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Policy analysis

A critical evaluation of the European drug strategy: Has it brought added value to drug policy making at the national level?

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ABSTRACT

Background: The current European Drug Strategy (EDS) and attendant Action Plan come to an end this year signalling a period of evaluation of and reflection on whether they have achieved their aims and objectives.
Methodology: This opinion based article seeks to add a critical and academic evaluation to the mix, which is focused on determining the extent to which the European drug policy has brought added value to drug policy that is formulated at the national level, in accordance with the principle of subsidiarity. The analysis presented here examines the five key areas defined by the EDS: coordination, demand reduction, supply reduction, international cooperation and information, research and evaluation.
Results: It suggests that, while clear benefits have been brought in the realm of information, research and evaluation and the development of harm reduction measures, there is still significant progress yet to be made.
Conclusion: It finds that neither the Commission's dedication to increasing focus on law-enforcement methods, nor the Council's prescription for 'more of the same' are particularly beneficial to the development of European drug policy. Instead, the priorities should be building on areas where added value has been engendered and on allowing diversity in policy to flourish.

Introduction

During the early 1970s, the European Community first turned its attention to the coordination of illicit drug policies. Given that the illegal drug trade affects all societies and occurs without respect for international borders, it was a natural contender for development at the European level, as part of the drive for an 'ever closer union'. Indeed, the 1961 United Nations (UN) Single Convention on Narcotic Drugs (UN, 1961) and the 1971 Convention on Psychotropic Drugs (UN, 1971) had already committed many nations to the recognition that "addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger" (UN, 1961, p. 1).

Difficulties arose, however, because two broad policy paradigms relating to illicit drugs were in operation in Europe at the time: a broadly liberal approach towards drug use and drug users and one that was more restrictive in practice. Two commissions were launched by the European Parliament (EP) to investigate this problem, one in 1986 and the other in 1991. Both, however, were to make inconclusive reports, with the committees remaining fundamentally divided (Blom & van Mastright, 1994). After receiving the report of the second of these commissions, the EP withdrew from attempting to judge the desirability of one method of drug control over another: instead, it was decided that drug policy was not to become an area of transfer of competencies at the EU level and would therefore be an area where the principle of subsidiarity would apply.

Article 3b of Title 1 of the Treaty of Maastricht deals with the limited intervention of the then EEC in national affairs: "In areas which do not fall within its exclusive competence, the Community shall take action, in accordance with the principle of subsidiarity, only if and in so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States and can therefore, by reason of the scale or effects of the proposed actions, be better achieved by the Community" (European Economic Community, 1992, p. 3) – in other words, the Community should only take action in these instances where their contribution brings added value to that already achieved at the national level. The key question addressed by this article is thus whether the development of drug policy at the European level has been in accordance with the principle of subsidiarity and has in fact brought added value to national drug policy making.

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Methodological note

Drug policy formulation at the European level is a complicated process involving actors from the Commission and the Council and from both DG Justice and DG Home, a working group of member state representatives (the Horizontal Drugs Group) and international bodies such as Europol, Eurojust and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). It would be a difficult job indeed, certainly within the space of this article, to adequately evaluate the contribution of all actors in European drug policy making, however, the main facets are distilled in its regularly drawn up Drug Strategy and Drug Action Plans. The first document outlining drug policy at the European level was the European Plan to Combat Drugs, which was drafted in 1990 and redrafted in 1992. This was followed by an EU Action Plan that ran from 1995 to 1999. In 2000, for the first time, an EU Drug Strategy was developed to disseminate general aims and objectives of drug policy at the European level and this was to be underpinned by a plan of specific actions. This strategy was renewed in 2005, with the new version ending in 2012.

It is the intention of this article to focus on evaluating the general principles, aims and objectives of European Drug Policy as outlined in this most recent (2005–2012) European Drug Strategy (EDS). The 2005–2012 Drug Strategy (Council of the European Union, 2004a) has been underpinned by two action plans, the first running from 2005 to 2008 and the second from 2009 to 2012. The most recent Action Plan (Council of the European Union, 2008) lists 72 specific actions that have been described in an independent evaluation as a "comprehensive 'wish list' of potential activities" (RAND, 2012). For this reason, the main focus will be on the EDS itself, with only occasional recourse being made to the Action Plans. The 2005–2012 EDS is divided into five priorities for European drug policy making: coordination, demand reduction, supply reduction, international cooperation and information, research and evaluation. This evaluation will also be broken down into these same five areas. The main aim of the 2005–2012 EDS is to "add value to national strategies while respecting the principles of subsidiarity and proportionality" (Council of the European Union, 2004a, p. 3). It will be evaluated here on the extent to which it has brought added value to each area.

Several difficulties do arise from adopting this methodology. Firstly, there is little consensus in defining and evaluating the concept of *added value*. Here it will be taken in its simple form as "the value resulting from EU support. . . which is additional to the value that would have resulted. . . at regional and national levels" (European Communities, 2000, p. 4), but, it should be noted that the concept is not without problems. Secondly, some of the specific policy implementations noted in the paper could be relevant to several of the five areas of priority. Where this occurs, discussion has been confined to the main area of relevance. Finally, it has not been possible to discuss all facets of the EDS in detail. Instead, a general outline of progress in each field has been given, with particular emphasis on certain examples. Where this has occurred, an effort has been made to choose key pieces of policy implementation and to explain why they have been chosen for further illumination.

The ending this year (2012) of the 2005–2012 EDS together with the 2009–2012 Action Plan has signalled a flurry of activity, including several internal evaluations of specific drug policy measures (Commission of the European Communities, 2009a, 2011a), an external evaluation of the strategy (RAND, 2012), a new communication from the Commission (Commission of the European Communities, 2011b) seeking to outline the future of drug policy development at the European level and a statement from the Council on the new EU drug strategy (Council of the European Union, 2012). These largely uncritical and sometimes contradictory evaluations and communications, together with academic commentary, official documents and a recent House of Lords Enquiry (House of Lords, 2012), are examined, with a critical eye, in the remainder of this article in an effort to understand whether European drug policy really has brought *added value* to that engendered at the national level.

Coordination

The current EU drugs strategy designates coordination as "key" (Council of the European Union, 2004a, p. 8) and defines its goals as ensuring the aims of the EDS are reflected in national drug strategies and that EU drug policy is adequately informed by national representatives on the Horizontal Drugs Group (HDG). Some commentators (RAND, 2012; Standring, 2012) have found the EU to have been successful in adding value in this area, citing in particular the prompting of member states without existing national drug strategies and action plans to adopt them: many of the newer member states and candidate countries have adopted the framework and objectives of the European level versions in their entirety. This analysis, however, is somewhat questionable. It is not contested that most EU member states now possess national drug related documents, or even that many of these claim to reflect EU aims and objectives, but rather that these EU aims and objectives are so broad and general as to be able to encompass the "zero tolerance approach of Sweden... the pragmatism of the Netherlands and. . . the policy of Portugal in relation to possession of drugs for personal use" (Fazey, 2011, p. 121). If such a broad range of national drug policies can be said to reflect the aims and objectives of EU drug policy then what *added value* can the formulation of those European guiding principles be bringing? Furthermore, it is generally acknowledged that it is the newer member states and candidate countries which are benefitting most from the introduction of new national documentation in this area (RAND, 2012) suggesting, at best, what Heichel, Pape, and Sommerer (2005) term b-convergence where "laggard countries catch up with leader countries over time" (Knill, 2005, p. 769).

The EDS further dictates that "the commission, the council and the European Parliament will also be encouraged to ensure clear coordination between their own activities on drugs" (Council of the European Union, 2004a). This coordination, however, is not clear, even in the most recent documents on drug policy evaluation from the Council and the Commission. Vice-President Vivianne Reding, the current Commissioner for Justice, Fundamental Rights and Citizenship, recently described the European drug strategy as "a thing of the past" (Reding, 2011, p. 251) while the Council has countered that "the EU needs an EU drugs strategy for 2013–2020" (Council of the European Union, 2012, p. 6). This is, perhaps, hardly surprising given that the Council is the forum for member state representation to the EU, while the Commission represents "the common interests and values of the EU" (IDPC, 2007, p. 2) itself. Nevertheless, it is hardly indicative of the successful implementation of *added value* in this area. Finally, Mike Trace, former chairman of the EMCDDA and current chairman of the IDPC, has suggested that the HDG, which is envisioned as the main informant to the development of European Drug policy, "is much weaker now than it has been in previous years: there is not really much political strength and momentum there" (Trace, 2011, p. 46).

Demand reduction

The 2005–2012 EDS calls for a "measurable reduction of the use of drugs" (Council of the European Union, 2004a, p. 10). While latest EU figures do show a stabilisation in the prevalence of drug