- The decriminalisation case study focused on the changes in the heroin and cannabis policy, using the Netherlands, Slovenia and Spain for the heroin policy and the Netherlands, Spain and the UK for the cannabis policy.
- For the case study on the growing interest in exploring the feasibility of regulation as drug control instrument we looked into developments in the fields of cannabis, tobacco and gambling policy. For cannabis we drew on the policy in the Netherlands, Spain and the UK, for tobacco on France and the Netherlands and for gambling on France, Slovenia and the UK.

Putting this selection in one table, gives the following overview:

	Harm reduction	Decriminalisation	Regulation
Heroin	NL, E, SI	NL, E, SI	
Cannabis		NL, E, UK	NL, E, UK
Tobacco	NL, F		NL, F
Gambling			UK, F, SI

## 2.2 Theoretical framework

Drug policy (governance) is a highly politicised and 'ideologised' area, the analysis of which is a complex undertaking. Drug policy implementation does not follow a linear model (problem-options-solutions-implementation). Various factors influence and intervene in policy making and implementation (Ritter and Bammer 2010). A wide range of stakeholders<sup>1</sup> are of influence: politicians and policymakers in the fields of health, justice, public order, safety, economy, etc.; researchers, general public, consumers, media, etc. These stakeholders represent different interests which are not necessarily only defined ex officio, i.e. by the (primary) interest that goes with the official position of a stakeholder. For example, the political agenda of a Minister of Health is generally not only health-driven. A number of other interests, for instant economic and party political / strategic arguments might play a role in his / her agenda. Finally, also personal ideological motives based on religious or moral beliefs might play a role here.

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<sup>1</sup> With 'stakeholders' we refer to all types of actors that have an influence on policy and governance processes. This includes individuals and organizations.

Numerous factors may work as barrier or as facilitator regarding the implementation of policy measures. Austerity due to the economic crisis is currently an important barrier. Interfering factors can be timing (e.g. 'right place – right time'), convergence of different interests, unforeseen, unplanned or unintended factors (online or internet gambling undermining control policies targeting land-based gambling), etc.

There are also contradictory elements in drug policy governance, e.g. contradictory interests in the decision making process. A well-known example is the government's economic interest in high tax income from tobacco and gambling, and on the other hand the mixed health and economic interest in limiting costs originating from health problems caused by smoking and gambling.

Finally, there are also measures meant to tackle a problem in one field, which have unintended consequences in another field. One example is the well-known designated driver (DES) campaign. This campaign aims to have a positive effect on road safety but is, at the same time, dubious seen from a health perspective in giving the message that as long as one stays sober the other passengers can drink without limitations. It is of interest that the stakeholders behind this campaign are in many cases alcohol producers and policymakers responsible for road safety (see also 4.4.2).

All together this is a highly complex field to study. We therefore needed a theoretical framework which would help us to chart all these different actors and factors and to get a structured picture of all relevant factors. We looked for a tool for analysing the process of policy (decision) making and implementation.

In an exchange with the UK Drug Policy Commission (UKDPC) and RAND Europe we made an inventory of key stakeholders and factors that played a part in drug policy governance. We listed stakeholders, interests / arguments, interfering factors (barriers and facilitators) and principles as a first step in developing the analytical tools for our analysis in the five sample Member States and we discussed different theoretical frameworks.

We also looked into the various theoretical frameworks which have been developed to analyse (addiction) governance and (drug) policy making and implementation.

### **2.2.1 Different theoretical models**

In the literature one can find different models useful for understanding and analysing political decision making processes (Ritter and Bammer 2010; Kingdon 1984 and 2003). Although all these models focus on the process of policy making and not so much on policy implementation, we think they are also useful to analyse the process of policy implementation, as the underlying decisions involve the same elements (stakeholders, etc.). Some models proved to be rather static, listing relevant factors graphically, representing links in generally rather simplified charts. The technical or rational model is one example. This model is based on the assumption that policy is a linear or circular process, starting with identifying the problem, followed by sorting out possible solutions and then selecting the most appropriate solution to be implemented. Others are more complex doing more justice to the multifaceted, dynamic reality of policy making. One example is the so-called incrementalist model viewing the policy making process not as one clear step towards pre-set goals, but describing it as small, accumulating steps (Hanney et al. 2003; Ritter and Bammer 2010). There are also models which are emphasising the importance of power, referring to interest groups and advocacy coalitions putting pressure on decision makers and influencing policy decisions (Ritter and Bammer 2010).

A very interesting model is the so-called **garbage can model**, developed by Cohen et al. (Kingdon 2003; Cohen et al. 1972), reflecting the dynamic character of policy making. It provides a theory



about the way big organisations work. There are three general characteristics. The first is the 'problematic preferences' meaning that the preferences of the members are not well-defined: the organisation is "a loose collection of ideas rather than a coherent structure; it discovers preferences through action more than it acts on the basis of preferences". (Cohen et al. 1972, p1) The second characteristic is an 'unclear technology': the members do not understand the processes in their organisation very well.

The third characteristic, 'fluid participation', refers to the fact that members participate at different moments in the decision making process. According to Cohen et al. four different streams run through these organisations and decision making structures: problems, solutions, participants and choice opportunities. The outcomes depend for an important part on the coupling of the streams to the choices (the garbage cans) which have to be made. This model provides a spot-on description of the frequently unorganised process of policy (decision) making, demonstrating that the supposed rationality is hard to find. For our purposes this model lacks the analytical sharpness necessary for discerning different factors.

Having looked at various models to analyse political decision making processes we came to the conclusion that for our research purposes a combination of elements of two models, the Multiple Streams model and the Health Policy Triangle, looked the most promising.

### **2.2.2 Multiple Streams Model**

The Multiple Streams Model of Kingdon, loosely based on Cohen's garbage can model, explores why some policy subjects are put on the governmental agenda, why actors in and outside the government pay attention to some policy proposals and not to others, and how issues end up on the decision agenda (Kingdon 2003). This model sees drug policy as organised anarchy (Ritter and Bammer 2010), allowing for understanding a complicated policy process by discerning between different processes.

Kingdon distinguishes in the process of policymaking three separate streams – problems, politics and policy. The 'problem stream' covers conditions that become noted and defined as important problems. Different factors make that a condition is viewed as a problem requiring policy attention. There are for instance indicators for the scale of a problem e.g. taken from monitoring data or focusing events that direct attention to the problem, e.g. a personal drama covered by media that pushes an issue on the political agenda and, finally, feedback on the failure of policy measures taken to tackle the problem.

The 'policy' stream' is characterised by Kingdon as 'primeval soup' where many ideas or proposals for change float around. Through a sort of natural selection some policy proposals survive and are considered for implementation. Kingdon explains that in order to be selected policy proposals need to meet certain criteria. These criteria include: technical feasibility, congruence with values of community members, and anticipation of future constraints including budget, public acceptability and politician's receptivity (Kingdon 2003).

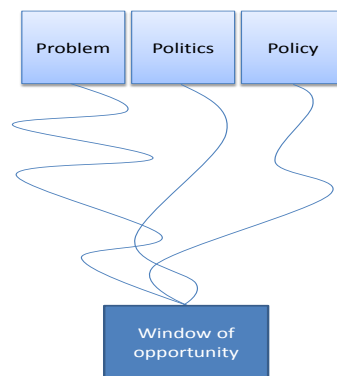
Finally, the 'political stream' relates to the political environment of policy making. Kingdon sees the political stream as quite independent from the policy and problem stream. It consists of organised political processes, different forms of consensus building and decision making, public opinion, national mood, election results, changes in administration, and partisan or ideological distribution in administrations.

At critical moments, these three streams come together, creating a 'policy window', offering an opportunity for policy change. Kingdon (1984 p174) argues, "A problem is recognised, a solution is

developed and available in the policy community, a political change makes the right time for policy change, and potential constraints are not severe". The politics stream plays a critical role in opening policy windows. It determines the status of a policy idea or proposal.

Each of the streams includes various groups, agencies and institutions that are involved in the policy process. Within policy areas the streams operate rather independently from one another until there is a change that causes two or more streams to meet in a window of opportunity. Such a change can be triggered by a shift in understanding of a problem, new possible solutions, or focusing events. However, these windows of opportunity are rare and usually the three streams float around independently of one another.

**Figure 1. Kingdon's Multiple Streams Model**



This Multiple Streams Model is clearly a very dynamic model for analysing policy making, reflecting the complex character of the decision making process which in fact consists of different concurrent processes which can go different directions. It concentrates on the timing and flow of policy making and implementation – taking a bigger-picture perspective – in contrast to other models which focus on individual steps or components of the policy process (Ritter and Bammer 2010).

Especially the notion of the 'policy window' is an important one, as it serves as heuristic to understand that a specific constellation of factors at a specific point in time can present a window of opportunity for a decision which in a different constellation, at a different point in time and in a different context might not be possible. It helps to appreciate the importance of context – political climate, timing, and changing realities – that must be dealt with in the policy making process. It also helps to explain (the impact of) unexpected events which suddenly might change the course of the streams and 'open' the window of opportunity for a policy or political decision, which was seen as unrealistic or even impossible before.

However, Kingdon's model has one major weakness: It is rather unspecific and therefore less useful for analysing and explaining specific governance developments or policy decisions as we intend to do in this study. The three streams are in themselves huge cans containing very diverse elements (stakeholders, interests and expectations, barriers and facilitators, etc.). Moreover the contents of the different cans overlap. Thereby as a tool it lacks the analytical sharpness and precision required for assessing and clearly identifying critical elements in developments or decisions. One can take from every 'can' something which fits to one's ideas and put together an explanation. Still, the model provides us with a useful visualisation of the policy making process and its dynamic and unpredictable course, facilitating better understanding of its complexity. It is a helpful tool to analyse and describe in retrospective the important factors that create a window of opportunity for a policy

change. In the analysis of current drug policy it can contribute to assess whether the time is ripe for a certain policy change.

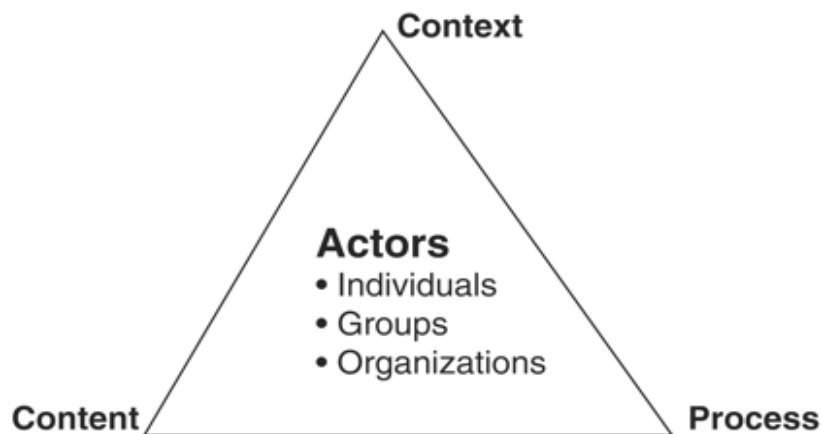
### 2.2.3 The Health Policy Triangle

To get a better grip on the factors influencing decision making processes we were in need of a more simple but sharp conceptual framework. We decided to follow a frequently used basic and pragmatic approach, differentiating between five different angles, which are also the key questions we want to answer in our case studies, to look at policy making:

- What
- How
- Who
- Where
- When.

These five questions can be found in the so-called Health Policy Triangle (HPT), a model developed by Walt and Gilson for the analysis of policy processes. Though more static than Kingdon's Multiple Streams Model, it offers a visualisation of the basic elements involved in policy making. The Health Policy Triangle model tries to capture the comprehensiveness of health policy analysis by focusing on the interaction between policy content, actors, context and process and their impact on policy making (see figure 2). It stresses that policy does not originate in a social vacuum, but is the result of complex social, political and economic interactions (Walt and Gilson 1994; Walt, Shiffman, Schneider, Murray, Brugh and Gilson 2008).

**Figure 2: The Health Policy Triangle – a model for health policy analysis. Source: Walt and Gilson (1994)**



**Content** refers to the **what**, the actual substance of a policy (Wouters et al. 2009). This can be found in among others policy documents, such as policy reports, action plans and laws.

**Process** refers to the **how** of policy making (Wouters et al. 2009). It refers to the way a policy is initiated, developed or formulated, negotiated, communicated, implemented and evaluated (Buse et al. 2005). Issues here are among others whether policy decisions are based on research, what is the role of evidence, whether the principals of good governance have been taken into account, etc.

**Actors** (or stakeholders) are the **who** in policy making (Wouters et al. 2009). They are individuals, groups of people and organisations, involved because they have a certain interest in making or implementing a policy (Buse et al. 2005). One key question for analysing policy making is among

others who has a say in policy making (which ministries, health sector / justice / police, treasury, interest groups, general public, media, etc.). Actors are placed in the centre of the triangle, underlining their key role in this model.

**Context** refers to the **where** and **when** of the policymaking process, to the historical, political, economic and social-cultural factors influencing policymaking (Wouters et al. 2009).

Content, process, actors and context are interrelated and influence each other. Actors shape the policy content and at the same time influence the policy making process. The process in its turn is affected by the policy context and affects the content of policies. The content reflects the interplay between all these concepts (Wouters et al. 2009).

The clear-cut separation of these elements is artificial indeed and reduces reality. Yet it is very useful for analytical purposes. It helps to have a clearer view of the different factors influencing policy making and to better understand the 'force field' in which policy making and governance take place. Although it is more specific because it unravels the knotty total in separate factors, it misses the dynamic of the Multiple Streams Model, which attempts to grasp the complex multi-faceted character of drug policy making.

#### **2.2.4 Combining the Multiple Streams Model and Health Policy Triangle**

We decided that for our research purposes a somewhat eclectic approach combining elements of the Multiple Streams Model and the Health Policy Triangle would be the best option. Both models emphasise the importance of the context of policy decision making. They consist of the same elements, the what, how, who, where and when. While the Health Policy Triangle is taking to pieces the policy making process and arranging the different elements in a logical order of separate groups, the Multiple Streams Model keeps the different elements together in diffuse streams, thereby doing more justice to reality.

Combining elements of both models enables us to capture the complexity and dynamic of the drug policy trends we focus on and serves as heuristics to analyse and understand the factors that have an impact on drug policy decisions and developments.

We decided to make a number of adjustments to the HPT in order to make it fit better with the Multiple Streams Model. We also included supporting and impeding factors (facilitators and barriers) for policy decisions and developments in the four areas of the triangle (content, context, process and actors).

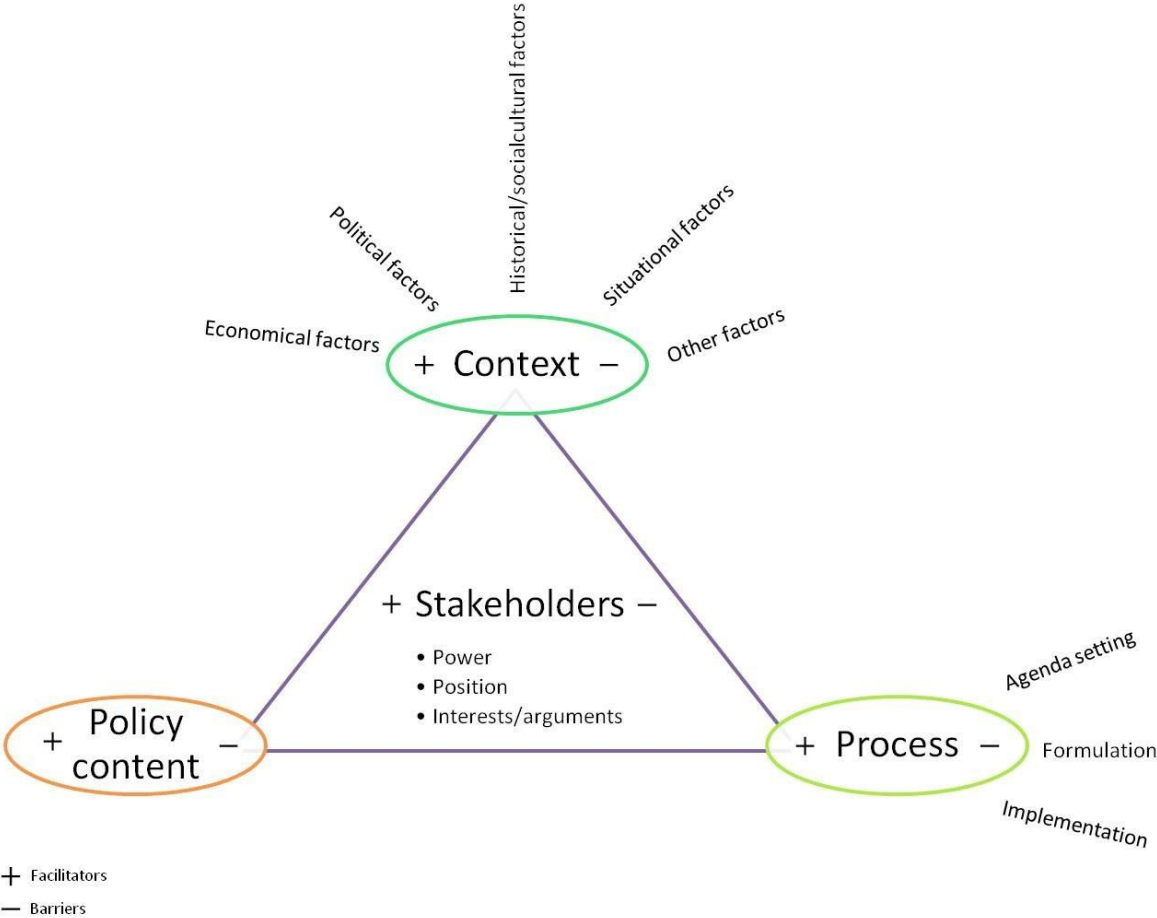
To provide a complete picture of the policy context, we also decided to distinguish between different relevant context factors. There are different ways to do so. Some authors choose a systematic approach, as for instance Leichter (1979), who distinguishes four types of factors determining the context of policymaking, i.e. situational factors (temporary conditions that can have an impact on policy such as epidemics and war), structural factors (elements of society that are rather stable (such as the type of economy, political system) and demographic features, cultural factors (such as the dominant religion, ethnicity etc.) and international or exogenous factors.

We decided to categorize the contextual factors which we considered relevant to the analysis of drug policy making and implementation in a more pragmatic way. We chose for differentiating between economic factors, political factors (including international factors), historical / social-cultural factors (including the different views on the nature of the drug problem, the different paradigms), situational factors or focusing events, and finally other significant factors. We also underlined the

involvement of many different actors and stakeholders in the policy making and implementation processes, having different positions (local, national and international) and power, representing different interests and using different arguments (see the introduction of this chapter). The increasing involvement of various stakeholders, which can be observed in the past decades in many EU Member States is a sign of the change from a primarily government oriented drug policy to a more governance based approach.

It is also a crucial element in 'good', i.e. well-functioning and effective drug policy governance (UK Drug Policy Commission 2012). Under process we decided to explicitly focus on the different stages of the governance process, i.e. agenda setting (the preparation phase), the actual formulation and the implementation.

**Figure 3: Adapted Health Policy Triangle of Walt and Gilson (1994)**



The two models served different purposes in the analyses for our case studies. The Health Policy Triangle provided us with the tools to get a better grip on relevant elements in the complex tangle of decision making processes underlying policy implementation, to break this jumble into pieces and arrange these pieces in groups of 'what', 'how', 'who', 'where' and 'when' (see under 3.3). The Multiple Streams Model was the heuristic that helped us to better understand the process of policy making and implementation, the relationships and influences between these elements. It was the tool we needed for 'composing the picture'.

## **2.3 Methodology and approach**

In order to better understand the factors and mechanisms influencing policy targeting heroin, cannabis, tobacco and gambling, we use qualitative, exploratory case studies outlining and analysing the structures, principles and processes, the interactions in the force-field between the different stakeholders, interests and other relevant, interfering factors. We started with a stocktaking exercise how policy in the four fields is implemented in the five sample EU Member States.

We developed a topic guide and – based on that – a country report format to systematically collect relevant information in the five selected Member States and to review relevant literature. The information collected was the basis for writing the case studies.

### **2.3.1 Stocktaking and topic guide**

We started with reviewing literature relevant for understanding drug policy governance. This included literature on policy making and governance theory as well as on policy making and implementation.

For selecting, reviewing and analysing relevant information from France, Slovenia, Spain and the UK we were assisted by colleagues from our partner organisations in these countries. As part of the information we needed for this study was not directly accessible for us (among others due to language barriers and the partly reflective character of the information), national experts were consulted by our partners in the five sample Member States.

We produced a **topic guide** for the systematic collection of relevant information, the basis for describing and analysing policy making and implementation and for identifying key factors and forces involved in policy and governance processes in the selected Member States. We used the elements of the Health Policy Triangle to structure this topic guide:

#### ***Policy content***

- What is the content of the current policies?

#### ***Context***

- Which economic factors play an important role in the context of these policies?
- Which political factors (including international factors) contribute to the policy context?
- Which historical / social-cultural factors contribute to the policy context?
- Which situational factors, or focusing events, contribute to the policy context?
- Which other factors contribute to the policy context?

#### ***Actors***

- Who are the main actors / stakeholders involved in the policy process and why?
- What are their main interests and arguments?
- What is their mutual relationship e.g. in terms of power balance and position?
- How are these actors / stakeholders influencing the policy content or how are they influenced by it?

#### ***Process***

- How, when and where: A short description of the key policy processes (e.g. agenda setting, formulation and implementation).

### 2.3.2 Country reports and literature review

As mentioned above, we decided to focus with each trend-substances / behaviours combination on one or two selected cases of policy governance. In order to describe and analyse these two cases we needed a basic overview of relevant factors in the preparation, enactment and implementation of important measures. We decided to make use of country reports to collect relevant information from the sample Member States. Based on the topic guide we developed a detailed format – similar to a structured questionnaire – facilitating a methodical comparison between the selected Member States. The country report format followed the structure of the Health Policy Triangle, built up around the following four concepts: policy content and process, stakeholders and context:

- Description of the actual situation regarding the three selected substances and gambling
  - Short general information on the Member State;
  - Indicator data / information on the situation regarding the selected substances and gambling;
  - Governance: formal policy documents and assessment of relevant policy measures taken, including a short description of existing mechanisms, structures and procedures for policy development in the Member States.
- Description / analysis of the four trends (i.e. the general convergence trend and the three specific trends mentioned above)
  - Assessing the influence of stakeholders (taking into account factors like access to decision makers, etc.);
  - Assessing the influence of arguments / interests;
  - Assessing the influence of existing structures and procedures, a.o. policy coordination, rules regarding transparency, accountability, etc.;
  - Assessing the influence of interfering factors (facilitators and barriers), including strategies of stakeholders, lobbying, 'windows of opportunity' (Kingdon 2003), etc.

We developed one country report format per selected substance / behaviour. These formats were sent to our partners in the respective Member States to guide their desk research. We asked our partners to provide us with draft country reports, which we reviewed. Matching the sample Member States with the selected substances and gambling and the selected trends resulted in the following list of country reports:

- Harm reduction and regulation of tobacco in France (see Appendix 1) produced by Maitena Milhet and Cristina Diaz Gomez, OFDT;
- Regulation of gambling in France (see Appendix 2), produced by Maitena Milhet and Cristina Diaz Gomez, OFDT;
- Harm reduction and decriminalisation of heroin in Slovenia (see Appendix 3), produced by Matej Kosir, Inštitut Za Raziskave In Razvoj UTRIP;
- Regulation of gambling in Slovenia (see Appendix 4), produced by Matej Kosir, Inštitut Za Raziskave In Razvoj UTRIP;
- Harm reduction and decriminalisation of heroin in Spain (see Appendix 5), produced by Maria Estrada, Departament de Salut – Generalitat de Catalunya;
- Decriminalisation and regulation of cannabis in Spain (see Appendix 6), produced by Maria Estrada, Departament de Salut – Generalitat de Catalunya;
- Decriminalisation and regulation of cannabis in the UK (see Appendix 7), produced by David Miller and Claire Harkins, University of Bath;
- Regulation of gambling in the UK (see Appendix 8), produced by David Miller and Claire Harkins, University of Bath.

As to complement the country reports produced by the partner countries, for the Netherlands Trimbo's Institute evaluated the decriminalisation of heroin and cannabis and the regulation of tobacco / cannabis by using its own available data collection from its National Drug Monitor and research publications.

For harm reduction (heroin and tobacco) and regulation (cannabis / tobacco), three research reports were produced by students of the Vrije Universiteit Amsterdam's Master in Management Policy Analysis & Entrepreneurship, supported and supervised by researchers of the Trimbo's Institute. These research reports were written on the basis of the common country report format:

- *Describing and analysing current and past practices and trends in the governance of illegal and legal substances in the EU. Opioid substitution treatment in the Netherlands* by Sophie Henken;
- *Did the Dutch smoking ban vanish into thin air? Analysis of the policy process and governance practice of the Dutch hospitality sector*, by Elke Elzinga;
- *The development of local cannabis and coffeeshop policy in Amsterdam and Utrecht*, by Sophie Henken.

If needed we sent additional questions to the partners. We then analysed and compared the data from all country studies. On issues where data were scant, of poor quality or simply not available we consulted other experts from the respective sample Member States. To receive additional and background information we used (parts of) the country report format as basis for this consultation and for an additional literature search. For the expert consultation we used interviews consisting of specific questions to obtain lacking information and to clarify information we had received through the country reports. For Slovenia we consulted an expert of the Ministry of Health, for France experts of the OFDT, for UK experts of UKDPC and RAND Europe, and for Spain experts of the Transnational Institute in Amsterdam and a representative of the social club movement. In the Netherlands we organised two focus groups for experts on e-cigarettes and tobacco harm reduction. The partners in the Member State assisted with collecting (and where necessary translating and summarising) relevant information. For collecting the required information on the Netherlands we used a comparable approach, using the country report formats to structure our scan of the available literature.

### **2.3.3 Case studies**

The country reports and the reviewed literature formed the basis material for the three case studies, one per selected trend, i.e. the wider acceptance of harm reduction, the trend towards a decriminalisation of use of illicit drugs and thirdly the growing interest in exploring the feasibility of regulation as drug control instrument. In the study of the decriminalisation trend we also focus on the other side of the coin: the tougher, more punitive approach to the supply of illicit drugs.

For these three trends we looked into processes, driving forces, stakeholders involved, the different interests / arguments playing a role, interfering factors and principles. With analysing these aspects in each case study we intend to identify and better understand forces and factors behind the selected drug policy trends. In the concluding discussions (see 7) we analyse and compare the developments of these trends in policies targeting the selected substances and gambling.



### 3 Convergence and divergence in EU drug policy

Before starting with the actual case studies, we first will look into some important general features of the convergence trend in EU drug policy. In our analysis of the developments of the drugs problem and drug policy in the period between 1998 and 2007 we found that in the decade covered by the study one can observe a worldwide trend of harmonisation of drug policy (Reuter and Trautmann 2009). We concluded then: “Looking into drug policy globally there is a surprising amount of agreement on the aims of drug policy and the measures to realise these aims. There is no real dissent about the essentials of supply and demand reduction. The only drug policy element, which still evokes substantial opposition from some countries, is harm reduction. The United States is one of the most vehement exponents of this opposition in the international arena. Harm reduction is still the decisive difference in drug policy. There are two conflicting overall long-term goals for drug policy. One is to *solve* the drug problem, i.e. to make society drug-free. The other is to *manage* the drug problem, i.e. to reduce, maintain or limit the growth of the drug problem and to limit or reduce the harmful consequences of drug use. These two aims still seem to mark the difference between what could be described as the two main drug policy models in the world. This is true when one looks at what is written in policy papers. The reality of the policy that is implemented differs in many cases from formal policy statements. Drug policy in the United States is a good example. Formal national policy statements clearly disregard harm reduction while some states have well-developed harm reduction policy and practices. Harm reduction services are relatively wide spread in many states.” (Trautmann et al. 2009, p229).

In this study we also found that looking at the process towards convergence one can identify two driving forces towards changes going: A bottom-up force to gain support for wider acceptance of an innovative approach and a top-down force pushing towards wider implementation of innovations. We will look first at these driving forces before analysing the three trends.

#### 3.1 The bottom-up force towards convergence

Most innovations in drug policy started bottom-up as criticism on and alternatives for established paradigms. Convergence can emerge from a dissenting policy choice for innovations in one or two countries that in a process of years is adopted by other countries, resulting in growing uniformity. In the field of drug policy quite a number of examples of this bottom-up development can be found. The wider acceptance and implementation of harm reduction is one well-known example (see 4). In the Netherlands and the UK harm reduction responses started to develop in the 1970s as criticism on the existing abstinence oriented drug treatment services. In a process starting from a marginalised position against the stand of powerful stakeholders harm reduction was gradually recognised as an important personal and public health measure. In countries like the Netherlands it developed into mainstream drug policy. It became a constituent of local and national drug policy planning, which can be seen as marking the turning point from a bottom-up to a top-down driving force.

This process in the Netherlands has in a way repeated itself in other EU Member States like Germany, France and Spain. A similar process can also be seen on an international level. Especially in EU drug policy harm reduction changed in the past two decades from a seriously disputed into a mainstream position. The acceptance of harm reduction by international bodies like the European Commission, WHO, UNAIDS and UNODC was the start of a turn from a bottom-up into a top-down force, at least in Europe (see 4) but also in a growing number of other countries.

The other two trends we analyse in this study, decriminalisation of drug use (see 5) and exploring the feasibility of regulation instead of prohibition in drug control policies (see 6), developed in a comparable way.

These two trends also started as criticism on what was viewed as an inappropriate approach: to penalize an individual for simply using illicit drugs. In many countries decriminalisation of drug use went hand in hand with the struggle for the realisation of harm reduction services. Also for exploring the feasibility of regulation, the bottom-up force played an important role, as can be taken from one of the best known examples of regulation policies, the cannabis coffee shops<sup>2</sup> in the Netherlands.

### **3.2 The top-down force towards convergence**

A top-down force towards convergence can be observed in the key concepts and objectives, but also in the key constituents and structure used in drug strategies and action plans. These policy papers shape the general framework of drug policy, but in many cases don't say much about the actual policy measures implemented. They are not seldom primarily political rhetoric, based on shared ideological concepts, rather than a genuine strategy or plan for tackling the actual drug problem a country is faced with. These basic concepts are commonly formulated in general terms, e.g. striving for a 'balanced and comprehensive' approach to drug problems, emphasising the need of a balance between supply and demand reduction.

"Sometimes they seem to be written to fulfil obligations needed to reach objectives in other policy fields rather than to actually frame the direction drug policy should take in a country. For example, countries in the process of acceding to the EU are expected to produce and adopt a national drug strategy. For this they receive support from other Member States, sometimes even in formal projects financed by the European Commission. Frequently, the EU Drug Strategy 2005-2012 has been and is used as the basis for this national strategy. Obviously this results in a high degree of uniformity. The mutual evaluation process of CICAD (Inter American Drug Abuse Control Commission) may have the same effect of creating more uniformity within Latin America and the Caribbean.

Another standardising factor is the work of the international fora that shape the implementation of the provisions of the international treaties. The CND<sup>3</sup>, INCB<sup>4</sup> and the EU Council and Commission work towards general agreement, giving guidance to policy plans and sometimes even recommending specific measures that should be taken for a successful approach to the drug problem. These fora put strong emphasis on shared efforts to tackle the drug problem. Some experts interviewed in this study referred explicitly to international pressure to comply with International Conventions as an explanation for changes in the drug laws and policy in their country." (Trautmann et al. 2009 p229).

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<sup>2</sup> Coffee shops are establishments in the Netherlands where the sale of cannabis for personal consumption by the public is tolerated by the authorities.

<sup>3</sup> The Commission on Narcotic Drugs (CND) was established by the Economic and Social Council (ECOSOC) resolution 9(I) in 1946, to assist the ECOSOC in supervising the application of the international drug control treaties. <http://www.unodc.org/unodc/commissions/CND/> [accessed 18 January 2014].

<sup>4</sup> The International Narcotics Control Board is the independent and quasi-judicial control organ for the implementation of the United Nations drug conventions. It plays an important role in monitoring enforcement of restrictions on narcotics and psychotropics and in deciding which precursors should be regulated. <http://www.incb.org/> [accessed 18 January 2014].

Still, our study of the global illicit drugs market shows that this convergence goes beyond policy plans. Looking at the policy measures or programmes implemented in countries all over the world in the decade 1998 – 2007 one can observe a convergence trend both in the field of demand reduction and supply reduction. Many countries show a growing emphasis on proven effective programmes in the field of drug education / drug prevention. There is also increasing budgetary and political support for drug treatment. OST is spreading not only in the EU – at the time of writing this study OST was available in 26 of the 27 EU Member States – but also to ‘unlikely’ countries like China and Iran. The same trend can be seen for other harm reduction measures, for instance for syringe distribution / exchange programs, which now run in many countries.

We found in many countries a reduced willingness to punish drug users. There is a clear trend towards a de facto decriminalization of drug use in many EU Member States. Several countries apply administrative sanctions for possession of small quantities for personal use. Drug use and the possession of small quantities for personal use are not defined anymore as criminal act, but as minor offence. The emphasis is on motivating drug users to undergo treatment.

This ‘softer approach’ towards drug users is mirrored at the supply side by an increasing toughness towards sellers, as can be taken from the increasing number of arrested drug sellers, from longer statutory sentences and longer actual sentences (Reuter and Trautmann 2009).

These processes work as a top-down driving force pushing towards convergences of drug policies in different countries. We concluded that the pressure on individual countries by international structures like UN and EU, through international agreements and by strong national forces like the United States on weaker parties are an important constituent of this top-down force. Economically weaker countries seem to be particularly susceptible to this pressure. The prospect of receiving economic support or other advantages or sometimes the threat of not receiving these advantages are incentives for introducing adaptations in various policy areas. This is a quite common phenomenon as we can see e.g. in the copying the EU Drug Strategy and of the EU Drug Action Plan in candidate EU Member States (Trautmann et al. 2009). As drug policy is in many countries not a priority issue, politicians might be prepared to concede on this particular issue in exchange for something they value as more important.

### **3.3 Divergence tendencies**

It would be, however, a simplification to say that there is only convergence of drug policies in EU Member States. In a Delphi study exploring expert views on how key trends of the illicit drugs market and policy responses in the EU are expected to develop in the next years, which is part of our study of the EU illicit drugs market (Trautmann et al. 2013), several experts pointed at recent divergence tendencies in EU drug policy, though the views were somewhat diverse. A few were of the opinion that this divergence might be a temporary phenomenon, just a phase in the process of EU policy making. More than half of the experts pointed in particular to signs that harm reduction is losing ground in the EU, at least in some Member States. And some respondents expected that a number of Member States will develop a more harsh, supply reduction oriented drug policy (Trautmann 2013).

“Some Member States with a tradition of well-developed harm reduction programmes seem to reconsider their policies and put more emphasis on abstinence oriented programmes. Other countries that never clearly adopted harm reduction as a pillar of their drug policy or even formally rejected harm reduction in political statements seem to do away with harm reduction. Several experts see the austerity budgets due to the economic crisis, the growing influence of conservatism and populist politics in EU countries as important factors supporting this tendency.”(Trautmann 2013).

There are several indications that after a period of growing convergence in EU drug policy divergence tendencies start to emerge. Italy, for example, moved in recent years – again – away from harm reduction policies. At the CND meetings in 2012 and 2013 the fragile consensus achieved among EU Member States in earlier meetings and in documents like the EU Drug Strategy 2005-2012 showed some signs of erosion, as can be taken from the position taken by Italy and Sweden (Edwards and Gallà 2014). The criticism on and the eroding support for harm reduction by some governments (including the Netherlands) and the emphasis on recovery in the UK can be seen as another indication for this divergence tendencies (Duke et al. 2013). The increased emphasis on supply reduction and security in some Member States and in the European Commission adds to this picture as does the more restrictive position of the UNODC.

Finally, it might well be that the general ‘EU weariness’, which can be observed in quite a number of EU Member States also plays a role here. On political level EU bashing seems to be a popular pastime. However too tight restrictions and too much pressure on EU consensus on various issues may have fuelled opposition against convergence in EU policies.

## **4 The wider acceptance of harm reduction**

Turning back to our actual case studies, we start with analysing the wider acceptance of harm reduction. In this study we focus on developments in the heroin and tobacco policy. For heroin we selected OST as example to look into processes of policy development and implementation in the Netherlands, Slovenia and Spain. For the tobacco policy we will concentrate on e-cigarettes in the Netherlands and France.

### **4.1 The early years: responding to the ‘heroin epidemic’**

The term ‘harm reduction’ came into use in the 1980s in the UK. The name as such may have been relatively new, but the harm reduction concept in drug treatment and care emerged much earlier. In the UK, harm reduction can be traced back to what some authors call the old "British System", which developed as a result of recommendations of the Rolleston Committee in the 1920s. This Departmental Committee on Morphine and Heroin Addiction, a group of leading British physicians, was appointed by the UK Ministry of Health to investigate morphine and heroin use and addiction. This committee concluded that in certain cases opiate maintenance treatment might be necessary to help opiate users lead useful lives. Already in 1926, the Rolleston Committee Report defined addiction as a chronic disease and legitimised the prescribing of injectable heroin on a maintenance basis.

The introduction of this view is also an important step towards the introduction of the health, or in fact more correctly, the disease paradigm for (problem) drug use. It also can be taken as the origins for the current OST programmes, which are legitimised by comparable arguments: a medical treatment for a chronic disease, which is sometimes compared with or legitimised by referring to insulin treatment for diabetes patients. Also in the Netherlands ‘substitution treatment’ became available for opiate and cocaine users in the years before the Second World War (Van Laar and Van Ooyen-Houben 2009, p47; Henken 2013).

#### **4.1.1 Context and process: social and political developments**

##### *Protest movements in Western Europe in the 1960s and 1970s*

Harm reduction services targeting users of illicit drugs, mainly heroin injectors, started to develop in the Netherlands and the UK from the 1970s onwards. In the Netherlands the first steps of harm reduction services can be traced back to the late 1960s. They emerged as part of a countermovement in youth services that looked for alternatives for the traditional youth care, which was seen as patronising and not geared to the actual needs of the young. This movement was part of a broader societal unrest caused by the discontent of many young people with the – in their view – predominant conservative and repressive mood in the post-war Netherlands. The young criticised the focus on reconstruction and order, on wealth and making career, and rebelled against the restrictive climate dominating their lives. There were strong anti-authoritarian and libertarian elements in this movement. Personal freedom, testing the limits, experimenting with new lifestyles and looking for pleasure were key concepts (Trautmann 1985; Blok 2011). Different Western European countries saw a strong protest movement of students and other young people against the established powers in society in the 1960s and 1970s.

This movement took different forms in different countries: from a student revolt in countries like France and Germany, and the hippies in many countries all over the world to radical left-wing groups like the Rote Armee Fraktion in Germany and the Brigate Rosse in Italy. The Provo's in the Netherlands<sup>5</sup> were different from all these groups. It was a unique movement strongly influenced by basically anarchistic ideas, a group of people of very diverse background (students, hippies, workers, etc.) and driven by a very diverse agenda (from fundamental societal change to environmental issues).

What we saw then was a clash between an achievement oriented restrictive ideology and hedonism / personal freedom. The use of then new drugs like cannabis, opium / heroin, LSD and amphetamines fitted well in this 'hedonistic' pursuit of personal freedom. The growing popularity of these drugs was closely linked with the protest movement. It can even partly be seen as an expression of it. The most prominent 'group' in the Dutch youth protest, the so-called Provo's even explicitly stated that they don't use the drugs of the establishment, namely alcohol and tobacco, but other drugs<sup>6</sup> (Trautmann 1991).

#### *A different context: Central Europe, societal changes in Slovenia*

The start of OST and other harm reduction services in other EU Member States around the 1980s generally took place in a similar way. In all EU countries it started bottom-up, as a countermovement against the background of wider social change. This is also true for countries in Central Europe, though that context was different, as the developments in Slovenia show. The climate of social and political change in the declining years of the communist system, the pursuit of independence and more personal freedom in the 1980s during the so-called Slovene Spring was the breeding ground for wider societal changes. In 1991 Slovenia separated from Yugoslavia and became an independent democratic state after years of protest from a mass democratic movement against communist rule. As in the Netherlands there was a hankering for change among young people, who were looking for new ways of life, opposing the restrictive rules of the past. Here too exploring the use of 'new' drugs fitted well with this climate and with a changing view how to deal with people having problems with their drug use. It was in this context that from the mid-eighties onwards harm reduction services started to develop, a development pushed forward by a group of doctors, social workers, researchers and policymakers. It was not so much a broad harm reduction movement but rather a group advocating for OST and other harm reduction measures. A group of medical doctors, psychiatrists, drug service workers and some researchers played a leading role in pushing for OST (Appendix 3; Trautmann et al. 2007). A small number of drug users were also involved.

The start of methadone maintenance treatment can be traced back to the initiative of a doctor in Vojnik in 1988, who started to prescribe methadone to a number of problem heroin users. This initiative was stopped because there were no legal provisions approving of this treatment. Still, this was the start of a debate about substitution treatment, which fitted in with the growing interest for harm reduction measures (Trautmann et al. 2007). People involved in this movement visited the Netherlands and the UK, looking for information about developing harm reduction policies and services.

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<sup>5</sup> Provo was a counterculture movement in the mid-1960s, which focused on provoking authoritarian or sometimes violent responses from authorities, by means of "non-violent bait", aiming to expose the autocratic and rigid features of the political system and shatter the self-righteousness of the authorities. Wikipedia, [http://en.wikipedia.org/wiki/Provo\\_%28movement%29](http://en.wikipedia.org/wiki/Provo_%28movement%29) [accessed 9 June 2014].

<sup>6</sup> Among others the Provos began "a disinformation campaign to demonstrate the establishment's complete ignorance on the subject of cannabis. The Provos set out to get busted for "consuming" tea, hay, or herbs instead of marijuana. The Provos would often call the police on themselves." Wikipedia, [http://en.wikipedia.org/wiki/Provo\\_%28movement%29](http://en.wikipedia.org/wiki/Provo_%28movement%29) [accessed 9 June 2014].

### *Societal changes in Spain: different focus*

In Spain not much reference can be found to social or political developments as relevant context for the introduction of harm reduction policies. Neither the societal changes that the country underwent after Franco's dictatorship ended in 1975, nor a harm reduction movement seem to have played a substantial role here (Gamella and Jiménez Rodrigo 2004; Appendix 5). Nevertheless, these societal changes had a major impact on drug policy, in particular on cannabis policy and decriminalisation. We will come back to this later on (see 5 and 6.1).

Still, the pressure on the authorities to develop harm reduction services allowing for an appropriate approach of the increasing number of heroin injectors was important. In particular health professionals, NGOs and drug users emphasised the health benefits for the drug users. The first law allowing methadone substitution treatment dates back to May 1983. However, this law provided a rather restrictive framework, using high-threshold inclusion criteria and a thorough control system, including among others the approval of a regional commission for each individual case. Treatment centres required an authorisation of the Department of Health (Appendix 5).

OST made a false start in Spain due to the specific historic context in which it took place. The early 1980s were a period in which the increased, stricter controls of the licit and illicit supply of drugs was a priority on the political agenda. Gamella and Jiménez Rodrigo describe this context as follows: "Beginning in 1983, the provision of psychoactive drugs was restricted both in pharmacies and in the prescription options open to physicians by law and by strict monitoring programs of the health department. Spanish pharmacies had become paradises for dope fiends, and heroin users often maintained themselves with opiates and tranquilizers obtained in these facilities ( ... ). The huge rise in the thefts and robberies of pharmacies (five pharmacies were robbed in 1975, compared to almost two thousand in 1979) was a visible part of the crime wave. Pharmacies were robbed mostly for drugs, but also for money ( ... ). In response to these trends, government policies restricted the availability of pharmaceuticals with potential for drug abuse. Amphetamine-type stimulants, for instance, widely available as diet pills, increasingly disappeared from prescriptions and as over-the-counter medications. Methadone maintenance programs were also curtailed between 1983 and 1991 ( ... )." (Gamella and Jiménez Rodrigo 2004 p631).

### *More on the context: the emerging drug use 'epidemic' and the inadequate treatment response*

Another important contextual factor contributing to the development of harm reduction, or to use the heuristic of the Multiple Streams Model, to the problem stream is the increase of drug use among young people from the 1970s onwards. It did not take long before some of these young people who started to use these new drugs ran into problems. This new wave of drug use, which 'washed over' countries in the EU and other parts of the world resulted in what became known as the drug problem in the 1980s.

The existing addiction care services were not able to formulate an adequate response to the problems these young people were facing. The only treatment options available were in fact abstinence oriented programmes for problem alcohol users. The same abstinence oriented paradigm was applied in newly developed treatment programmes for the users of the 'new' drugs in particular heroin, starting in the Netherlands with experimental clinical programmes and followed – already in 1972 – by the first drug-free therapeutic community (Blok 2011 pp187, De Kort 1995).

Also in countries like Slovenia and Spain the heroin epidemic and the absence of appropriate treatment responses were important factors contributing to the development of OST (Trautmann et al. 2007; Gamella and Jiménez Rodrigo 2004).

#### **4.1.2 Stakeholders and content**

##### *The harm reduction movement*

The protest movement of the young, turning away from the established norms and rules, criticising the conventional ways to tackle problems introduced new ideas and a new lifestyle including the use of certain 'new' drugs. At the same time they initiated new ways to deal with problem drug use. Pointing at the high drop-out and relapse rates, the alternative youth services were of the opinion that these treatment services were not able to meet the needs of these new clients. They blamed the lack of realism of the abstinence-oriented treatment and the patronizing, high-threshold approach for the failure of the addiction treatment centres to successfully reach the new drug users. It was time for a change. The youth services started to develop new services based on a philosophy of acceptance, normalisation and a low-threshold approach, including outreach work and drop-in centres. At the beginning these programmes were integrated in broader social services, aiming to assist young people looking for support with a variety of problems, from running away from home to problem drug use (Trautmann 1985). Soon the drug use related problems among young people began to play an increasingly prominent role, which required more specific responses. New services, specifically targeting drug users started to develop, aiming primarily at harm reduction instead of abstinence (Trautmann 1992).

##### *The emergence of alternative drug services in Amsterdam*

The starting point in the Netherlands was an 'outreach project' for the growing group of drug users among the so-called 'Vondelpark sleepers', a group of several hundred young people from all over the world who more or less lived in the Vondelpark, a city park in Amsterdam. It is estimated that around one quarter of these young people used illicit drugs (Blok 2008). The Vondelpark project started in 1971 and provided basic services like sleeping facilities, basic medical care, showers and lavatories. This project was a catalyst for the development of other harm reduction services, like outreach work services, drop-in centres, sometimes in combination with a night shelter and drug consumption facilities. One of them was the so-called HUK<sup>7</sup>, a drop-in centre with basic health and hygienic facilities (shower, meal, medical care, etc.) but also the first informally arranged drug consumption facility including needle exchange and a so-called 'house dealer', where visitors could buy their drugs. It opened its doors in 1974 after the Vondelpark was cleared because the situation was getting out of hand. These alternative services including some charitable services with a religious background like the Salvation Army and Stichting de Regenboog (the Rainbow Foundation) took care of young drug users who had not been reached successfully by the available abstinence oriented treatment services, which turned away drug users who could not maintain abstinence or had psychiatric problems (Blok 2008). The next harm reduction steps were methadone maintenance treatment (starting in the late 1970s) and the provision of syringes. The first syringe exchange programme in Amsterdam supported by the authorities was started in 1984 by the so-called MDHG<sup>8</sup> one of the "Junky Unions" in the Netherlands, an interest group of drug users, representing mainly heroin users.

<sup>7</sup> HUK was an abbreviation for 'Huis- en Uitkeringen Kamer' (Living and social security room).

<sup>8</sup> MDHG is an abbreviation which originally stood for Medicosocial Service for Heroin users. It was formed in 1977 by a group of people who were concerned with the results and effects of the official drug policy. To this group belonged doctors, social workers, parents of heroin users, people living in the neighbourhood of the scene, people simply interested in the drug problem, and of course users and ex-users. In the 1980s it turned into an interest group of drug users, supported by various professionals (Mol and Trautmann 1991).



The alternative youth services played an important role in the development of a harm reduction movement in the Netherlands, one element in the counter movements in various European countries of that time, as can be taken from the introduction of the term ‘harm reduction’. It were the people involved in the work of the Merseyside Drug Treatment and Information Centre in Liverpool who started to use this term for needle exchange and other services aimed at reducing the health harm related to drug use, in particular to injecting drugs like heroin. This Merseyside model was developed in response to a heroin epidemic in the early 1980s.

Russell Newcombe, one of the key players involved in the harm reduction development in the UK, summarised the definition as follows: “Harm reduction — also called damage limitation, risk reduction, and harm minimization — is a social policy which prioritizes the aim of decreasing the negative effects of drug use. Harm reduction is becoming the major alternative drug policy to abstinence, which prioritizes the aim of decreasing the prevalence or incidence of drug use. Harm reduction has its main roots in the scientific public health model, with deeper roots in humanitarianism and libertarianism. It therefore contrasts with abstinence, which is rooted more in the punitive law enforcement model, and in medical and religious paternalism.” (Newcombe 1987 p1).

This quote summarises the critique from a new player in the drug service field on the establishment, starting bottom-up from local initiatives. It reflects the polarised character of the confrontation between the abstinence and the harm reduction model, two drug treatment paradigms in the drugs field at that time. It is a political statement pervaded by the criticism on the then prevailing abstinence oriented drug treatment. This clash between conflicting views forms an important contextual element in the early years of the process of gradual acceptance of harm reduction services, which started as outsiders gaining wider recognition and finally resulted – at least in some EU Member States – as mainstream approach.

#### *The first initiatives on methadone maintenance treatment in Amsterdam*

The development of methadone maintenance treatment in the Netherlands can again serve as example. Methadone was first introduced in the Netherlands as medication to facilitate detoxification of opioid addicts in abstinence oriented drug treatment around 1968. It took some more years till methadone also popped up as maintenance treatment. The first step was taken by a General Practitioner in Amsterdam. One contextual element playing a role in his decision to start with this was that as an amateur painter he was a member of the artist club ‘De Kring’ in Amsterdam where many social critics (writers, poets, movie makers, painters) came together. Drug use was not uncommon among the members. This doctor started prescribing methadone for acquaintances. More GPs – some of them member of the same circles and even the same club – followed. These GPs also went through the available research literature on methadone maintenance and discussed the approach among themselves. From these small-scale, rather isolated initiatives the development of a national framework for OST started. In one decade, methadone treatment started to change from prescription solely for detoxification purposes to mainly maintenance treatment (De Kort 1995; Blok 2011).

The choice for methadone as OST medication in the Netherlands, and also in other EU countries, was made on the basis of experiences in the US. Methadone was the first well researched OST, apart from some small-scale use of morphine and heroin in the UK in the 1920s. Methadone was applied in the US as early as 1949 to mitigate withdrawal symptoms during the detoxification from heroin.

Dissatisfaction with the high relapse rate after detoxification led Dole, Nyswander and Kreek to experiment with methadone maintenance as substitution for heroin.

This treatment proved to be successful in terms of retention rates and social stabilisation of clients and in reducing the use of street heroin and heroin use related crime. The treatment approach developed by Dole and Nyswander was the basis for methadone maintenance treatment in the Netherlands (Driessen 2004).

*Important stakeholders: local policymakers, politicians, health professionals, charity and drug users*

In the Netherlands also policymakers and politicians were important stakeholders in initiating and supporting harm reduction services, particularly on local level (Henken 2013). Though also on national level they played an essential role. This does not mean that there was a unanimous view which direction to take. Among others the attitude towards OST signified a divide between policymakers. In his book on the history of drug policy in the Netherlands De Kort (1995) describes that the division between the traditional and alternative drug services at local level in Amsterdam during the 1970s also played a role on national level, between the two responsible ministries. The Ministry of CRM<sup>9</sup> opposed a criminal law approach and pleaded for a primarily psychosocial care approach for problem drug users, going beyond the limits of medical interventions. A policy brief in 1975 of that Ministry was very much in line with the goals of the "alternative" youth services. They supported a focus on the personal and societal vulnerability of drugs users running into problems. The Ministry of VOMIL<sup>10</sup> had a different, primarily medical view on the approach of problem use.

To resolve this dichotomy the Dutch government requested the National Health Council to draw up recommendations on care for opioid addicts. These recommendations were more in favour of a mainly medical approach. In the end the government followed these recommendations in 1976, choosing for this mainly medical drug treatment approach, though some elements of the 'alternative', psychosocial approach were included as well. In the years that followed, VOMIL primarily chose to focus on the medical aspects of drug treatment such as detoxification programs, while CRM still concentrated on reintegration of addicts into society (Van Laar and Van Ooyen-Houben 2009).

This growing acceptance of OST and other harm reduction services by policymakers and politicians can be taken as example of the processes described by Kingdon in his model. It can be understood as a combined working of the policy and the political stream: policymakers (and politicians) started to see particularly heroin use as a serious problem (the problem stream) requiring a response going beyond the services offered by the available drug treatment programmes. On political level one could see then increasing consensus that OST and other harm reduction services are appropriate responses. The situation then is an example of what Kingdon called a policy window created by the coming together of the problem, policy and political streams window: an opportunity to introduce fundamental changes in drug policy.

The support for these changes was even broader. There were more stakeholders that contributed to it. Also religious and charitable organisations, mainly from protestant origin, helped develop harm reduction services, in particular drop-in centres and night shelters. Various health and social services emerged on the scene, developing, implementing and professionalising a range of harm reduction services, from social support through outreach work to in-patient crisis centres including drug

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<sup>9</sup> CRM stood for 'Cultuur, Recreatie en Maatschappelijk Werk' (Culture, Recreation and Social Work). This Ministry covered the domain of social affairs.

<sup>10</sup> VOMIL stood for 'Volksgezondheid en Milieuhygiëne' (Public Health and Environmental Protection).

consumption facilities. Their staff, social workers and other professionals, also played a role in advocating appropriate harm reduction services in the political arena.

Regarding harm reduction advocacy, also groups like the above mentioned MDHG were important. It started simply as a group of people from very different backgrounds (doctors, social workers, parents of heroin users, people living in the neighbourhood of the scene, people simply interested in the drug problem, and of course users and ex-users) concerned about the neglect of the social and health problems of drug users, unhappy with the response of politicians, policymakers and service providers and searching for alternatives (Mol and Trautmann 1991; Henken 2013).

In Slovenia the most important protagonists of harm reduction were health professionals, policymakers and politicians from liberal parties. The debate about substitution treatment resulted in 1994 in the start of a national methadone maintenance treatment programme for problem heroin users under the final responsibility of the Ministry of Health. National guidelines for the treatment of problem heroin users, including methadone maintenance treatment, were adopted by the Health Council at the Ministry of Health in 1994 and methadone maintenance programmes were approved (Kastelic and Kostnapfel-Rihtar 2000). Since then the number of centres providing this treatment has steadily increased (Appendix 3).

In Spain the wider implementation of harm reduction measures like OST started rather late. According to Gamella and Jiménez Rodrigo, methadone substitution treatment nearly disappeared between 1983, the year in which it formally was permitted by law, and 1991. It took till the early 1990s before the wider implementation of OST started (Gamella and Jiménez Rodrigo 2004 p635). The most important proponents of OST were health professionals, NGOs and drug users, who underlined the health benefits for the drug users. Politicians and policymakers seemed to be especially concerned with public health, reducing public nuisance and drug use related crime as arguments in favour of introducing OST (Appendix 5).

#### *Researchers and scientists as decisive driving force*

There was one more group of stakeholders playing a striking role in the introduction and acceptance of harm reduction in the Netherlands: researchers and scientists. In a time when drug use among young people was an issue of concern on political level, in the media and in public opinion, causing sometimes heated debates, politicians and policymakers called for scientifically sound explanations of and approaches to the drug epidemic. Drug use was a new problem, for which no appropriate solutions were available. The approach to this challenge was a surprisingly rational one. For an appropriate response more, thorough information was needed. This resulted in the formation of two commissions, which were assigned with the task to explore and explain the nature and extent of the problem.

One was the so-called Hulsman Commission (1968-1971), installed by the National Federation of Mental Health Organisations and named after the chair of the Commission, Loek Hulsman, a criminal law professor at the University of Rotterdam. This commission had a diverse membership including law enforcement officials, alcohol treatment experts, psychiatrists, a drug use researcher and a sociologist. The commission's final report, presented in 1971, provided an extensive analysis of drug use and the social mechanisms behind drug problems providing arguments that prohibition of certain drugs, criminalising the production and use of these drugs is creating instead of solving problems (Stichting Algemeen Centraal Bureau voor de Geestelijke Volksgezondheid 1971).

The other one was the Baan Commission (1968-1972), installed by the government, and named after its chair, Pieter Baan, the Chief Inspector of Mental Health at the Ministry of Health. This commission

included some members of the Hulsman Commission, as well as officials from the Ministry of Justice, the Amsterdam Chief of Police, and other experts like psychiatrists and sociologists. Its mandate was to explore and explain the nature and extent of the drug problem and come up with recommendations how to deal with it appropriately.

The report of the Commission presented in 1972 came up with a number of interesting findings. It emphasised, among other things, that youth culture is a crucial determinant of drug use. The sometimes unusual behaviour of the cannabis-consuming young people had to be understood as a result of specific subculture norms and ideologies rather than pharmacology (Werkgroep Verdovende Middelen 1972).

These two reports presented the research findings available in their time and were meant as evidence base for the policy decisions to be taken. They defined the points of departure for the Dutch drug policy, as we know it today. The Baan report provided also an overview of risks that were associated with the use of different types of drugs. These risks were divided into physical damage, psychological damage and social damage. The core point in the recommendations of this report was the suggestion to divide drugs into those with 'inacceptable' and those with less serious risks for the user, thereby introducing the concepts of 'soft' and 'hard drugs'. The commission defined cannabis as soft drug and other drugs like heroin and amphetamines as hard drugs. Though further research was seen as needed for the final classification of some drugs, the report concluded that cannabis products were relatively benign with limited health risks (Werkgroep Verdovende Middelen 1972).

The report of the Baan Commission was the fundament for the Dutch Drug Law of 1976, in which the distinction between soft drugs and hard drugs was authorised. Its recommendations largely determined the course of the Netherlands' drug policy, establishing the core features of the Dutch system which are rooted in the concept of harm reduction. It marked the start of a formal drug policy, in which drugs were classified according to their risk, resulting in a separate policy for cannabis products and different legal provisions for hard drugs (Van Laar and Van Ooyen-Houben 2009). The rationale behind this was to separate the markets of soft and hard drugs. According to the Baan Commission's findings the stepping stone effect, i.e. the step of users from cannabis to hard drugs, has nothing to do with the substance or substance use related issues but with the fact that users can buy different illicit drugs from the same dealer.

It was science that introduced and supported the change from a crime to health paradigm. It was science that helped to create the policy window, by bringing together the problem stream, policy and political streams. Scientists provided the definition of the problem by emphasising that drug use was primarily a health (and social) issue and that it had to be addressed in the first place by health and social policy measures. The Hulsman and the Baan report contributed to the sense of urgency among policymakers and politicians and to a shared understanding among them regarding the appropriate policy choices. In the Netherlands this resulted in the health paradigm taking the lead in drug policy. The Ministry of Health became – and still is – the leading / coordinating Ministry in drug policy.

### *The opponents*

All these new initiatives met with severe opposition in particular from traditional, abstinence oriented treatment services because of their diverging treatment philosophy. According to the established treatment centres abstinence was the only acceptable and effective option. This is why in the Netherlands the first doctors prescribing methadone met with such fierce opposition. Substitution treatment was criticised for giving drugs to drug users, perpetuating their addiction by simply replacing one addictive substance by another. Providing syringes to injecting drug users later met with the same criticism: facilitating or encouraging drug use.

The philosophy of harm reduction, accepting drug using clients as they are, without stating any conditions, was seen as undermining the motivation to get abstinent (Driessen 2004 p3). In the early 1970s there were also representatives of the alternative youth services rejecting methadone treatment.

They saw it as an element of the traditional medical health care approach, defining drug use as disease and the drug users as patient (De Kort 1995 pp241). The same criticism was brought forward by mainly conservative politicians and some media (Blok 2008). Methadone maintenance treatment was expected to lead to a falling number of drug users undergoing drug-free treatment. Though, when these fears did not become true (Driessen 2004 p3), the opposition against OST (and other harm reduction measures) lessened.

In Slovenia the introduction of harm reduction encountered relatively mild opposition, compared with the fierce struggle in other European Member States like Germany and France. Important players in the abstinence-oriented group were conservative politicians, religious organisations and drug-free therapeutic communities. An evaluation of OST in Slovenia found that scientific evidence on the effectiveness of OST – but also of other treatment options – had not much bearing on the debate about drug treatment (Trautmann et al. 2007).

In Spain opponents were again mainly conservative political parties and abstinence-oriented treatment institutions and professionals. In particular the therapeutic communities frequently supported by the Catholic Church played a prominent role here (Appendix 3 and 5). Also here, one prominent argument again was that OST is just replacing one drug by another.

#### **4.1.3 Process and context again**

In the process towards a wider acceptance of harm reduction there are more contextual factors worth considering. There are two issues which deserve a closer look, because they seem to have played an important role as facilitators of the developments. One is about factors facilitating the importance of science or research in the Netherlands and the other about the importance of the AIDS epidemic in the wider acceptance of harm reduction.

##### *The political demand for evidence based drug policy making*

In the Netherlands research findings contributed substantially to the wider acceptance of harm reduction policies. This is partly explained by the fact that policymakers, politicians and other decision makers turned to science to find sound explanations about the nature of the growing drug epidemic and to get advice for effective, ‘evidence based’ ways to tackle this problem. The drug policy change in the Netherlands in the 1970s is in fact one of the rare examples of a largely rational approach to drug policy making and an example of evidence informed policy making, taking scientific evidence as point of departure. Confronted with a relatively new, social problem politicians and policy asked scientists to bring together the available research findings and to come up with recommendations that allow for an effective policy response.

The intriguing thing is that this happened in a time when evidence base was not really an issue in (drug) policy making. One important facilitator may have been the fact that it was not clear who had ownership of the new drug problem. Compared with the 1990s and the first years of the new millennium, when the public debate about the drugs problem reached its peak, a smaller number of stakeholders was involved in addressing the drug problem (Duke and Thom 2014). The territory was not yet as clearly divided as it is today. It was less clear who was responsible for what. There was no consensus among professionals on a leading paradigm: was the drug issue a health, crime or social

problem. There was no consensus how to define the problem and how to deal with it. Addiction treatment was primarily limited to alcohol and did not yet see the new drug use phenomenon as its responsibility.

#### *The need for evidence to respond to international criticism*

The drug policy developments in the Netherlands in the 1970s and 1980s were a special case in the world in their time. The UK was the only other country in the EU where harm reduction started so early. In nearly all EU Member States drug policy was principle-based at that time, heavily relying on the idea of a 'war on drugs' and regarding abstinence as the only acceptable aim of drug treatment. The Netherlands chose a more pragmatic approach, aiming at managing rather than solving the drug problem. Harm reduction was the distinctive feature of this policy which met severe criticism from other EU countries, in particular from Germany, France and Sweden (Boekhout van Solinge 2002; De Kort 1995 pp228). The criticism on the Dutch focused on the dreaded consequences of undue 'liberalism' and tolerance towards drug use. The lenient Dutch policy was expected to lead to an increase of drug use and to a massive export of drugs to other countries. In 1996 the then President of France, Chirac, called the Netherlands a 'narco-état'.<sup>11</sup>

This international criticism reinforced the emphasis on evidence base for drug policy decisions. Dutch drug policymakers (and politicians) realised that in this highly politicised arena, dominated by ideological arguments, they had to be able to prove that there were good reasons for their approach. They began to understand the importance of evidence to defend the diverging policy directions taken in the Netherlands against criticism from other countries. This was the reason for developing a thorough monitoring system by installing the so-called National Drug Monitor, including a wide variety of data collection on the drug problem and the policy responses. As emphasized by the then national drug coordinator Bob Keizer, the Netherlands were in need of solid data to show that Dutch drug policy worked rather well (Keizer, personal communication). This was the background for substantially investing in research and monitoring. In the 1990s the Dutch government also agreed with the French and the Swedish government, representing the two harshest critics of Dutch drug policy, to start two bilateral research projects, with a Dutch researcher studying the French and Swedish drug policy and a French and Swedish researcher analysing the Dutch drug policy. The Dutch research on France and Sweden was officially published (Boekhout van Solinge 2002). The French and Swedish reports, however, were never produced without giving reasons.

#### *The emergence of the AIDS epidemic: a focussing event*

In the 1980s one additional powerful factor emerged, which supported the wider acceptance and implementation of harm reduction. The outbreak of the AIDS epidemic among injecting drug users was an extra boost to this development. It made various governments in the EU and elsewhere more amenable to the principle of 'harm reduction' and marked the turn from a bottom-up to a top-down driven development. Drug injectors were recognised as a major risk group. In the Netherlands the AIDS epidemic set in when harm reduction was already relatively well accepted. The threat of HIV infection was just an extra boost to increase the efforts by extra investments in HIV prevention services. These included not only wider implementation and better accessibility of syringe exchange programmes, drug consumption facilities and OST treatment, but also new initiatives, as for instance a national training and development programme, supporting local drug services in their HIV

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<sup>11</sup> <http://www.trouw.nl/tr/nl/5009/Archief/archief/article/detail/2547785/1996/03/30/Het-opportunisme-van-Chirac.dhtml> [accessed 7 February 2014].

prevention work by developing innovative information and education programmes (Van Laar and Van Ooyen-Houben 2009, p47).

Also in Slovenia HIV/AIDS played a rather modest role in getting OST and other harm reduction measures accepted. Like in the Netherlands a wider implementation of harm reduction started already before the outbreak of the epidemic. Moreover, incidence and prevalence figures were and still are relatively low. General health considerations were the most important driving force behind the pleas for introducing harm reduction services (Trautmann et al. 2007 p25 and p43-46).

In other EU Member States AIDS played a more prominent role in getting harm reduction and particularly OST widely accepted. This was among others the case in Spain, where besides the high rates of overdose deaths concerns about the increasingly high HIV/AIDS incidence and prevalence rates from the mid-eighties were the most prominent reason to introduce substitution treatment on a national scale. The regulations became more lenient, e.g. by only requiring a diagnosis of heroin dependence made by a medical doctor, allowing a broader reach of substitution treatment. The obligation of the approval of a regional commission was abolished. For reasons of effectiveness OST was included as one element in a comprehensive package of harm reduction services, including among others information and prevention, outreach work, needle exchange, drug consumption facilities and overdose prevention (Appendix 5). Important stakeholders such as the national and regional health authorities got involved, with the aim to get harm reduction widely implemented. This marked a change to a top-down driven process. Wider political agreement and commitment of the three administration levels (national, regional and local) helped to make OST a priority on the political agenda. Another example of a coming together of the problem, policy and political stream creating a window of opportunity for a policy change.

## **4.2 Acceptance and wider implementation**

### *The first signs of a top-down force*

In the Netherlands the first signs of a top-down force towards wider implementation of OST can be observed rather early. While there are still ardent discussions between proponents and opponents the government stated already in 1975 that it was not opposed to methadone maintenance treatment as such, as long as it contributed to the wellbeing and reintegration of drugs users. In the 1976 recommendations the Dutch Health Council proposed methadone (maintenance) treatment as vital element. In 1978 the government adopted most of this proposal in the guidelines for the medical prescription of substitution treatment for problem drug users (Van der Stel 2010). According to these guidelines drug treatment services were allowed to provide methadone if they adhered to one of two objectives: either, for a short period of time in decreasing doses to reduce the dependency on heroin, or, for an indefinite period of time as part of a maintenance programme. In both cases methadone prescription had to be accompanied by psychosocial support programmes that would help the drug users' reintegration into society (ibid).

OST fitted well in the context in which the medical view on drug use, interpreting (problem) drug use as disease, had the upper hand. This went hand in hand with a change from a rather unstructured approach with a wide variety of treatment and care services lacking a clear division of tasks and coordination to a rather well organised system. Important elements in this change were mergers of small services in bigger organisations and the move from the idealism of the alternative services to pragmatism. For OST in Amsterdam this change meant that in the 1980s methadone prescription by different service providers including General Practitioners came under the control of the Municipal Health Service (Trautmann 1992).

In Slovenia OST also became mainstream rather early. Within six years after the first bottom-up start by a GP in 1988, a top-down initiative set in when a national methadone maintenance treatment programme was started under the responsibility of the Ministry of Health (Trautmann et al. 2007 p25 and p43-46).

#### **4.2.1 Context and process: combining different interests**

Within less than ten years methadone maintenance treatment was officially accepted practice in the Netherlands. This development was one element in a wider acceptance of a variety of harm reduction services. In particular local authorities in the areas of health and social affairs played an important role in acknowledging the value of harm reduction as an element of effective care for drug users. Amsterdam and Rotterdam were the forerunners. Taking a pragmatic and non-moralistic attitude towards drug use, these cities supported the development of a variety of harm reduction programmes. They started as early as the 1970s to support alternative drug services from outreach work and drop-in centres (which allowed drug use on their premises).

Also on national level one can observe the top-down force gaining momentum. The new drug law of 1976 set the agenda. In the mid-eighties, the government explicitly stated that the prevention of AIDS was more important than striving for abstinence or discouragement of drug use (Van der Stel 2010). The combination of health interests, public order and crime reduction considerations contributed to the prominent place OST got in Dutch drug policy.

In the mid-eighties harm reduction is mainstream drug policy in the Netherlands. Harm reduction is accepted as constituting element of the demand reduction pillar of drug policy, next to prevention and (abstinence-oriented) treatment. Whereas initially there was an either-or dichotomy between abstinence oriented and harm reduction services, now there is a shared understanding that both paradigms can fit in one drug policy approach (Van Laar and Van Ooyen-Houben 2009 p45-53).

#### *An additional argument: public order*

Over the years one can observe a shift in the arguments in favour of harm reduction. While in the early years health arguments were predominant, from the early 1990s on public order considerations started to play a more important role, as can be taken from the developments around drug consumption facilities in the Netherlands. Drug consumption facilities started to emerge in the late 1970s for health reasons, to allow for safe injecting. They were closed in the mid-1980s as being 'overcaring' and re-installed again in the mid-1990s for health and, more importantly, for public order reasons. Public nuisance caused by drug dealers and users became a major issue in the public debate in the 1980s.



*The shift from health to public order motives behind harm reduction policies: the history of drug consumption facilities in the Netherlands*

Already in the late 1970s two of the alternative drug services, the HUK and the Princenhof, which had the primary aim to improve the psychosocial functioning and health of the clients, offered their clients the possibility to inject drugs on their premises next to basic medical care, counselling, food, laundry and a shower. In 1985 the last of these two drug consumption facilities was closed by the local authorities. The argument was that these services were not appropriate as they represented a fatalistic approach by overcaring and not stimulating clients to change their life (Herwig-Lempp et al. 1993).

In 1990 Reverend Visser of St. Paul's church in Rotterdam, started a supervised injecting centre 'Perron Nul' (Platform Zero), close to Rotterdam Central Station to provide drug users with an alternative to using their drugs on the street. He also offered drug users the possibility to inject their drugs in the basement of his church which served as drop-in centre for drug users. These initiatives received some support from law enforcement and local authorities. In 1996, the city of Rotterdam formally supported the centre in the basement of the St. Paul's church ('Perron Nul' had to close in the meantime as the social and public order problems in and around the centre became unmanageable).

This reflected a general shift of opinion in Dutch drug policy. Local public nuisance problems had become a prominent issue in the drugs debate from the mid-1990s on, resulting in an increasingly stronger call for more strict law enforcement measures to uphold public order. Politicians, policymakers, police, media and citizens joined forces in this attempt. This resulted among others in changes in the drug treatment system, like the introduction of quasi-compulsory treatment and stricter measures to protect public order. In Amsterdam a 'city centre banning order' was introduced for drug users who repeatedly caused public nuisance. Another example is the so-called 'street junky project', a package of measures designed to push and force the group of so-called 'extremely problematic drug users' to kick the habit (van Laar and Van Ooyen-Houben 2009). However, after having tried to tackle public nuisance with more repressive measures, awareness grew that law enforcement, the so-called 'constraint and pressure' policies, which had developed as the key elements of Dutch drug policy in the late 1980s, were an insufficient response (Mol and Trautmann 1991).

Consequently, supervised injecting centres and other low-threshold facilities were promoted again; this time as measures to reduce public nuisance and harms associated with increasing street-based injecting. A positive newspaper report in 1995 on a Centre in Arnhem had a catalysing effect on other regions and on regional and national policy. Besides backing from the city council, the police and the Public Prosecution Service<sup>12</sup>, the national government supported this development. The guidelines published by the Public Prosecution Service in 1996 stated that the possession of drugs in Centres would be tolerated, provided that those facilities were approved by the local 'triangle consultation'<sup>13</sup> (Dolan et al. 2000).

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<sup>12</sup> In the Netherlands the "Public Prosecution Service is not a government department like, say, the Ministry of Defence or Social Affairs: together with the courts, it forms what is known as the judiciary, the authority responsible for the administration of justice. The Public Prosecution Service decides whether an offender must appear before the court and it prepares the indictment."  
[http://www.om.nl/vast\\_menu\\_blok/english/about\\_the\\_public/](http://www.om.nl/vast_menu_blok/english/about_the_public/) [accessed 17 January 2014].

<sup>13</sup> In the Netherlands a three party consultation (the so-called driehoeksoverleg') including the mayor, chief public prosecutor and chief of police are coordinating the local police and security policy.

The debate around public nuisance and crime proved to be an important contextual element pushing the wider implementation of harm reduction measures. Besides – and sometimes maybe even above – health considerations the interest to maintain public order and to reduce drug use related crime became an important supporting factor. Harm reduction measures like OST and drug consumption facilities now worked with a double aim: prevention of personal harm and prevention of public harm. The idealism of the early years of harm reduction made room for a pragmatism confirming the generally rather pragmatic orientation of drug policy in the Netherlands.

Also in Slovenia the wider acceptance of harm reduction can be explained by the growing awareness that harm reduction services bring forth health gains (protection against infectious diseases like HIV and hepatitis) and – at the same time – reduction of drug use related crime.

#### **4.2.2 *New stakeholders and a growing expert consensus***

These developments also meant that new stakeholders joined the ranks supporting harm reduction. In Amsterdam it was a coalition of the police, citizens and entrepreneurs in the neighbourhoods that were affected by drug use related nuisance and crime which was decisive in the support of ‘reintroduction’ of drug consumption facilities in Amsterdam from the mid-nineties on (Dolan et al. 2000).

This gradual acceptance of OST and other harm reduction measures has to be partly explained by a growing consensus among stakeholders that these measures can help to reduce health harm for drug users *and* the social problems linked with heroin use, like drug use related crime and public nuisance. The latter was a growing problem in many European cities which could be observed from the mid-1980s on. The so-called ‘street scenes’, groups of heroin users hanging around on the streets, openly buying and using drugs, stealing from passers-by and shoplifting in the neighbourhood were an issue high on the political agenda and prominently covered by the media. The measure considered most helpful to reduce these forms of nuisance and crime were apart from OST drug consumption facilities, or, in popular speech, injecting rooms. Switzerland was the first country to introduce injection rooms as an element of its formal drug policy. The first ‘Fixer Stübli’ opened its doors in 1986 (Dolan et al. 2000).

While in some EU Member States like the Netherlands and Germany harm reduction became mainstream, in other countries it remains highly debated. Slovenia is somewhat in between these positions. Though OST is not an important issue in the public political debate there is still a clear divide between supporters and opponents. While in other countries the view of complementary options prevails, the ‘either-or’ view is still quite dominant in Slovenia. From time to time the issue pops up in public debates, in which media and public opinion are generally more in favour of abstinence-oriented treatment. OST remains the most debated type of drug treatment. An evaluation of the OST programmes in Slovenia showed that OST is still a controversial, politicised issue in Slovenia (Trautmann et al. 2007).

### *Characteristics of the OST debate in Slovenia*

Three main perspectives play a role in this dispute about OST in Slovenia. Viewed from a *political-ideological perspective*, the different political parties do not have a clearly formulated stance pro or con. However, it becomes clear that conservative political parties are generally not in favour of OST (e.g. because it does not present a direct, short-term way out of addiction and is seen as rather expensive) while the attitude of liberal or progressive parties seem to be (on average) more positive (e.g. because OST reduces several risks for the drug user and its environment).

The *professional perspective* shows a divide between an abstinence-oriented and a harm reduction view. In the first view, the only legitimate aim of drug treatment is abstinence. Substitution treatment is thus not really considered as a treatment, but rather as maintaining addiction by providing another drug. Those arguments are mostly held in abstinence-oriented treatment institutions and by professionals connected with the Catholic Church. In the second view, OST is a necessary option for problem drug users who cannot stop using heroin. OST reduces further risk behaviour and health damage associated with the use of illicit drugs and offers perspectives for both stabilising and improving the patients' health and psychosocial functioning. This harm reduction view is dominated on the one hand by a medical and on the other hand by a psychosocial view on problem drug use. From the medical perspective, problem drug use is mainly viewed as a (psychiatric) disorder for which medication assisted treatment is important. OST is therefore seen as primarily belonging to the medical domain. From the psychosocial viewpoint, the focus is primarily on psychological health, well-being and psychosocial functioning of the patient, i.e. on the individual and on his / her social environment. This perspective also (or more explicitly) targets societal issues, e.g. the reduction of public nuisance or drug-related criminality. It also partly includes public health issues such as prevention of infectious diseases. The latter includes interventions aiming at behaviour change which are based on educational and psychological expertise. Health is still primarily a medical concept in Slovenia, though health involves much more than medical aspects, e.g. psychosocial well-functioning and self-perceived well-being. Due to the higher status and self-esteem of the medical profession (compared with the 'psychosocial' professions) and the medical nature of substitution treatment, the medical viewpoint is dominant in OST in Slovenia. This means that the psychosocial components of medically assisted treatment such as OST are not fully appreciated (Trautmann et al. 2007).

The *(political) power perspective* – overlapping the previous two – concerns the power attributed to persons or organisations that influence OST in Slovenia, e.g. the ability to raise and maintain funds and to influence political decision-making. An evaluation of the Slovenian OST programme showed that in Slovenia (political) power, i.e. factual influence on political decision-making, depends considerably on personal relationships rather than on a decision-making process, following formal rules and regulations. This implies that decisions are – at least partly – taken 'in backrooms' (Trautmann et al. 2007).

#### **4.2.3 The top-down forces on EU level**

When looking at the developments on EU level one can observe an analogy with a bottom-up driven process in the early years which later turned into a top-down force. It started with debates among Member States, triggered by the deviant drug policy of the Netherlands. In fact all other EU Member States (and many more countries) rejected the Dutch drug policy approach. The Netherlands faced harsh criticism and were under severe pressure to return to the drug policy mainstream. However a

closer look reveals that in many countries there were opponents of the traditional drug policy approach, pressing for a change towards a primarily health oriented drug policy. They followed the developments in the Netherlands and in the UK, especially in Liverpool, with great interest. Their number had been growing through the years and included besides workers and managers of drug services also politicians and policymakers. In particular local authorities from cities facing substantial drug use(rs) related problems, like for instance Frankfurt, Hamburg and Zürich, were very interested. Step by step other European countries started to change their views and applied elements of the Dutch approach. The earliest and most radical changes could be observed in Switzerland, which introduced, among others, drug consumption facilities and heroin assisted treatment. Through the years a growing number of countries introduced these changes. This had a major impact on the course of the drug policy discussions on EU level. Harm reduction moved from being an isolated position to an increasingly well-accepted drug policy approach (Rhodes and Hedrich 2010; Cook et al. 2010; MacGregor and Whiting 2010).

On EU level the change from a bottom-up to a top-down driven development became clearly visible at the beginning of the new millennium. The 2003 recommendation of the Council of the European Union encouraging all EU Member States to implement harm reduction measures including substitution treatment (Council of the European Union 2003) was a clear signal followed by the endorsement of the EU Drug Strategy 2005-2012, which stressed the inclusion of harm reduction measures as element of demand reduction (Council of the European Union 2004a). The debates in the preparation process of the Drug Strategy showed that harm reduction was still far from being a generally accepted concept (Edwards and Gallà 2014). But the result was a clear confirmation that the majority of EU Member States agreed with having harm reduction included as one element of the pursued 'balanced approach'. The former minority position of the Netherlands had turned in a majority position. Dutch drug policy moved from an isolated to a mainstream position, while Sweden (and Italy) moved the other way: from a mainstream position they became more isolated.

This consensus did not mean an end to tough confrontations about the issue, among others during the preparation of the annual CND meetings (Edwards and Gallà 2014). The debate is still going on. Still, one may conclude that OST and other harm reduction measures have turned into an integral part of drug policy in the EU and in many other countries. There might be differences regarding coverage and accessibility. Some countries work with low-threshold programmes while others have implemented more demanding inclusion criteria (Palacio-Vieira et al. 2014).

The top-down force behind a wider implementation of harm reduction is also illustrated by guidelines, manuals and other documents of international bodies like UNAIDS, UNODC and WHO recommending and assisting the implementation of harm reduction. UNAIDS, UNODC and WHO produced several documents advocating harm reduction measures (WHO/UNODC/UNAIDS, 2004a; 2004b, Trautmann et al. 2009).

The broader acceptance of harm reduction is also shown by the support of the European Commission to projects which were meant to enhance the development of harm reduction responses in EU Member States. One relevant example here is 'EuroMethwork' a network of EU Member States, which started in 1994 with the support of the European Commission and has the aim to assist with the implementation and professionalization of methadone treatment.<sup>14</sup>

And, lastly, there are now internationally operating interest groups advocating for the wider implementation of harm reduction, like the International Harm Reduction Association (IHRA). IHRA

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<sup>14</sup> <http://www.g4g.nl/euromethwork/> [accessed 21 August 2013].

produces among others reports on the state of the art of harm reduction and guidance documents for implementing harm reduction services.

### **4.3 Divergence tendencies in EU drug policy**

However, as mentioned above when discussing divergence tendencies in EU drug policy (see 3.3) harm reduction seems to have had its peak. Different factors seem to play a role here. One could be the stagnation of the heroin epidemic, an 'erosion of injecting and new heroin use' which can be observed in recent years in EU Member States (EMCDDA 2013). The average age of heroin users is rising and the number of new treatment entries is falling in the EU (EMCDDA 2013). In some Member States, e.g. in the Netherlands, this trend can be observed already for quite some years (Van Laar et al. 2013a). There have been almost no new entries in OST in Amsterdam in the past five years and injecting is almost totally replaced by chasing the dragon<sup>15</sup> (Van Brussel<sup>16</sup>, personal communication). This is expected to have an effect on the 'classic' harm reduction programmes: OST, syringe exchange and drug consumption facilities. The number of heroin users in OST is slowly decreasing. Syringe exchange nearly disappeared due to a drastically decreased demand. Most of the drug consumption facilities in the meantime only have visitors who 'chase the dragon'. Some of the facilities have been even closed due to decreased demand. An integrated care approach for problem drugs users implemented in recent years resulted in a decreasing number of homeless heroin users, contributing to the decreased demand for drug consumption facilities. This made the harm reduction responses less urgent, possibly having an impact on harm reduction in general, because in the public debate harm reduction is mainly linked with (problem) heroin use. Applications of harm reduction for the use of other drugs are less visible.

#### *Contributing factors: economic crisis and political conservatism*

Other factors contributing to a decreased importance or acceptance of harm reduction might be budget cuts as a consequence of the economic crisis and the growing weight of political conservatism and populism which leads to increased support of a more harsh, supply reduction oriented approach, as can be seen in many countries, including the Netherlands. Also on EU level there is more emphasis on security and supply reduction issues. This political climate seems also to work well as breeding ground for questioning again the usefulness and appropriateness of OST and to choose again for a more abstinence-oriented treatment approach. The UK with its renewed emphasis on recovery is one of the most explicit examples. In quite some Member States one can observe eroding support for harm reduction. In some countries like in Italy and Sweden one could see in recent years signs of growing opposition in particular among politicians and in the camp of supporters of a drug-free society (Trautmann 2013).

Another factor which might have contributed to the loss of support for harm reduction policies is a decreasing importance of drug policy on the political agenda. In times of an economic crisis there are other more urgent issues than harm reduction policies.

### **4.4 Harm reduction strategies for other licit and illicit drugs**

Harm reduction programmes / strategies have been and are still mainly perceived as instruments to deal with health risks related to (injecting) heroin use.

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<sup>15</sup> 'chasing the dragon' means inhaling the vapour from heated heroin base that has been placed on a piece of foil.

<sup>16</sup> Giel van Brussel was head of the unit Social and Mental Health Care at the Municipal Health Service in Amsterdam until December 2013.

Although heroin use prevalence is generally very low in EU Member States with – in the general population – a life time prevalence from below 1 till 2 per cent and regular use prevalence (last month prevalence) generally well below 0.2 per cent, heroin use played a major role in innovating drug policy responses and – even broader – shaping the picture of the ‘drug problem’ and our view on it.

#### **4.4.1 Healthy nightlife**

However, harm reduction strategies also started to find their way into approaches towards other substances, both illegal and legal. One example are the different programmes targeting health risks related to nightlife, which started to emerge in the late 1990s, involving the use of both illicit and licit drugs, from ecstasy and other Amphetamine Type Stimulants to cocaine and – still the most prominent drug in nightlife – alcohol. In different EU Member States approaches have been implemented to reduce the substance use related health risks involved in nightlife. There have been EC funded projects to support a more efficient use of the expertise available in different EU Member States, as for instance the ‘Healthy Nightlife Toolbox’, a project which produced a website “designed for local, regional and national policymakers and prevention workers, to help reduce harm from alcohol and drug use”. (HNT 2010) Another example are the activities of Club Health, an international network of organisations involved in developing materials and approaches and organising conferences on the issue of improving health and safety in nightlife.<sup>17</sup> For the nightlife setting the Party+ project developed environmental drug prevention strategies, using so-called ‘safer nightlife labels’ for clubs, parties, cities and NGOs that adhere to certain standards to make nightlife more safe. Examples of these standards are:

- “Accessibility to health promotion material and information (examples: leaflets, condoms, ear plugs);
- Improvement in the infrastructure to reduce risks such as dehydration (example: access to free fresh water);
- The training of the parties’ professionals (examples: first-aid, information about drugs or law, non-violent communication, noise pollution, etc.)”<sup>18</sup>.

The majority of these initiatives are driven by health professionals.

#### **4.4.2 Reducing alcohol use related harm**

Harm reduction approaches have also been developed in the field of licit drugs in particular targeting problem alcohol use. Some approaches can be seen as copying the substitution treatment approach, like alcohol dispensation programmes that provide limited, mainly low-alcohol drinks to chronic alcoholics, an approach used among others in Vancouver by the Managed Alcohol Program.<sup>19</sup>

Naltrexone – generally known as opiate antagonist used in the treatment of problem heroin users – is also used in the treatment of alcoholics. It reduces the pleasurable effects of alcohol and can therefore contribute to reduce levels of alcohol use (Srisurapanont and Jarusuraisin 2005). The latter, so-called moderation management, helping drinkers to cut back on their consumption of alcohol and encouraging safer drinking behaviour, is a very popular strategy to reduce alcohol use related health harm (Ogilvie 2001). There are various options of moderation management, ranging from

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<sup>17</sup> <http://club-health.eu/> [accessed 23 August 2013].

<sup>18</sup> <http://www.partyplus.eu/> [accessed 24 June 2014].

<sup>19</sup> Harm Reduction Part III – Chronic Alcoholics. Available at: <http://drugsandotherthings.wordpress.com/2012/02/19/harm-reduction-part-iii-chronic-alcoholics/> [accessed 24 August 2013].

psychotherapeutic treatment to peer-run self-help / support groups. There are also approaches fully based on self-management, with books or (anonymous) e-health applications that guide the user through moderation management. All these approaches are based on cognitive behavioural therapy. Health professionals and researchers are the most important protagonists behind all these initiatives.

Like in the field of heroin use, harm reduction targeting alcohol use is not limited to reducing health harms of the user. There are also strategies addressing harms caused by the user to his / her surroundings. One example are strategies to reduce drink driving. There are 'late night patron transport' schemes, i.e. free-ride-home programmes for (young) people going out in the weekend and the 'designated driver' campaigns, encouraging the selection of one person who remains sober as the responsible driver whilst others can have a drink. However, as already mentioned (see under 2.2), these campaigns may have a positive effect on road safety, but at the same time are questionable seen from the health perspective of the passengers of the designated driver. It can be seen as giving the message that as long as one person stays sober it is OK for the others to get drunk. As expected, the initiators and supporters of these schemes are in majority stakeholders involved in health issues and road safety, like Ministries of Transport. The campaigns are used all over the world and received broad support from media and celebrities (Winston 2013). Also the alcohol industry willingly supported these campaigns.<sup>20</sup>

Finally, there is also the strategy of reducing the quantity of harmful ingredients, such as the production of light alcoholic drinks, mainly low alcohol beer. This strategy is seen as dubious as it is clearly 'producer driven'. Though it undoubtedly serves the economic interests of producers, to maintain market share and profit, it can be qualified as harm reduction in that it reduces harm e.g. through helping to reduce the intake of alcohol.

#### **4.4.3 Reducing tobacco smoking related harm**

Strategies of reducing the amount of harmful ingredients can also be found with regards to tobacco products, where 'light cigarettes' were introduced with the claim that this would help to reduce health risks related to tobacco smoking.

Like with light alcohol products the introduction and promotion of so-called 'light' cigarettes was predominantly an initiative of the producers. In many countries the use of the term 'light cigarettes' was banned as misleading. The filters of these light cigarettes are prepared with small holes in them. Smoking machines controlling the tar and nicotine intake during smoking measure lower levels of both harmful substances, because additional air is inhaled through these holes. However, in a real life setting smokers prove to adapt their way of smoking, by closing the holes with their lips and fingers. They then inhale as much as they need to reach the nicotine level they are used to. In practice, the amount of tar inhaled may become even higher with these 'light' cigarettes than with regular cigarettes (Kozlowski and O'Connor 2002).

In the field of tobacco harm reduction options seem to be limited despite the fact that tobacco smoking is uniquely harmful, as it causes serious health harms, even when used exactly the way the manufacturer recommends. Nevertheless, harm reduction options would be useful since there are many chronic smokers who are unable or unwilling to become abstinent. Tobacco harm reduction focuses on ways to lower the health risks associated with using and particularly smoking tobacco.

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<sup>20</sup> STIVA – Dutch Foundation for the Responsible Use of Alcohol (2001). 'Deterring Drinking and Driving'. Available at: [http://gsri.worldwidebrewingalliance.org/php/initiatives/initiative.php?ini\\_id=439](http://gsri.worldwidebrewingalliance.org/php/initiatives/initiative.php?ini_id=439); CNW (2013). New Budweiser campaign backed by ground-breaking research on designated drivers. Available at: <http://www.newswire.ca/en/story/1204065/new-budweiser-campaign-backed-by-ground-breaking-research-on-designated-drivers> [accessed 13 October 2013].

The available evidence shows that reducing the number of cigarettes smoked per day does not substantially reduce the risks of cancer and cardiovascular problems and can therefore only be advised as a step towards complete abstinence. Other options include switching to snus or dipping tobacco (a moist powder tobacco product originating from a variant of dry 'snuff' which emerged in the early 19th century particularly in Sweden). This product is forbidden in European countries, except for Sweden. Non-tobacco nicotine delivery systems (plasters, chewing gum) can be used as part of smoking cessation, but are not intended for long-term substitution. Recently, many other alternatives appeared on the market, of which the electronic cigarette or e-cigarette is the most interesting example.

### *The emergence of the e-cigarette*

The e-cigarette is a battery-operated device emitting doses of vaporized nicotine, flavour and other chemicals that are inhaled in a way that mimics tobacco smoking. E-cigarettes were already developed in the late 1960s. The first commercially produced e-cigarettes came onto the market in China in 2004. Today they are available in many countries, including the USA, Europe and South America. They are increasingly popular and therefore also interesting for the industry. While the first e-cigarette brands were produced by small independent companies, today their production has become 'big business'. The tobacco industry too became interested in the e-cigarette production.<sup>21</sup>

From the start there has been debate concerning appropriate ways to regulate these products. Central question is whether this product is just a recreational smoking product that may be less harmful than regular cigarettes, or a device that can be helpful in reducing conventional smoking or even an aid in quitting, or a gateway to smoking for non-smoking youth.

### *The debate pro and con the e-cigarette: reducing or inducing harm*

This last concern increased when the tobacco industry was found to be interested in the product and started to buy a number of companies that produced e-cigarettes. This was seen as an attempt to make up for the decrease of traditional tobacco smokers.<sup>22</sup> Opponents of the e-cigarette warn not to make the same mistake as with tobacco: the e-cigarette is an addictive product that should be strictly controlled or even banned. They point out that the information provided by the industry should not be taken too serious as the interest of e-cigarette producers is profit making and not the health of the consumers.

Proponents argue that the e-cigarette brings the long awaited solution that may substantially reduce tobacco use. Proponents of the e-cigarettes, including their producers, users, some health policymakers and some health professionals, claim that by delivering nicotine directly to the lung, they are more effective and acceptable than nicotine replacement medicines, and should be readily available as cigarette substitutes. They claim that in doing so, the harmful consequences of smoking tobacco due to toxic ingredients like tar, carbon monoxide and other carcinogenic substances would drop dramatically. Proponents also argue that e-cigarettes deliver the experience of smoking while eliminating the health risks (and the smell) associated with tobacco smoke, thus also solving the problem of passive smoking (Polosa et al. 2013).

Although the e-cigarette has been marketed by its advocates as "not containing any toxins", producing "no first or second hand smoke", not containing "cancer causing chemicals as found in

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<sup>21</sup> <http://www.businessinsider.com/e-cigarettes-will-be-3-billion-market-2013-5> [accessed 18 January 2014].

<sup>22</sup> <http://www.cbsnews.com/news/tobacco-companies-bet-on-electronic-cigarettes/> [accessed 18 January 2014].



tobacco cigarettes”, producing “simply water vapour” and helping to “quit smoking” (Henningfield and Zaatari 2010), its opponents point out that the health effects of inhaling and exhaling vapour containing nicotine and other additives into the lungs are still a subject of uncertainty. Overall, there are only few controlled studies available investigating the benefits and possible risks of the use of the e-cigarette (Etter and Bullen 2011). At the time of writing this report the possible short and long-term health effects of inhaling nicotine vapour and other substances into the lungs are unclear. Opponents express their concern about the carcinogenic properties of nicotine, the inhalation of propylene glycol and flavours, the impurities in the e-liquid with toxic substances and also the behavioural effects of the e-cigarette. Since e-cigarettes do not produce ‘smoke’, many countries allow their use in smoke-free areas. Arguments against the introduction of e-cigarettes are that they might undermine the aims of policies to reduce smoking as laid down in regulations and laws. The e-cigarette might be a fancy product that re-normalises smoking. It also might work as a gateway to smoking.

Worldwide millions of tobacco smokers have tried e-cigarettes or used them more regularly. A majority of 69 per cent of EU citizens knew about e-cigarettes in 2012.<sup>23</sup> Around 38 per cent stated that they do not know if e-cigarettes are harmful or not. Seven per cent of EU citizens have tried e-cigarettes. Although the number of users in Europe is still small, this number might increase in the near future. The available research shows that currently many e-cigarette smokers use it instead of the conventional nicotine replacement therapy such as plasters or gum. Users ‘vape’ the e-cigarette to avoid relapse, as an aid in reducing and / or cessation of conventional cigarette smoking.

Nevertheless, opponents are concerned over the increasing number of young non-smokers trying the product. Still, there is no ‘hard evidence’ that the product functions as a gateway to smoking of conventional cigarettes. Youth tend to experiment, and some argue that young people can better experiment with the less harmful variant than with conventional cigarettes which are known to be highly addictive. Opponents also point at the lack of quality control of the product.

Although it was found that there are some e-cigarette brands of high quality design and manufacture, for most e-cigarettes there is no guarantee that the chemical composition is consistent and follows regular quality standards. There is also a lack of government set standards for acceptable designs, ingredients concentration, level of purity, safety and recommendations for safe use (Schaller et al. 2013).

The lack of evidence-based information on the e-cigarette (its toxicological aspects, its potential to support cessation, the possible gateway to smoking) limits policymakers’ ability to evaluate the potential public health consequences of their use.

In some countries, such as Australia, Brazil, Canada, Denmark and Switzerland, e-cigarettes are banned. The most frequently used arguments for this decision are that nicotine is a poisonous substance and that manufacturers have not provided any scientific evidence that the products are a safe and effective form of smoking cessation therapy, such as other nicotine replacement products. In some countries, such as Brazil, public consultation, including participation of consumer protection agencies, was an important component underlying the decision. Other countries, including the USA, are wrestling with regulation. In Europe, there are different responses on national as well as on European level (Magaldi 2014).

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<sup>23</sup> [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_385\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_385_en.pdf) [accessed 14 January 2014]

### *Lack of evidence for decision making: zig-zag policy in the Netherlands*

The popularity of e-cigarettes has increased in the Netherlands in recent years. The use has tripled in 2013 compared with 2012. The last figures show that 3 per cent of the general population in the Netherlands (15-75 years) is smoking e-cigarettes.

There is a widely shared consensus that availability of e-cigarettes should be regulated. However, the novelty of the product interferes with well-founded, consistent policy decisions. In the Netherlands, the e-cigarette came on the market in 2007. Since the product did not contain tobacco, or parts of tobacco, it did not fit in the Tobacco law and was classified under the Commodities Act (Warenwet).<sup>24</sup> Tobacco laws in some other countries do not stipulate as condition that products have to contain (elements of) tobacco to be included under this law. E.g., in Belgium the Tobacco law also poses a ban on similar products and elements that can put someone up to smoking or give the message that smoking is allowed. Belgium therefore classified the e-cigarette as medication. Norway banned all new types of tobacco or nicotine-containing products.<sup>24</sup> In January 2008, the Dutch Minister of Health declared that consumers should be able to take it for granted that the e-cigarette is a safe product and decided to bring the e-cigarette with a provisional regulation under the Medication Law.<sup>25</sup> Manufacturers had to register the product at the Medicines Evaluation Board and at the same time an official ban on advertising came into force. This was challenged before court by an e-cigarette producer. However, the judge decided to maintain the advertisement ban, arguing that it was rather likely that the e-cigarette would be classified as medication and the company was free to try to have the e-cigarette registered by the Medicines Evaluation Board.<sup>26</sup> The Minister of Health did not decide at that time on a permanent legal status of the e-cigarette, as he was awaiting a decision on European level.

Almost four years later, in December 2011, the (new) Minister of Health formally classified the e-cigarette as medication, although a collective European decision was still not taken.<sup>27</sup> She argued that a product can be classified as medication based on the way it is presented and / or because of its action. According to the Minister, the e-cigarette was to be classified as medication because of its action. Using pharmaceutical expertise, pure nicotine is isolated, stored in cartridges and administered through inhalation to cause relaxation or stimulation. Comparable products such as nicotine gum, lozenges, patches and inhalers were already previously classified as medication by the Medicines Evaluation Board. However, the industry again challenged this decision in court and the court decided in their favour.<sup>28</sup> This decision was based on the arguments that a fundamental difference between the e-cigarette and the nicotine inhaler is that this last one is presented as medication, while there are no medical claims on the e-cigarette. Further, the court argued that the pharmacological effect is not larger than from the conventional cigarette and public health risks are certainly smaller than for the conventional cigarette.<sup>29</sup> As a result, the e-cigarette is back in the Commodities Act since mid-2012.

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<sup>24</sup> Heijndijk, S. De juridische status van de elektronische sigaret in Nederland: een overzicht van de zoektocht naar een passend wettelijk kader. Oral presentation at the First congress of the Netherlands Network for Tobacco control; Utrecht, November 29, 2013.

<sup>25</sup> <http://www.rijksoverheid.nl/nieuws/2008/01/28/klink-elektronische-sigaret-op-europese-agenda.html> [accessed 14 January 2014]

<sup>26</sup> <http://www.rijksoverheid.nl/nieuws/2008/02/08/reclameverbod-e-sigaret-gehandhaafd.html> [accessed 14 January 2014].

<sup>27</sup> <http://www.rijksoverheid.nl/documenten-en-publicaties/kamerstukken/2011/12/23/kamerbrief-status-elektronische-sigaret.html> [accessed 14 January 2014].

<sup>28</sup> Arrest van 26 juni 2012, ECLI:NL:GHSGR:2012:BW8660

<sup>29</sup> Heijndijk, S. De juridische status van de elektronische sigaret in Nederland: een overzicht van de zoektocht naar een passend wettelijk kader. Oral presentation at the First congress of the Netherlands Network for Tobacco control; Utrecht, November 29, 2013.

With increasing knowledge over time, also the commotion about the possible health risks increased. In the second half of 2013, several publications on health implications of e-cigarettes intensified the discussion. The National Institute for Public Health and the Environment (RIVM) produced a fact sheet which warned against carcinogenic substances such as formaldehyde and tobacco-specific nitrosamines in the e-liquid, and misleading or unproven claims about the health effects of e-cigarettes. They also warned against the dangers of large doses of nicotine, the possible hazards of exhaled vapour, the lack of accurate information on the packages, and irritation of the respiratory system for the user.<sup>30</sup> The Nederlandse Voedsel- en Waren Autoriteit (NVWA, Dutch Food and Consumer Products Safety Authority) also warned about the dangers of opening cartridges by children, the health risks of nicotine for pregnant women and the possibility that the e-cigarette functions as a gateway to smoking.<sup>31</sup>

On the other side were the users suggesting that the negative information was lobby work from the tobacco and pharmaceutical industry, and also claiming that the government was looking for extra tax incomes.<sup>32</sup> They posted messages such as "do not listen to the National Institute for Public Health and the Environment if you want to stop smoking".<sup>33</sup> The State Secretary (now responsible for the tobacco files), decided to elaborate additional measures in the Consumer Law on the e-cigarette. One of these measures is an increase in the minimum age to 18 years for the sales of e-cigarettes. Many other measures are yet expected to come. This topic is rapidly developing and is far from settled.<sup>34</sup>

#### *Lack of evidence for decision making: hesitant policy in France*

As in the Netherlands e-cigarettes are widely available in France. In France some prevalence data are available. In 2013 the ETINCEL - OFDT electronic cigarette survey showed a lifetime prevalence of 18 per cent among the general population (15–75 years). Interestingly enough, nearly all of these 'lifetime users' were tobacco smokers (75 per cent) or former tobacco smokers (16 per cent). Although a relatively high number of young people aged 15 to 34 had tried an electronic cigarette, they rarely seem to become regular users: only 10 per cent of lifetime users in this age group used daily.

However, older French people were less frequently lifetime users but became daily users more often once they had tried it (26 per cent of people aged 50 to 75 years stating that they had tried an electronic cigarette vaped every day). Lifetime use by older people is undoubtedly less related to curiosity than to their smoking history and their need to find a solution for their addiction.

An interesting finding is that 1.2 per cent of the former smokers in the survey sample stated that they think that they definitely stopped smoking ordinary cigarettes (Lermenier and Palle 2014; Appendix 1). The available research data in France also point in the direction of an increasing popularity of e-cigarettes.

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<sup>30</sup> [http://www.rivm.nl/dsresource?objectid=rivmp:230704&type=org&disposition=inline&ns\\_nc=1](http://www.rivm.nl/dsresource?objectid=rivmp:230704&type=org&disposition=inline&ns_nc=1) [accessed 14 January 2014].

<sup>31</sup> <http://www.nvwa.nl/actueel/nieuws/nieuwsbericht/2041661/houd-navulverpakking-e-sigaret-met-nicotine-uit-buurt-van-kinderen> [accessed 14 January 2014].

<sup>32</sup> <http://www.esigaret.nl/forum/> [accessed 15 March 2014].

<sup>33</sup> <http://www.trouw.nl/tr/nl/6849/Sylvain-Ephimenco/article/detail/3555662/2013/12/03/Luister-niet-naar-RIVM-neem-een-e-sigaret-als-je-wilt-stoppen-met-roken.dhtml> [accessed 14 January 2014].

<sup>34</sup> <http://www.rijksoverheid.nl/documenten-en-publicaties/kamerstukken/2013/12/20/beantwoording-kamervragen-over-een-minimumleeftijd-voor-de-verkoop-van-e-sigaretten.html> [accessed 14 January 2014].

Like in the Netherlands the policy response to this new phenomenon is not decisive. Also here the uncertainties about the effects of e-cigarette smoking on health and on smoking behaviour (initiating smoking, substitution of regular cigarette smoking, etc.) played an important role. Till 2013 nothing much happened. Then, in May 2013, an expert report was presented to the Ministry of Health. Also the (work on the) EU Tobacco Products Directive marked a change to a less hesitant policy response (Appendix 1). The most recent governmental Cancer Plan (2014-2019) promotes research into the toxicity of e-cigarettes and their usefulness for smoking cessation. A governmental plan on tobacco is expected to be released later in 2014 possibly promoting measures for regulating the market of e-cigarettes (Appendix 1).

### *The emergence of EU regulations*

This debate about whether and how to regulate e-cigarettes is also conducted at EU level. In 2013 a revision of the Tobacco Products Directive was finally prepared, extending the scope of the Directive to new products like the e-cigarette (Directive 2014/40/EU ...). However, the debates about the best regulatory framework went far from smoothly. In fact, the issue how to regulate e-cigarettes resulted in a serious conflict, threatening to disrupt the overall reform of EU tobacco rules in the final weeks of negotiations. There were opposing proposals from the Member States (favouring regulation as a medicinal product) and the European Parliament (in favour of regulation as a consumer product). The conflict nearly escalated to the point that e-cigarettes would be simply removed from the proposal for a revised Tobacco Products Directive, to avoid that the entire package would fail. That would have been in line with the arguments of the e-cigarette proponents, who argue that the product doesn't belong in a Tobacco Products Directive because it contains no tobacco. A compromise was reached at long last, stating that EU law will regulate e-cigarettes as general commodities, while Member States may classify them as pharmaceuticals, if they wish. The European Parliament still has to vote on the deal, and the health ministers have yet to sign the agreement. At the time of writing this report, no major changes in this compromise are expected. The process at EU level is one of a rapidly changing sequence of sometimes diametrically opposed proposals. This may have to be ascribed to the active lobbying of different stakeholders which play a highly important role in this field and sometimes seem to be able to completely change the outcome of policy debates, as can be taken from the following.

The first proposal of the Member States was in favour of strictly regulating e-cigarettes as medicinal devices. Products above a certain nicotine threshold were only to be allowed if authorized as medicinal products. The main arguments of the Member States for this restrictive approach were concerns about possible yet unknown long-term health effects. However, e-cigarette manufacturers, supported by a growing number of e-cigarette users, actively lobbied against this medicinal regulation. At the time the European Parliament favoured regulation as general consumer product. They endorsed a permissive approach to the sale and use of e-cigarettes. Nevertheless, this proposal stated that the products should not be sold legally to anyone younger than 18 and tight restrictions on advertising and sponsorship should be in place, similar to those for regular cigarettes. The outcome of this debate was the compromise described above, in which the EU classifies the e-cigarette as a consumer product, while Member States are free to classify them as pharmaceuticals.

A second controversial issue has been the refillable cartridge. This issue was also solved by means of a compromise. Refillable e-cigarettes will not be banned for the time being, but this may change in the coming years, if Member States would ban them for safety reasons. In the controversy was that the Member States demanded an EU ban, while the European Parliament did not. The Member States expressed their concern that the cartridges are unsafe, among others because of unreliable nicotine content. Members of the European Parliament on the contrary, representing at least partly the voice of e-cigarette producers and users, argued that the wide range of refillable cartridges suits

the needs of the user. Restrictions would undermine the potential of e-cigarettes as a tool to quit smoking. In the compromise that was agreed, the sale of refillable cartridges no larger than 2 millilitres is permitted. Member States are allowed to ban specific types of cartridges, provided this is justified by safety concerns. If three Member States adopt a ban on a specific cartridge, the European Commission could unilaterally impose an EU wide ban. Manufacturers and users are afraid that this could allow bans on all refillable e-cigarettes through the back door. In fact this compromise implies that in the coming years it is for the national governments to decide whether or not to ban refillable e-cigarettes.<sup>35</sup>

Despite the tight regulation of the e-cigarette in the proposed revision of the Tobacco Products Directive, it remains unresolved where vaping is permitted. This decision is left to national and local jurisdictions.

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<sup>35</sup> [http://europa.eu/rapid/press-release\\_MEMO-14-134\\_en.htm](http://europa.eu/rapid/press-release_MEMO-14-134_en.htm) [accessed 3 March 2014];  
[http://www.europarl.europa.eu/pdfs/news/expert/infopress/20140221IPR36632/20140221IPR36632\\_en.pdf](http://www.europarl.europa.eu/pdfs/news/expert/infopress/20140221IPR36632/20140221IPR36632_en.pdf)  
[accessed 3 March 2014]

## 5 Decriminalisation of drug use

This case study is focused on the trend to treat the use of illicit drugs as a disease rather than a criminal offence. We decided to concentrate on the developments around heroin and cannabis, the two drugs which have been for some decades at the centre of the drug policy debates in most EU Member States. Decriminalisation of use (and possession of small quantities for personal use) has been a prominent issue in these debates. Originally we chose the Netherlands, Slovenia and Spain for analysing this trend in the field of heroin policy and we selected the Netherlands, Spain and the UK for analysing cannabis policy. From our literature review and the country reports we took that it would not make much sense to strictly differentiate in this case study between cannabis and heroin policy. Decriminalisation of drug use has been a strategy targeting illicit drugs in general. There are some differentiations between different drugs, usually cannabis possession is treated more lenient than other, 'harder' drugs. In case a country chooses for threshold quantities, to differentiate between possession for personal use and possession for selling, the amounts differ per drug with usually the least harsh approach to cannabis. We therefore decided to deal with cannabis and heroin at the same time.

There are differences of opinion about the definition of the concepts and the terminology used for different regimes, e.g. decriminalisation vs. depenalisation and prohibition vs. regulation and legalisation. We decided to use a pragmatic definition of decriminalisation, subsuming all measures that avoid criminal sanctions as response to drug use and possession of small quantities for personal use.<sup>36</sup>

### 5.1 The content: paradigm shift from crime to health

The decriminalisation trend basically has the same origins as the trend towards a wider acceptance of harm reduction. It is another element of the reform towards a drug policy understanding drug use primarily as a social and health issue. Despite the fact that the health (or disease) paradigm has a long tradition – from the early 20<sup>th</sup> century on opiate addiction has been interpreted as a disease in, among others, the Netherlands and the UK – the crime paradigm became the dominant perspective, at least till the 1970s or 1980s. Already in 1928 the possession of illicit drugs (including cannabis) was included in the penal code as criminal offence in the Netherlands. This happened also in other countries. There was a growing awareness of drug use related health risks and an increasing concern about the 'addiction' phenomenon (Blok 2011). These worries did not only concern opiates and other illicit drugs, but also alcohol. It were the times when alcohol use was problematized in many countries all over the world. In some countries these concerns resulted in restrictive regulations of the alcohol market, e.g. in Scandinavia, and in a single country even in a – temporary – ban. The 'Big Thirst' in the USA of the 1920s is the best known example of alcohol prohibition. In that time the international drug control efforts also started to emerge, taking off with initiatives in some countries. This restrictive mood had in the end great impact on national politics and policies all over the world.

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<sup>36</sup> In short the different regimes can be defined as follows:

- i) Full prohibition (i.e. no reform);
- ii) Prohibition with cautioning or diversion ('depenalisation');
- iii) Prohibition with civil penalties ('decriminalisation');
- iv) Partial prohibition, including:
  - a) '*De facto*' legalisation (i.e. possession remains technically illegal by law, but members of law enforcement/the judiciary may decide whether or not to enforce the law on a case by case basis);
  - b) '*De jure*' legalisation (i.e. the non-punishment of cannabis use is written into national law or cannabis possession is removed from the law governing illegal drug use – e.g. medicinal marijuana). (Room et al. 2008).

A series of international meetings and conventions were the first steps towards drug prohibition, starting with the Shanghai Conference in 1909, followed in 1912 by The Hague International Conference and leading to three Geneva conventions<sup>37</sup>. These efforts to ban the non-medical application of certain drugs finally resulted in the second half of the 20<sup>th</sup> century in the three international conventions<sup>38</sup>, which still rule drug policy today.

This ‘criminalisation’ trend did not make the health paradigm disappear from the scene. In fact, already in the first half of the 20<sup>th</sup> century one can see attempts to combine criminal justice and health measures to deal with illicit drugs more effectively. These efforts can be seen as forerunners of the currently prevailing notion of a comprehensive or balanced approach, a cornerstone of today’s drug policy in the EU as put into words in the EU drug strategies (Council of the European Union 2004a and 2012). In 1938 the State Supervision of Public Health in the Netherlands responded to a report of the Rotterdam police about the high number of drug addicts by emphasising that these addicts should not be treated as criminals but as ‘unfortunate creatures in need of help’. This was the basis for the cautious start of substitution treatment in the pre-war Netherlands (see 4.1; Van Laar and Van Ooyen-Houben 2009 p48). The report of the Rolleston Committee (1926) in the UK legitimising maintenance treatment with injectable heroin is another example of the influence of the health or disease paradigm (see 4.1).

The small-scale substitution treatment in the Netherlands was continued after the war. At the same time the use of several illicit drugs in the 1950s and 1960s became more popular among groups of young people. These new user groups faced a predominantly punitive approach, an inconsistency which gradually got under attack. It was criticised as unjust and ineffective. It was this criticism which opened the door for change, which in the beginning – in the 1960s – was limited to informal steps like turning a blind eye to the use of illicit drugs. These were the first amateurish steps to what became known as the tolerating or condoning (‘gedoog’) approach, a key element in today’s Dutch drug policy. The use of illicit drugs remained a criminal offence but police and justice refrained from active investigation and prosecution.

## **5.2 Context and process: social and political developments**

### **5.2.1 Critique on the crime paradigm: social developments in Western Europe in the 1960s and 1970s**

The development of decriminalisation followed the same course as the evolution of harm reduction, starting bottom-up as critique on the appropriateness of criminalising the users of illicit drugs (Rosmarin and Eastwood 2012; see also 4.1). The critics emphasised that it would be more apposite and beneficial to understand drug use and in particular problem use as a health and social issue. Penalising an individual for the fact the he or she is using drugs and possibly damaging him or herself was seen as not in line with the primary intentions of the penal law, i.e. to punish individuals for causing harm to a third party. Criminalising drug users was criticised as having detrimental effects on the social and health situation of the user, causing harm instead of helping to deal successfully with the problem (Stichting Algemeen Centraal Bureau voor de Geestelijke Volksgezondheid 1971; Werkgroep Verdovende Middelen 1972).

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<sup>37</sup> The 1925 Geneva Opium Conventions, the 1931 Geneva Narcotics Manufacturing and Distribution Limitation Convention, the 1931 Bangkok Opium Smoking Agreement and the 1936 Geneva Trafficking Convention.

<sup>38</sup> The 1961 Single Convention on Narcotic Drugs (followed in 1972 by the Protocol Amending the Single Convention on Narcotic Drug), the 1971 Convention on Psychotropic Substances and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

In the Netherlands this critique was initially expressed by the alternative youth services. Like in the case of harm reduction the wider countermovement agitating against the societal status quo was fertile soil for initiating this paradigm change (see 4.1). These services pointed out that criminalisation of drug use did not contribute to reduce the use of illicit drugs and related problems. It was their stance that the contrary was true. Criminalisation of drug use added to the 'drug problem' and the problems drug users face by marginalising young people of whom the majority were just experimenting with drugs use. Comparable with the development of harm reduction the protest movement of the 1960s and 1970s and the emergence of new forms of illicit drug use among young people were decisive contextual factors to get decriminalisation of drug use on the agenda (see 4.1).

Also in other countries one can observe this growing resistance against the criminalisation of drug use. In most cases this resistance coincided with the emergence of harm reduction. Decriminalisation of use was in fact seen as one strategy to reduce drug use related harms (Rosmarin and Eastwood 2012).

The crime paradigm came also under fire in the UK, but the focus of the criticism on criminalisation was somewhat different. Also here, in the wake of the emergence of harm reduction, one can find some support for decriminalising drug use, predominantly cannabis use. Also here informal decriminalisation of drug use and possession of small quantities for personal use became daily practice. Policemen were reported to regularly turn a blind eye to what was seen as minor offences. They confined themselves to an informal comment (informal warning), again predominantly to cannabis users. The only formal arrangement introduced was the option of a formal warning (caution), which is a spoken warning given by a police officer, when someone is caught with a small amount of cannabis for personal use. The latter is, strictly speaking, an example of depenalising rather than decriminalising (Appendix 7).

Again one can observe the link with harm reduction policies. This depenalisation policy is according to Dorn part of a harm minimisation approach which is embraced by the government's drug strategy "applying that logic to law enforcement by targeting trafficking in the drugs that do the most harm deemphasizing action in relation to drug users who consume cannabis or other drugs relatively unproblematically" (Dorn 2004 p533). Moreover, many independent experts, drug charities, researchers and even politicians and some senior police officers in the UK are reported to support depenalisation or decriminalisation of cannabis. However, there are no formal arrangements, no legislation around decriminalisation and there is no sign of any forthcoming legislation to readdress the issue (Appendix 7).

### **5.2.2 *The impact of societal changes: Slovenia and Spain***

Social unrest or changes seem to have worked as powerful contextual factors for innovations in drug policy. One example are the protest movements in Western European countries like the Netherlands (see 4.1.1 and 5.2.1). But this seems to be even more true for countries which underwent more drastic societal changes, as for instance Slovenia and Spain. There are substantial differences between these two countries. Slovenia was a rather enlightened communist country while Spain under Franco was a rather oppressive dictatorship. Still, the societal changes in these two countries have a number of things in common. They both underwent a transformation from a totalitarian to a democratic political system. One decisive factor may have been the breaking down of old structures and rules and the absence of well-established positions regarding new policies. The latter might be especially true for policies addressing relatively new social phenomena as drug use or the drug problem. In Slovenia these societal changes were the framework of initiatives to introduce both harm reduction (see 4.1.1) and decriminalisation of use.



People involved in developing harm reduction policies also supported decriminalisation of drug users and a more lenient approach to the possession of illicit drugs for personal use. Already since 1978 the possession of illicit drugs for personal use are defined as minor offence (Appendix 3).

### *Spain: the societal changes after Franco*

The developments around criminalisation and decriminalisation in Spain provide a special case. Gamella and Jiménez Rodrigo summarise these developments as follows: “As one of the first countries in Europe to decriminalize drug use, and one of the last to embrace harm reduction, Spain’s drug policies often appear to be rather contradictory.” (Gamella and Jiménez Rodrigo 2004 p623) Spain is the only country where use and possession of small quantities were formally decriminalised as early as 1982. The intriguing thing is that already in 1974 the Supreme Court decided that possession for personal use should not be prosecuted. This was in response to a change of the penal code in 1973, classifying possession for personal use as criminal offence. This means that already during Franco’s dictatorship drug use was decriminalised (Gamella and Jiménez Rodrigo 2004). In more recent years also self-supply of cannabis was subsumed under the concept of drug use. Cultivation of cannabis was treated as a criminal offence only in those cases where trafficking also was established (Dorn 2004).

The developments in Spain are idiosyncratic as they reflect the specifics of a country undergoing radical societal changes. The political transformation of post-Franco Spain into a democratic state seem to have been decisive for paving the way for the formal decriminalisation in 1982. Comparable to the situation in post-communist countries like Slovenia (see 4.1.1), societal changes seem to have been a context creating opportunities for fundamental changes in many areas, also in drug policy. The drastic policy changes introduced by Felipe Gonzalez’s socialist government included also two important drug policy measures: the decriminalisation of possession for personal use and the distinction between soft and hard drugs (Gamella and Jiménez Rodrigo 2004 p630).

In this case too Kindon’s Multiple Streams Model is useful as heuristic, which helps to understand the factors contributing to the change of drug policy though here the situation seems to have been much more complex. In the problem stream the ‘drug problem issues’ seemed to have been closely linked to the broader societal problems of repression in a totalitarian system. The urgency of the problems related to drug criminalisation might not be understandable without taking into account the more general problem of social repression in Franco’s Spain. The same seems to go for the policy and the political stream. The call for decriminalisation and the political support for decriminalisation also have fit well in the broader liberalisation programme in the post-Franco years. It is this particular situation which could have been a decisive factor in making the three streams join and creating the policy window for decriminalising drug use.

The urge to implement drastic changes rapidly, to replace old practices by new ones and the absence of a clear plan for drug policy making, may help to explain the inconsistencies in Spanish drug policy. From the available (English) literature which analyses the development of drug policy in Spain the picture arises of a rather patchy process. Decriminalisation came in very early, harm reduction rather late. Decriminalisation of use seems to have been a somewhat isolated response from the Supreme Court to a change of the penal code introducing criminalisation of drug use. It was not part of a broader drug policy plan. In the 1990s, one can observe again a tightening of the regulations of use and possession and at the same time a growing acceptance and implementation of harm reduction policies. While the use and possession of small quantities was de facto decriminalised in the Netherlands in 1982 one can observe in Spain a ‘recriminalisation’ tendency in the early 1990s.

The development towards a more strict policy regarding drug use and possession are explained by concerns about the substantial increase of cannabis use since the 1970s, interrupted by a period of decrease in the late 1980s (Ministerio de Sanidad, Servicios Sociales e Igualdad 2013; Gamella and Jiménez Rodrigo 2004). This policy was formalised in 1992 in the so-called Public Safety Law. This law called for administrative penalties for use and possession of small quantities in public spaces (Rosmarin and Eastwood 2012). Penalties for these offences may be suspended if the offender is subjected to a treatment for addiction (Appendix 5 and 6).

Though these regulations address all drugs, in Spain, as in many other countries, the dispute about decriminalisation / depenalisation centred on cannabis policy. Gamella and Jiménez Rodrigo show that in Spain cannabis policy was clearly the frontline in the clash between the camp supporting a more strict prohibition and the camp in favour of regulation. They summarise this conflict as follows:

“Moreover, cannabis is currently the cause of a social divide and a symbolic and political confrontation (...). Supporters of the present prohibitionist regime (and of an even more punitive one) see marijuana and its resin as dangerous drugs, harmful to physical and mental health, and the necessary gateway for the use of “harder” drugs such as cocaine, amphetamines, or heroin. Prohibitionists oppose any leniency in respect to cannabis dealers or those indulging in home cultivation, seed sales, and even consumption.

Among its defenders, marijuana is seen as safer, purer, and more natural than alcohol or tobacco: a non-addictive, benign, and even therapeutic “green” drug. The notion that its use somehow leads to the abuse of more dangerous drugs is derided or judged as exaggerated by the majority of experienced cannabis users (...). In particular, cannabis has a positive image among teenagers who grew up during the expansion of “drug education” and prevention programs of the late 1980s and 1990s (...).

Besides, ... , the tightening of regulations since 1992 has given a rebellious meaning to cannabis use during this period of maximum use and social acceptance (...). This apparent inconsistency has worked well for a new social movement that seeks cannabis legalization, a movement that has become increasingly vocal, articulate, and popular. Moreover, the spread of cannabis home cultivation is increasingly used as a grass-roots method of circumventing prohibition by tens of thousands of users who see cannabis controls and penalties as discriminatory, hypocritical, and counterproductive (...).” (Gamella and Jiménez Rodrigo 2004).

### **5.2.3 The response to the AIDS epidemic: syringe exchange and drug consumption facilities**

For decriminalisation of use the AIDS epidemic, or in fact the policy response to it, also formed an important contextual element. Linked with the introduction of certain harm reduction measures targeting specifically users of heroin and to a lesser degree users of cocaine and amphetamines additional arguments in favour of decriminalisation of use entered the debate. The emergence of the AIDS epidemic in the 1980s meant an extra boost to expand harm reduction services like drug consumption facilities and syringe exchange programmes to reduce infection risks (and other health harms related to injecting drugs). These services proved to conflict with the penalisation of drug use. As the use of these drugs was a criminal offence in many EU Member States, offering these services was in a formal sense ‘providing opportunity’ to commit a criminal offence. Among others in Germany this was seen as a principal obstacle for implementing these services, because it threatened drug service workers with becoming subject to criminal penalties. Legal provisions had to be amended to allow for an unimpeded implementation. This was an additional argument in favour of decriminalising the use of illicit drugs.

This proved to be complicated in some countries because the possession of illicit drugs for non-medical purposes was formally in conflict with the provisions of the 1961 Single Convention on Narcotic Drugs. The majority of EU Member States adhere to the legality principle, meaning that every registered criminal offence has to be prosecuted. However, various countries found their way around these provisions. In Germany the police and state attorneys followed the position of the then senior attorney of state in Frankfurt, Körner, on the legality of drug consumption facilities (Körner 2004). Körner emphasised that drug consumption facilities and needle exchange programmes cannot rightly be accused of providing opportunity to consume drugs.

They only offer the opportunity for drug users to consume already acquired substances in a less risky way. This position was gradually adopted in other EU Member States, pushing aside the formal legality principle and – according to different experts – disobeying the Single Convention’s provisions. The good of individual and public health prevailed over criminal law provisions (Körner 2004). This was another indication for the paradigm shift from a criminal law primacy in drug policy to health dominance.

#### **5.2.4 Convergence without EU support**

Though one can clearly observe a trend towards decriminalization of drug use in many EU Member States, there are no supranational EU forces pushing towards convergence. Unlike what happened with the trend towards a wider acceptance of harm reduction (see 4.2), no significant steps have been taken on EU level, pushing the Member States towards decriminalisation. Only diversion schemes (see 5.4.2) have been taken on board in the EU Drugs Strategy 2013-2020 and EU Action Plan on Drugs 2013-2016 (Council of the European Union 2012 and 2013). Still, undeniably a conversion towards decriminalisation has taken place in the majority of the EU Member States. It seems that debates and exchange of opinions have helped to shape consensus among Member States.

This convergence trend was initiated by strong bottom-up forces, particularly in the countries which had been the first to develop decriminalisation policies, as can be taken from the developments in the Netherlands, Slovenia and Spain (see 5.2.1).

### **5.3 Stakeholders**

The choice for the health paradigm to explain drug use received support from a variety of stakeholders. It was an appealing and acceptable choice for stakeholders from very different backgrounds. Besides health experts, professionals from health and social services, police officers, academics, politicians and policymakers, the general public could also go along with it. Though public opinion seems to be in majority against legalisation of currently illicit drugs, it does at the same time not support a harsh repressive approach to the users of these drugs. A substantial part of the media generally report rather positively, though in most countries they did not seem to be an essential factor in the paradigm change. In most EU Member States decriminalisation of drug use appeared to play a rather modest role in the public debates about drug policy issues (Appendix 3). However, the picture of the drug user as patient seemed to appeal to the general public and this might have been crucial for gaining wider acceptance. The choice for a primarily health or disease oriented approach was seen as a choice for a more enlightened and just perspective.

There of course was also opposition against this paradigm change. Opponents were among others afraid that decriminalising would give the wrong message, namely that drug use is not a problem.

This might lead to an increase of drug use. These opponents could be found among politicians, policymakers and religious organisations.

For at least some politicians' electoral considerations might have played a role in opposing a softening of the approach. The decriminalisation debate around cannabis in different countries all over the world provides some examples for this. However the opposition against the change towards the health paradigm seems to have been rather weak.

There are three stakeholder groups which had a major impact in the countries we studied: social movements, scientists and politicians. We will take a closer look at their roles.

### **5.3.1 Social movements**

As in the case of harm reduction social movements played an important role in pushing the issue of decriminalisation. In the Netherlands both the broader protest movement like the Provo's and the emerging alternative health and drug services were outspoken advocates of decriminalisation. While the Provo's mainly focused in their efforts on cannabis, the alternative health and drug services emphasised the need of decriminalising the use of all illicit drugs. The harm reduction movement was in many countries another noteworthy stakeholder embracing decriminalisation of use, with a strong focus on heroin use, and the health paradigm (Riley et al. 2012). However, this 'new' paradigm proved to have a downside. It includes connotations of drug use as disease, as can be taken from the slogan which was used by among others the German association of harm reduction services 'akzept'<sup>39</sup>: "Therapie statt Strafe" ("therapy instead of punishment"). This slogan proved to be a very compelling statement in the struggle against the predominantly repressive drug policy approach in Germany in the 1980s and 1990s. The marginalised position of drug users seemed to make it tempting for some workers in harm reduction services to assume the role of 'advocate of the outlawed' (Trautmann 1995). In later years doubts arose regarding the advantages of viewing (problem) drug use as disease. A growing number of critics pointed at the flaws of viewing drug use as disease in particular because of the risk of pathologising all forms of drug use.

#### *The 'cannabis social movement' in Spain (and other countries)*

The developments in Spain reveal some distinguishing features. The above mentioned 'recriminalisation' tendency in the early 1990s was opposed by an increasingly strong social movement of cannabis users, a movement which can be traced back to the 1960s. From being an outsider in the drug policy arena in Spain it became an increasingly influential player, both economically and culturally (EMCDDA 2012b). This social movement was and still is one of the most important stakeholders in Spain, campaigning for a radical change of the existing prohibitionist drug policy, in particular regarding cannabis. It calls for legalisation of not only the use but also the production and sales of cannabis. It demands to be heard in the drug policy debate as a legitimate stakeholder. It claims a place at the negotiating table campaigning for more citizen participation in European drug policy and demanding that the impact of drug policies at the level of citizens should be taken into consideration (Gamella and Jiménez Rodrigo 2004).

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<sup>39</sup> akzept is the federal association for acceptance orientated drug work and humane drug policies in Germany which was founded in 1990. It started off as a countermovement to the repressive drug policies of the late 1980s when ideas of harm reduction were widely rejected and the abstinence approach was predominant in drug services and policies. The intention of akzept was (and still is) to develop and implement measures of harm reduction with regard to i) the improvement of health of drug users and ii) change of the view of general society.

Nowadays the cannabis social movement can be found in many EU countries. This movement consists of heterogeneous pressure groups, usually a network of activist groups, individuals or organisations engaged in the issue. A variety of actors are involved in these movements in different countries, for example user groups, associations of growers, grow shop and coffee shop owners, journalists, health professionals, political parties, publishers of specialised magazines, etc. There are examples that groups from these movements have participated in dialogues and consultations with authorities, from incidental to more structural involvement (EMCDDA 2012b). ENCOD, the European Coalition for Just and Effective Drug Policies, which is heavily involved in the Belgian and European cannabis social movement, also participates in the Civil Society Forum on EU Drug Policy, initiated by the European Commission. It ‘serves as a platform for informal exchanges of views and information between the Commission and civil society organisations’.<sup>40</sup>

Prominent actors within the cannabis social movement in Spain are the ‘cannabis social clubs’, which started to emerge in 2002 (Barriuso Alonso 2011). They do not only oppose cannabis prohibition, but also want to end the juridical uncertainty regarding cultivation. They are in favour of a regulatory regime, replacing prohibition and allowing cannabis users to grow their own cannabis in a cooperative model (Barriuso Alonso 2011). This is one example of the growing trend to employ regulation measures as drug control policies (see 6).

### **5.3.2 The prominent role of science**

#### *Dutch drug policy in the 1970s*

Another important stakeholder in helping to get decriminalisation of drug use accepted was science. Particularly in the Netherlands scientists played a decisive role in the paradigm change from crime to health. The reports of the Hulsman and the Baan Commission also underpinned the view that criminalising drug use is counterproductive. It was one of their key arguments in favour of decriminalisation (see 4.1.2). These reports also mark the change from a bottom-up countermovement to a top-down driven reform like in the case of harm reduction. The Hulsman report stressed that criminalising drug use has a very limited effect on the extent of drug use and is therefore not an effective means to control or reduce drug use. The report came up with a rather elaborated plan how to implement decriminalisation. It suggested a number of steps in order to deal with the drug problems more successfully, to avoid marginalisation and exclusion, among others by fully decriminalising the use of cannabis and the possession of small quantities. The production and distribution of cannabis should – for the time being – remain within criminal law, but as misdemeanours. The use and possession of other drugs should also temporarily remain in the realm of criminal law, be it only as misdemeanours. However, in the long run these acts should also be decriminalized (Stichting Algemeen Centraal Bureau voor de Geestelijke Volksgezondheid 1971).

The report of the Baan Commission provided a thorough description of the negative consequences of criminalising drug use for the user. It focused for an important part on the cannabis issue. Responding to so-called ‘deviant’ behaviour by punitive measures was expected to in fact intensify this behaviour. In turn this might result in a spiral, impeding the return of people using drugs to a socially accepted lifestyle. The report also underlined that most drug use is a short-lasting experimentation by young people and that cannabis use is in most cases not the first step to the use of other, more dangerous drugs.

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<sup>40</sup> [http://ec.europa.eu/justice/anti-drugs/civil-society/index\\_en.htm](http://ec.europa.eu/justice/anti-drugs/civil-society/index_en.htm) [accessed 16 December 2013].

The report of the Hulsman Commission noted that it is the criminalisation of cannabis which is the link between cannabis use and the use of “harder” drugs. Another important conclusion was that drug users are better served with drug information and prevention efforts than with prosecution (Werkgroep Verdovende Middelen 1972).

Both reports clearly differentiated between separate political strategies for soft drugs and hard drugs and also for drug use and production and sales of drugs. This does not only reflect the differentiation between drugs presenting unacceptable risks to user and society and drugs which present less serious risks. It also reflects a strategic choice, telling us something about the feasibility of drug law reforms in that time. Decriminalising the use of illicit drugs was – due to the appealing health paradigm – better accepted by various stakeholders than decriminalising of production and sales. Decriminalising soft drugs was more acceptable than decriminalising hard drugs. However, even for those drugs that posed, according to the Baan Commission, unacceptable risks, the report concluded that using criminal law measures was not an appropriate approach. The commission also suggested a long-term goal of complete decriminalization, as soon a good treatment system was established. In the meantime, the justice system should only be used as a tool for getting heavy users into treatment.

These two reports corroborated the change from the crime paradigm to the health paradigm. They brought together the then available research evidence underpinning the view that criminalisation of drug use worsened problems for users and society. They contributed to a wider acceptance of this view. The health paradigm was embraced as leading concept in drug policy, giving the lead to the Netherlands Ministry of Health. The change of the Dutch drug law in 1976 resulted in a de facto decriminalisation of drug use.

#### *The criminalisation debate in the UK in the early 21<sup>st</sup> century: science overruled*

The UK is another example where science played a key role in the (de)criminalisation debate. Here the debate centred mainly around the classification of drugs according to their actual harmfulness, an issue which also played a role in the Netherlands, resulting in the differentiation between ‘hard drugs’ and ‘soft drugs’ in 1976 drug law. Despite this somewhat different focus of the Dutch and the British debates about criminalisation, in both countries scientific advice played a prominent role for backing drug policy decisions, in particular in the 1970s, the early years of national drug policies. One cornerstone of UK drug policy, the differentiation between three classes of drugs according to the harm perceived<sup>41</sup>, laid down in the 1971 Misuse of Drugs Act (MDA), is claimed to be firmly based on scientific evidence. The Misuse of Drugs Act is the primary piece of legislation governing illegal drugs or legal drugs intended for nonmedical purposes. The classification system acts as a guide to the police, and the judiciary in terms of sentencing.<sup>42</sup>

Scientific advice has traditionally an important say regarding the classification of drugs, as Monaghan (2014) notes: “A further key component of the 1971 legislation was that it established Britain’s first statutory expert advisory body on illicit drugs, the ACMD<sup>43</sup>. Amongst their many functions, the ACMD continuously review the UK drug situation, paying particular attention to the misuse (or the potential thereof) of drugs by the public to the extent that they might be considered a social problem.

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<sup>41</sup> These are currently: Class A, among others heroin, cocaine, crack, MDMA, LSD, Class B, among others amphetamine, barbiturates, cannabis, spice, and mephedrone and Class C, among others benzodiazepines, mild amphetamine type stimulants, GHB, rohypnol and ketamine.

<sup>42</sup> The Home Office, Drugs and the Law. [Online]. Available: <http://www.homeoffice.gov.uk/drugs/drug-law/> [accessed 2<sup>nd</sup> February 2013].

<sup>43</sup> Advisory Council of the Misuse of Drugs.

This is mainly achieved through the production of detailed and rigorous evidence reviews. Their membership is made up from across the scientific, industrial and professional sectors, but most of their work concentrates on the pharmacological evidence-base for existing and emerging substances thus embedding science, research and expertise into the decision-making process. For most of its existence it was common practice for the government to accept and act upon the recommendations of the council, although in a very high-profile way this relationship has been tumultuous over recent years, highlighted in recent public debates about the classification of ecstasy, magic mushrooms and, primarily, cannabis within the MDA.”

Indeed, the ‘tumultuous’ developments around the classification of cannabis present an interesting case, which shows that it is no longer a matter of course that political decisions follow the advice given by the ACMD. Cannabis was classified as a class B drug from the introduction of the Misuse of Drugs act in 1971. In 2001 the governing Labour Party announced plans to downgrade cannabis to a class C drug.<sup>44</sup> In January 2004 cannabis was reclassified as a class C drug. Evidence produced by the ACMD that cannabis was less harmful than other class A and B drugs was the driver behind this reclassification. The ACMD had been calling for such a step since the late 1970s.<sup>45</sup> This policy – which was also well supported by public opinion polls – resulted in less strict regimes and less harsh sanctions, which translated into a decrease of one third in cannabis arrests in the first year<sup>46</sup>. This reclassification in effect stopped people being arrested for possessing small amounts of cannabis. And there was the additional benefit of allowing the police to focus on what were seen as more harmful drugs and more serious offences.

In the following (2005) general election campaign Tony Blair, then Prime Minister, stated at an election event that the downgrading of cannabis might have been an error. He said that in light of evidence of the growing strength of some types of cannabis available in the UK that the classification would be re-examined.<sup>47</sup> After winning the election the issue of cannabis classification was in March 2005 once again given to the ACMD for an evaluation. This was primarily a response to warnings about the link between the use of particularly high-strength strains of cannabis (skunk) and certain kinds of mental illness. The ACMD published a second review later that year supporting the classification of cannabis as class C drug.<sup>48</sup> The then Home Secretary Charles Clarke accepted this and initiated a new educational programme for the public in relation to cannabis.

However, drug classification appeared again in media headlines in 2008. The government under new Prime Minister Gordon Brown raised concerns about cannabis once more. Again the ACMD was requested to produce a review. What followed is an interesting chapter in the history of UK drug policy making:

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<sup>44</sup> Alan Travis (Wednesday 24 October 2001). Cannabis laws eased in drug policy shakeup, The Guardian. [Online]. Available at: <http://www.guardian.co.uk/society/2001/oct/24/drugsandalcohol/> [accessed 4th February 2013].

<sup>45</sup> Schaffer Library of Drug Policy, The Police Foundation (1999). Drugs and the Law: Report of the independent inquiry into The Misuse of Drugs Act 1971. [Online]. Available at: <http://www.druglibrary.org/SCHAFFER/LIBRARY/studies/runciman/default.htm> [accessed 4th February 2013].

<sup>46</sup> Home Office, 28<sup>th</sup> January 2005, Cannabis Reclassification (Press release), National Archives. [Online]. Available at: [http://web.archive.org/web/20050412170503/http://www.homeoffice.gov.uk/n\\_story.asp?item\\_id=1222](http://web.archive.org/web/20050412170503/http://www.homeoffice.gov.uk/n_story.asp?item_id=1222) [accessed 4<sup>th</sup> February 2013].

<sup>47</sup> Philip Johnson and George Jones, 4<sup>th</sup> May 2005, Blair Hints at Error over Cannabis Downgrade, The Telegraph. [Online]. Available at: <http://www.telegraph.co.uk/news/uknews/1489263/Blair-hints-at-error-over-cannabis-downgrade.html> [accessed 4th February 2013].

<sup>48</sup> Advisory Council on the Misuse of Drugs (2005) The Advisory Council’s Report - Further consideration of the classification of cannabis under the Misuse of Drugs Act 1971.(2005), Home office. [Online]. Available at: <http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/cannabis-reclass-2005> [accessed 4th February 2013].

“The ACMD (2008) reported back that although there was a consistent, but ‘weak’ association between cannabis use and the development of psychotic illness, they remained resolute that cannabis was correctly classified as a class C substance. However, unlike in 2005, the Government ignored this advice and announced a reversal of the 2004 downgrading. Some informed observers argue this was done to demonstrate difference with the previous policies and to curry favour with certain parts of the media ( ... ). Whatever the underlying reasons, this was the origin of the dispute between Professor Nutt, the then Chair of the ACMD and the New Labour government. This was to later escalate, when in March 2009, the advisory council considered the legal status of ecstasy recommending a downgrading of its classification from class A to B (ACMD, 2009). The government’s decision to seemingly ignore outright this advice led to a heated exchange between Nutt and the then Home Secretary, Jacqui Smith. Later in 2009, relations between members of the ACMD and the government further deteriorated. Alan Johnson, who by this time had replaced Smith as Home Secretary, accused Nutt of overstepping his remit and of ‘campaigning against’ government policy in a lecture delivered in July 2009 where Nutt claimed that based on the existing science both cannabis and ecstasy are less harmful than legal drugs such as alcohol and should, therefore, be downgraded. Nutt was subsequently dismissed from the ACMD leading to the resignation of five other members.” (Monaghan 2014).

### **5.3.3 Politicisation of drug policy: the tension between scientific evidence and political decisions**

This clash between David Nutt and the Home Secretary illustrates the tension between two key stakeholders: scientists and politicians. It is frequently taken as an example of a collision between scientific evidence and political decision making and of a growing politicisation or ‘ideologisation’ of drug policy. It shows how science is overruled by political agendas and, perhaps, how policy decisions can be influenced by responses to perceived public opinion preferences. It also shows that drug policy is a field in which emotions and moral beliefs play an important role (Monaghan 2014). Drugs are seen as evil, drug users as victims, producers and sellers as villains.

Finally, the case of David Nutt also illustrates the complexity of the force field in which drug policy decisions are taken, shaped by different fractions of stakeholders (politicians, policymakers, scientists, health officials, media general public), different interests (health concerns, social concerns, political agendas, etc.) and contextual factors (the decriminalisation / depenalisation debate, elections, etc.) influencing drug policy decisions. It has been used in the literature as example to illustrate some particularly knotty features of drug policy making. One problem is that there is in fact no uncontested evidence base for drug policy decisions. E.g. scientific evidence on harmfulness of certain drugs is not ‘evident’ but consists of different types of evidence regarding among others physical, psychological and social harms to users and a wide variety of harms to others, e.g. injury, crime, environmental damage and economic costs (Nutt et al. 2007; Nutt et al. 2010; Van Amsterdam et al. 2010), which cannot all together be weighed ‘objectively’ or unambiguously. Determining harmfulness is therefore for an important part based on expert consensus.<sup>49</sup> There is no purely scientific, objective evidence neither for rankings of harmfulness of different drugs nor for policy decisions. Monaghan points out that “heavily politicised issues often conform to what Rittel and Webber (1974) term ‘wicked issues’. These are policy areas that defy neat solutions as there is little agreement on the nature of the problem in the first instance. In debates over the evidence-base for classification decisions, it is unclear whether the matter in hand is one of public health, law and order

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<sup>49</sup> One exception might be focussing on assessing the risk of adverse health effects of the intake of a substance. An interesting example is the so-called margin of exposure approach comparing health risks of different substances by calculating the ratio of toxicological threshold and the estimated human intake (Lachenmeier and Rehm 2014). However, the scope of such an approach is more limited, focussing on toxicological effects and leaving out the psychological and social impact, as generally included in assessments of drug harm.



or morality, or indeed, all three. This can have serious implications for developing an evidence-base for policy ..." (Monaghan 2014).

This tension between scientists and politicians can also be observed in other EU Member States. The policy developments around the Dutch cannabis coffee shops in recent years are another example. From the late 1990s one can observe a tightening of rules regarding coffee shops, which culminated in a package of policy measures announced in 2011, aiming to further constrict the selling of cannabis through the coffee shops. The element attracting most attention in the debate was the introduction of the so-called 'weed pass', a membership card for coffee shops (see 6.1.1). The aim of this measure was to reduce public nuisance (disturbances of public order) caused by foreigners coming in large numbers to buy cannabis, especially in the South of the country. The idea was to stem this 'drug tourism' by operating coffee shops as 'closed clubs' only selling to registered members. Only residents of the Netherlands who had registered with their local council were allowed as members (May and Skrine 2013). Experts from science and research criticised these plans as inappropriate for reaching the intended aims and pointed at the unintended consequences that could be expected. One unintended effect mentioned was an increase of street dealing accompanied by increased public nuisance. All these warnings were pushed aside by the Minister of Security and Justice. In 2012 the new restrictive measures were piloted in the three Southern provinces of the Netherlands. The research unit of the Ministry of Justice was assigned to evaluate the impact of this measure, including the unintended consequences. The evaluation report stated clearly that public nuisance caused by street dealing in the three provinces had increased (Van Ooyen-Houben et al. 2013).

This report was ignored by the Minister, despite the fact that it was produced by his own Ministry. He presented the piloting of the weed pass in the Parliament as a success, referring to a report of a Police Academy, which did not report unintended consequences (Politieacademie et al. 2013).

## **5.4 The content**

### **5.4.1 Different arguments**

The arguments in favour of decriminalisation were clearly quite diverse. Some arguments in favour of the health paradigm were based on research findings pointing at the negative health- and social effects of criminalisation for the user. Health considerations played the most important role in defending decriminalisation of drug use. Both public health concerns and the interest to protect the health of the individual user were important arguments. In this context unintended consequences standing in the way of realising vital harm reduction measures like syringe exchange and drug consumption facilities were also important. There were juridical arguments emphasising that penalising drug use is against the *raison d'être* of the penal code to punish individuals only in case of harm done to a third party. Drug use was seen 'as a crime without a victim'. Drug users at the most harm themselves. Supporters of decriminalisation also referred to economic advantages of decriminalisation of drug use. Decriminalising use is expected to substantially reduce the costs related to criminal prosecution and imprisonment of drug users. Moreover, the health and social advantages mentioned above (e.g. avoiding marginalisation and reducing health harms related to living conditions shaped by criminalisation) are expected to translate in cost reductions for the health care system (Rolles and Eastwood 2012). In the literature one can find quite a number of analyses of the expected economic impact of a general legalisation of drugs (production, sales and use), including some calculations of the economic consequences for the user (Miron and Waldoock 2010). Separate calculations of the economic meaning of decriminalisation of only use and possibly possession of small quantities for personal use are however rather rare.

Besides these rational arguments one can also detect emotional or moral connotations in the arguments supporting decriminalisation of drug use. For some stakeholders it might have been the disease paradigm rather than the health paradigm that convinced them. Viewing the drug user as a patient might have helped in getting decriminalisation accepted.

Considering drug use as disease fits well with the overall negative perception of drugs. Drugs are seen as dangerous or even evil. The images of drug users that prevail in the public opinion are pictures of losers or 'junkies'.

Overall, this broad mix of arguments, appealing to a wide range of stakeholders, may have helped in getting the broad support required for the change of the paradigm. It was taken on board of the policymaking agenda and received wide political support, opening a window of opportunity.

#### **5.4.2 The content: different options**

The trend towards decriminalisation of drug use and possession of small quantities for personal use can be observed in nearly all EU Member States and in many other countries (Rosmarin and Eastwood 2012). In most EU Member States use and possession of small quantities are not brought to court anymore. Still, the interpretation of what decriminalisation should entail and the attempts to decriminalise differ widely.

The Netherlands, one of the countries applying the expediency principle in its penal code, chose for a bit awkward looking approach. Since the legislator intended to leave open the opportunity for the police to seize drugs, the use of illicit drugs is not a criminal offence, but possession still is. Up to a certain threshold quantity (5 grams for 'soft drugs' like cannabis, 0.5 grams for 'hard drugs' like heroin and cocaine<sup>50</sup>) the possession of illicit drugs is formally a (criminal) offence but is not prosecuted. Above these threshold quantities possession is considered a criminal offence. The expediency principle implies that the Public Prosecutor has the discretionary power to refrain from prosecution of criminal offences if this is judged to be in the public interest. This discretionary power is delineated by a framework of guidelines including recommendations regarding the penalties to be imposed and priorities to be observed in investigating and prosecuting offences. Highest priority are large-scale production and trafficking; lowest priority possession for personal use. These Public Prosecutor's guidelines result in a de facto depenalisation of the possession of small quantities for personal use (Van Laar and Van Ooyen-Houben 2009; Rosmarin and Eastwood 2012, p27-28).

This contradictory looking differentiation between possession and use can also be found in other countries. Also in Slovenia the use of illicit drugs is not an offence. The possession of illicit drugs is considered since 1978 not a criminal but a minor offence under the Production and Trade in Illicit Drugs Act (Article 33) (adopted in 1999). An important element in the debates about the 1999 Act regulating the production and trade of illicit drugs was the issue of decriminalisation of use and possession of small quantities for personal use. However, there is no definition of threshold quantities. So in the majority of cases it is left to judicial discretion to decide whether a certain quantity is for personal use or not. According to this, unauthorised possession of drugs is subjected to a fine of between € 208 and up to € 625 or to imprisonment of 30 days. Individuals who possess a smaller quantity of illicit drug for one-off personal use are liable to a monetary fine of between € 42 and € 208 or a prison sentence of up to 5 days. Since 1980s there has been no known case of imprisonment for possession of illicit drugs for personal use (Appendix 3).

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<sup>50</sup> <http://www.emcdda.europa.eu/html.cfm/index99321EN.html> [accessed 16 January 2014].

Portugal and Spain went for a more formal decriminalisation. In Portugal the use or possession of any drug for personal use (without authorisation) is still illegal, but no longer defined as criminal offence but as an administrative one (EMCDDA 2011, p16). This policy change is seen as a major step forward, as it is a de jure decriminalisation (Domosławski 2011). This is true from the legal perspective.

However, there are comments pointing at the fact that for the drug user this change is not merely positive. A person held by the police in possession of drugs will generally have to appear in front of a dissuasion commission, which has the task to motivate drug users to undergo treatment. For some drug users this is a hassle they did not face in former days when the police turned a blind eye.

Rosmarin and Eastwood summarise the legal provisions regarding possession of illicit drugs in Spain as follows: “Under current law, if police find an individual in possession of up to 5 days’ worth of drugs – 200 grams of cannabis, 25 grams of cannabis resin, 2.4 grams of ecstasy, 3 grams of heroin, 7.5 grams of cocaine<sup>51</sup> – that individual is likely to face an administrative penalty issued by the police. Such sanctions can include a fine, suspension of an individual’s driver’s licence or firearms licence, or other minor penalties. Penalties are established by the Spanish Ministry of the Interior but local authorities may also determine sanctions in conjunction with a hearing before a local safety board if local laws or regulations for drug offences are present.

If an individual is found with a quantity above the threshold, that individual may go before a court or a local safety board, which considers the quantity together with other factors, including whether the individual is a known user, where the drugs were found, how they were stored, and the presence of large quantities of cash, to determine if the drugs were intended for self-consumption or trade.<sup>52</sup> Although Supreme Court precedent holds that possession of quantities over the 5-day threshold constitutes a crime, individuals apprehended with larger quantities have been acquitted of criminal liability. Many issues remain contestable in Spanish drug offence court proceedings, including whether a drug is ‘hard’ or ‘soft’ (which may impact the determination of a particular sanction) and whether the drugs were intended for use or distribution. If an individual is found to possess drugs for distribution or sale, custodial sentences are available to the court. For drug-dependent users, penalties or fines can be suspended if an offender agrees to attend treatment at an officially recognised service or centre.” (Rosmarin and Eastwood 2012 p34).

In some countries there has been no major change despite substantial support for decriminalisation by different stakeholders. One example of this is the UK. However, also in the UK informal decriminalisation of use and possession of small quantities for personal use is daily practice, although this has not been formalized.

For cannabis possession an ‘escalation’ penalty system is currently applied in the UK, meaning that the penalty issued is directly related to the number of times an individual has previously been caught in possession of cannabis. Caught in possession of cannabis for the first time a user will be issued with a cannabis warning. Caught in possession of cannabis for the second time a user will be issued with a Penalty Notice for Disorder for cannabis possession. These ‘Penalty Notices for Disorder’ are tickets that police officers can issue at the scene of an incident or in custody, meaning an on-the-spot fine of £80 (€92.59). Caught in possession of cannabis for the third time police officers will consider further action. This could include release without charge, caution, conditional caution or prosecution.

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<sup>51</sup> EMCDDA, Threshold quantities for drug offences. Available at: <http://www.emcdda.europa.eu/html.cfm/index99321EN.html>. [accessed 15 December 2013].

<sup>52</sup> EMCDDA, Threshold quantities for drug offences. Available at: <http://www.emcdda.europa.eu/html.cfm/index99321EN.html>. [accessed 15 December 2013].

All subsequent offences are likely to result in arrest. Under 18 year olds can expect to be arrested, taken to a police station where they may receive a reprimand, a final warning and a charge depending on the seriousness of the offence (Appendix 7).

There is however no generally applied definition of a small amount for personal use. Kent Police states on a cannabis fact sheet for their officers that “if it is large enough to identify it as cannabis then action needs to be taken.”<sup>53</sup> The police should have reasonable grounds to suspect possession with intent to supply, this could mean an individual has previously been known to supply cannabis or could be found in possession with a large quantity of cannabis or money, or cannabis related materials such as scales. The government announced that it was not prepared to introduce a threshold, which leaves the decision to be made by the police (Appendix 7).

#### *The half-half option: the carrot and the stick*

In various countries replacing the crime paradigm by the health or disease paradigm translated into other forms of a less repressive approach of the drug user. Besides de jure and de facto decriminalisation of drug use other options have been introduced to allow users of illicit drugs to avoid penalisation. Widely implemented approaches are the so-called diversion schemes: courts offer drug users the option to choose for treatment as alternative for imprisonment and so-called alternative sanctions. These options started to emerge in Europe in the 1970s (EMCDDA 2005).

In quite a number of countries these diversion schemes are not exclusively used for drug offences like use or possession of small quantities for personal use but also for rather minor drug use related offences like shoplifting or pickpocketing. This wider application explains why in some countries, like the Netherlands, diversion schemes were developed besides decriminalisation of use (and possession of small quantities).

There are also countries that offer a penalty reduction if the accused agrees to undergo treatment or to follow a social training programme. In Slovenia the Production and Trade in Illicit Drugs Act (Article 33 adopted in 1999) entails a provision, that drug users that have committed a minor drug related offence (possession of small quantities for personal use) may be subject to more lenient punishment if they voluntarily enter drug treatment or social security programmes approved by the Health Council at the Ministry of Health or by the Council for Drugs at the Ministry of Labour, Family and Social Affairs (Appendix 3).

Diversion schemes and penalty reductions – when applied to drug use and possession of small quantities for personal use – are in fact not decriminalisation but simply a less harsh approach, and in the cases where treatment replaces imprisonment, an example of depenalisation for the drug users who choose the treatment option. It acknowledges, however, the fact that drug use is – essentially – a health issue. It is a half-half option, leaving intact the penalisation of the use of certain drugs and the possession of small quantities for personal use, but introducing an option to avoid penal sanctions when choosing treatment. In some countries it appears to have been the first step towards further decriminalisation, while in other countries this option seems to be the only feasible option to refrain from prison sentences for drug users, frequently due to the opposition against further reaching steps.

The purpose behind the diversion schemes is to enhance the motivation of drug users to choose for treatment by using the threat of a prison sentence as the big stick, if they don't. This carrot and stick

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<sup>53</sup> Kent Police, Possession of cannabis. [Online]. Available at: [http://www.kent.police.uk/about\\_us/policies/m/m103.html](http://www.kent.police.uk/about_us/policies/m/m103.html) [accessed 5th February 2013].

approach is seen as a valuable strategy to get users abstinent. Diversion schemes are at least a partial adoption of the health paradigm: As drug use is a disease, people who suffer from this disease are best helped by getting them into treatment. Diversion schemes proved to be widely acceptable as it is understood as motivating users to give up drug use.

## **5.5 The other side of the coin: a harsher approach to producers and sellers**

Decriminalisation is a phenomenon which does not stand alone. Decriminalisation of use and the possession of small quantities are accompanied by a tougher, more punitive approach to the supply of illicit drugs in many countries all over the world. While in the meantime the majority of EU Member States sees it as inapt to treat drug use as a criminal offence, production and trafficking of illicit drugs are considered as serious crimes, causing harm to users and society, which calls for a tougher response (Trautmann et al. 2009; see also 2.3 and 5.2). It is rather common practice that countries that have adopted a decriminalisation approach significantly increase the sentences for drug supply offences. “Too often those convicted of non-violent drug supply offences receive custodial periods which are much harsher than other violent offences, such as rape and even murder” (Rosmarin and Eastwood 2012). Also on EU level a tougher approach of drug supply was embraced, as can be taken from the 2004 Council Framework Decision which laid down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking (Council of the European Union 2004b).

These two trends seem to be two sides of the same coin. A more lenient approach on the one side seems to go along well with a more repressive approach on the other side. However, it is not a surprising combination. It is yet another example of the carrot and stick approach in drug policy: in this case applied to the illicit drugs market, with the carrot for the users and the stick for the suppliers. It is the core of the balanced approach concept, a key feature of drug policy in the EU (and other parts of the world), combining demand reduction, consisting of social and health programmes, with supply reduction, consisting of mainly repressive, criminal justice measures.

What strikes the most is that this is an issue where the views of some supporters of decriminalisation of use and prohibitionists seem to meet each other. It speaks for itself that stakeholders supporting a prohibitionist approach are generally in favour of a tougher approach towards production and sales of illicit drugs. However, as mentioned above, there are also supporters of decriminalisation supporting a tougher approach of drug supply as a complementary element to decriminalisation of use. Explicit support from ‘decriminalists’ might still be limited, but there is some tacit consent.

### **5.5.1 Contextual factors in support**

There are some contextual factors supporting a tougher approach to supply of illicit drugs. In a study exploring the future expectations of a number of selected international drug experts regarding trends in the drugs market, we found that political factors are seen to play a role here.

“The trend seems to match with the current political agenda. It is seen as a political quick win for many politicians to be humane for the users, which are presented as patients or victims, and tough on those involved in production and trafficking as they are seen as evil and corrupting. The general public calls for tougher measures. Going easier on drugs in general might cost votes as the public's fear for illegal drugs is still substantial.

Getting tougher on producers and dealers also corresponds well with the growing political conservatism and the general trend of more punitive approaches to all kinds of socially undesirable behaviour, which can be seen in many EU Member States. Respondents also pointed to a stronger

emphasis on security by national governments and at EU level. Finally, also economic factors are seen as important. One respondent expects that there will be fewer funds available for crime prevention and social development.” (Trautmann 2013).

### **5.5.2 *The influence of moral values***

Moral values regarding drugs and drugs use also seem to be of influence when it comes to a tougher approach to drugs supply. Understanding (problem) drug use as disease makes it tempting to regard the suppliers of these drugs as unscrupulous ‘evildoers’, causing harm to their clientele and therefore deserving to be severely punished. This moralistic element in the view on the supplier is an important element in the package deal of decriminalisation of use and the toughening of the approach towards supply, as can be taken from the quote used above. Dorn argues that the logic of harm minimisation is applied to law enforcement “by targeting trafficking in the drugs that do the most harm deemphasizing action in relation to drug users who consume cannabis or other drugs relatively unproblematically.” (Dorn 2004 p533).

Toughening the approach to drug supply is justified with basically moral judgments: The view that a drugs user is a patient is mirrored by the picture of the producer and seller of drugs as criminal, causing harms to the user and the society. The users are victims, whose illness is abused by the producers and dealers. This picture feels somewhat uncomfortable as it is at odds with features of the reality: Many users of illicit drugs are also suppliers themselves, often to finance their own drug use.

But, more importantly, we do not regard the suppliers of alcohol and tobacco, the drugs most widely used and evidently causing the most serious health harms, as crooks (Nutt et al. 2007; Nutt et al. 2010; Van Amsterdam et al. 2010; WHO 2013a). Producing heroin is seen as an unscrupulous crime while at the same time we talk about the art of wine making.

## 6 Regulation

Our third case study explores the forces and factors behind the trend towards a wider application of regulation policies. This trend can be found for all four substances and behaviours we are looking at, i.e. cannabis, tobacco, gambling and even for heroin, be it to a rather limited degree. We decided to concentrate on the first three. For cannabis we draw on the policy in the Netherlands, Spain and the UK. For tobacco we focus on legislation and regulations regarding smoke free hospitality venues in France and the Netherlands and for gambling we limit ourselves to one case, i.e. aspects of control and regulation like in licensing policies in France, Slovenia and the UK.

Policy and governance targeting illicit drugs differ substantially from policy and governance targeting licit drugs. In the field of illicit drugs the policy framework is set by prohibition principles, which for drugs like heroin seem to be written in stone, while in case of licit drugs there is more room for manoeuvre: there are more policy options. Here we also chose a pragmatic definition, following the commonly used distinction between prohibition – banning certain acts like the production, sales and use of a substance under threat of criminal sanctions – and regulation – a policy controlling these acts by means of administrative law provisions (Levine and Reinerman 1991).

### *Regulation policies targeting illicit drugs: from prohibition to regulation*

With regards to illicit drugs this trend does not much more yet than carefully explore the feasibility of regulation instead of prohibition. However, there are a few examples of implemented measures. One example is the decriminalisation of use of illicit drugs and possession of small quantities for personal use as discussed above (see 5). It contains elements of regulation, e.g. replacing in well-defined cases criminal sanctions for use and for possession of small quantities for personal use with administrative sanctions. One element of regulation is for instance defining threshold quantities, meaning regulating until which amount possession of an illicit drug is taken as being intended for personal use and from which amount onwards it is taken as an indication for intention to sell. This seems to be also one of the few regulation elements that can be found in the case of heroin policy. Decriminalisation of use, though important for the user and for public health, does however not involve a substantial change of the prohibition policy framework governing drug policy.

There are, however, some elements in the present cannabis policy, which clearly go beyond the limits of the prevailing prohibition policy framework. In a growing number of countries cannabis regulation policies are considered, which include regulatory measures aiming at a controlled supply besides decriminalisation of use. There are two EU Member States where some form of regulation of cannabis supply has been implemented. The earliest example are the so-called coffee shops in the Netherlands (see below). A more recent example are the so-called cannabis social clubs in Spain. In recent years the public debate about regulating production and sales of cannabis gained momentum in a growing number of EU Member States. This development is not limited to the EU, as can be taken from the developments in the USA (Colorado and Washington) and in Uruguay, where the whole chain from production to trafficking and sales has been regulated. These policies represent the most radical changes.

### *Regulation policies targeting licit drugs: from unregulated to regulated*

This trend towards regulation of supply can also be observed in the debates about an appropriate policy response to the emerging New Psychoactive Substances (NPS). These so-called ‘legal highs’ are not (yet) controlled, neither by any systematic regulation nor by prohibition. In this case we can see besides arguments for prohibiting these substances also proposals making a case for considering alternative control regimes (Trautmann 2013; Sumnall H.R. et al. 2014). An interesting one is the

European Commission's proposal regarding regulation options for NPS (European Commission 2013). Another sign, that there is growing interest in exploring drug policy alternatives. While in the case of cannabis one can observe a momentum to move from prohibition to regulation, for NPS the fact that there is not yet a clear regulation regime seems to be used as opportunity to find alternatives for a prohibitionist approach. One option is to develop regulations making use of currently available regulatory regimes like medicines regulations, consumer protection law, foodstuff regulations and regulations relating to specific commodities, such as tobacco and alcohol, but also substances with other uses, such as solvents. Another option between prohibition and regulation, which is yet implemented in three EU Member States, are temporary control measures (Trautmann 2013).

But also in the field of the two most widely used licit drugs, alcohol and tobacco, regulation became a more and more prominent feature of governance. Regulation policies for both alcohol and tobacco intensified and extended in the past two decades. A similar picture can be observed with regards to gambling. We will illustrate this in the approach to tobacco and gambling. In the majority of EU Member States the focus of policy and governance is on more control (or even repression), e.g. regulations and measures reducing tobacco use and gambling.

This is one of the interesting features, when comparing developments of policies targeting licit substances (including gambling) on the one hand and targeting illicit substances on the other hand. For illicit drugs there seems to be a cautious trend from prohibition to regulation, from criminal to administrative law. In particular cannabis policy shows for quite some years a clear trend of moving away from the 'naturalness' of prohibition, away from a framework set by the provisions of the international conventions ruling drug policy today. At the same time the policy response to alcohol, tobacco and gambling is moving in the opposite direction, from a rather unregulated state to an increasingly strict regulation regime. In particular alcohol and tobacco regulation policies have become substantially stricter in the past two decades. In the majority of EU Member States the policy focus is on more strict controls, on provisions regulating production and sales and measures limiting retail and use. In the case of tobacco there are even voices proposing prohibition. More strict regulations can also be observed in the policy response towards gambling.

## **6.1 From prohibition to regulation: cannabis policy in the Netherlands, Spain and the UK**

The only illicit drug where the trend towards regulation – going beyond decriminalisation of use and possession of small quantities for personal use – has started to materialise is cannabis. For many years the Dutch coffee shops were the only example of a partial regulation of supply, which started in the 1970s. However, over time regulation of supply became a topic of discussion in many other countries. These debates were part of a broader discussion about alternatives for drug prohibition and the war on drugs, which has been going on for more than half a century. Much has been said earlier about these debates in the two case studies above (see 4 and 5). Regarding decriminalisation of use and regulation of supply cannabis has always been in the centre of this debate. Even in the US from 1960s onwards there have been pleas for cannabis decriminalisation. Between 1965 and 1985 one can observe in different states a trend towards a more lenient approach, as can be taken from reductions of criminal penalties in Oregon and Alaska (De Kort 1995; Blickman et al. 2014).

In this study we will concentrate mainly on the developments in the Netherlands and Spain, the only two EU Member States where a relatively well elaborated cannabis regulation model has been implemented. We will add a short note on the developments in the UK, one of the many countries in Europe where there are initiatives pushing towards replacing prohibition by a regulatory regime. We have chosen to discuss these three examples separately as they are rather unique processes reflecting differences regarding the social and historical context, the content and the process.



Whereas in the case of the wider acceptance of harm reduction and decriminalisation the processes in different countries have certain features in common, the two examples of cannabis supply regulation in the EU differ substantially. The debates about cannabis regulation in different EU Member States have much in common, among others the dissatisfaction with the effects of cannabis prohibition. The implemented policies and the policy plans differ considerably.

### **6.1.1 The coffee shops in the Netherlands**

#### *The context: roots of the Dutch coffee shops, the countermovement*

The regulation of cannabis sales in the Netherlands through the so-called coffee shops has the same roots as the emergence of harm reduction and decriminalisation. It can be traced back to the changes initiated by the countermovement in the 1960s and 1970s (see 4.1 and 5.2). Opposition against drug prohibition was a prominent issue on the agenda. The use of then relatively uncommon drugs had gained popularity. Cannabis was the most widely used drug. It was the ‘lifestyle drug’ of the protest movement like the Provo’s (see 4.1.1). Its use was a symbol of the resistance against the establishment (Blok 2011 pp. 146). Protest leaders, writers and musicians drew attention to the positive aspects of cannabis use and protested against cannabis prohibition. Koos Zwart<sup>54</sup>, working for a number of alternative magazines and for the radio, started to read his famous ‘stock market reports’ (beursberichten)<sup>55</sup> on the radio, giving details about the current quality and prices of the different marijuana and hash varieties on the market (De Kort 1995). People started to grow their own cannabis plants at home.

Cannabis, but sometimes also other drugs, were sold openly in youth centres like the famous Paradiso in Amsterdam. Some youth centres started to employ ‘huisdealers’ (licensed dealers) for cannabis products, to be able to control dealing and bar dealers in hard drugs. This phenomenon caused much commotion at local and national level. Heated debates followed between the different political and policy making stakeholders, including representatives of the Ministries of Justice, Social Affairs and Health, the police, and local authorities. Notwithstanding some repressive responses – e.g. prosecuting and sentencing staff of youth centres involved in licensed dealing – the prevailing attitude was hesitatingly positive, even among conservative politicians. The then Minister of Justice Van Agt (from the KVP, the Catholic People’s Party) stated that there were in certain situations and under certain conditions valid arguments in favour of licensed dealers. Condoning them might be, according to him, the lesser of evils. There was quite some support for a formal regulation, especially on local level. But the proponents on national level were aware of the fact that a formal regulation would conflict with the international conventions. The result of the debates was in the end again condoning: in 1977 it was decided by the Public Prosecution Service that licensed dealers would be prosecuted only if the so-called ‘triangle consultation’ decided to do so (De Kort 1995 p248). This licensed dealer system in youth centres was the forerunner of the formally regulated coffee shops.

#### *Stakeholders: Again the importance of science in Dutch drug policy in the 1970s*

At the background of this step towards formal condoning of coffee shops the reports of the Baan and the Hulsman commission, exploring and explaining the emerging ‘drug problem’, played again a crucial role. Their findings and recommendations were the foundation on which the new Dutch drug policy was built. They were translated into the 1976 ‘opium law’. These reports paved the way for

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<sup>54</sup> Interesting detail is that Koos Zwart was the son of Ms Irene Vorrink, the Netherlands Minister of Health, responsible for enacting the 1976 drug law, the fundament of the rather liberal Dutch drug policy.

<sup>55</sup> <http://www.geschiedenis24.nl/andere-tijden/afleveringen/2003-2004/Hasj.html/> [accessed 11 January 2014].

the formal acceptance of harm reduction and decriminalisation (see 4.1.2 and 5.3.2) but also for a formal regulation of selling cannabis.

It was the report of the Commission Baan with its strong focus on cannabis which opened the door for regulation of selling and for – to a limited level – producing cannabis by allowing home growing for personal use. The distinction between hard drugs posing unacceptable risks for user and society and soft drugs with less severe risks was one of the key features of the 1976 drug law. This distinction resulted in a strategy – proposed by the two commissions and the government – to start with the easiest, least controversial step. Decriminalisation of cannabis use was this first step. The second step was condoning sales of cannabis. The aim of these provisions was a separation of the drug markets (see 4.1.2). According to the Baan report a regulated, decriminalised selling of cannabis was an instrument to separate the cannabis market from the hard drug market. Intended results were first of all that users could buy cannabis at places where no other drugs are sold. Other intended results were that less cannabis users would switch to other (hard) drugs and that cannabis users would remain well integrated in society. The expectation was that they would not face the negative effects of criminalisation of use and possession. The only reservation formulated was the risk that this policy might lead to an unacceptable increase of problematic cannabis use. In that case these policy changes would have to be reconsidered.

More contentious steps were meant to be taken at a later stage. The Commission Baan concluded that regulating growing and trafficking was not yet feasible at that time. The production and distribution of cannabis should – for the time being – remain within criminal law, but as misdemeanours. The use and possession of other drugs should temporarily remain in the realm of criminal law, be it just as misdemeanours. However, in the long run they should also be decriminalized. The view to ultimately legalise cannabis also received support from politicians. De Kort refers to a Memorandum of the government of January 1974: “The use of cannabis products and the possession of them for personal use should be removed as soon as possible from the domain of criminal justice. However, this cannot be realized as yet, as it would bring us into conflict with our treaty obligations. The Government shall explore in international consultations whether it is feasible that agreements as the Single Convention be amended in a way that nations will be free to institute, at their discretion, a separate regime for cannabis products.” (De Kort 1994).

#### *Content: formally regulated coffee shops*

The conclusions from the Commission Baan were the basis for the provisions in the 1976 law that growing, selling and possessing of small quantities up to 30g of cannabis had to be treated as minor offence (misdemeanour) (De Kort 1995 p242). Still, cannabis supply (producing, trafficking and selling) remained a criminal offence. However, applying the expediency principle provided the legal basis for a condoning policy, resulting in a de facto decriminalisation of cannabis home growing and selling through coffee shops. These acts remain illegal but are defined as ‘low’ priority for criminal investigations. The Public Prosecutor in the Netherlands has the discretionary power to refrain from prosecution of criminal offences, if this is judged to be in the public interest. In 1980 the Ministry of Justice published supplementary guidelines regarding cannabis retail trade, stating that the police will only intervene ‘when cannabis retailers make themselves publicly known as such or doing their business in an otherwise provocative way’ (De Kort 1995 p254).

Coffee shops adhering to the agreed guidelines are de facto indemnified from prosecution. This situation has remained unchanged till today.<sup>56</sup>

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<sup>56</sup> <http://www.om.nl/organisatie/beleidsregels/overzicht/drugs/@160000/aanwijzing-opiumwet/> [accessed 17 January 2014].

As early as 1972 the first illegal and not formally regulated coffee shop ‘Mellow Yellow’ opened its doors in Amsterdam<sup>57</sup>, which was condoned by the Amsterdam authorities. From 1980 onwards coffee shops, formally condoned by the local authorities, emerged in a growing number of Dutch cities (Van Laar and Van Ooyen-Houben 2009, p50).

*The context: opportunities by uncertainties*

Overall, the new drug policy was a response full of uncertainties. It was a response to changes in society, to the youth revolt, and, to a new, unknown phenomenon: the evolving drug use among the young. The knowledge about this new phenomenon was limited. This is why policymakers and politicians turned to science to find an explanation of this phenomenon and to get advice what to do.

The drive for a change in society was not limited to the youth protest. There was a broader resistance against the predominant conservative and repressive mood in the post-war Netherlands with its focus on reconstruction and order. There was a strong emphasis on personal freedom and self-expression. It was also the time of changing views on values and morals, of experimenting with new lifestyles, of the sexual revolution. Social sciences, among others, strongly influenced by this spirit of change, were an important force in these changes. Social scientists fed the debate with new insights. The emerging ‘drug problem’ was an obvious target of reflection for social sciences. The efforts to adequately understand this phenomenon helped to generate the paradigm change from drug use explained as a crime to drug use understood as a health issue. This was of course no sudden change, but a process of thorough and vigorous discussions.

In this juncture the need for a new policy emerged. Drug policy was formulated in a phase of societal changes where much was uncertain. It was uncertain how drug use would develop, how the ‘drug problem’ could be explained appropriately and tackled effectively. In those days the ownership of the drug problem was not (yet) clear. Compared with today a more limited number of stakeholders was involved in the process of drug policy making. The responsibilities were not yet as clearly divided as they are today. There was no consensus yet on a leading paradigm: was it a health, crime or social problem. These uncertainties led to heated debates among the involved stakeholders.

These uncertainties may have been frustrating and standing in the way of formulating clear-cut policy solutions but they also had one important advantage: there was room for manoeuvre. It was an opportunity for innovations and testing new options. The uncertainties contributed to creating a window of opportunity for developing the three approaches discussed in this study: harm reduction, decriminalisation and regulation.

Another factor that may have contributed to more room for manoeuvre – compared with today – is the less far-reaching EU integration. In the 1970s and 1980s countries in the EU could operate more autonomously.

But in those days too there were factors limiting the room for manoeuvre: the international conventions, or sometimes rather the interpretation of the provisions in these conventions, were a constraint for regulating the supply of illicit drugs. Despite the fact that the exact meaning of these provisions had been subject of exegetic studies and debates there was no doubt that the conventions are meant to prohibit the supply of cannabis for non-medical purposes.

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<sup>57</sup> <http://www.geschiedenis24.nl/andere-tijden/afleveringen/2003-2004/Hasj.html/> [accessed 11 January 2014].

These uncertainties and restrictions help to explain why the response from the authorities to all these manifestations of change has been so inconsistent. Especially in the early years the response varied from harsh (arresting and imposing fines on sellers and users, closing venues where marijuana was sold) to lenient (condoning the selling). The lenient approach became particularly common among local authorities, paving the way to what became known as the Dutch 'condoning approach' to the selling of cannabis.

#### *Context and process: Tightening up the rules*

The spirit of change – manifested in the plan to start with decriminalising cannabis use and proceed step by step to a full legalisation of all illicit drugs – did not last long. One reason was that the expected change in the international conventions in the near future did not take place (De Kort 1995 p259). Besides the restrictions posed by these conventions serious criticism from other countries, in particular Germany, France, Sweden and the US, and from international bodies like INCB tempered the optimism (Van Laar and Van Ooyen-Houben 2009 pp55 and p325). It became clear that the original plans for further radical changes had not been realistic.

There were also national factors that caused the momentum for fundamental changes to drift away. An important factor was the rise of what could be called the 'hard drug problem' in the late 1970s. The concerns about the increasing use of heroin, cocaine and amphetamines made cannabis policy take a drop on the political agenda (De Kort 1995 p253). Though these concerns also fuelled doubts about the lenient approach to cannabis. The unintended consequences of the coffee shop policy, however, contributed to a 'mood change' and helped to put cannabis back on the political agenda. Coffee shops developed from small-scale, alternative establishments into commercial 'big' business. Production and wholesale of cannabis increased significantly, attracting, due to its illegal character, organised crime. 'Drug tourism', foreigners coming to buy cannabis in Dutch coffee shops, emerged triggering public order problems, particularly in the border regions (De Kort 1995 p256).

This 'change of scenery' made that the reform process ground to a hold after the first radical step of regulating cannabis retail had been taken through the coffee shops, which in the Netherlands became known as regulating the front door of the coffee shops. The intended regulation of the backdoor, providing coffee shops with stock was never realised. The only step taken was defining the maximum quantity coffee shops were allowed to have in stock to be condoned. Today this maximum is 500 gram, which is not sufficient to run a coffee shop in most cases, resulting in a complex delivery system which keeps the stock below this limit and at the same time allows for sufficient supply of different marijuana and hash varieties to serve the customers. This 'unfinished' reform process resulted in a contradictory policy: a regulated front door combined with an illegal backdoor, a flaw in the coffee shop system.

From the 1980s on one can observe a process of tightening the rules of the coffee shop policy (Henken 2012). In 1987 it was determined that coffee shops were not allowed to sell more than 30 gram per customer. They were not allowed to advertise and to sell cannabis to minors (under 18). In 1991 the stricter so-called AHOJ-G criteria came into force.

These criteria include:

- No **A**dvertising
- No selling of **H**ard drugs
- No Nuisance (**O**verlast)
- No selling to Young persons under 18 (**J**ongeren)
- No big (**G**root) quantities, i.e. above first 30 and later 5 grams per transaction.

The 1995 Drug Policy Paper ('Drugsnota') of the national government and the 2004 Cannabis Report ('Cannabisbrief') continued with more restrictions, among others reducing the maximum quantity per sale per customer per day to 5 grams. From the mid-nineties on the emphasis of the coffee shop policy shifted from health to public order. "In 1995 the policy on coffee shops started to focus on reducing the public nuisance factor (including drugs tourism) and criminality associated with coffee shops and cannabis cultivation. This took the form of measures such as stricter application of legislation, improved monitoring of compliance and expansion of administrative measures." (Van Laar and Van Ooyen-Houben 2009 p26).

In 2011 the trend towards a more restrictive coffee shop policy reached its peak with plans to introduce the so-called 'weed pass', a mandatory membership card for coffee shops, which was only available for residents of the Netherlands who had registered with their local council. This measure was meant to reduce public order problems caused by 'drug tourism', i.e. the substantial numbers of foreigners coming to buy cannabis, in particular in the Southern provinces of the Netherlands. Running coffee shops as 'closed clubs', only selling to registered members, was expected to solve this problem (see 5.3.3). The weed pass was introduced as an experiment in the Southern part of the Netherlands at the beginning of 2012. The plan was a national roll-out if the experiment would succeed. National elections resulting in a change of government brought a premature end to this experiment. The 'weed pass' disappeared from the political agenda. It was replaced by the so-called 'resident criterion', also implying that only Dutch residents can buy cannabis. However, municipalities are free to make their own policy on this point. Different cities already announced that they will not implement this rule.<sup>58</sup>

#### *The political context: tightening the rules and rising conservatism in politics*

In the 1980s the move towards a more restrictive coffee shop policy was for an important part motivated by concerns about unintended consequences of the coffee shop policy (see above), which were widely shared among politicians. Political conservatism played a more modest role. Naturally there were always conservative political parties with objections of principle against coffee shops. In particular the Christian democrats and some smaller 'orthodox' protestant parties opposed coffee shops on these grounds (De Kort 1995 pp256).

However, in the past decade political conservatism came to the fore in the process towards an increasingly restrictive coffee shop policy. In the Netherlands as well as in other EU Member States conservatism became more influential in social policy, a change which overall seems to be well-received by the public opinion and the media. This conservative mood seems to fit a more restrictive drug policy in general.

There is another factor, which also may have played a role here. According to experts consulted in our Delphi study exploring their views on how key trends of the illicit drugs market and policy responses in the EU are expected to develop in the coming years the economic crisis is a factor giving weight to conservatism.

A conservative political agenda seems to suit policy making during an economic crisis. Finally, the increasingly negative view on and tough approach towards producers and sellers (see 5.5) also fits in well here. It is in line with a general trend of more punitive approaches to all kinds of socially undesirable behaviour, which can be observed all over Europe (Trautmann 2013).

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<sup>58</sup> <http://nos.nl/artikel/456172-buitenlander-kan-blijven-blowen.html> [accessed 3 July 2014]

### *The political context: reaction to tightening the rules and the emergence of a supply lobby*

However, after nearly thirty years of tightening the rules for coffee shops there are signs of a growing opposition against the restrictive trend in the coffee shop policy. This opposition comes from different sides. On the political level the municipalities are taking the lead. An increasing number of Dutch cities are in favour of a regulated supply of the coffee shops as a way to reduce the problems of public order and organised crime. At the moment of writing this study, the mayors of more than 26 Dutch cities support this view.<sup>59</sup> Different models are being considered, from the Spanish social club model to licensed growing of cannabis under control of local authorities. The mayors of these 26 cities are putting pressure on the Minister of Security and Justice who opposes regulated supply, referring to the provisions of the international conventions.

It is intriguing to see a new stakeholder appear on the scene. Besides the 'cannabis movement' coffee shop owners became an increasingly important stakeholder in the opposition against the restrictive coffee shop policy. This seems to be a sign of an emerging cannabis supply lobby. It shows that trade organisations openly lobbying for their interests are emerging even in the margins of the illicit drugs market where prohibition is replaced by condoning policies.

Overt lobbying of suppliers is for obvious reasons – a formal lobby of producers and sellers of illicit drugs cannot exist – only possible in a legal market. The lobbies of alcohol and tobacco producers and sellers, the lobby for gambling and the lobby in the field of psychopharmaceuticals are well-known examples. The cannabis market forms an interesting case here. The emerging lobby of coffee shop owners in the Netherlands underlines the impact of regulation policies. In the Netherlands, where the selling of cannabis is 'semi-legal', unions of coffee shop owners are emerging, acting as a lobby of suppliers. Groups of coffee shop owners, sometimes even formally organised as for instance the 'Bond Cannabis Detailisten' (BCD, the Union of Cannabis Retailers), have started to openly participate in the debate about coffee shop policy. They were actively and visibly involved in the opposition against the so-called 'weed pass'. Their input was regularly covered by the media.

#### **6.1.2 The Spanish Cannabis Social Clubs**

Spain is another European country with an influential cannabis lobby, the so-called cannabis social movement, which has an explicit political agenda (see 5.3.1). Besides campaigning against prohibition policy in general the movement also presses the case of a formal regulation of cultivation to end the juridical uncertainty cannabis growers face. This cannabis movement, which dates back to the early 1960s, is also the breeding ground for the cannabis social clubs which started to emerge in 2002 and are now a prominent element within this movement (EMCDDA 2012b).

Cannabis use has a long tradition in Spain. Gamella and Jiménez Rodrigo refer to “an autochthonous tradition of cannabis consumption, derived from over a century of colonial adventures in Northern Africa. In the 1940s and 1950s, Moroccan marijuana was smoked in many cities, especially in Madrid, Barcelona, and other locations that maintained stronger links with the Spanish Protectorate, such as Algeciras, Malaga, Cadiz, Valencia, and Las Palmas (...).” (Gamella and Jiménez Rodrigo 2004, p626).

Cannabis use became an issue in the late 1960s and the 1970s, when it appeared as part of a youth counter culture. “In the late 1960s, the old tradition of cannabis consumption was fused with the emerging cosmopolitan, countercultural scenes (...). At that time, drug experimentation also became

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<sup>59</sup> <http://nos.nl/op3/artikel/575126-legalize-de-wietteelt-roepen-26-steden-in-koor.html> [accessed 23 January 2014].

associated with the opposition to the dictatorship, and smoking joints (“porros”) became a badge for most young leftist militants and even for many democrats (...)” (Gamella and Jiménez Rodrigo 2004 p627). As in the Netherlands the cannabis culture in Spain was also closely linked with a countermovement, an opposition against the established political system. Drug prohibition was one feature of this political system, which received much criticism.

#### *Context and process: how a contradictory policy fuelled home cultivation*

In 1982 the possession of small quantities for personal use was decriminalised in Spain (see 5.2.2). A meaningful step in a country where cannabis use became increasingly popular and widespread. From the 1970s on the cannabis use prevalence increased in the general population (15-64) and particularly among the young (15-34), although a slight decrease can be observed from 2011 onwards (Ministerio de Sanidad, Servicios Sociales e Igualdad 2013; Gamella and Jiménez Rodrigo 2004).

The 1992 Public Security Law brought about a tightening of the policy regarding drug use and possession. An individual using or carrying an illicit drug in public places risked an administrative sanction (a fine). This led in the subsequent years to an enormous rise of proceedings against users, in the majority cannabis users. Gamella and Jiménez Rodrigo refer to over 50,000 cases per year and come to the following assumption:

“It is now legitimate to ask how someone can smoke cannabis without risking a fine. Privately growing one’s own marijuana would suffice. This might explain why home cultivation of marijuana has boomed in Spain during the last decade. Many youngsters and adults cultivate hemp plants. They often get their seeds, implements, and knowledge from an increasing number of “grow shops” and “smart shops” that have been opened throughout the country. In the summer of 2002, a review of web pages and cannabis journals resulted in the identification of 197 such shops in over 40 Spanish cities. The average cultivator grows a few plants on his balcony or patio, but there are an increasing number of people who cultivate gardens and larger plots, and some who use advanced equipment and cultivate in closets using artificial lightning and even hydroponic techniques. The bulk of marijuana cultivation in Spain occurs out of sight, and growers are fairly discreet in their practice of this hobby.

Home cultivation is perceived to be an alternative to prohibition. The production of quality types of marijuana adapted to personal tastes is also a persistent motive. This method is also seen as an option to an illegal market that has increasingly been dominated by low quality hashish” (Gamella and Jiménez Rodrigo 2004, p643).

#### *Context and process: from home cultivation to cannabis social clubs*

These factors may indeed have contributed to the increasing popularity of home cultivation despite its still somewhat unclear legal status. There are reports of prosecution of larger scale cultivation, but growing for personal use has generally remained untouched. From individual growing for personal use it was just a small step to collective growing. Already in 1993 there were experiments with collective cultivation. To test the limits of the judicial response to collective home growing a group of cannabis activists, the Asociación Ramón Santos de Estudios Sobre el Cannabis (ARSEC) from Barcelona, asked the anti-drug public prosecutor in Catalonia if cooperative growing for personal use would be considered a crime. When the answer was negative they decided to grow, harvest and use cannabis and informed the media about this. This first attempt to get collective cannabis cultivation for personal use regulated or condoned failed. After having been acquitted initially by the provincial

court the activists were found guilty in the final instance (Barriuso 2011, pp2). However, in other cases cooperative growing was condoned. A well-known example is the Kalamudia association, which started in 1998 to grow and harvest 600 cannabis plants for 200 people without the public prosecutor intervening. This went on for three consecutive years. More initiatives followed.

This experience gave rise to an initiative aimed at a formalisation and stabilisation of these groups, laying the foundation of the social clubs. A Federation of Cannabis Clubs, consisting at the start in 2003 of 21 clubs, developed guidelines for how to manage these cooperatives within the framework of existing legislation, by only facilitating use in private (Rosmarin and Eastwood 2012). One reason for developing these guidelines was to end the juridical uncertainty regarding cultivation. Spanish law enforcement had been inconsistent in its response to the emergence of cannabis clubs. This Federation of Cannabis Clubs is, like the Union of Cannabis Retailers in the Netherlands, a sign of an emerging cannabis supply lobby.

This was the formal starting point of what became known as Cannabis Social Clubs (CSCs). The basic principle has remained unchanged: it is non-profit cannabis cultivation for personal use of the members of the club, which is in fact a group of producers. These social clubs are now officially registered associations. In 2011 their number was estimated anywhere between 100 and 300 (Barriuso 2011). Barriuso describes the working of the clubs as follows:

“The typical evolution of a cannabis social club starts with it being founded and recorded in the registry of associations. Next, the members who wish to approve a collective agreement on cultivation do so. The club rents or buys land, buildings, equipment and all that is necessary to cultivate and later distribute the harvest. The calculation of how much is cultivated is done on the basis of a prediction of each member’s consumption.

The care of the plants, according to the formula chosen in each club, is carried out by voluntary members, staff hired directly by the club, or professional cultivators (who are usually also members) who are paid for the land rental and the hours worked after producing the relevant invoices. The accounts are kept very thoroughly in case there is an investigation.

Distribution is done on the club’s premises, which are normally in commercial buildings or offices and only club members and accompanying adults can attend. It is distributed in small quantities, for more or less immediate consumption. Most CSC also have a consumption area for members, although they often allow small quantities to be taken away for consumption over the following few days, so members don’t have to attend on a daily basis. There is a maximum consumption limit, which is usually 2 or 3 gr/day, and this can only be exceeded in the case of users with medical needs that require higher doses.” (Barriuso 2011, p4).

#### *Process: consolidation, commercialisation and control*

While the coffee shops in the Netherlands through the years have changed from rather idealistic entrepreneurs into commercial business, most of the CSCs make no profit. However, in recent years one can observe a clear trend towards institutionalisation and commercialisation.

When commercialised the CSC model of course has business potential. “In some ways, they resemble large-scale illicit commercial cultivation, in the way that land, buildings and equipment can be purchased or rented to provide a space for cultivation. People are employed (or volunteer) to cultivate and maintain the cannabis as well as to harvest it. Cannabis is cultivated both indoors and outdoors. In addition to herbal cannabis, resin and other products (oil, creams, etc.) may be produced. Cannabis social clubs follow the allotment principle, whereby members pool resources



and distribute the harvest among themselves and apply strict guidelines, for example prohibiting re-sale.” (EMCDDA 2012b p76)

There are signs that in some cases it is used as a stalking horse tactic to grow cannabis for profit. The cannabis market covered by the CSCs is of course a business area offering promising economic opportunities. Parallel with this ‘institutionalisation’ the judicial framework also evolved, resulting in the conclusion that possession of cannabis, including large quantities, is not a criminal offence if there is no clear intention of trafficking (Rosmarin and Eastwood 2012).

This trend towards commercialisation of CSC contributed to increasing control efforts of municipalities. It is their responsibility to regulate the commercial activities within their local authority boundary. Municipalities as San Sebastian in Basque country and Girona in Catalonia have developed clear rules in a legal framework defining, among others, the minimum age of members (18 years), the minimum distance between CSCs and between CSCs and schools and health services and a ban on any kind of publicity and promotion activities (Appendix 6).

*Context: additional arguments / more good reasons*

The intention to get around the restrictive provisions of the 1992 Public Security Law regarding use and possession in public places seemed to have been the catalyst of the cannabis social clubs. But there were two more arguments for developing social clubs which are worth mentioning. One is the quality aspect, as briefly mentioned earlier. This might have been an additional motive for choosing this cooperative way of producing cannabis. Members of a CSC have more direct control of the quality of the cannabis they are using: they are able ‘to control the origin, quality and composition of what they are consuming’.

And finally there is the argument of decriminalising cannabis supply. By cooperative home growing the production and distribution of cannabis is effectively decriminalised. Some authors refer here to a separation of the markets, separating the cooperative supply from the illegal market. This differs from the separation of the market intended by the Dutch coffee shop policy. While the intentions of the latter were to separate the soft drugs (cannabis) market from the hard drugs market, the social club model allows for a separation of cooperative production and distribution from the criminal market.

### **6.1.3 Developments in the UK**

In the UK nothing really seems to be happening regarding a regulation of cannabis supply, at least not formally, on political level. It is a politically unpopular issue and unlikely to get support from any of the political parties (Appendix 7). This is not surprising, taking into account the events surrounding the classification of cannabis (see 5.3.2). Even the medical application of cannabis is formally not legal, except for certain synthetic cannabinoids under the name Sativex. Still, only in the case of chronic diseases treatment with Sativex is allowed.

So many “therapeutic” users still buy illicit marihuana (Appendix 7). There are reports that some users openly import medical cannabis from the Netherlands.<sup>60</sup>

However there are signs of some movement though this seems to be limited to groups opposing drug prohibition. The Beckley Foundation financed an interesting cost-benefit analysis of licensing and regulation of the cannabis market in England and Wales underlining the advantages of regulation (Bryan et al. 2013).

There are also reports about quite a number of ‘underground’ activities. The Guardian reported in 13 November 2013 under the title “Cannabis clubs blossoming in the UK” that there are 49 of these clubs in the UK “with members meeting to discuss the drug's production, its medicinal use and legalisation – and to get high”.<sup>61</sup>

#### **6.1.4 The process: limited to national initiatives**

Where harm reduction and, to a certain degree, decriminalisation of use moved from (marginal) opposition issues to mainstream positions, regulation of cannabis supply has remained highly controversial in Europe. This is even true for the Netherlands and Spain, where there is a tradition of regulated cannabis supply. The heated debates about this issue which are popping up in both countries again and again underline this. For the Netherlands it could be argued that while in the 1970s there was a policy window this momentum disappeared from the 1980s onwards. The window closed not just because of changes in the political stream, among others an increased focus on supply reduction, on security issues like public order, on enforcement of laws and an overall shift from liberalism to conservatism. Similar changes could also be observed in the policy stream. Also the view of policymakers seems to be dominated by a more conservative mood.

Even the mayors’ initiatives in the Netherlands are bottom-up opposition against the central government rather than signs of developing top-down forces. There is sporadic support by political parties in the Parliament. At the time of writing this report one liberal party in the Dutch Parliament prepared a proposal for a law laying the basis for condoning production and trade / sales of cannabis. This proposal follows the tradition of condoning policies in the Netherlands. Certain acts remain formally illegal but are condoned, meaning that police and justice will refrain from actual investigation and prosecution in specified cases. These cases will be laid down in guidelines of the Public Prosecution Service and define the scope for discretion.

As with the trend towards decriminalisation of use there has not been any significant top-down forces on EU level advocating the use of regulation regimes by Member States. Also in this field there were no initiatives by EU bodies to stimulate or support regulation initiatives. There are, however, debates about alternatives of the prohibition regime in other fields on EU level, as the European Commission’s proposal regarding regulation options for NPS shows (European Commission 2013).

The steps taken to regulate cannabis supply are primarily initiatives in Member States. The history of the coffee shops in the Netherlands and the Cannabis Social Clubs in Spain show this. This does not mean that these developments have only national significance. There has always been international interest in and exchange about these initiatives, as can be taken from the attempts to copy coffee shops in other EU Member States.

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<sup>60</sup> <http://www.clear-uk.org/legal-medical-cannabis-in-britain-achieved/> and <http://norml-uk.org/2013/10/legality-of-medical-cannabis-uk/> [accessed 19 January 2014].

<sup>61</sup> <http://www.theguardian.com/society/shortcuts/2013/nov/17/cannabis-clubs-blossoming-uk> [accessed 19 January 2014].

Another illustration is the plan of the city of Utrecht in the Netherlands to open a coffee shop based on the Spanish cannabis social club model. The CSC model is used as model for regulation of cannabis supply in more EU Member States as the Belgian ‘grow your own’ (‘trekt uw plant’)<sup>62</sup> and the Germany ‘East Side Growers’<sup>63</sup> show. So, there is exchange about different plans and options. Self-organisations like ENCOD<sup>64</sup> facilitate this exchange. There is also a substantial research body and exchange among researchers studying different options.<sup>65</sup> (Decorte et al. 2011).

## 6.2 From unregulated to regulated: tobacco policies in France and the Netherlands

While there are signs that cannabis policy is moving from prohibition to regulation, tobacco policy is travelling in the opposite direction, from a pretty unregulated regime in the early 20<sup>th</sup> century to a nowadays rather restrictive policy, consisting of a set of proven effective control measures. The World Bank has described the following six tobacco control policies, aiming to reduce tobacco use and tobacco-related health damage, which are seen as highly cost-effective:

- Higher taxes on cigarettes and other tobacco products;
- Bans on smoking in public and work places: schools, health facilities, public transport, restaurants, cinemas etc.;
- Comprehensive bans on advertising and promotion of all tobacco products, logos and brand names;
- Better consumer information: counter-advertising, media coverage, research findings;
- Large, direct warning labels on cigarette boxes and other tobacco products;
- Help for smokers who wish to quit, including increased access to Nicotine Replacement (NRT) and other cessation therapies.<sup>66</sup>

Joossens and Raw used this selection of policies to develop their Tobacco Control Scale (TCS), quantifying the implementation of tobacco regulation to compare the implementation of tobacco control policies in 31 European countries. Their report shows the wide implementation of regulation policies (Joossens and Raw 2011). The background and introduction of tobacco control policies is extremely well documented. There is ample research into all aspects of tobacco use and tobacco policy.

We decided to select one of these policies for our case study: the ban on smoking in public places, and particularly in the hospitality sector, focussing in particular on the development of legislation and regulations in France and the Netherlands. This clearly is the policy which attracted the most attention in the debates about tobacco regulation. It is an issue which incites a serious controversy and heated debates between protagonists and opponents. Several stakeholders have become deeply involved in this debate. A variety of factors plays a role here; some of them are emotional rather than rational. This policy addresses not only the health damage to the smoker but also the health damage to others through so-called passive smoking. It at the same time conflicts with the economic interests of tobacco producers (and the government) and is criticised as limiting the freedom of the smoker.

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<sup>62</sup> <http://www.trektuwplant.be/csc/> [accessed 19 January 2014].

<sup>63</sup> <http://www.cannabis-clubs.de/> [accessed 19 January 2014].

<sup>64</sup> <http://www.encoded.org/info/-English-en-.html> [accessed 19 January 2014].

<sup>65</sup> <http://www.issdp.org/>; <http://worldwideweeds.nl/> [accessed 19 January 2014].

<sup>66</sup> <http://siteresources.worldbank.org/INTPH/Resources/376086-1238076532997/TobaccoControl2010Nov15.pdf> [accessed 5 March 2014].

We start with a historic excursus as the history of tobacco use in Europe (and other parts of the world) reveals some interesting features of the complex process how a new substance appears at one point out of nowhere, meets strong refusal, then gets widely accepted and finally again is increasingly coming under attack.

### **6.2.1 *The historical context: emergence and popularisation of a new drug***

Tobacco was introduced in Europe in the early 16<sup>th</sup> century. Spanish traders brought it from Mexico. Besides other forms of use smoking tobacco started to spread over Europe in the second half of the 16<sup>th</sup> century. In the first centuries there is no consistent view on tobacco use – in particular on smoking. There are differences of opinion between what we now would call ‘experts’, differences in ‘policy’ between countries and also differences in time: There was tobacco prohibition in some American States in between periods of legal tobacco production, selling and use. These changes in tobacco regime can also be observed in some European countries. From the start there was opposition against tobacco use. In the early years this opposition was for an important part based on moral grounds. It was a resistance against a new phenomenon emerging in society. Smoking was a completely new way of consuming a substance. This probably made tobacco more suspicious than other new substances like coffee, tea and cocoa which could be drunk (or eaten), the then common ways of using a substance. A concept or terminology for this new phenomenon did not exist as yet. In the available literature one can find references to ‘drinking fog’ or ‘dry drunkenness’. This new habit was seen as pernicious, a deterioration of morals and causing health harm (Borio 2003; Schivelbusch 1982).

Nevertheless, overall one can observe a wide-spread positive view of tobacco in Europe from the 17<sup>th</sup> till the 19<sup>th</sup> century. Tobacco is commended as effective remedy against various conditions, interestingly enough also against shortness of breath and persistent cough (Schivelbusch 1982, p388; Borio 2003). Smoking is also seen as what could be called an early version of today’s intelligence enhancement drug. Schivelbusch refers to two Dutch doctors (Bontekoe and Beintema von Palma), who propagated that tobacco smoking had positive effects on intellectual work, a view widely held in the 17<sup>th</sup> and 18<sup>th</sup> century. Bontekoe was convinced of the positive effects of many then new substances, such as tobacco, coffee and tea.

From the early years on tobacco also became increasingly popular as a ‘goody’, a substance which helps the smoker to enjoy or relax a substance for ‘recreational settings’, as we would call it today. It was a part of culture, a ‘lifestyle drug’ all over the world. Emperor Frederick William I of Prussia advocated the use of tobacco (and beer). He regularly organised so-called “Tabakskollegiums” (tobacco colleges) in the first half of the 18<sup>th</sup> century, meetings with ministers, officers and confidants to discuss political issues, while enjoying smoking tobacco from clay pipes and drinking beer (Walther 1982, p367). This is one of the examples pointing in the direction that tobacco also got features of a ‘lifestyle drug’. Tobacco smoking became an element of enjoying leisure time (Hess 1986).

Schivelbusch points at another interesting aspect of this development. Through the decennia lifestyle changed, life became faster, which is reflected in the evolution of tobacco smoking. While in the 17<sup>th</sup> century people (mostly men) smoked pipe, a rather time consuming way of smoking, in the 19<sup>th</sup> century cigar smoking appeared on the scene, still requiring attention and time, ‘quality time’ as we would call it now. In the 20<sup>th</sup> century the cigarette took over, allowing for a quick moment of relaxation. Cigarette smoking became more and more an element of mass culture. Pipe and cigar smoking became more and more a way or symbol to distinguish oneself from the ‘masses’. Some call it signs of ‘snob appeal’.

From the 19<sup>th</sup> century onwards tobacco smoking spread out over society. Schivelbusch refers to this development as 'the social and spatial expansion of smoking'. One noticeable element in the social expansion was that in the second half of the 19<sup>th</sup> century smoking gained popularity among women. Tobacco smoking had been a men's affair for centuries. Different authors point at a special dimension of cigarette smoking by women. Smoking became an issue in women's emancipation. Claiming the right to smoke was one issue in the struggle for an equal position with men (Schivelbusch 1982). A fascinating description can be found in Amos and Haglund's paper "From social taboo to "torch of freedom": the marketing of cigarettes to women (Amos and Haglund 2000).

### *Smoking and women emancipation*

"When the Irish born American femme fatale Lola Montez had her photograph taken at a Boston studio in 1851, neither she nor anyone else could foresee the future symbolic value of the cigarette as a sign of emancipation for women and the tragic development that we are now facing with women as the next wave of the tobacco epidemic. With the dress and hairstyle that she was wearing in the photograph Lola Montez could have passed for a lady, if it wasn't for the cigarette which stood out so effectively against her black gloved hand. Used as the focal point of this picture, the cigarette was intended to be provocative. Ladies in 1851 did not smoke, and the very notion that women and girls might be experimenting with cigarettes was certainly not acknowledged publicly. Indeed smoking by women in North America and Europe had long been associated with loose morals and dubious sexual behaviour. As far back as the 17th century Dutch painters had used tobacco and smoking to symbolise human folly. The only women shown smoking in these paintings were either whores or procuresses. Similarly in the 19th century women smokers were viewed as fallen women, with smoking the occupational symbol of prostitution. Indeed cigarettes became a common prop in Victorian erotic photography. Only rebellious, bohemian intellectuals and artists such as George Sands dared challenge these social mores. So widespread was the social stigma attached to women smoking that as late as 1908 a woman in New York was arrested for smoking a cigarette in public, and in 1921 a bill was proposed in the US Congress to ban women from smoking in the District of Columbia.

It is therefore remarkable that within 50 years of the invention of the mass produced cigarette, smoking among women in North America and northern Europe has become socially acceptable and even socially desirable. This was due not only to the dramatic changes in the social and economic status of women over this period, but also to the way in which the tobacco industry capitalised on changing social attitudes towards women by promoting smoking as a symbol of emancipation, a "torch of freedom". This message is still being promoted today by the tobacco industry around the world, particularly in countries which have recently undergone or are undergoing rapid social change." (Amos and Haglund 2000).

Besides this social expansion Schivelbusch also points at spatial expansion of smoking. Till the middle of the 19<sup>th</sup> century smoking mainly took place in certain premises where men gathered for a smoke. These could be clubs or lounges but also the special smoke- or gentlemen rooms in bourgeois apartments. Smoking outside in public was disapproved of and sometimes even legally prohibited. The development of tobacco smoking from elite to mass culture, from gentlemen club to street culture, had political connotations. The opposition against bans on smoking in public was, at least in some countries, a remarkably important element in the struggle for societal changes in various European countries in the middle of the 19<sup>th</sup> century (Schivelbusch 1982, pp397).

Tobacco smoking became increasingly popular all over the world, with in some countries regular use

prevalence figures among adults of well above fifty per cent. Cigarette smoking became lifestyle, commended in advertising as expression of freedom and adventure (Marlboro), as an element in having good times and enjoying life (Stuyvesant), as part of a chic way of life (Dunhill), etc.

This positive picture was embraced by the smokers. Smoking was presented and regarded as something attractive. Smoking was popular and widely accepted.

The fact that tobacco and particularly cigarette smoking became an element of mass culture had important consequences in other areas. Mass consumption meant also mass production. The steadily increasing tobacco market presented a huge opportunity to make money. Already in the 17<sup>th</sup> century tobacco production started to play a substantial role in some countries, among others in Spain. In the 19<sup>th</sup> century tobacco production was wide spread and an economically important factor in many countries. In 1860 Virginia and North Carolina counted 348 tobacco factories. For the Netherlands tobacco became an important element in the profits gained from the colonies, in particular from Sumatra. Tobacco advertising emerged and became prominently visible, reflecting the growing economic interest of the producers. From the start of the 20<sup>th</sup> century tobacco producers became an increasingly powerful lobby influencing attempts to control (Borio 2003; Hess 1986).

Tobacco gained economic importance not only for the producers but also, as source of tax revenues, for governments. It started with import taxes. They were introduced already in the 16<sup>th</sup> century, among others in England, where they were increased by 4,000 per cent in 1604. In 1660 the growing of tobacco was forbidden – except for small quantities in physic gardens – to protect the tax income from tobacco import from Virginia. In the late 18<sup>th</sup> century excise taxes were introduced in the United States (Borio 2003).

All these developments resulted in a rather unregulated state regarding tobacco in Europe from the late 19<sup>th</sup> century on. Till the middle of the 20<sup>th</sup> century one of the few visible regulatory measures were the separation of smokers and non-smokers in trains and planes. In different countries, like for instance in France, smoking was traditionally forbidden in theatres and cinemas. However, this ban was introduced for safety reasons. Health was not an issue.

However, in the same period the opposition against tobacco use, in particular against smoking started to emerge. As with alcohol this opposition had strong religious roots and moral connotations comparable with the alcohol temperance movement (National Commission on Marijuana and Drug Abuse 1995). From the late 19<sup>th</sup> century a growing opposition against tobacco smoking can be observed in many States in the US and in other countries (Borio 2003). From the early 20<sup>th</sup> century research evidence started to appear proving the health hazards of tobacco (smoking). The call for stricter regulation became louder, having increasing impact in EU Member States from the middle of the 20<sup>th</sup> century on. Step by step regulation policies became stricter. There were even voices in favour of prohibition (Proctor 2013). In the following section we will explore which factors contributed to the tightening up of tobacco control policies.

### **6.2.2 Context and process: research evidence calling for regulation**

The short summary of the popularisation of tobacco use all over the world shows that social developments, changing lifestyle, moral views, health considerations and economic factors were key ingredients in shaping the tobacco market and the tobacco problem as we know it today. In Europe it took till the middle of the 20<sup>th</sup> century before efforts set in to curb tobacco use, employing a range of restrictive measures. The main driving force behind this trend towards stricter tobacco regulation policies is the mounting evidence for the serious health damage caused particularly by tobacco smoking. In the past century an overwhelming body of evidence has been brought together, showing

the negative health consequences of smoking tobacco. One milestone in this development was the publication of the first study linking lung cancer with smoking in 1939 (National Commission on Marihuana and Drug Abuse 1995).

There are a substantial number of – minor and major – diseases related to smoking. Lung cancer, coronary heart disease and chronic obstructive pulmonary disease (COPD) are the most common health consequences of smoking. The number of ‘smoking attributable deaths’ is substantial. In 2000 it was 656,000 for the then 25 EU Member States (The ASPECT Consortium 2004). In 2010 smoking killed 19,214 people in the Netherlands, where lung cancer was responsible for the highest mortality-share (STIVORO 2011). Of all lifestyle factors tobacco contributes the most to the total burden of disease. A Dutch study found 13 per cent DALY loss due to tobacco use opposed to 4.5 per cent DALY loss due to heavy drinking (de Hollander et al. 2006). Due to an increased risk on several diseases the life-expectancy of smokers in the Netherlands is 6-8 years lower compared to non-smokers (Van Baal et al 2006) and 21 per cent of the total amount of years of life lost is caused by tobacco (de Hollander et al. 2006). Tobacco is therefore the most lethal, avoidable risk factor (Peto et al. 2003). In France smoking-attributable mortality is even higher. Thirty-three per cent of all deaths for 35-69 years old in 2000 was smoking-attributable. Lung cancer mortality went up from around 15,000 in 1950 to close to 50,000 around the 1990s and then slowly dropped (The ASPECT Consortium 2004).

In recent years various studies have been published comparing the harm caused by various licit and illicit drugs. They show that tobacco and alcohol, the most widely used drugs in the world, are among the substances causing the most serious health harm on a large scale (Nutt et al. 2007 Nutt et al. 2010; Van Amsterdam et al. 2010).

#### *An additional contextual element: passive smoking*

There is one additional peculiarity which sets tobacco smoking apart from the use of other substances like alcohol and many illicit drugs. Tobacco smoking does not only involve health risks for the smoker; it also affects the health of people in the surroundings of the actual smoker. This so-called passive smoking also involves the risk of smoking related morbidity and even mortality (The ASPECT Consortium 2004). In second-hand smoke, that consists of the exhaled smoke from smokers and the smoke directly from a burning cigarette, 50 carcinogens have been identified (Gezondheidsraad 2003). Research shows that passive smoking creates an additional risk of 20 per cent on lung cancer and 25 per cent on coronary heart diseases (Spreen and Mot 2008). Furthermore, there are indications that it increases the probability of respiratory diseases.

Passive smoking in the hospitality sector has an extra dimension because employees working in pubs, restaurants, etc. are constantly exposed to high levels of second-hand smoke, which leads to an increased risk on smoking related diseases. Estimations about these risks vary; the European Commission calculated the additional risk on getting lung cancer as 50 per cent for hospitality employees (European Commission 2007). International research has shown that in regions where smoking bans apply, the risk on acute heart failure as a result of passive smoking has decreased by 17 per cent (Meyers et al. 2009; Lightwood and Glantz 2009).

The issue of inevitably harming a third party by simply consuming in the presence of others seems to have been a very powerful element in the change towards a ban on smoking in public places. For other substances you may have some potential side effects affecting third parties, in particular harming others due the effects of the substance on the behaviour of the user, like drink driving or aggressive behaviour under the influence of alcohol. The use of other substances can also increase the risk of aggressive behaviour, e.g. the use of cocaine. In particular the use of crack cocaine is associated with aggressive behaviour. Other substances, like magic mushrooms or LSD but also some

psychopharmaceuticals like rohypnol, can result in psychotiform reactions, which can result in behaviour damaging third parties. However, all these behavioural consequences are not inevitable. In those cases the use merely increases the likelihood of certain behaviour.

#### *Evidence taken: growing concern and awareness*

The mounting evidence on the harmfulness of smoking seems to have had a major impact on the way tobacco smoking became perceived. In the second half of the 20<sup>th</sup> century one can observe a growing concern about the health damage caused by smoking. It translated step by step into awareness among health professionals, policy makers and the general public that something needed to be done. Using Kingdon's model, this can be understood as a coming together of the problem and the policy streams. One important factor contributing to a widely shared sense of urgency is that the research evidence brought together is not seriously debated anymore, except maybe for attempts of producers to sow seeds of doubts and for the anecdotal stories that one has a grandfather who has smoked all his life is still in good health. The body of evidence was and is beyond question. There is a striking quote of Doll in the report of the ASPECT Consortium underlining the overwhelming evidence of the harmfulness of smoking. When examining the numerous harmful effects of tobacco he stated: "That so many diseases - major and minor - should be related to smoking is one of the most astonishing findings of medical research ... less astonishing perhaps than the fact that so many people have ignored it." (The ASPECT Consortium 2004 p38; Doll 1999).

#### **6.2.3 Towards stricter regulation: the process and the content**

Leaving aside the rather scattered attempts of tobacco regulation, which popped up in different countries since the 16<sup>th</sup> century, a serious, well-orchestrated widely supported efforts aiming at the reduction of health damage started to emerge as late as the 1960s. In that time a sense of urgency among politicians started to develop, resulting in a window of opportunity for introducing stricter tobacco control policies. In the US the first steps were taken from the 1960s onwards. Based on the available evidence on the serious health harm caused by smoking the Federal Trade Commission came to the conclusion that cigarette advertising was misleading and that producers and advertisers had a responsibility to warn the public of the health hazards of smoking. The first step was the Cigarette Labelling and Advertising Act, requiring that all cigarette packages and advertisements have to carry a label stating that tobacco smoking is dangerous to health. The introduction of this measure is also an early example of the influence of the producers' lobby. Through the delaying tactics of the producers it took a number of years to get the measure realised. In the end the statement was toned down and the Federal Trade Commission had to agree to refrain from further labelling on packages and health warnings in advertisements for the coming years (National Commission on Marihuana and Drug Abuse 1995; Borio 2003).

Europe followed some years later. From the 1970s onward various restrictive regulation policies have been introduced in many Member States and other countries in the world. The Netherlands were one of the rather 'slow' countries.

#### *Building an international policy framework*

The growing health concerns also resulted in international initiatives to support and guide national responses. The World Health Organisation has contributed substantially to the development of tobacco control policies all over the world, in line with its responsibility "for providing leadership on



global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, ...".<sup>67</sup> WHO's Framework Convention on Tobacco Control (FCTC) of 2003 was a key element in shaping international tobacco control policies.

The catalogue of measures in the FCTC is generally summarized by the acronym 'MPOWER':

- Monitor tobacco use and prevention policies
- Protect people against tobacco smoke
- Offer help to quit tobacco use
- Warn about the dangers of tobacco
- Enforce bans on tobacco advertising, promotion and sponsorship
- Raise taxes on tobacco.

One important goal of the FCTC is to prevent a smoking epidemic in the developing countries. It also provides a framework meant as guidance for countries to develop evidence-based tobacco control policies (WHO 2003). The FCTC has been ratified by 168 countries, among which the Netherlands (January 2005) and France (October 2004)

During a meeting in July 2007 the Conference of Parties of the FCTC adopted guidelines on achieving complete smoke-free environments. This Convention-article states that within five years of ratification signatory countries should protect their citizens against tobacco smoke in indoor workplaces, indoor public places, public transport and, if desirable, in other public areas. Exemptions based on health or juridical arguments are not acceptable. A supplementary recommendation of the WHO underlines the importance of campaigns to inform the public on health consequences of second-hand smoke and the necessity of a smoking ban, to ensure public support and a smooth implementation of smoke-free policies (WHO 2007a).

A weak point of the FCTC is that officially its provisions are binding for the signatory countries but no sanctions apply for non-compliance. Some provisions are not very specific and can be interpreted in different ways (Elzinga 2013) as can be taken from the following article: "Each Party shall adopt and implement in areas of existing national jurisdiction as determined by national law and actively promote at other jurisdictional levels the adoption and implementation of effective legislative, executive, administrative and / or other measures, providing for protection from exposure to tobacco smoke in indoor workplaces, public transport, indoor public places and, as appropriate, other public places." However, the guidelines for implementation developed in the years after the acceptance of the Framework Convention are much more specific (WHO 2013b). The problem is that these guidelines have not been signed by the signatories of the Framework Convention.

The EU has also taken initiatives towards a more restrictive tobacco control policy. However, the European Commission generally has a more limited responsibility in the field of health policies. In line with the EU principles each piece of legislation enacted in the Union has to be based on one of the EU treaties. These treaties still reveal that the origins and *raison d'être* of the EU is primarily the creation of a common market. Health policies are for an important part the responsibility of the Member States. The EU's tobacco control policies are based on Article 152 EC of the Treaty of Maastricht which obliges "the Community to ensure a high level of health protection in all its policies and to cooperate on health policy with international institutions. It also requires Member States to coordinate their health policies and programmes. This article also serves as a legal base for so-called "soft law", resolutions and recommendations on public health policy which set guidelines for the Member States but which are not legally binding. However, article 152(4)(c) explicitly excludes the harmonisation of the laws and regulations of the Member States other than for blood products, organs, and in the veterinary and phytosanitary fields where the objective is the protection of public

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<sup>67</sup> <http://www.who.int/about/en/> [accessed 27 March 2014].

health. Thus in proposing legislation on tobacco control the Commission has used the internal market legal basis, which the Court has found to be suitable for some but not all of its tobacco-control legislation.” (The ASPECT Consortium 2004 p100).

The weak point in choosing this legal basis for tobacco control policy – aiming at reducing smoking-related death and disease – is that restricting for instance advertising and use of tobacco products for health reasons can be in conflict with the open market principle of the EU as this limits the free movement and promotion of legal products. As a result of this narrow foundation on internal market regulation, four out of six regulations were challenged by the tobacco industry or by Member States. Still, some considerable improvements in tobacco control have been made since 1985, when tobacco control became a central topic in the public health policy of the European community. The endorsement of the Tobacco Products Directive in 2002 meant an important step forward, resulting among others in mandatory labelling, stating the levels of tar, nicotine and carbon monoxide (WHO 2007b, Directive 2001/37/EC ...).

Finally, in 2013, after a long and complicated process of talks, in which tobacco industry lobbyists played an important role, a compromise was reached on a revision of the Tobacco Products Directive, extending the scope of the Directive to new products like the e-cigarette (see 4.4.3). The final revised Directive includes among others bans on any misleading labelling, on cross-border distance sales and on adding flavours which are meant to make the taste of cigarettes more attractive. In the near future health warnings (combinations of pictures and text) will have to cover 65 per cent of the front and the back of the cigarette packages (Directive 2014/40/EU ...).

The initiatives of WHO and the EU have reinforced each other. In November 2009, a council recommendation on smoke-free environments was adopted by the EU, which recommended Member States to fully protect their citizens from tobacco smoke in enclosed public places, workplaces and public transport as stated in the FCTC. This recommendation included a term of three years after the adoption of the treaty. In addition, the EU encourages States to enhance smoking bans with supporting measures and to strengthen cooperation at EU level (European Commission 2013).

Both WHO and the European Commission have contributed to the efforts to reduce tobacco use by commissioning research, by bringing together the evidence base for effective policies and by developing overview and guidance documents to stimulate and support the development of tobacco control policies on national level. These efforts contributed as a top-down force towards converging tobacco control policy approaches in the EU and other parts of the world.

Finally initiatives taken in individual Member States may also have supported a wider implementation of tobacco control policies. Similar to the regulation trend in cannabis policy (see 6.1) and the decriminalisation trend (see 7.2.4) these national examples seem to have worked as catalysts for debates and initiatives in other countries. Ireland and the UK were the first EU Member States to implement a total smoking ban in the hospitality sector (The International Tobacco Control Policy Evaluation Project 2012). Both countries implemented a total smoking ban for all indoor work and public places (European Commission 2009a). In Ireland the smoke-free measure exists since March 2004 and is evaluated as very effective. It resulted in a smoking-decline from 85 per cent to 3 per cent in restaurants and 98 per cent to 5 per cent in bars and pubs (The International Tobacco Control Policy Evaluation Project 2012). Also the implementation in the UK was very effective, implemented between March 2006 and July 2007 (European Commission 2009a). The smoke-free policies in these two countries had a wider impact, leading to an international exchange about these initiatives.

## France

Also in France it were health concerns which formed the background for the first step taken in 1976 with Article 16 of the Veil Act<sup>68</sup> which states: “Decrees will determine when and where forbidding to smoke will be set in (special) places for collective use where smoking can have hazardous consequences for health. In premises or vehicles where smokers and non-smokers are welcome in distinct areas, the space assigned for non-smokers can't be smaller than half of the whole.” (Appendix 1) This resulted in a decree released in 1977 stating that smoking is forbidden among others in any public premise when the ventilation does not meet specific features, in primary and in lower / junior secondary schools, in any place attended by pupils when they are present, etc.

In 1991, the main law for tobacco regulation, the loi Evin<sup>69</sup>, was endorsed and came into force in 1992. This law regulates a smoking ban in all public and work places except in places where it is explicitly allowed. Smoking areas can be introduced in places such as bars and restaurants under certain conditions of ventilation (The ASPECT Consortium 2004 p263). Based on the 1991 Evin Act a new bylaw<sup>70</sup> was prepared, which significantly strengthened the former rules. It was the first step towards a stricter regulation that followed in 2006. A parliamentary study group about the issue of passive smoking was held from May 2006 to July 2006. It was chaired by a MP (Claude Évin), who had been the Minister responsible for the 1991 Act, the "loi Évin". The group's recommendations formed the basis for a new decree in 2006. After three law proposals had failed due to opposition against stricter regulations the Government seemed to have been under pressure to make a decision. The WHO Framework Convention on Tobacco Control is likely to have contributed to the introduction of the new regulation. The decree was endorsed in 2006 and went into force from February 1<sup>st</sup> 2007, with the exception of in 'beverages on-premises' sites, casinos, game clubs, tobacco selling places, night-clubs, hotels and restaurants. In these hospitality venues the new rules became enforceable from January 1<sup>st</sup> 2008. This law still allows for smoking zones under strict conditions: a closed venue equipped with a ventilation device and not allowed for minors under 16. It is said that these very strict requirements for smoking rooms (size, ventilation norms, closure of the doors, cleaning) are almost impossible to meet (Joossens and Raw 2011).

There was quite a lot of opposition against these regulations, resulting in, among others, a lack of cooperation by the agencies responsible for controlling the implementation of the stricter rules. The inspectors of regulations regarding work places ('inspecteurs du travail') refused to report work places where the legislation was not or poorly applied. The police did not get orders to control the compliance of hospitality venues to the smoke-free rules and did not caution or impose fines in case of breaches of the law. Police and judiciary authorities did not rank the smoking ban in hospitality venues as a priority (Appendix 1). Another factor impeding the implementation was that funding for tobacco control had been substantially reduced and is under further attack (Joossens and Raw 2011).

Still, Joossens and Raw conclude that France “successfully implemented smoke free legislation in 2007-2008 despite enforcement problems with outside terraces”. A supportive factor may have been the compliance of smokers who widely accepted the fact that they had to smoke outside. Owners and managers of hospitality venues are also reported to have changed their mind about the smoke-free policy.

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<sup>68</sup> Loi 76-616 du 9 juillet 1976 relative à la lutte contre le tabagisme.

<sup>69</sup> Loi 91-32 du 10 janvier 1991 relative à la lutte contre le tabagisme et l'alcoolisme.

<sup>70</sup> décret n° 2006-1386 du 15 novembre 2006.

France is ranked 6<sup>th</sup> (of 30) on the Tobacco Control Scales 2010 in Europe (total score) and 7<sup>th</sup> regarding the implementation of smoke-free public places, scoring 6 on a scale of 8 for 'Bars and restaurants (Joossens and Raw 2011).

*The Netherlands: the messy route to a ban on smoking in hospitality venues*

In the Netherlands it wasn't until the late 1980s that the first Tobacco Act was developed. Before that time there were no legal regulations regarding smoking despite the fact that one could observe growing awareness and concerns about the health impact of smoking. The Tobacco Act was implemented in January 1990 (STIVORO 2012), requiring smoke-free governmental, health care, educational and social service institutions (Rennen and Willemsen 2012). This 1990 smoke free legislation remained unchanged for quite some time, although in 1997 the Minister of Health (from D66, a social-liberal political party) already proposed to introduce smoke-free workplaces. It took until 2002 to pass this change of the Tobacco Act in the parliament and another two years to get it implemented (STIVORO 2012).

What followed then was a process of around twenty years of rapid changes forward, to a more strict control policy, and back again to a more lenient approach. The decisive factor which made this process so messy was the unstable political situation with fast changing governments. In the past two decades most governments did not complete the full government term of four years. Other complicating factors were the increasingly vehement conflicts between opponents and supporters of smoke-free hospitality venues. The tobacco industry and interest groups of the hospitality sector were effective in their lobby, having good connections with liberal-conservative politicians. This was used to smooth and slow down the process of implementation, in particular in periods when conservative and liberal parties were in charge (see also 6.2.5).

Still the Netherlands is ranked 13<sup>th</sup> (of 30) on the Tobacco Control Scales 2010 in Europe (total score) and 14<sup>th</sup> regarding the implementation of smoke-free public places, scoring 5 on a scale of 8 for 'Bars and restaurants (Joossens and Raw 2011).

### *The zig-zag course of tobacco control policy in the Netherlands*

In January 2004 the revised Tobacco Act entered into force (Prins and Willemsen 2004), enjoining smoke-free indoor workplaces and public transport, but leaving authority to the Minister of Health to allow exemptions or expansions of provisions. The then conservative-liberal Minister of Health made ample use of these possibilities, among others by initially excluding hospitality venues like pubs and restaurants from the ban. The 'Koninklijke Horeca Nederland' (KHN, 'Royal Hotel and Catering Industry Netherlands'), the organisation representing the interests of hospitality entrepreneurs in the Netherlands, claimed that a direct enforcement of such a ban would result in economic problems for the sector due to decreasing numbers of customers (Van der Meij 2009; Rennen and Willemsen 2012). KHN emphasised that voluntary self-regulation of the sector would be more effective in the long run than regulation enforced by law (Gonzalez and Glantz 2011). This exemption for the hospitality sector was supposed to be temporary, allowing in the meantime a self-regulating process to reduce smoking in pubs, restaurants, etc. This gradual self-regulation was also proposed as a suitable approach to prepare customers, employees and employers for a non-smoking policy.

However, the monitoring of the process showed that the goals set for 2005 were not met. The sector was given one more chance to improve the results through self-regulation, if the targets would not be achieved in the following year, the exemption rule would be annulled. Although one year later some progress had been made, the conclusion of the Ministry of Health was that the self-regulation process did not work sufficiently (Weyers 2010).

The growing criticism on the lenient attitude of the Ministry seems to have played a role here. In 2006 a coalition of organisations, pursuing stricter regulation policies, consisting of researchers, health NGOs and anti-smoking pressure groups, launched a general tobacco policy agenda, which among others included the abrogation of the exemption rule for the hospitality sector. Their lobby to get this issue on the political agenda was successful. Media attention may well have contributed to this too (Gonzalez and Glantz 2011). A change of government was also of influence. In February 2007, a new government was installed, formed by a coalition of Christian Democrats and Social Democrats. This new government prioritised the realisation of a smoke-free hospitality sector (Van der Meij 2009). After ample discussions with all the relevant stakeholders the new Christian Democrat Minister of Health decided in mid-2007 to abolish the exemption rule (Elzinga 2013).

The smoke-free policy for hospitality venues entered into force by July 2008 by amendment of the 2002 Tobacco Act. It applied to the sector as total, thus also including owner-run pubs (without personnel) which first were exempted because the issue of a smoke-free work environment did not apply to them (Van der Meij 2009). The only exemption made was for venues with a separate smoking room for clients without attendants. The Minister decided to start off with an introduction period, to give venues the time to get used to enforcing the smoke-free policy. In that period offenders were just cautioned and not yet fined. After three months the authorities started penalising offences with fines. To prepare the implementation of the smoking ban the Ministry of Health also commissioned a media campaign in late 2007 and early 2008 to inform the public about the new policy. Strange enough this campaign did not follow the above mentioned recommendation of the WHO to inform the public about the serious health consequences of passive smoking and the need of a smoking ban, to try to get public support for a smoke-free hospitality sector (WHO 2007a). At the same time also other measures to discourage tobacco smoking were implemented, such as a tax increase and another campaign to promote quitting and support quitters (Gonzalez and Glantz 2011; Van der Meij 2009).

In the first three months after the introduction of the new regulations, the compliance of the hospitality venues in the Netherlands was high with 95 per cent (Voedsel- en Waren Autoriteit<sup>71</sup> 2008) and comparable to compliance scores in other countries implementing these measures (Gonzalez and Glantz 2011). The compliance of pubs, bars and clubs, however, was rather low from the start, only 74 per cent. A substantial part of this so-called 'wet' hospitality sector, primarily serving drinks, refused adhering to the new rules, claiming that making their venues smoke-free would result in unacceptable economic losses. The compliance of this sector dropped even further to 53 per cent in November 2008 (Voedsel- en Waren Autoriteit 2008; Elzinga 2013).

Research indeed showed declining revenues. However, there are reasons to doubt that this decline can be solely attributed to the smoking ban. Research, commissioned by the 'Royal Hospitality Netherlands' (KHN), found that 42 per cent of the hospitality entrepreneurs faced a sales decrease in 2008 of, on average, 21 per cent compared to 2007 (Sanderse 2008). According to the hospitality entrepreneurs half of this decline was caused by the smoking ban. Nevertheless, also 31 per cent of the entrepreneurs reported equal sales and 23 per cent even an increase in sales compared to the year before. According to two other studies (from Statistics Netherlands<sup>72</sup> and TNS NIPO<sup>73</sup>) the economic losses started in fact before the smoke-free regulations were implemented. Price increases, the economic crisis which set in in 2007, decreasing consumer confidence and season / weather factors may also have been of influence.

What followed were years of a rather messy process of policy making, characterised by political and judicial struggle between supporters and opponents of a smoke-free hospitality sector. The Minister of Health responded to noncompliance with stricter enforcement of the smoke-free regulation, resulting in criminal prosecution and closure of repeatedly noncompliant pubs and clubs. This helped to increase compliance. However, the case of one owner-run small pub (without personnel) in 2009 led to a change. Initially the owner was convicted. The organisation of small pub owners, receiving financial, strategic and juridical support from the tobacco industry, started an appeal. This resulted in acquittal. According to the judge the tobacco act did not apply to bars without personnel. The Minister announced plans to adapt the law, while appealing to a higher court. While waiting for this judgment the Ministry ordered to put on hold the controls of small pubs without employees. The litigation ended in February 2010, when the Supreme Court ruled that the tobacco act was also applicable to small pubs without personnel. After the final sentence the compliance rates went up to 72 per cent (Elzinga 2013; Gonzalez and Glantz 2011).

In Spring 2010 the Christian-Social Democrat coalition fell and was replaced by a Liberal-Christian Democrat government in October 2010. This government with a clear liberal-conservative agenda again granted dispensation of the smoke-free policy for small pubs, resulting in a drop of compliance by pubs and clubs to 50 per cent, while other hospitality venues showed a compliance of 90 per cent (INTRAVAL 2011; Gonzalez and Glantz 2011).

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<sup>71</sup> Netherlands Food and Consumer Product Safety Authority

<sup>72</sup> Statistics Netherlands is an independent agency, responsible for collecting and processing data in order to publish statistics to be used in practice, by policymakers and for scientific research. In addition to its responsibility for (official) national statistics, Statistics Netherlands also has the task of producing European (community) statistics.

<sup>73</sup> TNS NIPO is a leading Dutch market research agency.

Research showed that the enforcement of the smoke-free policy measures was ineffective and that less and less pubs and bars complied with the rules, leading again to a more strict enforcement. In July 2011 the Minister of Health decided to double the fines for hospitality entrepreneurs violating the rules. The Tobacco Act of July 2011 stated that all workplaces, including hospitality venues, must be smoke-free. Still, there were special designated smoking rooms in hospitality venues for customers, as long they were not served there. The Tobacco Act and the Regulation Implementing Smoke-free Workplaces included the provision that publicly accessible premises, i.e. also owner run pubs without personnel, had to be smoke-free. Still, the Ministry held to the exemption rule excluding particularly small (not bigger than 70m<sup>2</sup>) owner run pubs without personnel and almost exclusively providing beverages, from the smoking ban (Elzinga 2013).

After another sudden change of administration in September 2012 a coalition of the Liberal and the Social Democrat party took over. They intend to introduce again a smoke-free policy for the hospitality sector as a whole, also including all owner-run pubs. The target date for introducing this change is 1 July 2014.

#### **6.2.4 Stakeholders and interests: the clash between the pros and cons**

The messy process towards more restrictive tobacco control policies in the Netherlands reflects – besides the unstable political climate in the Netherlands – a sharp conflict between different stakeholders. The coming about of a smoke-free hospitality sector has been a process characterised by a fierce clash between the proponents and opponents of a smoke-free hospitality sector and by the repeatedly changing positions of power of stakeholders involved in both camps. It clearly is the most focal battlefield in the controversy between the supporters and challengers of more restrictive tobacco policies. A wide variety of stakeholders have been involved at both fronts. The most outspoken and powerful opposing stakeholders are the tobacco industry and the organisations representing the interests of hospitality entrepreneurs, particularly the powerful KHN, representing 20,000 associated hospitality venues, i.e. the majority of the Dutch hospitality sector. The most influential stakeholders in support of more restrictive regulations are researchers, health services and anti-smoking pressure groups, which form together the so-called ‘smoke-free coalition’.

There are many more actors or stakeholders involved in the issue of a smoke-free hospitality sector and other restrictive tobacco regulations. However their involvement and influence is more limited. Examples are health insurance companies with an interest in reducing health care costs and the pharmaceutical industry involved in making products like nicotine patches and nicotine chewing gum used as aid to quit smoking. There are also interest groups of smokers, opposing the smoking ban in hospitality venues. They are generally not so well organised and therefore less powerful. Though, there are examples like in the Netherlands the ‘Stichting Rokers Belangen’ (SRB, Foundation of Smokers Interests), which became more influential through the active support of the tobacco industry.

#### *The role of politics: politicians and government*

Politicians can be found in both camps. The process towards stricter regulation policies illustrates this (see 6.2.3). Generally, the traditional conservative parties like the Liberals and Christian Democrats in the Netherlands and the Liberals and the National Front in France oppose and retard the steps towards stricter regulations, while parties with usually more progressive agendas like the Social

Democrats, the Socialists, the Progressive Liberals and the Greens support these steps.

This picture is a bit of a simplification. Reality has more nuances. There are exceptions 'confirming the rule'. It was for instance a Christian Democrat Minister of Health who decided in 2007 to end the exemption rule for small pubs.

The government, though clearly powerful in defining policies, is not so much a stakeholder but more the final decision maker, influenced by the interests and agendas of various stakeholders, first of all of course by the 'political colour', the interests and agendas of the political party or parties forming the government. A change of government can result in a change of tobacco control policies, as the developments in the Netherlands show (see 6.2.3).

The government is also a 'conglomerate' of Ministries, representing the interests of the domains they cover and looking after the interests of the stakeholders operating in these domains. Three Ministries are involved in tobacco policy: The Ministry of Health, the Ministry of Finances and the Ministry of Economic Affairs. In the Netherlands the Ministry of Health has since the 1990's the final responsibility for tobacco policy, the tobacco law and of course health measures taken regarding tobacco use. The Ministry of Finance has no direct responsibility for tobacco policy in order to avoid conflict of interests. It is responsible for taxes and excise duties applicable to tobacco. In 2004 the total tax on cigarettes was 73 per cent of the retail price in the EU15 (The ASPECT Consortium 2004). As both France and the Netherlands have a substantial tobacco manufacturing industry contributing significantly to the countries' export volume, the Ministry of Economic Affairs also plays a role in tobacco policy, keeping an eye on securing the economic interests. In the Netherlands the Food and Consumer Product Safety Authority is part of the Ministry of Economic Affairs with the task to monitor and enforce the compliance to the tobacco law (Elzinga 2013).

The interests of the different ministerial domains may conflict. During the economic crisis of the past years the balance between the economic interests (tax income, employment, etc.) and the health interests may have swayed more towards maintaining the economic interests. There may also be contradictions in the interests and influence of the political parties forming a government and the interests and influence of the stakeholders in one ministerial domain. The unpredictable developments in Dutch politics since the early 1980s with rapidly changing governments help to explain the muddled process towards a more restrictive tobacco policy in the Netherlands. The fast changes of coalitions, from more right wing to more left wing and back again, meant changes of influence of these different interests. In some cases the government seemed at best an instrument used by the two camps to realise their interests.

### *The media*

The media are also divided over both camps. They generally do not have a clear-cut stance in favour or against stricter tobacco control policies, though the issue of smoke-free hospitality venues received quite some media coverage, not just in the form of news articles but also through background articles and documentaries about the context and impact of these policies. The political orientation of media determines their view. Some media are more supportive of 'right wing' politics, others are more in favour of 'left wing' politics. Some journalists will be more interested in the subject than others. It is however not easy to gauge the influence of the media. Media are of course not neutral. A study on the content and the coverage of the smoke-free regulation in Dutch newspapers between March 2008 and April 2009 concluded that 57 per cent of the articles was negative about the regulation. Almost one third of the articles, 29 per cent, took a positive position on the ban, while 5 per cent was mixed and 9 per cent was neutral (Nagelhout et al. 2012). The media's position towards the smoking ban differed substantially, but the majority of articles published in the researched period had a negative view on the ban. Journalists with a negative view



accused the government among others of 'being a babysitter' and 'challenging individual freedom' (Nagelhout et al. 2011).

There are reports that media advocacy has been used by the tobacco industry to promote their vision. The tobacco industry was accused of framing the media coverage on the ban by focusing on the economical side-effects (Nagelhout et al. 2011; Nagelhout et al. 2012).

On the other hand, media also covered the view of the proponents of stricter smoke-free regulations, criticising the government for disregarding the health damage done to non-smokers, leaving smokers to their fate and weighing the commercial interests of the industry above the health benefits for their population (Arnott et al. 2012). There are studies that show how mass media can impact the policy making process (Buse et al. 2005). The media can bring issues and public opinion's views to the attention of the government and evoke a response. The media seem to be especially potent to set the governmental agenda. Media can also frame certain messages and influence how people view certain issues. They can also influence the significance of an issue by extensive coverage. In tobacco control, media advocacy was used as a strategy among others to get attention and set the agenda (Mamudu et al. 2011).

In conclusion, both supporters and opponents have used the media to communicate their position and arguments. Related to tobacco-policy, the media have proven to be effective in influencing the public opinion and the government agenda (Buse et al. 2005; Nagelhout et al. 2012). The media can be considered to be a medium rather than a real stakeholder.

### *The important role of lobbying*

The development towards stricter tobacco regulation policies is not so much characterised by bottom-up and top-down processes, but rather by a clash between two conflicting interests: at the one side the protection of health and at the other side the protection of economic interests. Though in the early years of the controversy the stakeholders defending the health interests can be seen as counter-force, struggling against the (also) then dominant power of the tobacco producers (Borio 2003; Hess 1986).

There is one more distinctive feature in the development towards stricter tobacco regulation policies. Lobbying plays a key role in influencing and shaping these policies. Different from control policy making in the field of illicit drugs, where an overt producers lobby is essentially impossible (see 6.1.1), the controversy about tobacco control policy is for an important part fought by lobbying. The lobbies of the two camps employ increasingly well thought-out strategies to influence policymakers and politicians.

The tobacco industry lobby is clearly the most powerful player in this game, boasting a long tradition (Borio 2003) and, compared to the lobby of the proponents of more strict tobacco control policies, with ample funds for professional campaigns. Besides consumer marketing, influencing policy decisions is a key strategy to keep the business profitable, especially in a situation where the industry faces the threat of more restrictive control policies (The ASPECT Consortium 2004).

#### **6.2.5 The lobby against a stricter tobacco regulation**

The lobby against stricter tobacco regulation in the hospitality sector consists of three stakeholder groups: the tobacco industry, the organisations representing the interests of hospitality entrepreneurs and interest groups of smokers. The latter are the least important. They are generally

not so well organised and have modest (economic) power despite the fact that they receive support from the tobacco industry. We therefore decided to focus here on the tobacco industry and the hospitality sector.

### *The tobacco industry in the Member States*

“Thus lobbying or ‘stakeholder marketing’ is as much standard business practice as consumer marketing. ... Any industry would do the same in such circumstances, even if the tobacco industry's methods, which, as we will see, include a predilection for smuggling, would be unacceptable in other corporate sectors.

However, tobacco is not a standard business. Cigarettes are uniquely harmful, in that they kill even when used precisely as the manufacturer recommends. No other product does this. Alcohol, cars and even food products (given the obesity epidemic) kill people, but only when abused. In addition, ... , the sheer scale of the harm done by tobacco is unprecedented. It is this public health threat that has led to increasingly severe limitations on tobacco's consumer marketing. However, by contrast, stakeholder marketing remains entirely unfettered, and, arguably, from the tobacco industry's perspective, all the more important.” (The ASPECT Consortium 2004 p195).

The lobby of the tobacco industry and of tobacco producer interest groups is the most influential opponent of stricter tobacco regulations. Both France and the Netherlands have a substantial tobacco industry. France is one of the five primary tobacco producing EU Member States, but tobacco growing has decreased dramatically in France in the past decades. Moreover, tobacco farming represents only a small share of agricultural activity in the EU. In the 15 ‘old’ Member States about 0.1 per cent of the agricultural area is in use for tobacco growing (The ASPECT Consortium 2004).

In the Netherlands companies like British American Tobacco, Philip Morris, Imperial Tobacco Netherlands and Japan Tobacco International are active. British American Tobacco and Philip Morris are the two big ones. The Philip Morris plant in Bergen op Zoom is the largest Philip Morris factory in terms of production capacity but will be closed in autumn 2014 due to the decreased demand for cigarettes. The bulk of their production is exported. British American Tobacco has a major factory in Groningen. Imperial Tobacco Netherlands is particularly known for producing shag (or rolling) tobacco.

Besides these companies there are two tobacco producers interest groups active in the Netherlands. One represents the shag tobacco industry (The Dutch Shag Manufacturers Association); the other one represents the substantially bigger cigarette branch organisation ‘Stichting Sigaretten Industry’ (SSI, ‘Foundation Cigarette Industry’). SSI represents all cigarette producers except Philip Morris, which since September 2005 operates independently due to diverging opinions on tobacco policies. Philip Morris has decided to comply with the tobacco discouragement policies (Elzinga 2013).

In France, Philip Morris International is the leader of the cigarette market (40.2 per cent of the market thanks to Marlboro and other Philip Morris brands). The Seita group (ex-Altadis Imperial Tobacco) represents 25.2 per cent market share, followed by Japan Tobacco International (Camel, Winston, etc.) and British American Tobacco (Lucky Strike, Benson & Hedge, etc.) with 17.1 per cent and 16.4 per cent market share respectively in 2013.

A network of around 40 distributors, the most famous being Logista France (ex-Altadis distribution) distributes the brands of the tobacco industry. The other distributors are specialised in pipe-tobacco or cigars.

Though there are some differences between the tactics and arguments of these different tobacco production stakeholders, overall their objectives and policies are identical. Their intention is to influence policy decisions and undermine the smoking ban. One of their tactics is to create, influence, mobilise and / or fund 'front groups', such as associations of pub owners or smokers' right groups. These groups receive support to fight the smoking bans in the interests of the industry.

They suggest alternatives for a smoking ban, like ventilation, air filtration or separate rooms for smokers and non-smokers. Another often used tactic is to challenge the legal provisions, by arguing that these provisions are difficult or even impossible to enforce and / or violating the fundamental rights of both the smoker and the hospitality entrepreneur. A popular strategy is also to plead for self-regulation as a more effective strategy than a legal ban. In addition, the industry tries to weaken bans by lobby efforts or through donations to political parties. Finally, tactics include advertising, lawsuits, and attempts to put a stop to the researcher's funding (WHO 2012; Landman and Glantz 2009)<sup>74</sup>.

These tactics can also be found in the Netherlands, where the industry among others stated that the hospitality sector would have difficulties with enforcing the legal provisions and suffer severe revenue losses. They also initiated and supported the protest of the hospitality sector (Baltesen and Rosenberg 2009b) and supported smokers interest groups in the fight for their 'right to smoke'. Another tactic was 'informing' the media, which frequently happened indirectly through organisations sponsored by or otherwise related to the industry (Elzinga 2013).

And then, most importantly, there are the attempts of directly influencing policy-making through lobbying. The tobacco industry or tobacco producer interest groups liaise with political parties or individual politicians to gain support for their interests. There are different factors which make politicians susceptible to lobbying. Besides presenting possible personal advantages for politicians, arguments like the economic importance of tax revenues and employment also contribute to successful lobbying.

In the Netherlands there have been several examples of politicians having close ties with the tobacco industry. Among others the previous Christian Democrat Minister of Defence (2010-2012) was a paid advisor of British American Tobacco up until only some months before his appointment as Minister. The spokesman of British American Tobacco stated that this minister was an important factor in realising their strategy. Piquant detail was that the minister did not report his activities for BAT though candidate ministers are obliged to reveal this information.<sup>75</sup> Another example is the current Minister of Health, who has been nicknamed in a TV documentary the 'Minister of tobacco' because of her policy of toning down the tobacco control measures, in particular the smoke-free regulations for the hospitality sector. In this documentary she was praised for her rather supportive attitude towards the tobacco industry and the hospitality sector. One of the interviewed tobacco industry lobbyists boasted about the regular and very helpful contacts with the Minister. Several quality media have revealed her rather close contacts with the tobacco industry and important members of tobacco-pressure groups.<sup>76</sup> Still, the Minister herself has always denied these contacts. Interestingly

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<sup>74</sup> Tobacco Industry Tactics Used to Undermine Smoke-free Policies.

[http://global.tobaccofreekids.org/en/resources\\_detail/tobacco\\_industry\\_tactics\\_used\\_to\\_undermine\\_smoke\\_free\\_policies](http://global.tobaccofreekids.org/en/resources_detail/tobacco_industry_tactics_used_to_undermine_smoke_free_policies) [accessed 21 March 2014].

<sup>75</sup> Hillen verzweeg advieswerk. [NRC 22 November 2010](http://vorige.nrc.nl/binnenland/article2643635.ece/Hillen_verzweeg_advieswerk). [http://vorige.nrc.nl/binnenland/article2643635.ece/Hillen\\_verzweeg\\_advieswerk](http://vorige.nrc.nl/binnenland/article2643635.ece/Hillen_verzweeg_advieswerk) [accessed 5 June 2012].

<sup>76</sup> Bouma, J. Tabakslobby spreekt mee in Den Haag. [Trouw 21 December 2012](http://www.trouw.nl/tr/nl/4500/Politiek/article/detail/3087760/2011/12/21/Tabakslobby-spreekt-mee-in-Den-Haag.dhtml).

<http://www.trouw.nl/tr/nl/4500/Politiek/article/detail/3087760/2011/12/21/Tabakslobby-spreekt-mee-in-Den-Haag.dhtml> [accessed 21 March 2014]; Innige band minister en tabakslobby. [Trouw 20 October 2011](http://www.trouw.nl/tr/nl/5009/Archief/archief/article/detail/2982378/2011/10/22/Innige-band-minister-en-tabakslobby.dhtml).

<http://www.trouw.nl/tr/nl/5009/Archief/archief/article/detail/2982378/2011/10/22/Innige-band-minister-en-tabakslobby.dhtml>

enough, before her appointment as Minister she worked for VNO NCW, an employers' interest organisation, as secretary of public health and labour market. It was in that position that she took a negative stance towards smoke-free workplaces.<sup>77</sup>

Also for France various examples of tobacco industry lobbying can be found. As in some other countries the industry, and Philip Morris in particular, is very active in utilizing the media. Regular press luncheons are organised to brief the media or a number of selected journalists on the findings from research financed by the industry, which rebut the findings from the WHO and other organisations of standing. Additionally journalists are invited among others to sport and cultural events sponsored by Philip Morris. This 'courtship of journalists' is reported to have brought about considerable and positive press coverage and tight, personal contacts with prominent journalists (The ASPECT Consortium 2004).

Besides attempts to influence public opinion and political decisions directly, also more indirect strategies have proven to be successful. One interesting example are the science prizes awarded by Philip Morris, which were for the first time introduced in France. This was a full success, as it received the official patronage of the Ministry of Industry and Scientific Research and opened the door for 'excellent contacts with the scientific advisor to President Mitterand'. This successful initiative was repeated in different EU Member States (The ASPECT Consortium 2004).

#### *The tobacco industry lobby on EU level*

The ASPECT consortium's report 'Tobacco or Health in the European Union' gives a thorough insight how the tobacco industry lobby works on EU level (2004). According to this report the industry lobby started rather slow and was not a unified sector effort. It was done by the companies separately, with Philip Morris as the most important player, having a market share of 36.5 per cent in 2003. This may have contributed to the rather smooth introduction of the first EU tobacco control directives on labelling, advertising, tar yields and taxation around 1990.

The process of the revision of the Tobacco Products Directive in 2013 shows that the lobbying of the tobacco industry has become much more effective through the years. A thoroughly planned approach was developed, based on a systematic analysis of threats and opportunities. The industry saw it as one of the biggest threats that the growing health concerns would make the EU take the same direction as the United States, introducing strict advertising bans and smoke-free work and public places. Important strategies to 'avoid or delay' a strict advertising ban, as was introduced in the US, were among others to maintain a 'blocking minority' against an EC advertising ban and to prepare compromise proposals for the negotiations about EU directives to weaken the ban, e.g. pleading for voluntary, self-regulation measures – which would ensure better commitment in the long run – instead of enforceable legal provisions.

The report also underlines that the complexity of EU decision making meant an opportunity for the tobacco industry: "The complexity of the EU decision making was arguably a mixed blessing for the tobacco industry. On the one hand, it meant that threats could come from many directions; on the other, it offered multiple points of potential influence. However, given that the industry was trying to prevent rather than introduce legislation, the complexity tended to work in their favour. They could

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[accessed 21 March 2014]; Minister van Tabak. VPRO Documentary transcription. ZEMBLA 2011. <http://zembla.vara.nl/Minister-van-tabak.10328.0.html> [accessed 15 May 2012].

<sup>77</sup> Minister van Tabak. VPRO Documentary transcription. ZEMBLA 2011. <http://zembla.vara.nl/Minister-van-tabak.10328.0.html> [accessed 15 May 2012].

work at constructing legislative obstacles for at least six different levels: the Member States, the Council of Ministers, the European Parliament, the European Commission, EU officials or civil servants and a range of advisors and expert committees.

There is evidence that the industry has tried to influence all the above mentioned gremia. However, they have put most energy into, and had most success with, the first two groups.

The Member States have a fundamental impact on EU decision making, so the general principle of encouraging moderation about tobacco control at country level is attractive.” (The ASPECT Consortium 2004 p202).

#### *The hospitality sector*

The hospitality sector is another powerful opponent of a stricter smoke-free policy in pubs, restaurants, etc. (see also 8.2.3 and 8.2.4). The developments in the Netherlands provide an illustrative example for this. Besides the quite influential ‘Koninklijke Horeca Nederland’ (KHN) there are the smaller interest groups: ‘Red de Kleine Horeca Ondernemer’ (KHO, ‘Save the Small Hospitality Entrepreneur’). The KHN has played an important role in negotiating with the Minister of Health in the process of developing the smoking ban to safeguard the interests of the hospitality sector (Gonzalez and Glantz 2011).

In their position paper the KHN underlines the complexity of the issue, referring to the involvement of fundamental rights, the people’s right to a healthy living environment, the smoker’s right to consume a legal product and the entrepreneur’s authority over their own premises. The paper states that the government has to find a compromise between these sometimes conflicting rights. It also emphasises that rules have to be clear and well enforced. Solutions to better manage the smoking ban are welcome, as long as they are equal, voluntary, feasible and affordable for all entrepreneurs. Interestingly enough the KHN was initially not an opponent of a smoke-free policy. They were in fact against the exemptions for venues with a smoking area, for party tents, etc. The announcement of exemptions changed things. When the Minister decided in favour of exemptions the KHN distanced itself from the implementation of the smoke-free policy of the Ministry (Koninklijke Horeca Nederland 2010). Currently, the KHN is mainly fulfilling an advisory role for its members and is generally supportive of the implementation of the smoking ban (Elzinga 2013).

When the KHN accepted the smoke-free policies, small owner-run pubs felt no longer supported and formed their own action interest group, the KHO, representing around 1,200 venues and receiving financial support from the tobacco industry (Baltesen and Rosenberg 2009b). The KHO is clearly more fanatical. They oppose the ban publicly, using the media to influence public opinion and to create sympathy and support. A small study revealed that the tobacco industry uses KHO (and other smokers’ interest groups) to get media attention and sympathy for these ‘poor owners of small pubs’. The industry helps to make KHO visible by helping to organise demonstrations against the smoking ban (Elzinga 2013). KHO also supported owners of small pubs in lawsuits against the smoke-free regulations. They argued that insisting on a smoking ban in small pubs is unequal treatment, because small pubs do not have space and money to establish a separate smoking room. They addressed politicians with their pleas for exemption rules, referring to the fact that the law is not applicable to owner-run pubs since they do not have employees who need to be protected against passive smoking. They also refer to the financial damage and threatening bankruptcy for small pubs.<sup>78</sup>

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<sup>78</sup> [http://kleinehoreca.info/downloads/Brief\\_Tjeenk-Willink.pdf](http://kleinehoreca.info/downloads/Brief_Tjeenk-Willink.pdf) [accessed 24 March 2014].

### *Alliances and connections between stakeholders*

There are alliances between the three stakeholders, which form the lobby against stricter tobacco regulation in the hospitality sector. They generally support each other's efforts. Obviously the tobacco industry is closely related to the interest groups of tobacco producers. Both have close contacts with the smokers interest groups, like 'Forces Nederland' and 'Stichting Rokers Belangen' (SRB, Foundations Smokers' Interests). There are also links with the hospitality sector. The initiator of SRB is also the 'founding father' of the interest group of small pub owners, KHO. Forces Nederland is also linked to KHO, since they share a board member. Both SRB and KHO receive financial, strategic and juridical aid from the industry (Baltesen and Rosenberg 2009b; Elzinga 2013).

KHN states not to have contacts with the tobacco industry (Koninklijke Horeca Nederland 2010). KHO, in contrary, was found to have linkages to the tobacco industry. The founders of KHO were experienced smoking-lobbyists with connections to Forces Nederland, SRB and the SSI (Foundation Cigarette Industry) (Baltesen and Rosenberg 2009a). Quality newspaper NRC claims that the chairman receives €50,000 yearly from the tobacco industry (BAT), among others to enable proceedings (Baltesen and Rosenberg 2009a).

#### **6.2.6 The lobby for a stricter tobacco regulation**

Besides advocates for more restrictive regulations regarding smoking among researchers and health professionals anti-smoke lobbies have emerged in many countries, putting pressure on politicians to install more strict tobacco control policies. In the Netherlands pressure groups decided to form the so-called 'smoke-free coalition'. This 'anti-smoke' lobby consists of the 'Stichting Volksgezondheid en Roken' (STIVORO, the Foundation Public Health and Smoking<sup>79</sup>), three health foundations, each specialised on different illnesses related to smoking, i.e. the 'Long Fonds' ('Lung Foundation'), the 'Hart Stichting' ('Hart Foundation') and 'KWF Kanker Bestrijding' ('Foundation Fight against Cancer'), and the foundation 'Clean Air Nederland' (CAN)<sup>80</sup>.

There are various links among these different organisations. STIVORO has been founded by the three health foundations. These foundations also established, together with CAN, the alliance 'Nederland Rookvrij' ('The Netherlands Smoke-free'), a cooperation of public and private organisations, including all the organisations named above, which are working for 'a society in which nobody has to suffer or die from the consequences of smoking'.<sup>81</sup>

The primary interest of the 'smoke-free coalition' is the protection of public health. They strive for a total smoking ban, without exceptions, and therefore disagree with the current regulation policies. The members of the coalition are involved in a variety of activities. They produced a shadow report on the implementation of the WHO Framework Convention on Tobacco Control (FCTC) (WHO 2012) stating that the Dutch tobacco policy is not in line with the FCTC and not effective enough (Rennen and Willemsen 2012). Members of the smoke-free coalition have also engaged in research to produce further evidence for the dangers of smoking and the need of stricter regulation policies. This evidence is used for lobbying at the Ministry for tightening up policies and to get supportive media coverage for this message.

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<sup>79</sup> STIVORO is an NGO that aims for a smoke-free future and improvement of public health, by the developing or generating and applying knowledge on tobacco-use and addiction.

<sup>80</sup> CAN is an interest group fighting for 'clean air'. They stand up for people who are hindered by second hand smoke.

<sup>81</sup> <http://www.alliantienederlandrookvrij.nl/alliantie/> [accessed 1 April 2014].

In 2012 a group of authors in the Lancet accused the Dutch government of "abandoning smokers to their fate" (Arnott et al. 2012). They stated that the Dutch government no longer protected smokers from their addiction and neglected non-smokers. The authors reacted to, among others, the cutbacks in tobacco control operations and the earlier decision of the Dutch government to partly reverse the existing smoke-free legislation in the hospitality sector. They regarded this as incomprehensible, as the evidence of the harmfulness of tobacco accumulates and is more persuasive than ever. This direct involvement of researchers in lobbying for stricter tobacco regulation encountered the criticism that their research was driven by a political agenda and that the researchers involved had turned from advocates into activists, which was seen as jeopardizing their independency.

The opposition of 'anti-tobacco' researchers against less harmful alternatives like the e-cigarette is sometime also seen as sign that their position is belief rather than evidence driven.<sup>82</sup>

Among the proponents of stricter policies there are differences in tone and approach. Comparably with the opponents they work with an increasingly professional strategy. They use media to get their message across, they target political parties which oppose the lenient approach of the two traditional liberal-conservative parties. The tone and approach of some lobbyists for stricter control policies is becoming more aggressive. In March 2012 CAN started legal proceedings against the decision of the government to temper the smoking ban in the hospitality sector. It is their view that allowing for exemptions makes it even more difficult to enforce compliance. CAN tried to force the government by means of a lawsuit to end the indistinctness of the smoke-free policy in the Netherlands. In May 2013, the court judged in favour of the state. CAN has declared to appeal to higher court and the juridical decision has to be awaited (Clean Air Nederland 2012).

**6.2.7 Context and process: Changing attitude and behaviour**

All these efforts to come to a more strict tobacco regulation policy – and most probably also the public debate about this – seem to have had some effect on the extent of smoking. Over the last decades one can observe a drop in tobacco (cigarette) sales, in smoking prevalence in the EU, an increase of the number of ex-smokers and of people who never smoked, and a change towards a more negative attitude towards smoking (European Commission 2003 and 2012). These trends differ substantially over the Member States and over time. While the Eurobarometer data for the EU show for example a stabilisation of the number of smokers, ex-smokers and people who never have smoked for the period 2009 – 2012, the period between 2003 and 2009 shows a clear decline of the number of smokers and an increase of ex-smokers and people who never smoked all over the EU.

	Smokers	Ex-smokers	Never smoked
2003	39,4%	18.5%	41.6%
2006	33%	21%	47%
2009	29%	22%	49%
2012	28%	21%	51%

(European Commission 2003 and 2012)

The figures for the Netherlands show an even more impressive development. While in 1970 59 per cent of the population smoked occasionally (male 75 per cent, female 42 per cent), in 2012 this figure was down to 25.9 per cent (male 26.7 per cent, female 25.2 per cent). For daily smokers the

<sup>82</sup> <http://www.irishexaminer.com/viewpoints/columnists/terry-prone/obstinate-anti-smoking-lobby-rejects-science-of-safe-alternatives-252005.html> [accessed 29th May 2014].

prevalence went down from 30.6 per cent in 2000 (male 34.4 per cent, female 27 per cent) to 19.7 per cent in 2012 (male 19.7 per cent, female 19.4 per cent) (Van Laar et al. 2013b).

In France the general prevalence of smokers among people aged 15-75 years was estimated at 33.7 per cent in 2010 (Beck et al. 2011). This prevalence decreased under 30 per cent in 2012 (European Commission 2012a). At the end of 2013 the prevalence were to reach around 27% [25.5 per cent - 29.3 per cent]. However, in 2010, around 13.4 million of French people aged 11-75 years were daily smokers and the number has increased since 2005. After a decrease since the 1950's, the proportion of regular smokers and daily smokers among people aged 18-75 years increased between 2005 and 2010 (OFDT 2013).

In youth, the prevalence drop was substantial and the very recent increase is modest and limited to male smokers. The percentage of daily smokers in the general population (18-75) in 2010 is 30 per cent, among young people (15-24) 39.5 per cent (Beck et al. 2011). However, these figures must be balanced by youth smoking at 17. In 2011, more than four out of ten young people aged 17 declare they had smoked the previous month (Spilka et al. 2012). In addition, if the proportion of young daily smokers decreased between 2005 and 2008, youth daily smoking at 17 increased between 2008 and 2011 (31.5 cent compared with 28.9 per cent).

### *Change of attitudes*

One also can observe a change of attitude towards smoking in the past decades. Smoking is perceived less positive than in the period when tobacco control policies were not yet existent. There do not seem to be many studies about the actual attitudes and social norms regarding smoking. There is for instance a review of studies in the US which states a link between intensified tobacco control policies and a more negative attitude towards smoking (Gutman 2011).

There are other studies underlining that the awareness of the negative health effects of smoking clearly had an effect on the attitude towards smoking, resulting in an increasing number of smokers stopping smoking or attempting stopping (The ASPECT Consortium 2004 p150). There is also growing support for anti-smoking policy measures. The ASPECT Consortium summarizes this support as follows:

- “Putting picture health warnings on all tobacco product packages receives the most support (76%). Furthermore, 73% of EU citizens are in favour of introducing security features to curb illicit trade of cigarettes, even if it makes them more expensive;
- On average, 58% of citizens support measures to make tobacco less visible and attractive, such as keeping tobacco products out of sight in shops or curbing the use of attractive flavours and colours. Public support has gone up for all anti-tobacco policy measure except for increasing taxes on tobacco products which is, however, still supported by majority of respondents (53%).
- Unsurprisingly, non-smokers are consistently more likely to support all these measures than smokers. In particular, non-smokers are more in favour of increasing taxes on tobacco products than smokers (a difference of 50 points).;
- A third (33%) of smokers and ex-smokers in the EU say health warnings on tobacco packs have / have had an impact on their attitudes and behaviour towards smoking. 15% of ex-smokers say that warnings encouraged them to quit smoking, in comparison to 4% of current smokers.
- 38% of those aged 15-24 say that health warnings on cigarette packs influence their attitudes and/or behaviour, both figures being above the EU average;



- However, there is only partial agreement that health warnings on tobacco packs prevent young people from starting smoking. Around a quarter (26%) of EU citizens believe that these warnings discourage young people, while 70% think this is not the case;
- Young respondents themselves are slightly more positive in this respect; 28% of respondents aged 15-24 believe that health warnings on tobacco packs help young people not to start smoking.” (European Commission 2012a p101).

Still, looking at the Netherlands, the Dutch are still relatively tolerant towards smoking (and traditionally not very positive towards government interference with issues that are seen as belonging to the realm of ‘personal freedom’). An international comparison showed that the attitude of Dutch smokers towards smoking differs considerably from the attitude of smokers in other countries. Twenty-two per cent of the Dutch smokers think negatively about smoking, in contrast to France where this accounts for half of the smokers, or Brazil where 81 per cent perceives smoking as a bad habit (The International Tobacco Control Policy Evaluation Project 2010).

Sixty-one per cent of the Dutch-smokers think smoking is unhealthy or dangerous to others. In the UK and France respectively 83 per cent and 96 per cent thinks smoking is harmful to others (The International Tobacco Control Policy Evaluation Project 2011; Willemsen 2011).

At the end of 2008 a survey showed that 52 per cent of the Dutch did not support the SFHS-policy in bars and clubs and that 31 per cent was not in favour of smoke-free restaurants (European Commission 2009b). A different study covering the same period found that almost 25 per cent of the ‘wet’ hospitality sector did not comply with the smoke-free rules, while in other venues this accounted for only 5 to 10 per cent (INTRAVAL 2010).

Nevertheless, also in the Netherlands the acceptance of smoking is decreasing. Smoking in the presence of non-smokers is seen as irresponsible behaviour. This is particularly true for parents smoking in the presence of their children. Producing and – to a lesser degree – selling tobacco, lobbying for the tobacco industry is seen more and more as unethical.<sup>83</sup>

The move to a more restrictive approach towards tobacco came from different sides. It was not so much a paradigm change as rather a change from a widely accepted habit to a predominantly negatively viewed habit. This change also contained some bottom-up influences e.g. from people complaining about nuisance by smokers. Passive smoking was a crucial argument in their complaints. This was later underpinned by research that passive smoking was indeed harmful.

There is no direct proof that the stricter tobacco control measures introduced in EU Member States since the 1980s resulted in lower tobacco smoking prevalence. The course of developments may be better understood as a more complex aggregate of processes which supported and reinforced each other. The research findings about the health damage caused by smoking may have led to growing concerns among health researchers and professionals and were brought to the attention of politicians, policy makers and the general population. This may have given rise to wider concerns and the emerging sense of urgency that something had to be done to reduce the health toll paid by smoking. The call for more restrictive control measures seems to have received gradually more support. The first measures implemented seem to have met fierce opposition, causing heated debates between supporters and opponents, attracting wider attention to the issue. These debates may have created wider awareness and broader support of stricter control policies. It also seems to have influenced the attitude towards smoking, both among the non-smokers and the smokers.

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<sup>83</sup> <http://www.tabaknee.nl/home> [accessed 2 April 2014].

### 6.3 From unregulated to regulated: gambling policy

For gambling we limit our study to aspects of control and regulation in licensing policies in France, Slovenia and the UK. Gambling and gaming<sup>84</sup> policy has developed in a similar way as tobacco policy did: from a rather unregulated state to an increasingly restrictive control regime.

However, compared with smoking gambling is a much less prominent issue in the public debate and while there is an abundance of research literature on tobacco and tobacco policy, much less research has been done in the field of gambling. We did not find a lot of research literature in France and Slovenia, while in the UK different aspects of gambling have been thoroughly researched. We therefore decided to regularly stress the commonalities and differences of gambling control efforts with tobacco control policy.

#### 6.3.1 The context and the process: the history of gambling and gambling policy

##### *The history of gambling*

Compared with tobacco use gambling has clearly a longer history. A common statement in the literature about gambling is that gambling is a universal phenomenon, which can be observed in all human cultures. Though gambling is common behaviour all over the world, there is some research which questions the correctness of this universality claim. According to this research gambling is not a universal but a “social, cultural and economic phenomenon, a remarkably flexible way of redistributing wealth, which is embedded in the socio-cultural systems of societies, constituting, for example: a leveller of differences in wealth in egalitarian communities, an arena for individuals to achieve and contest prestige in hierarchical social environments, and a multifaceted leisure product in modern commercial societies”. (Binde 2005)

##### *The history of gambling regulation in the UK*

Various publications show that gambling control policies also have a long history. For instance in the UK gaming control efforts can be traced back till 1388, when dicing was prohibited as response to the increasing popularity of dicing and of other forms of gambling. It carries on with diverse control efforts through the centuries till today (Munting 1996, Miers 2004 and Appendix 8). The report ‘Gambling in the United States’ shows that gambling control policies can be traced back to the 17<sup>th</sup> century in the former European colonies in America (1997). Various arguments played a role in these early attempts to restrict gambling.

In the UK counteracting cheating and fraud seems to have been one of the main reasons to introduce restrictions. However, most measures like the prohibition of dicing are reported to have had very

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<sup>84</sup> In the literature gambling and gaming are generally used interchangeably. There is no clear differentiation between the two words. We follow the definitions provided by Bühringer et al. He defines gambling as “wagering of material value on an incident with uncertain outcome:

- two or more parties are involved (one can be an organisation)
- the outcome is solely or predominantly defined by chance rather than skills
- a redistribution of assets (often money) takes place, typically within a short period of time
- the term covers all forms, whether land-based or interactive/online, lotteries, betting or games (roulette, poker etc.)” (Bühringer et al. 2013 p2).

According to the authors gaming “is sometimes used to characterise the playing of low risk games (e.g. specific types of slot machines) with limited stakes, wins and losses. As gaming is neither consistently defined nor frequently used, the term gambling covers all such subtypes of games in this paper.” (ibid)

limited effects. Other motives that contributed to stricter gambling control policies were side effects of the English Reformation. Gambling was next to gaming and drinking one of the 'nasty' pleasures prevalent in monasteries. Dissolving the monasteries in the late 1530s was accompanied by a ban on gambling. What followed under the Tudor dynasty – which ended in 1603 – were selective legal measures against particular games and groups. From the Puritan side the attacks on the Catholic clergy for sinful activities such as “unlearnedness, whoredom, drunkenness, gaming, gambling, hunting, hawking, wrestling” continued. All these attempts to control gambling are again described as being rather unsuccessful, as well as the later attempts when, after the Restoration had set in, various forms of gambling and particularly betting became increasingly popular in the UK of the 18<sup>th</sup> century. By some authors it is seen as a palliative for suffering from poverty and misery. However, betting was popular among the poor, who betted on pitch and toss, crown and anchor, cock-fighting, and the rich who betted on the lottery, on cards and on stocks (Munting 1996). From the 18<sup>th</sup> century betting on sports and games became increasingly popular in the UK. Gambling and gaming control legislation was introduced time and again to counteract cheating like match fixing but also to reduce the prevalence of gambling among the lower classes and to prevent dramatic losses of property among the wealthy (Miers 2004; Appendix 8).

In the 19<sup>th</sup> century the efforts to control gambling increased. Important drivers were concerns about the corrupting influence of gambling on sports, and moral concerns about the devastating economic effects of gambling on the poor. Also concerns about the burden of an increasing caseload of disputes over gambling debts for the courts played a role. Other considerations were fears about moral decay, gambling might undermine work ethic, and about increasing crime rates, losses may be conducive to crime. Social concerns became more prominent through the years and control policies became stricter. In 1890 the National Anti-Gambling League (NAGL) was founded which objected gambling for moral-religious and practical reasons. Gambling was seen as sinful, immoral behaviour but also as source of 'secondary poverty', meaning that the poor involved in gambling lost the bit of money they had. The NAGL turned into a rather influential pressure group which had some success in pushing for stricter gambling control policies. NAGL's efforts also contributed to continuing public interest in the gambling issue. Another influential factor in the opposition to gambling in the first decades of the 20<sup>th</sup> century was the church. This opposition contributed to the making of more restrictive legislation, e.g. the ban on street betting in 1906. It later also successfully opposed the call for legal regulation of gambling as an answer to the problems with effectively implementing a ban on betting (Munting 1996).

After the Second World War the gambling market in the UK changed substantially. Just to name some of these changes: While betting on dog-racing lost popularity, football pools became increasingly popular. Taxing of these football pools increased from 10 to 42.5 per cent. A general betting duty was introduced. In the 1960s a liberalisation of gaming regulations set in which seems to reflect a general increased 'permissiveness' and the realisation that the then existing control regulations were difficult if not impossible to enforce. The provisions of the 1960 Betting and Gaming Act resulted in a dramatic increase of gambling in the UK (Munting 1996). While this act was meant to counteract commercial gambling and allow private gambling it did quite the opposite due to one unlucky formulation: gaming would be allowed in case the chances are equally favourable to all players. This of course also applied to commercial gambling. This made that the 1960 Betting and Gaming Act unintentionally worked as a boost to the commercial gaming industry and a dramatic increase in gambling. These developments and the association between organised crime and the UK gambling industry became of concern to politicians, the media and the general public. The 1968 Gambling Act formed the attempt to correct the effects of the 1960 Act and its amendments of 1963 by introducing stricter control measures focusing on strict licensing and more active enforcement (Appendix 8).

### *The history of gambling regulation in France and Slovenia*

While for the UK rather detailed research is available on the developments of gambling and gambling control from the Middle Ages onwards, the information for France and Slovenia is scarcer. Still there are some interesting findings

France shows a shift from a ban to liberalisation and – rather recently – back again to attempts of more strict controls. After a period of banning gambling it became gradually legal from the last third of the eighteenth century onwards. Still, gambling remained well regulated by the government through a state monopoly regime. The first step was the introduction of the royal lottery. In 1806 casinos followed, as laid down in a decree which allowed the Commissioner of Police to issue licenses. In 1931 Pari Mutuel Urbain was founded, a state controlled organisation for horse race betting. In 1933 the National Lottery followed. These three organisations remained for many years the three main gambling operators in France, holding the largest share of the gambling market till 2010, when with the introduction of a new legal framework the state monopoly, held by the 'Française des Jeux' and the Pari Mutuel Urbain, ceased to exist.

The 2010 law was also a response to the increasing use of illegal online<sup>85</sup> or internet gambling possibilities. It intended to introduce a controlled competition, introducing regulations for gambling providers of the three gambling categories: sports betting, horse racing and poker. The law delegates the regulation of the online gambling market to an independent administrative authority, ARJEL (Regulatory Authority online gambling), responsible for assigning licenses to gambling operators on the Internet and controlling their activity. This law resulted in an explosive growth of online gambling. One year after legal internet-based betting sites had become available, they had generated 2.9 million active gambler accounts (Appendix 2).

There is one remarkable aspect in the developments of gambling control policy in Slovenia. In the Socialist Federal Republic of Yugoslavia, of which Slovenia was part till 1991, gambling was forbidden for the citizens of the country but allowed to foreigners. It was a convenient source of income. After the societal change in 1991 a general liberalisation of gambling control policies set in, opening up gambling opportunities to Slovene citizens but keeping gambling under state control. The casinos remained traditionally strongly orientated at attracting foreigners (Appendix 4). The new gambling control policy was laid down in the 1995 Gaming Act, followed by a number of amendments in 2001, 2003 and 2010. The Gaming Act resulted in a strictly state controlled market, in which companies can get a concession under strict and well-defined conditions, defining among others regulations on technical requirements for gaming devices, on the supervising system for gaming devices and on licenses for employees in the casino industry. There are only three concession holders: Loterija Slovenije (The Lottery of Slovenia), Športna loterija (The Sports Lottery) and Casino Kobarid, all three are Slovenian companies.

#### **6.3.2 Context and process: health and social consequences of gambling**

The background and process of introducing control policies targeting gambling differs substantially from that of the tobacco control policies. A decisive factor behind the tough and unified tobacco control policies has been the serious health damage caused by smoking (and other forms of tobacco use). 'Compulsive' or 'pathological gambling' does not cause any physical health damage. This seems

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<sup>85</sup> We use the term 'online gambling' for all forms of gambling or gaming using digital access via internet, mobile devices or interactive TV.

to make the case for a stricter control approach less strong. However, problem gambling may have a serious and broad health and social impact. The social impact was already an issue in the 19<sup>th</sup> century. One can find reference to the corrupting influence of gambling on sports, to the disruptive economic impact of gambling on especially deprived people and also reference to gambling related crime. Gambling related crime includes on the one hand directly gambling related offences like illegal gambling, cheating or crime to abet gambling and on the other hand property crime to make money for gambling or for making up for losses (see 6.3.1).

Understanding habitual forms of gambling as health problem appeared much later. The first notions of compulsive gambling in the literature can be found in the late 19<sup>th</sup> century. After the Second World War the concept of compulsive or addictive gambling emerged in the professional literature. Unlike the concept of tobacco addiction it was less well accepted by health experts, policymakers and politicians. The developments in the UK show that in the early years it was not taken too seriously. Munting refers to a statement that compulsive gambling was “like the yeti, it was much spoken but rarely seen” (Munting 1996 p200). It took some decades before the concept of gambling addiction or compulsive gambling was more generally accepted.

Also in France and Slovenia concerns rose regarding the health and social consequences of gambling. But in these countries, too, these concerns never became an issue comparable with tobacco. It is neither a real political priority nor an important issue in the public debate.

In more recent years indications have been found for ‘neuropsychological deficits’, caused by compulsive gambling. There is evidence of psychiatric consequences of pathological gambling like increasing depression, anxiety, obsessions and mood disorders, closely linked with the serious social consequences of gambling, like financial problems (debts, bankruptcy), crime and disruptive impact on social surroundings (Fong 2005). These findings resulted in the inclusion of compulsive or pathological gambling in the international disease classification systems ICD and DSM as mental disorder (Petry et al. 2013).

Still, the absence of a ‘tangible’ physical disease seems to make pathological gambling a less compelling problem than tobacco smoking. Other factors may also play a role. The prevalence of problem gambling is rather low compared with that of smoking. Based on a compilation of available data from selected EU Member States, between 0.1 and 0.8 per cent of the general population is estimated to have a gambling disorder and another 0.1 till 2.2 per cent ‘demonstrate potentially problematic gambling involvement’ (Sassen et al. 2011). For Slovenia 1.45 per cent of the adult population is reported to be problematic gamblers and 0.46 per cent pathological gamblers. However, among the young the figures seem to be substantially higher, as can be taken from a number of regional surveys. For the Goriška region (in Western Slovenia close to the Italian border) the figures for 13-15 years old are 4.14 per cent and 2.57 per cent, for the Dolenjska region (in the South-East of Slovenia) 4.09 per cent and 3.73 percent (Appendix 4). For France 1.3 per cent of the adult population is reported to be problematic gamblers and 0.4 per cent pathological gamblers (Costes et al. 2011).

Also the fact that gambling is generally less visible than smoking might be a contributing factor here. Gambling is not a public activity, such as smoking is. It is predominantly an ‘indoor’ activity, either in designated venues like among others casinos or betting offices or at home at the computer. Finally, gambling does not have direct negative effects on the social surroundings like passive smoking.

Nevertheless, gambling has been widespread in Europe and other parts of the world for centuries. The available data show that in recent years the gambling market is rapidly growing in the EU. While

the EU-wide<sup>86</sup> gross wins of 'traditional' forms of (land-based) gambling grew in the period 2003 – 2015 roughly with 50 percent, from 54.89 to 72.65 billion Euro, the gross wins of online gambling multiplied in the same period by twelve, from 1.11 to 13.08 billion Euro (Bühringer et al. 2013). The continuous development of online technology, which includes besides internet smartphone technology and digital TV, creates new opportunities for online gambling. These gambling services operate across borders and are therefore able to duck out of the control of Member States' gambling control authorities which generally were installed to target land-based gambling. Despite the fact that, due to a lack of control, fraud is a real risk, consumers in Europe use these online gambling services as they are frequently more competitive. Concerns about the growth and risks of in particular the online gambling market is one element behind the attempts to introduce stricter gambling control policies including Europe-wide measures.

### **6.3.3 The stakeholders in the diverse gambling market**

#### *Diversity of the gambling market*

There is one more important difference between the tobacco and the gambling market. The tobacco market is dominated by one product: cigarettes. All other tobacco varieties (pipe tobacco, cigars, snuff, chew, snus, etc.) play a minor role. For gambling the market is much more fragmented and varied. It is divided in different segments, many of which have a substantial market share. This diversity is nothing new. The history of gambling in the UK shows that this diversity has been a characteristic for centuries. Dice and card games, lotteries, sport betting, all these forms of gambling have been there for ages (Munting 1996).

The current gambling market covers a wide variety of land-based gambling opportunities, which can be used in venues or by mail:

- Casinos (e.g., roulette, black jack, poker, slot machines)
- Gambling and bingo halls, amusement arcades, bars (e.g., slot machines)
- Lottery shops / outlets (e.g., lottery tickets and scratch cards)
- Betting shops (e.g., betting on horse and dog racing)

Next to these traditional forms of gambling there is the rapidly growing market of online gambling, covering gambling and gaming using digital access via internet, mobile devices or interactive TV. Overall, one can find here various gambling opportunities which are also available as land-based gambling. Sometimes live sports betting is also possible.

The EU shows also a geographic diversity. The gambling market differs substantially between Member States. There are substantial differences in gambling preferences in different countries. UK has a traditionally strong sport betting market, while in France and Slovenia casinos play a prominent role.

#### *Conflicting economic interests of politics and policymakers*

A shared feature of tobacco and gambling control policies are economic arguments or interests against more restrictive control policies. The substantial revenues from gambling make the attitude of governments ambiguous: while the Ministries of Health and Social Affairs and other health agencies generally support more strict control policies – be it that in the case of tobacco this drive is stronger due to the high health toll of tobacco use – the Ministries of Finance and Economic Affairs are usually

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<sup>86</sup> These figures are for 27 Member States, Croatia is not yet included.

against strict control policies aimed at limiting or reducing (certain forms of) gambling.

Nevertheless, in the case of gambling the situation is somewhat more complex. States profit in different ways from gambling. One can differentiate between two common ways of generating state income. One is through tax revenues from gambling by private, generally licensed entrepreneurs, which means the state takes a share of the total income or profit from gambling. The other way, more profitable, is 'taking it all', through a state monopoly, either for the total gambling sector or for certain areas. In the latter cases where the state is directly involved in providing gambling opportunities the contradictions between economic interests of the gambling entrepreneur and the interests of a regulating agency to protect gamblers from health and social harms are painfully clear. A prominent part of gambling regulations in these countries are measures which have been developed with the primary aim of increasing the public share of revenues from the gambling market. These national economic interests are the reason that the gambling regulation policy is frequently under the authority of the Ministries of Economic Affairs or Finances (Brotherhood, Atkinson & Sumnall 2012).

These Ministries generally support strict regulation measures like a state monopoly, helping to secure state income, regularly using the argument that a state controlled system would be more able to protect citizens (Appendix 2, 4 and 8). In many countries the gambling revenues are an important and regularly scheduled contribution to public budgets.

Still, in most EU Member States a trend towards privatisation and further regulation of gambling can be observed. State monopolies tend to be abandoned. This does not necessarily mean giving up revenues from gambling. It seems to be rather a strategy aiming to secure or consolidate a certain level of revenues. A reduction of revenues from traditional land-based gambling is compensated by on-line gambling revenues through providing a legally regulated basis (see France under 6.3.2).

#### *Absence of powerful proponents of stricter gambling control*

There is another essential difference between gambling and tobacco policies. While in the case of tobacco we saw a fierce conflict between proponents and opponents of stricter regulations, a comparable open and heavily polarised conflict cannot be observed in the field of gambling. There are no powerful alliances of proponents, as in the case of smoking, where we found in the Netherlands the 'smoke-free coalition' or 'The Netherlands Smoke-free', both coalitions of fairly diverse organisations, which had joined forces to realise more rigorous control policies. The existing groups of anti-gambling activists are much less influential. The factors summed up under 8.3.2 may play a role here, too: Gambling is less visible than smoking. It is not a public activity as smoking is. It is predominantly an 'indoor' activity, either in designated venues or at home. Finally, gambling does not have direct negative effects on the social surroundings like passive smoking.

In the UK the National Anti-Gambling League (NAGL), formed in 1890, is reported to have had some influence in its early years. But through the years NAGL and its successor, the Churches' Council on Gambling (CCG) founded in 1933, lost much of their power and influence from the 1930s onwards. They did not form a unified block and received limited support from public opinion. Gambling was not seen any more as social evil, it was rather widely accepted. Government and political establishment showed an increasing tolerance towards gambling, as the reports from the two Royal Commissions on Lotteries and Betting 1932-33 and 1949-51 show (Munting 1996).

Nowadays gambling is not much of an issue in most of the EU Member States, neither in the political arena nor in the public debate. It also plays a modest role in the media in all three countries we selected for our studies (Appendix 2, 4 and 8). It is ranked low on the priority list of political parties.

Still, gambling has been taken on board of the European Commission's agenda, be it in moderate steps. The European Commission commissioned an extensive "Study of Gambling Services in the Internal Market of the European Union" to better understand the impact of laws regulating gambling on the internal market, both in the field of gambling as such and in related areas like charity and tourism. This study shows how seriously the economic aspects of gambling and gambling regulation are taken (Swiss Institute of Comparative Law 2006).

The focus of the European Commission is mainly on online gambling. This has to be understood as a response to the strong growth of online gambling, which started to cause serious concerns (see 6.3.2). In 2011 the European Commission published a Green Paper<sup>87</sup>, launching a "public consultation on all relevant public policy challenges and possible internal market issues resulting from the rapid development of both licit and unauthorised on-line gambling offers directed at citizens located in the EU" (European Commission 2011). Exploring the views on regulatory measures is one issue in this paper, though very carefully formulated and integrated in a much broader range of issues, apparently to avoid any appearance of bias. In 2012 the European Commission published a communication to the European Parliament and other European Union bodies, exclusively focussing on the regulation of online gambling. The focus is on the following five key challenges:

- Compliance of national regulatory frameworks with EU law
- Enhancing administrative cooperation and efficient enforcement
- Protecting consumers and citizens, minors and vulnerable groups
- Preventing fraud and money laundering
- Safeguarding the integrity of sports and preventing match-fixing (European Commission 2012b).

Compared with the EU efforts in the field of tobacco control policy, which resulted after a long struggle in an at least partly quite explicit Tobacco Products Directive (Directive 2014/40/EU ...), gambling control policies play a rather marginal role in EU policy debates with accordingly weak outcomes.

#### *Absence of a unified, powerful front of opponents of stricter gambling control*

The resemblance between the gambling and tobacco control policy goes further than the development towards stricter control policies. There is also the substantial investment in lobbying and the strong influence of the gambling industry on policy making. The substantial efforts of the gambling lobby in Member States and in Brussels are a sign of the economic importance and the lucrateness of gambling. Gambling is very profitable business (see 6.3.2). It is easy money in the sense that one can earn substantial sums of money with limited investments. While certain forms of land-based gambling might require serious starting capital, making a gambling website does not need a lot of investment.

The diversity of the gambling market is reflected in a fragmentation of the gambling lobby, promoting a liberalisation of the market. Still it is seen as a strong lobby, divided over different branches for different types of gambling. There is a wide variety of lobby groups for casinos, for slot machines, for bookmakers, for online gambling, etc. There is even a website where one can find an

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<sup>87</sup> "Green Papers are documents published by the European Commission to stimulate discussion on given topics at European level. They invite the relevant parties (bodies or individuals) to participate in a consultation process and debate on the basis of the proposals they put forward. Green Papers may give rise to legislative developments that are then outlined in White Papers."  
[http://europa.eu/legislation\\_summaries/glossary/green\\_paper\\_en.htm](http://europa.eu/legislation_summaries/glossary/green_paper_en.htm) [accessed 25 June 2014].



impressive list of gambling lobbyists. It proudly states: “We track every lobbyist, firm and client that lobbies Gaming Gambling Casino issues.”<sup>88</sup> These different lobby groups sometimes have conflicting interests, as can be taken from the decision of the casino lobby in the US to stop advocacy for online gambling. Background for this decision was a conflict in the casino lobby between proponents and opponents of a law that aimed at a federal ban on online gambling.<sup>89</sup>

Lobbying in the field of gambling has a long tradition. The same goes for the diversity of the lobby. Munting refers in his book to different lobby groups in the UK that have emerged from the late 19<sup>th</sup> century onwards. He also refers to a conflict between the National Bookmakers Protection Society (NBPA), a merger of a number of regional organisations which came into being in 1932, and small bookmakers about the legalisation of off-course cash betting shops. The NBPA was against this legalisation, whereas the small bookmakers were in favour (Munting 1996).

These are just two examples of conflicting interests of different gambling lobby groups. There are many more. However, there are also commonalities. They all try to secure their economic interests. One prominent shared theme of the gambling entrepreneurs and their lobby groups is privatisation or liberalisation of the gambling market. At the same time entrepreneurs and lobby groups do their utmost to maintain their privileges. The clash between the providers of land-based and of online gambling opportunities is one example. But there is also competition between different land-based gambling opportunities (see the last paragraph of this section).

A search on Google reveals how active, widespread and diverse gambling lobbying is. There are websites of a variety of interest and lobby groups for different types of gambling and gaming. It shows that lobbying is not a hidden activity but happens in broad daylight. The following, extensive quote on the European online gaming law from the website of the ‘C5 Group – Business Information in a Global Context’ is illustrative for this:

“2013 will be a year of incredible opportunity for online gaming operators and industry service providers. European member states such as Germany, Netherlands and Sweden are in the process of liberalizing their markets, while recent developments in America are also set to further enhance the global value of the gaming industry by opening the doors to online gaming in the world’s largest gaming market.

Lucrative commercial opportunities exist, however there remains a great level of disparity in online gaming regulations, between both individual member states and at a European level. Coupled with the commencement of infringement proceedings against operators who do not hold valid licenses, it is imperative that operators and their business partners fully comprehend the regulatory landscape in order to assess their risk profile and identify the opportunities for lawful commercial expansion.

C5’s 3rd European Online Gaming Law Forum is the only online gaming conference in Europe written directly for the in-house counsel and private practice lawyers dealing with the regulatory and commercial challenges facing the industry. Here industry leaders share their expertise and real-life experiences on:

- Positioning yourself to take advantage of the commercial opportunities presented by newly liberalised markets in Europe and America
- Deciphering the current regulatory standards for online gaming in Europe and the inherent risks when operating in a grey market

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<sup>88</sup> <http://lobbydata.com/Directory/Issue/Gaming-Gambling-Casino> [accessed 25 June 2014].

<sup>89</sup> “Casino lobby drops pro-Internet gambling advocacy”. <http://finance.yahoo.com/news/casino-lobby-drops-pro-internet-175205271.html> [accessed 25 June 2014].

- Managing the complexities of multi-jurisdictional licenses
- Staying one step ahead of the social gaming revolution
- Utilising your online gaming expertise in strategic partnerships with US companies
- Minimising your operating costs through the implementation of legally compliant taxation structures
- Capitalising on additional revenue streams through the utilisation of mobile gaming
- Developing commercial strategies to strengthen your online gaming presence.”<sup>90</sup>

However, besides these blunt business organisations also generally more serious and respected firms seem to find the gambling business too tempting to ignore it. PricewaterhouseCoopers (PwC) knows how to carefully formulate their economic interests:

“In the last few years, a large number of internet gaming operators have established themselves in Malta. The Lotteries and Gaming Authority has to date issued over 400 licences. The industry is in a trail-blazing stage. Several countries are changing their policies in order to find a balance between citizen freedom and protecting that same citizen from possible fraud, crime and addiction.

PwC recognises the importance of the industry to the economy of Malta and supports the concept that good governance and regulation is the solution to protecting players and particularly vulnerable groups. History has shown that protectionism generally serves the unscrupulous more than the righteous.”<sup>91</sup>

After this display of serious concern PwC offers its services, praising Malta among others as follows:

“Apart from a stable and comprehensive regulatory framework protecting both operators and players, there are various factors which have contributed to Malta's success in attracting remote gaming operations. Some of the principal advantages include:

- Attractive gaming licensing fees, gaming taxes and beneficial effective corporate tax rates on gaming operations
- Rapid, efficient and relatively low cost licensing application procedures
- Availability of an English-speaking skilled work-force and highly competitive salaries
- Malta has a sound reputation as an ICT hub with global operators present such as IBM, Oracle, Microsoft, and Cisco Systems.”<sup>87</sup>

Finally, here is one example that shows how active and alert the gambling lobby operates. Albert & Geiger, a lobbying law firm based in Brussels and Berlin, representing “the Gauselmann Group, a German manufacturer of gambling machines and operator of gambling halls, active in several EU-Member States”, contacted by mail all the ALICE RAP experts working on gambling. In this mail they stated that they had heard about ALICE RAP’s work in the field of gambling addiction and would like to share their views with the ALICE RAP experts involved in this subject: “It is our position that slot machines shall be treated differently from other gaming activities, considering their lower pathology potential and their lower impact, in terms of number of players and of amount of money (as it has been demonstrated by recent studies, carried out in particular in Germany).” On request the ALICE RAP researchers were sent three documents that underpinned this view, one of which was with an ALICE RAP expert as principle author.

This mail is also a nice example of the competition between providers of different gambling

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<sup>90</sup> <http://www.c5-online.com/2013/539/european-online-gaming-law> [accessed 25 June 2014].

<sup>91</sup> <http://www.mondaq.com/x/236594/Gaming/Remote+Gaming+In+Malta+Our+Service+Offering> [accessed 2 April 2014].

opportunities, emphasising that slot machines are much more innocent than other forms of gambling.

#### **6.3.4 The content: towards stricter regulation**

These substantial lobby efforts have not been able to prevent the emergence of a trend towards stricter gambling regulation policies, both on national level and EU-wide. Still, this trend is clearly less strong than in the field of tobacco, but initiatives in several Member States and on EU level helped to get things moving towards stricter measures (see 6.3.3).

##### *Differences of national gambling control policies*

There are substantial differences in gambling control policies between EU Member States (Swiss Institute of Comparative Law, 2006). Not only the (legal) measures differ but also the rigorousness of policies and the views on how to balance economic interests of the government and the gambling entrepreneurs on the one hand and regulations to protect the gambling population on the other hand.

“Major differences in national gambling regulations take the form of:

- State monopoly or competitive market
- Share of public and private operators
- Type and amount of taxation and other forms of public revenues
- Access-oriented and / or process-oriented gambling regulations and control
- Age regulations and factual age verification
- Legal access to interactive gambling
- Availability and enforcement of self-exclusion and exclusion by third parties of people who experience gambling problems
- Selection criteria for, and control of content of gambling sites
- Degree and type of advertising permitted
- Regulations on direct financial funding of problem gambling support services and research.”  
(Bühringer et al. 2013).

These differences reflect the absence of an effective international policy framework, as was developed for tobacco. There are no substantial international forces towards a more uniform control policy, except for the efforts of the European Commission, mentioned above, to reach agreement among the Member States regarding a more effective control of online gambling. This lack of coordination and the limited sense of urgency among stakeholders have contributed to the differences described and make that in the case of gambling the process of developing control policies is more scattered and diverse. Another factor that may have contributed to the current diversity of policy responses is the yet mentioned diverse gambling market across Europe.

##### *Commonalities of national gambling control policies*

There are also commonalities in gambling control policies in EU Member States. Some are general elements of ‘addiction’ regulation policies or ‘addiction’ prevention. Age limits for instance are very widely applied (Appendix 2, 4 and 8). Also limitations on advertising are very common. All these measures apply of course only to control policies targeting licit drugs and gambling opportunities.

Another commonality is a general liberalisation trend. State control in the form of state monopolies

do not fit in today's EU economic policies not only in the field of gambling control policies. The EU single market does not allow for national state monopolies. In the past two decades state control on gambling has been traded in for a partly regulated free market approach.

## 7 Concluding discussions

In the case studies above we identified forces and factors influencing the development of the three drug policy trends we selected for our case studies:

- The wider acceptance of harm reduction
- The decriminalisation of drug use (and possession of small quantities for personal use), accompanied by a tougher, more punitive approach to the production and trafficking of illicit drugs
- The growing interest in exploring the feasibility of regulation as drug control instrument

We looked into processes, contextual driving forces, stakeholders involved, the different interests and arguments that play a role and interfering factors and principles, in order to better understand the process of policy making and governance. The case studies show both commonalities and differences between the three trends and between the developments in different EU Member States. However, the three trends have one feature in common: a growing harmonisation of 'addiction' policies in EU Member States.

The changes analysed in our case studies reflect a complex process of changing realities at different levels, which influence each other. We looked at changing circumstances (societal changes), changing views and value systems (paradigm shifts, stakeholders consensus), changing value / importance of certain interests and arguments and changing alliances of stakeholders.

In these concluding discussions we will concentrate on a selection of prominent issues in these developments, using the structure of the Health Policy Triangle:

- The process: convergence of policies in the EU
- The content: the paradigm changes, well-being as possible alternative for the health (illness) paradigm and the irrational elements in (governance of) drug policy
- The stakeholders: factors contributing to the influence of stakeholders, taking a closer look into the role of three selected stakeholders: science and research, the supply lobby and social movements
- The context: the impact of societal mood and social changes and uncertainties creating opportunities.

### 7.1 The process: convergence of policies

Our earlier research on the international market of illicit drugs indicated a convergence trend for illicit drugs (Reuter and Trautmann 2009; Trautmann et al. 2009). In line with other research our case studies show that there is also convergence in the fields of tobacco and gambling policy. Convergence seems to be an overarching key trend, which can be observed in the EU as well as in other parts of the world. Still, the process and outcomes of convergence differ substantially between the policy fields and between countries.

One commonality of the three trends is that all trends started bottom-up as critique on existing policies, or, as can be taken from the case studies focusing on tobacco and gambling, sometimes rather as criticism about the absence of a regulation policy. Concerns regarding health and social harms of substance use and gambling played a decisive role for all three trends. Tobacco control policies are perhaps the most convincing example of the pivotal role of health concerns in developing increasingly stricter control policies. It was the mounting research evidence for the health harms of tobacco and the wide acceptance of this evidence that led to growing criticism on the absence or softness of tobacco control policies. Stricter tobacco control measures became inevitable.

International efforts, like the WHO's Framework Convention on Tobacco Control and the EU Tobacco Products Directive, contributed – as a top-down force – substantially to the successful implementation of tobacco control in the EU (see 6.2.3). These documents and the international debates triggered by them also worked as a driving force towards convergence of tobacco control policies in many countries. In the case of gambling the negative health impact, combined with negative social consequences (see 6.3), also worked as a driver towards stricter control policies. However, in this field the consensus was clearly less strong.

For illicit drugs it was rather the concern about the (unintended) health consequences of drug prohibition which led to the opposition against the existing control policies. The critics questioned the suitability of these policies, pointing among others at the negative health and social consequences of criminalization (see 4.2.1, 5.2.1 and 6.1). All three trends in the illicit drugs field show in the early stages a primarily bottom-up driven process, which – in case of the wider implementation of harm reduction and decriminalisation of use – later turned into a process where top-down forces played a dominant role.

For the wider acceptance of harm reduction this development is the most explicit. Harm reduction developed from a rather marginal position to a mainstream position in the EU. Today, harm reduction measures are implemented in all EU Member States, though there are still several countries where there is, at least once in a while, some debate about their appropriateness. Here the top-down forces can also be observed at EU level. Harm reduction has been taken on board as one of the elements of a comprehensive drug policy in EU drug policy documents (see 4.2.3).

Decriminalisation of drug use and possession of small quantities for personal use is also widely implemented in EU Member States. However, decriminalisation, except for diversion schemes, was never formally supported by EU drug policy documents (see 5.2.4). This may help to understand the differences between Member States' decriminalisation policies. The, nevertheless, broad consensus in the EU on the usefulness of decriminalisation may have been shaped by the debates and cross-border exchange of experiences among experts and policymakers.

Exploring the feasibility of regulation as drug control instrument is still mainly limited to random regional or national initiatives, in which bottom-up criticism on the prevailing prohibitionist approach prevails. However, the heated debates of the past decade, the international exchange of experiences and the discussions about regulation of cannabis supply have resulted in a broader basis for change here. There seems to be a cautious trend away from prohibition towards regulation, from criminal to administrative law. Cannabis policy is the most striking example of that move away from prohibition. This trend can be observed in a growing number of countries.

Regulation is also an issue in the field of licit drugs. The policy response to alcohol, tobacco and gambling is moving in the other direction, from a rather unregulated state to increasingly stricter regulation (see 6). Regulation policies targeting alcohol, tobacco and gambling have become substantially stricter in the past decades. This contrary move is driven by the same questions as the developments in the field of illicit drugs: what are appropriate policies and what are effective policy instruments to control demand and supply, reflecting a wide consensus that 'addictions' require control or regulation. There seems to be growing consensus that regulating policies by regimes comparable with medicines regulations, consumer protection law, foodstuff regulations and regulations relating to specific commodities are the way to go. This trend can also be observed in the debates about an appropriate policy response to the emerging New Psychoactive Substances (NPS).

Besides this convergence there are, more recently, also signs of emerging divergence (see 3.3). By some authors this divergence tendency is sometimes understood as a phase in a policy cycle, as an inevitable swing back of the pendulum.

In several countries one can observe for instance manifestations of dissatisfaction with harm reduction. In a number of countries there are doubts concerning the usefulness and appropriateness of OST. In the UK, for example, one can see a revival embracing the value of an abstinence-oriented treatment approach. Support for harm reduction seems to be eroding. Also in countries with a traditionally strong dislike of harm reduction policies one can see in recent years a growing opposition in particular among supporters of a drug-free society (Trautmann 2013). A supporting factor might be the austerity budgets due to the economic crisis and the growing influence of political conservatism and populism, supporting a more repressive, supply reduction oriented approach. This development is clearly visible in many Member States, including the Netherlands. Finally, the increased emphasis on security and public order issues at Member State and EU level may also have been an influential factor.

These tendencies do not seem to indicate another paradigm change. It seems to be a revival of old assumptions, i.e. abstinence-oriented focus and anti-harm reduction resentments, rather than a step to a radical change of view.

## **7.2 The content: changing of views, changing of paradigms**

A helpful concept to better understand this process of convergence can be found in the work of Thomas Kuhn (2012) and Ludwig Fleck (1979) on paradigm changes. Both argue that science is necessarily based on expert consensus on how phenomena have to be explained. Science is therefore not fact based but grounded on the prevailing perceptions of facts, on a set of beliefs that are shared by a scientific community. This set of beliefs or assumptions are paradigms which are supported by research findings. A paradigm is generally accepted if it is seen as better than other competing assumptions. This does not mean that it will explain all the facts with which it may be confronted. Open questions will lead to further research which, according to Kuhn, tends to look for further confirmation of the paradigm. Confirming research results make the paradigm more robust and contribute to wider consensus and acceptance.

Kuhn points out that science tends to be conservative. Scientists tend to defend their paradigms and will often suppress new and / or diverging views which contradict or undermine their views. Kuhn poses that research is not so much about discovering the unknown, but rather "a strenuous and devoted attempt to force nature into the conceptual boxes supplied by professional education" (Kuhn 2012). According to Kuhn, paradigm changes appear when anomalies are discovered and acknowledged. They are generally initiated by research findings discordant with the prevailing paradigm. Despite the fact that science generally is rather conservative, scientific research repeatedly uncovers new and unforeseen phenomena, leading time and again to the development of new theories.

Kuhn, but above all Fleck, show convincingly that a paradigm in the field of science is not so much rooted in scientific or research facts. In particular Ludwig Fleck's book – with a slightly cynic touch called 'The Genesis and Development of a Scientific Fact' – makes a reasonable case for explaining this process as a socio-psychological process. Changes of power or influence among different 'schools' of researchers holding different perceptions or assumptions seem to play a more decisive role than 'scientific evidence'.

This theory of paradigm change is also a useful heuristic for better understanding the developments of the trends we focus on. It is particularly useful for explaining the shifts in the policy targeting illicit drugs, which have been more radical than the changes concerning licit drugs and gambling. Translated into that field it means that a change of the majority of stakeholders (not only scientists) in support of a new view plays a decisive role in a paradigm change.

All the three convergence trends we analysed can be understood as paradigm changes, as the emergence of a new consensus among influential stakeholders, a prevailing perception how elements of the 'drugs problem' have to be explained. It is the result of socio-psychological processes in the policymaking and governance arena.

The change towards a wider acceptance of harm reduction can be seen as a change of the objective of health interventions. While fifty years ago the predominant or even exclusive objective of drug treatment was abstinence, today this has at least partly been replaced in many countries by harm reduction. In some countries harm reduction has started to play a role also in drug education, aimed at reducing drug use related health damage among young people experimenting with drugs, and in drug treatment, e.g. aimed at a reduction of consumption levels.

The trend towards decriminalisation of use of illicit drugs reflects a change of 'essence', understanding the use of these drugs not as a crime but as a health issue. The choice for regulation is a change of the drug control approach of currently illicit drugs, choosing for regulation instead of prohibition.

These changing views also show that a paradigm change does not necessarily mean that one view is simply replaced by another view. Different paradigms can also exist side by side. The history of decriminalisation of use shows that there were periods when the crime and health paradigm coexisted, generally one being more dominant than the other, and sometimes swapped positions (see 5.1).

The change from the crime to the health paradigm also shows that a new paradigm is not necessarily in – all respects – better than the old one. It is simply a change in expert consensus on what is an appropriate understanding of a phenomenon. Replacing the crime paradigm by the health paradigm was welcomed by many as a major step forward in the direction of a more suitable understanding of drug use. It was seen as opening the door to a more effective and humane approach to the drug user. However, as already mentioned, there is one uncomfortable issue regarding the choice for the health paradigm. The dividing line between the health paradigm and a disease paradigm proves to be thin. It is only a small step from interpreting drug use as health issue to the view of drug use as disease. The latter is in fact a specific interpretation of the health paradigm (see 4.1).

It was the growing awareness of the health problems related to the regular and uncontrollable use of substances like alcohol and opiates, which led to the emergence of the addiction concept. The 1926 Rolleston Committee Report is one of the first documents defining opiate addiction as a chronic disease and legitimising OST, i.e. the prescription of injectable heroin on a maintenance basis (see 4.1). It was this addiction concept that opened the door for a wide acceptance of the disease paradigm. There are of course forms of drug use (including alcohol and tobacco use) that are harmful or self-destructive and can be seen as pathological. Many heroin users, for instance, face serious social and health problems, which call for medical and social help. This is also true for the use of other substances, illicit drugs like cocaine and amphetamines but also the widely used licit substances like alcohol and tobacco. Understanding drug use as a health issue and defining addiction or problem use as a disease, were therefore important steps forward, pushing back the criminalisation approach and paving the way for introducing health measures like harm reduction and treatment like OST.

Some unintended consequences of this disease paradigm went unnoticed by many. Several critics point out that using the disease paradigm involves the risk of 'pathologising' all forms of drug use (see 5.3.1) and denying phenomena of unproblematic use for, among others, recreational or spiritual purposes. Replacing the term 'addict' by simply 'drug user' contributed to muddling together addiction / problem use and 'non-addictive' forms of drug use. This criticism emphasises that not all



drug use can be defined as pathology. Viewing drug use as a disease puts the user wrongfully in the role of patient in need of treatment.

An additional criticism is that the disease paradigm like the crime paradigm is a concept that may be used for control purposes. The paradigm change implies replacing the control via the criminal justice system by control through the medical system. From a Foucauldian perspective of the disciplinary society the paradigm change can be interpreted as changing just the means of ‘disciplining’ (Foucault n.d.). The drug user remains subject of control or disciplining policies and is not in charge of his/her own life. The Portuguese model of de jure decriminalization can be taken as an interesting example of this. Drug use in Portugal is defined as an administrative offence and no longer as a criminal offence. Criminal charges have been replaced by the obligation to appear in front of a ‘dissuasion’ committee, which has the task to motivate drug users to undergo treatment. It is in fact a kind of diversion scheme, aiming to increase the motivation of the drug user to undergo treatment. What looks like a major step forward from a legal perspective is in many cases no change at all or even a step backwards for drug users. For some of them this means a hassle they did not have to face in former days when the police sometimes turned a blind eye on them (see 5.4.2).

Another problematic issue closely linked with introducing the disease paradigm for drug use is that this softening of the approach towards the users is closely tied with a hardening of the approach to the producer and seller. It looks very much like a ‘conditional sale’. Getting tougher on suppliers is widely accepted as part of a fair deal in combination with the decriminalisation of use. The users are seen as patients in need of treatment or as victims. The producers, traffickers or sellers are seen as villains, making available the drugs which ‘devastate’ the lives of users and therefore deserve harsh punishment.

### **7.2.1 *Alternative: the well-being paradigm?***

The disease paradigm proves to have serious shortcomings. There are only some forms of drug use that can be interpreted as (expression of) pathology, disease or ill-health. The health paradigm seems to be more suitable to explain drug use. Health issues play a prominent role in all forms of drug use. It covers both some negative and some positive sides to drugs and drug use. The health paradigm is useful to understand the detrimental effects as for instance the potential health harm of drugs, the health risks of problem use and the ‘pathology’ of addiction. However, it can also help to see the positive effects like the application of nowadays illicit drugs in medical treatment and the psychological benefits of drug use. Still, though all drug use involves health issues, not all drug use can be fully understood from the perspective of the health paradigm, as for example experimental use or use for recreational or spiritual purposes.

A key element in the research work of ALICE RAP is to reframe the general understanding of addiction. The aim is to use the input from the different research areas and disciplines brought together in the project to come to a new understanding, which can contribute to a more effective approach of addictions. The discussions among the researchers involved centre on the usefulness of the well-being concept for this reframing exercise.

Compared with the health paradigm, well-being might indeed be a more appropriate paradigm to explain the drug use and addiction phenomenon. Well-being seems to be – at least for the time being – the most suitable paradigm to look at and understand drug use. It covers a broader spectrum than the health paradigm. It helps to grasp the negative impact of (problem) drug use, reducing well-being, but is also useful in understanding the positive sides. It serves a framework in which the recreational and ritual drug use can be understood as enhancing well-being. It also is useful for understanding drug use as coping behaviour, as attempts to deal with negative or stressful emotions.

An important added value of the well-being paradigm is that it allows to acknowledge and better understand the positive effects of drug use.

These can be simply pleasure and relaxation, changing perspectives and transcendent experiences but also religious / ritual applications of drugs, which are widespread in different cultures.

### **7.2.2 Content: irrational elements in (governance of) drug policy**

A complicating factor in policymaking and governance targeting drugs and addiction is the influence of moral judgments or beliefs and other irrational perceptions. Much has been said about this. Drugs are seen as evil or demonic, drug use as depraved behaviour or paving the way to immorality. Losing self-control, changing perception and mood as a consequence of drug use are important elements contributing to this perception. The complexity or ambiguity of drugs might play a role, too. Most substances which we see as 'drugs' today have not always been drugs in the common negative meaning of the word with its moralistic connotations. Drugs have also been and some still are used for other purposes, for instance for medical purposes, but also for pleasure and recreation and even for spiritual or ritual purposes.

For licit drugs irrational elements may play a less prominent role. Here control policies are for an important driven by 'rational' motives, i.e. the undeniable evidence of health problems caused by alcohol and tobacco. Though also for tobacco and especially for alcohol one can find examples that these substances are viewed as evil. The 'demon drink' has been a prominent feature in the struggle for alcohol prohibition. For tobacco one can find interesting examples in history (see 6.2.1). The activist approach which has been chosen by some proponents of stricter tobacco and alcohol control policies sometimes shows features of a crusade rather than a rationally driven opposition. This criticism has also been voiced on researchers who chose for a rather activist approach, which sometimes seems to be based on belief rather than on evidence (see 6.2.6).

In the field of illicit drugs the role of irrational elements is clearly stronger (see 2.2 and 5.3.3). The ideal of a drug-free world and the concept of a war on drugs are just two examples of the politically and ideologically charged character of drug control policy. Pino Arlacchi, the former executive director of the United Nations Drug Control Programme (UNDCP), stated in 1990: "A drug-free world, we can do it".<sup>92</sup> The debates about illicit drugs are full of ideological statements. Connotations of 'good and evil' play an important role. The use of illicit drugs evoke moralistic judgments, which can be taken from the picture of the user as victim or patient and the supplier as a criminal, which deserves severe punishment (see 5.5.2). Even the argument that the health paradigm is more 'humane' has moralist connotations.

In fact, the distinction between licit and illicit drugs is ideology rather than evidence based. It is not based on the harmfulness of the substances. Various research shows that tobacco and alcohol, the most widely used drugs in the world, are among the substances causing the most serious health harm (Nutt et al. 2007 Nutt et al. 2010; Van Amsterdam et al. 2010).

These moralist views and beliefs still play an important role in shaping the public debate about drugs. This is not only true for parts of the 'conservative' camp, supporting a war on drugs aimed at a drug-free world, but also for some 'reformers', who seem fond of the picture of the drug user as a victim and a patient (see 5.3.1). These moralist views and ideological connotations are an influential 'content' factor in the developments of the trends we covered in our case studies. They work as

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<sup>92</sup> <http://www.un.org/ga/20special/> [accessed 10th May 2014].

barriers as well as facilitators for the wider implementation of harm reduction and decriminalisation of use.

### **7.3 Selected stakeholders**

Various stakeholders contributed to the course the three drug policy trends took. The actual influence of stakeholders on changes in policy and governance depended on various factors. One factor is the political and economic power of the involved stakeholders. Political power does not only rest on for instance the size of a political party, taking a certain stance in the drug policy debate. It also rests on factors like its net of influence among other policy decision makers. Do other decision makers support the political views and beliefs behind the policy choices made? The relevance of economics speaks for itself. The influence of the tobacco and alcohol industry is a recurring theme in drug policy analyses.

Another factor determining stakeholders' influence is the extent and vigour of support within a certain stakeholders group and, more important, within coalitions of different stakeholder groups. Broad support in one stakeholders group and / or in a stakeholders coalition, representing different policy areas and interests, adds to the influence on the decision making process. Also variety seems to count. Support from diverse stakeholder groups helps to make a difference, as the wider acceptance and implementation of harm reduction measures like OST and drug consumption facilities in the Netherlands shows. While these services were promoted initially by the social movement, alternative health services, health authorities and other policymakers primarily driven by health interests, in the following years police and justice, the communities affected by 'public nuisance' caused by drug users and the media followed (see 4.2). This resulted in a broad coalition of stakeholders with a shared aim, but driven by different interests. Besides health protection there was also the interest of securing public order and the economic interests of entrepreneurs in the neighbourhoods running shops, restaurants and pubs. There was a growing understanding that a broader stakeholder coalition was helpful to bring about policy changes like the introduction of drug consumption facilities. This 'joint venture' did not just mean a broader basis for changes. It also reflected an increased sense of urgency, which contributed to the vigour of stakeholders' support.

Finally, timeliness is an important factor. 'Right time – right place' are decisive for allowing changes to happen. This refers to the context of policy making. The societal mood is an important element here (see below under 7.4.1). It can for instance be doubted whether the drug policy reforms in the Netherlands of the 1970s would have been possible in the current political climate.

All these factors help to create a policy window for changes. They play an important role in 'synchronising' the problem, policy and political stream. The widening consensus among different stakeholder groups also contributed to the basis for the paradigm changes (see 7.2).

The case studies show that various stakeholders have influenced the development of the three trends. Though politicians and policymakers played, of course, a decisive role in the decision making process we decided to focus in these concluding discussions on three stakeholder groups, because of their importance and their special role in the development of the three trends covered in this study: science and research, the supply lobby and the social movements. Social movements and science played a key role in challenging dominant paradigms, functioning as facilitators of changes.

#### **7.3.1 Influence of science and research**

Despite the highly politicised and ideologically charged character of in particular the policy targeting

illicit drugs (see 7.2.2) and the strong influence of economic interests of the producers (lobby) in the field of licit drugs and gambling, the influence of science has been substantial and – at least from time to time – decisive. Evidence has played an important role in many policy decisions. The changes in Dutch drug policy in the 1970s (see 4, 5 and 6.1) and the increasingly stricter tobacco control policies (see 6.2) are good examples of the latter.

Nevertheless, the critics about the still rather limited impact of science on drug policy and governance have a point. The radical change in Dutch drug policy, culminating in the 1976 drug law, may be one of the few examples of a drug policy change which for an important part was guided by evidence. Politicians and policy makers consulted scientists and took on board the then available evidence as the fundament for their decisions, at a time when evidence base was not yet a prominent issue in (drug) policy making. The then existing policy and health service responses could not effectively deal with the problems young people faced. Science was one of the elements contributing to a window of opportunity. In the 1980s the research evidence for effective HIV prevention contributed to the wider implementation of harm reduction strategies in many countries.

Still, generally speaking, political and ideological arguments dominated policy decisions in the field of illicit drugs in many countries. This is also true for the Netherlands, where after a promising start in the 1970s and 1980s political and ideological motives gained importance, particularly in the field of cannabis policy. In different countries one can find examples showing that scientific evidence is simply ignored or overruled by political or ideological agendas (see 5.3.3).

#### *The complexity of the 'evidence' concept*

However, the issue of scientific evidence is more complex than frequently suggested. Though there are cases of rather indisputable evidence – the proof of harmfulness of tobacco is one example – in most cases there is no uncontested evidence base for drug policy decisions. The debates about comparing the harmfulness of different drugs are one example. Here, the evidence consists of a composition of different indicators for different elements of harmfulness, among others physical, psychological and social harms to users and a wide variety of harms to others e.g. injury, crime, environmental damage and economic costs (Nutt et al. 2007; Nutt et al. 2010; Van Amsterdam et al. 2010). These indicators cannot be weighed (against each other) 'objectively' or unambiguously, to come to one integrated 'fact-based' drug harm indicator. For some of these indicators it is even difficult to find a solid measurement. This is true for social harms related to drug use, which are difficult to define. It is hard to establish unambiguously a relationship between drug use and these harms. These definitions are susceptible for being charged by values and beliefs. This means that, similar to what we said about paradigms, determining harmfulness is based on expert consensus rather than on scientific facts. There is no purely scientific, objective evidence neither for rankings of harmfulness of different drugs nor for policy decisions (see 5.3.3).

Another complicating factor is conflicting evidence. Harmfulness of cannabis is a prominent example, as the ongoing discussion shows. The recent debates about whether high THC content results in an increase of psychosis among users underline this. In a politicised and polarised debate ambiguity of evidence results in selective use of evidence. The different camps tend to select the evidence which supports their position.

There is no easy way out of these dilemmas. As Monaghan shows, it is rather complicated. While evidence-based decision making is seen as a key element of good governance Monaghan emphasises that policy decisions are not just a technocratic process of following the 'evidence'. Policy choices are made in a process of democratic decision-making, weighing the available evidence and taking into account other considerations of a government (Monaghan 2014).

### **7.3.2 The supply lobby**

There are different lobbies active in the drugs and gambling market. There are lobbies pro and con stricter control policies. We decided to focus here mainly on the most powerful lobby: the supply lobby. As can be taken from the alcohol and tobacco market the producers' lobby is due to their economic power clearly the most influential stakeholders lobby. However also the 'sellers', the retail and hospitality business play a significant role (see 6.2.5). Alcohol and tobacco producers are an influential party in the political arena regarding the decision making process.

Our case study on the trend towards stricter tobacco control policies shows that in this area the supply lobby is, besides science and research, the other influential stakeholders group. Due to the focus of our study – stricter tobacco regulation in the hospitality sector – the supply lobby included besides the tobacco industry also the organisations representing the interests of hospitality entrepreneurs and interest groups of smokers. The first is clearly the most powerful in the lobby against stricter tobacco regulations and plays the role of natural adversary of science and research, which are advocates of more restrictive tobacco control policies (see 6.2.4). This picture reveals another moralist perception in the area of drug policy making and governance. While scientists and researchers are generally seen as the good guys the lobbyists of producers and sellers of drugs are generally seen as the bad guys. This is in fact very similar to the moralist view behind the tougher approach to suppliers of illicit drugs (see 5.5.2). Negative intentions are attributed to drug producers and sellers, while science and research are rather seen as been driven by altruistic motives, disregarding the economic interests of science and research (salary, research funding) and the urge to become a name both as an individual and as an institution.

There is one intriguing consequence of the shift from prohibition towards regulation of cannabis supply. For obvious reasons openly lobbying for the interests of cannabis suppliers was non-existent under prohibitionist rules. In the Netherlands, where the selling of cannabis through so-called coffee shops is tolerated, unions of coffee shop owners have emerged in the margins of the still illicit but condoned cannabis market, acting as a lobby for the interests of cannabis retailers. They are formally organised as for instance the 'Bond Cannabis Detailisten' (BCD, the Union of Cannabis Retailers) and nowadays participate openly in the debate about coffee shop policy (see 6.1.1). The Federation of Cannabis Clubs in Spain is another example of trade organisations openly lobbying for their interests, emerging in the margins of the illicit drugs market, where prohibition is replaced by condoning policies (see 6.1.2).

### **7.3.3 Social movements**

From the 1960s onwards a – relatively<sup>93</sup> – new stakeholder appears on the scene in different EU Member States, claiming a say in drug policy debates. Social movements of mainly young people emerged all over Europe, opposing the established social order, which – in the view of the protesters – was predominantly conservative and restrictive. These social movements differed regarding their scope and political orientation (see 4.1.1). In some countries the drug issue appeared on their agenda. In four of our five sample Member States social movements popped up, opposing the generally repressive policies which targeted the use of the then emerging new illicit drugs.

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<sup>93</sup> In the history of drug control policies one can find more social movements that have played a role in the policy making process. One of the well-known examples is the temperance movement, a social movement urging personal moderation in the consumption of alcohol and promoting complete abstinence. The 'teetotalists' use their political influence to pressure governments to enact alcohol laws to regulate the availability of alcohol or even its complete prohibition.

They were an important element in the bottom-up forces pushing for new approaches, setting the trends which we covered in our case studies: the introduction of harm reduction, the push for decriminalisation of use and regulation instead of a prohibition regime.

These social movements differed substantially per country. In the Netherlands changing the drug policy was an important issue on the agenda of the Provo's, the most prominent 'group' in the Dutch protest movement. The alternative youth services, which formed the basis for alternative drug services and the harm reduction movement, were another important player. This broad social movement gained wider support rather quickly, paving the way for fundamental change, covering the introduction of harm reduction, decriminalisation of use and partial regulation of cannabis. In Slovenia and Spain the drastic social and political changes from a totalitarian state to a democracy were the breeding ground for wider societal changes, including drug policy changes. Needless to say that the processes of social change in both countries differed substantially due to the specifics of their national history (see 5.3.1). There were also differences regarding the changes in drug policy: in Slovenia the changes started with a focus on developing harm reduction services due to a particularly strong harm reduction movement, which started to emerge before the social changes set in (see 4.1.1). The changes in Spain took off with a focus on decriminalisation of use, in particular cannabis use. Spain has had a strong cannabis social movement since a long time (see 5.3.1). Here too the first steps had been made before the fall of the Franco government. In the UK it started with harm reduction. Tying in with the tradition started in the 1920s with the work of the Rolleston Committee (see 4.1) the harm reduction movement took off in Liverpool in the 1980s without being embedded in a substantial wider social movement.

These differences show that the national social context in these four countries shaped the scope and orientation of the social movement. The social movements were definitely not the most powerful stakeholders in the drug policy changes. Still, they were clearly influential. They provided new answers to pressing questions and helped setting the agenda of the drug policy debate. They were successful in claiming a place at the negotiating table, also because their ideas were rather quickly embraced by policymakers and politicians. They simply seem to have been at the right time at the right place with their ideas for better managing the drug use (and HIV) problem.

In many cases they were not a permanent factor in the drug policy arena. They were a temporary phenomenon, being of importance at a certain phase of drug policy development. The Provo's have gone, the harm reduction movement has faded into the background in many EU Member States. This may be a side effect of the stagnation of the heroin epidemic and the eroding support for harm reduction (see 4.3). At the same time the cannabis social movement has gained influence in several European countries (see 5.3.1). Here the current – worldwide – debate about cannabis regulation policies, based on the doubts about the appropriateness of cannabis prohibition, is an important contextual factor (Decorte et al. 2011; Apfel et al. 2014).

#### **7.4 Key contextual factors**

In our case studies numerous examples of contextual factors influencing policymaking and governance were passed in review; historical factors like the changing scenery of tobacco and gambling control policies (see 6.2.1 and 6.3.1) and the historic context of the development of harm reduction, of decriminalisation of use and of exploring regulation alternatives for prohibition (see 4.1, 5.2 and 6.1); economic factors like the economic arguments against stricter tobacco control policies (see 6.2.5) and the impact of the economic crisis on drug policy decisions (see 3.3, 4.3, 6.1.1, 6.2.3 and 6.2.4); political factors like the rising conservatism in recent years (see 3.3, 4.1, 4.2.2, 4.3, 5.5.1, 6.1.1, 6.1.4, 6.2.3, 6.2.4 and 6.2.6); and social-cultural factors like the social and political factors supporting the introduction of harm reduction, decriminalisation of use and regulation

policies (see 4.1.1, 4.2.1, 5.2, 5.3.1, 6.2.1 and 6.2.7).

Contextual factors are decisive in determining the influence of a certain stakeholder or specific policy content in the decision making process. It was for instance the historic social-political context which gave influence to science in the Dutch drug policy changes in the 1970s and which made the policy content proposed by scientists and social movements generally acceptable.

In the following section we will discuss a number of contextual factors that had a major impact on the drug policy changes in the past decades: the social mood, the societal environment and changes, and closely linked to the latter: ‘uncertainties’ in a changing policy or governance environment.

#### **7.4.1 Important contextual factors: social mood, societal environment and changes**

At different points in our case studies we came across references to the societal mood as explanation for drug policy changes. The best documented examples were found for the Netherlands. Here, the predominant conservative and restrictive mood, characteristic for the post-war reconstruction era, with a strong focus on discipline and order, was the breeding ground for the protest movement, which emerged from the 1960s onwards, resulting in the 1970s ‘mood for a change’. A libertarian oriented social movement helped to initiate the drug policy changes in the 1970s (see 4.1.1). In more recent years one can observe a swing back to political conservatism, a restoration trend, emphasising public order and security, both by national governments and at EU level. Not only in the Netherlands, but all over Europe conservatism has become more influential in social policy, a change which fits well with the economic crisis and is supported by the public opinion and the media. This conservative mood is in favour of a more restrictive drug policy in general. The tough approach on drugs supply fits this general conservative mood. As already mentioned, it can be doubted whether the drug policy reforms of the 1970s would have been possible in the current political climate.

An additional factor restricting policy changes – not only in the drugs field – is the nowadays more limited room for manoeuvre for individual EU Member States due to a more embracing EU integration. In the 1970s and 1980s countries in the EU could operate more autonomously than today. During the debates about the Dutch drug policy changes in the 1970s considerations about an EU drug policy framework were absent. There was no EU drug policy framework as we know it today. This does not mean that the absence of an EU drug policy framework only meant ‘opportunities’ for drug policy changes. At the same time it meant threats as the fierce opposition of various EU Member States to the changes in the Netherlands show. In the end it were EU drug policy documents like the Council recommendations on harm reduction and the EU Drugs Strategy 2005-2012, which propagated the EU-wide introduction of harm reduction.

Societal changes were another significant contextual factor. To a certain degree the Netherlands illustrates this well. The protest movement of the 1960s and 1970s ‘shook’ the quiet, self-contented life in the post-war Netherlands and resulted in memorable changes. However important some changes may have been at the time, they were not fundamental. This cannot be said about Slovenia and Spain. These two countries saw essential societal changes. These societal changes in Slovenia, Spain and also in the Netherlands helped to create a policy window for drug policy changes.

#### **7.4.2 Some specifics: uncertainties create opportunities**

One specific feature of societal changes is important here. Societal changes, in particular radical transformations as we saw in Slovenia and Spain, bring about changes in the political environment of and ideas about policy and governance. They are a result of a policy window for general societal changes and at the same time an ideal setting for policy windows for ‘detail’ changes.

There is a widely shared perception of a fundamental problem (the problem stream), a generally felt sense of urgency for far-reaching changes (the policy stream) and a broad consensus about the directions of the changes (the political stream). The drug policy changes in the Netherlands, Slovenia and Spain clearly profited from this spirit of change.

These transformation processes are coupled with uncertainties. The transformation in Slovenia and Spain from a totalitarian to a democratic political system implied the breaking down of old structures and rules and the absence of well-established positions regarding new policies. This may have been particularly true for policies addressing relatively new social phenomena such as the then emerging 'drug problem'. The societal changes in the Netherlands, Slovenia and Spain had a major impact on various areas, especially on drug policy issues. In all three countries the ownership of the drug problem was not yet clearly defined. There was no consensus on a leading paradigm: was the drug issue a health, crime or social problem? There was no consensus how to define the problem and how to deal with it. The territory was not yet divided, allocating clear responsibilities to different stakeholders (see 6.1.1).

Overall, the drug policy response was therefore characterised by uncertainties. It was a response to a changing societal environment, to rebelling social movements, and, to a new unknown phenomenon: the evolving 'drug problem'. The knowledge about this new phenomenon was limited. There were no clear-cut, approved answers to this challenge. This is why policymakers and politicians turned to science to find an explanation of this phenomenon and to get advice what to do.

These uncertainties revealed the need for new effective policy responses and provided opportunities for policy innovations and for experimenting with new approaches. It contributed to a window of opportunity for developing harm reduction, for decriminalising drug use and – in the Netherlands – for experimenting with regulation as alternative for prohibition. There was room for manoeuvre, despite the limitations posed by the international conventions.

These uncertainties and restrictions also help to explain why the response from the authorities to all these manifestations of change has been sometimes rather inconsistent. Especially in the early years the response varied from harsh to lenient. In the Netherlands the lenient approach was particularly common among local authorities, paving the way to what became known as the Dutch 'condoning approach' towards the selling of cannabis.

## **7.5 From government to governance**

There is one more interesting feature in the policy changes we have analysed in our case studies: Political and policy decisions in European societies until well into the 20th century were usually taken by politicians without much interference of other stakeholders. Politicians were of course supported by civil servants who prepared the decision making process. And, where deemed necessary, experts were consulted. The drug policy changes starting in the 1970s show a growing involvement of various stakeholders, both in the policy making process and the implementation of policy measures. This change has been noted by different authors particularly in the UK, emphasising that in the past three decades the number of stakeholders involved in addressing the drug problem had increased (Duke et al. 2013; Duke and Thom 2014; Singleton and Rubin 2014). It is seen as one important element of a general change of the ways policy is made and implemented in contemporary 'Western' societies. In the UK and other English speaking countries it is framed as a change from government to governance (see 1). It is one of the important themes in current (drug) policy studies (see for instance the Special Issues of the International Journal of Drug Policy August 2014).



The drug policy changes in the Netherlands of the 1970s illustrate the growing influence of different stakeholders. This change came from two directions. On the one hand the government itself was looking for actively involving stakeholders, which it considered useful for making drug policy more effective. At national level this was mainly limited to involving scientists who were invited to analyse the problem and provide recommendations how to address the problem (see 4.1.2, 5.3.2 and 6.1.1). At local level this move to a broader basis for policy decisions was more noticeable. When in Amsterdam the drug problem spread over the city, affecting the quality of life in different neighbourhoods, the city government allowed the involvement of a growing number of stakeholders in its search for solutions (see 6.1.2). Health services, representatives of the affected communities, residents, owners of shops, bars and restaurants and the police were actively involved in the search for effective policy responses. This broader coalition was seen as helpful to get wider consensus and commitment concerning the policy choices to be made. Combining different interests and arguments (see 4.2.1 and 5.4.2) contributed to a wider acceptance of the policy measures.

Besides this top-down driven change there were also bottom-up forces towards a broader stakeholder involvement. The youth protest, the alternative youth services and the first harm reduction services demanded from the start that their critique on the existing drug policy would be heard and that their proposals for alternative responses would be taken into consideration (see 4.1.2). Also the involvement of representatives of communities affected by the drugs problem started bottom-up as critique on failing policies to maintain public order (see 4.2.1). Also they demanded to get involved in the decision making process. At a later stage also the coffee shop owners became a stakeholder of some importance in the decisions regarding the coffee shop policy (see 6.1.1). These stakeholders coming from the ranks of the opposition against government policies appeared at the negotiating table not so much by invitation, but by claiming a place at that table. The climate of social changes of that time was an important contextual factor, which helped to speed up the process not only in the Netherlands, but also in countries like Slovenia and Spain. The protest movement and other opposition groups and political parties in many European countries called the old structures into question, in which the authority of the government was undisputed. They demanded to be heard in the decision making process.

The increased stakeholder involvement can also be observed in other 'drug policy' fields. Among others the struggle for smoke-free hospitality venues in the Netherlands shows an increased participation of stakeholders in and around the political decision making process. Both among supporters and opponents a move towards broader and more powerful coalitions could be observed (see 6.2.3, 6.2.4 and 6.2.5).

In many countries this move 'from government to governance' in drug policy seems to have taken place without much reflection. There is no mention of the concept of governance in the literature about the early years of these drug policy changes. The governance concept providing the theoretical framework to explain this new reality was developed later particularly in the UK and Australia (see 1). One factor mentioned in the Dutch literature on the drug policy changes is the emergence of articulate stakeholders with an interest in or affected by the drug problem (De Kort 1995; Blok 2011). These stakeholders started to ask questions and required to have their say in drug policy making. They held politicians responsible for their decisions, resulting in a change of the political landscape. Today we would call these changes signs of emerging governance.

Drug policy making proves to be an area where the urge for a change has been particularly pressing. Drug policy is a complex area and drug policy making is a challenging process. Many of the challenges have been mentioned in the case studies above (see among others 2.2). Drug policy is a highly politicised or 'ideologised' area, in which moral judgments or beliefs and other irrational perceptions play an important role.

A wide range of interests are at stake, e.g. concerning health, rule of law, public safety, economy and research but also ideological motives. Some of these interests are contradictory, e.g. the government's interest in high tax income from tobacco and gambling and at the same its interest in limiting health damage and related health care costs. The number of affected stakeholders is substantial, also because of serious unintended consequences of drug policy measures (see 2.2, 5.3.3, 5.4.1 and 6.1.1).

This complexity and the dissatisfaction with the current practice of drug policy making led to efforts aiming to improve the policy making process. The UK Drug Policy Commission has systematically elaborated what good drug policy governance means, resulting in useful guidance documents (UK Drug Policy Commission 2012; Singleton and Rubin 2014). The basis for this was an extensive expert consultation, resulting in a list of eight areas that are important for good drug policy governance. These areas include besides stakeholder engagement, clarity of overarching goals, strong leadership, coordination of policy efforts, policy design, use of evidence base, implementation and accountability and scrutiny (Hamilton et al. 2012).

## **7.6 Concluding remarks**

With our case studies we intended to contribute to a better understanding of factors that influence drug policy decision making and shape the governance of drug policy. Using the Health Policy Triangle as a heuristic to unravel and order the factors of influence we discerned between content, process, actors or stakeholders and context. We combined this somewhat static approach with elements of Kingdon's Multiple Streams Model, another heuristic that helped us to better understand the dynamic processes of drug policy making and implementation, the relationships and influences between these factors of influence. This model allowed us to 'compose the picture'. Combining elements of both models was a useful approach for capturing the complexity and dynamic of the drug policy trends we were focussing on (see 2.2.4).

The question is of course what are practical implications of our case studies? Are there any lessons to be learnt from these analyses? In this last part we will look into this. We will limit ourselves to pointing out some general practical conclusions.

### **7.6.1 The context**

The context of policy making and implementation: the historical, political, economic and social-cultural factors influencing policymaking are given circumstances. They define the room for manoeuvre at a certain point in time. There is not much one can do about these factors except taking them into account. It is the context which determines for an important part whether the chosen aims and objectives of policy measures are realistic and achievable, whether there are barriers or facilitators for achieving aims and objectives. Examining the context, including a risk analysis, should be an integral part of exploring drug policy alternatives. One option here is a SWOT analysis by experts. One particularly useful format to do this are expert focus groups, which can help to identify strong and weak points of a policy measure and contextual opportunities and threats as regards its implementation. Such an exercise can also help to identify possible unintended consequences.

### **7.6.2 The content**

The policy content, generally laid down in a policy paper or plan, describes the underlying reasons for developing a specific policy, its objectives and the measures to be taken. Important factors determining the policy content are the context and the perception of the problem that requires policy interventions.

A useful tool or format for systematically developing a policy plan is a LogFrame matrix (see Appendix 9), which allows for splitting the plan into logically linked constituents, including overall objectives, specific objectives, expected results and activities to realise objectives and results. It describes the logic of the interventions along the line of these four constituents. It sets the indicators to measure the achievements, defines the sources of information and means which will be used to verify the indicators and, finally, elaborates assumptions. The latter includes a risk analysis, or – even better – a full SWOT. A reflection on unintended consequences is also worth consideration here. To facilitate the feasibility and evaluability of a policy plan the objectives should be SMART<sup>94</sup>. The feasibility of the objectives depends for an important part on contextual factors, as they determine the ‘play area’ of policymaking.

A LogFrame matrix helps to reflect on all relevant elements of a policy plan in a specific and structured way. This systematic presentation of all elements also facilitates the evaluability of a strategy. It is particularly helpful for assessing the internal logic and consistency of a policy paper. Are the objectives formulated in a SMART way? Do the expected results represent a realisation of the objectives? Are the selected activities the most appropriate way to reach the objectives and to realise the expected results? Are the selected indicators indeed proof for having achieved the expected results? These are all questions which can be checked in a critical reflection by experts involved in a specific field of policy making and implementation. For this exercise focus groups are again a useful method to critically check all relevant elements and their logical connections. Through focus groups one can consult experts, compare their views and work towards consensus.

By including a division of tasks among stakeholders, defining who is responsible for which activity, a LogFrame also can facilitate accountability.

### **7.6.3 The process**

The process of policy making and implementation lies at the core of governance. Here the concept of good governance comes in again. UKDPC's work on this subject provides guidance here (see 7.5). Key theme in the work of UKDPC was ‘how to make drug policy better’, which is also the title of its legacy publication (UK Drug Policy Commission 2012). In this report the authors list characteristics of good governance and provide seven recommendations how to improve policy making and implementation. It may look a bit like a moral appeal to the ones responsible for policy making. Nevertheless, it is an excellent checklist of or standard for good policy making, covering the following areas: stakeholder engagement, clarity of overarching goals, strong leadership, coordination of policy efforts, policy design, use of evidence base, implementation and accountability and scrutiny (Hamilton et al. 2012).

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<sup>94</sup> SMART stands for **S**pecific, **M**easurable, **A**ppropriate, **R**ealistic and **T**imely.

#### **7.6.4 The stakeholders**

From UKDPC's definition of good governance follows that involvement of all relevant stakeholders in the process is essential for effective policy making and implementation. Therefore it should be standard procedure to identify all stakeholders either affected by or with a professional interest in a certain problem. There may be cases where this exercise will result in a rather long list. In those cases one could decide to produce a shortlist of the most important stakeholders involved.

There are various examples of token involvement, which in some cases is nothing more than simply informing stakeholders and at the most asking a number of questions without taking the input on board. Evidently this 'token involvement' will cause frustration and not result in active commitment and feelings of ownership. Effective stakeholders' involvement consists of active involvement, consultation of and discussions with relevant stakeholders. One important step at the start of the process is to identify the interests of the different stakeholders in order to get a clear picture where the discrepancies and commonalities lie. This analysis is important for identifying possible win-win situations between stakeholders with different interests, which might be combined for a certain purpose, namely forming as broad as possible stakeholder coalitions. The example of the successful implementation of drug consumption facilities in the Netherlands shows the importance of broad coalitions, combining different interests for one specific purpose (see 7.3). Breaking ground for consensus and building coalitions is an essential part for successful policy making and implementation.

#### **7.6.5 The policy window**

This brings us back to a key heuristic from Kingdon's Multiple Streams Model for understanding policy changes: the policy window or window of opportunity. Building stakeholder coalitions, looking for win-win situations can be understood as pushing for a policy window. The concept of a policy window provides a convincing picture, which helps to understand the conditions or requirements for a policy change. The coming together of the three streams (problem, policy and political stream) is a decisive condition for policy change to happen. These policy windows can of course not be constructed. There are too many variables and stakeholders involved in it. The best one can do is try to support factors in favour of a window of opportunity. In these concluding remarks various points have been mentioned which should be considered when thinking how to facilitate policy changes.

A paradigm change reflecting a wider consensus among stakeholders can also be understood in terms of a policy window. Stakeholders' consensus plays a crucial role in all three streams: in the problem stream a consensus concerning the urgency of a problem; in the policy stream a consensus on the 'solution' of the problem, i.e. a feasible and effective policy proposal; and lastly in the political stream a majority of politicians supporting this policy proposal.

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## Appendix 1: Country report: Harm reduction and regulation of tobacco in France

### Country report ALICE RAP WP14

#### France Tobacco

In this study we focus on two selected cases of governance *practice*. For being able to describe and analyse these two cases we need a basic overview of relevant factors in the preparation, enactment and implementation of important measures and regulating provisions in the legislation or otherwise. This questionnaire will result in a country report and focuses on two selected cases of governance practice related to tobacco use: legislation and regulations regarding **smoke free hospitality venues** and **e-cigarettes**.

The structure of this country report format is based on an adapted version of the health policy triangle of Walt & Gilson (1994)<sup>95</sup>. This is built up around the following four concepts: policy content and process, stakeholders and context (for more detailed information see the project proposal).

Important: Please fill out this format as completely as possible, but limit yourself to the key elements. At a later stage we might contact you for additional information.

### I Policy process and contents

The World Bank has described six tobacco control policies, which are seen as highly cost-effective<sup>96</sup>. Joossens & Raw (2011)<sup>97</sup> have used these policies to base their Tobacco Control Scale (TCS) upon (see annex 1). This scale quantifies the implementation of tobacco control policies for different European countries to allow for comparison. The six policies include<sup>2</sup>:

- A - Higher taxes
- B - Bans on smoking in public and work places
- C - Better consumer information
- D - Bans on advertising and promotion
- E - Large and direct warning labels
- F - Cessation therapy.

In our study, we decided to only focus on B and F.

#### 1. Smoke free hospitality venues

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<sup>95</sup> Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health policy and planning*, 9(4), 353-370.

<sup>96</sup> World Bank (2011). *Tobacco Control: at a glance*. World bank: February 2011.

<sup>97</sup> Joossens, L. & Raw, M. (2011). *The Tobacco Control Scale 2010 in Europe*. Brussels: Association of European Cancer Leagues 28-03-2011.

**Does the tobacco legislation in your country include bans/restrictions on smoking in public and work places?**

- yes  
 no

**1.1 In depth information on *legislation* regarding smoke-free hospitality venues**

**1.1.1 Please provide information, in bullet points, on the preparation and enactment of the first legislation and regulations on smoke-free hospitality venues. Include dates (year).**

*Please give your answer in the box below*

→ **Before 1976**, smoking was long ago forbidden in some places like theaters and movie theaters for safety considerations. The department of Health was in no way involved in these regulations.

→ **1976**

Article 16 of the Veil Act (Loi 76-616 du 9 juillet 1976 relative à la lutte contre le tabagisme) says :  
Decrees will determine when and where forbidding to smoke will be set in (special) places for collective use where smoking can have hazardous consequences for health.

In premises or vehicles where smokers and non smokers are welcome in distinct areas, the space assigned for non smokers can't be smaller than half of the whole.

One decree has actually been released in 1977 (12 september)

It says

that:

It is forbidden to smoke :

in any public premise when the ventilation does not meet specific features ;

in primary and in lower/junior secondary schools, in any place attended by pupils when they are present. In high-schools (upper secondary schools) and universities, bylaws must say where smoking is forbidden ;

in any premise welcoming young people aged under 16 for recreation or holidays ;

in places of hospitals and health care facilities where patients are welcome ;

in places where food is stored, or transformed or prepared before being sold ;

in public transportation when the vehicle is dedicated to welcome young people aged under 16. In

other public transportation means except in buses, a smoking area can be set up on no more than half of the seats if there is an effective device preventing the smoke to be spread everywhere ;

in the elevators ;

Displaying signs of these various prohibitions become compulsory.

Describes also which fines are enforceable.

→ 1991 loi Évin (Loi 91-32 du 10 janvier 1991 relative à la lutte contre le tabagisme et l'alcoolisme)

Says that it is forbidden to smoke in any place dedicated to "collective use" except where it is explicitly allowed.

Bylaw (decree in May 1991) attempted to organise the ban in cafés, restaurants, schools, ... but remained more or less ineffective.

**1.1.2 Please provide information, in bullet points, on the preparation and enactment of the current legislation and regulations on smoke-free hospitality venues. Please include dates (year).**

*Please give your answer in the box below*

Anchored to the 1991 Evin Act a new bylaw (décret n° 2006-1386 du 15 novembre 2006) significantly strengthens the former rules.

Further to the decree FIVE circulars gave details about the right implementation of the new rules:

- Circulaire du 24 novembre 2006 concernant la lutte contre le tabagisme (J.O. n° 281 du 5 décembre 2006 page 18276);
- Circulaire du 27 novembre 2006 relative aux conditions d'application dans les services de l'Etat et des établissements publics qui en relèvent de l'interdiction de fumer dans les lieux à usage collectif, prévue par le décret n° 2006-1386 du 15 novembre 2006 (J.O n° 281 du 5 décembre 2006 page 18289);
- Circulaire du 29 novembre 2006 relative à l'interdiction de fumer pour les personnels et les élèves dans les établissements d'enseignement et de formation (J.O. n° 281 du 5 décembre 2006 page 18282);
- Circulaire du 29 novembre 2006 relative à l'interdiction de fumer dans les lieux à usage collectif (J.O. n° 281 du 5 décembre 2006 page 18285);
- Circulaire du 4 décembre 2006 concernant la réglementation relative à la lutte contre le tabagisme (J.O. n° 281 du 5 décembre 2006 page 18283);

**1.1.3 Please provide information, in bullet points, on any relevant changes between the *first* legislation and regulations on smoke-free hospitality venues and the *current* legislation and regulations. Include the year(s) of change.**

*Please give your answer in the box below*

The 2006 decree was enforceable from February 1<sup>st</sup> 2007 everywhere except in beverages on-premises, casinos, game clubs, tobacco selling places, night-clubs, hotels and restaurants. In these hospitality venues the new rules became enforceable from January 1<sup>st</sup> 2008.

In primary and secondary schools the new rules expand the tobacco smoking ban to the whole space including open spaces and prohibits any organized smoking place.

Smoking prohibition come over being the general rule in workplaces, collective transportation means and every closed and covered hospitality venues including bars, restaurants, night-clubs, tobacco selling places and casinos. It allows to organize smoking zones under tight conditions: a shut place maintained underpressure vs outside, equipped with a smoke extracting device, etc. and forbidden to minors under 16.

**1.1.4 Briefly describe key events and underlying reasons in the process of preparing and adapting the legislation and regulations on smoke-free hospitality venues (chronologically, with accompanying dates).**

*Please give your answer in the box below*

A parliamentary study group was held from May 2006 to July 2006 (printed on october 4<sup>th</sup>) about the specific matter of environmental tobacco smoking. It was headed by a MP (Claude Évin) who

was formerly the Minister who gave birth to the 1991 Act used to be called "loi Évin". The group recommended at large what the 2006 decree decided.

The writer is not aware of all the underlying reasons which led to create the study group, but notices that former to the study group, at least 3 legislative proposals had been released by different groups of MPs in order to improve the implementation of the regulation on smoke free hospitality venues, or to prevent a forthcoming total ban (Bur, 13/10/2005; Evin, 28/02/2006; Zumkeller O1/03/2006). None of them succeeded to be enacted, but the Government was under pressure to make a decision.

**1.1.5 Please identify the five stakeholders who played the most important role in supporting the preparation and enactment of the legislation and regulations on smoke-free hospitality venues.**

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
Government	Research evidence on effectiveness of measures (Bad implementation of the former rules + Public opinion surveys)	7	1	1	4
Anti-smoking groups	Specific association does exist in France focussed on non-smokers rights. Has been very demanding and knew pretty well the technical file	2	1	3	6
Judiciary	Judgement of the Supreme Court ("Cassation" court) on 29/06/2005 made compulsory for the employer to get a result securely in protecting the worker's health facing passive smoking.	6	1	1	7
Public at large	Constantly displayed a large majority in favor of smoke-free venues, smokers opinions were positive about it either.	5	1	2	4

*Any additional comments, please give your answer in the box below*

Members of Parliament in favor of the new regulation were belonging to different political groups, usually opposed.

**1.1.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations on smoke-free hospitality venues. List their interests and arguments and score their power.**

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
Hospitality/catering industry	Their representative assumed and predicted that the whole profession will be vanishing if smoking should be prohibited. Fear of the perspective to loose many patrons in cafés.	5	2	4	1
A minority in smokers	Prohibition affects private freedom and self-determination.	3	2	4	1

*Any additional comments, please give your answer in the box below*

Unsatisfied smokers were few and could not organize themselves with evidence that they were independent from the support of tobacco business.

**1.1.7 If international politics or policy have influenced the preparation, introduction or adaptation of this legislation or these regulations in your country, please explain.**

*Please give your answer in the box below*

Yes, the WHO Framework Convention on Tobacco Control is likely to have influenced the new regulation.

**1.1.8 Please summarize in bullet points the key elements (content) of the legislation or other regulations with regards to smoke-free hospitality venues as they are in force to date.**

*Please give your answer in the box below*

Smoking is forbidden in all the hospitality venues except (if decided by the responsible person) in dedicated rooms subject to tight conditions.  
Transport, education and health activities do not allow such dedicated rooms.  
(<http://vosdroits.service-public.fr/particuliers/F160.xhtml>)

**1.1.9 If any modifications of the legislation or regulations are expected in the near future, please shortly describe contents and reasons.**

*Please give your answer in the box below*

No modifications are expected in the near future. Nevertheless judiciary decisions to come may influence some interpretations of the decree like allowing to smoke in a café terrace even completely closed with plastic walls.

## 1.2 In depth information on the implementation of measures/ regulating provisions in the legislation or otherwise regarding smoke-free hospitality venues

The latest data from the Tobacco Control Scale are provided in the table below. These are results from January 2011. Please add if there are in the meantime changes. See annex 3 for explanation of scoring system

Table 1. Smoke-free public places score on January 1<sup>st</sup> 2011: 21/22 points

	Bars and restaurants <sup>1</sup>	Public transport <sup>2</sup>	Public places <sup>3</sup> (educational, health, governmental, theatres)	Work place <sup>4</sup>	Total
Max. Points	8	2	2	10	22
Score NL	4	2	1	6	13
Score F	8	2	1	10	21
Score F 2012	6	2	2	10	18

Source: Joossens & Raw, 2011

### 1.2.1 What is the level of implementation in your country of measures on smoke-free hospitality venues? Please rate on a scale from 1-7.

1= not implemented at all; 7=fully implemented in the whole country and all relevant settings.

1	2	3	4	5	6	7
					X	

*Any comments on level of implementation, please give your answer in the box below*

Mark 10 in workplaces is true when looking at the legislation. Implementations measures would indicate "4" (75 % of workplaces are free).

### 1.2.2 Please describe factors facilitating the implementation of measures on smoke-free hospitality venues (e.g., public opinion, organisational aspects, positive media attention, ...)

*Please give your answer in the box below*

A large compliance in smokers who accept easily to go outdoors is the main factor. Owners and managers have changed their mind about smoke-free regulation.

**1.2.3 Please describe barriers for the implementation of measures on smoke-free hospitality venues (e.g., public opinion, financial restrictions, organisational aspects, negative media attention).**

*Please give your answer in the box below*

1/ The public administrators best positioned to be in charge with checking up the implementation of workplaces regulation (Inspecteurs du travail) refused to report on places where the legislation was not or poorly applied.  
 2/ The police is not actually asked to check up on infringements in hospitality venues and dispense fines, warnings or simple reminders of the law

**1.2.4 In case stakeholders involved in the implementation of measures on smoke-free hospitality venues (see question 1.1.5 and 1.1.6) differ from those involved in the preparation and enactment of the legislation, or have another ranking, please specify.**

*Please give your answer in the box below*

Yes, police and judiciary authorities do not rank the smoking ban in hospitality venues as a priority and differ from Parliament members and the Minister who prepared and enacted the last decree content.

**2 E-cigarettes**

**Availability of e-cigarettes:**

Are they widely available?

1= not available at all; 7=available in the whole country and in all shops where they sell tobacco products.

1	2	3	4	5	6	7
					x	

Where are they sold (specialized tobacco shops, which other shops?)

Specialized e-cigarettes shops, tobacco shops, drug stores, non specialized stores (i.e: supermarkets,...)

**Is there advertising?**

Yes. There is no formal ban.

**If yes: in media (newspapers, magazines, tv, etc.)**

Advertising appears mostly outside and inside specialized e-cigarettes shops and tobacco shops.

Advertising also appears in a few DTT channels and in professional journals of tobacco sellers. There is no massive advertising campaigns.

## **Use of e-cigarettes:**

Any indications about prevalence of use?

In 2013, OFDT carried out a specific survey regarding the use of E-cigarettes. The results are as follow (source: Lermenier, A; Palle, C., Results of the ETINCEL - OFDT electronic cigarette survey : Prevalence, purchase and use behaviours, reasons for using electronic cigarettes, OFDT, memorandum 2014-01).

In late 2013, 18% of the people surveyed, or 8 to 9 million individuals, stated having used an electronic cigarette at least once. This is 2.5 times the number seen in March 2012 (7%). More men (22% vs. 15% of women) and young people (31% of people aged 15-24 vs. 20% of 35-44 years old and 9% of 55-64 years old) stated this lifetime electronic cigarette use. Nearly all of these lifetime users were (tobacco) smokers (75%) or former (tobacco) smokers (16%).

Six percent (6%) of French people, or one third of the 18% lifetime users, had engaged in last month use (recent use) of an electronic cigarette. Although certain lifetime users stated having never or almost never smoked tobacco, all recent vapers are or were smokers. They use the electronic cigarette mainly to try quitting (51%) or reducing their tobacco use (11.5%). In contrast with lifetime use, which is seen more frequently in men, recent (and daily) electronic cigarette use does not differ with gender.

Three-quarters (76%) of last month vapers began using an electronic cigarette less than six months prior to the survey, i.e. starting in April or May 2013. Only 13% had begun their use over a year ago. Over 90% of recent vapers used a nicotine-containing liquid or refill. Four in ten vapers chose a dose of 7 to 12 mg/ml, while three in ten used a lower dose (1 to 6 mg/ml) and the same number chose a higher dose (12 to 20 mg/ml). Over half of vapers bought their electronic cigarette and refills in a speciality store, while nearly 25% bought it from a tobacconist's and 9% on the Internet.

More than half (54%) of recent electronic cigarette users, or 3.3% of all French people (1.1 to 1.9 million people), used their electronic cigarette daily: 67% were smokers and 33 % were former smokers.

Although a relatively high number of young people aged 15 to 34 had tried an electronic cigarette, they rarely seem to become regular users: only 10% of lifetime users in this age group used daily. However, older French people were less frequently lifetime users but more often became daily users once they had tried it (26% of people aged 50 to 75 years stating that they had tried an electronic cigarette vaped every day). Lifetime use by older French people is undoubtedly less related to curiosity than to their smoking history and their need to find a solution to their addiction.

Any indications about an increase of their popularity?

88% of 15-75 years old know at least the word "E-cigarette" (source : ETINCEL-OFDT survey, November 2013) instead of 66% in march 2012 (Eurobaromètre spécial tabac).

Among tobacco smokers?

In late 2013, 51% of smokers declare they have tried an E-cigarette (instead of 12% of former smokers and 3,5% of non smokers (or people that have hardly smoked). 17% of smokers have vaped the previous month instead of 4% of former smokers.

Are there indications that they are gaining popularity among non-smokers?



9% of life time users have never smoked or just to try but all the recent users (in the previous month) are smokers or former smokers. There is no previous comparable survey.

**Does the tobacco legislation in your country include regulations regarding e-cigarettes?**

- yes
- no

**2.1.1 Please provide information, in bullet points, on the preparation and enactment of the legislation and regulations around e-cigarettes. Please include dates (year).**

*Please give your answer in the box below*

**2013-2014** : preparation and adoption of the European tobacco directive  
**2013**: inclusion of an amendment in the Consumer Affairs Act (Hamon Acts) regarding a ban of sales to minors (adopted in the beginning of 2014. Enforcement Decree not yet released)  
**2013** : The ministry of Health refers the case of the lack of ban on advertising to the Council of State (the answer announced for the end of 2013 has not been given yet)  
**Mai 2013** : expert report and their recommendations regarding the Electronic cigarette are submitted to the Ministry of Health which had given a mission at the OFDT on that matter

**2.1.4 Briefly describe key events and underlying reasons in the process of preparing and adapting the legislation and regulations as they are in force to date (chronologically, with accompanying dates).**

*Please give your answer in the box below*

**Mai 2013** : expert report and their recommendations regarding the Electronic cigarette are submitted to the Ministry of Health which had given a mission at the OFDT on that matter  
**2013-2014** : preparation and adoption of the european tobacco directive

**2.1.5 Please identify the five stakeholders who played the most important role in supporting the preparation and enactment of the legislation and regulations around e-cigarettes**

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
Ministry of health	Public Health	7			7

<b>FIVAPE (inter-professional federation of vapes)</b>	<b>Defend the interests of the E-cigarette' professionals (promotion of a framework but "light" / ask for training for sellers, a better monitoring of the quality and safety of products / Don't ask for the monopoly of sale) (economical lobby)</b>				
<b>Confederation of tobacconists</b>	<b>Defend the interests of tobacconists (sale monopoly or at least same rules for the E-cigarette than for tobacco) (economical lobby)</b>				
<b>SYNAPCE (Trade union E-cigarette)</b>	<b>Defend the interests of the E-cigarette' professionals</b>				
<b>AIDUCE (association of users of E-cigarettes)</b>	<b>Defense of the interests of users.</b>				

*Any additional comments, please give your answer in the box below*

difficult to state on the scales...

**2.1.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations around e-cigarettes. List their interests and arguments and score their power.**

All the stakeholders are (officially) in favor of a legal framework but their objectives are different. The professionals and users are in favor of the maximum liberty to vape and the greatest possible diversity of products.

<b>Stakeholder</b>	<b>Possible interest/arguments</b>	<b>Political power (1-7)</b>	<b>Financial power (1-7)</b>	<b>PR power (1-7)</b>	<b>Knowledge based power (1-7)</b>

*Any additional comments, please give your answer in the box below*

**2.1.7 If EU politics or policy have influenced the introduction/adaptation of this legislation or these regulations in your country, please explain.**

*Please give your answer in the box below*

The political will to establish rapidly a french regulation didn't appear very strong before the adoption of the European directive. The very last governmental Cancer Plan (2014-2019) promotes research dealing with the evaluation of the toxicity of electronic cigarettes and their interest for smoking cessation. A governmental plan on tobacco will be released later this year (2014) and might promote measures regulating the market of Electronic cigarettes

**2.1.8 Please summarize in bullet points the key elements (content) of the legislation or other regulations with regards to e-cigarettes as they are in force to date.**

*Please give your answer in the box below*

2011: following a view on that matter of the ANSM (National Agency of the Security of Medicinal products and health products) the maximum nicotine level of al liquids/refills/cartridges/disposable electronic cigarettes must be 20mg/ml. Otherwise it must be considered as a medicine and must be granted marketing authorization. This is not a legal coercion.  
2014: adoption of the "Hamon act" (10 March) and so of the ban of sale for minors.

**2.1.9 If any modifications of the legislation or regulations expected in the near future, please shortly describe contents and reasons.**

*Please give your answer in the box below*

**2.1.10 In case no legislation and other regulations regarding e-cigarettes exist, please mention any attempts made to have this regulated and why they did not succeed.**

*Please give your answer in the box below*

**II Contextual information**

Please complete the following questions/tables with the latest data available (please also state the source).

**1 General information on country**

**1.1. Area (km<sup>2</sup>):** .....674 800

**1.2. Population size:** .....65 Millions

## 2 Prevalence of tobacco use

### 2.1 Prevalence of tobacco use by youngsters

		Most recent data (%)	Year
Percentage ever smoked tobacco	11-years old	8,8	2010
	13-years old	25,4	2010
	15-years old	55,5	2010
Percentage smoking tobacco at least once a week (Not exactly once a week but 10 times in previous 30 days)	11-years old	0,6	2010
	13-years old	3,8	2010
	15-years old	18,9	2010
Percentage daily smoking tobacco (generated from school grades figures. Figures by age remained unavailable for the writer)	11-years old	< 2	2010
	13-years old	7,9	2010
	15-years old	15,8	2010

Source:

Suggested source: HBSC, 2012

### 2.2 Prevalence of tobacco use in population

		Most recent data (%)	Year
Percentage of occasional smokers <sup>a</sup>	General population (15-64) *(15-85)	5,5*	2010
	Youth (15-24)	NA	2010
Percentage of daily smokers	General population (15-64) *(18-75)	30*	2010
	Youth (15-24) *(18-25)	39,5*	2010

a. Occasional smokers refers to non-daily smoking. Adding up occasional and daily smoking gives the total amount of smokers.

Source: Baromètre santé 2010

### 2.3 Prevalence of heavy smokers

Heavy smokers are people who smoke 20 or more cigarettes/roll-ups per day.

	Most recent data (%)	Year
Prevalence in whole population (15-64)	NA	
Prevalence in smokers	NA	

Source:

### 2.4 Prevalence of second-hand smoking (SHS)

	Most recent data (%)	Year
Percentage of non-smokers (>15-64) exposed to SHS	NA	

Percentage of children (≤15) exposed to SHS	NA	
Percentage of adults with children (0-18) that indicates smoking occurs indoor	NA	

Source:

### 2.5 Quitting (attempts)

	Most recent data (%/n)	Year
Percentage of smokers that attempted to stop in a year	NA	
Percentage of people that uses any aid for stop-smoking	NA	

Source:

### 2.6 Cigarette consumption

	Most recent data (n)	Year
Total amount of cigarettes and roll-ups consumed in one year	61 billions	2010

Source: Altadis

Please briefly describe the trend in prevalence of tobacco use and related parameters (see above) during the past ten years

*Please give your answer in the box below*

2002/2012 : general prevalence first decreased from 2002 to 2008 and increased afterwards (from 2008 most probably). In youth, the prevalence drop was very important and the very recent rebound is weak and only masculine.

### 2.7 Influence of tobacco use prevalence on governance implementation

Did the tobacco use prevalence influence the implementation of legislation/ regulations on smoke free hospitality venues?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
			X			

### 3 Health context

### 3.1 Tobacco related morbidity

	Most recent data (year)
Burden of disease due to tobacco-use as percentage of total burden of disease (preferably in DALY's)	NA
Years of Life Lost (YLL) due to tobacco-use as percentage of total YLL	NA

Source:

### 3.2 Tobacco related mortality

	Most recent data	Year
Number of smoking attributed deaths	73 000	2011
Total number of smoking attributed deaths / total deaths (all ages)	13,4 %	2011

Source: Hill, IGR

Suggested source: WHO database

Please describe briefly the trend in tobacco related morbidity/ mortality in the past ten years, stating where possible percentages from or around 2002 onward:

*Please give your answer in the box below*

The trend in mortality *should be* slightly decreasing due to the male cancers incidence which is reduced as is tobacco smoking prevalence since the 50's. Female cancers incidence is dramatically increasing but the figures remain low.  
It is a qualitative estimation : attributed deaths are increasing in Hill's published studies (60 000 to 73 000) but the autor mentioned a methodological shift.

### 3.3 Influence of tobacco use-related health consequences on governance implementation.

Did the tobacco use-related health consequences influence the implementation of smoke-free hospitality venues?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
				X		

Please briefly describe the influence of the health context on these two cases:

Please give your answer in the box below

The common accepted figure of death attributable to ETS in France was 3 000.

#### 4 Economical context

This section focuses on general economical information, data on public spending (direct and indirect) on tobacco, state revenues from taxes and excise duties and economic information on tobacco business (production, sales).

##### 4.1 General economical circumstances

	Most recent data	Year
Gross national income per capita (PPP international (€ or £))	42 420 \$	2011
Total health expenditures per capita (€ or £)	3 755*	2011
Total health expenditures as percentage of GDP (€ or £)	12 %	2011

\* considering 64 M capita in 2011 and 240,3 billions € (dépense courante de santé).

Source: INSEE

##### 4.2 State expenditures and revenues

###### 4.2.1 Expenditures (direct and indirect) on consequences of smoking

	Most recent data	Year
Direct expenditures <sup>1</sup>	18,3 b €	2010
Direct expenditures as percentage of total health expenditures (%)	8 %	2010
Indirect expenditures <sup>2</sup>	29,5 b €	2010

Source: Association DNF

1. Direct costs include expenses associated with healthcare for smoking-related diseases among actual smokers and passive smokers<sup>98</sup>.
2. Indirect costs are connected to productivity losses, lost income taxes and social security expenses for patient-smokers, patient passive smokers and for informal caretakers (people who would have had a paid job otherwise)<sup>4</sup>.

###### 4.2.2 State revenues

	Most recent data	Year
Tobacco tax revenues from excise duties	13,8 billions €	2011

Source:

<sup>98</sup> Ross, H. (2004). The economics of tobacco and tobacco control in the European Union (Eds), *Tobacco or Health in the European Union: past present and future* (pp. 69 - 93). Luxembourg: Office for Official Publications of the European Communities.

**4.2.3 Tobacco Control budget** according to Joossens & Raw (2011). Data from 2009. Please complete if data from 2011 are available.

	<b>Max. score</b>	Score or amount NL	<b>Score or amount F 2011 (TBC)</b>
<b>Tobacco control budget in national currency in 2009 (x1000)</b>		€4,050	€ 2,820
<b>Tobacco control budget in Euro in 2009 (x1000)</b>		€4,050	€ 2,820
<b>Tobacco control budget in 2009 in € per capita</b>		€0.25	€ 0,04
<b>GDP in PPS EU=100</b>		131	NA
<b>Tobacco control budget per capita PPS in 2009</b>		0.19	NA
<b>Tobacco Control Budget score<sup>1</sup></b>	15	1	

1) The country which spends 2 euro per capita on tobacco control, based on EU average GDP per capita expressed in PPP, receives 15 points. Netherlands would receive 15 if the spending would be €2\*1.31=€2.62 per capita; UK if the spending would be €2\*1.12=€2.24

Source: Joossens & Raw, 2011

**4.2.4 Please describe briefly the trend in state expenditures and revenues in the past ten years.**

*Please give your answer in the box below*

Revenues have been growing up (+ 40 % more or less) due to increased levels of accise taxes. They have the function to replenish Social Security budget (like retirement pensions for farmers) and are in no way linked to dedicated tobacco state expenditures whose trend in the past ten years is not known (available) in our sources now on.

### 4.3. Tobacco industry

#### 4.3.1 Tobacco manufacturing

Is there any tobacco manufacturing in the country?

- yes  
 no

If yes, please describe briefly the trend in the tobacco manufacturing in the past ten years.

*Please give your answer in the box below*

Decreasing.

#### 4.3.2 Turnover tobacco industry

	<b>Most recent data</b>	<b>Year</b>
<b>Tobacco-processing industry turnover (in €)</b>	NOT FOUND	

Source:



#### 4.3.3 Trend in tobacco sales

Please describe briefly the trend in the past ten years.

*Please give your answer in the box below*

If cigarettes are the best indicator, cig sales are declining (97,1 billions units in 1991 to 54,1 in 2011. (Source : La revue des tabacs, issued by Ofdt)

#### 4.3.4 Turnover tobacco sales

	Most recent data	Year
Tobacco sales turnover (in €)	17,5 billions € *	2011

\* including all taxes.

**Source:** Source : La revue des tabacs, issued by Ofdt

### 5. Political context

#### 5.1 Did the political context influence the implementation of smoke-free hospitality venues?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence) and describe this influence briefly.

1	2	3	4	5	6	7

### 6. Historical/Socio-cultural context

#### 6.1 Did the historical/socio-cultural context influence the implementation of smoke-free hospitality venues?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
						X

### III. Key publications

Please include a list of key publications used to complete this report.

Please also add the full references of the sources you have used. In case you have included expert opinions please provide the name of the experts as well as the date and source of communication (e.g. personal communication).

*Please list the publications in the box below*

Pierre Morange (rapporteur), Claude Evin (Président de la mission d'information), *Rapport sur l'interdiction du tabac dans les lieux publics*, Assemblée Nationale, n° 3353, 311 p., déposé le 4 octobre 2006 sur le Bureau de l'Assemblée.

Bernadette Roussille, *L'interdiction de fumer dans les lieux accueillant du public en France*, Inspection Générale des Affaires Sociales, rapport IGAS n° 2005 193, décembre 2005, Paris, La Documentation française, 2006, 57 p. + annexes.

DNF (Droit des non-fumeurs), *Le tabac en France entre 2006 et 2009 ; évolution des comportements, détournement de la loi et nouvelles menaces*, Paris, DNF, 9 décembre 2009, brochure 76 p.

François Beck, Romain Guignard, Jean-Baptiste Richard, Jean-Louis Wilquin, Patrick Peretti-Watel, *Augmentation récente du tabagisme en France : principaux résultats du Baromètre santé, France, 2010*, Bull. Epidém. Hebd., 31 mai 2011, n°21-22, 230-233.

Objectif 4 : tabagisme passif, in *L'état de santé de la population en France - Suivi des objectifs annexés à la loi de santé publique - Rapport 2011*, Sandrine Danet (dir.), Paris, DREES, 2011, 338 p., 138-141.

OFDT (Observatoire Français des Drogues et des Toxicomanies), chiffres-clés du tabac publié sur site web à l'adresse : [http://www.ofdt.fr/ofdtdev/live/produits/tabac/general.html#aff\\_rech](http://www.ofdt.fr/ofdtdev/live/produits/tabac/general.html#aff_rech)

Governmental information on : <http://www.tabac.gouv.fr/>

Serge Karsenty, expert: personal communications, october 2012 to january 2013.

## Appendix 2: Country report: Regulation of gambling in France

### Country report ALICE RAP WP14

#### France GAMBLING

In this study we focus on two selected cases of governance *practice*. For being able to describe and analyse these two cases we need a basic overview of relevant factors in the preparation, enactment and implementation of important measures and regulating provisions in the legislation or otherwise. This questionnaire will result in a country report and focuses on one case of governance practice related to gambling: aspects of **control and regulation**, e.g. licensing.

The structure of this country report format is based on an adapted version of the health policy triangle of Walt & Gilson (1994)<sup>99</sup>. This is built up around the following four concepts: policy content and process, stakeholders and context (for more detailed information see the project proposal).

Important: Please fill out this format as completely as possible, but limit yourself to the key elements. At a later stage we might contact you for additional information.

### I Policy process and contents

#### 1. Relevant aspects of control and regulation in gambling legislation and other regulations and standards

##### 1.1 Which types of gambling does the gambling regulation in your country include:

	Is it regulated?	Is it legal?
<b>Table games in casino's ( e.g., cards, dice, roulette, with a croupier or poker dealer)</b>	Y	Y
<b>Electronic gaming in casino's (e.g., slot machine, video poker)</b>	Y	Y
<b>Other gambling in casino's (bingo, keno)</b>	Y	Y
<b>Gambling games not in casino's (lotteries, scratchcards, bingo)</b>	Y	Y
<b>Fixed-odds betting (sports or other events; in a fixed odds betting the pay-out is agreed at the time the bet is sold)</b>	Y	Y

<sup>99</sup> Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health policy and planning*, 9(4), 353-370.

Parimutual betting (gambling on horse racing, greyhound racing, sporting events; in a parimutual betting the final pay-out is not determined until the pool is closed)	Y	Y
Internet gambling	Y	Y
Any other (please list)	Y/N	Y/N

*Additional comments, please give your answer in the box below*

--

**1.2 Does your gambling regulation include regulations on:**

		Short description:
Licensing	Y	
Taxes	Y	
Rules of (casino) games	Y	
Age limits	Y	
Advertising	Y	
Consumer information	?	
Prevention and/or treatment of problematic gambling	Y	
A regulating agency	Y	

**1.3 Is the regulating agency in your country involved in**

		Any remarks
Licensing (issuing, levying fines, revoking)	Y	
Accounting systems (providing financial information, e.g., to the government)	Y	
Auditing	N	
Advising national or local government on gambling issues	Y	

Investigating and prosecuting illegal gambling	N	
Remote gambling, e.g., betting online (internet) or by telephone	Y	
The spreading of gambling/betting	Y	

**2 In depth information on the preparation and enactment of the legislation and other regulations in gambling control and regulation**

**2.1 Please provide information, in bullet points, on the preparation and enactment of the first legislation and regulations regarding gambling control. Please include dates (year).**

*Please give your answer in the box below*

Initially banned in France, gambling was legalized gradually from the last third of the eighteenth century, including the creation of the royal lottery. In the nineteenth century, casinos were implemented in France (decree of 1806 which allowed the Commissioner of Police to issue permits derogation for resorts), then in the twentieth century the PMU- horses races (Pari Mutuel Urbain 1931) and the National Lottery (in 1933). These three gambling operators shared in France the largest share of the gambling industry until the opening up of online gambling activities with the new legal framework in 2010.

**2.2 Please provide information, in bullet points, on the preparation and enactment of the current legislation and regulations on gambling control and regulation. Please include dates (year).**

*Please give your answer in the box below*

In 2010, France adopted a new legal framework (law of May 12th, 2010) which opens up and regulates online gambling for three gambling categories – sports betting, horse racing and poker – and brought an end to the state monopoly held by the 'Française des Jeux' and the PMU. One year after they had become available, the legal internet-based betting sites had generated 2.9 million active gambler accounts.

**2.3 Please provide information, in bullet points, on any relevant changes between the first legislation and regulations on gambling control and regulation and the current legislation and regulations. Please include the year(s) of change.**

*Please give your answer in the box below*

**2.4 Briefly describe key events and underlying reasons in the process of preparing and adapting the legislation and regulations on gambling control and regulation (chronologically, with accompanying dates).**

*Please give your answer in the box below*

Faced with a growing illegal supply of gambling on the Internet, and to meet a request of the European Commission, the French government adopted in 2010 a regulatory framework regulating the sector of online gambling. Transposition into French law of European Directive, the law n ° 2010-476 of 12 May 2010 introduced a "controlled opening to competition" the market of online gambling, ending the state monopoly of the FDJ and the PMU. The law entrusts the regulation of the market of gambling and online gambling in an independent administrative authority, ARJEL (Regulatory Authority online gambling), responsible for assigning licenses to gambling operators on the Internet, control their activity and participate, in conjunction with the ministries of interior and justice, to the fight against illegal offer.

**2.5 Please identify the five stakeholders who played the most important role in supporting the preparation and enactment of the legislation and regulations on gambling control and regulation.**

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
Ministry of Finance	Taxes	7	4		3
Ministry of Interior	Public security	6	3		3
Ministry of Agriculture	Equine industry	4	2		3
Ministry of Health	Public health	2	2		3

*Any additional comments, please give your answer in the box below*

**2.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations on gambling control and regulation. List their interests and arguments and score their power.**

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
FDJ	To defend their monopoly / to limit the opening of the new online gambling market	3	4		4
PMU	To defend their monopoly / to limit the opening of the new online gambling market	3	4		3
Casinos	to limit the opening of the new online gambling market	3	4		3
Private gambling online operators	To get a less regulated online gambling market	3	4		4

*Any additional comments, please give your answer in the box below*

There was no separation between the stakeholders in favor or against the law.  
 The new law focused on the opening of online gambling (see above) was necessary because the European context.  
 The respective roles were based on their own interests.

**2.7 If international politics or policy have influenced the introduction/adaptation of this legislation or these regulations in your country, please explain.**

*Please give your answer in the box below*

See 2.4

**2.8 If any modifications of the legislation or regulations are expected in the near future, please describe briefly contents and reasons.**

*Please give your answer in the box below*

NO  
 Maybe, just an update of the law in the two next years

**3 In depth information on the implementation of regulating provisions in the legislation or otherwise on gambling control and regulation**

**3.1 What is the level of implementation of gambling control and regulation in your country? Please rate on a scale from 1-7.**

1= not implemented at all; 7=fully implemented in the whole country and all relevant settings.

1	2	3	4	5	6	7
					x	

*Any comments on level of implementation, please give your answer in the box below*

7 for on line gambling  
The weakest point is the application of the prohibition of sales to minors scratch games and the inability to fully control the Internet

**3.2 Please describe factors facilitating the implementation (e.g., public opinion, economic interests, organisational aspects, positive media attention, ...).**

*Please give your answer in the box below*

Public opinion is fairly neutral on this area.  
Public health concern has been reinforced by the important role of tax revenue (important given the high level of gambling taxes) in a context of a the state budget crisis.  
Last, The law set up a regulatory authority with significant financial resources being taken from bets.

**3.3 Please describe barriers for the implementation (e.g., public opinion, financial restrictions, housing problems, organisational aspects, negative media attention).**

*Please give your answer in the box below*

**3.4 In case stakeholders involved in the implementation of gambling control and regulation (see question 2.5 and 2.6) differ from those involved in the preparation and enactment of the legislation, or have another ranking, please comment on that.**

*Please give your answer in the box below*



--

## II Contextual information

Please complete the following questions/tables with the latest data available (with accompanying source). Describe the trend in the data (in terms of decreasing/increasing) over approximately the last ten years.

### 1 General information on country

1.1 Area (km<sup>2</sup>): 552000

1.2 Population size: 65 millions

### 2 Prevalence of gambling

#### 2.1 Prevalence of gambling in the general population (15-64 years)

	Most recent data (%)	Year
Lifetime gambling		
Last year gambling	47,8	2010
Last month gambling		

Source: Baromètre santé 2010, module jeux d'argent et de hasard; INPES/OFDT

Please briefly describe the trend in prevalence of gambling during the past ten years.

*Please give your answer in the box below*

Population : 18-75 years
--------------------------

#### 2.2 Influence of gambling prevalence on governance implementation

**Did the prevalence of gambling influence the implementation of the legislation on gambling control and regulation?**

yes

no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the gambling prevalence on gambling control and regulation.  
*Please give your answer in the box below*

### 3 Health context

#### 3.1 Number of problem gamblers

	Most recent data	Year
Number of problematic gamblers	200000	2010
Number of gamblers in treatment	1500	2012

If possible, use DSM definition. If you use any other definition of problematic gambling, please specify:

**Source: Baromètre santé 2010, module jeux d'argent et de hasard; INPES/OFDI  
Enquête de la Fédération Addiction 2012**

#### 3.2 Gambling related morbidity and social loss

**3.2.1 If you have any national data on the prevalence of co-morbid psychopathology, on burden of disease (DALY's) or productivity loss, please provide it here.**

*Please give your answer in the box below*

#### **Baromètre santé 2010, module jeux d'argent et de hasard; INPES/OFDI**

Tool used : CPGI criteria (Ferris and Wynne, 2001), includes 9 items each of which is rated from 0 to 3, depending on the frequency of the corresponding occurrences. The overall score can thus range from 0 to 27. It allows the following typology to be established: "gambler without problems" (score = 0); "low-risk gambler" (score = 1-2), "moderate-risk gambler" (score = 3-7) and "excessive gambler" (score = 8 or more).

The prevalence of "excessive" gambling in France is estimated to be 0.4% and that of "moderate-risk" gambling to be 0.9%. In numerical terms, approximately 200000 French citizens are excessive gamblers and 400000 are "moderate-risk" gamblers.

#### **Enquête de la Fédération Addiction 2012**

Personal extrapolation based on the results of a survey carried out on about 30% of "specialized addiction treatment centers". These centers cover all drugs addiction and "no drug" addiction like gambling addiction.

**3.2.2 Please briefly describe the trend in prevalence of problem gambling and related morbidity in the past ten years stating where possible percentages from or around 2002 onward.**

*Please give your answer in the box below*

No trends because the first measure was done in 2010

### 3.3 Influence of gambling-related health consequences on governance implementation

Did the gambling related health consequences influence the implementation of state monopoly and licensing?

yes

no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
			x			

Please briefly describe the influence of the health context on gambling control and regulation.

*Please give your answer in the box below*

Public health concern has been considered for itself but also used for other purposes as : get a high level of gambling taxes, preserve a part of state monopoly.

## 4 Economical context

This section focuses on general economical information and data on public spending (direct and indirect) related to gambling. Please provide data as far as available.

### 4.1 General economical circumstances

	Most recent data	Year
Gross national income per capita (PPP international (€ or £))	27550 €	2012
Total health expenditures per capita (€ or £)	2700 €	2010
Total health expenditures as percentage of GDP (€ or £)	12,1	2010

Source: INSEE, DREES

### 4.2 State expenditures and revenues

**4.2.1 If you have any data on (direct or indirect) expenditures on the health consequences of gambling, or on the expenditure related to crime control related to gambling, please provide them here.**

*Please give your answer in the box below*

Not yet but we have an ongoing study on gambling social costs.  
Results expected in November 2013

**4.2.2 If you have any data on state revenues from taxes on gambling, please provide them here.**

*Please give your answer in the box below*

About 5 billions €

**4.3 Gambling industry**

**If you have any data on the turnover in the gambling industry (in Euros), please provide them here.**

*Please give your answer in the box below*

In 2005, turnovers:  
Casinos : 18,9 billions €  
FDJ : 8,9 billions €  
PMU : 8,0 billions €

**4.4 Economical context influencing implementation of measures on gambling control and regulation.**

**4.5 Did the economical context (e.g. the economic crisis) influence the implementation of measures on gambling control and regulation?**

yes

no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
					x	

Please briefly describe the influence of the economical context on gambling control and regulation:

*Please give your answer in the box below*

See above

**5. Political context**

**Did the political context influence the implementation of gambling control and regulation?**

yes

no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the political context on gambling control and regulation.

*Please give your answer in the box below*

### 6. Historical/Socio-cultural context

Did the historical/socio-cultural context influence the implementation of gambling control and regulation?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
					x	

Please briefly describe the influence of the historical/socio-cultural context on gambling control and regulation.

*Please give your answer in the box below*

France has been out of the prohibition very slowly during all the twentieth century to gradually switch into a “strong regulatory” approach: deny everything ... but, notwithstanding, some gambling activities that state regulates very strictly.  
Faced with the development of the Internet and the difficulty of controlling this space, the 2010 law follows the same approach: strong regulation.

### III. Key publications

Please include a list of key publications used to complete this report.

Please also add the full references of the sources you have used. In case you have included expert opinions please provide the name of the experts as well as the date and source of communication (e.g. personal communication).

*Please list the publications in the box below*

Costes J.M, Pousset M, Eroukmanoff V, Le Nezet O, Richard J.B, Guignard R, Beck F, Arwidson P. Les niveaux et pratiques des jeux de hasard et d’argent en 2010. Baromètre santé 2010, module jeux de hasard et d’argent Inpes/OFD Tendencies, 2011, n°77, 8 p.

INSERM (2008). Expertise collective : Jeux de hasard et d'argent, contextes et addictions. Les éditions INSERM.

Lamour, J. F. (2009). Rapport sur le projet de loi relatif à l'ouverture à la concurrence et à la régulation du secteur des jeux d'argent et de hasard en ligne, Assemblée Nationale, 512 p.

Trucy, F. (2006). Rapport d'information sur l'évolution des jeux de hasard et d'argent. Sénat,.

## Appendix 3: Country report: Harm reduction and decriminalisation of heroin in Slovenia

### Country report ALICE RAP WP14

Slovenia

HEROIN

In this study we focus on two selected cases of governance *practice*. For being able to describe and analyse these two cases we need a basic overview of relevant factors in the preparation, enactment and implementation of important measures and regulating provisions in the legislation or otherwise. This questionnaire will result in a country report and focuses on two selected cases of governance practice related to heroin use: the introduction of **opioid substitution treatment (OST)** as example for a harm reduction measure, **decriminalisation of use and possession of small quantities for personal use** as an example of decriminalisation

The structure of this country report format is based on an adapted version of the health policy triangle of Walt & Gilson (1994)<sup>100</sup>. This is built up around the following four concepts: policy content and process, stakeholders and context (for more detailed information see the project proposal).

Important: Please fill out this format as completely as possible, but limit yourself to the key elements. At a later stage we might contact you for additional information.

### I Policy process and contents

#### General legislation regarding heroin

In case your country uses a differentiation in classes of illegal drugs (e.g., class A, B or C; or “soft” and “hard” drugs) please specify the classes, describe in which class heroin is included and summarize in bullet points the key features of this differentiation.

*Please give your answer in the box below*

On the basis of the Production and Trade in Illicit Drugs Act, (Official Gazette of the Republic of Slovenia, No. 108/1999; amendments 44/2000), the Decree on the Classification of Illicit Drugs was adopted in 2000 (Official Gazette of the Republic of Slovenia, No. 49/2000; revision 8/2001; amendments 49/2001; 78/2002; 53/2004; 122/2007; 102/2009; 95/2010 and 58/2011). The Decree divides drugs into groups I, II, and III according to their medicinal use and according to the level of risk to human health as a possible result of their abuse. The list of groups of drugs is a component part of the Decree and is updated with new drugs as required.

Group I: plants and substances which are very dangerous to human health due to the severe

<sup>100</sup> Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health policy and planning*, 9(4), 353-370.

consequences which can result from their abuse and which are not used in medicine (heroin, coca leaves, opium poppy concentrate, cannabis/THC, PCP, MDMA, MDA, MDE, khat, mescaline, psilocybin, BZP, mephedrone etc.);

Group II: plants and substances considered highly dangerous, due to the severe consequences which can result from their abuse, and which can be used in medicine (cocaine, amphetamine, methamphetamine, opium, morphine, codeine, methadone, buprenorphine, etc.);

Group III: plants and substances of medium danger, due to the consequences which can result from their abuse, and which can be used in medicine (mostly barbiturate and non-barbiturate hypnotics and anti-epileptics, benzodiazepine anxiolytics and hypnotics, and stimulants and anorectics /arylalkylamin and others, such as: GHB and 2 C-B).

## 1. Opioid substitution treatment (OST)

**Which medication is provided through your OST programmes in your country?**

	<b>If yes, please indicate with X</b>	<b>If yes, started in [year]</b>
<b>methadone</b>	X	1994 (official start)
<b>buprenorphine</b>	X	2005
<b>heroin</b>		
<b>other: slow-release morphine</b>	X	2005
<b>other: suboxone</b>	X	2007

### 1.1 In depth information on the preparation and enactment of the legislation and other regulations regarding OST

**1.1.1 Please provide information, in bullet points, on the preparation and enactment of the first legislation and regulations around OST. Specify for each type of medication separately.**

*Please give your answer in the box below*

The Prevention of the Use of Illicit Drugs and Dealing with Consumers of Illicit Drugs Act (Official Gazette of the Republic of Slovenia, No. 98/1999; amendments 2/2004) specifies measures which include informational, medical and educational as well as counselling activities, medical treatment, social security services and programmes for coping with social problems related to the consumption of illicit drugs, and monitoring of the consumption of illicit drugs.

Under Art. 8, the treatment of drug users takes place within the residential and out-patient facilities, which are approved by the Health Council. It is carried out by individuals and legal persons who should fulfill certain statutory requirements related to the performance of health services. Methadone maintenance and maintenance using other substitution substances, previously approved by the Health Council at the Ministry of Health, is also considered a treatment method.



**1.1.2 Please provide information, in bullet points, on the preparation and enactment of the current legislation and regulations around OST. Specify for each type of medication. separately.**

*Please give your answer in the box below*

Still the same legislation.

**1.1.3 Please provide information, in bullet points, on any relevant changes between the first legislation and regulations around OST and the current legislation and regulations. Specify for each type of medication separately and include the year of change.**

*Please give your answer in the box below*

Still the same legislation. No changes since first legislation.

**1.1.4 Briefly describe key events and underlying reasons in the process of preparing and adapting the legislation and regulations to establish OST (chronologically, with accompanying dates).**

*Please give your answer in the box below*

Still the same legislation. No changes since first legislation.

**1.1.5 Please identify the five stakeholders who played the most important role in supporting the preparation and enactment of the legislation and regulations on OST.**

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
<b>Andrej Kastelic</b> (governmental health care sector - addiction care)	Health – public Health – individual (protection of users)	4	4	7	7
<b>Tatja Kostnapfel</b> (national policymaker) (advisor at the Ministry of Health)	Health – public	5	5	4	6
<b>Milan Krek</b> (national	Health – public Health – individual	4	3	6	7

policy maker) (Government Office for Drugs - director)	(protection of users)				
<b>Dr Marjan Jereb</b> (national politician / Minister of Health)	Health – public	7	7	6	4
<b>Dunja Piškur-Kosmač</b> (national politician / State Secretary at the Ministry of Health)	Health – public	7	7	6	6

*Any additional comments, please write in the box below*

Government Office for Drugs was established in 1999, so its influence in the case of substitution treatment related legislation was not crucial. On the basis of this law national strategy was developed and adopted in 2004 which included also chapter on medical treatment.

**1.1.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations on OST. List their interests and arguments and score their power.**

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)

*Any additional comments, please write in the box below*

There was no opposition to the law as this field was never regulated before. All important stakeholders were in favour to this law including substitution treatment of drug users. There was some minor opposition to methadone itself occasionally (mostly right-wing/conservative politicians) but nothing important and influential. The law was never in real danger.

**1.1.7 In case international politics or policy have influenced the preparation, introduction or adaptation of this legislation or these regulations in your country, please explain.**

*Please give your answer in the box below*

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Basically only UN conventions and declarations on illicit drugs were foundation for our legislation in that field. There was no other international influence detected in the process. On the basis of adopted legislation in 1999 Slovenia started to develop its own drug strategy which was adopted in 2004 and valid until 2009. This strategy is based on EU action plan on drugs 2000-2004.

**1.1.8 Please summarize in bullet points the key elements (content) of the legislation or other regulations with regards to OST as they are in force to date.**

*Please give your answer in the box below*

Treatment of consumers of illicit drugs shall be carried out in the form of hospital and outpatient clinic treatment programmes approved by the Health Council;

The treatment shall be carried out by natural and legal persons who fulfil the conditions defined for the performance of medical activities in accordance with the legislation and regulations governing medical activity;

Treatment shall also be deemed to be maintenance with methadone and with other substitutes approved by the Health Council;

For the implementation of outpatient clinic activity for the prevention and treatment of addiction, centres for the prevention and treatment of addiction to illicit drugs shall be organised on the primary level as part of the public health service network;

The activity of the centres shall be carried out by the persons specified in the second paragraph on the basis of a concession, or by public health institutions.

The minister responsible for health shall appoint the body for the coordination of the centres for the prevention and treatment of addiction to illicit drugs, which shall propose a treatment doctrine, verify the implementation of the addiction treatment doctrine and coordinate professional cooperation between the centres for the prevention and treatment of addiction to illicit drugs;

The composition and method of work of the coordination body for the centres for the prevention and treatment of addiction to illicit drugs shall be set out in more detail by the minister responsible for health;

For the implementation of hospital and specialist outpatient clinic treatment, the Government of the Republic of Slovenia shall establish a public health institution – the Centre for Treatment of Illicit Drugs Addicts;

Hospital treatment shall be deemed to be hospital detoxification, psychosocio-therapeutic treatment, extended treatment, and health rehabilitation.

**1.1.9 In case any modifications of the legislation or regulations are expected in the near future, please briefly describe contents and reasons.**

*Please give your answer in the box below*

No modifications are expected in the future.

**1.2 In depth information on the *implementation* of regulating provisions in the legislation or otherwise regarding OST.**

**1.2.1 What is the level of implementation of OST in your country? Please rate on a scale from 1-7.**  
 1= not implemented at all (OST is not available); 7=fully implemented in the whole country and all relevant settings (including prisons).

1	2	3	4	5	6	7
						X

*Any comments on the level of implementation, please write in the box below*

Drug-related treatment is available within the framework of the public health national service network. Treatment takes place primarily at one of 19 centres for the Prevention and Treatment of Drug Addiction (CPTDAs), which are run as a franchise or as a public health service. To provide hospital and treatment at special clinics, the government has established a public health centre — the Centre for the Treatment of Drug Addicts — at the Ljubljana Psychiatric Clinic. Substitution treatment is available also for imprisoned persons in prisons.

**1.2.2 Please describe factors facilitating the implementation (e.g., public opinion, organisational aspects, positive media attention, ...).**

*Please give your answer in the box below*

Substitution treatment and its implementation are not an important issue in the public (political) debate but it occurred from time to time in the past that public debate, public opinion and media went more in favour of abstinence-oriented drug treatment. In last few years this kind of debate is not the case anymore. Also harm reduction-oriented approach is well-accepted in Slovenia now. In our opinion it was crucial for present situation that addiction treatment professionals and policy makers had several evidence-based arguments in favour to substitution treatment while debating this issue in public (e.g. protecting people from HIV/hepatitis, decreasing criminality etc.).

**1.2.3 Please describe barriers for the implementation (e.g., public opinion, financial restrictions, housing problems, organisational aspects, negative media attention).**

*Please give your answer in the box below*

There were some intentions in the past to argue against substitution treatment (mostly against methadone) or influence public opinion and media reporting to be more in favour of abstinence-oriented treatment. Those arguments came mostly from abstinence-oriented treatment institutions and professionals connected with Catholic church etc. Nowadays this debate is not the case anymore.

**1.2.4 In case stakeholders involved in the implementation of OST (see question 1.1 e and f) differ from those involved in the preparation and enactment of the legislation, or have another ranking, please comment on that.**

*Please give your answer in the box below*

N.a.

## **2. Use and possession of small quantities for personal use**

**Is there any legislation or are there regulations around decriminalisation of use and possession of small quantities for personal use?**

- yes**  
 **no**

**If yes**, continue;

**If no**, proceed to question 2.1.10.

### **2.1 In depth information on the preparation and enactment of the legislation and other regulations regarding use and possession of small quantities for personal use**

**2.1.1 Please provide information, in bullet points, on the preparation and enactment of the first legislation and regulations around decriminalisation of use and possession of small quantities for personal use. Please include dates (year).**

*Please give your answer in the box below*

The use (consumption) per se of drugs is not an offence in Slovenia, but illegal possession of drugs is considered a minor offence under the Production and Trade in Illicit Drugs Act (Article 33) (adopted in 1999). According to this, unauthorised possession of drugs is subjected to a fine of between € 208 and up to € 625 or to imprisonment of 30 days. Individuals who possess a smaller quantity of illicit drug for one-off personal use are liable to a monetary fine of between € 42 and € 208 or a prison sentence of up to 5 days for such an offence. According to the provisions of the Misdemeanors Act, the persons committing such an offence may be subject to more lenient punishment if they voluntarily enter the programme of treatment for illicit drug users or social security programmes approved by the Health Council at the Ministry of Health or by the Council for Drugs at the Ministry of Labour, Family and Social Affairs. There is no limit quantity yet to indicate what personal use is, but this is being discussed.

**2.1.2 Please provide information, in bullet points, on the preparation and enactment of the current legislation and regulations around decriminalisation of use and possession of small quantities for personal use. Please include dates (year).**

*Please give your answer in the box below*

Still the same legislation.

**2.1.3 Please provide information, in bullet points, on any relevant changes between the first legislation and regulations around decriminalisation of use and possession of small quantities for personal use and the current legislation and regulations. Include the year(s) of change.**

*Please give your answer in the box below*

No significant changes which influenced use and possession of small quantities for personal use.

**2.1.4 Briefly describe key events and underlying reasons in the process of preparing and adapting the legislation and regulations to establish a decriminalisation of use and possession of small quantities for personal use (chronologically, with accompanying dates).**

*Please give your answer in the box below*

In Slovenia, possession of illicit drugs is minor (not criminal) offence since 1978. Since 1980s there is no known case of imprisonment for possession of illicit drugs for personal use. Mostly fines were used for such offences even that prison sentences are foreseen in the law (also in the present one). In 1999, the Ministry of Health prepared a new draft legislation regulating also possession of illicit drugs (Production of and Trade in Illicit Drugs Act) which was adopted by the National Assembly in 1999. In the process of adoption of this particular law several discussions occurred and most of them were focusing on “decriminalisation and possession of small quantities for personal use”. It was rather short but very active period of discussion (couple of months during the legislative procedure) which involved several key stakeholders (e.g. health and social sector, police officers, academics, policymakers and politicians) and civil society as well (both pro- and contra-decriminalisation and possession for personal use). More liberal and social-democratic politicians, professionals and representatives of NGOs were on the pro-decriminalisation side and more conservative, Christian-democratic and right-wing politicians were on contra-decriminalisation side of discussion. Political majority was pro-decriminalisation oriented, so the law was finally adopted in December 1999 with special article on “possession” and special paragraph on “small quantities for personal use”. Up to now, quantities are not yet defined.

**2.1.5 Please identify the five stakeholders who played the most important role in supporting the preparation and enactment of the legislation and regulations on decriminalisation of use and possession of small quantities for personal use.**

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Political power	Financial power	PR power	Knowledge based power
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		(1-7)	(1-7)	(1-7)	(1-7)
<b>Tatja Kostnapfel</b> (national policymaker) (advisor at the Ministry of Health)	Health – public	5	5	4	6
<b>Milan Krek</b> (national policymaker) (Government Office for Drugs - director)	Health – public Health – individual (protection of users)	4	3	6	7
<b>Dr Marjan Jereb</b> (national politician / Minister of Health)	Health – public	7	7	6	4
<b>Dunja Piškur-Kosmač</b> (national politician / State Secretary at the Ministry of Health)	Health – public	7	7	6	6
<b>Roman Jakič</b> (member of the National Assembly 1996-2000) (Liberal Democratic Party)	Health – individual (protection of users) Health - public	7	4	7	5

*Any additional comments, please write in the box below*

The Resolution on the National Drug Programme 2004-2009 provided for certain amendments to the existing legislation. With regards to the penal policy, the Resolution provided for an examination of the possibility of setting stricter penalties for dealers in illicit drugs and those who render opportunities for consumption of illicit drugs to minors in schools themselves or in the near vicinity and on the premises where young persons are involved in activities, or for those who

influence minors or vulnerable people. The Resolution also provided faster proceedings before the authorities which adopt decisions on violations and on criminal proceedings, but above all, strived for the earliest possible hearings whenever drug addiction leads to criminal offences.

In compliance with the Production and Trade in Illicit Drugs Act, the illegal possession of drugs was again classified as a minor offence. On the basis of the Resolution, the possibility of amending the stated act was planned to be examined in order to determine the limit for the quantity of an illicit drug for personal use and the quantity that can no longer be classified as such. In this case, amendments was planned to be made to the criminal law as well. Another matter that was provided to be studied is whether it is sensible and effective to sanction the possession of illicit drugs up to the quantity the users need for a one-off use if other circumstances do not indicate a possibility for greater abuse of illicit drugs. At the same time, it would make sense to attract expert groups capable of providing professional assistance to individual perpetrators immediately upon the detection of criminal conduct. In this regard, the Council for Drugs at the Ministry of Labour, Family and Social Affairs (this Council was never really operational) along with the Health Council at the Ministry of Health should set up health or social security programmes for dealing with perpetrators of offences who have been caught with minor quantities of illicit drugs for one-off personal use. The response and cooperation of an offender should be an important component in decisions adopted by judicial authorities regarding sanctions, however, some thought should also be given to alternative sanctions (administrative penalties, and similar) and provisions made for them. None of these activities mentioned above were realised since the Resolution was adopted in 2004. Some of them were again included in the draft of new national programme which was not yet sent to the governmental procedure and wider public discussion.

**2.1.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations on decriminalisation of use and possession of small quantities for personal use. List their interests and arguments and score their power.**

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
<b>Branko Kelemina</b> (member of the National Assembly 1996-2000 – Slovenian Democratic Party – conservative)	Security - public Morals / values / ideology	3	2	3	3
<b>Janez Čebulj</b> (member of the National	Security - public Morals / values / ideology	2	2	2	2



Assembly 1996-2000 – Slovenian Democratic Party - conservative)					
<b>Rudolf Petan</b> (member of the National Assembly 1996-2000 – Slovenian Democratic Party - conservative)	Security - public Morals / values / ideology	2	2	2	2
<b>Vincencij Demšar</b> (member of the National Assembly 1996-2000 – Slovenian People's Party / Slovenian Christian Democrats - conservative)	Security - public Morals / values / ideology	2	2	2	2
<b>Pavel Rupar</b> (member of the National Assembly 1996-2000 – Slovenian Democratic Party - conservative)	Security - public Morals / values / ideology	3	2	4	3

*Any additional comments, please write in the box below*

All mentioned members of Slovenian parliament (National Assembly) are not active in politics anymore. There was not very active discussion on this issue in the parliament except in the parliamentary committee responsible for health issues and rather short discussion during adoption process of the law in the parliament (assembly meeting).

**2.1.7 In case international politics or policy have influenced the preparation, introduction or adaptation of this legislation or these regulations in your country, please explain.**

*Please give your answer in the box below*

No international influence to the preparation, introduction or adaptation of this legislation was registered. In some discussions (by civil society organisations and Government Office for Drugs) the UN Declaration 1998 was mentioned as an argument for decriminalisation of drug users.

**2.1.8 Please summarize in bullet points the key elements (content) of the legislation or other regulations with regards to use and possession of small quantities of heroin for personal use as they are in force to date. E.g., are use and/or possession of small quantities still a crime, what are the sanctions, what is the definition of a small quantity?**

*Please give your answer in the box below*

The use (consumption) per se of drugs is not an offence in Slovenia, but illegal possession of drugs is considered a minor offence under the Production and Trade in Illicit Drugs Act (Article 33) (adopted in 1999).

Unauthorized possession of drugs is subjected to a fine of between € 42 and € 208 or to imprisonment of 30 days.

Individuals who possess a smaller quantity of illicit drug for one-off personal use are liable to a monetary fine of between € 208 and up to € 625 or a prison sentence of up to 5 days.

The persons committing such an offence may be subject to more lenient punishment if they voluntarily enter the programme of treatment for illicit drug users or social security programmes approved by the Ministry of Health or by the Ministry of Labour, Family and Social Affairs.

There is no limit quantity yet to indicate what personal use is, but this is being discussed.

**2.1.9 If any modifications of the legislation or regulations expected in the near future, please briefly describe contents and reasons.**

*Please give your answer in the box below*

Yes, but at the moment changes are not realistic as new national strategy has to be introduced and adopted first by the government and the National Assembly. This process is ongoing already since 2009 and we still don't know when the strategy is planned to be adopted by the government and the parliament. Regarding possession issue only limit quantity what personal use is being discussed and could be defined by the law in the near future. No other changes are expected.

**2.1.10 In case no legislation and other regulations regarding use and possession of small quantities for personal use exist, please mention any attempts/proposals made to have this regulated and why it did not succeed.**

Please give your answer in the box below

N.a.

**2.2 In depth information on the implementation of regulating provisions in the legislation or otherwise regarding use and possession of small quantities for personal use**

In the answers to the questions below, please describe briefly in bullet points the specifics of the implementation. If no legislation or other regulations regarding use and possession of small quantities for personal use exist, please scroll down the page to section II Contextual information.

**2.2.1 What is the level of implementation regarding use and possession of small quantities for personal use in your country? Please rate on a scale from 1-7.**

1= not implemented at all; 7=fully implemented in the whole country and all relevant settings.

1	2	3	4	5	6	7
					X	

Any comments on the level of implementation, please write in the box below.

The only missing legislative category regarding implementation is defined quantities for personal use, so in most of the cases courts (judges) decide by discretion or they consult experts.

**2.2.2 Please describe factors facilitating the implementation (e.g., support from the police, public opinion, organisational aspects, positive media attention, ...).**

Please give your answer in the box below

Regarding legislation on possession of illicit drugs for personal use, Slovenia is categorised as rather liberal country. The priorities of police are more focused on organized crime not on drug users themselves (since the end of 1990s). Public opinion seems to be in general against legalization, but not supportive to repression against drug users as well. There was no specific public opinion survey yet on this issue. There was one minor survey in newspaper Delo about 10 years ago (concretely on "recreational" and medical cannabis) which showed attitude against legalization of cannabis and in favour to medicinal use of cannabis. In 2011, Eurobarometer survey showed that 94 % of young Slovenians (age 15-24) think that heroin should continue to be banned (91 % of them support cocaine ban, 89 % ecstasy ban and 49 % cannabis ban). 46 % of young Slovenians support cannabis should be regulated (similar to alcohol and tobacco). On question "what do you think are the three most effective ways for public authorities to reduce drugs problems" 63 % of them think it's "tough measures against drug dealers and traffickers", 33 % of them think it's "tough measures against drug users" and 20 % of them think it's "making drugs legal". Regarding media there is practically no media coverage for illicit drug issues (articles or news on illicit drugs are published only occasionally).

**2.2.3 Please describe barriers for the implementation (e.g., prevailing attitude towards harm reduction).**

*Please give your answer in the box below*

In Slovenia, also so-called harm reduction NGOs support decriminalisation of drug users and milder regulation regarding possession of illicit drugs for personal use. There are not many opponents to decriminalisation in professional and civil society sector. Since legislation was introduced and adopted (1999) there was no serious political intention to change it.

**2.2.4 In case stakeholders involved in the implementation of the measures regarding use and possession of small quantities for personal use (see question 2.1.5 and 2.1.6) differ from those involved in the preparation and enactment of the legislation, or have another ranking, please comment on that.**

*Please give your answer in the box below*

N.a.

## II Contextual information

Please complete the following questions/tables with the latest data available (please also state the source).

### 1 General information on country

**1.1 Area (km<sup>2</sup>):** 20,273 km<sup>2</sup>

**1.2 Population size:** 2.050.189 (estimation in 2011)

### 2 Prevalence of heroin use

#### 2.1 Prevalence of heroin use in the general population (15-64 years)

	Most recent data (%)	Year
Lifetime use	0,8	2010
Last year use	not available	/
Last month use	not available	/

**Source:** National Public Health Institute, 2011

Please briefly describe the **trend in prevalence of heroin use in the general population** during the past ten years in terms of decreasing/increasing, stating where possible percentages from or around 2002.

*Please give your answer in the box below*

The European Health Interview Survey was conducted in Slovenia for the first time and is to be repeated in five-year intervals. Data were gathered through interviews conducted by the National Institute of Public Health at the end of 2007. The observation unit of the survey included Slovenian residents aged 15 and above and living in private households (not institutionalised). The sample size comprised 3 400 persons aged 15 or more. The European Health Interview Survey included two issues that relate to drug use. In the 12 months prior to the date of the survey, cannabis was consumed by 2.6 % of the respondents, and other drugs by 0.9 % of individuals who were aged 15 years and over. Among users of cannabis and other drugs, there are more men than women. In the 15- to 64-years age group, cannabis was consumed by 4.8 % of men and 1.3 % of women. Separate data for heroin is not available.

In 2010, the National Institute of Public Health (NIPH) conducted a pilot study on drug use in the general population aged 15 to 64 applying the EMCDDA methodology. The aim of the study was to test the questionnaire and the interviewing methods and the obtained data therefore do not represent the actual situation regarding drug use in the general population in Slovenia but merely provide an indicative picture of the situation in this field. The study used a mix mode survey, with the initial phase comprising online interviews, the second telephone interviews and the last face to face interviews. The sample comprised 500 people and 259 people from across Slovenia provided answers to the questionnaire, of that 45.9% of men (n=119) and 54.1% of women (n=140). The response rate was 55%. 47.1% of respondents were under the age of 40. The only available data on heroin is lifetime prevalence (0,8 %).

## 2.2 Number of problem users

Please use the EMCDDA definitions

	Most recent data	Year
<b>Number of problem heroin users</b>	10.654	2004
<b>Percentage of last year injectors</b>	not available	/
<b>Number of heroin users that is in substitution treatment</b>	3.557	2012

**Source:** National Public Health Institute, 2012

Please briefly describe the **trend in prevalence of problem heroin use and injecting** in the past ten years in terms of decreasing/increasing, stating where possible percentages from or around 2002.

*Please give your answer in the box below*

Data on risk behaviours among users who entered a programme for the first time show that the proportion of users who injected drugs in the past 30 days before entering a programme is only 20%. The proportion of people who injected drugs during 30 days before admission is decreasing – from 49.2% in 2005 to 31.6% in 2011. As mentioned there were only 20% of such drug users among the people who entered a programme for the first time in 2011.

Treatment demand data in Slovenia is collected through the nationwide network of the Centres for the Prevention and Treatment of Illicit Drug Addiction (CPTDA). In 2010, 18 outpatient treatment centres and the Centre for the Treatment of Drug Addiction at the Ljubljana Psychiatric Hospital

submitted treatment demand data. In 2010, the total number of reported clients in treatment was 797, among them 277 entered treatment for the first time.

In 2010, 90.9 % of all clients entering treatment reported opioids as their primary drug. This was followed by 5.4 % for cannabis and 2.5 % for cocaine. Among first-time treatment clients, 83.3 % reported opioids as their main problem substance, followed by 11.3 % for cannabis and 3.6 % for cocaine. About 19 % of all clients entering treatment were aged less than 25. A higher percentage in age distribution was reported among new treatment clients, with 31 % being under the age of 25. With regards to gender distribution among all clients entering treatment in 2010, 79.4 % were male, whereas 20.6 % were female. A similar gender distribution was reported in 2010 among new treatment clients entering treatment, at 77.3 % for males and 22.7 % for females.

### 2.3 Influence of heroin use prevalence on governance implementation

Did the heroin use prevalence influence the implementation of **opioid substitution treatment**?

- yes  
 **no**

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
X						

Did the heroin use prevalence influence the implementation of **measures regarding possession and use of small quantities**:

- yes  
 **no**

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
X						

## 3 Health context

### 3.1 Heroin use related morbidity in IDUs\*

	Most recent data on prevalence (%)	Most recent data on absolute number of infected IDUs	Year
<b>HIV</b>	1,9	not available	2011
<b>Hepatitis C</b>	28,5	not available	2011

\*IDU= injecting drug user; if possible, provide data on *ever injecting drug users*.

If you use another definition, please specify: .....

Source:

### 3.2 Heroin related mortality

	Most recent data	Year
Direct heroin use related mortality (overdoses, etc.)	10 (of total 24 drug-related deaths)	2011
Indirect heroin use related mortality (related to lifestyle, infectious diseases, etc.)	A cohort study on this issue is available in <i><b>National Report 2012</b></i>	2012

Source: National Public Health Institute, 2012

Please describe briefly the trend in heroin related morbidity and mortality in the past ten years, stating where possible percentages from or around 2002.

*Please give your answer in the box below*

No prevalence rates are available for drug-related diseases among the whole population of (injecting) drug users. Several studies among sub-populations on HIV prevalence were conducted among tested groups of injecting drug users and those in treatment during the period 2002 to 2010. These indicated HIV prevalence rates around 0.4 % among confidentially- and voluntarily-tested IDUs who were treated for the first time in the network of outpatient centres and non-governmental needle and syringe exchange programmes in 2010. There has been no new HIV case with a history of IDU reported since 2001.

The prevalence rate of antibodies against the hepatitis B virus (HBV) was 5.3 % in 2010 (compared to 10.4 % in 2003) among the treatment clients. The prevalence rate of antibodies against hepatitis C virus (HCV) was 21.5 % in 2010 (compared to 23.4 in 2009). However, there is a high risk of under-reporting of cases both for HCV and HBV.

In 2010, data on drug-related deaths are reported based on data from the General Mortality Register. There were 25 direct drug-related deaths in 2010, which continues a declining trend since 2007 (28 in 2009, 36 in 2008, 42 in 2007, 39 in 2006 and 44 in 2005). Around 84 % of death cases occurred in men, and the mean age at death was 34 years. All reported death cases have been confirmed by toxicological results and indicates involvement of opiates in less than half of the registered case (48 %). Drug-related deaths were defined as deaths due to accidental poisoning, intentional poisoning and poisoning of undetermined intent.

### 3.3 Influence of heroin use-related health consequences on governance implementation

Did the heroin use-related health consequences influence the implementation of opioid substitution treatment?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
X						

Did the heroin use-related health consequences influence the implementation of measures regarding use and possession of small quantities for personal use:

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
X						

Please briefly describe the influence of the health context on these two cases:

*Please give your answer in the box below*

There is no influence of heroin use-related consequences on governance implementation.

#### 4 Economical context

This section focuses on general economical information and data on public spending (direct and indirect) on heroin. Please provide data as far as available.

##### 4.1 General economical circumstances

	Most recent data	Year
Gross national income per capita (PPP international) (€)	17.620	2011
Total health expenditures per capita (€)	1.869	2010
Total health expenditures as percentage of GDP (€)	9,0	2010

**Source:** Statistical Office of the Republic of Slovenia; OECD Health Data 2012; Eurostat Statistics Database; WHO Global Health Expenditure Database

##### 4.2 State expenditures

If you have any data on (direct or indirect) expenditures on the health consequences of heroin use, or on the expenditure related to crime control related to heroin use, production or trafficking, please provide them here.

*Please give your answer in the box below*

Detailed information is available in Chapter 12.2 Drug-related public expenditure of the National Report 2012:

[http://www.ivz.si/nacionalna\\_porocila?pi=5& 5 Filename=attName.png& 5 MediaId=6174& 5 AutoResize=false&pl=168-5.3](http://www.ivz.si/nacionalna_porocila?pi=5& 5 Filename=attName.png& 5 MediaId=6174& 5 AutoResize=false&pl=168-5.3)



**4.3 Economical context influencing implementation of opioid substitution treatment and measures with regard to use and possession of small quantities of heroin for personal use**

Did the economical context influence the implementation of **opioid substitution treatment**?

- yes
- no**

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
<b>X</b>						

Did the economical context influence the implementation of measures with regard to use and possession of small quantities of heroin for personal use?

- yes
- no**

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
<b>X</b>						

Please briefly describe the influence of the economical context on these two cases.

*Please give your answer in the box below*

There is no influence of economical context on governance implementation.

**5. Political context**

Did the **political context** influence the implementation of opioid substitution treatment?

- yes
- no**

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
<b>X</b>						

Did the political context influence the implementation of measures with regard to use and possession of small quantities of heroin for personal use?

- yes
- no**

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
X						

Please briefly describe the influence of the political context on these two cases.

*Please give your answer in the box below*

There is no influence of political context on governance implementation.

### 6. Historical/Socio-cultural context

**Did the historical/socio-cultural context influence the implementation of opioid substitution treatment?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
X						

**Did the historical/socio-cultural context influence the implementation of measures with regard to use and possession of small quantities of heroin for personal use?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
X						

Please briefly describe the influence of the historical/socio-cultural context on these two cases.

*Please give your answer in the box below*

There is no historical/socio-cultural influence of context on governance implementation.

### III. Key publications

Please add the full references of the sources you have used. In case you have included expert opinions, please provide the name of the experts as well as the date and source of communication (e.g. personal communication).

*Please list the publications in the box below*

National Reports on Drug Situation in Slovenia: [http://www.ivz.si/nacionalna\\_porocila](http://www.ivz.si/nacionalna_porocila)

Franz Trautmann, Nino Rode, André van Gageldonk, Daan van der Gouwe, Esther Croes, Romana Zidar, Heino Stöver, Mojca Gašparič, Nuša Konec–Juričič (2007). Evaluation of substitution maintenance treatment in Slovenia – assessing quality and efficiency. Trimbos Institute Netherlands, Institute of Mental Health and Addiction and Faculty of Social Work, University of Ljubljana. Utrecht and Ljubljana.



## Appendix 4: Country report: Regulation of gambling in Slovenia

### Country report ALICE RAP WP14

#### Slovenia GAMBLING

In this study we focus on two selected cases of governance *practice*. For being able to describe and analyse these two cases we need a basic overview of relevant factors in the preparation, enactment and implementation of important measures and regulating provisions in the legislation or otherwise. This questionnaire will result in a country report and focuses on one case of governance practice related to gambling: aspects of **control and regulation**, e.g. licensing.

The structure of this country report format is based on an adapted version of the health policy triangle of Walt & Gilson (1994)<sup>101</sup>. This is built up around the following four concepts: policy content and process, stakeholders and context (for more detailed information see the project proposal).

Important: Please fill out this format as completely as possible, but limit yourself to the key elements. At a later stage we might contact you for additional information.

#### I Policy process and contents

##### 1. Relevant aspects of control and regulation in gambling legislation and other regulations and standards

###### 1.1 Which types of gambling does the gambling regulation in your country include:

	Is it regulated?	Is it legal?
<b>Table games in casino's ( e.g., cards, dice, roulette, with a croupier or poker dealer)</b>	Y	Y
<b>Electronic gaming in casino's (e.g., slot machine, video poker)</b>	Y	Y
<b>Other gambling in casino's (bingo, keno)</b>	Y (only in casino)	Y
<b>Gambling games not in casino's (lotteries, scratchcards, bingo)</b>	Y	Y
<b>Fixed-odds betting (sports or other events; in a fixed odds betting the pay-out is agreed at the time the bet is sold)</b>	N	N

<sup>101</sup> Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health policy and planning*, 9(4), 353-370.

<b>Parimutual betting (gambling on horse racing, greyhound racing, sporting events; in a parimutual betting the final pay-out is not determined until the pool is closed)</b>	Y	Y
<b>Internet gambling</b>	Y	Y (only 2 lotteries and HIT, others are not legal)
<b>Any other (please list)</b>	/	/

*Additional comments, please give your answer in the box below*

/
---

**1.2 Does your gambling regulation include regulations on:**

		<b>Short description:</b>
<b>Licensing</b>	Y	
<b>Taxes</b>	Y	
<b>Rules of (casino) games</b>	Y	
<b>Age limits</b>	Y	Minimum 18 years old are allowed in casinos. ID is needed.
<b>Advertising</b>	Y	Only for concession holders. Advertising needs to be balanced (stressing threats as well).
<b>Consumer information</b>	Y	Recently concession holders need to inform consumers (flyers) about risk of acceding gambling and probabilities of gains.
<b>Prevention and/or treatment of problematic gambling</b>	N	
<b>A regulating agency</b>	Y	Regulating agency is not working any more (from 1.1.2013 onwards). Its responsibilities are transferred to the Ministry of Finance and Tax Administration of the Republic of Slovenia.

**1.3 Is the regulating agency\* in your country involved in**

		<b>Any remarks</b>
<b>Licensing (issuing, levying fines, revoking)</b>	Y	
<b>Accounting systems (providing financial information, e.g., to the government)</b>	Y	
<b>Auditing</b>	Y	Concession contractors

<b>Advising national or local government on gambling issues</b>	Y	
<b>Investigating and prosecuting illegal gambling</b>	Y	
<b>Remote gambling, e.g., betting online (internet) or by telephone</b>	Y	Special regulation from 2008
<b>The spreading of gambling/betting</b>	Y	

\* For gambling there is no independent regulatory agency in Slovenia at the moment. Until 1<sup>st</sup> of January 2013 the Office for Gaming Supervision (within the Ministry of Finance) existed, but since then the controlling tasks were assigned to Tax Administration of the Republic of Slovenia and the legislative and administrative tasks to the Ministry of Finance.

## **2 In depth information on the preparation and enactment of the legislation and other regulations in gambling control and regulation**

### **2.1 Please provide information, in bullet points, on the preparation and enactment of the first legislation and regulations regarding gambling control. Please include dates (year).**

*Please give your answer in the box below*

Gaming was forbidden for Yugoslav citizens (Slovenia was part of former Yugoslavia until 1991) since mid-70s, so only foreign citizens were allowed to enter casinos.  
 In 1962 first Yugoslav law on gaming/gambling was adopted which included lotteries, tombola, sport betting, lotto and other similar games. There was one minor change/update of the law in 1965.  
 In September 1965 first Slovenian law on gaming/gambling that included games which were organized in casinos. Only foreigners were allowed to enter casinos according to this law. The law was changed and updated in 1980 and 1986, but it still didn't allow Slovenian citizens to play those special games.

### **2.2 Please provide information, in bullet points, on the preparation and enactment of the current legislation and regulations on gambling control and regulation. Please include dates (year).**

*Please give your answer in the box below*

The system of organising gaming in Slovenia is regulated with the 1995 Gaming Act, which was amended in October 2001, in October 2003, in February 2010 and December 2010 (consolidating text is published in the Official Gazette of the Republic of Slovenia, no. 14/11).  
 On the basis of this Act the following regulations were issued: (a) Regulation on technical requirements for gaming devices and conformity assessment procedure; (b) Regulation on Institutions for Issuing Gaming Device Test Reports; (c) Regulation on the supervisory information

system of gaming device; (d) Regulation on organising games on slot machines in gaming halls; (e) Regulation on licenses for employees in casino industry; (f) Regulation on detailed criteria that need to be fulfilled by permanent organisers of classical games; (g) Regulation on societies and non-profit humanitarian organisations that are allowed to organise classical gaming occasionally.

The current legislation differs classic gaming/gambling and special gaming/gambling. Classic games include: numeric lotteries, lotteries with the currently known winnings, quiz lotteries, tombola, lotto, sports forecasts, sports betting and similar games. Special games include: games that players play against the casino or against each other at specific gaming tables with beads, dices, cards, slot screens or on the slot machines and betting and other similar games in accordance with international standards.

There is also internet gaming (or gaming on other telecommunication tools) allowed on the basis of the law, but only to the companies which have concession for permanent organization of classic gaming/gambling or concession for organization of special gaming/gambling in casinos. The companies with concessions are: Loterija Slovenije (The Lottery of Slovenia), Športna loterija (The Sports Lottery), Casino Kobarid.

Slovenian legislation in the field of gambling regulates in detail the conditions for granting concessions (a type of company, location, minimum share capital). The concessions are decided by the Government of the Republic of Slovenia at the discretion. The law also provides a concession fee. The special gaming/gambling tax is defined in the Gaming Tax Act (adopted in 1999, changed in 2001).

The Gaming Act also provides that the applicant for the award of concessions submits already in the application the rules for each game, which will be implemented in the casino. Visiting the casino is restricted to persons aged 18 and over.

The advertising relating to gaming is forbidden for persons with no concession.

Companies that obtain a concession for gambling shall inform gaming participants about the risks, particularly the possibility of addiction to gambling, provide them with guidance on responsible gaming and information about where they can get help related to addiction.

The player can require from the company, which has the concession for gambling in a casino, a written statement which prohibit him participation in gaming/gambling for at least six months and a maximum of three years.

**2.3 Please provide information, in bullet points, on any relevant changes between the first legislation and regulations on gambling control and regulation and the current legislation and regulations. Please include the year(s) of change.**

*Please give your answer in the box below*

The current Gaming Act (1995) was changed or updated for the five times. The main changes were as follows:

- 2001: introduction of compulsory technical test and license for each gaming device; introduction of the possibility of organizing games via the internet, and the introduction of compulsory control information system of gaming devices, the introduction of permits (licenses) to work in the business of gaming/gambling; introduction of gaming salons.



- 2003: the explicit enactment of discretion by reference to criteria that are taking into account and limiting the number of licenses in Slovenia; determine the ownership structure of the casino concession holders; required prior approval of the Minister for the change in ownership; determine the procedure for the determination of the individual (geographically defined) tourist areas which are entitled to get income from gaming/gambling tax in casinos and gaming salons.
- 2010: introduction of blocked websites, which hold an illegal online gambling.
- 2010: transfer of jurisdiction to rule on restricting access to web pages, which hold an illegal gambling with the Office for Gaming Supervision to the Administrative Court of the Republic of Slovenia.
- 2012: abolition of the Office for Gaming Supervision; gambling is now controlled by the Tax Administration of the Republic of Slovenia, while the Ministry of Finance conducts procedures relating to the granting and renewal of concessions, monitors and analyzes the regulation of the activities of gaming and prepares development documents and regulations on gambling.

**2.4 Briefly describe key events and underlying reasons in the process of preparing and adapting the legislation and regulations on gambling control and regulation (chronologically, with accompanying dates).**

*Please give your answer in the box below*

2012: abolition of the Office for Gaming Supervision: Government stated that the reason for abolition is a rationalization of the public sector and reduction of costs of renting offices and operating costs of premises.

**2.5 Please identify the five stakeholders who played the most important role in supporting the preparation and enactment of the legislation and regulations on gambling control and regulation.**

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
Emil Mihalič	Ex-director of the Office for Gambling Supervision within the Ministry of Finance (policy maker; economical/budget interest)	5	2	3	7
Urška Cvelbar	Ministry of Finance (senior public official responsible for gaming/gambling) (policy maker; economical/budget interest)	4	4	3	6
Janja Jereb	Ministry of Finance (public official responsible for gaming/gambling) (policy maker; economical/budget interest)	3	3	3	7

*Any additional comments, please give your answer in the box below*

The scores are based on my personal opinion and my experience and knowledge gained during the process of fulfilling this questionnaire. It probably does show the reality in the field, but still it can give some hints on situation. Nobody of my contacts was willing to answer this section.

**2.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations on gambling control and regulation. List their interests and arguments and score their power.**

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
Dr Marko Jaklič	University of Ljubljana, Faculty of Economics (science/researcher)	1	1	3	6
Helena Golubovič	Združenja igralnih salonov PROZIS (Association of casinos and gaming salons PROZIS) (gambling industry)	2	5	5	7
Joc Pečečnik	Združenja igralnih salonov PROZIS (Association of casinos and gaming salons PROZIS) (gambling industry)	3	7	6	7
Tilen Majnardi	HIT (gambling company) – corporate communication head (gambling industry)	2	5	7	7
Janez Sirše	International Institute of Tourism and ex-president of National Tourism Association (tourism industry)	3	2	3	6

*Any additional comments, please give your answer in the box below*

The scores are based on my personal opinion and my experience and knowledge gained during the process of fulfilling this questionnaire. It probably does show the reality in the field, but still it can give some hints on situation. Nobody of my contacts was willing to answer this section of the questionnaire. Some typical statements of key persons: Prof Dr Jaklič: The state should withdraw ownership and change the tax system. He expresses a lot of criticism on present situation and regulation. Mrs Golubovič: Current tax legislation means in long-term the burial of Slovenian gaming, not its development. She supports the abolition of gaming/gambling websites as they are too risky for addition of young people etc. Mr Majnardi: High taxes work destimulating in terms of investment and thereby directly inhibit the development of Slovenian tourism and gaming industry.

**2.7 If international politics or policy have influenced the introduction/adaptation of this legislation or these regulations in your country, please explain.**

*Please give your answer in the box below*

No international political or policy influence detected in this field.

**2.8 If any modifications of the legislation or regulations are expected in the near future, please describe briefly contents and reasons.**

*Please give your answer in the box below*

No modifications expected as far as I know from communication with key stakeholders. There was a discussion (but not recently, mostly in 2005) on building a big entertainment centre (with casinos) near the city of Nova Gorica (western Slovenia). There was an intention of HIT company (main casino company in Slovenia) and Harrah's Entertainment from Las Vegas to sign the contract and this was initially supported by the Government at that time (conservative right-wing coalition). The deal was never (until today) processed to the contract and real investment. There were some strong appeals against the entertainment centre from some local stakeholders who were afraid of increasing problems with gambling addiction, prostitution, criminality etc. among local population and wider. Local authorities basically supported the investment due to economic reason (e.g. new jobs, more tourism, new income for local budget etc.).

**3 In depth information on the implementation of regulating provisions in the legislation or otherwise on gambling control and regulation**

**3.1 What is the level of implementation of gambling control and regulation in your country? Please rate on a scale from 1-7.**

1= not implemented at all; 7=fully implemented in the whole country and all relevant settings.

1	2	3	4	5	6	7
					X	

*Any comments on level of implementation, please give your answer in the box below*

The score is based on my personal opinion and my experience and knowledge gained during the process of fulfilling this questionnaire.

**3.2 Please describe factors facilitating the implementation (e.g., public opinion, economic interests, organisational aspects, positive media attention, ...).**

*Please give your answer in the box below*

There is not much public or media attention at the moment to this topic. The system is relatively stable with some little changes to the legislation from time to time. The biggest change was last year as the Office of Gaming Supervision was abolished, but the tasks remain the same and they were just transferred to other sectors within the Ministry of Finance and to the Tax Administration of the Republic of Slovenia. This particular change had no influence on implementation yet as it is valid since 1<sup>st</sup> of January 2013. There was also no particular media or other public attention to this issue (e.g. only few very general news articles in main media).

**3.3 Please describe barriers for the implementation (e.g., public opinion, financial restrictions, housing problems, organisational aspects, negative media attention).**

Please give your answer in the box below

No particular barriers. Sometimes discussions appear initiated by gambling industry on lower taxation and negative impact of high taxes on employment, income and tourism. It seems that gambling industry is struggling with problems during financial crisis.

**3.4 In case stakeholders involved in the implementation of gambling control and regulation (see question 2.5 and 2.6) differ from those involved in the preparation and enactment of the legislation, or have another ranking, please comment on that.**

Please give your answer in the box below

Differentiation between different stakeholders is rather logical in Slovenia. From one side there is government interested in taxes and budget income and from the other side there are gambling industry, experts in economics and tourism supporting development of tourism and employment in gambling industry. Sometimes arguments on gambling addiction, prostitution and crime appear in the public but the influence of such arguments is minor.

## II Contextual information

Please complete the following questions/tables with the latest data available (with accompanying source). Describe the trend in the data (in terms of decreasing/increasing) over approximately the last ten years.

### 1 General information on country

**1.1 Area (km<sup>2</sup>):** 20,273 km<sup>2</sup>

**1.2 Population size:** 2.055.262 (July 1<sup>st</sup> 2012<sup>102</sup>)

### 2 Prevalence of gambling

#### 2.1 Prevalence of gambling in the general population (15-64 years)

	Most recent data (%)	Year
<b>Lifetime gambling</b>		
<b>Last year gambling</b>	Approx. 1/3 of population has played at least one game in last year (mostly lotto, express lottery tickets, sports bets and other classic games)	2009 (description on study below)
<b>Last month gambling</b>		

<sup>102</sup> Source: statistical office of the Republic of Slovenia

**Source:** School of Advanced Social Studies, Nova Gorica (2009)

Please briefly describe the trend in prevalence of gambling during the past ten years.

*Please give your answer in the box below*

In Slovenia only one prevalence study has been conducted in general population – in 2009. This analysis showed that 1,45 % of general population are problem gamblers and 0,46 % are pathological gamblers. We assume numbers are these days higher. Data among the teens from 2010 show trend of higher addiction problems (internet plays an important role in this development).

## 2.2 Influence of gambling prevalence on governance implementation

**Did the prevalence of gambling influence the implementation of the legislation on gambling control and regulation?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the gambling prevalence on gambling control and regulation.

*Please give your answer in the box below*

## 3 Health context

### 3.1 Number of problem gamblers

	Most recent data	Year
<b>Number of problematic gamblers</b>	1,45% - adult population in Slovenia	2009
	4,14% - 13-15 years old - Goriška region	2010
	4,09% - 13-15 years old - Dolenjska region	2010
<b>Number of pathological gamblers</b>	0,46% - adult population in Slovenia	2009
	2,57% - 13-15 years old - Goriška region	2010
	3,73% - 13-15 years old - Dolenjska region	2010
<b>Number of gamblers in treatment</b>	25 (Centre for addiction treatment, Nova Gorica)	2009
	45 FUDŠ (Faculty of Applied Social Sciences) – National Institute for Psychotherapy	2007-2010

If possible, use DSM definition. If you use any other definition of problematic gambling, please specify:

Source: SOGS test (in all three cases – the only data available for Slovenia)

### 3.2 Gambling related morbidity and social loss

**3.2.1 If you have any national data on the prevalence of co-morbid psychopathology, on burden of disease (DALY's) or productivity loss, please provide it here.**

*Please give your answer in the box below*

No information.

**3.2.2 Please briefly describe the trend in prevalence of problem gambling and related morbidity in the past ten years stating where possible percentages from or around 2002 onward.**

*Please give your answer in the box below*

Trend goes to internet addiction and internet gambling. Recent study among the teens (13-15 years old) shows 5-times higher probability of developing gambling addiction. This is mainly due to internet addiction because they don't go to casinos (age restriction).

### 3.3 Influence of gambling-related health consequences on governance implementation

Did the gambling related health consequences influence the implementation of state monopoly and licensing?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the health context on gambling control and regulation.

*Please give your answer in the box below*

/

## 4 Economical context

This section focuses on general economical information and data on public spending (direct and indirect) related to gambling. Please provide data as far as available.

#### 4.1 General economical circumstances

	Most recent data	Year
Gross national income per capita (PPP international) (€)	17.620	2011
Total health expenditures per capita (€)	1.869	2011
Total health expenditures as percentage of GDP (€)	9,0	2011

Source: Statistical Office of the Republic of Slovenia; OECD Health Data 2012; Eurostat Statistics Database; WHO Global Health Expenditure Database

#### 4.2 State expenditures and revenues

**4.2.1 If you have any data on (direct or indirect) expenditures on the health consequences of gambling, or on the expenditure related to crime control related to gambling, please provide them here.**

*Please give your answer in the box below*

It is not state funded – pathological gamblers “fall” in other addiction mechanisms (alcohol, drugs). There are no separate funds. Data are also not available.

**4.2.2 If you have any data on state revenues from taxes on gambling, please provide them here.**

*Please give your answer in the box below*

The information which was given to us by the Ministry of Finance is about 70 million € of state revenue in 2012 from taxes on gambling.

#### 4.3 Gambling industry

**If you have any data on the turnover in the gambling industry (in Euros), please provide them here.**

*Please give your answer in the box below*

Income from gambling in Slovenia in 2011 was 369,5 million € (gross):

71 million € lottery

171,2 million € casinos

127,3 million € gaming halls (source: regulatory body in Slovenia).

This money goes to state budget (60 %), local communities (17 %), Foundation of organizations for

handicap people and humanitarian organisations (15 %), sports organizations (8 %).

Legal division of concessions is a bit different from practice according to the Law on Gambling (Article 46): Foundation of organisations for handicap people and humanitarian organisations (2,2 %), Foundation for sport (2,2 %), state budget (47,8 %) and local communities in the particular local area (47,8 %).

#### 4.4 Economical context influencing implementation of measures on gambling control and regulation.

**Did the economical context (e.g. the economic crisis) influence the implementation of measures on gambling control and regulation?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the economical context on gambling control and regulation:  
*Please give your answer in the box below*

/

#### 5. Political context

**Did the political context influence the implementation of gambling control and regulation?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the political context on gambling control and regulation.

*Please give your answer in the box below*

Last changes were implemented mostly due to general recent developments in the field of gambling where responsible gambling become "must" for regulator.



## 6. Historical/Socio-cultural context

Did the historical/socio-cultural context influence the implementation of gambling control and regulation?

**yes**

no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
					X	

Please briefly describe the influence of the historical/socio-cultural context on gambling control and regulation.

*Please give your answer in the box below*

In our previous country Yugoslavia (Slovenia became independent in 1991) gambling was reserved just for foreign tourists. In communism this activity had negative connotation, therefore not much attention was paid to state regulation and state intervention. This connotation is alive also today, although situation is not the same any more:

Although we find mainly foreign tourists in gambling halls and casinos at Slovenian border, locals are present as well, especially inland

60% of gambling profits goes to state budget, the rest to non-profit organizations (for handicap people, sports organizations etc.) and to local communities, however state regulation in terms of responsible gambling is still weak.

From 1.1. 2013 regulatory body in the field of gambling is abolished and its activities transferred to Ministry of Finance – partly to the Tax Administration of the Republic of Slovenia. This could mean that state regulation is so successful that separate regulatory body is not needed or that gambling regulation does not receive enough attention. We believe it is the latter.

## III. Key publications

Please include a list of key publications used to complete this report.

Please also add the full references of the sources you have used. In case you have included expert opinions please provide the name of the experts as well as the date and source of communication (e.g. personal communication).

*Please list the publications in the box below*

MACUR, Mirna, MAKAROVIČ, Matej, RONČEVIČ, Borut (2009): Slovenia. In: MEYER, Gerhard (ed.). *Challenges, prevention and interventions : problem gambling in Europe*. New York: Springer, cop.

2009, str. 265-280.

MAKAROVIČ, Matej, MACUR, Mirna, RONČEVIČ, Borut (2011): Policy challenges of problem gambling in Slovenia. *Ljetopis socijalnog rada*, 2011, vol. 18, no. 1, str. 127-152.

MACUR, Mirna, MAKAROVIČ, Matej, RONČEVIČ, Borut, VEHOVAR, Urban, ZOREC, Klavdija (2008): *Družbeni stroški igralništva v Sloveniji*. Nova Gorica: Fakulteta za uporabne družbene študije, 2008. 205 str.

BESEDNJAK VALIČ, Tamara (2012): How to assess the impacts of gambling industry on regional environment : the question of social field. In: **Multifaceted nature of collaboration in contemporary world. (p. 301-324)**

BESEDNJAK VALIČ, Tamara (2011): Putting ethical issues of tourism industry in socio/economic perspective, the Slovenian case of Goriška region. In: **Innovative issues and approaches in social sciences [Electronic] ISSN: 1855-0541.- Vol. 4, no. 1 (2011), str. 45-67**

BESEDNJAK, Tamara (2010): Contemplation on responsible behaviour of gambling industry : case of Slovenia and Goriška region. In: **Contemporary world between freedom and security.- Str. 105-124**

MACUR, Mirna (2010): Družbeno odgovorno igralništvo : model evalvacije = Problem gambling : evaluation model. *Raziskave in razprave*, 2010, letn. 3, št. 1, str. 3-27.

MAKAROVIČ, Matej (2008): Igralništvo v slovenskih medijih: med protiigralniškim in korporacijskim diskurzom = Gambling in the slovenian media: between anti-gambling and corporate discourse / Matej Makarovič. In: **Raziskave in razprave [Electronic] = Research and discussion ISSN: 1855-4148.- Letn. 1, št. 1-3 (2008), str. 187-211**

BESEDNJAK, Tamara (2008): Prekomerno igranje na srečo pri zaposlenih v igralništvu: dejavniki tveganja = Excessive gambling: risk factors for casino employees / Tamara Besednjak. In: **Raziskave in razprave [Electronic] = Research and discussion ISSN: 1855-4148.- Letn. 1, št. 1-3 (2008), str. 37-62**

Peter Topić on gambling addiction:

**[http://www.zadovoljna.si/clanek/trend\\_report/v-pricakovanju-sanjskega-dobitka.html](http://www.zadovoljna.si/clanek/trend_report/v-pricakovanju-sanjskega-dobitka.html)**

**<http://vizita.si/clanek/dusevnost/zasvojenost-z-igrami-na-sreco.html>**

**<http://www.viva.si/Zasvojenost/9495/Je-zasvojenost-bolezen-ali-izbira>**

## Appendix 5: Country report: Harm reduction and decriminalisation of heroin in Spain

### Country report ALICE RAP WP14

#### SPAIN - CATALONIA

#### HEROIN

In this study we focus on two selected cases of governance practice. For being able to describe and analyse these two cases we need a basic overview of relevant factors in the preparation, enactment and implementation of important measures and regulating provisions in the legislation or otherwise. This questionnaire will result in a country report and focuses on two selected cases of governance practice related to heroin use: the introduction of opioid substitution treatment (OST) as example for an harm reduction measures, decriminalisation of use and possession of small quantities for personal use as an example of decriminalisation

The structure of this country report format is based on an adapted version of the health policy triangle of Walt & Gilson (1994)<sup>103</sup>. This is built up around the following four concepts: policy content and process, stakeholders and context (for more detailed information see the project proposal).

Important: Please fill out this format as completely as possible, but limit yourself to the key elements. At a later stage we might contact you for additional information.

### I Policy process and contents

#### General legislation regarding heroin

In case your country uses a differentiation in classes of illegal drugs (e.g., class A, B or C; or “soft” and “hard” drugs) please specify the classes, describe in which class heroin is included and summarize in bullet points the key features of this differentiation.

Please give your answer in the box below

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<sup>103</sup> Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. Health policy and planning, 9(4), 353-370.

In Spain, possession or use of little amounts has never been criminalized. But, since the "Public Safety law" (1992), if someone carries or consumes drugs in public space then he/she can receive a sanction (administrative). The amounts of those fines ranging from 300.51 to 450.76 of Euros (although it is contemplated that can reach 30,000 Euros; penalties for these offenses may be suspended if the offender is subjected to a treatment for addiction). If the amount of substance is too high, and there's a suspect that he or she could be trafficking, then police will detain him and send the case to the Court.

In the juridical way (not in the administrative) there's a difference between hard/and soft drugs, and heroin is considered hard.

In relation to heroin, oriented traffic quantities are set at around 16 grams, equivalent to 0.25 grams per dose, four doses daily for 4 or 5 days. But this is not a fix rule; it depends on the judge's criteria, this is coming from the jurisprudence.

**1. Opioid substitution treatment (OST)**

Which medication is provided through your OST programmes in your country?

	If yes, please indicate with X	If yes, started in [year]
methadone	x	1985
buprenorphine	x	2012
heroin	Clinical Study (Catalonia, Andalucia)	2007
other: [please list]		

**1.1 In depth information on the preparation and enactment of the legislation and other regulations regarding OST**

1.1.1 Please provide information, in bullet points, on the preparation and enactment of the first legislation and regulations around OST. Specify for each type of medication separately.

Please give your answer in the box below

The first law is from May 1983 and only contemplated the use of methadone in the following conditions:

- Criteria for inclusion in treatment:

- be at least 18 years
- opiate dependence or at least 3 years of evolution
- serious organ complications
- not concomitant with severe polydrug use (alcohol, drugs ...)
- no severe psychiatric illness
- guarantee to have completed at least two drug-free treatments

- The inclusion of the patient in the program required approval of the individualized treatment plan by a regional commission created "ad hoc".

- The dosage guidelines should be established at the minimum doses necessary and in any case could be above 40 mg / day, except possibly in the case of express authorization of the regional commission.

- Treatment centers could only be authorized by the Department of Health

- Attendance at the center of the patient should be daily during the first 3 months of treatment, including holidays, and after this time could facilitate maximum medication for 3 days with prior authorization of the regional commission and never with a higher dose to 15 mg / day.

1.1.2 Please provide information, in bullet points, on the preparation and enactment of the current legislation and regulations around OST. Specify for each type of medication. separately.

Please give your answer in the box below

Current legislation is January 1990 and supplemented in 1996.

In Catalonia, there's a "good practice" referring to political agreements; since 1996 there's a round table where all the political parties have a delegate. In this meeting point drug policies are debated and it helps not to use drugs as a "political weapon" to attack each other. In 2007 this structure was refunded and it stills helping a lot to develop open minded policies.

1.1.3 Please provide information, in bullet points, on any relevant changes between the first legislation and regulations around OST and the current legislation and regulations. Specify for each type of medication separately and include the year of change.

Please give your answer in the box below

In relation to the first major legislation the following contributions are:

- Foresees the use of other (than methadone) opiates in maintenance treatments.
- Prioritize the use of methadone extemporaneous solution but does not exclude other presentations.
- It provides, exceptionally, treatment prescription by physicians not within institutions or accredited services (private health).
- Treatment plans should not be approved by the regional commission.
- The inclusion a criterion requires only confirmed diagnosis of dependence.
- The dosage is not regulated and is a clinical judgment.

1.1.4 Briefly describe key events and underlying reasons in the process of preparing and adapting the legislation and regulations to establish OST (chronologically, with accompanying dates).

Please give your answer in the box below

- AIDS Epidemic
- Public visualization of drug consumption
- Criminal problems associated drug use

1.1.5 Please identify the five stakeholders who played the most important role in supporting the preparation and enactment of the legislation and regulations on OST.

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
Spanish National Drug Plan	Public health	7			
Regional Plan on Drugs	Public health	6			
Health Professionals	Scientific evidence, individual health				5
Drug Users	Right to treatment			2	
Civil society	Morality, ideological			2	

Any additional comments, please write in the box below

It was not just a regulation to promote OST, also all the educational and outreach programs to push more effective and efficient OSF programs:  
 (but each region of Spain has a different level of implementation of them)  
 Needle exchange programs  
 Needle exchange programs in prison  
 Hygienic consumption rooms  
 Open areas of consumption  
 Overdose program  
 Educational Project of Active Users  
 Snowball project  
 Hepatitis C project

1.1.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations on OST. List their interests and arguments and score their power.

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
Health Professionals	Morality, ideological				2
Civil society	Morality, ideological				4
Mass Media	Morality, ideological				4

Any additional comments, please write in the box below

1.1.7 In case international politics or policy have influenced the preparation, introduction or adaptation of this legislation or these regulations in your country, please explain.

Please give your answer in the box below

British System

1.1.8 Please summarize in bullet points the key elements (content) of the legislation or other regulations with regards to OST as they are in force to date.

Please give your answer in the box below

1.1.9 In case any modifications of the legislation or regulations are expected in the near future, please briefly describe contents and reasons.

Please give your answer in the box below

Authorization for the use of heroin in maintenance treatment

**1.2 In depth information on the implementation of regulating provisions in the legislation or otherwise regarding OST.**

1.2.1 What is the level of implementation of OST in your country? Please rate on a scale from 1-7.

1= not available); 7=fully country and all prisons).

1	2	3	4	5	6	7
						x

implemented at all (OST is not implemented in the whole relevant settings (including

Any comments on the level of implementation, please write in the box below

1.2.2 Please describe factors facilitating the implementation (e.g., public opinion, organisational aspects, positive media attention, ...).

Please give your answer in the box below

- Political agreement
- Commitment of all relevant administrations: national, regional, local.
- Prioritization of its funding

1.2.3 Please describe barriers for the implementation (e.g., public opinion, financial restrictions, housing problems, organisational aspects, negative media attention).

Please give your answer in the box below

- NIMBY
- Public opinion: "replacing one addiction for another"

1.2.4 In case stakeholders involved in the implementation of OST (see question 1.1 e and f) differ from those involved in the preparation and enactment of the legislation, or have another ranking, please comment on that.

Please give your answer in the box below

The regional plans were consulted and involved in the creation of the Spanish National Drug Plan



## 2. Use and possession of small quantities for personal use

Is there any legislation or are there regulations around decriminalisation of use and possession of small quantities for personal use?

yes

X no

If yes, continue;

If no, proceed to question 2.1.10.

### **2.1 In depth information on the preparation and enactment of the legislation and other regulations regarding use and possession of small quantities for personal use**

2.1.1 Please provide information, in bullet points, on the preparation and enactment of the first legislation and regulations around decriminalisation of use and possession of small quantities for personal use. Please include dates (year).

Please give your answer in the box below

2.1.2 Please provide information, in bullet points, on the preparation and enactment of the current legislation and regulations around decriminalisation of use and possession of small quantities for personal use. Please include dates (year).

Please give your answer in the box below

2.1.3 Please provide information, in bullet points, on any relevant changes between the first legislation and regulations around decriminalisation of use and possession of small quantities for personal use and the current legislation and regulations. Include the year(s) of change.

Please give your answer in the box below

2.1.4 Briefly describe key events and underlying reasons in the process of preparing and adapting the legislation and regulations to establish a decriminalisation of use and possession of small quantities for personal use (chronologically, with accompanying dates).

Please give your answer in the box below

2.1.5 Please identify the five stakeholders who played the most important role in supporting the preparation and enactment of the legislation and regulations on decriminalisation of use and possession of small quantities for personal use.

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)

Any additional comments, please write in the box below

2.1.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations on decriminalisation of use and possession of small quantities for personal use. List their interests and arguments and score their power.

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)

Any additional comments, please write in the box below

2.1.7 In case international politics or policy have influenced the preparation, introduction or adaptation of this legislation or these regulations in your country, please explain.

Please give your answer in the box below

2.1.8 Please summarize in bullet points the key elements (content) of the legislation or other regulations with regards to use and possession of small quantities of heroin for personal use as they are in force to date. E.g., are use and/or possession of small quantities still a crime, what are the sanctions, what is the definition of a small quantity?

Please give your answer in the box below

2.1.9 If any modifications of the legislation or regulations expected in the near future, please briefly describe contents and reasons.

Please give your answer in the box below

2.1.10 In case no legislation and other regulations regarding use and possession of small quantities for personal use exist, please mention any attempts/proposals made to have this regulated and why it did not succeed.

Please give your answer in the box below

In Spain, possession or use of little amounts has never been criminalized. But, since the "Public Safety law" (1992), if someone carries or consumes drugs in public space then he/she can receive a sanction (administrative). The amounts of those fines ranging from 300.51 to 450.76 of Euros (although it is contemplated that can reach 30,000 Euros; penalties for these offenses may be suspended if the offender is subjected to a treatment for addiction). If the amount of substance is too high, and there's a suspect that he or she could be trafficking, then police will detain him and send the case to the Court.

In the juridical way (not in the administrative) there's a difference between hard/and soft drugs, and heroin is considered hard.

In relation to heroin, oriented traffic quantities are set at around 16 grams, equivalent to 0.25 grams per dose, four doses daily for 4 or 5 days. But this is not a fix rule; it depends on the judge's criteria, this is coming from the jurisprudence.

**2.2 In depth information on the implementation of regulating provisions in the legislation or otherwise regarding use and possession of small quantities for personal use**

In the answers to the questions below, please describe briefly in bullet points the specifics of the implementation. If no legislation or other regulations regarding use and possession of small quantities for personal use exist, please scroll down the page to section II Contextual information.

2.2.1 What is the level of implementation regarding use and possession of small quantities for personal use in your country? Please rate on a scale from 1-7.

1= not implemented at all; 7=fully implemented in the whole country and all relevant settings.

1	2	3	4	5	6	7
				X		

Any comments on the level of implementation, please write in the box below.

2.2.2 Please describe factors facilitating the implementation (e.g., support from the police, public opinion, organisational aspects, positive media attention, ...).

Please give your answer in the box below

Public opinion pressure  
Sometimes media attention

2.2.3 Please describe barriers for the implementation (e.g., prevailing attitude towards harm reduction).

Please give your answer in the box below

NiMBY  
In some cases, difficulties between the political agreements and the local administration.  
Lack of Funding

2.2.4 In case stakeholders involved in the implementation of the measures regarding use and possession of small quantities for personal use (see question 2.1.5 and 2.1.6) differ from those involved in the preparation and enactment of the legislation, or have another ranking, please comment on that.

Please give your answer in the box below

Especially health and drug workers find it difficult to make compatible drug care in the streets and police law enforcement, so sometimes they try to find ways to work together. Our best experience is when all stakeholders from an area with high drug use and dealing work together and try to harmonize their aims.

## II Contextual information

Please complete the following questions/tables with the latest data available (please also state the source).

This Data is From CATALONIA, not SPAIN

### 1 General information on country

1.1 Area (km<sup>2</sup>): 32.000 km<sup>2</sup>

1.2 Population size: 7.570.908 (2012)

### 2 Prevalence of heroin use

2.1 Prevalence of heroin use in the general population (15-64 years)

	Most recent data (%)	Year
Lifetime use	0.6	2009
Last year use	0.1	2009
Last month use	0.1	2009

Source: Household survey on alcohol and drug consumption held every 2 years and carried out by the Spanish and Catalan Government

Please briefly describe the trend in prevalence of heroin use in the general population during the past ten years in terms of decreasing/increasing, stating where possible percentages from or around 2002.

Please give your answer in the box below

Although the treatment demand Indicator shows a clear drop on heroin admissions, survey show no significant differences in the last 10 years.

2.2 Number of problem users

Please use the EMCDDA definitions

	Most recent data	Year
Number of problem heroin users	No data	
Percentage of last year injectors	No data	
Number of heroin users that is in substitution treatment	7.103	31 <sup>st</sup> December 2009

Source: Catalan Drug Information System (SIDC)

Please briefly describe the trend in prevalence of problem heroin use and injecting in the past ten years in terms of decreasing/increasing, stating where possible percentages from or around 2002.

Please give your answer in the box below

In 1999 3.649 people were admitted to treatment for heroin addiction. That percentage went down to 1916 in 2009

In 1999 about 50 % of people admitted to treatment used injected heroin, in 2009 that percentage went down to about 30 %

### 2.3 Influence of heroin use prevalence on governance implementation

Did the heroin use prevalence influence the implementation of opioid substitution treatment?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
						X

Did the heroin use prevalence influence the implementation of measures regarding possession and use of small quantities:

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>
	X					

### 3 Health context

#### 3.1 Heroin use related morbidity in IDUs\*

	Most recent data on prevalence (%)	Most recent data on absolute number of infected IDUs	Year
HIV	About 40 %	No data	2010 - 11
Hepatitis C	About 80 %	No data	2010 - 11

\*IDU= injecting drug user; if possible, provide data on ever injecting drug users.

If you use another definition, please specify: .....

Source: Biannual cross-sectional survey on behavioral and biological indicators among clients of harm reduction services carried out by the Catalan Government

#### 3.2 Heroin related mortality

	Most recent data	Year
Direct heroin use related mortality (overdoses, etc.)	60 (city of Barcelona only) Barcelona has 1.615.448 inhabitants	2011
Indirect heroin use related mortality (related to lifestyle, infectious diseases, etc.)	No data	

Source: Public health Agency of Barcelona

Please describe briefly the trend in heroin related morbidity and mortality in the past ten years, stating where possible percentages from or around 2002.

Please give your answer in the box below

In 2001 there were 87 people dying from heroin overdose in Barcelona city
---

### 3.3 Influence of heroin use-related health consequences on governance implementation

Did the heroin use-related health consequences influence the implementation of opioid substitution treatment?

yes

no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
						X

Did the heroin use-related health consequences influence the implementation of measures regarding use and possession of small quantities for personal use:

yes

no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
	X					

Please briefly describe the influence of the health context on these two cases:

Please give your answer in the box below

Many young people in Catalonia got addicted to heroin, mostly injected, in the 80s and beginning of the 90s. There was a high percentage of people who got the HIV infection and many others died of overdose what was seen as a kind of health emergency.

#### 4 Economical context

This section focuses on general economical information and data on public spending (direct and indirect) on heroin. Please provide data as far as available.

##### 4.1 General economical circumstances of **SPAIN**

	Most recent data	Year
Gross national income per capita (PPP international (€ or £))	22.875,56EUR	2011
Total health expenditures per capita (€ or£)	2.126,36 EUR	2011
Total health expenditures as percentage of GDP (€ or £)	9,5(%DP)	2010

Source:

##### 4.2 State expenditures

If you have any data on (direct or indirect) expenditures on the health consequences of heroin use, or on the expenditure related to crime control related to heroin use, production or trafficking, please provide them here.

Please give your answer in the box below

No specific data but there has been a significant decrease in relation to:  
 Crime decreases  
 Decreases in the number of infections new HIV / AIDS among those users of drugs  
 Decreases in mortality, morbidity

##### 4.3 Economical context influencing implementation of opioid substitution treatment and measures with regard to use and possession of small quantities of heroin for personal use

Did the economical context influence the implementation of opioid substitution treatment?

yes X

no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
				X		



Did the economical context influence the implementation of measures with regard to use and possession of small quantities of heroin for personal use?

X yes

no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
				X		

Please briefly describe the influence of the economical context on these two cases.

Please give your answer in the box below

Methadone is cheaper than other opioid substitution programs, that made it easier to implement and maintain.
--

### 5. Political context

Did the political context influence the implementation of opioid substitution treatment?

X yes

no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
					X	

Did the political context influence the implementation of measures with regard to use and possession of small quantities of heroin for personal use?

X yes

no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
					X	

Please briefly describe the influence of the political context on these two cases.

Please give your answer in the box below

The Methadone treatment has been easy to implement. But all the other harm reduction services or other opioid substitution programs had had a lot of political barriers.

### Historical/Socio-cultural context

Did the historical/socio-cultural context influence the implementation of opioid substitution treatment?

- X yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
					X	

Did the historical/socio-cultural context influence the implementation of measures with regard to use and possession of small quantities of heroin for personal use?

- X yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
					X	

Please briefly describe the influence of the historical/socio-cultural context on these two cases.  
Please give your answer in the box below

### III. Key publications

Please add the full references of the sources you have used. In case you have included expert opinions, please provide the name of the experts as well as the date and source of communication (e.g. personal communication).

Please list the publications in the box below

Manual de mantenimiento con metadona. Manual de pràctica clínica (Methadone Maintenance Manual. Clinical Practice Manual) Generalitat de Catalunya, Departament de Salut, 2009

**[http://www20.gencat.cat/docs/canalsalut/Home%20Canal%20Salut/Professionals/Temes de salut/Droques/documents/manual.pdf](http://www20.gencat.cat/docs/canalsalut/Home%20Canal%20Salut/Professionals/Temes_de_salut/Droques/documents/manual.pdf)**



## Appendix 6: Country report: Decriminalisation of Cannabis in Spain

### Country report ALICE RAP WP14

#### SPAIN

#### CANNABIS

In this study we focus on two selected cases of governance *practice*. For being able to describe and analyse these two cases we need a basic overview of relevant factors in the preparation, enactment and implementation of important measures and regulating provisions in the legislation or otherwise. This questionnaire will result in a country report and focuses on two selected cases of governance practice related to heroin use: **decriminalisation of use and possession of small quantities for personal use** as an example of decriminalisation and the introduction of **regulated selling** (such as social clubs or coffee shops) as example for regulation replacing prohibition.

The structure of this country report format is based on an adapted version of the health policy triangle of Walt & Gilson (1994)<sup>104</sup>. This is built up around the following four concepts: policy content and process, stakeholders and context (for more detailed information see the project proposal).

Important: Please fill out this format as completely as possible, but limit yourself to the key elements. At a later stage we might contact you for additional information.

### I Policy process and contents

#### General legislation regarding cannabis

In case your country uses a **differentiation in classes of illegal drugs (e.g., class A, B or C; or “soft” and “hard” drugs)** please specify the classes, describe in which class cannabis is included and summarize in bullet points the key features of this differentiation.

*Please give your answer in the box below*

In Spain, little amounts had never been criminalized. But, if someone carries or consumes drugs in public spaces then he/she can receive a sanction (administrative). If the amount is too high, and there's a suspect that he or she could be trafficking, then police will detain him and send the case to a trial (juridical way).  
In the juridical way (not in the administrative) there's a difference between hard/and soft drugs, and cannabis is considered soft.

#### 1. Use and possession of small quantities of cannabis for personal use

##### 1.1 In depth information on the *preparation and enactment of the legislation and other regulations* regarding use and possession of small quantities for personal use

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<sup>104</sup> Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health policy and planning*, 9(4), 353-370.

**1.1.1 Please provide information, in bullet points, on the preparation and enactment of the first legislation and regulations around decriminalisation of use and possession of small quantities for personal use. Please include dates (year).**

*Please give your answer in the box below*

**In Spain, small quantities for personal use had never been criminalized.**

Laws and regulations listed in chronographic order

[\(\[http://www.pnsd.msc.es/Categoria2/legisla/pdf/Relaciones/LE\\\_CRONO\\\_JULIO2012.pdf\]\(http://www.pnsd.msc.es/Categoria2/legisla/pdf/Relaciones/LE\_CRONO\_JULIO2012.pdf\)\)](http://www.pnsd.msc.es/Categoria2/legisla/pdf/Relaciones/LE_CRONO_JULIO2012.pdf)

1rst:

Year 1918

Royal decree of 31 July 1918 laying the regulation for trade and supply of toxic and especially those exercising narcotic action, antipyretic or anesthetic.

**1.1.2 Please provide information, in bullet points, on the preparation and enactment of the current legislation and regulations around decriminalisation of use and possession of small quantities for personal use. Please include dates (year).**

*Please give your answer in the box below*

**In Spain, small quantities for personal use had never been criminalized.**

Regulation of production, uses, consumption and trafficking: criminal laws and administrative:

1. Criminal Law:

Organic Law 10/1995, of 23 November, the Criminal Code.

ORGANIC LAW 15/2003, of 25 November, BY AMENDING Organic Law 10/1995 of 23 NOVEMBER, THE CRIMINAL CODE

Organic Law 5/2010, of 22 June, BY AMENDING Organic Law 10/1995 of 23 NOVEMBER, THE CRIMINAL CODE

2. Administrative rules:

Organic Law 1/1992, of 21 February, PROTECTION OF PUBLIC SAFETY.

Royal Decree 1079/1993, of 2 July, REGULATING THE DELIVERY ON ADMINISTRATIVE PENALTIES DRUG.

**1.1.3 Please provide information, in bullet points, on any relevant changes between the first legislation and regulations around decriminalisation of use and possession of small quantities for personal use and the current legislation and regulations. Include the year(s) of change.**

Please give your answer in the box below

**In Spain, small quantities for personal use had never been criminalized.**

- The Penal Code of 1983, reflects the revised enacted by Decree of 14 September 1973, under the Act of 15 November 1971. The reform of June 25, 1983, softens the penalties in Article 44, relating to commercial transactions or narcotic drugs. The criminal law defines and punishes the crime against public health, committed by toxic drugs or narcotics and typifies a crime risk of imminent danger to health posed collective human society, which is consumed by the threat to health that, although not

specific damage occurs. In 1983 softened the penalties for re-raising them in the important reforming L.O. 1/1988 of 24 March, in which he re-wording section 344, and joined the Criminal Code Articles 344 bis), 344 bis b) 344 bis c) 344 d bis), 344 bis e), f 344a).

-The Penal Code of 1995. The 1995 Criminal Code, Article 368 stated in the content of Article 344 of the Criminal Code of 1973, maintaining the same system criminalization of behaviors, called "cascading" because the phrase "or otherwise "it aims to cover all phases of trafficking for avoid any gaps in behaviors that contiene<sup>27</sup>. The acts referred to in art. 368 of the Penal Code are those who are directed to unlawful consumption. Are unlawful acts because it is not in the same justification or endorsement of legal, administrative or regulatory. The Law on April 8, 1967 gives the State control stranglehold on all actions relating to such substances, absolute control which is justified by industrial purposes, therapeutic, scientific and academics. As the impugned conduct is criminal law that project exclusively on illicit drug toxic narcotic drugs aimed at the transmission of drug to a third party and run in disagreement with the law. The L. O. 5/1010, of June 22, amending L. O. 10/1995 of 23 November Penal Code, Article 368 remains in its content, but amending Article 368 penalties and decreases.

**1.1.4 Briefly describe key events and underlying reasons in the process of preparing and adapting the legislation and regulations to establish a decriminalisation of use and possession of small quantities for personal use (chronologically, with accompanying dates).**

Please give your answer in the box below

**In Spain, small quantities for personal use had never been criminalized.**

**1.5 Please identify the five stakeholders who played the most important role in supporting the preparation and enactment of the legislation and regulations on decriminalisation of use and possession of small quantities for personal use.**

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Politic	Financia	PR	Knowledg
-------------	-----------------------------	---------	----------	----	----------

		al power (1-7)	l power (1-7)	power (1-7)	e based power (1-7)

*Any additional comments, please write in the box below*

**In Spain, small quantities for personal use had never been criminalized.**

**1.1.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations on decriminalisation of use and possession of small quantities for personal use.  
List their interests and arguments and score their power.**

Stakeholder	Possible interest/arguments	Politic al power (1-7)	Financia l power (1-7)	PR power (1-7)	Knowledg e based power (1-7)

*Any additional comments, please write in the box below*

**In Spain, small quantities for personal use had never been criminalized.**

**1.1.7 In case international politics or policy have influenced the preparation, introduction or adaptation of this legislation or these regulations in your country, please explain.**

*Please give your answer in the box below*

**In Spain, small quantities for personal use had never been criminalized.**



**1.1.8 Please summarize in bullet points the key elements (content) of the legislation or other regulations with regards to use and possession of small quantities of cannabis for personal use as they are in force to date, e.g., are use and/or possession of small quantities still a crime, what are the sanctions, what is the definition of a small quantity?**

*Please give your answer in the box below*

The Spanish justice does not consider an offense; the own consumption, purchase and possession of small quantities for personal consumption. However, it should be noted that even if such conduct does not constitute a crime and not be punished by the Penal Code, may be administratively sanctioned according to the Law of Protection of Public Safety, which considers misconduct consumption illegal drugs in public places or possession for personal consumption and the abandonment of the tools to consume in the same places. The amounts of these fines ranging from 300.51 to 450.76 of Euros (although it is contemplated that can reach 30,000 Euros) and in some cases may be accompanied by the withdrawal of the driving license.

Referring to the quantities:

The scales used in these cases are: considered intended for personal consumption amounts not exceeding those which the user usually takes up to 3-5 days (in exceptional cases can become 10 or 12) and everything that happens there is estimated almost automatically offered for traffic. In principle, the courts assessed in each particular case the degree of psychic and physical dependence of the consumer and accordingly calculate the amount of drug needed for such days. However, besides being quite difficult to falsify and mislead on these valuations, the courts can refer as indicative criteria to quantities that can legally considered the maximum for the consumption of an addict. These amounts are not clearly stipulated, but are derived from the review of sentences gotten so far, with special attention to the Supreme Court. Based on all this case law, the question of the amount is as below:

The maximum daily consumption of cannabis is estimated at 5 grams of hashish, 15 to 20 grams of marijuana and 0.6 grams of hash oil. This multiplied for up to five days gives a total amount for the consumption of 25 grams of hashish (although the Supreme Court often point 50, so presumably would be 10 days or computed taking into account the status of cannabis as seriously harmful to health), 75-100 grams of marijuana and three grams of hash oil. Finally, there are also factors that increase the sentence; some are generic (such as recidivism) and others specific to drug trafficking. The specific are, among others, sell to under 18 years, selling in schools, military facilities, prisons or hospitals, selling to people who are in treatment to disengage, owning / employee of a public and sell in the workplace , adulterating drugs increasing the risk to health or be an officer, authority or have a medical degree and trafficking advantage of the profession. When these aggravating circumstances, the penalties for not very harmful substances (cannabis) can go up to four years and six months, and in cases of extreme gravity to six years and nine months.

**1.1.9 If any modifications of the legislation or regulations are expected in the near future, please shortly describe contents and reasons.**

*Please give your answer in the box below*

**1.1.10 In case no legislation and other regulations regarding use and possession of small quantities for personal use exist, please mention any attempts/proposals made to have this regulated and why they did not succeed.**

*Please give your answer in the box below*

In 2006, the following political parties; Izquierda Unida, Izquierda Verde e Iniciativa per Catalunya take a step forward in their stances regarding cannabis antiprohibitionists with the presentation of this initiative modification of Public Safety Act (1/1992), better known as Corcuera Law.

The proposed amendment would entail the abolition of Article 25de that Act, and paragraph 2 of Article 28.

This would end the penalties for possession and consumption on the street, they come with so much tax collection effort squeezing the economies of stoners, thus avoiding the PSOE government to beat back year after year's record by raising fines and this concept.

There still no date for this debate, as it has just received the proposal by the Bureau of the Congress in this term.

**1.2 In depth information on the *implementation* of regulating provisions in the legislation or otherwise regarding use and possession of small quantities for personal use**

**1.2.1 What is the level of implementation in your country of measures on use and possession of small quantities for personal use? Please rate on a scale from 1-7.**

1= not implemented at all; 7=fully implemented in the whole country and all relevant settings.

1	2	3	4	5	6	7
			X			

*Any comments on level of implementation, please write in the box below*

Personal use and possession are legal except in public spaces.

**1.2.2 Please describe factors facilitating the implementation (e.g., public opinion, organisational aspects, positive media attention, ...).**

*Please give your answer in the box below*

It hadn't been implemented, because it has always been like that.

**1.2.3 Please describe barriers for the implementation (e.g., public opinion, financial restrictions, organisational aspects, negative media attention).**

*Please give your answer in the box below*

It hadn't been implemented, because it has always been like that.

**1.2.4 In case stakeholders involved in the implementation of the measures regarding use and possession of small quantities for personal use (see question 1.1.5 and 1.1.6) differ from those involved in the preparation and enactment of the legislation, or have another ranking, please specify.**

*Please give your answer in the box below*

It hadn't been implemented, because it has always been like that.

## **2. Regulated selling of cannabis**

Is there any legislation or are there regulations around regulated selling of cannabis in your country?

yes

no

**If yes**, continue

**If no**, proceed to question 2.1.10

### **2.1 In depth information on the *preparation and enactment of the legislation and other regulations* regarding regulated selling of cannabis**

**2.1.1 Please provide information, in bullet points, on the preparation and enactment of the first legislation and regulations around regulated selling of cannabis.**

*Please give your answer in the box below*

It's therapeutic/medic cannabis; commercial name: SATIVEX

In 2001, Catalonia's parliament unanimously decided to ask the central government in Madrid legalize the medical use of cannabis. The resolution states that parliament should "take all necessary administrative measures to authorize the use of cannabis," but adds that the medicinal properties of cannabis' have been known for thousands of years "and that several scientific studies have shown benefit in several diseases among which are cancer, multiple sclerosis and epilepsy. Similar projects are launched during the same period in other regions of Spain as Andalucía. Soon after, it is processed in the regional parliaments of Aragon and Balearic Islands voted unanimously for a bill in favor of legalizing the sale of medical cannabis in order to incite the central government in Madrid to do the same.

**2.1.2 Please provide information, in bullet points, on the preparation and enactment of the current legislation and regulations around regulated selling of cannabis.**

*Please give your answer in the box below*

It's the same as above

**2.1.3 Please provide information, in bullet points, on any relevant changes between the first legislation and regulations around regulated selling of cannabis and the current legislation and regulations. Include the year of change.**

*Please give your answer in the box below*

No relevant changes since 2001

**2.1.4 Briefly describe key events and underlying reasons in the process of preparing the legislation and regulations to establish a regulation of selling cannabis (chronologically, with accompanying dates).**

*Please give your answer in the box below*

Year 2000- The civil society, mainly through cancer associations and with the “help” of the College of Pharmacists pushed the Catalan parliament to ask (to the Spanish parliament) a specific regulation of the medical cannabis.

**2.1.5 Please identify the five stakeholders who played the most important role in supporting the preparation and enactment of the legislation and regulations around regulated selling of cannabis.**

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
All the political parties	There was a need expressed by the civil society	7			
Civil Society, cancer associations	They felt that therapeutic cannabis was an interesting treatment and that the Public health service should implement it			7	7
Pharmacists' College	They were the main allies of the civil society and the bridge to the public administration			7	7
Pharmaceutical companies	An interest to develop and sell SATIVEX		4		

Any additional comments, please write in the box below

**2.1.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations around regulated selling of cannabis. List their interests and arguments and score their power.**

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)

Any additional comments, please write in the box below

There was no opposition. In fact, what finally happened is that the pharmaceutical company reduced the scope of diseases that could be subject of treatment with Sativex, they just maintained the chronic ones. So many “therapeutic” users still buy marihuana.

**2.1.7 In case international politics or policy have influenced the preparation, introduction or adaptation of this legislation or these regulations in your country, please explain.**

Please give your answer in the box below

**2.1.8 Please summarize in bullet points the key elements (content) of the legislation or other regulations with regards to regulated selling of cannabis as they are in force to date.**

Please give your answer in the box below

SATIVEX is approved for:  
Approved indication: "Additional treatment for symptom improvement in patients with moderate to severe spasticity due to multiple sclerosis (MS) who have not responded adequately to other anti-spasticity medication and who have shown a clinically significant improvement in symptoms related with spasticity during an initial trial of therapy."

**2.1.9 In case any modifications of the legislation or regulations are expected in the near future, please shortly describe contents and reasons.**

Please give your answer in the box below

**2.1.10 In case no legislation and other regulations regarding regulated selling of cannabis exist, please mention any attempts made to have this regulated and why they did not succeed.**

Please give your answer in the box below

**2.2 In depth information on the *implementation* of regulating provisions in the legislation or otherwise regarding regulated selling of cannabis**

In the answers to the questions below, please describe briefly in bullet points the specifics of the implementation.

**2.2.1 What is the level of implementation regarding regulated selling of cannabis in your country? Please rate on a scale from 1-7.**

1= not implemented at all; 7=fully implemented in the whole country and all relevant settings.

1	2	3	4	5	6	7
	X					

*Any comments on level of implementation, please give your answer in the box below:*

There's no specific law. But the cannabis activists and other entrepreneurs had developed the "Cannabis Social Clubs/Associations". In fact, there's no "selling" inside those clubs, there's distribution of weed, but not selling. The associated members put money to keep the activity of the club going on; and one of the activities of the club is to grow weed.

Cannabis social clubs (CSC) are non-commercial organisations of users who get together to cultivate and distribute enough cannabis to meet their personal needs without having to turn to the black market. They are based on the fact that the consumption of illegal drugs has never been considered a crime under Spanish legislation. Taking advantage of this grey area, private clubs that produce cannabis for non-profit distribution solely to a closed group of adult members have existed for years. Since their appearance in 2002, CSCs have enabled several thousand people to stop financing the black market and to know the quality and origin of what they are consuming, whilst creating jobs and tax revenue. All of this has happened without having to withdraw from existing UN drug

\* The appearance of cannabis social clubs (CSC) in Spain in 2002 has enabled thousands of people to legally grow their own marijuana supply for personal consumption and ensure that it is good quality.

\* Clubs began to appear throughout the country, due to a grey area in Spanish legislation, and through a legal registry system for groups of users those who collectively cultivate marijuana.

\* The CSC boom occurred after various Supreme Court decisions that stated that cultivation for personal use is not a crime as it is not destined for trafficking

**If no legislation or other regulations regarding regulated selling of cannabis exist, please go to section II (contextual information).**

**2.2.2 Please describe factors facilitating the implementation (e.g., support from the police, public opinion, organisational aspects, positive media attention ...)**

*Please give your answer in the box below*

The cannabis activists and other entrepreneurs who put themselves in juridical risk. And, I in the other hand, the justice system that has, after many trials, never send no one at jail for this activity.

**2.2.3 Please describe barriers for the implementation (e.g., prevailing attitude towards harm reduction).**

*Please give your answer in the box below*

As there's no specific regulation, there's a lot of juridical/police vulnerability. Each region in Spain has a different reality, so there are places where a lot of clubs are going on (or are more visible) and other with less amount.

**2.2.4 In case stakeholders involved in the implementation of the measures regarding regulated selling of cannabis (see question 2.1.5 and 2.1.6) differ from those involved in the preparation and enactment of the legislation, or have another ranking, please specify.**

*Please give your answer in the box below*

Law firms (private sector)

## **II Contextual information**

Please complete the following questions/tables with the latest data available (with accompanying source). Describe the trend in the data (in terms of decreasing/increasing) over approximately the last ten years.

### **1 General information on country**

**2.1.1. Area (km<sup>2</sup>):** 504.645 km<sup>2</sup>

**2.1.2. Population size:** 47. 265. 321 people

### **2 Prevalence of cannabis use**

**2.1 Prevalence of cannabis use in the general population (15-64 years)**

	Most recent data (%)	Year
Lifetime use	27.4	2011
Last year use	9.6	2011
Last month use	7	2011

Source:

Please briefly describe the **trend in prevalence of cannabis use in the general population** during the past ten years in terms of decreasing/increasing, stating where possible percentages from or around 2002 onward.

*Please give your answer in the box below*

Since 2011 the trend is decreasing, (last year use) 2001:9.2% 2003: 11.3% 2005:11.2% 2007:10.1% 2009:10.6%

**2.2 Influence of cannabis use prevalence on governance implementation**

Did the cannabis use prevalence influence the implementation of **legislation/ regulations on use and possession of small quantities for personal use?**

- yes
- X no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Did the cannabis use prevalence influence the implementation of **regulated selling?**

- yes
- X no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the cannabis use prevalence **on these two cases:**

*Please give your answer in the box below*



### 3 Health context

#### 3.1 Number of problem cannabis users

Please use the EMCDDA definitions

	Most recent data	Year
Number of problem cannabis users	No data	
Number of cannabis users that is in treatment	9511	2009

Source: [http://www.pnsd.msc.es/Categoria2/observa/pdf/Tratamiento1991\\_2009.pdf](http://www.pnsd.msc.es/Categoria2/observa/pdf/Tratamiento1991_2009.pdf)

#### 3.2 Cannabis related morbidity and social loss

If you have any national data or information on the prevalence of co-morbid psychopathology, on burden of disease (DALY's) or productivity loss, please provide it here:

*Please give your answer in the box below*

No data
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Please describe briefly the trend in cannabis related morbidity/ social loss in the past ten years:

*Please give your answer in the box below*

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#### 3.3 Influence of cannabis use-related health consequences on governance implementation

Did the cannabis use-related health consequences influence the implementation of **legislation/ regulations on use and possession of small quantities for personal use?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Did the cannabis use-related health consequences influence the implementation of **regulated selling?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the health context **on these two cases:**

*Please give your answer in the box below*

#### 4 Economical context

This section focuses on general economical information and data on public spending (direct and indirect) on cannabis. Please provide data as far as available.

##### 4.1 General economical circumstances

	Most recent data	Year
Gross national income per capita (PPP international (€ or £))	22,875.56 EUR	2011
Total health expenditures per capita (€ or £)	2.12636 EUR	2011
Total health expenditures as percentage of GDP (€ or £)	9.5 (%GDP)	2010

Source: <http://www.worldbank.org/>

##### 4.2 State expenditures

If you have any data on (direct or indirect) expenditures on the health consequences of cannabis use, or on the expenditure related to crime control related to cannabis use, production or trafficking, please provide them here

*Please give your answer in the box below*

##### 4.3 Economical context influencing implementation of **legislation/ regulations on use and possession of small quantities for personal use and regulated selling**

Did the economical context influence the implementation of **legislation/ regulations on use and possession of small quantities for personal use?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Did the economical context influence the implementation of **regulated selling**?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the economical context **on these two cases**:

*Please give your answer in the box below*

## 5. Political context

**5.1 Did the political context influence the implementation of legislation/ regulations on use and possession of small quantities for personal use?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Did the political context influence the implementation of **regulated selling**?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the political context **on these two cases**:

Please give your answer in the box below

--

## 6. Historical/Socio-cultural context

### 6.1 Did the historical/socio-cultural context influence the implementation of legislation/regulations on use and possession of small quantities for personal use?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Did the historical/socio-cultural context influence the implementation of **regulated selling**?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the historical/socio-cultural context on these two cases:

Please give your answer in the box below

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## III. Key publications

Please include a list of key publications used to complete this report.

Please also add the full references of the sources you have used. In case you have included expert opinions please provide the name of the experts as well as the date and source of communication (e.g. personal communication).

Please list the publications in the box below

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## Appendix 7: Country report: Decriminalisation and regulation of cannabis in UK

### Country report ALICE RAP WP14 United Kingdom CANNABIS

In this study we focus on two selected cases of governance *practice*. For being able to describe and analyse these two cases we need a basic overview of relevant factors in the preparation, enactment and implementation of important measures and regulating provisions in the legislation or otherwise. This questionnaire will result in a country report and focuses on two selected cases of governance practice related to heroin use: **decriminalisation of use and possession of small quantities for personal use** as an example of decriminalisation and the introduction of **regulated selling** (such as social clubs or coffee shops) as example for regulation replacing prohibition.

The structure of this country report format is based on an adapted version of the health policy triangle of Walt & Gilson (1994)<sup>105</sup>. This is built up around the following four concepts: policy content and process, stakeholders and context (for more detailed information see the project proposal).

Important: Please fill out this format as completely as possible, but limit yourself to the key elements. At a later stage we might contact you for additional information.

#### I Policy process and contents

##### General legislation regarding cannabis

In case your country uses **a differentiation in classes of illegal drugs (e.g., class A, B or C; or “soft” and “hard” drugs)** please specify the classes, describe in which class cannabis is included and summarize in bullet points the key features of this differentiation.

*Please give your answer in the box below*

The Misuse of Drugs Act 1971 is the primary piece of legislation governing illegal drugs or legal drugs intended for non medical purposes. It consolidated existing pieces of legislation and became the key means by which the British state prosecutes the production, supply or possession of controlled substances. Under the act drugs are termed controlled substances and are split into three categories according to the harm perceived and the penalties carried for possession, production and supply. The classification system acts as a guide to the police, and the judiciary in terms of sentencing.<sup>106</sup> The drugs listed on the following table are designated as controlled drugs under the Misuse of Drugs Act 1971. Class A drugs are considered to be the most harmful. Under

<sup>105</sup> Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health policy and planning*, 9(4), 353-370.

<sup>106</sup> The Home Office, *Drugs and the Law*. [Online]. Available: <http://www.homeoffice.gov.uk/drugs/drug-law/> accessed 2<sup>nd</sup> February 2013.

the terms of the Misuse of Drugs Act 1971 it is unlawful to possess a controlled substance, possess with intent to supply a controlled drug, supply or offer to supply whether as a gift or sale, and to allow a house to be used by people taking controlled drugs.<sup>107</sup>

Cannabis is a class B drug under the UK classification. Cannabis was classified as a class b drug from the introduction of the Misuse of Drugs act in 1971 until 2004 when it was reclassified as a class c drug, in 2009 cannabis was again reclassified as a class b drug where it currently remains.

UK Drug Classifications <sup>108</sup>			
Band	Drug <sup>109</sup>	Penalty for Possession	Penalty for Dealing
Class A	Heroin, cocaine, crack, LSD, ecstasy (MDMA), 2CB, mescaline, methadone, methamphetamine, morphine, opium, pethedine, psilocybin (raw or processed magic mushrooms), DMT (Dimethyltryptamine), palfium, phencyclidine.	Up to 7 years prison an unlimited fine or both	Up to life prison an unlimited fine or both
Class B	Amphetamine, barbiturates, codeine, dexamphetamine, DF118 (dihydrocodeine), methaqualone, cannabis, spice (synthetic cannabinoids sprayed onto herbal smoking products), mephedrone and related cathinones, naphyrone, ritalin (methylphenidate). * Many Class B drugs became Class A when prepared for injection.	Up to 5 years prison an unlimited fine or both	Up to 14 years prison and unlimited fine or both
Class C	Benzodiazepine tranquilisers, mild amphetamine type stimulants, gammaHydroxyButyrate (GHB), GBL, rohypnol, ketamine, BZP (Benzylpiperazine), anabolic steroids (when supplied).	Up to 2 years prison and unlimited fine or both (This applies to temazepam and valium for possession)	Up to 14 years prison and unlimited fine or both

<sup>107</sup> The Home Office, Drugs and the Law. [Online]. Available: <http://www.homeoffice.gov.uk/drugs/drug-law/> accessed 2<sup>nd</sup> February 2013.

<sup>108</sup> Scottish Crime and Drug Enforcement Agency, Drug Classes and Penalties. [Online]. Available: <http://www.sdea.police.uk/drugsinfo.htm> accessed 1st February 2013

<sup>109</sup> Essex Young People's Drug & Alcohol Service, Drugs and the Law. [Online]. Available: <http://www.eypdas.org.uk/drugs-you/drugs-and-the-law.aspx> accessed 1st February 2013

		without prescription)	
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## 1. Use and possession of small quantities of cannabis for personal use

### 1.1 In depth information on the *preparation and enactment of the legislation and other regulations* regarding use and possession of small quantities for personal use

#### 1.1.1 Please provide information, in bullet points, on the preparation and enactment of the first legislation and regulations around decriminalisation of use and possession of small quantities for personal use. Please include dates (year).

*Please give your answer in the box below*

There is no legislation or regulation around the decriminalization of cannabis. Cannabis became illegal in the UK on the 28<sup>th</sup> of September 1928 following the implementation of the Dangerous Drugs Act 1925.<sup>110</sup> The first piece of legislation relating to controlled substances had been the Dangerous Drug Act of 1920.<sup>111</sup> There was little interest in cannabis by UK policy makers at this time cannabis was relatively unknown in the UK, and the British state had economic interests in the production of cannabis in India.<sup>112</sup> The decision to legislate on cannabis came from growing international pressure from fellow members of the League of Nations. African countries and America lobbied for international cooperation on drugs; initially opium. Cannabis was added later as a result of a request from Egypt and Turkey.<sup>113</sup> This resulted in the 1928 Coca Leaves and Indian hemp regulation which in effect rendered cannabis an illegal substance. Cannabis was added to the Poisons Schedule by the Pharmaceutical Society in 1924 this meant that there regulations placed on who could buy and sell cannabis substances even before it was prohibited.<sup>114</sup>

#### 1.1.2 Please provide information, in bullet points, on the preparation and enactment of the current legislation and regulations around decriminalisation of use and possession of small quantities for personal use. Please include dates (year).

<sup>110</sup> Independent Drug Monitoring Unit, How Cannabis was Criminalised. [Online]. Available: <http://www.idmu.co.uk/historical.htm> accessed 2nd February 2013

<sup>111</sup> Home Office (2006) Review of UK Drugs Classification System-A public Consultation, Crime and Drug Strategy Directorate. [Online]. Available: [http://www.drugquality.org/files/Review\\_of\\_Drugs\\_Classification\\_Consultation\\_Paper.pdf](http://www.drugquality.org/files/Review_of_Drugs_Classification_Consultation_Paper.pdf) accessed 2nd February 2013

1 <sup>112</sup> James Mills (2005) **Cannabis Britannica: Empire, Trade, and Prohibition 1800-1928**, Oxford University Press  
[http://books.google.co.uk/books/about/Cannabis\\_Britannica.html?id=qMhaD7iuF8gC](http://books.google.co.uk/books/about/Cannabis_Britannica.html?id=qMhaD7iuF8gC)

<sup>113</sup> Independent Drugs Monitor Unit, How Cannabis was Criminalized. [Online]. Available: <http://www.idmu.co.uk/historical.htm> accessed 2nd February 2013

<sup>114</sup> James Mills (2005) **Cannabis Britannica: Empire, Trade, and Prohibition 1800-1928**, Oxford University Press  
[http://books.google.co.uk/books/about/Cannabis\\_Britannica.html?id=qMhaD7iuF8gC](http://books.google.co.uk/books/about/Cannabis_Britannica.html?id=qMhaD7iuF8gC)

*Please give your answer in the box below*

There is no legislation around decriminalisation. In 2009 Cannabis was reclassified as a class B drug after a short time as class C drug (2004-2009). The 1971 Misuse of Drugs act introduced the drugs classification system which placed cannabis in band B until 2004 when it was placed in band C. There is no legislation around decriminalization. In 2009 cannabis was reclassified form a class C drug to a Class B drug. This was done despite advice from the government's own advisory group on drugs advising against the move, this caused some controversy at the time.

**1.1.3 Please provide information, in bullet points, on any relevant changes between the first legislation and regulations around decriminalisation of use and possession of small quantities for personal use and the current legislation and regulations. Include the year(s) of change.**

*Please give your answer in the box below*

The 1971 Misuse of Drugs act has been the most significant piece of legislation regarding controlled substances since the prohibition legislation in the 1920s. Since 1971 the most significant change to cannabis regulation was its movement from a class B drug to a class C drug and back again to class B and the new guidance on police procedure and the subsequent sentencing changes, outlines in the table given in answer to question1. 1.4

**1.1.4 Briefly describe key events and underlying reasons in the process of preparing and adapting the legislation and regulations to establish a decriminalisation of use and possession of small quantities for personal use (chronologically, with accompanying dates).**

*Please give your answer in the box below*

There are no plans to decriminalize cannabis in the UK. Changes have been confusing and policy on cannabis muddled. Since the 1971 Misuse of Drugs Act cannabis had been classified as a class B drug. In 2001 the governing Labour Party announced plans to downgrade cannabis to a class C drug.<sup>115</sup> This in effect stopped people being arrested for possessing small amounts of cannabis. This policy was supported by public opinion polls and the Advisory Council on the Misuse of Drugs (ACMD) had been calling for such a step since the late 1970s.<sup>116</sup> There was a further benefit of freeing up police resources to

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<sup>115</sup> Alan Travis (Wednesday 24 October 2001). Cannabis laws eased in drug policy shakeup, The Guardian. [Online]. Available: <http://www.guardian.co.uk/society/2001/oct/24/drugsandalcohol> Retrieved accessed 4th February 2013

<sup>116</sup> Schaffer Library of Drug Policy, The Police Foundation (1999). **Drugs and the Law: Report of the independent inquiry into The Misuse of Drugs Act 1971**. [Online]. Available: <http://www.druglibrary.org/SCHAFFER/LIBRARY/studies/runciman/default.htm> accessed 4th February 2013



focus on more harmful drugs and more serious offences. In January 2004 cannabis was reclassified as a class C drug, resulting in a decrease of one third in cannabis arrests in the first year<sup>117</sup> In the following general election campaign Tony Blair, the then Prime Minister, told parents at an election event that the downgrading of cannabis might have been an error. He said that in light of evidence of the growing strength of some types of cannabis available in the UK that the classification would be re-examined.<sup>118</sup> After winning the election the issue of cannabis classification was once again given to the Advisory Council on the Misuse of Drugs (ACMD) for an evaluation. The ACMD reported in 2005 that the classification of cannabis should remain class C<sup>119</sup> the home secretary accepted this and initiated a new educational programme for the public in relation to cannabis.

In 2007 the then Prime Minister Gordon Brown's government again raised concerns surrounding the strength of cannabis particularly 'skunk' that had become more common. Jacqui Smith the then Home Secretary led a review and against the advice of the ACMD cannabis was reclassified as a class B drug in January 2009 where it remains.<sup>120</sup>

**1.5 Please identify the five stakeholders who played the most important role in *supporting the preparation and enactment* of the legislation and regulations on decriminalisation of use and possession of small quantities for personal use.**

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Politic	Financia	PR	Knowledg
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<sup>117</sup>Home Office, 28<sup>th</sup> January 2005, Cannabis Reclassification (Press release), National Archives. [Online].

Available:[http://web.archive.org/web/20050412170503/http://www.homeoffice.gov.uk/n\\_story.asp?item\\_id=1222](http://web.archive.org/web/20050412170503/http://www.homeoffice.gov.uk/n_story.asp?item_id=1222) accessed 4<sup>th</sup> February 2013

<sup>118</sup> Philip Johnson and George Jones, 4<sup>th</sup> May 2005, Blair Hints at Error over Cannabis Downgrade, The Telegraph. [Online]. Available: <http://www.telegraph.co.uk/news/uknews/1489263/Blair-hints-at-error-over-cannabis-downgrade.html> accessed 4th February 2013

2 <sup>119</sup> Advisory Council on the Misuse of Drugs (2005) The Advisory Council's Report - Further consideration of the classification of cannabis under the Misuse of Drugs Act 1971.(2005), Home office. [Online]. Available: <http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/cannabis-reclass-2005> accessed 4th February 2013

3 <sup>120</sup> **Victoria Ward, 20<sup>th</sup> November 2012**, Jacqui Smith admits cannabis reclassification was wrong, The Telegraph. [Online]. Available: <http://www.telegraph.co.uk/news/politics/9688040/Jacqui-Smith-admits-cannabis-reclassification-was-wrong.html> accessed 5th February 2013

		Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
The Labour Government	Did not want to appear “soft” on the issue of drugs during the 2005 election campaign, coupled with fears and media stories about increased strength of cannabis and particularly skunk.	7	5	3	1
SANE, a mental health charity	Argued that downgrading the classification of cannabis from B to C gave the wrong message and suggested it was safe to use. SANE were concerned with the link between cannabis and mental health.	1	1	1	4
Some senior police officers	The view from the police was mixed with some senior officers arguing for cannabis to stay as a class B drug, while others supported downgrading.	5	2	3	4
Certain media outlets	Attacks on the governments drug policy and demands for a more hard line approach were evident in some influential news papers	6	6	6	3

*Any additional comments, please write in the box below*

It is difficult to measure with any certainty who the most important stakeholders were, with the exception of the then government who were the drivers of the reclassification of cannabis, both when it was downgraded and upgraded.

**1.1.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations on decriminalisation of use and possession of small quantities for personal use.**

**List their interests and arguments and score their power.**

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
Advisory Council on the Misuse	Evidence based arguments	1	1	1	7

of Drugs					
Some Senior Police Officers	The view from the police was mixed with some senior officers arguing for cannabis to stay as a class B drug, while others supported downgrading.	5	2	3	4
Drugscope, UK drugs charity	No evidence classifying cannabis as class B would be useful and public opinion was in the main against it.	1	1	1	5
Magistrates Association	Felt it would undermine the efforts made to change the approach to cannabis since 2004.	3	1	1	4

*Any additional comments, please write in the box below*

**Again, it is difficult to measure the influence of these stakeholders.**

**1.1.7 In case international politics or policy have influenced the preparation, introduction or adaptation of this legislation or these regulations in your country, please explain.**

*Please give your answer in the box below*

**1.1.8 Please summarize in bullet points the key elements (content) of the legislation or other regulations with regards to use and possession of small quantities of cannabis for personal use as they are in force to date, e.g., are use and/or possession of small quantities still a crime, what are the sanctions, what is the definition of a small quantity?**

*Please give your answer in the box below*

The government's decision to reclassify cannabis to Class B under the Misuse of Drugs Act 1971 was announced by Home Secretary on 7 May 2008. Cannabis was reclassified to Class B on 26 January 2009. The change in classification was at odds with advice given to the government by the Advisory Council on the Misuse of Drugs (ACMD) in 2008 when they recommended that cannabis remain a Class C drug, as a result of a review of the evidence on the harms posed by cannabis. The reclassification of cannabis had implications for sentencing and the way police deal with cases involving cannabis. The number of times an offence is recorded make a difference on the procedure taken by the police, this is known as the Escalation Penalty System and was introduced in 2009 (details bellow).

As a Class B drug, the maximum penalty for supplying or producing cannabis is 14 years

imprisonment and/or an unlimited fine, this remains unchanged from when the drug was Class C. A new 'escalation' penalty system for cannabis possession means that the penalty issued is directly related to the number of times an individual has previously been caught in possession of the drug. Caught in possession of cannabis for the first time - they will be issued with a cannabis warning. A cannabis warning is a spoken warning given by a police officer, either on the street or at the police station. The police have the option of using a cannabis warning when someone is caught with a small amount of cannabis for personal use.

Caught in possession of cannabis for the second time - They will be issued with a Penalty Notice for Disorder (PND) for cannabis possession. PNDs are tickets that police officers can issue at the scene of an incident or in custody - they carry an on-the-spot fine of £80 (€92.59). .

Caught in possession of Cannabis for the third time - police officers will consider further action. This could include release without charge, caution, conditional caution or prosecution. All subsequent offences likely to result in arrest.

Under 18 year olds can expect to be arrested, taken to a police station where they may receive a reprimand, a final warning and a charge depending on the seriousness of the offence.

The definition of a small amount, for personal use is not clear. Kent Police state on a cannabis fact sheet for their officers that "If it is large enough to identify it as Cannabis then action needs to be taken."<sup>121</sup> The police should have reasonable grounds to suspect possession with intent to supply, this could mean an individual has previously been known to supply cannabis or could be found in possession with a large quantity of cannabis or money, or cannabis related materials such as scales. The government announced that it was not prepared to introduce a threshold, which leaves the decision to be made by the police.

**1.1.9 If any modifications of the legislation or regulations are expected in the near future, please shortly describe contents and reasons.**

*Please give your answer in the box below*

**1.1.10 In case no legislation and other regulations regarding use and possession of small quantities for personal use exist, please mention any attempts/proposals made to have this regulated and why they did not succeed.**

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<sup>121</sup> Kent Police, Possession of cannabis. [Online]. Available: [http://www.kent.police.uk/about\\_us/policies/m/m103.html](http://www.kent.police.uk/about_us/policies/m/m103.html) accessed 5th February 2013

Please give your answer in the box below

Many independent experts, drugs charities, researchers and even politicians and some senior police officers support the decriminalization of cannabis. There is no sign of any forthcoming legislation to readdress the issue.

**1.2 In depth information on the *implementation* of regulating provisions in the legislation or otherwise regarding use and possession of small quantities for personal use**

**1.2.1 What is the level of implementation in your country of measures on use and possession of small quantities for personal use? Please rate on a scale from 1-7.**

1= not implemented at all; 7=fully implemented in the whole country and all relevant settings.

1	2	3	4	5	6	7
		*				

Any comments on level of implementation, please write in the box below

Difficult to say with any certainty given the power of the police to act with discretion.

**1.2.2 Please describe factors facilitating the implementation (e.g., public opinion, organisational aspects, positive media attention, ...).**

Please give your answer in the box below

**1.2.3 Please describe barriers for the implementation (e.g., public opinion, financial restrictions, organisational aspects, negative media attention).**

Please give your answer in the box below

**1.2.4 In case stakeholders involved in the implementation of the measures regarding use and possession of small quantities for personal use (see question 1.1.5 and 1.1.6) differ from those involved in the preparation and enactment of the legislation, or have another ranking, please specify.**

Please give your answer in the box below

## 2. Regulated selling of cannabis

Is there any legislation or are there regulations around regulated selling of cannabis in your country?

\*no

If **yes**, continue

If **no**, proceed to question 2.1.10

### 2.1 In depth information on the *preparation and enactment of the legislation and other regulations* regarding regulated selling of cannabis

2.1.1 Please provide information, in bullet points, on the preparation and enactment of the first legislation and regulations around regulated selling of cannabis.

*Please give your answer in the box below*

2.1.2 Please provide information, in bullet points, on the preparation and enactment of the current legislation and regulations around regulated selling of cannabis.

*Please give your answer in the box below*

2.1.3 Please provide information, in bullet points, on any relevant changes between the first legislation and regulations around regulated selling of cannabis and the current legislation and regulations. Include the year of change.

*Please give your answer in the box below*

2.1.4 Briefly describe key events and underlying reasons in the process of preparing the legislation and regulations to establish a regulation of selling cannabis (chronologically, with accompanying dates).

*Please give your answer in the box below*

2.1.5 Please identify the five stakeholders who played the most important role in supporting the preparation and enactment of the legislation and regulations around regulated selling of cannabis.

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)

*Any additional comments, please write in the box below*

**2.1.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations around regulated selling of cannabis. List their interests and arguments and score their power.**

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)

*Any additional comments, please write in the box below*

There was no opposition. In fact, what finally happened is that the pharmaceutical company reduced the scope of diseases that could be subject of treatment with Sativex, they just maintained the chronic ones. So many “therapeutic” users still buy marihuana.

**2.1.7 In case international politics or policy have influenced the preparation, introduction or adaptation of this legislation or these regulations in your country, please explain.**

*Please give your answer in the box below*

**2.1.8 Please summarize in bullet points the key elements (content) of the legislation or other regulations with regards to regulated selling of cannabis as they are in force to date.**

Please give your answer in the box below

**2.1.9 In case any modifications of the legislation or regulations are expected in the near future, please shortly describe contents and reasons.**

Please give your answer in the box below

**2.1.10 In case no legislation and other regulations regarding regulated selling of cannabis exist, please mention any attempts made to have this regulated and why they did not succeed.**

Please give your answer in the box below

This is politically unpopular and unlikely to attract support from any of the political parties.

**2.2 In depth information on the *implementation* of regulating provisions in the legislation or otherwise regarding regulated selling of cannabis**

In the answers to the questions below, please describe briefly in bullet points the specifics of the implementation.

**2.2.1 What is the level of implementation regarding regulated selling of cannabis in your country? Please rate on a scale from 1-7.**

1= not implemented at all; 7=fully implemented in the whole country and all relevant settings.

1	2	3	4	5	6	7
1						

Any comments on level of implementation, please give your answer in the box below:

**If no legislation or other regulations regarding regulated selling of cannabis exist, please go to section II (contextual information).**

**2.2.2 Please describe factors facilitating the implementation (e.g., support from the police, public opinion, organisational aspects, positive media attention ...)**

Please give your answer in the box below



**2.2.3 Please describe barriers for the implementation (e.g., prevailing attitude towards harm reduction).**

*Please give your answer in the box below*

**2.2.4 In case stakeholders involved in the implementation of the measures regarding regulated selling of cannabis (see question 2.1.5 and 2.1.6) differ from those involved in the preparation and enactment of the legislation, or have another ranking, please specify.**

*Please give your answer in the box below*

## II Contextual information

Please complete the following questions/tables with the latest data available (with accompanying source). Describe the trend in the data (in terms of decreasing/increasing) over approximately the last ten years.

### 1 General information on country

**2.1.1. Area (km<sup>2</sup>):** 224,101 km<sup>2</sup>

**2.1.2. Population size:** 59,789,194

### 2 Prevalence of cannabis use

#### 2.1 Prevalence of cannabis use in the general population (15-64 years)

	Most recent data (%)	Most Recent Data (%)	Most Recent Data (%)
	England & Wales 2011-2012 <sup>122</sup>	Scotland 2010-2011 <sup>123</sup>	Northern Ireland 2011-2012 <sup>124</sup>

<sup>122</sup>People aged 16 to 64 years living in private households. Home Office, 2012. Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales. Home Office Statistical Bulletin. Available at: <http://www.homeoffice.gov.uk/publications/science-research-statistics/researchstatistics/crime-research/drugs-misuse-dec-1112/> accessed 5<sup>th</sup> February 2013

<sup>123</sup> People aged 16 to 59. Scottish Government Social Research, 2012. 2010/11 Scottish Crime And Justice Survey: Drug Use. Edinburgh: Scottish Government. p22. [Online]. Available: <http://www.scotland.gov.uk/Topics/Statistics/Browse/Crime-Justice/Publications/publications> accessed 5<sup>th</sup> February 2013

<sup>124</sup> Adults living in private households aged 16 to 64 years. National Advisory Committee on Drugs (NACD) & Public Health Information and Research Branch (PHIRB), 2011. Drug Use in Ireland &

<b>Lifetime use</b>	31%	21.6%	34%
<b>Last year use</b>	7%	7.6%	5%
<b>Last month use</b>	4%	3%	3%

Please briefly describe the **trend in prevalence of cannabis use in the general population** during the past ten years in terms of decreasing/increasing, stating where possible percentages from or around 2002 onward.

*Please give your answer in the box below*

<b>Proportion of 16 to 59 year olds reporting use of drugs in the last year, 1996 to 2011/12, %<sup>125</sup></b>					
<b>England &amp; Wales</b>					
<b>Year</b>	<b>1996</b>	<b>2006/7</b>	<b>2008/09</b>	<b>2010/11</b>	<b>2011/12</b>
<b>Cannabis</b>	9.5	8.2	7.9	6.8	6.9

<b>Proportion of Adults (16+) in Scotland reporting as having taken cannabis in the last year, %</b>						
<b>Year</b>	<b>2003</b>	<b>2004</b>	<b>2008/09</b>	<b>2009/10</b>	<b>2010/11</b>	
<b>Cannabis</b>	8 <sup>126</sup>	6 <sup>127</sup>	6.2 <sup>128</sup>	6.1 <sup>129</sup>	5.6 <sup>130</sup>	

Northern Ireland First Results from the 2010/11 Drug Prevalence Survey. Bulletin 1.

[http://www.dhsspsni.gov.uk/bulletin\\_2.pdf](http://www.dhsspsni.gov.uk/bulletin_2.pdf) accessed 5<sup>th</sup> February 2013

<sup>125</sup> Office for National Statistics 2012, Crime Survey for England and Wales 2011/12. [Online]. Available: <http://www.crimesurvey.co.uk/previous-research.html> accessed 5th February 2013

<sup>126</sup> The Scottish Government, 2004, Scottish Crime Survey 2003. [Online]. Available: <http://www.scotland.gov.uk/Resource/Doc/30859/0024985.pdf> accessed 5th February 2013

<sup>127</sup> The Scottish Government, 2004, Drug Misuse in Scotland: Findings from 2004 Scottish Crime and Victimization Survey. [Online]. Available: <http://www.scotland.gov.uk/Publications/2006/07/19095705/1> accessed 6th February 2013

<sup>128</sup> The Scottish Government, 2009, Prevalence of Illicit Drug use in Scotland, Scottish Crime and Drugs Survey 2008-2009. [Online]. Available: <http://www.scotland.gov.uk/Publications/2010/02/19144504/6> accessed 6th February 2013

<sup>129</sup> The Scottish Government, 2009, Prevalence of Illicit Drug use in Scotland, Scottish Crime and Drugs Survey 2009-2010. [Online]. Available: <http://www.scotland.gov.uk/Publications/2011/01/21134813/6> accessed 6th February 2013

<sup>130</sup> The Scottish Government, 2011, Prevalence of Illicit Drug use in Scotland, Scottish Crime and Drugs Survey 2010-2011. [Online]. Available: <http://www.scotland.gov.uk/Resource/0039/00390472.pdf> accessed 5th February 2013

Proportion of Adults (16+) in Northern Ireland reporting as having taken cannabis in the last year, %							
Year	2002/03	2004	2006/07	2008/09	2009/10	2010/11	
Cannabis	5 <sup>131</sup>		6.3 <sup>132</sup>	5 <sup>133</sup>		9 <sup>134</sup>	

## 2.2 Influence of cannabis use prevalence on governance implementation

Did the cannabis use prevalence influence the implementation of **legislation/ regulations on use and possession of small quantities for personal use?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
X						

Did the cannabis use prevalence influence the implementation of **regulated selling?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
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<sup>131</sup> Department of Health, Social Services and Public Safety Northern Ireland, 2005, Drug Use in Ireland & Northern Ireland First Results (Revised) from the 2002/2003 Drug Prevalence Survey, National Advisory Committee on Drugs (NACD) & Drug and Alcohol Information and Research Unit (DAIRU) June 2005. [Online]. Available: [http://www.dhsspsni.gov.uk/drug\\_use\\_bulletin1.pdf](http://www.dhsspsni.gov.uk/drug_use_bulletin1.pdf) accessed 6th February 2013

<sup>132</sup> Alcohol and Drug Research Unit (2007) *2007 National Report (2006 data) to the EMCDDA by the Reitox National Focal Point. Ireland: new developments, trends and in-depth information on selected issues*. Dublin: Health Research Board. [Online]. Available: [http://www.drugs.ie/resources/statistics/prevalence\\_ireland/](http://www.drugs.ie/resources/statistics/prevalence_ireland/) accessed 6<sup>th</sup> February 2013

<sup>133</sup> Department of Justice Northern Ireland, 2009, Experience of Drug Misuse: Findings from the 2008/09 Northern Ireland Crime Survey. [Online]. Available: [http://www.dojni.gov.uk/index/statistics-research/stats-research-publications/nics\\_2008-09\\_drugs\\_bulletin.pdf](http://www.dojni.gov.uk/index/statistics-research/stats-research-publications/nics_2008-09_drugs_bulletin.pdf) accessed 6th February 2013

<sup>134</sup> Department of Health, Social Services and Public Safety, 2011 Drug Prevalence Survey: Regional Drug Task Force (Ireland) and Health and Social Care Trust (Northern Ireland) Results [Online]. Available: [http://www.drugs.ie/resourcesfiles/research/2012/drug\\_use\\_ireland2012.pdf](http://www.drugs.ie/resourcesfiles/research/2012/drug_use_ireland2012.pdf) accessed 6th February 2013

X						
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Please briefly describe the influence of the cannabis use prevalence **on these two cases**:

*Please give your answer in the box below*

### 3 Health context

#### 3.1 Number of problem cannabis users

Please use the EMCDDA definitions

	Most recent data	Year
<b>Number of problem cannabis users</b>	n/a	
<b>Number of cannabis users that is in treatment</b>	Scotland 2413 (30% Of <i>new</i> clients seeking treatment services in Scotland) <sup>135</sup>	2010-2011
<b>Number of cannabis users that is in treatment</b>	England 15,194 (8% of clients seeking drug treatment services in England) <sup>136</sup>	2011-2012
<b>Number of cannabis users that is in treatment</b>	Wales 2149 (Referrals for treatment) <sup>137</sup>	2011-2012
<b>Number of cannabis users that is in treatment</b>	Northern Ireland 1088 (referrals for treatment) <sup>138</sup>	2009-2010

<sup>135</sup> NHS National Services Scotland 28<sup>th</sup> February 2012, Drug Misuse Statistics Scotland 2011, Available: <http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2012-02-28/2012-02-28-dmss2011-report.pdf> accessed 20th January 2013

<sup>136</sup> Department of Health, 4<sup>th</sup> October 2012 Statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2011– 31 March 2012 Vol. 1: The Numbers. Available: <http://www.nta.nhs.uk/uploads/statisticsfromndtms20112vol1thenumbersfinal.pdf> accessed 20th January 2013

<sup>137</sup> StatsWales, 2012, Referrals by main substance and age 2011-2012, Available: <https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/Substance-Misuse/Referrals-by-MainSubstance-AgeGroup> accessed 21st February 2013

<sup>138</sup> Department of Health, Social Services & Public Safety, 2010, Statistics from the Northern Ireland Drug Misuse Database: 1 April 2009 – 31 March 2010. Available: [http://www.dhsspsni.gov.uk/dmd\\_bulletin\\_2009\\_10.pdf](http://www.dhsspsni.gov.uk/dmd_bulletin_2009_10.pdf) accessed 3rd March 2013

<b>Total</b>	20,844	
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### 3.2 Cannabis related morbidity and social loss

If you have any national data or information on the prevalence of co-morbid psychopathology, on burden of disease (DALY's) or productivity loss, please provide it here:

*Please give your answer in the box below*

Not available
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Please describe briefly the trend in cannabis related morbidity/ social loss in the past ten years:

*Please give your answer in the box below*

Not available
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### 3.3 Influence of cannabis use-related health consequences on governance implementation

Did the cannabis use-related health consequences influence the implementation of **legislation/ regulations on use and possession of small quantities for personal use?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
X						

Did the cannabis use-related health consequences influence the implementation of **regulated selling?**

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
X						

Please briefly describe the influence of the health context **on these two cases:**

*Please give your answer in the box below*

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#### 4 Economical context

This section focuses on general economical information and data on public spending (direct and indirect) on cannabis. Please provide data as far as available.

##### 4.1 General economical circumstances

	Most recent data	Year
<b>Gross national income per capita (PPP international (€ or £))</b>	\$35,840 <sup>139</sup> €26,541.30 £22,785.35	2010
<b>Total health expenditures per capita (€ or £)</b>	Government Spending \$2918 €2161.01 £1852.86 Total Spending \$3479.56 <sup>140</sup> €2576.59 £2208.97	2010
<b>Total health expenditures as percentage of GDP (€ or £)</b>	9.7 (%GDP) <sup>141</sup>	2010

Source:

##### 4.2 State expenditures

If you have any data on (direct or indirect) expenditures on the health consequences of cannabis use, or on the expenditure related to crime control related to cannabis use, production or trafficking, please provide them here

*Please give your answer in the box below*

No research has been found on the economic and social costs of Class B and C drugs such as amphetamines or cannabis. <sup>142</sup>
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<sup>139</sup> Global Health Observatory Support Data Repository Demographic and socioeconomic statistics: Population Available: <http://apps.who.int/gho/data/> accessed 15<sup>th</sup> January 2013

<sup>140</sup> WHO Global Health Observatory Support Data Repository, Health expenditure: Health expenditure per capita Available: <http://apps.who.int/gho/data/> accessed 15<sup>th</sup> January 2013

<sup>141</sup> Adam Jurd, 2<sup>nd</sup> May 2012, Expenditure on Healthcare in the UK, 1997-2010, Office for National Statistics, Available: [http://www.ons.gov.uk/ons/dcp171766\\_264293.pdf](http://www.ons.gov.uk/ons/dcp171766_264293.pdf)

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**4.3 Economical context influencing implementation of legislation/ regulations on use and possession of small quantities for personal use and regulated selling**

Did the economical context influence the implementation of legislation/ regulations on use and possession of small quantities for personal use?

- yes
- no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Did the economical context influence the implementation of regulated selling?

- yes
- no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the economical context on these two cases:

*Please give your answer in the box below*

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**5. Political context**

**5.1 Did the political context influence the implementation of legislation/ regulations on use and possession of small quantities for personal use?**

- X yes

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

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<sup>142</sup> Transform Drug Policy Foundation (2009) A Comparison of the Cost-effectiveness of Prohibition and Regulation of Drugs. [Online]. Available: <http://www.tdpf.org.uk/TransformCBApaper.pdf>

1	2	3	4	5	6	7
					x	

Did the political context influence the implementation of **regulated selling**?

- yes  
 no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
					X	

Please briefly describe the influence of the political context **on these two cases**:

*Please give your answer in the box below*

## 6. Historical/Socio-cultural context

**6.1 Did the historical/socio-cultural context influence the implementation of legislation/ regulations on use and possession of small quantities for personal use?**

- X yes

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
					X	

Did the historical/socio-cultural context influence the implementation of **regulated selling**?

- X yes

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
				X		

Please briefly describe the influence of the historical/socio-cultural context on these two cases:

*Please give your answer in the box below*



The history of cannabis in the UK is as a banned substance, that remains.

### **III. Key publications**

Please include a list of key publications used to complete this report.

Please also add the full references of the sources you have used. In case you have included expert opinions please provide the name of the experts as well as the date and source of communication (e.g. personal communication).

*Please list the publications in the box below*

Footnoted throughout



## Appendix 8: Country report: Regulation of gambling in UK

### Country report ALICE RAP WP14 United Kingdom GAMBLING

In this study we focus on two selected cases of governance *practice*. For being able to describe and analyse these two cases we need a basic overview of relevant factors in the preparation, enactment and implementation of important measures and regulating provisions in the legislation or otherwise. This questionnaire will result in a country report and focuses on one case of governance practice related to gambling: aspects of **control and regulation**, e.g. licensing.

The structure of this country report format is based on an adapted version of the health policy triangle of Walt & Gilson (1994)<sup>143</sup>. This is built up around the following four concepts: policy content and process, stakeholders and context (for more detailed information see the project proposal).

Important: Please fill out this format as completely as possible, but limit yourself to the key elements. At a later stage we might contact you for additional information n.

#### I Policy process and contents

##### Relevant aspects of control and regulation in gambling legislation and other regulations and standards

The United Kingdom is comprised of three countries, and the devolved administration in Northern Ireland. Since 2005 in England, Wales and Scotland gambling has been regulated by the Gambling Commission and local authority licensing boards. In Northern Ireland gambling is regulated differently. The main body of this report focuses on gambling regulation in Great Britain, mainland UK; details on Northern Ireland are given briefly below.

##### Northern Ireland

According to the 2011 census Northern Ireland has a population of 1.811 million people.<sup>144</sup> Gambling regulation in Northern Ireland, with the exception of the National Lottery, was last amended in the Betting, Gaming, Lotteries and Amusements (NI) Order 1985.<sup>145</sup> In January 2013 plans to update the

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<sup>143</sup> Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health policy and planning*, 9(4), 353-370.

<sup>144</sup> Northern Ireland Statistics and Research Agency, (2011) *Census 2011 Key Statistics for wards and small areas for Northern Ireland*, [Online]. Available: <http://www.nisra.gov.uk/Census/2011Census.html> accessed 30th January 2013

<sup>145</sup> Northern Ireland Department of Social Development, February 2011, *Future Regulation of Gambling in Northern Ireland*, [Online]. Available:

exiting legislation were announced by the NI Department of Social Development.<sup>146</sup> In Northern Ireland the regulation is applicable to gambling at betting tracks, and bookmakers, gaming machines, bingo and lotteries. Casinos are prohibited, and there are no plans to revoke this ban within the forthcoming policy review, nor are there plans to allow betting shops or bingo houses to open on Sundays.<sup>147</sup>

In 2009 the Department of Social Development undertook the first comprehensive survey on gambling in NI as part of a review of gambling regulation. The findings suggested that the prevalence of problem gambling is three times higher in Northern Ireland than in the rest of the UK, approximately one out of every fifty people had a problem with gambling.<sup>148</sup> In February 2011 the department launched a consultation to gauge the response of stakeholders and interested parties.<sup>149</sup> The review found that three out of four adults had taken part in some form of gambling within the past 12 months with the most popular form of gambling being the National Lottery (51%).<sup>150</sup>

The Minister responsible for gambling regulation in Northern Ireland, on making the announcement that the regulation surrounding gambling was to be updated, stated "My priority is to minimise the harmful effects of gambling,".... The new law will be underpinned by objectives aimed at keeping crime out of gambling, ensuring fairness within the gambling industry and protecting the young and vulnerable."<sup>151</sup> He also expressed the view that the current regulatory framework was insufficient for

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**[http://www.dsdni.gov.uk/index/law\\_and\\_legislation/social\\_policy/strategic-review-gambling.htm](http://www.dsdni.gov.uk/index/law_and_legislation/social_policy/strategic-review-gambling.htm) accessed 30th January 2013**

4 <sup>146</sup> Pinsent Masons, 14<sup>th</sup> January 2013, Northern Ireland to review "out of date" gambling laws, Out-Law.com, [Online] Available: <http://www.out-law.com/en/articles/2013/january/northern-ireland-to-review-out-of-date-gambling-laws/> accessed 22<sup>nd</sup> January 2013.

<sup>147</sup>Pinsent Masons, 14<sup>th</sup> January 2013, Northern Ireland to review "out of date" gambling laws, Out-Law.com, [Online] Available: <http://www.out-law.com/en/articles/2013/january/northern-ireland-to-review-out-of-date-gambling-laws/> accessed 30th January 2013.

<sup>148</sup>Northern Ireland Department of Social Development, February 2011, *Future Regulation of Gambling in Northern Ireland*, [Online]. Available:

**[http://www.dsdni.gov.uk/index/law\\_and\\_legislation/social\\_policy/strategic-review-gambling.htm](http://www.dsdni.gov.uk/index/law_and_legislation/social_policy/strategic-review-gambling.htm) accessed 30th January 2013**

<sup>149</sup>Northern Ireland Department of Social Development, February 2011, *Future Regulation of Gambling in Northern Ireland*, [Online]. Available:

**[http://www.dsdni.gov.uk/index/law\\_and\\_legislation/social\\_policy/strategic-review-gambling.htm](http://www.dsdni.gov.uk/index/law_and_legislation/social_policy/strategic-review-gambling.htm) accessed 30th January 2013**

<sup>150</sup>Northern Ireland, Department of Social Development 6<sup>th</sup> June 2010, *Gambling Prevalence Survey 2010*, [Online]. Available: <http://www.northernireland.gov.uk/news-dsd-061210-the-northern-ireland> Accessed 30th January 2013.

<sup>151</sup>Pinsent Masons, 14<sup>th</sup> January 2013, Northern Ireland to review "out of date" gambling laws, Out-Law.com, [Online] Available: <http://www.out-law.com/en/articles/2013/january/northern-ireland-to-review-out-of-date-gambling-laws/> accessed 30th January 2013

dealing with new forms of gambling (online) and that the new legislation would consider liberalizing some aspects of gambling control, particularly advertising restrictions and strict rules around prize draws. The protection of the young and vulnerable will be an aspect of the new legislation. The draft legislation on the proposed changes to existing gambling regulation will be presented to the Northern Ireland Assembly before the end of 2015.

In Northern Ireland, the legal age for football pool betting is 16, and there is no age limit for playing fruit machines in arcades on games with a cash prize of £8. In pubs fruit machines are restricted to a maximum £15 cash prize and there are no age restrictions on play, though house rules may apply.

Gambling in Britain: England, Scotland & Wales

**1.1 Which types of gambling does the gambling regulation in your country include:**

	Is it regulated?	Is it legal?
<b>Table games in casino's ( e.g., cards, dice, roulette, with a croupier or poker dealer)</b>	Y	Y
<b>Electronic gaming in casino's (e.g., slot machine, video poker)</b>	Y	Y
<b>Other gambling in casino's (bingo, keno)</b>	Y	Y
<b>Gambling games not in casino's (lotteries, scratchcards, bingo)</b>	Y	Y
<b>Fixed-odds betting (sports or other events; in a fixed odds betting the pay-out is agreed at the time the bet is sold)</b>	Y	Y
<b>Parimutual betting (gambling on horse racing, greyhound racing, sporting events; in a parimutual betting the final pay-out is not determined until the pool is closed)</b>	Y	Y
<b>Internet gambling</b>	Y	Y
<b>Arcades (Gambling Machines)</b>	Y	Y


*Additional comments, please give your answer in the box below*

**1.2 Does your gambling regulation include regulations on:**

		<b>Short description:</b>
<b>Licensing</b>	Y	<p>Since 2005 all companies and individuals offering gambling; except for the National Lottery and spread betting (see below) must apply to the Gambling Commission and to the local authority for a license. Local Authorities license premises while the Gambling Commission licenses companies and individuals. The Gambling Commission was set up as part of the 2005 Gambling Act to work in conjunction with local authorities to license and regulate the UK's gambling industry.<sup>152</sup></p> <p>The Gambling Commission considers the suitability of applicants for commercial gambling licenses. Factors for consideration include: identity, financial circumstances, integrity, competence and criminality. A demonstration of the applicant's understanding of the regulation is also required, this is done by considering the operators potential policies to ensure compliance to regulations. Local authorities are responsible for licensing premises, rather than individuals. The Gambling Commission issues licenses and oversees the enforcement of UK gambling regulations.</p> <p>The National Lottery is licensed and regulated by the National Lottery Commission, a Non-Departmental Public Body, sponsored by the governmental Department for Culture, Media and Sport. The National Lottery Commission operates independently from the government. There are plans by the current government to merge the National Lottery Commission with the Gambling Commission.<sup>153</sup></p> <p>Spread Betting is regulated by the Financial Services Authority (FSA). The Financial Services Authority (FSA) is an independent non-governmental body, given statutory powers by the Financial Services and Markets Act 2000. Figure one illustrate the FSA's operating framework. The FSA has no obligation to consider problem gambling.</p>

<sup>152</sup> The Gambling Commission, Who We are & What We Do, [Online]. Available: <http://www.gamblingcommission.gov.uk/pdf/Who%20we%20are%20and%20what%20we%20do%20-%20April%202011.pdf> accessed 8<sup>th</sup> January 2013.

<sup>153</sup> The National Lottery Commission, About the National Lottery Commission, [Online] Available: <http://www.natlotcomm.gov.uk/about-the-national-lottery-commission.html> accessed 3rd January 2013

		<p>Figure 1. 154</p>  <p>There are 10 types of operating licenses and two types of personal licenses (managerial and operational)</p>
<p><b>Taxes</b></p>	<p>Y</p>	<p>Before 2001 the UK had one of the lowest rates of gambling taxation in the EU. Amendments to the regulations saw tax rates for gambling firms increase to 15% and the 9% betting duty paid by consumers was abolished.<sup>155</sup> This change in the law resulted in many UK based gambling corporations relocating their business to other countries where tax rates placed on gambling are significantly lower. This enabled companies to take advantage of UK rules that allowed firms to operate with the UK and pay tax on gambling profits elsewhere. Firms operating out with the UK were not liable to pay tax on bets placed unless the company had a physical presence in the UK, for example shops, or machines. In May 2011 the law changed in order to collect tax on bets made or games played in the UK.<sup>156</sup> The new tax regime for gambling companies should be fully implemented by 2014. However, large gambling corporations such as William Hill have said that they will mount a legal challenge against the UK</p>

<sup>154</sup> Financial Services Authority, Our Operating Framework, [Online] Available: <http://www.fsa.gov.uk/pages/about/what/approach/framework/> Accessed 3<sup>rd</sup> January 2013

<sup>155</sup> Matthew Pitt 23<sup>rd</sup> March 2012, What Does the Change in UK Gambling Tax Laws Mean to You?, Poker News UK, [Online] Available: <http://uk.pokernews.com/news/2012/03/what-does-the-change-in-uk-gambling-tax-laws-mean-to-you-8159.htm> accessed 3<sup>rd</sup> January 2013

<sup>156</sup> Jason Gorrige, 27<sup>th</sup> March 2012, UK Confirms Gambling Tax Changes, Tax-News.com, London [Online]. Available: [http://www.tax-news.com/news/UK\\_Confirms\\_Gambling\\_Tax\\_Changes\\_54613.html](http://www.tax-news.com/news/UK_Confirms_Gambling_Tax_Changes_54613.html) accessed 29<sup>th</sup> December 2012

		<p>government on the basis that the new rules discriminate against companies operating in the UK and constitute a significant trade barrier that is at odds with European law.<sup>157</sup></p> <p>Tax rules and regulations are the responsibility of the UK treasury and the Chancellor of the Exchequer the remit of this government department is concerned only with gambling taxation. The regulation of gambling is the responsibility of local authorities and the Gambling Commission and is overseen by the governmental department for Media, Culture &amp; Sport.</p>
<b>Rules of (casino) games</b>	Y/N	The most popular casino games are regulated. However, liberalization in 2011 means that trialing new games no longer need the approval of the regulator. Instead, the regulator issues a list of games that are not allowed to be played. There are no games on this list.
<b>Age limits</b>	Y	<p>There are a range of age limits and caveats in the law with regards to age limits for gambling in the UK. In most circumstances individuals must be 18 years old to gamble legally. It is an offence to bet with someone known to be under 18 years old. Those under 18 years of age are prohibited from entering public betting shops or casinos, although under 18s are permitted entrance to licensed bingo outlets and bingo games but they are prohibited from playing.</p> <p>Purchasers of Lottery tickets and scratch cards in a registered public lottery must be 16; there are no restrictions on private lottery games.<sup>158</sup></p> <p>Staff working in the UK gambling industry are required to have training in the prevention of underage gambling and awareness of company policy and procedure in this area.<sup>159</sup></p>
<b>Consumer information</b>	Y	Gambling operators in the UK must provide information on all of their products and services and details of where further information is available. <sup>160</sup>

<sup>157</sup>Natalie Thomas, 30<sup>th</sup> July 2012, William Hill prepares to challenge UK online gaming tax, The Telegraph, [Online]. Available: <http://www.telegraph.co.uk/finance/newsbysector/retailandconsumer/leisure/9436762/William-Hill-prepares-to-challenge-UK-online-gaming-tax.html> accessed 3rd January 2013

<sup>158</sup>Citizens Advice Bureau, *Restrictions on Buying Goods & Services*, [Online]. Available: [http://www.adviceguide.org.uk/england/debt\\_e/young\\_people\\_money\\_and\\_consumer\\_rights.htm#restrictions\\_on\\_buying\\_goods\\_and\\_services](http://www.adviceguide.org.uk/england/debt_e/young_people_money_and_consumer_rights.htm#restrictions_on_buying_goods_and_services) Accessed 3<sup>rd</sup> December 2012

<sup>159</sup>Gamble Aware, *Consumer Information and Protection*, [Online]. Available: <http://www.gambleaware.co.uk/consumer-protection/> Accessed 10<sup>th</sup> January 2013



<p><b>Prevention and/or treatment of problematic gambling</b></p>	<p>Y</p>	<p>The 2005 Gambling Act requires a range of standards to be met with respect to the prevention of problem gambling. The statutory licensing objectives of the committee are to preventing gambling from being a source of crime or disorder, being associated with crime or disorder or being used to support crime and ensuring that gambling is conducted in a fair and open way protecting children and other vulnerable persons from being harmed or exploited by gambling.<sup>161</sup></p> <p>All staff must be trained to recognise customers who are problem gamblers and to thereafter follow their particular company's procedure accordingly.</p> <p>Operators are required to allow customers to be voluntarily excluded from gambling for a period of time, usually 6 months to a year.</p> <p>Some gambling corporations allow customers to bet with them using a credit card, this is becoming less common as gambling companies make further corporate social responsibility commitments.</p> <p>One of the main objectives of the Gambling Act 2005 was to loosen regulatory control. In order to balance this dominant objective companies offering gambling products and services became required to demonstrate a commitment to gambling harm reduction. An important component of this approach involved the gambling industry pledging voluntarily around £3 million pounds per year towards gambling research and supporting problem gambling treatment.</p>
<p><b>A regulating agency</b></p>	<p>Y</p>	<p>The 2005 Gambling Act made provisions for the establishment of the Gambling Commission to oversee the regulation of UK commercial gambling (with the exception of the National Lottery and spread betting).<sup>162</sup> Although there are plans to include the remit of the National Lottery Commission within the Gambling Commission's jurisdiction.</p>

<sup>160</sup>Gamble Aware, *Consumer Information and Protection*, [Online]. Available: <http://www.gambleaware.co.uk/consumer-protection/> Accessed 10<sup>th</sup> January 2013

<sup>161</sup>The Gambling Commission, October 2012, Corporate Governance Framework, [Online]. Available: <http://www.gamblingcommission.gov.uk/pdf/Corporate%20governance%20framework%20-%20Main%20Document%20-%20October%202012.pdf> Accessed 10<sup>th</sup> January 2013

<sup>162</sup>The Gambling Commission, *Home Page*, [Online]. Available: <http://www.gamblingcommission.gov.uk/default.aspx> Accessed 8th December 2012.

### 1.3 Is the regulating agency in your country involved in

<p><b>Licensing (issuing, levying fines, revoking)</b></p>	<p>Y</p>	<p><b>The Gambling Commission monitors compliance of the Gambling Act 2005. The Gambling Commission has a range of powers which include:</b><sup>163</sup></p> <p>Issuing a warning to a licence holder  Attaching an additional condition to a licence  Removing or amending a condition to a licence  Suspending a licence at the outset, or following a review  Revoking a licence  Imposing a financial penalty following breach of a licence condition.</p> <p>In order to enforce the regulations the gambling Commission has the power to:  Carry out review and make visits to gambling sites  Give advice and guidance regarding compliance to licence holders.  Take action, both remedial and preventative  Impose additional licensing conditions  Review licence holder’s financial information.</p> <p>Annually a list of sanctions against operators is published by the Gambling Commission. <sup>164</sup> The Gambling Act 2005 established the Gambling Appeals Tribunal (GAT) which was transferred to the First-tier Tribunal (Gambling) in January 2010 following reforms of the Tribunal system by the Tribunals Courts and Enforcement Act 2007.<sup>165</sup></p>
<p><b>Accounting systems (providing financial information, e.g., to the government)</b></p>	<p>Y</p>	<p>The Gambling Commission can audit operators in the UK and review their financial data. They do not have to report to government but must adhere to the tribunal</p>

<sup>163</sup> The Gambling Commission, Regulatory Action, [Online]. Available: [http://www.gamblingcommission.gov.uk/licensing\\_compliance\\_enfo/regulatory\\_action.aspx](http://www.gamblingcommission.gov.uk/licensing_compliance_enfo/regulatory_action.aspx) accessed 10th January 2013

<sup>164</sup> The Gambling Commission, Operator Licences Regulatory Decisions, [Online]. Available: <http://www.gamblingcommission.gov.uk/PDF/Regulatory%20sanctions%20register%20operator%20licences%20-%20November%202012.pdf> Accessed 14<sup>th</sup> January 2013

<sup>165</sup> <sup>165</sup> The Gambling Commission, Regulatory Action, [Online]. Available: [http://www.gamblingcommission.gov.uk/licensing\\_compliance\\_enfo/regulatory\\_action.aspx](http://www.gamblingcommission.gov.uk/licensing_compliance_enfo/regulatory_action.aspx) accessed 10th January 2013

		process if a licence holder chooses to appeal a Gambling Commission decision.
<b>Auditing</b>	Y	The Gambling Commission has the power to review the financial information of members to ensure compliance or to investigate any suspected breaches of the regulations.
<b>Advising national or local government on gambling issues</b>	Y	The Gambling Commission has a responsibility under the 2005 Gambling act to provide the government with advice and information on gambling. For this reason the Commission has a research programme. <sup>166</sup> The Gambling Commission undertakes the collection of data on adult gambling and problem gambling in the UK. They do this by completing a quarterly omnibus survey to gather data on participation in gambling. Gambling questions asked in the Health Survey for England and the Scottish Health Survey are also used by the Commission. <sup>167</sup>
<b>Investigating and prosecuting illegal gambling</b>	Y	Yes, the Commission does have the power to pursue prosecutions, however this is highly unlikely. If criminal activity or wrongdoing is uncovered by the Gambling Commission's compliance work then the police would be notified. The Gambling Commission can not prosecute license holders and would in these circumstances be required to report any criminal offence to the police. <sup>168</sup>
<b>Remote gambling, e.g., betting online (internet) or by telephone</b>	Y	The Gambling Commission has a role to play in the regulation of online gambling, it issues licences for remote operators. There are different licenses required depending on the type of game played and not one license for
<b>The spreading of gambling/betting</b>		The Gambling Act 2005 was designed to stimulate growth in the gambling industry however; they do not have a formal role in the promotion of gambling. The Commission can be seen to promote gambling in the UK

<sup>166</sup> The Gambling Commission, *Gambling Research*, [Online]. Available: [http://www.gamblingcommission.gov.uk/research\\_consultations/research.aspx](http://www.gamblingcommission.gov.uk/research_consultations/research.aspx) Accessed 14th January 2013

<sup>167</sup> The Gambling Commission, *Gambling Research*, [Online]. Available: [http://www.gamblingcommission.gov.uk/research\\_consultations/research.aspx](http://www.gamblingcommission.gov.uk/research_consultations/research.aspx) Accessed 14th January 2013

<sup>168</sup> The Gambling Commission, September 2009, *Licensing, compliance and enforcement policy statement*, [Online]. Available: <http://www.gamblingcommission.gov.uk/pdf/Licensing%20compliance%20and%20enforcement%20policy%20statement%20-%20September%202009.pdf> accessed 8<sup>th</sup> December 2012.

		by enforcing regulations in order that the sector appears fair and maintains professional standards.
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## 2 In depth information on the preparation and enactment of the legislation and other regulations in gambling control and regulation

### 2.1 Please provide information, in bullet points, on the preparation and enactment of the first legislation and regulations regarding gambling control. Please include dates (year).

*Please give your answer in the box below*

Historically speaking, there has been a range of attempts to regulate gaming and gambling in the UK. This section provides a brief discussion of some historical factors in UK gambling regulation and follows with a timeline of events, which is not exhaustive. The most recent changes to UK gambling regulation occurred in 2005, prior to that the legislation had been in place since the 1960s.

To state with any certainty which regulation was the first in UK statute is complex. For example, in 1388 popular dicing games were prohibited by the monarch on the grounds that they were a distraction that was undermining “English supremacy at archery”.<sup>169</sup> In 1541 Henry the VIII outlawed working people from gaming at all times, with the exception of Christmas. Although the banning of games is not the same as the banning of gambling, according to Meir this “made unlawful the obvious pretext for gambling transactions.”<sup>170</sup> The Gaming Act of 1710, presided over by Queen Anne, increased the financial penalties for fraud in gambling and decreed that any sum over £10 lost could be recovered within three months. This was in an effort to protect the wealthy from losing their inheritances through gambling. Smaller losses made by the less wealthy were regarded as character building and no protection was offered to them.<sup>171</sup>

Over the following centuries attempts to legislate or regulate gaming and gambling were grounded in efforts to stamp out cheating and fraud, limiting the prevalence of gambling for the lower and working classes and protecting the wealthy from heavy losses. Elements of the 1541 and 1710 legislation remained part of UK gambling regulation until the 1960s. As Meir notes “This [the 1710 gaming Act] coupled with Henry the VIII statute of 1541 formed a pattern of gambling control that persisted, despite changes to legal technicalities until the Betting and Gaming Act of 1960”.<sup>172</sup>

<sup>169</sup> Meirs, D. (2004) *Regulating Gambling: Past, Present, and Future*, Chapter 1 page 21, Oxford Scholarship Online published 2010, [Online]. Available: <http://fds.oup.com/www.oup.co.uk/pdf/0-19-927615-3.pdf> accessed 10th January 2013

<sup>170</sup> Meirs, D. (2004) *Regulating Gambling: Past, Present, and Future*, Chapter 1 page 21, Oxford Scholarship Online published 2010, [Online]. Available: <http://fds.oup.com/www.oup.co.uk/pdf/0-19-927615-3.pdf> accessed 10th January 2013

<sup>171</sup> Meirs, D. (2004) *Regulating Gambling: Past, Present, and Future*, Chapter 1 page 21, Oxford Scholarship Online published 2010, [Online]. Available: <http://fds.oup.com/www.oup.co.uk/pdf/0-19-927615-3.pdf> accessed 10th January 2013

<sup>172</sup> Meirs, D. (2004) *Regulating Gambling: Past, Present, and Future*, Chapter 1 page 28, Oxford Scholarship Online, published 2010, [Online]. Available: <http://fds.oup.com/www.oup.co.uk/pdf/0-19-927615-3.pdf> accessed 10th January 2013

Professional bookmakers are evident in the UK from the late eighteenth century the 1845 Gaming Act made contracts over wagers unenforceable. This led to bookmakers seeking to secure cash in advance, and resulted in increased demand for cash betting houses. In 1853 the Betting Act sought to rectify this by enforcing tighter restrictions on betting houses, this had the unintended consequence of forcing betting onto the streets where enforcement was near impossible. Street betting became unlawful under the 1906 Betting Act. The legislation allowed for on course betting, off course betting was only permissible if bets were made by post or telephone. Regardless of legislative changes prohibiting off course cash betting it continued to grow.

The Betting & Gaming Act 1960 swept away previous gambling regulation and made it lawful for a bookmaker to run a cash betting office provided both he and his office were licensed. This act (and subsequent additions) served as the cornerstone of UK gambling regulation until the 2005 gambling act. The Gaming and Betting Act 1960 sought to modernise gambling regulation and to liberalise the previous prohibitionist stance that had developed historically. The 1960 Act legalised betting shops and, despite its original intention to permit private gaming, it inadvertently led to an explosion of commercial gaming which could take place in locations such as restaurants, bingo halls and members' clubs.

The Primary aim of the Betting & Gaming Act 1960 was to prohibit commercial gambling while, simultaneously, allowing private gaming.

“The Betting & Gaming Act 1960 was meant to outlaw commercial gaming but allow private gaming. It is argued that if the principles put forward in the Royal Commission Report (no bankers games – all players having equal chances) then the Act would probably have succeeded in outlawing commercial gaming. However, the addition of Section 32 (1) (a) (ii) of the Act, instead of simply stating that gaming would be legal only if the chances in the game were equal to all players now stated that it would be legal where “...gaming is so conducted that the chances therein are equally favourable to all the players”. The legislators had disastrously added a variable to the law. This variable (the term favourable) would provide justification for “banker’s games” and resulted in the establishment of a large unexpected gaming industry in the United Kingdom.”<sup>173</sup>

It is widely accepted that the unintended consequences of the 1960 act coupled with amendments made in 1963 had the unintended consequence of dramatically increasing gambling in the UK. Under the act off course betting became legal in licensed betting premises the licenses ensured that taxes and betting levies became collectable by the state. The gaming industry, which the legislation had not intended to legalise, grew to include commercial gaming clubs and casinos; furthermore, alcohol and entertainment became part of the UK gambling industry. The UK gambling industry grew at a rate that became of concern to politicians, the media and the general public, and the association between organised crime and the UK gambling industry was another area of concern. The poorly drafted act hindered the enforcement of regulation.

The Gaming Act 1968

The Gaming Act 1968 sought to rectify the errors made in UK gambling regulation in the 1960 and

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<sup>173</sup> Murphy, Seamus, The Gaming Act 1968 Executive Summary, The Gambling Consultant, [Online]. Available: <http://www.gamblingconsultant.co.uk/the-gaming-act-1968-executiv/> accessed 24<sup>th</sup> January 2013.

1963 acts. Licensing and enforcement were the cornerstones of the 1968 act, and in turn the main focus of gambling regulation. Local licensing magistrates would grant licenses and enforcement of the regulations would be overseen by the police. The Gambling Board was established, a body that could carry out inspections on premises object to licenses being granted to certain organisations or individuals. The 1968 regulation also made in mandatory for members clubs; where betting or gaming may be a secondary activity, to apply for licenses. The 1968 act forced licensees to demonstrate a local demand for their businesses in order to obtain a license. License operators were required to be assessed in order to ensure they were suitable to hold a license, and advertising gaming and gambling were prohibited. Casinos were only able to operate within certain areas, decided by parliament, (Originally these we 30 local authority areas (the main cities and towns) proposed by the Gaming Board. The Board later added to the existing gaming areas to include any county borough in England or Wales outside Greater London with a population of 125,000 or more and any county of a city in Scotland. This meant that from 1972 until the law was changed in 2007 (when the Gambling Act 2005 came into force), casinos could only be located within 52 permitted areas in Britain.<sup>174</sup>

#### Timeline

1388 Dicing prohibited

1541 Henry VIII prohibits the working classes from gaming, apart from at Christmas.

1710 Gaming Act allowed recovery of loses, increases penalties for fraud and cheating, and protected individuals against large loses. The smaller loses encountered by the poor were seen as character building and unimportant, the aim was to protect the wealthy from ruin.

1738 Gaming Act prohibited some games, which resulted in the creation of different games which were prohibited in 1739. This subsequent ban resulted in the development of the game of roulette.

1744 Gaming Act prohibited roulette

1751 The Disorderly Houses Act sought to reduce disorder in premises this included gambling and drunkenness.

1774 Gaming Act made it illegal to take out insurance, or bet, on another person's life.

1823 Lotteries Act, prohibited private lotteries

1844 Parliamentary Select Committee on Gambling was established, to 'to inquire into the existing statutes against gaming of every kind, to ascertain to what extent these statutes are evaded, and to consider whether any and what amendment should be made in such statutes'<sup>175</sup> The Committee found existing gambling regulation to be unworkable.

1845 Gaming Act, certain aspects of this statute remained in an amended form until 2007.

1853 Betting Houses Act, brought gambling premises under legislation and was an effort to prevent working class people for gambling in 'sporting public houses'

1854 Gaming Houses Act

1906 Street Betting Act made it an offence to transact bets in the street or other public places. This

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<sup>174</sup> Murphy, Seamus, [The Gaming Act 1968 Executive Summary](#), The Gambling Consultant, Available: [The Gaming Act 1968 - Executive Summary](#) accessed 24<sup>th</sup> January 2013.

<sup>175</sup> Miers, D. 2002 *OFGAM? OFBET? The Regulation of Commercial Gambling as a Leisure Industry Entertainment Law*, Vol.1, No.1, Spring 2002, pp.20–51 Published by Frank Cass, [Online]. Available: <http://www2.warwick.ac.uk/fac/soc/law/elj/eslj/issues/volume1/number1/miers.pdf> accessed 11th January 2013

was avowed class legislation: as the Metropolitan Police Commissioner, Sir Edward Henry, observed, working-class gambling was a very great public evil which 'cries out' for a remedy. 'Contrary to principle', he concluded, 'we need one law for the rich and one for the poor'. The anomalies embedded in the law as a result of a century of uncertain enforcement were matters of comment by Royal Commissions in the early 1930s and immediately following the Second World War; but change was, until the 1960s, confined to the 'small lottery' problem.

1951 Royal Commission on Betting, gaming and lotteries  
1960 The Gaming and Betting Act<sup>176</sup>  
The Betting, Gaming and Lotteries Act, 1963.<sup>177</sup>  
The Gaming Act, 1968.

**2.2 Please provide information, in bullet points, on the preparation and enactment of the current legislation and regulations on gambling control and regulation. Please include dates (year).**

*Please give your answer in the box below*

UK Gambling Regulation 2001-2007  
July 2001, The Budd Report<sup>178</sup>  
In 2000 the Home Office, then responsible for gambling regulation, (in 2001 this responsibility was transferred to the Department of Culture Media & Sport (DCMS)) commissioned a gambling policy review chaired by Sir Alan Budd a former Treasury Department adviser. The report considered gambling regulation and the challenges to the industry posed by internet gambling. The final report was published in July 2001 and contained 175 recommendations.  
March 2002, *A Safe Bet for Success*<sup>179</sup> was published by the DMCS as the governmental response to the Budd report and set out the objectives in reforming gambling regulation. The primary rationale was not to tighten up gambling regulation, rather, the review was seen as a means of liberalising and simplifying existing statute, giving customers more choice and ultimately stimulating the UK gambling industry to the benefit of the British economy.<sup>180</sup> (Meirs 2006)

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<sup>176</sup>Parliament UK, Hansard Publications, *The Betting and Gaming Act, 1960*. **The National Archive** [Online]. Available: <http://hansard.millbanksystems.com/a...aming-act-1960> accessed 10th January 2013

<sup>177</sup>Parliament UK, Hansard Publications, *The Betting Gaming & Lotteries Act 1963*. **The National Archive** [Online]. Available: <http://www.legislation.gov.uk/ukpga/1963/2/contents> accessed 12th January 2013

<sup>178</sup>Department for Culture Media and Sport, 2001, *Gambling Review Report, 2001*, **The Stationary Office** Cm. 5206 16 (Oxford University Press 2004). [Online]. Available: <http://www.official-documents.gov.uk/document/hc0102/hc10/1016/1016.pdf> accessed 10th December 2012

<sup>179</sup>Department for Culture Media and Sport, 2001 *A Safe Bet for Success*, **The Stationary Office** 2001 Cm 5397. [Online]. Available: [http://www.hblb.org.uk/documents/92\\_WhitePaper\\_A\\_Safe\\_Bet\\_For\\_Success.pdf](http://www.hblb.org.uk/documents/92_WhitePaper_A_Safe_Bet_For_Success.pdf) accessed 10th December 2012

<sup>180</sup>David Meirs, 2006, *Implementing the Great Britain's Gambling Act 2005; The Gambling Commission and the Casino Question*, **Gaming Law Review**, Volume 10, Number 5, 2006 Mary Ann

June 2002, Culture, Media and Sport Select Committee, *The Government's Proposals for Gambling: Nothing to lose?*<sup>181</sup> This report set out the accumulative recommendations from the DCMS and from the Budd report.

November 2003 the draft bill on gambling<sup>182</sup> regulations was published by DCMS. The government had accepted most of the Budd Report recommendations.

5<sup>th</sup> February and 12<sup>th</sup> March 2004 Draft Gambling Bill Additional Clauses was published.<sup>183</sup>

7<sup>th</sup> April 2004, Joint Committee on the Draft Gambling Bill published their first report<sup>184</sup> The Joint Committee had opened a consultation and interests parties and stakeholders were given the opportunity to respond to the proposals for new gambling legislation by the 28<sup>th</sup> of February 2004.

14<sup>th</sup> June 2004, Government's response to the Committee's Report, published by the Department for Culture, Media and Sport on 14 June 2004<sup>185</sup>

22<sup>nd</sup> July 2004 Report of the Joint Committee on the Draft Gambling Bill (Regional Casinos), HL 146-I HC 843-I, Session 2003-04<sup>186</sup>

September 2004 Government's response to the Committee's Report<sup>187</sup>, published by the Department for Culture, Media and Sport on 22 September

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Liebert, Inc. [Online]. Available: <http://online.liebertpub.com/doi/abs/10.1089/glr.2006.10.472> [Subscription Required] accessed 10th December 2012

<sup>181</sup>Culture, Media and Sport Select Committee, *The Government's Proposals for Gambling: Nothing to Lose?* **The Stationary Office**, 2001–02; HC 827 <http://www.parliament.the-stationery-office.co.uk/pa/cm200102/cmselect/cmcmds/827/827.pdf>

<sup>182</sup>Department for Culture Media and Sport, 2003, *DRAFT GAMBLING BILL, 2003* Cm. 6014-I-IV. [Online]. Available: [http://www.culture.gov.uk/images/consultations/Under\\_18s\\_employment\\_on\\_tracks\\_consultation.pdf](http://www.culture.gov.uk/images/consultations/Under_18s_employment_on_tracks_consultation.pdf)

<sup>183</sup> Department for Culture Media and Sport, *Draft Gambling Bill Additional Clauses*, 4<sup>th</sup> February & 12<sup>th</sup> March 2004. [Online]. Available: [http://webarchive.nationalarchives.gov.uk/+http://www.culture.gov.uk/global/publications/archive/2004/gambling\\_bill\\_additional.htm](http://webarchive.nationalarchives.gov.uk/+http://www.culture.gov.uk/global/publications/archive/2004/gambling_bill_additional.htm) Accessed 10th December 2012

<sup>184</sup> Gambling Review Joint Committee, 2004, *The Draft Gambling Bill*, first Report 2004-04, H.C. 139-I, H.L. Paper 63, at 352–55. Available: <http://www.publications.parliament.uk/pa/jt/jtgamb.htm> accessed 8th December 2012

<sup>185</sup>Department for Culture, Media and Sport, 22 September 2004, *Government's response to the Committee's Report* (Cm 6330), published by the Department for Culture Media and Sport, [Online]. Available: <http://www.parliament.uk/business/committees/committees-archive/jcdqb-rg/> Accessed 8<sup>th</sup> December 2012

<sup>186</sup> House of Lords & House of Commons Joint Committee on the Draft Gambling Bill (Regional Casinos) *Draft Gambling Bill (Regional Casinos)*. [Online]. Available: <http://www.publications.parliament.uk/pa/jt200304/jtselect/jtreqc/146/146.pdf> accessed 8th December 2012

<sup>187</sup> Department for Culture, Media and Sport, 22 September 2004, *Government's response to the Committee's Report* (Cm 6330), published by the Department for Culture Media and Sport, [Online].



The first reading of the Gambling Bill to the UK parliament took place on the 19<sup>th</sup> of October 2004, at the second reading the bill was passed on the 2<sup>nd</sup> of November 2004 with 286 votes to 212 giving the government a majority of 74.

9<sup>th</sup>-16<sup>th</sup> November 2004 committee sessions.<sup>188</sup> The next step for the bill was to go through the committee stage of the process where governmental bills are further scrutinised before becoming statute.

16<sup>th</sup> December 2004, DCMS issued a press release that set to calm fears over one of the most controversial aspects of the bill which was in the licensing of large casinos, or as they became known throughout the course of this debate Super Casinos.<sup>189</sup> The Conservative Party refused to support the bill until the number of prospective licences for Super Casinos was reduced. During the bills reading in the House of Lords amendments were made to reduce the number of super casino licenses from eight to one<sup>190</sup>

25<sup>th</sup> January 2005, Gambling Act 2005 was published<sup>191</sup>

September 2007 the Gambling act came into full force and replaced The Betting and Gaming Lotteries Act of 1963, The Gambling Act 1968 and the Lotteries and Amusements Act 1976.

1<sup>st</sup> October 2005 the Gambling Commission was established as set out in the Gambling Act 2005 and replaced the work of the now defunct Gaming Board for Great Britain.<sup>192</sup>

March 2006 ***Licensing Authority Policy Statement (First Appointed Day) Order 2006***<sup>193</sup>

March 2006 ***Licensing Authority Policy Statement (England and Wales) Regulations 2006***<sup>194</sup>

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Available: <http://www.parliament.uk/business/committees/committees-archive/jcdqb-rg/>

Accessed 8<sup>th</sup> December 2012

<sup>188</sup> House of Commons, 2004, Gambling Bill in Standing Committee B, Available:

<http://www.publications.parliament.uk/pa/cm200304/cmstand/b/cm gamb.htm> accessed 8th December 2012

<sup>189</sup>Department for Culture, Media & Sport, 16<sup>th</sup> December 2004, *Government Sets Out Cautious Approach To New Casino Regime*, [Online]. Available:

[http://webarchive.nationalarchives.gov.uk/+http://www.culture.gov.uk/global/press\\_notices/archive\\_2004/dcms168\\_04.htm](http://webarchive.nationalarchives.gov.uk/+http://www.culture.gov.uk/global/press_notices/archive_2004/dcms168_04.htm) accessed 7th December 2012.

<sup>190</sup>House of Lords, 12<sup>th</sup> March 2004, *Gambling Bill, Amendments*. [Online]. Available:

[http://webarchive.nationalarchives.gov.uk/+http://www.culture.gov.uk/global/press\\_notices/archive\\_2004/dcms168\\_04.htm](http://webarchive.nationalarchives.gov.uk/+http://www.culture.gov.uk/global/press_notices/archive_2004/dcms168_04.htm) accessed 8th December 2012

<sup>191</sup> The National Archives, *Gambling Act 2005*, Legislation.UK.Gov 25<sup>th</sup> April 2005. [Online]. Available:

<http://www.legislation.gov.uk/ukpga/2005/19/contents> Accessed 19th November 2012

<sup>192</sup> The National Archives, *Gambling Act 2005*, Legislation.UK.Gov 25<sup>th</sup> April 2005. [Online]. Available:

<http://www.legislation.gov.uk/ukpga/2005/19/contents> Accessed 19th November 2012

<sup>193</sup>The National Archives, *Gambling Act 2005, Gambling Act 2005 (Licensing Authority Policy Statement) (First Appointed Day) Order 2006*. Legislation.UK.Gov [Online]. Available:

<http://www.legislation.gov.uk/uksi/2006/637/article/1/made> accessed 19th November 2012.

<sup>194</sup>The National Archives, March 2006, *The Gambling Act 2005 (Licensing Authority Policy Statement) (England and Wales) Regulations 2006*. Legislation.UK.Gov [Online]. Available:

<http://www.legislation.gov.uk/uksi/2006/636/contents/made> accessed 19th November 2012.

March 2006 **Licensing Authority Policy Statement (Scotland) Regulations 2006**<sup>195</sup>  
 July 2007 **Horse Race Totalisator Board Order**<sup>196</sup>  
 July 2007 **Horse Race Betting Levy Order**<sup>197</sup>  
 August 2007 **Advertising of Foreign Gambling Regulations 2007**<sup>198</sup>  
 January 2008 **Advertising of Foreign Gambling (Amendment) (No2) Regulations**  
 June 2012 The Gambling Act 2005 (Amendment of Schedule)

**2.3 Please provide information, in bullet points, on any relevant changes between the first legislation and regulations on gambling control and regulation and the current legislation and regulations. Please include the year(s) of change.**

*Please give your answer in the box below*

The 2005 Gambling Act brought the regulation of gambling under one regulatory body, the Gambling Commission. (with the exception of spread betting, the National Lottery is in the process of becoming regulated by the Gambling Commission) A fragmented regulatory system was regarded of one of the two fundamental flaws in the previous regulatory framework, this sets out to rectify this.

The second fundamental flaw was that the previous regulator had limited and narrow enforcement powers. The current regulation has increased the monitoring and enforcement powers of the regulator in addition to revoking licenses the Gambling Commission can issue warnings, unlimited fines or financial penalties, impose additional licensing conditions.

The Gambling Commission monitors the industry by allowing provision of particular types of gambling and by monitoring who can provide gambling products and services.

The division of regulatory functions at both local and national levels has been a feature of UK gambling regulation since the 1960s.

Casinos, bookmakers and online betting sites will be able to advertise their services on TV and radio in the UK for the first time.

Increased standards required from applicants for licenses to operate gambling have been used to justify multiple gambling products and services operating under one license.

Commercial gambling is largely restricted to premises operating under license this is an attempt to

<sup>195</sup> The National Archive, March 2006, **Licensing Authority Policy Statement (Scotland) Regulations 2006**, Legislation.UK.Gov. [Online]. Available: <http://www.legislation.gov.uk/ssi/2006/154/contents/made> accessed 19th November 2012.

<sup>196</sup> The National Archive, 2007, The Gambling Act 2005 (The Horse Race Totalisator Board) Legislation.UK.Gov. [Online]. Available: <http://www.legislation.gov.uk/uksi/2007/2102/contents/made> accessed 21<sup>st</sup> November 2012.

<sup>197</sup> The National Archive, 2007, The Gambling Act (Horse Racing Betting Levy) Legislation.UK.Gov. [Online]. Available: <http://www.legislation.gov.uk/uksi/2007/2159/contents/made> accessed 21<sup>st</sup> November 2012

<sup>198</sup> The National Archive, 2007, The Gambling Act 2005 (Advertising of Foreign Gambling) Regulation 2007, Legislation.UK.Gov. [Online]. Available: <http://www.legislation.gov.uk/uksi/2007/2329/contents/made> accessed 21<sup>st</sup> December 2012

stop, or at least reduce, causal or ambient gambling.

The tightening of industry standards has been used to justify a more liberal approach to the activities that take place within a licensed venue.

The most fundamental difference between past regulatory regimes and the 2005 Gambling Act is the inherent commitment to stimulating the UK gambling market in order to benefit the UK economy.

The current regulatory system continues to regard crime free, fair and honest gambling and the protection of the young and the vulnerable

The Gambling Commission is expected to allow gambling that is consistent with the act's objectives which are: Preventing gambling from being a source of crime or disorder, ensuring gambling is conducted in a fair and open way; protecting children and vulnerable people from harm.

The development of the Gambling Appeal Tribunal hears appeals from operators unhappy with Gambling Commission regulatory decisions.

The Gambling Act 2005 set out definitions for all of the key terms and concepts in gambling, for the first time giving statutory definitions for key gambling terms and concepts. (eg gambling, lottery, gaming, betting are now defined by statute in UK law)

**2.4 Briefly describe key events and underlying reasons in the process of preparing and adapting the legislation and regulations on gambling control and regulation (chronologically, with accompanying dates).**

*Please give your answer in the box below*

The underlying reason for changes to gambling regulation resultant in the Gambling Act 2005 was to stimulate the market for the benefit of the UK economy. Key events in the development of the new regulation are outlined in 2.2

**2.5 Please identify the five stakeholders who played the most important role in supporting the preparation and enactment of the legislation and regulations on gambling control and regulation.**

- What are their main interests and arguments (see list of possible interests and arguments in annex 2)?
- Please score their influence on a 1-7 scale with regard to political power, financial power, PR power and power based on (scientific) knowledge.

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
Labour Party Government who proposed, developed and implemented the regulation	To stimulate the industry to increase state revenues and to modernise the regulation to take account of technological changes.	7	6	4	5

Sir Alan Budd	Carried out the review on behalf of the government, most of his report's recommendations were enacted in the legislation.	7	1	3	7
Association of British Book Makers	Industry liberalisation and economic gain	5	7	7	6
National Casino Industry Forum	Industry liberalisation and economic gain	5	7	7	6
Betfair	Industry liberalisation and economic gain	5	7	7	6

*Any additional comments, please give your answer in the box below*

It is difficult to measure who were the most dominant stakeholders in the process, therefore a selection of stakeholders have been chosen.

DCMS, Gambling Act 2005, Consultation Responses can be found here.

<http://www.publications.parliament.uk/pa/cm201213/cmselect/cmcmds/421/42114.htm>

**2.6 Please identify the five stakeholders who played the most important role in opposing the preparation and enactment of the legislation and regulations on gambling control and regulation. List their interests and arguments and score their power.**

Stakeholder	Possible interest/arguments	Political power (1-7)	Financial power (1-7)	PR power (1-7)	Knowledge based power (1-7)
Gambling Watch	Independent activist group who oppose the growth and spread of gambling	1	1	1	1
Salvation Army	Religious group who oppose the spread and growth of gambling	1	1	1	1
Quaker Action on Alcohol & Drugs	Religious group who oppose the spread and growth of gambling	1	1	1	1
Methodist Church in Great Britain	Religious group who oppose the spread and growth of gambling	1	1	1	1
Professor Jim Orford, University of Birmingham	Gambling specialist who warned the government at the select committee hearing that liberalising the regulation would lead to increased problematic	1	1	1	7

	gambling.				
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*Any additional comments, please give your answer in the box below*

It is difficult to measure who were the most dominant stakeholders in the process, therefore a selection of stakeholders have been chosen. The UK has a very weak anti-gambling lobby.

**2.7 If international politics or policy have influenced the introduction/adaptation of this legislation or these regulations in your country, please explain.**

*Please give your answer in the box below*

**2.8 If any modifications of the legislation or regulations are expected in the near future, please describe briefly contents and reasons.**

*Please give your answer in the box below*

In May 2011 the law changed in order to collect tax on bets made or games played in the UK.<sup>199</sup> The new tax regime for gambling companies should be fully implemented by 2014. However, large gambling corporations such as William Hill have said that they will mount a legal challenge against the UK government on the basis that the new rules discriminate against companies operating in the UK and constitute a significant trade barrier that is at odds with European law.<sup>200</sup>

**3 In depth information on the implementation of regulating provisions in the legislation or otherwise on gambling control and regulation**

**3.1 What is the level of implementation of gambling control and regulation in your country? Please rate on a scale from 1-7.**

1= not implemented at all; 7=fully implemented in the whole country and all relevant settings.

1	2	3	4	5	6	7
						7

*Any comments on level of implementation, please give your answer in the box below*

5 <sup>199</sup>Jason Gorrige, 27<sup>th</sup> March 2012, UK Confirms Gambling Tax Changes, Tax-News.com, London [Online]. Available: [http://www.tax-news.com/news/UK\\_Confirms\\_Gambling\\_Tax\\_Changes\\_54613.html](http://www.tax-news.com/news/UK_Confirms_Gambling_Tax_Changes_54613.html) accessed 29th December 2012

6 <sup>200</sup>Natalie Thomas, 30<sup>th</sup> July 2012, William Hill prepares to challenge UK online gaming tax, The Telegraph. [Online]. Available: <http://www.telegraph.co.uk/finance/newsbysector/retailandconsumer/leisure/9436762/William-Hill-prepares-to-challenge-UK-online-gaming-tax.html> accessed 3rd January 2013

The implementation of regulating provisions in the UK is complete, however the rules have been considerably liberalized since the 1960s.

**3.2 Please describe factors facilitating the implementation (e.g., public opinion, economic interests, organisational aspects, positive media attention, ...).**

*Please give your answer in the box below*

Corporate lobbying, neoliberal governments, economic globalization.

**3.3 Please describe barriers for the implementation (e.g., public opinion, financial restrictions, housing problems, organisational aspects, negative media attention).**

*Please give your answer in the box below*

There was only one controversial aspect of the regulation the case of the Super Casino, this received a lot of media attention and finally the plans were shelved.<sup>201</sup>

**3.4 In case stakeholders involved in the implementation of gambling control and regulation (see question 2.5 and 2.6) differ from those involved in the preparation and enactment of the legislation, or have another ranking, please comment on that.**

*Please give your answer in the box below*

## **II Contextual information**

Please complete the following questions/tables with the latest data available (with accompanying source). Describe the trend in the data (in terms of decreasing/increasing) over approximately the last ten years.

### **1 General information on country**

**1.1 Area (km<sup>2</sup>) 244,101 Km**

**1.2 Population size: 59,789,194**

### **2 Prevalence of gambling**

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<sup>201</sup>BBC News, 26<sup>th</sup> February 2008, Q&A: Super-casino plan ditched. [Online]. Available: [http://news.bbc.co.uk/1/hi/uk\\_politics/5298682.stm](http://news.bbc.co.uk/1/hi/uk_politics/5298682.stm) accessed 1st February 2013

## 2.1 Prevalence of gambling in the general population (15-64 years)

	Most recent data (%)	Year
Lifetime gambling	n/a	
Last year gambling	73% (35.5 million adults) <sup>202</sup>	2010
Last month gambling	47% (47% men 40% women) <sup>203</sup>	2010

Source: Gambling Commission, British Gambling Prevalence Survey, 2010

<http://www.gamblingcommission.gov.uk/PDF/British%20Gambling%20Prevalence%20Survey%202010.pdf> accessed 3<sup>rd</sup> December 2012.

Please briefly describe the trend in prevalence of gambling during the past ten years.

*Please give your answer in the box below*

There have only been three UK gambling prevalence surveys conducted in the UK, 1999, 2007 and 2010. The figures from 2010 equates to around 35.5 million adults engaging in gambling over the course of a year. This represents a return to rates observed in 1999 (72%) and an increase from the rate observed in 2007 (68%) Overall, 73% of adults aged 16 and over had gambled on one or more activity in the year 2009-2010. The National Lottery Draw was the most popular activity, with 59% of adults purchasing tickets in the past 12 months. The next most popular activities were other lotteries (25%) and scratch cards (24%), followed by betting on horse races (16%), playing slot machines (13%) and private betting (11%). The largest increase in gambling occurred among women, where rates have increased from 65% in 2007 to 71% in 2010.

## 2.2 Influence of gambling prevalence on governance implementation

**Did the prevalence of gambling influence the implementation of the legislation on gambling control and regulation?**

- yes  
\* no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
*						

Please briefly describe the influence of the gambling prevalence on gambling control and regulation.

<sup>202</sup> Gambling Commission, 2010, *British Gambling Prevalence Survey, 2010*, [Online]. Available <http://www.gamblingcommission.gov.uk/PDF/British%20Gambling%20Prevalence%20Survey%202010.pdf> accessed 17<sup>th</sup> December

<sup>203</sup> Gambling Commission, 2010, *British Gambling Prevalence Survey, 2010*, [Online]. Available <http://www.gamblingcommission.gov.uk/PDF/British%20Gambling%20Prevalence%20Survey%202010.pdf> accessed 17<sup>th</sup> December

Please give your answer in the box below

Part of the rationale behind the Gambling Act 2005 was to give consumers more choice and make gambling easier, a ban on advertising gambling on television was lifted too. Therefore it is not the case that the prevalence of problem gambling led to tighter regulations, the rules were relaxed, primarily to stimulate the UK gambling industry and in turn increase state revenues. The liberalisation of the gambling industry was offset by the inclusion of a more powerful regulator.

### 3 Health context

#### 3.1 Number of problem gamblers

	Most recent data	Year
<b>Number of problematic gamblers</b>	<p>According to the British Gambling Prevalence Survey: “Depending on the screen used, the rate for problem gambling in the UK is either 0.7% or 0.9%” *.<sup>204</sup></p> <p>The National Health Service say “There may be as many as 250,000 problem gamblers in the UK”<sup>205</sup></p> <p>The Royal Psychiatric Association estimate that 9 people in every 1000 have a gambling habit that is problematic. With a further 70 people out of every 1000 gamble at risky levels that can become a problem in the future.<sup>206</sup></p>	2010
<b>Number of gamblers in treatment</b>	n/a	

**If possible, use DSM definition. If you use any other definition of problematic gambling, please specify:** \*The British Gambling Prevalence Survey uses two measures, the DSM-IV and the Canadian Problem Gambling Severity Index. Using the DSM-IV screen the percentage of problematic gamblers was found to be 0.9% while the 0.7% figure comes from the PGSI.

#### 3.2 Gambling related morbidity and social loss

##### 3.2.1 If you have any national data on the prevalence of co-morbid psychopathology, on burden of disease (DALY's) or productivity loss, please provide it here.

<sup>204</sup>Gamble Aware, Gambling Facts & figures. [Online]. Available: <http://www.gambleaware.co.uk/gambling-facts-and-figures/> accessed 29<sup>th</sup> January 2013.

<sup>205</sup>NHS Choices, Gambling Addiction. [Online]. Available: <http://www.nhs.uk/Livewell/addiction/Pages/gamblingaddiction.aspx> accessed 29th January 2013

<sup>206</sup>Royal Psychiatric Association, Online Problem Gambling Leaflet. [Online]. Available: <http://www.rcpsych.ac.uk/expertadvice/problems/problemgambling.aspx> accessed 16th January 2013



Please give your answer in the box below

I have not been able to find any data on this,

**3.2.2 Please briefly describe the trend in prevalence of problem gambling and related morbidity in the past ten years stating where possible percentages from or around 2002 onward.**

Please give your answer in the box below

I have not been able to find any data on this

**3.3 Influence of gambling-related health consequences on governance implementation**

Did the gambling related health consequences influence the implementation of state monopoly and licensing?

- yes  
\* no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
*						

Please briefly describe the influence of the health context on gambling control and regulation.

Please give your answer in the box below

The driving force behind current regulation and controls was to stimulate growth in order to gain economic rewards for the industry and in turn the state. Conditions related to health form part of the legislation but did not shape it.

**4 Economical context**

This section focuses on general economical information and data on public spending (direct and indirect) related to gambling. Please provide data as far as available.

**4.1 General economical circumstances**

	Most recent data	Year
Gross national income per capita (PPP international (€ or £))	\$35,840 <sup>207</sup>	2010

<sup>207</sup> Global Health Observatory Support Data Repository Demographic and socioeconomic statistics: Population Available: <http://apps.who.int/gho/data/> accessed 15<sup>th</sup> January 2013

	€26,541.30 £22,785.35	
<b>Total health expenditures per capita (€ or £)</b>	Government Spending \$2918 €2161.01 £1852.86 Total Spending \$3479.56 <sup>208</sup> €2576.59 £2208.97	2010
<b>Total health expenditures as percentage of GDP (€ or £)</b>	9.7% <sup>209</sup>	2010

## 4.2 State expenditures and revenues

**4.2.1 If you have any data on (direct or indirect) expenditures on the health consequences of gambling, or on the expenditure related to crime control related to gambling, please provide them here.**

*Please give your answer in the box below*

According to GAMCARE an industry supported gambling charity, there has been no research into the social costs of gambling in the UK<sup>210</sup>. GAMCARE used research from North America to base their estimate of the cost of gambling in Great Britain at some £3.6 billion per year. Grinols and Mustard (2001) found the average annual social cost per problem gambler of around £8000 pa.<sup>211</sup> GAMCARE use this figure of £8000, and the estimated 450,000 of problem gamblers in the UK to reach this figure. This is a general claim and is not broken down into specific categories, such as crime or health.

There has been little research on the impacts of legal, commercial gambling in Great Britain. Brown and Fisher (1996) and a recent report for the Scottish Executive by Reith and

<sup>208</sup> WHO Global Health Observatory Support Data Repository, Health expenditure: Health expenditure per capita Available: <http://apps.who.int/gho/data/> accessed 15<sup>th</sup> January 2013

<sup>209</sup> Adam Jurd, 2<sup>nd</sup> May 2012, Expenditure on Healthcare in the UK, 1997-2010, Office for National Statistics, Available: [http://www.ons.gov.uk/ons/dcp171766\\_264293.pdf](http://www.ons.gov.uk/ons/dcp171766_264293.pdf)

<sup>210</sup> GAMCARE, 2012, Annual Review and Plan 2012-2015, Available: [http://www.gamcare.org.uk/data/files/ANNUAL\\_REVIEW\\_AND\\_PLAN\\_9\\_NOV.pdf](http://www.gamcare.org.uk/data/files/ANNUAL_REVIEW_AND_PLAN_9_NOV.pdf) accessed 15<sup>th</sup> January 2013

<sup>211</sup> Grinols, E L. and Mustard, DB. 2001. "Business and Social Profitability: Evaluating Industries with Externalities, The Case of the Casino Industry." Managerial and Decision Economics, vol. 22: 143-162.

ScotCen, 2006 are the only UK specific studies located. The Scottish report concluded that: Evidence on the impacts of gambling for the U.K. is 'extremely thin and much of the available material is methodologically weak and open to interpretation' (Reith & ScotCen, 2006, p12); Only limited research has been conducted with sample sizes sufficient to robustly identify problem gambling impacts.

#### 4.2.2 If you have any data on state revenues from taxes on gambling, please provide them here.

*Please give your answer in the box below*

The Gambling Commission estimates that the operators it regulates (all excluding the National Lottery and Spread Betting) generated around £6 billion in gross gambling yield (stakes less winnings paid out) in 2009/10. Around £1.5 billion is paid in gambling taxes to the Government each year.<sup>212</sup>

#### 4.3 Gambling industry

If you have any data on the turnover in the gambling industry (in Euros), please provide them here.

*Please give your answer in the box below*

UK Casinos & Gaming Sector Value 2011<sup>213</sup>

\$14.3 billion      £8.9 billion      €13.9 billion

##### **Breakdown**

Sports & Related Betting 38.2%

Lotteries 35.5%

Casinos 8.6%

Other 17.6%

\*Other includes: Bingo, Slot machines located outside casinos, Pachinko etc.

#### 4.4 Economical context influencing implementation of measures on gambling control and regulation.

#### 4.5 Did the economical context (e.g. the economic crisis) influence the implementation of measures on gambling control and regulation?

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<sup>212</sup> GambleAware, Facts & figures, Available: <http://www.gambleaware.co.uk/gambling-facts-and-figures/> accessed 3<sup>rd</sup> December 2012

<sup>213</sup> MarketLine Industry Profiles, 19<sup>th</sup> of September 2011 UK Casino & Gaming Available <http://advantage.marketline.com.ezp2.bath.ac.uk/Product?pid=MLIP0740-0016> [Subscription required] accessed 29<sup>th</sup> December 2012

- yes
- \* no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
*						

Please briefly describe the influence of the economical context on gambling control and regulation:  
*Please give your answer in the box below*

UK gambling control and regulation came into force in 2005 before the current economic crisis and therefore this did not have an impact. The driving force behind the regulation was to stimulate the gambling industry for economic gain for the sector and the state through taxation.

**5. Political context**

**Did the political context influence the implementation of gambling control and regulation?**

- yes
- no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7

Please briefly describe the influence of the political context on gambling control and regulation.

*Please give your answer in the box below*

There was broad cross party support for liberalizing gambling regulation in the UK, and little opposition from stakeholders and the public.

**6. Historical/Socio-cultural context**

Did the historical/socio-cultural context influence the implementation of gambling control and regulation?

- \* yes
- no

If yes, rate it on a scale from 1-7 (1 = no influence, 7 = maximum influence).

1	2	3	4	5	6	7
				*		

Please briefly describe the influence of the historical/socio-cultural context on gambling control and regulation.

*Please give your answer in the box below*

Stimulating the UK's gambling industry was the main reason for the current regulatory framework, although technological advances and the advent of online gambling were also factors in the regulatory changes. The UK retains a mixture of licensing and monitoring in the current framework, an approach evident throughout the history of UK gambling regulation.

### **III. Key publications**

Please include a list of key publications used to complete this report.

Please also add the full references of the sources you have used. In case you have included expert opinions please provide the name of the experts as well as the date and source of communication (e.g. personal communication).

*Please list the publications in the box below*

Footnoted throughout



## Appendix 9: Logical framework matrixes (LogFrame)

(Source: Trautmann and Braam 2009)

A LogFrame Matrix is used to plan, monitor and evaluate a project or programme. The LogFrame is a tool, which helps to organize, coordinate and perform activities in a project or programme. The LogFrame is constructed on four levels: overall objectives, specific objectives, results and activities.

The highest level is the **overall objective**. Overall objectives describe the general goals of the programme: e.g. improving the health situation of a target group that is not reached by social and health services.

This overall objective can be broken up in a number of **project purposes**. Specific objectives might be used to enlarge the reach of a service among the target group, to reduce unhealthy behaviour in the target group, to train staff to reach the target group, etc.

The specific objectives can be translated in **results** of the project or programme, e.g. the concrete outputs or improvements to be achieved, e.g. that more individuals from the target group make use of social and health services, that less health problems (e.g. HIV infection) occur among the target group and that staff is sufficiently trained to reach the target group.

Finally, to achieve these results **activities** have to be undertaken that are appropriate to achieve these results. This could be e.g. outreach work or peer support. Other activities might be training of peers and outreach workers.

For each of the four levels there is a separate row in the LogFrame.

	<b>Intervention Logic</b>	<b>Objectively verifiable indicators of achievement</b>	<b>Sources and means of verification</b>	<b>Assumptions</b>
<b>Overall objectives</b>	What is the overall broader objective to which the project will contribute?	What are the key indicators related to the overall objective?	What are the sources of information for these indicators?	
<b>Project Purpose</b>	What are the specific objectives which the project shall achieve?	What are the quantitative or qualitative indicators showing whether and to what extent the project's specific objectives are achieved?	What are the sources of information that exist or can be collected? What are the methods required to get this information?	What are the factors and conditions not under the direct control of the project which are necessary to achieve these objectives? What risks have to be considered?
<b>Expected Results</b>	What are the concrete outputs envisaged to	What are the indicators to measure	What are the sources of information for	What external factors and conditions must

	achieve the specific objectives? What are the envisaged effects and benefits of the project? What improvements and changes will be produced by the project?	whether and to what extent the project achieves the envisaged results and effects?	these indicators?	be realised to obtain the expected outputs and results on schedule?
<b>Activities</b>	What are the key activities to be carried out and in what sequence in order to produce the expected results?	Means: What are the means required to implement these activities, eg personnel, equipment, training, studies, supplies, operational facilities, etc	What are the sources of information about project progress?	What preconditions are required before the project starts? What conditions outside of the project's direct control have to be present for the implementation of the planned activities?

(source: The European Commission's Delegation to India, Bhutan, Nepal and the Maldives  
[http://www.delind.cec.eu.int/en/csn/civil\\_society/eccp/eccp-logical\\_framework.xls](http://www.delind.cec.eu.int/en/csn/civil_society/eccp/eccp-logical_framework.xls))

Each LogFrame has four columns. In the first columns you find the **intervention logic**, i.e. descriptions of the overall objective, specific objectives, results and activities.

In the second columns you define **(objectively verifiable) indicators** for the objectives, results and activities. What are key indicators for the overall objective; what are SMART (Specific, Measurable, Appropriate, Realistic and Timely) indicators measuring the realisation of the specific objectives; what are SMART indicators measuring the achievement of the envisaged results; what are the means required to implement the activities (human resources, equipment, training, etc.).

**Sources and means of verification** clearly specify the means and the sources of information that tells us something about the indicator. We need to consider what information has to be collected, how it will / can be collected (method), who will be responsible and the frequency with which the information should be provided.

**Assumptions** refer to **risk factors** (what might prevent objectives from being achieved) **and supportive factors** (conditions that must be met or are helpful in order for project objectives to be achieved).