6. Western and Central Europe: towards a cohesive model for drug policies?

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INTRODUCTION

Just as the geography of Europe is disputed, so is its social and cultural identity. Shaped by a dense history, European states share a centuries-old institutional heritage. They have been engaged since the Second World War in a powerful process of political integration. And yet European nations remain diverse, with linguistic and cultural differences so entrenched that it is sometimes said that this very diversity is the first characteristic of "European civilization" (Wintle, 1997). This observation also applies to drug policy.

From the creation of European maritime empires which turned many psychoactive substances into global commodities in the seventeenth and eighteenth centuries (Mills & Barton, 2007) to the great historical about-face which precipitated the shift in priorities of Western political elites from the promotion of intoxicants to their partial prohibition, European states share a common history as a drug "distribution engine" (Courtwright, 2001, 53). They then contributed to the establishment of a global drug control regime which they are still unanimously implementing. And they now often speak with one voice when the drug issue is debated in international arenas, especially at the United Nations (UN), most often to champion human rights, prevention and treatment.

Yet, in spite of this political proximity, drug problems and drug policies are far from identical in European states. Against many indicators, diversity seems to prevail over similarity. Countries such as Portugal and the Czech Republic pioneered the decriminalization of drugs, while for many years in some parts of the Netherlands authorities have permitted the sale of cannabis via prosecutorial discretion and the "coffee shop" system. At the same time and to varying degrees, countries such as France, the UK and Hungary have focused their response on the criminalization of people who use drugs.

In order to account for this dialectic of diversity and unity in the field of drug policy, this chapter provides an overview of the drug issue and of the governance structure of drug policies in Europe. First, we review the latest available figures on the prevalence of illicit drug use and the state of national markets which show that Europe is not only a land of consumption and trafficking but also of production and exportation. We then demonstrate how the continental integration process and the rise of subnational actors, especially cities, has challenged the centrality of European states and led to the development of multilevel governance in the design of drug policies. Finally, we identify a cultural model of drug policy that favours treatment and reintegration of users rather than deprivation of their liberty. This model, in which harm reduction plays an important role, is now dominant in Europe even though variation between states still exists with regard to legal penalties and sentencing practices that punish drug offences. Our argument also turns the spotlight on various legal instruments, be they transnational, such as the European Union (EU) response to new psychoactive substances, or national, such as the

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Portuguese decriminalization experience which demonstrate that Europe is a place of innovation in the field of drug policy.

THE BALKANS, AT THE MARGINS OF EUROPE?

While the boundaries of Europe are still to be determined, the Balkan Peninsula (sometimes called Southeast Europe) is clearly part of this geographical unit. Several of its states (Bulgaria, Croatia, Greece, Slovenia) belong to the EU and all others are, officially or not, candidates to the club.

Because of their position, between opiate-producing countries in the East and lucrative markets in the West, these states have long served as a drug-trafficking corridor known as the Balkans route. In the hands of organized crime, this channel reached a new dimension following the collapse of the Soviet empire and the Yugoslavian state (Glenny, 2008). Seizures of heroin at key stages of the route show that the region remains a transit region. Moreover, cultivation of cannabis in Albania has turned this country into a large-scale exporter to many neighbouring countries (UNODC, 2014). In spite of the visible availability of drugs, the frequency of drug use in the general population is comparable with the situation in other European states (EMCDDA, 2015a) with prevalence lower for some substances (e.g. heroin) and higher for others (e.g. cocaine).

The Balkan history of drug trafficking explains harsh local legislation which often punishes drug supply with mandatory minimum sentences (EMCDDA, 2014). Over the last decade, international cooperation within the Balkan Peninsula and between the EU and the Balkan countries that are candidates to the EU have increased. New multilateral instruments have been established to promote transnational law enforcement and to establish drug monitoring systems. It remains to be seen what results will be brought about on the ground by these institutional developments although one can reasonably expect growing legal convergence with the rest of European countries under the auspices of EU "soft power".

DRUG USE AND THE DRUG MARKET IN EUROPE

The dark (or hidden) figure of drug offences makes it very difficult to adduce presumptive numbers regarding illicit drug use and drug trafficking. The gap between reported and unreported crimes exists for all violations but it is thought to be higher for drug offences. However harmful these crimes are for society, they are often victimless acts involving consenting parties and, as a result, they are rarely reported to the authorities. Official statistics exist, though, based on large-scale surveys and analysis of wastewater (EMCDDA, 2016a), and they provide rough estimates of the level of drug use in Europe. Mapping out the European drug market is even more difficult, as its size and structure can only be indirectly inferred from the estimate of drug users or derived from law enforcement agencies statistics (EMCDDA, 2016b). Observation is all the more complicated, as drug-trafficking patterns quickly change under the influence of globalization, technological changes and the development of the internet as a commercial medium. In addition to figures provided by national administrations, European data are gathered, analysed and synthetized in various reports by the European Monitoring Center for

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Drugs and Drug Addiction (EMCDDA).[1] In spite of the methodological limits of all measures of crime and the specific institutional constraints influencing EU agencies, the EMCDDA has succeeded in producing knowledge and information considered to be reliable and legitimate in the institutional field of drug policy research (Bergeron, 2017). The following will accordingly rely on these findings to describe what is commonly known about the drug issue in Europe.

Drug Use Prevalence

In 2018 more than 92 million individuals aged 15 to 64 (over a quarter of the population in the EU) are estimated to have tried illicit drugs during their lives.[2] Young adults (aged 15–34) constitute a high portion of this number, especially with respect to recent drug use, as an estimated 18.9 million of them have used drugs in the last year. Poly-drug consumption is not rare and the number of substances in use has increased in the last decade.

Unsurprisingly, cannabis is the most common illicit drug, an estimated 87.6 million have tried it during their lives. More than 14 per cent of young adults have used cannabis in the last year and it is estimated that around 1 per cent of the European population are daily, or almost daily, users. These high rates of prevalence, which have slowly increased over the last decade, confirm the thesis of the normalization of cannabis in Europe; the recreational use of this drug has gradually been integrated into the lifestyles of an ever-larger part of the population (Pennay & Measham, 2016). This observation must nevertheless be qualified because great geographic diversity remains across the continent (e.g. while last year prevalence rates among 15- to 34-year-olds reached 21.5 per cent in France, it remained below 4 per cent in Hungary) and decreasing trends can be observed in a few countries (e.g. Denmark). This normalization is accompanied by an increasing trend in high-risk cannabis use (EMCDDA, 2015b) revealed by a larger number of individuals entering treatment for cannabis problems (more than 150 000 in 2016).

Compared to cannabis, other illicit drugs affect a more limited number of persons. Cocaine, the second most popular illicit drug used in Europe, has been tried by around 17.0 million European adults (aged 15–64), or 5.1 per cent of this age group, during their lives. Among young adults (aged 15–34) use prevalence last year reached 1.9 per cent, with higher figures in Southern and Western Europe. Although cocaine use appears stable over the last decade, a recent increase in high-risk use can be surmised from the growing number of socially well-integrated users entering specialized treatment for problems related to cocaine use. A number of other illicit psychotropic substances are used in Europe. MDMA, amphetamine and methamphetamine use, although recurrent, shows great disparity with methamphetamine consumption largely restricted to the Czech Republic and Slovakia. Ketamine, GHB, natural or synthetic hallucinogens and new psychoactive substance (NPS) use is also found. Although consumed both by recreational and chronic and marginalized drug users, their overall prevalence levels have been generally low.

The same can be said of opioid use, which remains relatively rare in Europe. Opioid use is nonetheless a major drug issue in Europe; the low prevalence rate, estimated at 0.4 per cent of the EU adult population (around 1.3 million users), should not divert attention from the high

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[1] See http://www.emcdda.europa.eu

[2] Unless mentioned otherwise, the data provided in the following development comes from Chapter 2 of the EMCDDA (2018a) *European Drug Report*.

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number of problematic heroin users (in contrast to other substances, there are few occasional users of heroin). Although heroin remains the most commonly used illicit opioid, licit synthetic opioids (such as methadone, buprenorphine and fentanyl) are now increasingly misused across the continent. Unsurprisingly, opioid use is the main reason for entering specialized drug treatment in Europe. Following the two main waves of heroin addiction in the mid-1970s and in the mid- to late-1990s, opioids remain associated with the more harmful practice of injection and account for much of the morbidity and mortality related to drug use. In spite of these developments, and the existence of an ageing population of problematic poly-drug users (which seems to be here to stay) the spectre of a US-like crisis has been kept at bay for now.

The Drug Market

Long considered a land of drug consumption importing from southern countries, Europe remains a major market for the consumption of illicit drugs produced abroad and smuggled in through a variety of channels. But it has also become an area of production, as evidenced by the shutdown of synthetic drug laboratories and cannabis growing facilities. Keeping in mind the persistence of important knowledge gaps and underreporting risks, it is estimated that the EU retail drug market was worth at least €24 billion (range €21 to 31 billion) in 2013.[3] The organizations involved in this market range from lone individuals or small-scale groups often involved in "social supply" to large profit-oriented criminal organizations. While it is common for organized crime groups to diversify with multiple drugs, the market segmentation allows for a sectoral analysis based on substances.

The cannabis retail market is the biggest in the European illicit drug market. It is estimated at over €9 billion, just under two-fifths of the total illicit market in drugs. Europe has for many years imported Moroccan and Afghan cannabis resin, but police seizures also suggest the importation of marginal volumes of cannabis herb from Africa and America. More recently Europe has become a herbal cannabis zone of production. In the last 15 years, domestic production – be it small-scale cultivation or major plantations – has developed and partly displaced imported resin in some countries (EMCDDA, 2012; EMCDDA, 2017a). This shift goes hand in hand with the increased potency of herbal products in recent years due to sophisticated production techniques and the production of new strains of hybrid cannabis. Given the sheer scale of the market, organized crime has come to play a major role in cannabis trafficking in Europe alongside small "social suppliers" with no mercantile intent. Key players include Moroccan, Dutch, Vietnamese and Albanian-speaking groups which run cannabis plantations, supply equipment and know-how across borders, and smuggle cannabis into and within the EU. Despite the Europeanization of the cannabis trade by transnational criminal groups, retail markets remain segmented along national borders. This diversity, which appears dependent on legislative differences and the varying degree of tolerance towards cannabis, is reflected in the level of market overlap between cannabis and other drugs.[4]

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[3] Unless mentioned otherwise, the following data comes from the EMCDDA and Europol joint publication, *EU Drug Markets Report: In-depth Analysis* (EMCDDA/Europol, 2016).

[4] It might be that the greater the tolerance towards small-scale cannabis trade and cannabis social clubs, the more specialized the cannabis market … and the less the overlap between the various drug markets (EMCDDA/Europol, 2016, 69).

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Compared to the cannabis market, which is partly supplied by local production, most opioids consumed in Europe are manufactured from opium production in South-west Asia, principally Afghanistan, and smuggled to Europe, especially through Turkey and the Balkans. Heroin predominates in this market, estimated to be worth over €6.8 billion annually (the second largest retail drug market in Europe), but the opioid market has grown with substitution medicines and new synthetic opioids now available to consumers. Like heroin, the cultivation of coca and the production of cocaine occur almost exclusively outside Europe. The drug is produced in South America then transported by sea and air to Europe following various trafficking routes, via Colombia, Brazil, Venezuela, the Caribbean and West Africa. Feeding an estimated €5 billion retail market, almost one-quarter of the total illicit market in drugs, this profitable industry appears to be in the hands of highly innovative criminal groups using sophisticated techniques and corruption to secure the entire transportation chain from America to Europe. Interacting with the cocaine market, synthetic stimulants (amphetamine, methamphetamine and MDMA) are for the most part produced in Europe, mainly Benelux and central Europe (EMCDDA, 2015c). This production, which fuels a European market estimated at around €2 billion, is also partly exported to the Americas and Australia. In addition to these well-known synthetic drugs, a market for new psychoactive substances is currently developing, as evidenced by seizure data from law enforcement agencies. The increased commodification in the NPS market is revealed in the cat and mouse game whereby drug control legislation is circumvented by the synthesizing of new substances such as synthetic cannabinoids. These new drugs, often manufactured in China then shipped to Europe, are easily available through the web as well as in "bricks-and-mortar" shops making the most of regulatory framework deficiencies.

MULTILEVEL GOVERNANCE OF DRUG POLICY IN EUROPE

Confronting the drug issue in Europe has long been seen as a task to be performed at the national level under the auspices of the international drug control regime, the establishment of which most European states have contributed to. During most of the twentieth century, European states abided by their expanding obligations to restrict the production, trade and use of psychoactive substances with no regard for each other's internal strategies. Since the 1970s, though, the accelerated deepening of the integration process of the continent has resulted in the development of a distinct transnational European drug policy on top of national policies (Colson & Bergeron, 2017). Simultaneously, the last decades have seen the rise of subnational actors, especially cities, in the design of local responses to drug issues. This relative erosion of the state has weakened the dichotomy between domestic and international politics traditionally used to explain the policy-making process in drug policy. As European political systems seem characterized both by increased unity and increased fragmentation, multilevel governance (Bache, 2012) offers an appropriate analytical framework to better understand the dynamics at play and discuss the existence of European convergence in the field of drug policy (Chatwin, 2011, 149–164). This necessitates the identification of three distinct territorial tiers: transnational, national and subnational.

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Transnational European Drug Policy

Though framed as an international necessity from the negotiation of the first opium conventions, drug control was hardly a subject of regional cooperation in Europe before the 1970s. It was only when the threat of a "drug epidemic" developed in the late 1960s that an intergovernmental "co-operation group to combat drug abuse and illicit trafficking in drugs" was set up in 1971 to allow European states to share their experience and knowledge in the field of drug abuse and drug trafficking (Nagler, 1987). This group (named after its instigator, the French President Pompidou) now includes 38 states.[5] Although still active, it has suffered from competition with the EU, now the major actor of transnational drug policy in the region.

The development of political interest in the drug issue beginning in the 1980s, in what was then the European Community (EC), is demonstrated by a variety of European Parliament resolutions and reports. The creation, in 1989, of the European Committee to Combat Drugs (CELAD), an *ad hoc* political committee established by the European Council to coordinate drug-related activities within the EC, gave drugs a more prominent place on the European political agenda (Estievenart, 1995). With drug-related matters formally added to the area of competence of the EU in 1991 (Maastricht Treaty), an EU drug policy slowly came into being. Such a development is in line with a general constitutional evolution transforming the EU into a guarantor of the security and health of the nationals of the Member States. In its latest version (2009) the Treaty on the functioning of the EU explicitly provides regulatory powers to fight "illicit drug trafficking" (Art. 83(1)) and reduce "drugs-related health damage" (Art. 168 (1)).

The dynamics of European decision-making on drugs are complex. Beyond the objective of tackling drug trafficking – a criminal activity which might benefit from the abolition of internal borders within an integrated union – the need to respond to European public opinion anxious about drug-related crime and addiction motivated European politicians to take action (Boekhout Van Solinge, 2002, 80–90). With a view to promoting research and facilitating scientific based decision-making, the institutionalization of an EU drug policy included the establishment of a European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Once set in motion by the European Council, the Council and the Commission produced a number of policy documents promoting harmonization between Member States. Three "strategies" were successively adopted by the European Council[6] presenting a comprehensive approach linking drug supply reduction, drug demand reduction, and European coordination and international cooperation.

The EU has rarely resorted to binding legal instruments to bring Member States' drug laws closer in line (for example, by laying down minimum penalties in the field of illicit drug trafficking[7] or by requiring the ban of specific NPS at the EU level[8]). Indeed, much of European

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5 See https://www.coe.int/en/web/pompidou

6 The last one was issued in 2012: European Council (2012) *EU Drugs Strategy (2013–20)*. Official Journal of the European Union C 402/1, 29.12.2012, 1–10.

7 Council Framework Decision 2004/757/JHA of 25 October 2004 laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking. Official Journal of the European Union L 335, 11.11.2004, 8–11

8 Directive (EU) 2017/2103 of the European Parliament and of the Council of 15 November 2017 amending Council Framework Decision 2004/757/JHA in order to include new psychoactive substances in the definition of "drug" and repealing Council Decision 2005/387/JHA. Official Journal of the European Union L 305, 21.11.2017, 12–18.

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harmonization of domestic policies has been brought about through the constitution of transnational networks of domestic experts and the development of "soft law" such as the formulation of resolutions, recommendations, guidelines and action plans. There is some evidence that this institutional mix has brought about policy convergence among the Member States and even beyond, in neighbouring countries who are candidates to join the EU or associated in one way or another with the EMCDDA (Bergeron, 2011). Nevertheless, national specificities still prevail in institutional responses to the drug issue in Europe.

EU RESPONSE TO NPS

The EU response to NPS offers a good example of the way the EU used drug policy to develop the European integrationist project. Soon after the EU was given new powers to combat drug addiction and drug trafficking (Maastricht Treaty in 1993), designer drugs started to find an established user-base on the recreational drug scene (King, 2011). Combined with the scarcity of data available on the subject, this made these new substances an ideal object of regulation for applying new European competencies (Colson, 2017).

In a European Joint Action adopted in 1997 and a 2005 Council Decision (2005/387/JHA), the EU targeted synthetic drugs with "limited therapeutic values" not listed in the UN Drug Conventions but which nonetheless pose a "serious threat to public health". It established a three-step process encompassing: (1) a rapid information exchange on NPS (the so-called early warning system) involving Member States and several EU agencies; (2) a risk assessment by a scientific committee set up at the European level, and (3) a decision-making process led by the European Commission and the Council to bring NPS substances under a pan-European ban. Ultimately, once the European procedure is complete, Member States have the obligation to submit the new substance identified by the Council to control measures and criminal penalties as provided for under their national legislation, by virtue of their international commitment to the international drug control regime (Art. 9).

Since NPS made their way to the top of the EU drug policy agenda, the number of substances identified as well as monitored by the EU has continued to increase, reaching almost 100 new substances in 2015 (570 substances from 2005 to 2015). Compared to this figure, the number of risk assessments remained low. This discrepancy led to the amendment of the Council decision[9] to allow for a swifter legal response. The limits of the framework established by the EU is further provided by a comparative perspective on Member States' domestic law (EMCDDA, 2015e). National governments have developed different legal responses to NPS. While some countries have used consumer safety or legislation on medicines to outlaw the distribution of NPS, others have extended and adapted existing drug laws to include new substances, while a third group has devised new legislation to specifically tackle NPS. Member States' laws in the field of NPS remain diverse in spite of the EU's effort to provide a common framework to deal with the problem.

[9] Regulation (EU) 2017/2101 of the European Parliament and of the Council of 15 November 2017 amending Regulation (EC) No 1920/2006 as regards information exchange on, and an early warning system and risk assessment procedure for, new psychoactive substances. Official Journal of the European Union L 305, 21.11.2017, 1–7.

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National European Drug Policies

In spite of an obligation to abide by the global prohibition regime and a shared commitment to EU policies, each European state has developed their own way of dealing with drug use and drug trafficking (Boekhout Van Solinge, 2004, esp. Ch. 6). Within the international drug control framework, textual ambiguity allows states some leeway in the implementation of global prohibition. EU action, meanwhile, remains limited in scope and power. On the one hand, illicit drugs remain an area where subsidiarity reigns supreme and the autonomy of Member States is prioritized, except when the objectives of the proposed action are not sufficiently achievable at the national level. On the other hand, when specific measures are eventually adopted by the EU, they either bring limited added value compared to international law (Kert & Lehner, 2013), or belong to the realm of soft law and appear toothless. In spite of their dual commitment to UN drug control conventions and EU instruments, European domestic drug policies are varied: while some states faithfully implement the prohibitive norm at the regime's core, others have been engaging in "soft defection" for many years (Bewley-Taylor, 2012).

The range of European drug policy models is often highlighted by reference to the Swedish and the Dutch examples, two countries at either ends of a continuum from a very punitive form of drug prohibition to the most tolerant (Chatwin, 2016). But there is more to European diversity than coffee shops in the Netherlands and a Swedish policy of zero tolerance. And any attempt to describe European drug policies by reference to a scale of punitiveness falls short of conveying the complexity of the matter.

When it comes to developing policy responses the extent of the drugs problem itself seems to be less of an influence than institutional and political determinants among which are: political values, a particular notion of citizenship, the organization of a given political system, specific legal and administrative traditions and stable institutional power balances, the role of expertise and the weight of science in shaping/framing public policy, degrees of independence and involvement of the medical profession and pharmacists, and the access of social movements to the locus of public power and the legitimacy of these actions. Many studies claim that the particularities of national public policies are due primarily to such singularities, which, in the last analysis, reflect cultural habitus. Thus, for example, neither the French nexus between a strongly institutionalized harm-reduction model and an enduring repressive legal framework (Obradovic, 2017), nor the Italian to-ing and fro-ing from decriminalization to harsh punishment of drug use (Zuffa, 2017) can be explained without taking account of their respective political histories and cultural idiosyncrasies. The process of drug policy reform is always heavily influenced by local constitutional features: Switzerland's early innovations in harm reduction owe much to the country's federal structure and dispersion of powers (Zobel, 2017). While common historical patterns can be highlighted in the policies and policy instruments used across Europe (e.g. the laws passed against drug use and sale in the 1920s, then again in the 1970s, and those passed in the 1980s and 1990s in response to the HIV/AIDS epidemic) (Berridge, 1996), national case-studies have drawn attention to the formal diversity of these relatively synchronous policy responses and to the influence of individual contributions in the shaping of these responses. National drug policy trajectories are not only determined by cultural legacies but also by prominent public figures (be they civic leaders, public health professionals or academics), as demonstrated by the liberal Portuguese reforms (Hughes, 2017) and the more conservative Polish example (Malinowska, 2017).

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DECRIMINALIZATION: THE PORTUGUESE EXPERIENCE

Portuguese drug policy has attracted significant attention in the media and the international arena. In an early departure from a traditional repressive model, Portugal decriminalized drug use at the beginning of the twentieth century. Characterized by a generally low level of illicit drug use yet a high degree of problematic heroin use, the late 1990s offered a window of opportunity for this reform. In a post-dictatorship constitutional context which placed a strong emphasis on human rights, the increased visibility of the drug problem created an agenda-setting opportunity for reform. Vocal advocates among criminal justice officials and within the health sector challenged the benefits of criminalization. National expert bodies highlighted systemic flaws in Portuguese drug policy: they questioned the abstinence model and argued in favour of prevention and harm reduction. These recommendations were widely discussed and eventually implemented in full (Hughes, 2017).

Under Portuguese law 30/2000 the possession of any illicit drug for personal use remains illegal. However, the status of this act has been downgraded from a criminal offence to an administrative one dealt with under an administrative procedure. According to the new law, any person caught in possession of no more than ten daily doses of drugs (an amount which had been established in a previous regulation) will have their drugs seized and will be reported to a regional Commission for the Dissuasion of Drug Abuse (CDT). In theory, users found in possession of more than ten daily doses can still be prosecuted in a criminal court for a criminal offence but in practice most people convicted under Portuguese drug law are traffickers.

The CDTs assess drug users arrested by the police. Composed of a legal expert, a health professional and a social worker, these commissions explore the pattern of drug use of the referred offenders. In order to treat addiction, the CDTs determine the most appropriate interventions, which include warnings, bans on going to certain places or meeting certain people, obligations to undergo drug treatment, removal of professional licence, community service, fines … The vast majority of CDT rulings are suspended sentences for non-addicted users and provisional suspensions with an agreement to undergo treatment for addicted users. In addition to this legal response, Portuguese drug policy includes harm-reduction interventions such as drop-in centres and shelters for addicts, mobile centres for the prevention of infectious diseases, low threshold substitution programmes, syringe exchange schemes …

Subnational European Drug Policies

In European countries, the definition of a drug policy in line with international and EU requirements lies essentially with the national government. In the last three decades, though, local authorities have taken control over various aspects of the public response to drug issues. In this respect, cities have become more autonomous political actors. Observed in many domains, even in unitary states such as France and the UK, the discharge of legally regulated tasks by local decentralized public bodies has notably occurred in the field of health and social services, and police interventions. Cities have often been overshadowed in the analysis of drug policies focused at a higher level. Yet it is precisely at the local level, in big metropolises such as

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Frankfurt, Glasgow, Barcelona, Marseilles or Zurich, that new strategies to address the drug problem have often been designed (EMCDDA, 2015d).

It is not surprising that cities have become kingpins of innovation in drug policy. More than two-thirds of the European population live in urban areas, which are usually at the forefront of social and cultural shifts, including changes in the use of psychoactive substances. Large metropoles display structural features likely to increase both recreational and problematic consumption as well as drug trafficking (e.g. transportation hubs, large nightlife areas, deprived neighbourhoods). This, in turn, can sometimes create a strong pull-effect on drug users living on the outskirts of a city. This process was observed in the 1980s when open drug scenes of sometimes hundreds of users multiplied in European cities. Born out of the concentration of drug users around harm-reduction services, these open scenes dramatically confronted citizens with drug use and drug dealing (see, 20 years apart, Bless et al., 1995, and Waal et al., 2014).

The increased visibility of the health and social risks – especially public disorder – associated with drug use contributed heavily to the development of drug policies in many municipalities. Formulated under the control of city constituencies, these policies are influenced by local administrative authorities (e.g. health and social services, public order agencies) as well as various activist groups. Local non-governmental organizations (NGOs) operating on the front line of harm reduction have often pushed for new measures to be implemented (e.g. low threshold shelters, needle and syringe exchanges, drug consumption facilities). This type of advocacy, in turn, has often met with opposition from local communities opposed to the creation of such facilities. To smooth these antagonisms, city governments have often proved able to develop coordination schemes between key local actors and to address drug-related problems with a policy "mix", where repressive elements are included in social work, and elements of care are included in police operations (Kübler & Wälti, 2001).

Local tensions between different visions of the drug issue (i.e. public health v. public order) reflect divergences that also characterize drugs policies at the national and international political level. Urban experimentation has allowed for the pacification of ideological conflicts between voluntary sectors and local communities in favour of a more pragmatic approach. This collective learning process has subsequently contributed to shaping transnational and domestic policies according to a "bottom up" approach as cities came together to establish cooperative networks[10] in order to exchange political agendas and promote good practices (ECDP, 2001). A good example of this can be found in the European Cities on Drug Policy (ECDP), a pro-harm-reduction platform led by civic leaders from the cities of Amsterdam, Frankfurt, Merseyside and Zurich. Created in the early 1990s, this platform highlighted the limits of existing policies and contributed to the definition of a pan-European model of drug policy.

[10] Thus, concurring city networks which promoted opposing approaches in urban drug policies were created in the 1990s: the liberal European Cities on Drug Policy (ECDP) on the one hand and, on the other hand, the more conservative European Cities Against Drugs (ECAD), still active online.

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A EUROPEAN CULTURAL MODEL FOR DRUG POLICY[11]

Although variation exists between European states regarding legal penalties and the sentencing practices to punish drug supply (EMCDDA, 2017c), reaching a binding agreement on the legitimacy of harsh repression for drug-trafficking or drug-money-laundering has proved relatively easy within the EU framework. By contrast, legal and political attitudes towards simple using and harm reduction have long remained more conflictual. For almost three decades a policy discourse and a legal attitude that favour treating and reintegrating users rather than depriving them of their liberty has been developing at the European level. There are strong signs that a cultural model for drug policy is emerging with enough cohesion to be able to claim that the EU and European states (including non-EU Member States) have reached shared positions on legal practices towards "simple" drug users (i.e. use without intention of distributing or selling) and the political acceptability of harm-reduction measures. This culturally distinctive model is reflected in policy discourse and actual policies distinct from those in other geographical regions. It provides a shared matrix for conceiving and reflecting on the problems of drug use *and* developing solutions oriented towards alternatives to coercive sanctions and harm reduction.

Alternatives to Coercive Sanctions

Modes for dealing with the legal offence of using substances classified as narcotics or, in countries that do not punish use, possession of such substances for personal use, has long varied greatly between European states (EMCDDA, 2005; Derks et al., 1999). This fact reveals the substantial nature of national juridical traditions (EMCDDA, 2009; and more generally Newburn & Sparks, 2004). However, it is not incompatible with the observation that a number of recent currents, likewise quite diverse but nonetheless comparable, attest to a general tendency to see use as an offence which should no longer be punished by a prison sentence, or at least should only be thus punished as infrequently as possible, with the complementary understanding that treatment and reintegration measures are to be preferred (EMCDDA, 2015f). In Spain (from 1991), Italy (from 1992), Portugal (from 2001) and the Czech Republic (from 1999) for all narcotics, and in Belgium (from 2003), Ireland (from as early as 1977), and Luxembourg (from 2001) for cannabis only, the legal measures applied for the offence of use (or possession of small quantities for personal use) involve very little in the way of deprivation of freedom if there are no aggravating circumstances or if the accused/user is not a repeat offender. The laws provide for punishment of these offences with a vast range of other sanctions instead: warnings, fines, driving licence suspension or, for foreigners, cancellation/suspension of residence permit (Italy). Other countries (Austria [law passed in 1998], Germany [in 1994 and 1998], France [in 1999 and 2019], Denmark [1992], and Hungary [2003] and the UK [2004]) have chosen to pass or amend laws in order either to restrict the possibility of incarceration to particular, strictly defined situations or to give "greater evaluating power" to the public authorities (EMCDDA, 2005) in decisions of whether or not to punish; the point being to avoid punishing drug use by prison sentences.

[11] These developments draw upon Bergeron (2011).

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It cannot be inferred from these changes in legal dispositions that there is no longer the will to control simple use in any EU country. The principle of prohibiting simple use or possession of small quantities for personal use has in no way been called into question in most European states. On the contrary, there are still countries where users can be given prison sentences (and some are). Moreover, the new arrangements have not been stabilized everywhere; some countries, such as Denmark in 2004 and Italy in 2006, periodically submit them to harsh critical re-examination. However, it can reasonably be claimed that in many EU countries, regardless of the legal technique chosen (passing a new law abolishing penalties that deprive liberty, amending an existing law so as to limit the conditions in which prison sentences may be issued, no change to an existing law but a decree specifying how it is to be applied, etc.), drug use is increasingly less likely to be perceived as an offence serious enough to deserve the harshest sanction allowed by the legislative systems of democratic EU countries (i.e. incarceration), whereas treatment and reintegration are clearly put forward as the most legitimate solutions for handling an arrested user.

In addition, use repression policy in some countries can be said to have undergone relative[12] *de facto* (as opposed to *de jure*) depenalization, a process that can be defined as what happens when it becomes highly unlikely for legally punishable behaviour to be punished with a court sentence. Depenalization occurred in several European countries (EMCDDA 2002, 2005), and some comparative studies seem to suggest, without really managing to demonstrate it, that "police activity (i.e., on the streets) seems concentrated on dissuading people from using by a high number of arrests, especially for cannabis-related offences, while at the judiciary level (i.e., vis-à-vis users) there seems a tendency to dismiss cases or suspend procedures involving probation orders (at least for first offenders) or, if necessary, to require the user to get treatment and even psychological help" (EMCDDA 2005, 19).[13] And it seems that "many use-related offences – often the majority – do not reach court, as they are dealt with at an earlier stage" (EMCDDA, 2009, 13). The conclusion is that "the majority of countries would give fines (some warnings, some community work orders) for personal use offences, but in Central and Eastern European countries … there was a clear preference for suspended prison sentences" (EMCDDA, 2009, 14).

Taken together, the relatively convergent practices constitute an emerging regulation model characterized by practices that tend to avoid issuing sentences that would deprive simple users of their freedom while favouring therapeutic or integrative measures (though these practices are unevenly distributed within/among Member States and their regions). Recently such a regulation model has been explicitly recognized and collectively appropriated at the level of EU institutions as the Council of the European Union issued conclusions "Promoting the use of alternatives to coercive sanctions for drug using offenders". Although not legally binding, this official statement represents a significant political commitment to "the need for the Member States to provide and apply … alternative measures to coercive sanctions for

[12] Relative in the sense that it varies in intensity from one territory to another and does not preclude penal conviction.

[13] This, of course, depends entirely on national legal configurations and principles, since certain countries operate in accordance with the legality principle, others with the principle of responding most appropriately to the particular case at hand.

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drug using offenders … while also looking at a possible reduction of health-related harms and minimisation of social risks".[14]

DOMESTICATING CANNABIS IN EUROPE

Seemingly immune from the legalization wave which is taking place on the American continent, all European states have maintained cannabis prohibition. This formal interdiction is actually enforced in some countries (e.g. Sweden) but is only symbolic in others where cannabis offences have been to a large extent decriminalized (e.g. Czech Republic). While medicinal cannabis (both herbal and galenic) is making inroads in the field of conventional medicine in an increasing number of European countries (EMCDDA, 2018b), several jurisdictions have been softening their prohibitionist stance and developing tolerant policies regarding recreational cannabis. Luxembourg, however, is officially contemplating fully fledged legalization, and the Swiss government has recently proposed allowing up to 5,000 people smoke cannabis legally in pilot studies with a view to shaping new rules for recreational use of the drug.

1. Dutch Coffee Shops and the Separation of Drug Markets

While cultivation, supply and personal possession of cannabis remain criminal offences in the Netherlands, a tolerance to low level sales has existed since the 1960s. It eventually led to the establishment of hundreds of "coffee shops". These cannabis sales outlets are allowed by some local authorities under certain conditions (no advertising, no hard drugs on the premises, no sales to minors, limitation of transaction size …). The main justification for this tolerance is that it serves a public health goal by contributing to the separation of soft and hard drug markets (Grund & Breeksema, 2017). While sales of small quantities (the front door) are exempt from prosecution, the cultivation of larger quantities and the supply of cannabis to (the back door of) coffee shops remains a priority for law enforcement. In 2018, this ambiguity, known as the "back door problem", led the Dutch government to plan an experiment on the legal supply of cannabis to coffee shops. The trial, which should be carried out for four years in several municipalities, will have its impact on public health and public safety supervised by a research consortium.

2. Cannabis Social Clubs and "Shared Drug Use"

Cannabis social clubs provide another model of advanced decriminalization (Decorte & Pardal, 2017). Promoted by activists in several European states, these clubs have multiplied in Spain under the umbrella of "shared drug use" which is not considered an offence in domestic law (Diaz Gomez & Martin Gonzales, 2017). Following persistent testing of legal boundaries by civil society, the Spanish Supreme Court interpreted the Penal Code in a way that allows for behaviour prior to drug use (planting, growing, distributing, etc.) so long as it is for personal use and not for trafficking purposes. Building on this interpretation, a new

[14] Council conclusions (8 March 2018) promoting the use of alternatives to coercive sanctions for drug using offenders. Available at: http://data.consilium.europa.eu/doc/document/ST-6931-2018-INIT/en/pdf

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type of non-profit organization has come into being with the official purpose of collecting and distributing cannabis to their members (Marks, 2019). Since 2001, hundreds of these cannabis social clubs have been established. Although these associations received partial recognition from, and legal guidance through, some city councils and autonomous communities, their status is far from secure. They are tolerated by the authorities as long as their access is restricted and consumption remains private and not visible to the public.

3. Cannabis Light and Cannabidiol

More recently, new types of herbal cannabis and cannabis oils have found their way onto the legal market in several European countries (Italy, Luxembourg, Switzerland …) thanks to the lawfulness of industrial hemp, a centuries-old business with commercial uses like clothing, construction material and animal feed (EMCDDA, 2017b, 8). Hemp, which belongs to the cannabis plant species but contains less than 0.2 per cent of psychoactive substance tetrahydrocannabinol (THC), is allowed for industrial purposes by EU law. Making the most of this legislation, audacious cannabis entrepreneurs have extended the traditional hemp industry to flowers and oil containing a low level of THC but higher levels of cannabidiol (CBD), another cannabinoid not listed under international drug conventions. Since 2017, many shops selling these cannabis products have opened. European states' response varies greatly, some allowing open sale under certain conditions, while others have banned it, often with little effect (for example in France).

Medicalization of Social Control

A discernible regulation model for public health policy, the other instrument for social control of drug use, has also emerged. It will come as no surprise that, like repression policies, public health policies on drugs and treatment facilities began developing in European countries within the framework of institutional and cultural habitus that shaped them in particular ways. In the 1980s and 1990s the choice of therapeutic initiatives and clinical approaches in Europe were decisively conditioned by national and local institutional variables, particularly those pertaining to the arrangements structuring the medical profession, its commitment to working on certain approaches to the problem rather than others, the professional dynamic of medical specialties, and the degree to which the profession could act independently of the political authorities. The UK, where the medical profession was deeply involved, drew on its tradition of opiate prescription as a means of developing methadone use (Berridge, 1996). France, in the shadow of the ubiquitous Jacques Lacan and in the context of a radical transformation of the psychiatric field (Bergeron, 1999), fell for psychoanalysis. The Netherlands developed various solutions, including harm- and risk-reduction measures, while Italy wove a vast network of therapeutic communities.

The sudden appearance of HIV/AIDS in the mid-1980s considerably upset this situation. It gradually became clear in European countries that the strategic option of requiring that treatment *cure* drug addiction and, in some countries, the maniacal attempt to require abstinence (France [Bergeron, 1999] and Sweden [Tham, 1995] among others) were not compatible with the risks implied by the growing HIV/AIDS epidemic. Though national paces varied greatly and public health traditions and systems reflected differing welfare-state models (Cattacin & Lucas, 1999), many European countries decided to begin developing and applying more

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strictly preventive and palliative policies. Specific attention was paid to both obvious and possible consequences of opiate use. What political scientists call "advocacy coalitions" (Sabatier & Jenkins-Smith, 1993) or "public policy communities" (Grange, 2005) began to form in a great many countries; vast networks of actors from diverse backgrounds and activities (physicians working for humanitarian associations, associations of former drug users, addiction treatment professionals, physicians specialized in preventing HIV infection and treating AIDS, sociologists, etc.), all with relatively similar views on what kinds of public health and treatment policies should be designed and implemented. These actors argued that it was necessary to reorder the priorities of therapeutic policy.

Building on the support from anti-AIDS activists who had been able to obtain positions of political influence, these actors succeeded in putting the so-called "harm and risk reduction" model – first developed in the Netherlands (Boekhout Van Solinge, 2004; Grund & Breeksema, 2017) – on the policy agenda, first in the UK, Switzerland and Holland (mid-1980s), ultimately (late 1990s) in the most resistant countries (France and Sweden, among others). There is no need to examine these policy and political events and processes in detail here, but it should be pointed out that a number of important harm- and risk-reduction instruments (distribution of sterile injection equipment, extensive distribution of substitution substances [methadone, and in some countries buprenorphine and other medicines], "low threshold" treatment centres, targeted prevention campaigns, etc.) have now become part of the "legitimate" strategy of most Member States, to the point where a significant number of them have ratified the necessity for such measures by making them part of their laws (Heidrich & Pirona, 2017). The EU, meanwhile, officially recognized their importance by way of a Council recommendation, unanimously adopted in 2003.[15]

It is true that the implementation level for these policies (i.e. degree to which user populations are covered) and the accessibility of their programmes still vary considerably by country and "setting" (e.g. prison). Some measures are still subject to controversy, such as controlled distribution of heroin or medically supervised injection centres. In some Member States actors are quick to challenge these policies as unsound as soon as the political context allows (this occurred in France during Nicolas Sarkozy's presidency). Still, the diverse measures do represent an overall policy approach that it would be difficult to fully contest today, an approach that has been implemented throughout the EU, according to annual EMCDDA annual reports (the 2003 European Council recommendation is part of the *acquis communautaires* that new Member States have to transpose into the national context before their admission to the EU). This overall policy approach clearly signifies that European states have recognized – and (to varying degrees) are willing to assume the political consequences of that recognition – that drug use is not, as was thought in the 1970s and 1980s, some sudden fever that could be "knocked out" of the "patient" but indeed a lasting anthropological fact in Western societies, and that not only its causes, but also its risk-heavy consequences, should be dealt with.

The development of risk-reduction policies should therefore be thought of as a process whereby a problem once grasped and defined otherwise – namely in terms of public order and security – was transformed into a public health problem. This process was the result of a "twofold operation: translating social phenomena into public health language, and fitting this

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[15] Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence. (2003/488/EC). Available at: https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2003:165:0031:0033:en:PDF

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new reality into public space" (Fassin, 1998, 14–15). It has not been without impact on the representations of drugs, users, and uses. The new public health grammar has worked to fit drugs and drug use into an overall understanding in terms of risk: there are now high- and lower-risk drugs, just as there are types of behaviour that can be characterized as high- and lower-risk. There was a time when "drugs" was a generic term encompassing multiple substances and any and all types of drug use were equally demonized. As has occurred for many other problems (Beck, 1992), risk has become the unit by which drugs and ways of using are ranked and classified; drugs and drug use are now part of a vast continent of "high-risk/risky behaviours" or "risk factors". This development unquestionably reflects the domination of epidemiology, a favoured academic idiom for assigning causes in the area of public health.

As drug problems came to be cast in terms of risk and public health, the medicalization of addiction has become stronger. While extensive methadone distribution has been interpreted by several analysts as a move to medicalize anomic uses, in that a social state is regulated by the administration of a medicine, it is also important to point out the rise of etiological explanations directly linked to biomedicine, particularly neurobiology. In several European countries, there is now a greater will among policy-makers, at least those working in the area of public health, to conceive of illicit drug use, psychoactive medicines, alcohol and tobacco as *all* likely to lead to risky practices, even to dependence. A number of scientific studies have obtained unprecedented political success by insisting on the fact that addictions of any kind, regardless of the substance or behaviour (gambling, bulimia, etc.), should be understood as resulting from chronic neurobiological dysfunction (based indifferently on innate or acquired vulnerability). The understanding is that the same neurobiological (dopaminergic) pathways are implicated in all types of addiction. Though there are at present no more than a few public policies providing for comprehensive therapeutic treatment centres that would handle every kind of addictive behaviour (France and Spain have such policies), prevention policies have been developed that synoptically target all substances. "Biologization" of this sort is having the effect of further medicalizing the types of drug policy that got under way with the advent of HIV/AIDS, and casting them even more fully in terms of a public health issue, by undermining bases for legal distinctions between licit and illicit substances, together with the exceptional status of drug use regulation, all in the name of medical thinking.

REFERENCES

Bache I. (2012), "Multi-Level Governance in the European Union", in Levi-Faur D. (ed.), *The Oxford Handbook of Governance*, Oxford: OUP, 628–641.

Beck U. (1992), *Risk Society: Towards a New Modernity*, Thousand Oaks, CA: Sage.

Bergeron H. (1999), *L'État et la toxicomanie. Histoire d'une singularité française*, Paris: Presses universitaires de France.

Bergeron H. (2011), "The Culture of Drug Policy", in Hunt G., Milhet M., Bergeron H. (eds.), *Drugs and Culture: Knowledge, Consumption and Policy*, Farnham: Ashgate Publishing, 273–294.

Bergeron H. (2017), "The Soft Power of the European Monitoring Centre for Drugs and Drug Addiction", in Colson R., Bergeron H. (eds.), *European Drug Policies: The Ways of Reform*, Abingdon: Routledge, 40–56.

Berridge V. (1996), "European Drug Policy: The Need for Historical Perspectives", *European Addiction Research*, 2(4), 219–225.

Bewley-Taylor D. (2012), *International Drug Control: Consensus Fractured*, Cambridge: Cambridge University Press.

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Bless R., Korf D., Freeman M. (1995), “Open Drug Scenes: A Cross-national Comparison of Concepts and Urban Strategies”, *European Addiction Research*, 1, 128–138.
Boekhout Van Solinge T. (2002), *Drugs and Decision-making in the European Union*, Amsterdam: CEDRO/Mets en Schilt.
Boekhout Van Solinge T. (2004), *Dealing with Drugs in Europe. An Investigation of European Drug Control Experiences: France, the Netherlands and Sweden*, The Hague: BJu Legal Publishers.
Cattacin S., Lucas B. (1999), “Autorégulation, intervention étatique, mise en réseau. Les transformations de l’Etat social en Europe. Les cas du VIH/SIDA, de l’abus d’alcool et des drogues illégales”, *Revue française de sciences politiques*, 49(3), 379–398.
Chatwin C. (2011), *Drug Policy Harmonization and the European Union*, Basingstoke: Palgrave Macmillan.
Chatwin C. (2016), “Mixed Messages from Europe on Drug Policy Reform: The Cases of Sweden and the Netherlands”, *Journal of Drug Policy Analysis* [Online]. Available at: http://dx.doi.org/10.1515/jdpa-2015-0009 [Accessed 19 December 2019].
Colson R. (2017), “Harmonizing NPS Legislation Across the European Union: A Utopia?”, in Corazza O., Roman-Urrestarazu A. (eds.), *Novel Psychoactive Substances: Policy, Economics and Drug Regulation*, Berlin: Springer, 143–153.
Colson R., Bergeron H., (2017a), “European Drug Policies in Context”, in Colson R., Bergeron H. (eds.), *European Drug Policies: The Ways of Reform*, Abingdon: Routledge, 1–10.
Courtwright, D.T. (2001), *Forces of Habit: Drugs and the Making of the Modern World*, Cambridge, MA/London: Harvard University Press.
Decorte T., Pardal M. (2017), “Cannabis Social Clubs in Europe: Prospects and Limits”, in Colson R., Bergeron H. (eds.), *European Drug Policies: The Ways of Reform*, Abingdon: Routledge, 285–299.
Derks J., Van Kalmthout A., Albrecht H.J. (1999), *Current and Future Drug Policy Studies in Europe*, Freiburg: Max Planck Institute for Foreign and International Penal Law.
Diaz Gomez C., Martin Gonzales E. (2017), “Spanish Drug Policy”, in Colson R., Bergeron H. (eds.), *European Drug Policies: The Ways of Reform*, Abingdon: Routledge, 182–194.
ECDP (2001), *Co-operation and Community Consensus: The Multi-Agency Approach to Effective Local Drug Policies*, Frankfurt am Main: ECDP.
EMCDDA (2002), *Prosecution of Drug Users in Europe: Varying Pathways to Similar Objectives*, Luxembourg: Publications Office of the European Union.
EMCDDA (2005), *Illicit Drug Use in the EU: Legislative Approaches*, Luxembourg: Publications Office of the European Union.
EMCDDA (2009), *Drug Offenses: Sentencing and Other Outcomes*, Luxembourg: Publications Office of the European Union.
EMCDDA (2012), *Cannabis Production and Markets in Europe*, Luxembourg: Publications Office of the European Union.
EMCDDA (2014), *Drug Law Offences in the Western Balkan Region: From Definition to Monitoring*. Available at: http://www.emcdda.europa.eu/publications/technical-reports/drug-law-offences-western-balkan-countries_en [Accessed 19 December 2019].
EMCDDA (2015a), *Drug Use and its Consequences in the Western Balkans 2006–14*, Luxembourg: Publications Office of the European Union.
EMCDDA (2015b), *Characteristics of Frequent and High-risk Cannabis Users*, Luxembourg: Publications Office of the European Union.
EMCDDA (2015c), *Synthetic Drug Production in Europe*, Luxembourg: Publications Office of the European Union.
EMCDDA (2015d), *Drugs Policy and the City in Europe*, Luxembourg: Publications Office of the European Union.
EMCDDA (2015e), *New Psychoactive Substances in Europe: Innovative Legal Responses*, Luxembourg: Publications Office of the European Union.
EMCDDA (2015f), *Alternatives to Punishment for Drug-using Offenders*, Luxembourg: Publications Office of the European Union.
EMCDDA (2016a), *Assessing Illicit Drugs in Wastewater: Advances in Wastewater-based Drug Epidemiology*, Luxembourg: Publications Office of the European Union.

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EMCDDA (2016b), *Estimating the Size of the Main Illicit Retail Drug Markets in Europe*, Luxembourg: Publications Office of the European Union.
EMCDDA (2017a), *Changes in Europe's Cannabis Resin Market*, Luxembourg: Publications Office of the European Union.
EMCDDA (2017b), *Cannabis Legislation in Europe: An Overview*, Luxembourg: Publications Office of the European Union.
EMCDDA (2017c), *Drug Trafficking Penalties Across the European Union: A Survey of Expert Opinion*, Luxembourg: Publications Office of the European Union.
EMCDDA (2018a), *European Drug Report 2018*, Luxembourg: Publications Office of the European Union.
EMCDDA (2018b), *Medical Use of Cannabis and Cannabinoids: Questions and Answers for Policymaking*, Luxembourg: Publications Office of the European Union.
EMCDDA/Europol (2016), *EU Drug Markets Report: In-depth Analysis*, Luxembourg: Publications Office of the European Union, 2016.
Estievenart G. (1995), "The European Community and the Global Drug Phenomenon: Current Situation and Outlook", in Estievenart G. (ed.). *Policies and Strategies to Combat Drugs in Europe. The Treaty on Europen Union: Framework for a New European Strategy to Combat Drugs?*, Dordrecht: Martinus Nijhoff Publishers, 50–93.
Fassin D. (1998), *Les Figures urbaines de la santé publique*, Paris: La Découverte.
Glenny M. (2008), *McMafia: Crime Without Frontiers*, London: Bodley Head.
Grange A. (2005), *L'Europe des Drogues. L'apprentissage de la Réduction des Risques aux Pays-Bas, en France et en Italie*, Paris: L'Harmattan.
Grund J.P.C., Breeksema J.J. (2017), "Drug Policy in the Netherlands", in Colson R., Bergeron H. (eds.), *European Drug Policies: The Ways of Reform*, Abingdon: Routledge, 128–148.
Heidrich D., Pirona A. (2017), "The Changing Face of Harm Reduction in Europe", in Colson R., Bergeron H. (eds.), *European Drug Policies: The Ways of Reform*, Abingdon: Routledge, 254–271.
Hughes C.E. (2017), "Portuguese Drug Policy", in Colson R., Bergeron H. (eds.), *European Drug Policies: The Ways of Reform*, Abingdon: Routledge, 164–181.
Kert R., Lehner A. (2013), "Content and Impact of Approximation: The Case of Drug Trafficking", in Galli, F., Weyembergh, A. (eds.), *Approximation of Substantive Criminal Law in the EU: The Way Forward*, Brussels: Editions de l'Université de Bruxelles, 169–188.
King, L. (2011), "A Brief History of Psychoactive Substances", *Drug Testing and Analysis*, 3, 401–403.
Kübler D., Wälti S. (2001), "Drug Policy-Making in Metropolitan Areas: Urban Conflicts and Governance", *International Journal of Urban and Regional Research*, 25(1), 35–54.
Malinowska K. (2017), "Polish Drug Policy", in Colson R., Bergeron H. (eds.), *European Drug Policies: The Ways of Reform*, Abingdon: Routledge, 149–163.
Marks A. (2019), "Defining 'Personal Consumption' in Drug Legislation and Spanish Cannabis Clubs", *International & Comparative Law Quarterly*, 68(1), 193–223.
Mills J.H., Barton P. (2007), *Drugs and Empires: Essays in Modern Imperialism and Intoxication*, Basingstoke: Palgrave Macmillan.
Nagler N.A. (1987), "The Council of Europe Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (the Pompidou Group)", *Bulletin on Narcotics*, 39(1), 31–40.
Newburn T., Sparks R. (2004), "Criminal Justice and Political Cultures", in Newburn T., Sparks R. (eds.), *Criminal Justice and Political Cultures: National and International Dimension of Crime Control*, Cullompton: Willan Publishing, 1–15.
Obradovic I. (2017), "French Drug Policy", in Colson R., Bergeron H. (eds.), *European Drug Policies: The Ways of Reform*, Abingdon: Routledge, 87–99.
Pennay A.E., Measham F.C. (2016), "The Normalisation Thesis – 20 Years Later", *Drugs: Education, Prevention and Policy*, 23(3), 187–189.
Sabatier P., Jenkins-Smith H. (eds.) (1993), *Policy Change and Learning. An Advocacy Coalition Framework*, Boulder: Westview Press.
Tham H. (1995), "Drug Control as a National Project: The Case of Sweden", *The Journal of Drug Issues*, 25(1), 113–128.
UNODC (2014), *The Illicit Drug Trade through South-Eastern Europe*, Vienna: United Nations.

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Waal H., Clausen T., Gjersing L., Gossop M. (2014), "Open Drug Scenes: Responses of Five European Cities", *BMC Public Health*, 14(853). Available at: https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-14-853 [accessed 19 December 2019].
Wintle M. (1997), "Cultural Identity in Europe: Shared Experience", in Wintle M. (ed.), *Culture and Identity in Europe*, Aldershot: Ashgate Publishing, 9–32.
Zobel F. (2017), "Swiss Drug Policy", in Colson R., Bergeron H. (eds.), *European Drug Policies: The Ways of Reform*, Abingdon: Routledge, 206–216.
Zuffa G. (2017), "Italian Drug Policy", in Colson R., Bergeron H. (eds.), *European Drug Policies: The Ways of Reform*, Abingdon: Routledge, 114–127.

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