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

Governance view

Deliverable 13.1, Work Package 13

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This deliverable is a synthesis of the work carried out in the context of the Work package 13 of the Governance view Area of the ALICE RAP (Addictions and Lifestyles in Contemporary Europe - Reframing Addiction's Project) and it is complemented by the book "Governance of Addictions – European Public Policies" that has been accepted to be published by Oxford University Press.

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Summary

Despite the efforts made since the first international convention on drugs was adopted a hundred years ago, our society is still searching for effective and consensual ways to deal with addictive substances and behaviours. In part, this is due to the fact that addictions fall into the framework of wicked issues.

Our study is aimed at reviewing the current approaches for governing addictive substances in the 27 European Union member states plus Norway to find out if there are different typologies and ultimately to help the reframing of the governance of addictive substances in Europe. Information for the 28 countries was gathered and tables and reports where produced with key information from each country. We took into consideration contextual measures and control measures such as Esping-Andersen welfare states regimes, OECD better life initiative, Sustainable Governance Indicators, World Values Survey data and Corruption Perception Index indicators. We also reviewed the history of addictions since the 19th century and took into account the current trends in addictions in Europe.

From all the information gathered a qualitative analysis was conducted, jointly with quantitative and statistical data work, followed by semi-structured interviews and an online survey to experts in the field. The final classification was made on the basis of two axes, one reflecting the strategy and the broad vision on drugs and addiction policies and the other one presenting the structure upon which the governance is developed. Nineteen key policy characteristics have been used to cluster the 28 countries into different groups.

4 different typologies of governance of addiction have been obtained. Model 1 gathers eight countries and their focus is on illicit substances, i.e. cannabis and heroin. They mostly have a well-being and relational management strategy combined with a comprehensive structure. They have decriminalized the possession of illicit substances (mostly cannabis) and have many harm reduction policies. Model 2 groups 6 countries which have focused their national policies on regulating licit substances, especially tobacco and alcohol. Model 3 includes a heterogeneous group of countries from the socioeconomic point of view. Their particularity is that they can be considered countries in transition from one model to another. Model 4 countries belong to the traditional model. They don't have a public health approach in most cases and tend to regulate the supply demand from a perspective of the ministry of the interior.

The work undertaken, despite the limitations and problems encountered in collecting the information, has allowed the identification of four European governance views that coexist in Europe. Some of the country groupings may seem strange but they are the result of the methodology and categorization used. This new perspective shows the importance of the challenges and complexities of the addiction field and also the high impact on their governance of contextual factors (geopolitics), culture and traditions, among others.

Keywords: addictions, governance, drugs, Europe, decriminalization, harm reduction, regulation.

1. Introduction

This report arises from work undertaken in workpackage 13 of Area 5 of the ALICE RAP project, in which it was planned to document the typology of different views of governance of addictions in all European Member States and Norway. The methodology used and the activities done follow exactly those originally proposed in the DoW.

The enormous task of collecting as much information as possible from databases and country stakeholders and analysing and categorizing it in an accessible way took us more than one year of work. The final triangulation of information for commonalities, differences and lessons across countries and across addictions was only possible by running a cluster analysis of the information once organized in a two-model axes covering the areas of structure and strategy.

The value of the exercise that has been carried out can only be appreciated when you consider that even today, 100 years after the first international convention on drugs was adopted, our society is still searching for effective and consensual ways to deal with addictive substances and behaviours.

Thus, the models build on the traditional classifications but, by not being limited to them, in our opinion they give a more achurate vision of the complexity of addiction governance and of the progress, at least on the part of some European countries, in trying to leave behind the old models of control that have been shown to be of little use for resolving the challenges that go with addicitons.

1.1. Addictions: a growing global concern

The consumption of alcohol and drugs has been evolving and transforming throughout history. In the last decades, the 'traditional', liturgical and cultural ways of consuming drugs have evolved, mainly due to the process of globalization (Díaz, 1998), into more consumerist and recreational patterns of use (Pavarini 1983). Parallel to this evolution, three general models of tackling addictions emerged: the moral paradigm, the assistentialist and the public health approach. The moral paradigm was a reactive and puritan response to the popularization of drugs and promoted a moral crusade against drugs and nowadays still exist but its relevance is slowly decreasing. The assistentialist paradigm emerged in the context of the development of the Welfare state and it characterized by a scientific approach to addiction as an illness. The last one, the public-health paradigm emerged as a result of the popularization of heroin consumption and the emergence of AIDS and HIV that forced society to change their views and to introduce public health oriented measures, as harm reduction programs. More recently, consumption has become normalized and socially accepted and part of the hegemonic cultural model, specially among youth, with the diffusion of polydrug consumption especially of alcohol, cannabis, cocaine, methylenedioxy-N-methylamphetamine (MDMA), etc. (Díaz et al. 2004).

Nowadays, the health and social harms and costs to the users and the others associated with drug use are large, especially among the youngest and the most disadvantaged groups and it is estimated that around 800,000 people die every year due to substance consumption, which represents 0.16% of the 28's total population (ALICE-RAP 2012). These figures have resulted in a growing concern and a joint mobilization of all stakeholders (from governments to civil society) to find ways to effectively deal with them.

Besides the growing concern, there are still a lot of areas of controversy including a long-lasting debate around the term addiction itself. On one side, there are those who argue in

favour of a more medicalized definition, whereas others have a more epidemiological and public health oriented one. The fact is that it continues to be widely used and terms and definitions have an important influence on how drug related policies and strategies are developed, their contents and how they are implemented.

Bearing in mind the diversity of consumption scenarios, its progressive normalization in some contexts, and even its trivialisation in others, and also the huge social and health costs associated with drug use and the complexity of the addiction topic, western societies have been forced to find renewed policies and better adapt to these realities.

In order to limit, somehow, the work to be done, it was decided to focus only on substance-related addictions and especially on alcohol, tobacco, heroin and cannabis substances. In addition to that, in order to align with other activities carried out in Area 5, we took into consideration the three trends proposed by Trautmann to characterize public policies for addictions (Trautmann 2013):

- The first trend, **decriminalization** of drug use is especially relevant for illicit drugs like cannabis and heroin. This is characterized as a health-oriented approach that no longer regards drug consumers as criminals but as patients. In parallel, consumption and/or possession of small amounts for personal use are treated as misdemeanour and not as criminal offences (Reuter and Trautmann 2009).

- The second trend is a wider introduction of harm reduction policies for both illicit and licit substances. Since the beginning of the 2000s, harm reduction acceptance has significantly increased among European countries and has also been embraced by international organisations such as the EU, WHO and United Nations, and is recognized as a characteristic of public health-oriented policies. Harm reduction appeared as a practice with the heroin boom during the 80s and the consequent need to find ways to deal with its consequences.

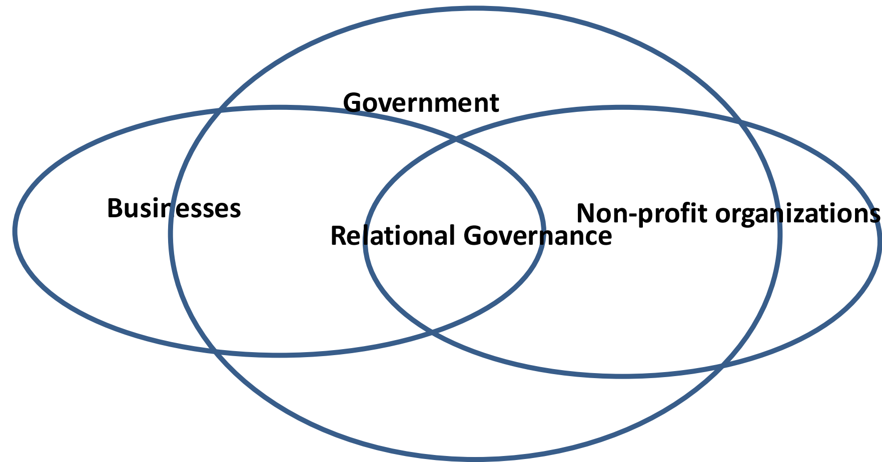
- The third trend is a shift from repression to a regulation approach. This trend has been the main approach to deal with licit substances like alcohol and tobacco, but has also been developed for cannabis in recent experiences in different countries.

Finally, we also took into account the impact of the harmonization process at EU level towards convergence in addiction policies in its member states.

1.2. Governance

Governance is 'the processes and structures of public policy decision making and management that engage people constructively across the boundaries of public agencies, levels of government, and/or the public, private and civic spheres in order to carry out a public purpose that could not otherwise be accomplished' (Emerson et al. 2012: 2).Our focus is governance (see Figure 1) in an attempt to go beyond what governments do and take into also into account the role of businesses and non-profit organisations. The work undertaken tries to analyse how this collaboration occurs in the key processes of policy-making: decision-making, implementation, and evaluation and accountability.

Figure 1. **Map of Governance**



Source: compiled by the authors

Addictions can be considered wicked problems (Rittel and Webber 1973: 160), which by definition are inherently resistant to a clear and agreed solution and that cannot be solved unless the public agencies are prepared to work in partnership, at different levels, with other public, civil society and business organisations' (Kickert et al. 1997; Stoker 1998; Bovaird 2004) Mendoza and Vernis state (2008: 392)

Addiction governance does not follow the traditional linear model (problem-options-solution-implementation) and is influenced by many stakeholders, public, private and non-profit from fields like health, justice, public order, safety, economy, trade, etc.

1.3. Context

In doing our research, we aimed at having a broad and trans-diciplinary perspective going beyond the health and public health models to classify countries. To do so, it was essential to take into consideration existing comparative studies using indicators that are key for the governance of addictions.

The most important one, as a starting point, is the Wellbeing model developed by the OECD in 2011[1] which measure well-being and progress of countries through the collection of subjective measures of material living conditions (housing, income, jobs, etc.) and quality of life (education, health, life satisfaction, etc). When information was not available such as in the case of Latvia, Lithuania, Romania, Bulgaria, Cyprus and Malta (non-OECD members) the gap was covered by collecting additional data from Eurostat database (2012)[2].

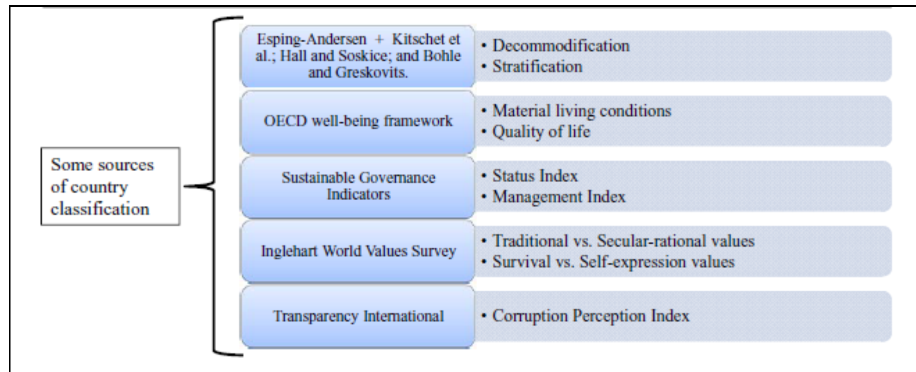
In addition, we built our model also taking into account (see Figure 2) the welfare state model (Esping-Andersen 1990; Ferrera 1996; Hall and Soskice 2001; Bohle and Greskovits 2006) to know the way that country structures governance. We included the indicators of "Sustainable Governance" (Bertelsmann Stiftung 2011)[3], 'a cross-national survey that identifies reform needs and highlights forward-looking practices'. We considered the Status Index, which 'examines the quality of democracy and performance in key policy fields' such as economy and

[1] http://www.oecdbetterlifeindex.org/
[2] http://epp.eurostat.ec.europa.eu
[3] http://www.sgi-network.org/

employment, social affairs, security and resources. We also covered the Management Index, focused on 'governance capacities in terms of steering capability and accountability', hence, it examines the executive capacity of different actors to formulate, coordinate and implement policies, as well as their accountability. Information was available for all countries except the non-OECD members listed above, Estonia and Slovenia (OECD members since 2010 but excluded by Bertelsmann Stiftung study).

We also took into account socio-cultural factors as Inglehart's World Values Survey data (Inglehart and Wezel 2005 and 2010) , and the classification of the countries based upon two major dimensions of cross-cultural variation: (1) Traditional vs. Secular-rational (TradRatvalues) and (2) Survival vs. Self-expression values (SurvSelfvalues). The former 'reflects the contrast between societies in which religion is very important and those where it is not' (WVS 2012)[4]. On the other hand, Survival/Self-expression values are linked to the transition from industrial society to knowledge society, in which an increasing share of the population has grown up taking survival for granted, and their priorities have shifted from economic and physical security toward well-being, self-expression and quality of life.

Figure 2. **Context analysis´sources**



Source: compiled by the authors

Finally, special emphasis is placed on contextualizing this according to the EU's supranational role and on how it influences the governance of addiction of each member state. Since 1980, the EU has had a policy on drugs and addictions that has produced some harmonization in areas such as law enforcement and police cooperation but states are sovereign and influential in this area. By introducing this international and supranational perspective we take into account path-dependency (Levi 1997: 28) and policy diffusion theories Braun and Gilardi (2006: 299) and the 'geopolitics of drugs', which considers the main trafficking routes, the effects of organized crime and conflicts between lobbies and decision-makers.

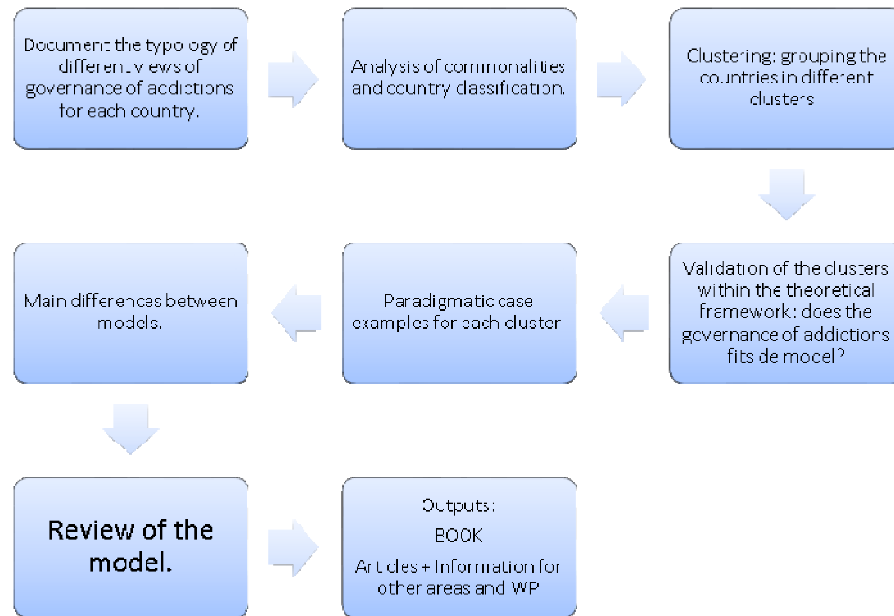
In summary, our work is aimed at reviewing the current approaches for governing addictive substances in the 27 European Union member states plus Norway in order to learn from them, to find out if there are different typologies and ultimately to help the reframing of the governance of addictive substances in Europe by identifying existing weaknesses and shortcomings and facilitating the definition of innovative and more integrative approaches.

[4] http://www.worldvaluessurvey.org/

2. What we did

The study conducted is mainly qualitative, though it has been complemented with a quantitative analysis, semi-structured interviews and an online survey. The study has been done in three stages organized in the following processes (see Figure 3):

***Figure 3.* The research process**



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2.1. Information gathering

The first one, carried out from September 2011 to November 2012, focused, on documenting and analysing the typologies of governance of addictions in the 28 countries taking into account, as much as possible, the role of the state, businesses and not-for-profit organisations, analysing governance practices, public policies and stakeholders' roles and including the OECD's 2011 well-being framework. We covered national strategies, action plans, legislation and national evaluations from the beginning of 2005 to the end of 2011. Apart from this, we searched at specific documents dealing with alcohol, tobacco, heroin and cannabis and specific country's laws related to penalties for possessing, consuming and trafficking illicit substances, as well as those laws regulating production, distribution, age limits, advertising and marketing of licit substances. In this phase also documents produced by international organizations and agencies such as the World Health Organization (WHO), United Nations (UN) and the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA) were taken into account (See Figure 4).

Figure 4. **Sources of information gathering**

Source: compiled by the authors

The first organization of all this information was done using drug policy classifications (see Figure 5). In the case of illegal drugs, prevention; treatment; harm reduction; social assistance & reintegration programs; drug trade; and drug production related policies (Babor et al. 2010). For legal drugs, we used the model proposed by Österberg and Karlson (1998) consisting in production and distribution; age limits and personal control; prices and taxes; advertising, marketing and sponsorship; institutional agreements and international cooperation; research, monitoring and surveillance for legal drugs. In addition we took into account the performance of each country in the alcohol and tobacco policy scales developed by Österberg and Karlsson (2012) and Joossens and Raw (2010) respectively.

Figure 5. **Drug policy classifications**

Source: compiled by the authors

Despite being split during the process of information gathering, licit and illicit substances have been regarded together when trying to stablish the European models of governance of addictions.

We also took into account not only the content but the whole political process of policy making; how each country organizes its policy, which ministries and departments are involved along the planning, policy-making and implementation process and what kind of stakeholders[5], either public or private, are involved in the different stages of the governance of drugs and addictions. We kept a very wide perspective including in the analysis issues like manufacturing, trafficking, possession, consumption, prevention, treatment and social reintegration of affected individuals and their immediate environment.

Despite placing the focus on the official governmental approach, in order to present the governance of addictions from a relational approach and more aligned to Emerson et al.'s definition of governance (2011), we found it necessary and convenient to complement and contrast this vision with the media and experts and introduce the main stakeholders involved in both the policy-making and the implementation process.

On one side, we have contrasted and expanded official information with that provided by national newspapers. Two political newspapers, one left-wing and the other one right-wing, and a third financial newspaper have been analysed. The newspapers were chosen based on the amount of sales, their popularity and their national recognition and credibility. We have searched for specific news showing how governments and different stakeholders deal with each other and interact to solve addiction and drug problems.

In addition, eighteen interviews with experts from fourteen EU countries were conducted. Specifically, the interviewees were ALICE RAP participants, i.e. experts in the field of addictions especially focused on research[6]. The interviews were semi-structured with two parts, one on national issues and a second one on the international domain. Finally, in order to contrast as well as to confirm our final model, we launched a survey to 200 experts from around Europe (N=91), where questions regarding their countries policies where asked.

2.2. Classifying and defining typologies

The second one, from December 2012 to August 2013, consisted of classifying the countries taking into account the commonalities and divergences found and their organisational structure to implement the policies.

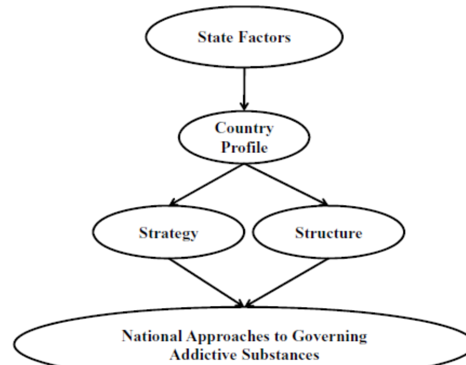
All information and data gathered has been classified into country tables with two sections (See Appendix 1). The first one presents the contextual measures which are size, population, GDP, OECD well-being and progress, levels of consumption and the international and geopolitical situation of the country in relation to drugs trafficking. Secondly, the table presents the policy measures, which include the main focus of the national strategy and the action plan currently being implemented, but also looks at former strategies and action plans in order to contrast and see the political trend of the country. This section also takes into consideration which are the ministries involved in managing the governance of addictions, if there is any ad hoc coordinator body and the relation with private and non-profit organizations, i.e. the relational governance. Finally, the policy measures section includes, if they exist,

[5] We define stakeholders as the set of relevant players in determining the policy and the governance of addictions in each country

[6] See annex 1 for more information regarding the interviewees.

specific laws and regulations, how the country classifies drugs and which are the penalties for possession, consumption and drug trafficking. Tables also include relevant good practices and a policy timeline from the year 2000 to 2011 in order to see the evolution and whether elections and parties affect how addictions are governed. From the country tables (see Appendix 2) an in-depth country report is also produced so as to complement and provide further information when required. The contents of the country report are closely related to the ones provided by country tables and extendedly present both contextual and policy measures plus all the information gathered through media coverage (see Figure 6).

Figure 6. **Model for the analysis: reviewing the current approaches for governing addictive substances in the 27 European Union member states plus Norway**



Source: compiled by the authors

2.3. Grouping countries

Throughout the information gathering process, we conducted team discussions on a weekly basis. In those discussions we were constantly questioning the information, the gaps, and the possible biases we had. These analyses -country by country- allowed us to look for commonalities and differences in policy approaches. Hence, the methodology used is a comparative case analysis, using in-depth qualitative information and large N data.

As presented in Figure 6, we take into account two levels of analysis: state factors and country profile (this last focusses on the specific policy factors on addictions). Both levels are composed by a mix of quantitative and qualitative information.

The state factors include indicators and control variables (i.e. welfare state regimes, OECD better life index, Sustainable Governance Indicators and Corruption Perception Index), to properly interpret the results on policies regarding the contextual factors.

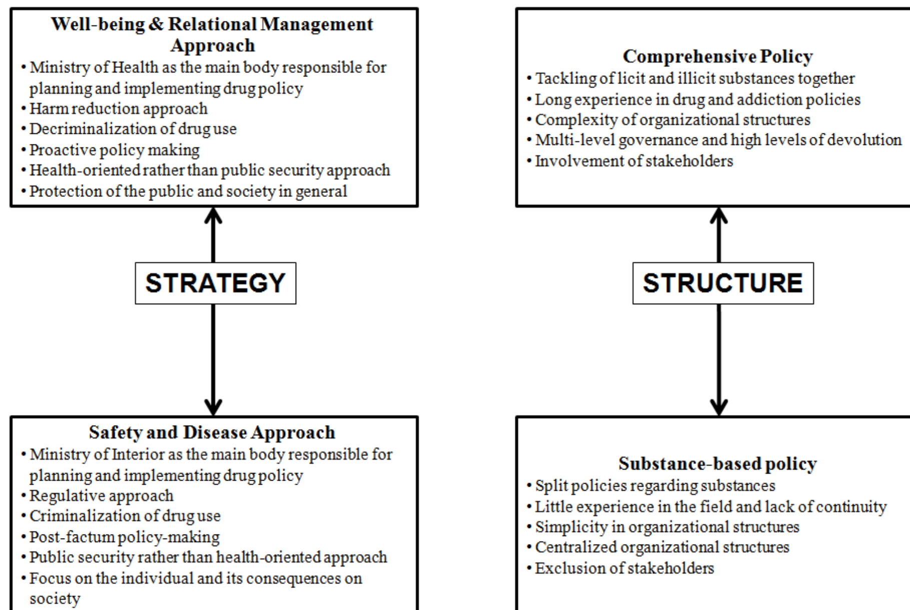
The country profile is defined by a set of variables that enable us to see the main characteristics affecting the governance of addictions, but also influencing the stakeholders involved in the policy process. In this regard, country profile and stakeholders not only affect the governance of addictive substances, they are also interrelated.

The qualitative study has allowed us to establish a preliminary classification of each country. However, through all the gathered knowledge and the available data we have agreed a set of

indicators for strategy and structure, the key variables to classify the countries into different models of governance of addictions.

For strategy, we understand the content of the policy and the focus and priorities of each country when governing addictive substances. Structure, on the other hand, focuses on the organization and the involvement of public, non-profit and private stakeholders in the different stages of the governance of addictions. We have undertaken a naming process[7] to establish the labels which represents the extremes of each concept (see Figure7).

***Figure 7.* Indicators for country classification on strategy and structure**



Source: compiled by the authors

Therefore, the analysis is the result of the transformation of key indicators for each of the concepts into categorical data. The concept 'strategy' is based on 10 indicators while the concept 'structure' has 9 indicators allowing us to measure and compare each country's approach regarding the governance of addictions (see Figure 8).

[7] Adopted from marketing field, naming are the techniques for the creation of a brand name. Naming requires a process of creating brand identity for the product apart from the rest, which at the same time represents the concept behind.

Figure 8. Operationalization of variables for the cluster analysis

Strategy	
1.Ministry of Health	Is the Ministry of Health responsible for drug and addiction policies? (Y=1 | N=0)
2.Classification determines penalties	Does drug classification determine penalties? (Y=1 | N=0)
3.Decriminalize possession	Does the country embrace decriminalization policies? (Y=1 | N=0)
4.Injection rooms	Does the country provide injection rooms? (Y=1 | N=0)
5.Alcohol policy scales	Does the country rank above the EU average in the alcohol policy scale? (Y=1 | N=0)
6.Tobacco control scale	Does the country rank above the EU average in the tobacco control scale? (Y=1 | N=0)
7.Supply reduction in national strategy	Supply reduction is not one of the priorities in the National Strategy of the country (Y=1 | N=0) Versus treatment, prevention and harm reduction
8.Public health in national strategy	Does the national strategy have a public-health perspective on its aims? (Y=1 | N=0)
9.Well-being in national strategy	Does the national strategy has a well-being perspective its aims? (Y=1 | N=0)
Structure	
1.Tackle licit & illicit substances together	Does the country tackle together licit and illicit substances? (Y=1 | N=0)
2.Transversality	Ratio of ministries ivolved in the governance of drugs addictions (>50%=1 | <50%=0)
3.Nonprofit organizations in decision-making	Are non-profit organizations involved in the decision-making process? (Y=1 | N=0)
4.Private organization in decision-making	Are private organization involved in the decision-making process? (Y=1 | N=0)
5.Ad hoc coordinator body	Has the country a coordinator or and *ad hoc* body for addictions? (Y=1 | N=0)
6.Policy making devolution	Does this country devolve policy-making to decentralized structures? (Y=1 | N=0)
7.Implementation devolution	Does this country devolve implementation to decentralized structures? (Y=1 | N=0)
8.Addiction on objectives	Is the concept of addiction on the objectives of the national strategy? (Y=1 | N=0)
9.Trajectory	Has this country long standing regulatory policies on drugs? (Before the 1st EU report=1 | After EU report=0)

Source: compiled by the authors

The final output obtained from this analysis is the 'Governance of Addictions', which reflects how the aforementioned variables influence the focus and the organization of countries and what kind of strategy and structure do these countries embed to tackle drugs and addictions.

2.3.1 Strategy

At one extreme of the 'strategy' concept we place the 'safety and disease approach' which reflects an individualistic approach criminalizing the drug user who is regarded as a diseased person and/or an offender. Furthermore, countries with this vision normally give more weight to supply reduction policies especially focused on traffic of illicit substances and controlled by security-oriented Ministries, i.e. Interior, Home Office and Justice. Finally, those countries classified as having a 'safety and disease approach' will have strict penalties and will not make sophisticated distinctions of penalties depending on the substance. At the other extreme, we place those countries with a 'well-being and relational management approach', which are characterized by having high levels of social acceptance for tackling drugs and addictions. This means that their citizens are in general more understanding regarding drug use and drug

addicts, these countries also take up the idea of individual freedom, thus, individual actions will be respected as long as they do not risk the freedom of another individual.

Furthermore, the 'well-being and relational management approach' embraces the three trends mentioned in the introduction: decriminalization, harm-reduction and regulation. Hence, these countries decriminalize drug use and in some instances even drug possession in small quantities. They also embrace a social vision by taking into account the social consequences of substance consumption and substance addictions and dealing with them through harm reduction policies. Finally, most of these countries' policies are evidence-based, previously contrasted with research and empirically and aimed at protecting public and society in general through regulation.

2.3.2. Structure

In the case of 'structure', we have differentiated EU countries based on their policy making and their organizational structures when dealing with substances and addictions. In one of the extremes we have the 'substance-based policy' countries, the ones splitting policies regarding substances, with short experience in the field and with some inconsistencies due to their lack of continuity regarding addictive substances' policies. In this sense, they are considered to be followers of the EU guidelines and the establishment of their structures and policies try to be aligned with those promoted by the EU. Another characteristic of 'substance-based policy' countries is their organizational structure based on addictive and drug-related problems. Furthermore, it seems that policies and structures are only build when a problem appears, hence, they do not anticipate the problem but lag behind addictive substances trends (i.e. reactive policy-making).

On the other extreme of the concept, we have placed those countries having a 'comprehensive policy'. This means that they embrace holistic political strategies including substances, either licit or illicit, and behaviours. Moreover, these countries have a long experience in drug and addiction policies, which normally leads to more complex and transversal structures, i.e. more ministries and departments involved and higher levels of interdependence when dealing with drug-related problems.

The process by which we have grouped the 28 countries has been based on the 19 aforementioned indicators. We have used these characteristics to conduct a Cluster Analysis.

2.4. Clustering

We used cluster analysis, as exploratory tool, in order to identify groups in data that share similar features but also that are different to other groups. We had a matrix with *C* countries and *I* items or indicators that represent characteristics of the policies. The *CxI* matrix is used to guess which countries tend to have similar policies and its transpose (*IxC* is used to guess which policies tend to go together). More specifically, we used Gower's similarity measure that takes into account symmetric combinations to give the same importance to the fact of having the characteristic or not having it. We were interested in pure bidirectional similarity, meaning that having or having not a policy was equally important for calculating the distances between countries. Once similarity measures between countries and policy items were produced, the distances between them are organized using hierarchical clustering, meaning that the data itself chooses the number of clusters. To do so, we used the Ward method of agglomeration, which minimizes the sum of the squares of the distances.

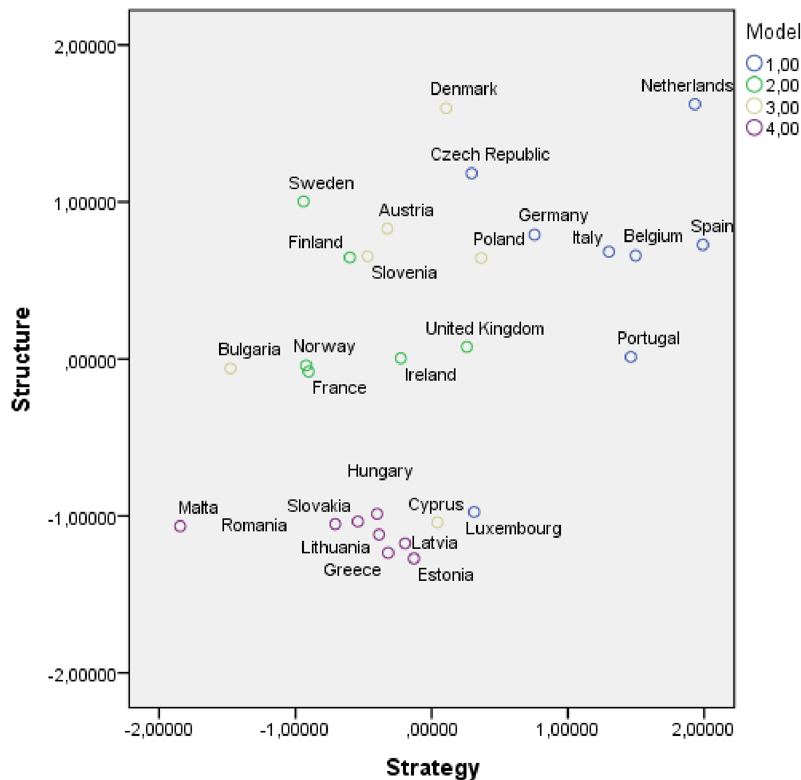
3. What we found

With the hierarchical clustering we generated Figure 9 of the distribution of similarities between countries. The axes show the distance between pairs of observations.

As it can be seen in the figure below, structure differences are more striking among countries than strategy ones in the whole model. Thus, we can say that when both variables, strategy and structure, are aggregated policy clusters for addictions in Europe, are driven by strategy.

In the upper right part we identify those countries in Model 1 (in blue), except for Luxembourg that is at the lower-right part of the Figure. At the upper-central part of the figure we find all the countries in Model 3 (in grey), except for Bulgaria and Cyprus. The upper-left part of the figure is occupied by Model 2 countries (in green). Finally, all the countries in the lower-left part of the figure belong to Model 4 (in purple).

***Figure 9*. Country positioning regarding cluster analysis on structure and strategy**



Source: compiled by the authors

In the following tables you will find a summary of the main characteristics and contextual measures of the models resulting from our analysis.

Table 1. **Models characteristics and countries within**

Model	Characteristics	Countries
1	A 'well-being and relational management' strategy with a comprehensive structure. Focus on illicit substances	Belgium, Czech Republic, Germany, Italy, Luxemburg, Netherlands, Portugal and Spain
2	Strict regulation on licit substances (tobacco and alcohol).	Finland, France, Ireland, Norway, Sweden and the United Kingdom
3	Most divergent countries of the sample. They do not follow a clear trend.	Austria, Bulgaria, Cyprus, Denmark, Poland and Slovenia
4	Not embraced the three trends. They have a 'safety and disease' strategy combined with a 'substance-based structure'.	Estonia, Greece, Hungary, Latvia, Lithuania, Malta, Romania and Slovakia

Source: compiled by the authors

3.1. Model 1

Countries in this model show high commonalities regarding strategies applied. They embrace to certain extent the three trends exposed in our introduction: decriminalization, harm reduction and regulation. None of them have a well-being perspective on their aims. None of them have supply reduction as one of the top priorities in their aims and all of them decriminalize possession of drugs. Proactive efforts when dealing with illicit substances and the introduction of innovative policies as injection rooms (half of the countries) are implemented. Nevertheless, there is no much implementation of evidence based policies for licit substances. This is shown in their rating below the 28's mean in alcohol and tobacco scales. To embrace a complete 'well-being and relational management' strategy, the countries in this model should overcome their gaps regarding licit substances and boost evidence-based regulations for tobacco and alcohol.

On the other side, there are significant structure divergences among the countries in this model. The soundest commonalities regarding structure are the transversality through which these countries face drugs and addiction problems, and that all them establish an ad hoc coordinator body for addictions policies. Ministry of health tends to be the responsible institution, and countries in this model are characterized by the devolution of the implementation process, and their long trajectory in legislating illicit drugs.

Regading alcohol and drug consumption, in Model 1 we find two differentiated groups especially when focusing our attention on illicit substances' levels of consumption. While the majority of the countries have similar levels of consumption as the ones reported, on average, by the 28's, the Czech Republic, Italy and Spain notoriously surpass this mean and have levels of consumption way above the 28's average. Regarding licit substances, these countries consumption is either at similar or below the 28's average. The only countries surpassing the levels of alcohol consumption in both levels, recorded and unrecorded, are the Czech Republic and Portugal.

3.2. Model 2

The main commonality of this model is the significant degree and amount of evidence-based regulative policies. It is also characterized by high rates in both alcohol and tobacco scales. In this cluster, only two countries decriminalize possession of illicit drugs and the Anglo-Saxons are the only ones that determine penalties according to their legal classification. Countries in this model tend to control through regulation policies specially in the area of licit substances, which include regulations limiting the retail and use of tobacco and alcohol. In a nutshell, their policies regarding illicit substances are still closer to a safety and disease strategy than to a well-being and relational management one.

There is not a clear pattern of the six countries regarding structure variables. Some commonalities follow. All of the countries in this model have organized an ad hoc body to deal with addictions, devolve implementation to decentralized structures and do not have "addiction" as such as an objective in their national strategies. Most of these countries in this group, tackle licit and illicit substances together, involve not-for-profit organizations in the decision-making process and have long experience legislating drug-related issues. All are unitary states, but half of the countries devolve policy-making to decentralized structures (regional and local governments).

In Model 2. we can identify different patterns of alcohol consumption between the Nordic and the Anglo-Saxon countries. Whereas Nordic countries have their own classification, the Anglo-Saxon's and France, are classified in the Central-western model. More specifically, the level of alcohol consumption in Finland, Norway and Sweden is below the EU average, while the UK, Ireland and France report higher levels of alcohol consumption, both recorded and unrecorded, than the EU average (Anderson et al. 2012). Regarding tobacco and cannabis their levels of consumption is quite similar though we can still distinguish the same two groups, the Nordics and the Anglo-Saxons plus France. However, the presence of two groups is not as clear as in the case of alcohol consumption. While the Nordics tend to have lower levels of consumption than the 28's average for all the substances, the later report either similar or slightly higher levels of substance consumption.

3.3. Model 3

Countries in this model have different approaches, there is not a clear trend. None of the countries decriminalize possession nor do they have injection rooms as a harm reduction policy, and their tobacco control scales are below the mid-point. They tend to have the Ministry of Health as the responsible institution to tackle drug and addiction issues and prioritizatize treatment and prevention issues before supply reduction ones. No clear pattern regarding licit drugs. Hence alcohol regulation is not an exception and while Austria, Bulgaria, Cyprus and Denmark rate below the mean (although Denmark is very close to the 28's average), Poland and Slovenia have stricter evidence-based regulations than the 28's. On the other hand, tobacco control scale is, in every country within Model 3, below the midpoint scale. In summary, although it is difficult to identify a cross-cutting trend regarding these countries' strategy, it seems that they tend to have a safety and disease strategy rather than a well-being and relational management one. The strategy of these countries is mainly characterized by placing the Ministry of Health as the main responsible institution and foster treatment, prevention and harm reduction above supply reduction measures. Taking all this into account we could say that these countries have been clustered together for not having a set of

characteristics: decriminalization of possession, injection rooms, tobacco control scale, and public-health on aims.

The countries in this model are more scattered in structure than in strategy. Austria and Denmark rate among the top ten in this dimension, Cyprus and Bulgaria have very few characteristics of a complex structure. Denmark and the Netherlands do not have an ad hoc coordinating body but have the highest rates in the discrimination parameter for structure. These countries do not tackle licit and illicit substances together; hence they focus on the substances rather than on addictions. None of the countries involve not-for-profit and private organisations in the decision-making process. Most of the countries in this model devolve policy-making and implementation to decentralized structures. Furthermore, this model shows some divergences when we analyse their transversality and trajectory. Finally, only half of the countries involve more than 50% of their ministries in the governance of addictions and, once again, half of the countries have long trajectory legislating drugs and addictions.

In the countries gathered in the third model, levels of consumption are above the 28's average, except for Cyprus which rates way below the mean not only for licit substances consumption but also for illicit. All the countries surpass the 28's mean for both alcohol and tobacco levels of consumption.

3.4. Model 4

This model is closer to a 'safety and disease approach' than to a 'well-being and relational management' one. Countries in this cluster share a traditional' drug and addiction policies, and have not yet embraced a public-health perspective. They still regard drugs and addictions as an issue to be tackled through a security-oriented perspective. Thus, their focus is on supply reduction and, regarding demand, they look at prevention and treatment, being harm reduction measures residual. Except for Greece (ministry of health), the ministry of interior or the prime minister holds the responsibility for addictions policies. Probably because of the alcohol related problems of these countries, during the last years, central-eastern European countries have become stricter and raised their excise-duties on alcohol (Karlsson et al., 2012). Tobacco, on the other hand, still is loosely regulated and only Malta scores above than the mid-point in the tobacco control scale. Countries in this model are mainly reactive and tend to follow the EU trends by producing very similar strategies and action plans as the ones approved by the EU.

The Baltic States (Estonia, Latvia and Lithuania) are grouped together in this cluster, and are the most dissimilar to the rest of the countries within this model by the fact that the three states have stricter and evidence-based regulations on alcohol and are the only ones that have decriminalized possession of cannabis.

This is the only model where we see higher levels of coincidence in the structure cluster than in strategy, except for Hungary. Main characteristics in this domain are the presence of and ad hoc coordinator body, the inexistent involvement of not-for-profit and private organizations in the decision making, the non-devolution of policy-making and implementation to decentralized structures and the exclusion of the concept addiction in the aims. There is not a clear pattern regarding licit and illicit substances. Some countries tackle them together while others do not. Half of the countries involve more than 50% of their ministries in the governance of addictions, and some of them have relatively long trajectory legislating illicit drugs.

Finally, by taking into account their pattern of alcohol consumption, most of the countries in Model 4 have been classified as 'Central-eastern and eastern Europe' states (Anderson et al., 2012). This means that most of these countries report a higher rates of unrecorded consumption and are characterized by patterns of irregular heavy drinking. As noted by the WHO (2004), spirits have played a 'relatively large role in most of these countries (Anderson et al., 2012: 11), and, differences between recorded and unrecorded alcohol consumption are the highest within our sample. Regarding cannabis Estonia and Slovakia report higher levels than the 28's average; secondly, Latvia and Lithuania have almost the same levels as the ones reported on average by the 28's; finally, the rest of the countries (i.e. Greece, Hungary, Malta and Romania), have levels of cannabis prevalence significantly below the 28's mean.

3.5. Comparing addiction and contextual classifications.

Of the different contextual measures analysed (welfare state regimes, the OECD better life initiative variables, Inglehart's World Values Survey, etc.) and the different models obtained, the most salient information is listed in Table 2, below. No clear relationship has been found between these classifications and the addiction models. In addition, we did not find complete concurrence between prior studies related to the consumption of one substance, such as that undertaken by Anderson et al. (2012) for alcohol patterns, and our final classification.

For example, when considering the welfare state regime of a country and the models of addictions governance, the classification 'Trend-setters in illicit substances model' gathers together continental and Mediterranean countries; the classification 'Regulation of licit substances model' integrates Nordic, Anglo-Saxons and continental countries; and in the 'Transitioning model' continental, eastern, and Mediterranean countries are clustered together; finally, the 'Traditional model' mainly comprises countries of Eastern Europe, along with two non-CEEC states. Given these clusterings, we cannot state unequivocally that the welfare state regimes determine public policies for addictions. However, we can infer that they are highly influenced by them. The same stands for the classifications compared with other aspects.

Having said this, we must note some interesting common contextual features within the models. Firstly, all CEEC states, except for Greece, which are grouped under the Traditional model have survival rather than self-expression values. This means that their citizens place the emphasis on economic and physical security; they are ethnocentric and report low levels of trust and tolerance. Furthermore, as Anderson et al. (2012) remark, notable coincidences can be seen when comparing the Esping-Andersen work and different patterns of alcohol consumption in European areas.

All countries in the 'Regulation of licit substances model' report economic indicator scores greater than the average for the 28 countries (Eurostat, 2011), as well as higher quality of life and material living conditions (OECD, 2011). This is mainly attributable to the presence of the Nordic countries, which rate among the top countries for most of the indicators. On the other end of the scale, we find countries in the 'Traditional model', which rate below the in all contextual indicators. Within the group 'Trend-setters for illicit substances model', Mediterranean countries rate below the mean while the Continental countries have better rates. In the 'Transitioning model' group, a greater divergence among countries can be seen.

Table 2. Results contrast with former classifications on contextual measures

	Model 1	Model 2	Model 3	Model 4
Welfare state regimes	Continental and Mediterranean	Nordics (Finland, Norway and Finland), Anglo-Saxons (Ireland and the United Kingdom) and Continental (France)	Continental and Nordic welfare state regimes plus Cyprus and Slovenia, which, are not classified into any of the four welfare states regimes.	All CEEC and former satellites of the USSR except for the Czech Republic (in Model 1) and Bulgaria and Poland (in Model 3) and two Mediterranean countries: Greece and Malta.
OECD indicators	Founding members – 7 out of 10 and the rest 5 out of 10. More divergences in the living conditions ones.	High standards of well-being both in quality of life and material living conditions variables specially among the Nordics followed by UK and then France.	Outstanding differences within this Model. Bulgaria having the lowest GDP with Austria and Denmark in the top ten in economic and non-material domains Bulgaria nor Cyprus are OECD member states.	Half of these countries are not OECD member states, those within this model and members of the OECD (i.e. Estonia, Greece, Hungary and Slovakia) report, on average, between one and two points below the average for quality of life and material living conditions.
Inglehart's World Values Survey	Mainly Catholic except Germany and Netherlands which are protestant. Countries in this group also tend to have self-expression values.	Rational values. Except Ireland that has traditional values	Catholic Europe group except for Cyprus (not classified) and Bulgaria (excommunist) country.	All the countries except for Greece and Malta (i.e. all former USSR countries), have 'survival values' instead of 'self-expression values'.
Corruption index	Discrepancies. Czech Republic and Italy below 5 (out of 10) but the rest above 10. Netherlands and Luxembourg, lowest corruption perception.	Nordic countries better than the EU average.		Index scores are, on average, 2 points below the EU mean, i.e. 4,98 out of 10.

GDP	High in Luxembourg, Belgium, Germany and Netherlands and low in Italy, Portugal, Czech Republic and Spain.	Nordic countries better than the EU average.		Below the 28's mean in GDP per capita and levels of income. Higher unemployment rates than the 28's average.

Source: compiled by the authors

4. Discussion, conclusions and recommendations

The work undertaken has allowed the identification of four typologies for governing addictive substances in the 27 European Union member states plus Norway:

- Model 1 countries have passed laws that decriminalize use and possession of illicit substances and, at the same time, give much importance to harm reduction policies, a practice that is growing in these countries.
- Model 2 countries have implemented strict but evidence-based regulations aimed at reducing the levels of alcohol and tobacco consumption and enhancing societal well-being.
- Model 3 and 4 still have a way to go if they want to embrace decriminalization, regulation and harm reduction policies.

This is the first time that this kind of study has been conducted, which makes it both a challenge and an opportunity. It is worth remembering that we look at the 'strategic picture', i.e. how the 28 countries develop their governance of addictions. Thus, when grouping the countries, the emphasis is placed on the broad strategy of each country and its organizational design without losing sight of the theoretical framework and control variables.

Furthermore, it is noteworthy that the classification is continuous and dynamic, countries can circulate through it and the classification of each country can vary throughout time. More interestingly, this first attempt to present governance of addictions regimes can also be used to compare the 28 countries analysed with other non-European countries allowing us to see how much these non-European countries differ from the four approaches presented by us or whether these countries are aligned with one of the four clusters presented.

Each model stresses a dominant perspective, either for strategy and structure, although this does not exclude them from embracing other characteristics. In this respect, we note that most of the countries have the Ministry of Health as the institution in charge of coordinating policy-making and implementation of drug and addiction policies, moreover, they do not place supply reduction among the top priorities in their national strategies, and almost every country has an ad hoc body gathering representatives from different ministries, and even from not-for-profit and the private spheres, that coordinates drug and addiction policies. On the other hand, some characteristics are conspicuous by their absence, these are: injection rooms, public health in national strategy, well-being in national strategy and addiction in national strategy.

4.1. Limitations

We note that there are several limitations to our results (such as the choice of variables and breadth of comparison drawn) and also that it is likely that we have not been able to capture all particularities of the countries under study. However, as far as we are aware of, this study represents the first attempt to cluster European countries according to their public drugs and addictions policies. The strategy and structure variables used have allowed us to analyse similarities and differences among the countries and led us to propose the four final models.

We have already mentioned some limitations to the study: a) a lack of information provided which would allow a complete view of relational governance. This has been solved, as far as possible, by media coverage, expert interviews and using a survey; b) the limited accessibility of official documents, which has hindered the analysis, and the variety of languages, making some translation necessary which has slowed down the work process; c) the fact that not all theoretical frameworks currently in use cover all 28 countries, a limitation we have attempted to solve by constructing a compendium of contextual and control variables.

It could also be argued that one limitation is that our study only deals with four substances (heroin, cannabis, tobacco and alcohol). Although we do exclude relevant addictive substances and behaviours, such as cocaine, synthetic drugs and gambling, we consider that the four substances studied provide a broad picture of the approaches used in the 28 countries in tackling addictions and drug abuse. Having said this, other substances and even addictive behaviours have been taken into account, when necessary and relevant, and in order to gain a better understanding of a country's governance model. In addition, it could be claimed, regarding the study focus, that we only look at the national level, and that federal states, regions and cities can have relevant policies which contradict others within a country on some aspects. That being true, we maintain that our intention is to provide an overview and that this does not enable us to look into the details and specific policies provided by regions, municipalities and city councils (which we also find would not make sense given the aims of the study).

4.2. Final remarks

Despite these limitations, we see the work is an opportunity and a point of departure for future studies in the field of governance and addictions. It is anticipated that the establishment of different governance of addictions models should allow experts in the field to analyse new and better ways to deal with addictions and redesign their governance approach. Within ALICE RAP, this work is conceived as a basis for building the future perspectives on how the problems of addiction can be tackled effectively by governments, NGOs and businesses.

As mentioned above, structure follows strategy, and, therefore, public policy on addictions is dependent the sectorial approach and former classifications. This helps to explain the non-intuitive classifications of some countries, and groupings of traditional ones, which are not useful in this case.

None of the models described here fully embraces the three trends mentioned in the introduction, indicating that they may be influenced by different forces and traditions that rarely coexist at a country level, at least up until now and looking at our analysis. The three trends (decriminalization of use and possession of illicit substances, broader acceptance for harm reduction perspectives and an increasing focus on regulatory politics) are found primarily in models 1 and 2.

Finally, the traditional division of addiction policies into those that aim for demand reduction and others for supply reduction is still very prevalent in Europe. And, furthermore, the influence of the EU strategy has an impact on the different countries. There is a clear tendency to align countries' drug strategies to the EU minimum requirements and recommendations. Concurrently, seems rather unrealistic to adopt a single EU- wide policy given the different historical paths, socio-economic standards, values and geostrategic locations which affect the levels of consumption and the final governance of addictions in different countries across the EU.

It is clear that a better governance of addictions in the EU is possible and that some countries are doing very well in some areas. The challenge now is to bring the best from the different models into one governance model, given the number and variety of variables and stakeholders involved.

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5. Appendixes

Appendix 1. Country information

Country Name:			
	Contextual Measures		
		Country	**EU (27)**
Total Population[8]	%		
	Total		
Average Age			
GDP per capita[9]	Index EU 100		
	Euros/Inhabitant		
Unemployment rate[1]	Total Population (%)		
	Under 25 (%)		
Inequality	At risk poverty rate (2010)[10]		
	Framework Indicators		
		Country	**EU (27+1)**
Esping-Andersen welfare state			
OECD well-being indicators[11]			
Income			
Jobs			
Housing			
Community			
Education			
Environment			
Governance			
Health			
Life Satisfaction			
Safety			
Work-Life Balance			
World Values Survey Index			
TradRat Values			
SurvSelf Values			
Sustainable Gov. Index			
Status Index			
Management Index			
Corruption Perception Index			

[8] Source: EUROSTAT, year 2011
[9] Source: EUROSTAT, year 2010
[10] Source: EUROSTAT (2010): http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=ilc_li02&lang=en
[11] Source: OECD (2011): "Better Life Initiative"

Consumption Measures		Country	EU (27+1)
Alcohol: Average adult (15+) per capita consumption in liters[12]	Recorded		
	Recorded + unrecorded		
Tobacco[13]	% of smokers		
	Cigarettes per day		
Cannabis Annual Prevalence [14]	All Adults 15-64		
	Young Adults 15-34		
	Youth 15-24		
Heroin: Prevalence of injecting drug use (overall type of drug use, rate/1000)[15]	Lower		
	Upper		
Primary drug abuse among persons treated[16]	Cannabis		
	Opioids		
Geopolitics of drugs			
Position in a drug traffic route (gateway, traffic, transhipment point, final destination)			
Major drug traffic			
Policy Measures			
Last National Strategy (year, main focus)			
Last National Action Plan (year, main actors)			
Current National Strategy (year, main focus and differences between the last)			
Current National Plan (year, main focus and differences between the last)			
Accountability (presence and direction)			
Information availability (presence and language)			
Ministry Responsible			
Ministries involved			
Budget specificities (information transparency, clearness and % of something)[17]			
Specific Coordination Organism			
Definition of Addictions			
Specific law and regulation (presence/absence and changes overtime, main objective)	Alcohol		
	Tobacco		
	Illicit drugs		
Public-Private collaboration (presence/absence, type (prevention, treatment, etc.; main actors)	General		
	Alcohol		
	Tobacco		
	Illicit Drugs		

[12] Source: WHO (2005). Average (unweight, own elaboration) Europe.
[13] Source: EUROBAROMETER about Tobacco (2010).
[14] Source: EMCDDA (2011). Average (unweight, own elaboration) Europe.
[15] Source: EMCDDA (2005, 2006, 2007, 2008, 2009, 2010, 2011). Average (unweight, own elaboration) Europe.
[16] Source: UNODC, Annual Reports Questionnaires (ARQ) (2008). Average (unweight) Europe, according to World Drug Report 2011.
[17] Source: National Reports 2010, 2009.

		Country	EU
Policy planning (devolution: y/n)			
Implementation (devolution: y/n)			
Classification of drugs[18]	Main laws and lists of substances		
	Classification determines penalty		
	Application of laws		
Illegal consumption of drugs[19]	Legal basis and definition of offence		
	Penalty established		
Illegal possession of drugs[20]	Description		
	Basic possession offences and penalties		
Illegal Drug Trafficking[21]	Penalties (imprisonment)		
	User-dealers difference		
Best Practices			
General (year, drug governance, type)			
Substance specific (year, type: prevention, treatment, etc.)	Alcohol		
	Tobacco		
	Cannabis		
	Heroin		
Media coverage			
Policy timeline			

Source: compiled by the authors

[18] Source, year 2012, EMCDDA.
[19] EMCDDA, year 2010. prohibitions such as use in prison, transport, school, workplace, in front of minors.
[20] Source: year 2012, EMCDDA
[21] Source: EMCDDA, year 2011.

Appendix 2. Country data

Variables	Population (28EU%)	Territory (28EU%)	GDP per capita (EU=100)	Euros/ Inhabitant	Unemployment rate	Unemployment rate (Youth)
Austria	1,65	1,74	129	35700	4,2	8,3
Belgium	2,15	0,63	118	33700	7,2	18,7
Bulgaria	1,48	2,31	45	4800	11,2	26,6
Cyprus	0,16	0,19	92	21100	7,8	22,4
Czech Republic	2,07	1,64	80	14900	6,7	18
Denmark	1,1	0,90	125	43200	7,6	14,2
Estonia	0,0002	0,94	67	11900	12,5	22,3
Finland	1,1	7,01	116	35200	7,8	20,1
France	12,8	13,38	107	30600	9,7	22,9
Germany	16,08	7,43	120	31700	5,9	8,6
Greece	2,23	2,74	82	18500	17,7	44,4
Hungary	1,96	1,93	66	10000	10,9	26,1
Ireland	0,88	1,46	127	35400	14,4	29,4
Italy	11,92	6,27	101	26000	8,4	29,1
Latvia	0,4	1,34	58	9800	15,4	29,1
Lithuania	0,6	1,36	62	10200	15,4	32,9
Luxemburg	0,01	0,05	274	82100	4,8	15,6
Malta	0,08	0,01	83	15500	6,5	13,7
Netherlands	3,28	0,86	131	36100	4,4	7,6
Norway	0,97	8,01	189	70500	3,3	8,9
Poland	7,51	6,50	65	9300	9,7	25,8
Portugal	2,09	1,93	65	16000	12,9	30,1
Romania	4,21	4,96	49	5800	7,4	23,7
Spain	9,28	10,50	99	23100	21,7	46,4
Slovakia	1,07	1,02	73	12700	13,5	33,2
Slovenia	0,4	0,42	84	17600	8,2	15,7
Sweden	1,9	9,36	126	41100	7,5	22,9
UK	12,28	5,09	108	27900	8	21,1

Variables	Well-being (average)	Material Living Conditions (W-B)	Quality of Life (W-B)	OECD Status (average)	OECD Status (ranking)
Austria	7,26	6.45	7.56	6,86	11
Belgium	7,35	6.86	7.53	7,17	10
Bulgaria		-	-	-	-
Cyprus		-	-	-	-
Czech Republic	6,04	4.23	6.71	6,78	12
Denmark	7,79	5.9	8.5	8,34	4
Estonia	4,67	2.53	5.47	-	-
Finland	7,48	5.53	8.21	8,52	3
France	6,77	6.06	7.03	6,74	13
Germany	7,15	6.2	7.51	7,77	5
Greece	5,26	4.1	5.7	5,12	20
Hungary	4,95	2.9	5.72	5,94	17
Ireland	7,30	5.86	7.83	7,37	8
Italy	6,17	5.46	6.43	5,70	18
Latvia		-	-	-	-
Lithuania		-	-	-	-
Luxemburg	7,48	7.56	7.45	7,60	7
Malta		-	-	-	-
Netherlands	7,69	7.26	7.85	7,63	6
Norway	7,90	6.73	8.33	8,64	2
Poland	5,34	3.33	6.08	6,33	16
Portugal	5,26	4.76	5.45	6,59	14
Romania		-	-	-	-
Spain	5,37	3.1	6.22	6,35	15
Slovakia	6,26	4.86	6.78	5,48	19
Slovenia	6,50	4.93	7.08	-	-
Sweden	7,80	6.23	8.38	8,65	1
UK	7,43	6.7	7.7	7,22	9

Variables	OECD Management (average)	OECD Management (ranking)	Year entry into the EU	Political structure of the country	Religion
Austria	6,39	9	1995	Federal	Catholicism
Belgium	6,00	12	1952	Federal	Catholicism
Bulgaria	-	-	2007	Unitary	Ortodoxy
Cyprus	-	-	2004	Unitary	Catholicism
Czech Republic	5,88	13	2004	Regionalized	Catholicism
Denmark	7,9	3	1973	Unitary	Protestantism
Estonia	-	-	2004	Unitary	Protestantism
Finland	7,79	4	1995	Unitary	Protestantism
France	5,82	14	1952	Unitary	Catholicism
Germany	6,84	6	1952	Federal	Protestantism & Catholicism
Greece	4,54	20	1981	Unitary	Orthodox Christianism
Hungary	5,71	17	2004	Unitary	Catholicism
Ireland	6,33	10	1973	Unitary	Catholicisim
Italy	5,62	18	1952	Regionalized	Catholicism
Latvia	-	-	2004	Unitary	Protestantism & Catholicism
Lithuania	-	-	2004	Unitary	Catholicism
Luxemburg	7,05	5	1952	Unitary	Catholicism
Malta	-	-	2004	Unitary	Catholicism
Netherlands	6,84	7	1952	Regionalized	Protestantism & Catholicism
Norway	8,2	2	-	Unitary	Protestantism
Poland	5,79	15	2004	Unitary	Catholicism
Portugal	5,76	16	1986	Unitary	Catholicism
Romania	-	-	2007	Unitary	Ortodoxy
Spain	6,03	11	1986	Regionalized	Catholicism
Slovakia	4,75	19	2004	Regionalized	Catholicism
Slovenia	-	-	2004	Regionalized	Catholicism
Sweden	8,29	1	1995	Unitary	Protestantism
UK	6,82	8	1973	Unitary	Christianity

Variables	Inglehart (Traditional Rat. Values)	Inglehart (Survival Self. Values)	At risk poverty rate	GINI Index	Human Development Index
Austria	0,25	1,43	12,1	26,3	0,9
Belgium	0,5	1,13	14,6	26,3	0,9
Bulgaria	1,13	-1,01	20,7	33,2	0,8
Cyprus	-0,56	0,13	15,8	29,1	0,8
Czech Republic	1,23	0,38	9,0	25,2	0,9
Denmark	1,16	1,87	13,3	27,8	0,9
Estonia	1,27	-1,19	15,8	31,9	0,8
Finland	0,82	1,12	13,1	25,8	0,9
France	0,63	1,13	13,3	30,8	0,9
Germany	1,17	0,44	15,6	29,0	0,9
Greece	0,77	0,55	20,1	33,6	0,9
Hungary	0,4	-1,22	12,3	26,9	0,8
Ireland	-0,91	1,18	16,1	33,2	0,9
Italy	0,13	0,6	18,2	31,2	0,9
Latvia	0,72	-1,27	21,3	35,2	0,8
Lithuania	0,98	-1	20,2	32,9	0,8
Luxemburg	0,42	1,13	14,5	27,2	0,9
Malta	-	-	15,0	27,4	0,8
Netherlands	0,71	1,39	10,3	25,8	0,9
Norway	1,39	2,17	11,2	22,9	0,9
Poland	-0,78	-0,14	17,6	31,1	0,8
Portugal	-0,9	0,49	17,9	34,2	0,8
Romania	-0,39	-1,55	21,1	33,2	0,8
Spain	0,09	0,54	20,7	34,0	0,9
Slovakia	0,67	-0,43	12,0	25,9	0,8
Slovenia	0,73	0,36	12,7	23,8	0,9
Sweden	1,86	2,35	12,9	24,4	9,0
UK	0,06	1,68	17,1	33,0	0,9

Variables	Corruption Perception Index	Corruption Perception Index (ranking)	Location regarding trafficking	Major drug trafficked	FCTC ratification year
Austria	7,9	8	Transshipment point & Traffic	Cannabis	2005
Belgium	7,1	10	Transshipment point & Producer	Cannabis & Sinthetic drugs	2005
Bulgaria	3,6	27	Strategic	Heroin	2005

			connection		
Cyprus	6,3	14	Transit & Final destination	Cannabis & Heroin	2005
Czech Republic	4,6	22	Transshipment point & Producer	Cannabis	Not ratified
Denmark	9,4	1	Transit & Final destination	Cannabis	2004
Estonia	6,4	12	Transshipment & destination point	-	2005
Finland	9,4	2	Transit & Final destination	-	2005
France	6,8	11	Transit & Final destination	Cannabis	2004
Germany	7,9	7	Transit & Final destination	Sinthetic drugs & Cannabis	2004
Greece	3,5	28	Entry point & Transit	Heroin	2006
Hungary	4,7	21	Transshipment point	Heroin & Cannabis	2004
Ireland	8	6	Transshipment point	Cannabis & Heroin	2005
Italy	3,9	25	Entry point & Transit	Cannabis	2008
Latvia	4,2	24	Transshipment point	Sinthetic drugs & Heroin	2005
Lithuania	4,8	20	Transshipment point	-	2004
Luxemburg	8,5	5	Transit	Cannabis & Heroin	2005
Malta	5,6	18	Transit	Heroin & Cannabis	2003
Netherlands	8,8	3	Producer & Traffic	Cannabis	2005
Norway	9	19	Final Destination	Cannabis	2003
Poland	6	17	Producer & Traffic	-	2006
Portugal	6,1	26	Entry point	Cannabis & Cocaine	2005
Romania	4,3	23	Transshipment point	Heroin	2006
Spain	6,2	15	Entry point & Traffic	Cannabis	2005
Slovakia	6,4	13	Traffic	Cannabis	2004
Slovenia	6,1	16	Traffic	-	2005
Sweden	9,3	9	Traffic & Final destination	-	2005
UK	8,6	4	Final destination	Heroin	2004

Variables	Party to the 1961 Single Convention	Party to the 1961 Single Convention as amended in 1972	Ratification 1971 Convention on Psychotropic Substances	Party to the 1988 Convention against illicit traffic in Narcotic Drugs and Psychotropic Subtances
Austria	1961	1978	1997	1989
Belgium	1961	1984	1995	1989
Bulgaria	1996	1996	1972	1992
Cyprus	1969	1973	1973	1990
Czech Republic	1993	1993	1993	1993
Denmark	1961	1975	1971	1988
Estonia	Not ratified	1996	1996	2000
Finland	1961	1973	1971	1989
France	1969	1975	1971	1989
Germany	1961	1975	1971	1989
Greece	1972	1985	1977	1992
Hungary	1961	1987	1971	1989
Ireland	1980	1980	1992	1989
Italy	1961	1975	1981	1988
Latvia	1993	1993	1993	1994
Lithuania	1994	1994	1994	1998
Luxemburg	1961	1987	1993	1989
Malta	1990	1990	1990	1996
Netherlands	1961	1987	1993	1989
Norway	1961	1973	1975	1988
Poland	1961	1993	1975	1989
Portugal	1961	1979	1979	1989
Romania	1974	1974	1993	1993
Spain	1961	1977	1973	1988
Slovakia	1993	1993	1993	1993
Slovenia	-	1992	1992	1992
Sweden	1961	1972	1972	1991
UK	1961	1978	1971	1988

Variables	Alcohol consummption - recorded - (EU)	Alcohol consummption - unrecorded - (EU)	Alcohol price (EU=100) (Alcohol scales)	BAC
Austria	12,6	13,24	95	0,05
Belgium	9,8	10,77	101	0,05
Bulgaria	11,2	12,44	77	0,05
Cyprus	8,3	9,3	119	0,05
Czech Republic	15	16,45	89	0,02
Denmark	11,4	13,37	135	0,05
Estonia	13,8	15,57	106	0,02
Finland	9,7	12,52	170	0,05
France	13,3	13,66	95	0,05
Germany	11,8	12,81	91	0,05
Greece	9	10,75	105	0,05
Hungary	12,3	16,27	84	0,02
Ireland	13,4	14,41	167	0,08
Italy	8,3	10,68	113	0,05
Latvia	9,5	12,5	118	0,05
Lithuania	12	15,03	99	0,05
Luxemburg	12	13,01	96	0,05
Malta	3,9	4,3	98	0,08
Netherlands	9,6	10,06	99	0,05
Norway	6,2	7,81	234	0,02
Poland	9,6	13,25	89	0,02
Portugal	12,5	14,55	86	0,05
Romania	11,3	15,3	70	0,02
Spain	10,2	11,62	84	0,05
Slovakia	10,3	13,33	97	0,02
Slovenia	12,2	15,19	102	0,05
Sweden	6,7	10,3	138	0,02
UK	11,7	13,37	117	0,08

Variables	Tobacco consumption - % of smokers	Tobacco consumption - cigarettes per day	Tobacco control scale (0-100) The Tobacco Control Scale 2010 in Europe	Cannabis Prevalence All Adults 15-64	Cannabis Prevalence Young Adults 15-34	Cannabis Prevalence Youth 15-24
Austria	34	17,7	32	3,5	6,6	10,6
Belgium	30	15,7	50	5,1	11,2	11,9
Bulgaria	30	15,8	40	2,7	6	8,7
Cyprus	23,9	21,7	40	4,4	7,9	7,5
Czech Republic	24,9	13,9	34	11,1	21,6	29,5
Denmark	29	14,6	46	5,4	13,5	18,9
Estonia	33,3	-	43	6	13.6	19.4
Finland	21	12,8	52	3,6	8	9,1
France	26,1	12,2	55	8,6	16,7	21,7
Germany	25	14,7	37	4,8	11,1	15,1
Greece	27,6	21,4	32	1,7	3,2	3,6
Hungary	38	16,3	34	2,3	5,7	10,1
Ireland	31	16	69	6,3	10,4	13,1
Italy	24,5	13	47	14,3	20,3	22,3
Latvia	32,7	13,1	44	4,9	9,7	12,9
Lithuania	30	12,6	41	5,6	9,9	12,8
Luxemburg	25	17,2	33			
Malta	25,7	16,3	52	0,8	1,9	-
Netherlands	24	14,2	46	5,4	9,5	11,4
Norway	-	-	62	3,8	7	8,4
Poland	29,9	15,3	43	2,7	5,3	7,5
Portugal	16,4	15,5	43	3,6	6,7	6,6
Romania	30	15	45	0,4	0,9	1,5
Spain	28,1	13,9	46	10,6	19,4	23,9
Slovakia	19,2	13,5	41	6,9	14,7	20,4
Slovenia	34,6	17,2	44	3,1	6,9	7,3
Sweden	16	10,1	51	2,8	6,2	7,3
UK	26,7	14,6	77	8,4	15,9	21,2

Variables	Heroin Prevalence Lower (EU)	Heroin Prevalence Upper (EU)	Drug related deaths (%)	Durg Users in prison (%)	VIH Adult Prevalence (2009)	HIV Infections newly diagnosed in injecting drug users (2009)	AIDS cases in injecting drugs users (2009)
Austria	2,19	4,19	207		0,3	-	16 (2008)
Belgium	3,46	4,24	-		0,2	13	5
Bulgaria	-	-	41		0,1	74	7
Cyprus	2,1	3	-		-	0	0
Czech Republic	3,68	4,6	29		0,1	4	2
Denmark	2,81	4,7	222 (2009)		0,2	14	3
Estonia	-	-	101		1,2	85	26
Finland	4,3	5,7	156		0,1	12	2
France	-	-	365 (2009)		0,4	94	34
Germany	2,27	3,03	1276 (2009)		0,1	100	13
Greece	1,19	1,69	-		0,1	12	3
Hungary	-	-	20		0,1	0	0
Ireland	2	3,37	112 (2004)		0,2	29	8
Italy	9,7	10,2	530 (2002)		0,3	113	201
Latvia	3,1	6,2	7		0,7	74	47
Lithuania	-	-	51		0,1	117	20
Luxemburg	3,9	6	8		0,3	0	0
Malta	5,5	6	5		0,1	0	0
Netherlands	0,2	0,4	94		0,2	1	6
Norway	2,8	3,9	285 (2009)		0,1	11	-
Poland	3,7	4,7	-		0,1	39	30
Portugal	4,3	7,4	26		0,6	142	70
Romania	-	-	-		0,1	1	2
Spain	1,2	1,3	160 (2009)		0,4	184	333
Slovakia	2	3	-		0,1	1	0
Slovenia	6,63	9,2	25		0,1	0	0
Sweden	-	-	267 (2009)		0,1	24	6 (2007)
UK	2,86	5,76	1930		0,2	149	15

Variables	Responsible Ministry	Ad hoc body/agency/organization	Participants (speakers) to the UN CND	List of participants UN CND (2012)
Austria	Ministry of Health	Federal Drug Coordination Office & the Federal Drug Forum	Federal Minister for Health	Federal Ministry for European and International Affairs; Federal Ministry of Health
Belgium	Ministry of Public Health	General Drugs Cell		Ministry of Justice; Minsitry of Public Helath and Environment
Bulgaria	Ministry of Health	National Drug Addiction Center; National Council on Narcotic Substances; National Focal Point on Drugs and Drug Addictions; Anaylitical Unit on Narcotic Substances; Regional Councils for Narcotic Substances.	Deputy Minister of Health, National Coordinator on Drug Demand Reduction	Ministry of Health (Drugs & Centre for Addictions); Ministry of Foreign Affairs
Cyprus	Ministry of Health & Ministry of Education	Cyrpus Anti Drugs Council		Cyprus Police (Drug Law Enforcement Unit)
Czech Republic	Prime Minister	Government Council for Drug Policy Coordination. This body has a secretariat that includes the Czech National Monitoring Center for Drugs and Drug Addiction (Czech national focal point)	Minister of the Interior of the Czech Republic	National Drug Coordinator; Ministry of Health
Denmark	Ministry of Interior and Health	-	Minister of Health and Prevention	Ministry of Health
Estonia	Ministry of Social Affairs			Ministry of Social Affairs; Ministry of Interior
Finland	Minsitry of Social Affairs and Health	Drug Policy Co-ordination Group		Ministry of Social Affairs and Health; Ministry of Interior
France	Health, Education and Interior	Inter-ministerial mission to fight against drugs and addictions.		Chairman of the Interministerial Mission for the Fight against Drug Addiction; Directorate of Strategic Affairs, Branch of Transversals Chairman of the Interministerial Mission for the

				Fight against Drug Addiction; Directorate of Strategic Affairs, Branch of Transversals Threats
Germany	Ministry of Health and Social Scurity	Government Commissioner on Narcotic Drugs & the Drug and Addiction Council		Head of Division, Federal Ministry of Health; Office of the Federal Government Drug Commissioner
Greece	Ministry of Health and Social Solidarity	OKANA	Deputy Minister of Health and Social Solidarity	Ministry of Foreign Affairs; President of the Organization against Drugs
Hungary	Ministry of Social Affairs and Labor	Coordination Committee on Drug Affairs (CCDA). It is chaired by the Secreatary of State for Social Affairs and since 2007 includes representatives from 4 NGOs.		National Coordinator of Drug Affairs, Ministry of National Resources
Ireland	Ministry of Health	Office of the Minster of drugs	Minister of State, Department of Community, Rural and Gaeltacht Affairs	International Terrorism, Illicit Drugs and Afghanistan, Department of Foreign Affairs and Trade; Department of Health
Italy	Departamento anti droga del President Council of Ministers	Anti Drug Department	Under-Secretary of State Presidency of the Council of the Ministers	Director of the Central Directorate for Anti-drug Services, Ministry of Interior; Ministry of Foreign Affairs
Latvia	Ministry of Interior	Co-ordination Commission of Narcotic Drug Control and Combat against Drug Addiction		(Representative to the UN CND)
Lithuania	Drug Control Department under the Government of the Republic of Lithuania	Lithuanian Republic Parliamentary Commission of Drug Addiction and Alcohol Dependence		Director of Drug, Tobacco and Alcohol Control Department
Luxemburg	Ministry of Health, Justice and Foreign Affairs	National Drug Coordinator, Inter-ministerial Commission on Drugs and the COCSIT		Pharmacist Inspector, Division of Medicine and Pharmacy,

				Department of Health
Malta	Ministry of Justice, Dialogue and Family	SEDQA (National Agency Against Dependency)		(Representative to the UN CND)
Netherlands	Ministry of Health, Welfare and Sport + Ministry of Security and Justice.	-		Ministry of Health, Welfare and Sport; Ministry of Justice
Norway	Ministry of Health and Care Services	Stoltenberg Committee	Minister of Health and Care Services	Ministry of Health and Care Services; Senior Adviser, Ministry of Foreign Affairs
Poland	Ministry of Health	National Bureau of Drug prevention & the Council for Counteracting Drug Addiciton		Director, National Bureau for Drug Prevention; Chief Sanitary Inspector
Portugal	Ministry of Health	Institute on Drugs and Drug Addiction	Secretary of State for Health	President of the Institute on Drug and Drug Addiction, I.P.
Romania	Prime Minister	National Anti-drug Agency (NAA) [Under the coord. of the Ministry of Interior and Adm. Reform]		Head of International Relations and Program Unit, National Anti-drug Agency
Spain	Ministry of Health Social Services and equality	Governmental Delegation of the National Plan on Drugs		Secretario de Estado de Servicios Sociales e Igualdad, Ministerio de Sanidad, Servicios Sociales e Igualdad; Delegado del Gobierno para el Plan Nacional sobre Drogas, Ministerio de Sanidad, Servicios Sociales e Igualdad
Slovakia	Prime Minister [Ministry of Health for Demand R. & Ministry of	Board of Ministers for Drug Addiction and Drug Control of the Slovak Republic & General Secreatriat	Deputy Prime Minister and President of the Board of Ministers for	Director, Department for Anti-Drug Strategy Coordination,

	Interior for Supply R.]		Drug Dependencies and Drug Control	Governmental Office; Director, Center for Drug Abuse Treatment, Ministry of Health
Slovenia	Ministry of Health (Interior at a 2nd lelvel)	Government Commission fro Drugs of the Republic of Slovenia	Minister of Health	Undersecretary, Ministry of Health
Sweden	Ministries of Public Health, Justice, Finance and Foreign Affairs	SAMANT / Alcohol, Narcotic Drugs, Doping and Tobacco (ANDT) Secretaritat	Minister for Elderly Care and Public Health	Director, Ministry of Health and Social Affairs
UK	Ministry of Interior (Home Office)	Advisory Council on Misuse of Drugs (ACMD)	Parliamentary Under-Secretary of State for Crime Reduction	UK National Drugs Coordinator, Director, Home Office; Drugs and Alcohol Unit, Home Office

Variables	WHO Alcohol	Policy Planning	Implementation
Austria	Head of the Division II /1; Federal Ministry of Health Opportunities Ombudsman for Non smoking Protection; Legal and technical issues of tobacco, alcohol and substances; Addictions	Centralized and Regionalized	The 9 provinces drawn up drug strategies and play important roles with regard to the adoption and implementaiton of drug policy measures.
Belgium	Tobacco and alcohol political expert; FPS Public health	Centralized with some devolution	Devolution (Federal)
Bulgaria	Senior Expert; Public Health Department; Ministry of Health	Centralized	By Regional Councils on Narcotic Substances
Cyprus	Ministry of Health	Y	Y
Czech Republic	National Public Health Institute	Centralized	14 regional coordiantors provide activities' coordination
Denmark	Senior consultant; Center for Prevention and Health Promotion; National Board of Health	National level	Municipalities
Estonia	Chief specialist; Ministry of Social Affairs	-	-
Finland	Ministerial Counsellor, Legal Affairs; Department of Promotion Welfare and Health	National level	Municipalities

	Ministry of Social Affairs		
France	Deputy Head of Office; Office of addictive practices (MC2); Directorate General of Health Ministry of Labour and Employment	Centralized	Devolution (region, departments, cities)
Germany	Division Addiction and Drugs; Federal Ministry of Health	Centralized and Federal	Federal and Municipalities
Greece	Ass. Prof of Psychiatry and President of the Greek Organization Against Drugs (O.K.A.N.A.)		
Hungary	Head of National Centre for Addiction National Institute for Health Development/National Centre for Addictions	Regionalized	Centrlaized
Ireland	Department of Health and Children	National level	Both
Italy	Senior Investigator; National Institute of Health Istituto Superiore di Sanità	Y	Y
Latvia	Chief of Addiction Medicine Unit; Riga Centre Psychiatry and Addiction Medicine		
Lithuania	Director of the Public Health Department; Ministry of Health of the Republic of Lithuania	National level	Local level
Luxemburg	Chief Medical Officer Service; Division of Preventive Medicine; Directorate of Health	Centralized	Centralized
Malta	Operations Director SEDQA (FSWS); Ministry for Justice, Dialogue and the Family	National level	National level
Netherlands	Policy Adviser; Nutrition, Health Protection & Prevention Department; Ministry of Health, Welfare and Sport	Regionalized	Centralized
Norway	Senior Adviser; Norwegian Ministry of Health and Care	National level	National and municipal
Poland	Deputy Director; Department of Public Health; Ministry of Health	Centralized	Provincial drug coordinators are responsible for coordination of regioanl drug policy
Portugal	Member of the Executive Board; Institute on Drugs and Drug Addiction	Y	Y
Romania	Head of Health Status Evaluation Department; National Institute of Public Health		
Spain	Head of prevention area; Subdirectorate General of Health Promotion and Epidemiology; Ministry of Health, Social Policy and	Y	Y

	Equity		
Slovakia	Chief expert; Centre for treatment of Drug Dependencies; Ministry of Health	Centralized	Devolution
Slovenia	Head; Sector for Health Promotion and Healthy Lifestyles; Ministry of Health	Centralized	Local Action Groups (coordinate and prepare concrete measures at local level)
Sweden	Director; Department of Public Health; The Swedish Ministry of Health and Social Affairs	National level	Municipalities and NGOs
UK	Alcohol Policy Manager; Health Improvement and Protection; Department of Health	National and regional level	Regional and municipalities + NGOs

Appendix 3. List of interviews

Country	Interviewees	Institution
Austria	Cornelius Goos	Anton Proksch Institut: Therapy Centre for the Treatment of Addictions
Belgium		
Bulgaria		
Cyprus		
Czech Republic		
Denmark	Vibeke Asmussen Frank	Aarhus Universitet
Estonia		
Finland	Esa Österberg	THL
	Matilda Hellman	University of Helsinki
France	Eric Janssen	French Observatory of Drugs and Drug Addiction
Germany	Gerhard Bühringer	Technische Universität Dresden
Greece		
Hungary		
Ireland	Joseph Barry	Trinity College
Italy	Emanuele Scafato	National Center of Alcohol
Latvia		
Lithuania		
Luxemburg		
Malta		
The Netherlands	Franz Trautmann	Trimbos Institute
Norway	Maurice Mittlermark	University of Bergen
Poland	Witold Zatonski	National Cancer Institute, Warsaw
Portugal	Fernanda Feijao	Portuguese Institute on Drugs and Drug Addiction
Romania		
Slovakia		
Slovenia	Matej Kosir	UTRIP
Spain	Joan Colom	Catalan Government
Sweden	Robin Room	Stockholm University
	Ian Gilmore	n.a.
United Kingdom	John Holmes	University of Sheffield
	David Nutt	Imperial College
International	Cornelius Goos	n.a.

Source: compiled by the authors

Appendix 4. Survey respondents

Country	Number of responses	Country	Number of responses
Austria	5	Latvia	6
Belgium	2	Lithuania	3
Bulgaria	1	Luxemburg	0
Cyprus	2	Malta	3
Czech Republic	3	Netherlands	6
Denmark	3	Norway	4
Estonia	2	Poland	4
Finland	2	Portugal	6
France	2	Romania	1
Germany	8	Slovakia	0
Greece	2	Slovenia	4
Hungary	0	Spain	4
Ireland	4	Sweden	6
Italy	4	UK	4
Total	40	Total	51

Source: compiled by the authors