Studying travelling Drug Policy Ideas; How are the Norwegian Governance Traditions shaping the Idea of the Portuguese Decriminalization Model?

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Abstract

In June 2010, the Stoltenberg Committee delivered a comprehensive report on the use of illicit drugs to the Norwegian government. It proposed significant changes on how to handle drug usage and addiction problems and proposed direct action based on the Portuguese Drug Strategy Plan.

This thesis examines the political implementation of two proposals from the Stoltenberg Committee's Report on Drugs that call for the de-criminalization of the use of illicit drugs, focusing on the process of adaptation and implementation of the Portuguese model into a Norwegian context. The analysis uses translation theory and concepts of de-contextualization and contextualization to understand and explore how travelling ideas and knowledge can be understood as a translation process between different welfare state traditions.

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1. Introduction

The thesis presents a case study on the Norwegian restructuring process in handling drug usage and addiction.

Between 2009–2012, the Norwegian government has prepared for a White Paper on drug policy, and in regard to this work, two reports regarding the legal framework of handling drug use and addiction was published;

The Stoltenberg Committee's Report on drugs, June 2010, and

The Workgroup's report on Alternative responses to soft drug related crime, 2011.

This month, the 22nd of June 2012 was White Paper released; named «A comprehensive drug policy on: alcohol – drugs – narcotics». It is expected that the Workgroups proposals are implemented in the White Paper.

For more than ten years ago, Portugal established a comprehensive drug policy, and de-criminalized use of all kind of drugs. This has attracted international attention, and has become a popular subject for before- and after studies regarding drug policy research. The Portuguese drug situation has among others showed that de-criminalizing drug use not necessarily leads to prevalence of drug use, or more problematic use. In the debates regarding drug policy, the Portuguese de-criminalization model is describes as successful.

With its de-criminalization model, Portugal has moved its responses to drug use and possession from punitive sanctions under its Criminal Code to administrative offences, established in Article 2.1, Law no. 30/2000. Drug use and possession is no longer regarded as a criminal offence, but rather a matter for health and social services.

The starting points for our analysis are two comparable systems of handling drug use and addiction; the Portuguese de-criminalization model, CDT (Commission for the Dissuasion of Drug Addiction), and the Alternative responses to soft drug crime, named Interventions, suggested in the Workgroup report.

The Stoltenberg Committee found that the Portuguese de-criminalization model handles drug users and addicts with dignity due to its more humane and non-repressive approach, following-up individual cases and offering treatment instead of punitive action for drug offences. The Committee focuses on the Portuguese model's judicial and organizational structure, which regulates and ensures that the drug user gets follow-up assistance and treatment.

In proposals 3 and 4, the Stoltenberg Committee directly refers to the Portuguese drug policy and national de-criminalization model in handling drug use and the possession of drugs, and suggests the adoption and implementation of a scheme of non-punitive sanctions for handling drug use, offering help and following-up on individual cases, organized by interdisciplinary commissions.

The Stoltenberg Committee's proposals for establishing interdisciplinary tribunals were based on the CDT, the *Portuguese Commission for the Dissuasion of Drug Addiction* (Comissão para a Dissuasão da Toxicodependência). The CDT assesses measures for persons using drugs and offers diverse responses adjusted to the individual's drug problems.

Three national policy documents are essential for this case study; one Portuguese document; The Portuguese Drug Strategy Plan 1998 which resulted in the De-criminalizing Law no. 30/2000, of 29th of November, and two Norwegian documents; The Stoltenberg Committee's Report on Drugs, June 2010, and the Workgroup's Report, June 2011.

This thesis will examine the translation of the Portuguese de-criminalization model on drugs, and the Norwegian governance traditions' impact on the Stoltenberg Committee's proposals 3 & 4.

The research questions are as follows:

1. Why was the Portuguese drug policy model translated into the Norwegian context?

- **1.1** How did the Workgroup adapt and implement the Stoltenberg Committee's proposals 3 & 4?
- **1.2** What is the divergence and convergence between (the original idea;) the Portuguese CDT, and the translated version; the Workgroups suggested Interventions?

2. How do Norwegian governance traditions impact on and transform the Stoltenberg Committee's proposals based upon the Portuguese de-criminalization?

- **2.1** What are historically the crucial elements the Norwegian drug policy governance traditions are based on?
- **2.2** Can these elements from the Norwegian Governance traditions be recognized in the Workgroups report?

3. How can the Norwegian translation of the Portuguese de-criminalization model impact on the handling of drug use and addiction?

- **3.1** What practical consequences can the proposed interventions have on the individual drug user?
- **3.2** And what are the differences between today's and «tomorrows» practice of the police's handling drug users?

In order to examine the Norwegian governance traditions regarding drug use and addiction, we will look back at the origins of the debate on drug policy, which started in the middle of the 1960s.

We found interest in earlier studies pointing on how the value- and attitude based information became a fundamental element already from the establishment of the Norwegian drug policy. An important objective in preventive work was to strengthen people's resistance towards behaviour that includes experimenting with narcotic drugs[1].

When analyzing the implementation of the Stoltenberg Committee's proposals 3 & 4, we will bear in mind these value based elements in the area of drug policy, and how it can affect decisions based on the use of discretion; as the Workgroup recommended as a condition in the Interventions suggested Interventions.

1 Fjær, S. 2004:149

The dignified treatment of drug users and addicts was a fundamental element throughout the entire Report on drugs. The Stoltenberg Committee found that the Portuguese de-criminalization model called for the dignified treatment of drug users. We are interested in how Norwegian governance traditions in the area of illicit drugs are value based, and the implications arising from the fact that the Workgroups' suggested alternative interventions leave a lot of room for discretionary action. We question if value based elements and the proposed use of discretion in handling drug users, can be an obstacle to the argument for treating drug users with dignity, due to the possibility of discrimination towards the individual drug users' attitude and values rather than their actual actions.

The analysis of governance traditions and the de-contextualization and contextualization process, which consists of adapting, implementing and integrating the Portuguese de-criminalization model, is based primarily on the Workgroup Report of 2011, and secondly on earlier studies of Norwegian national drug policy documents.

The theoretical contributions and literature used for this study are found in studies of European, Norwegian and Portuguese drug policy processes and cooperation, trends and translations, and in theories of transnational historical perspectives, using an actor and interest-based focus on transnational policymaking.

These theories are useful for the purpose of this study; to examine travelling ideas and the influence of knowledge and its contribution to the harmonization of the European drug policy. Since travelling ideas and knowledge are informal and unstructured, and to a certain extent not yet a developed field, we need to apply theories that examine these processes, that can go beyond formal structures and are able to discover crucial elements in translation processes.

One theoretical approach suitable for examining the adaptation and implementation processes is found in Kjell Arne Røviks's theoretical approach based on Translation Studies, inspired by the theory of translation between languages. The theory is about the spreading, transfer and implementation of ideas and knowledge between different contexts, and a translation process consisting partly of de-contextualization and partly of contextualization. The concept is that ideas leave one context and enter a new one. When dealing with these issues, an important question is what happens with the idea in a translation process?

The theory focuses on the prominent actors, their incentives and arenas and will be suitable for us to examine how the Portuguese de-criminalization idea has travelled from Portuguese de-contextualization, to Norwegian contextualization.

This thesis' structure

This thesis consists of eight chapters.

After the Introduction, follows this case study's methodological foundation in chapter 2. It explains and explores the different elements in a case study, and why it is found proper for this thesis objectives.

Chapter 3 regards this study's theoretical approaches and perspectives, and the literature used for examining and analyzing the Norwegian translation of the Portuguese de-criminalization model. It has found the uses theoretical approaches suitable for this case study, and one of the theories are "lend" from an other discipline; theories developed and used in organizational institutionalism. It has been interesting to use "new" theories to explore the processes between travelling ideas.

In chapter 4, the historical background ahead the Portuguese and Norwegian restructuring processes of their drug policy is presented. This is both interesting and explanatory for the conditional contexts the two processes was created in.

Chapter 5 follows in the footprints of the Norwegian translators, and are also a presentation of the Portuguese history, and the Portuguese model, based on visits, observation and interviews.

Chapter 6, The Translation in Practice, presents the translation process, and the three committees, reports, and the two models in handling drug use and addiction; namely the Portuguese CDT and the Workgroups proposed Interventions.

Chapter 7 analyze and examine the use of discretion, and the value based governance traditions in the Norwegian drug policy.

In chapter 8, the thesis concludes and gives some final comments and thoughts regarding the findings.

2. Case studies, design and methodology

2.1 How to define Case Study as a social research method?

Case study has over time become an acceptable and well-used research method in the area of social sciences.

Robert K. Yin is a prominent and a much referred to scientist and writer of case study research, and I have chosen to use one of his classic books, «Case Study Research» as a guide for the methodology in this study.

Case Study is criticized for being a «soft» method, lacking rigidity, and providing little basis for scientific generalization[1] and therefore, not seen as universally valid.

Though, this is found as an appropriate and well suitable research tool for the approach and form of this study. In the following chapter we will present how case study can be both rigorous and have universal validity. Case study is suitable for studies in for example social sciences, which cover one or several units in-depth, and Yin find three criteria for when the method is appropriate to use:

> **1)** the research question is formed with *'how'* or *'where'*,
> **2)** it does not require control of behavioural events, and
> **3)** it focuses on contemporary events.[2]

It is well suited for evaluation research, when it comes to cases, which are descriptive, explanatory or exploratory. Case study does not have to focus on just one case, there can be multiple case studies, qualitative or quantitative studies, and it is a method which is also used in other areas such as finance and psychology.

These three criteria condition whether case study is an appropriate method for a particular study, and they address the kind of research questions that the study asks, to what extent the researcher has control over the behavioural events, and if the focus is more historical or based on contemporary events. The more *'how'* or *'why'* questions there are, the less

1 Yin, R.K. 2009:14
2 Yin, R.K. 2009:3

control the researcher has over the events and the more contemporary the questions are, the more suitable the study will be for a case study approach.

2.2 This case study's approach

The methodical approach is found in qualitative methodology proper for in-depth studies, which can examine decisions and processes involving decision-making. Case study has this ability, as Schramm says[1]:

> «The essence of a case study, the central tendency among all types of case study, is that it tries to illuminate a decision or set of *decisions*: why they were taken, how they were implemented, and with what result.»

This paper seeks an in-depth understanding of a translation process, and tries to examine decision-making in one specific case; the restructuring process of Norwegian drug addiction policy through the Stoltenberg Committee's Report on Drugs, specifically, proposals 3 & 4.

The concept of *translation* comes from the Norwegian political scientist Kjell Arne Røvik, who developed a translation-theoretical perspective on the transfer of ideas and knowledge between organizations.

The theory describes the transfer and implementation of ideas and knowledge; from the original practice, its transformation into an idea, called the de-contextualization process, the transportation of these ideas to their adoptive recipients, and finally the translation process and implementation of the ideas, called the contextualization process. The theory contributes to the methodical approach by examine the important elements in this process.

Case study allows us to explore the *'how'* and *'why'* in the decision-making, and to investigate important elements, such as the diversity of the actors, arenas, incentives, the multi-level decision making, amongst other things. This will contribute to the in-depth understanding of the travelling phenomenon of ideas and knowledge in the area of drug addiction.

1 Schramm in R.K. 2009:17

Case Study's Evidence

This thesis uses two sorts of evidence; documentation and interviews; three national policy documents on handling drug addiction, and three interviews, set up as guided conversations.

About the three reports

The Stoltenberg Committee's report is the starting point of the restructuring process. The Stoltenberg Committee was appointed by the Norwegian Government on 6th of March 2009, to come up with suggestions for *how to submit proposals for ways in which the neediest substance abusers can get better help* (from the Stoltenberg Committee's mandate).

The Stoltenberg Committee came up with 24 proposals in total, two of which, namely numbers 3 & 4, refer directly to the Portuguese de-criminalization model on illicit drugs, and the Portuguese Drug Strategy 2001. The two proposals deal with the legal and judicial framework of handling illicit drug use and addiction, and this lead to a new report in June 2011, the Workgroup report on the Stoltenberg Report on drugs.

This paper will examine the three reports, in chronological order. The Portuguese Drug Strategy represents the idea of de-criminalization. The Stoltenberg Report is at the centre of the translation process, while the Work Group's report represents the contextualization and implementation of the idea.

The three reports are, as already showed, all part of the same restructuring process, with different roles. The research therefore has a comparative approach between the Portuguese and Norwegian responses in shaping their drug addiction policy, without being a comparative study.

The main process, which is of interest to this thesis, is the translation process; how the Norwegian government translates and implements Portuguese knowledge and ideas. The Work Group report is in this sense this study's main point of reference.

The documents are different in size; the Portuguese Drug Strategy and the Work Group report are both between 150–200 pages, while the Stoltenberg Report on Drugs is 48 pages long.

2.3 The interviews

The interviews in this study were set up as guided conversations rather than structured enquires[1], and ask 'how' questions rather than 'why' questions.

The interviews are open-ended and have an informative character.

They are in-depth interviews with key information regarding the Portuguese model; in this case João Goulão was one of the Portuguese committee's medical experts, and Nuno Portugal, vice president in CDT (Commission for the Dissuasion of Drug Addiction). The interviews were recorded, after their consents. Both interviews had a duration of around two hours, and the both interviewed are persons have publicly roles, though differently (see chapter 5).

The Stoltenberg Committee, and the Workgroup had study trips to Portugal during their work with the reports. Two of the places they visited were IDT and CDT, and they had meeting with both João Goulão and Nuno Portugal. In chapter 5 we have followed in their «footprints».

2.4 Types of Research Questions

This is an in-depth study which seeks a broader understanding of the travel of ideas and knowledge regarding national and international handling of drug addiction problems, and its impact on national and international governance in the area of drug policy, especially with regard to innovation and restructuring of policy measures.

As already mentioned, the case study questions are crucial for deciding on the research's methological approach.

The research questions are:

1. Why was the Portuguese drug policy model translated into the Norwegian context?

  1.1 How did the Workgroup adapt and implement the Stoltenberg Committee's proposals 3 & 4?

1 Yin 2009

1.2 What is the divergence and convergence between (the original idea;) the Portuguese CDT, and the translated version; the Workgroups suggested Interventions?

2. How do Norwegian governance traditions impact on and transform the Stoltenberg Committee's proposals based upon the Portuguese de-criminalization?

   2.1 What are historically the crucial elements the Norwegian drug policy governance traditions are based on?

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3. How can the Norwegian translation of the Portuguese de-criminalization model impact on the handling of drug use and addiction?

   3.1 What practical consequences can the proposed interventions have on the individual drug user?

   3.2 And what are the differences between today's and «tomorrows» practice of the police's handling drug users?

The research questions have a clear *'how'* and *'why'* form, which means they are more explanatory, and that the case requires an «extensive and in-depth description of some social phenomenon». But this study also tries to examine the incidence of a phenomenon, the transfer of knowledge and ideas on drug addiction problems, how the translation process takes place. We want to describe and find the important elements in this process; the actors, arenas, different incentives, governance traditions, regulations etc.

This study is therefore both *explanatory* and *descriptive*, and do not «require control of behavioural events as they focus on contemporary events»[1].

2.5 Universal Validity and the role of theory

Regarding the universal validity of case studies, also known as extern, Yin says case study is generalizing, not to populations or universes in the traditional sense, as statistical generalizing, but rather in sense of *generalize* and *expand* theoretical propositions. A case study can contribute to the actual field through an in-depth and thorough research, and highlight interesting phenomenon and processes, and important issues can be explored.

1 Yin, 2009

The aim of this study is not to generalize some phenomenon to be universal, but from this study's theoretical framework, which is a part of the case study, the case can contribute to the same theory and be used in similar case studies, and from several cases these results can be generalized.

This form for generalization is not a statistical one. The statistical generalizing requires a large range of cases, which is not relevant for case studies. Simplified we can say that the statistical generalization is made from the inference about a universe, based on «empirical data collected from a sample from that universe»[1], while in case study it is not made any inference from the data collected to a wider universe or a general population, rather it is an in-depth study of one or several cases.

Though it is not statistical generalizing, meaning it only gives insight in one particular case, it can serve as an analytical generalization; the study's results will serve as a contribution to an existing theory on the field. This contribution can be critical, innovative or challenging, and it can also highlight new areas that the existing theory did not include. The translation approach used here on the travel of drug policy ideas can contribute to the drug policy field, by bringing new angles to the field.

2.6 Ethical Awareness

«Ethical awareness is the moral norms for scientific research»[2]. In all studies, there are ethical rules, which are basic principles behind every independent work. The research ethics is based on, amongst other things, the Law of personal protection and Law of personal registers.

Informed consent

Regarding my collection of data; it is mainly based upon existing written literature, and interviews. The interviews are with high profile people, all used to appearing publically, they are all key personalities within their professions and they were aware of the purpose of this study at the time of the interviews.

1 Yin, 2009
2 K. Ringdal, 2001:85

Both of them received the questions and the topics of my study about a week before the interview. One read the questions the same day that the interview took place. They were also asked their permission to record the interviews, and agreed.

When this is said, about the interviewed persons; this was not a survey or a topic of personal character.

Regarding plagiarism or directly copying text without making the reader aware that the text is not my own, this is a difficult issue, because when working with and reading the same text several times, I have to be extra aware of this. I have, when quoting sentences or phrases, put them in quotation marks, and when the general text is influenced by external literature, I have made reference to the author.

As for information from articles found on the Internet or in the library, I have in each case referred to the article or text and the publisher.

Regarding copying others studies, as far as I know, there are no other studies with a similar approach to this one.

3. Theoretical Perspectives

The theoretical contributions and literature used for this paper is found in studies of European anti-drugs policy processes and cooperation, governance traditions, trends and translations, and in theories of trans-national historical perspectives.

These theories are found useful for this study's purpose; to examine travelling ideas and the influence of knowledge and its contribution to the harmonization of the European drug policy area. Since travelling ideas and knowledge are informal and unstructured, and to a certain extent not yet a developed field, we found need of applying theories from other fields. These are able to examine these processes, goes beyond the formal structures, and are able to discover crucial elements in a translation process.

The research questions are as follows:

1. Why was the Portuguese drug policy model translated into the Norwegian context?
  - **1.1** How did the Workgroup adapt and implement the Stoltenberg Committee's proposals 3 & 4?
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2. How do Norwegian governance traditions impact on and transform the Stoltenberg Committee's proposals based upon the Portuguese de-criminalization?
  - **2.1** What are historically the crucial elements the Norwegian drug policy governance traditions are based on?
  - **2.2** Can these elements from the Norwegian Governance traditions be recognized in the Workgroups report?

3. How can the Norwegian translation of the Portuguese de-criminalization model impact on the handling of drug use and addiction?
  - **3.1** What practical consequences can the proposed interventions have on the individual drug user?
  - **3.2** And what are the differences between today's and «tomorrows» practice of the police's handling drug users?

The study questions and its topics is lead out from the case study's purpose;

This thesis examines the Norwegian translation of the Portuguese drug policy model and the Norwegian governance traditions impact and transformation of the Stoltenberg Committee's proposals, based upon the Portuguese de-criminalization model. (From the Introduction)

3.1 The Translation approach

Research question number **1** will be addressed as both the *translation question*; the question is about *what* Norway learned from the Portuguese de-criminalization model, and comparative (see next section). To search for the answer; *why* was the Portuguese drug policy model translated into the Norwegian context, we will have to examine the translation process.

To be able to do an in-depth research on this translation process between Portugal and Norway, it requires a theory which allows us to examine and discover all the crucial elements of this kind of process, and at the same time it must have focus on the travel of knowledge and ideas from one context to a different context.

One theoretical approach suitable for this study is found in Kjell Arne Røvik's *Translation Theory*. The theory is about spreading, transfer and influence of ideas and knowledge between different contexts, inspired from theory of translation between languages (see more, chapter about Translation Theory, chapter 3.2).

3.1.2 The Comparative approach

Question 1 & 2 has a comparative approach, regarding *how* the different national contexts and its traditions of governance's impact on the national drug policy, and the differences and similarities between the Portuguese de-criminalization mode, and the Norwegian proposed Interventions. The theoretical approach is found in theory which is able to go beyond the traditional welfare state model-thinking; which is categorizing different welfare states into models, and defines specificities in the different models, and generalize the different nations within each model.

Instead of focusing on these categories' specificities and generalizing each models national quality, the theoretical approach for this study is found in theory on «trans-national historical perspective on social work».

The comparative approach in this theory is not between the different welfare-state models, but rather on «recognizing cross-national comparative political, cultural and economic practices», and Kettunen examine «the national welfare states in the Nordic countries as trans-national historical constructions».

This approach is historical instrumental, and let us examine important structures and elements difficult to discover with the traditional comparative welfare state theory. It goes beyond the models and categorizations, and focus on how «inter- and transnational processes have been constitutive of the making of national welfare states».[1]

The understanding of the different elements' role will contribute to this case in order to understand how the different institutional contexts and traditions of governance shape the response of Portugal and Norway, expressed in the national policy documents.

The Workgroup's report implements and adapts the Portuguese de-criminalization model after the Stoltenberg reports proposals. How can the mentioned elements explain the divergence between the Portuguese and Norwegian response to drug addiction problems, and the different choices the two countries made in the restructuring process?

3.1.3 Analytical approach

The role of trends and travelling ideas and knowledge, are especially interesting in the area of drug addiction policy because of the lack of agreement on a common European drug policy, and as EU has defined it as an area of subsidiarity. Despite this, there are common trends in drug addiction strategies, and convergence among different member states. Good drug policy practices and knowledge can provide valuable lessons. Furthermore, when it comes to innovation and restructuring processes, nations often look to drug policy ideas and practices beyond their national borders.

While there has been a clear convergence in measures to reduce the supply of drugs and anti-drugs trafficking policies since late 1980s[2], there is still a clear divergence between the member states' national policy in handling of drug addiction. The social policy area,

1 Kettunen & Petersen, 2011:2
2 Elvins, 2003

as harm reduction, demand-reduction and preventive measures is an area under the EU's principle of Subsidiarity.

This question addresses theories which are able to examine the area of trends and translations, production of knowledge, trans-national decision-making, multi-level governance and other elements important for how drug policy trends and travelling ideas and knowledge in the area of drug addiction influence the harmonization of European drug policy.

The theoretical approach fond to this study's analytical approach based on perspectives on European anti-drug policies, found in Elvins[1] and Kettunen and Petersen[2], and earlier studies on Norwegian governance traditions and national drug policies from Fjær[3].

Epistemic Community

In the area of production of knowledge, it is especially of interest the theory of power sharing in the international system and how the continuous increase of cross-national formal and informal cooperation impact on the power of national governments[4]. In the debate, the role of epistemic communities becomes interesting for this study.

The theory of epistemic community is well developed by Peter M. Haas[5] and is dealing with the growing role of networks of knowledge-based experts. Haas defines an epistemic community to be a network that may consist of professionals from different disciplines and backgrounds, but have in common:

1. *A shared set of normative and principled beliefs*, which provide a value-based rationale for the social action of community members;
2. *Shared causal beliefs;* which are derived from their analysis of practices leading or contributing to a central set of problems in their domain and which then serve as the basis for elucidating the multiple linkages between possible policy actions and desired outcomes;
3. *Shared notions of validity* – internally defined criteria of weighing and validating knowledge in the domain of their expertise

1 2003
2 2011
3 2004, 2008
4 Elvins, M. 2003:41
5 Elvins, M. 2003:53

4. *A common policy enterprise* – a set of common practices associated with a set of problems to which their professional competence is directed, presumably out of the conviction that human welfare will be enhanced as a consequence[1].

The idea is that in the policy field there is a growing international cooperation, -agreements and -impact on countries national policy, and because of a huge and over-complex field, it has be more common that national policy-makers seeks knowledge, information and advices from experts within the actual field or discipline. The cognitive and normative elements are seen to be crucial in the epistemic communities.

Haas claims in Elvins, M.[2] *the increasing uncertainties of modern international governance have led policymakers to turn to new and different channels of advice, often with the result that international policy coordination is enhanced.*

This is interesting in our area of travelling ideas and knowledge; ideas and knowledge can travel through expert networks, or epistemic communities, by that expert networks seeks knowledge through their international expert-colleagues across national borders. This exchange of knowledge and policy-ideas is not within a national context, but rather experts exchanging good practice and knowledge between expert networks, and not between nations. And as Haas points on: with the result that international policy coordination is enhanced.

Regarding power sharing, within the theories about epistemic community, control over knowledge and information is an important dimension of power[3]. In this way, the policy-makers get advices and knowledge-based policy measures, given from the epistemic community, which often is ideas and knowledge travelled across national borders, and ideas from different national contexts. Can this be a different way of looking at international harmonization of the drug policy, informal, but yet with influence? Can travelling ideas and knowledge and international exchange of national drug policy ideas contribute to a greater convergence in harm reduction strategies?

1 Elvins, 2003:54
2 2003:55
3 Elvins, 2003:50

The policy-makers are not forced to follow the epistemic community advices, but the expert network have been given the confidence out from who they are, their expertise and that they are suppose to work with a policy idea out from a knowledge-based approach, without ideological, political or administrative incentives.

In other words; the policy-makers have given the «best men» their trust. If the policy makers then choose to not follow the expert-group, it will immediately be huge concern about the consequences of *not* acting according the expert-groups advices. To ignore the advices will be a great concern of uncertainty, and is a situation policy-makers prefer to avoid. Regarding Haas, uncertainty on the part of decision-makers is argued to be the main *germination* factor behind the emergence of epistemic communities.

Policy-makers growing demand for seeking advices in expert networks is that epistemic communities is believed to offer an alternative and neutral source of advice and knowledge, which means that it is more accepted across different political interests, it is based on consensus and common understanding rather than by negotiations, and there is a common acceptance that the outcomes are qualitative better. When policy-makers are dealing with issues in a complex area, without having much knowledge or political guidance, or where there are strong but different opinions, it is often considered as less confrontational to seek advices from a neutral group of experts[1].

This thesis examines if both the Portuguese committee behind the Portuguese Drug Strategy, and the Stoltenberg Committee behind the Report on drugs can be defined as epistemic communities. The both committees were appointed by their national governments to work out a better way in handling and meet controlled drug use, -possession and -addiction.

The committees was appointed solely for its specific committee work, and the members were, though different composed, believed to find best solution, independent of political or administrative motives. They were also both influenced of international knowledge and experience, and from different countries national drug policies they found interesting and represented good practices with good outcomes. Both of the committees had also a

1 Elvins, 2003:55

wide scope of freedom, their mandate was clear, without any political or administrative restrictions.

As in epistemic communities, the committee's actors and incentives are of great importance, also within Røvik's translation theory.

In both of the committees the members were chosen out from individual capacities and characters, and professional background, regardless their political, administrative or institutional belonging.

The Workgroup had a quite different starting point; the mandate was to implement and adapt the Stoltenberg committee's proposal 3 & 4, and it was clearly expressed that a de-criminalization question regarding use and possession on drugs was not to be considered. The Workgroup's mandate also asked for the statement of the Norwegian current law, look at what categories of people could need alternative to responses and follow-up measures regarding controlled drug abuse. The mandate requested the Workgroup to specially explain and examine the Portuguese model from the Stoltenberg Committee's proposals, and a new project tried out in Norway, a scheme with the Drug Rehab Programme with Court Supervision (ND), which has similarities with the Portuguese interdisciplinary tribunals, CDT (Comissão para a Dissuasão de Toxicodependência). The Workgroup was asked to consider new ways of handling drug related crime, and «think» alternative.

The Workgroup members were all professionals from the state ministries, and they were anonymous in the sense that the name is known, but their role was by virtue of their positions in their belonging ministry and in the quality of their professional work.

3.2 The Translation Theory

The relevance of translation studies' and Røvik's approach

The theoretical perspective presented in this chapter is based on Kjell Arne Røvik's *Translation Theory*, inspired by international academic «translation studies» from the 1970s. Røvik has found the translation approach suitable for organizational restructuring processes in order to identify institutional and organizational questions.

Translation studies changed and developed in the 1980s and -90s from a theory mainly focusing on how to reproduce and translate pure text, towards a broader meaning of translation, including an awareness of the translated languages' culture and context.

Bassnett and Lefervere call this *The cultural turn in translation studies*[1].

Translation studies should no longer focus only on linguistics and language, but equally on cultural issues between different contexts. Rubel and Rosman in Røvik[2] define the change as follows: *Translation in its broadest sense, means cross-cultural understanding.*

Knowledge and understanding of the context surrounding the different languages is as important as the idea itself regarding the transfer of ideas and knowledge from one context to another.

With regard to the analysis in this study, the transfer of drug policy ideas and knowledge, it is important to understand the ideas' national contexts, the Portuguese and Norwegian governance traditions and their structures. An awareness of how the different national specificities influence the area of drug policy-making, and what the elements are, is crucial for understanding the Norwegian translation of the Portuguese de-criminalization model. In chapter 4 & 5 the historical background and the interviewed narratives also show how crucial some historical events can impact on the national policy development.

Røvik developed a translation studies theory directed at organizational and institutional ideas and knowledge, and his concepts and vocabulary explain the transfer process of ideas and knowledge between different organizations.

This thesis examines questions regarding drug-addiction policy ideas, and uses the theoretical approach from Røvik's organizational theories. Røvik argues that it is necessary to look at the transfer process of knowledge as a translation, and that translation studies should no longer be restricted to studies of languages, but rather to a broader field, which in principle can be used on all forms of social communication and expression.

1 Røvik, 2007:252
2 2007: 253

The transfer process of ideas and knowledge can, according to Røvik, be understood in the same way as we examine the translation process between languages.

A concept of ideas which is successful and becomes attractive for others to adopt, can be compared to a bestselling book published in different languages. The translator needs to have knowledge and an understanding of both languages and their respective cultures in order for the book to be equally successful in each country.

This concept can be transferred to the translation of ideas; the idea leaves one context, travels, integrates and spreads into one or several new contexts. The translation consists partly of a *de-contextualization* (detachment from the context), partly of a *contextualization* (implementation) of ideas, and the translation process and the skill of the translators are crucial for how successful the translation becomes.

Unlike objects, ideas and knowledge are not physical things, and consequently they are highly modifiable.

To transfer an object from one context to another will normally not change the physical aspect of it, while e.g. a (travelling) drug policy idea will always diverge from the original idea to some extent.

In this study we have chosen to use Røvik's translation theory in order to describe the processes which takes place from when an idea starts to travel (from practice to idea), when it detaches from its context, travels, and finally adopts and adapts to a new context. In other words, what is «happening» with the idea in the translation process?

The translation approach is found appropriate for this study's aim. In the next sections the theoretical base for the translation theory will be presented.

Røvik points out four important questions in developing translation theory. This study will introduce these as the principal elements for the translation theory. Thereafter the translation process is presented in parts; de-contextualization, and contextualization.

Four principal questions

1. Why are some ideas and concepts becoming so attractive to others that they choose to adopt and implement them (or parts of them) into their national policy?
2. Why do they wish to adopt these ideas?
3. Who are the actors (the translators) and
4. What is behind the request for change?

When a specific and relevant policy idea has proven successful, it is fair to believe that others will be attracted to that idea and want to copy it or more exactly; the successful results it has produced. Further we are interested in, amongst others, why Norway found interest in the Portuguese drug policy, who were the prominent actors, and what exactly did they believe to achieve with adopting and adapt the model into the Norwegian context?

The different translators, their incentives and contextual conditions are crucial elements in understanding further how the translation processes develop.

Røvik sets up four principal questions to work out his translation theory. These are the:
1. Incentives. *Why are ideas and knowledge often translated? What are the possible different incentives behind a translation process?*

This study focuses on the question, why do nations translate other nations' drug policy practices or ideas? What are the different incentives behind the Norwegian translation of the Portuguese drug policy model?

According to Røvik, a translation can be intended, or unintended. An unintended translation can appear when ideas are translated , without a specific purpose intended for that translation. It can for instance be a person's influence on an idea, which contributes to an unintended translation.

For this case study, the translation is intended, and the motives in an intended translation can roughly be divided into three categories;

The first is a clear and rationally expressed decision; an organization wants to translate a good and relevant idea in order to bring it into their own context, and makes a local version of the idea. The incentive is to use the idea adapted to their context, believing that implementing the idea will improve the organization.

The second motive is when the translation process takes place in a context of conflicts between contradictory parts, where negotiations drive the process in particular directions.

The third is when the translation of an idea results from more hidden or implicit motives or from more symbolic or status-related considerations. A translation can have symbolic motives, in the area of policy making. Regarding policy and political issues; can translating 'great' and famous policy ideas symbolise that those adopting the translation are themselves innovative,

An examination of the motives for translation is crucial to this study, especially when these are linked to the different actors and governance levels in the three different processes. How do the incentives form and influence the three different drug-policy processes in the policy making process?

2. The competence of the translators. *Who are the translators? Who are the mediators of the ideas and knowledge between different contexts? And where is it taking place?*

The translators who mediate ideas between different contexts are central elements in translation theory. How do the translators impact on *what* is translated, and *how* it is translated?

According to Røvik, it is essential to know something about the translator's competence and his/her impact and role. He also claims that a theory or methodology on these issues is needed to examine the translation process.

The roles of the mediators (from now on named translators or actors) are crucial throughout the entire translation process. For this study it will be especially important to focus on the different actors and where the translation takes place in the contextualisation process between the Stoltenberg Committee's Report and the Work Group's Report, to be able to

examine and understand the differences and similarities in the results that the two reports produce.

The translators, where the decisions' takes place, and their incentives during de-contextualization, in our case the mediators between the Portuguese and Norwegian translation, will also be examined. Here it will be important to examine what the mediators wanted to export, *who* they were and what did they mediate.

Who were the mediators for the Norwegian process, what did they import and transfer to the Norwegian context, and why (the incentives).

Røvik emphasizes the importance of examining and understanding the translators' competences regarding what *knowledge* the mediators have about the ideas and the contexts. Contrary to what usually happens in translations between different languages, where the same translator is used to translate from the original language to the translated language. When it comes to the translation of ideas and knowledge, different people are involved, and not only two but often several people, and from different arenas with often different incentives. This can represent a big challenge to the different actors, who may very well be extremely knowledgeable about «their» own ideas and context, but be quite lacking in knowledge about other elements in the same process. The contexts are also crucial regarding the idea; it can work very well in one context, but not in others. Also, it has arisen out from some specific conditions, which is not present in the adoptive context.

Røvik also questions the translators' visibility; how crucial should a translator's role be? How important are the mediators' personal incentives? And to what degree should a translator influence the process? This issue comes across in the literature as a conflicting debate. Some argue that the translator's role is to reproduce the language as precisely as possible, as the «invisible» translator, without his/her own «fingerprints». Others emphasize the translator's role, and attach great importance to the process.

It will be important to have a theory regarding this issue in order to examine and understand the actors' impact on the decision-making process involved in this type of translating. Again, in this case, this has to be directly linked to the incentives and arenas when examining the translator's role.

3. Translation Rules. *Are there any general rules in translation of ideas and knowledge? Can we recognize patterns and identify rules for the de-contextualization and the contextualization process?*[1] *To what extent does the translator reform the idea?*

These questions are the basis for a theory regarding the translation processes' possibilities and limitations. Can we find rules, and a theory to examine and explain to what degree the translated idea is transformed from the original? How much «freedom» is the translator given?

Where are the translator's limitations? In our case it is crucial to examine to what extent the Norwegian process has transformed the Portuguese de-criminalization idea. What did the Norwegian translation do with the Portuguese idea?

Røvik[2] asks how «*translationable*» a practice or idea de facto is. Are some ideas and concepts more suitable for translation than others, and if so, is it possible to recognize these?

Within translation studies there are two opposite opinions regarding this question. The first position is called the rationalistic-universal position; ideas and opinions are universal and in principal suitable for transfer and translation between different cultures and languages[3]. This means that ideas and opinions are basically the same and universal, independent of the language and culture and general contextual conditions.

The other position is opposite; ideas and opinions are dependent and attached to the context, culture and language, and cannot be detached without loosing important parts of the idea[4]. This position defines ideas and knowledge as unsuitable for transfer and translation.

A theory on rules of interpretation would help us to look at the elements that the Norwegian actors adopted, adapted and changed from the Portuguese model. What is «left» of the original concept? And how successful is the translation?

1 Røvik, 2007: 257
2 2007: 257
3 Røvik, 2007: 257, quotation from Pym & Turk, Rubel & Rosman
4 Røvik: 258, quotation from Quale

4. The Translation's Effect. What is the translated idea's influence on the new context? Here Røvik[1] also points out two opposite positions regarding the question;

The first position is again an example taken from the literature, where the translation's objective is to transfer the text only, i.e. to transform the foreign language into another language. This position will not take into consideration the culture and context of the languages. The aim is simply to communicate the text into another language.

The other position is based on the idea that the translator has to adapt the text to the new culture and context, and take into consideration the translation's objective, which to a great extent is based on the incentives for the new translation. The translator's main purpose is to make the text functional in its new context, and the translator is given the freedom to make necessary changes regarding the translation's objective. The approach to the translation is pragmatic and the purpose of the translation is to make the text as functional as possible in its new context[2].

In our study, will we focus mainly on the last position; the translation has a clear objective expressed in the different reports. The Workgroup's mandate was to implement, integrate and adapt the Stoltenberg Committee's proposals 3 & 4 into a Norwegian structure and context. The Workgroup were pragmatic regarding the mandate they were given, and the implementation was to a great extent adjusted to the Norwegian structural and legal context.

To examine the translated idea's effect on the context, can contribute to develop theory on crucial elements in the operationalization process (when contextualizing).

The tranlation's effect is one of the important elements in the contextualization part, and, for this study it will be theoretically treated as it is relevant for the total translation process. Empirically this study does not involve examination of the translation's effect isolated as the implementation- and integration process of Stoltenberg Committee's Report is still in progress.

1 2007: 259
2 Røvik, 2007: 259

Regarding this case study, the four above mentioned principles will be guiding in our analysis and examination of the Norwegian translation process of the Portuguese drug policy model. The Norwegian actors were very different from each other regarding the committees' compositions, incentives and translation rules, though their works regarded the same proposals. It will be interesting to examine how their mandates stated their translations rules; the Stoltenberg Committee were given great freedom regarding their mandate, and the members were former politicians, persons from idealistic work, and none of them with drug related professional background.

The Workgroup, which consisted of highly competent civil servants from the government adimistration, had a rigour and clear mandate in implementing and adapting the Stoltenberg Committee's proposals, and the majority with legal professional background, all belonging to the state ministries.

3.2.1 Introduction of the De-contextualization and Contextualization

Røvik[1] finds it practical to divide and examine the translation process in two sections, in chronological order. The translation process can be seen as a process from where ideas in certain practices disconnect from their original context, travel and transfer to a new context where there is an attempt to adopt and adapt them into the new practice. This process is manly about what «happens» with the idea. How much and to what degree does the translation process and the new context influence and change the idea?

One reason for dividing the translation process into two sections, is that there are often different processes involved within de-contextualization and contextualization, regarding time, arenas, incentives and actors, and also the different contexts themselves. In a translation from one language to another, the process is normally carried out in the same context, using the same translator. However, when it comes to translating ideas, the processes are often separated[2].

1 2007: 260
2 Røvik, 2007: 260

The first part of the translation theory is de-contextualization; «an attempt to detach something from its context»[1]. This is a process where identified practices are brought out of their context and transformed with the intention of transferring them to other contexts[2].

De-contextualization is primary about how to turn a practice, or in our case, a policy model, into an idea, and to be able to transfer and adapt this idea into other contexts. At this stage, it will abstract from the original idea or practice, in order to be able to detach itself from its original context.

The process of detachment generalises the idea and makes it universal which is necessary to make it transferable. In this process it becomes more adaptable, but at the same time more abstract, and vague. At this stage it has tried to achieve «a conceptually representation; i.e. it conceptualizes, describes and gives a linguistic character»[3]. This is a crucial stage because of the room for interpretation of the original idea.

The second part of the translation theory is contextualization; «Contextualization here is understood as ideas, which, to varying degrees, are representations of practices from certain contexts, where an attempt has been made to introduce them into a new organizational context»[4].

Dividing the translation process however, will be theoretically, and de-contextualization and contextualization will not be treated fully separately.

1 Røvik, 2007: 248
2 Røvik, 2007: 260
3 Røvik, 2007: 262
4 Røvik, 2007: 293

4. Historical Background

This part looks at the historical background of the Portuguese and Norwegian process of restructuring their national drug policies, respectively the Portuguese De-criminalization law 30/2000, and the Norwegian preparation for the White Paper on drugs, June 2012.

It also presents the existing legal frameworks of the Portuguese and Norwegian drug policy on handling drug use and possession.

This part bears in mind the study's focus on governance traditions, and the translation's crucial elements (see chapter 3, translation theory), the actors, their incentives and their arena, which here means their historical and local contexts.

Who were the prominent actors, their incentives, and what was their institutional context in the respective restructuring processes?

It is interesting that there are common characteristics in the Portuguese and the Norwegian drug situation before the appointment of both the Portuguese committee behind the Drug Strategy Plan, 1998, and the Stoltenberg Committee's Report on Drugs, although the two countries are both geographically and culturally quite different from each other.

4.1 Towards de-criminalization

Recent Portuguese history, namely, from the beginning of the twentieth century, is different from general European development at this time. After the Second World War, Portugal was one of the few western European countries with a dictatorship, which lasted until the fall of the Salazar regime in 1974. Drug use and addiction was a minor problem, as it was «*a firmly Catholic, traditional, conservative society governed by the authoritarian dictatorship of Antonio Salazar*»[1]. (See also chapter 5, interview with Goulão.)

The «hippie-movement» in the 1960s introduced a period of drug use and experimentation to most of the western world and Europe which did not reach the, at that time, isolated Portugal.

1 Domoslawski, A. 2011:13

Due to Portugal's geographical location, the country is today one of the main entry points for drugs into the European market. It is a transit nation for the trafficking of cocaine, heroin, cannabis and other drugs. In 2006, more than 34.5 tonnes of cocaine were confiscated, and it is estimated that 77 % of the drugs seized in Portugal are destined for other European countries[1].

Associations to the «new freedom»

One common explanation on the Portuguese drug phenomenon is that Portugal was not prepared for handling the drug problems. After the Salazar regime, there was very little common knowledge and experience with drugs and drug use and addiction.

«It was a sudden increase in the experimenting of drugs after the democratic revolution of 1974»[2], which was associated with the new found freedom. The democratic revolution also represented the end of the colonial war in Africa, and both Portuguese migrants and soldiers returning to Portugal, brought with them habits of using drugs, mainly marijuana, which in some colonies had been grown and used openly[3].

National legislations on drugs

Portugal began its drug legislation in 1920, with a national legal framework adapted to the recommendations of the International Opium Convention of 1912.

1 Hughes, C. & Stevens, A. 2010:3
2 EMCDDA. 2011:10
3 Domoslawski, A. 2011:13

Towards decriminalization

1920	1970	1971	1973	1974
First legislation on drugs	First law to regulate production, traffic and use. First national legal framework for the criminalization of drug use	Portugal ratified the 1961 UN Single Convention	First treatment service opened	Establishment of Youth Studies Centre, and Drug Criminal Investigation Centre

From then and 40 years on, until after Salazar's death in 1970, no other legislation was passed in Portugal on illicit drugs.

In 1970, Portugal got its first law to regulate the production, trafficking and use of narcotics[1], and provided a legal framework for the criminalization of drug use[2].

In 1971, Portugal became part of the international anti-drug cooperation programmes, through ratifying of the UN Single Convention on Narcotic Drugs of 1961, and afterwards they also ratified the UN Convention on Psychotropic Substances of 1971 and the UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988[3].

In the period between 1970 and 1974, before the end of the authoritarian government, the focus in political debates and drug policy, was on the moral issues. Drug use was seen as a social opposition to the political regime, and capable of inciting criminal activity. The aim became to stop the contagion of the drug phenomenon. Drug use, which was considered dangerous, or encouraging others to consume drugs, had a maximum penalty of up to two years in prison.

Criminal and Preventive Studies

With the sudden increase of drug use and experimentation, two governmental bodies were established; the Drug Criminal Investigation Centre and the Youth Studies Centre.

1 Decree-Law 420/70
2 EMCDDA. 2011:10
3 EMCDDA. 2011:9

1976	1983	1987	1993	1999	2000
First legal document mention decriminalization on drug use	Adapted UN Convention 1971. Recognises the drug users need of medical care	Increase of heroin problems. First national program to fight against drugs (Projecto VIDA)	Primary Portuguese law on supply reduction. Law states sanctions are designed to encourage the drug user to seek treatment	Approval of the Portuguese Drug Strategy Plan (1998)	Law 30/2000 Now 29th, decriminalize drug consumption

The latter had, amongst other things, «the mandate to develop studies on drug issues, particularly in the areas of treatment and prevention»[1]. The Youth Centre is seen to have played a crucial role in establishing Portugal as a prominent actor in the area of drugs. It was given an equal role as the criminal investigations, and can be one explanation for the early drive towards health and social care for drug use.

Already in 1976, considerations for the de-criminalization of drug use were introduced in the Portuguese legal framework. Proposals were made to enlarge the Youth Centre's role regarding handling drug use, and to move the «concept of drug use as a criminal act»[2] to work under an administrative framework. It also proposed to move the responses of drug use to qualify a drug user as a patient, not as a criminal[3].

Treatment before sanction

In 1983, a new national legal framework, decree-law 430/83, adapted the UN -71 convention and strengthened the repressive measures on drug trafficking. At the same time, the law stated that the drug user had status as a patient in need of medical care, and the priority was to provide treatment before punish. This law was, according to EMCDDA, the first progressive move towards a drug policy that clearly prioritizes early intervention and treatment before punitive sanctions.

The approach towards a de-criminalization of the use of drugs, continued on this path, with the Youth Centre as a prominent actor in the drug policy discourse.

Problematic heroin use had started to increase, and in 1987 the first National Programme to Fight Against Drugs, Projecto VIDA, was put into force. This programme presented an integrated and comprehensive drug policy, aiming at both demand and supply reducing[4].

A further step towards a less punitive drug policy, was a new drug law in 1993, regarding supply reduction. In the preamble, the law declared sanctions on drug use to be a «quasi-symbolic manner». It explained further that the sanction system was designed to encourage the user to seek treatment[5].

1 EMCDDA. 2011:10
2 EMCDDA. 2011:11
3 Trigueiros et al. 2010, EMCDDA. 2011:119
4 EMCDDA. 2011:12
5 Dias, L. 2007:86

Low prevalence – problematic use

In the 1990s the problematic heroin use became a growing concern in society, and though the life time prevalence on illicit drugs has historically always been low in Portugal (7.8 % in 2001), the intravenous heroin use caused an alarming increase of HIV/Aids, Tuberculosis and Hepatitis B and C[1]. In 1999 Portugal had the highest rate in Europe of Aids among injecting drug users, and at the same time drug-related deaths had increased more than 50 % in two years, to a peak of 369[2].

Though the life time prevalence on illicit drugs was also low at the time, problematic drug use was the subject of social concern, and a Euro-Barometer survey in 1997 showed that the main concern in the population was the main social problem of Portugal[3].

A travelling drug policy model

The Portuguese Drug Strategy Plan was made in 1998, and approved by the government in 1999. The De-criminalization Law 30/2000 which followed was put into force a year later. More than twenty years with the ongoing dilemma between a desire to help, and to criminalize drug users, came to an end.

Now with twelve years of experience, the Portuguese de-criminalization model concept still attracts international attention, and has become a travelling drug-policy idea across national borders. There are even published recipes on how to implement the strategy into other national drug policies. The fact that it is possible to examine the consquences of this policy with 'before and after' studies, and since it is a comprehensive and conceptual model, it has become a popular research tool.

The Portuguese drug situation at present shows no increase in the general use of illicit drugs, nor any drug tourism, as critical voices predicted. The problematic drug use, drug related deaths and infectious diseases are reduced, so too the burden of drug offenders on the criminal justice system. And, Casal Ventoso, once Europe's biggest open and permanent drug scene, named Europe's drug bazaar, is today a quite neighbourhood in Lisbon. There are now no permanent drug scenes in Lisbon.

1 Hughes & Stevens. 2010:3
2 IDT
3 Domoslawski, A. 2011:14

Three interesting aspects of the de-criminalization model are highlighted in the Portuguese Drug policy profile, published by the EMCDDA;

1. The focus for restructuring the drug policy was the problematic use of heroin. This is opposite to other countries when changing their laws; usually the concern is an increase of the use of cannabis amongst young people.
2. De-criminalization is only one element of the Portuguese model; important elements are also moving the responses from the Ministry of Justice to the Ministry of Health, a comprehensive and integrated plan, use evaluation as a policy management tool, and bringing alcohol and drug policy closer together. It is best described as a public health policy founded on values such as humanism, pragmatism and participation.
3. The Portuguese model is not a «magic bullet», and does not clearly distinguish from other European countries' development. But the policy response to drug problems in a pragmatic and innovative way, and to develop a transparent, coherent and well-structured policy[1].

4.2 A restrictive and value-based foundation

In order to examine Norwegian governance traditions, we will look back at the origins of the drug policy debate, based on earlier studies. Norway had its first experience with the «new» drug phenomenon in the middle of the 1960s, which was about recreational drug use, regulated through the UN Single Convention on Narcotic Drugs, 1961. The use of drugs was seen as an element of youth culture, and rebellion and political radicalism. The Norwegian Director for Public Health at that time, Karl Evang, saw this as a breach of the Norwegian objective, which was to make young people active participants in politics and in society in general. The main focus was to create a collective value based attitude in the preventive work. This approach became one of the main elements in shaping Norwegian drug policy[2]. At this time, drug use was seen as a potential threat to the society.

Education against drugs

The use of educational measures were, from the beginning an issue for controversy, and finding a balance between educational and value-based preventive work became a power

1 EMCDDA. 2011:24
2 Fjær, S. 2008:158

struggle between the general public and professional experts, politicians and civil servants. The experts were sceptical towards the stigmatization a value-based approach could lead to. On the other hand, however, it was difficult to find proper measures for educate the entire society where the great majority of people did not actually use illicit drugs[1].

Protect the society

Karl Evang was in retirement when he compiled the 'White Paper' on Drug Policy, 1976. He is seen as the main contributor towards opening a public debate for dealing with drug problems as a public health issue[2], and one of the prominent actors in public health policy.

The policy was built upon two main objectives:

1. to stop the spread of illegal drugs in society, and
2. to strengthen people's resistance towards behaviour that includes experimenting with the use of narcotic drugs.

Up to the present, these objectives have been the foundations for the drug policy, aiming to protect and educate the Norwegian population.

The principal of 'stopping contagion' was a measure inherited from the fight against tuberculosis, which was based on the idea that, for the purposes of sanitation, it was important to separate the healthy from the infected. It was believed that people's resistance would develop in several ways[3]. The drug problem was seen as an epidemic threat, although based on the expectation that the situation would improve, and that social resistance towards the use of illicit drugs would increase. It was easy to agree with strengthening a system for controlling the illegal drug trade, but it was not obvious that it would be useful to criminalize the use of drugs [4]. In 1967 the Penal Law Advisory Council recommended the criminalization of controlled drugs. The Norwegian authorities chose to act with great determination when confronted with a minor social problem[5].

1 Fjær, S. 2008:158
2 Fjær, S. 2008:148
3 Fjær, S. 2008:149
4 Fjær, S. 2008:146
5 Fjær, S. 2008:155

Low prevalence – problematic use

Norway has faced huge challenges over the last two decades due to problems arising from the use of syringes, especially by heroine addicts, and the high mortality rate caused by drug overdoses. As with Portugal, Norway has historically low lifetime prevalence on illicit drugs, at present we are slightly above Portugal regarding the use of common drugs.

Despite Norway's restrictive policy on the use and possession of drugs, tremendous efforts made and resources spent dealing with the problem, low tolerance towards the use of illicit drugs and punitive sanctions under the Criminal Code, the strategy seems to be unsuccessful, especially when it comes to the neediest drug addicts.

With between 250 to 300 drug related deaths per annum over the last 15 years (peaking in 2001 at nearly 400 drug-related deaths), giving Norway the highest mortality rate for deaths resulting from drug overdoses in Europe, permanent and open drug scenes and poor health and living conditions amongst the poorer drug users, public debates question Norwegian drug policy and its handling of drug users and drug addicts.

There are common agreement on the fact that the number of problematic drug users (estimated at between 6,600 and 12,300 people, 2008, EMCDDA), and drug-related deaths are too high. At the same time, there is still a broad support for a restrictive drug policy.

Towards harm reduction

In the 1980s, at the beginning of the HIV epidemic, Norway started to develop measures to reduce the danger of contagion through intravenous drug usage (IDU). During the 90s, Norway developed a range of different harm reducing measures, such as program for the free exchange of syringes, different low threshold measures, a medical assisted rehabilitation program (MAR) , and the establishment of injecting rooms in Oslo, 2005.

At that time, Norway moved from a zero-tolerance approach towards harm reduction and low threshold measures. Yet any kind of use or possession of illicit drugs was and is still illegal.

How to help?

In March 2009 the Norwegian government appointed a committee with a mandate to *… submit proposals for ways in which the neediest substance abusers can get better help.* It was also asked to look at the possibility of heroin-assisted treatment.

The appointment of the Stoltenberg Committee was a result of the on-going public debate about the poor living conditions of problematic drug users.

The starting point for the debate was the open and permanent drug scene situated around Oslo Central Station, and visible problematic drug usage in streets and public places. The drug users' poor living conditions became an issue for public discussions, and questioned the lack of dignity, and that they obviously should be considered as sick and not criminal.

Workers involved with problems on the street, user organizations and others working with Oslo's problematic drug users, claimed that the police had their own local practices and that they treated people suspected of drug use arbitrarily, fined people and tried to expel them from certain areas or prohibit them from remaining in certain places, and arrested people with no formal explanation. This was considered an undignified treatment of a vulnerable group and stigmatisation of drug users. The local police and authorities, however, defended their practices and claimed that they treated drug users with dignity in accordance with the law and regulations.

The problematic drug situation has lead Norway to look at how other nations meet their drug related problems. The Stoltenberg Committee introduced alternative approaches to meeting these challenges in their report, giving, amongst other things the example of the Portuguese de-criminalization model.

4.3 Legal frameworks in Portugal and Norway

Within European countries, there are differences on how to handle concerns regarding illicit drug use and addiction. There are some measures that can be seen as having a more positive impact than others on people with drug addictions. The Stoltenberg Committee attempted to find countries which have succeeded more than others regarding treatment and services with positive impact on drug addiction, and the drug users' quality of life.

Portugal has been most radical in its official drug policy among EU countries, though Amsterdam is probably more well known as the radical city in Europe regarding drugs. The Netherlands is radical in the sense that they differentiate between between soft and hard drugs, and allows regulated possession, acquisition and use of soft drugs.

With the Portuguese law on de-criminalization, Law no. 30/2000, of 29th of November, Portugal is unique in Europe. The law de-criminalizes use, acquisition and possession of drugs for individual consumption for up to 10 days of all types of drugs. The de-criminalization is solely regarding drug use; there is no softening on the restrictions regarding the distribution of drugs, as the coffee shops in Amsterdam is.

4.3.1 The Norwegian Legal Frameworks

At present, the Norwegian drug-policy works between three main laws; sanctions under the Criminal code, § 162 and § 317, which represents the Norwegian law's strictest penal codes, and under the Medicines Act, § 22. § 24 and § 31.

Norway is one of Europe's strictest countries regarding penalties for involvement with illicit drugs. In Norway the Medicine Act, § 22, regulates what is seen as drugs. The Medicine Act is used in less serious situations, such as the consumption and possession of small amounts of drugs, where the maximum punitive sanction is up to six months. The Criminal Code, § 162, from 1968, deals with the professional trade of drugs. The ordinary penal sanction is two years, with serious crimes receiving the maximum penalty of 10 years, and for especially serious crimes, the maximum penalty is 21 years, which also is the penalty for 'life time' in Norway.

The other sanction under the criminal code is § 317, which deals with aggravated receiving and other economical profit. The length of penalty is the same as § 162; respectively 2, 10 or 21 years[1].

In Norway it has been widely discussed if Norway should reduce its strict penalties regarding soft drug related crimes (mainly the use and possession of drugs for personal consumption), and regarding working on a completely new Penal Code. The commission that worked out the proposals for parliament and the government, proposed de-crimi-

1 The Ministry of Health and Care, the Drug-legalisation

nalization of drugs, based on the «harm-consequence-principle». Both parliament and the government turned down the proposals.

4.3.2 The Portuguese Legal Frameworks

In Portugal today there are no criminal punitive sanctions regarding possession, consumption or acquisition of drugs for personal consumption, but these acts constitute instead administrative offences.

De-criminalization is, according to the Portuguese Drug Strategy[1]: «A case of replacing the prohibition as a criminal offence, with the prohibition as a more appropriate administrative sanction». The de-criminalization law comes out from the criminal law, and use of drugs is still not legal.

When using the term legalisation of drugs, it means a complete removal of all forms of sanctions.

During the process of creating the new law, Portugal had to be aware of one of the «backbones» of the international drug policy, the three abovementioned United Nations' Conventions on Narcotic drugs of -61, -71, -88.

The committee behind The Portuguese Drug Strategy was established on the 16th of February in 1998. It was by order of the minister attached to the Prime Minister, at present (May 2011) the Prime Minister in Portugal, José Sócrates. The strategy-plan was handed over to the Government on 2nd of October 1998.

This Strategy-plan was accepted fully by the Government, so the de-criminalization law, Law no. 30/2000, of 29th of November, is directly based on the Drug-strategy's proposals and recommendations.

1 1998:39

5. In the Pathway of the Translators

Both the Stoltenberg Committee and the Workgroup visited several institutions and actors relevant to the Portuguese drug policy, during their work on the report.

This study has followed in the footsteps of the Stoltenberg Committee and the Workgroup on two of their visits to Portugal; namely to the Portuguese Institute on Drugs and Drug Addiction (IDT) and the Commission for the Dissuasion of Drug Addiction, hereafter (CDT) situated in Lisbon.

This part presents interviews with two people representing the Portuguese model; **João Goulão**, member of the Portuguese Drug Strategy committee and president of the IDT, and **Nuno Portugal**, vice president of the CDT, Lisbon. The visit to the CDT also consisted of an observation of a CDT meeting with a drug user. Both the Stoltenberg Committee and the Workgroup attended a meeting at the dissuasion commission. Both visits were made during March 2011.

IDT is the national drug institute in Portugal, and is responsible for national plans against drug use and drug addiction. According to law 30/2000, article 5.4, they «shall provide the commissions with administrative support and technical support respectively». The commissions means the CDT, the de-criminalization «in practice», meaning the commission responsible for the administrative responses to drug users.

The CDT is the:
… interdisciplinary tribunals that assess measures for persons who are arrested for the use and possession of drugs the Stoltenberg Committee refers to in proposal 4.

As discussed in chapter 2, the guiding interviews for this case study follow the principles of open-ended interviews, and the interviewed are considered more as informants rather than respondents[1].

The interviews were recorded. The presentations of the interviews have a narrative style, and are the interviewed persons' versions, based on the recording.

1 Yin, R.K. (2009:107)

This part also takes into consideration the translation's actors, incentives and the contexts (arenas).

5.1 João Goulão

João Goulão proved to be an interesting person. He was in the committee of the Portuguese Drug Strategy, and has been a central person in the European drug field up to the present day, both as the President of IDT, and at currently as the Chairman of EMCDDA.

EMCDDA (European Monitoring Centre for Drugs and Drug and Drug Addiction) is one of the main actors in the field of drug research and evidence based information, and provides the EU and its member states with information on drugs and drug addiction in Europe. It is one of the EU decentralized agencies, and is located in the centre of Lisbon.

At the beginning of the interview, Goulão said that to answer my questions, it was important to explain the historical background that lead to today's well-known Portuguese Model. In the presented version Goulão covers the questions he had received ahead of the interview.

Though we have presented the historical background (chapter 4), we find it interesting and relevant to tell Goulão's personal version.

Because, as he said, «it is not only the de-criminalization that makes our model, it is a comprehensive system, developed on the circumstances they had to deal with as a society, quite different from the rest of Europe».

Goulão's version of the Portuguese drug policy

From 1926 and until the democratic revolution in 1974, Portugal was placed under a strict military regime, most of the time ruled by the dictator António de Oliveira Salazar.

After the revolution, Portugal was a new and almost open market for drugs. Under the strict regime of dictatorship, the country was very isolated, and most of the people had a complete lack of both access to, and information about drugs.

It was also strict regarding general information about the world's society, all public information was filtered and under strict censorship.

An example of how isolated the country was, is the international critical voices against the colonial wars the Portuguese continued in Angola and Mozambique. The international society condemned Portugal for maintaining the wars, but this was unknown by the general population. Their men were not allowed to cross the border because they were intended to participate in the colonial wars.

Another important thing, the hippie and student movements in France and many other parts of the world, in the 60s passed by Portugal. While the other European and western countries had their hippie movement, and were already experienced with different substance use, this was almost unheard of in Portugal.

And then, suddenly, everything changed; thousands of soldiers came back from the colonies; Angola, Mozambique, Guinea-Bissau, with the habit of using marihuana, and bringing with them «tons» of grass. At the same time, the association of the use of drugs to the idea of freedom was present, and the world almost opened up for them, and many were open to experiences with new things.

The Portuguese people were completely naive at that time regarding drugs. It became easy to shift from one to another; from hashish and then to more heavy drugs as heroin, because they didn't have any knowledge of the different drugs and the consequences. It was a boom of experimentation. In the late 70s, «everyone» was smoking cannabis, but at the same time it started a market for heroin.

Portugal as a society was unprepared to deal with it, so it was a very attractive market for trafficking, and also geographical Portugal became, and still is one of the transit countries for the drug distribution to the rest of west-Europe.

The «boom of experimentation» was crossing all classes in Portuguese society, but when heroin came in, it mostly spread amongst marginalized people, many of them unemployed. A lot of people got «hooked» on heroin. At the same time, HIV and AIDS entered Portugal, and there were enormous problems with the infections due to syringe use, and

there were lot of crimes connected to the drugs problem. In the late 80s, and in the beginning of the 90s, it was estimated that 1 % of the total population in Portugal was addicted to heroin, i.e. around 100 000 people. The situation was terrible, many people died, many got infected with AIDS and HIV, or died from overdoses through the use of syringes.

And they had a huge problem with public visibility.

Casal Ventoso, a neighbourhood in Lisbon, close to the river, was at that time, the late 80s to 1997, Europe's biggest open drug scene. Most of the people living there were linked to activities around the harbour.

Many of them had been working in the navy, but after Portugal gave up its colonies, the naval activity decreased drastically, and a lot of people became unemployed. They had enormous difficulty in surviving, and many of them became involved in drug trafficking. Casal Ventoso became the biggest «supermarket» for drugs in Europe; between 5.000–6.000 people went there to buy and sell every day. You could find everything there.

Portugal has always had low prevalence of total drug use in the population compared to other European countries. In 2001 7.8 % of 15–64 year old people in Portugal had never used illicit drugs (so called life-time prevalence). For comparison, in the same year, 34 % of 16–59 year olds in the United Kingdom had used illicit drugs.

(In Norway, in 2004, the lifetime prevalence of total drug use between 15–64 year old, was 17 %.)

But at that time, late in the 80s, Portugal had a very narrow gap between the prevalence of total drug use, and problematic drug use, mostly intravenous heroin consumption. Almost all drug use in Portugal was problematic. In other countries there is usually a big gap between the amount of people that experiment and occasionally use drugs, and the problematic drug users.

With problematic drug use amongst 100.000 people at the beginning of the 1990s, it became an enormous public problem in terms of health, in terms of justice, of criminality

and public nuisance. And the problem of heroin was growing, it was no longer a problem only among marginalized groups, it affected the entire society.

The risks associated with the use of syringes were very problematic and life threatening, and the risk of overdoses, risk of infections, AIDS, HIV, Hepatitis B and C and Tuberculosis. In 1999 Portugal had the highest prevalence of HIV among drug addicts injecting heroin, in addition to the consequences of heroin itself.

«Everybody» knew of someone that was addicted to drugs, and in 1997 the drug problem was the 1st political problem in Portugal, and the biggest concern amongst people, before unemployment and or financial concerns.

At this time, Portugal received great financial support from the EU, so it was in a better financial situation then than it is today. This is important to have in mind regarding such huge projects as the Portuguese Model.

The first early responses that the Portuguese Government installed, in the late 70s, were under the Ministry of Justice. During the next decade, until 1987, there where no developments in states interventions, so during that period Portugal had a lot of private clinics and organizations were installed, offering services and treatment for drug addiction. Some were very profitable.

In 1987 the first public centre for drug-addicts, Centro das Taipas, were created under the Ministry of Health, and then a lot of centres were established under the Ministry of Health.

(Goulão was at that time, in 1987, a medical doctor in the Algarve, but was asked to start one of those centres in the Algarve, an area that had huge drug related problems. He opened the first centre in the south, called SPAT in 1988. From 1988, Goulão was responsible for creating other centres, in the south. In 1992 a service that was responsible for running all these centres, called SPTT, was created and all the centres that had been set up under the Ministry of Justice, and all the centres that were set up under the Ministry of Health, were now under the same response; in SPTT.)

(In 1997 Goulão became president of this service, at national level. He made it possible for all treatment centres to have substitution treatments with methadone. Eight hundred people were on a methadone programme before 1997.)
Parenthesis; my comments.

At this time Portugal was at the height of its drugs problem, and José Socrates was at that time Portugal's Minister of Youth. One day Socrates declared that something radical had to be done. At that time, the drug problems where tremendous, and despite the fact that more and more centres where opening, spending more and more money, it seemed that the problem was just getting worse.

A committee of people to make an assessment of the Portuguese drug situation was therefore established, and to work out a Drug Strategy plan, appointed by José Socrates.

Amendments

At the time José Socrates was the Minister for Youth, his brother had a problematic heroin addiction. Golão was at that time Socrates' brother's medical doctor, and had close contact with the family. Also, the president of the parliament at that time had a daughter with a heavy and problematic heroin addiction, and she later died of an overdose.

Why bring this into this part? The report from Portugal, which was created more than ten years ago, and the Norwegian one at present, are found to have the same human, individual approach towards drug users. The personal interest can be one of several important elements to this approach in social policy. The committee's chairman of the Stoltenberg report, Thorvald Stoltenberg, is also close to a person addicted to drugs. A personal, individual and caring relation might possibly have had an impact on the approach towards handling drug addiction.

Categorizing people into groups, can make us forget that they are individuals. The Norwegian criminologist Nils Christie once wrote that a group of people that are different from us, is also easier to treat differently. If we can identify with them, and feel we belong to the same group, we will also more easily recognise them and treat them as «one of us». He says that this consciousness is used in war as a strategy; the more unlike us the prisoners are,

the easier is it to treat these prisoners in an inhumane manner. It is often effective to draw an enemy image very different from our own.

5.2 CDT – Interview and observation

CDT Lisbon

In March 2011, we attended one of the dissuasion commission's meetings at the CDT. The following represents a normal procedure within the commission, and an interview with one of the two vice presidents in the CDT Lisbon

The appointment with Nuno Portugal was on a Monday. He assumed it would be possible to attend a meeting with a user, if firstly, they received a user, and secondly, if the said user would accept having an observer present.

A police referral to the CDT

The procedure before a user enters the CDT is usually as follows:

The police makes a note of a person they see using drugs in public, and they will make a police report, normally at the police station. The police will weight the substance, and analyse it. The users are not arrested, but they have to identify themselves, and the user gets a paper with a referral to the CDT service which is closest to where they are located.

The referral indicates where to meet, within 72 hours. On weekdays, he/she will be asked to go on the next day. The objective is; the faster the identification works, the more likely they are to present themselves.

After this process, the user is no longer an issue for the police, they are free to go, and the police now close their «case», unless the person is below 18 years of age.

This is the case when the user is not in possession of more than ten days worth of drugs for personal use. If the person was caught selling or dealing then this is considered a crime. Because only use, possession and acquisition for less than ten days use is not considered as a crime, but it still is illegal and leads to an administrative offence, which is handed by the CDT.

Narrative – observation of a normal procedure at the CDT

Monday morning, at nine o'clock, I was entering the reception of the CDT office. While waiting for my contact, Nuno Portugal, two young men entered the reception. One of them was the person whose meeting I had the possibility of attending. They communicated with the secretary and delivered their police report for the CDT to start a procedure. The report is a description of the time and place of the incident, the kind of substance, the amount, and personal details.

Then I was asked to enter the meeting room. Nuno Portugal informed me of the procedures, and meanwhile another of his colleagues, from the technical support team was assessing one of the users.

The dissuasion board consist of nine people, divided in three teams at three different levels. First, is the administrative team, who are responsible for all the paperwork, faxes, e-mails etc.

Then, is a technical supporting team, which consists of one clinical psychologist, and two social workers. Their role is to provide information about drug use, addiction, the consequences, and the risks, and penalties. They are responsible for a preliminary interview, which normally has a duration of between 30-40 minutes, with the user, to establish what is his/her background is; their profession, family relations, drug usage, housing conditions, or if the have social or psychological problems. This interview should help the whole team to decide if the person has a problematic relation to the drugs, if the user is addicted, or if it is a situation of a recreational user. Here the law no. 30/2000, of 29 of November, article 15, regarding penalties, comes in.

The law, article 15, nr 2, says: «Non-pecuniary penalties shall be applied to addicted consumers».

If the person is considered to be an addict, it cannot be considered a crime, and no sanctions, like a financial fine, will be used. If they are considered drug addicts, it is assumed that they already channel all of their money towards supporting their drug addiction. Of course this can be hard to decide on after only one interview, but in unclear cases, the commission usually listens to the users' own explanation. If he/she doesn't consider

himself to be addicted, they will leave it at that. If they are unsure, they will make a new appointment for a new meeting where they can go deeper in the situation with the user. This second interview is voluntary.

Right after the preliminary interview, the user attends a hearing, and it is at this stage that they make the decisions. This team consists of one jurist, one clinical psychologist, and one sociologist. This is the more formal stage of the procedure, and normally lasts about 15 minutes. This team will confirm the police report, and assess the situation of the user. If the person is considered to be a non-addict, the law specifically says that for the first time, the CDT has to suspend the procedure, without applying any sanctions. The objective is that it works as a warning, and they are now informed about the use of drugs and the consequences of doing so. The only consequence, for first timers, is that they will be registered in a central register in the CDT system, which does not have any link to criminal records. It is an internal record that only allows the CDT to know if a person has been in the process before. The only other public authority that can have access to this record is the court, but for as long as Nuno Portugal has been working there, which is 10 years, this has never. The suspension period for non-addicts is around 4 months.

Nuno Portugal compared the financial fines that are given to the non-addicts with the same fines you get if you are caught by the police driving too fast, up to a certain level, or have been consuming alcohol, up to a certain level. If it is too fast, or too much alcohol with respect to the law, it will be considered a crime, you put others in danger, and it is dealt with under the justice system. If not, it is to be considered as an administrative offence, and not a crime, and it does not go on the criminal record.

If the person is considered to be an addict, there cannot, as already stated, be sanctioned by a financial fine, but with other measures, like community service, they can revoke their driver licence, or a licence for bearing weapons, or other issues that are seen as a possible danger for a third person. This is under the same law, article 17, nr. 2.

For the person who is considered to be addicted to drugs;
If the user voluntarily undergoes treatment, the commission has to suspend the procedure. The suspension period for drug addicts is longer, at least 9 months, if he/she voluntarily undergoes treatment, because the treatment is considered to be for a longer period. Every

3rd month the CDT will control with the treatment facility where the client undergoes the treatment, how the treatment is working, according to the plan the user decided with their therapist. This is what the CDT needs as information, not what it includes, if it is a medical treatment, the regularity of the treatment or other information they don't need to know, only that the treatment is in accordance with the plan between the user and the therapist. Normally it is one of the members from the technical supporting team that is controlling this, and keeping in contact with the therapist. The communication between the CDT and the treatment services normally works very well, because they are a part of the same institute, the IDT, which belongs to the health system.

So, they usually know the people involved, so the communication between them can work rapidly, normally a phone call are sufficient to get the information.

Before the de-criminalization law, Nuno Portugal tells me, the procedure was very extensive, because it was under the justice system, so if went to the court, and the court often decided on treatment or a prison sentence. If the decision was for treatment, the justice system often «lost» control of the users in the treatment system, and the consequences were that many people didn't undergo the treatment, and there were no links or effective communication between the justice system and the treatment services. Today communication is done in one day, normally.

One of the problems that can occur between the police and the CDT, is that the police, if they find a person using drugs in public and the situation is not serious, they just information about where the user got his/her drugs from, and then they let the person go, without referring them to the CDT. It happens, but it is not a huge problem.

This is a very strong principle in the CDT, that the user has to be followed up immediately, and there have to be clear responses.

The CDT also underlines client confidentiality, so none of the information from the CDT will go out to any others, such as parents (if the user is over 18 year of age), schools, employers etc. When they are under 18 year, the parents have to be present at the hearing.

In 95 % of procedures the person will know the outcome of the meeting immediately.

Nuno Portugal says it is not realistic to believe in a drug free society, even if we wish to. So, again, we have to adapt reality to the pragmatic and humanistic principle, and treat the people who need it, and ask for it, as soon as possible, and access to the best option for each individual. As to the waiting lists in Norway, he says they don't have a problem with the waiting lists, and he says, very pragmatically, if more people need medical treatment, buy more methadone. It's as simple as that, he says. Give them the treatment they need.

A user meets the commission

When the user entered the meeting room for the hearing, Nuno Portugal and one of his colleagues, a jurist, from the same team were present. They were sitting around a table, and the situation was informal, and it was a very fast procedure.

The user was a young man, he was informed briefly about the hearing, and they asked him about his own situation, if he thought of himself as an addict. He answered no, but during the hearing it was clear that he had other problems in organizing his life. He had dropped out of university, and was without work. He wanted to get a proper job, but had problems applying for them and was living at home. The hearing ended with an agreement between the user and the CDT, which stated that the CDT should offer him an educational programme inside the information/educational system, because it was what he was interested in.

No procedures were opened, and he did not get a financial fine, since this was his first meeting in the dissuasion board.

6. The Translation in Practice

In this chapter we explore and analyse the Norwegian translation of the Portuguese Drug Strategy. We examine how the Portuguese de-criminalization model on the use of illicit drugs became a travelling drug policy idea, and how and why Norway became interested in the de-criminalization model.

We are interested in what became the common ground between the Portuguese Committee and the Stoltenberg Committee, and ask:

> What did the Stoltenberg Committee recognize in the Portuguese model that responded to their mandate, approach and values?

We are also interested in the Workgroup's implementation and operationalization of the Stoltenberg Committee's proposals 3 & 4.

The aim of this study is to:

> *… examine the translation of the Portuguese drug policy model and the Norwegian governance traditions' impact on and transformation of the Stoltenberg Committee's proposals, based upon the de-criminalization model.*

We repeat our research questions in number 1:

1. Why was the Portuguese drug policy model translated into the Norwegian context?

1.1 How did the Workgroup adapt and implement the Stoltenberg Committee's proposals 3 & 4?

1.2 What are the differences and similarities between the Portuguese CDT, the original idea, and the translated version; the Workgroup's suggested Interventions?

We use the theoretical translation approach from K.A. Røvik (see chapter 3) to examine the transfer and implementation process. A translation process consists partly of de-contextualization and partly of contextualization, meaning a practice or idea's *detachment from* their original context, and the same idea's *attachment into* a different and new context.

To use translation terminology: The idea in this study is the de-criminalization model, the practice. The practice becomes more general, turning into an idea and leaves the Portu-

guese context. The idea travels through the Stoltenberg Committee's proposal 3 & 4, and is implemented and becomes operational in the Norwegian context through the Workgroup's report.

This presentation starts with the different committees of the national documents. The translators, their incentives and the arenas of each of these committees are of interest to our study and give an indication of *who* is interpreting the policy, at what level or *arena*, and thereby what their *incentives* might be. Thereafter we present each of the three national drug policy documents, namely the Portuguese Drug Strategy, 1998, The Stoltenberg Committee's Report on Drugs, 2010, and the Workgroup Report, 2011.

The reports resulted in two different interventions for handling drug use and addictions, namely Portuguese de-criminalization, in practice, The Commission for the Dissuasion of drug Addiction (CDT), and the suggested Interventions; Alternative responses to soft drug related crimes; the Workgroup's implementation of the Stoltenberg Committee's proposals 3 & 4. These are explained within their respective reports, and graphically shown in figure 1 (CDT) and figure 2 (Alternative responses to drug crime; Interventions). Through the translation approach the process will be both explained and analyzed.

The empirical basis for this study are the three drug policy documents mentioned in the above paragraph.

We also bear in mind the different committee's translators, incentives and arenas, which are crucial elements in the translation theory (chapter 3).

6.1 The Translators

The theories and literature about power sharing, the growing use of epistemic communities, informal transnational cooperation and the production of knowledge in complex policy areas (chapter 3) are also of interest to our study. We found these theories especially important in the area of international drug policy. The different committees are of great interest to us. These theories focus on the actors and stakeholders, and Røvik's translation theories look at the actors, their incentives and the arenas for the translations. We acknowledge these approaches in this presentation.

A committee of experts – The Portuguese Committee

The committee responsible for the Portuguese Drug Strategy was made up of experts, mainly professionals and specialists within the field of drug addiction, with backgrounds in science and medicine.

The committee consisted of nine members.

They were all well known experts within their respective professions, related to drug use and addiction except for two; the committee's chairman, Prof. Alexandre Quintanilha, a well respected scientist and president of the national Ethical Committee for Health, and the second member was a judge, whose mandate was to qualify the legality of the proposals in the report.

The other members were three psychiatrists, one psychologist, one criminologist, one medical doctor (João Goulão) and one sociologist.

The judge was the only member that was against the proposal for de-criminalization.

Their mandate was to *«finally adopt a genuine national strategy in the fight against drugs, along the lines of those that have been adopted in other countries»*[1]. The aim was to make a national act on narcotic drugs, which resulted in a strategy plan and ended in the establishment of the Portuguese De-criminalization Law no. 30/2000.

The committee was established in February 1998 and appointed by the Minister attached to the Prime Minister at the time, José Sócrates, and their findings in the report were handed over to the Portuguese government in October of the same year.

We refer to them as the *expert group*.

An advisory committee – The Stoltenberg Committee

The Stoltenberg Committee's composition was different to the Portuguese committee. None of the nine members in the group had a professional background in the field of drug

1 From the Introduction to The Portuguese Drug Strategy

addiction. Several of the committee's members were former politicians with broad political representation, and were well known publicly.

All nine members had a solid professional background and most of them were recognized public figures with influential positions, either at the time or before joining the committee. Four of the members respectively represented the four major political parties in Norway, and the five others held positions which uphold good social values and responsibility, namely a representative from the «Street Hospital», an Emiritus bishop, a public prosecutor, a deputy chief of police and a director of a research institution. In other words, the committee had a broad political representation together with members representing the state church, «the street», the legal profession and the scientific community.

Their mandate was *to submit proposals for ways in which the neediest substance abusers can get better help*.

The committee's chairman, Thorvald Stoltenberg, is a well known spokesman for a humane approach towards dealing with drug users and drug addicts. He has a solid international diplomatic and political background, and is also the father of Norway's current Prime Minister. He has also publicly shared his and his family's experiences with a daughter who for many years had a problematic heroin addiction.

He has for many years campaigned for people with drug addiction problems and their right to be treated with dignity, and he has addressed addiction problems as a health and social responsibility, and not as a criminal problem. He claims that people with drug addiction problems need health and social help and need to be socially accepted, not punished under the penal code. He is also known as a member of the Global Commission on Drug Policy, a highly profiled international drug policy committee, which amongst other things, states that the war on drugs has failed, and recommends a global legalization of drugs.

Though he is a strong spokesman for a humane approach in drug policy, his views are not formed by professional knowledge in this field.

The committee was proposed by the Norwegian Minister of Health and Care Services, Bjarne Håkon Hanssen, March 2009, and the report handed over to the government in June 2010. The committee is referred to here as the *advisory group*.

Central Government Administration – The Workgroup

The members of the Workgroup had, again, a different composition from both of the other two former committees. While the Portuguese Committee was an expert group and the Stoltenberg Committee was an advisory group, the members of the Workgroup were all from government ministries, and highly qualified civil servants.

The Workgroup consisted of twelve members, all civil servants from three different sectors. Eight of the twelve members were from the Ministry of Justice and Police; three of them were special judicial advisors, and five were civil servants with judicial/police professional backgrounds. There were three civil servants from the Ministry of Health and Care, and one civil servant from the Ministry of Child, Equality and Inclusion. The head of the Workgroup, Karl Otto Thorheim, is a senior advisor from the Ministry of Justice and Public Security.

While the two previous committees' mandates were to mark out a new course for a national drug policy, the Workgroup's mandate was to adapt and implement the Stoltenberg Committee's proposals, 3 and 4, into a Norwegian context.

The Workgroup was appointed by the Norwegian government in December 2010, and the group delivered their report in June 2011. The report is now implemented in the White Paper on Drugs, submitted from the government on 22.6.2010.

This study refer to this group as the *civil cervants*.

6.2 The Original Drug Policy Idea

The Portuguese de-criminalization model was created by the Portuguese Drug Strategy of October 1998, and finally established in the Portuguese de-criminalization law, no. 30/2000 of 29th of November. The law was a direct implementation of the proposed model from the Drug Strategy.

Further reference to the Drug Strategy and the de-criminalization model, is based on what this study finds relevant in the Stoltenberg Committee's proposals 3 & 4.

The Portuguese Drug Strategy Plan

The foundations for the Drug Strategy are found in the Humanistic and Pragmatic principles.

A person with a drug addiction problem is recognized as a person with a disease, and it will no longer be considered a crime to be in possession of drugs for personal consumption.

The Portuguese drug policy model is build upon eight Principles, six General Objectives, and thirteen Strategic Options. The relevant elements will be presented here. The general objectives and the strategic options follow from the principles. The relevant strategic options will be presented in; 2, 4 - 6, and 11 &13. The aims and messages from the Portuguese Drug Strategy, that we present here, can be recognized in the Stoltenberg committee's proposals. The following are relevant to proposal 3 & 4 in the The Stoltenberg Committee's Report on Drugs.

6.2.1 The Structuring Principles

1. *The principle of international cooperation*

This consists of the recognition of Portugal's international role and the responsibility of national drug policies to implement international, and the importance of the harmonization of the UN framework. This was a concern when Portugal opted for de-criminalization, and after the de-criminalization law, there were critical voices from UN, although Portugal was still accepted as a member of the UN. Principle 1 also emphasizes bilateral and multilateral cooperation, especially within Spanish and Portuguese speaking countries, and within the framework of Ibero-American cooperation.

2. *The principle of prevention*

To work out preventive interventions to combat the demand for illicit drugs, through education and information. Primary prevention comes from preventive initiatives in schools and places to reach adolescents and young adults, through the use of mass media, the

selection and knowledge of target-groups, and to the use of publicity to inform people of the consequences of using drugs.

3. *The humanistic principle*

This is the recognition of the human dignity of people involved with drugs, and also a strong understanding of the complexity and relevance of the individual, their families and background, and an awareness of drug addiction as an illness. The State is «responsible for the drug addict's constitutional right to health and the avoidance of social exclusion, without prejudice to his/her individual responsibility».

There are concrete implications, arising from this principle:

- Drug addicts who seek treatment will be guaranteed access to treatment and professional care that follows individual cases in the process of attempting to quit taking drugs.
- Minimum standards of the quality of services related to drug use will be guaranteed through a demanding system of licensing and monitoring.
- Emphasis will be put on promoting incentives for the effective social and professional reintegration of drug addicts, through measures of positive discrimination. One of these measures is that the IDT has the possibility to financially support employers if they hire a person with drug addiction problems. This is to help the person to integrate, both socially and professionally «back into society». One supportive measure is that employers will not have to pay the usual employers' contributions if they employ such a person.
- Adopting harm reduction policies. This is to preserve an awareness among drug addicts of their own dignity. There will also be access to treatment and programmes that minimize social exclusion.
- Offering and guaranteeing imprisoned drug addicts assess to treatment, and promoting treatment programmes as an alternative to prison terms.

4. *The principle of pragmatism*

This principle is, regarding the strategy plan, the principle that «inspires the Portuguese drug strategy, complements the humanistic principle», and also represents an attitude of «openness to innovation». It is clear that, the attitude when dealing with drug related

issues has to be pragmatic, without dogma, and it has to be open to scientifically proven results, and to adopt measures and solutions that are appropriate and suitable.

Portugal shall also be open and interested in other countries' innovative experiments in the area of drugs, and pay special attention to harm reduction measures and the therapeutic administration of substances, and evaluate their results.

5. *The principle of security*

This principle is about securing and protecting people and property, in public health, against crime, for peace and public order. Six concrete messages have come out of this:

1. To fight against illicit drug trafficking;
2. The legal recognition of permitting the seizure of illicit drugs by police authorities and the activities necessary to combat trafficking;
3. Maintenance of the illegality of use and possession of drugs;
4. Use of differentiated penalties for acts involving drugs that are more dangerous;
5. Promotion of harm reduction policies, to reduce the risk of spreading infectious diseases, reduction of crimes associated with drug addiction, and promotion of social and professional reintegration of drug addicts; and
6. To promote special security measures in schools and places frequented by adolescents and young adults.

6. *The principle of coordination and rationalisation of resources*

This is an organisational principle. It is how public authorities shall ensure the coordination between the different departments and other services in the area of drugs. It also ensures optimisation of resources, to avoid overlaps and waste. It is about how to use and coordinate the resources in best possible way.

7. *The principle of subsidiarity*

This principle is about the distribution of responsibilities and competencies, and how to make decisions and take action, at the lowest possible administrative level, and as «close» to the population as possible, except if the objectives are better served and fulfilled at a higher level.

Three sub-principles are used to consolidate the principle;

1. *The principle of de-centralization*. This requires involvement of local authorities, especially in the area of primary prevention for drug addiction issues; and
2. *The principle of de-concentration*. A model for structuring central administration organisations, so that local administration should provide services that are closer to the population, and lastly;
3. *The principle of centralization*, which means that responsibilities relating to drug abuse are centralized in one administrative office.

8. *Principle of participation*

This is about how to optimize the participation of citizens, associations and institutions regarding drugs, to support initiatives from institutions representing civil society that provide preventive measures, increase awareness and mobilization among families and other local actors, especially young people, and also mass media.

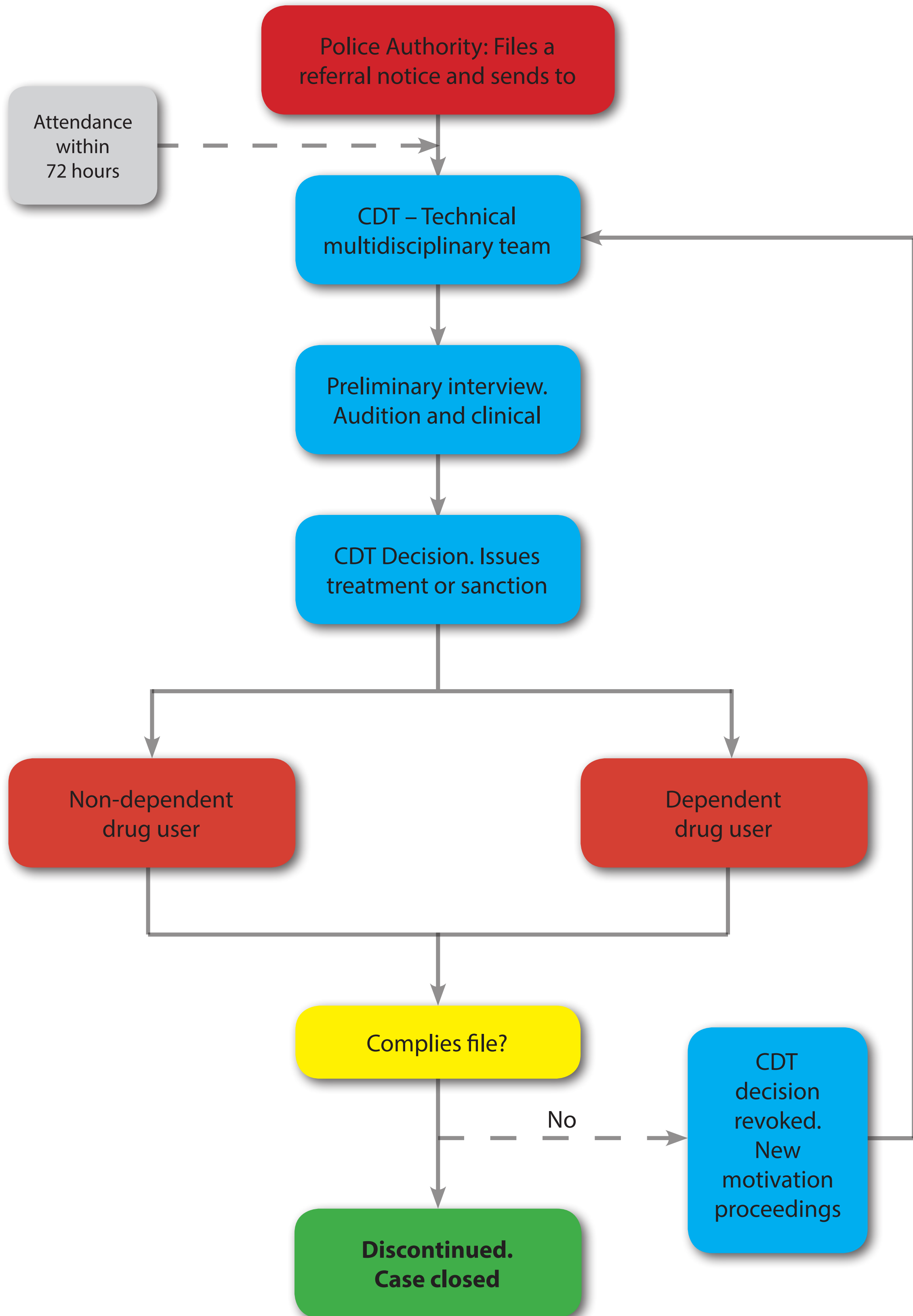
The principle also includes the role of a network of private institutions that provides services for treatment and social reintegration of drug addicts, and to use incentives for these institutions through financial funding to be granted to families, and the most needy.

6.2.2 Strategic Options

These are the 13 fundamental strategic options that the Portuguese drug strategy is developed on. I will, in numerical order, present 6 of the 13 strategies.

2. *De-criminalize the use of drugs, prohibiting their use under administrative regulations.* This comes from the 3rd principle, about the recognition of human dignity in the area of drugs and the «awareness of drug addiction as an illness» is critical. As mentioned earlier, the principle recognizes the state's responsibility to ensure the drug addict's constitutional right to health and avoidance of social exclusion, without prejudice to his/her individual responsibility.

Following on from this, the humanistic principle, which is one of the strongest principles and a basic principle of the UN conventions for human rights, as the Drug strategy plan interprets it, is by, its very nature, leading towards de-criminalization of an individual's use of drugs.


CDT
Commission for the Dissuasion of Drug Addiction
Police Authority: Files a referral notice and sends to
Attendance within 72 hours
CDT – Technical multidisciplinary team
Preliminary interview. Audition and clinical
CDT Decision. Issues treatment or sanction
Non-dependent drug user
Dependent drug user
Complies file?
No
CDT decision revoked. New motivation proceedings
Discontinued. Case closed

We can also find in the 5th principle, about security, article d), the differentiated penalties on drug-related acts.

In Portugal, drug addiction is recognized as an illness, not a crime, and is a health issue. Though drugs continue to be illegal, and serious crimes are still dealt with by the justice system and punitive sanction used under the penal code.

Option nr. 2 is especially interesting regarding the Stoltenberg committee's report, proposals 3 & 4.

4. *To extend and improve the quality and response capacity of the health care network for drug addicts.* This option ensures access to networks of treatment for all drug addicts who seek it.

This option comes from principle 3, the humanistic principle, article a), that guarantees all drug addicts who seek treatment, access to services offering treatment. We can also look at principles 6 and 7, which are about the coordination and rationalisation of resources, and the principle of subsidiary, about the distribution of responsibilities and competencies, and where decisions are taken, as already mentioned.

5. *To extend harm reduction policies.* Suggested harm reduction policies are, for example, centres for exchanging syringes or needles, low threshold administration of substitute treatments, e.g. methadone, and establishing special information and motivation centres for drug-addicts.

This option comes from several of the principles; 3 d), the humanistic principle, principle 4 a) on pragmatism, and the promotion of harm reduction policies, and principle 5 e), on security, with implications from the principle of pragmatism, of harm reduction policies.

6. *To promote and encourage the implementation of initiatives to support the social and professional reintegration of drug addicts, including exceptional methods of positive discrimination.* This is related to principle 3 c), the humanistic principle, and the promotion of incentives for effective social and professional reintegration of drug addicts, as measures of positive discrimination, which I already mentioned.

11. *To adopt a simplified model of interdepartmental political coordination for the development of a national drug strategy.* The option is to centralize the responsibilities of primary prevention in the IDT, and to provide regional services responsible for building dynamic partnerships with local authorities.

This comes from principle 7, on subsidiarity; distributing the responsibilities and competencies on a level as close as possible to the general public, but also the principle of centralization of responses.

13. *To double public investment to PTE 32 billion (at a rate of 10 % per annum) over the next five years.* This option is to secure the financial part of the expenses attached to the implementation of the national drug strategy. It also relates to the development of the special drug prevention programme in prisons.

The Stoltenberg Committee has not done any assessment of the expenses regarding the implementation of their strategy. In 2010, Norway used around 5 billion NOK, six hundred and forty million Euros, on drug related issues, and this is not including social support or expenses arising from related criminal charges.

The Portuguese Strategy plan, as we know, was accepted in full and the law came into force in 2001.

Amendment to CDT

Firstly, just again to show a clear link to the Portuguese Drug Strategy plan; as already mentioned, the foundation for the Portuguese drug strategy were the principles, objectives and strategic options. These again were built on the basic principles of pragmatism and humanism, which are the basic principles of the Strategy plan.

Behind the CDT, we find the basic principles of pragmatism and humanism, in how it is recognised and put into force. We find pragmatism and humanism also in how it works, with no prejudice or punitive responses towards the user. It use concrete and accurate information about drugs, addiction, the consequences of using them, without scary propagandas, moralizing or mechanisms to make the user feel less worthy because of his/her use of drugs. We also recognise the pragmatic principle in how the system has a differentiated

approach to the user; if the user does not seem to have a problem, and is not expressing this, they do not try to force any treatment or other measures on them. The opposite is true if they see that the user has a problem. Then they will try to help by providing information about services and measures that the CDT, together with their partners, can offer. There are a huge variety of measures, from appointments with psychologists without obligation, to more high-threshold treatments like medical treatment or treatment in institutions for a longer period etc.

They also give information on low threshold measures that are offered, especially in big cities, such as Lisbon, where you find low threshold methadone treatment, syringe exchange programmes, services that offers consultation with nurses and doctors without any appointment and services that offer, for example, free HIV and hepatitis testing.

Another pragmatic and humanistic approach is the offer of cooperation and help regarding the user's future. During a meeting with the user, they assess the person's life situation. If the person expresses that he/she has a satisfing life, with studies or work, proper housing etc, this is considered to be good, and they will not follow up this person. They try to see the whole person and his/her situation, and do not just focus on the drug use.

If the person is seen to have a life without work, proper housing or other important issues, the CDT will offer that person a variety of possibilities such as courses or educational programmes, information on how to find different services, and also help with options for housing.

In accordance with the humanistic principle, is the recognition of the user as an individual, and as a whole. They see the user in a holistic perspective, were the drug use is a part of the whole situation. The drug use can have a strong impact, or a small impact on the user's life. If they are addicted to drugs, or have a problematic relation with drugs, the addiction is recognized as a disease, and then he/she is guarantied, by the Portuguese state, «the right to health and the avoidance of social exclusion», and «a guarantee of access to treatment for all drug addicts who seek treatment» (from the 3rd principle). This is a logical step following from this principle, to how the CDT functions.

The humanistic principle is also present in the fact that drug addicts do not get a criminal record, because this is considered as a social stigma that can cause more problems for the drug addict. With a criminal record it will also be more difficult to re-integrate into society, to get work or apply for licences etc. This also relates to the pragmatic principle in so much as it is easier to integrate without a criminal record.

Another important issue, also relating to principle 3, humanism, is the recognition of the addict as a person who is sick, and acquiring knowledge about the disease. Knowledge is important, because it is gives an understanding of the comprehensive picture, that this is disease is prone to a relapses, for example. Most of the addicts will relapse, and this is a part of the disease, it is not a crime.

We also follow the line from the principle 6 and 7, about the coordination and rationalisation of resources, and the principle of subsidiarity, that implies the distribution of responses and competencies, on a low level, local if possible, and close to the population.

There are established CDT offices in the whole of Portugal, at regional level.

6.2.3 The Practice of a CDT

The CDT's legal framework is established in Article 5.1:

> «Offences shall be processed and the respective penalties applied by a commission referred to *as commission for the dissuasion of drug addiction*, especially created for this purpose, operating in the premises of the civil governments».

Today 18 districts have at least one established CDT. There are 22 CDT's in Portugal; 18 Commissions on the mainland, 1 in Madeira, 3 in Azores, the autonomous regions.

Procedures (step by step)

1. The individual user: an occasional or dependent drug user or in possession of drugs.
2. The Police Authority: files a referral notice and sends it to the CDT.
3. The CDT – a technical multidisciplinary team made up of: a legal representative, psychologist and social worker.

4. The Audition (hearing) and Clinical Diagnosis: looks at consumption, makes a preliminary registration and a psychosocial analysis.
5. The CDT Decision: issues treatment or sanctions.

Type of Responses or Interventions

Dependent drug user:

Provisional file suspension –The individual must periodically report for treatment at a local health centre, hospital, or with an appointed technical team.

Occasional/Non dependent drug user:

Provisional file suspension. In this case the individual must report periodically to the police station or health centre where he/she will be given psychological support. He/she will be banned from going to certain designated places, and required to do community service or be given a fine.

If the user complies his/her file will be closed. If not, the technical team can issue new proceedings and the CDT decision will be replaced by another more appropriate decision.

Networking: (partners associated with the Portuguese Decriminalization Model)

- Courts
- Police Authorities
- Health Centres
- Civil Governments
- Hospitals
- Integrated Responses Centres
- Treatment Centres
- Social Services
- Children's and Youngsters' at Risk Commissions
- Employment and Professional Training Institute
- Prison Services
- Social reintegration Institute
- Others

Each CDT team consist of nine members divided into three teams. Article 7 of Law no. 30/2000, of 29th of November, describes the commission's composition:

«One of the members of the commission shall be a legal expert appointed by the ministry of Justice, and the Minister of Health and the member of the Government responsible for the coordination of the drugs and drug addiction policies shall appoint the other two, who shall be chosen from doctors, psychologists, sociologists, social services workers or others with appropriate professional expertise in the field of drug addiction, who in the course of their duties shall guard against any possible direct therapeutic interest of ethical conflict».

6.3 A Drug policy Model as a Travelling Idea

In March 2009 the Norwegian government appointed a committee with a mandate to *… submit proposals for ways in which the neediest substance abusers can get better help*[1]. The committee was also asked to consider at the possibility of heroin-assisted treatment.

The appointment of the Stoltenberg Committee (named by the committee's chairman Thorvald Stoltenberg) was made by the Minister for Health and Care Services at that time, Bjarne Håkon Hanssen (see also chapter 4). The debate questioned the lack of dignity of these users who should obviously be considered as sick and in need of help, instead of be given punitive sanctions. Hanssen became personally involved, and before his appointment he expressed his frustration at not being able to reach drug users with proper measures.

The committee which consisted of high profile public figures, (more information about the committees under 6.1) handed over their report to the government on the 16th of June 2010.

The report on 48 pages consisted of 22 proposals, and focus on illicit drug use and addiction.

The report was meant as preparation for the government's white paper on drugs, and submitted for public hearing. In December 2010, the government appointed a Workgroup to

1 Stoltenberg Committee's Report on drugs, 2010

assess, evaluate and consolidate two of the proposals from the Stoltenberg Committee's Report on drugs, proposals 3 & 4.

Following part will present these two proposals, which suggest alternative reactions to drug use and establishment of interdisciplinary tribunals, with direct reference to the Portuguese de-criminalization model.

The Stoltenberg Committee's Proposals 3 & 4

> **Proposal 3:** *Offer agreements on follow-up as an alternative to prosecution and registration in the National Register of Convictions.*

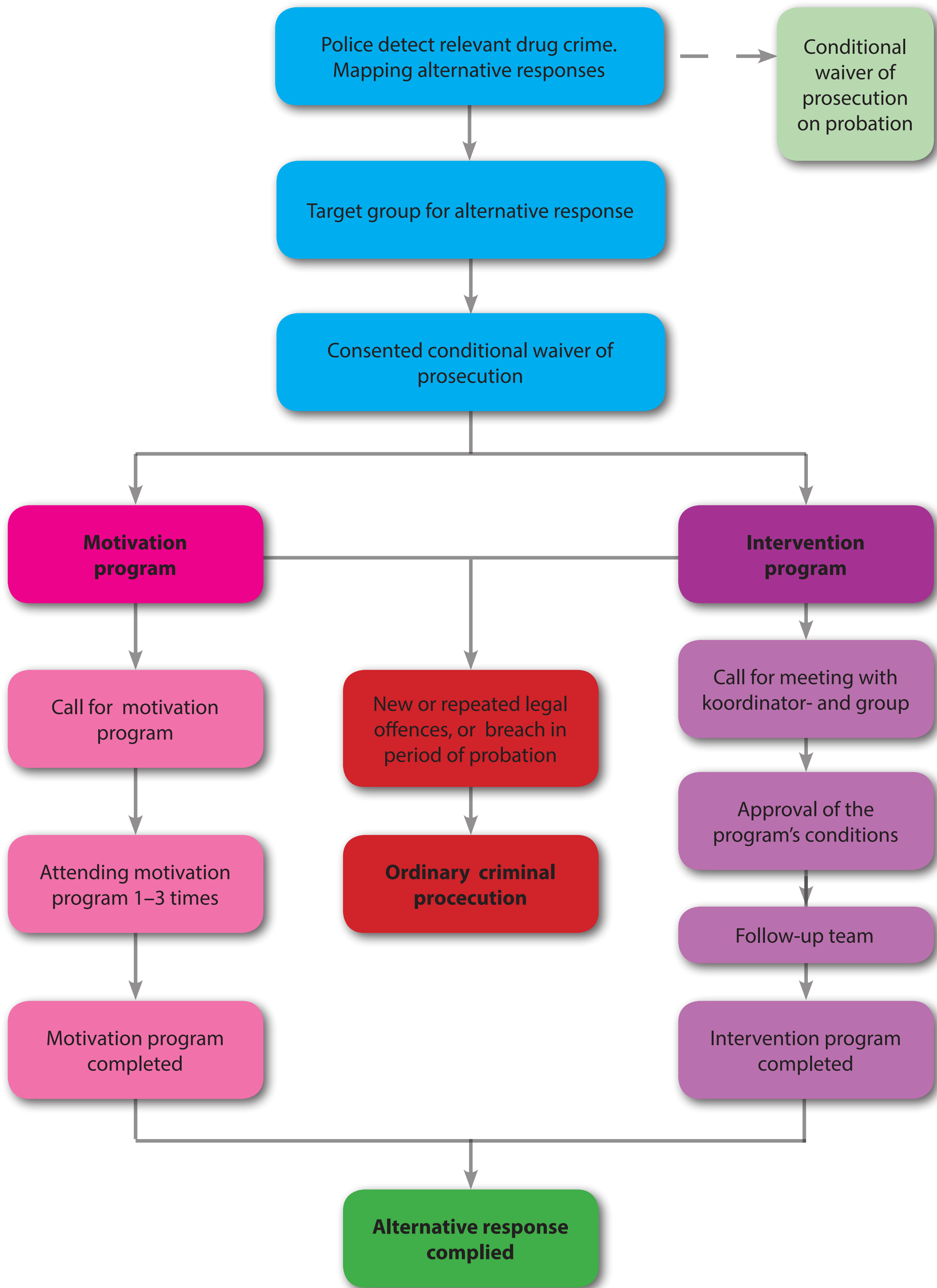
In proposal 3 the committee starts with a description of the different ways drugs are used in our society; for some people it is about experimental use, it is associated with excitement, while it for other people it is an expression of a problematic life situation. For the latter group, a fine or a prison sentence will not help, and will cause even more problems and extra burden.

The committee believe that this people need help with treatment and follow up rather than punishment. The problem that should be solved is the cause of why they abuse drugs.

In some places in Norway the police have developed models which offer young people experimenting with drugs, alternative reactions to punitive sanctions and registration in the National Register of Convictions. As an alternative to punitive sanctions, there can be a so-called «drug-contract», an agreement of participation in a treatment and a follow-up program, or other agreements. In many of those places cooperation between the police and the municipality has grown, and good interdisciplinary cooperation between the police and child welfare workers aiming to prevent youth crime, has also developed.

The experience with this interdisciplinary cooperation and drug-contracts, as an alterative to punitive reactions, has been very positive, and the committee recommend further development of this model.

They propose these kinds of alternative responses should be offered to all drug users throughout the whole country, and that the services should be developed under a tribunal


Interventions
Alternative responses to drug crime
Police detect relevant drug crime. Mapping alternative responses
Conditional waiver of prosecution on probation
Target group for alternative response
Consented conditional waiver of prosecution
Motivation program
Intervention program
Call for motivation program
New or repeated legal offences, or breach in period of probation
Call for meeting with koordinator- and group
Approval of the program's conditions
Attending motivation program 1–3 times
Ordinary criminal procecution
Follow-up team
Motivation program completed
Intervention program completed
Alternative response complied

model. The further development of this tribunal commission will be inspired from the model of the Portuguese commissions for the Dissuasion of Drug Addiction, in Portuguese «Comissão para a Dissuasão da Toxicodependência», from now on CDT.

> **Proposal 4:** *Establish interdisciplinary tribunals that assess measures for persons who are arrested for the use and possession of drugs.*

Proposal 4 starts with a general observation of countries which have developed alternatives to punishment for people arrested for use and/or possession of drugs, and where prosecution and imprisonment are poor instruments in preventing the spread of substance abuse.

The committee therefore focused on the tribunal scheme established in Portugal (ie. the CDT) and especially on the issues regarding treatment and follow-up instead of prosecution, and to moving the responses from the justice to the health sector. It also emphasized the diversity of responses the non-addicted and addicted can be offered, and that the addicted motivates for treatment, which normally has a waiting period for 1–2 weeks.

The Portuguese tribunals are interdisciplinary, and have an individual approach towards users.

Proposal 4 refers to the positive results Portugal can show after the establishment of the de-criminalization model of 2000, with a significant decline in drug related deaths and HIV, a clear reduction in the number of inmates with drug problems, and a reduction in substance use among young people. The committee strongly recommend that the experience deriving from this model are valuable for the further development of the Norwegian commission model, and to change their focus from prosecution to treatment and follow-up, both for those with incipient drug problems and for drug addicts. The committee underlines the important differences in dealing with drug use and addiction between Norway and Portugal; in the latter drug addicts are not dealt with by a court, but by the health and social services authorities.

Amendment – The aims of the Stoltenberg Committee

In the introduction to the Stoltenberg Committee's Report on drugs it is estimated that around 8.000 people in Norway use heroin, and thousands of people are addicted to drugs. The majority are men, as it is in other countries.

According to EMCDDA reports on Norway, there are between 8.600-12.000 people injecting heroin, and the most recent available studies estimates that there are between 6.600 to 12.300 heavy drug users. The EMCDDA defines problematic drug use as intravenous drug use (IDU) or long duration / regular drug use of opiates, cocaine and / or amphetamines[1].

The focus of the introduction is to help people who are addicted to drugs. The reports target group are people «like everyone else, each person is different», with a drug addiction.

Because of the recognition of every drug addict as an individual person, with rights and acknowledgements, according to humanistic principles, the need of individuals and adapted treatment at the time when it is needed, is strongly recommended. Help should be given to personal needs, independent of what kind of addiction or substances he/she uses. The report pronounced that the use of, and the focus of punitive sanctions are not regarded as a solution to drug problems.

The introduction also shows its pragmatic approach. For example, when it emphasizes the need for realistic expectations regarding treatment and rehabilitation. Out in the field, professionals know that relapses are usual, more so than not actually, so it is important to be give a drug user many chances, even when they relapse.

The report also emphasizes the unworthy conditions that many of the problematic drug addicts live with, and that many of them are living in poverty, with physical and mental problems. There are also many negative feelings associated with being addicted to drugs, such as shame and guilt, self-loathing and humiliation. Here readers, and society are asked to do a great job; help the person by simply accepting them and showing them respect.

Many problematic drug addicts need help to change their whole lives; there is not only the drug itself that is the problem, but also unemployment, their relationship to family and

1 Country overview: Norway, Situation summary, EMCDDA

society, poor living conditions, debt problems and health problems. The report says: «the treatment of drug addiction is about straightening out a whole life.»

What if the drug addicted person were your daughter, sister, brother? The report asks us this question, to make us aware that «they» are one of us, not a group of one kind of human being, different to us. They are people, like us, not just «drug addicts». Drug addicts are one of us. And how do we want to be treated? Or how do we want members of our family to be treated? The report tells us that they also depend on acceptance from society, to ensure their integrity, dignity and respect and to realize hopes. The human approach is strongly present here and the recognition that all of us are unique, and need to be treated uniquely.

The Stoltenberg Committee emphasizes human approach, principles and values.

6.4 Contextualization and Operationalization

In December 2010, the Ministry of Justice and Public Security, and the Ministry of Health and Care Services, appointed an inter-ministerial workgroup to implement The Stoltenberg Committee's proposals 3 & 4, entitled:

Reactions to the use and possession of drugs (from The Stoltenberg Report):

> **Proposal 3:** *Agree upon procedures for follow-up as an alternative to prosecution and registration in the National Register of Convictions.*
>
> **Proposal 4:** *Establish interdisciplinary tribunals that assess measures for persons who are arrested for the use and possession of drugs.*

The Workgroup's mandate was to «assess and evaluate alternative responses to minor drug related offences and implement the actual proposals. The committee should continue to interpret the ideas behind the Portuguese model, but at the same time, adapt them to the existing Norwegian structures and practices.

The government also emphasized that considerations for the decriminalization of drug use and possession of drugs was not part of the mandate.

In July 2011, the Workgroup Committee presented their report, based on the Stoltenberg Report on Drugs, proposals 3 & 4.

6.4.1 The contextualization

The Workgroup's Interventions – Conditional waiver of Prosecution

Unlike in Portugal, the Norwegian drug policy's legal framework is not written in one law. As already mentioned, the legal regulations come from two main laws. Sanctions can be applied under the Criminal Code, § 162 and § 317, which represents the Norwegian penal code, and under the Medicines Act, § 22, § 24 and § 31.

The Workgroup's mandate called for consideration of alternative responses to «minor criminal offences involving drugs» but de-criminalization was not to be considered, as the Criminal Code Commission of 2005 already examined this issue. This commission was an 'expert group', established in 1980 to revise the Criminal Code. At the time, it recommended de-criminalizing the use and possession of drugs for individual consumption, but the recommendation was not approved and the government did not find it necessary to a re-examine this issue.

The Stoltenberg Committee's proposals 3 & 4 were to agree on procedures for follow-up as an alternative to prosecution and registration in the National Register of Convictions, and to establish interdisciplinary tribunals that assess measures for persons who are arrested for the use and possession of drugs.

However, in the Workgroup's mandate the «use and possession» of drugs was classified as «drug related crimes».

The Workgroup suggested two possible routes for intervention as «alternative responses to minor violations of the law involving drugs», consisting of either a *motivational conversation*, or an *intervention program*, depending on the kind of intervention the police or prosecuting authority find suitable for each individual.

The Workgroup found that the target group for alternative interventions should not depend on the type of drug problem, but rather on whether the person is willing to partici-

pate in the interventions. If the person is unwilling to do so, then he/she will be subject to normal criminal prosecution.

The Workgroup concluded that alternative responses are available for all kinds of drug users, but «the Workgroup will, first of all, focus its attention on users who have not yet developed drug addictions».[1]

Alternative responses carry a special conditional waiver of prosecution, which means, that provided the intervention is completed, the offence will not be registered in the National Register of Convictions.

The interventions target the *use and possession* of drugs regarding the Medicine Act §24, 1st subsection and § 31, 2nd subsection, and storage, cf. the Criminal Code, §162, 1st subsection.

6.4.2 A discretion based de-criminalization model

The Workgroup suggested two alternative programs for intervention, which can be offered in response to crimes related to the use and possession of drugs, depending on various conditions.

As figure 1. show us, the Portuguese CDT is not an alternative to punitive sanctions for the use and possession of drugs. It is the only response to this kind of drugs related issue. If the police authorities find that a person is a drug user, as categorized by the law, the procedures are regulated and the drug user has to attend the relevant CDT office within 72 hours. The criteria for attending CDT interventions are controlled by the de-criminalization law and regulations.

The Workgroup's interventions, however, are not alternatives to punitive sanctions, but are, *possible* interventions, based upon the police or prosecuting authority's judgement and discretion, and the drug user's attitude and consent. There are no clear rules or regulations or specific criteria for following one course of action as opposed to another. It is primarily a decision for the police or prosecuting authority, depending on whether the drug user is found to be more suitable for one intervention or the other.

1 Workgroup report, 2011:112

There are no clear regulations in the Workgroup's report regarding the *amount* of drugs in a person's possession that constitute for a criminal offence, nor clear definitions for 'use and possession'. They refer to earlier documentation stating the difference between possession and storage, which are between one to two user doses.

According to the Portuguese de-criminalization law, the limit for non-punitive possession is 10 days for individual drug use, independent of the type of drugs[1].

The Workgroup state that the Portuguese amount for non punitive use constitutes a considerably risk of spreading, and suggest a more restrictive policy.

The Workgroup does not want to be more specific, but states that decisions should be based on discretion:

> «The Workgroup does not wish to specify criteria for regarding the amount of user doses. … Where the limit should be drawn, should be judged with discretion, and it has to, amongst other things, depend on the kind of drugs»[2].

The report sets out the following conditions:

> «With regard to intervention programs, the prosecuting authority and the courts are given a wide basis for discretion on the selection of suitable candidates»[3].

If he/she is found to be eligible for alternative responses by the police, and the drug user gives his/her consent, the drug user will start to attend one of the alternative intervention programs.

6.4.3 Alternative responses

Intervention Program (long duration intervention)

1. The police detect a relevant drug crime and propose alternative responses
2. The prosecuting authority or law court selects the actual candidates
3. The candidate gives his/her consent
4. If not, the candidate is sentenced to regular punitive sanctions

1 Article 2.2, Law no. 30/2000, of 29th November
2 Workgroup report, 2011:116
3 Workgroup report, 20011:151

5. If they do consent; a coordinator and coordination group call the offender for a meeting
6. The offender/candidate agrees to the conditions
7. If not, regular punitive sanctions will apply
8. If they consent; a follow-up team is assigned to the individual

If no further legal offences are committed after the agreement is completed, and the offender complies with the agreement, the intervention is considered complete.

Motivation program/conversation (short interventions):

1. The prosecuting authority or court of law selects the candidates for the program.
2. The candidate gives his/her consent.
3. If not, regular punitive sanctions apply.
4. If they consent, a person responsible for the motivation conversation, someone from the police or health care services, call the candidate for a conversation, up to a maximum of three times.
5. If the candidate accepts the agreement and complies with it, the intervention is complete.
6. If the candidate does not keep to the agreement, or commits further legal offences, then he/she will be sentenced in the normal way.

The candidate has a responsibility to make an self-assessment report to the prosecuting authority before entering the program.

6.4.4 Intervention Program, under the Mediation Board

A long-term intervention: up to two years. The Mediation Board is a public body, under the Ministry of Justice.

It is created from principles and values from restorative justice and assumes interdisciplinary cooperation at different administrative levels (it nominates representatives from police or childcare services if the user is under 18) and appoints a person with special competences in the area drugs.

A follow-up team; a multi-disciplinary team that works out the content of the intervention program.

There is a coordination group responsible for each follow-up team in each district.
The coordinator nominates team participants to work in partnership with the offender.
The follow-up team is an ad-hoc organization; the coordinator is the only permanent person.

Drug users that have, or are in danger of developing problematic drug use, should be offered an extended intervention program, if he/she is found to be a suitable candidate for this program.

The coordinating group's responsibility will be to assess the drug offender, to draw up a plan for the intervention program and coordinate the arrangements in the program.

It is not up to the prosecuting authorities or the law courts to work out the content of the program. This should be undertaken by a follow-up team in the Mediation Board, as a consent-based element of a criminal response for young people who commit serious crimes, or repeated crimes.

The follow-up team is an ad-hoc organization, and will work out the program's details. They are responsible for closely overseeing that the drug offender completes the undertaken intervention.

The team can consist of persons from different work places, such as from public civil services, the teaching profession, or persons close to the offender, such as family members and others from the person's private network.

Drug use is defined as a crime without a victim[1]. The Mediation Board is, looks to the law, for cases where you have an offended. In this case, the Workgroup calls for changes in the law so the Mediation Board can also treat cases without an offender.

The offender needs to confess to the crime to have access to the intervention program.

1 Workgroup report, 2011:39, 130-132

6.4.5 Motivation Program

In some cases, the police can decide not to give any punitive or responses to the arrested person, if he/she seems to understand the situation, and express an attidude against drug use.

The report says:

> «Sometimes there is no need for motivation programs. The police authorities are very good at analyzing drug related issues and capable of making a competent assessment of a person under arrest. After a young person has been arrested and questioned for a minor drugs crime, he/she may understand the seriousness of the situation will stop using controlled drugs in the future. If so, for obvious reasons, the prosecuting authority will give a conditional waiver of prosecution on probation, jf. § 69, 2nd sub-section without further special requirements[1].

The Motivation Program is a program of short duration. It will be based on a methodology for this type of short interventions as recommended by WHO (the UN World Health Organization). The procedure is the same as for the Intervention program regarding consideration of candidates for interventions, but the intervention is short-term, and relevant for young people who have not been using drugs for very long and whose use of them is not very problematic. The Workgroup assumes that most of the candidates for interventions will belong to this group.

The motivation program's content, regarding how many times (usually between 1-3 conversations) and what focus the interventions should consist of, will be based upon a report that the drug user must compose him/herself and deliver to the person in charge of the program before the intervention starts.

The Motivation program will normally be between a representative from the police or the health sector, and the offender. To secure professional expertise, the person (police or health worker) should be educated in and have experience with well documented knowledge-based methodology.

1 Workgroup report, 2011:152

In the case of both interventions; if the offender is in breach of the contract, or stops his/her participation, he/she will first be given another chance or several chances, depending on the circumstances. If it is found that the interventions are not suitable, the offender will be subject to normal criminal prosecution

7 Use of discretion and value-based Governance Traditions

In this part of the thesis, we will focus on the Workgroup's interventions, and the differences and similarities between the Stoltenberg Committee's proposals 3 & 4, based on the CDT commission in the Portuguese decriminalization model, and the Workgroup proposals for alternatives to punitive responses for minor drug related crimes. What are the actors' incentives in the Workgroup's report, and how do they translate, interpret and understand the Portuguese decriminalization model?

The Workgroup's objective behind the proposals for alternative responses to drug related crimes is expressed as:

> «… first of all, to change the drug offender's attitude to controlled drugs, and thereby prevent him from using drugs repeatedly»[1].

Here it is understood that the Workgroup aims to address and respond to the drug offender's *attitude* towards drugs, rather than the action of using drugs.

In chapter 2.1 of the Workgroup report, defining the different concepts of decriminalization, legalization and softening of the Penal Code, the report discusses whether the proposed alternative responses can be understood as softening punishment. It concludes that the alternative responses are not comparable with traditional criminal sanctions; the proposals' objective is to give «effective punishment – thereby addressing the real problem; drug use»[2].

In the preceding chapters, this paper has been focusing on the differences and similarities between the Portuguese de-criminalization model and the Workgroup's proposed interventions, and the Norwegian governance traditions.

Earlier literature (referred to in chapter 4) shows that the value based elements have been prominent in the establishment of Norwegian preventive drug policy with regard to handling drug use, from its origins in the mid-sixties, and that the balance between knowl-

1 Workgroup report, 2011:31
2 Workgroup report, 2011:18

edge based, and the value based information were a issue of dispute through the establishment of the drug preventive work.

This study has found that these elements are also present in current Norwegian drug policy, through the analysis of the Workgroup's report and its arguments for intervention, amongst others things, when the report emphasizes that the individual drug user's *will and correct attitude* towards drug use is a condition for attending the interventions.

We have also found that the Norwegian governance traditions regarding the Criminal Code, and passing sentences is, to a certain extent, based on precedent and the use of discretion.

As to the Norwegian method for passing sentences, the Workgroup says:

> «Norwegian courts have no general regulations regarding what kind of circumstances the court should emphasize for passing sentences. Within the sentencing framework, the court has relative freedom regarding both the sentence's duration and what issues the court should emphasize in the sentence»[1].

Precedence within drug related cases regarding sentences have shown that the type of drug is relevant to the sentencing process, with softer punitive sanctions given to cannabis as opposed to heroin cases.

The Workgroup reports that interventions are also to a certain extent based on discretion, when it comes to decisions on *who* is a suitable candidate for the interventions, what kind of interventions, and *whether* punitive sanctions should be given at all, in cases where police can give conditional waiver of prosecution on probation, without further special conditions[2].

Chapter 12 of the Workgroup report is about the target group for the interventions, and 12.4, about the criminal circumstances. The Workgroup discusses the principle of fairly before the law, and concludes that the use and scope of discretion that the police and pros-

1 Workgroup report, 2011:77
2 Workgroup report, 2011:152

ecuting authorities are given, are not in breach of the principle of equality before the law. They refer to the principle that the law shall be understood to be applied fairly in all cases.

The Workgroup also referred the precedence used in drug related sentences, that:

> «In some cases, individual conditions, not least special rehabilitation situations and where there is a strong intent for personal improvement, can be shown special considerations»[1].

The Workgroup refers to several cases where the Supreme Court has shown these above-mentioned special considerations, and has given the offender a suspended sentence and community sentence.

1 Workgroup report, 2011:117

8. Conclusion

This thesis aimed to examine the Norwegian translation of the Portuguese drug policy model, and the Norwegian governance traditions' impact and transformation of the Stoltenberg Committee's proposals, based upon the Portuguese de-criminalization model.

The main asked research questions were as follows:

1. Why was the Portuguese drug policy model translated into the Norwegian context?
2. How do Norwegian governance traditions impact on and transform the Stoltenberg Committee's proposals based upon the Portuguese de-criminalization?
3. How can the Norwegian translation of the Portuguese de-criminalization model impact on the handling of drug use and addiction?

This study has drawn several interesting conclusions, and broadened our awareness of the relationship between policy governance traditions and the Norwegian legal traditions' use of discretion in the Norwegian drug policy field.

This relationship is especially interesting given *society's general trust* in the Nordic welfare system, as welfare state-studies often emphasize (i.a. Esping-Andersen's in *Three Worlds of Welfare Capitalism*, 2006).

The reputation of the Nordic Welfare State is quite exclusive in the world and highly praised. It scores highly on democratic issues; the welfare system is universal, and it protects society's most vulnerable groups. The welfare state also scores highly when it comes to equality before the law, and regarding the freedom of speech.

The starting point for this case study is the Stoltenberg Committee's Report on Drugs and their proposals 3 & 4, based on the Portuguese decriminalization of drugs. Their mandate was to…

> *«submit proposals for ways in which the neediest substance abusers can get better help».*

The committee tried to focus on a drug policy that could offer help with dignity, and proposed the removal of criminal sanctions when dealing with drug users and addicts. In this paper we have named the report's approach as a 'dignity discourse' 'discourse for dignified treatment', which is seen as an important incentive behind the Stoltenberg Committee's

recommendation to follow the Portuguese model. One can assume that the Stoltenberg Committee believed the Portuguese drug policy represents this dignity discourse.

The report was part of a Norwegian restructuring process on drugs and addiction, and the Stoltenberg Committee was appointed to suggest better ways of handling drug use and possession, which was seen as problematic in Norwegian society. Problematic drug use and the high mortality rate due to drug overdoses, is especially challenging.

Yet, this case study has not focused on neediest, or *less well off substance abusers*. The Workgroup report worked out proposals for alternative responses to drug related crimes, which was their mandate.

Even so, one of the findings in this study is that the proposed alternative responses to drug related crimes may have a *negative* impact on the group of the neediest substance abusers, even when the responses are better at *preventing* people from becoming depended on drugs.

It appears that an important element in Norwegian drug policy governance traditions is the value-based and normative issue in preventative drug related work from the beginning of the creation of the Norwegian drug policy strategy, and this has been prominent in shaping today's drug strategy.

The relevant Norwegian legal framework regarding drug use and possession has evolved from the Medical Act and Criminal Code. The Criminal Code in general allows room for the use of discretion, together with the customary legal procedures, which is normal within the Norwegian legal system. The normative governance traditions in the area of drugs, can therefore be believed to have an impact on the legal traditions, when this is based on, not only the two different laws, but also on the broad use of discretion.

The conclusion of this thesis is that the Norwegian governance traditions of value-based and normative drug policy, are shaping the Workgroup report's proposals of alternative reactions on drug related crime, and that the Portuguese model is translated and transformed within the Norwegian historical governance traditions.

The Workgroup report requests a greater use of alternative sanctions *if* the drug user is found to be suitable for the intervention, amongst other things, that he/she has the right attitude, and is willing and dedicated to improving.

The Portuguese drug policy strategy is based on one drug policy law, where the law and the strategy plan regulate the drug policy, both regarding the handling of drug use and possession procedures, and the administrative and organizational foundations and structures. It offers an alternative response for drug users, with several possible outcomes.

This can, regarding the Esping-Andersens welfare theories, be a consequence of the Mediterranean welfare state model, where the trust to the state is less regarding a social security system.

The Portuguese de-criminalization idea has travelled to Norway, and it has been shaped by Norwegian governance and legal traditions. The incentives and arenas of the different prominent actors, people involved, have been a crucial element shaping the decisions that have been made. The Stoltenberg Committee was found to be a value-based group, and they made value-based proposals. They found that the Portuguese decriminalization model represents a successful practice with regard to these ideas, and that it guarantees the drug users' dignity and rights. The appointment of the Stoltenberg Committee can be understood as the Norwegian Government's wish to symbolise that they take the drug problems serious. Without knowing how, and without clear strategies, they were seeking for advices.

The Stoltenberg Committee can be seen as an epistemic community as they could be understood as *offering policy-makers an alternative and objective/neutral source of advice and knowledge; that is, in some sense external to state structures and interests*.

The Workgroup's composition was quite different from the Stoltenberg Committee. Its members all came from state administration posts, and their mandate was not to suggest new ways of handling drug use and addiction, but rather to adapt and implement the suggested alternative responses regarding their mandate into the Norwegian legal and administrative system. Their suggestions were, to a great extent, based upon existing laws and regulations, and their proposals were to maintain Norwegian governance and

legal traditions within the drug policy. The alternative responses did not *replace* punitive sanctions and prosecution or registration in the National Register of Convictions, but proposed *Interventions*, organizational structures that became a possible outcome of an arrest, depending on the police/prosecuting authority's decisions. But as this study sees it, the possibility of alternative responses in itself, is not new, as the police and prosecuting authorities already practiced this.

This thesis concludes that the Workgroup's proposals can be an obstacle to the 'dignity discourse' as found by the Stoltenberg Committee in the Portuguese Drug Strategy and Decriminalization Model. Not regarding the suggested drug policy content, but rather the lack of regulations to secure the user's the proper response.

The normative basis for today's drug policy is known to be the attitude of the majority of people in the society. As this study sees it, the suggested alternative responses, continues the opportunity for the normative governance traditions to continue using the same course of action in handling drug use and addiction.

As this paper sees it, the system makes it possible to punish people more for not having the "right" conduct and attitude, than for the act of taking drugs in itself. People with high integrity and the 'right' society values, are more likely to be accepted as relevant persons for alternative responses, or for no punishment at all if the police considers that the person does not have a history of repetitive drug offences and is unlikely to repeat the offence.

This paper conclude that the use of discretion established in the law, in an area were value-based and normative governance traditions have been a characteristic elements, has great probability to represent an obstacle for the dignity discourse.

This is a democratic problem for the society in general, for our weak/vulnerable group of drug addicted in special.

In this regard; João Goulão pronounced that decriminalization creates a legal framework for implementing policies to reduce the harm caused by drug consumption, and to socially reintegrate drug dependent persons.

The Workgroup's proposals, can, therefore, continue the prejudice and the different treatment of drug users, based on the user's attitude towards the drugs, and not based on the act of taking drugs in itself.

The Portuguese decriminalization idea has travelled to Norway and shaped Norwegian governance traditions. The Workgroup's suggested alternative reactions are likely to be more suitable for and used on people with the "correct" social values and norms. The general trust in the state might be one of the reasons that the most people accept the polices' use of discretion, as the majority also share and believe in current governance traditions and values.

Some of Norwegian society's most vulnerable groups can loose out in a system based on the use of discretion regarding what is a breach of 'normal social values'.

Final

The national and international knowledge of drug policy and their handling of drug addiction problems have impact on each other, and an understanding of these travel- and implementation processes can give a better insight in how the European cooperation can achieve a better and more comprehensive European drug policy, and what the harmonization and convergence can consist of.

Innovation and good practice in the area of drug addiction policy- and governance is of great interests for policy makers and others to evaluate and learn from. How can we best ensure that an idea gives the wanted outcomes even when it travels across borders and cultures? When examples are to follow, how to translate and implement the knowledge into other contexts the best possible way?

Regarding innovation and development on a complex field within governance of addiction problems, it is crucial to be able to understand these spreading- and travelling-of-ideas-processes, and hopefully this study on the Norwegian restructuring process bring a greater understanding to this policy area using the theories with trans-national and translation perspectives.

In the area of illicit drug policy making and governance, it is a growing demand of coordination and harmonization, and for a common understanding on how to meet the challenges around policy area on addiction. This study is a contribution to the knowledge of European trends and strategies in politics and governance of addiction problems, and to a broader understanding of the European countries' national drug-policies' impact on other nation's policy. What is similar, and what is different in their way of handling these problems, and how important is the historical and structural context on their choices?

This study can hopefully contribute to these questions.

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