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Handcuffs or Stethoscopes: A Cross-National Examination of the Influence that Political Institutions and Bureaucracy have on Public Policies Concerning Illegal Drugs

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This dissertation is dedicated to all those who fight for truth when the status quo rejects it. Knowledge is everything. Stand and be counted.

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ABSTRACT

This dissertation attempts to explain why cross-national variation exists in government approaches to dealing with illegal drugs. As other scholars have shown, several domestic and international political factors do account for some of this variance. However less is known of the effect that bureaucratic dominance and political institutions may have on drug policy.

This research argues that bureaucrats define problems in ways that make their services the best possible solution to policymakers. Mediating the ability of bureaucrats to influence drug policy outcomes are political institutions. Certain institutional structures foster a competitive policymaking environment while others foster a more cooperative policymaking environment. In the former of these, law enforcement approaches to the drug problem are often retained as the status quo because competition between policy actors prevents consideration of alternatives. In the latter environment however, prevention, treatment, and harm reduction approaches to the drug problem are developed because cooperation between policymakers allows other actors—namely public health bureaucrats—to influence drug policy decision making.

To test this argument, I constructed an original dataset that includes over 4,000 observations of drug policy in 101 democracies. Institutional data on intergovernmental relations, regime type, political bargaining, electoral design, and cameralism were regressed on 6 different drug policy indices: law enforcement, deterrence-based prevention, abstinence-based treatment, education-based prevention, substitution-based treatment, and harm reduction. While controlling for government resource capacity, severity of the drug problem, international pressure, and political ideology, I found that institutions explain a portion of the variance in drug policy outcomes.

Providing in-depth information about these phenomena is a large amount of field data I collected while interviewing 155 politicians, bureaucrats, interest group leaders, and service providers. Respondents from all four of the case countries examined in this research—including United States, Canada, Austria, and Netherlands—report that bureaucrats play a major role in the formation of drug policy. Which bureaucrats have the most influence on policymakers is largely a function of domestic political conditions, international political factors, and political institutions.

KEY WORDS: comparative public policy, drug policy, political institutions, bureaucratic dominance, law enforcement, harm reduction, drug treatment, drug prevention, Canada, United States, Austria, Netherlands, policy venues, political bargaining, intergovernmental relations, regime type, cameralism, electoral design, pluralism, corporatism, federalism, unitary governance, parliamentary democracy, presidentialism, bicameral legislatures, unicameral legislatures, proportional representation, single member districts, cooperative policymaking environments, competitive policymaking environments.

CHAPTER ONE

"It is difficult to get a man to understand something
when his salary depends on him not understanding it"

– Upton Sinclair

1.0 INTRODUCTION

In a world that is getting increasingly smaller, interconnected, and in a way less diverse, why are there so few similarities in public policy as we move across democracies? Of the many different policy domains we can compare, drug policy is very different cross-nationally. Whereas some countries choose a law enforcement or prevention approach to the drug problem, others have explored options from the treatment and harm reduction approaches. More recently, several countries have engineered a drug strategy that combines all four approaches. In these cases, an important question worth answering is what makes a country's solution to the drug problem lean towards one approach over the other? The goal of this dissertation is to answer that very question.

Knowing why countries choose the drug policies they do is important on many levels. From a comparative politics perspective it would be useful for scholars to examine specific

policy domains and identify the factors which cause the most similarities and differences across nations. From a public policy perspective, knowing what drives the decision-making of different actors in the policy process surrounding illegal drugs may offer new understandings of how decision-makers behave overall. From a practitioner's perspective, revealing the sources of restraint to policy innovation and reform may enable aspiring policy actors to think more strategically about what they are doing, or are about to do.

To answer the question of why differences exist among state approaches to the drug problem requires a look at a variety of factors. The first place to look is at the most obvious influences on policymaking: domestic political factors. As many other scholars have illustrated (Blanchard, 1972; Binder, 1999; Converse & Pierce, 1979; Eichenberg, 1989; Elazar, 1972; Sigelman, 1976), political factors such as public opinion and the media, political culture, partisan conditions within government, and party discipline have a considerable impact on the decision-making of policymakers. At a national level, these are the first determinants of public policy that scholars examine. Their theories are quite strong, and their results are often supportive of their arguments.

Another area to look at when trying to explain variation among national approaches to the drug problem is outside of a country's domestic political system. As several scholars have shown (Bernstein & Cashore, 2000; Gourevitch, 1978; Risse-Kappen, 1995), international institutions and diplomatic pressure limit the alternatives domestic policymakers may consider in dealing with domestic matters. The explanations that past scholars provide on how international political factors affect policymaking are very useful. These findings—as well as those on domestic influences of drug policy—inform us of the complex-nature of policymaking and are explored throughout different sections of this research.

A fourth area that is very important to look at is the nature of a country's policymaking environment. The design of a country's political institutions largely shapes the interactions of policy actors with the political system. As such, more competitive political institutions foster conditions of conflict, checks and balances, and a constant desire of triumph among policy actors. In such an environment, policy is made through victories won in battles with other policy actors. In more cooperative policymaking environments however, policy is made through consensus-style decision-making that requires the collective effort of multiple policymakers. Political institutions in such environments foster conditions of accommodation, mutual bargaining, and a constant desire among policymakers to work with one another—for cooperation is often the only way that policy goals can be achieved.

In the area of drug policy, the impact of political institutions and the nature of a country's policymaking environment on policy outcomes are seldom explored. While there is great merit in determining the extent to which certain domestic and international political factors shape drug policy, so much more has yet to be learned about the role of political institutions. One scholar that has taken this approach to explaining drug policy (Benoit, 20003) argues that institutions matter: "[D]rug policy is a product of the legislative process, and its variations, too, are shaped by the ways in which political institutions mediate the fortunes of policy agendas"(p.270).

Other researchers also find that in policymaking, institutions are important because the influence that some actors actually have on the policymaking process is largely mediated by institutional structures within their own political system (Cameron, 1978; Crepaz, 1998; Hicks & Swank, 1992). As this research intends to explore, variation in institutional structures allows for certain policy actors to dominate the problem definition stage of the policymaking process, therefore allowing them to advance their solutions to the drug problem.

The final way to explore variation in drug policy is by looking at the behavior of actors within the actual public policy process. Several public policy scholars (Edelman, 1988; Kingdon, 1995; Stone, 2002) have developed policymaking arguments that focus on elected policymakers. Their findings demonstrate that the role of the political elite in public policy is very pronounced, and indeed a strong determinant of policy outcomes. However placing so much emphasis on one group of policy actors creates a major void in our understandings of policymaking. Taking into consideration the role of bureaucrats is very useful, and as this research tries to show, necessary.

Examining the role of bureaucrats is important because quite often the determination of a country's approach to the illicit drug problem is the manner in which bureaucrats define the drug problem. Defining the drug problem in a certain way leads to the adoption of certain solutions. Within policymaking networks, a particular definition of a problem is protected and promoted so that elected officials can gain political points and bureaucratic leaders can gain administrative resources (Howlett & Ramesh, 1995). As past researchers (Woll, 1978) have shown, the combined effort of these actors ultimately shapes the strategies governments use to address social and economic problems within their nations.

This research examines the four ways to explaining why differences in drug policy exist cross-nationally. The first part of this dissertation explores what other scholars have contributed towards the domestic, international, institutional, and bureaucratic explanations of drug policy. This research then narrows its focus on a combined institutional-bureaucratic dominance explanation of drug policy. The main argument driving this approach is that bureaucratic actors define policy problems in ways that make them the solution. The extent to which other bureaucratic actors can redefine the problem—and ultimately shape the government's solution to a problem—is dependent upon the relationships between policy actors. The behavior of policy

actors within these relationships is largely determined by the country's policymaking environment; which is determined by its political institutions.

Throughout the exploration of this argument, constant attention is given to the domestic and international explanations of drug policy. In the case studies which follow the literature review, it is clear that all four explanations of drug policy are plausible. In-depth analysis of drug policy in Canada, Netherlands, United States, and Austria reveal that all four explanations of variance in illegal drug policy are useful.

To test the argument that institutions matter, I created an original and quite exhaustive dataset on six different solutions to the drug problem: law enforcement, deterrence-based prevention, abstinence-based prevention, substitution-based treatment, and harm reduction. Controlling for political ideology, government resource capacity, international pressure, and the severity of the drug problem, I investigated the impact that five different political institutions have on drug policy: political bargaining, regime type, intergovernmental relations, cameralism, and electoral design.

Results of the quantitative section reveal that institutions do matter. Proportional representation, parliamentary regimes, and to a lesser extent unitary governance; all foster cooperative policymaking conditions that have allowed for innovations in harm reduction, substitution-based treatment, and education-based prevention to overcome the status quo. Likewise, regression results and correlations reveal that single member districts, presidentialism, and pluralism create competitive policymaking environments that have worked to maintain status quo drug policies like law enforcement, deterrence-based prevention, and abstinence-based treatment.

The quantitative findings also show support for the domestic and international explanations of drug policy variation. Strong findings show that political ideology and government resource capacity often play a part in determining a country's approach to the drug problem. While having less of an overall impact, international pressure and the severity of a country's drug problem also help explain why countries have the drug policies that they do.

The final part of this research once again examines all four explanations of drug policy variation, but with more emphasis on bureaucrat dominance and the extent to which political institutions mediate the effect that some actors have on drug policy. Interviews with over 150 politicians, bureaucrats, interest group leaders, and practitioners revealed strong support for the hypotheses made in this research.

Respondents from the United States explained how America's drug policy is largely dominated by law enforcement bureaucrats who are resource driven. Their control over the status quo is protected by the politicization of the drug problem which stems from the competitive nature of the country's policymaking environment. Canadian respondents revealed how certain obstacles to drug law reformers have prevented massive developments in drug policy approaches to harm reduction. However because health bureaucrats have been able to dominate drug policy decision-making, Canada's approach to the drug problem is beginning to become one of public health.

In Europe, the interviews I held with Austrian respondents very clearly demonstrated how political institutions mediate the effect of certain actors on the drug policy process. Austria's approach to the drug problem has been geared towards treatment and harm reduction, mainly because the *social partnership*—otherwise known as corporatism, has fostered consensus-style decision making in public policy. As for the Netherlands, Dutch interviewees

overwhelmingly agreed that the country's system of proportional representation created a need for coalition-building among political parties. This severely undermined any efforts to politicize the drug problem. Both processes in Netherlands and Austria allowed for the opinions of experts and scientists from the field of public health to influence drug policy decision making.

The qualitative portion of this research also examined to some extent, the strength of drug policy arguments that focus on domestic and international factors. Interviews, particularly in Canada and Holland, revealed that international pressure does limit the alternatives that drug policy actors may consider. In the United States and Austria, domestic political conditions were shown to have a major impact on drug policy developments.

Overall, the research explained herein provides readers with a greater understanding of why variation exists in drug policy across different democracies. The single-most important contribution this research makes to the field of political science is that theories from the subfield of comparative politics and models from the subfield of policy studies are congruent. As such, more researchers should feel encouraged to explore different ways of examining political phenomena. The mixed methodology used in this research certainly suggests that such an approach to social inquiry is very possible, and fruitful.

In summary, the work of past scholars is reviewed to help us understand bureaucratic dominance, political institutions, and the six different solutions to the drug problem. Following this, case studies of the policymaking climate and drug policy strategies of Canada, United States, Austria, and Netherlands will prepare the reader for the quantitative and qualitative portions of the methodology section. While cross-national empirical tests demonstrate that a relationship exists between political institutions and drug policy in several democracies; elite interviews with drug policy actors in the four case study countries offers some in-depth

observations of bureaucratic dominance and drug policy. Because both domestic and international political factors play such a key role in drug policy, this research constantly maintains awareness of the potential effects they may have on the phenomenon studied in this project. Prior to examining the different explanations of drug policy, it is important to understand the different solutions to drug problem, as well as the interactions of actors who advocate each solution.

1.1 Competing Drug Policy Venues

Like most policy areas with multiple solutions to the same problem, different groups of drug policy actors work with and against one another to influence policy outcomes. The extent to which each group actually influences policymaking depends on a variety of things—most of which are explored in this research. Prior to the current project, other scholars have spent considerable time identifying how some groups eventually dominate the policy process. Some argue that one group's dominance can weaken; which allows for another policy group to take the lead.

Exploring these dynamics, one pair of researchers (Rochefort & Cobb, 1994) argue that over time some policy actors become the accepted authority on certain issue areas. This senses of *problem ownership* leads to what others describe as policy monopolies (Sabatier & Jenkins-Smith, 1999), which are maintained by one group's ability to define a given problem in a way that makes them the solution. As other researchers (Baumgartner & Jones, 1993) find however, such monopolies or policy *venues* can lose their dominance on that issue area. This most often occurs when the *image* of a certain problem or issue area changes.

In the realm of drug policy, there tends to be a spectrum that is formed between the law enforcement, prevention, treatment, and harm reduction venues. Each of these groups has their

own understanding of the drug problem, and consequently approaches the issue with different solutions. The dominance of one drug policy venue over another depends largely on the image of the drug problem in each country. As other drug scholars have shown (MacCoun & Reuter, 2001; Nadelman, 1988), the image of drug use in some countries is that such behavior is criminogenic. This places drug policy in the venue of law enforcement, and to a lesser extent prevention. In contrast, the image of drug use in other countries is that substance abuse is a concern of public health. This places drug policy in the venue of harm reduction and treatment.

A very important part of exploring variation in drug policy is to understand the relationships between the different venues. For the most part, proponents of prevention and treatment policies can find support from advocates of both law enforcement and harm reduction. However this support is often contingent on how liberal or conservative drug policy actors view the treatment and prevention methods proposed. Prevention methods that are based on deterrence and scare tactics do not get support from harm reduction or even some treatment proponents. However those that are based on education and information sharing are supported by both law enforcement and harm reduction advocates. Likewise, those treatment methods which appear to minimize the use of drugs (substitution-based treatment) rather than stop the use of drugs (abstinence-based treatment) are supported by harm reduction proponents but not law enforcement proponents. These dynamics have some significant implications for the questions being asked in this research.

The source of the polarization between the two extremes—law enforcement and harm reduction—is rooted in the irreconcilable differences between the values and goals of the two advocate groups. This conflict often deters drug policy actors from collaborating with members

of the opposite drug policy venue. A strong catalyst of this quarrel is the ambiguous national drug strategies of each country.

In her research on national drug policies in Europe, Cesoni (1995) finds that most national drug strategies are vague in declaring the means that should be used to achieve the desired end of drug use. Consequently, professionals in both venues compete for all available drug control resources. In addition, because there are also no policy directives that indicate a need for collaboration, one venue ends up trying to dominate the other.

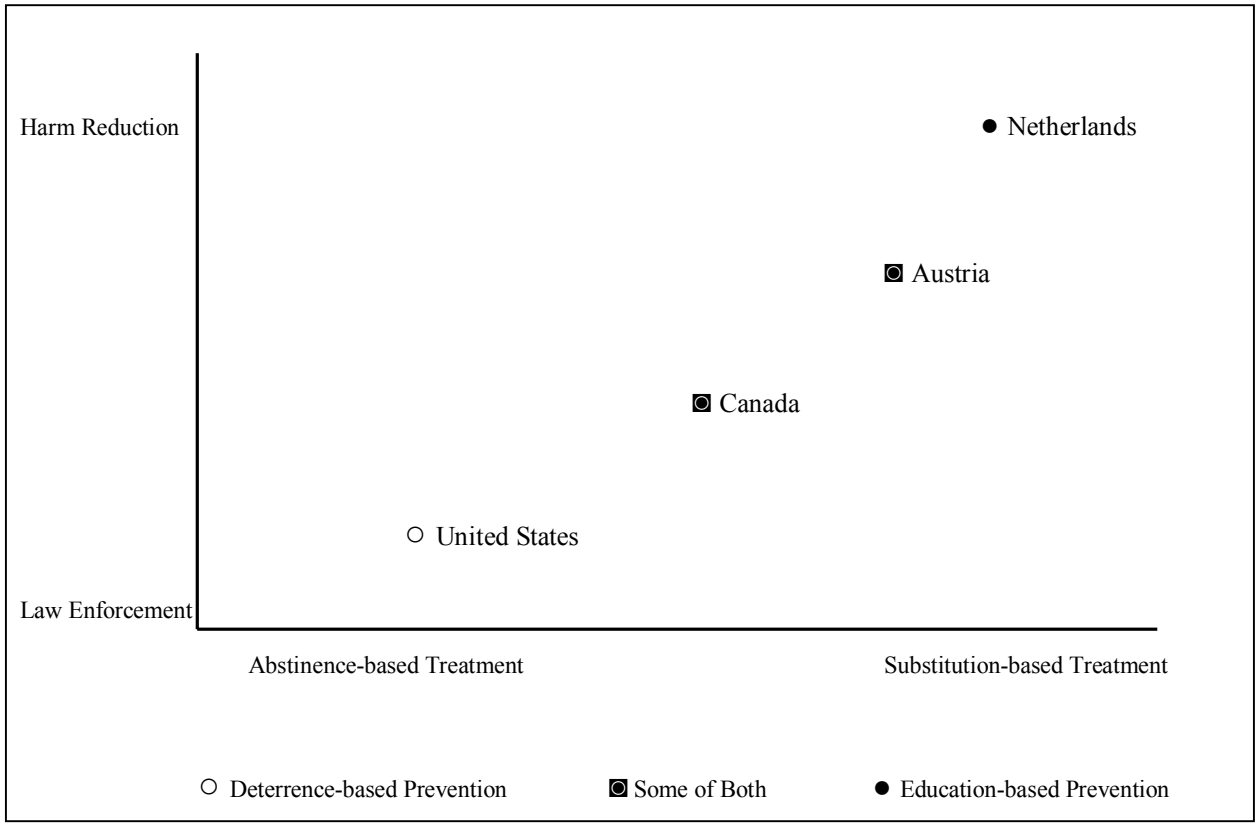
In the last decade and a half however, there has been a slight change in the relationship of drug policy professionals within certain countries. In several Western European countries and Canada, harm reduction and treatment proponents have made attempts to cooperate with law enforcement officials to reduce the rates of drug use and crime, while at the same time not compromising the health care of drug users (International Harm Reduction Association, 2004; Nilson, 2004). Similarly, proponents of the law enforcement approach in Canada, Australia, New Zealand, and the United States have made it possible for certain harm reduction strategies to be implemented without completely dismantling well-entrenched punitive policies (Erickson, et. al., 1997). Despite such efforts, conflict still seems to characterize the relationship between the different drug policy venues.

In brief, law enforcement approaches to drug policy rely on the deterrence and punishment of the criminal justice system to curb drug use. Treatment approaches rely on medical and psycho-sociological tools to help addicts recover from their addiction. Within the treatment pillar, some are based more on abstinence models whereas as others see the importance of stabilization and the use of substitution methods. Prevention approaches all rely on a variety of tactics to stop drug use before it happens. The difference between many types of prevention

programs is their reliance on deterrence versus education. Finally, harm reduction approaches recognize the difficulties of drug addiction and aim to stabilize the user while also reducing the harms of both drug use and harmful drugs laws.

Figure 1.1 illustrates the array of drug policies that the four case countries in this study currently maintain. The four different venues examined in this research are responsible for providing six different categories of drug policy instruments. Law enforcement and harm reduction are at polar ends of a drug policy spectrum that is based on ideology, normalization, and a degree of rapport that exists between the agent implementing the policy and the target group receiving the benefits/costs of that policy. In between these opposites are two variants of treatment and prevention.

Figure 1.1
Drug Policy Spectrums 2008



While abstinence-based treatment and deterrence-based prevention are closer to law enforcement in terms of ideology, normalization, and agent-client rapport, substitution-based treatment and education-based prevention are closer to harm reduction.

For most countries, their original drug policies are law enforcement driven with some form of deterrence-based prevention. This was largely the result of morality based policies that are use the justice system to enforce such laws. During the 1970s, Canada and the United States were highly committed to such an approach with some regional developments in abstinence-based treatment. When drug policies started to shift in the 1980s and 1990s they moved away from law enforcement and deterrence-based treatment, and towards a stronger commitment to substitution-based treatment and education-based prevention. The final development that often accompanies these latter changes is harm reduction.

In both Canada and the United States, there has been far less conflict over shifts towards treatment and prevention than there has been over shifts towards either law enforcement or harm reduction. On a global level of comparison, while Canada has moved closer to harm reduction and further from law enforcement, the United States is still considered to have a strong law enforcement approach to the drug problem.

Netherlands and Austria also began with a law enforcement approach to the problem. In the 1970s however, they both quickly changed their drug policies to include elements of education-based treatment, substitution-based treatment and harm reduction. While Netherlands had a much stronger harm reduction approach to the drug problem during this era, Austria increased its commitments to harm reduction and substitution treatment in the 1980s. For the last two decades, both countries have stayed in roughly the same level of commitment for all six drug policy types.

The following sections provide a very useful overview of each drug policy venue. The history within and between each venue tells us a lot about drug policy formation and the interactions among actors who are responsible for its formulation. While law enforcement and harm reduction serve as two independent venues, the two types of treatment and prevention approaches are often represented in the same venues. This is why the following review of drug policy venues includes law enforcement, prevention, treatment, and harm reduction.

1.1.1 Law Enforcement Venue

On one end of the drug policy spectrum, law enforcement officials argue that drugs cause irreparable harm to society and that sanctions will make people refrain from using drugs. It is feared by such policy actors that reducing penalties, or worse, full legalization, will bring normative erosion and widen the availability and consumption of drugs (Korf, 1995). As such, the law enforcement approach to the drug problem is based on the notion of deterrence. According to the criminological understanding of *deterrence theory*, drug users and dealers are deterred from using or trafficking drugs because the costs of penal sanctions usually outweigh the benefits of drug use (Akers, 2000). Considering this, the higher the punitive consequences of drug use, production, and trafficking, the lower the occurrence of these behaviors.

In using deterrence theory as their justification for law enforcement instruments, policymakers are able to link drugs to crime—for deterrence theory is a criminological argument. As such, when drugs and crime are linked, law enforcement bureaucrats are able to capitalize on the crime-drug nexus, thereby bringing in more support for their services. According to Rasmussen and Benson (1994), if policy actors are able to show that drugs and crime are related, then a strong law enforcement effort against drugs can not only reduce drugs but also reduce

other types of crime. In essence, approaching the drug problem through a law enforcement approach becomes a positive sum game.

The result of this mentality, according to some observers (Derks & van Kalmthout, 1995), is a considerably large integration of various criminal justice agencies and organizations that converge to arrive at one overarching goal: eradicate drugs and drug-related crime. When so many actors within one venue agree that drug use is not only a crime, but causal to other types of crimes, the law enforcement paradigm becomes a very strong and unified front for prohibition. In more competitive policymaking environments, this makes the law enforcement venue a very powerful drug policy actor.

It is important to note that not all national drug strategies that are law enforcement-driven subscribe to the punitive doctrines described in much of the policy rhetoric surrounding this issue. In fact, there is considerable variation in the degree of *punitiveness* among different law enforcement strategies, particularly when it comes to distinguishing users from dealers.

According to Goode's (1997) cross-national research on penalties provided by law, as one moves across different jurisdictions within the same country, there is variation between sanctions imposed on users and dealers. In addition, while the stated policy may be to eradicate all drug offenses with the use of the criminal justice system, priorities of law enforcement agencies often focus on users instead of dealers. Finally, the likelihood of a court to carry out the maximum specified sentence is greater for drug dealers than it is for drug users. The point of this information is that although several countries proclaim to have a strong law enforcement drug strategy, there is great variation in exactly how *punitive* their criminal justice policies are. Table 1.1 illustrates the various law enforcement instruments used against illegal drugs[1].

[1] For a list of sources for information appearing in this table see the Drug Policy Data Sources Table located in the appendices.

Regardless of variation in the punitiveness of national drug strategies, it is quite apparent that "elements of the drug enforcement system are controlled by distinct political and bureaucratic organizations, each operating under perspectives and procedures that are not necessarily governed by compelling concern for the formulation and execution of an effective drug policy" (Rasmussen & Benson, 1994:12).

Table 1.1
Law Enforcement Instruments[2]*

Instrument	NETH	AUS	CAN	USA
Prison sentence for small amounts of hard drugs	No	No	Yes	Yes
Prison sentence for small amounts of soft drugs	No	No	Some	Yes
Mandatory minimum sentences	No	No	No	Yes
Civil asset forfeiture	No	Yes	Yes	Yes
Drug Courts	No	Yes	Yes	Yes
Severe prison sentence for trafficking	Yes	Yes	Yes	Yes
Drug control appropriations for law enforcement	1/3	1/2	2/3	3/4

*With the exception of United States—whose drug laws fall under the authority of the states (except trafficking)—all of these instruments are provided and financed by the national government. The last row indicates the proportion of the drug control budget that is spent on law enforcement.

Essentially, what Rasmussen and Benson suggest is that the deterrence model of the law enforcement approach does not allow for drug policy to be implemented in the most effective manner. Instead of examining drug use as an illness that is in need of medical attention, the law enforcement approach treats drug users as rational actors that choose to benefit from the effects of drugs even if this means they are at risk of being sanctioned by law. This essentially defines the drug problem as a crime.

This exclusionary approach to addressing the drug problem has not gone without ridicule. In a comprehensive study of America's 'War on Drugs', Bertram et al. (1996) reveal that the law enforcement approach to drugs has been a quick-fix which has actually perpetuated the drug problem in the United States. Not only have criminal justice players undermined the efforts of

[2] Unlike the other three countries in this research, Austria does not distinguish hard drugs from soft drugs. Under national law, all illegal drugs are viewed equally.

health and harm reduction professionals to minimize the harms of drugs (see section 2.1), but they have actually increased crime and the use and sale of drugs in the United States.

To illustrate, Bertram et al. reveal that while cracking down on drug producers and sellers, criminal justice agencies make the black market more risky. This increases the cost of drugs, which raises profit, and in turn attracts more sellers and producers to the lucrative drug trade. Explaining these phenomena a bit further, Caulkins and Reuter (1998) suggest that as prices for drugs increase because of the risk of legal sanctions, there is a matching increase in the crimes committed to purchase the more expensive drugs. While users have to find more money to buy drugs, dealers must form greater commitments to protect their assets.

Similar studies (Benson et al., 1992) reveal that as law enforcement agencies chase drug sellers out of one neighborhood, they end up relocating to another neighborhood. The result is increased violence between different drug sellers who compete to dominate the drug market in their locale. Perhaps the most unanticipated consequence of the law enforcement approach is that such tactics lead to increased potency of drugs (easier to transport covertly); increased domestic production; and substitution of harsher drugs (cocaine) for softer drugs (marijuana) because of volume differences (Thornton, 1991; Rasmussen & Benton, 1994). On an international level, law enforcement efforts of American agencies to reduce the supply of drugs in Latin America have exacerbated numerous civil conflicts in this region (Sussman, 2002).

Now although the literature on drug policy seems to be overly critical of the law enforcement approach to the drug problem, there are those who point to its merit. Explaining the need for at least some moderate enforcement of drug laws, Goode (1997) suggests that in the absence of such enforcement, drug abuse would be much worse. Essentially, some punitive drug laws are needed to deter the production, selling, and consumption of illicit drugs. Without the

threat of government sanction, there is a chance that the problems of drug use will escalate to levels beyond what they are at now. Goode concludes that while law enforcement does not reduce the incidence of drug use, it at the very least works to contain the problem.

While it is not the intent of this paper to determine whether law enforcement is a counterproductive instrument to use in addressing the drug problem, these arguments are necessary to consider when examining the conflict between drug policy actors. Quite often, the buildup of support for other drug policy venues—such as treatment and harm reduction—are a direct result of political and bureaucratic actors who realize that law enforcement may actually be perpetuating the drug problem.

1.1.2 Prevention Venue

The prevention venue in drug policy may be the least known of the four different approaches to the problem. While it reaches more users and non-users than the other three venues combined, the dynamics within this venue and between prevention and the other venues are somewhat troublesome. Despite this, the prevention venue often does enjoy support from actors in all three of the other venues. The key determinant of support however is in the types of prevention program being provided (Paglia & Room, 1999).

All types of prevention programs can be divided into two separate groups: those that are deterrence-based and those that are education-based. Deterrence based prevention efforts rely on negative reinforcement. This not only reminds the drug user of what risks he or she are taking by engaging in drug use behavior, but warns non-users of the consequences of drug use. The other type of prevention is education-based prevention methods. These programs provide accurate and reliable information about drug use, with the hopes that observers of this information will make the right decisions for their health.

In the 1970s, it was quite common that prevention experts combined different tactics from the two camps into one program. As Swisher et al. (1971) explains drug education programs included scare tactics, two-sided presentations, and the use of authority figures, students as teachers, curricular integration, sensitivity groups, and humour. For a large part of the 1960s and 1970s prevention efforts focused on youth, largely because it seemed that young people were most at-risk for drug use. However over the years, prevention experts began to conclude that prevention efforts focused exclusively on youth were ineffective. In response, several prevention experts started to expand their services to include programming that targeted youth, their families, and their communities (Nelson, 1989). These services often included mass media campaigns, community movements, and public education seminars.

One of the programs that targeted adults rather than youth was workplace drug testing. In the late 1980s and early 1990s drug testing of employees in both the public and private sector was used to deter employees from using illicit substances. One selling point of this type of prevention to employers was that drug use supposedly diminished the performance of workers on the job. Another was that the overall costs of drug abuse to employers are tremendously high (de Bernardo, 1987).

Over the years considerable criticism has developed in response to the growing trend of workplace drug testing. Conor (1994) felt that the testing failed to deter the most dangerous forms of substance abuse (including binges and drug use by the non-employed). Conor also believed that workplace drug testing was bad because the actual tests performed on the workers tested for exposure to drugs rather than the employee's ability to perform. Finally, when employees felt like their privacy was being threatened, their attitude and work behaviors may be adversely affected.

Another big criticism of workplace drug testing is that when employers would relieve workers from the job for testing positive for drug use, the loss of a job would lead to more drug use then anything. These problems are similar to the ones drug users experience when they cannot receive food stamps, access to education, employment, or public housing because of a drug conviction. Problematic is that these are the essential services treatment and harm reduction workers are trying to provide to users so that they stay off drugs (Drug Policy Alliance, 2007).

While the critiques of workplace drug-testing are numerous, there are equally as many against the entire deterrence-based model of prevention. The National Association for Public Health Policy (1999) claimed that the prohibitionist approach of deterrence-based drug prevention has forced prevention facilitators to portray drugs in ways that justify their prohibition, with no hint of the positive effects the user experiences. The Association goes on to report that the use of scare tactics have no effect on the decision of young people to use drugs. In fact, they may very well move them further away from the professionals who they need to meet with.

In light of the criticism towards the deterrence-based approach to prevention, several developments have occurred in the education-based camp. Generally, these programs have a broader health education approach that involves more than just drug education. Personal skill-building and decision making exercises help members of the target group become prepared to act in their own best interest when confronted with drugs (National Association for Public Health Policy, 1999). Other factors include acceptance of the fact that people use drugs and have their own reason to. Leaving out the positive information about drug abuse is just as bad as not informing them of the negative. A more recent evaluation of prevention programming (Paglia & Room, 1999) found that the most important thing past prevention programs lacked was the

realization that young people are not very forward-thinking. As such, it is much more effective to design strategies that relate to the immediate harms of drug use rather than harms which may come several years down the road.

Perhaps the most important aspect of the newer education-based approaches to drug prevention is the realization that different programs should be used for different groups (Paglia & Room, 1999). Understanding this need, Kumpfer and Baxley (cited in Paglia & Room, 1999) revised a classification system based on target groups. Universal prevention programs use broad sweeping messages to target the entire population. Examples of this include media campaigns, police education programs, health warning labels, and laws regulating a minimum drinking age. Selective prevention programs target subgroups that are at high risk of substance abuse. Community-based groups that provide mentoring, tutoring, skills development and recreational activities are often the most effective selective prevention techniques. Lastly, indicated prevention programs are designed to prevent abuse among those who already use drugs or are showing early signs of drug use. Tools of this kind of prevention include outreach programs that engage and work with youth to minimize the harms associated with drug use.

Overall the prevention venue has had some struggles—especially within. The dispute between deterrence-based prevention and education-based prevention makes it difficult for policymakers to decide what is best for society. When actors from law enforcement, treatment, and harm reduction enter the debate, it makes matters even more difficult to sort out.

Another struggle the prevention venue experiences is in its overall evaluation. The fact that society needs law enforcement, treatment, and most of all harm reduction, suggests that perhaps prevention experts are not doing their job. Scholars like Botvin (1990) report that a variety of prevention programs do increase knowledge and awareness. They have also had an

impact on the attitudes of people towards drugs. However as Botvin explains, "rarely have any of these interventions had an impact on substance-use behavior" (p.46). Softening these claims Brochu (2006) reveals that like treatment, prevention has been proven to have statistically and clinically significant effects. The key however, is that not every prevention program is effective. Thus it is the job of professionals and policymakers to determine which ones are.

As the current research hopes to show, deterrence-based prevention programs seem to surface more in countries with certain types of policymaking environments, whereas education-based prevention programs seem to appear in countries with other types of policymaking environments. The prevention instruments listed in Table 1.2 help us understand the strategies of prevention that our case countries prefer.

Table 1.2
Prevention Instruments[3]*

Instrument	NETH	AUS	CAN	USA
Police administered education	No	No	Yes	Yes
Fear campaigns	No	No	Yes	Yes
Workplace drug testing	No	No	Some	Some
School drug testing	No	No	No	Some
Recreation activities	Yes	Yes	Some	Some
Skills training	Yes	Yes	some	Some
Outreach to target groups	Yes	Yes	Yes	Yes
Addictions curriculum in school	Yes	Some	Some	Some
Health professional administered education	Yes	Some	Some	Some

* All of these instruments are provided regionally/nationally and funded nationally.

1.1.3 Treatment Venue

The third and perhaps largest venue of drug policy is the treatment venue. Almost all countries, whether they are rich or poor, place a considerable emphasis on the importance of treatment. The strength in the treatment venue is that it not only reduces overall drug use by helping addicts shed their addictions, but in the long run it is much more efficient than law

[3] For a list of sources for information appearing in this table see the Data Sources Table located in the appendices.

enforcement. According to the National Association for Public Health Policy (1999), policymakers in the United States spend billions of dollars in law enforcement trying to tackle not only drug use, but the problems caused by drug use. According to the Association, a more efficient response would be a strong commitment to actual treatment programs that will minimize drug use before it leads to other problems in society.

While there has been a global emphasis on the treatment approach to the drug problem for quite some time, a more considerable emphasis came in the 1970s. At that time governments, mainly in westernized democracies, put more effort into funding community-based treatment agencies. In the United States in particular, the federal government increased funding to treatment agencies tenfold over a 5 year span. This growth came largely from the realization among some policy actors that drug addiction was a disease. This helped treatment professionals links the needs of addicts to the programmatic goals of health institutions (Peyrot, 1991).

Despite the rapid growth of support for the treatment venue in the 1970s, it was and is still difficult for treatment professionals to maintain the support they need to effectively address the problem. In many occasions where not enough initial funding is provided, treatment programs do not appear to fulfill their potential. The effect of this is often made worse by the reality that drug addiction is not an easy problem to address. In fact, some addicts need to seek multiple types of treatment several times to finally kick their habit. These conditions make it even more difficult for governments to maintain, let alone increase funding for treatment (Peyrot, 1991).

Although governments cause problems for the treatment sector, professionals within this venue have also caused problems for themselves. As one group (National Association for Public Health Policy, 1999) observes, the treatment profession has narrowed its focus on drugs rather

than on the human-drug interaction. This forces treatment programs to ignore the many other social implications of drug use and addiction. The result is an array of simple solutions for complex problems that results in considerable uncertainty about the legitimacy of the treatment venue.

Fortunately for the treatment sector, alternative formulae for financing treatment have been developed by different levels of government. In the United States for example, the federal government provides funding to states based on social indicators. Once a state receives the funding, the responsible agency examines the need of treatment and prevention programs based on a variety of social indicators: economic status, population movement, kin and friendship networks, demographic composition, community involvement, education, etc. Two of the major indicators used throughout America's states are risk factors (ie: residential stability) and consequences of the drug problem (ie: hospital admissions for overdose) (Gorman & Labouvie, 2000). Such funding criteria have made it somewhat easier for drug treatment services to be developed.

While law enforcement approaches to the drug problem still tend to take the largest portion of drug money in several countries' budgets, treatment allocations are starting to become more observed. One of the reasons that treatment has developed such a strong presence in most countries is because of semi-compatible relationships with the other three approaches to the drug problem. Whereas prevention and law enforcement tend to have opposite objectives from harm reduction in terms of drug use, and prevention and harm reduction tend to have opposite objectives from law enforcement in terms of the consequences of drug use, there are few asymmetries between treatment and the other venues.

At the end of most days, everyone's goal in the world of drug policy is to limit drug use. Proponents in all four venues agree on this end however disagree on the means to that end. It seems however that everyone disagrees with the means of treatment less than they do the means of the other three venues. In fact, it can be seen in most countries that treatment professionals are very much able to cooperate with professionals in the other three venues.

Many prevention programs are housed organizationally within or alongside treatment programs (SAMHSA, 2007). When prevention does not work for drug users, the problem then falls in the hands of treatment experts. Quite often, treatment experts also play a significant role in making sure prevention programs are armed with proper information on drug abuse. As for law enforcement, the development of several drug treatment courts in Europe, North America, the Pacific, and the Caribbean symbolize a realization within the criminal justice community that treatment is the number one solution to drug use (National Association of Drug Court Professionals, 2007). Finally, harm reduction professionals who are successful at stabilizing drug addicts eventually try and encourage them to seek the treatment services they are in need of (Hathaway, 2002).

The support from multiple venues within drug policy has strengthened the treatment venue; however it has also caused some fragmentation within the treatment profession. The diversity of treatment options that exists within the profession forces some aspects of treatment to be supported by the harm reduction venue, and others to be supported by the prevention and law enforcement venue. This divide leads to a group of treatment options that are substitution-based and another group of treatment options that are abstinence-based.

Substitution-based models of drug treatment are designed for drug addicts that refuse to stop using drugs, or have tried various other methods of treatment and just can't free themselves

from the disease of addiction. Substitution-based treatments are also provided to pregnant women because a sudden stop in the use of heroin or other opiates could severely harm the mother and unborn child. Generally, abstinence-based models of treatment do not work for chronic opiate users (Erickson, et al, 1997). As such, it is safer and more effective in the long run to provide this group with a substitute drug.

The overall purpose of substitution treatment is to reduce the use of illicit substances from the black market—which often contain impurities that are undetectable to most users; prevent the spread of HIV and hepatitis; reduce the need of addicts to commit crime to support their addiction; minimize the chances of overdose; socialize and stabilize the addict by getting them on a daily schedule or routine, which may in the long run help them rearrange their priorities in life (CEEHRN, 2007). With the exception of heroin maintenance (provided through supervised injection or smoking), all drugs in substitution treatment are administered orally. The purpose of this is so that the patient does not sell the drugs on the black market. The need for a case worker or doctor to oversee the consumption of the substitution drug does lead to long wait times. This can be problematic for heavy drug users who are in desperate need of help (EMCDDA, 2005).

One of the most common forms of substitution treatment is methadone. Methadone is a synthetic agent used to occupy the brain receptor sites affected by heroin or other opiates. Generally, it is used to block the euphoric effects of opiates, relieve the cravings for the drug, and relieve the symptoms associated with withdrawal. The benefit of this treatment is that it has a shorter impact on the user and it can be administered orally. It is often combined with drug counseling, resocialization, and in some cases vocational training. The length of treatment ranges

from 12 months to 2 years depending on the patient (Department of Health and Human Services, 2002).

Another substitution-based treatment is buprenorphine. This drug is considered a partial agonist, which means the overall effect of the drug on humans is considerably less than that received from heroin or methadone. The reason that many governments are choosing to sponsor buprenorphine programs is because the drug can be just as effective as methadone maintenance but provides less of a risk of overdose and has milder withdrawal symptoms. Most importantly, it provides less of a euphoric sensation which decreases the likelihood of the drug being diverted to illicit markets (EMCDDA, 2005). While the most common forms of substitution treatment are methadone and buprenorphine, a few others exist. Luxembourg uses a drug called mephenon while Belgium and Germany use dihydrocodeine (CEEHRN, 2007).

Despite the growing numbers of substitution-based treatment programs in the world, abstinence-based treatment is still the number one method used by treatment professionals. The ultimate goal of this form of treatment is to enable the addict to achieve lasting abstinence from drug use. While this may not happen for a period of time, there are some more immediate goals. These include reducing overall drug use, improving the patient's ability to function, and minimizing the medical and social complications of drug abuse and addiction (NIDA, 2007a).

To help patient's achieve abstinence, treatment professionals have come up with three steps—either used in a sequence or separate—that can result in abstinence. The first is detoxification. Generally, detox is the phase where the addict physically gets off the drugs. This involves the withdrawal phase of treatment which although severely uncomfortable and difficult to get through, is made easier by the various services available in a detox facility. According to Drug Rehab Referral (2005), there are three types detox that addictions professionals can help

clients get through. Medical detox involves the oversight of a medical professional who makes sure that there are no complications during the withdrawal phase. Physical detox involves the development of a quality health regimen. Finally, emotional detox involves counseling and emotional support to assist the psychological trauma that comes with eliminating something from your body that has been in it for so long.

The next part of the process is the actual treatment which helps addicts become abstinent. Over the years many different forms have developed. Generally they are behavioral in nature and involve some sort of group or individual work with a treatment specialist. These include cognitive behavioral therapy, multidimensional family therapy, supportive-expressive psychotherapy, individualized drug counseling, motivational enhancement therapy, stimulus control, urge control, and social control. All of these can be provided through residential or outpatient treatment services in both private and public settings (NIDAa, 2007).

Once the treatment portion of the process is complete, it is often the insistence of addictions professionals to provide some sort of assistance with relapse prevention. According to America's National Institute on Drug Abuse, relapse prevention encompasses several cognitive-behavioral strategies that help the patient maintain their abstinence. Techniques used in this process include "exploring the positive and negative consequences of continued use, self-monitoring to recognize drug cravings early on and to identify high-risk situations for use, and developing strategies for coping with and avoiding high risk situations and the desire to use" (NIDA, 2007b:1).

The many different approaches to drug treatment are not limited to innovations available to the general public. Over the years several new models of treatment have been developed to work alongside the correctional programming provided in the criminal justice system. Taxman,

Perdoni, and Harrison's (2007) research on adult offenders in the United States reveals that drug-involved offenders are likely to have dependence rates that are four times greater than those among the general public. As such, the criminal justice system is being pressured to provide effective substance abuse services throughout all aspects of its programming: intensive supervision, day reporting, vocational education, work release, parole, probation, etc.

One type of innovation that is starting to be used in different parts of the world—but especially North America—is the drug treatment court. They are designed to provide judicially-supervised treatment in lieu of prison, for offenders who have a drug problem that is related to their illegal activities. Quite often the offender has the option to go through a drug treatment court program or go through traditional criminal justice processing. For the many offenders that do choose the former of the two, they are given speedy access to treatment, undergo intensive supervision and drug testing, and receive positive reinforcement for compliance and negative reinforcement for non-compliance. Once they follow all orders of the court, including abstinence for 3 months to 1 year, the offenders graduate from the program. At that point in time they revisit the prosecutor and judge to receive a sentence for the original crime they admitted to committing. This sentence does not usually involve incarceration and is often much shorter than a sentence they would have received without going through the program (CSSA, 2007a).

The treatment venue is perhaps the most diverse of the four venues of drug policy. With that comes a considerable amount of fragmentation. Treatment actors are both private and public in nature; they are also divided within and across different levels of government. Also, as Table 1.3 illustrates, even within single countries only certain types of treatment services are provided and/or covered by the federal government. When one type of service is funded by one level of government and others on a separate level, it adds to the fragmentation. Although the

various practices of treatment appear in many parts of the world, it is often difficult for professionals with even a single country or region to compare results and evaluate the effectiveness of their instruments. Still, treatment is generally supported by advocates of the three other venues. While it may not receive the same amount of appropriations as the other venues in some countries, it definitely has a place in every nation that attempts to address the drug problem.

Table 1.3
Treatment Instruments[4]

Instrument	NETH	AUS	CAN	USA
Substitution-based Treatment	Yes**	Yes**	Yes*	Yes*
12 step programming	Yes	Yes	Yes	Yes
Mandatory treatment	No	Some	No	Some
Residential Treatment	Yes*	Yes*	Yes*	Yes*
Outpatient Treatment	Yes*	Yes*	Yes*	Yes*
Drug Treatment Courts	No	Yes*	Yes**	Yes**
Treatment within Prisons	Yes**	Yes**	Yes**	Yes**
Detox	Yes*	Yes*	Yes*	Yes*

* Denotes that the program is supported by the federal government in principle.
** Denotes that the program is financially supported by the federal government.

1.1.4 Harm Reduction Venue

Turning to harm reduction, this policy venue sees drug use as something that cannot be entirely controlled by government. Within this venue, it is commonly understood that some humans will always seek the pleasure they receive from using psychoactive substances. Thus, while governments should continue to promote abstinence, they also must recognize that some individuals will continue to use drugs.

Because of this, there is a need for services that help minimize the harms that drug use brings upon drug users, their families, and society. According to Reuter and Caulkins (1998), the general goals of harm reduction include reducing violence related to drug distribution, lowering

[4] For a list of sources for information appearing in this table see the Data Sources Table located in the appendices.

mortality and morbidity rates among the drug dependent, and reducing the costs stemming from and created by drug control interventions themselves. When providing harm reduction services, pharmacologists and psychiatrists inform users on safer ways to use their drugs of choice, regardless of whether someone is a recreational or dependent drug user.

Stated differently, "the essential feature of harm reduction is the attempt to ameliorate the adverse health, social, or economic consequences associated with the use of mood-altering substances without necessarily requiring a reduction in the consumption of these substances"(Inciardi & Harrison, 2000:viii). Common instruments of the harm reduction approach are displayed in Table 1.4.

The uniqueness of harm reduction instruments is that most of these interventions focus on integrating or reintegrating drug users into society. There are careful measures taken not to further isolate, demonize, or ostracize drug users and their families. The reason for this is because of the damaging effect that such experiences have on drug users and deviant persons alike. Considerable research in criminology and sociology has found that labeling or stigmatizing drug users and other deviant individuals places them even further away from the status quo (Akers, 1997; Becker, 1963; Link & Phelon, 1999). This makes them considerably less likely to not only seek the treatment they need but also integrate back into society.

Table 1.4
Harm Reduction Instruments[5]

Instrument	NETH	AUS	CAN	USA
Safe-injection sites/consumption rooms	Yes*	No	Yes*	No
De facto decriminalization of drugs	Yes+	Yes+	Yes+	Some+
Decriminalization of drugs	Yes**	No	No	No
Heroin maintenance	Yes*	No	No	No
Medicinal use of marijuana	Yes**	No	Yes**	Some+
Needle exchange programs	Yes**	Yes**	Yes*	Yes+
Drug testing at raves/parties	No	Yes+	Some+	Yes+
Harm reduction outreach for high risk populations	Yes**	Yes**	Some*	Some+
Tolerance zones	Yes**	No	Yes+	No
Pill Testing[a]	Some*	Some*	Some	Some

\+ Denotes that the program is not supported by the federal government in anyway.
* Denotes that the program is supported by the federal government in principle.
** Denotes that the program is financially supported by the federal government.
[a] Pill testing that occurs in Canada and the United States is *underground*.

With the appropriate normalization protocol in place, harm reduction professionals try to maximize the number of drug users in contact with drug treatment, outreach, and other public health services. The result is a variety of programs aimed at reducing the harms associated with drug use and the laws aimed at punishing drug use. Throughout this process, perhaps the most important guiding principle is that harm reduction does not require abstinence. While harm reduction is not inconsistent with the long-term goals of abstinence, it accepts the fact that users may continue to use drugs even during or after treatment (Erickson, et al. 1997).

The roots of harm reduction are found mainly in Western Europe. As early as 1926, British authorities realized the necessity of heroin and morphine maintenance. Several hundred opiate addicts who became dependent on the drug as medical patients were prescribed heroin and morphine. The program operated without incident until the 1960s. During that time several doctors carelessly prescribed heroin to patients who began to take the drug recreationally. In 1967, Britain's *Dangerous Drugs Act* curtailed the maintenance of heroin to a small group of

[5] For a list of sources for information appearing in this table see the Data Sources Table located in the appendices.

licensed treatment therapists. By 1975, 12 percent of Britain's opiate addicts were being prescribed heroin, the rest were given oral methadone. Today, less than one percent of Britain's opiate addicts are prescribed heroin (MacCoun & Reuter, 1999).

Near the time that Britain had slowed down its development of heroin maintenance, Switzerland was experiencing high addiction rates that led to several social problems which affected non-drug users. In response, the city of Zurich developed a tolerance zone called the Platzspitz. Known as *Needle Park*, the Platzspitz served as an area where drug users could administer, sell, and buy their drugs without bother from the police. The purpose of this was to minimize on the number of drug activities in other areas of the city and have drug users concentrated in one area where health professionals could provide them with clean needles and emergency assistance in the event of an overdose. By 1992 however, Swiss officials had decided that the park had become too unsightly, not to mention embarrassing, and eventually closed it to drug users (Huber, 1994).

In place of Platzspitz, the Swiss offered a different type of harm reduction service to its addicts. Designed to lower HIV infection and overdoses is the *safe injection site*. Given a variety of names—consumption room, smoke room, shooting gallery, supervised injection facility—the safe injection site was developed in various sites across Switzerland to provide users with a sterile, supervised, safe environment for them to administer their drugs (Huber, 1994).

While Switzerland has had considerable success with such facilities, several other countries have also experimented with safe injection sites. In recent years, Dutch, Canadian and Australian local governments have provided similar services in areas with extremely high rates of intravenous drug users. According to the Vancouver Coastal Health Authority, a supervised injection site is a "controlled health care setting where drug users inject drugs under supervision

and receive health care, counseling, and referral to health and social services, including drug treatment"(City of Vancouver, 2006:1). To the addicts, it is a place where they can administer their drugs in a setting where they are not in threat of being victimized if they happen to doze off. To the public, it is a facility that keeps drug users off of the streets, particularly when they are smoking or injecting their drugs (Nilson, 2004).

By 1993, the Swiss government found that more alternatives needed to be provided to heroin users. As a result of significant political pressure, a three-year heroin maintenance experiment was allowed. The purpose of the program was to give hardcore heroin addicts who have failed other treatment programs the opportunity to have their drug prescribed to them by medical doctors. Ensuring addicts that their heroin will be provided to them minimizes the need for them to purchase their drugs on the Black Market. Doing so minimizes the risk of receiving impure heroin, using it in a dangerous place, or encountering violence when purchasing their heroin (Fanacci, 2005).

The results of the program demonstrated more stability and a better state of health for the participants. Within 18 months of entering the program, 69 percent of its participants were enrolled in treatment. Half of the drop-outs went to another form of maintenance therapy (methadone) and the other half went into some form of abstinence-based treatment. During the course of the experiment, the crime and unemployment rates among the participants dropped significantly. As a result, the Swiss government authorized an extensive expansion of the program to accommodate a larger percentage of the country's heroin addicts (MacCoun & Reuter, 1999: 29).

Over the next few years, cities and sub-national governments in Germany, Spain, Britain, Netherlands, Canada, and Australia started to seek federal permission to establish heroin

prescription experiments similar to the Swiss trials (Drug Policy Alliance, 2006). Currently, Germany, Netherlands, and Spain have started to provide heroin maintenance in place of substitution treatments (CEEHRN, 2007).

While different attempts to expand substitution treatment, heroin maintenance, and safe injection sites were occurring around the world, a less difficult sell to politicians was needle exchange programs. Based on a public health need to reduce rates of HIV and Hepatitis C, several needle exchange programs have been introduced across many developed democracies. The very first form of a needle exchange program was in Berkeley, California during the early 1970s. There, doctors would intentionally leave packages of clean needles in a place where heroin users could see them. As the doctors turned their backs, the needles disappeared (Lane, 1993).

More direct needle exchanges started to take place in Amsterdam during the summer of 1984. In 1986, a graduate student named Jon Parker started to provide clean syringes to intravenous drug users in Connecticut and Massachusetts. Finally, in 1988 Dave Purchase set up the first publicly supported needle exchange program in Tacoma, Washington (Lane, 1993). Over the years, needle exchange programs were introduced all over the world. Some countries—including Switzerland, Germany, Spain, Moldova, Kyrgyzstan, Belarus, Luxembourg, and Estonia—even provide needle exchange programs within their prisons (Pepper, 2007; Stöver & Nelles, 2003).

Although thousands of needle exchange programs have been set up across the globe, one battle within the needle exchange service sector is whether users should receive free needles at all times or receive needles only upon the return of used needles. While civic-minded decision makers believe the latter reduces the number of needles that litter the streets, true harm reduction

advocates point out the that it is not as safe for drug users to have to carry dirty needles back to the point of exchange. Quite often, this dispute is settled by the governing forces who determine both the rules of the exchange and the budget of the operation (Carey, 1998).

Overall, the variety of harm reduction services offered in a country varies. Attempts to mediate between prohibition and legalization result in a variety of programs designed to minimize the harms of drug use and drug enforcement. As a policy program, harm reduction gained considerable strength during the outbreak of the AIDS epidemic. As drug users were putting themselves at-risk for such diseases, there was a greater demand for programs that helped minimize the harms to drug users and their families (Drucker, 1997).

While instruments of the harm reduction venue are both innovative and promising to its proponents, they are not without flaw. Perhaps the most obvious problem from a prohibition standpoint is that harm reduction measures may lead to increased drug use. Defenders of the status quo suggest that harm reduction programs minimize the deterrent effect that the justice system has on potential drug users. They argue that programs like safe injection sites, decriminalization, and tolerance zones remove the fear of consequence, which is quite often the sole reason that people abstain from drug use in the first place. While there is no evidence of this effect, many opponents of the movement feel that allowing some people to maintain their addiction does nothing more than send the message to curious youth that drug use is no longer unacceptable (Souder, 2005).

While most treatment professionals will disagree with the above characterization of harm reduction, they will say that addiction maintenance is still not a healthy alternative to abstinence. Some treatment professionals who advocate an abstinence-based approach have argued that while harm reduction may not lead to more drug use, it does not contribute to the end-all goal of

public health, and that is to end drug addiction (Voth, 2005). A final difficulty of harm reduction is that it may give potential drug users the false sense of security that if they lose control of their drug problem, the government is more than willing to intervene and provide help. Such behavior not only places drugs users in harm's way, but also can act to overload the treatment system (Goode, 1998).

Many critiques of harm reduction are based on ideology and stem from moral reasoning as opposed to logic and scientific discourse (Nadelman, 1988). Some harm reduction advocates try to overcome this barrier by showing how useful the venue's instruments are for a variety of stakeholders. While offering testimony in front of a House Committee in Canada, Dr. Mark Tyndall from the University of British Columbia explained that "from the merchant who wants to run a business, to the seniors' group who want safe streets, to the provincial government trying to balance health budgets, to the political activists who demand social justice, to the police who want to reduce crime, to the street-involved person who has just witnessed a friend's overdose, the status quo is not an option. It must be made clear to all groups who are impacted by drug use that a harm-reduction approach in no way promotes or legitimizes the use of drugs but rather is a rational approach that will benefit us all"(Special Committee on Non-medical Use of Drugs, 2002:79).

Although harm reduction professionals do have their fair share of obstacles to overcome, one of the more paralyzing restraints they face is not in the instruments they lobby to use, but in their organization. The one weakness of the harm reduction venue is that it is often fragmented, and not nearly as organized as the law enforcement or to a lesser extent, treatment venue. According to Reuter and MacCoun (1996), in many countries harm reduction has not developed

into a policy or program. Instead it has survived mainly as a set of goals for more ambiguous drug policies and programs.

Thus, caught in the heuristic descriptions of academics and drug researchers, *harm reduction* has no specific organization, agency, or cabinet head that represents and controls the entire venue. While several federal health departments (Canada, Netherlands, Austria) recognize harm reduction as an important part of the four pillars to drug control—the others being law enforcement, treatment, and prevention—it still is mainly organized and administered through local governments or grass roots organizations.

As such, it is difficult for harm reduction advocates to rally their support around one fixed entity that can overcome the entrepreneurial competition of the law enforcement venue. As will be explained further in this research, the law enforcement venue is dominant in most countries largely because of self-reinforcing processes. Dating back to the onset of drug prohibition, criminal justice bureaucrats have been able to dominate the drug issue by continually defining it as a crime problem. Despite these forces however, the harm reduction venue has developed into a well-functioning and highly successful policy venue in several democracies. While the majority of this has occurred because of specific domestic preferences and international factors, certain institutional structures have also allowed for these processes to occur.

1.2 Summary

Dynamics within and between the four drug policy venues help us identify parts of the puzzle behind variance in drug policies across countries. The image of the drug problem in each country is the single most effective determinant of the venue in which drug policy is designed. Venues determine how a problem is defined, and ultimately what the best alternatives for dealing

with the drug problem are. As this research illustrates however, there are multiple influences on these processes, and ultimately on the policy outcomes of drug policy actors.

Domestic political understandings of the issue suggest that a variety of political conditions affect the behavior of policy actors and what image a nation has of its drug problem. International explanations of drug policy variation point to different pressures from outside the domestic political system; which ultimately have an impact on drug policy. Advocates of the institutional perspective believe that the structure of a country's political system fosters certain policymaking conditions that affect the dynamics between drug policy venues, and consequently the image of the drug problem. Finally, the bureaucratic dominance explanation of drug policy, suggests that drug policy is a function of the advice given to politicians by bureaucrats who strive to maintain their services as the core solution to the problem.

The next chapter of this dissertation explores the arguments made by these four different approaches to explaining drug policy. Following this, the case studies that make up Chapter 3 will illustrate some of the dynamics explored in the literature. Canada and the United States are excellent examples of competitive policymaking environments and Austria and the Netherlands are perfect examples of cooperative policymaking environments. Chapter 3 will conclude with an introduction of the main institutional and bureaucratic arguments tested in this research.

The fourth chapter of this dissertation illustrates how I tested different institutional and bureaucratic dominance hypotheses on drug policy formation. The findings demonstrate that cross-national variation in drug policy occurs because different bureaucrats are able to define the drug problem in a way that meets the needs of their venue. The ability of these bureaucrats to control the image of the drug problem—and ultimately define the problem—is mediated by the political institutions of each country. Since institutional structures vary cross-nationally, so do

policymaking environments, and ultimately drug policy outcomes. More is also learned about the effect of domestic and international factors affecting drug policy.

The fifth and final chapter of this work discusses the main themes appearing throughout this research. A brief overview of the findings reiterates that notion that there are four different approaches to explaining variation in drug policy. While all four were examined to some extent in this research, explanations involving institutions and bureaucratic dominance were the focus. The conclusion of this dissertation is that scholars of comparative politics and policy studies should consider collaborating on more research projects in the future—both in terms of methodology and theory. The results may be of great benefit to the discipline of political science, as well as to policy actors hoping to use our resources as an aid to their strategic policymaking endeavors.

CHAPTER TWO

2.0 FOUR EXPLANATIONS OF DRUG POLICY

The literatures reviewed within this chapter describe a variety of arguments that can be used to explain variation in drug policy across different countries. While some of the theories presented in this chapter speak specifically to the dynamics of drug policymaking, others are generalizations of all policymaking and the conditions which affect the decisions and behavior of actors within the political system.

Each of the four sections that make up this chapter covers one approach to explaining drug policy. Although each approach is based upon entirely different understandings of what affects policymaking, there is significant room for overlap in trying to arrive at an answer to the question driving this research. As such, while the current project is mostly interested in exploring institutional and bureaucratic explanations of drug policy, several components of the domestic and international arguments are included in this analysis.

2.1 Domestic Political Factors

Several of the most influential factors affecting drug policy formation at the domestic level are public opinion and the media, partisan conditions, party discipline, political culture, and political ideology. The following subsections will provide some background information on each of these domestic factors and how they may influence drug policy. This section concludes with a brief discussion on why it may not be appropriate to include some of these factors as explanatory variables in this analysis of drug policy. One of the main reasons for this is because many of the domestic political factors affecting drug policy are embedded in the political institutions under

examination in this research. Despite this, there are several parts of the qualitative analysis that reveal the strengths of some of these domestic political factors.

2.1.1 Public Opinion

When studying policymaking within democracies, it is useful to acknowledge the importance of public opinion. As Hansen (1998) observes, democracy exists where the preferences of ordinary citizens count for something in the creation of public policy. Taking a more hard line approach, Key (1961) warns that "unless mass views have some place in the shaping of policy, all the talk about democracy is nonsense"(p.7). In light of this, several scholars have set out to evaluate the responsiveness of democracy (Eichenberg, 1989; Jacobs, 1989; Risse-Kappen, 1991). To do so they focus on the important relationship between public opinion and public policy.

An early examination of government responsiveness is Erikson's 1976 article on the correlation between public opinion and policy decisions within the 50 American states. In his analysis, Erikson explains that some form of direct popular pressure accounts for the translation of public opinion into public policy. This occurs when voters choose their legislators on the basis of their position on issues; or when legislators take public opinion into account when deciding how to act in certain areas. Researchers a decade later also found support for the thesis that public opinion shapes policy.

Examining public opinion and policy data in the U.S. from 1935 to 1979, Page and Shapiro (1983) find considerable congruence between changes in public preferences and in policy. They conclude that public opinion is often a proximate cause of policy and that policy is affected more so by public opinion than the latter is affected by the former. This research was later supported by a group (Wright, Erikson, & McIner, 1987) who found that citizen preferences

are even more important than economic and social factors in explaining policy liberalism and reform.

Despite considerable support for the democratic responsiveness model of public policy, there are empirical studies which refute the way it describes the pubic opinion-policy nexus. In their work on Canadian politics, Petry (1999) and Johnston (1986) find that the congruency of public opinion and public policy is limited. Petry reveals these limitations to be only during the formulation of economic, foreign, and redistributive policies; or when the Mulroney conservatives were in power.

Other skeptics of the role that public opinion plays in policymaking take the pressure group view of politics. Early interest group theorists (McConnell, 1966; Schattschneider, 1960) propose that the effectiveness of public opinion in shaping policy is minimal because the American political system in favor of well-organized business and professional groups. This conclusion is supported by Brooks (1985, 1987, 1990) who conducted empirical work in Britain, France, Germany, and United States to find that the ruling business elite play a larger role in policymaking than does public opinion. More recent findings (Gray et. al, 2000) try to moderate the argument by suggesting that while specific interests of groups weaken the responsiveness of government to the public, more liberal reforms can occur if more massive public opinion is in favor of such reform.

While some researchers doubt the effectiveness of public opinion in shaping public policy, there are more who believe that the relationship exists in the reverse: that politics and policy shape public opinion. Mill (1962) and Key (1961) were two of the first scholars to point out that political leaders act not only as educators to the public on certain issues, but as advocates of the policies they feel will further public interest the most. Others write that politicians

manipulate the public with lies and deceptive symbols (Edelman, 1964; Miliband, 1976; Wise, 1977).

In his work in *Constructing the Political Spectacle*, Murray Edelman (1988) makes the point that policy entrepreneurs will shape a political issue in a way that eventually delivers positive public opinion right to their doorstep; even if the information or symbols they are providing are inaccurate. In the field of illegal drug policy, such tactics have quite often been used by conservative interests to secure and build upon the prohibition status quo that dominates many national drug strategies (Bertram et al., 1996; Rasmussen & Benson, 1994). The fact that public opinion is remarkably well-structured and partial to the status quo on a normal day—not to mention one when politicians mold public opinion—makes it extremely difficult for reformers to prevail.

In the event that exaggerated and untruthful language does not affect public opinion as often as these scholars report, there is still much about the relationship between public opinion and public policy that is unknown. In his review of the existing research on this topic, Page (1994) felt that we still do not know the impact of public opinion on policy, under what circumstances it occurs, or what kinds of democratic institutions foster this relationship. Jacobs and Shapiro (1994) agree that more specifics need to be learned about this nexus in order for the public opinion-policy theorists to more accurately explain policy outcomes.

For the purposes of the current research, valuable insight is provided by the aforementioned works on public opinion and policy. Within the study of drug policy, it is important to account for public opinion. There are two reasons for this. In competitive political systems, policy actors may exploit the public ignorance and fear of drug use to their political benefit. In cooperative political systems, policy actors are often free to educate the public on

controversial matters without being ridiculed by political opponents. Case studies and elite interviews illustrate the extent to which each of these activities occurs.

2.1.2 Media

The relationship between drug policy and the media is important because of the effect that the latter has on both public opinion and policy. Early observers (Cohen, 1963) note that the media may not be all that effective at telling people what to think, but are extremely effective at telling people what to think about. In their research on the 1968 Presidential Election, McCoombs and Shaw (1972) found a strong correlation between what the media were emphasizing and what voters in their sample thought the major issues of the campaign were. Several studies conducted shortly after this observation also support the notion that media shape the political agendas of decision makers (Blanchard, 1974; Lambeth, 1978).

Some researchers are more cynical of the media than this. Page (1996) argues that the media use their publications and broadcasts to try and change the beliefs and policy preferences of mass and/or elite audiences. Presumably, this indirectly affects policy decisions. After studying the responses of American television viewers to a pre-arranged single media event on national television, Cook (1983) and her colleagues found that the media influenced the views that the general public and elected policymakers had on the issue. More recent research (Iyenger, 1991) develops this argument by suggesting that the media frame issues in a way that has a considerable effect on the public's opinion of that issue. The image that a public and their politicians have on an issue is an incredibly strong determinant of problem definition.

While political scientists continue to search for more convincing evidence of the effect that media have on policy, we can agree that at a minimum the media does affect policymaking in some way. A quick survey of the research on media and politics reveals that researchers

(Brody, 1991; Zaller, 1992) are agreeing on the more subtle—as opposed to direct—relations between the media, the public, and policymakers. If anything, high coverage of a particular event or issue does increase the salience of that issue. As Kingdon (1994) points out, specific *focusing events* can attract a lot of media attention to an issue. This allows policymakers with a viable solution to benefit from the public concern over the matter. Notable examples in the area of drug policy are large drug seizures, a series of overdoses within a single community or region, or an arrest or overdose involving famous actors, musicians, or athletes.

Of course the salience of drug use in the media is not the only way that the general public is exposed to the issue. In fact there is a big difference in opinion between publics who learn about drug issues through the media and those that learn about drug issues first-hand. Research in 11 different European cities shows that people who are not exposed to the drug problem and only know of it through media, are more inclined to a repressive approach to drug use. In contrast, those people who are personally or professionally affected by drug use believe that a health approach is the appropriate response (Korf, Bless, & Nottelman, 1998).

These findings are important to the study of drug policy. Since government solutions to this issue are so dependent upon the public's image of the drug problem, the way media cover stories related to drug use can have a major effect on venue that is given responsibility over the matter. Knowing that the media plays an important yet limited role in preference formation is particularly relevant to the elite interview sections of this research.

2.1.3 Partisan Conditions

Another domestic political factor that is very much related to the subject of this research is the partisan conditions within a country's government. While institutional design is important, the cooperation and conflict that occurs within government is often dependent upon the political

parties of the actors involved. In the body of research on legislative productivity, conditions such as unitary party government and strong executive leadership lead to high policy productivity (Fiorina, 1980; Key, 1964; Sundquist, 1988). In contrast, when the majority of seats in a legislature is held by a different party than the executive, divided government can lead to gridlock, paralysis, and legislative slumps (Binder, 1999; Linz, 1990; Mainwaring, 1993). Research by Shugart (1995) suggests that the timing of elections, localization rules of the campaign, and ballot-type all add to the unpredictability of how and when divided government can occur. In a controversial area like drug policy, legislative stalemate can become a real problem for policy reformers.

While a majority of the research on legislative productivity focuses on divided government within presidential systems, studies on minority governments in parliamentary systems also reveal less productive policymaking (Forsey, 1964; Lyon, 1984). The multiple forms of minority government show that not only do the relations between policy actors become more complex in parliamentary systems, but they also become less predictable (Valentine & Pope, 1973). For the purposes of this research, it is safe to assume that the legislative holdups in parliamentary systems with minority governments have a restraining effect on policy production that is at least equal to or greater than that within presidential systems plagued by divided government.

Of course, not all scholars agree that legislative productivity is stymied by these partisan conditions. In his well-known work *Divided We Govern*, Mayhew (1991) argues that unified government does not correlate with surges in legislative productivity and that periods of divided government do not necessarily lead to legislative gridlock. Supporting Mayhew, Jones (1994) declares that divided government is a legitimate and even productive form of lawmaking. In later

work, Jones (1995) added that there is no link between legislative deadlock and divided government. In research on parliamentary systems, Strom (1985) examined 323 postwar governments in 15 parliamentary democracies to find that minority governments are superior to majority coalitions in that they enhance systemic responsiveness and accountability. Doing so ultimately made their legislative efforts more legitimate and therefore supported.

Several responses to these attacks on the conventional thinking of partisan conditions are that the methods and logic developed in this camp are weak (Coleman, 1999; Kelly, 1993). To illustrate, Edwards, Barrett, and Peake (1997) argue that Mayhew concentrated on policies that *passed* under different partisan conditions as opposed to those that *did not pass*. Others criticize Mayhew not just on methodology but on theory. James Sundquist (1992) condemned Mayhew's findings for overlooking the impact of divided government on delaying the passage of policy. Some are even concerned that researchers like Mayhew completely ignore the role that partisan conditions play in sparking institutional conflict (Kernell, 1991).

While several scholars have argued over the question of whether divided and minority governments impede legislative productivity, some assert that it all largely depends upon the type of legislation being considered. One group in particular examined time series data on the U.S. Congress to find that divided government depresses the production of landmark legislation but increases the production of trivial laws (Howell, et al., 2000). The reason for this is because landmark legislation (a) represents big changes in the status quo; and (b) allows the legislating group to make policy based on an alternative ideology. The implications of these findings to the current research are that the size and type of legislation can alter the influence that partisan conditions have on policymaking productivity.

To explain, Krutz (2000) claims that while divided and minority governments can limit legislative productivity, omnibus bills can be used to overcome partisan differences between the branches of government. Used to control the agenda and build coalitions, omnibus legislation acts to join a large collection of policies under one package. According to Krutz "by focusing on the part of the bill that is widely supported, party leaders (who assemble the bill) can take attention away from controversial items in certain substantive areas" (p.533). American policymakers continuously use this tactic to pass drug policies that may not have been passed on their own had they not been bundled into an omnibus bill (Drug Policy Alliance, 2006).

In summary, partisan conditions play a big part in drug policy outcomes. The ability of drug policy actors formulate the policies they desire often depends on the relationships they have with other policy actors. As some of the elite interview data reveal, legislative deadlock has prevented drug reforms in several countries—this has helped retain both law enforcement and harm reduction status quos. As a result of these conditions, the institutional variables on electoral design and regime type are particularly important in the study of drug policy.

2.1.4 Party Discipline

While domestic partisan conditions within government can affect drug policy, discipline within a party can also affect the development of drug policy. Under most circumstances, political parties can be seen as unitary actors with well-defined goals. However as Downs (1957) points out, we can only conceptualize them as unitary actors if the members of the party are disciplined. According to Mainwaring and Linan (1997), party discipline is the extent to which members of the same political party vote together in highly contested role call votes. A disciplined party is therefore one in which elected members of the legislature vote together on

contested issues. On the other hand, undisciplined parties are those which are divided on issues that cleave the legislature as a whole.

Party discipline is an important element of successful government. It often determines not only the legislative outcome of votes, but also the ability of parties to bargain with one another. Several studies recognize the importance of party discipline in parliamentary systems where the executive must maintain confidence of the legislative members of parliament (McRae, 1967; Satori, 1994). However without strong party discipline, Presidents have a tough time predicting and maintaining the support they need to make policy. Thus, party discipline is important in both styles of government.

The significance that party discipline has towards the study of drug policy is that when legislating on controversial issues like illegal drugs, the discipline of a party may have a significant influence on the outcome of a policy. According to Converse and Pierce (1979), when parties are disciplined the party itself becomes the primary vehicle of representation. When parties are less disciplined however, individual politicians or factions begin to represent citizens and organized interests. As such, in countries where certain orientations of drug policy have prevailed for several years, it is easier for would-be reformers to deviate from party lines and advance an alternative drug policy agenda. In contrast however, defenders of the status quo also have the same options of defection if their party begins to move towards policy reform.

A necessary piece of information regarding party discipline and its affect on public policy is that the design of a country's political system has a major impact on the behavior of party members. As Hertig (1978) illustrates, several characteristics of the Swiss political system facilitate the deviation from party discipline. These characteristics include strong regionalization, fixed term limits, and a large governing coalition that leaves little room for an opposition party to

create conditions necessary of strong party discipline within the governing party. In contrast to the Swiss, closed party lists and intra-legislative organization lead to very high party discipline in the Argentine Congress (Jones, 2002).

The relationship between party discipline and institutional design is important to the current research. While party discipline lies outside the institutional explanation of drug policy advanced here, it is necessary to be aware of its dynamics throughout the different stages of this research. One of the reasons is because in most proportional electoral systems, party discipline is considerably strong—especially compared to single member districts where the candidate is often the centre of attention. Under such conditions, it is less likely that politicians will go out on their own and create politics around the drug issue. As my field data from Europe indicate, party discipline is what has prevented drug policy from being politicized and exploited for electoral gain in Netherlands, and to a much lesser extent Austria.

2.1.5 Political Culture

In the study of public policy, researchers seldom account for the political culture that may shape (or be shaped by) the decision making of policy actors. Aaron Wildavsky (1987) defines political culture as shared values that legitimate social practices. One of the clearest implications of political culture to the study of drug policy is that these so-called shared values condition how individuals adapt to changes in social practices.

According to Inglehart (1990), certain incentives to change or maintain the social practices of the status quo are embodied in our institutions. As such, if a country has a political culture that provides incentives to compete against one another, that country's political institutions may very well foster a policymaking environment that maintains the status quo. However if a country has a political culture that encourages cooperation and collaboration, its

political institutions will foster a policymaking environment that considers alternatives to the status quo. These dynamics are very important to the development of the current research.

Perhaps one of the earliest—if not the most discussed—works on political culture is Almond and Verba's (1963) *The Civic Culture*. The pair suggests that political culture is the collection of "attitudes towards the political system and its various parts, and attitudes towards the role of the self in the system" (p.13). They warn that political culture is not only separate from the political system but may or may not be congruent with the structure of the political system. This serves as an important piece of information for researchers who explore the determinants of drug policy—especially reform.

While this notion of political culture and policymaking supports the current research, there are critics of *The Civic Culture*. Lijphart (1989) berates Almond and Verba for overemphasizing the importance of political culture. He argues that the concept is too ambiguous and should be narrowed down to one that is purely political. Different critics (Pateman, 1989) argue that political culture should be seen as the outcome, not the cause of political process. One scholar (Barry, 1978) even suggested that it is the various institutions of democracy which produce the political culture of a nation and not the reverse.

Despite these remarks, some observers do agree that political culture is important and should be emphasized as the link between society and government. In his review of existing research on the subject, Street (1994) confessed that Almond and Verba need to view it as a concept that refers to more than the attitudes people hold to politicians and political structures. Street claims that political culture "is made up for a complex of feelings and images deriving from the home and work, from manifestos and popular culture"(p.113).

Working to address this issue, Elazar (1972) created a tripartite of political cultures in the United States. According to Elazar, *moralistic* political culture sees politics as behavior devoted to the development of a good society. Some of the major components of the moralistic culture are issue oriented citizens, high levels of participation, and competent professional bureaucracies. The moralistic political culture accepts government intervention so long as it promotes public good and not private economic enrichment. The *individualistic* political culture sees politics as a legitimate arena for social mobility and private enrichment. Many of the elements important in moralistic culture are not important in individualistic culture. Finally, the *traditionalistic* political culture sees politics as characterized by hierarchical relationships. Low-level participation is acceptable for the elite know best. Skilled professional bureaucrats are frowned upon because they undermine the personal ties upon which political relationships are based.

While Elazar's models of political culture are based upon his research experiences in America, there is good reason to believe that similar differences will occur across nations as opposed to states. Interviews with respondents at various levels of the political system may indicate some support to the idea that different political cultures form within the larger polity. Several empirical studies on American States find that political culture not only varies across states but also has an independent effect on state public policy outputs and political participation (Dean, 1980; Johnson, 1976; Sigelman, 1976; Sharkansky, 1969). In fact one researcher (Ritt, 1974) was even able to confirm the hypothesis that moralistic political cultures foster reform, while those with individualistic or traditionalistic political cultures do not.

Overall, past research on political culture leads this research to suggest that an important determinant of drug policy may very well be the political culture of a nation. If a country's polity

sees the role of government as being one that addresses specific issues for the purpose of bettering society, then certain pragmatic drug policies may be developed. However if the dominant political culture of a country cares most about the freedom and liberty of individuals, its government may be prone to maintaining policies that hold individuals accountable to their own actions, regardless of their need of government assistance. The difficulty of testing this argument however is that political culture is not easily measured, particularly across countries.

2.1.6 Political Ideology

A more attainable indicator that represents the overall preferences of the public is political ideology. According to Mahler (1995), "ideology is a set of ideas that relate to the social/political world and that provide a general guideline for some action"(p.37). Political ideology "provides politicians with a broad conceptual map of politics into which political events , current problems, electors' preferences and other parties' policies can be fitted"(Budge, 1994:446). In the simplest sense, political ideology is a classification of collective positions that individuals or groups hold on issues within the scope of public policy. The ideological views that voters share on matters pertaining to politics should be congruent with those of the decision makers that are elected to represent them. While this is often the case in democracies, scholars have disagreed to some extent.

In the study of American politics, there is considerable conflict over the extent to which ideology shapes decision-making in politics. Some (Entman, 1983) argue that political decision-making is shaped by the personal ideology of the politician. Others (Jackson, 1964) contend that the decisions of policymakers are rarely the products of individual experiences and philosophies. Instead, politicians act in the interest of their constituents and the mass ideology that they form. The problem of this understanding to some scholars is that it overlooks limitations in

communication between policymakers and their constituency. As Miller (1970) points out, inadequate communication channels between constituents and their representatives, along with constituency ignorance of policy issues and politicians undermines the communication assumed by most researchers.

Despite this claim, it is difficult to refute the relationship between voter preferences and policy decisions in a democracy. Within the democratic process, those political actors with ideologies congruent to those of a certain threshold of the voting public become elected. Their ideas, combined with the preferences of voters, eventually turn into policy. This process demonstrates the strong relationship between partisan votes and policy preferences. Assuming that the outcome of elections serves as a strong indicator for voter preferences, party choice has become the dominant predictor of political ideology in comparative politics research (Inglehart & Huber, 1995).

In most studies on this topic, scholars have ranked political ideology on a left to right scale. One of the earliest attempts to justify this was Inglehart and Klingemann's (1976) study of mass publics in Europe. Their findings led them to the conclusion that the left-right dimension has a partisanship component as well as an ideological component made up of value orientations and current political issues. Using multiple methods, more recent research (Gabel & Huber, 2000; Inglehart & Huber, 1995; Knutsen, 1997) has supported the thesis that party choice among voters is a strong indicator of political ideology.

As for the role of ideology in drug policy, I am confident that the former has a strong effect on the latter. A variety of comparative research on social welfare, criminal justice, and health policy (Cameron, 1978; Castles, 1982; Huber & Stevens, 2000; Maioni, 1997; Rowland & Carp, 1980) has shown that the left-rightness of voters—and ultimately the representatives they

elect—has a major impact on the sorts of policies governments produce. This is the same for drug policy. In the current research, it is important to account for the liberalness or conservativeness of a country and the effect this may have on drug policy. While political institutions and bureaucratic dominance should explain drug policy differences across countries, it is important to control for the effect that political ideology has on policy preferences.

When conducting cross-national research, it is important to take the time necessary of pointing out concepts or definitions that may have different meanings to different readers. One clarification that is seemingly important in discussions of drug policy does concern political ideology; specifically the contrast between what is liberal and what is conservative. In several European countries, including those explored in this research, these terms are used to explain the government's role in the economy as opposed to its role in society. As such, liberal refers to an open free-market economy whereas conservative refers to closed and protected economies.

In North America, these terms are used to describe one's belief in the way government should control society. As such, left or liberal means to be of the thought that government should do what it can to promote equality and protect the minority. Right or conservative means to be of the thought that government should abstain from too much societal involvement, yet strive to protect freedoms and promote individual mobility while protecting ideals of the status quo. All uses of the terms liberal and conservative will hereafter be used in the North American context. Even in the summation and analysis of interview data, I used the North American meaning of these terms—although most respondents did as well[6].

[6] In the cases where I was not certain of which understanding a respondent had of ideology, I simply asked them to clarify.

2.1.7 Exploring Domestic Explanations of Drug Policy

Of the previously mentioned factors, political ideology offers the most utility as a control variable because it is an extremely close representation of the feelings that polities and their governments have towards issues concerning the state. Political ideology is important to include in this study because it is often the strongest determinant of policy preferences. According to respondents I interviewed, as well as other drug policy researchers (Benoit, 2003; Giffen, Endicott, & Lambert,1991; Goode, 1997), there is a strong relationship between the political party that controls government and the types of drug policies it creates. While more left-leaning individuals or groups seem to be more willing to accept innovations in treatment and harm reduction policies, rightists prefer to maintain a strong law enforcement approach with abstinence-based treatment and deterrence-based prevention programs. As such, including a control variable for political ideology in the quantitative sections of this research will be very beneficial to this research.

By including an indicator of political ideology, I will be able to get by without using a control for public opinion or the media. As previous sections in this research explain, the ideology of the sitting government is a rough but adequate measure of public opinion and the media[7]. I will also not include a control for partisan conditions in my quantitative analysis. The reason for this is because existing research on legislative deadlock caused by partisan conditions is not conclusive enough to justify using a control for divided or minority government in this research. In addition, the institutional structure of electoral design will most likely be correlated with partisan conditions and party discipline, particularly in multi-party countries with proportional representation. Finally, I will not include a control for political culture due to the

[7] As explained in the methodology of this research, the most prevalent indicator of a country's political ideology is the ideology of the sitting government—either across time or in a single year.

fact that a country's style of political bargaining often accounts for the nature of relations between its government and people.

Although my quantitative methodology does not include a control variable for many of the domestic factors explored in this research, the above overview of these policy determinants will become very useful in the analysis of data retrieved in the qualitative methodology. Much of the interview data does contain extensive dialogue on the role that public opinion, partisan conditions, party discipline, media, and political culture play in the formation and implementation of drug policy.

2.2 International Political Factors

Although this research focuses mostly on internal explanations of drug policy, it is important to acknowledge the influence of international factors. Essentially there are two main sources of influence on domestic drug policy that stems from abroad. The first is the effect that international institutions have on the decision making of policy actors at home. Most often, restraints that stem from international institutions are limited to setting boundaries on the types of drug policy alternatives member countries can consider. The second type of influence from abroad is a little more direct. Diplomatic pressure in the area of drug policy can be quite burdensome to countries engaged in drug policymaking, especially if the pressure is coming from a larger nation they depend upon.

2.2.1 International Institutions

Governments across the globe are steadily losing their autonomy on issues that have traditionally been considered domestic (Gourevitch, 1978). Changes in the international system have allowed for infiltration of domestic policymaking process. Because of this, not only foreign state actors but actors who do not operate on behalf of a state are beginning to influence

domestic policymaking (Risse-Kappen, 1995). These actors are mainly transnational organizations or international institutions.

The former refer to organizations that are autonomous from government and flow across borders. Examples of this are the World Bank, PETA, and the International Harm Reduction Association. On the other hand, international institutions are sets of rules and norms that define and prescribe standards of behavior and activity among states (Keohane, 1989). Although transnational organizations have an external importance to some aspects of domestic policy (economics and trade), their influence on drug policy is limited. Transnational organizations involved in drug policy behave very much like domestic interest groups. On the other hand, international institutions like the United Nations and the European Union influence policies by bringing norms in the international sphere to the domestic political arena (Bernstein & Cashore, 2000)[8].

The influence that international institutions have on domestic politics spans many different policy areas. Whether it is education (McNeely, 1995), forestry (Bernstein & Cashore, 2000), or agriculture (Coleman & Skogstad, 1995), policy areas that were traditionally domestic are now being influenced by international institutions. The problem this poses to some researchers however is that larger more powerful countries are able to work within international institutions to help make the norms of that body match its own (Meltzer, 1976). As explained by Krasner (1981), international institutions are created by powerful states to suit their own interests. To maintain international legitimacy, these states must grant the institution certain autonomy from the state.

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[8] While the current research considers the EU as an international institution, some regional integration scholars (Caporaso, 1996) would classify it as a form of state. However others (Scharpf, 1988) contend that the supranationalism of such entities could never amount to state status, and thus will always remain international institutions.

Illustrating this in the area of drug policy, Bewley-Taylor (1999) examined international drug control from 1909 to 1997. His findings reveal that the United States has almost single handedly shaped the international drug control regime in the framework of the United Nations; that which Nadelman (1993) claims, was developed by the United States in the first place. Although the United Nations Office on Drugs and Crime is designed to be autonomous from the influence of individual countries, it is under constant pressure from the U.S. to reject the harm reduction approach and denounce the instruments its advocates endorse (Transnational Institute, 2005).

Providing some evidence of the difficult conditions in the UN, Thoumi (2002) describes his professional research experiences at the UN Office on Drugs and Crime: "The UN has promoted a repressive anti-drug agenda and does not allow open debate of many of the key anti-drug issues currently discussed in many countries"(p.161). The result of this norm is that many government officials from member countries are hesitant to experiment with strategies that do not align with the prohibition-based policy guidelines of the United Nations Conventions.

In short, the 1961 Single Convention on Narcotic Drugs called for international cooperation in limiting drug production, trafficking, and possession. The *1971 Convention on Psychotropic Substances* was a response to the diversification of the drug market and drug abuse. It calls for law enforcement attention to a new array of synthetic drugs. Finally, the *1988 Convention against the Illicit Trafficking in Narcotic Drugs and Psychotropic Substances* strengthens the United Nations stance against trafficking while also condemning money laundering and the diversification of precursor chemicals. In addition, it also provides for international cooperation through extradition of drug traffickers, controlled deliveries, and transfer of proceedings (UNODC, 2006).

Compliance to the UN conventions is monitored by the International Narcotics Control Board. The role of this board is to work with member countries to ensure that they are legislating the policies that will help countries comply with the three drug conventions. Because these conventions are not self-executing, it is up to individual parties to the conventions to pass laws that will enable them to carry out the provisions. While the International Narcotics Control Board does report on adherence to the conventions, there are no specific mechanisms of enforcement that the UN can use to make sure that countries are following through with the provisions (United Nations Office on Drugs and Crime, 1988).

Although the conventions have been in existence for so many years, one of the problems with these agreements is that they do not conform to the needs of all countries. In his work on coca leaves in the Andean countries, Thoumi (2004) finds that the various UN conventions wrongfully declare coca chewing as bad and that indigenous communities should be weaned off the substance. While most Latin American countries have agreed with the conventions, Bolivia did not. Of the long list of reasons why their Bolivian government did not agree to the convention was that the coca leaf by itself is not a psychotropic substance, it has widespread medicinal value, and it has industrial uses. Although Bolivia has made these claims at various international meetings since 1988, no amendments have been made to the conventions.

While the UN has long attempted to influence the drug policies of member countries, the European Union is also starting to try and have an impact on the domestic drug policies of its member states. In 2004 the Council of the European Union developed a European framework for drug control. Known as the EU Drug Strategy 2005-2012, the framework aims to foster the development of national drug strategies that use a balanced approach of supply and demand reduction policies. After careful evaluation, officials within the EU believed that an EU Action

Plan was necessary to compensate for the deficiencies in the original framework. Both the Strategy and the Action Plan promote the development of instruments from all four venues explored in this research (EMCDDA, 2006).

Compliance of member countries to the guidelines provided in the EU Drug Strategy and EU Action Plan is not regulated by institutional law. While it is monitored by an organization known as the European Monitoring Centre for Drugs and Drugs Addiction, no effective enforcement mechanisms exist. Like the UN conventions, the European framework is an agreement among member states to work towards certain goals in drug policy. Though it does grant its members the freedom to experiment within a multidisciplinary approach, members of the EU are still bound by the 1988 UN Convention—which the EU itself ratified. This is the closest element of the framework that resembles an enforcement mechanism. As such, the extent to which countries follow the UN Convention is also up to individual countries.

The effect of the EU and UN on domestic drug policy is difficult to measure. However there is no denying that they do matter. Some problems are difficult to solve solely within the domestic sphere. While most developed countries have instruments necessary to deal with the drug problem, they often lack the jurisdiction necessary to address the problem globally. As such, international institutions become collective authorities on the matter. As Chawla (2004) explains, institutions like the UN Office on Drugs and Crime have a comparative advantage in closing the gap that nation-states leave open. Whereas governments usually enjoy autonomy in dealing with purely domestic issues, those like drug production, trafficking, and possession become concerns of the international community.

Despite the internationalization of drug policy, the greater portion of decision-making on the matter is still left up to domestic governments. In fact, some of the very states who ratified

the first few narcotic conventions are the very same countries most opposed to the direction the UN is taking on drug policy. Developments in Netherlands, Germany, and even Austria do not completely conform to the norms specified in the conventions. However, because of domestic conditions that support a change towards the harm reduction status quo, new developments in drug policy have taken place. As the case studies in this research show, many state and local governments in the United States have also taken steps away from the protocol laid out in the UN conventions—namely through attempts to decriminalize marijuana and provide needle exchanges.

2.2.2 Diplomatic Pressure

If states manage to retain their policymaking autonomy from the influence of international institutions, there is yet another force at the international level that may interfere with domestic policymaking. Much of the literature on foreign aid (Dudley & Montmarquette, 1976; Meernik, Krueger, & Poe, 1998; Wittkopf, 1975) and foreign trade (Cable, 1996; Dixon & Moon, 1993; Luard 1980; Pollins, 1985) suggests that with certain tactics, states can shape the domestic policy outcomes of other states. Both subtle and aggressive forms of policy persuasion have occurred in drug policy.

As Nadelman (1988) reveals, U.S. diplomats have pressured governments around the world to follow the American lead and enact supply and demand reduction policies that are based upon prohibition and abstinence. Diplomatic visits between France's executive and parliamentary leaders in Den Haag have also been laden with talks of drug policy and how the Dutch approach to the matter is just too liberal (De Koning, 2002). Even smaller countries like Luxemburg and Belgium have received backlash from the French for not protecting their borders from Dutch drug tourists (Maclean's, 1996).

In various forms, diplomatic pressure has been exercised between nations who wish to have their drug policies endorsed by others. One of the most active countries in spreading its drug policy preferences is the United States. Since the marijuana infestation of the 1970s, the cocaine epidemic of the 1980s, and the heroin crash of the 1990s, the United States government has applied significant pressure on Latin American countries to reduce illicit drug production. It has even persuaded several of them to accept and cooperate with its anti-drug interdiction efforts.

One of the reasons prohibition countries like the United States push for a supply side approach to drugs is because it has powerful political appeal on a domestic level. As Mathea Falco explains, "blaming foreigners for America's recurring drug epidemics provides convenient if distant targets for public anger that might otherwise be directed toward elected officials. Getting foreign farmers to stop growing drug crops seems easier than curbing America's appetite for drugs"(1996:121).

Although some observers (Friesendorf, 2006) have shown that these tactics do nothing more than displace drug production and diversify drug trafficking, there is a continual commitment by the U.S. government to eradicate illegal drugs at the source. Doing so requires considerable persuasion on the part of American diplomats and drug enforcement officials who meet regularly with foreign governments on the matter (Walsh, 2004).

Although a majority of these operations are said to work for American drug policy leaders, they are not without consequence to both countries involved. Research by Stokes (2003) on U.S. interdiction efforts in developing countries shows that American military assistance can exacerbate human rights abuses by strengthening security forces and paramilitaries, thus undermining the proper government control of the country's own military. A consequence of

these tactics to America is that they can fuel anti-U.S. nationalist sentiments. Such was the case even in Mexico, one of America's closest allies (Cottom & Cottom, 2001).

2.2.3 Exploring International Explanations of Drug Policy

Past literature on the effect that conditions in the international sphere have on domestic policy will be very useful in the qualitative section of my methodology. The benefit of open discussions with policy actors is that almost any variable can become part of your data. Diplomatic pressure and limitations set by international institutions have a substantial impact on the behavior of actors within a country's political system. Discussions with respondents on these dynamics do provide a more comprehensive understanding of drug policy.

In the quantitative section of this research I have decided to use a control for international pressure. As the methodology indicates, effective indicators for direct pressure from international institutions are not available. Either the data are limited, or insufficient variances in the data that are available make the indicators ineffective. On the other hand, data measuring a country's dependence on the international sphere are plentiful and normally distributed. This type of control will help account for all forms of pressure that countries experience from outside their borders.

In close, the above discussion on international political factors describes a lot of conflict within the area of drug policy. While stakes are high for policy actors in many issue areas, this is usually because the actors are pursuing different goals. However in drug policy, all actors are pursuing the same goal, just through different means. The most effective way to explain the dynamics of the relationships between policy actors is to examine the impact of political institutions.

2.3 The Institutional Factors

One caveat in public policy literature is that it seldom accounts for the influence that political institutions have on the behavior of actors within the policy process. Another is that their studies rarely involve analysis at the cross-national level. Even some of the main contributions in policy theory that guide this research fail to account for both institutions and changes in policymaking across countries.

In their popular study of America's nuclear energy industry for example, Baumgartner and Jones' (1993) conceptualization of policy *images* and *venues* applies only to the policy venues and images in competitive political systems like the United States. What it does not account for is venue and image formation in more cooperative political systems such as Austria and Netherlands, neither of which politicizes drug abuse to the extent that it is in the polities of the United States and to a smaller extent Canada. As this research is designed to confirm, the variation in how drug policy is handled among these (and other) nations stems largely from institutional factors.

According to Grafstein (1988), institutions are both human products and constraints on those participating within them. Political institutions in particular play a large part in constraining the actors which operate within them. Loewenstein (1953) describes institutions as being the framework and apparatus necessary for the rational organization and orderly functioning of social life. He adds that "they constitute established conduct and action patterns operating with a certain degree of permanency and reasonably predictable standards of regularity…In short, institutions are the elements of state machinery"(p.696).

In his work on political institutions, Crepaz (1998) describes the policymaking environments of political systems as being defined by their institutions. Political systems may

contain a variety of both competitive and collective *veto points*. Competitive vetoes occur when different political actors operate through separate institutions with mutual veto powers (ie: federalism, bicameralism, and presidential government). Collective veto points emerge where political actors converge towards a central consensus; one that derives largely from their commitment to work together in order to achieve policy goals (ie: corporatism, proportional representation, parliamentary regimes). In short, the institutional design of a state largely determines the nature of its policymaking environment.

Supporting these claims, Tsebelis (1995) contends that different institutional structures create different conditions for policymaking. Some institutional structures offer more veto points than others. Those systems with many competitive veto points create difficult conditions for policy change to occur. As such, the more competitive structures that exist in a political system, the less potential for policy change to occur.

Similar findings by Huber, Ragin, and Stephens (1993) demonstrate that when power is dispersed among government institutions it is easier to block reform legislation thus reinforcing the status quo. The main institutional factors examined in their research were federalism, presidentialism, bicameralism, single member districts, and provisions for referenda. Finally in Crepaz's (1998) own research, collective political institutions tend to drive up welfare expenditures; whereas competitive institutional structures have depressing effects on welfare expenditures.

The main reason for this effect is that political institutions that are collective in nature provide fewer veto opportunities to actors that otherwise would be involved in the policymaking process. An excellent example of this is corporatism and the minimizing effect it has on competition among policy actors. According to Scruggs (1999), the reason that efficient

policymaking exists in corporatist countries is because such institutional structures limit the number of actors involved in decision making. The purpose of this tactic is to promote social stability by increasing policy consensus, which comes through nothing other then cooperation and concessions made between the actors involved in the policy process (Lange & Garrett, 1985; Wilensky, 2002).

Another illustration of the effect that the number of veto players has on policymaking is cameralism. According to Levmore (1992), policymaking in bicameral legislatures requires a strong *winset*—if one even exists. In general terms, a winset is the overlap of policy preferences from two different groups. As such, the fewer the veto players (ie: unicameralism) the higher the probability that new policies or policy change can be achieved. Likewise, in research on intergovernmental relations, unitary governments are found to accomplish considerably more policymaking and reform than federalist governments (Hicks & Swank, 1992; Lijphart, 1999; Wilensky, 2002).

A common theme that should be evident in this research is that competitive institutional structures tend to maintain the status quo while collective institutional structures tend to foster policy change and development. Describing these phenomena quite effectively, Crepaz (1998) suggests that collective political institutions are more successful at breaking away from the status quo. Quite often the result is a creation of pragmatic policies that far exceed the expectations of the former policy. In contrast, competitive political institutions lead to parochialism and susceptibility to the pressures of district-specific interests. The result is national policies that are incoherent and often degenerative (Pierson, 2004).

While scholars like Crepaz and Tsebelis examine how institutions affect change, others have examined the relationship between political institutions and policy outcomes. In 1992,

Hicks and Swank examined social welfare expenditures against several political and institutional variables. Included in the former was government partisanship and electoral turnout. Making up the latter were political bargaining and intergovernmental relations. Other variables they included which are prevalent to this research include policy legacy, and the self-interested behavior of politicians and bureaucrats.

Their findings reveal that social welfare expenditures increased with the presence of cooperative institutional structures like corporatism and unitary governance. On a political level, they found that an increase in welfare expenditures was associated with high electoral turnout, left governments, and center governments. Hicks and Swank conclude that corporatism, unitary governance, and left or center-led coalition governments fostered a consensual policymaking environment that led to higher social welfare expenditures.

The contribution of these findings to the current research is that cooperative institutional structures worked to reduce the barriers that social welfare actors had to overcome in order to secure increased welfare commitments. Similar to drug policy, actors in the various venues must work against the status quo to provide increased government services to a minority group. Hicks and Swank's research offers considerable support to the treatment and harm reduction arguments made in this research. Both an increase in welfare expenditures and liberal drug policies are more probable when the barriers of more competitive policymaking environments are not present.

2.3.1 Institutional Factors and Drug Policy

To reiterate these findings in terms of the current research, all democracies seem to have started with a fairly significant law enforcement approach to the problem. As such, they rely upon various mechanisms of the justice system to deter and prevent drug use. This allowed the image of the drug problem to be one of criminality. Over time, many countries developed a

variety of different kinds of treatment and prevention approaches. Some are based on deterrence and total abstinence while others are based on public education and substitution-based approaches. More recently, some countries are developing harm reduction approaches to the drug problem which aim to stabilize the drug user and minimize the harms of drug use and inappropriate drug laws. In order for these types of policies to develop, the image of the problem has to be framed in a way that shifts the control of drug policy away from the law enforcement venue.

Of the more liberal (education-based prevention, substitution-based treatment, harm reduction) developments in drug policy, most have occurred in countries with collective institutional structures that have fostered a policymaking environment that is friendly to open dialogue on an issue. These structures include proportional representation, unitary governance, a parliamentary system, single chamber or unicameral legislature, and corporatist political bargaining. Traditionally, corporatism was a term used to describe formal arrangements between economic actors—including the government. However this style of bargaining has filtered down to other policy areas, largely because of the ties between social policy and economic policy in many of Europe's welfare states.

As this research hopes to confirm, there are several reasons why more liberal drug policies are able to develop in countries with more cooperative political institutions. One is that structures like proportional representation foster cooperation. In this type of electoral system, the success of governing coalitions is largely dependent upon the ability of the coalition members to put aside their political differences and focus on their collective agenda. As this research argues, such an environment reduces the common politicization of valence issues that occurs in the competitive policymaking environment of states with a majoritarian electoral design.

Consequently, bureaucrats from the public health venue encounter fewer political obstacles when trying to frame the drug issue as a health rather than crime problem.

Similarly, corporatism forces decision makers to work towards a consensus. This ensures that all policy actors have a chance to express their interests. When this occurs, hopeful drug reformers are able to speak about new alternatives to the drug problem. This eventually leads to the involvement of experts and bureaucrats who are able to convince policymakers of the utility in more liberal solutions to the drug problem.

Another reason that certain institutional structures may be associated with drug policy is because they act to centralize decision-making power. In parliamentary regimes, with unicameral legislatures that govern the country unitarily, there is less room for competitive relationships that can thwart the development of new alternatives in drug policy.

In contrast to this, the more conservative (law enforcement, deterrence-based prevention, abstinence treatment) status quo that dominates drug policy in many political systems is mostly the result of competitive institutional structures which trump temptations of policy change. These competitive institutional structures include single member districts, federalism, a presidential system, bicameral legislature, and pluralist political bargaining.

With more actors levying for power, it is difficult to build the level of cooperation necessary of considering alternatives to the status quo. For example, in political systems with a president that is not only battling the legislature but dealing with the intense rivalry of political parties who are competing for majority support, it is very difficult for reformers to reframe the image of a country's drug problem. This is especially so when they have to compete against non-government interests that lobby the government on behalf of the status quo. Consequently, the

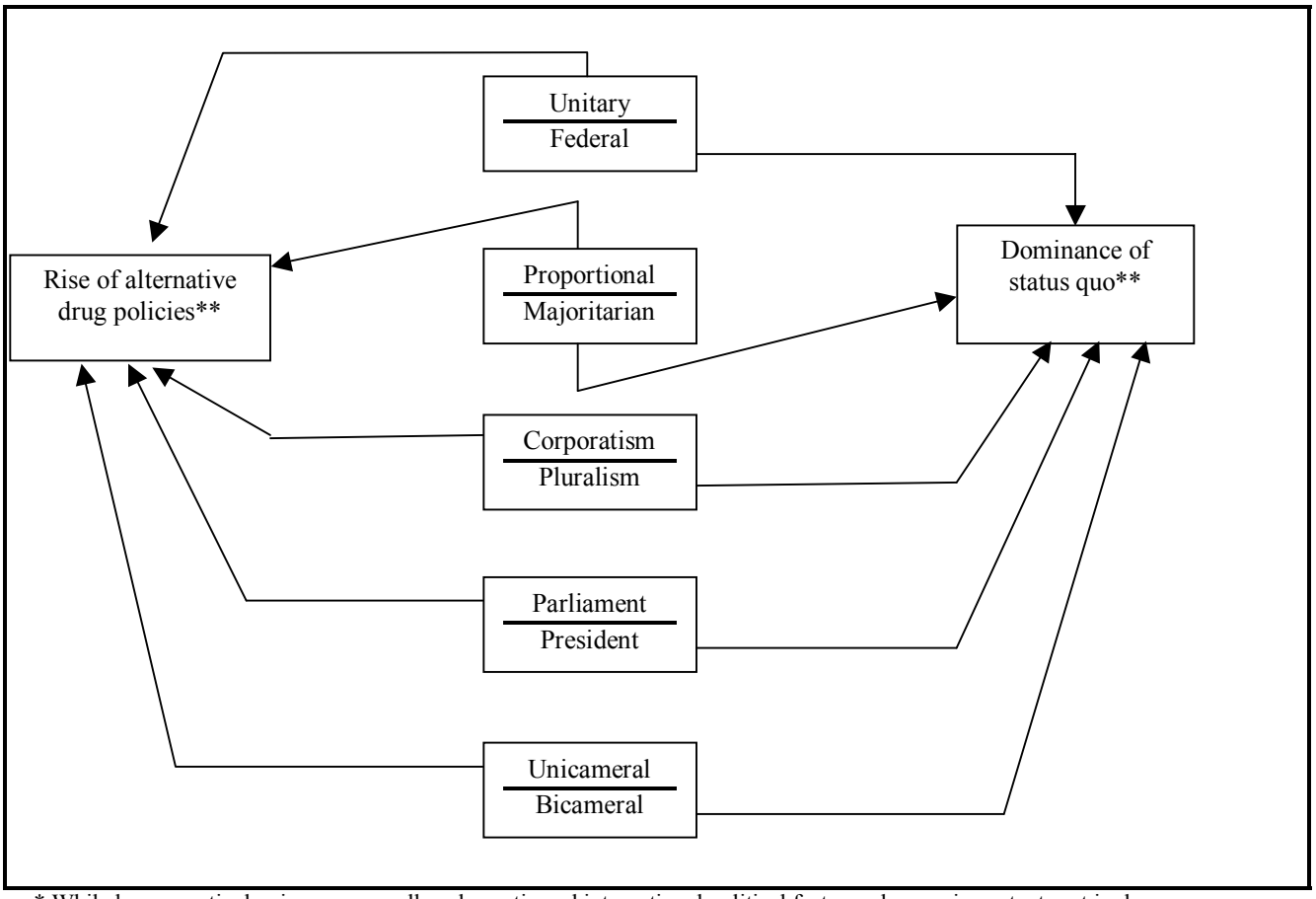
bureaucrats who have traditionally defined the problem (ie: police) are able to maintain their dominance over the country's drug policy agenda.

The current research proposes that drug policy is defined by bureaucrats in a way that secures them the resources that they need and desire. However the dominance of one bureaucrat's definition over another is mediated by certain institutional structures. Figure 2.1 depicts these relationships.

To illustrate some of the relationships in Figure 2.1, there is strong competition among political actors in the United States (Turner, 2000). Consequently, although there are numerous prevention and treatment programs in the U.S., drug policy in America has allowed for criminality to continue as the dominant image of drugs in America. As several interviews reveal in the qualitative section, it is often unsafe for policy actors to speak against the law enforcement Status quo. The result is a very strong and exclusive venue controlled by law enforcement.

In Canada, drug policy seems to be guided predominately by the law enforcement venue, yet has begun to shift towards the treatment and harm reduction venues. This may be due to the structural shift of party politics that Canada's parliamentary system has allowed for (Carty, Cross, & Young, 2000). Of course, the Tory victory in the 2006 federal election may have a dampening effect on this trend. Despite these developments, the two biggest impediments to development of alternative drug strategies in Canada is the politicization of the issue caused by single-member districts and the divide of the implementation of health programs that stems from Canada's federalist structure.

Figure 2.1.
Institutional Effects on Drug Policy Outcomes*



* While bureaucratic dominance, as well as domestic and international political factors, plays an important part in drug policymaking, this picture is designed to highlight the relationship between institutional structures and drug policy.
** Alternative drug policies include those described as harm reduction, substitution-based treatment, and education-based prevention. In contrast, status quo drug policies include various law enforcement approaches, abstinence-based treatments, and deterrence-based prevention.

Historically, both Canada and the United States implemented law enforcement strategies to undermine the efforts of immigrants who were trying to find employment in North America (Rasmussen & Benson, 1994; Solomon & Usprich, 1991). This research hopes to show how elements of each country's institutional structure has maintained the law enforcement status quo in the United States, but has started to strengthen alternative approaches to drug policy in Canada.

On the other side of both the Atlantic and drug policy spectrum, the Netherlands has managed to develop a strong harm-reduction drug strategy. In the 1960s and early 1970s however, it did rely on law enforcement as the primary solution to the drug problem. The literature on executive-legislative relations in the Netherlands (Andeweg, 1992), reveals that the need for a coalition to form a government maximizes the potential of cooperation between the parties. This combined with corporatist bargaining arrangements prevents Dutch policymakers from politicizing the drug problem, and allows for a more logical and fair examination of drug policy alternatives. The result is a triumph of the harm reduction venue, which was formerly inferior to the law enforcement venue (Leuw, 1994). The results of this study's quantitative and qualitative methodologies confirm these findings.

Finally, in Austria there is a development of the harm reduction and substitution-based treatment venues that equals that of the law enforcement venue. This can largely be attributed to corporatism, unitary governance, and proportional representation. A long history of consensus-driven decision making and coalition building between political parties has reduced conflict over this matter; which has ultimately allowed for treatment and harm reduction bureaucrats to influence the policy process. In recent years however, political linkage between drugs and unwanted foreigners has strengthened the law enforcement venue. The ability of certain policy actors to politicize drug use in this manner may be a result of the diminishing cooperative decision making that has accompanied the recent decline of corporatism in Austria (Pelinka, 1998). This phenomenon is discussed more in the qualitative section of this research.

2.3.2 Summary

In summary, policy actors have attempted to define the drug problem in a way that results in their service being the most viable solution. In some countries, competitive institutional

structures have allowed the status quo venue of law enforcement to maintain dominance of the drug policy domain (United States). However in other countries, cooperative institutional structures have allowed for the alternative venues like treatment, prevention, and harm reduction to gain strength (Canada/Austria) and even to surpass the once-dominant law enforcement venue (Netherlands). This research will attempt to determine how institutional structures affect the drug policymaking process. Doing so will require a look at institutions, as well as the extent to which they mediate the influence of policy actors—namely bureaucrats.

2.4 The Dominance of Problem-Defining Bureaucrats

In his book economy and society, Max Weber (reprinted in1968) warned that bureaucratic development tends to create government in which rule by—rather than simply through—administrators tends to increase. The failure of political leaders to control the bureaucracy allows bureaucrats to set goals and determine the direction of policy. While opponents (Tulis, 1986; Wood & Waterman, 1991, 1994) of this view argue that political leaders can overcome the strength of the civil service, there is a lot that an examination of bureaucratic dominance and political institutions can tell us of the drug policymaking process.

The argument tested in this research is that policy actors define the drug problem in a way that benefits them; whether that is politically or professionally. Depending on the institutional structures of a country's political system, certain bureaucratic actors are able to dominate the problem definition stage of the policy process. In more collective political systems like the Netherlands and Austria, consensus among various policy actors as to how the drug problem should be solved is quite achievable. The result is a commitment towards harm reduction and treatment. In contrast, competitive political systems like those in Canada and the United States present more difficult circumstances to achieve the cooperation necessary for

alternatives of the status quo to be considered. The result is a dominance of one policy group over another; which in most competitive policymaking environments, is law enforcement.

The basis of this argument is rooted in a strong tradition of public policy literature that has explained the problem definition stage as one which is driven by the interests of those who define the problem. According to Anderson (1984), defining the policy problem is not only a very important process, but one that is equally complicated. When policymakers propose several definitions of a problem, the one which prevails usually shapes the solutions to that problem. In the case of drug policy, if drug use is defined as a crime problem, then the services of law enforcement bureaucrats becomes the main solution. However if drug use is defined as a public health problem, then the services of social workers, addictions experts and health practitioners from the harm-reduction and treatment domains becomes the main solution. Lastly, prevention proponents seem to get support no matter which bureaucrats dominate the drug policy process.

According to Edwards and Sharkansky (1978), there is little agreement among policymakers during the problem definition stage because of differences in political culture, differences in self-interest, and technical disagreement. Expounding upon one of these reasons, Dunn (1982) argues that policy actors define problems differently on the sole basis of self-interest. As political and bureaucratic actors try to maintain their occupancy of certain political and professional positions, they must protect and promote their interests and those of their constituents. Otherwise, they will fail to mobilize the resources (votes/appropriations) they need to remain in these positions of power and authority. Asserting this claim, Stone's (2002) analysis of policy problems reveals that the definition stage is not about defining goals and measuring ones' distance from those goals. Rather it is about molding the problem in a way that fits one's own solution.

Supporting this description of the problem definition stage, Kingdon (1995) asserts that during this process, policy actors define the problem in a way that enables *linkage* to their solution. According to Kingdon, policymakers are reluctant to admit that a problem exists unless they already have a viable solution in place—for a problem without such a solution is a dangerous and embarrassing political situation. As such, when policymakers define the drug policy problem, they do so in a way which ensures that their solution not only exists, but will be the most effective of all possible alternatives. Along the same lines, Wildavsky (1979) continues the argument a bit further by suggesting that a problem is actually a situation for which a solution already exists.

The result of this behavior, according to Rochefort and Cobb (1994), is problem ownership. This process occurs when a particular group of dominant policy actors, become the accepted authority for information and values concerning a problem's causes, consequences, and solutions. Another conceptualization of this process are *policy monopolies*, which are groups of governmental and professional actors who form a policy subsystem that basically determines the way a problem is defined and how it should be solved (Sabatier & Jenkins-Smith, 1999). Essentially, this dominance of problem definition is what determines the solutions used to solve policy problems. These policy monopolies which are used to secure the interests of problem-defining actors are crucial in making sure that a problem is seen and understood to be one of a particular subsystem's domain.

Important to the understanding of policy monopolies however is that they do lose their dominance over certain policy domains. Explaining this phenomenon, Baumgartner and Jones (1993) examine the nuclear power policy domain to show how the definition of a problem—that

was originally defined by members of one policy monopoly—changed once it became observed and defined by members from another policy monopoly.

According to Baumgartner and Jones, policy *images* are the way in which a certain issue is discussed and understood. Policy *venues* on the other hand are the institutions or groups in government and society that make decisions regarding certain issues. In the case of nuclear power, the image of this policy was that it was good for America in terms of providing efficient sources of power. The venue from the 1940s to 1970s was naturally that of the energy production domain. Eventually in the 1980s however, the image of nuclear power began to degrade. As concerns for public safety grew, nuclear power issues gradually became discussed in a public health venue, and not in the energy production venue.

Of course, sometimes the image of a certain issue can change sharply when a critical incident occurs. A prime example in nuclear energy is Three-Mile Island in New York. As the image of nuclear energy was already on the decline, a major disaster in the industry caused the tone of the image to shift dramatically. Such occurrences end up having a significant impact on how an issue is viewed. The incident at Three-Mile Island significantly pushed nuclear energy towards the health and environmental venues. In summary, certain issues can not only be examined in multiple venues, but can eventually be switched from one venue to another, depending on the policy image and the rate at which it changes.

Adapting this model to explain drug policy subsystems, Baumgartner and Jones note that one more factor must be taken into consideration. To begin, drugs are a *valence* issue, which essentially means that it is generally agreed by everyone that the existing condition is a problem. However where conflict occurs is in arriving at solutions to this problem. For example, prior to the 1972 election, Nixon officials declared that education and treatment were needed to solve

this problem. Immediately after his victory, the issue was referred back to bureaucrats who proposed changes in the pre-election solutions to the drug problem. By the time the Reagan and Bush administrations came around, government officials were implementing strict law enforcement initiatives to solve the problem of drug abuse (Marion, 1994).

According to Baumgartner and Jones, valence issues are tempting issues for politicians to discuss, but they are not easy problems to solve. In fact, valence issues allow politicians to run against the problem rather than support a specific solution. Although these issues are able to gain wide public and government attention, once a solution is in place, the issue is left in the hands of professionals who for a long time have already dominated the official thinking about the policy responses to such problems. Therefore, in terms of policy image and venue, it seems as if there are certain images of the drug problem that keep it in certain venues as opposed to others.

2.4.1 Applying Bureaucratic Policy Theory to Drug Policy

Illustrating the usefulness of this approach to the analysis of policy formation, several drug policy scholars have also arrived at the very same descriptions of the policy process. According to Meier (2002), bureaucratic agencies are responsible for the implementation of a policy. They also become major players in the formation of drug policy not only because of their experiences at the implementation stage, but because they are experts in that domain whereas politicians are not. During the formulation of a policy, bureaucrats influence political actors to define the drug problem as one that involves them as a solution. This often guarantees them exclusive ownership of that policy domain.

As scholars have found in countries with health-dominated national strategies, medical professionals and social workers have worked together to convince lawmakers that drug use is a medical and social problem that requires government assistance, not punishment (MacCoun &

Reuter, 2002). Likewise, in countries with prohibitionist national strategies, law enforcement agencies continually convince political leaders of the linkage between crime and drugs so that they will remain the primary venue responsible for addressing the drug problem (Cripps, 1997). The outcome of two different groups trying to define the same policy problem is essentially competition among bureaucratic actors responsible for serving the same public.

According to Breton and Wintrobe (1994), this process of *entrepreneurial competition* occurs all through the drug policy process. Essentially, bureaucrats pursue their subjective goals by selectively seeking and implementing policy innovations that make their outcome on drug use the preferred solution. By competing to generate demand of one's own services, bureaucrats engage in lobbying, policy manipulation, and the selective release of information to specific policy audiences responsible for the final decision.

Illustrating this behavior, Schechter (2002) found that in one separate incident, politicians in the United States knowingly and extensively distorted the results of a major study of needle exchange programs in Canada. This incident was enough to place a serious halt to any form of funding that may go to potential needle exchange studies in the United States. Offering another illustration, Bertram et al. (1996) argue that the biggest obstacle to treatment and prevention programs in the United States is a lack of public support. They add that since legitimate authorities such as politicians and law enforcement officials continue to label drug users not as 'sick persons' but as 'criminals', it is almost impossible to gain enough support from law-abiding citizenry.

Perhaps one of the most obvious illustrations of bureaucratic competition for a monopoly over drug policy is that in the last few decades of drug liberalization, several policy actors have acted not only in support of furthering their role in the drug problem, but have become defensive

against any types of reform that may jeopardize their monopoly on the issue. According to Isralowitz (2002), in many prohibitionist countries like the United States, law enforcement bureaucrats resist any movements toward decriminalization and legalization because they want to maintain their power over the share of resources allocated to the drug problem.

In other studies, Meier (1992) found that within the United States, individuals who seek to modify the predominant law enforcement approach to drug use are taking a major political risk because law enforcement advocates may label them as 'soft on crime'. In light of the reputed linkage between drugs and crime that exists in American politics, this is very detrimental to one's political and even bureaucratic capital.

In the event that one group of drug policy actors dominates the other, the careers of the former are often secured. According to Leuw and Haen-Marshall (1994), political and bureaucratic careers are made through the drug policy subsystem. In essence, the popularity of politicians is boosted when they can champion non-controversial and gratuitous policy platforms at election time. The result is a sector of the bureaucracy that gains from enhanced funding to 'fight the drug war'. Parallel to this process, drug policy also helps simplify and neutralize the structural and cultural strains in society. Common cleavages such as marginality, deprivation, alienation and ethnic tensions can conveniently be attributed to the evil drug problem. This again, creates support for one drug policy venue over another.

In all, these studies demonstrate that bureaucrats and other policy actors compete to shape what Baumgartner and Jones describe as the *image* of drug policy. Consequently, this determines the drug policy *venue* in which a country's drug strategy is formulated. If certain sectors of the bureaucracy do maintain a monopoly over the drug policy domain, it is to their benefit to continue defining the drug problem in a way that makes their services the only viable solution.

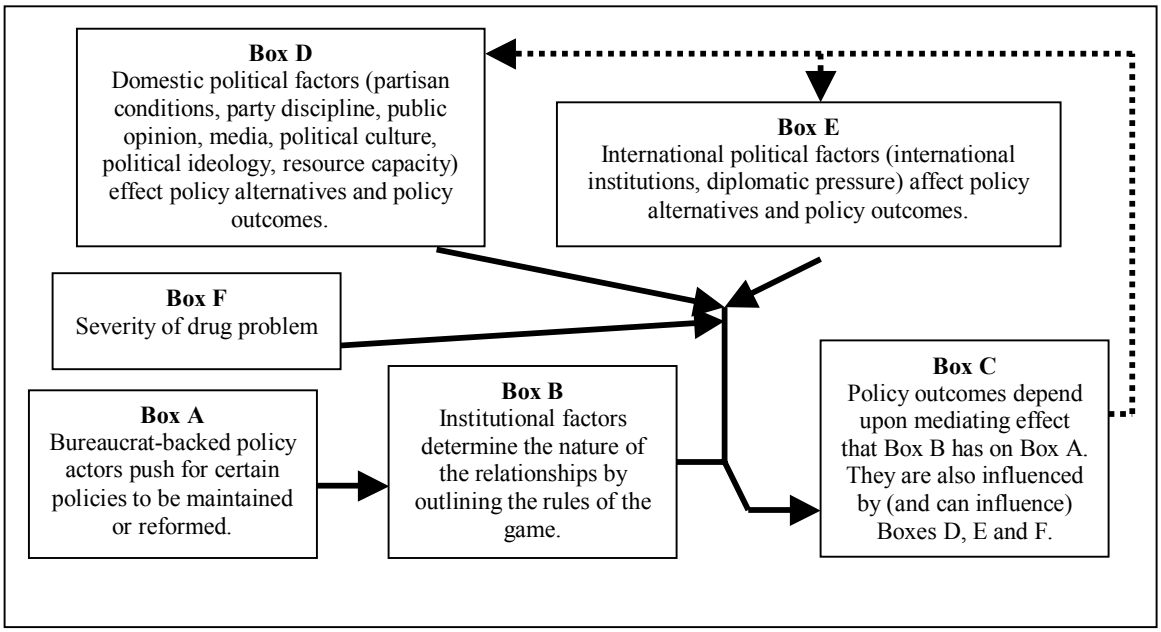
Essentially, this process explains why some countries equip their drug bureaucrats with handcuffs and other countries equip their drug bureaucrats with stethoscopes.

2.5 The Tested Argument

The general argument tested throughout this research is that institutional structures create policymaking environments that are favorable for an issue to be addressed in one venue over the other, or collaboratively in both. Interacting with these effects are the strengths of bureaucrats to shape drug policy outcomes—mainly by defining the drug problem in ways that fit their preferred solutions. Often combined with these interactions are domestic and international political factors that tend to have a considerable impact on the final decisions of policymakers. The series of brief case studies provided in the next chapter offers a glimpse at some of these dynamics that are tested in this research.

While the following case studies do not completely describe the way institutions and bureaucratic dominance affect drug policy, they do offer some guidance for the qualitative and quantitative portions which follow the case study. Perhaps the most important finding revealed in Chapter 3 is that even in case studies of only four countries, cooperative and competitive institutional structures appear to have an affect on public policy. Figure 2.2 illustrates the different dynamics of drug policy. Although other factors may affect drug policy (see boxes D, E, F), this research concerns those dynamics within and between boxes A, B, and C of Figure 2.2.

Figure 2.2
The Dynamics of the Drug Policy Process



CHAPTER THREE

3.0 CASE STUDIES

Recall that the purpose of this research is to explain variation in drug policy across different democracies. One argument made in this research is that bureaucrats are the main policy actors who politicians turn to when they require decision-making advice. The desire for bureaucrats to maintain their role in the policy process often conditions them to define policy problems in ways that make their outputs the desired solution. As such, the way an image is framed determines the drug policy venue which is able to dominate the problem definition stage.

The other argument made in this research is that political institutions mediate the effect that bureaucrats have on drug policy. Some institutional structures foster a cooperative policymaking environment that allows for alternatives to the status quo to be considered. In such environments, bureaucrats from different drug policy venues are able to access decision makers and convince them of the utility in defining the drug problem their way. Other institutional structures create a competitive policymaking environment which makes it hard for non-status quo venues to reframe the image of the drug problem. When this occurs, it is very difficult for bureaucrats outside of the status quo—which is usually law enforcement—to have an impact on the decisions of policymakers.

Helpful in studying drug policy at the cross-national level is the realization that there is often a tenuous relationship between a nation's policy rhetoric, its formal drug policies, and the actual implementation of those policies (MacCoun, et al., 1995). While it would be easiest to ignore policy rhetoric and focus on formal policies encoded in law, even formal policies have symbolic influences that transcend the intensity of their implementation. As such, the result is

communication of moral statements that influence authorities and the compliance of bureaucrats to these demands (MacCoun & Reuter, 2002). The current research strives to acknowledge this realization by focusing on the actual drug policies that are implemented rather than the rhetoric that accompany them.

Keeping these observations in mind, the following section attempts to illustrate how institutional design has allowed for law enforcement venues to remain dominant in some nations, while they have been, or may be, overpowered by harm reduction, education-based prevention, and substitution treatment venues in other nations. For each case study, the corresponding subsections begin with a brief look at the institutional structures that have allowed for certain drug policy venues to dominate over others (see Table 3.1). These are followed by descriptions of the resulting drug policy implementations. This series of case studies begins with a country that has perhaps the most competitive policymaking environment of all four countries examined in this research.

Table 3.1
Institutional Structures of Case Countries

Institutional Structure	USA	CAN	AUS	NETH
Electoral Design	Single Mem.	Single Mem.	Proportional	Proportional
Political Bargaining	Pluralist	Pluralist	Corporatist	Corporatist
Intergovernmental Relations	Federalist	Federalist	Federalist	Unitary
Cameralism	Bicameral	Bicameral	Bicameral	Bicameral
Executive Type	Presidential	Parliament	Parliament	Parliament

3.1 United States

The research I have conducted on the United States informs readers of the dominance that the law enforcement venue has enjoyed over the past 40 years. Attempts of reforming the status quo are often stymied by various factors within America's competitive political environment. In

the respective order, all of these factors can be attributed to presidentialism, bicameralism, and majoritarian elections; federalism; and pluralism.

The first of these factors is the politicization of the drug issue. Any policy actor, who attempts to reframe the drug issue as anything except one of crime, faces severe political backlash. Mentioning alternatives to the long-standing emphasis on prevention and law enforcement brings few votes to politicians or camaraderie from fellow political actors. Even bureaucrats who mention the utility of harm reduction and some forms of treatment soon find that proposals of change are not received well on any decision-maker's desk.

Another factor is that the law enforcement bureaucracy is organized nationally, sub-nationally, and locally. With policymakers from all levels of government turning to police officers to define for them the drug problem, it is difficult for bureaucrats from the treatment and harm reduction venues to have any influence. Though the health venue in the United States is organized nationally, the decentralized and private health care delivery system rarely coalesces around national matters that may or may not fall into their jurisdiction (ie: addictions).

The last factor I cover in this research regards competition between competing interests. Not only is the status quo reinforced by political and bureaucratic actors in American drug policy, but many interest groups, religious associations, and non-profit organizations fight for the attention of government so that the status quo is retained. Despite valiant efforts of many outside actors, treatment and to a much lesser extent harm reduction, are rarely put on the government's agenda.

Despite the obstacles to treatment and harm reduction, actors within these venues have achieved small amounts of success over the years. In the treatment venue, bureaucrats within the Substance Abuse and Mental Health Services administration have acquired an enormous amount

of federal funds that they distribute to the states so that they can provide treatment services to users. Less successful, harm reduction has managed to make some in-roads in a few states; however Congress has made it clear that no federal funding shall be spent on instruments provided through this venue. The most recent successes of harm reduction actors have been through judicial decisions handed down in the state court system. Other triumphs are local initiatives that are funded through state and municipal governments, or philanthropists (Drug Policy Alliance, 2007).

Institutions

As mentioned, the policymaking environment in the United States can be characterized as relatively conflict-ridden and status quo-friendly. It has several institutional structures that have allowed for the dominance of the law enforcement venue to persist. First, conditions of pluralism often make it difficult for efficient policymaking, particularly if one venue of a two-sided issue has a strong legacy in that policy area.

In his research on policy subsystems, Smith (1993) finds that open policy networks that characterize extremely pluralist political systems like the United States, are considerably more conflict-ridden than the closed policy communities of corporatist-type states. In pluralist environments, political actors tend to see the problem in the way that the most dominant group sees the problem. The group that eventually gets to define the problem in a way that leads to the adoption of their solution is often very organized and has considerable access to policymakers. In the United States, that group happens to be the law enforcement venue and various supporters of prohibition. In short, the legacy of the law enforcement venue in the drug policy domain makes it very easy for punitive proponents to dominate over alternative strategies to addressing the drug problem (Bertram et. al, 1996).

Another institutional factor that has allowed for law enforcement dominance is the majoritarian design of America's electoral system. In the United States, majority elections have entrenched a weak pair of political parties. In efforts to win votes, political actors in America are forced not only to remain vague in their policy statements, but even more so, refrain from violating the status quo. Because of this, the alleged linkage between crime and drugs in America has prevented an examination of the harm reduction strategy (Nadelman, 2004). Any and all proposals that deviate from the law enforcement paradigm in America are met with fierce opposition. This is largely because of America's dichotomous political ideology that is fostered by the single member district voting system.

The third institutional structure that has allowed for law enforcement dominance in the United States is federalism. Strong separation of state and national policy jurisdiction over areas such as education, healthcare, and social welfare, have forced harm reduction advocates to develop their instruments largely at the state and municipal level (MacCoun & Reuter, 2001). In contrast, law enforcement professionals in the United States have been able to overcome the federalist division of government services for two reasons.

First, there are a variety of government agencies at the federal level that allocates all or at least some portion of their efforts to illicit drug control: Drug Enforcement Administration; Federal Bureau of Investigation; Immigration and Naturalization Service; U.S. Marshals Service; Bureau of Alcohol Tobacco, and Firearms; U.S. Customs Service; Internal Revenue Service; U.S. Coast Guard; Air Force; Army; Navy; and the Postal Inspection Service (Abadinsky, 2004). All of these efforts combined clearly elevate the law enforcement venue to paradigmatic status in the drug policy domain.

The second way criminal justice agencies in the United States have been able to overcome the obstacle of federalism is that although semi-autonomous from one another, local and state law enforcement authorities have been organized nationally. Whether symbolic or practical, several initiatives to fight crime by both Congress and the Executive have poured substantial funding into local and state agencies (Marion, 1994). The purpose of this funding is to unite law enforcement professionals in the fight against drugs and crime (Cole & Gertz, 1998). Quite often, federal sharing of seized assets with state and local police makes the latter more inclined to follow federal objectives than listen and react to local preferences. Consequently, such efforts have allowed law enforcement actors to overcome the decentralization of government in America. Other drug policy actors have not been able to overcome this obstacle as successfully.

Another institutional factor effecting drug policy in America is regime type. America's presidential executive often allows for drug policy—particularly those drug policies originating in the White House—to become a very political matter. Managing the topic area for the President is the Office of National Drug Control Policy and its Drug Czar. The role of the czar is to coordinate the different actors involved in the drug policy process. However having a small resource base limits the ONDCP to being a token leader of drug policy with very little power. In contrast, those with the actual power of legislation and spending (Congress) are the ones that get little recognition of handling the matter. The result is conflict and competition that occurs between the two institutions, even within party lines (Committee on Government Reform, 2006).

The final institutional structure—also competitive in nature—is America's bicameral legislature. Comparative research (Tsebelis & Money, 1997) has shown that competition between chambers of bicameral legislatures help maintain the status quo. These findings are very

representative of the relations within the U.S. Congress. Political competition between the Senate and House in the United States can be very harsh, especially because each chamber's terms are staggered. As the interviews conducted during the qualitative portion of this research reveal, drug policy objectives are different between the House, Senate, and even the President.

Perhaps the best summary of America's political institutions and its policymaking is offered in John Kingdon's *America the Unusual*: "As Americans became accustomed to arrangements like the separation of powers, bicameralism, and federalism, they came to expect rather little of government in comparison with citizens of other countries…After all, the founders had deliberately constructed these governmental institutions so that they wouldn't work smoothly"(p.54).

Image Framing

The consequence of political institutions on policymaking in the United States makes adherence to the status quo more likely than the broad acceptance of its alternatives. In order for drug policy actors to succeed in placing harm reduction and treatment higher on the political agenda, they need to reframe the country's image of the drug problem. However the politicization of this issue combined with the strong dominance of the law enforcement venue make changes to the image of drug use very difficult. Consequently America has retained its crime definition of the drug policy, which firmly plants the drug issue in the law enforcement venue—and to a lesser extent prevention.

3.1.1 American Drug Policy

On the account that pluralism, single member districts, federalism, bicameralism, and a presidential executive have benefited the law enforcement venue in the United States, it has been able to maintain its dominance over drug policy decision making. Several major sources of this

dominance have been legislation passed in Congress. The Harrison Act of 1914 was a major development in the direction of law enforcement. Years later, legislation such as the Boggs Act of 1951, the Narcotic Control Act of 1956, and the Controlled Substances Act of 1970 have continually reinforced the role of criminal justice agents in the fight against drugs (Belenko, 2000).

American Law Enforcement Venue

Turning toward the actual law enforcement bureaucracy, a steady growth of the agencies involved in the process has also contributed to the dominance of the law enforcement venue. According to Bertram et al. (1996), the law enforcement venue in the United States has grown considerably in the last century. A contributing factor to this growth is the dedication of law enforcement officials and politicians to America's 'War on Drugs'. Fueled by the rhetoric of politicians, criminal justice leaders have continually re-structured and expanded their agencies to attract government funding set aside to fight the war. As law enforcement agencies continue to expand, their ability to organize, offer expert advice, and monopolize the drug policy process increases considerably.

Another important factor of law enforcement growth is the element of civil asset forfeiture. Thanks to both civil and criminal forfeiture statutes at both the state and federal level, police agencies can seize a variety of contraband and proceeds from persons charged with drug offenses. Aside from drugs and paraphernalia used as evidence against accused persons, law enforcement agents in the United States can seize all related assets to the accused person's drug activity (money, vehicles, homes, aircraft, vessels, boats, real estate, stock, etc.) (Abadinsky, 2004).

When these seizures are made, all items become property of the police agency/agencies responsible for the arrest. According to Rasmussen and Benson (1994), asset forfeiture laws in the United States allow law enforcement agencies to generate revenues that are not limited by interbureaucratic competition for resources. This in turn fosters much more coordination and cooperation between law enforcement agencies not just to fight the drug war, but to develop a very strong and unitary venue that is more able to dominate the drug policymaking process in competitive policymaking environments.

Although the dominance of the law enforcement venue in America is well-documented (Coulter, 2004), other approaches to the drug problem are utilized in the U.S. Similar to even the harm reduction countries in this study, the United States does have a strong history of treatment and prevention measures. For the most part, treatment and prevention programs are funded federally and administered by community-based groups through state governments. Many developments, particularly in the treatment venue, have also occurred in the private sector.

American Prevention Venue

Moving to the prevention venue, the United States has a moderate deterrence-based approach to prevention. One of the most common forms of prevention in the United States is mass media campaigning. Both federal and state dollars have been spent on commercials that either directly describe the harms of drug use or provide graphic analogies (ex: in the 1980s an egg frying in a pan was meant to symbolize the effect that drugs had on the human brain). More recent campaign efforts are more fact-based and targeted to at-risk groups (youth, low-income families). Launched in 2005, Above the Influence features a series of television, print, and web-based interactive advertisements that take advantage of the thrill teens acquire when they resist negative influences (Above the Influence, 2007).

Other prevention tactics America relies on are student drug testing and workplace drug testing. The former are paid for with federal grants but administered by local school districts that choose to implement them. School drug testing programs are based on the notion that a drug free lifestyle requires providing youth with disincentives to using drugs. Within participating schools, random students are pulled from classrooms and asked to provide a urine sample. Those who test positive for drug use are no longer allowed to participate in school programs. Treatment services and counseling are offered to those who test positive. Testing cannot result in referral to law enforcement agencies or adversely affect the student's involvement in academic endeavors. The purpose of the program is to provide youth with an excuse to say no to drugs (The White House, 2006).

While the Bush Administration supports school drug testing, others are not so supportive. Critics (Kern et. al., 2006) argue that school based testing not only discourages students from joining extra-curricular activities, but if caught, they are socially embarrassed amongst their peers. Such an experience may lead to less of a commitment to school and more involvement with drugs.

Whereas school drug testing is paid for with government funds, workplace testing is primarily financed by employers. The federal government does however provide considerable information to employers—including training—on how to manage a Comprehensive Drug-Free Workplace Program. These services are provided by the Division of Workplace Programs within the Department of Health and Human Services Substance Abuse and Mental Health Services Administration (Division of Workplace Programs, 2007).

Other prevention services used in the United States include drug education within schools. Generally there are two ways. The first is through the actual curriculum from

kindergarten to grade 12. The Department of Education provides resource guides to educators who are teaching students about drug use (Department of Education, 2007). The other way is through a program called Drug Abuse Resistance Education. Otherwise known as D.A.R.E., this program brings police officers into the schools to talk to youth about the dangers of drugs. Private, non-profit, local, state, and federal funds are used to support this program (D.A.R.E., 2007).

Including the drug prevention options mentioned in this work, as well as those not fully described (faith-based initiatives, community-based projects) in this work, there are a high number of prevention programs available in the United States. To coordinate this large network, the federal government created the Office of Substance Abuse Prevention in 1986. In 1992 this agency was transformed into the Center for Substance Abuse Prevention (CSAP) which falls under the responsibility of the Substance Abuse and Mental Health Services Administration. The primary role of CSAP is to provide grants to various states and communities to create an effective prevention infrastructure. In 2004 the Executive branch of government introduced the Drug Free Communities program which provides grants of up to $100,000 to community coalitions that mobilize their community to prevent drug use among youth (CSAP, 2007).

Overall, the prevention venue in the United States is enormous. The vastness of this venue may very well make it difficult for prevention workers to come together and deal with the tradeoff between deterrence-based prevention and education-based prevention. So far, the former of the two seems to be attracting more government support than the latter.

American Treatment Venue

In the many cases where prevention does not work properly, treatment programs have been created to address the drug problem. A long history of changes in the practices of

addictions professionals has led to a unique treatment history. Dating back to the mid 19th century, pharmaceutical companies developed medicines that were used to relieve addiction. Over time, many of these turned out to hold addictive properties themselves (Musto, 1973). In place of these traditional approaches, there occurred a rapid development of psychological treatment programs in the 1960s. Unfortunately, as some observers report (De Leon, 1995), such programs became high threshold and limited to those with severe but manageable withdrawal risk, and who were in need of medical monitoring.

To help increase the quality and level of services offered to Americans, Congress developed several organizations to tackle the problem of drug use. In the 1970s, the National Institute of Drug Abuse was designed to monitor the amount and location of drug use throughout the country. Two decades later the Office of National Drug Control Policy was created to develop a national drug control strategy and coordinate the nation's effort. At that time the Substance Abuse and Mental Health Administration was developed within the Department of Health and Human Services to coordinate the delivery of funds to state and community-based treatment providers (CSAT, 2007).

Within this massive bureaucratic structure two agencies were developed that serve as the main entities of prevention and treatment in the United States. The Center for Substance Abuse Treatment promotes the quality and availability of community-based groups to improve and expand existing treatment services. The Center for Substance Abuse Prevention was created to improve the accessibility and quality of substance abuse prevention services. Both do so through the Substance Abuse Prevention and Treatment Block Grant program (CSAT, 2007).

Through this federal grant program, combined with both state and private contributions, treatment organizations are able to provide a variety of services to drug users. These include

substitution-based treatment using buprenorphine, naltrexone, and/or methadone; and abstinence-based treatment including outpatient treatment, self-help groups, twelve-step groups, partial hospitalization, long-term residential therapeutic communities (Inciardi & McElrath, 1995; The Partnership for a Drug-Free America, 2007). All of these services are provided by 11,000 different treatment agencies. This vast amount of treatment agencies, centers, organizations, and clinics makes up a very large and complex network of treatment professionals.

To help addictions professionals overcome the fragmentation of their profession, the Substance Abuse and Mental Health Services Administration engineered Partners for Recovery. This program provides technical resources to those who deliver services for the prevention and treatment of substance abuse. The aim is to provide a method of communication between all providers that enables them to improve services and systems of care. To help addicts and their families find a proper treatment, the U.S. government has set up several locater programs to help connect addicts to professionals: Mental Health Services Locator and the Substance Abuse Treatment Facility Locator (SAMHSA, 2007).

Despite the services of Partners of Recovery, or even the non-government services provided by organizations like Partnership for a Drug-Free America, there is considerable fragmentation within the treatment profession. This has a tendency to serve as an obstacle to the treatment venue when it has to compete with the other drug policy venues, namely law enforcement.

Perhaps even more frustrating for treatment professionals than their fragmented network is that the admissions policies of many treatment programs in the United States depend largely on financial status of the addict and their family rather than on matching patient needs and program resources (Abadinsky, 2004). Such admissions policies may help explain why only 25%

of 5 million Americans in need of drug treatment are actually receiving the help they need (National Association for Public Health Policy, 1999). Realizing the problem of these statistics, President Bush II recently introduced the Access to Recovery initiative which provides vouchers to clients so that they can afford treatment services[9].

Although drug addicts seem to have an array of treatment options to choose from, many of these instruments are still driven by the goal of abstinence. Problematic of this to harm reduction advocates, is that they do not protect users, their families, and society from drug use when these treatment programs fail or are not available (Nadelman, 2004). Organizing to try and control the damage caused by this problem, several harm reduction proponents have provided some services to drug users in the United States.

American Harm Reduction Venue

One of the longest running harm reduction services in America is needle exchange. Since the early 1980s community-based groups have provided clean needles to intravenous drug users to help minimize their chances of becoming infected with HIV or other blood pathogens. Nearly 200 needle exchange programs throughout 38 states provide such services to drug users. Countless academic and government research has shown that they are reducing the levels of HIV and Hepatitis C among America's intravenous drug users (Harm Reduction Coalition, 2007). Despite the success of America's needle exchange programs, federal laws prohibit harm reduction service providers from using federal dollars to support any type of needle exchange programs. As a result, most funding either comes from state or local governments, as well as private donors or non-profit grantors such as the North American Syringe Exchange Network (NASEN, 2007).

[9] Evaluations on the effectiveness of this initiative could not be found during the preparation of this project.

A lesser known yet very innovative harm reduction service in America is provided by an organization known as DanceSafe. With 14 chapters in United States and one in Calgary, DanceSafe provides on-site pill testing to recreational drug users at raves, night clubs, and parties since 1998. A non-profit organization run solely on donations, DanceSafe volunteers set up booths outside of dance events with testing equipment. The volunteers take a sample from the pill then give the pill back to the user. Once the user receives the pill they run tests to determine if the contents of the pill were exactly what the drug user thought they were. Quite often DanceSafe volunteers will detect chemicals that resemble ecstasy or other rave drugs, but are not actually rave drugs. They then share this information with the user and it is up to them to decide whether they want to ingest the pill or not (DanceSafe, 2007).

In an article describing the services provided by DanceSafe, Reed (2007) finds that DanceSafe offers a much needed harm reduction alternative to the government's abstinence-based prevention programming. While the harms of drug use are never completely gone, users who have their pills checked by DanceSafe are less likely to ingest a contaminated drug that may hurt them severely. While federal justice officials refuse to acknowledge the existence of DanceSafe, local law enforcement is quite cooperative.

The organization (DanceSafe, 2007) reports that "in every city where DanceSafe has tested pills onsite, we have had the support of the local police. The officers present have granted users amnesty, agreeing not to arrest them for utilizing our testing services. Similar amnesty has been given to needle exchange programs, addiction treatment centers and emergency room staff treating overdose victims. If the police started arresting users who sought out these health services, they would no longer be utilized, and more people would die"(p.2).

While some efforts have been made to provide harm reduction services to drug users in America, some say they are not enough. One group that feels this way is the National Association for Public Health Policy (1999). In an article published in their own journal, the Association offered several policy recommendations that will move the drug problem in America from the criminal justice venue to the public health venue. Some of these recommendations include a redistribution of federal drug control funds to prevention, treatment, and research; methadone treatment and heroin maintenance to all heroin addicts seeking such treatment; needle exchange programs in every community with intravenous drug use; a federal reclassification of marijuana so that it can be used medically; an expansion of federal financial support beyond abstinence only models of prevention; drug education programs and media campaigns that minimize the use of scare tactics; curtailment of foreign interdiction, for blaming other countries for America's drug addiction is inappropriate; and reconsideration of drug laws to reduce the harm of current policies (pp.277-278).

Since the time of these recommendations, movement has been made on a few of these initiatives. However, their scope is limited to within the states that have made such reform efforts. The reluctance of federal policymakers to review the law enforcement status quo in the United States makes it quite difficult for the harm reduction venue to develop and expand its services to the country's drug users.

American Summary

In close, the United States' drug control network is largely dominated by the very law enforcement actors that define the drug problem. Although the treatment venue is gaining some considerable support, it is very centrist, and not towards the direction of harm reduction. Skeptics (Bertram et al., 1996) argue that the development of a strong harm reduction venue in the United

States would be very difficult. If it were to occur however, some argue that a major change in public opinion towards drugs and drug users would need to occur (MacCoun & Reuter, 2001). Others take a more theoretical approach and suggest that any movement towards harm reduction in America would have to happen incrementally or through one enormous paradigmatic shift (Coulter, 2004).

Both of these options require the image of drugs to be changed from one of crime to one of illness. When this occurs, the issue can be framed in a way that necessitates an increased role of bureaucrats from the public health sector. Both of these options would also require at least some acquiescence of actors in the law enforcement venue as well as a considerable strengthening of the harm reduction and/or treatment venues. This research predicts that such conditions for a dramatic change are very unlikely.

As such, perhaps the only way for an alternative venue to gain some strength in defining America's drug problem is incrementally. While the main argument of this research suggests that there are certain features of a pluralist, federalist, majoritarian political system that make it difficult for the treatment and harm reduction venue to gain strength, this does not rule out the possibility of this event occurring.

Although this research hypothesizes that federalism helps to maintain the status quo by fragmenting the drug policy network, the anti-hypothesis may explain the only possibility of drug reform in America. That is that drug reform efforts—particularly those in the area of harm reduction—are occurring more and more at the state and local level. If harm reduction advocates can build enough momentum for change, they could see reform at the national level.

A unique finding that is discussed in multiple sections of this research is the relationship between the treatment and harm reduction venues. In the three other countries examined in this

research there is a strong relationship between these two venues. In fact, actors from each venue have often worked together to redefine the drug problem and make reforms they felt were necessary. In practice, it is often harm reduction professionals who stabilize users enough that they make the personal decision to seek help from treatment providers.

In the United States however, there seems to be animosity between the two—especially between abstinence-based treatment professionals and harm reduction service providers. While it is difficult to measure the origin and strength of this contentious relationship, the fact that America's drug policy is driven by abstinence-focused law enforcement and prevention actors may explain some of this hostility. In laymen's terms, perhaps the buy-in for treatment actors is to dissociate themselves from harm reduction—whose goals are incompatible with those in law enforcement and prevention.

3.2 Canada

The case study on Canada's approach to the drug problem reveals many of the same obstacles to reform that exist in the United States. A long history of dominance by criminal justice actors combined with some, but less politicization of the drug issue, has undermined many of the reforms proposed by other drug policy actors. The difference between the United States and Canada is that in the latter, some of these reform efforts have been successful. This case study will focus on three major determinants of this success.

First, Canada's parliamentary regime—particularly during years of a majority liberal government—has enabled the executive to push liberal drug policies through that may not have been achievable under different political and institutional conditions. Strong executive leadership in the Trudeau years opened a few doors. Second, during the 1990s Canada's two-party system gave way to one of multiple parties. During this time, the conservative-liberal stronghold on

parliament was undermined by the election of several members of the New Democratic Party, as well as an introduction of the Reform Party and the Bloc Quebecois to the House of Commons. To some extent, this has had a depressing effect on the politicization of valence issues like addiction. Also, NDP and BQ are traditionally more left-leaning parties than the liberals. The now defunct Reform Party played a big part in splitting the right-wing electorate. As such, in-roads to reform no longer required a strong liberal majority government.

Another major feat in Canadian drug policy is that the health venue has managed to become the lead actor in drug policy. This is in part a function of some of the phenomena described above, and in part of function of the fact that Canada's federalist structure has centralized tendencies in some issue area. Responsible for the coordination of Canada's National Drug Strategy, Health Canada works with actors from treatment, prevention, harm reduction, and law enforcement to deliver a balanced approach to the drug problem. As field interviews will later reveal however, there is some contention over how balanced this approach really is.

Institutions

Generally, Canada has been observed as having a content polity, one that lacks the political strife of other national polities. As Lipset (cited in Metcalfe, 1997:92) describes, part of the explanation for such political tranquility is that Canada is a counterrevolutionary nation devoid of quests for individual liberty and mobilization. The resulting policymaking environment is one that tends to be cooperative despite its many competitive institutional structures. Contrary to these observations however, there are many times in which the Canadian polity is bombarded with divergence. Regionalism, social class, culture, language, and even race are crucial elements of conflict that make policymaking a very difficult process (Archer et. al., 1995).

From an institutional perspective however, perhaps one of the greatest sources of inefficient policymaking is pluralism. According to Wilensky (2002), countries with pluralist bargaining structures seem to be the most inefficient at creating policy, particularly social welfare policy. In Siaroff's (1999) highly regarded examination of political bargaining among rich democracies, Canada was ranked the most pluralist state of 24 countries in the study[10]. Considering this, the argument is made that a large factor of Canada's struggle with altering the law enforcement status quo over the past half century was due to the competitive and very conflicting nature of its pluralist bargaining structure. Elite interviews should reveal how police associations and conservative interest groups push for a punitive drug policy in Canada.

Now although Canada's drug policy has historically been dominated by the law enforcement venue—mainly because of pluralism—there are other institutional structures which have allowed for recent proposals of harm reduction bureaucrats to be considered. As mentioned in the introduction to this section, Canada's parliamentary regime has allowed for harm reduction concerns to be voiced in government; particularly because of the re-entrance of three opposition parties into parliament.

To explain, for nearly fifty years, the Liberal and Conservative parties dominated federal politics. As the Canadian government moved into the 1990s however, things began to change. In fact, as Carty, Cross, and Young (2000) declare, "Canadian party politics collapsed in the 1990s"(p.3). The resulting change was the emergence of the Bloc Québécois and the Reform Party. In addition, there was a resurgence of support for the New Democrat Party—which has strong socialist principles and is supportive of harm reduction approaches to the drug problem.

[10] Canada was followed by Greece, United Kingdom, United States, Bahamas…etc, respectively.

Essentially what Carty, Cross, and Young explain here is that the over-representation of Conservative and Liberal seats in the House of Commons came to an end in the 1990s[11]. This allowed for other parties to have a greater share of seats in Parliament (Archer et al., 1995). As such, the traditional left-right conflict that retained the law enforcement status quo for so many years (similar to the U.S. case), was disintegrated by the stronger presence of a truly multi-party system. The argument of this research is that these changes to party politics forced a more equal—and consequently more logical—approach to the drug policy issues facing Canada. Had it not been for Prime Ministerial fear of a loss of confidence vote in the House, the law enforcement venue may have continued to dominate Canada's drug policy.

As for the third institutional variable, Canada's more centralized federalist system has actually contributed to the advancement of the harm reduction venue. According to Pal and Weaver (2003), federalism in Canada is much different from that in the United States. In the American case, regional interests are expressed directly in national institutions such as the Senate. However in Canada, although the Senate was designed to do the same thing, it lacks considerable credibility as a forum for regional representation. As a result, the role of regional representation has been taken up by the executives of each province. Because there is no constant contact between provincial executive leaders and the national Cabinet—which is backed by a strong and highly disciplined party—the resulting decision-making structure is very centralized.

The consequence for drug policymakers is an administration of social, legal, and economic programs that falls under the authority of the national government. Those programs involved in the drug policy network are Health Canada, RCMP, Corrections Canada, Transport Canada, Revenue Canada, Canada Justice, Canadian Heritage Foundation, and the Department of

[11] Due to Canada's electoral formula, the Liberal and Conservative parties' share of legislative seats have exceeded their share of the popular vote in 11 of 16 elections since 1945.

Foreign Affairs. All of these groups, whether from the harm reduction or law enforcement venue, provide a variety of cooperative services to Canadians affected by illicit drugs (Quigley, 1998).

In summary, while Canada is a federalist democracy, it behaves like a unitary state on many issues pertaining to drug policy. Canada's more centralized governing system encourages the efforts of harm reduction advocates because liberalizers do not have to deal with the barriers of a decentralized governing system. While private, municipal and even state-level harm reduction professionals in the United States struggle to be included at the national level, harm reduction entrepreneurs already hold bureaucratic positions in existing federal organizations. This is seen in Health Canada, which is technically the lead agency responsible for coordinating Canada's response to the drug problem..

Moving to electoral design, Canada's majoritarian representation in Parliament offers some barriers to policy reform in drug control. While Canada's parliamentary executive forces party coalition in a lot of areas, there is still room for polarization in other areas. Historically, Canada's two major parties—the Conservatives and the Liberals—fought for the center vote needed to win in single-member districts. While this has not politicized drug policy to the extent that it has in America, politics definitely plays a part in Canada's drug policy.

The final institutional structure to discuss is Canada's bicameral legislature. Canada's senate was originally intended to be a weaker chamber than the lower house. In the past century its legislative power has steadily eroded (Kornberg & Mishler, 1976). While there are very few power struggles between the House and Senate in any type of policy, there have been some developments in drug policy. In 2002, the Senate Special Committee on Illicit Drugs recommended several liberal reforms that the government should make. While the House did consider some reforms, it tightened up its restrictions on other parts of Canadian drug law.

Image Framing

The paradox of Canada's approach to the drug problem is that while drug use is defined as an illness, the law enforcement venue still plays a major role in drug policy. During the 1960s and 1970s the law enforcement venue was able to define the drug problem as an issue of crime and deviance. However since then, advocates from the harm reduction and treatment venues have managed to foster enough political support to reframe the drug problem as a concern of public health. Perhaps the effort of drug policy actors to maintain law enforcement in the four-pillar approach is the compromise that originally allowed for the alternative policy venues to gain some influence over decision-making on this issue (Riley, 1998). As interview data will later demonstrate, Health Canada may officially have the lead role in Canadian drug policy; however as the field data suggest, there are many people who feel that it is still dominated by enforcement.

3.2.1 Canadian Drug Policy

The historical foundation of Canada's national drug policy is very similar to its counterpart south of the border. Canada's first drug policy was implemented in 1908. Deemed the *Opium Act*, this legislation was a response to the increased and perceived spread of opiate use mainly by Asian immigrants on the west coast. Overtime, policies of a more punitive nature started to characterize Canada's drug laws (Boyd, 1988).

Following the *Opium and Drug Act* of 1911, Canada began to expand its bureaucracy to control the newly developed drug problem. In 1920, the Royal Canadian Mounted Police (hereafter referred to as the RCMP) was founded to enforce federal law. Since it was not uniformly welcomed, the RCMP relied upon rigorous drug enforcement efforts to legitimize its existence (Solomon & Green, 1988).

By the end of the 1920s, under belated influence of the 1912 Hague Opium Convention and pressure from the United States to minimize illicit drug exports from Canada, the Opium and Drug Act was strengthened. In 1929 the Canadian government renamed it the *Opium and Narcotic Drug Act*, reinforced record-keeping procedures, and increased some penalties. This became Canada's main drug policy instrument for the next several decades (Riley, 1998; Solomon & Green, 1988).

During the 1950s, the punitive model of drug policy became increasingly challenged by the emerging medical model of drug addiction (Fischer, 2000). In response, the medical model of drug abuse was crushed by the *Narcotics Control Act* passed in 1961. In part influenced by the Single Convention of Narcotic Drugs international treaty and resentful law enforcement advocates, Canadian policymakers strengthened the prohibition approach to drug policy (Riley, 1998).

While Canadian drug policy sat idle for almost two decades[12], in 1986, just two days after President Reagan declared 'War on Drugs' in the United States, Prime Minister Mulroney surprised Canadians when he announced that, "drug abuse has become an epidemic which undermines our economic as well as our social fabric"(Erickson, 1992:2). Bewildering Canadian drug professionals and researchers who knew that Canada's drug problems had neither worsened nor gone away, Mulroney announced Canada's Drug Strategy. Some researchers (Fischer, 1994) suggest that not only did Mulroney announce this strategy 'coincidentally' right after Reagan announced America's War on Drugs, but he did so at a time when the Progressive Conservative party was dramatically low in the polls and in dire need of public support. This suggests a strong element of drug politicization that derives from single-member districts.

[12] There was some development towards more liberal drug policies during the 1960s and 1970s (ie: Le Dain Commission). However most of these efforts were quashed by strong law enforcement advocates.

As it was introduced, Canada's Drug Strategy was comprised of a balance between harm reduction, treatment, prevention, and law enforcement. The aim of this four-pillar approach was to reduce drug-related harm to individuals and communities, while also minimizing demand and supply for illicit substances (Fischer, 1994). In general, Canada's 1986 Drug Strategy brought new resources to public education, treatment and rehabilitation, law enforcement and research (Giffen, Endicott, & Lambert, 1991).

Over the years this plan has been renewed several times. However, a strong criticism of these renewals is that they have slowly deviated from the original strategy of harm reduction and treatment first, and enforcement second. In fact, after a second renewal in 1997, the balance of funds fell in favor of enforcement bureaucrats, clearly benefiting them more than the harm reduction and harm reduction advocates (Illicit Drugs…, 2001).

As part of so-called 'housekeeping' duties, possibly influenced by the growing concerns for illegitimate punishment of drug users, the Canadian government began to explore alternative drug policies in the 1990s (Fischer, Erickson & Smart, 1996). In May of 1997, Parliament passed the Canadian Drugs and Substances Act (hereafter referred to as CDSA). In all, the CDSA placed Canada again in a position of uncertainty regarding drug control. While there was a push for reform to incorporate a stronger harm reduction approach to drug policy, there remained hesitation on a part of policymakers that inevitably has left Canada in a flux between the two major drug policy venues.

Canadian Law Enforcement Venue

Although elected policymakers struggled with the balance between the four pillars of drug policy, the law enforcement venue played somewhat of an active role in promoting liberal changes to their own operations. In the 1960s and 1970s, professionals in the criminal justice

system began to reevaluate the positions they once held on drug use behavior. Overflowing court rooms and increasing rates of young persons charged with offenses of drug possession tempted police administrators and the courts to consider more discretionary alternatives to drug control. More lenient sentences and even alternative forms of sanctions began to appear in various levels of the Canadian justice system (Giffen, Endicott, & Lambert, 1991).

In the 1980s and 1990s, particularly in larger urban centers, Canadian criminal justice agents began to take a *de facto* approach to enforcing drug laws. Although some policymakers remain rigid on the issue, both prosecutors and judiciaries have softened penalties for minor possession. This tactic not only allows agents in the justice system to devote more energy to other crimes, but it also minimizes the harm which restrictive penalties place upon drug users (Riley, 1998).

In light of these developments, enforcement agencies have appeared to remove themselves from the forefront of the drug policy domain. Instead, they now view themselves in equal partnership with health and education professionals in the attempt to reduce the harms that drugs cause (Health, Education, and Enforcement in Partnership, no date; RCMP, 2002). As such, while current drug legislation may favor the law enforcement venue over the harm reduction venue, the implementation of that strategy is much more balanced between the two venues.

A recent development in the justice system that has helped the treatment venue crawl from underneath the shadows of the law enforcement venue is the drug treatment court. In 1998, Canada opened its first drug treatment court as a pilot project in Toronto. Like treatment courts in other countries, Canada's drug treatment court structure originated from the shared idea of criminal justice professionals that an emphasis on treatment rather than on incarceration will help

address the root causes of some types of criminal behavior (Toronto Drug Treatment Court, 2003).

The success of the first drug treatment court led to a second court that was opened in Vancouver. By 2003 the federal government committed to four new drug treatment courts to be located in Edmonton, Regina, Winnipeg, and Ottawa. According to the Department of Justice Canada (2005), all six drug treatment courts are designed to provide an intensive, court-monitored alternative to incarceration that will eventually break the cycle of dependency so that offenders can become more productive members of society.

As the justice system has been slowly moving towards a treatment-oriented approach to the drug problem, the prevention venue has managed to gain some momentum as well. The reason for this is not so much because advocates within the venue are pushing for advancement, but because the federal government is trying to maintain a balanced approach to the drug problem.

Canadian Prevention Venue

At the head of the prevention venue, Health Canada has "an ongoing public education campaign to inform youth, in a non-judgmental way, about the harmful effects of marihuana, alcohol, and other substances and to encourage healthy decision-making" (Government of Canada, no date). The campaign does not use fear tactics or deterrence mechanisms. Simply the facts are shared with youth and the decision is mainly left up to them.

The approach Canada takes to providing prevention services is similar to the model described by Kumpfler and Baxley (cited in Paglia & Room, 1999). Universal prevention services are provided through school drug education programs, public awareness campaigns, multi-component community initiatives, and various measures to control the availability and

price of substances. Selective prevention services are provided in Canada to help at-risk people develop the coping strategies and other life skills needed to remain drug free. Employment programs, academic tutoring, activity centres, and cultural events are all used to help at-risk Canadians stay clear of substance use. Finally, some people are not addicted to drugs but their substance use has affected their lives. Thus, indicated prevention programs such as outreach, one-on-one counseling, and primary treatment are available (CSSA, 2007c).

As discussed earlier, the prevention venue is not well organized. Generally, Health Canada provides direction and funding for provincial and local health officials to develop prevention programs that meet their local needs. The result is a venue that seems to sit idle among the other three venues in Canadian drug policy.

Canadian Treatment Venue

As mentioned, the treatment venue in Canada has gained some recognition as being one of the most important pillars in Canada's Drug Strategy. The primary responsibility of treatment belongs to the provinces and territories. Health Canada shares the cost of some treatment and rehabilitation programs for specific groups such as youth and women. Generally however, federal funds used for treating other target groups come out of a general fund called the Health and Social Transfer (Government of Canada, no date).

Within Canada, general practitioners can be reimbursed for providing counseling and pharmacological treatments to patients with drug problems. Generally however, most doctors refer their patients to one of the 800 treatment agencies located throughout Canada. While many are community-based, several are located in hospitals or clinics funded by the provincial government. The main types of intervention available in Canada include methadone substitution treatment, detoxification, outpatient care, day patient care, short and long term residential,

outreach, and walk-in services. Within these types of interventions treatment professionals tend to mostly use a biopsychosocial approach; which includes drug education, problem-solving counseling, cognitive and behavioral skills training, motivational enhancement, and 12-step approaches (CSSA, 2007b).

One of Canada's greatest achievements in the treatment venue is the work its addictions professionals have done with addicted prisoners. The Correctional Service of Canada is recognized internationally for the effective programming it has provided to federal offenders. Three internationally-accredited substance abuse programs provide low, moderate, and high intensity treatment services to offenders based on their needs and sentencing (Government of Canada, no date).

Some of the major problems experienced by treatment professionals in Canada are regional disparity in the number and types of treatment available, as well as an increase in the complexity of cases with multiple problems. These conditions cause drug use to be higher especially among aboriginal populations both in the rural and urban setting (CSSA, 1997b). To address these problems, several federal initiatives provided by Health Canada have been designed to assist provinces in offering treatment services that are specific to the needs of youth, women and aboriginals (Government of Canada, no date).

Canadian Harm Reduction Venue

Although the treatment venue does enjoy some strength in Canada, the harm reduction venue has gained some considerable strength—relative its own strength in years past. Canada's harm reduction advocates have steadily been working with both Ottawa and the provincial governments to develop programs to reduce the harms caused by drugs and drug enforcement. Dating back to the 1940s, several attempts were made to provide drug users with what is now

known as methadone treatment. While the first few experiments failed to materialize into anything substantial, they did pave the way for Canada's current methadone program (Fischer, 2000). With Canada's acceptance of the concept of substitution-based treatment, Canadian researchers and some policymakers have actually examined the feasibility of heroin maintenance programs (Brissette, 2001).

The real development of Canada's harm reduction venue came not in substitution-treatment or heroin maintenance innovations, but in safe injection. In 2003, Vancouver opened up North America's first safe injection site. Despite fierce criticism from American policymakers, a community-based organization known as Insite received both federal and provincial funds to deliver a safe, clean, and medically-staffed facility for intravenous drug users to inject their drug of choice (Nilson, 2004). To operate legally, Health Canada granted Insite a three year exemption from Section 56 of the Controlled Drugs and Substances Act. In 2006, the federal government extended this exemption to the end of 2007—during which time no other exemptions would be made for other safe injection facilities in Canada (Vancouver Coastal Health Authority, 2007).

While Canada awaits the decision of the federal government on whether future safe injection sites can be created, syringe exchange programs have continued to grow over the years. Canada's first syringe exchange programs were inspired by the findings of researchers in Edinburgh, Scotland and New York City. Hoping to reduce the threat of AIDS before it grew out of control among Canadian drug users, the Federal government in 1989 funded pilot programs of needle exchange services (Lane, 1993). While it was during the 1980s that Vancouver, Montreal, and Toronto first offered needle exchange programs, many other Canadian cities now offer clean syringes to drug users (Harm Reduction Coalition, 2007). According to the Special Committee

on Non-Medical Use of Drugs (2002:82), up to 200 needle exchange programs may currently exist in Canada.

Another harm reduction innovation designed to protect Canadians from the prosecution by the legal system is the federal government's recent legislation that permits registered sick people to purchase and consume marijuana for medical purposes (OCMA, 2004). In 2001, the House passed a bill that allowed patients, who have tried all other forms of treatment for their illnesses, to legally obtain marijuana from a licensed producer. While some groups—such as the BC Compassion Club—are able to grow and sell marijuana, Health Canada also grows its own. One of the major complaints that surfaced several times was that not only was the government-grown marijuana of poor quality, but it was heavily overpriced. As a result, over 127 of first 278 patients who received their marijuana from Health Canada did not pay for it. Consequently they were cut off (Clarke, 2007).

Canadian Summary

The harm reduction and treatment services offered to drug users in Canada demonstrate that there is movement away from the law enforcement status quo. In contrast to the United States, where treatment is the only direction of movement, Canadian policymakers have recognized the utility of harm reduction by treating it as an equal venue to treatment, prevention, and law enforcement. As this research hopes to show, the cooperation between drug policy actors from different venues may be the result of the collective policymaking environment that is fostered by Canada's parliamentary regime and more centralized federalist government.

The conflict between drug policy actors that has occurred in Canada may also be consequential to the country's pluralist bargaining structure and majoritarian electoral rules. If public health entrepreneurs continue to capitalize on the cooperative mechanisms offered by

Canada's collective institutional structures, the country's drug policy could eventually be completely defined by policy actors outside of the law enforcement venue. Currently however, the long-time dominance of the law enforcement bureaucracy—that benefits from the politicization of the drug issue—still has considerable influence over decisions regarding illicit drugs.

3.3 Austria

Austria offers a very clear contrast to both drug policy and the political institutions found in North America. The case study reveals that harm reduction and treatment bureaucrats have been able to dominate drug policy decisions in Austria. The literature—which is also supported by field interviews—suggests that this dominance does not come by force, but through cooperative examinations of alternatives to law enforcement. While Austria's original drug policy looked a lot like that of Canada and the United States original policies, some changes have occurred.

There are multiple sources for these changes. One has been the effect that proportional representation has had on the relationships political between actors. The partisan cooperation that stems from the need to form a government coalition reduces the politicization of the drug issue. This has allowed for policymakers to consider alternatives to the law enforcement status quo.

Another factor that explains change is the country's political bargaining system. As demonstrated in the literature, and more so in the interviews, is that corporatist political bargaining fosters consensus-style decision-making within government. This provides an opportunity for all actors to voice their position on an issue. The result is that addictions experts and health bureaucrats have been able to convince Austria's political elite and public, of the

utility in both treatment and harm reduction. They were able to do so without interference or resistance of the law enforcement venue.

The final source of Austria's public health approach to the drug problem is the multi-decade tenure of the Social Democrats in parliament. This era allowed for considerable expansion of the Austrian welfare state, including the entrenchment of a new status quo regarding drug policy: *treatment first, punishment second*. After the fall of this regime, a significant electoral dealignment occurred in Austria—one that allowed for the advancement of women in politics, environmentalism, and social development. Since that time, even conservative governments have come out in support of the public health approach to the drug problem.

Institutions

The institutional structures of Austria's political system serve as great comparisons to those in North American political systems. While Austria is similar to Canada in parliamentary design, it is somewhat similar to the United States in terms of government decentralization. In contrast to both Canada and the United States however, Austria's corporatist political bargaining structure serves to mediate some of the policymaking inefficiencies caused by other characteristics of its institutional design.

Beginning with the latter, Austria's *social partnership*—also know as corporatism—has been the driving force behind cooperative social and economic policymaking for most of the 20th Century. According to Pelinka (1998), while corporatism has been used to secure different things for different social and economic groups in Austria, uniformly it represents social peace and domestic stability. In terms of testable hypotheses, this research tries to reveal how corporatism has ensured harm reduction advocates an equal opportunity to influence drug policies in Austria.

When this occurred, experts and bureaucrats from the public health domain were able to shape drug policy in a way that fit the service goals of treatment and harm reduction professionals.

Unfortunately for these venues however, recent changes to the corporatist structure may minimize their role in the future. According to past research (Crepaz, 1995), Austrian corporatism has shielded the government from massive societal change. As such, the actual influence of certain groups has not always been equivalent of their attempts to exert such influence. Growing tired of these consensus-building tactics that often exclude other actors, the Austrian parliament has been reclaiming its function as a true lawmaking body. Corporatist bodies in Austria are finding it difficult not only to match the increasing power of this opposition, but are also finding it difficult to deal with new political issues (Crepaz, 1994).

The implication of this for drug policy is that a weakening of Austria's corporatist political bargaining structure may result in a less than equal representation of drug policy actors. The result is a push towards morality-based drug policies instead of science-based policies. As interviews with key policy actors in Austria reveal, this is very well starting to be the case in drug policy.

Turning towards the proportional representation of the Austrian public, it is believed that drug reformers have benefited from the need for coalition governments to maintain solidarity on contentious issues. Over the past three decades, coalition governments have been forced to put aside their political differences and take the time to consider alternatives that are pragmatic and sensible. Such cooperation has led to a growth in the influence that harm reduction and treatment actors have over drug policy.

One very useful illustration of the extent to which proportional representation limits the politicization of drug policy regards immigrants. In recent years, there has been a growing

distaste for immigrants among homogenous circles in Austria (Eisenbach-Stangil, 2003; Pelinka 1998; Plasser & Ulram, 1999). As evidenced by field interviews, some right-wing politicians have even tried to construct a nexus between immigrants and the drug problem. They fail to dominate the mainstream perception of the drug problem because several coalition members of government believe it is a health problem and not an immigrant problem. As such, the harm reduction and treatment bureaucrats remain the main advisors on issues related to addictions.

Another effect Austria's system of proportional representation has on drug policy is that changes in party alignment may reorganize the priorities of elected officials regarding this issue. Historically, Austria's party system has been stabilized by high voter turnout and density of organization membership (Pelinka & Plasser, 1989). Traditional cleavages that separated voters and their political parties were industrial labor versus enterprise, secularism versus Catholicism, and German versus Austrian nationalism. These various groupings of voters have led Austrian political culture to be described as *pillared* (Powell, 1979).

In the 1980s however, new divisions of the electorate occurred as Austria became more educated, female-friendly, and concerned with new policy issues such as the environment and immigration. The result was a party dealignment that occurred in both minor and major political parties (Plasser & Ulram, 1999). The changes that began to occur in Austrian politics represent to some observers (Ulram, 1989) an end to social approval of government intervention in society via the social-welfare state, but also a major weakening of the law-and-order syndrome that has dominated Austrian policymaking. In years to come, this could either strengthen or undermine the public health approach to drugs in Austria.

The implications of these dynamics to drug policy are central to the arguments made in this research. While Austrian parties are becoming concerned more and more with social

pressures to restructure the welfare-state and curtail strong government intervention, they are being caught in a dilemma between providing services that are diffuse (society) or concentrated (drug users) (Plasser & Ulram, 1999). The basic question is whether government should provide society with protection from drug users (prohibition) or provide drug users with tools to minimize the harms their behavior causes themselves and perhaps society (harm reduction). This case study shows that in recent years, legislators in Austria have actually favored the latter half of this dilemma.

The third institutional structure forces Austria to depart in similarity from the Netherlands, and become more similar to the United States. According to several analyses of the Constitution, federalism in Austria is relatively underdeveloped (Adamovich, Funk, & Holzinger, cited in Pelinka, 1998:65). In fact, constitutionally the nine provinces—or Laender as they're called, have very little jurisdiction over many economic and social matters.

However, according to Pelinka (1998), provinces do enjoy a sort of *de facto* autonomy that has allowed for the creation of 'anti-Vienna' sentiments at the regional level. Observers of this phenomenon (Barth-Scalmani, et al., 1997) indicate that Austria's *de facto* federalism is largely the result of major divides between national and regional identity. In addition, the regional identities of the provinces motivate sub-national leaders to further their own interests, which often require lobbying for more state autonomy.

Despite these informal arrangements, it appears that the federal government has retained considerable control over drug policy. This control stems from two separate intergovernmental arrangements. The first is that all drug law is federal, and while police officers are managed sub-nationally, their actions are ultimately accountable to the federal ministries of Interior and Justice. The second is that while harm reduction, treatment, and prevention programs fall under

the responsibility of sub-national governments, the federal government—via the national drug coordinator within the Ministry of Health—sets firm limits on what sorts of programming can be offered to drug users. It is important to note however, that most innovations in Austrian drug policy started at the Laender level.

Austria's parliamentary regime offers some unique conditions for drug control. While the Chancellor of Austria is head of state, he often acts as chair of the cabinet rather than a chief of cabinet. As for the President of Austria, this role is largely symbolic and any decisions he makes are largely at the suggestion of the Chancellor. The result is a government that is mostly cabinet-run (Muller, 1994). While members of parliament do have some legislative influence, it is only in terms of the direction of policies rather than the content of policies themselves. As interview data will reveal, while individual party speakers lead discussion on this issue in parliament, the Austrian cabinet makes the final decisions on drug policy. This is becoming more so because of international pressures.

At last, the public health approach to drug policy in Austria has been enabled by a smooth relationship between the two chambers in the legislature. Austria's bicameral parliament must pass all bills that become law. The reason that few drug policy proposals have been hung up in the legislature is because the Bundesrat or upper chamber, very rarely vetoes legislation that stems from the lower chamber, also known as the Nationalrat.

This occurs because of three separate but equal factors. First, the Nationalrat has jurisdiction over significantly more issues than the Bundesrat. Second, the Nationalrat can overturn vetoes from the Bundesrat so long as half of its members are present to participate in a reiteration vote; and a majority of those members vote to overturn the veto. Third, parliamentary committees can often contain members of both chambers. Their meetings can include

observation by executive members of the Laender governments. A strong relationship exists between the provincial governments (or diets) and the Bundesrat; for the latter are elected by the legislative bodies of the provinces (Parliamentary Administration, 2000).

Many of these dynamics are also described by data retrieved through interviews with parliamentarians in Austria. Several respondents show that bicameralism does not necessarily have the impeding effect on drug policy that it may have in other countries with more competitive legislative chambers.

Image Framing

The uniqueness of Austria's stymied institutional arrangement has fostered a policymaking environment that has allowed for new actors to redefine the drug problem. The minimal politicization of the drug issue and the entrance of health bureaucrats and experts into consensus-based decision making have afforded actors from the treatment and harm reduction venues an opportunity to reframe the drug issue to be a concern of public health. Long-time social democratic governance and a passive upper chamber have also helped reduce the barriers to defining the drug problem in a way that makes treatment and harm reduction instruments the most practical solution.

As the next section will illustrate, harm reduction and treatment initiatives in Austria are largely carried out at the sub-national level, yet monitored by health bureaucrats at the federal level. While the law enforcement venue is organized sub-nationally, it too is administered nationally. The equal playing field between the different drug policy venues has helped alleviate some of the resistance to reform that affect public health advocates in other federalist countries.

3.3.1 Austrian Drug Policy

In Austria, there is a consensus that drug policy should be focused on *treatment first, punishment second*. While this consensus is highly supported throughout Austria, it did not occur overnight. Long-term political changes gradually forced police and health officials to cooperate on the drug issue and arrive at a consensus that is both effective and supportive of one another's organizational goals. One of these political changes was in the priorities of political factions.

As mentioned, Austrian parties have become concerned more and more with social pressures to restructure the welfare-state and curtail strong government intervention (Ulram, 1989). Consequently, Austria has been caught in a dilemma of whether to provide society with protection from deviant drug users or provide drug users with services to minimize the harms their behavior causes to the health of themselves and society. So far, Austrian policymakers have managed to strike a cooperative balance between the various approaches to the drug problem.

While one is in the works, Austria currently has no official drug strategy. Essentially there exists a collage of sub-national and local policies that are monitored and often financed by the federal government. As such, while Austria is a unitary country, the autonomy that its provinces enjoy, make it behave like a federalist state (Pelinka, 1998).

This *de facto* federalism allows for the sub-national and local governments to develop many criminal justice and public health programs that are aimed at dealing with the drug problem. Seven of the country's nine provinces have developed their own drug strategies. These strategies share many of the same principles. The first is that there must be a balance between the use of health tools aimed at reducing demand for drugs and law enforcement tools aimed at reducing the supply of drugs. The second is that drug use should not be legalized but

decriminalized[13]. Third, drug addiction should be acknowledged as a disease not an immoral life choice. Finally, because the aim of a drug-free society is unrealistic, measures should be taken to reduce the social and bodily harm caused by drug use (ÖBIG, 1999).

Despite the autonomy of sub-national governments to develop drug policy, there are two points of control that the national government has over the lower-level governments. The first is that all drug law is federal, and while police officers are managed sub-nationally, their actions are ultimately accountable to the federal ministries of Interior and Justice. The second is that while prevention, treatment, and harm reduction programs fall under the responsibility of sub-national governments, the federal government—via the *National Drug Coordinator* within the Ministry of Health—sets firm limits on what sorts of programming can be provided to address the drug problem.

In the early 1990s, a federal law was passed that created a formal office of drug policy. Led by an appointee from within the Ministry of Health, the National Drug Coordinator works with respondents from Justice and the Interior to monitor and develop Austrian drug policy. A significant part of this position is to chair the *National Drug Forum*, which is a body made of drug coordinators from each province, representatives from the four political parties, and bureaucrats from the federal ministries of Health, Justice, Interior, Education Science and Culture, Social Security Generations and Consumer Protection, Defense, Agriculture Forestry Environment and Water Management, Transport Innovation and Technology, Foreign Affairs, and Finance. The purpose of the National Drug Forum is to develop and share different initiatives within the law enforcement, prevention, treatment, and harm reduction framework. While the National Drug Forum serves as the federalist element of Austrian drug policy, the agenda of this group is largely controlled by the national drug coordinator (Haas, et al., 2005).

[13] It is important to note that in Austria drug possession is a crime, however drug use is not.

In administering and shaping the country's drug policies, the national drug forum is very critical of a law enforcement-only approach. Many of the members feel that the consequences of being arrested cause undesirable effects (job/family problems) that end up causing more harm to the drug user and their environment than just drug use alone. However they, together with the National Drug Coordinator, recognize the utility and importance of police involvement in drug abuse. The result of this is an approach that depends upon a consensus of what is needed to effectively address the drug problem (Haas et al., 2005).

The drug problem in Austria is somewhat smaller than it is in other countries of Western Europe or North America. Of drug use and drug trafficking, Austria tends to be bothered more so by trafficking. In fact, the U.S. Bureau of International Narcotics and Law Enforcement Affairs (2002) reports Austria to be a major transit point for drugs coming into Western Europe from the East. While it does have more trafficking problems than user problems, the mere presence of the former has lead to more of the latter. The result has led to the development of four approaches to the drug problem in Austria: law enforcement, prevention, treatment, and harm reduction.

Austrian Law Enforcement Venue

On the criminal justice side of the spectrum, law enforcement agencies tend to focus their efforts more on drug traffickers and producers than on individual users. In fact, legislation passed in October of 2001 permanently lifted restraints on police powers to investigate and punish all drug traffickers—but particularly those involved in organized crime (Eisenbach-Stangl, 2003). Despite efforts to focus on drug traffickers, police officers in Austria do encounter drug users.

Different than in other democracies, police officers in Austria are under a *principle of legality* that requires police officers to report and process all offenses they see or investigate—including the smallest amounts of possession. The lack of discretion that police officers have

however does not represent an end to alternative options for drug users. In place of officer discretion is a process where persons charged with possession or persons charged with other offences related to drug use are sent to the municipal health authority. There they must register themselves with a health officer and develop an action plan that suits their condition and that will take them off of drugs and away from crime. They are not charged with an offense, nor is there any lasting record of their involvement with drugs. If after two years they are not reported by the police to have had any other encounters with drugs, their file is destroyed.

On the other hand, if a drug dependent person is charged and convicted with a crime, they are sent to prison. During that time they undergo withdrawal therapy. After one half to two thirds of the sentence, they can be released from prison if they agree to undergo long-term drug treatment outside of the prison. In both cases, drug addicts are allowed to pick any treatment facility and type of treatment they prefer. If they do not have the means to pay for this service, the federal government will provide the funding (Haas, et al., 2005).

Austrian Prevention Venue

Unlike many countries that experience contention surrounding the use of law enforcement, it is in the field of prevention where Austrians actually experience some conflict. Several prevention programs supported by the Ministry of Education were created in the 1980s to teach children about the harms of drug use. These programs were informational and not designed to instill fear of drugs. After considerable pressure from harm reduction and education experts, these programs replaced the fear-driven programs of the 1970s that were designed to scare youth from getting involved with drugs in the first place (Fehervary, 1989). In the past ten years however, some programming designed to scare rather than educate youth about drugs have began to surface. While formal education and unbiased information sharing are still the dominant

forms of prevention in Austria, there is some criticism coming from conservatives who favor the deterrent approach to drug prevention.

Currently, Austria's prevention venue is fragmented across the different local governments and Landers. A variety of programs within the education-based prevention model have been designed for Austrians. Many of them are geared towards youth. 'Becoming Independent' is a health promotion and substance abuse prevention program set up in schools across the country. A traveling exhibition known as 'Have you Got the Hang of Everything?' tries to sensitize youth on the development of addiction and addiction prevention. A type of selective prevention program offered in the Lander of Graz is 'Step by Step'. The general aim of this program is to identify and provide support services to school-aged youth who are at-risk developing drug abuse behavior and the possible psychological, physical and social problems which can occur as a result. Finally, an indicted program to be discussed later in this section is a pill-testing service known as ChEckiT! (EMCDDA, 2007).

Austrian Treatment Venue

In the area of treatment, another conflict has seemed to develop within Austria's drug policy community. In the 1970s substitution treatment became the main method of drug treatment for some addicts. Inspired by similar programs in Switzerland and Germany, Austria's addictions experts lobbied to have the government provide morphine and methadone to hard-core opiate addicts. Stepping into a harm-reduction style of treatment, addictions services agencies came under fire for providing prescriptions of morphine and methadone to drug users who in turn sold their dosages on the street to buy heroin. While regulations are currently being developed to minimize the opportunities for patients to take their prescriptions into the general public, there is still considerable conflict over this type of treatment.

Aside from substitution treatment, there are several other forms of treatment provided by local and provincial health authorities. A variety of in-patient and out-patient services are available, with both short-term and long-term commitments. Within many of the in-patient facilities, detoxification and withdrawal treatment help addicts break away from their addiction. Counseling, follow-up care, and support for both recovering addicts and their families are provided mainly by the out-patient facilities. A number of employment and social reintegration programs help former users create some stability in their lives and help them restore some of what they had lost to their illness. The most important component of the treatment services offered in Austria is flexibility. Since not all programs work for every addict, there is some flexibility, understanding, and patience for clients who relapse (Drugs-Coordination Office of Vienna, 1999).

Austrian Harm Reduction Venue

Turning to harm reduction, this method is the most decentralized of the approaches Austrians use to deal with substance abuse. As explained, the *de facto* federalism of the country has led to various harm reduction innovations throughout the country. Designed mainly as a tool of public health, harm reduction services are designed to minimize the harms associated with drug use. Such harms are infectious diseases caused by unclean needles, unsafe administration of drugs, stigmatization, criminalization, and victimization.

Some of the harm reduction instruments found throughout Austria are needle-exchange programs, on-site drug safety checks, low threshold treatment and education services, and mobile drug programs; which are teams of social workers and nurses who visit areas of high drug use to provide syringes, condoms, food, and referral to drug treatment and harm reduction agencies (AC Company, 2004). A common harm reduction device placed in many Austrian cities is the

vending machine. At the cost of one Euro, customers can purchase a small box containing two syringes, a condom, an antiseptic wipe, filters, and vitamin C. While many may think the vitamin C is provided to boost the immune system, it is actually included in the packet as an agent to break down the drugs into a liquid so that users do not accidentally inject solid drug particles into their veins.

One harm reduction innovation almost exclusive to Europe is the re-integration programming provided in only a few regions of Austria. Essentially, these programs aim at integrating drug users into the regular labor market by means of low threshold job opportunities. Primarily, clients in Austria are given work in postal services, screen printing, and renovation. Sources independent of Austria's harm reduction network report that the country's re-integration programs are quite successful at helping addicts overcome the barriers to the labour market that are caused by the client's addictions (International Harm Reduction Development Program, 2002).

Perhaps one of the most comprehensive harm reduction associations offering these types of programs is in the capital city of Vienna. Translated as the Vienna Social Project Association, *Verein Wiener Sozialprojekte* provides a variety of low-threshold services to the city's drug user population. Although most of the projects that the Association operates are funded exclusively by the city, some are partially funded by the federal government.

The oldest component of the program is the *Ganslwirt* drop-in center. Located near a major shopping area of Vienna, Ganslwirt provides needle exchanges, recreational activities, food, refreshments, counseling services, treatment referrals, minor heath services, and acts as a nighttime emergency shelter for the city's addicts. All year round, Ganslwirt provides these services for free of charge and without the requirement of health insurance.

The second program provided by the Verein Wiener Sozialprojekte is *Streetwork*. Similar to Ganslwirt, it provides a needle exchange, condom distribution, treatment referrals, and counseling. The key function of this program is that it provides these services through a van. Being mobile allows certified social workers to visit different parts of the city where drug users either live or congregate. This exposes more addicts to the harm reduction tools that will minimize their risks and eventually introduce them to a healthier life style—namely treatment.

One of the most important programs offered by the association is the *Betreutes Wohnen*. This program provides supervised accommodations for persons with drug-related problems. The general conditions of the program are that a person be motivated, cooperative, in-need, have no un-served prison sentences, and at least 18 years of age. The clients are provided with apartment flats for an initial period of three months. After this time, a contract is signed and renewed every six months for a total period of 2 years. The purpose of the program is to alleviate the user's stress of finding housing so that they can focus on the reintegration and treatment services they need to become a functioning drug-free member of society.

The fourth program administered by the Vienna Social Project Association is *Fix und Fertig*. This socio-economic employment project is aimed at helping former addicts or those recovering addicts enrolled in a substitution program. It is designed to eliminate the handicaps most drug users experience when trying to find employment. By providing various employment experiences in the trades and services industry, recovering or former addicts can slowly learn how to become organized and responsible while also earning some money. Programs such as Fix und Fertig have been very effective in reintegrating drug users and recovering addicts into society.

Perhaps the most well-known, yet controversial program offered in Vienna is the *ChEckiT!* program. The main objectives of this program are threefold: the first it to prevent users from ingesting drugs that are more dangerous than the user thought they would be. The second is to demonstrate to drug users that there are many hidden dangers in all forms of drug use. The third objective is to allow health scientists and police professionals to learn and document the types of drugs and their purity levels that are circulating throughout the region. ChEckiT! is aimed at those people who consume party drugs that come in the form of a pill.

On an operational level, a booth or table will be set up near the entrance of a rave or party. Positioned at that booth are medical experts and chemists who perform tests on the substances provided to them by the party-goers. When a drug user approaches the booth he or she swipes their pill on a small piece of sandpaper. The staff test that sample using portable equipment. While the testing is being complete, the outreach workers at the booth talk to the user about different alternatives he or she can consider for help with their substance abuse issues. The outreach worker also asks several informational questions to learn more about the user's drug history and patterns of behavior. These responses go towards helping health and police professionals better understand the drug situation in the community.

Once the test is complete the client is told whether or not the drug was what he or she thought it was. If a test comes back showing that a drug was not what the buyer said it was, then an announcement is usually made on the venue's sound system informing other patrons that some *bad drugs* are circulating throughout the venue. More often than not, the announcements prevent drug users from ingesting pills that turned out to be a substance more dangerous than the actual drug the users were intending to ingest.

The most important role in this process is that of the local police. The only way that drug users will confide in the ChEckiT! staff is if the police promise to refrain from searching or arresting any drug users within a certain radius of the party. The only time drugs are confiscated from the party-goers is if during the testing stage a staff member intentionally or accidentally touches the pill belonging to the user. Not retaining the drug after such an incident would be a violation of Austrian law on controlled substances.

While many police and health professionals support ChEckiT!, there is considerable criticism of the program. Many say it is sending the wrong message to youth who may be interested in experimenting with party drugs. Currently, the program is subsidized by the City of Vienna. While the ChEckiT! program has been tried in the province of Tirol, it largely maintains its operations in the city of Vienna. So far, the federal government has not taken any position in favor or against the program. This is similar to DanceSafe in the United States—which appears to act beyond the visibility of federal bureaucrats or policymakers (Reed, 2007).

The single acknowledgement of ChEckiT! by the federal government is in the permission statements of the Justice and Health Ministries. Each states that pill-testing is permitted so long as it is done within the framework of a scientific institution and that no staff member touches the pills without retaining them from the drug user. As such, the staff of ChEckiT! are employed by the Medical University of Vienna's Department of Toxicology (Fact File, 2006).

Austrian Summary

The combination of the criminal justice, treatment, and harm reduction approaches to the drug problem in Austria provides an important lesson to those who argue for one method over the other. Much of the literature and political rhetoric surrounding drug policy is caught up in the dispute between prohibition and harm reduction ideology. Through collective decision making

and cooperation, Austrian health bureaucrats have developed an approach to the drug problem that protects the laws of society while also protecting drug users from the secondary harms of both their drug use and their country's drug laws.

One problem of the Austrian drug situation is that while Austria strives to define the drug problem as a health rather than crime issue, the implementation of policies that reflect this understanding are not provided equally. Most of the drug treatment services offered in Austria are only available for Austrians or foreigners with insurance coverage that will help offset the costs of such programming. Consequently, the low threshold services that operate anonymously and free of charge are bombarded with drug addicts from other regions of the country and areas of Europe. The result is a high number of people in need of care who are turned away because these centers do not have the capacity to treat all of them at the same time (AC Company, 2004).

Although no national drug strategy recognizes the need for a balance between the health and criminal justice venues, an informal arrangement has dominated its drug policy for thirty years. This arrangement—*treatment first, punishment second*—has been fostered by the cooperative policymaking environment created by its political institutions. The arrangement is led by a Drug Policy Coordinator within the Health Ministry, who is responsible for meeting with sub-coordinators from his own ministry, as well as Justice and the Interior. As elite interviews reveal, these actors are currently formulating an official drug strategy that will codify Austria's approach to the drug problem.

As this research hopes to show, two structures in particular have helped in the development of harm reduction in Austria. On the one hand, proportional representation prevents the possibility of total polarization of the drug issue. By forcing political parties to form a coalition, issues like drug policy are not skewed by partisan conflict. On the other hand,

corporatism insures that all venues are positioned at the bargaining table. So far, this has allowed for a variety of expert and bureaucrat opinions to be heard during the decision-making process. As both existing literature and field data reveal, the decline of corporatism in Austria may have a negative impact on the overall influence that certain actors have on the drug policy process.

3.4 Netherlands

Of the four case countries examined in this research, Holland appears to have the strongest harm reduction venue and the most cooperative political institutions. Its drug policy is almost completely run by health bureaucrats, who consistently work to legitimate the programs and services that are offered. While Dutch drug policy makers are not totally immune to criticisms from domestic actors, their only real concern stems from the international sphere.

Like most countries, Netherlands began with a prohibition approach to the drug problem. As case studies and interviews reveal, actors within the law enforcement venue were the first to realize that drug abuse was not a crime problem. Beginning in the 1970s political actors cooperated to also accept this realization. Institutional mechanisms such as corporatism and proportional representation worked to minimize political conflict over the issue and entrust experts and bureaucrats to develop new alternatives to the drug problem. The direction they took was away from law enforcement and towards harm reduction.

Institutions

Drug policymaking in the Netherlands is directly enhanced by several of the institutional structures highlighted in this research. This observation is supported by Hemerijck and Visser (2000) who find that how well Dutch politicians work together to manage social problems has largely been a function of its institutional structures as much as it has been a function of actor preferences, strategic goals, power resources, and control over their constituencies.

Beginning with Holland's political bargaining structure, corporatism has managed to make Dutch policymaking a unique phenomenon to observe. As early as the 1960s, scholars (Lijphart, 1968) revealed that despite major social and ideological fragmentation in the Netherlands, Dutch policymakers were able to work under conditions of cooperation and consensus. According to Hemerijck and Visser (2000), while many factions of Dutch society have their own interests and goals, not one of these actors is autonomous to choose its most favored response. The reason for this is because Dutch policymaking—like other corporatist countries—is critically dependent on the partial agreement of different factions.

To foster agreement between these groups, corporatism in Netherlands acts as an intermediate mechanism that shapes the behavior of those involved. Most often, the successful coalition of such parties involves arrangements between unions, employers, and the government on matters pertaining mostly to incomes policy (Woldendorp, 2005). However, the interactions of this tripartite relationship are not limited just to incomes policy.

Several scholars have actually found that in Netherlands—among other Western European democracies—the culture of formal bargaining arrangements between economic groups has transcended into other areas of public policy as well (Hicks & Swank, 1992; Wilensky, 2002). One of these areas includes drug policy and the informal arrangements that exist between law enforcement, harm reduction professionals, and government officials.

The major difference between Dutch corporatism and that of other states with cooperative bargaining structures is that often Dutch policymaking is considered a 'process of accommodation'. To explain, the reason Dutch corporatism has maintained its institutional status despite so much conflict is because only a minimal amount of consensus is required on fundamental issues. According to Lijphart (1968), although weak and narrow, Dutch national

consensus works because it "contains the crucial component of a widely shared attitude that the existing system ought to be maintained and not be allowed to disintegrate" (p.103).

Considering this, the harm reduction venue in the Netherlands has been able dominate the drug policy process in part because there was a consensus involving proponents of this approach. To protect the drug policy network from disintegration, the law enforcement venue was accommodated with certain provisions, but the harm reduction approach ended up dominating the policy process when it entered Holland's drug policy network.

Another catalyst of the harm reduction efforts in the Netherlands is the country's electoral system. Proportional representation has allowed for considerable cooperation among party leaders. In fact, according to Andeweg's (1992) analysis of executive-legislative relations in the Netherlands, proportional representation has allowed for cross-party alliances that have been based on various policy interests. In particular, the inevitable coalition building that accompanies proportional representation in the Netherlands has allowed for drug policy to remain non-polarized. In a sense, the divisions of class and culture in the Netherlands seem to be blurred by party coalitions that form to effectively develop Dutch drug policy.

As for intergovernmental bargaining, federalism is for the most part scarce in the Netherlands. In the realm of drug policy however, there is a unique arrangement between the national and local governments. The chief bureaucratic department responsible for drug policy in the Netherlands is the Ministry of Health, Welfare, and Sport. This centralization ensures that there is an emphasis on harm reduction and treatment rather than law enforcement only (U.S. Bureau of European and Eurasian Affairs, 2004).

Where the Netherlands differs from other unitary governments, is that the Ministry of Health, Welfare, and Sport coordinates its efforts with the Ministries of Justice and the Interior,

to *municipalize* the implementation of drug policies created by the national government. Under these circumstances, local authorities are given discretion when it comes to enforcement efforts, but are required to avoid deviating from harm reduction efforts commanded by the Ministry of Health, Welfare, and Sport. It is through these loosely defined guidelines that municipalities have made several innovations in harm reduction (Coulter, 2004).

While the Netherlands' unique intergovernmental relations in the domain of drug policy are quite different than other harm reduction states, so is the makeup of their parliamentary regime. In Dutch Parliament, while there is a bicameral legislature, the two chambers seldom come into conflict with one another during the policy process. Where competition occurs is between the Cabinet and the elected members of the Tweedekamer, or House.

This dualism is symbolized by the architecture of the legislature. While the Tweedekamer and Eerste Kamer sit side by side, the cabinet and executive sit facing the rest of parliament (Andeweg & Irwin, 2002). While this arrangement may appear like a separation of powers design, it still holds considerable characteristics of a parliamentary regime. Fortunately for policy reformers, considerable coalition building within the Tweedekamer, Eerste Kamer, and Cabinet prevent many issues from becoming politicized. For the most part, policies are made to address issues rather than serve interests of groups (Polsby, 1975).

Image Framing

Both the evidence of this case study and interviews with respondents suggest that the harm reduction venue has been able to dominate because of Holland's cooperative policymaking environment. Such conditions have allowed for non-politicized discussions of the drug problem that are friendly to new ideas. During the 1970s, bureaucrats within the Ministry of Health were able to reframe the drug issue as one that concerned public health. Concepts such as

normalization, pragmatism, and Dutch tolerance led to a national acceptance of this new definition to the problem.

Despite the dominance of the harm reduction venue, the law enforcement venue still plays a major role; particularly where trafficking is concerned. The case study—supported by interview data—reveals that on a domestic level, the harm reduction approach to drugs in the Netherlands is maintained by universal support for the new status quo. The only major threat to Dutch drug policy stem from outside the country's borders. This includes drug tourism and international pressure.

3.4.1 Dutch Drug Policy

Infamous for its liberal approach to addressing the drug problem, the Netherlands has been at the forefront of the harm reduction movement since the concept's beginning in the 1970s. Known for their decriminalization of soft drugs and limited-penal approach to dealing with hard drugs, officials in the Netherlands have gone beyond the 'norm' of conventional drug policy. In fact, Dutch drug policy is often criticized for deviating too much from the law enforcement status quo that dominates the international system (United Nations International Drug Control Programme, 1997).

A considerable source of Dutch deviance from the international status quo is that drug policy is quite removed from politics (Leuw, 1994). As mentioned in the preceding section, a considerable portion of policy responsibilities is delegated to the Ministry of Health, Welfare, and Sport. This delegation is supported by all of the major parties in the Netherlands (Coulter, 2004). The resulting drug policy is a pragmatic program that uses a variety of instruments to help users and punish traffickers.

Historically, the first tools used to address the drug problem in the Netherlands came out of the *Opium Act* of 1919. This statute was primarily concerned with controlling the trade of drugs, for at this time drug addiction was not a major social problem in the Netherlands. By the 1950s however, enforcement of the possession clauses of the Opium Act grew stronger as drug-using Asian immigrants began to populate the larger urban centers. In 1976, a major amendment to the Opium Act curbed the role of law enforcement in drug efforts. According to the revised Opium Act, there must be a distinction made between hard drugs and soft drugs. While the possession of the former remained illegal, possession of the latter was decriminalized for personal use (Ministry of Health, Welfare & Sport, 1995).

The purpose of distinguishing between offences involving soft drugs such as cannabis products and hard drugs like cocaine and heroin, is to separate the markets of these two drug groups. In other words, the primary reason for this policy was to prevent young people who experiment with soft drugs from being exposed to more dangerous substances. The result of this legislation was a development of the marijuana drug trade that was eventually moved into legitimate coffee shops that the government continues to regulate (Horstink-Von Meyenfeldt, 1996).

A coffee shop is a café or catering establishment that sells cannabis under strict conditions. Owners of these shops are exempt from prosecution for selling cannabis products if they meet certain criteria: shops may not sell more than 5 grams per person per visit; they may not sell hard drugs; they may not advertise what they sell; they must not constitute a nuisance for surrounding businesses or residents; and they must not sell soft drugs to minors (under 18) or let them on the premises. If coffee shop owners break the rules they face administrative procedures

(closing of the business), criminal prosecution, or both (Ministry of Health, Welfare & Sport, 2003).

While coffee shops allowed Dutch authorities to separate the drug markets and protect soft drug users, other reforms were made to protect hard drug users. The 1976 amendment to the Opium Act opened the door for the harm reduction venue to develop its instruments. Following the amendment, a new framework for drug policy began to relieve drug users of being accountable for social marginality, deterioration, and degradation that accompany their addictions. Instead, it became understood that these adversities were consequences of society's choice to prohibit and punish drug use (Leuw & Marshall, 1994). Overtime, Dutch drug policy developed into an entirely different solution to the drug problem than was available to bureaucrats before the 1970s.

The resulting pillars of the Dutch solution to the drug problem are threefold: to prevent or reduce the damage of drug use in terms of public health, public order and safety; to maintain a safety net for users who cannot yet receive standard care; and to promote social (re)integration of the drug user (AC Company, 2004b). Complimentary to this framework are several characteristics which can be used to describe drug policy in the Netherlands: separation of drug users and traffickers, strong service provisions, normalization of the drug user, empirical logic, decriminalization of drug use, and cost-efficiency[14].

Dutch Law Enforcement Venue

The separation of users and dealers largely can be attributed to the work of bureaucrats in the Ministries of Justice and Interior. The starting point of government in this venue is that criminal-law interventions should not result in additional harm to drug users. The emphasis is on

[14] These among other characteristics of Dutch drug policy were compiled by students in Phillip Coulter's drug policy seminar at the University of New Orleans in the Fall of 2002.

combating trade and limiting rather than punishing use. Within the law enforcement venue, criminal justice professionals insure that soft drugs are sold in coffee shops and hard drugs are not sold at all. It is legal to possess 30 grams of cannabis. Anything more is punishable by trafficking laws. As for hard drugs, users can possess no more than 0.5 grams before they are charged with a criminal offense. Those caught with 0.5 grams or less are considered a low priority for criminal investigators (Ministry of Health, Welfare & Sport, 2003).

Duty-wise, the Ministry of Justice is responsible for enforcing drug laws. This includes both criminal investigations and prosecutions. The Ministry of the Interior is responsible for administering local authorities, including the police. Together these groups focus their efforts on dismantling criminal organizations that produce and sell cannabis or hard drugs. Due to their efforts, combined with the lengthening of sentences for drug trafficking, the prison system in Holland has had to expand over the last two decades (Ministry of Health, Welfare & Sport, 2003).

Although the law enforcement venue seeks to arrest and punish drug traffickers, a different approach is taken with addicts who come in contact with the justice system. When a drug user is arrested, the police officer usually tries to put the offender in contact with an aid worker who can provide some immediate services to the offender. If an offender is arrested several times—and those arrests lead to a charge and conviction—the offender is given the option of punishment or treatment. For drug users that do receive punishment, either by their own choice or that of the court system, clinical treatment is available during the last stages of the punishment (Ministry of Health, Welfare & Sport, 2003).

An innovation unique to the Netherlands is the role of resettlement officers. These individuals offer guidance to and monitoring of the offender, while also keeping the magistrate

informed of their progress. Resettlement officers work with treatment and reintegration workers to make sure the offender is able to get a clean start (Ministry of Health, Welfare & Sport, 2003).

Dutch Prevention Venue

Perhaps one of the things Netherlands is known for—particularly in treatment and harm reduction venues—is innovation. The regionalization of the prevention venue has allowed for some innovative developments at local levels. Some of these developments include programs that are aimed at parents, immigrants, and the homeless. One prevention program unique to Netherlands is known as 'Outsider'. Selective in nature, Outsider provides a prevention-oriented networking service for employees of night clubs and bars that are at high-risk of being exposed to drugs (EMCDDA, 2007). Another selective prevention innovation is a project called 'Unity'. This program is a peer-based prevention measure that is outreach in nature. Volunteers of Unity attend concerts, parties, and dances to provide safety tips on drug use and addictions (Unity, 2007).

In addition to these specialty programs, the government of Netherlands provides significant funding to its schools so that they can provide drug education in both primary and secondary schools (EMCDDA, 2007). In 2000, a universal campaign was developed by the Trimbos institute in partnership with over 60 regional health care institutions. Known as 'Drugs: don't be fooled', this national media campaign "encouraged and improved communication about drugs between young people and their parents, and to influence the information-seeking behavior of young people"(Ministry of Health, Welfare & Sport, 2002:12).

The array of prevention programs provided in Netherlands is funded mainly by the federal government. Through the Support and Information Centre for Drugs and Safety, as well as the National Support Centre for the Prevention of Addiction and Substance Use, the federal

government tries to promote the sharing of best practices within the country's prevention network. At the delivery level of services, schools, addict care institutions, harm reduction agencies, and municipal health centres deliver a variety of prevention programs to curb drug use in Holland (Ministry of Health, Welfare & Sport, 2002).

Dutch Treatment Venue

As much as the Dutch have developed the practice of education-based prevention, their most original creation is the partnership they have formed between harm reduction and treatment. Harm reduction services like consumption rooms and heroin maintenance programs often are often the first step users take towards accessing treatment services. These services allow users to not only stabilize, but develop rapport with professionals who can eventually get them the treatment help they need (Ministry of Health, Welfare & Sport, 2002).

One of the key things that allow Dutch harm reduction programs to send users to treatment is that treatment options maintain a low threshold. Minimal admission requirements—sometimes even anonymous admission—allows the user to receive the initial assistance he or she needs. Once low threshold treatments begin to work, the client is then funneled into more demanding programs that eventually get them on the road to abstinence (Duncan & Nicholson, 1997).

Typical programs that are provided to Dutch addicts are divided into outpatient treatment, semi-residential services, and inpatient treatment. Other instruments used in Dutch treatment include detoxification, addict reintegration programs, low threshold abstinence treatment, and social pensions (Spruit, 2002). These services are provided by a broad network of generic treatment programs that are based mainly on reintegrating the client back into society. Over 100 outpatient facilities and around 60 inpatient facilities make up the foundation of treatment

services in Holland. These facilities are managed by 33 different treatment agencies, 18 of which offer clinical care and 10 of which offer ambulatory or mobile care.

The majority of treatment services in Netherlands are provided by community-based organizations that receive funding directly from the federal-funded regional health authorities. However, one type of care funded by municipalities is that offered by Consultation Officers for Alcohol and Drugs (CADs). Although mainly mobile, CADs do offer services and support to professionals in social work and healthcare facilities. The main types of services provided by CADs include crisis relief, distribution of methadone, social counseling, treatment assistance, social skills training, and psychotherapy. While addicts receive most of the services CADs provide, these professionals also provide services to members of the addict's family (Ministry of Health, Welfare & Sport, 2003).

As for substitution treatment, it is mainly provided by professionals in specialized facilities or mobile units. It is important to realize however, that over 200 General Practitioners do provide some sort of methadone treatment to addicts (EMCDDA, 2007). This illustrates the abundance of the substitution-based treatment services in Netherlands.

One type of substitution treatment used in Netherlands that is not often practiced elsewhere is the combination of methadone and heroin. In the late 1990s Dutch officials authorized an experiment with 50 heroin addicts. Dividing the sample into three groups, the scientists compared the effectiveness of methadone treatment, to methadone treatment that was combined with heroin maintenance. The findings were quite encouraging (Cohen, 1998). As a result, federal officials allowed for the expansion of heroin maintenance programs in different parts of the country (van Kolfschooten, 2002).

Dutch Harm Reduction Venue

The link between treatment and harm reduction is quite strong in the Netherlands. The relationship between these two venues, combined with the cooperation treatment professionals have with criminal justice professionals, may have made the development of other harm reduction instruments easier. Some of these instruments include needle exchange programs and decriminalization. Others include safe-injection sites and a number of 'tolerance zones' that are designed to keep drugs users away from the community while using drugs. Doing so protects drug users from harms associated with using drugs on the street and protects society from dangerous drug users who can become a threat to public safety (Uitermark, 2004).

One such harm reduction facility in Netherlands is Centrum Maliebaan. Located in the city of Utrecht, Maliebaan offers a wide variety of services to addicts. The main reason drug users attend the facility is to administer their drugs in one of the two consumption rooms. The first room is an injection room. In the room is a sink and a lower extremities wash basin for users to clean the parts of the body they will inject the drugs into. Stools and a few tables line the walls of the injection room so that users can sit down to achieve their fix. In the smokers' room are more chairs and tables, along with a fairly reliable ventilation system. Between the two rooms is a nurses' station with windows on each side. When entering either of the user rooms, addicts can approach the nurse for a variety of drug use instruments such as tinfoil, filters, needles, elastics, and bandages. Nurses are there to also provide emergency assistance and treatment referral.

Aside from the consumption rooms, Maliebaan also provides a laundry service, showers, inexpensive food, computer usage, counseling, and treatment referrals. The goal of the center is to reduce the harms and strains associated with drug use so that the lifestyle of drug users becomes less detrimental to themselves and society. The police in Utrecht have a strong working

relationship with Centrum Maliebaan and the drug users know that of they are going to use drugs, the police expect them to go to Maliebaan.

Most of the services like Centrum Maliebaan are paid for by the national government; but are administered by state and local governments or health authorities. As mentioned in the last section, it is important to note that a unique federalist-type arrangement exists in Netherlands' drug policy network. While the rules and regulations regarding drug treatment and enforcement are centralized in the federal ministries, individual provinces and their municipalities are given discretion as to what types of programs they will offer to drug users and the level of enforcement they will use against hard drug users. Thus, while the Ministry of Health, Welfare, and Sport provides 95 percent of the funding for harm reduction instruments used in the Netherlands, it is up to local harm reduction, police, and government officials to decide what tools they want to use in addressing the drug problem (AC Company, 2004b).

Special Issue: International Dynamics of Dutch Drug Policy

In examining this array of programs and the flexibility of the drug laws in the Netherlands, it becomes quite apparent that such liberalizations may cause Dutch officials some grief on the level of foreign policy. Indeed, since the 1910s Dutch officials have been pressured by leaders of other countries to strengthen their law enforcement approach to drug use. In fact, according to one observer (Korf, 1995), the Opium Act of 1919 was largely the result of diplomatic pressure from the United States. In 1995, relations between France and the Netherlands were strained when French officials claimed that its country's drug problems were due to their proximity of Holland and its lax drug laws (Boekhout van Solinge, 1999).

Such friction between nations and their domestic policies have also escalated to the supranational level. In his analysis of harm reduction initiatives in international institutions,

Wever (1994) reveals that these bodies are ill-suited for developing harm reduction programs. Unfortunately for the harm reduction venue, the international drug strategy formalized by international conventions almost completely focuses on the control of drug trafficking. The only reason Dutch drug policy is not in violation of these international conventions is because these agreements call for the criminalization of possession, trafficking, dealing, and production of illicit drugs. While the Opium Act does meet this legislation requirement, most supranational agreements do not provide clauses that specify the level of enforcement required of such legislation (Silvis, 1994).

Netherlands Summary

In summary, the harm reduction venue has been able to define the drug problem in the Netherlands as a public health problem rather than a crime problem because of several institutional mechanisms. Corporatism may very well have allowed for the cooperation between policy actors that is needed for the development of a pragmatic approach to the drug problem. Holland's electoral system has ensured that the drug issue did not become politicized during the development of the harm reduction venue. Finally, the centralization of Dutch drug policy formation and the decentralization of its implementation have not only allowed for different innovations of harm reduction, but have protected its advocates from criticisms by regions who do not wish to adopt its programs.

By controlling the image of the drug problem in Netherlands, public health bureaucrats have been able to develop policy instruments in both treatment and harm reduction. What is unique among Dutch bureaucrats, as compared to their counterparts in other countries, is that there is a strong working relationship between those from the law enforcement, prevention, treatment, and harm reduction venues. While other countries have legislated national drug

strategies that dictate a balance approach, Holland has championed the actual practice of such an approach.

Two of the biggest threats to this relationship however stem from outside of the Netherlands: immigration and international pressure. Although these forces have not yet led to any major changes in Dutch drug policy, past literature and interview data suggest that both will act to change the conditions and options that Dutch policymakers have in the area of drug policy.

Regarding the latter, recent evidence suggests that domestic groups who depend on international relationships may be willing to sacrifice certain harm reduction instruments for stronger relations with foreign countries and international institutions—particularly the United States, France, the European Union, and United Nations. As for the former, continued immigration and increases in drug tourism are straining existing harm reduction services and causing their progress to look ineffective in the eyes of harsh evaluators (Boekhout van Solinge, 1999).

3.5 Case Study Conclusion

The case studies provided in this research reveal some detailed information about the drug policy activities of four different countries. Differences in drug policy, political institutions and bureaucratic influence exist between all four countries. The reasons for this have a lot to do with the arguments tested in this research. The role that bureaucrats play in shaping drug policy outcomes is explored in great detail through field interviews conducted in each country. The affect that institutions have on drug policy outcomes is explored through quantitative analysis. While the four case studies included in this chapter help illustrate some of the dynamics explored in the field interviews, they are particularly useful in illustrating the dynamics that are tested in the quantitative chapter of this research.

As in the cases observed above, a parliamentary system with proportional representation allows for multiple perspectives of the same problem. With respect to valence issues like drugs—where policy actors fight over the solution rather than the problem—this is especially true. The reason for this is because despite the numerous perspectives, few align or oppose one another solely for political advantage. In addition, a multi-party system with strong party discipline that results from such electoral systems minimizes the chances of the issue becoming politicized in the way that it does when people are (a) fighting over the policy goal, as in non-valence issues); or (b) fighting over the solution and the goal, as in the competitive policy environments of countries with single member districts and/or presidential systems. In these electoral systems, the linkage between crime (or immigrants) and drugs is used to ensure that law enforcement bureaucrats can continue to define the drug problem in a way that emphasizes their solution.

In more corporatist policymaking environments, actors from both sides of the drug policy arena are able to secure a spot at the bargaining table. Such consensus type decision-making fosters much of the cooperation needed to allow law enforcement and harm reduction leaders to work out an effective solution to the drug problem[15]. In pluralist systems however, no collective bargaining arrangements exist between policy actors. As such, the bureaucratic traditions of the law enforcement paradigm continue to overpower the reform efforts of harm reduction advocates.

As for regime type and cameralism, parliamentary systems and unicameral legislatures create a more collective policymaking environment. In parliamentary systems, drug policy liberalizers tend to be sheltered from the competitive forces that harm their counterparts in

[15] Some acknowledge that the reverse effect of corporatism can occur. To illustrate, Hemerijck and Visser (2000) warn that corporatism can inhibit efficient policymaking because of the need for extensive compromises and coalition information. Achieving these conditions is not always easy.

presidential systems where there is more conflict between the executive and legislative branches of government. Likewise, unicameral legislatures reduce the number of veto players—particularly those who act as a group—that can interrupt reform efforts.

The one caveat of the institutional theory driving this research regards intergovernmental relations. The main argument of this project suggests that in more decentralized systems with policy venues that already suffer from group fragmentation, such as the harm reduction and prevention venues, drug liberalizers face considerable challenges when trying to compete with policy venues that are able to overcome the barriers of decentralization. In the case of drug policy, law enforcement agencies are able to overcome the barriers to organization that are posed by federalism. Strong partnerships between state and national agencies, combined with the uniform policy of 'demand reduction', allow these groups to dominate the drug policymaking process. Unless organized under a strong centralized authority over the bureaucracy, harm reduction groups cannot compete with their more superior opponents. This understanding of federalism is consistent with what has happened in United States, Bulgaria and Mexico.
On the other hand however, liberal drug policies have the ability to foster in federalist countries because of the options that sub-national and local governments have the opportunity to experiment with new ideas and tailor existing policies to meet their own needs. In several countries, this has resulted in a bottom-up type of reform that can change drug policy across the entire country. This can be seen in countries like Switzerland, Czech Republic and Australia.

CHAPTER FOUR

4.0 QUANTITATIVE METHODOLOGY

The question posed at the beginning of this research was: why is there variation in drug policy across different democracies? During the process I took to try and answer that question, several more have surfaced: What factors allow some drug policy actors to dominate over others? Why are some approaches to drug policy used more than other approaches? How are some countries more able to implement alternative solutions to the drug problem than are other countries? Most importantly, how do political institutions mediate the effect of bureaucrats on all of these things? Since the cross national literature on drug policy is quite limited, answering these questions may be a first in the field.

The most effective way to answer the questions of this research is to adopt a methodology that incorporates both quantitative and qualitative tools. The former of the two should be able to tell us which institutional factors have an influence on a country's drug policy. The latter should provide an in-depth description of bureaucratic dominance and how these institutional structures shape the relationships of actors within drug policy subsystems. The use of a mixed methodology is supported in the work of Hult and Walcott (1999) who insist that quantitative data help us describe why something works, while qualitative data help us describe how something works.

4.1 Data Analysis

In trying to learn more about the relationship between institutional structures and a country's drug policy, it is important that we identify the correct variables. I propose that while controlling for the severity of a country's drug problem, international pressure, government

resource capacity, and political ideology; certain institutional factors have strong implications towards the design of a country's illicit drug policy. These structures include regime type, political bargaining, intergovernmental relations, cameralism, and electoral design. While they may not have as much of an impact as the domestic and international factors discussed earlier, these institutional structures should explain some variance in drug policy.

In particular, I hypothesize that a parliamentary regime, corporatism, a unitary government, a unicameral legislature, and proportional representation all contribute to a cooperative policy environment. In such an environment, ideas are proposed by political actors who are willing to hear the different alternatives to dealing with the drug problem than the status quo. If this hypothesis is correct, the findings should reveal a positive relationship between these institutional structures and education-based prevention, substitution-based treatment, and harm reduction.

In the reverse, I also hypothesize that a presidential executive, pluralism, federalism, bicameralism, and single-member districts all contribute to the creation of a competitive policy environment. In this environment, the status quo is retained by bureaucrats and political actors who benefit from a punitive drug policy. If this hypothesis is correct, there should be a positive relationship between these institutional factors and law enforcement, deterrence-based prevention, and abstinence-based treatment policies.

The strength and direction of the relationships predicted above cannot occur in isolation of other factors. As mentioned throughout this work, many other factors clearly have an impact on drug policy. It is predicted that controls for the severity of the drug problem, government resource capacity, political ideology and international pressure will help explain some the variance in drug policy commitments among countries in the quantitative sample of this research.

4.1.1 Dependent Variables

To measure my dependent variable I created indices for each of the six approaches to drug policy discussed in this research: law enforcement, deterrence-based prevention, abstinence-based treatment, education-based prevention, substitution-based treatment, and harm reduction. Located in the appendices is the Data Sources Table; which includes cites for the various articles, websites, and references I used to find each country's drug policy instruments. Some of the major data sources I used include the U.S. Bureau of International Narcotics and Law Enforcement Affairs Drug Strategy Report (2002), the European Monitoring Centre for Drugs and Drug Addiction (2007), the Central and Eastern European Harm Reduction Network (2003), and the United States Bureau of Justice Statistics (2007).

Despite the resources offered by these and many other data sources, there is still a concern for missing data. For many of the 35 drug policy instruments explored in this research, between 20 and 30 percent of the sample's data are missing. While assumptions made based off of regional trends, national drug policy rhetoric, resource capacity, and cultural-political norms could be made accurately in a lot of cases, none were made in this project. The dataset created for this project is limited to the factual, unbiased, and often double-checked sources that are listed in the Data Sources Table (see appendices).

To construct the indices for my dependent variables, I examined the policy instruments used in a country's approach to the drug problem. For each of the aforementioned policy-types discussed in this research, I created a score that is based off of points. Each policy instrument existing within a country received 1 point if it is present in at least one region of a country and two points if is present in more than one region. Countries were coded as 0 if it was reported that an instrument was not offered in their country. Using an example from harm reduction, the

Netherlands has injection sites in multiple parts of the country, Canada has one, Austria and the United States have none. Respectfully, their scores would be two points for Netherlands, one point for Canada, and zero for Austria and the United States.

At the end of this coding process, I took the sum of all values in each of the six categories to arrive at a final score. Since there is considerable missing data for several countries, it was important to account for the number of observations actually made in each country. As such, I divided the summed score of each drug policy category by two times the number of observations that were reported for each type of drug policy in all 101 countries. This produced a 0-1 drug policy index score for each of the six different approaches to the drug problem. These indices serve as my six dependent variables.

The six dependent variables I used in this analysis are law enforcement, harm reduction, abstinence-based treatment, substitution-based treatment, education-based prevention, and deterrence-based prevention. Prior to constructing the indices, I coded each country based on the number of policy instruments it has under each of these six policy types. Across all 101 democracies, I expected there to be more variation in the indices for law enforcement and harm reduction than across the different approaches to treatment and prevention. The reason for this is because most countries offer various types of treatment and prevention services. While there is a small divide within the treatment and prevention venues, it is much less severe than the rift between the law enforcement and harm reduction venues.

The instruments I coded for the law enforcement dependent variable are prison for small amounts of hard drugs, prison for small amounts of soft drugs, mandatory minimum sentences, civil asset forfeiture, severe prison sentences for trafficking, and drug courts. For the purposes of this research, a country has civil asset forfeiture laws if the government can seize and maintain

control of all assets that either aided in the commission of a drug offense or were purchased from the proceeds of committing a drug offense—mainly trafficking. Severe sentences for trafficking were identified when the punishment for this offense was at least 3 times as harsh as simple possession of drugs. Finally, countries were coded as having drug courts if the justice system gave drug addicted guilty offenders treatment and rehabilitation opportunities as an alternative to or in combination with incarceration.

The deterrence-based prevention variable was scored on programs that depend upon fear tactics that emphasize the secondary consequences of drug use. Programs of this nature include police education in public or in schools, fear campaigns aimed at target groups or the general population, voluntary and non-voluntary drug testing at schools, and voluntary and non-voluntary workplace drug testing. The instruments counted toward the education-based prevention variable include health-based media campaigns, health curricula in schools, skills training, recreation opportunities for target groups, and prevention outreach.

The instruments for the abstinence-based treatment variable include treatment outreach, detoxification, mandatory treatment, out-patient care, inpatient care, treatment while in prison, and low threshold treatment. Low threshold treatment occurs where preliminary treatment services are offered to addicts without the requirement of providing identification, government documents, or other requirements of treatment (ie: abstinence). The difference between mandatory treatment and drug courts is that addicts found guilty of an offence—that is not necessarily a drug offense—are given the option of drug treatment when sentenced by the courts. Mandatory drug treatment however does not have to accompany a non-drug offense nor does it have to be issued by a court. In some countries, persons found intoxicated are sent by the

magistrate to a mandatory drug treatment program. In many cases, no charges are laid and no record is kept (ie: Austria).

The various instruments of substitution-based treatment include methadone substitution treatment, buprenorphine substitution treatment, and a category including all other substitution based treatments. Methadone treatment is an intense commitment on a part of the government to sustain the livelihoods of drug users. Buprenorphine is used by many governments who do not wish to provide methadone, as it is both cheaper and less euphoric than methadone (Rapeli, et al. 2007). Several countries use a variety of other drugs in their substitution treatments for a variety of reasons, many of which are not relevant to this research. While many countries allow the prescription of these drugs to patients, only countries where such prescriptions are accompanied by some sort of drug treatment program or counseling are coded as having substitution treatment.

The instruments of harm reduction that I included for coding were heroin maintenance, safe injection or consumption sites, medicinal marijuana, decriminalization, *de facto* decriminalization, needle exchange programs, on-site pill testing, harm reduction outreach, tolerance zones, and reintegration programs. Countries that were coded as having decriminalization were automatically coded as having *de facto* decriminalization to set them apart from countries that had only *de facto* decriminalization. Instituted decriminalization is much more of a commitment to harm reduction than the *de facto* kind which is often only sporadic and limited to certain regions of a country. On-site pill testing was a difficult indicator to code in that while many countries have pill-testing, much of it is unbeknown to the government. Since this research focuses on policymaking, only countries with pill-testing that is sponsored or at the very least *known of* by the government, is coded as having on-site pill testing.

The same difficulties did not exist for needle exchanges, safe injection sites, or harm reduction outreach as most government are very aware of these services being offered to their drug users.

4.1.2 Independent Variables

To measure my independent variables, I adopted existing institutional indicators from fellow researchers. The first of those that I borrowed from others was Lijphart's (1999) extension of Allan Siaroff's (1999) indicator for political bargaining. Building upon Siaroff's work on 24 industrial democracies, Lijphart expanded the total count of countries by twelve. According to Lijphart, Siaroff took eight basic contrasts of corporatism and pluralism, and rated 24 democracies on these aspects[16]. The rating is based on the political bargaining structures of the 21 countries between 1963 and 1970, and for all 24 democracies between 1983 and 1990.

The data appear on a continuum of 0 through 4, including raw decimal numbers. According to Lijphart, the absence of pluralism signifies the presence of corporatism. As such, the inversion of a pluralist scale can serve as a corporatist scale. In Lijphart's *Patterns of Democracy* the scores of pluralism range from a theoretical low of zero to a theoretical high of four. For the purposes of this research, the lower a country's pluralism score is the more corporatist its political bargaining structure is. As such, a 0 represents total pluralism and a 4 represents total corporatism.

My indicator of electoral design was borrowed from Beck's et al. (2005) work for the Development Research Group of the World Bank. According to Beck and colleagues, countries are coded as a "1" for proportional, if candidates are elected based on the percent of votes

[16] Siaroff's eight aspects of contrast between pluralist and corporatist bargaining structures include three indicators of social partnership (annual average of strike volumes, nature and goals of trade unions, legal and state support for unions and union power); three indicators of industry-level co-ordination (nature of economic ties and outlook of firms, and extent of co-determination in the workplace); and three overall national policymaking patterns (nature of conflict resolution in national industrial adjustment and wage setting, extent of generalized political exchange in industrial relations and policy making, and general nature of public-private interaction).

received by their party. Countries are coded as a "0" for non-proportional, if candidates are elected if they receive more votes than any other candidate. I kept the group's coding scheme for electoral design in its current format.

To measure whether a country is a parliamentary or presidential democracy I borrowed from Freedom House (2003) categorizations of electoral democracies. According to Freedom House, a presidential-parliamentary democracy is one where an elected leader enjoys autonomy from the legislature. A parliamentary democracy exits where the elected head of government is approved by the legislature. For the purposes of this research, a presidential-parliamentary system is coded as 0, and a parliamentary system is coded as 1. Within Freedom House's dataset of electoral democracies, several had missing information. Data from the CIA World Factbook (2005) were used to code Antigua and Barbuda, Burundi, Dominican Republic, Haiti, Iran, and Zambia.

Moving to intergovernmental relations, the CIA World Factbook (2005) describes federalism as existing when sovereign powers are formally divided—usually by means of a constitution—between a central authority and a number of constituent regions (states, colonies, or provinces) so that each region retains some management of its internal affairs. In federalist states, the power of sub-national states cannot be removed without their approval. The absence of federalism—unitary governance—exists when the central government exerts influence directly upon both individuals as well as upon the regional units. In this research, federalism is coded as a "0" while a unitary government is coded as a "1".

Data for countries with missing intergovernmental relations values were borrowed from Beck et al. (2005). According to the World Bank researchers, a country is federalist if its sub-national governments have authority over taxing, spending, or various forms of legislation. Their

data are coded the same as the data I borrowed from the CIA World Factbook: federalism is coded as "0" and unitary governance is coded as "1".

Data for the last of my independent variables—cameralism—were borrowed from the U.S. Department of State (2005). For this indicator, countries with one chamber in their legislature were coded "1" for unicameralism. Countries with two or more chambers in their legislature will be coded as a "0" for bicameralism. Tri-cameral legislatures are coded as bicameral because three chambers in a legislature will generate no more competitiveness in the policy environment than bicameral ones. The reason behind this is that the third chamber has the potential to act as a tie-breaker for the other two. Such behavior makes it act like a bicameral legislature.

A final independent variable that I used separate from the above-mentioned variables was an index representing the countries' overall institutions. As discussed, the more cooperative institutional structures (parliamentary regime, proportional representation, unitary governance, unicameralism, and corporatism) are coded with higher numbers than the more competitive institutional structures (presidential regime, majoritarian voting, federalism, bicameralism, and pluralism). As such, all countries fall along a spectrum of cooperative to competitive, in terms of policymaking environments—much like the political bargaining variable. To construct the index I first calculated the sum of each country's institutional score for all five of the original institutional variables. Because the political bargaining variable has a low *N,* I controlled for missing data by dividing the summed score by two times the number of observations.

4.1.3 Control Variables

As outlined in previous sections of this research, the other factors that affect the behavior and decisions of drug policy actors are domestic and international political factors, as well as the

severity of the drug problem and government resource capacity. Of the domestic political factors discussed in this research, I included a control for political ideology. Many strong conservatives support the role of law enforcement and deterrence in dealing with the drug problem. In contrast, many strong liberals support the public health and harm reduction approach to the drug problem. While many policy areas show a strong following at the center of political ideology, drug policy is seldom one of these areas. Nonetheless, there are some countries with political ideologies that favor a balanced approach to the issue at hand.

The most widely used measurement of ideology is a left-to-right scale (Heemin & Fording, 2003; Inglehart & Huber, 1995; Woldendorp, Keman, & Budge, 1993). For the purposes of studying public policy, it is best to select a measurement of ideology that is closest to the policymaking process. Some researchers have used voter ideology scores based upon mass polling of public values (Knutsen, 1997) or the total votes a party receives after an election (Oddbjørn, 1997). While these indicators are valid, they are not the type of ideology indicator that will bring us close the policy process.

The best indicator of political ideology to use as a control variable is the number of government seats a party has across time. In their work on partisan governance and the social democratic service state, Huber and Stevens (2000) focused on the number of government seats that parties in their sample had across time. They found that by using this indicator of ideology, they were able to account for the effects of long-term incumbency or even ideological hegemony. Doing so allows for researchers to better control for the effect of political ideology on public policy.

In a similar measurement of ideology, Bjørnskov's (2005) study on economic growth and party ideology borrows data from Beck et al. (2002) to measure the ideology of parties who held

government seats. In coding the variables, Beck and his colleagues code the largest government party at anytime between 1975 and 2000 according to whether they had a leftwing, centrist, or rightwing ideology. Parties were coded first with their name (Conservative, Christian Democrats, Socialists), then with respect to the economic policy outlines in their party platforms and agendas. Because the data originate from Europe, those parties with liberal platforms or names are actually coded as conservative. The reason for this is because liberalness in European economic terms refers to liberal economic policies as opposed to socialist or protectionist economic policies (Beck et. al., 2002).

To some observers, a limitation of using ideology as a variable alongside institutional variables is that political institutions are responsive to and reflective of the specific ideology which governs the political system (Loewenstein, 1953). To some extent, institutions are a product of the ideological orientations of a country's founders. However I believe that political culture explains political institutions more than ideology does. In using a left-right scale to measure ideology I am confident that I am able to control for political ideology without their being a strong correlation between the five independent variables and the ideology control variable.

To construct this variable I used data from Beck's et al. (2005) updated dataset for the year 1990 through to 2004. While their data go as far back as 1975, it wasn't until around 1990 that the world realized and began implementing some of the alternatives to law enforcement that harm reduction offered. As such, most of the political ideology that would have had an impact on national drug policy is after 1990. For each country I averaged the number of government seats a party has held over the 15 year period. This conversion matches the non-temporal data used for

the other variables in this study. Scores of the party ideology data are coded as "0" for right, "1" for centrist, and "2" for left.

In the rare case that countries have an even number of left versus right seats within that 15 year period, or in the case that they only differed by 1 year, I coded them as centrist. While this does not represent the parties in place during the time period, it does represent the balance in ideology over that time period that may very well have had an impact on drug policymaking. Countries coded as centrist because of this decision include United States, United Kingdom, St. Lucia, Norway, Czech Republic, Denmark, Netherlands, Spain, and Trinidad and Tobago.

The second political control variable I used was an indictor for international pressure. Originally I had hoped to use membership in the United Nations—specifically, signatory status of the UN drug conventions. However all of the countries included in this dataset are signatories to the UN conventions (UNODC, 2006). As such, the lack of variation in the UN data would not allow such an indicator to be very useful in this research.

Another consideration I had was membership in the European Union. As some of the interview data reveal, domestic drug policy is certainly influenced by some of the guidelines set by the European Monitoring Centre on Drugs and Drug Addiction. However two problems arose which led me to decide against using this as an indicator. The first is that there are a very limited number of observations that could be generated from an EU membership variable. The second reason is that members of the European Union are bound by 1988 UN drug convention; one that the European Union was a part of. As such, many of the drug policy directives coming from the EU are guided by those set by the UN (EMCDDA, 2006). Being that the entire sample signed onto these conventions at one point, there would be little advantage in using EU membership as a control for international pressure.

The final indicator for international pressure that I eventually adopted was the ratio of trade to gross domestic product. I chose this indicator for several reasons. The first was that nearly complete data were available for it. The second was that across the sample of countries, there was variation in this variable. The third and most important reason is that the ratio of a country's trade to its gross domestic product shows exactly how dependent a country is on the international system. As such, countries with higher trade to GDP ratios would be more dependent on trade with other nations—and as this research argues—more susceptible to the pressure that other countries place upon one another in the area of illegal drug policy.

To create this control variable, I borrowed data from the World Trade Organization (2007). According to this group, "trade to GDP ratio is estimated as an economy's total trade of goods and commercial services (exports, imports and balance of payments) divided by the GDP, on the basis of data for the latest three years available". Collectors of these figures explain GDP to be measured in market terms and with market exchange rates.

Another control variable that I included in this research is government resource capacity. Including this variable allows for the control of private economic resources and state economic resources that enable some countries to provide more drug policy instruments than others. Early research on political systems shows that economic capability in the private sector has just as much of a substantial impact on policy outputs as economic capability in the public sector (Dye, 1966). For this control, I gathered from the U.S. Department of State (2005). According to this agency, Gross Domestic Product is the total value of all goods and services produced in a country in relation to its population.

It is important that Gross Domestic Product per capita be used as a measure of resource capacity instead of police expenditures, social welfare expenditures, or health expenditures,

because political institutions have been shown to affect the overall amount of funds each of those sectors receive from the government (Crepaz, 1994; Hicks & Swank, 1992). Including an indicator of commitments to social welfare will increase the threats of multicollinearity, therefore falsely decreasing the significance of our results.

The final control variable I chose to include in this analysis is the severity of the drug problem. I predict that this control will not be overly successful in explaining variance in the dependent variables. The reason for this is because usage rates are not so much related to the direction of drug policy. By examining the case countries of this research, we can see that Netherlands and United States have considerable problems in illegal drug use—yet the two commit to entirely different approaches to dealing with the drug problem. Similarly, Canada and Austria have less drug problems, with more moderate responses to the drug problem, and in slightly opposite directions. This is supported in other comparative drug policy research that shows how a country's drug policy is not related to drug prevalence in anyway (Reuband, 1998).

However, to test the hypotheses without controlling for the problem that drug policies are designed to address would deprive this project of its ability to demonstrate exactly how related or unrelated drug usage is to drug policy. There is a possibility that drug usage may not be related to the direction of a country's approach to the drug problem, but it may be related to the intensity of a country's approach to the drug problem.

Though some researchers claim that drug use statistics are very incongruent and often inaccurate (Sterk-Elifson, 2005), this project attempts to build a drug usage control that overcomes these hazards. To do so, I borrowed data from the United Nations Office of Drugs and Crime (2007) *World Drug Report*. Their data measure the percentage of persons 15 to 64 years of age who have self-identified as using one of five different groups of drugs: cocaine,

opiates, cannabis, ecstasy, and amphetamines. I used the sum of these percentages to indicate the total drug use in each country.

While the raw data that results from these calculations may not represent the actual proportion of self-identifying drug users in each country, using the sum of the UN's data is the best way to develop an effective control variable. Using any other arrangement of these data runs the risk of biasing the variable—for if drug use does matter, then each type of drug use will solicit different drug policy instruments (ie: opiates = safe injection sites; cannabis = decriminalization; ecstasy = pill testing).

4.1.4 The Quantitative Sample

The sample I used in the quantitative portion of this research included all democracies that I could find at least 70% of the data for all 49 variables measured in this research. Democracies were identified using the Freedom House (2007) classification of democracy. Countries qualify as democratic if they have a competitive, multiparty political system; universal adult suffrage for all citizens (except prisoners); regularly contested elections that are free, fair, secure, in absence of voter fraud, and representative of the public will; and public access of major political parties through media and campaigning.

While the sample of democracies used in this research began with a considerably higher *N*, sufficient data could only be found for 101 democracies. As such, the countries studied in this portion of the project were selected based on dependent variable data availability.

One initial limitation of this research is that while a significant amount of dependent variable data were found for all countries, those with remarkably less also happened to be those in the developing world. Including the GDP per capita control and being mindful of the

important role that government resource capacity plays in drug policy should help minimize the effect that this limitation has on my research.

Of the independent variables, there is considerable missing data on the political bargaining variable. The reason for this is because the two existing studies on this topic (Lijphart, 1999; Siaroff, 1999) provide a combined *N* of 36. Nonetheless, there were sufficient data for the remaining independent variables used in this analysis.

Beginning with law enforcement, most countries tended to rely on some form of law enforcement instrument in their approach to the illicit drug problem. Overall, the average country reached a score of 5.9 out of a range 0 to 12 on the law enforcement index. As Table 4.1 shows, law enforcement instruments of drug policy are mostly implemented across multiple regions of countries as opposed to one in particular. Generally, a majority of countries adopted measures that include civil asset forfeiture and strict sentences for drug traffickers. In contrast, a slight majority chose not to commit to mandatory minimums or drug courts. The big contrasts in the sample tend to be over imprisoning both hard and soft drug possessors.

The only real surprise in the law enforcement data was a complete turnaround of Bulgaria's drug laws in 2004. While most of the world's countries seem to be liberalizing their drug laws regarding possession, the Bulgarian National Assembly changed possession of soft and hard drugs for personal use from an administrative offense requiring no imprisonment, to a quite significant crime punishable by sanctions laid out in the Penal Code. Several international bodies, including the European Union critiqued this amendment. Changes have yet to be completely finished (Hemp Info, 2006).

Table 4.1
Law Enforcement Instruments

Instrument	None	One Region	More than One Region	*N*	Missing
prison soft drugs	43	0	57	100	1
prison hard drugs	33	0	68	101	0
mandatory min.	39	0	22	61	40
asset forfeiture	15	1	44	60	41
stiff sentence	7	0	82	89	12
drug court	50	0	26	76	25

Despite strong commitments of our sample to law enforcement efforts, fewer states seemed to employ deterrence-based prevention methods, many of which go hand in hand with law enforcement objectives. One of the major problems with this dependent variable was missing data. The average country score was 1.6, with a low of 0 and a high of only 8. Table 4.2 reveals there to be more of an emphasis placed on police education and fear tactics than school and workplace drug testing. This may be in large part because the former two have been around much longer than the latter innovations.

Table 4.2
Deterrence-Based Prevention Instruments

Instrument	None	One Region	More than One Region	*N*	Missing
police education	34	1	34	69	32
fear tactics	34	1	34	68	32
school testing	63	1	6	70	31
workplace testing	60	1	5	66	35

The other prevention variable seemed to yield different results. As Table 4.3 illustrates, a majority of countries are committed to combating the drug problem through education rather than deterrence-based policy instruments. Another easy observation to make is that education-based anti-drug policy initiatives are implemented far more so both locally and regionally than law enforcement or deterrence-based initiatives. There also seems to be a more even distribution

of countries choosing to implement education-based prevention policies across the three different levels. With a low of 0 and a high of 10, the average education-based prevention score was 4.5.

Table 4.3
Education-Based Prevention Instruments

Instrument	None	One Region	More than One Region	*N*	Missing
health curricula	9	5	69	83	18
skills training	21	10	32	63	38
recreation	32	2	21	55	46
health campaign	6	10	60	76	25
prevention outreach	21	4	33	58	43

Turning to the treatment instruments, the abstinence-based treatment index is second to the harm reduction index in having the most number of instruments available to policymakers. This again supports the reason why each dependent variable index is examined independently from the other dependent variable indices—for there is really no fair way to compare them. As Table 4.4 shows, abstinence-based treatment methods seem to be provided less in individual regions, and more in multiple regions. With a low of 0 and a high of 14, the average abstinence-based treatment score was 6.3.

The main difficulty in conducting cross-national research on drug policy that includes analyses of treatment and prevention is that very little data exist on these topics. The current research includes these policy domains to avoid overemphasizing the clash between harm reduction and law enforcement. As such, while there are higher rates of missing data in the prevention and treatment indices, they are still of great benefit to this research.

Table 4.4
Abstinence-Based Treatment Instruments

Instrument	None	One Region	More than One Region	*N*	Missing
treatment outreach	22	4	31	57	44
outpatient	8	5	70	86	15
inpatient	2	7	77	83	18
low threshold	30	7	28	65	36
mandatory treatment	30	0	17	47	54
detoxification	7	6	50	63	38
prison treatment	23	4	31	58	43

The substitution-based treatment data, while limited in the number of instruments, flourished in terms of data availability. The average country score was 1.9, while the maximum score was 6. Methadone maintenance is provided within sample countries slightly more so than buprenorphine. All other substitution-based treatments (ie: morphine) are implanted at quite lower rates than the other two forms. In total, 53 countries in this sample offer some form of substitution-based treatment. Considering the cost of this type of treatment, combined with the fact that it is not abstinence based, it is surprising that at least 50% of the sample engages in this initiative. Table 4.5 shows the some of the similarities and differences in data between the three different categories of substitution-based treatment.

Table 4.5
Substitution-Based Treatment Instruments

Instrument	None	One Region	More than One Region	*N*	Missing
methadone	43	5	44	92	9
buprenorphine	56	7	29	92	9
other	45	6	13	64	37

Last of the six drug policy types, harm reduction appears to be the least utilized, yet has a higher score average (3.9) than both substitution-based treatment and deterrence-based prevention. This is most likely due to wide range of data (high=20, low-0). While many countries

do not subscribe to harm reduction, those that do, accomplish a lot with it. While Table 11 does not illustrate this, a quick examination of the sample's drug policy scores reveal that most countries which engage in harm reduction tend to commit, or at the very least 'experiment', with quite a few instruments[17].

As Table 4.6 illustrates, the data show that of the harm reduction instruments adopted by the sample's countries, there is a gradual increase in implementation as we move away from the single region and towards the multi-region level. The most common instrument used—at the multi-regional level of course—is needle exchange. Second to that is harm reduction outreach. Although separate from needle exchange, harm reduction outreach often accompanies this instrument. Table 11 illustrates the commitment of countries to each instrument in the harm reduction index.

Table 4.6
Harm Reduction Instruments

Instrument	None	One Region	More than One Region	*N*	Missing
heroin maintenance	88	0	8	96	5
medical marijuana	79	2	5	86	15
decriminalization	62	0	13	75	26
de facto decriminal…	46	0	24	70	31
needle exchange	38	5	45	88	13
tolerance zones	76	0	3	79	22
safe sites	78	2	7	87	14
harm red. outreach	35	7	36	78	23
pill testing	75	1	10	86	15
reintegration program	46	4	27	77	24

The sample used in this research offers sufficient data to create the six different indices used in this research. When all data for each drug policy approach are combined into one

[17] For the purposes of this research, experiments in drug policy (which are almost always limited to harm reduction) were included in the dataset if they lasted for more than 2 years. A norm among most developed countries is to run a harm reduction program as a so-called 'experiment' so that they avoid domestic and international flack. Many of these so-called experiments have been renewed several times, leading the instrument to be engaged for upwards of 5 to 8 years.

category the lowest *N* is 91. The data range from a low of 0 in all categories, to a high of 20 in the harm reduction category. A frequency distribution performed on the six drug policy indices and six drug policy scores reveal how many countries had adopted policy instruments from each of the different approaches to drug policy. The second last column on the right side of Table 4.7 shows the number of countries subscribing to at least one or more policy instruments in each of the six approaches. The far right column shows the remaining number of countries in the sample that did not choose to adopt at least one policy instrument from each drug policy approach.

Table 4.7
Summary Statistics for Drug Policy Indices and Scores*

Variable	*N*	Mean	Std.D	Mean	Max	Yes	No
Law Enforcement	101	0.632	0.28	5.9	12	98	3
Deterrence Prevention	91	0.389	2.48	1.6	8	53	38
Education Prevention	93	0.689	4.03	4.5	10	83	10
Abstinence Treatment	93	0.701	4.96	6.3	14	90	3
Substitution Treatment	92	0.390	2.45	1.9	6	52	40
Harm Reduction	94	0.223	6.07	3.9	20	60	34

* Figures in green shade represent drug policy indices while figures in blue shade represent drug policy scores.

When examining the raw drug policy scores of each country, it appears that sample countries subscribe to law enforcement and abstinence-based treatment the most, followed by education-based prevention and harm reduction second, then deterrence-based prevention and substitution treatment third. However when controlling for the amount of observations made in each variable, abstinence-based treatment, education-based prevention, and law enforcement are the most sought-after approaches to the drug problem; while deterrence-based prevention, substitution-based treatment, and harm reduction are less utilized.

To illustrate the variety of countries endorsing certain approaches to the drug problem, Table 4.8 shows the top 10 committing countries per drug policy type. Data for the case study countries that did not make it to the top ten are included underneath the list of other countries that were in the top ten.

Table 4.8
Top Ten Countries per Policy Type

Index	Countries
Law Enforcement	Thailand (12); United States (12); Philippines (11); Romania (19); Japan (10); Israel (10); Bahamas (10); Sierra Leone (10); St. Vincent & Grenadines (10); St. Lucia (10) **Case:** Canada (8); Austria (4); Netherlands (2)
Deterrence-based Prevention	Philippines (8); United States (8); New Zealand (6); South Africa (6); Nicaragua (6); Mexico (6); Iceland (4); Ecuador (5); Ukraine (4); Georgia (4) **Case:** Canada (2); Austria (0); Netherlands (0)
Education-based Prevention	Netherlands (10); United Kingdom (10); Austria (10); Spain (10); Canada (10); Norway (10); Belgium (10); Australia (10); Italy (10); Slovenia (10) **Case:** United States (2)
Abstinence-based Treatment	Switzerland (14); Austria (14); Canada (12); Netherlands (12); United Kingdom (12); Australia (12); Ireland (12); United States (12); Greece (12); Taiwan (12)
Substitution-based Treatment	United Kingdom (6); Switzerland (6); Slovenia (6); Portugal (6); Netherlands (6); Luxembourg (6); Germany (6); Austria (6); France (6); Belgium (6) **Case:** United States (4); Canada (4)
Harm Reduction	Switzerland (20); Netherlands (20); Spain (18); Canada (17); Australia (15); Germany (12); Czech Republic (12); United Kingdom (11); Austria (10); United States (10)

Moving to the other side of the regression model, I had better luck obtaining more complete data. With the exception of political bargaining, the independent variable data collected for this research was fairly comprehensive. Data analyzed for regime type show an *N* of 98 with 45 countries presidential and 53 parliamentary regimes. In total, 73 countries have proportional representation while 28 countries have an alternative electoral design. The intergovernmental relations variable shows less skewness with 34 states being federalist and 67 having unitary governance. The cameralism data reveal 59 of our sample countries to have unicameral

legislatures while the remaining 42 are bicameral. Finally, a recoding of the political bargaining variable into a dichotomous scheme shows that with a low *N* of thirty-five, 21 countries are pluralist while 14 are corporatist.

Of the four control variables used in this research, the sample's most evenly distributed data are found in the political ideology control variable. With an *N* of 87, exactly 30 countries were coded as conservative, 27 as centrist, and 30 as liberal. This distribution is satisfying in that at the very least we know that the sample of countries chosen for this research represent all different types of political ideology. Just as varied, yet less evenly distributed, the data of our sample show that 53 countries have a GDP per capita that is less than $9,999, 20 have a GDP per capita between $10,000 and $19,999 and 28 have a GDP per capita that is over $20,000 (U.S.). Including these data in the analysis will help us take into account and manage the effect that political ideology and resource capacity have on drug policy.

The control data I used for international pressure revealed a wide range of possible influences that international factors can have on domestic decision-making. Though data on the ratio of trade to GDP revealed a slightly skewed distribution in the sample, it is not severe enough to merit any transformations of the data. Finally, data on drug usage revealed that the maximum combined score of drug use is 23 (Ghana), followed by 22.8 (Australia) and 21.3 (Canada). By far, the lowest drug usage scores were 0.02 (Sao Tome & Principe) and 0.07 (Moldova). Table 4.9 illustrates some summary statistics about the independent and control variables used in this research.

Table 4.9
Summary Statistics for the Independent and Control Variables

Variable	*N*	Missing	Applicable Statistics
Regime Type	98	3	presidential = 45; parliamentary = 53
Electoral Design	101	0	majoritarian = 28; proportional representation = 73
Intergovernmental R.	101	0	federalism = 34; unitary governance = 67
Cameralism	101	0	bicameral = 42; unicameral = 59
Political Bargaining	35	66	pluralism = 21; corporatism = 14
Resource Capacity*	101	0	poor = 53; moderate = 20; rich = 28
Political Ideology	87	14	conservative = 30; centrist = 27; liberal = 30
International Pressure	95	6	min = 25.9; max = 214.8; mean = 88.7; std.d = 39.7
Drug Usage	95	6	min = 0.02%; max = 23%; mean = 6.6%; std.d = 5.6

***** *Poor* means a country's GDP per capita is less than $9,999 (U.S.); *moderate* means it is between $10,000 and $19,999; and *rich* means a country's GDP per capita is over $20,000.

The data I gathered for the institutional index had a very normal distribution. While this variable does not serve as the core explanatory variable of this research, its high *N* certainly enables it to be very powerful in examining the effect of political institutions on drug policy. As Table 4.10 illustrates, this sample includes several countries with cooperative policymaking environments as well as several with more competitive policymaking environments.

Table 4.10
Institutional Index Summary Statistics and Country Scores*

Variable Statistics	Top Ten Cooperative	Top Ten Competitive
mean = 0.35 max = 0.76 min = 0 std.d = 0.16 *N* = 101	Norway (0.75); Sweden (0.75); Denmark (0.70); Israel (0.69); Netherlands (0.68); Finland (0.67); Luxembourg (0.66); Iceland (0.57); Mauritius (0.54); Austria (0.53)	Chile (0); Haiti (0); Mexico (0); United States (0.06); France (0.11); Argentina (0.12); Bolivia (0.12); Brazil (0.12); Burundi (0.12); Philippines (0.12)

***** The only case country to not make in the top ten was Canada (0.14); which ranked 11th in the competitive category.

4.1.5 Testing the Hypotheses

The purpose of the empirical portion of this research is to detect the direction, strength, and significance of relationships which may happen to exist between the indicators of political institutions and drug policy that were created for this study. Using ordinary least squares

regression analysis, I tested the hypotheses proposed in Figure 4.1. As outlined, several different types of predictions were tested to examine the effect of institutions on drug policy.

Figure 4.1
Hypotheses Tested

Competitive Policymaking Predictions	**Cooperative Policymaking Predictions**
A1+B1+D1+E1+K1+K2+K3+K4 → LE A1+B1+D1+E1+K1+K2+K3+K4 → DBP A1+B1+D1+E1+K1+K2+K3+K4 → ABT	A2+B2+D2+E2+K1+K2+K3+K4→ EDP A2+B2+D2+E2+K1+K2+K3+K4→ SBT A2+B2+D2+E2+K1+K2+K3+K4→ HR
C1+K1+K2+K3+K4 → LE C1+K1+K2+K3+K4 → ABT C1+K1+K2+K3+K4 → DBP	C1+K1+K2+K3+K4 → EDP C1+K1+K2+K3+K4 → SBT C1+K1+K2+K3+K4 → HR
Z1+K1+K2+K3+K4→ LE, DBP & ABT (negative)	Z1+K1+K2+K3+K4→ EBP, SBT & HR (positive)

Independent Variables	**Dependent Variables**
Electoral Design (A1=majoritarian/A2=proportional) Intergovernmental Relations (B1=federalism/B2=unitary) Political Bargaining (C1=pluralism/C2=corporatism) Cameralism (D1=bicameralism/D2=unicameralism) Regime Type (E1=presidential/E2=parliamentary) Institutions Index (Z1= sum of all institution data)	Law Enforcement (LE) Harm Reduction (HR) Abstinence-Based Treatment (ABT) Substitution-Based Treatment (SBT) Deterrence-Based Prevention (DBP) Education-Based Prevention (EDP)

Control Variables
Political Ideology (K1); Resource Capacity (K2); International Pressure (K3); Problem Severity (K4)

To begin the process, I designed 6 full models that included regime type, electoral design, intergovernmental relations, cameralism, and the four control variables. Political bargaining was left out of the main model because of the limited number of data available for the variable. I also created 36 individual models that included all the control variables and at least one institutional variable (or the institutions index). Only predictions for the individual models containing political bargaining and the institutions index are illustrated in Figure 4.1.

Specific to the institutions index, I predict that a negative relationship will exist between this variable and law enforcement, deterrence-based prevention, and abstinence-based treatment. In contrast, I predict that a positive relationship will exist between this variable and education-

based prevention, substitution-based treatment, and harm reduction. This should occur because all cooperative institutions are coded with higher numbers than are their competitive counterparts.

To prepare for the regression analyses there were some transformations I had to make to the original data. In order to use political ideology in a regression I transformed the three different categories into two separate dummy variables. Holding conservative ideology as a base, I included a dummy for centrist and a dummy for liberal ideology. When examining the distribution of GDP per capita I found the data to be skewed towards lower levels of GDP per capita. To avoid complications caused by this, I used a logarithm of this variable in all 42 models. The distributions of data measuring drug usage and international pressure were even. Correlation tests between the indicators for resource capacity and international pressure revealed no significant relationship between these controls.

When testing the hypotheses I used robust standard errors. The small dataset, combined with the high number of explanatory variables, makes cautious empirical interpretation a smart choice. After running the 42 different regressions, I performed several diagnostics on each model. The first diagnostic test performed was for omitted variable bias. A Ramsey regression specific error test used to examine the fitted values for the dependent variables demonstrated no omitted variable bias. Pearson Correlation revealed there to be no relationship between the independent variables used in the same type of models. Variance inflating factors examined after each regression also showed no sign of multicollinearity within individual models.

Of variables used in the full models compared to the individual models, political bargaining happened to be correlated with proportional representation. This is supported by other researchers (Knag, 1998; Wilenksy, 2002) who point out that before corporatism becomes fully

entrenched into a country's political system, it is often fostered by the political environment that stems from proportional electoral systems. This occurrence of multicollinearity does not affect the results of this research because political bargaining is included in the short models while proportional representation is included in the full models.

The final diagnostic performed on each model was a Cook-Weisberg multiplier to test for heteroskedasticity. While almost all of the models conformed to general Gausian assumptions of ordinary least squares, those tested on harm reduction, abstinence-based treatment and education-based prevention revealed heteroskedasticity. Bar graphs of the distribution for each dependent variable revealed considerable skewness.

Since most of the data included observations of 0, a normal logarithm of the skewed variables would reduce the *N* of each regression. Instead I used a zero-skewness log of these three dependent variables. Regression comparisons of the original models versus the zero-skewed logarithm models showed that the transformations eliminated the problem of heteroskedasticity in all but one of the models. The abstinence-based treatment model—both the full and most of the short models—involved some amount of heteroskedasticity. I trust that the use of robust standard errors helped reduce a portion of the effect this problem poses to the overall results.

4.2 Quantitative Findings

The findings of this project reveal some considerable support for the hypotheses driving this research. In total, 42 models were tested using three main sets of explanatory variables. The first six models included regime type, electoral design, intergovernmental relations, cameralism, a centrist dummy, a liberal dummy, a log of GDP per capita, drug usage, and the ratio of trade to

GDP. The next 30 models included all the controls and at least one institutional variable. The final 6 models included all the controls and the institutions index.

The first dependent variable examined was the law enforcement index. Results of the full model were significant at the 0.001 level. With an R^2 of 30%, the overall explanation of the variance in the dependent variable was moderate. Significant coefficients found in this model support the hypothesis that single member districts are more likely to result in increased law enforcement instruments than in electoral systems based on proportional representation. Results of regime type in the smaller model were significant only to the 0.05 level. The only other variable that had a significant impact on law enforcement was the government resource capacity control. The direction of the coefficient shows that poorer countries are more likely to have law enforcement instruments. This certainly justifies the use of this variable, for most countries begin with law enforcement approaches to the drug problem because the infrastructure is already set up to deal with crime anyway. These results are summarized in Table 4.11.

The next variable examined was the index for deterrence-based prevention. Though significant, the results of the full model regression show that the models are weaker than those examined in the analyses of law enforcement. While most of the individual models are significant, their explanation of variance in deterrence-based prevention is weak. The only controls that had any significant relationship to this dependent variable were the liberal dummy and the log of GDP per capita. As Table 4.12 illustrates, the relationship between deterrence-based prevention and regime type, electoral design, political bargaining and the institutions index occurs in the direction that I predicted; however the strength and significance of these relationship are not strong enough to support the hypotheses made in this research.

Table 4.11
Results for the Law Enforcement Index[a]

	Full Model	Regime Type Model	Electoral Design Model	IG Relations Model	Cameralism Model	Political Bargaining Model	Inst. Index Model
Regime Type	-0.471 (0.071)	-0.023 (0.075)	--	--	--	--	--
Electoral Design	-0.252 (0.064***	--	-0.228 (0.061)**	--	--	--	--
IG Relations	-0.053 (0.092)	--	--	-0.000 (0.071)	--	--	--
Cameralism	0.113 (0.078)	--	--	--	0.031 (0.065)	--	--
Political Bargaining	--	--	--	--	--	-0.115 (0.043)	--
Institutions	--	--	--	--	--	--	-0.227 (0.190)
Centrist	0.000 (0.071)	0.009 (0.081)	0.006 (0.006)	0.008 (0.078)	0.001 (0.079)	-0.095 (0.109)	0.009 (0.076)
Liberal	0.012 (0.074)	-0.018 (0.075)	-0.004 (0.075)	-0.021 (0.075)	-0.020 (0.074)	-0.044 (0.104)	0.009 (0.076)
GDP	-0.116 (0.074)***	-0.148 (0.043)**	-0.137 (0.037)**	-0.155 (0.037)**	-0.153 (0.036)**	-0.032 (0.067)	-0.022 (0.751)**
Trade	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)	0.000 (0.000)	0.000 (0.001)	-0.001 (0.001)	0.005 (0.000)
Drug Use	0.002 0.000	0.006 (0.005)	0.002 (0.005)	0.006 (0.005)	0.006 (0.005)	-0.003 (0.007)	0.005 (0.005)
N	79	79	80	80	80	34	80
R^2	0.307	0.164	0.284	0.165	0.168	0.312	0.181
Prob>F	0.002	0.009	0.000	0.008	0.008	0.008	0.001

[a] Numbers before parentheses are coefficients. Numbers in parentheses are robust standard errors.
* Indicates significance at the 0.10 level.
** Indicates significance at the 0.05 level.
*** Indicates significance at the 0.001 level.

Table 4.12
Results for the Deterrence-Based Prevention Index[a]

	Full Model	Regime Type Model	Electoral Design Model	IG Relations Model	Cameralism Model	Political Bargaining Model	Inst. Index Model
Regime Type	-0.137 (0.124)	-0.149 (0.119)	--	--	--	--	--
Electoral Design	-0.145 (0.119)	--	-0.153 (0.117)	--	--	--	--
IG Relations	0.076 (0.012)	--	--	0.015 (0.103)	--	--	--
Cameralism	-0.072 (0.117)	--	--	--	-0.054 (0.096)	--	--
Political Bargaining	--	--	--	--	--	-0.054 (0.072)	--
Institutions	--	--	--	--	--	--	-0.394 (0.285)
Centrist	-0.095 (0.121)	-0.072 (0.110)	-0.099 (0.119)	-0.081 (0.121)	-0.054 (0.096)	-0.055 (0.072)	-0.086 (0.120)
Liberal	-0.226 (0.114)**	-0.072 (0.110)**	-0.249 (0.109)**	-0.251 (0.108)**	-0.252 (0.109)**	-0.116 (0.159)	-0.210 (0.109)**
GDP	-0.092 (0.078)	-0.106 (0.072)*	-0.133 (0.064)*	-0.150 (0.063)**	-0.157 (0.063)**	-0.050 (0.162)	-0.199 (0.064)**
Trade	-0.371 (0.001)	0.000 (0.001)	-0.133 (0.064)	-0.000 (0.001)	-0.000 (0.001)	0.002 (0.002)	-0.000 (0.001)
Drug Use	0.002 (0.009)	0.004 (0.008)	0.001 (0.008)	0.004 (0.008)	0.004 (0.008)	0.001 (0.011)	0.001 (0.008)
N	70	70	70	70	70	30	70
R^2	0.198	0.116	0.173	0.145	0.149	0.133	0.171
Prob>F	0.041	0.066	0.021	0.031	0.036	0.071	0.034

[a] Numbers before parentheses are coefficients. Numbers in parentheses are robust standard errors.
* Indicates significance at the 0.10 level.
** Indicates significance at the 0.05 level.
*** Indicates significance at the 0.001 level.

Moving to the final set of predictions made on competitive policymaking environments, regression results on abstinence-based treatment are not very satisfying. The model as a whole lacks significance, as do all of the individual models. Even the control variables failed to have any significant explanatory power on the variation of abstinence-based treatment. This may very

well be the result of heteroskedasticity caused by skewness in the dependent variable. A variety of diagnostic measures were taken to fix the problem caused by the distribution of data in this index; however all of them failed to remove heteroskedasticity from the model. The final model illustrated in Table 4.13 is the model with the least amount of heteroskedasticity.

Table 4.13
Results for the Zero-Skewed Logarithm of the Abstinence-Based Treatment Index[a]

	Full Model	Regime Type Model	Electoral Design Model	IG Relations Model	Cameralism Model	Political Bargaining Model	Inst. Index Model
Regime Type	-0.002 (0.201)	-0.035 (0.193)	--	--	--	--	--
Electoral Design	-0.049 (0.171)	--	-0.031 (0.165)	--	--	--	--
IG Relations	0.171 (0.223)	--	--	0.106 (0.148)	--	--	--
Cameralism	-0.007 (0.208)	--	--	--	0.096 (0.136)	--	--
Political Bargaining	--	--	--	--	--	-0.022 (0.104)	--
Institutions	--	--	--	--	--	--	0.294 (0.412)
Centrist	0.095 (0.151)	0.109 (0.149)	0.100 (0.141)	0.101 (0.144)	0.113 (0.136)	0.050 (0.195)	0.184 (0.141)
Liberal	0.103 (0.162)	0.093 (0.155)	0.086 (0.154)	0.102 (0.155)	0.095 (0.115)	-0.063 (0.232)	0.090 (0.156)
GDP	-0.102 (0.125)	-0.118 (0.124)	-0.125 (0.108)	-0.108 (0.103)	-0.122 (0.106)	0.145 (0.147)	-0.148 (0.117)
Trade	0.000 (0.001)	0.001 (0.001)	-0.125 (0.108)	0.000 (0.001)	0.000 (0.001)	-0.001 (0.002)	-0.006 (0.001)
Drug Use	-0.001 (0.120)	-0.002 (0.012)	-0.002 (0.012)	-0.000 (0.012)	-0.001 (0.012)	-0.020 (0.017)	-0.000 (0.012)
N	72	72	72	72	72	34	72
R^2	0.068	0.049	0.049	0.067	0.057	0.086	0.050
Prob>F	0.835	0.665	0.683	0.555	0.574	0.426	0.647

[a] Numbers before parentheses are coefficients. Numbers in parentheses are robust standard errors.
* Indicates significance at the 0.10 level.
** Indicates significance at the 0.05 level.
*** Indicates significance at the 0.001 level.

Turning to the testing of hypotheses made of cooperative policymaking environments, the full model explained 23% of the variation in the zero-skewed logarithm of the education-based prevention index. Contributing to the strength of this model, the indicator for international pressure does have a significant positive relationship with the dependent variable. Another control with some explanatory power was drug usage. It appears that countries with higher drug usage scores appear in countries with fewer commitments to education-based prevention.

The same results were found in the individual models. The only exception was that the individual model tested with intergovernmental relations significantly explained 18% of the variation in country commitments to abstinence-based prevention. The direction of the intergovernmental relations coefficient shows that federalist countries are more apt to pursue such approaches to the drug problem (see Table 4.14).

The substitution-based treatment index appears to be affected mainly by electoral design, regime type, resource capacity, and liberal political ideology. The full model explains 58% of the variation in commitments to substitution-based treatment. As Table 4.15 shows, the relationship between electoral design and substitution-based treatment is significant at the 0.001 level. Also, the relationship between regime type and the dependent variable is significant at the 0.05 level. The positive direction of these relationships bring great support to my prediction that proportional representation and parliamentary regimes have a positive impact on the commitment of governments to substitution-based treatments like methadone, buprenorphine, as well as others.

Table 4.14

Results for the Zero-Skewed Logarithm of the Education-Based Prevention Index[a]

	Full Model	Regime Type Model	Electoral Design Model	IG Relations Model	Cameralism Model	Political Bargaining Model	Inst. Index Model
Regime Type	-0.366 (0.465)	0.064 (0.111)	--	--	--	--	--
Electoral Design	-0.480 (0.384)	--	-0.431 (0.367)	--	--	--	--
IG Relations	0.661 (0.495)	--	--	0.641 (0.331)**	--	--	--
Cameralism	-0.117 (0.443)	--	--	--	0.287 (0.307)	--	--
Political Bargaining	--	--	--	--	--	-0.250 (0.176)	--
Institutions	--	--	--	--	--	--	-0.790 (0.100)
Centrist	-0.348 (0.387)	-0.090 (0.097)	-0.046 (0.089)	-0.062 (0.093)	-0.096 (0.115)	-0.077 (0.177)	0.355 (0.369)
Liberal	-0.256 (0.347)	0.015 (0.087)	0.014 (0.085)	0.010 (0.084)	-0.051 (0.108)	0.075 (0.112)	0.335 (0.369)
GDP	-0.132 (0.266)	0.082 (0.060)	0.075 (0.046)	-0.082 (0.046)	-0.097 (0.063)	0.076 (0.112)	-0.245 (0.232)
Trade	0.006 (0.004)*	-0.001 (0.000)*	0.075 (0.046)*	-0.001 (0.000)	-0.006 (0.001)*	-0.000 (0.000)	-0.007 (0.003)*
Drug Use	-0.049 (0.030)*	-0.011 (0.005)*	-0.014 (0.006)**	-0.009 (0.006)**	-0.045 (0.007)*	-0.061 (0.032)*	-0.053 (0.026)**
N	74	74	75	75	75	34	75
R^2	0.230	0.162	0.159	0.180	0.150	0.176	0.148
Prob>F	0.003	0.012	0.013	0.000	0.032	0.099	0.020

[a] Numbers before parentheses are coefficients. Numbers in parentheses are robust standard errors.
* Indicates significance at the 0.10 level.
** Indicates significance at the 0.05 level.
*** Indicates significance at the 0.001 level.

Within the individual models, regime type and electoral design were again significant. The model testing the institutions index revealed that 55% of the variation in commitments to substitution-based treatment can be explained. The significant coefficients show that an increase

in the institutions index is strongly associated with an increase in the substitution-based treatment index.

The control variables in the substitution-based treatment models I found to have a significant relationship to the dependent variable were the indicators for liberalism, government resource capacity and drug usage. While the former two had significance in both the full and individual models, drug usage was only significant in the full model and the individual model with electoral design and the institutions index as the main explanatory variables. The indicator for international pressure showed a very weak positive relationship to substitution-based treatment in the regime type model.

The final regression analysis was on the harm reduction index. The full model revealed that a positive and significant relationship exists between proportional representation and harm reduction instruments. While not significant, the direction of the impact that regime type has on harm reduction is supportive of the hypotheses made. Surprisingly however, unicameral legislatures were shown to have a strong negative impact on harm reduction; indicating that bicameral countries are more likely to have higher harm reduction commitments. Also, though not significant, federalism appears to be more related to harm reduction than is unitary governance. This offers some support to the counter-hypotheses of this research.

Within the individual models, cameralism was the only independent variable to exert any significant influence over harm reduction commitments. The results support the counter hypothesis, that bicameralism is more related to harm reduction than is unicameralism. All of the individual models had an average R^2 of 30% and were significant at the 0.001 level.

Table 4.15
Results for the Substitution-Based Treatment Index[a]

	Full Model	Regime Type Model	Electoral Design Model	IG Relations Model	Cameralism Model	Political Bargaining Model	Inst. Index Model
Regime Type	0.138 (0.087)*	0.151 (0.083)*	--	--	--	--	--
Electoral Design	0.220 (0.074)***	--	0.222 (0.069)***	--	--	--	--
IG Relations	-0.022 (0.083)	--	--	0.010 (0.074)	--	--	--
Cameralism	0.024 (0.074)	--	--	--	0.044 (0.070)	--	--
Political Bargaining	--	--	--	--	--	0.017 (0.057)	--
Institutions	--	--	--	--	--	--	0.471 (0.189)**
Centrist	0.108 (0.078)	0.089 (0.088)	0.112 (0.076)	0.097 (0.087)	0.099 (0.087)	0.154 (0.521)	0.097 (0.084)
Liberal	0.156 (0.089)*	0.172 (0.086)**	0.179 (0.086)**	0.195 (0.083)**	0.195 (0.081)**	0.261 (0.152)*	0.196 (0.082)**
GDP	0.291 (0.051)***	0.300 (0.051)***	0.338 (0.040)***	0.350 (0.041)***	0.353 (0.041)***	0.338 (0.111)**	0.317 (0.043)***
Trade	-0.130 (0.001)	0.000 (0.001)	0.000 (0.001)	0.000 (0.001)	0.000 (0.001)	0.002 (0.002)	0.000 (0.001)
Drug Use	0.011 (0.005)**	0.007 (0.005)	0.011 (0.005)**	0.007 (0.005)	0.007 (0.005)	0.003 (0.012)	0.010 (0.005)*
N	74	74	75	75	75	33	75
R^2	0.587	0.530	0.571	0.518	0.521	0.398	0.552
Prob>F	0.000	0.000	0.000	0.000	0.000	0.001	0.000

[a] Numbers before parentheses are coefficients. Numbers in parentheses are robust standard errors.
* Indicates significance at the 0.10 level.
** Indicates significance at the 0.05 level.
*** Indicates significance at the 0.001 level.

As for the control variables, several results came out as predicted. In the full model, both of the indicators for political ideology as well as the indicator for government resource capacity showed strong positive relationships with commitments to harm reduction. In the individual models, the liberal dummy and the log of GDP per capita were strong throughout. The centrist

dummy and drug usage indicator were significant in only a few of the individual models (see Table 4.16).

Table 4.16
Results for the Zero-Skewed Logarithm of the Harm Reduction Index[a]

	Full Model	Regime Type Model	Electoral Design Model	IG Relations Model	Cameralism Model	Political Bargaining Model	Inst. Index Model
Regime Type	0.001 (0.245)	-0.009 (0.263)	--	--	--	--	--
Electoral Design	0.621 (0.225)**	--	0.481 (0.217)	--	--	--	--
IG Relations	-0.028 (0.228)	--	--	-0.225 (0.234)	--	--	--
Cameralism	-0.463 (0.231)**	--	--	--	-0.338 (0.219)*	--	--
Political Bargaining	--	--	--	--	--	0.159 (0.195)	--
Institutions	--	--	--	--	--	--	-0.356 (0.593)
Centrist	0.461 (0.268)*	0.417 (0.290)	0.424 (0.268)*	0.376 (0.282)	-0.338 (0.219)	0.523 (0.481)	-0.356 (0.593)
Liberal	0.476 (0.261)*	0.572 (0.264)**	0.531 (0.269)**	0.554 (0.265)**	0.346 (0.282)	0.572 (0.449)	0.378 (0.284)
GDP	0.485 (0.144)***	0.595 (0.154)***	0.564 (0.145)***	0.592 (0.138)***	0.556 (0.261)**	0.283 (0.283)	0.572 (0.263)**
Trade	-0.001 (0.003)	-0.002 (0.003)	-0.002 (0.002)	-0.001 (0.002)	-0.001 (0.002)	-0.000 (0.005)	-0.002 (0.002)
Drug Use	0.028 (0.019)	0.021 (0.018)	0.030 (0.019)*	0.019 (0.018)	0.019 (0.018)	0.079 (0.031)**	0.019 (0.019)
N	75	75	76	76	76	33	76
R^2	0.382	0.291	0.336	0.308	0.322	0.374	0.301
Prob>F	0.000	0.000	0.000	0.000	0.000	0.000	0.001

[a] Numbers before parentheses are coefficients. Numbers in parentheses are robust standard errors.
* Indicates significance at the 0.10 level.
** Indicates significance at the 0.05 level.
*** Indicates significance at the 0.001 level.

As mentioned in the opening paragraph of this section, I anticipated the weak results generated from the data-poor indicator of political bargaining. In a second attempt to empirically

observe the relationship between political bargaining and the six drug policy indices I used a Pearson's Correlation to determine the direction of relations between the variables. The results show that political bargaining is negative correlation with a country's commitment to the implementation of law enforcement instruments. As such, when pluralism increases, so does the number of law enforcement and instruments that a country implements.

Although not statistically significant, Table 4.17 shows that the correlations between political bargaining and both harm reduction and substitution-based treatment are in a positive direction; meaning corporatism may lead to policymaking conditions that foster the acceptance of such drug policy alternatives. In contrast, the correlation between harm reduction and deterrence-based prevention is in a negative direction. These findings do offer guidance to answering some of the questions explored in this research. Although these results are not as informative as those obtained through the regressions, they do tell us that political bargaining may very well tell us something about drug policies across countries.

Table 4.17
Correlation Results for Political Bargaining[a]

Drug Policy Index	**Correlation Results**
Law Enforcement	(-0.441)**
Deterrence-Based Prevention	(-0.245)
Abstinence-Based Treatment	(0.050)
Education-Based Prevention	(-0.091)
Substitution-Based Treatment	(0.130)
Harm Reduction	(0.037)

[a] Numbers in parentheses indicate correlation strength and direction.
** Indicates significance at the 0.05 level.

While running correlations, I also decided to try some extra analyses using the remaining independent and control variables. The tests showed several correlation results that support the hypotheses made in this research. Law enforcement is negatively correlated with political bargaining, regime type, electoral design, and the institutions index. This suggests that more

competitive institutional structures like pluralism, presidentialism, and majoritarian systems lead to law enforcement solutions to the drug problem. Likewise, I found deterrence-based prevention to also be negatively correlated with electoral design and the institutions index.

In cooperative policymaking environments, I found that education-based prevention is positively correlated with intergovernmental relations. This suggests that unitary governance enables policymakers to make more commitments in this approach. Substitution-based treatment is positively correlated with the institutions index; which suggests that more cooperative institutions lead to substitution based treatment practices. Finally, I found that harm reduction is positively correlated with electoral design and regime type; which supports the argument that proportional representation and parliamentary democracy removes many of the barriers that prevent harm reduction innovation from occurring.

Though some of the correlation results support the hypotheses made in this research, some support the counter-hypotheses. It appears that education-based prevention is negatively correlated with electoral design. This implies that majoritarian voting structures are more related to education-based prevention. Also, the negative correlation between cameralism and harm reduction suggests that bicameral legislatures produce more harm reduction commitments than unicameral legislatures. This was also found in the regression results.

While some of the correlation results do not necessarily reject the null hypotheses, they definitely help us realize that there is something important going on between drug policy and political institutions. This is particularly relevant as we continue on to the qualitative portion of this project. To summarize the quantitative results found through both regression and correlation analyses, Table 4.18 lists the variables I had predicted would affect each index, as well as the actual determinants and correlations found in this research.

Table 4.18
Predicted Determinants & Correlates versus Actual Determinants & Correlates*

Drug Policy	Predicted Determinants/ Correlates	Actual Significant Determinants	Actual Significant Correlates
Law Enforcement	presidential regime, pluralism, federalism, single member districts, bicameralism	single member districts	pluralism, presidential regime, single member districts
Deterrence-based Prevention	presidential regime, pluralism, federalism, single member districts, bicameralism	none	single member districts
Abstinence-based Treatment	presidential regime, pluralism, federalism, single member districts, bicameralism	none	none
Education-based Prevention	parliamentary regime, corporatism, proportional representation, unitary governance, unicameralism	*federalism*	single member districts, unitary governance
Substitution-based Treatment	parliamentary regime, corporatism, proportional representation, unitary governance, unicameralism	proportional representation, parliamentary regime	proportional representation
Harm Reduction	parliamentary regime, corporatism, proportional representation, unitary governance, unicameralism	proportional representation, *bicameralism*	parliamentary regime, proportional representation, *bicameralism*

* All determinants and correlates are significant to at least the 0.100 level, but mostly to 0.05 or 0.001 level. The *italicized* institutions represent support for the counter-hypotheses.

4.2.1 Quantitative Summary

The results of the quantitative analysis are a strong first step towards identifying the role that political institutions play in drug policy. With the exception of the abstinence-based treatment variable, all the models used to explain drug policy had significant R^2s that ranged from a low of 0.11 to a high of 0.55. Both the full and individual models were able to explain significant variation in drug policy across a large majority of the sample.

As this research argues, many other determinants—including government resource capacity, political ideology, international pressure, and severity of the drug problem—can also affect drug policy. However, the effect that political institutions have on drug policy is an

important one. As the findings reveal, several institutional structures have a significant and somewhat strong impact on a country's commitment to the six different types of drug policy explored in this paper.

The positive influence that single-member districts have on law enforcement policies reinforces my argument that competitive policymaking environments provide barriers to reform that end up protecting and even advancing the law enforcement status quo. The correlation between law enforcement and pluralism, presidential regime, and single member districts; and between deterrence-based prevention and single-member districts, also add strength to this notion.

Turning towards my theory that a cooperative policymaking environment leads to more harm reduction, substitution-based treatment and education-based prevention; some support has been found in the quantitative results. The positive impact that proportional representation has on substitution-based treatment and harm reduction is very encouraging. This demonstrates that as political leaders are forced to form coalitions, there is less resistance to develop more liberal approaches to the drug problem. The strong positive correlations between proportional representation and substitution-based treatment; between harm reduction and both parliamentary regime and proportional representation; and between education-based prevention and unitary governance, are also supportive of the arguments made in this research.

The control variables used in this research definitely provide us with knowledge on drug policy that we didn't have before. According to regression results, conservative political ideology explains some of the variation in deterrence-based prevention. In contrast, increases in liberal political ideology are related to increases in both substitution-based treatment and harm

reduction. These findings confirm the notion that politics and the positions of political parties do play a part in the drug policy process.

The control for government resource capacity also helped explain governmental approaches to the drug problem. As the findings illustrate, the growth of a country's GDP per capita is associated with a decrease in commitments made to law enforcement, deterrence-based prevention, and education-based prevention. In the reverse, an increase in a country's GDP per capita is associated with an increase in its commitments to instruments of harm reduction and substitution-based treatment. Assuming that all countries start with a law enforcement approach to the drug problem, these findings help us infer that countries with the means to pursue alternative drug control strategies indeed do so.

Less effective in explaining variation in the dependent variables were international pressure and drug usage. While the theoretical reasoning for including these two controls is strong, the empirical results suggest that perhaps the explanatory power of these two variables is limited. Regression results reveal that the significant impact of international pressure on drug policy is limited to commitments of education-based prevention. More in-depth research on this approach to the drug problem could reveal that richer countries provide increased opportunities for poorer countries to learn how to address demand-side issues by educating the public on addictions-related issues.

On the topic of drug use, regression results reveal that countries with more severe drug problems make more commitments to substitution-based treatment approaches. A possible explanation for this may be that policymakers in more drug-consuming countries realize the need to stabilize users with the types of instruments available under a substitution-based approach to

treatment. This realization comes from the fact that many people use drugs, and the effects of the problem are far more visible than in countries where drug consumption is less apparent.

Not so easy to explain is the significant negative relationship between the severity of the drug problem and education-based prevention. The only theoretical explanation this research can provide is that the relationship between drug policy and drug usage may be endogenous. In other words, the reason why some countries have such high rates of drug use is because they have fewer commitments to education-based prevention programs. Additional research may also find that the same circumstances could exist between drug usage and deterrence-based prevention.

Although several predictions were confirmed in this research, I found a number of unexplained relationships within the empirical results. The first is the negative impact that unicameral legislatures have on harm reduction. I argue throughout this paper that unicameral legislatures provide fewer barriers to drug reform than do bicameral legislatures; but perhaps the status quo is maintained by unicameral legislatures that do not often hear alternative ideas that may very well come from an opposite chamber. This explanation may also account for the correlation I found between these two variables.

Another surprise was the correlation of education-based prevention to federalism. This may very well be attributable to opportunities of innovation and exploration that come with regionalization of drug policy. As several of the respondents I interviewed suggest, drug policy changes often happen at the local or regional level before they happened at the national level. Perhaps these findings offer empirical support for that position.

4.2.2 Quantitative Limitations

Although the quantitative section of this methodology did yield some solid results, there are some limitations that I have had to work with. The first is data availability. While I have

created what may be one of the first cross-national drug policy datasets in the world, the average number of observations for each index is between 91 and 101. While controlling for the number of observations allowed me to perform some statistical operations, more data would have significantly increased the selection of empirical tools I could have considered.

Another related limitation inherent to this project is that there exists almost no opportunity to use time-series data. Since most countries have the same political institutions for several decades, it is difficult to expand the number of cases beyond the number of democracies in the world. Adding to the problem, most countries have only really started addressing the drug issue in the 1970s. As such, only three decades of very slow-moving drug policy initiatives does not offer very much variation to study.

Perhaps the most important data limitation is in the individual instruments I used to build the indices. Essentially, each one is built from indications I found through extensive case research of all 101 countries. While I searched for each country numerous times and through multiple methods, there is a strong possibility that I did not find sufficient data for those countries. Furthermore, some drug policy instruments (ie: needle exchange) are cited in the literature far more than others (ie: fear campaigning). As such, there is a chance that some indices are not represented as well as others. Despite this limitation however, one good thing is that almost always when I found data for a particular variable, I found it for almost all countries. This is a far less threatening of a mistake than finding data for all variables but not for all countries.

A fourth limitation concerns the strength of the indicator I used to control for international pressure. Finding a perfect indicator would be very difficult. In many developing countries it is difficult to determine whether certain drug policy instruments were implemented

because of domestic preference and resource capacity or because an outside actor either provided the instrument or guided the developing country towards providing that instrument. Some good examples I found while building the database was Latin American states who receive D.A.R.E. training or funding from the United States. In Asia and Africa, several countries receive harm reduction money from different non-profit philanthropists to provide things such as needle exchanges and harm reduction outreach.

A related observation I had was that many of the countries which receive law enforcement and prevention support from the United States also have many of the same institutional variables. As such, without very specific measurement, it would be very difficult to differentiate the influence that the United States has on these developing countries from the influence that their political institutions (which resemble America's institutions) have on drug policy.

To construct a variable that measured the exact influence of international pressure on drug policy would be extremely difficult. One reason is that finding data on whether a country self-finances a policy instrument or receives assistance from abroad would be extremely time-consuming. In the rare cases where I could identify whether a country received outside money for drug policy, the data were limited to deterrence-based prevention funds from the United States Government, and needle exchange funds from George Soros' Open Society Institute. Not only are there many other sources of drug policy money, but these two contributors generally only give money to certain beneficiaries. Since each has a totally opposite agenda for the world, especially where drug policy is concerned, those beneficiaries are usually different groups of countries altogether. As such, trying to find sufficient data for this type of international influence is not possible within the scope and time restraints of this research.

Another reason why it would be difficult to measure the exact level of international pressure is because even if one could find some form of data, unless the researcher completed a case study (with interviews) on each country in the dataset, it would be impossible to differentiate between countries whose political actors want certain drug policy instruments—and can only afford them if they receive outside funding—and developing countries who do not necessarily desire a certain drug policy instrument but are being pressured to accept it by outside contributors. While an indicator of foreign aid may help in a sample of developing countries, these data would not tell us anything about the international pressure experienced by developed countries (most of whom do not receive foreign aid).

In light of these restraints, I used a more generic indicator of international pressure that measured each country's dependence on the international system. While this variable did manage to account for some variation in drug policy, future researchers should consider developing a more specific indicator of international pressure on drug policy. When doing so, they may also want to consider finding a way to tie in an indicator for government resource capacity; as richer nations (ie: United States) tend to help poorer nations in the easiest ways they know how (law enforcement).

Despite these limitations to the quantitative section of this research, we now know that there is some sort of measurable relationship between institutional design and the types of drug policy instruments democracies choose to implement. Missing from the picture however is a complete explanation of the way in which that relationship is structured. Furthermore, what in particular does the policymaking environment do to bureaucrats who often have a major influence on the policy process? Only elite interviews with those on the front line of drug policy decision making will help us find out.

CHAPTER FIVE

5.0 QUALITATIVE METHODOLOGY

To compliment as well as answer some of the unanswered questions explored in the quantitative analysis, I conducted interviews with various participants in the policy process who could provide a more complete understanding of the relationship between political institutions, bureaucratic dominance, and illegal drug policy. According to Lilleker (2003), elite interviews can provide an immense amount of information that otherwise would not be available through empirical analysis or even extensive literature reviews. Interviews with appropriate respondents can reveal a significant amount of detail, insight, and historical knowledge that would otherwise be missed. In particular, they are designed to target people directly involved in politics (Dexter, 1970). As Fitz and Halpin (1994) find in their research on education policy, elite interviews help researchers identify and understand the individuals and policy networks involved in the policy process. These groups and their level of influence could easily go undetected without such tactics.

In the current research, political elites, bureaucrats, interest group leaders, and service providers in Canada, the United States, Netherlands, and Austria were interviewed. The roles of these four groups in drug policy are equally important. To establish a list of potential interviewees, I accomplished three tasks. The first was a review of recent drug policy legislation, press releases, websites, and government directories to see who is involved in the drug policy process. My second task was to meet with other drug policy scholars who were able to provide me with the names and positions of individuals they felt met the needs of my research.

Once in the field, I utilized my third technique of identifying respondents: snowballing. According to Beamer (2002), snowballing allows a researcher to garner a rich amount of information on potential respondents and their role in the political process. While snowballing runs the risk of directing the researcher to irrelevant respondents, the benefits of even a few solid interviews is well worth the researcher's time. In a quasi-structured fashion, I interviewed each respondent in-person or on the telephone. According to Davies (2001), interviewing elites in this manner allows for the respondent to cover a variety of topics that the researcher may not have thought about. In return, the interviewer also maintains some control over the direction of the interview.

During the interviews there was a series of topics in which I wanted the respondents to discuss. The first was their involvement in drug policy and the level of influence that they perceived to have. This information informed me of where in the drug policy arena each respondent belonged and what kind of relationship he/she had with other members of the same network. Having these data allowed me to more accurately compare responses across policy actors and countries.

Another topic area I discussed with respondents was their country's national drug strategy and why they thought it existed in the current format. While broad, this discussion informed me of how they view drug policy and the history behind its creation in their country. During this discussion I found out a little more about the actors involved in each country's drug policy network, and began to piece together the positions of each actor in the drug policy spectrum.

Moving to more specific areas of the matter, I asked respondents to describe to me the relationships between the actors involved in their country's drug policy environment. I asked

them to give me examples of specific events where actors in one policy domain played an active role in either supporting or sabotaging the drug policy proposals of actors at other ends of the ideological spectrum. Near the end of this conversation—if the interviewee had not mentioned the role of bureaucrats yet—I asked if they could tell me about the role of bureaucrats in drug policy formation, and in particular, the efforts they have had/not had in trying to change or maintain the drug policy status quo.

Moving back to a broader level of analysis, I then asked the respondents a three stage question regarding institutional structures and drug policy liberalization. In the first stage, I asked each respondent if she knows of a major explanatory factor in the relationships (whether they be cooperative or competitive) between drug policy actors in their country. I then mentioned institutional design and inquired their thoughts on its involvement in the politics of drug policy. Finally, I asked respondents to envision their country's drug policy subsystem under a different set of political rules and institutional design. This last topic of discussion allowed me to learn how policy actors see their relationships with others as a function of institutional design, personality, or pure chance.

With any set of questions, there are some limitations. The first one I anticipated was that some respondents may be so involved in their own sector of the country's drug policy subsystem that they don't know much about the role and influence of others. In contrast, some may be so knowledgeable of the policy environment surrounding illicit drugs that they may oversimplify the dynamics involved. As some researchers warn (Glynn & Booth, 1979), elites at all ranks can often minimize the complexity of the political system, and ultimately overemphasize their own power and positioning within that system.

To avoid these over or underestimates from spoiling an interviewee's response, I was sure to ask clarification questions at different points throughout the interviews. The questions I have designed solicit enough dialogue on 'policy actors' that I am confident an accurate assessment of the respondent's perception of himself and others can be drawn from the interview. Such practices are simple steps towards achieving convergent validity—or consistent orientation—in the responses (Judd, Smith, & Kiddler, 1991).

The next set of weaknesses I saw with these topics was specific to the conversation on institutions. While I assumed that most respondents would be somewhat familiar with political rules and institutional design, I had to be careful in asking questions about how these structures are related to drug policy liberalization. Many respondents had been involved in politics long enough to comment on these factors. Some were even formally trained to examine institutional implications in policymaking. Yet there still was a few who do not see the political system in this manner; as such I had to accept that.

To ensure that the responses can be compared across similar actors and countries, I had to make it clear which institutions I was inquiring about. As such, during this particular part of the interview I took a step towards more structured interviewing and requested that respondents at least comment on a few of the institutional structures in my study. Where this was not possible, I urged them to inform me of what aspects of their political system made their country's drug policy different from that of another. If anything, the purpose of this was to enhance discriminate validity, which exists when the respondent's attention is focused on the construct (Judd, Smith & Kiddler, 1991).

In analyzing the results of these interviews, I utilized basic content analysis. If certain descriptions or features of a response appeared similar, I coded them the same. Upon the end of

the coding process, I started to group both the popular and rare responses. As most qualitative analyses turn out, the bulk of the results section in this project is spent summarizing what the respondents have said about drug control, policy actors, and political institutions. An outline of the questions I posed during the interviews is located in the appendices.

5.1 The Qualitative Sample

As for case selection used in this research, I have chosen to include the United States and the Netherlands because they sit at two opposite ends of the drug policy spectrum. Sitting in the middle—in terms of our dependent variable—are Canada and Austria. Some researchers (King, Keohane, & Verba, 1994) warn that selecting cases based on the variation of the dependent variable is bad. However others (Beamer, 1999; Dion, 1990) counter that doing so guarantees an examination of the dependent variable at all possible levels (ie: high, medium, low). In support of this claim, I am confident that my selected countries are a solid pick.

When it comes to justifying the sample of respondents I have selected, there is no doubt that political elites, bureaucrats, interest group leaders, and service providers are the main actors involved in drug policy. While in each country, I mainly focused on drug policy actors stationed in the capital city. The reason for this is solely because most participants in this process are located within the capital. I did however venture outside of the capital to interview respondents at the regional and municipal levels, particularly in areas with significant developments in the area of drug policy.

Of the respondents interviewed for this research, a majority were federal, with a few municipal and even less sub-national. In general, I tried to find respondents who had some sort of interest or tie to drug policy. Many of the elected and appointed political officials I interviewed were chosen based on their involvement in certain committees, portfolios, or critic positions that

were drug policy-oriented. Others were chosen because they did not have a specific tie to drug policy and could offer a very neutral understanding of drug policy. Bureaucrats were chosen mainly based upon the wing of the bureaucracy they served under (ie: health, justice, interior, etc.). When it came to interest group leaders, advocacy groups, or national associations, I tried to find an even balance between the interests represented by these groups. Finally, academics, researchers, and practitioners were solicited based upon their areas of expertise.

An additional category that I developed for three respondents in Netherlands was that of diplomats and foreign agents. Of all four countries, Netherlands was the only one which hosted diplomats and foreign agents with a specific focus on drug policy. The Drug Enforcement Administration has several country attaches and special agents working at the American Embassy in Den Haag. While these individuals do not necessarily have direct access to Dutch policymaking, they do meet with Dutch officials to learn about their goals and strategies for approaching the drug problem. These individuals are also responsible for coordinating diplomatic visits from American policymakers and bureaucrats who do try to influence the design of Dutch drug policy[18].

As Table 5.1 illustrates, the largest categories of respondents were federal politicians and federal bureaucrats. I spent a considerable amount of time trying to interview those at the core of formulating, implementing, and evaluating drug policy. While not as numerous, respondents in other categories were just as helpful in explaining the drug policy process, how it works, and what affects it. Activists and lobbyists often spend a lot of time analyzing drug policy and meeting with those responsible for this policy domain. Practitioners and their national associations are important assets to this research in that they are not only the ones who provide

[18] As an interesting side note, while I was at the American Embassy one of my respondents was busy making an itinerary for a visit from U.S. Drug Czar John Walters.

direct services to drug users, but are far removed from the politics of drug control—something even bureaucrats have trouble avoiding. Finally, fellow researchers and academics are critical to ensuring that I am gaining an accurate and *localized* understanding the interaction of institutions, bureaucrats, and drug policy. A list of the agencies and organizations the respondents represent is located in Table A.3 of the appendices.

Table 5.1
Respondent Categories by Country

Category	USA	CAN	AUS	NETH
municipal policymakers (elected)	0	1	1	2
sub-national policymakers (elected)	0	0	4	0
federal policymakers (elected/appointed)	4	13	14	15
federal political staffers	12	2	2	2
municipal bureaucrats	0	1	1	2
sub-national bureaucrats	0	0	4	3
federal bureaucrats	10	7	2	9
academics and researchers	2	5	3	5
activists and lobbyists	9	4	0	0
practitioners and service providers	1	1	2	3
professional associations	4	2	1	0
diplomats and foreign agents	0	0	0	2
N = (155)	***42***	***36***	***34***	***43***

In terms of access to respondents, I found that in all countries it was quite possible to get interviews with practitioners, academics, researchers, activists, and lobbyists. Interviews with national professionals' association executives were also attainable, but with less ease and longer wait times. Overall, it seemed to me that time restrictions and hectic schedules of these individuals served as the only real barrier to access. When it came to interviewing policymakers and their bureaucrats, considerable differences in my access to these individuals existed between countries.

Of all four cases, it seemed that respondents in United States were the most difficult to secure interviews with. The low number of elected officials shows that the schedules of these

individuals offer almost no time for researchers. Those elected officials I did interview in America happened to have either a strong constituent or committee interest in drug policy, and were thus more interested to meet with someone studying the topic. In a lot of cases, interviews with the political staffers of several politicians were offered to me as the next best thing. As Table 5.1 shows, I took that opportunity a dozen times.

As for bureaucrats in America, overall access to these individuals was more possible, yet the hurdles to gaining that access were considerably higher. In one particular quest for an interview with an official who relocated to the Pentagon, I not only had to provide them with references for myself, but a preliminary copy of this work as well as sample copies of other articles I have published on topics completely unrelated to drug policy. It surprised me that in almost all cases, bureaucrats in the United States were protected far more than their political leaders situated in the Congressional buildings.

While I cannot confirm this in anyway, it seemed that several of my requests for interviews with American Congressmen, Senators, and even top-level bureaucrats were denied because of my topic, the country I come from, and even the *liberal* degree I was seeking. I often wondered if I could have been granted more access if I had told certain potential respondents about my masters in criminal justice rather than my pursuance of a PhD in political science.

Nonetheless I cannot complain, for the individuals I managed to interview were a strong representation of all parts of the drug policy domain. While I would have liked to have interviewed more elected officials at the federal level, other field researchers in the DC area have informed me that I was lucky to secure the interviews I did get. The meetings I had with political staffers from both political parties in the United States were also very helpful, and provided some of the very rich information I was after to begin with.

In Canada, access to respondents was easier to come by than in the U.S. However it was not as easy as I thought it would be. To my surprise, the security, screening, and even questioning of my purpose for meeting respondents was much more intense in Ottawa than in Washington. Even from a physical security perspective, I had to be escorted around the House of Commons whereas once I passed the first metal detector on Capitol Hill, I was free to roam. From a research perspective this was great, for I ended up going office to office setting up appointments with staffers and politicians.

The positive thing about doing field research in Ottawa was that organizationally, things are smaller than in America. As such, once the first few respondents brought me through for an interview, others in the same building became more comfortable and relaxed with my presence. Some respondents even called some of their colleagues while I was in their office. Those calls resulted in interviews with respondents I most likely would not have had the opportunity to interview. This occurred during my visits to Parliament Hill and the various bureaucrat offices across the street.

The one problem I encountered in Ottawa was one that field researchers don't often encounter: the government collapsed. During the third week of my stay in the capital, all three opposition parties stood together in a vote of non-confidence that sent all politicians and their staffers scurrying home to try and get re-elected. The city became a ghost-town overnight. Fortunately however, I was aware of the potential for a government collapse and frontloaded my list of potential interviews with politicians so that I could interview them before they all vacated their offices. The benefit of the non-confidence vote however, was that it gave top bureaucrats—who had to sit idle—more time to meet and discuss with me the politics of drug policy.

While over in Austria, I had a few more barriers to deal with. The first was language. While I was very lucky that many Austrians spoke English, it seemed that fewer did at the administrative level than at the top levels of an organization. As such, while most of the respondents I interviewed were fluent in English, many of their support staff were not. Trying to exchange emails, phone numbers, directions, and requests was a real challenge sometimes.

A second obstacle I had to work around in Austria concerned facilities. My flat was an hour commute to the University of Vienna where I could access the Internet at no charge. Across the street from my flat was a call shop where I could pay to make calls. In my flat was a phone I could receive calls but could not make calls. The first few weeks were quite hectic as I not only had to juggle my presence at all three communication locations on a daily basis, but had to attend the interviews that I did secure. By the fourth week in Vienna however I did manage to gain Internet access in my flat, which cut out my long trips to the University of Vienna and gave me extra time to meet with respondents. Overcoming these obstacles did pay off; for I managed to secure interviews with at least half of the respondents I wanted to meet with.

After the end of my first month in Vienna, I moved to Innsbruck where I had received some financial and office support from the University of Innsbruck. While this was convenient for my own personal needs, Tirol was great for my research needs. The reason for this was because Tirol is one of the few Austrian Landers which had a severe enough drug problem to be of concern and jurisdiction for politicians and bureaucrats at the sub-national level. Access to these individuals was made easier by my affiliation with the Canadian Studies Centre and Manfred Kohler, a former student of mine who served as a charming translator and excellent contributor to the success of the interviews I had with politicians and bureaucrats in Tirol.

Of all four countries, my set up in Netherlands was the most ideal. To begin, everything that matters in government and politics was within five kilometers from my office and flat. The bureaucrats and politicians at all levels were more than happy to spend time with me. In fact, several of them not only ensured that they had answered my questions thoroughly, but arranged for lunches, coffee dates, and phone calls between myself and other important actors in Dutch drug policy. Of all the people I tried to get interviews with, only one refused. This could have been avoided, however I was becoming a little too excited with my string of good luck and asked to interview the Minister of Justice. Had I not asked and they not refused my request (time restraints), my response rate in Holland would have been near perfect.

Although response rate is not a concern for this research (because I am not generalizing onto any particular population) I do share this with readers to show how cooperative the Dutch were with this project. Their cooperation allowed me to interview every major actor in Dutch drug policy, dating back to the 1960s. While I could not possibly include every important actor in my field research in the other three cases, the small size of the country, its tight drug policy network, and Dutch openness to academic inquiry, made it very possible for me to interview an amazing mix of respondents who are responsible for Dutch drug policy, where it has come from, and where it is headed.

Overall, the sample I have developed for the qualitative portion of this research involves 155 respondents of different backgrounds, responsibilities, jurisdiction, motive, and most of all capacity to affect drug policy outcomes. Interviews with respondents were conducted between November of 2005 and May of 2006. I am confident that this sample provides me with a broad and diverse source of information that has allowed me to acquire a more in-depth understanding of the phenomena studied in this research. The sample within each country includes respondents

from all of the major groups of actors who play a part in drug policy decision-making. While a total *N* of 155 is a strong start towards good qualitative research, the fact that all 155 respondents were interviewed mostly in person (less than 15 by telephone), adds extra merit to this sample.

5.2 Interview Process

To obtain interviews I generally began with an email followed up by a phone call, but sometimes the reverse. On average it took two phone calls and three emails to secure an interview. Once an interview time and location was secured, I would always try to phone ahead and make sure no plans have changed. The only time I did not make it to an interview was in Utrecht, Netherlands. I was scheduled to meet with a researcher and health coordinator at a drug policy think tank but could not find the place until two hours after the interview was scheduled to start. In retrospect, I'm happy the interviewee left his office for the weekend as I'm quite sure that after frantically trying to find his office on foot for two hours I would have been visibly upset and unsightly for an office setting. The train ride home to Den Haag that night seemed exceptionally long.

Most interviews were about one hour to one and a half hours in length. The shortest interview was with an American Congressman that lasted 16 minutes. After realizing that his time spent with me was filled up with his own digressing rather than dialogue on the topic I was interested in, he lined me up with two of his senior staffers on the drug policy file. The longest interview I had was also in Washington, and lasted four and a half hours. A major victory for my research efforts, this former high level drug policy advisor to Presidents Clinton and Bush II not only spent all that time telling me about American drug policy from a White House perspective, but drove me to my next appointment quite a distance from my office.

On the topic of location, most interviews were conducted in the respondent's office, in a boardroom adjacent to their office, or in a coffee shop down the street from their office. One exception was in a private banquet room at the Canadian Centre on Substance Abuse conference held in Toronto. I attended the conference in anticipation of being able to interview a whole bunch of drug policy stakeholders without having to phone or fly all over the country. My goals were more than met at that conference.

Another exception was in Washington, DC. Several respondents—all federal bureaucrats—preferred to meet me at my office located in the School of Public Affairs at American University. Most of them explained that with heightened security measures it would be easier for them to come to my office rather than have me come to their office. An alternative explanation offered by one respondent was that "it's nice to get out of the office".

A final exception was in the small town of Dordrecht, Netherlands. There I interviewed a 90 year old respondent in his own home. I was quite pleased to have this experience, for not only was his house magnificent, but many Dutch policy actors point to this respondent as being the single most important founding father of Dutch drug policy. What made this interview more unique was that few people have heard or seen from him in years. Eager to learn from this accomplished individual, I searched hard and found him. The stories he shared and the explanations he offered me were like none other I heard throughout all of my travels. After discussing the formation of drug policy in Netherlands, I was amazed at how much I learned. While he enjoyed my company, after the third hour of intense conversation he grew tired and had to lay down for a nap.

Overall, most interviews went extremely well. Some respondents were quick and to the point while others elaborated upon their answers. Occasionally I had a respondent go way off

track. Knowing that I only had a certain amount of time to interview these respondents before our time was up, I really had to look for breaks in their sentences that would allow me to bring them back to the *real* issues of concern—without seeming rude of course.

One particularly interesting session was with an elected member of a parliament. Before entering politics, this respondent was an academic and apparently missed graduate school debate over methodology. While this individual eventually gave me a wonderful interview, and bought me supper, this all wasn't until after he/she chastised my methods for being biased because I was interviewing respondents then analyzing their descriptions on my own. While we failed to come to a mutual consensus on the scientific method, we did agree that significant differences exist between what I was taught about methods of social inquiry in North America and what he/she was taught about methods of social inquiry in Europe.

Most of the respondents were quite pleased with the interview process and some even requested that I send them a copy of my results upon completion. The atmosphere of most interviews was quite relaxing. There was one interview I had in the United States however that was a little intense, for me of course. The respondent was a former deputy director of the White House Office of National Drug Control Policy. While interviewing him at his new office in the Pentagon, I had to sit in a room with him, his legal advisor, an armed guard, and a media relations person who documented the entire interview with a tape recorder. Before the interview started his lawyer and media relations person gave me a solid 'talking to' on what should not happen following the interview.

Another less comfortable interview happened while interviewing a Canadian member of parliament. While we were sitting in the office of the respondent, the parliamentarian called upon his staffer to ask if he had checked me out properly. The staffer informed him that if something

went wrong with the results of that interview he would make one call to my university and I would not graduate.

While nothing came—nor should come—of either of these incidents, it is important to share with readers the intensity of these situations. Drug policy is not a very comfortable topic for stakeholders to talk about, particularly in competitive policymaking environments like Canada and the United States. As such, some individuals—like two of my respondents—are very careful of whom they share their opinions on drug control with. Because of this, all interviews conducted for this research are confidential.

At the beginning of the field research I interviewed 3 respondents with the use of an electronic recorder. After reviewing the tapes at the end of the day I made the decision to stop taping interviews and make better use of a pen and notebook. This decision was based on efficiency, cost-effectiveness, and the fact that recording devices can make some respondents less inclined to share their full opinions. By the end of my field research, I collected over 600 single-spaced pages of field notes that describe what respondents had told me during the interviews.

In close, the interview process was quite easy-going. I tried to guide the conversations using the instrument located in the appendices. Some respondents offered more than what was asked, while others were less eager to be so comprehensive. The data collected from the field however is rich, detailed, and will surely contribute towards a better understanding of the relationships between political institutions, the actors within those institutions, and the drug policies they create.

5.3 Qualitative Findings

The interviews conducted in this research provided an incredibly detailed account of what really happens in the world of drug policy. Several of the questions asked during these interviews generate answers that can be counted and compared across case countries. Others are best kept in their original form and discussed in the various subsections within this findings section.

When interviewing respondents I began by briefing them on the topic and purpose of my research. I followed this by obtaining their informed consent to go ahead with the interview. The first question I asked was about the respondent's involvement in their country's drug policy. This gave me an indication of how in-depth their understanding and knowledge of the topic may be. As a researcher, I am also not able to know exactly what each respondent does or does not do within the decision-making process. Clarifying the role of respondents in drug policy certainly helps.

A majority of the respondents described what they actually do or have done in the area of drug policy as opposed to what they could do. Many responses turned out to be profession-specific. Examples of these responses include "provide options for policymakers, implement the policies, enforce laws created by government, help drug users with their addiction, minimize the harms of drugs to drug users, and arrest and assist in the prosecution of drug offenders".

The next question I asked respondents was how many years they have spent in their line of work and how many of those years were specifically related to drug policy. The average length of time each person was in their current position was 13.4 years, while 10.8 years was the average amount of time spent with matters pertaining to illegal drugs. These data tell us that the sample chosen for this study does have a significant level of expertise and familiarity in this subject matter. As Table 5.2 shows, there is slight variation across respondents from each of the four countries.

Table 5.2
Years of Service and Years of Drug-Specific Service*

	USA	CAN	AUS	NETH
average	12	14.9	14.9	12
	(9.2)	(9)	(14.9)	(10.3)
maximum	26	35	35	30
	(26)	(35)	(35)	(25)
minimum	3	1	2	3
	(0)	(0)	(0)	(0)

*The values appearing without parentheses represent years of service while the values with parentheses represent years of drug-specific service.

The next three questions I asked respondents were somewhat self-descriptive and in the context of power perceptions. The first asked how they came into their current position. Knowing if a respondent was hired, appointed, or elected may help us understand some of the reasons why they have the views on drug policy that they do have. By circumstance, I interviewed more hired people in the United States and Netherlands than any other group. My respondents in Canada and Austria were nearly balanced between hired and elected persons.

The second question inquired as to the respondent's level of influence on drug policy in their country. While responses to this question may not always be accurate, they do inform us of the perceived strength respondents have of their own position in terms of shaping drug policy. This helps not only in grouping respondents into like categories, but allows us to see important trends in respondent categories across the four case countries. A large number (n=90) of respondents felt that they had at least some level of influence while fewer (n=25) felt that that had a considerable amount of influence over drug policy.

The third question about the respondent was whether the level of influence their position has on drug policy should be greater or lesser than it already is. This question was designed to measure frustrations within the sample towards the status quo. If respondents answered in favor of the status quo in later questions, but stressed a need for more power when answering this

question, there may be some inconsistency that needs further exploring. The same can be said about those who wish their profession had less of an influence. A larger number of respondents (*n*=84) were comfortable with their current level of influence while a less substantial number (*n*=54) desired more influence over drug policy.

The findings of these three questions are illustrated in Table 5.3. Along with those are findings related to drug policy, the role of bureaucrats and politicians in drug policy, and the effect that institutions have on drug policymaking. Data on these topics came from answers to the more substantive questions that I explained in section earlier sections of this research. As Table 5.3 illustrates, there are several themes which appear in these data.

On the topic of change, more respondents (*n*=81) believed that their country's drug policy had changed than those who did not (*n*=57). On a country by country basis, a higher number of American respondents did not believe that change occurred. While a majority of respondents in the other three countries believed change had occurred, the gap between Dutch respondents who believed change occurred (*n*=21) and those who did not (*n*=16) was narrower.

Discussions on drug policy effectiveness revealed that a lot of respondents felt their country's drug policy was either somewhat effective or somewhat not effective. The only substantial deviation from this trend was in Netherlands—where 11 respondents felt that their country's drug policy was highly effective. Discussions of the actual drug policy approaches favored by respondents demonstrated a strong support for treatment and harm reduction. A larger group of respondents (*n*=71) believed that their countries drug laws were too strict. A smaller bunch (*n*=58) thought that the current drug laws were acceptable.

While discussing the effect of politics and the bureaucracy on drug policy, a majority (*n*=114) of respondents believed that these two factors caused problems from drug policy actors.

Based on the responses provided in the interviews, it appears that politics causes more problems in all four countries, with the bureaucracy causing moderate problems in Canada and the United States. This may have something to do with the fact that the drug issue has considerable public salience (USA, *n*=26; CAN, *n*=18), is exploited by politicians for votes (USA, *n*=22; CAN, *n*=16), and decisions on drug policy that are made in these two countries are based more on public opinion than on science (USA, *n*=33; CAN, *n*=17).

One of the most fruitful areas of discussion I had with respondents was in the area of political institutions. Combined, a total of 101 respondents identified political institutions as having some sort of an influence on drug policy. Of the five institutional structures explored in this research, intergovernmental relations, electoral design, and political bargaining were the most often reported structures as having an impact on drug policy. Though the extent of this impact is not reflected in Tables 5.3 and 45.4, the content analysis presented in the following pages does address political institutions more fully.

Table 5.3
Means of Reaching Current Position and Perception of Power

Question	Answer	USA	CAN	AUS	NETH	TOTAL
Means of Reaching Current Position	respondent was hired:	36	14	14	26	90
	respondent was appointed:	2	13	6	1	22
	respondent was elected:	4	9	14	15	42
	missing:	0	0	0	0	0
Current Level of Influence	lots of influence:	6	8	5	6	25
	some level of influence:	27	25	17	21	90
	no influence:	7	1	10	12	30
	missing:	2	2	2	4	10
Aspired Level of Influence	need more influence:	12	21	10	11	54
	need less influence:	0	0	0	0	0
	current influence is ok:	25	11	22	26	84
	missing:	5	2	2	6	15

Table 5.4
Drug Policy Answers

Question	Answer	USA	CAN	AUS	NETH	TOTAL
Changes to country's drug policy	drug policy has changed:	17	24	19	21	81
	drug policy has not changed:	23	7	11	16	57
	missing:	2	5	4	6	17
Effectiveness of country's drug policy	highly effective:	3	1	5	11	20
	somewhat effective:	17	14	7	18	56
	somewhat not effective:	11	13	16	7	47
	not effective at all:	8	8	1	1	18
	missing:	3	0	5	6	14
Best drug policy approach	law enforcement:	9	4	1	3	17
	prevention:	4	2	4	5	15
	treatment:	16	13	15	6	50
	harm reduction:	10	10	9	22	51
	combination:	3	15	4	4	26
	missing:	0	2	1	3	6
Strictness of drug laws	too strict:	23	22	22	4	71
	acceptable:	15	6	11	26	58
	not strict enough:	3	0	0	6	9
	not enforced:	0	4	0	0	4
	missing:	1	4	1	7	13
What causes most problems in drug policy	politics:	27	18	16	25	86
	bureaucracy:	11	13	4	0	28
	neither:	2	0	11	15	28
	missing:	2	5	4	3	14
Public salience on matter	salient:	26	18	7	15	66
	not salient:	10	4	22	23	59
	missing:	6	14	5	5	30
If drug policy is exploited for votes	yes:	22	16	8	7	53
	no:	8	2	20	29	59
	missing:	12	18	6	7	43
Whether decisions are based on science or public opinion	science:	4	3	22	23	52
	public opinion:	33	17	7	6	63
	both:	1	0	0	3	4
	missing:	4	16	5	9	34
Which institutions affect drug policy	intergovernmental bargaining:	12	8	7	3	30
	electoral design:	7	5	6	13	31
	cameralism:	2	1	1	1	5
	regime type:	3	1	2	0	6
	political bargaining:	4	3	9	6	22
	none affect drug policy:	0	0	1	1	2
	combination:	0	0	2	3	5
	missing:	14	18	6	16	54

5.3.1 Interview Responses

Within each of the following subsections, several topics are discussed. The first includes identification of the country's drug policy, where it came from, and how it has changed. The second topic includes lengthy discussion on what led to these changes and how the relationships

between policy actors—whether they are cooperative or competitive—affect policymaking in the drug domain. The next discussion surrounds the role of bureaucrats and how they may help or hamper reform efforts in drug policy. Politicians are also important and their behavior is discussed as well. Finally, the last part of each subsection is devoted to the role of institutions in drug policy and how different institutional structures may or may not lead to different policy outcomes. While I begin each section with an introduction of the main themes appearing in each country's sample, I conclude with an overview of what is really learned from these interviews.

5.3.2 American Interviews

The interviews held with respondents in the United States provided some detailed understanding of the way in which drug policy has remained somewhat unchanged over the last 50 years. The main theme deriving from the field research in Washington was that the fierce competition for votes between politicians, and for resources between bureaucrats, is what has maintained the status quo drug policy in America. When describing drug policy dynamics, the respondents seemed to refer back to the conflict between political actors, bureaucrat actors from different venues, and even actors within the same venue. The major consensus from a variety of respondents was that law enforcement is the dominant drug policy venue in America while the treatment venue—although supported by many actors—still struggles to compete with law enforcement.

Drug Policy in the United States

The discussions I had with respondents on America's national drug strategy revealed an emphasis on law enforcement, with a strong acceptance of treatment. No matter which approach to illicit drugs respondents supported, almost all identified the law enforcement approach as being the most dominant orientation of drug policy. A high level bureaucrat from Border Patrol

Services revealed that 70 percent of the country's focus is on eradication, law enforcement, and border security while only 30 percent of the focus is on treatment, prevention, and education. This claim was supported by the director of one practitioner's association who felt that America had a very strong criminal justice approach to the drug problem, one that was based on criminalization and incarceration versus treatment and rehabilitation.

Of those who supported the law enforcement status quo, many identified the utility that public policy has in deterring people from using drugs. Others suggested that a strong criminal justice approach not only prevents further drug use but protects society from the harms that drugs and drug users may cause. One respondent revealed that a combination of different strategies—one that is led by the justice system—is the best alternative. This former senior civil servant for the Office of National Drug Control Policy believed that prevention, treatment, and law enforcement are all key parts of America's strategy for dealing with drugs. The lynchpin of course is the over 1,600 drug courts that use the power of law to direct drug users into the proper treatment they need.

Of course not all respondents were supportive of the law enforcement venue. The problem of this approach, according to some respondents, was that although treatment was accepted as the most logical choice for addressing addictions, law enforcement tools like the court system continue to dominate. The executive director of a national addiction professionals association explained that there are generally two parts to America's drug strategy: public health and public safety. The latter generally falls under the direction of state government while the former falls under that of the federal government. The problem of this arrangement is that in public health, the main client is the individual, while in public safety the main client is the public. Since federal interests are those of the public instead of the individual, there is an

overbearing emphasis on the public safety approach to drug policy. This emphasis is carried down to the states through grant restrictions and federal laws. That is why we see so many drug courts in America.

Some of the respondents I interviewed for this research felt that America's approach to drugs is based on a criminal justice model rather than a health model only because of a lack of understanding on the issue. An interest group leader opposed to the law enforcement approach felt that drug prohibition is fueled by morality and legitimized by manipulated data. A harsher critic who also happens to be a Democratic Congressman deemed that "America takes the position that you can moralize and penalize drug use with public policy…Certain ostracizing of people is somehow rationalized in terms of drug policy". Finally, a representative from a drug reform group believed that America's national drug strategy is "an oversimplified approach that says illegal drugs are bad, that all use is abuse, and that users should be punished".

Compared to my Canadian sample, it seems that respondents in America are much more in agreement on the nature of their country's approach to the illegal drug problem. While not all respondents are in agreement on what constitutes the most effective drug strategy, they generally will agree that the law enforcement approach is the status quo.

Origin of America's Drug Policy

According to some respondents, the Harrison Act of the early 20th century appears to be the major starting point for America's approach to the drug problem. This legislation allowed for the criminal justice system to become the main venue for dealing with the drug problem. According to one respondent from a legal interest group, "from the onset, the law enforcement status quo developed in an era where no one knew anything about drugs. Right up until the mid 1980s everyone assumed drug use was a behavioral problem that needed police attention. The

stereotyping of drug users has continued from those years and makes it hard to change public opinion".

This perspective was shared by a legislative assistant to a Republican Congressman who said that "addiction has long been viewed as a problem of crime and deviance. In 1956, the American Medical Association decided that addiction was a disease—yet people continued to view it as a moral failing. The stigma attached to it makes change difficult". Adding to this, the policymaker claimed that "people never hear about treatment working. They only hear about relapses. As such, politicians in tight races will never say no to the police by reaching out and supporting treatment initiatives".

A public affairs respondent from the Drug Enforcement Administration felt that the law enforcement approach to drug policy originated and has been maintained because of the effectiveness of the criminal justice system in dealing with this matter. He stated that "The current U.S. drug strategy does not include alternative measures like harm reduction because such an approach doesn't stop people from using drugs". According to this respondent, "laws stop people from using drugs by forcing people into getting the treatment they need".

A more cynical view of drug policy effectiveness also offers some explanation into why the law enforcement status quo has been retained over the years. The President of a harm reduction interest group believes that "America's national strategy is effective in what it has been designed to do, and that is imprison people. It does not curb drug use. If anything, it has divided the country, made drugs more dangerous, and ostracized users so that they have no chance of returning to mainstream society. When politicians see drug arrests increase they see that as progress. No one looks at reduction in drug use or its consequences as progress and that's why we still have a law enforcement approach to dealing with addictions".

Throughout the interviews, there surfaced several understandings of America's drug policy origin that criticized the law enforcement dominance. A representative from the Criminal Justice Policy Foundation believed that:

> "U.S. drug policy has largely been an instrument used to control the races. Brits pushed opium on the Chinese so that they could attract cheap labour. Then the USA allowed for this so it too could benefit. Overtime, the overwhelming migration of the Chinese and Mexicans prompted the government to undermine these groups through the criminalization of marijuana and opium. After segregation the war on drugs became a tool to contain blacks in a rationally neutral mater. This resulted in drugs becoming a black urban problem with ultimately undermined black opportunities to get jobs, buy homes, and contribute to society".

An alternative explanation of the criminal justice dominance in drug policy was offered by an addictions researcher from a policy think tank. She felt that while the drug problem has been always controlled by law enforcement interests, that control over the matter is being enhanced by a booming prison industry that is gradually becoming controlled by the private sector. The result is that both prison unions and owners lobby government to maintain the status quo drug policy. Contributing to the lobbying aspect of America's drug policy origin, a Democrat Congressman reported that society, and therefore politicians, are always more appreciative of police than they are of drug counselors. As such, the law enforcement agenda seems to dominate drug policy decision-making.

One of the most critical answers to the question regarding the origin of America's drug policy came from an all female group that advocates for unrestricted use of medical marijuana. The respondent believed that "drug policy is *that way* because human rights and respect for life fall far below respect for political fundraising. The compromise of liberty and diminished value of human life have ruined the USA".

Once again, no matter the perspective respondents had towards the law enforcement approach, there was a general consensus that the *Harrison Act* paved the way for drug use in

America to be predominantly a criminal justice issue. While there were significant develops in treatment and prevention, change has been hard to come by in the last century.

Exploring Change in American Drug Policy

While many of the respondents felt that drug use has always been a law enforcement issue in America, some felt that there was a time in the 1970s when American policymakers tried to move towards treatment. One notable example came from a representative of a national addictions association who pointed out that when Nixon originally founded the Office of National Drug Control Policy, 70 percent of its budget went to treatment/demand and 30 percent went to law enforcement. In the last two decades that has switched, for treatment/demand now gets 30 percent and law enforcement gets 70 percent.

A second example is described by a representative from a sentencing guidelines advocacy group. She reported that up until the 1980s there was discretion-based sentencing that worked well for a treatment-type model of rehabilitation. However in the 1980s a number of national leaders got concerned about the drug problem and Congress passed the Sentencing Reform Act. This allowed for mandatory minimums, which largely reflected the status quo attitude that America could protect itself by locking people up.

These two examples show that while America has a predominately law enforcement oriented approach to drug policy; efforts are being made to try and change that. The director of a national legal advocacy group revealed that more and more politicians are acknowledging that treatment is important and that non-violent offenders don't need to be locked up. One of the biggest factors triggering this realization is that state governments are tired of spending massive amounts of money on corrections when other services—like treatment and education—are suffering.

This observation was also shared by a representative of the Criminal Justice Policy Foundation who revealed that there are a number of drug reforms occurring at the state level. According to the respondent, there are two main reasons for this: "One reason is that the costs of not reforming are too high, considering that state leaders know of and are sick of the costs of prohibition. The second reason is that states are small enough political units that reformers can actually have a fighting chance". One legislative assistant in the U.S. Senate added that the incremental changes which have occurred in America have occurred because of innovative solutions introduced by states. In other words, the only way America will change its drug policy is state by state.

In these cases of change, it appears that the change occurs only after some form of partnership is built between treatment and law enforcement actors. According to a respondent from the U.S. Bureau of Prisons, increased cooperation between criminal justice and treatment actors has allowed for more innovative strategies of dealing with addictions. One notable innovation is the drug court system. According to a Democrat Congressman, the drug court system is a product of the partnership between law enforcement and treatment. One of the reasons this partnership was able to form was because it keeps law enforcement in and harm reduction out—something that is very inline with the status quo.

Of course one of the most difficult tasks involved in drug reform is overcoming the many different barriers to change. A legislative assistant to a Republican Senator felt that "change is difficult to come by because the law enforcement apparatus already exists. It is much easier to funnel dollars into existing programs than it is to put money into new programs; besides, funding law enforcement is much more acceptable". A legislative director to a Democrat Congressmen believed that, "culturally we have become less accepting of certain vices and behaviors, as a

result change in drug policy has been slow". Making a more specific claim, one respondent felt that the biggest impediment to change is the federal government: "needle exchanges have been proven to be incredibly important, however politicians in Washington don't allow for federal money to support these life-saving initiatives".

While many respondents pointed to politicians as the biggest barrier to change, others pointed to bureaucrats. A legislative director in the U.S. Congress felt that change is slow mainly because politicians turn to bureaucrats for advice: "unfortunately for reformers, bureaucrats are not agents of change—they're agents of the status quo. As a result, the only real option for change comes from congressional oversight of the bureaucracy". A respondent from the FBI felt that it is the attention of both politicians and bureaucrats which determines change: "Currently, the national focus on anti-terrorism has placed drug reform on the backburner both in Congress and in the government's bureaucratic offices. As a result, change will most likely not occur anytime soon".

When change does occur, it seems that certain conditions must be present. As already discussed in this section, change is much easier at the state level where there are fewer actors involved. Another important element identified by a Congressman from California is that change occurs only when non-minority groups take up the cause. For example, in the State of California seniors took up medical marijuana. This helped the entire cause, for if a group of college students took up the cause all would have been lost.

A third important part of the puzzle is the role of police officers and their acceptance for change. Several respondents noted that the only time they saw change happening was when criminal justice professionals joined in a partnership with treatment professionals to provide some sort of justice-administered treatment program. While the partnership between different

venues usually occurs between law enforcement and either treatment and/or prevention, there are on a few occasions when law enforcement and harm reduction form a partnership. A Congressman from the Democratic Party revealed that in some areas of the country where the police support needle exchange programs, "harm reduction professionals have been able to change some of the public's perception on drug users—this ultimately affects the thinking of politicians".

One aspect of the change process discussed by only a few respondents was party politics. From those who spoke on this topic, it seems that traditionally the Democrats favored treatment approaches to the drug problem while Republicans favored the law enforcement approach. In speaking about this polarization, the director of a national justice research group believes that Democrats often do not have enough strength at the federal level to stop the drug war. In contrast, they do at the state level. This is why we see 13 states that have passed legislation allowing for the use of medical marijuana. A political staffer to a Republican Congressman noticed the same polarization on the issue. He described that, "The Clinton administration thought that if you fought demand then you would reduce supply. As a result they downsized law enforcement and increased spending on treatment and prevention. When the Bush administration took over, there started to be a major focus on four areas of dug policy: eradication, treatment, prevention, and interdiction[19].

Of course the polarization of drug policy between Republicans and Democrats is not a consensus among the respondents. A director of the congressional affairs team in a federal law enforcement agency disclosed that "the one thing that's changed in drug policy is the blending of

[19] Note that most respondents from all four countries identify treatment, prevention, harm reduction, and law enforcement as the four main pillars of drug control. However, two respondents in the USA reported interdiction, eradication, treatment, and prevention to be the four main pillars---thus leaving harm reduction totally out of the reign of possibilities.

partisan lines on the issue. Now we see Republicans talking about treatment and Democrats talking about law enforcement". The respondent continued on by admitting that the debate has stayed the same, however some of the positions of actors have changed. In the end, he did confess that law enforcement still fairs better under Republican governance and prevention/treatment fair better under Democrat governance.

If there is one common theme in the discussion on change in drug policy, it is that change does not happen very easily or quickly. One respondent's comments illustrate the long-term dedication needed to see change occur in drug policy decision-making: "[With respect to drug reform,] a vision is something that unfolds, not something that somebody sees…I enjoy this job because what comes about is a remarkable opportunity to do things that you never imagined doing. I have a restless soul and a revolutionary heart that are much needed to get through this process".

Ideal Drug Strategy

The discussion on partisan polarization of drug policy serves as a good introduction to the most favored approaches to solving the drug problem. The interviews with American drug policy actors revealed an array of drug strategies that respondents would design if it were up to them. Some favor a harm reduction approach, and others would enhance the current law enforcement efforts. A majority felt that they would try and find a balance between prevention, treatment, and law enforcement.

Of the latter group, a former director of the ONDCP shared that a careful balance between treatment and prevention would result in the best outcomes for America. A Democrat Congressman felt that if the design of America's drug strategy were solely in his hands, the most

emphasis would be placed on treatment while a significant amount of resources would be put towards harm reduction.

Of the very few respondents who disclosed that law enforcement was their preferred approach, most believe that deterrence—as opposed to the actual punishment of incarceration—was the key element that could lead to less drug use in America. In fact, only three respondents reported that stiffer jail sentences would lead to less drug use. Speaking about the effectiveness of deterrence, an officer with the Drug Enforcement Administration felt that a criminal justice approach was important because of the intricate relationship between crime and drugs. A Republican congressional staffer explained that drugs are illegal, and the most important tool to fight crime is law enforcement. Finally, a respondent from the ONDCP believe that deterrence measures such as school-based testing and the criminal justice system are the most effective tools to use in reducing the drug problem.

Similar to law enforcement, very few respondents referred to prevention as the end-all-be-all drug strategy. Of those who preferred this method, a DEA agent felt that education-based prevention in schools and the greater community was essential. Likewise, a high level decision maker from the Safe and Drug Free Schools and Communities Program within the Department of Education felt that increased prevention was far more important than any other strategy available. With an effective prevention strategy, there would be little need for treatment and almost no need for law enforcement.

Of those who felt that treatment was essential, a legislative assistant to a Democrat Senator felt that America does not have enough treatment services, and that not everyone who uses drugs could be put in jail. A high-level bureaucrat in the ONDCP felt that more improved access to treatment would be beneficial. This respondent felt that "there is room for law

enforcement on the trafficking side of things but overall it's really a health policy issue". A program director from the Bureau of Prisons explained that it is essential to place decision makers in ONDCP and the Department of Justice who actually know something about treatment. One respondent from the Drug Policy Alliance felt that the government should make insurance companies cover treatment services because an addiction is a disease.

Within the group of respondents who felt that treatment was important, there appeared a divide between those who felt treatment should be administered by the criminal justice venue and those who thought it should not. Of the former, a Republican Congressman felt that mandatory treatment which is suspended and sanctioned was important. He also felt that normalization of drug use is wrong and harm reduction doesn't help users at all. The Congressman concluded by saying that "the two strongest correlates of a decrease in drug use is perception of risk and social disapproval". A high level policy advisor with the ONDCP felt that mandatory treatment was important, for if drug users are sent to treatment by a judge and do not succeed, they will face jail time—which serves as a great motivator to complete proper treatment.

In contrast, the respondent from a research institute in the areas of crime and justice believed that "We have too many addicts and mental health patients in prison. There needs to be a way to effectively provide addictions programs without interference from the justice system". A public relations coordinator with a national addictions coalition group felt that forced treatment is a waste of time and resources. Drug addicts have to be personally ready for treatment. Jail time will only prolong their recovery process.

The final group of respondents talked about their vision for a drug strategy that involved a strong emphasis on harm reduction. A respondent from the Criminal Justice Policy Foundation

said that he would change the entire way America addresses the drug problem. He furthers with, "The worst part of the current approach is that those people who are suffering from addiction the worst (ie: street junkies/relapse victims) are being punished on top of their addiction. While rich people enjoy their booze and cigars the drug addict who has lost control of his life is thrown in prison". A respondent from the Drug Policy Alliance expressed his support for harm reduction by suggesting that "not only do certain measures of this approach reduce the harms of drugs to both users and society, but harm reduction can also be used to get drug users into the treatment they need".

Drug Policy Actors

The above discussions I had with respondents revealed a lot about American drug policy, where it has come from, and where it may or may not be headed. As the interviews progressed, more and more emphasis was placed on the actors involved and the relationships these actors have with one another. The following section describes these actors and outlines some dynamics of their relationships.

Of all respondents, the most common actors mentioned in the interviews were bureaucratic actors. This came at somewhat of a surprise considering America tends to be fixated on its politicians as opposed to its bureaucrats. Many of these actors include agencies like Substance Abuse and Mental Health Services Administration, ONDCP, FBI, DEA, Justice, Border Services, Immigration, National Security Administration, Health and Human Services, National Institute on Drug Abuse, Alcohol Tobacco & Firearms, and Partnership for a Drug-Free America.

The political actors identified by respondents as playing a major role in drug policy include members of the Congress and Senate, as well as the President. One respondent from a

legal interest group identified Congressmen Davis, Ramstad, and Kennedy; as well as Senators Spector, Hagel, and Baucus to be the main political leaders on the issue. A respondent from the DEA revealed the Attorney General Ashcroft and Whitehouse Drug Czar John Walters as the two single most important actors in drug policy. Several respondents also pointed out that the Speaker of the Congress had played an important role in the topic of drug policy. Speaker Hastert had developed a task force which works to keep drug policy on the agenda so that the ONDCP will begin listening to Congress' view on the matter.

Outside of policymakers and bureaucrats, some interviewees reported the National Association of State Alcohol and Drug Abuse Directors, the Governor's Association, the Legal Action Centre, Marijuana Policy Project, and Open Society Institute to have some sort of an influence on drug policy. One respondent even reported that the media serves as a major actor in that it drives public opinion on crime and drugs.

On several occasions, individuals were pointed out as having an influence on the process. The president of one harm reduction interest group mentioned that Ethan Nadelman from the Drug Policy Alliance had done a good job at encouraging reform at different levels of government. Similarly, a representative from the National Association for Addictions Professionals felt that U.S. Drug Czar John Walters is the face of drug policy in America: "His biggest supports are all from law enforcement, which adds to perpetuation of the status quo".

The large number of important actors in American drug policy definitely allows for some interesting dynamics. A staffer from the House Committee on Criminal Justice and Drug Policy felt that "because there are so many actors, it is hard to determine who was in charge. At times it seems that even the director of ONDCP is not even sure of who is in charge". A volunteer with Civil Air Patrol Services complained that the federal civil service is too massive and that it

should really be consolidated. The respondent concluded with "the ONDCP is not doing a very good job at coordinating the drug war".

One of the things which may very well add to this confusion is that not every actor can accurately show how effective they are at addressing the drug problem. As one congressional staff director shared, "Despite the number of health and prevention agencies involved in drug policy, they tend to be overshadowed by agencies in law enforcement—mainly because they have more visible results in arresting dope dealers than in treating users". A representative with the DEA explained that the reason why his agency gets so much support from the government is because they are the only agency with a single mission of drugs. Social welfare and health agencies are overwhelmed with other issues to concentrate their efforts enough to make a big impression on policymakers.

This observation was also made by a legislative assistant for the Senate who said that "within the competition between law enforcement and treatment, the former usually wins because it is easier for them to show effectiveness. More so, treatment appears to be more expensive and difficult to administer because it is a drug-specific service; whereas law enforcement offers multiple services".

Determining who the most important actor(s) in drug policy are is not always accomplished by comparing their role in the process. A Congressman from the Democrat Party has observed that "the most important actors in any policy field are the powerful ones. The powerful actors are those who can shut off the influence of others". The Congressman illustrated this by describing how the Democrat Congress created ONDCP to hold Reagan responsible for drug control failure. Its purpose was to coordinate the massive multi-agency effort needed to run a successful drug strategy. The problem with the ONDCP is that while it has some limited

budget control over other agencies, it does not have organizational control—which ultimately controls the influence of the agencies involved in drug control.

Overall, there was a variety of actors identified as having some sort of influence on drug policy. The conversations I had with respondents on the dynamics of these actors and their relationships led to thorough discussions on the competition and cooperation of these actors in the drug policymaking process.

The Relationships between Actors: Cooperation and Conflict

Within the American sample of respondents, two of the most common understandings of the relationships between actors in drug policy were that (a) there is a lot of competition and (b) that competition occurs between many different sets of actors. Speaking about these circumstances, a government relations manager with a national professional association explained that "[i]t is hard to predict policy outcomes in drug policy because support and resistance comes from every which direction". Speaking of government in particular the respondent said "It seems there are allies and enemies on both sides of the isle and in all three branches".

A respondent who works as a staff director to a congressional committee revealed a big difference between America and countries that have a parliamentary democracy. In the USA, legislators not only have to strategize against one another but also against the Whitehouse, even if it is held by the same party. In this case, the Republican staffer shared with me congressional literature from the Republican Party that criticized both the Democrat plans for drug policy and President Bush's plans for drug policy.

Of course it is not only politicians that compete with one another over the drug matter. As eluded to earlier in this analysis, there is a significant field of competition within the

bureaucracy. The director of a criminal justice watch group informed me that bureaucrats are in a constant fight to scare off reformers, for they threaten their (bureaucrat's) agenda and resources. Another respondent, this time from within the federal bureaucracy, felt that there is also strong competition from within the bureaucracy for various pieces of the pie: "If bureaucrats don't defend and maintain their purpose they will be out of a job real soon".

The conflict between bureaucrats and between bureaucrats and other actors is no different than the competition between politicians: it is based on power asymmetries. A policy advisor to the House Speaker suggested that "the relationship between different policy actors is not so much one of conflict as much as it is one of sorting out priorities". Speaking of the contrast between law enforcement and treatment, he expanded upon this by explaining that getting politicians to choose one group as their priority over the other often becomes the entire focus in drug policy. Illustrating this claim, a strategic planning officer with a federal enforcement agency admitted that his agency generally tries to forecast what they will need in 5 to 10 years. However when doing this they have to balance their needs with (a) what the President and OMB have in mind, and (b) what other parts of the drug policy bureaucracy have in mind. Following this, they must package together a proposal that will meet or beat the requests of others.

Perhaps one of the clearest illustrations of power asymmetries in drug policy networks is decision-making within groups. The director of public policy within a national professional association explained that "a lot of decision-making in drug policy—particularly during the implementation stage—is done on boards. The problem of this is that some members are lower-level bureaucrats tucked away somewhere in the health department while others are cabinet level drug czars for governors. There is definitely a consensus at the end of the day—but how voluntary that consensus is we do not know".

Over the years it has seemed that law enforcement actors have been able to overpower their rivals when it comes to competing for drug resources. A respondent from the Legal Action Center explained that "there is really no competition between law enforcement and treatment because law enforcement is much larger and dominant over treatment. The reason we can never have open debate between law enforcement and the other approaches is because the public supports law enforcement; which means we lose every time". Another reason why law enforcement seems to be dominant in drug policy, according to a representative from the Community Anti-Drug Coalition of America is because "it's easier to get ahead when your organization represents the status quo, you are organized, localized, and most of all vocal".

On occasion it is possible for non-enforcement actors to win the attention of Congress and push for change. However as one political staffer found, "that's usually only after these people get help from interest groups and the courts".

In trying to understand why dominant groups continue to pull in resources while their counterparts remain inferior, I found the words of a policy advisor from the ONDCP to be exceptionally helpful: "even if Congress sees the utility in treatment, they quickly find out how hard it is to take money away from multi-tasking police agencies and give it to single-issued drug counselors—especially under our current terror threat". The one solution that many respondents offered in response to this reality was that if criminal justice leaders would stand beside their treatment counterparts and inform political leaders of its importance then perhaps more could be done to solve the drug problem. The setback however is that law enforcement actors have to be concerned with maintaining their own assets. This is illustrated in the comments of a DEA agent who felt that "Our agency gets nothing out of treatment slots. While the DEA is not against treatment, it's not in the best interest of the agency for drug money to go towards treatment".

While competition between different policy actors is anticipated throughout the policy process, the tactics used during that process are not so predictable. The president of a national harm reduction group explained that "one of the most irritating things in trying to develop harm reduction initiatives is that we not only have to compete with prohibition bureaucrats, but also prohibition interest groups. Since the public takes most prohibition bureaucrats seriously, that trust spreads over to the anti-drug interest groups. Take the Family Research Council for instance, the problem is that groups like theirs make shit up half the time, twist the truth, and call their beliefs scientific-evidence. Unfortunately for us, because their message is the same one as the police, everyone believes them and thinks all harm reduction advocates are legalizers".

A similar complaint came from a harm reduction professional who complained about American political reactions to injection sites being introduced in some Canadian cities. The respondent was dismayed by the fact that a U.S. Congressman would intentionally distort the findings of Canadian researchers—who were evaluating the Vancouver project—just to prove how wrong harm reduction is.

In all, the competition for power and resources, which is described by these respondents, stems from the fact that there are different ways to solve the drug problem. An interviewee from the DEA believed that competition occurs between different groups not because they have different ends, but because they have different means to that end. The respondent explained that "the goal of U.S. drug policy is uniform across the country: minimize drug use. Unfortunately conflict arises when trying to find ways to achieve that goal".

Even in the case where drug policy actors agree on the same means to achieving a goal, there can still be some competition. A policy officer with the FBI explained that it's not so much that law enforcement and health don't get along as much as it's that both sides are so vast that

they have trouble fostering enough internal cooperation to become compatible with the other venues. As one respondent from the National Association of State Alcohol and Drug Abuse Directors explained, government funding is divided between law enforcement, prevention and treatment. From this point, all the different sectors within each group compete for funds. As such, there is infighting with the venues that really serve to weaken the credibility of that venue. Examples he gave of this were prison treatment, public treatment, and private treatment services.

A respondent from a national addictions association shared a similar story: "Even within Health and Human Services—which is the second largest budget next to defense—there is a slim chance of treatment getting the funding that they need. Treatment folks have to fight for money against cancer, heart disease, aids, etc. We're at the back of the line because drug addiction is not a politically savvy issue. Sadly, the first opportunity for many users to get treatment is in the criminal justice system".

Of course infighting is not limited to competition for resources. Within the reform camp there is an even split on the purpose of reform. As a drug policy analyst from one non-profit organization explained, "half of libertarians want to clear the civil injustice of drug regulation and the others want to cure a social problem. The consequence is that the average American doesn't see drug use as a civil right and so all reformers get lumped into one group".

Of the many discussions I had with respondents on the cooperation and competition between actors, almost none talked about cooperation. Those that did, spoke about cooperation within the same venue (ie: various law enforcement agencies). Perhaps this is a function of my sample being based largely at the federal level of policymaking. Perhaps discussions with local drug policy actors would have revealed more detailed insight into the cooperation between police, treatment providers, prevention facilitators, and harm reduction specialists. One cynical

observation made of cooperation came from the communications coordinator of a national reform group: “On a government level there does seem to be some cooperation, for treatment specialists in America are so abstinence-geared that they themselves don’t fight with law enforcement”.

To determine why these relationships existed in the way that they did, only a few respondents had an answer to share. One theme deriving from these discussions revealed that competition between different actors was largely circumstantial rather than purposive. In other words, scarcity of resources and even jurisdiction confusion can lead to competition between different policy actors. The other theme, focused on cooperation, revealed that cooperation was the intention of many policy actors, however the means to achieving such an end often leads them towards competition anyway.

Illustrating the former of these two themes, an FBI agent explained that the circumstances surrounding the roles of law enforcement and health actors in drug policy do not necessarily cause competition between these groups as much as they create conditions which make cooperation unlikely. When this occurs, it becomes more difficult to prevent competition. One circumstance very likely to limit cooperation—and thus allow for competition to occur—is the vastness of these two venues. As the respondent explained, “the health and law enforcement sectors are so big that it’s hard for them to have cooperation within, let alone with other outside venues”.

Addressing this same sort of phenomena, the director of psychology services for one federal agency felt that cooperation was a very difficult thing to achieve between agencies largely because the government bureaucracy is so large. She then explained that “In trying to address this issue, the government ends up wasting so many resources on formal cross-training

and seminars that try to bring everyone up to speed on what the others are doing. There should be continuous dialogue between these groups so that the drug problem is approached by a unified bureaucracy. Currently, every agency is running around doing their own thing; which leads to competition and infighting [within government]".

Of the groups who do engage in competition within one another, one respondent claimed that the bigger more prepared ones are those who end up on top. This CEO of a national anti-drug group believed that "certain groups are more successful when they represent the status quo, they are organized, and they are vocal". She concluded by explaining that these larger more organized groups end up building upon their successes and eventually overpower the other groups involved in the policy process.

Speaking of cooperation between different groups, several respondents talked about how difficult it was for different actors to achieve cooperation; mainly because of different sets of goals developed by different actors. A different set of respondents believed that cooperation occurs when people shared a common goal. However it dissolves when conflict develops over the means to achieve that goal. Finally, others explained that while achieving cooperation was not impossible, deciding what direction to head following the formation of that cooperation proved to be difficult.

One respondent explained that in many ways cooperation was a function of government decentralization. In other words, as we move towards grassroots venues of lower levels of policymaking, more cooperation occurs. Examples the respondent gave were when police, treatment, and prevention professionals at the local and state levels cooperate for specific projects or events.

The Role of Bureaucrats in America Drug Policy

From my discussion with respondents on the role of bureaucrats I found three types of answers. The first type of answer was given by respondents who took the question quite literally. In other words, their answers focused the day to day duties of bureaucrats and what they *should* be doing in drug policy. The second type of answers focused on the dominance of bureaucrats in the drug policy process and how most bureaucracies were oriented towards achieving self-preservation above all else. The third type of responses concerned the dynamics between bureaucrats and their elected/appointed leaders in government.

Offering a more direct answer to the question, a respondent from the Legal Action Center explained the role of bureaucrats to be one of implementing policy. Another believed that the job of bureaucrats was to provide expert advice to politicians when the latter are making decisions. A third respondent offered a more specific answer: "In U.S. drug policy the ONDCP tends to set policy while Congress sets the direction. While there are some limitations on the ONDCP—like congressional oversight—, it does have sole responsibility of coordinating America's drug policies. One respondent felt that he could not answer this question, for there were too many different bureaucrats to summarize their role as one. He did however feel that it was important to understand the relationship between bureaucratic actors as they often affect one another's role in the policy process.

This serves as a good transition to the second group of respondents, whose answers focus on the self-preserving behavior of bureaucrats. A respondent from the Criminal Justice Foundation explained that bureaucrats tend to push their own agenda, particularly law enforcement. On certain issues they try to push forward, only to be pulled back if Congress steps in. An agent within the congressional affairs branch of a federal law enforcement agency

reported that bureaucrats naturally ask for more resources and continuation of their programs. These processes make it hard to suggest changes in the status quo. A respondent from Border Patrol Services provided a useful illustration of how bureaucracies always try to make sure they're purpose is protected: "The role of Customs was to keep drugs out of the U.S. In doing so, they've created a legacy around the drug issue. Before 911 that was our main task. Nowadays, we have to spend most of our time on terrorism. That is what's keeping the funding coming our way".

As suggested in the opening of this section, some respondents talked about the resistance to change that many bureaucrats have. This in turn, has somewhat of an effect on public policy. A respondent from the non-profit sector felt that when bureaucrats carry out their duties of policy implementation, they do so while constantly resisting change. The respondent continued by suggesting that "the ONDCP is supposed to coordinate drug policy so that bureaucratic resistance doesn't happen, however they are extremely ineffective". Another angle taken by some respondents was that in an effort to resist change, bureaucrats constantly reinforce the status quo. A respondent from the Harm Reduction Coalition described how all bureaucrats are too scared to propose new and innovative approaches—thus retaining the status quo. He furthered with "A classic example is the Centers for Disease Control. They haven't come close to examining condoms, syringe exchange, or substitution treatment just because they are fearful of delineating from the norm".

The third type of answer involves those that tell us something about the dynamics that exist between government and the bureaucracy. An assistant commissioner in the federal bureaucracy found that bureaucrats can often push their own agenda because of the fragmentation of government. Offering a practical example, "when one congressional committee

says one thing, then another says something different, and the courts conclude with yet something even more different, bureaucrats get lost in the shuffle and end up going in their own direction". The response was mimicked by a strategic planning officer with a federal criminal justice agency: "Structure and organization of bureaucracy plays a big part in how things are done. Organizing agencies under Homeland Security vs. ONDCP certainly affects the focus of the bureaucracy".

Of course the behavior of bureaucrats is not always dictated by the direction or lack of direction given by government. As some respondents experienced, some bureaucrats will actively lobby governments to make decisions in their own favor. As one DEA agent revealed, "We normally provide information to Congress when they ask. However we don't always wait for their invite. We approach Congress with certain policy proposals that they may not know. Within the bureaucracy the DEA can add drugs and all their variations to the Controlled Drugs and Substances Act without going through a long a drawn out procedure. We also have emergency procedures for certain drugs. Our recommendations go directly to the FDA and they act on it".

Another respondent, this one a policy advisor to a House committee, felt that "on the drug policy file, the executive is weak. ONDCP officials will come to the Hill and talk with committee staff. It is clear that they have very little knowledge. In contrast, bureaucrats from agencies will come over and sell their agencies very effectively because they know their own programs and resources very well". Behavior such as this does lead us towards making the observation that bureaucrats play an active role in the policy process—perhaps one that may be on the side of self-preservation.

Problems Caused by Politics and the Bureaucracy

One of the most effective questions at soliciting responses from interviewees regarded the problems that are caused by politics and the bureaucracy. There tended to be a variety of answers to this question. Some started with general complaints about the bureaucracy, while others had broad criticisms of politics. More specific observations were shared about the treatment, law enforcement, and harm reduction venues. Some felt that the topic of drug policy itself brought on problems while one respondent felt that his own agency made sure there were no problems at all: "We have very strong drug laws which make things easier for us. Since drugs are such a fast moving problem, the DEA is a very aggressive agency that streamlines the policymaking process it is involved in so that we don't get hung up in the type of bureaucratic problems other agencies experience".

Regarding problems specific to drug policy, several respondents felt that the nature of the issue causes problems that affect the behavior of all policy actors involved. The first real problem that stems from drug policy itself is that it is taboo. According to one director of a national professionals association, nobody wants to touch the issue because of the chance that others perceive them to have the wrong position on the issue. As one respondent shared, "drug policy is unique in that it is a policy area of enormous public interest and discussion—yet is subject to clichés. These jokes and stereotypes have deterred legislators from considering reform".

A different respondent revealed that "drug policy is one of only a few issue areas where politicians lose public support for supporting the truth. Legislators admit privately that legalization is the only way to reach drug users, however they will never admit that publicly". Offering some historical information, a respondent from the Marijuana Policy Project revealed

that many politicians have continued to fight for the drug war because several other politicians lost elections in the 80s for speaking out against it.

One respondent who was once an advisor in the ONDCP pointed out that such circumstances deliver consequences: "no one wants to touch the drug problem because it's contentious. The result is that it is difficult to protect the budget. Congress and the President take money away from it without anyone defending it". In most circumstances, law enforcement ends up gaining more support than the other drug policy venues. When this occurs, there is a tendency for law enforcement bureaucrats and their political supporters to preserve the status quo, which leads to issue ownership.

As one respondent explains, "the biggest problem with drug policy is that every agency is like a dog. It pisses around its territory and tells everyone else to stay away". This view was shared by another respondent who felt that in politics, some people think they own the issue. To illustrate, the respondent explained that "in the 90s we switched the responsibility of methamphetamine research from law enforcement to the health sector. A powerful senator was outraged because we made this change without his involvement".

One of the reasons why certain groups may have ownership over an issue stems back to the relationship between bureaucrats and their elected leaders. As one agent with the DEA revealed, "Congress always looks towards the most obvious bureaucrats for expert advice. Since we are the only single-issue agency that focuses on drugs, they always come to us. The problem is that all we can tell them is what we know from our experiences, which are biased". This was echoed by a second respondent who used to work for ONDCP: "Law enforcement always maintains its support because of the positive assessment it regularly gets. At evaluation time, treatment and prevention are less able to come up with raw numbers because of the nature of

their service. In contrast, all law enforcement has to do is show how many arrests and seizures they've made and Congress continues their support for this venue".

One outlier among those who talked about problems inherent to drug policy is one Congressman's assessment of the drug economy. According to the member, "the big problem in drug policy is that neither politicians nor bureaucrats recognize the role of capitalism in the drug market. We constantly protect the freedoms of a free market economy yet expect the marketing of drugs to stop because of laws passed by government. We're never going to succeed!"

Problems in Drug Policy that Stem from Politics

While the American respondents mentioned a number of problems inherent to drug policy, several mentioned problems that stem from politics. The general theme among respondents who talked about politics was that the drug issue was quite politicized. This meant that the steady competition between the two parties often leads to even more conflict over contentious issues such as drug policy. The director of a non-profit advocacy group stated that "when it comes to drugs, politicians spend more time trying to make one another look bad than they do trying to do something good". A communications coordinator with a different group commented that the obsession with partisan competition is so intense that sometimes you can't even tell which party is supporting which side of the issue. This respondent followed with, "the drug war is nothing more than a partisan enterprise. In fact, the difference between Democrats and Republicans is a matter of degree and not of kind".

This last observation was shared by another respondent who was a senior staffer for a House committee: "One of the biggest problems in drug policy is the inconsistency between parties concerning the issue. When Clinton got in he slashed the budget of ONDCP to almost nothing. Then once the Republicans gained control of Congress he beefed up ONDCP's budget

considerably". This statement illustrates some of the difficulties that politics brings any issue area, especially when the executive and legislative branches are controlled by different parties.

Another problem that politics creates in drug policy is the distance between politicians and other actors. On account of the constant competition for power, policymakers tend to distance themselves from other actors to increase their own power and autonomy. When this occurs, several problems tend to develop. A high level federal bureaucrat revealed that there is a large disconnect between what the bureaucracy is capable of and what politicians think the bureaucracy is capable of. A respondent from an interest group also found there to be a distance between politicians and not only bureaucrats, but all policy actors: "The problem in drug policy is that there is a strong disconnect between what people think and what other people think people think. This leads to a lot of misrepresentation and hesitation". Such conditions would explain why one lobbyist observed that "new ideas are rarely heard in Congress. Even when things like needle exchange actually work, Congressmen don't want anything to do with it because of fear and narrow-mindedness".

A third set of problems within drug policy that stems from politics regards access to the political agenda. A policy analyst with a national addictions association revealed that "the biggest problem in drug policy is not so much getting politicians to agree but to get the drug issue on their agenda. It seems that over the last decade, the leadership has stopped this issue from reaching the floor all that often because it is not very politically savvy". Another respondent, this one a senior political staffer to a House Committee chair person, claimed that "even in the event that Congress looks at the drug issue, there are so many other issues to examine that they end up looking for a quick fix so they can move on to other stuff". A

Democrat congressional staffer added that "the problem with Congress is its like herding cats—getting them all to focus on the same thing is very difficult".

The final group of explanations that show how politics causes problems in drug policy concerns the general public. Several respondents referred to the basic principles of democracy—whereby the will of the people is what governments eventually legislate. A respondent from the Crime and Justice Institute illustrated this position by explaining that "the biggest problem in drug policy is rooted far deeper than politics or the bureaucracy. The greatest obstacle for successful drug reform comes from the fact that people want to legislate moral and religious values instead of pragmatic policy". A different respondent also discussed how public opinion thwarts drug policy developments: "True to American ideals, the public doesn't want the bureaucracy controlling policy [ie: by implementing treatment] and so they demand that politicians stay in control—which ultimately perpetuates the status quo".

Problems in Drug Policy that Stem from the Bureaucracy

Though many respondents focused on politics when answering the question, more talked about the bureaucracy and how the civil service can cause problems in drug policy. One of the most common complaints was that the large size of America's federal bureaucracy leads to inefficiency and confusion. A former deputy director of ONDCP explained that "there are so many bureaucrat actors involved [in drug policy] that people from treatment end up competing not only with law enforcement, but with one another". Another respondent remarked that "the bureaucracy is so large that there is constant overlap. The result is we have several agencies doing the same thing".

A consequence of the vastness of America's civil service is that decision making becomes much more difficult. A staffer from the House Committee on Criminal Justice and Drug

Policy revealed that "because of the vast size of the bureaucracy, there is rarely any communication between different groups. This makes policymaking and implementation very difficult". Likewise, a former White House advisor said that the bureaucracy is so large that it takes over its own operations. When the Office of Management and Budget wants to avoid being embarrassed it checks with the bureaucracy to make sure things are ok. However, because the bureaucracy is so big and fragmented, it takes a very long time to return some answers to the OMB".

Another consequence of this vastness is that the bureaucracy has started to gain its own autonomy from the government. To summarize what one lobbyist said, the bureaucracy uses its sheer size to protect its interests and maintain its role in drug policy. In a later conversation, the same respondent added that "The federal bureaucracy has grown so much that it has started to self-perpetuate. Law enforcement has always benefited from the criminal justice status quo. But now treatment referrals through the court system are causing the treatment sector to also benefit and perpetuate the drug war complex that has developed within our civil service".

Throughout the interviews, there were three respondents who believed that the purpose of creating the ONDCP was to manage the drug bureaucracy so that these sorts of problems wouldn't exist. However as one respondent explained, the ONDCP has been very ineffective at coordinating the bureaucracy largely because its director is a political appointee working within the bureaucracy. Another respondent felt that the ONDCP has no power to control the budget of agencies involved in drug policy, as such they have little impact on the activities of drug policy actors in the civil service.

As one Democrat Congressman explained, even the ONDCP suffers from some of the same self-perpetuation tendencies as other agencies in the civil service: "The bureaucracy is so

large that it ends up doing want it wants in the end anyway. When he came into office, President Bush II promoted the importance of treatment and community-based prevention. However his new drug czar criticized McCaffery and Clinton for turning America into a therapeutic state. The result was a tougher approach to drugs that stemmed from the bureaucracy".

In all, both politics and the bureaucracy appear to have a negative impact on the policy process surrounding drugs. While the different impacts each of these have on the policy process varies per respondent, one thing that is constant is the theme of competition among the policy actors. Almost all the feedback I received during this conversation was focused on ways in which the competitive nature of politicians and bureaucrats thwarted development in drug policy. Most of this emphasis however seemed to be on the problems caused by bureaucrats—particularly those from law enforcement.

According to most respondents, within the law enforcement venue there is a sense of dominance that carries throughout the venue. Whether it is intentional or unintentional matters very little as the strength of this venue compared to others has managed to cause some major problems in drug policy. The director of a justice policy think tank discussed with me some of the ways in which law enforcement has managed to monopolize the drug issue. When doing so, they end up choking off the access other venues (like treatment and harm reduction) have to policymakers: "The law enforcement sector of the bureaucracy controls the image of drugs. Because they benefit from criminalization they are reluctant to define drug use as something other than criminal behavior. This is compounded by the fact that politicians want to look like they are pro-police and thus give the DEA, FBI, Customs, and Coast Guard more money that what they asked for".

A similar explanation for this came from the director of a national addictions professionals association: “Because there are so many actors involved in drug policy, people become confused and end up relying upon law enforcement because they know that it is an issue that involves the justice system”. This explanation shows that in many ways the dominance of the law enforcement venue has allowed for this venue to become the default venue for the many policy actors who are not familiar with this issue area.

Another explanation of law enforcement dominance mentioned by a respondent from the treatment sector was that law enforcement has managed to split its focus on the drug issue—which ultimately necessitates more government support than other venues that have only a single focus. As one treatment expert argued, “law enforcement preoccupies itself with both the demand and supply side of drugs”. As such, they require twice the amount of resources than treatment or prevention groups who only focus on the demand side. This not only ensures that law enforcement will always be a larger venue that the others, but it practically guarantees them to be the only venue to deal with at least one whole part of the drug issue—and that is the supply side.

The strength of the law enforcement sector in the bureaucracy and the problems it apparently causes within drug policy were described by respondents from different venues. Some of them spoke of the sheer size of the law enforcement sector and how it is able to foster the continuation of its own growth because of its size. Others identified the role of law and how it has made it easier for law enforcement bureaucrats to dominate the issue. One lawyer from an interest group charged that “the Justice Department pushes for longer sentences so it looks like they’re lowering crime—which in turn gets them more government support”. Some even reported on how the failure of the other venues to achieve the size and capability of the law

enforcement venue makes the smaller venues look unorganized and ineffective to out-of-touch policymakers. Illustrating the dismay heard in many of the respondents from treatment and harm reduction are the words of one director from a national treatment association: "We in treatment have been fighting the law enforcement balance for 30 years…and we haven't even made a dent".

Although most respondents who identified problems caused by the law enforcement venue left the blame with this group, a few stood in defense of law enforcement. In speaking on why harm reduction hasn't been able to develop in parity with law enforcement, an FBI agent revealed that "bureaucrats are not holding them up; it's the public and politicians that don't support harm reduction. The FBI will continue to do what it needs to do based on what it is told to do. When the public feels that drugs are not a crime problem then we'll shift our focus to something else. Most of us in law enforcement are not too dependent on the status quo, we have lots of different priorities—except maybe the DEA, they are pretty much a one track agency."

Supporting this position, a high level official within the Food and Drug Administration deemed that "the current political climate makes it difficult for bureaucrats to acknowledge that harm reduction is good. The religious right and White House status quo creates a fear in the bureaucracy to accept things like needle exchange". This perspective that bureaucrats are at the mercy of politicians who are driven by public opinion was also shared by a treatment professional: "Americans just don't see drugs as a public health issue—it's still largely a public safety issue. [As such], everyone ends up turning to law enforcement personnel, whose job it is to enforce the will of the people upon society".

Other complaints about the bureaucracy that were specific to one drug policy venue were limited to treatment and harm reduction. A respondent from the Legal Action Center revealed

that the big problem of treatment is that they are never able to accurately monitor their success and share their results with the government. The confidentiality and anonymity—especially in non-government programs, makes it difficult for policymakers to see the effectiveness of treatment. As a result, those addicts who fail in treatment and go through the justice system are the only ones visible to policymakers. The result is an increased treatment budget for the justice system at the expense of the treatment sector on the outside.

This perception was also shared by a respondent from the Food and Drug Administration who believed that "there are not nearly enough resources used to measure success in treatment. Compared to law enforcement—who measure success on arrest rates—treatment looks unorganized". A respondent from the Drug Policy Alliance added that "the statistics in treatment are no good at all. They've changed the math over the years and altered the way they count things. Using these poor data, there is no way for treatment people to convince government to change the status quo".

Another complaint about the treatment sector regarded the cohesiveness of non-government and bureaucratic groups within treatment. An official from the Bureau of Prisons found that the treatment community doesn't lobby as a group. As a result their efforts are fragmented and weak in comparison to their counterparts in law enforcement. Another complaint from the same respondent was that the treatment sector was very inconsistent in terms of skill and ability. This ultimately leads to less convincing proposals to policymakers. He concludes with, "what they really need to do is professionalize the treatment sector; there are too many low-educated former addicts running the show and it's bringing them all down".

Like the above-mentioned critique of treatment, the criticism made of harm reduction was also focused on internal mechanisms. A political staffer for a Republican Congressman

found that the harm reduction camp causes problems not only for itself but for others simply because it lacks a uniform voice on the drug issue: "In the House we have Democrats wanting to decriminalize drugs and cut law enforcement funding in the hopes of building more resources for harm reduction. Yet when in the White House the Democrats want nothing to do with that cause. At a state level, there is a growing group of people who think that marijuana is ok and that it even has medicinal value. This causes confusion and makes people think drugs are ok when they are not".

A second critique of harm reduction was offered by one of the founders of needle exchange in the United States. Still working in the profession, the respondent claimed that "because there are so many harsh laws affecting harm reduction—at the state and federal levels, many harm reduction services have had to go underground". In a follow up conversation on this topic, the respondent revealed this to be problematic in three ways. The first is that it paints all harm reduction advocates as deviant evaders of the status quo. The second is that it does not allow for professionals to measure the effectiveness of this programming and share it with policymakers. Third, it keeps the venue fragmented and disorganized, which is one of its biggest weaknesses.

In summary, there are some problems inherent to drug policy that apparently come with the territory. Overcoming these issues is often difficult, if not impossible. As revealed by the respondents, both politics and the bureaucracy also cause problems for drug policy. Of the latter, there is no real way to find out why so many respondents who pointed out problems of the bureaucracy pointed to law enforcement. However, considering what was learned from the discussions in this section, there is one possible explanation.

During the interviews, most law enforcement respondents did not point out problems with the other venues because they did not see these venues as a threat. In other words, their venue was paramount to the others, and was responsible for maintaining the status quo—which in America they are doing. Respondents from other venues however saw law enforcement as a threat to their mandate and so focused on problems caused by law enforcement bureaucrats throughout our conversation on this topic. While just a guess, the rich data deriving from the interviews do suggest that this guess may very well be accurate.

Public Opinion and Drug Policy

Some of the discussions described above ventured slightly into the domain of public opinion and the role it has in the politics of drug policy. Within the American sample of respondents, some felt that the issue was not very salient with the public. The legislative director for a Republican congressman believed that "In the last 10 years, drug policy has lost salience as an issue that the public cares about. Basically dope and crime have been overshadowed by terrorism and homeland security." Several other respondents of different backgrounds also believed that drugs have really fallen out of the public's mind and consequently off the radar screen of Congress. One exception however is crystal methamphetamine, which seems to be bringing the issue into light particularly in rural areas.

In contrast, there were many more respondents who felt that this issue was pertinent to the interests of the public, and as such, several political developments have occurred because of it. A legislative assistant to a Democrat Senator revealed that the intensity of the drug issue in government circles is quite high: "There is a real danger with this issue in that any politician or bureaucrat who brushes up against this issue—even lightly—becomes targeted". This would explain why the communications coordinator for a decriminalization advocacy group felt that

only one side of the issue is ever voiced: “drug policy is very political in the sense that politics have trumped the sharing of ideas. However it is not political in the sense of open debate”.

Other respondents felt the same way. In fact, when asked if drug policy has ever been exploited for votes, over half of the American sample answered affirmatively. One of these individuals was an employee of the Drug Policy Alliance who claimed that “The general political perception is that supporters of reform are soft on crime. Politicians are fear-driven species that never want to be associated with drug reform. On a regular basis, employers of the criminal justice system—and especially corrections workers unions—put lots of support behind candidates who stay tough on drugs. It is these politicians who get elected again and again”.

The politicization of drug policy is defiantly something that most respondents recognize in their daily work. However the extent to which it stays within party lines is more difficult to gauge. A chief of the congressional affairs office within one of the federal law enforcement agencies revealed that “over the years partisan lines on this issue have blended. You have Republicans pushing for treatment and Democrats pushing for law enforcement all over the place. Though partisan differences are harder to pinpoint, rhetoric and the politicization of drug policy is still there”.

This becomes more apparent when discussing with respondents the balance between public opinion and science in government decision making regarding drug policy. A large majority of the sample believed that policymakers weighed public opinion more than scientific fact when it came to making decisions on issues related to drugs. A director within one of the branches of the Food and Drug Administration felt strongly that “Politics trumps science every time!” This respondent later explained that needle exchange was found by SAMHSA to offer great public health benefits. However because of the politicization of the issue, no federal

funding was allowed to go towards needle exchange. The respondent concluded the answer with "we put a lot of morality into our decision making and little to no science in at all". This position was echoed by an employee of A Partnership for a Drug-Free America: "Science is important when it comes to informing politicians, but desires of constituents are important when it comes to informing decision-making".

When politics and the quest for votes are put aside, it seems that advocates for drug law reform still face an uphill battle. Some of the respondents described how the country has little compassion for drug users and their problems. One respondent described that the average taxpayer does not feel that they should support someone who made a bad choice in life. In fact, the only way the public generally supports addictions funding is for addicts in the criminal justice system—where they are hidden away and the public is protected.

A different respondent found that the biggest obstacle for treatment and harm reduction advocates is that the public does not see addiction as an illness, but a crime. In fact, she added that "even health professionals have a hard time viewing the average meth client as a patient instead of a criminal". One legislative assistant to a Republican Congressman summarized his opinion of the matter in a similar fashion: "there is no public acceptance that drug addiction is a disease. It is seen as a morale failing; which makes it real tough for politicians to narrow their health agendas and push for treatment".

These obstacles become even more difficult to overcome when even the media has a right-of-center perception of the problem. According to one lobbyist, "The problem with the drug domain and the public perspective of it is that politicians and the media always focus on one side of the issue. In other policy areas with leftist interest groups—like the environmental movement for example—the media will interview Greenpeace of the Sierra Club. However you

never see them interviewing the Marijuana Policy Project or the Harm Reduction Coalition. No, they go straight to the ONDCP or the DEA every time they want to do a story on drugs. It's maddening!"

In close, it seems as if the competitive nature of drug policy in America may very well be routed in the conflict between public opinion and science. The respondents have revealed that there is a tendency for politicians to follow the public will, even if it goes against what scientific fact tells them. When a politician or bureaucrat does not follow the status quo, others will attack them. Considering this, if strategy is one of the major reasons for politicians and bureaucrats to behave in the way that they do around this issue, then it would be useful to identify the effect that political institutions have on this behavior.

Political Institutions and Drug Policy

The institutions of America's political system offer a dynamic environment to construct public policy from within. Discussions I had with the respondents revealed two common themes among the sample. The first was that the effect of each institutional structure on drug policy very pronounced. In other words, there were very few respondents who felt that political institutions had a slightly indirect influence on drug policy. Those who identified the effect of institutions on drug policy, made it clear that the effect was very strong and noticeable. The second theme was that most of America's political institutions lead to conditions of conflict between different groups involved in the policy process. The only exception of course was federalism and the opportunities of innovation that come with this structure.

Of all respondents, about a handful identified pluralism has having an effect on drug policy. The legislative director for one Congressman felt that pluralism makes the policy process more difficult because it brings in so many actors: "as the number of actors increases, so does the

complexity of the decision-making process". The respondent continued by describing that when this occurs, the resulting decisions may not necessarily be those that the original developers of the idea had in mind. Illustrating some of this, a reform lobbyist explained that "pluralism has allowed for interest groups and businesses to gain access to politicians. The privatization of some parts of the criminal justice industry has made it more difficult for legislators to consider alternatives to the status quo".

Providing more details on the dynamics of this process, an advisor to the House Speaker shared that pluralism affects drug policy in that it allows for dominance of some groups over others. Because of time restraints, it is often the case that this pool of experts or lobbyists is the only group Congress gets to hear from. The result is that "the policy outcomes tend to reflect the understandings of this group above anyone else".

Of course time restraints are not the only factor that may affect the impact of lobbyists. Speaking on the outcomes of lobbying, the vice president of a national research center on addictions explained that while pluralism does bring new ideas to government, this is dependent upon the decision makers' perception of the lobbyists: "New ideas introduced through lobbying efforts are what advances reform in drug policy. The only problem is that traditionally the trade associations of drug professionals haven't been all that effective because government sees them as interest groups instead of professionals and experts".

Although it seems that most respondents spoke of the repressive impact that pluralism brings to drug policy, a legislative assistant in the Senate raised the point that if it were not for pluralism, the entire harm reduction venue would be half of what it is. Speaking mainly of the lobbying efforts in Washington, the respondent revealed that whereas treatment, prevention, and law enforcement groups are organized throughout the country—and usually through some form

of government bureaucracy—harm reduction is not. As such, it is through lobbying efforts—that are afforded by pluralism—that allow for harm reduction advocates to have a presence in the policy process.

One of the most discussed institutional factors in the U.S. field interviews was federalism. Most respondents—no matter their job or familiarity with government—had an understanding of federalism and the impact it has on drug policy. This made for considerably fruitful conversations across the board. The two main themes appearing within the federalism discussions with American respondents were that it leads to (a) competition between different levels of government and (b) innovation in drug policy.

Speaking on the former theme, the director of a national addiction professionals association said that "federalism has really fragmented things in drug policy. This leads to competition not only between the existing groups [ie: law enforcement, treatment, etc.] but between different levels of government. What's worse is that it places different demands and expectations upon the different groups involved". To provide an example of this process, the respondent explained how treatment comes from Health and Human Services, to the State governments, then to State health departments, through to regional health authorities, and finally to the various treatment clinics. If one level of government wished to implement something different, they would have to convince others above and below them that they have a right to implement such change. He concluded that this is only an example of public treatment, whereas private treatment involves completely different actors.

The most common discussion on federalism and drug policy regarded the increased possibility for innovation. During the institutional discussions I held with respondents, a unit director from the Legal Action Center was quick to point out that "any reform that occurs in drug

policy—particularly in treatment or harm reduction—is done so at the state level". The reason she gave for this was twofold: (a) drug policy actors seem to gain closer access to policymakers at the state level; and (b) there is less politics surrounding the drug issue at the state level as compared to the federal level. A different respondent, this one a congressional staffer, agreed that federalism aids in the innovation process because the barriers of reform are less of a threat at the state level. He added that in federal circles, the political stakes are so high in any policy area, that change comes by very slowly and very seldom.

Speaking more so about the benefits of federalism to state level drug reformers, a Republican Congressman informed me that federalism allows for states to develop their own drug policies and tailor them to fit their own needs. He followed with, "this is very important, considering the diversity of the drug problem across our country". This same observation was made by a senatorial assistant who added that "while federalism does allow for the innovation that is much needed in drug policy, it does force people to work from the bottom up with very little help at the top".

While most respondents on federalism talked about the sub-national side of the relationship, few talked about things from a national perspective. One respondent was a legislative assistant to a Republican Senator. He explained that, the federal government tries its best to set national priorities on drug policy. However the impact on states varies across the country. Largely, the influence of the federal government on each state has to do with the types of grants each state hopes to receive and what their own priorities are regarding the matter.

A respondent from the harm reduction venue also commented on the national side of federalism in drug policy: "While the federal government acknowledges that states have considerable controls over drug reform, they can push their way around on issues that are

important to them". The example the respondent gave was needle exchange and the federal government's refusal to support any state program that incorporates needle exchange services into programs paid for with federal funds. Again, while needle exchanges are the jurisdiction of state law, the federal government has very effectively limited the number of needle exchanges in America.

Based on the answers of respondents to previous questions, one of the most obvious institutions to have an influence on drug policy is electoral design. America's single member district voting has developed two parties that have politicized drug policy beyond what many of the respondents had desired. The director of a justice think tank explained that "our majoritarian system forces politicians to fight for the middle. When doing so they end up exploiting the fears of voters to get ahead of one another. The result is that no one can push for change or they will appear soft on crime. The classic example is when a politician campaigns on the promise to get tougher on crime in lieu of the fact that judges are liberal and defense lawyers are slimy".

The same sort of competitive understandings regarding America's voting system were shared by several other respondents. An individual from the Marijuana Policy Project felt that "America's two party system makes sure that anyone who questions the status quo becomes a target of everyone else—even Republicans!" The legislative assistant to a Republican Senator felt that the conditions between the two parties make it impossible to work towards good discussion on issues—at least one with sensible outcomes". Lastly, a respondent from the Women's Alliance for Medical Marijuana explained that "A two party system creates too much conflict. It creates an environment that gets caught up in rhetoric instead of pragmatic policy. Changing the system and its policies is very difficult".

While America's two party system has led to a competitive party system, it has also contributed to the demise of party discipline. In discussing the weakness of political parties on the drug topic, the staff director of a House Committee admitted that "both parties are weak—at times it seems like we have 435 different political parties in the House. While the Democrats do not want to be associated with harm reduction or legalization, some pockets of the Democrats are supportive of these approaches. Party discipline is even worse in the Senate. On many occasions I've seen Republican Senators who have supported leftist drug policies and Democrat Senators who have supported rightist drug policies. Such dynamics make predicting drug policy outcomes really difficult sometimes".

In short, the common theme among these understandings is that America's electoral design leads to two extremely weak parties, which makes competition inevitable and smooth policymaking impossible. To many respondents, the polarization that results from this process has minimized the opportunity for change to occur. Summarizing this phenomenon, one respondent from a reform advocacy group felt very strongly that America's status quo drug policy has been entrenched largely because of the country's electoral design: "The single member district design of America's voting structure leaves little room for representation of the truth. The drug issue always becomes polarized and there is never any room for nuanced discussion".

The fourth political institution discussed in this section was regime type. Once again, the respondents identified an institutional structure that led to a more competitive policymaking system. The first respondent to spend some time discussing how the three branches of government affected drug policy was an assistant to a Senator in the Republican caucus. Based on his years of experience on the Hill, the respondent explained that between the three branches

of government, there is hardly any cooperation on the drug file at all: "Each branch goes off and does its own thing. Then they end up being totally dysfunctional where drug policy is concerned".

Another respondent who talked about presidentialism revealed a different kind of consequence. The executive director of a lobbyist front explained that the constant tug and pull between the legislative and executive branches has actually led to reform at the state level. In expounding upon this, the respondent explained that most drug reform groups are aware of the utter chaos surrounding drug policy in Washington and so make better use of their time and efforts at the state level. According to her and several other respondents, it's working.

The final respondent I'd like to discuss in this analysis is a government relations officer within a national treatment professionals association. This individual found that one of the biggest impacts regime type has on drug policy is that anyone who wants to affect drug policy has to be heard by two different sets of ears: those in the White House and those in the Capitol Building. When trying to change the status quo it is very difficult with one decision-making venue, let alone two. According to the respondent, "the work for us becomes much harder the more each branch wants to have a stake in drug policy. The tasks get even more complicated when we have a divided government".

The final institutional factor discussed in the field interviews was cameralism. While only a few identified it as having a major impact on drug policy, those who knew of it provided some great details. The first was an employee with the National Association of Addictions Professionals, who said that having two chambers is helpful in that it allows for something to be killed in one chamber if it some how passed on the other chamber. While this second-chance

device seemed very useful to the respondent, he did admit that it could have the reverse effect on policy that he thought was good and others thought was bad.

The second respondent to discuss America's bicameral legislature in some detail was a senior policy advisor to a House Committee. This individual found that on rare occasions having two chambers helped move things quicker because the original chamber would try to pass the bill smoothly so that the second chamber would not notice any chaos. However, more often than not having two chambers slows down the policy process because it adds one more decision maker to the table.

A more in-depth understanding of bicameralism was offered by the CEO of a civic action group. In her explanation of the policy process, the respondent revealed that quite often, when one chamber is preparing a bill, they'll try and shape it in a way that the other chamber will like it. She found that, "since this is done in committee and away from the original chamber, some very different bills end up coming out—some that look nothing like the original. In the area of drug policy some really strange things have happened, particularly when the two chambers are controlled by different parties".

The final respondent I would like to discuss offered a very different view of the role that cameralism plays in drug policy. The senatorial assistant was confident that America's bicameral legislature did not have too much of an effect on drug policy. The reason he offered was that both chambers are equally challenged with balancing the tradeoff between demand and supply, then at the same time confronting their constituents with their decisions. While this position does not offer a whole lot of support for the arguments driving this research, it is useful in reminding us that not every move made in politics is attributable to political institutions.

Envisioning Drug Policy Under Different Political Institutions

Many of the interviews I conducted in the U.S. were with respondents who had less time to spend with me than their counterparts from the other three case countries. As a result, I didn't spend much time talking with them about their predictions for how America's drug policy would look under different political institutions. Many of those who I did speak to weren't really sure how it would affect things entirely. Some mentioned that a multiparty system may minimize partisan conflict whereas others thought that unitary governance would lead to less innovation in drug policy—as the federal government is focused on prohibition.

A respondent from the Criminal Justice Foundation felt that if America had a different electoral system, policymaking would be different all together. Speaking on drug policy, the respondent explained that "If the USA had a PR system there would be more opportunity for alternative ideas to be pushed into the mix". He furthered by saying that the current system does not allow for minority views to be considered in the realm of options for drug policy. A system based on proportional representation would bring more parties, less politicization, and increased opportunities for harm reduction and treatment to grow.

American Overview

The field interviews with respondents in the United States revealed a lot of information about drug policy in that country. While the interview process was more demanding—in terms of obtaining interview times, and even re-booking appointments, I managed to get a lot of useful information from the respondents. Overall I managed to get a well-balanced sample of respondents; which was something I didn't think I could achieve in America considering the topic of the research.

Throughout the interviews, it was clear that law enforcement was the more dominant approach, with treatment and prevention further behind. With the exception of many local and some state commitments to harm reduction, this venue is very weak in America. The dominance of the law enforcement venue stems from the Harrison Act passed in the early 20th Century. This ultimately committed the U.S. to a law enforcement approach towards the drug problem. According to many of the respondents, a strong drug war complex has been developing ever since.

Changing the direction of America's approach to the drug problem is very difficult because of a few things that fall outside of the controls of reformers. One is the fear that bureaucrats and politicians have. It is believed that anyone who suggests changes to the status quo will become targeted and lose their job, credibility, or both. Another barrier to change is that the constant promotion of the prohibition approach by politicians and bureaucrats continues to reinforce the status quo, making it awfully difficult to alter. Though these barriers are in place, subtle changes have occurred. According to respondents, most of this has been accomplished at the state level.

According to respondents, though there are many actors in the drug policy process, not all play an equal role. While it is difficult to measure exactly which actors played a larger role in the eyes of respondents, there was definitely an emphasis on the ONDCP, Congress, and the President. Other policy actors include the entire health and law enforcement bureaucracies, a few specific politicians, and a score of non-profit organizations and interest groups. It was reported that the relationships between and within these groups were competitive. Whether it be to attain resources, shape the political agenda, or control drug policy, there is always a conflict within this issue area.

Some of the problems identified by respondents include those caused by bureaucrats, by politicians, and by specific policy venues—including treatment, law enforcement, and to a lesser extent, harm reduction. Some of the other problems identified were those inherent to drug policy itself, as well as ones caused by public opinion and political salience. Most of the respondents were confident that in American drug policy, public opinion plays more of a role in decision making than does the scientific advice of experts.

The discussions of political institutions and drug policy that I had with respondents offer considerable support to the hypotheses tested in this research. While the quantitative data compiled for this project have been used to test these relationships, the rich descriptions of these phenomena provide a detailed account of what actual drug policy actors see in the field. In the eyes of these respondents, single member districts, a presidential regime, bicameralism, and pluralism all turned out to create a more competitive policymaking environment in the United States.

To some respondents, federalism created a competitive policymaking environment because it added that many more actors into the process. The division of labour and added expectations often leads to uncertainties which result in conflict. To other respondents however, federalism allowed for smoother policymaking because it allows drug policies to (a) be tailored to the needs of states, and (b) it allows drug reformers easier access to decision makers.

In close, my field research in the United States confirmed some things to me while also forcing me to question others. As I had predicted, the law enforcement status quo was largely a product of bureaucratic dominance and political institutions that foster a competitive policymaking environment. Surprising however, was that the two main phenomena under study here—bureaucratic dominance and political institutions—seemed to have a combined effect on

drug policy. As many of the respondents reported, the bureaucrats and politicians in control of drug policy feed off of one another to build their own resources. They will continue to do so as long as law enforcement remains the dominant approach to the drug problem.

5.3.3 Canadian Interviews

The interviews I conducted in Canada revealed several common themes about drug policy. The first is that there is some discrepancy in how balanced the different approaches to drug policy really are. The second is that bureaucrats play a significant role in Canadian drug policy. The third theme arriving from the interviews is that there seems to be a change occurring in Canadian drug policy. Thanks to institutional restraints and bureaucratic resistance however, that change is happening very slowly. I have divided this subsection into the different categories of discussion I had with respondents.

Canadian Drug Policy

A majority of respondents described Canadian drug policy as having a balanced approach to the four pillars: law enforcement, prevention, treatment, and harm reduction. While most respondents agreed that these four pillars existed, there was considerable variation in their understandings of the extent to which these pillars existed. One senator who has played a major role in recent drug reform efforts described the four pillar approach as "wonderful rhetoric but horrible reality". He revealed that the studies we refer to say that drugs are a health and social issue, yet our policies show something totally different. Instead of approaching the issue with health and social instruments we marginalize users, criminalize their addictions, and spend 95% of our drug policy appropriations on law enforcement.

Offering a different perspective of this pillar imbalance, a high-ranking member of the Royal Canadian Mounted Police Drug and Organized Crime Unit explained that traditionally we

were a law enforcement country. However over time we have tried to take a more treatment-oriented approach. This transition made drug policy so unorganized that we did not do an effective job at addressing the problem. The result was the development for harm reduction, which according to the respondent, "was a huge mistake". He felt that if we better organized law enforcement, treatment, and prevention, we would not have a need for harm reduction, which is not only becoming the dominant approach to dealing with the problem, but is really messing things up.

A third respondent also skeptical of the so-called balance approach revealed that within drug policy, it has usually been bureaucrats that have development and implemented law enforcement, prevention, and treatment initiatives. However it has been academics and activists who have developed harm reduction. This does not allow for an easy implementation of harm reduction—mainly because there are no bureaucrats who champion it.

Offering some more insight to this debate, a Liberal member of parliament explained that while we tend to have a more restrictive approach to the drug situation, our methods are supportive of the harm reduction philosophy. A high-ranking executive member of the Canadian Centre on Substance Abuse echoed these claims by explaining that, "although drug laws are on the books, Health Canada is the lead player on drugs, which allows us to approach the situation with health professionals". Overall the main understanding of the respondents was that we do have four different approaches or pillars to solving the drug problem. While it was harder to find a consensus on the extent to which these pillars were *balanced*, they did agree on their existence.

One thing which really pulled all respondents together on the pillar issue was the comparison to the United States. Several respondents felt that while we may have some reliance on the criminal justice system, it is nothing like that in America. An executive member of the

Canadian Association of Chiefs of Police felt that while we do approach the drug problem with police, we definitely do not have a war on drugs, like in the United States. One researcher from a Toronto-based think tank expressed that we certainly have some injustices, but ours are nowhere near those like in the U.S. Softening these comparisons a bit, one analyst from the Canadian Centre on Substance Abuse explained that Canada sits between Europe and the United States in terms of its drug policy. While we borrow law enforcement ideas from the United States, we borrow harm reduction, treatment, and some prevention ideas from Europe.

The Origin of Canadian Drug Policy

When I asked the respondents where this four-pillar approach to drug policy came from, several explained that it has been a work in progress. Generally, Canada started out with a strong law enforcement approach to the drug problem, and then in the 1980s it moved towards a more balanced approach with health at the core. While most respondents agree with this understanding, several did not. Some even felt that we haven't moved very far from our law enforcement origins.

An activist and analyst from the Canadian Foundation for Drug Policy explained that in the early 1900s, Prime Minister King had to manage Asian rail workers who were willing to work for less pay than white people. Drug laws were passed in only a few weeks because no one really knew what drugs were. Eventually, the existence of the RCMP became justified when they were given jurisdiction over this new criminal problem. Over the years, the RCMP remained the sole venue for drug policy. A hired lobbyist within the same organization said that the law enforcement approach to the drug problem has remained intact for years. This is chiefly because of bureaucrats who reinforce the status quo and politicians who realize the almost non-existent political advantage that can be found in pushing for drug reform.

Explaining Change in Canadian Drug Policy

Of those who do feel that we have changed our drug polices over the years, most cite the increasing importance of the health venue. A Conservative member of parliament believed that 25 years ago people in health stayed away from drugs because it was a moral issue. The attachment of AIDS to drug use however has allowed for the development of alternative approaches—particularly harm reduction. He added that "nowadays, it seems that most people in health and clinical settings are critical towards prohibition". Adding to this explanation, a former advisor to the Solicitor General revealed that while AIDS was what allowed for the creation of harm reduction, having a strong health infrastructure certainly helped out a lot too.

Another catalyst of change according to one senior bureaucrat is that in the last 20 years, policymaking has moved away from relying on policy-based evidence and towards relying on evidence-based policy. In other words, policymakers are starting to take a closer look at the facts presented to them. According to a senior manager in Corrections Canada, this is evident in the many studies which show that law enforcement is not effective on its own.

While reform has occurred, getting these changes in drug policy has not been easy. One Member of Parliament felt that change itself has been hard to come by. It seems to only arrive when there is focus on an issue on an annual basis. In fact focusing events don't even lead to change in the world of drug policy because people have little sympathy for drug users. A different respondent believed that change was hard to come by because to get change, political actors must promote change of a paradigm before they can change policy. When drugs are illegal, and as a result everyone sees them as dangerous, it is politically unwise to try and promote an alternative view of drugs.

One interesting account of why change is difficult came from a high ranking official in Health Canada's Drug Strategy and Controlled Substances Programme. Her understanding was that the real barrier to change is in the relationship between bureaucrats and politicians. In terms of policy change, bureaucrats cannot promote change. Their job is to be open to change and implement change. It is the job of politicians to promote change. A problem occurs when politicians turn around and rely on the advice of dormant bureaucrats. They end up getting advice which not only is reflective of the status quo, but does not lead the politicians towards change.

Perhaps the most unexpected answer on the topic of change came from a different conservative member of parliament who is adamantly opposed to harm reduction alternatives to the status quo. In referring to the fight to maintain prohibition, the parliamentarian believed that "it takes a deal of courage to defend things such as abstinence, education, and non-legalization, but I think it is worth it". The reason I am surprised by this comment is because most respondents feel that change within drug policy means changing the current regime from one of law enforcement to one of harm reduction, with the former being the status quo of course. Clearly this respondent felt that the law enforcement regime was being threatened from alternative drug strategies and that insuring its sustainability was an uphill battle.

Ideal Drug Strategies

Moving somewhat away from the discussion on existing drug policy, I asked respondents to share with me their ideal drug strategy. A majority of the respondents expressed a major interest in the development of treatment and prevention. Responses varied on how much importance they put on harm reduction and law enforcement. Some believed one or both of these should be a part of a national approach to the drug problem, while others thought it made matters

worse. Additional responses included mandatory treatment, target-group specific approaches, and equal integration of the four approaches.

One respondent felt that while we do need to maintain the four pillars approach, we must try harder at removing the stigma attached to drug users. This is not only bad for the drug users, but when such stigma exists drug policy is politically a loser issue and one that is hard to generate public support for. A second respondent agreed, however pointed out that if political actors tried hard enough they could find political mileage in dropping the historical categories of drug types that have criminalized addiction for so many years.

The one response unlike any other on the topic of aspiring drug strategies involved a discussion on organization. An RCMP coordinator suggested that "we would be more effective on all four approaches to the drug problem if we had a central command post—such as a drug czar". This brings my analysis to a very important consensus among most of the respondents: that Canadian drug policy is very horizontal. The result is that there seems to be no clear direction or control on the matter.

Drug Policy Actors

When I asked respondents who they thought was in control of Canadian drug policy, an overwhelming majority listed several agencies within the federal bureaucracy. These agencies include Public Safety and Emergency Preparedness, Health Canada, National Security, Revenue Canada, Immigration, and Border Services. Others mentioned politicians, judges, non-profit groups, and professional associations. Of all the actors listed in their response, very seldom could they point out a main leader. Those who did identify a central authority on the subject matter however, pointed to Health Canada. Despite the official lead role that Health Canada plays in drug policy, many respondents complained that drug policy in the country is not organized

properly. The horizontalness of the drug policy network makes drug management difficult for bureaucrats and politicians alike.

The Relationships between Actors: Cooperation and Conflict

One of the fallouts from horizontal organization is that there is a certain level of competition which occurs because there are so many actors involved. An executive member of the Canadian Association of Chiefs of Police found that though there is an effort within drug policy to be cooperative, conflict ends up occurring because the involved stakeholders have different views of what should be done. A Liberal member of parliament felt that another cause of conflict within drug policy is the competition for resources. While the different sectors of the drug policy bureaucracy have their own budgets, it seems that drug-specific appropriations come in one package that everyone is supposed to share. A policy analyst with the Canadian Foundation for Drug Policy felt that there is often competition between bureaucrats for the attention of politicians, and competition between politicians for control of bureaucrats. The result is a lot of mixed messages that end up being tossed around in lieu of no central command.

Tired of the conflict within drug policy, some respondents felt that competition within a single policy area is quite ridiculous, especially if everyone wants the same thing in the end. A Conservative member of parliament felt that Canadian drug policy is way too competitive: “In Canada we have a war on drugs, but it’s between law enforcement and harm reduction. In drug policy you are either a warrior or a harm reductionist. Both sides have gone too far in trying to secure their position”. A senior bureaucrat from Health Canada had a similar conclusion: “Harm reduction and abstinence folks are constantly fighting one another. This wastes time and ruins their collective credibility. In the end, different programs work for different people”.

Despite the conflict that occurs as a result of Canada's horizontal drug strategy, there is a certain level of cooperation that does occur. One respondent viewed cooperation in drug policy as occurring largely because of the nature of the drug problem itself. Addictions cut across so many bureaucratic lines that different stakeholders have to cooperate in order to be effective. The major problem however is in trying to figure out who does what. Another respondent revealed that there really shouldn't be competition or even confusion among drug policy actors. Everyone—including the police, health department, and justice people—all have their own distinctive roles in the problem.

On that note, several respondents provided different examples of cooperation that stem from the multi-actor or horizontal approach to Canadian drug policy. One is the Health Enforcement Partnership that exists to cross the ideas and interests of health providers with those of law enforcement professionals. The Canadian Centre on Substance Abuse was also a common example given by respondents. Its role is to bring various groups together in one setting, where they can discuss different approaches to addressing the drug problem. There is also a cooperative relationship between bureaucrats and non-profit organizations and interest groups. All three do research, provide information, and generate alternatives. Non-government actors like interest group and non-profit workers try to spend a lot of time with bureaucrats because the latter will eventually be asked by politicians to shape policy.

As each of the respondents finished identifying the conditions of cooperation and/or conflict in Canadian drug policy, I asked if they had any ideas of why such relationships exist in the way that they do. A more general answer on cooperation was provided by a researcher at the Canadian Centre on Substance Abuse. He explained that things are cooperative in Canada because stakeholders work towards a consensus. There is no drug czar for Canadian drug policy

that decides what we should do. It is a collection of different ideas and interests that are combined to deal with a single problem. This position was echoed by another respondent who felt that while we sometimes may disagree on means, we all agree that the problem exists and that it should end. A senior research officer with Health Canada even mentioned that "in order for our drug policies to work out, we all have to get along with one another". Finally, a member of parliament believe that cooperation comes from the realization that not one single pillar is sufficient on its own, all are necessary.

An interesting observation made by an above-mentioned respondent was that public support for the bureaucracy also makes it easier for these groups to cooperate. Whereas Americans distrust their bureaucracy but love their politicians, Canadians hate their politicians and respect their bureaucrats. The respect for the latter encourages them to cooperate on issues that involve the efforts of many different actors. As such, while competition occurs between politicians, bureaucrats feel they need to have solidarity and consistency. He concluded with, "Look, we're the only country in the world with a civil servant (Mountie) as our national symbol".

These explanations of cooperation between actors are based on the assumption that it is voluntary, that the actors involved choose to be cooperative. Another respondent felt however that there are some things which may coerce cooperation between bureaucrats. A senior advisor in the office of the Solicitor General felt that cooperation in drug policy occurs between different sectors of the bureaucracy because in order for a given cause (ie: drug policy) to get Treasury Department funding a horizontal approach must involve everyone. Apparently the treasury board often turns down stand alones. This perspective is supported by several respondents who

mentioned that more central government controls from the political level force cooperation among policy actors so that their cause is both efficient and uniform.

When it comes to explaining competition between actors, several respondents shared their views. One analyst with the Canadian Foundation for Drug Policy said that there is hostility in some areas of drug policy because it is largely inherent to the situation; basically, different groups have different ideas on how to solve the problem. When they are both after the same resources to fund their different programs conflict tends to occur. A Senator from Saskatchewan felt that within politics, the competition between political actors can have an impact on policies. In some occasions, certain parties will push for or against something just to be in contrast with the other parties. A different Senator observed that conflict can also occur between experienced bureaucrats and the cabinet ministers they are responsible to. When one is tough and the other is weak, acquiescence usually occurs. However conflict can result when both are strong, stubborn, and skilled and what they do.

The Role of Bureaucrats in Canadian Drug Policy

The discussions on actors within drug policy and the relationships that they have with one another tended to focus a lot on bureaucrats. Using a question on the survey, I asked respondents what they thought the role of bureaucrats was in drug policy and what efforts they have made towards or against making changes in drug policy. There responses varied a bit, however some common themes were definitely noticeable.

The first was that bureaucrats provide services to the public on behalf of the government. When doing so they try to remain neutral on topics, however when asked by politicians about certain things, their answers are based on their own professional experiences, which are usually not neutral. A respondent from the law enforcement community believed that bureaucrats are

apolitical. Their job is to provide research to parliament and give advice to government. However when doing this, they give the advice they know, which is often from within their own profession and not necessarily neutral.

To illustrate this respondent's claim, when policymakers solicit the advice of a police officer on matters pertaining to drugs, her advice will be police-oriented. The same goes for treatment, prevention, and harm reduction professionals. This problem was pointed out by a drug reformer who said that many of the committees in the House and Senate bring in experts from the RCMP or the United States—both of which groups will deliver a law enforcement analysis of the problem.

The same type of response was given by a Liberal member of parliament. In describing the role of bureaucrats, the respondent explained that they are experts in their field, and because of this are asked to draft up legislation. The legislation they draft up contains policy approaches that they are familiar with. Soon after, elected policymakers see this legislation as coming from the experts, and do little in terms of critiquing or assessing it—mainly because it came from experts.

A similar explanation for why bureaucrats act in the way that they do is that there are really no incentives for anyone to challenge bureaucrats, even from within the bureaucracy. A Conservative parliamentarian felt that the expertise and longevity of bureaucrats has allowed for the civil service to take on a life of its own. In speaking, the MP claimed that "there seems to be this big veil of secrecy on how government programs are run. The whistleblowers we do have are not protected very well, and so there is little incentive to challenge the status quo".

The second theme revealed in the interviews was that bureaucrats intentionally provide information to politicians that preserves and promotes their role in drug policy. One critical

respondent expressed that bureaucrats have a tradition of maintaining themselves. When bureaucrats are asked to present something to politicians, there is definitely a presence of problem inflation and even dishonesty. As such, bureaucrats end up maintaining the status quo by making it difficult for politicians to consider different alternatives.

Another respondent suspicious of the role bureaucrats play in policymaking claimed that the role of civil servants is so strong that even if a majority of parliament votes on an issue, bureaucrats can act in ways that overpower the changes. This can occur through stalling, re-evaluating circumstances, or intentionally misinterpreting the legislation given to them. A less aggressive account of bureaucrats came from a health bureaucrat who felt that the role of bureaucrats is to modernize and develop legislation. When doing so, they are given considerable control over drug policy.

The third theme about the role of bureaucrats in drug policy is that without even trying to affect the policy process, their presence makes a difference. One example of this was provided by a member of parliament who admitted that politicians realize that bureaucrats know far more than themselves about certain issue areas. As such, challenging the way bureaucrats do things with little or no reason to do so is not very smart, politically. Since politicians end up leaving certain issues to those with expertise, bureaucrats end up either running astray or continuing to do what they have been doing for years.

One member of parliament also had the same understanding. He felt that "generally bureaucrats are more powerful than people think. There seems to be an institutional memory of policies and approaches to issues. When bureaucrats are pushed by politicians to follow the will of the elected they do so. However once the pushing stops, they fall back to what they remember—the old status quo". Examples (as offered by the respondent) of when politicians

stop pushing include when an issue loses salience, when there is an election, or when there is a new government.

Overall, the discussion on the role of bureaucrats was very informative and supports the bureaucratic dominance theory driving this paper. As several respondents suggest, the role of bureaucrats in drug policy is far greater than they or the public understand it to be. One of the clearest indications of this came from an interview with a Deputy Secretary to Cabinet. The respondent explained that most policymaking is done at the bureaucratic level. Ministers tend to only get involved if there is a problem or when an issue is salient. During an election, bureaucrats within the Privy Council—which is the machinery of government—draft up policy alternatives based on the platforms of the candidates and their parties. Whoever wins gets their policy book while the other one is stored for next time.

It is important to note that while most respondents described the intentional and direct role bureaucrats play in drug policy, there are different perspectives. A researcher from the Canadian Centre on Substance Abuse explained that bureaucrats would rather not be involved with policymaking, especially drug policy: "They are scared stiff by the drug portfolio and are not very motivated by reform. In addition, their desire to always reduce conflict doesn't always lead to things getting done. In short, bureaucrats know the right answers but are afraid to ask where it is politically risky to do so".

Problems of Drug Policy that Stem from Bureaucrats

In the discussions on the role that bureaucracy plays in drug policy, it was apparent that bureaucrats may cause problems. To delve deeper into this topic, I asked respondents if there was anything about the bureaucracy that would cause problems in drug policy. One of the main

concerns seemed to be that bureaucrats move too slowly, particularly when they want to avoid change.

A senator reported that civil servants can't get anything done in less than two years. When they really want to, they can do anything to prevent change from occurring. A similar response came from a lobbyist who believed that bureaucrats have a vested interest in the status quo. Currently, too many groups profit from it and while several of them know the truth, they have a mortgage to pay. A policy analyst and activist felt that bureaucrats are too afraid to speak out against the status quo, even when they know the truth. Within the bureaucracy it seems the only way to maintain your job is to protect the status quo. Speaking of prohibition, the respondent felt that people will lose more than their job if we maintain the status quo (ie: human rights, dignity, privacy, etc.).

One of the harshest criticisms of law enforcement bureaucrats came from a New Democrat Member of Parliament: "Anytime you want to try and change the status quo you face big barriers. There is no other issue in society that has more irrationality drummed into our heads than drug policy. The police own the issue and when they go out and make big busts they call for one hundred new police officers".

Although some respondents felt that bureaucrats intentionally maintained the status quo, others felt it was more circumstantial than intentional. For example, a Liberal MP found that bureaucrats work slowly because they don't want to make a mistake and lose their job. When politicians are not there to encourage or force change, it very well may not occur on its own.

It seemed that for the most part, a lot of the policy problems in the drug domain were caused by law enforcement. There were however some respondents who felt that health bureaucrats have also caused their share of problems. A senior research officer with Health

Canada felt that medical experts do nothing more than tell drug users to stop using drugs and that they need help, yet do not treat the users like patients. The health care system ends up bouncing drug users around to different services and when they are asked by the government how many drug users they have as patients, they say none.

A different respondent complained that there is a major disconnect between the drug issue and broader health concerns that stem from the problem. Health professionals treat millions of patients who have conditions (ie: liver problems, lung cancer, heart disease) that are caused by drugs. When reporting these cases to the government, they do not say it was caused by drugs. Police on the other hand have thousands of clients who are involved in crime because of drugs. In contrast to their colleagues in health, they do not hesitate at all to tell the media and politicians that drugs are a major determinant of their caseload.

Problems in Drug Policy That Stem from Politics

While many Canadian respondents pointed to the bureaucracy as impeding reform in drug policy, an equal amount complained about politics as well. The reasons for why politicians cause problems in the development of drug policy are quite similar to those of bureaucrats: they want to keep their jobs. A municipal drug coordinator reported that the main difficulty of policymaking is that nothing moves unless it is moved politically. Nine out of ten politicians will not touch the issue of illegal drugs. Offering an explanation for this, a longtime senator revealed that public opinion is never in favor of looking at new ways to deal with the drug problem. No party is willing to propose something alternative when they are trying to win a majority of the votes. As a result, there is rarely any political momentum to create change.

In the event that drug policy does make it onto the policy agenda, it is hard to keep it on that agenda. One reason for that is the same reason is difficult to get on the agenda in the first

place. The second reason, according to an addictions bureaucrat in Manitoba, is that when government says it will address an issue the public believes the government's word and then loses interest in that topic. Politicians in turn sense this disinterest and allow it to slip back off the agenda.

Another reason why drug policy seems to slip off the political agenda is because when it is there, politicians often get caught up in a fight between law enforcement and harm reduction. As several respondents suggested, harm reduction has replaced the *no-no's* of liberal crime legislation in the 1980s. When left-leaning political parties would propose alternative strategies to dealing with crime, conservatives would accuse them of being soft on crime. This behavior ended up deterring liberals from pushing further reforms.

A similar story came from a New Democrat parliamentarian who found that "there are major political points for playing the fear and law and order card. When I started taking a different viewpoint on the drug issue, people used to say I was crazy and wouldn't get elected again. Politicians look good standing beside the police. But all the law enforcement approach to drugs does is fuel crime and shove drug problems from one area over to another".

While several harm reduction advocates shared a similar story, there was one respondent who provided an example of political exploitation of drug policy in the reverse. A Conservative member of parliament felt that the big problem politics causes drug policy is when politicians support harm reduction because it gives them an easy way out of the drug debate. Having less users and needles on the streets does not actually solve the drug problem, but it certainly is a politically beneficial quick-fix that elected policymakers are looking for. The result, according to the respondent, is reforms based on political strategy as opposed to responsible policymaking.

The idea that politics itself is an impediment to drug policymaking—in either direction—was shared by a few of the respondents interviewed for this research. One senator experienced that "there is not much talk of policy on the Hill, only politics—so much so that Liberals end up getting conservative policies passed that Conservatives could never get passed". Another political impediment to sound drug policy is that the window of politicians is quite small, and as one MP explained, "legislators want quick results in time for an election". When this occurs, it is hard to find solid evaluation results. The result is a demise of certain experimental reforms.

One respondent from the law enforcement policy sector revealed a very important part of the political process. In both politics and the bureaucracy, the only time change is contemplated is when leaders consider it. Within politics, the leaders of the parties do not want tackle the problem publicly, as they may want to avoid putting themselves in less public favor than the other party's leader. The consequence to drug policy is that there is no central leadership or command within this domain. It is simply shoved off to bureaucrats who are forced to work on the issue with no specific direction from their political leaders.

The reasons that respondents offered for why politicians and bureaucrats cause problems in drug policy were quite consistent with one another. The respondents basically agreed that fear of losing one's job, status, or resources, were the main reasons policy actors failed to show support for alternatives to the status quo policies regarding illegal drugs. One of the main sources of this fear is that bureaucrats respond to politicians, and politicians respond to public opinion. Public opinion is often in support of the status quo—mainly because it knows nothing else.

Public Opinion and Drug Policy

One of the important political factors explored in the literature review section of this research was the affect that public opinion has on drug policy. While it is not the intent of this research to test that relationship, examining it may help us better understand the behavior of politicians when dealing with the subject matter. The interviews revealed three main themes. All were different ways that public opinion thwarts drug reform. One minority opinion by an individual respondent offers the only contrast.

The first problem of public opinion identified in the interviews with Canadian stakeholders was that government moves in a direction of the public. As is often the case in drug policy, when the public does not care about the matter, there is no political following on the issue. The result is that the status quo remains. A Conservative member of parliament explained this by using the example of drug policy in the United States. According to the respondent, American government officials have put lots of money into law enforcement yet the drug problem is not going away. The only reason why law enforcement remains the status quo is because a) they don't care about the issue, and b) they know no other alternative.

Another explanation of the way public opinion may maintain the status quo in Canada is that drug addiction seems to be a moral issue. An independent drug law reformer and lobbyist revealed that "drug policy in Canada is a political issue because it is a moral issue. Rock-climbing, smoking, and drinking, all have the same dangers as drug use, yet only drugs are illegal because they are morally wrong. When politicians try to correct this, they are painted as having bad morals and poor decision-making skills.

A third explanation for why public opinion may impede drug reform is that the general public does not see the drug issue as a priority. The result is that politicians do not see it as a

priority. Describing this phenomenon, a municipal police inspector explained that "the average citizen does not see drug users as worthy of treatment when they are on a waiting list for heart surgery". The result is either a reliance on law enforcement or a temporary fix like harm reduction. Both slow the implementation of effective interventions like proper treatment and prevention.

While most of the respondents felt that public opinion impedes the process of drug reform, there was one respondent who felt that it had contributed towards drug policy development. A senior research officer with Health Canada believed that despite significant stereotyping of drug users, it has been strong public support of alternative addictions strategies that has led to some state of the art tools in addiction treatment. While this suggestion is in contrast to those of many other respondents, it is similar to those of others in that all respondents who discussed this topic felt that public opinion plays at least some role in drug policy.

Political Institutions and Drug Policy

The belief of respondents that public opinion affects drug policy is not in contrast to the hypotheses of this research. If anything, it supports them; for a strong relationship between public opinion and public policy outcomes shows that the political process does indeed matter. Some of the most influential factors on the political process are political institutions—many of which are explored in this research. When asked to discuss the effect that political institutions have on drug policy, quite a few of the respondents provided very informative responses.

Of these responses, a few involved making the connection between one particular institutional structure and a drug policy outcome. Others explained how the design of Canada's political system affects the implementation of drug policies rather than the creation of them. The

third and largest group of responses on institutions tended to talk about one institutional structure and how it affected the actual drug policy process.

Within the first group, some respondents made the connection between political institutions and policy outcomes. A civil servant from Health Canada believed that federalism in Canada has allowed for law enforcement to be managed federally, while treatment and prevention are managed provincially. Harm reduction on the other hand is often a non-profit or interest group thing. The result of this division of labour is a major disconnect between these groups. Despite the efforts of Health Canada to balance all four pillars of Canada's drug strategy, the fragmentation caused by federalism allows for less of a commitment to certain drug policies as centralization of that domain decreases.

While the policy outcomes of certain approaches to the drug problem are less in more decentralized areas, there is some benefit to the autonomy of say harm reduction or treatment experts. A different bureaucrat within Health Canada mentioned that federalism does allow for innovation at the local and provincial level. This in turn does provide new alternatives for policymakers to consider at the federal level. While there are currently no federal programs that are a directly influenced by local drug programs (ie: needle exchange), the endorsement of harm reduction and substitution treatment by the federal government is an indication of the effect that localized drug policy may have on federal drug policy.

One respondent felt that while federalism was important in shaping policy outcomes, the multi-party system in Canada ensured that different approaches to the drug problem were considered. With the New Democrats and Bloc Quebecois always offering a third dimension to the Liberal and Conservative debates, it has been easier for alternative outcomes in drug policy—namely those in the area of harm reduction.

Although some respondents felt that institutional structure has an impact on policy outcomes, one researcher from the Canadian Centre on Substance Abuse was not too sure if is actually does: "The American political system has checks and balances yet they have one of the most repressive drug strategies in the world. They have defined civil liberties and case law in the United States, yet they have continuous violations of civil liberties and rights with respect to harsh drug laws". My explanation to this respondent would be that the reason America hasn't changed its drug policies is because of the institutional barriers presented to policymakers. However a second institutional observation of his would have challenged my argument: "In Canada there doesn't seem to be as many institutional barriers, yet not much changed has happened. Since the Le Dain commission, New Democrats and Liberals have pushed for reform but nothing has happened".

This observation is important in that it adds some qualitative support to the empirical results of this research. In the quantitative section I developed drug policy indices that are a reflection of a country's commitment to a certain approach to drug policy. While this respondent does not believe much change has happened, other respondents believe that plenty of change has occurred over the years. What explains the difference between these understandings is the rate at which change has occurred.

In terms of the drug policy indices, had I of created an annual index for drug policy, Canada may not have the high harm reduction or treatment index scores relative to Netherlands or Germany, but in absolute terms its score most likely would have risen over the years. The same could be said about law enforcement, only in the negative direction for traditional law enforcement and the positive direction for *de facto* law enforcement such as decriminalization,

etc. The bottom line is that there is considerable utility in using a measurement of commitment to various drug policies by counting their actual drug policy instruments.

The second type of response offered to the institutional question is that political institutions shape the implementation of drug policy. A municipal police inspector claimed that federalism leads to inconsistent implementation of drug policies. When different levels of government have responsibility to implement some policies (ie: treatment, harm reduction) and the federal government is responsible for implementing a different set of policies (ie: law enforcement), there is no way that a balance between the four pillars can be achieved. This position was echoed by a senior bureaucrat in the Public Safety and Emergency Preparedness ministry who claimed that federalism most definitely makes it hard for a national strategy to be implemented equally across the board. The fragmentation of the system totally prevents that.

As respondents held different views on the role of federalism in shaping policy outcomes, the same divide occurred between respondent views on federalism and policy implementation. Several respondents pointed out that federalism allows the provinces to find their own solutions to the drug problem or at the very least implement federal solutions in a way that meets their own needs and capacity. One respondent in particular felt that it was a benefit to drug policy that federalism exist, for it allows innovation. At the federal level there is no room for innovation, particularly in drug policy. The reason for that is because of constant media attention coupled with a very large and diverse electorate.

The third type of response offered regarded the effect that political institutions have on the policymaking process. These responses are particularly useful in achieving the goal of this research, which is to identify how institutions shape the behavior of policy actors. Unlike the other two types of responses, federalism did not seem to be a major factor in drug policymaking.

Rather, other institutional factors such as cameralism, electoral design, executive type, and political bargaining all had an important impact.

One of the most common responses to the institutional question was that the bicameral legislature allows for a second chamber which often takes the opportunity to examine things more closely. In Canada, the Senate is referred to as being the second sober thought. Several respondents commented on this. One senator believed that the Senate has a memory, and is able to compare data across long periods of time. Whereas members of the House are bound by elections, senators have the opportunity to take a strong look at things. A member of parliament felt that the senate was able to do research and come up with pragmatic conclusions—free of politics. In fact, he mentioned that "senators are allowed to look at more objective issues that would be difficult for MPs to thoroughly examine".

The reason why senators are given the luxury of examining issues for long lengths of time and free of politics is because they are appointed for life (or until they reach the age of 75). As one lobbyist remarked, "senators are appointed for life, which absolves them of political constraints. On top of this, they tend to listen better, have more experiences in life, and don't have to respond to public opinion—which often is very ill informed". While many respondents shared the view that bicameralism brings senators, which in turn brings responsible policy judgment, not all respondents were convinced of their effectiveness.

A Conservative member of parliament believed that while senators are good at vetoing legislation, they have difficulty passing it. He continued by saying that "all the studies they complete over the years are great, and very insightful, but in the end all they do is collect dust. The real decision-making occurs in the House, where the interests of voters are first and foremost". This understanding of cameralism puts a new spin on other descriptions of

cameralism and the effect that it may have on drug policy. If this MP is correct, and the Canadian Senate really doesn't have a whole lot of policy-making power, then the observations of other respondents would indicate that the Senate is an easier branch of government to pass innovative ideas through, rather than one that accomplishes change. In the event that this respondent's description of the Senate is wrong—which much of the literature on Canadian government suggests he is—then the responses of other interviewees should indicate that if drug reform is what policy actors want, the Senate is the place to start in Canada.

Another institutional factor described as having an effect on the drug policy process was pluralism. A provincial addictions coordinator revealed that it is hard to ignore the effect that lobbying has done to reform drug laws in Canada. Interest groups such as the Canadian Foundation for Drug Policy, and non-profits like the Compassion Club in Vancouver, have had a tremendous amount of success in convincing policymakers to consider alternative solutions to the drug problem. Of course the extent to which pluralism effects drug policy is not limited to harm reduction innovations. As one respondent from the treatment sector observed, several prohibitionist groups, churches, and even police associations have made sure that the role of law enforcement in drug policy is not diminished. The most appropriate remark on this issue came from a Senator and former judge: "the benefit of pluralism is that it allows interest groups to generate alternatives of any kind; that bureaucrats would probably never come up with because they do not generally promote change".

A third institutional factor affecting drug policy is regime type. According to some respondents, Canada's parliamentary system limits the ability of checks and balances to have an impact on drug reform. Whereas in a congressional system the legislative body can propose alternatives to the executive, no such avenue exists in Canada. One respondent elected to the

House of Commons revealed that "even if backbenchers proposed a private members' bill, the Prime Minister owns the media spotlight, and can always decide how the public perceives the issue". The benefit of having a parliamentary system, according to a policy researcher, is that when the right party is in power, reforms can be pushed through so long as there is a majority government.

The final political institution discussed under this question was electoral design. A few respondents made the very same connection to single member district voting and drug policy that is made in this research. A policy analyst and lawyer believed that because Canadian politicians must fight over the centre vote to win, drug policy ends up being a partisan issue. No one likes drug users and so politicians try to make grounds on one another by competing to see who is toughest on drugs. A Liberal MP felt that within the House of Commons, the politics between the parties makes passing drug reform almost impossible. While some of the opposition parties may not be necessarily opposed to certain drug policies in their own thinking, they vote against it just to be in contrast with the governing party.

Overall, the problem of the third type of responses—regarding institutional design and policymaking—is that with the exception of those speaking about electoral design, not many of them support the arguments made in this research. While I argue that some of Canada's political institutions create competitive policymaking conditions that can hold up drug reform, several respondents felt that Canada's political institutions actually helped the development of drug policy. Some believed that federalism breeds innovation which provides tested alternatives to federal decision makers. Pluralism allows interest groups to deliver knew ideas to policymakers who would otherwise not receive them. Some respondents claimed that Canada's parliamentary system allows for power to be centralized in the Prime Minister. According to my theory, this

should lead to smoother reforms. However in the mind of one parliamentarian, alternatives to the status quo are only considered at the will of the Prime Minister.

In this case, I believe that the support my respondents have for Canada's institutions mainly comes from the fact that they know no other. I am not arguing that they are wrong and my assertions are right, it is just that most respondents in my sample have experiences that are limited to the institutions of Canada. As a result, they must work with and appreciate what they have. In anticipation of these types of responses, I developed a question that asked respondents to envision their country's drug strategy under a different set of political institutions. The results showed more support for the arguments made in this research.

Envisioning Drug Policy under Different Political Institutions

When asked to predict the nature of Canada's drug policy under a different set of political rules and institutional structures the respondents came up with some very different answers. Some felt that the policy outcomes would be the same, although the paths to getting those outcomes would obviously be different. Other respondents felt that if Canada had more cooperative institutional structures there would definitely be more room for alternatives to the status quo, and possibly even new drug policies. A third group, consisting of one parliamentarian, found that if we had more competitive institutional structures we would have more reason to expect alternatives to the status quo.

Within the first group, an executive member of a non-profit drug policy group at arms' length from the government felt that Canada would have different policy developments in other sectors, but not drug policy. The latter is very different from other policy areas and although there may be different ways to come up with solutions, they would still be the same. Another respondent elaborated on this claim by saying that the way to getting policy outcomes would be

different; however the drug policies would be the same. He explained this by suggesting that political institutions do not act as determinants of drug policy. Instead they act as obstacles or catalysts of the drug policies that are already set in a certain direction.

Having an alternative perspective on what Canada's drug policy would look like under different institutions, a Liberal member of parliament predicted that "if we had proportional representation, the New Democrat Party would have more seats and they would be able to convince Liberals of the utility found in harm reduction". The same respondent commented on the American political system by suggesting that in a presidential system, the efficiency of drug policy making would be considerably worse [than in a parliamentary system]. The checks and balances between Congress and the President would hold reform up considerably. A bureaucrat from the Office of Privy Council speculated that "if we had a system of proportional representation more parties could be involved in the political process, which leads to coalitions. These coalitions break down the politicization of issues and may allow for alternative drug policies like harm reduction".

The last type of response offered was by the same Conservative Party MP who provided us with a critique of Canada's parliamentary regime. In predicting what Canada's drug policies would look like under different institutions he again turned to a discussion on regime type: "If Canada had a presidential system of checks and balances between the executive and the legislative body, the House and Senate would have more autonomy to suggest alternatives to the status quo. Overall, we need more of a division of power in government to get things done".

The above-mentioned predictions made by the various respondents are important to the current research in that they show that institutions do matter. In fact, the preceding discussion on Canada's institutions and their effect on drug policy also pointed out that institutions do matter.

The only difference was that largely, the hypotheses made in this research tended to be supported by the predicted responses of interviewees rather than evaluative responses of the interviewees. Nonetheless, it is an achievement to have found respondents who recognize the role that institutions play in drug policy, and more so of an achievement to have found respondents that can discuss the different ways that drug policy is affected by the design of a country's political institutions.

Canadian Overview

The wide array of responses to the questions I posed has provided a plethora of information on the topic. It seems that within Canada, the four-pillar drug strategy is product in the making. While some respondents feel that it is balanced, others do not believe it is quite there yet. The role of bureaucrats is a particularly important one. While they are the actors responsible for implementing policy, their expertise and often-times monopoly on a certain issue area affords them the leverage to affect policymaking in ways that they themselves do not even know they can. The relationship between politicians and bureaucrats are particularly important in Canada. As the members of Cabinet focus on issues that maintain public support, they often turn to bureaucrats for *expert* advice that is rarely questioned by the pro-bureaucrat polity of Canada.

When it comes to institutions, there are mixed levels of support for the current research. Almost all respondents felt that there political institutions definitely affect drug policy. Differences occurred however between those who thought institutions affect the means but not the ends and those who thought institutions affect the means and subsequently the ends. Of the latter type, two explanations appeared. One was that while cooperative institutional structures lead to drug policy reform because there are fewer barriers. The other is that competitive

institutional structures provide an avenue for other political actors to suggest alternatives to the status quo.

In summary, the Canadian respondents provided a fairly complete and thorough dialogue about the interactions of drug policy, bureaucrats, and political institutions. This discussion was heavily laden with examples, particularly those stemming from observations made of bureaucrats in the policy process. Detail was also rich in the political sphere. Uniformly, the sample of Canadian respondents felt that politicians make decisions on drug policy that are based not so much on their own convictions, but on the information they receive from bureaucrats, public opinion, and one another. Influencing these processes, political institutions place barriers to some reform decisions while advancing others.

5.3.4 Austrian Interviews

The common theme of the discussions I had with respondents involves the development of Austria's drug policy. While answering many of my questions, most of the respondents would always revert back to the historical development of Austria's drug policy and how the long time running social partnership fostered an atmosphere that led to pragmatic decision-making on this matter. Many of the answers to questions I had asked respondents were replied to with answers that involved either (a) this tradition of consensus-building within policymaking, or (b) the fact that Austria—through the work of scientists—has collectively realized that a drug addiction is an illness that requires treatment first, punishment second. It is only in recent years that respondents have noticed a slight deviation away from this norm in the field of drug policy.

Overall, the answers provided by respondents were rich in terms of depth and detail. There was a lot of repetition not so much within the answers of single respondents, but more so across different respondents. With the exception of a few differences (that are mentioned in the

following sections), there was a broad understanding of Austrian drug policy that was shared throughout the sample. This offers considerable reliability to the findings revealed through field research in Austria.

Austrian Drug Policy

The responses regarding Austria's drug policy can easily be divided into three groups. The first group shared some information regarding the nature of Austrian drug policy and what principles it is based upon. The second group involves those who spoke about the emphasis on treatment and harm reduction. Many respondents explained on how these two venues truly dominated Austrian drug policy. The third group felt that there was a mix between several different venues including harm reduction and treatment, but also law enforcement and prevention.

Setting the tone for the first group, a project administrator within the harm reduction venue described Austrian drug policy as treating users as having a mental illness and treating traffickers as criminals. Another respondent explained that "there is a balance between demand reduction and supply reduction; however we have been very progressive in developing alternatives to punishment at the level of the prosecutor, the courts, and prison". The most common summary of Austria's drug policy of course was that it is based on the principle of *treatment first, punishment second*.

Contributing to the second group, many respondents pointed out the balance between harm reduction and treatment. Some explained that the two services fit well together, and that harm reduction services in particular got more addicts into treatment than any other service. An elected member of the People's Party reported that Austria has an approach to drug policy that incorporates treatment and harm reduction; however a substantial commitment was made to

substitution treatment. Explaining the reason for this emphasis on substitution treatment, a drug researcher in the medical field explained that: "For years we have placed a lot of emphasis on harm reduction simply because abstinence is unrealistic for so many users".

This emphasis on substitution treatment has not impressed all the respondents in this sample. Criticizing the approach taken by government, an elected parliamentarian of the Freedom Party felt that, "this is a dangerous approach to take because it does not get people off drugs like abstinence policies do. Unfortunately for us, the public in Austria is in support of the current policy which is on the left end of the spectrum". Another critic of Austria's emphasis on harm reduction instruments was a Member of Parliament from the People's Party. In commenting on the use of treatment instead of punishment for marijuana, the respondent complained that "this de facto decriminalization of marijuana in Austria has led to problems with immigrants who end coming here to traffic drugs".

Of course not all respondents felt that Austria limited its drug policies to instruments of treatment and harm reduction. Many explained that a careful balance has been struck between law enforcement, prevention, treatment, and harm reduction. Boasting the success of this balance, a right-wing member of parliament explained that, "we prosecute professional dealers and send addicts to places where they can get help with their illness. We offer substitution-based treatment because we know that they work. Our needle exchange programs are widely supported and we have solid reintegration programs that help users get back into society. On the topic of consumption rooms, our heroin problem is not big enough to warrant such a facility".

While most respondents generalized on the types of drug policies used in Austria, some pointed to the divide in drug policy caused by federalism. One respondent, who was a parliamentarian from the Social Democrat Party, explained that "federally we focus on supply

reduction through the use of law enforcement while provincially users are dealt with through the provincial health bureaucracy". An elected member of the Green Party agreed in principle but explained it using a different tone, "the national government has a more restrictive approach to drug policy whereas cities have a less restrictive approach to drug policy".

Though no mention was made from my part regarding the drug policies of other countries, one respondent felt that it was necessary to defend harm reduction within the balance: "the system is based on four pillars: prevention, treatment, harm reduction, and law enforcement. While Americans call it harm promotion, we feel it is important to provide harm reduction services because prevention doesn't always work". This remark illustrates some of the challenges harm reduction advocates face, despite forming the status quo drug policy in Austria.

Ideal Drug Strategies

Interviews with respondents in Austria failed to generate a significant amount of discussion on the ideal drug strategies of respondents. One reason was because many of them had so much to say on other discussion topics that time became the factor which caused me to exclude some of the discussion topics. Another reason was because most of them were content with their country's approach to the drug problem. The only difference was that many of them wanted a change in the degree to which certain policies were implemented.

Of those who I managed to spend some time with on this topic, quite a few wished to strengthen the balance between harm reduction and treatment. It was not as if they preferred one over the other. It just seemed that they wanted to enhance the current approach if anything else. Some of the respondents called for consumption rooms, while others believed properly supervised heroin maintenance would be an important asset in dealing with issues of substance abuse.

Another group of respondents spent some time discussing the merits of decriminalization and legalization. Speaking about the latter, a parliamentarian from the Green Party felt that legalizing marijuana would severely undermine the black market and organized crime: "we would have to work more at the prevention level in schools and do more research into the causes of drug abuse, but taking it out of the hands of criminals is the first thing we need to do".

A member of the provincial assembly in Tirol felt that decriminalization was essential: "we need to decriminalize drugs because when sick people are arrested they are pushed further into the drug scene and away from mainstream society. The criminalization of cannabis especially is dangerous in that it is exposing kids to dealers who want to sell them harder drugs". An elected member of the Green Party had very similar feelings: "The illusion conservatives have is that we're pushing for a drug tolerance zone but we are not. Alcohol and smoking are allowed everywhere and they cause more economic and health problems that drugs. Because of criminalization, addicts are seen as deviant instead of sick".

Though most respondents who I discussed this topic with agreed that harm reduction services should be enhanced; one alluded to the fact that many of them need fixing. The ideal drug strategy for one municipal drug coordinator is one which incorporates substitution programs that are designed in a way which prevents the prescribed drugs from reaching the black market. The respondent explained that "too much of the morphine we are prescribing is ending up on the street. Doctors unions are strong and they are pushing to maintain the right for general practitioners to prescribe morphine, but hey really need to tighten up the process".

Origin of Austrian Drug Policy

The origin of Austria's drug policy was explained by respondents as coming from a variety of sources. None of the explanations offered in the field interviews seemed to contradict

one another. If anything, they work well in collectively telling a story about how one country was able to change from having a drug policy based on law enforcement, to an elaborate set of approaches based on treatment and harm reduction.

The first group of responses regarding the origin of Austrian drug policy focused on the consensus-building relationships that exist within the policy process. As one program coordinator within the Austrian Health Institute explained in great detail, "No party is against the principle of treatment before punishment; it's a consensus in Austrian drug policy. The reason we have the status quo is because it started out early on as the product of consensus-building. In other countries, conservative parties go against it and politicize it. However in Austria—especially in the 1980s—the parties worked close together, which allowed for people to accept the fact that addicts are ill persons and not deviant persons".

This respondent was not the only one to describe the effect that consensus-building has had on drug policy in Austria. A research analyst with the People's Party explained that while Austria is a conservative society, we have a good understanding of users and support treatment and harm reduction initiatives designed to help them. This realization is a product of consensus-building that stems back to the long history of our political economy". An elected member of the People's Party added that the so-called social partnership in Austria has allowed for experts and professionals to come in and share their understandings of the drug issue. Apparently, this has led to pragmatic drug policies that are unique to Austria (ie: reintegration programs).

As revealed by these and other respondents, one of the main outcomes of consensus-building around the drug issue was the fact that it allowed for politics to be put aside and for experts to come in and help people realize that addiction was an illness. However different respondents explained that there are other sources for this realization as well.

As one psychiatrist noted, the outbreak of AIDS in the 1980s really pushed a lot of politicians to open their eyes to the reality of addictions and support initiatives that minimize harm and treat addictions at the same time. A social project coordinator revealed another source of Austria's realization that addiction was an illness: "We observed the experiences of Germany and Switzerland and realized that drug addiction was an illness requiring proper treatment and harm reduction programming".

Once the drug problem became defined as a problem of public health, more actors from this venue started to take charge and shape the policies that were produced. A deputy head in the Ministry of Interior suggested that "Austria has never really had an official drug strategy; it's always been a development of the Health Ministry since the beginning". Another respondent felt that a lot of the innovations in drug policy came from the health sector in the provinces, largely because they (provinces) had no opportunity to do anything in law enforcement but could do something in health. A third respondent, this one from the Ministry of Justice explained that "harm reduction initiatives were put into place after people defined the drug problem as a matter of public health. Substitution treatment and needle exchanges were adopted immediately after they were defined by law as health-related measures".

Of course, the current state of Austrian drug policy is not only the result of health professionals becoming involved. As a respondent from the Institution for Addictions Research in Vienna describes, "During the 1970s law enforcement did prevention work and medical personnel did treatment work. A real shift occurred in the 1980s when social workers and psychotherapists pushed for more humane ways to deal with users. This resulted in services designed to treat addicts as sick persons not criminals. This also allowed for the development of substitution treatment—which was greatly needed, for most users can't quit on the spot".

A social explanation for why Austrians were so accepting of the health approach to addictions involved neither experts nor consensus-building. One respondent from a provincial government agency reported that "Austrians are big consumers of alcohol. Many have friends or family members that suffer from addiction to alcohol. The sympathy for drug addicts and support for the treatment and harm reduction movement comes largely from this".

Another explanation for how Austria developed its health approach to drug policy is political in nature. Several respondents pointed to the long reign of the Social Democrats, who were instrumental in pushing for a new approach to the drug problem. A member of the National Drug Forum revealed that the Social Democratic Party worked hard to overhaul drug policy in Austria. For the past three decades their work has remained in tact because experts, politicians, and bureaucrats support it. The reason for this support is because the Social Democrats made sure to include everyone in on the building process. A different respondent felt that Austria's drug policy is the product of "a strong past of Social Democratic governance that has developed community efforts to work together and build policies that take care of people".

While discussing this explanation with those respondents who identified politics as playing a big part, I asked them why they felt health has remained the status quo, considering there is a new government. A parliamentarian from the People's Party explained that "the retention of the health status quo has remained strong because it has been institutionalized and everyone supports it". A politician from the municipal level chose to answer my question by discussing how conservatives can take left-wing positions on issues that liberals could never take and get away with. She concluded with "when the minister from the conservative coalition stood up to support this approach, it made little sense for anyone in the liberal opposition to stand up and ridicule him".

Another reason for the health approach becoming status quo was offered by a Social Democrat member of parliament: "Law enforcement has been prevented from becoming the status quo drug policy because the country believes that it is not a proper solution. The health and harm reduction approach is the status quo because we know it's the right one". As discussed previously, the reason why many Austrians believed it to be 'the right one' was because according to one respondent, "the beliefs of professionals were considered over politics. When experts came their ideas were heard by everyone".

While discussing the origins of Austrian drug policy it occurred to me that there was unanimous support for harm reduction. The one exception however was consumption rooms. After I inquired about this to a few respondents, a very high level drug coordinator from the federal government explained that "we don't have consumption rooms because they are not inline with United Nations or European Union conventions. While we can get around these conventions if we wanted to, there's also no political discussion in Austria for consumption rooms. Also, there are no open problem areas and we have low-threshold facilities that provide enough services". This answer was common among many of the respondents I spoke to, even those from the harm reduction camp.

Based on what was said by respondents during the interviews, the origin of Austrian drug policy is a diverse one. It seems that consensus-building within Austrian decision making opened the doors for experts to be involved in drug policy discussions. The AIDS epidemic, followed by the steady involvement of health bureaucrats in drug policy decision making led to a broad acceptance that drug addiction is an illness and not a crime. Consequently, the treatment and harm reduction venues took precedence over the law enforcement venue. According to some

respondents however, none of this could be possible without the steady command of the Social Democratic Party who believed in treatment first and punishment second.

Exploring Change in Austrian Drug Policy

The steady development of Austrian drug policy over the last four decades (including the current one), has been punctured by three incidents of change. The first was covered quite a bit during the discussions I had with respondents on the origin of Austrian drug policy. This involved the change from law enforcement to treatment in the 1970s. The second was a stronger commitment to harm reduction that happened in the 1980s. The third involves the subtle changes made by the current conservative government towards the law enforcement approach to the problem.

As many respondents discussed throughout the interviews, the first big set of changes in Austrian drug policy came when the government changed in the 1970s. As the commissioner of a municipal drug program explained, "After the war we had a conservative government for a very long time. There wasn't much we could do for drug addicts under such a government. Then in later years we had decades of both Labour and Social Democratic governments. It was during these years when Austria was able to develop a harm reduction and treatment approach to addictions".

A respondent from the Austrian Health Institute added to this description: "In the early years there was a major overhaul of the justice system's approach to the drug problem. This allowed for many referrals of addicts to other agencies instead of the justice system. Eventually the programming was extended to other criminals who had addictions issues. This was a product of a movement by Social Democrats to form an affiliation between government and scientists".

The general consensus among most respondents was that change occurred in the 1970s because of a movement lead by Social Democrats. To achieve these changes however the government needed to work closely with those most familiar with addictions and issues surrounding illicit drugs. Once this was achieved, it was important to work cooperatively and collectively with others in the political system to prevent conflict from stymieing their progress. The consensus they developed around the issue allowed for further changes to develop in later years.

During the 1980s the prevention venue saw some pragmatic changes that largely were a product of uninterrupted communication between government and education professionals. A former provincial drug coordinator from the Southern region of Austria revealed that, "in the 1970s prevention people focused on scare tactics whereas in the 1980s they focused on building clients up as individuals; giving them the confidence to say no and be happy with that choice". It was also during the decade of the 80s that harm reduction really started to develop in Austria. The AIDS epidemic was a major catalyst for reforms that led to needle exchanges, street outreach workers, and reintegration programs. As one respondent remembered, "the 80s was a time when politicians and bureaucrats worked hard to solve the AIDS crisis collectively".

When discussing this first wave of change that happened in Austrian drug policy I asked some of the respondents to explain how these changes occurred. If it was the Social Democrats that led to these changes then what made it so easy for them? The respondents pointed to a variety of political and institutional factors that led to this. Others recalled that treatment and harm reduction were the logical things to do at the time.

A researcher in the drug field believed that harm reduction came about because of professionals lobbying the government during the AIDS crisis. She described it as "It was a quiet

fight, really". A Member of Parliament for the People's Party explained that "over time we went out and learned about the issue; which let the policy take on a health orientation. It was really a cooperative gesture between all parties; we sat down collectively and decided that the health approach was the way to go".

To my surprise a number of respondents pointed out that some of the changes in Austrian drug policy were made because of realizations policy actors had while observing the policies of other countries. A federal politician recalled that regionalization of Europe helped harm reduction quite a bit: "Our connection to the EU forced us to harmonize data collection to EU standards. This allowed us to compare data and realize that countries with harm reduction, needle exchange, and low-threshold services had less HIV." A member of parliament for the Social Democratic Party echoed that, "we learned from the experiences of other countries that it was a question of public health instead of public safety". Another parliamentarian also mentioned that the small size of Austria allowed for politicians, bureaucrats, and law enforcement to look at other countries and talk amongst each other what was best for Austrians.

Interestingly, not all respondents recalled this first era of change to be absolutely free of law enforcement ideas. A very experienced drug commissioner explained that while drug policy is not a very political issue in Austria, he did witness one occasion where politics did have an changing impact on drug policy in the mid 1970s: "Within the Ministry of Justice some top civil servants were pushing the government to change the drug laws to include a punishment for traffickers. At the time the drug problem wasn't a big deal and so it was basically the politics of justice that took over. Since then, Austria's slogan has been treatment first and punishment second, when before it was just treatment."

The other era of change in Austrian drug policy was not as immense nor so long ago. This change really has two parts. The first is a decline in the popularity of harm reduction. Illustrating this, an employee of Vienna Social Projects explained that "harm reduction is starting to have less clout now than it did in the 90s because it has been established for a while and the novelty is wearing off". The other part is that recently a conservative government has taken charge in Vienna. As several respondents have suggested, they either will or have been subtly changing the country's drug policy back into its original law enforcement approach.

Illustrating these dynamics, an elected member of the Green Party shared that politically, she sees a change in drug policy: "Before politicians said treatment first and punishment second because they believed it to be true. Since there is no SPO-OVP coalition anymore, politicians only say it to sound good. They are losing sight of purpose and what we learned in earlier years. Now it seems that politicians are all about punishment". This was echoed by a political staffer from the SPO who felt that "Before the SPO-OVP coalition broke up there was a steady move to harm reduction. Now the new government has forced a conservative shift towards law enforcement".

More specific accusations of change were provided by other respondents. A Socialist parliamentarian recalled that "over the last 30 years there's been a shift to a more liberal approach to drug policy. However it seems that in the last 4 years we're slowly moving back to law enforcement. This is due to the entrance of the Freedom Party into government". An addictions researcher offered a very similar explanation: "There has been a slight shift away from harm reduction and towards law enforcement. This comes with imprisonment of addicts that has increased mainly because of immigrants. More and more people with addictions or mental health issues are going to prison instead of treatment".

A respondent from a Vienna drug program explained his position using some concrete examples of what changes have taken place: “In the last few years there have been some subtle changes made by the conservatives. They lowered the grams of heroin possession from 5 grams to 3 grams, and have increased expenditures on law enforcement while they have decreased expenditures on treatment. In addition, they force offenders to choose between treatment and punishment when it used to be the judge’s decision.” A colleague of this respondent reported that “recently the conservatives decreased the allowable levels of heroin for the crime of possession. They did this because they wanted to crackdown on drugs without challenging the treatment before punishment status quo”.

Although most respondents identified change as occurring in recent years, some were not so sure of this. An elected member of the Freedom Party expressed how change was hard to come by because social workers, journalists, and drug experts constantly bombard the bureaucracy and politicians with pro-harm reduction rhetoric. Another respondent felt that even change towards more treatment and harm reduction was difficult: “Change towards increased treatment and harm reduction is difficult. Unless you have public opinion and power on your side it won’t happen. Mass media is not neutral because their viewers want to see how bad users are”.

One respondent pointed out that the absence of change was positive for Austria: “There haven’t been any real changes, which is a good thing. Too many other European countries change their drug policies every time a new party takes over. This isn’t good because users need time to slowly adapt to and trust the system they are entering”.

In summary, the discussions with respondents on the topic of change revealed three eras of change in Austrian drug policy. The first occurred in the 1970s and was largely attributable to the strong Social Democratic government. The cooperation they formed with other parties on this

issue area allowed for scientists and experts to convince policymakers that treatment was a better approach than law enforcement. During the 1980s, the continued cooperation between the coalition parties, and the absence of politics in this issue, combined with the AIDS epidemic to secure a strong future for harm reduction in Austria. By the end of the 1990s however, it seemed that harm reduction grew old and people forgot about the troubles earlier policymakers found with the law enforcement approach. At this time, the media went against the status quo for what some respondents describe as "more controversial stories". Eventually, when the long lasting coalition between the OVP and SPO was replaced with one including the Freedom Party, slight changes were made to include less of an emphasis on harm reduction and more of an emphasis on law enforcement.

The strength of the harm reduction and treatment venues under a cooperative government, and in the absence of politicization, offers great strength to the arguments tested in this research. While harm reduction and treatment are still the main approaches to the drug problem in Austria, the recent attempts to build up the law enforcement venue show that the latter occurs more under conditions of competitive policymaking than in more cooperative conditions. According to the hypotheses of this research, harm reduction and treatment should remain the more dominant approaches to the drug problem so long as the drug discussion remains fair and open to everyone.

Drug Policy Actors

Through discussions with the Austrians, I soon learned who was responsible for much of the dynamics discussed in the preceding paragraphs. The majority of actors that were mentioned ended up being other respondents that I had interviewed. This strengthens the credibility of the

sample. Other actors included those who I intended to meet, but for a variety of reasons could not.

The most often mentioned actors of Austrian drug policy were the Ministers of Health, Justice, and the Interior. It was clear that the Health Ministry took the lead of all three; however the extent of its power is limited. Some of the respondents explained how this is possible. A municipal drug program commissioner revealed that "the Health Ministry is a big player in terms of coordinating drug policy but it is limited in spending power". A respondent who conducts research at a medical facility spoke in similar terms: "the Health Ministry has the lead; however it is only symbolic because it really has no financial resources".

As for the Ministries of Justice and the Interior, these actors coordinate the implementation and protection of laws regarding illegal drugs. Most respondents admitted that these two played a role in drug policy, but a limited one. The coordinator of an addictions research institute explained that the police—via the interior—try to get their own way quite often. However the Health Ministry makes sure to control the autonomy of law enforcement.

The second most mentioned actors were the National Drug Coordinator and the National Drug Forum, which includes the National Drug Coordinator as chairperson, as well as the provincial drug coordinators. Several respondents pointed to the National Drug Coordinator as the single most visible authority on drug policy in the country. A respondent from the Austrian Health Institute believed that the most important actors are those in the bureaucracy, especially the ones in coordinator positions at the national and sub-national levels. A Member of Parliament from the People's Party felt that these drug coordinators are exceptionally powerful because they have public opinion on their side.

The one thing that appeared consistent across the answers of many different respondents was that the bureaucratic actors play a major role in drug policy at all times. A treatment service provider believed that "the main actors are the drug coordinators and the bureaucracy. Politicians stay out of it unless something extreme is proposed like consumption rooms". Another respondent explained that "no matter which parties are in power, it's always the same actors who are controlling drug policy: bureaucrats". A Member of Parliament for the Green Party explained that bureaucrats are powerful simply because politicians choose not to be involved: "Bureaucrats are the main actors because politicians don't do much. We have a talking parliament in Austria, not a working parliament".

Another group of government actors mentioned in the interviews played a key role to only a few of my respondents. Included this group are the Ministries of Education and Social Work—particularly on the reintegration side of things. One respondent from the Social Democratic party believed that the ministers of health within the Lander governments actually had a significant role—mainly because they can exercise a certain degree of autonomy in designing and implementing drug policies under the health approach.

An interesting description of municipal policy actors came from someone who once worked as the main drug advisor to a former mayor: "The Lander of Vienna plays a unique role. It has 25% of Austria's population and 33% of Austria's drug users. Since the nation has no national drug strategy yet, Vienna has sort of filled that void. It has done this by setting examples for other cities to follow, and by influencing the federal politicians on what the importance of harm reduction and treatment are. The one group that Vienna hasn't been able to influence too much is the Lander. It seems that the further from the capital Lander are, the more they rely on criminal justice approaches [to the drug problem]."

As for actors outside of government, a select group of experts, scholars, and professional associations seem to have somewhat of an influence on decision-making. One Member of Parliament revealed that non-government actors such as private practitioners groups, drug addicts, and the Vienna Chamber of Doctors have all been effective at stopping conservatives from changing Austria's approach to the drug problem. A different parliamentarian stated that "there's a body of experts who always seem to influence the political scene". A former drug coordinator revealed that "smaller networks have been formulated over the years to shape drug policy when the opportunity comes. Through great cooperation, these networks manage to yield a lot of influence".

In all, it seems that the actors on the minds of the respondents are those who are responsible for carrying out policies or adapting them to meet their own needs. Very few, if any, of the respondents actually talked about elected policymakers and those who provide direct services to parliament. Half of the respondents who mentioned the Ministries of Health, Justice, and the Interior described the influence as coming from the ministers' desks. While the other half believed that the power in the ministries was exercised from bureaucrats within. Only one felt that no one had an influence: "being drug policy is pretty dormant right now, I don't really see many people involved".

The Relationships between Actors: Cooperation and Conflict

Interviews with respondents showed that there is generally a cooperative relationship between drug policy actors in Austria. Some of the themes appearing in the answers of respondents are that cooperation is very common in drug policy, it is a product of multiple things, and it occurs between diverse groups. The exception to this is over a few issues that mostly pertain to jurisdiction and distribution of resources. According to respondents,

competition seems to occur when federal and provincial leaders spar over certain harm reduction policies and the allocation of resources to both treatment and harm reduction services.

On the cooperative end of the spectrum, most respondents agreed that harmony exists between the actors involved in drug policy, and has for a long time. A parliamentarian from the People's Party commented that there is a strong consensus on drug policy that is rarely disrupted. A psychiatrist explained that there was a good working relationship between all the actors. A provincial drug coordinator offered that "the relationships between policy actors in Austria are quite smooth—mainly because we are a smaller country and most politicians know each other and know what to expect. That lack of uncertainty usually leads to more cooperative relationships".

Since most respondents felt that drug policy in Austria was cooperative, I spent more time asking them to tell me why this cooperation existed. Their reasons varied significantly. The wide range of explanations that the respondents offered included organizational, institutional, historical, cultural, and political conditions that foster some sort of compatibility between different policy actors. The most common response however was that cooperation existed because most drug policy actors acknowledge that drug use is a public health problem.

Offering an illustration of some organizational reasons, a deputy head from the Ministry of Interior sensed that cooperation exists largely because civil servants and politicians have distinct roles: "bureaucrats offer policy alternatives and politicians set direction based on which alternatives they choose". A municipal bureaucrat claimed that cooperation exists because it is the core reason for success in government. He believed that "achieving success in drug policy depends on the extent to which you can coordinate your agencies and services involved".

Some of the institutional reasons for cooperation focused on the role of corporatism in Austrian drug policy. A law professor spoke of how the allied occupation forced government and business to manage their relations underground. This informal partnership made for strong breeding groups of consensus-style decision making that has essentially allowed for cooperation to develop in every issue area—including drug policy. A different respondent also mentioned corporatism, and how the social partnership leads to more consensus-based bargaining between policy actors; which results in more cooperation all around.

The few who offered some political explanations of cooperation focused on some of the reasons expressed in other parts of this analysis. A parliamentarian for the People's Party proposed that there is cooperation in Austrian drug policy because there are so many political parties in Austria. She explained that, "this creates the need for a middle ground where cooperation can take place". Another respondent felt that things were generally cooperative on the drug file mainly because the National Drug Forum is made of bureaucrats and experts instead of politicians. According to this respondent, "bureaucrats stay on after elections and so focus on problems and solutions rather than politics". A third respondent felt that bureaucrats and politicians both see the utility of having a balance of multiple actors involved in the national drug strategy.

From a cultural perspective, one respondent explained that Austrian drug policy is cooperative by default: "Austrians do not talk about controversial issues—if they do, they prefer to talk clandestinely. No one speaks frankly about the issue; everything is talked about in undertones. As such, if politicians don't cooperate with one another on the drug issue they'll be forced to talk outside of their ambiguity and become targets themselves".

Only one historical reason for Austria's cooperation was offered by a long time observer of Austrian drug policy: "The reason for strong cooperation between political parties in Austria was because the top leaders were in concentration camps together. There was an inherent loyalty towards one another that even politics couldn't defy. For 30 years after the war they cooperated on initiatives to build the country and make sure everyone was taken care of. This became known as our social partnership. The only ones who hate the partnership were the Freedom Party. They were at the concentration camps too, but they were the wardens".

The most popular answers by respondents involved the popularity of the health approach among drug policy actors in Austria. Many of the respondents explained that cooperation existed in drug policy because almost everyone acknowledges that drug addiction is a health problem which requires instruments from the treatment and harm reduction venues. One respondent claimed that cooperation exists because everyone agrees on the perception of the problem. Another felt that there is no conflict in drug policy because "no politicians or interest groups are outright against harm reduction—not ones with any influence anyway".

While many respondents were confident that the cooperation in drug policy was strong, others felt differently. A service provider from the treatment venue found that there is a good working relationship between the actors involved. With the exception of the Freedom Party, there is a consensus that harm reduction is good. However expansion of harm reduction beyond what already exists is avoided because no one wants to upset the cooperative balance in the parties. A similar account was shared by a professor in Tirol: "While consensus-building brought drug policy to where it is today, I am afraid that those conditions do not exist anymore. Young politicians don't understand the importance of the social partnership. They also don't work hard to maintain coalitions between the larger parties".

This leads us to the discussions I had with respondents on competition with Austrian drug policy. The most difficult thing about analyzing the information I received from these talks was that there were so many different reasons for competition that it was challenging to organize them in to common groups or themes. I eventually managed to sort each response into one of three groups. These include institutional, organization, and political explanations for how competition exists in Austrian drug policy.

The main institutional explanations described by respondents surrounded federalism. A coordinator within the federal bureaucracy explained that one of the more noticeable fights in drug policy is between the federal and provincial governments, and they are usually over financial resources. He explained that while 10% of drug money is paid by the federal government, 40% by the provinces, 10% by municipalities, and 40% by non-profit groups; the federal government still tries to control the activities of the provinces. The latter feel that because they're paying a larger share, they should have more autonomy to do as they please.

Another issue surrounding federalism regards implementation of policies. As a researcher in the drug field recalls, "A conflict once occurred between the two levels of government when the federal Minister of Health tried to block needle exchanges. Eventually they failed because harm reduction is within provincial jurisdiction and the Lander would not acquiesce on that issue." A different respondent happened share the same observations: "The federal government manages the supply side while the Lander manages the demand side. Problems arise when the federal government sets limitations on what the Lander can do."

The political explanations of competition were limited in this sample. Those that were offered however delivered some insight into the contrasts between liberals and conservatives on the drug issue. One respondent who had worked in the bureaucracy for a number of years

explained that the different political parties usually got along when discussing drug policy. However the recent entrance of the Freedom Party into government has caused some polarization between the liberal parties in opposition and the conservative parties in government that were never there before. According to a different respondent, not helping matters on a political front is that the Federal Drug Coordinator is a conservative while the provincial drug coordinators all tend to be liberal on the drug issue. While the federal drug coordinator has jurisdictional power over the Lander delegates, it does not always make for smooth decision making.

An issue which often brings on political troubles in drug policy actually concerns the advice of experts and professionals. According to an elected provincial legislator from the Social Democrat Party, the competition between experts in the service sector makes it extremely hard for politicians to sort out their own position on issues. When this occurs, politicians end up playing politics on science, which undermines everyone's credibility.

One of the most common categories of responses included organizational explanations of conflict. The reasons given by respondents usually involve some sort of clash between different parts of the bureaucracy. One example was offered by a municipal drug coordinator who discussed how competition can heat up when the judicial system and police service do not cooperate with harm reduction and treatment professionals in the area. According to the respondent, the drug program in Vienna is the only one that involves full cooperation with all parties. Other parts of the country experience conflict between these groups.

Another organizational problem with the bureaucracy concerns the health minister and the federal drug coordinator. According to a treatment specialist, "it's really hard to determine who controls drug policy right now because there is polarization between the Minister of Health

and the National Drug Coordinator. While it is more of an administrative argument than a theoretical or political one, it is still hard to determine who is really in charge".

According to several other respondents, such conflict is not limited to policy actors within the bureaucracy. A senior parliamentarian of the People's Party explained that on occasion there are stark contrasts between bureaucrats who would like to liberalize and politicians who do not. A federal police officer added that conflict also occurs when provincial delegates on the National Drug Forum want more leeway with matters than politicians give to them.

The discussions I have had with respondents on the relationships between drug policy actors in Austria reveal that there is significant cooperation between many actors. This stems from the fact that most people accept that the drug problem is a public health issue, and that there is a strong history of consensus-building in Austria—which ultimately led to the collective understanding of the issue. Of course there are some conflicts in drug policy that come up now and again. According to the respondents, these conflicts usually involve jurisdictional squabbles between different levels of government, or ideological differences between parties, or between politicians and bureaucrats.

The Role of Bureaucrats in Austrian Drug Policy

It appears that Austria is not unlike the other countries studied in this research. The role of bureaucrats is an important one—both in the implementation and formulation of public policy. Many of the respondents described the influence of bureaucrats while others spent time talking about the reasons for their autonomy. It was clear that of all bureaucrats, those in the Ministry of Health were the most influential when it came to shaping Austrian drug policy.

Illustrating these themes are several respondents who see bureaucrats as playing a major role in drug policy. A high level bureaucrat from the law enforcement venue was very willing to describe who was in charge of Austrian drug policy: "Bureaucrats are really the ones who make drug policy in Austria. Politicians may be there to say yes or no but the civil servants within the Health Ministry are the ones who shape drug policy". A similar observation came from a drug researcher who felt that "bureaucrats are the sole body that comes with regulations in drug policy. At most, politicians shape the direction of policy and bureaucrats do the rest". A legal scholar felt nearly the same way. His understanding was that politicians only talk about drug policy at election time. When there is no election the control of drug policy goes to bureaucrats.

When bureaucrats write policies and oversee their implementation, the experience allows them to maintain a very powerful role in drug policy. Some say that they play a more important role than politicians. As one parliamentarian from the Green Party explained, top level bureaucrats often issue regulations through their ministers that totally bypass politicians. When this occurs, politicians are not aware of what regulations are made and thus surrender even more power to bureaucrats in the hope that they know what's going on. A bureaucrat from the Ministry of Justice also felt that in some ways bureaucrats have more power over an issue than politicians: "When politicians are in power they have very little work to do because civil servants are doing it all for them. However when politicians are in opposition, they not only have to keep tabs on the government but they have to research their own policy ideas". Offering the clearest illustration of how bureaucrats overpower politicians came from a drug law researcher: "It seems that law enforcement is pushed by politicians and harm reduction is pushed by bureaucrats. If I'm right, then I guess you now have a better idea of who controls drug policy in Austria."

While several respondents pointed out the fact that bureaucrats fill in for politicians in duties related to policymaking, one explained how they also fill in for other policy actors. A political staffer from the People's Party explains, "Austria has very few NGOs, interest groups, think tanks, or foundations. As a result, bureaucrats end up doing most of the monitoring, analyses, and proposal writing". This accounts for why I did not interview any respondents from interest groups in Austria.

One of the reasons why bureaucrats have so much influence in drug policy is because of their expertise in the area. For several years, the practice has been for bureaucrats to investigate possible solutions to problems and select the alternative with the most potential according to their judgment. A parliamentarian from the Social Democratic Party found that "most policy comes from bureaucrats who are life-long careerists familiar with the issues and with the policy process surrounding that issue". An elected member from the People's Party agreed with his counterpart in that bureaucrats are the ones who both write and research policy alternatives on the drug topic. According to the long-time parliamentarian, this started back in the 1970s when the government made a real effort to include practitioners, experts, and service providers in the discussions.

Of course the extent to which the expertise of bureaucrats wins them jurisdiction over the issue is largely dependent upon other factors. One is the desire of politicians to shape policies in certain ways. A federal civil servant explained that bureaucrats work amongst themselves and alongside other experts until politicians step in and go for or against harm reduction. A federal politician revealed that "bureaucrat dominance depends on the issue area. It seems that major topics are dealt with by politicians whereas less salient topics are dealt with through the

bureaucracy. Lately, drug policy regarding immigrants has been politically guided while the rest is taken care of by the bureaucracy".

The other factor affecting the influence of bureaucrats is autonomy. Several respondents discussed that autonomy allows bureaucrats to formulate policies around their own desires largely because politicians stay away from the issue. Offering support for this, a national drug researcher explained that drug policy is not very politicized. As such politicians tend not to have a specific interest in the subject and end up letting bureaucrats and experts deal with it. A Social Democratic parliamentarian revealed that "no matter what party is in power, bureaucrats tend to dominate in policymaking. Members of parliament usually acquiesce to policies pushed by bureaucrats via the ministry".

Of course the autonomy of bureaucrats is not always constant. According to some respondents it can change just as the influence of their expertise can change. One respondent focused on resource capacity and explained that the autonomy of bureaucrats from government is dependent totally upon resources: "bureaucrats are powerful, so long as they have finances". Another respondent felt that the level of autonomy and freedom of bureaucrats depends on the individual and the relationships they have with others in the policy process. The reason for this is because there are many bureaucrats who get pushed into certain positions by experts and politicians. According to the respondent, "whether they are strong and knowledgeable will determine how free they are to make their own decisions".

In summary, the role of bureaucrats is definitely an important one in Austrian drug policy. The Health Ministry plays an essential part—which has largely been afforded to them because of their expertise in the drug field. Bureaucrats enjoy autonomy from politicians mainly because the latter try to stay away from the drug issue; which can become very contentious at

times. The extent to which bureaucrats can influence drug policy is dependent upon their autonomy, level of expertise, individual strength and knowledge, and of course the politicians' desires to let bureaucrats control the issue.

Problems in Drug Policy that Stem from Politics and the Bureaucracy

The lengthy conversations I had with drug policy actors in Austria revealed more problems than I anticipated. While the nature of these problems is similar to those revealed in Canada and the United States, their severity is more difficult to compare. The respondents in Austria focused on a variety of problems caused by bureaucrats or the bureaucracy. They also talked about those that stem from both.

One problem revealed by a Member of Parliament from the People's Party is that politicians are happy when they do not hear about problems in drug policy. This causes bureaucrats to continue what they are doing without the issue ever being discussed, reviewed, or fixed. A similar dilemma was explained by a Social Democratic politician: "On occasion, bureaucrats push the wrong answer even if they know it is wrong. Sometimes they do this when the politicians have already latched onto the idea and are pushing it ahead themselves".

A different sort of problem that is jointly caused by politicians and bureaucrats involves the perception they have of drug users. A city drug commissioner pointed out that "the drug users which politicians and bureaucrats base their choices in drug policy on are criminals, prostitutes, losers, and inbreeds. There are so many other drug users out there who are not visibly deviant and deserve a fair chance. Unfortunately however, they don't get one because politicians and bureaucrats never see them".

The final critic of these two drug policy actors regards their slowness in getting things achieved. A harm reduction service provider explained how both the bureaucracy and the

politicians move tremendously slowly on issues pertaining to drug policy. What worsens matters is that each of them reviews policy alternatives at different times, so when one finally is on the ball and ready to move forward the other is way behind. According to the respondent, this process continues in a cycle and is very difficult to stop.

Problems in Drug Policy that Stem from the Bureaucracy

The problems specific to the Austrian bureaucracy include many that have not been pointed out in interviews with Canadian or American respondents. It seems that the cooperative nature of policymaking in Austria holds true even when discussing problems. As such, there wasn't a whole lot of criticizing that when on between respondents from different venues. In fact, a majority of the Austrian respondents had their own unique problem that they attributed to being the fault of the bureaucracy. Since covering all of these problems in this analysis would not be beneficial to this research, I have selected seven problems to discuss. My selection was based upon one of two factors: (a) more than one respondent mentioned the problem or a problem very similar; or (b) they fell in support or against some of the themes explored in this research.

The first problem identified in the bureaucracy was mentioned by a member of the People's Party, who commented that "there is sometimes a big problem of budgeting in the civil service. We give them money and they try to fund things how they see fit rather than what their budget is". The problem of fiscal management within the bureaucracy wasn't raised as much as criticisms on the poor budgets they received from politicians.

Second, a trio of criticisms regarding the organization of the bureaucracy offered some insight into the complexity of the civil service as it relates to drug policy. The first was provided by a medical researcher who found that there were too many drug coordinators in the National

Drug Forum and that more centralization was needed. She believed that the fragmentation made it difficult to identify who was in charge and who reformers could approach with certain issues they wanted to discuss. Another critic expressed concern that it was very difficult to measure performance in drug policy because very few bureaucratic institutions are set up to adapt to the changing drug problem. This respondent clarified this position by offering the example of how most provincial health ministries are designed to focus on one approach to the drug problem. The final criticism offered was that of the three ministries responsible for Austrian drug policy, only one fully understood the concept of harm reduction and the science behind it all.

The next set of criticisms all focused on harm reduction and the problems that this venue causes. A parliamentarian from the Freedom Party complained that bureaucrats are in control of public opinion for a variety of reasons. Knowing this, they will say that anything which stands in contrast to harm reduction or any of its principles is inhumane, right wing, and dangerous. The respondent furthered that "politicians are oblivious to the dangers of harm reduction simply because bureaucrats support it".

A Member of Parliament from the Social Democratic Party offered a different kind of criticism: "Harm reduction bureaucrats are so concerned with protecting their approach to the drug problem that they forget about the best way to help people is to encourage them not to do drugs in the first place". Related to this complaint was one offered by a drug enforcement agent in the Lander of Tirol: "The law enforcement sector works hard to stop traffickers and convey the message to people that drugs are bad. It is very frustrating when we see mixed messages given from the harm reduction people who say drugs are not bad if you do them safely".

Problems in Drug Policy that Stem from Politics

Respondents who felt that politics caused problems in drug policy seemed to stay within two related themes. The first was that the behavior of politicians prevented certain developments in drug policy from happening. A member of the Green Party complained that the nexus conservative politicians have created between immigrants and drugs: "This connection makes it difficult to have anymore positive changes similar to the ones we've already achieved." A similar critique of the conservatives was offered by a different Green Party Parliamentarian who said that "too few experts in the field of drug policy are ever heard. As a result, non-expert conservatives move in to fill the void and make drug policy more restrictive".

Several respondents who talked about ways in which politics thwarted development offered some specific examples in their answers. One respondent believed that the single reason safe injection sites do not exist in Austria is because of politics. He believed that the matter was not a popular alternative with the public and that most supporters of such a facility don't want to face criticism from conservative politicians. A similar story was shared by someone from an addiction professionals association: "political opposition to heroin maintenance makes it difficult for anyone to advance in this field".

One of the reasons why certain political actors have been successful in preventing further development in the areas of harm reduction and substitution treatment is because they have nearly eliminated any opportunities for these alternatives to be discussed. According to one parliamentarian, "Politically, the conservative government has closed the door on any discussion on liberalization—even if it makes sense. This is not good for sound policymaking in drug policy".

The second theme was that politicians have caused these problems in their quest for votes. While most respondents saved this conversation for the questions I had on political exploitation and public opinion, a few insisted on discussing these phenomena under this topic. One of these respondents was a Member of Parliament for the Green Party. He explained that there are some political parties who try to use drug policy to win elections. When doing so, they do not think pragmatically about the issue and are not willing to discuss alternatives because "they are all about the votes".

If politicians are going against certain harm reduction and treatment approaches to get votes, then there must be little support for these initiatives in the public. This is exactly what two respondents talked about. A member of the People's Party explained that "our drug policy is in good shape, however the uniformed citizenry wants stricter punishments the more they no longer view drug addicts as sick people." A service coordinator from the harm reduction venue offered a similar description: "In many cases, politicians and the public don't accept that there's a drug problem; and so most money goes to prevention instead of treatment".

Other Problems in Drug Policy

When it comes to identifying problems in drug policy the Austrian respondents had milder answers than those of my North American respondents. Another intriguing difference was that when asked to describe problems in drug policy that stem from politics or the bureaucracy many of them could not point to immediate problems caused by these entities. They did however mention other problems caused by the drug policies themselves, federalism, funding arrangements, and international influences.

Several respondents in the sample mentioned that the current drug polices in Austria bring on problems that neither bureaucrats nor politicians were directly responsible for. One

consequence of harm reduction facilities is that if they are offered in one major centre and not in surrounding communities then those cities with the facility end up attracting more users to the city. As one service coordinator feels, "Law enforcement proponents then turn around and attack harm reduction cities for having such high user populations". Another consequence is the fact that a lot of clients are abusing the current system of substitution treatment. As one worried city councilor explained, "If general practitioners and other service providers don't get a handle on things the conservative government is going to shut things down—which means all users on a program will go back to street heroin".

Another set of problems that stem from drug policy itself are challenges that bureaucrats face during the implementation of these policies. A high level drug advisor in the federal government believed that one of the major problems is that there is no distinction between hard drugs and soft drugs: "This makes it very difficult at times because we are forced to treat all users the same when their problems are very different. Marijuana can't be legalized or decriminalized under current law because all drugs are grouped together." An issue concerning Austria's criminal laws that causes problems in drug policy was raised by someone from the Ministry of Interior: "Police in Austria have no discretion to change or arrest people. While this gets some people into treatment faster than they would on their own, I'm not sure if this does anything for casual or recreational drug users".

A third issue that does not necessarily concern bureaucrats or politicians is conflict between experts in the drug field. In the field of harm reduction, a provincial drug coordinator noted that different experts say different things—especially on the topic of consumption rooms. The result is that politicians are left very bewildered, and almost doubtful of future advice from experts. A service provider shared a similar observation: "There is a conflict within the

professional side of addictions that really confuses politicians. General practitioners and pharmacies want to maintain their right to prescribe and distribute morphine while substitution treatment providers want exclusive handling of the drug. When this tension gets publicized, it casts a dark shadow over the whole harm reduction approach".

A problem mentioned by one respondent from the Lander of Tirol is a product of political conflict and bureaucratic dominance as much as it is a problem of contradiction among experts. According to the respondent, Tirolean drug policy is stuck stagnation between the harm reduction and law enforcement venues. Since each side is so eagerly defending their role in drug policy it is almost impossible to achieve any developments in either venue, let alone pursue developments in prevention or treatment.

One of the big complaints among several respondents regarded funding arrangements. It seems that although Austria is committed to a health approach to the problem, professionals in treatment and harm reduction did not feel that they are receiving adequate funding. One respondent explained that a major disappointment in treatment is that while there are so many different causes for addictions, the monies appropriated for treatment—while generous—are not nearly enough to offer comprehensive programming. A different respondent claimed that treatment services were not funded equally across the nation. A researcher from the Medical University of Vienna explained that "there is a major shortage of treatment money directly aimed at drug addicts; which is bad, because psychiatric wards in major hospitals don't accept drug addicts". From the abstinence side of the field, one respondent complained that too much money was going towards law enforcement and not enough was going into prevention.

On the topic of federalism, several respondents revealed that conflict between the interests of the federal and provincial governments led to problems in drug policy. An elected

member of the People's Party explained that for some unknown reason the tradition in Austria was to ask permission three times to do anything. He strongly felt that the Lander need autonomy once they are given their drug budgets from the government. A similar observation came from a Social Democrat: "Though the provinces have autonomy in drug policy, that freedom is limited to administering drug programs either prescribed or approved by the federal government. Being there is a conservative government right now that makes things very difficult."

Rare in the interviews I conducted for this project was any talk on the relations between the national and municipal levels of government. However a provincial legislator in Tirol felt that there was a strong divide between the ambitions of the federal and city governments in Austria: "The cities are focused on harm reduction and developing sufficient services around this principle. The federal government however tends to be more conservative on this issue and pushes for a police approach".

The last set of problems discussed outside of those caused by politics or the bureaucracy were those stemming from the international system. A harm reduction service provider discussed the problems of Europe's regionalization and how the intertwining of policy is restraining Austria in a lot of areas—particularly harm reduction. A drug policy advisor within the Ministry of Justice also recognized the limitations set by the European Union: "Joining the EU is causing us problems because now we have to accept their punishment for possession which is contrary to the Austrian way of dealing with illegal drugs". A former provincial drug coordinator extended this complaint to other transnational bodies. She found that there is not a whole lot of room for Austria to develop drug policy because of guidelines set up by the United States, European Union, and United Nations.

To summarize, the problems policy actors experience with the drug issue vary quite a bit in Austria. While some of the more common complaints about the bureaucracy and politics surfaced in this sample, many unique ones were also present. This leads one to believe that drug policy in Austria operates differently than in Canada or the United States. While some of the problems were similar to those found in North America, the difference in severity combined with the uniqueness of some illustrates the contrast in policymaking environments between Austria and its North American allies.

Politics and Public Opinion

Though the topic of public opinion, politicization, and vote-grabbing came up in the previous section, respondents provided more detailed information in answering questions directly aimed at the role of politics and public opinion in Austrian drug policy. The bulk of the answers provided by the respondents indicate that the drug issue is politicized to a very limited extent. Most respondents felt that the issue wasn't a political one at all, let alone exploited for votes. However there were some who believed that politics lied within the issue. Fewer felt that public opinion of the issue combined with negative media attention had a big impact.

The strongest assertion that politics plays a part in drug policy came from a law professor who is very familiar with Austrian drug policy. He believed that drug policy is often used by politicians to gain coverage in media headlines. Even during the coalition years between the SPO and OVP, several would talk about drug policy to grab a few votes from one another. A different law professor talked about drug politicization in more current times: "When the SPO-OVP coalition broke and the OVP joined with the FPO to form government, they announced at their very first press conference that they will fight against drugs and drug addicts. They did this only to win more votes". One respondent even claimed that some politicians will twist statistics to

show how the health approach is counterproductive: "…[T]heir leader said user rates were going up when it was actually treatment rates that went up".

Two other respondents agreed that certain policy actors play politics on the drug issue, but to a more limited extent. The first felt that "there is generally very low politicization of this issue. However at election time the People's Party and List Pim Fortyn try to make it an issue so that they can steel votes from the Green Party". The second revealed that the issue does not get too political, "however there are some low-blows given to the Green Party on marijuana legalization".

One of the main issues that have caused politicization of drug policy is immigration. While in most countries there is a nexus between drugs and crime, it appears that Austria's exploding immigrant population is a sore spot in voters that some politicians have been willing to exploit. A social project coordinator from Vienna discussed how drug trafficking is being linked more and more with racist stereotypes of foreigners. A fellow project coordinator felt that right-wing political parties have forged a link between drug dealers and asylum seekers to win easy votes at election time.

The linkage between these two issue areas has led to problems in both. Speaking on how the linkage causes problems for drug policy actors, a provincial drug coordinator found that "the only reason the public is concerned about the issue is because it is linked to immigrants coming here selling dope". As for problems caused in immigration policy, a member of the OVP offered a very useful illustration: "In Austria we have more of a dealer problem than we have a drug problem. Many dealers are Nigerian immigrants who come to sell drugs. It becomes hard for politicians to convince the public not to have stereotypes when most dealers are black. The result is that some politicians are calling for a stop to asylum seekers."

Contributing to the politicization of drug policy are two related factors that several respondents pointed out. The first is media, while the second is public opinion. Speaking about the former of the two, a Green Party Member of Parliament informed me that drug policy does not make it into media that much. The only time it does is when the Freedom and People's parties compete to see who can critique marijuana legalization the most. He also found that when harm reduction is covered by the media, "it is tainted to look bad".

A complaint about the media from a conservative politician had a different story: "It is difficult to change public opinion on some things. Media is not interested in broad discussions on topics—they are only interested in the final product; which is problematic for politicians because the public discussion on issues does not occur. The result is that experts, interest groups, and ministers end up having the only influence on drug policy."

Whereas the media has a direct effect on the politicization of drug policy, public opinion plays a weaker and less direct role. A city councilor from the Social Democrats complained that "it is difficult to generate public support on the issue. It's not that they're against us, they just don't feel it's an important topic". In a follow-up question, the respondent explained that the result of this disinterest is a void in public opinion that conservative politicians end up filling with their own opinion on the mater.

A different respondent felt that while the general public is supportive of helping people in need, they are easily swayed against this principle when politicians point out that helping drug addicts places a cost on them. The respondent illustrated this by talking about different times when unemployment was high yet government spent money on reintegration programs for drug users.

A third respondent who discussed public opinion felt that it generally does not lead to major political battles, however the behavior of politicians is defiantly limited by what the public believes or does not believe. "One thing is for sure, you can't win elections on liberalization because the public doesn't differentiate between the sick and the sinners."

While a few admitted that drug policy is politicized in Austria, more tried to play down the role that politics has in this issue. A law enforcement officer felt that while the issue was political in the sense that politicians deal with it, it is not polarized. In other words, the issue is not the subject of fierce competition between the parties. A municipal drug coordinator also felt that the issue comes up in political bickering, but it rarely dominates the entire argument.

Some respondents believed that politics in drug policy only seems to surround certain issues as opposed to the entire policy area. A project administrator from the substitution treatment venue revealed that "politicians do politicize things to a certain extent—particularly on issues related to safe injection sites; however it's not out of control like in other countries. Even though we have lots of treatment and harm reduction services, there is still this crime-drug nexus that always pops up in political discussions of drugs."

The reason there is such little politicalization of the issue, according to one respondent, is because there is a common understanding of proper solutions to the drug problem. The Social Democratic Member of Parliament explained how "every country has right-wing politicians who push for law enforcement. However anyone who has thought about the problem or worked in this issue—including conservatives—will push for health answers".

In contrast to the above-mentioned respondents, several other people in the sample believed the issue was not politicized at all. Their explanations reveal that the reason why politics does not occur within drug policy is because politicians are careful not to cause problems

within such a volatile issue area. A Social Democrat parliamentarian discussed how the issue is not very political: "[The issue]…is a taboo thing. All parties tend to handle it in a quiet manner". An elected member of the Green Party shared that the issue is not political because it has the potential to become political. She illustrated using an example of drug policy liberalization: "One of the most contentious things in drug policy is marijuana legalization. Unfortunately, while it makes sense, it is an issue we can lose votes on even within our own party. As such, we keep quiet and nobody plays politics on the addiction problem". A conservative parliamentarian believed that "Socialists don't mention legalization and the Freedom Party doesn't mention prohibition because they're each scared of one another's reaction".

One respondent felt that in his Lander, there was not even a need to be quiet about things—for politics was just plain out of sight on this issue: "Drugs are definitely not political in the sense of liberalism and conservatism. In Tirol we are a strong OVP province yet we were the first to have substitution treatment. In other provinces with a long history of SPO governance, such developments did not happen so early[20].

After several respondents informed me that the drug issue was not politicized, I started to ask them for some explanations of this. Much of their answers seemed to focus on the fact that everyone agrees that harm reduction is the best approach to the drug problem. As a result, this venue has become significantly paramount over the other venues.

Illustrating this, a member of the People's Party explained that the politicization of drug policy does not occur because everyone agrees on the current approach to the policy. A researcher from an addiction professionals association offered that while there was some politics

[20] In a discussion with a different respondent from Tirol, I was informed that the reason the province's OVP government adopted substitution treatment was because a judge decided not to convict a university professor for prescribing heroin to drug addicts in an experiment. During this case, several experts from different disciplines testified before the judge. These same experts testified before the Justice Minister, who then allowed for substitution treatment in Tirol.

played around harm reduction when it was first introduced, "everyone—including the police—knows that harm reduction is needed".

Two other attempts at explaining why drug policy is not a very political issue came from respondents who felt that the way in which the existing policy was made prevents any politicization of the issue from occurring. The first was an elected member of the Freedom Party who felt that the long-time reign of Social Democrats allowed for harm reduction to become institutionalized: "There is political conflict, but it doesn't amount to much because the status quo is harm reduction; which is a Social Democratic initiative that is widely supported by the public. There is too much resistance to change for us to do anything. As such Austrian drug policy will be one that provides drugs rather than fights to eliminate drugs".

The second response came from a political researcher from the People's Party. His answer refers back to some of the institutional and cultural explanations of policymaking discussed in other parts of this analysis: "There is a national consensus in Austria not to instrumentalize or exploit the drug issue for political aims. I believe that our long-time social partnership has something to do with it."

Overall, the discussions I had with respondents on the politics of drug policy showed me that things were much smoother on the Austrian political front than they are in Canada or the United States. The exploitation of the drug issue by politicians that happens in other countries certainly does not happen to the same extent in Austria. As several respondents identified, the reasons for this may be that there is a shared understanding on the problem and its required solutions; there is a fear among political competitors that touching the drug issue will lead to loss of political capital; and that the political bargaining structures in Austria have worked to

minimize the exploitation of this issue for political gain. For those respondents who did see some politicization of the drug issue, a biased media and uniformed public does certainly not help.

Public Opinion vs. Science

The tradeoff between science and public opinion does not escape countries with the cooperative policymaking environments discussed in this research. Close to half a dozen respondents from the sample believed that Austrian drug policy was guided by public opinion before science. Of these respondents, most felt that politicians lean towards public opinion in decision making when they are not familiar with an issue or when the public is not familiar with an issue.

Illustrating this, a treatment project administrator felt that "politicians turn to public opinion when they don't know much about the issue. When it comes to the issue of drug reform, the public doesn't know much either". Also offering an example is an experienced psychiatrist in the drug field: "The attitude towards users makes it hard to get public support for harm reduction. That stigma follows them [(drug users)] through treatment and into daily life. Politicians end up playing on this for support—which makes it hard to develop the harm reduction services that drug users need".

A third respondent who felt that political decisions were driven by public opinion provided a more detailed account of the policy process. The Green Party Member of Parliament explained that there isn't a great level of influence that science has on public policy. If policymakers believe that scientists have a good idea they will accept that idea behind closed doors; so that they do not look hypocritical. The respondent felt that "over anything else, most politicians go for what they think is good politically".

A larger number of respondents in the sample disagreed with the idea that Austrian politicians are driven by public opinion. Most believed that drug policy in Austria was guided by the advice of scientists and experts in the fields of addictions, treatment, and harm reduction. Offering some historical support for this, a member of the People's Party explained that "In the 1970s, when Austria took an entirely different approach to the drug problem, it was the advice of scientists and scholars that helped us realize that police and justice agencies do not offer the most effective tools in fixing the drug problem". Supporting this explanation, a Social Democrat politician claimed that "We have maintained a public health approach to drugs because through science, we know it is the right approach".

When I talked with respondents about science and reasons on why politicians lean towards the advice of experts as opposed to the often-times uninformed expectations of the public, most answered with, "they know that science is right". Two respondents however offered a different kind of explanation.

The first respondent shared his institutional understanding for why politicians lean to science in making decisions in drug policy. The federal bureaucrat explained that because of proportional representation, politicians are not so concerned with the entire public as much as they are with those who they have aligned or closely aligned interests with. This allows them to make their decisions based on science instead of public opinion. A different respondent provided a political illustration through by using an recent example: "Recently, the conservatives tried to cut funding to Checkit!. However the initiative didn't even make it to parliament because they knew the other parties would stop them. It was the international notoriety of the program that saved it. It is very scientific based program".

Though politics and institutions may play a part in helping politicians side with science over public opinion, much of that is also attributable to the individual. A service provider recalled the time when a more powerful drug policy actor was stuck in a dilemma between science and public opinion on a decision pertaining to Checkit! "The former Freedom Party Secretary of Health leans towards American ideas when it comes to drug policy. However while he is against it as a politician, as a medical doctor he knows that rave testing is good and thus did not object to it being allowed in Austria."

Of course most of the respondents who felt that Austrian politicians lean towards science did not ignore the importance of public opinion in decision making. Some pointed out to the fact that when making decisions based on science, politicians must still need to maintain public support. A Green Party Member of Parliament explained how some politicians use science to educate the public and earn their support in decisions they make in drug policy. She did add however that "of course sometimes it does not always work this way—especially if the opposition parties or media intervene". A parliamentarian from the People's Party claimed that "politicians usually side with science, but they realize the need to get the public on board with the new findings of science".

Responses on this topic reveal that politicians in Austria do have to choose between leaning towards science or public opinion when making decisions in drug policy. Some of the respondents offered support for the argument that certain aspects of Austria's political system—including corporatism and proportional representation—make it easier for politicians to lean towards science without facing extreme repercussions. The discussions I had with respondents on this topic served as a great transition into the lengthier talks I had with them on political institutions and drug policy.

Political Institutions and Drug Policy

Respondents in Austria seemed more familiar with the role of political institutions in policymaking than their counterparts in North America were familiar with theirs. Within the sample there was variation in institutions mentioned by respondents. Several discussed federalism and the benefits and problems it brings to drug policy. Quite a few discussed the efficient policymaking that was fostered by proportional representation and corporatism. Only two respondents mentioned anything about executive type and cameralism.

Of all institutions discussed during the interviews, the only problematic institution for most respondents was federalism. The concern that these individuals had was that the federal government thwarted drug policy development in the Lander. One of the reasons mentioned by a high level bureaucrat in the law enforcement venue was that although provinces are responsible for providing health care, treatment, and harm reduction services, the national government still tries to set the direction of these services. Another respondent shared a similar complaint: "Even though the provinces are responsible for providing health services, if they want new things in treatment and harm reduction they have to get permission from the federal government."

Many of the respondents who took issue with federalism found that the jurisdictional division of drug policy venues between the federal and provincial governments caused problems for provincial governments wishing to pursue their own drug policy agenda. One respondent found that even the inactivity of the federal government in health and harm reduction causes some inequality issues across the country: "While our national government makes sure that law enforcement plays a uniform role in drug policy across Austria, the other approaches used—like harm reduction and prevention—are only present in provinces that commit to offering these kind of programming."

A related issue with federalism regarded funding. A federal politician from the Green Party pointed out that federalism allows for hypocrisy to continue in Austrian drug policy. She claimed that while the national approach to drug policy focused on treatment first, punishment second; most treatment centers are under funded while law enforcement continues to maintain a plethora of resources. She concluded with, "I don't think it's a political thing, it's just that provincial bureaucrats have less to work with than federal bureaucrats".

A second group of respondents who discussed federalism tended to provide more favorable reviews of this institution. The common thread among their responses was that federalism allows for innovation in drug policy. Of course, most admitted something very characteristic to Austria's quasi-federalist structure and that is that there is a limiting aspect of unitary governance in many policy areas and illicit drugs is one of them.

One of these individuals was a political staffer from the Social Democratic Party. He believed that federalism allowed provinces to tailor drug policy to their own needs while still allowing the federal government to set guidelines that they want provinces to follow. A different respondent felt that one of the great strengths of Austria's quasi-federalist structure was that it has the benefits of both unitary governance and federalism. This allows for individualism among the provinces without leading to deadlock that happens in other more federalist nations.

Another benefit of federalism identified in the field research was that it also allows for different Lander to learn from one another. Speaking about this inter-provincial behavior, a psychiatrist from the Institution for Addictions Research in Vienna observed that "federalism allows provinces like Vienna to experiment and develop ideas which then influence the practices of other provinces. In some areas of Austria, the smaller governments cooperate, share information, and push the federal government to move forward on certain initiatives."

While Austria's quasi-federalism provides the opportunity of innovation within provinces; the sharing of ideas between provinces; and consistent guidance by the federal government it was not linked to the development of Austria's overall approach to drug problem as much as proportional representation and corporatism were. According to respondents, both of these institutional structures contributed to the cooperative, consensus-based decision making that resulted in Austria's pragmatic drug policies.

Of those respondents who discussed proportional representation, many found that it kept the drug issue non-politicized. One of these individuals was a provincial legislator from the People's Party: "By allowing for a multi-party political system, proportional voting fosters broad input, alternative ideas, and more group discussions than just fighting between two larger political clubs". Sharing this observation, a federal parliamentarian found that proportional representation has allowed almost all political parties to have a say; which has ultimately prevented the issue from becoming politicized. The results according this respondent are that "scientists were able to contribute their opinions, which have largely led to our emphasis on a health solution".

The other benefit that proportional representation brings to drug policy is party discipline. An addictions professional explained that Austria's voting structure limits individual politicians from trying to pioneer certain positions in drug policy. He explained that the parties have to be aware of what one another are doing, and so individuals can't go out on a limb and try to shake up controversy in the drug file. Citing the immigration-drugs nexus in Austria, the respondent concluded that if parties decide to stir up politics in drug policy they do it together but it rarely works.

A big part of the reason why proportional representation allows for cooperative decision-making which is free from politicizing rhetoric on drug policy is coalition-building. Several respondents who discussed electoral design believed that the coalition framework has led to a decision-making environment that is free of the intense political conflict that prevents informed policymaking from occurring. A Member of Parliament elected under the Social Democratic banner explained that "The PR system makes parties and not individuals strong. When this occurs strong coalitions form that are based on cooperation and fair negotiations. At the beginning of each term in office, the governing coalition members work out their differences on the issue areas. It is because these talks that drug policy is kept relatively pragmatic".

Another theme that comes from the coalition discussions is the strategizing political parties endure in while they are part of a coalition. According to a provincial legislator from Tirol, proportional representation has led to coalitions in government which ultimately affect the way parties behave. On the drug file, certain parties will refrain from voicing their own views because they do not want to risk disrupting the coalition they have with other parties who may think differently on drugs.

Of course the downside of this behavior is stagnation. More than one respondent felt that the tiptoeing which goes on in governing coalitions has led to significant policy developments in the drug field, but it has also allowed for lost opportunity. An addictions researcher expressed her concern that larger parties who do see the utility in harm reduction will not venture further into that area because they know their partners won't be friendly to the idea. Likewise, more conservative members of the coalition won't push for law enforcement reforms if they know that doing so will disrupt the harmony within the coalition. The result is that no drug policies of any kind are developed.

The third institutional structure discussed by interviewees was political bargaining. According to a number of respondents, corporatism has fostered consensus-style decision-making that makes sure the interests of everyone are heard. One individual who talked about the inclusiveness of corporatism is a long time elected member of the People's Party: "There's not a whole lot of lobbying in Austria, mainly because everyone is involved in talks that happen before decisions are taken to parliament. This stems from a long history of unions and employee organizations that have worked things out before approaching the government."

The history of this so-called social partnership is very important to most of the respondents I met with. Several of them talked about how the social partnership first affected economic decision-making; then grew to affect decision-making in other issue areas. One of these individuals was a Social Democrat policymaker: "Our social partnership in Austria originated between economic groups. The purpose for this partnership was for parties to arrive at a consensus through cooperative decision-making before approaching government with their collective decision. This style of decision-making transferred to other areas which has allowed for more sensible discussions around issues like drug policy."

Once the social partnership grew in Austria, it started to change the way policy actors at all levels behaved. This resulted in more people becoming involved in collective-decision making and more policies that were built upon consensus. One respondent described to me how corporatism has fostered cooperation among different policy actors. This cooperation is a big reason for why the health approach has become the status quo in Austria—mainly because the "right" people were allowed access to the decision making process. Another respondent illustrated exactly who was let into the decision-making process because of corporatism: "The cooperation between ministers, civic groups, professional associations, unions, experts, and

parliament that has developed because of our social partnership has led to a consensus on treatment first, punishment second."

Some of the policy actors I met with felt that corporatism had some real feats of its own—in terms of the grander policy process. One of these respondents was a researcher within the treatment profession who summarized some of the feats of corporatism: "For years we had a system of chambers that worked very well towards consensus-building. Under this system everyone was taken care of. We lived in a very stable world. In fact some say that this group made more law than politicians. It is this style of bargaining that contributed towards everyone having an understanding of drug use and the implementation of the health approach."

Other respondents however felt that while corporatism definitely leads to a consensus on issues, there is a price to pay. A political staffer from the People's Party believed that "The difficulty regarding corporatism was that there was a price for consensus in a lot of areas that were usually competitive. That price was that change comes very slow. This position was also taken by a People's Party legislator in Tirol who believed that "the social partnership definitely slows policymaking, but it does generate consensus building among those who are involved".

A more direct consequence to drug policy was mentioned by a respondent from a professionals association. She revealed that since corporatism allows a large number of players equal influence in bargaining arrangements, the interests of different groups must always be considered. The result is that it is really hard for parliament to make in big moves in drug policy. According to the respondent, "considering most of the harm reduction programs we don't have yet are considered big moves in drug policy, nothing really happens anymore". In referring to consumption rooms and heroin maintenance, the respondent clearly expressed her belief that harm reduction in Austria was at its peak.

The other political institutions mentioned in this research were executive type and cameralism. Neither was discussed by more than two respondents. The remarks of the respondents who commented on these institutions had very little in common. A parliamentarian from the People's Party revealed that cameralism plays a small part in that many members of the Budesprat have strong connections to those in the Nationalrat. Apparently, this allows the upper chamber to pressure the lower chamber on issues they are concerned with. Another function the respondent discussed was that a considerable amount of policy development occurs in the upper chamber before it goes to parliament. While definitely having an impact in what the lower chamber decides, most of the work done by the Budesprat goes unseen.

In contrast to this, a second respondent felt that cameralism did not have much of an impact on drug policy. The parliamentarian—also from the People's Party—felt that the Budesprat had the ability to prolong issues and add new information, but it could never really stop the lower chamber from doing anything. As such, there is very little conflict between the chambers that could hold up policymaking in any way.

The lone respondent who talked about Austria's executive revealed that constitutionally the Chancellor has a lot of potential in terms of influencing drug policy outcomes. While the executive in Austria rarely dominates the discussion on this topic, fellow party members must follow the lineage of their leader. The respondent later softened his answer by adding that the Chancellor still has to gain support from other powerful people in parliament before he acts on his own.

While most respondents felt that at least one of Austria's institutional structures had an impact on drug policy there were a few exceptions. A political staffer from the Social Democratic Party felt that corporatism plays no part in drug policy mainly because "the social

partnership does not extend to policy areas beyond business and labor". A provincial legislator from the People's Party also felt that corporatism did not have an impact. This respondent believed that drug policy was too small of an issue to be affected by the interactions involved in the social partnership.

The same respondent had thoughts about other institutions that are very useful to the current research. His ideas on federalism and proportional representation were quite different than those of the other respondents. On electoral design, the legislator felt that coalitions caused by proportional representation require a significant amount of interests to be amalgamated. The result of this is stagnation; which explains why the health status quo remains strong in Austria. Speaking on intergovernmental relations, the respondent felt that federalism was very week in Austria. This combined with the growing regionalization of Europe suggests that the provinces have almost no power to exercise. As a result, drug policy is largely designed by the Health Ministry and the National Drug Coordinator.

Another unique understanding of institutions was that there is a combined effect between corporatism and proportional representation that has led to the cooperation needed to bring Austrian drug policy where it is today. A liberal-minded politician explained that the political parties in Austria are very integrated into society. The members of parties are very active in multiple sectors of society. According to the respondent, "The strong ties between political parties and societies that has resulted from this civic engagement leads to political decision-making that is well-informed, and based upon consensus".

Making a more direct insinuation of the combined effect of proportional representation and corporatism was a drug program coordinator in the federal bureaucracy: "The PR system allowed for a consensus republic which fostered a social partnership between unions,

government, and employers. This style of policymaking was very strong in the 1980s when we adopted the treatment before punishment perspective. Without these conditions, we would not have been able to achieve the drug policy initiatives that we have".

In closing, the discussions I had with respondents on political institutions provide detailed understandings of the way some policy actors see institutional structures affecting drug policy. Quite a few respondents felt that federalism had one of two impacts on drug policy. The first was that it offers opportunities for drug policy innovation at the provincial level. The second was that there really is no federalism in Austria because the federal government controls drug policy from Vienna. One respondent realized the dichotomy of intergovernmental relations that Austria appears to have: "While federalism has allowed for innovation, the federal government exercises a lot of control. We need a uniform strategy—both on paper and in practice."

The social partnership which has formed in Austria seems to have played a role in health becoming the dominant drug policy venue. According to several respondents, consensus-building among all actors involved in the policy process has led to the inclusion of scientists and experts—who have helped politicians realize the utility of treatment and harm reduction. Based on these discussions, it appears that corporatism most definitely has some sort of an impact on drug policy.

When speaking about electoral design, most respondents agreed that proportional representation leads to partisan discipline and coalition building. Both of these factors reduce the politicization of drug policy that happens in other electoral systems. The key feature of proportional representation is that a variety of interests are represented, and success only comes if the final decision was based on all of those interests collectively.

The general view of proportional representation, as well as corporatism, was that while both of these structures lead to a more cooperative policymaking environment, they have the tendency to slow the policy process down. Some respondents even suggested that these institutions create stagnation—mainly because drug policy actors want to avoid conflict. One respondent was a city councilor from Innsbruck. She felt that if Austria had a majoritarian voting system that there would not be so many parties, which would lead to more efficient decision-making. Near the end of her answer she cautioned that such an institution would bring a consequence to drug policy: "there would not be a requirement for all-party decision making".

The limited discussion I have with respondents on executive type and cameralism showed some weak support for the hypotheses driving this research. Two respondents explained that Austria's parliamentary regime can make decision-making in drug policy more efficient. This is dependent upon the makeup of the governing coalition and the autonomy the Chancellor enjoys from other policy actors in parliament. The respondents who mentioned cameralism were doubtful that disputes between the two chambers cause problems in Austrian drug policy. As described by two respondents, this is mainly on account for the weakness of the upper chamber.

Austrian Overview

The field interviews I conducted in Austria were very useful in filling in many of the voids left by the literature on Austrian drug policy. Though often repetitive, the answers I received from this sample of respondents were very rich in detail and depth. The descriptions of Austrian drug policy reveal this country to have a four-pillared approach to the drug problem with a major emphasis put on treatment and harm reduction. This status quo was supported by many of the respondents who believed that treatment should come before punishment because drug addiction is a disease.

The relationships between the actors in Austrian drug policy have generally been cooperative. With the health venue at the helm, Austrian drug policy has gradually developed into a multi-venue policy area that includes police, health professionals, and harm reduction service providers. Politically there is some difference between parties on the left and those on the right. However politicization of the issue has been avoided because (a) bureaucrats have taken responsibility for this issue (via the National Drug Forum); (b) Austrian drug policy was developed and entrenched under a strong social democratic government—that has shaped the status quo on this issue; and (b) political institutions foster a cooperative policymaking environment.

In speaking of the latter of these three, many respondents have pointed to the role that Austria's social partnership (corporatism) has played in policymaking. A long tradition of consensus-style decision making has created an opportunity for all interests to be heard equally. This is one of the most-mentioned institutional reasons for why scientists and harm reduction advocates were able to influence drug policy.

Another institutional structure mentioned by many respondents was proportional representation. The coalition building which becomes necessary in Austria's multi-party political system is one of the reasons why the drug issue—as well as many other issues—have not become politicized. Members of the governing coalition work with one another to overcome their differences and deliver a unified policy agenda.

While Austria's health approach to the drug problem still dominates, there have been some subtle changes to the intensity of that approach. This has occurred because of three different activities. The first is that corporatism in Austria—while still intact—is weakening. According to some respondents, newer politicians do not understand the historical reasons for the

social partnership nor do they as easily see the utility in cooperation that their forefathers once did.

The second reason for why there have been some slight changes in Austria's in drug policy is because of steady increase in immigrants that has become problematic in the eyes of many Austrians. Some right-wing politicians have constructed a nexus between these immigrants and drug trafficking. The dynamics which stem from this have ultimately changed the way Austrian politicians interact on this issue.

The final reason that subtle changes have been made to the status quo is because the harm reduction approach to drug policy has been around long enough for its novelty to wear off a bit. As some respondents discussed, people are not as intrigued by fixing social problems with innovative approaches as they once were. When this occurs, it is less likely that politicians will spend time defending past policies.

While these changes have slightly weakened the overall health approach, the changes made during the time when harm reduction and treatment were first developed in Austria are most striking—and very important for answering the questions driving this research. Many respondents explained that the law enforcement approach was no longer seen as an effective solution to the drug problem. Thanks to a cooperative policymaking environment—which was largely the product of corporatism and proportional representation—health bureaucrats were able to define the drug problem as an illness. This allowed for them to dominate the drug policy agenda and institute their venue as the main decision-making venue of drug policy in Austria.

5.3.5 Dutch Interviews

The Dutch interviews provided me with some very unique observations. The first observation that became very concrete in Netherlands was that the respondents I interviewed for

this research discussed drug policymaking in the context of their own nation. As such, while they discuss change it is usually in absolute terms rather than relative terms. Many of the Dutch respondents spent time comparing themselves to other countries. Some however, only compared themselves to what they used to be. While this has occurred in all four of the samples, it was most noticeable in Netherlands, and to a lesser extent Austria.

The second observation I had was that despite having incredible diversity in detail of their answers, there was very little contradiction in the substance of their answers. While pro-harm reduction respondents and pro-law enforcement respondents in the three other countries had very different understandings of their country's drug policy origins, dynamics, and changes; the same was not so in Netherlands. It seemed that no matter what political ideology or drug policy venue a respondent was from, and no matter how different their answer was compared to other respondents, all of the answers to the questions I asked respondents in Netherlands could be compiled into one larger explanation.

Since the Dutch answers appeared to be in a puzzle format—where they all fit together rather than in an array of different answers—it was very easy to identify the common theme among their responses. That theme is that that there are very strong cultural, institutional, and historical factors that have contributed to design of Holland's drug policy. These different factors have worked together and separately over the years to deliver an approach to the drug problem that is pragmatic, evidence-based, and broadly supported. The only main threat to this approach stems from international factors that fall outside of the control of those who have developed the harm reduction venue for so many years.

Dutch Drug Policy

The drug problem in the Netherlands is addressed with a variety of drug policy instruments—many of those are from the harm reduction venue. The main instruments revealed by respondents were marijuana legalization, substitution treatment, heroin maintenance, needle exchanges, consumption rooms, outreach, drop-in centres, and rehabilitation. A key component of Dutch drug policy that was mentioned by several respondents was the concept of normalization. Another key component was the separation of hard drugs from soft drugs. Both of these form the harm reduction framework that dominates drug policy in the Netherlands.

A drug policy researcher at the University of Utrecht explained that harm reduction has grown to be a very strong part of Dutch drug policy because of a consensus that "drug policy doesn't influence the levels of use, it influences the conditions and consequences of drug use in both health and justice". Another respondent agreed that it was important to focus on the consequences of drug use—especially those that the government has control over. This conservative Member of Parliament claimed that to be tough on drugs makes it more difficult for government to control the situation. He also felt that "when you use a repressive approach you not only drive up the market but you force users into hiding, and away from the services they need".

Of course, harm reduction is not the only drug policy approach used in Netherlands. Other respondents explained that there was a strong commitment to harm reduction in the demand and supply sides, and a smaller commitment to law enforcement only on the supply side. Very few respondents mentioned treatment directly—mainly because most treatment in the Netherlands is in the form of substitution-based methods; which to many respondents is a harm reduction tool. Prevention was mentioned only a few times.

Illustrating the skewed balance between harm reduction and law enforcement, a marijuana policy advisor from the Ministry of Justice described that "we have a very harm reduction driven approach. The police stay away from and will not prosecute addicts for usage. They have a priority with criminal networks and traffickers". A high level bureaucrat in the Ministry of Justice described that "a key feature of our drug policy is prevention and harm reduction while another is a tough policy towards the production and trafficking of drugs". Finally a municipal drug policy advisor explained that "we keep an important balance between harm reduction that takes users off the street and law enforcement that deals with traffickers and organized crime".

Origin of Dutch Drug Policy

The interviews with the respondents in Netherlands revealed a number of factors which have led to the development of Dutch drug policy. Many of them offered stories on regional development and historical events. Some discussed cooperation and the role of experts in educating politicians and bureaucrats on the realties behind addiction. Several respondents chose to discuss political winds of change that allowed for certain developments to take place while others concluded that it was basic logic that led to the decisions which were made over the years. Once the foundation for the health approach was built, it became the status quo. To some respondents, certain reinforcement mechanisms combined with the above-mentioned factors have led to a long-time dominance of the harm reduction venue in Netherlands.

Of those respondents who talked about historical explanations of Dutch drug policy, a few focused on specific events or realizations that helped policymakers see the utility of an alternative approach to law enforcement. One respondent who focused on particular points in history was a long time drug policy reformer within the Ministry of Health. He explained that at

a 1970 Rotterdam outdoor music festival known as Rockfest, an overabundance of people were using illegal drugs. The police decided not to enforce the law but plainly observed and studied the behavior of users. This respondent explained this informal decriminalization to be the "beginning of liberalization".

A Christian Democrat parliamentarian offered a different perspective on the exact same historical event: "the current drug policy came from the decriminalization movement in the 1960s and 1970s that was aimed at a few concert goers. Since then some things have really gotten out of hand. This new movement was based on the notion that some people will always use drugs and so it will be impossible to help people use them in a safe way if prohibited".

These historical descriptions set the original development of Holland's current harm reduction strategy in the early 1970s. From this period on, many new developments in the area of harm reduction began to unfold. As many respondents described, most Dutch drug policy evolved at the regional level. It was after a steady growth of harm reduction practices in cities and towns that the national government began to consider the instruments it would support. As one respondent claimed, lots of harm reduction initiatives came from municipal governments that were led by progressive politicians. Another revealed that Holland's approach to the drug problem came from municipal health departments reaching out and helping users with whatever programs they could come up with.

Several respondents came up with some very detailed descriptions of these processes. A drug policy researcher offered a good illustration of these advances: "A lot of it came from developments at the regional level. Many clinics that fall out of the mainstream health delivery system were the ones who experimented with different harm reduction programs. Most of them provide services to homeless, users, prostitutes, and immigrants. Because they were out of the

scope of the ministry, they were able to champion new things like needle exchange, condoms, advice, and addictions counseling".

Some respondents claimed that many of the regional developments involved some contravention of existing laws—but were allowed because they appeared to work. One minister who has worked with hundreds of addicts over the years explained his experience in developing consumption rooms: "I provided users with places they could use drugs. It was forbidden at the beginning but I convinced the police to give me the benefit of the doubt that it would reduce harm and crime".

Another respondent also shared a very detailed account of one community's experiences in harm reduction innovation:

> "The owners of a mall started a day center for users so that they would stay away from shoppers. It wasn't enough because there was no housing and the existing homeless shelters had rules against addicts because they don't mix well with non-addicts and the staff was not well trained. In the 1990s, the municipal health district decided to build hostel facilities throughout all communities. There was no threshold and people could use their own drugs in these rooms. We also provided three more user rooms throughout the city while general practitioners provided health care at some of the drop-in centers and night shelters…We provided outreach and tried to keep contact with sick people who have been dropped out of the system. The reintegration programs we set up allowed people to come and go when they wanted to work. In all, I find that when you treat people like humans, health care will become dominant and justice will subside."

As evident in the stories shared by these respondents, most regional developments in Dutch drug policy were accomplished before higher-level policymakers even became aware of the situation. As one respondent suggested, it was as if the lower level bureaucrats on the front line were the ones who were first exposed to the drug problem, and consequently were the ones that decided in favor of harm reduction solutions to the problem. According to a different respondent, another reason why these developments occurred at the local level was because of a "socialist governance tradition in urban centers and a desire to put power in municipalities".

According to this respondent, it is these forces which have led to the regional creation of Dutch drug policy.

Once the regional policy developments started to increase, it seemed that more and more experts became involved in the attempt to develop a drug policy based on scientific facts. A former drug policy head in the federal bureaucracy describes his experiences during this time, "We had the political winds at our back. We were intellectual thinkers at the time and people listened to us. This allowed for drug policy to become a health issue, and justice largely stayed out of it. We were able to maintain the harm reduction approach because we kept data that showed our progress. This gave the politicians a reason to continue supporting harm reduction".

As experts became involved in the process, an increasing number of politicians began to see the utility of the harm reduction approach to the drug problem. As some respondents pointed out, there were a variety of political conditions which also led to an easier adoption of the harm reduction method. A political science professor believed that the *purple coalition*—which was an alliance of three leftist parties—allowed for a lot of socially progressive changes to occur in Holland. A harm reduction service provider and a senator both believed that major breakthroughs in heroin maintenance were possible because of two different cabinets that did not include members of the Christian Democrat Party. One respondent believed that it was natural for certain groups to support harm reduction: "The concept of normalization was based on the principle that social exclusion was not the solution. Taking care of others was part of Social Democrat and Protestant traditions in Netherlands."

Another thing which brought political support for harm reduction was the logic behind it all. According to many respondents, minimizing the immediate harms of drugs to users and then treating them as sick people just made sense. Illustrating this, a policy advisor in the Justice

Ministry revealed that "Dutch are very realistic; they accept that people will always use drugs so it's best to minimize harms." Another respondent believed that the Health Ministry adopted normalization because it was a matter of living and dying and treatment and prohibition were just not good enough.

A third aspect that led to broad political support was that morality was left out of the drug discussion. A policy advisor to a city mayor explained that politicians found an interest in harm reduction because morality was not a factor in decision-making. A law professor explained his thoughts on several contentious issues: "It's interesting how people in other countries can arrive at opinions and discussions on controversial issues like drug policy, abortion, euthanasia, prostitution—and expect them to be turned into law. In Holland, it is clear that we use law as a practical instrument, not one that codifies the morals of others".

One of the major themes that appeared in the interviews was that cooperation also played a major role in giving politicians the opportunity to consider various alternatives. As a Christian Democrat Member of Parliament commented, "Our drug strategy came because of the way politicians are willing to cooperate and accept the opinions of minorities". This cooperation not only reduced the interference that accompanies competition, but it created a policymaking environment that was based on pragmatism.

Of course not all of the support that harm reduction advocates received from politicians came easily. Some derived from very strategic endeavors that were coordinated by bureaucrats in the civil service. A government psychiatrist explained that his team had to travel to the United States to convince Dutch policymakers that abstinence was not possible for many addicts and that people were dying because they went without heroin. One crafter of Dutch drug policy explained that "we separated hard from soft drugs for two reasons. The first was for the standard

harm reduction reason [separate the markets]; the second was to offer a compromise internationally. The only way to get cannabis criminalized was to convince outside actors that cannabis was separate from other drugs".

Once the harm reduction venue began to dominate drug policy in Netherlands, several conditions began to develop that maintained harm reduction as the status quo. A federal politician explained that "Once the country's drug policy became based upon harm reduction, that status quo dominated the image that people had on drug use. That's why it has remained so strong over the years". A respondent from the Ministry of Justice offered three reasons for why the harm reduction status quo has been retained in Netherlands: a) Dutch criminal justice people are widely against the war on drugs mentality; b) political parties in Netherlands are all for harm reduction; c) the Ministry of Health has taken the lead in drug policy.

Exploring Changes in Dutch Drug Policy

The discussions I had with respondents on the origins of Dutch drug policy revealed some changes in way Holland's government approaches the drug problem. Like Austria, some are divided into discussions on change that happened before harm reduction became the status quo, and others focus on discussions of change that happened after harm reduction became the status quo. In addition to these topics, some respondents discussed how the dynamics of drug policy have changed. Of course there were several who felt no changes have occurred.

The group of respondents who described changes that occurred in the 1970s and 1980s felt that a strong law enforcement approach to the drug problem was the original strategy. In time, different factors led to the advancement of the harm reduction venue and the development of several innovative approaches to the drug problem. One answer from a respondent that

touched on a lot of different factors came from a professor of criminology who described historical developments that led to a change in Netherlands' drug policy:

> "The first big change came in the 1970s when the legal system was confronted with offenders that did not fit with the stereotype of criminals. They were students and artists. Police and judges knew of no way to deal with it. Herman Cohen brought in the labeling theory perspective from the USA. Then Hullsman and Baan investigated this even more. This brought on the need and justification for harm reduction. It was the bomb that exploded normalization. Eddy Engelsman from the Health Ministry took the lead and we eventually had needle exchange, substitution treatment, and outreach. In the 1990s ecstasy changed the way we viewed hard drugs—it was used by many different types of people while the other hard drugs were used only by certain groups. This allowed for developments of safe injection sites and rave testing. These were the last developments in harm reduction we have had since the modern swings towards repression."

As described, the first set of changes that occurred in Dutch drug policy included a massive switch from law enforcement to harm reduction. While most respondents talked about the growth of harm reduction, some discussed the changes made within the criminal justice system. One legal scholar from Rotterdam explained that a lot of changes in the criminal justice system were not necessarily caused by the growing movement of harm reduction as much as they were a product of historical and cultural factors. In fact he claimed that it was internal changes to the legal system that opened up Dutch drug policy to other alternatives—like harm reduction: "In the 1970s it was a lot easier to get support for penal reform because so many people experienced imprisonment under German occupation. This served us well, because it plowed the way for what came next."

The other set of changes that respondents talked about were more recent. Some of these are the result of international pressures, while others are a product of domestic political changes. Speaking about the former, a criminologist explained that because of the expansion of the European Union, Holland's Justice Ministry has started to play a bit of a role in drug policy; whereas before the European Union Netherlands' drug policy was completely coordinated by the

Health Ministry. A respondent who once worked in the Ministry of Health explained that "due to international pressures we've made some cosmetic changes to our drug policy. These new law enforcement measures are nothing serious; we just did them to make United States, Belgium, Germany and the United Nations happy". A policy analyst from the Ministry of Interior noted that, "we used to be more liberal—but international pressure is changing all of that".

The domestic political changes which have led to some change in drug policy seem to be focused on new conservative coalitions that have governed Netherlands in recent years. Commenting on this are several respondents who feel that the conservative government has pushed for a more repressive approach to the drug problem. An elected member of the Labour Party revealed that "we have seen a shift from a health care to a criminal justice mentality; mainly because the CDA is being normative and moralistic on the issue". Offering an example of these changes was a municipal drug coordinator: "We used to have dealing houses where dealers had to provide good quality drugs and either pay taxes or provide money for humanitarian needs that went towards user programs. The police and prosecutors left these dealers alone. Then when the Tweedekamer changed we were no longer allowed to run this program".

Other changes that respondents attribute to a new era of political conservativism include the recent intensification of policies regarding the trafficking and production of hard drugs; the ability of mayors to close down buildings that they suspect grow-ops are being conducted in; and significant limitations to the way in which drug-testing for Rave enthusiasts is carried out. While these changes do not undermine the harm reduction venue, they definitely are policies that derive from the law enforcement venue.

Most of the discussions I had with respondents on the topic of change focused on changes in actual approaches to the drug problem. However some respondents noticed different dynamics

that have occurred recently. One respondent felt that the weakening of the harm reduction venue was attributable to the decreasing novelty of this approach: "The slow descend to a more repressive approach to drug policy has come because the excitement for harm reduction has dwindled". Another felt that there has been a change in the relationships between policy actors; which has ultimately resulted in less flexibility around innovations in harm reduction.

A third respondent observed that recent pressure tactics from mayors to liberalize drug policy are not as effective as they used to be. In fact, he believed that they were counterproductive. The reason for that is because any issues concerning intergovernmental relations require the involvement of the Interior Minister, who also happens to be the person responsible for policing. Compounding this problem is that the Interior Ministry is being forced to address issues of drug tourism that were never as common before.

Despite the many discussions I had on change, there were other discussions I held with respondents who felt that change was not a very common thing in Dutch drug policy. A Christian Democrat parliamentarian claimed that, "There have not been any changes on the issue. It's been the same way for 20 years". Another respondent shared that once the harm reduction venue was established in the 1970s not much has changed since then. Another elected member of the Christian Democrat party felt that the harm reduction status quo is so strongly supported by some members of the coalition government that even reforms regarding coffee shops are out of the question.

Of the changes that have occurred in Dutch drug policy, accomplishing these feats has been very difficult. According to federal drug coordinator, "any movement that we've had in drug policy has been more muddling through than big changes". A second respondent believed

that change is not only incremental, but also very limited to the extent that a policy can deviate from the status quo.

One of the reasons that change is so hard to come by has a lot to do with the structure of government. A bureaucrat within the Ministry of Justice explained that "you won't ever see drastic changes Dutch drug policy because out government is not set up for that. Coalitions make things go slow and steady and in the right direction". A social researcher explained that change in drug policy is difficult in Netherlands because politicians and bureaucrats know that the current strategy is the best there is. Thus, the consensus-style decision-making in Netherlands will always lead policymakers to deliver the most pragmatic policies.

Ideal Drug Strategies

Respondents in Netherlands who discussed their views of what an ideal drug strategy contains tended to focus on the laws regulating marijuana. Again the purpose of asking this question was to identify some parts of each country's drug strategy that respondents believed were lacking.

One issue that many respondents would try and resolve if given the opportunity is the coffee shops. A few would get rid of them all together, mainly because they are fuelling the black market. More however would open the back door and regulate the production and distribution of marijuana. A municipal policy advisor said that he would open the back door of coffee shops because "currently, they are supported by the black market which is fueling crime, illegal grow-ops, and health and safety hazards". One parliamentarian explained that "we must regulate the back door and undermine the market. We can't have welfare moms supporting family and growing cannabis". In speaking of a mayor's recent efforts in lobbying the national

government on this issue, one respondent claimed that "We need to give the mayor of Maastricht an opportunity to prove that regulation works".

One of the key things which were visible in the answers of respondents to this question was that the desire to liberalize marijuana policy crossed all party lines. An elected member of the Christian Democrat Party disclosed that she would expand coffee shops in rural areas. The reason for this is because users in non-urban areas have no choice but to get their marijuana from the criminal underworld. A member of Lijst Pim Fortuyn felt that "we are a conservative party, but we are very liberal on some issues. We want to legalize soft drugs, tax it, and take them out of the criminal world". A parliamentarian from the People's Party claimed that the best solution for Netherlands would be to legalize all drugs in order to undermine the black market, "for its organized crime that is causing a lot of problems".

These sorts of responses—if reflective of the actual thinking among the parties—could explain why there is considerable cooperation between the different actors in Dutch drug policy. The only respondent who opted for a totally different approach to the drug problem was a policy advisor to the SGP: "There is no difference between hard and soft drugs—both should be prohibited equally. A repression approach will not work alone, but it will have a reducing effect on drug use. Legalizing will only make it worse." Even in the mind of this respondent, there is a need for other approaches to the drug problem; which would help to foster cooperation in dealing with the drug issue.

Drug Policy Actors

The actors that respondents revealed to have a significant influence in drug policy were generally the same five actors. These included the Ministers of Health, Justice, and the Interior; the city Mayors; and the drug speakers from each party. Some respondents mentioned smaller

political parties and a few individuals who were involved in the original formation of Dutch drug policy.

The most important actor in the eyes of most respondents was the Minister of Health. Of those who talked about the role of other actors, most at least mentioned that the Health Minister plays some sort of a role in drug policy. The Health Minister was identified as playing a lead role mainly because addiction is considered a health problem in Netherlands. The service providers who deliver treatment, harm reduction, and prevention services are all part of the health bureaucracy.

One thing that some respondents mentioned about the health venue was that it is beginning to weaken as a hegemonic actor in drug policy. A Christian Democrat explained that the health bureaucracy is the main actor until things get politicized. Once this happens, elected people start to play a bigger role. A high level bureaucrat within the Ministry of Health shared that "Our ministry has a big influence; however it is limited by decentralization. The influence of health bureaucrats in particular comes in the form of providing research and advice, then forming the national policy after the politicians set the direction".

Another reason the Health Ministry is starting to play less of a dominant role is because of the growing influence that the Ministry of Justice has in drug policy. Several respondents discussed how this was occurring. A policy advisor in the marijuana unit at the Ministry of Justice reported that his unit is starting to play a larger role in drug policy because crime and marijuana are starting to become linked. Much of this has to do with drug tourism and the huge growers industry that is fueled by the back door policy and export. Another respondent felt that "Health is still the dominant actor, however Justice has had to come in and deal with some of the consequences of liberalization—namely grow-ops, drug tourism, and criminal networks that

supply the coffee shops". This observation was also made by a former bureaucrat from the Health Ministry revealed that Justice is playing a larger role because of trafficking and organized crime.

Another reason for why the Justice Minister has been gaining strength in drug policy is because of the fact that reforms in this area require changes to law—an area he has exclusiveness over. Commenting on this, a municipal policy advisor explained that the Justice Minister has a unique power over all other ministers because they have to go through the Justice Ministry with any proposed changes to law. This respondent described the Justice Minster as the "gatekeeper" because "everyone turns to him to see if they're violating any international treaties". A city councilor in Amsterdam felt that the Justice Minister has influence over drug policy because he controlled law, which makes him a very powerful actor in any issue related to the law.

A third factor that may explain why some respondents felt the Justice Minister was encroaching on the jurisdiction of the Health Minister is personality. An elected member of the Labour Party explained that "the Minster of Justice is a very strong politician—an old school CDA. The Minster of Health stays away from drug policy because it is too delicate of an issue". Another respondent found that "the Justice Minister's recent refusal to support a petition of opening the back door earned him lots of support and respect". A municipal bureaucrat revealed that the Justice Minister is becoming more powerful because the current Health Minister is not giving much priority to drug policy. As a result, the Justice Minister is slowly moving in on that unclaimed territory.

Of course not all respondents were convinced that the Justice Minister or Health Minister controlled drug policy single-handedly. Some respondents felt that there was a balance of powers between these two ministries, or between these two and other ministries. One respondent

revealed that the Health and Justice Ministries are important, but they share influence over drug policy with the Minster of Interior; who controls the organization of the police. A health bureaucrat felt that Justice dealt with the supply side, and Health—through the cities—dealt with the demand side. Another felt that the growing internationalization of the drug problem has made the Minster of Foreign Affairs an important actor in drug policy.

The next group of actors mentioned by respondents was the party speakers on the drug issue. A few respondents I interviewed—including several party speakers on drug policy—revealed that these actors play a special role in that they have the ability to shape the direction of their party's position on the issue. One respondent who spoke of this was an elected member of the Labour Party: "Speakers of parties play a big role. They are the expert on a topic and are to lead the party towards a point of view on that issue. Their strength has to do with trust, political understanding, knowledge of the material, outspokenness, and overall representation of the party."

According to some respondents, the one limiter on the influence of party speakers is when the drug issue becomes politicized. As a Social Party parliamentarian described, "Speakers of an issue have influence on policy as individuals. Those people lose influence however when an issue becomes more salient or political." Another respondent felt a similar way about this: "Party speakers generally lead a party on an issue. However when the issue is politically charged the Minster and party take over."

Some respondents who talked about party speakers and their parties revealed that certain conditions allows for particular speakers to have more influence over their counterparts from other parties. A Labour Party parliamentarian explained that speakers from minority parties can often hold the larger parties hostage on issues related to harm reduction and legalization. This is

largely attributable to the dynamics which exist between parties in a governing coalition. Another respondent felt that the speakers of governing parties have more influence when his or her party has a high number of seats in the coalition, the speaker has strong personal stature, and there is little to no politicization of the issue.

The fifth set of actors included the mayors of the cities in Netherlands—particularly Amsterdam, Rotterdam, Den Haag, and Utrecht. Three respondents identified the mayors of these four large cities as being national actors in Dutch drug policy. Two other respondents added the city of Maastricht to this list for his recent statements regarding marijuana legalization. As one of these respondents explained, "The mayor of Maastricht has become a national player because he supports opening back doors and the rest of his party doesn't. Because of this, other parties support him very much".

While a number of respondents identified municipalities as having an influence in Dutch drug policy, they had different opinions on the extent of the mayors' influence. A drug policy researcher felt that the national government developed drug policy while the cities were responsible for seeing that they were properly implemented. This suggests that drug policy in Netherlands operates in a top-down approach. Other respondents however believed that the opposite relationship existed—that it was cities which influenced the drug policy activities of the federal government.

One of these individuals was the mayor of a smaller city in southern Holland: "Mayors have a lot of autonomy within the context of national law. How we implement and enforce laws is our discretion. Naturally, we have a good exchange of information with other cities. The number of cops and type of harm reduction programs offered is up to us". A different respondent

explained that “The Hague is in its own aquarium of elites that really have no effect on drug policy. It was largely created by local governments long ago, and still is”.

The final group of policy actors discussed in the interviews was individuals. It is important to include these individuals in this analysis because each of them was mentioned several times by different respondents. The first was Dr. Baan, an expert who led the first commission on drugs in Netherlands. Next was Loek Hullsman, a legal scholar who chaired the Hullsman Commission, and who many respondents point to as being the father of Dutch drug policy. Eddy Englesman was a long-time policy planner in the Ministry of Health; as well Ed Leeuw who was a policy developer in the Ministry of Justice.

Much of the success these individuals had in shaping drug policy could have been timing, institutional structures, or political will. Some part of their success however can be explained by their individual abilities to get the job done. Speaking of one of these individuals, a former policy researcher in the Ministry of Justice revealed that “Eddy Englesman was the dominant figure which found ways to spread pragmatic views throughout government. He was influential because he had clear thoughts and was effective in his work. Eddy is the one who made sure Dutch thinking became Dutch policy”. Another respondent explained that Loek Hullsman drew the blueprints and Eddy Englesman built the building. I was fortunate to have the opportunity to interview three of these four forefathers.

Interesting about the Dutch interviews was that no one mentioned any interest groups or non-profit actors that tried to influence Dutch drug policy. While the political bargaining structure of Netherlands may have something to do with this, some respondents had their own assumptions. A health bureaucrat found that “there are no NGOs against harm reduction or drug liberalization and cities play the role of advocate for harm reduction. They want 1000 new heroin

maintenance beds; many mayors want to experiment with opening back doors of coffee shops". A different civil servant from the Ministry of Health proposed his understanding of the matter: "It's funny that we don't have any NGOs, interest groups, or public movements for harm reduction. Perhaps the government alleviates the need for such groups".

Based on the responses given in the interviews, there doesn't seem to be a wide circle of actors that influence Dutch drug policy. The federal ministries, mayors of municipalities, party speakers, and a few key bureaucrats have really been the ones to control drug policy in Holland for the better part of 30 years. Within this small network of actors, there are some interesting patterns which emerged in the discussions. According to respondents, the cooperative relationships between these actors are what have led to the development of Netherlands' harm reduction status quo.

Relationships between Policy Actors: Cooperation and Conflict

As evident throughout this analysis, cooperation is an important factor that has led to the development of Holland's drug policy. Many of the respondents explained that cooperation has been the key factor in making sure that Dutch drug policy was driven by practical reasoning instead of morality and political competition. Some respondents explained that cooperation has led to a broad understanding and support of liberal drug policies. Others point to the fact that cooperation has developed and maintained the public health status quo in Netherlands.

One problem of cooperation in Netherlands is that it does not leave much room for the consideration of alternatives. While most respondents point to cooperation as being the only reason harm reduction was able to thrive, others find that too much cooperation has led to groupthink. A Christian Democrat parliamentarian felt that "the problem of cooperation is that within the addiction services sector, there is too much of it. They end up all agreeing on things

and fail to point out mistakes". Another respondent noticed that the strong cooperative network between policy actors in Netherlands leaves little room for evaluation of the national drug approach: "if anyone stands up and questions the consensus on drug policy—even if there's a problem—they're seen as troublemakers."

Though cooperation has played a big part in drug policy, there are some conflicts which exist between policy actors. Generally, these conflicts are limited to two groups. The first occurs between political parties and the second occurs between different levels of government. The respondents in this sample believed that conflict within both of these groups does have an impact on drug policy outcomes.

Speaking of the first group, several respondents pointed to the conflict that occurs between the conservative Christian Democrat Party and parties on the liberal end of the ideological spectrum. A researcher from the Trimbos Institute reported that the CDA has shut down drug-testing at raves in an effort to signal to young people that drugs are bad. This has caused uproar among leftist parties who feel that such harm reduction measures are necessary in reducing the risks of drugs that users will take regardless of the government's message. Another respondent explained that some the CDA and some smaller parties do not agree with the liberalization of Dutch drug policy. Other parties in the Tweedekamer however are preventing this group from voicing repressive ideas about drug policy.

While the CDA are often targeted for causing conflict in drug policy, ideological battles that have occurred between other actors. As a Labour Parliamentarian described, "Despite the perceived cooperation on the issue, political parties are on polar opposites when it comes to harm reduction versus law enforcement. No one is in the middle and cooperation ends up occurring only because of the need to form a coalition". Another respondent pointed out that the

differences which occur in parliament are also present in the federal cabinet: "Our Justice and Interior ministers are against back door regulation while Health is for it. Since the issue is legal in nature, the Justice Minister's opinion takes precedence".

Through discussions with many respondents, it seemed that the issue of the back door of coffee shops is a major point of contention between different policy actors. As one senior policy advisor in the Interior Ministry explained, "There is tremendous cooperation when talking about the front door. However the fight starts as soon as people start talking about the back door." This issue was covered in more detail during the discussions I had with respondents on the problems that have occurred in drug policy.

The other place conflict occurs in drug policy is between different levels of government. In fact one respondent felt that conflict in drug policy was not so much a left-right argument as much as it was a national-local argument. The general observation of most respondents was that local governments want to experiment with legally supplied coffee shops. The problem however is that the national government is opposed to these developments. As the mayor of one town explained, "The national government wasn't pleased when we moved the coffee shops closer to the border however it was logical because most customers were Germans anyway. This cut down on nuisance from drug tourism".

Several respondents explained that one of the reasons for conflict occurring between the different levels of government was purely international. As one parliamentarian explained, "Most ministers are international strategists rather than domestic policymakers. This becomes problematic when the rest of the politicians they work with are worried about what's happening in Netherlands". Another respondent explained that the closer to ground level politicians are, the more likely they are to support reforms to open the back door. While local politicians are

fighting to help drug users, federal politicians spend their time catering to the desires of France and United States.

Further illustrating these claims, a researcher within the Justice Ministry offered a detailed explanation of the conflict which exists in Dutch drug policy:

> "There is a stress between national and municipal policies. Those at the local level know what is needed to solve the problem of drug tourism, trafficking, nuisance, and criminality. However, the national government is more removed and has to cope with national and international pressure. The Minister of Justice believes that further liberalization of drug policy will not work unless all of Europe makes some reforms. Drug tourism will prevent us from getting anywhere".

While the political and intergovernmental conflicts that occur in drug policy are usually separate, there are occasions when the two interact. One respondent revealed that the political leaders at the lower level tend to be social democrats while those at the national level are more conservative. The result is an acceleration of the conflicts that are inherent between these two groups to begin with. As mentioned once before in this analysis, a municipal civil servant explained that intergovernmental conflict can even occur between policymakers from the same party. In the city of Maastricht, the Christian Democrats from the local government believe in opening the back door of coffee shops to legalization while their colleagues at the national level are against it.

In summary, there are a few conflicts between drug policy actors in Netherlands. These conflicts are either caused by differences in political ideology or differences in the level of government that policymakers are working from. The most common response to my questions on the relationships of policy actors was that they were cooperative. Quite a few respondents pointed to this cooperation have being one of the most important factors in the formation of Holland's public health approach to the drug problem. Exploring the different causes of cooperation is very important for this research.

Explaining Cooperation in Dutch Drug Policy

To many respondents, cooperation was the main reason for the harm reduction venue to become the status quo in Netherlands. Putting ideological differences aside and spending time learning about the issue has been a major benefit to the development of Holland's drug policy. According to respondents, there are a variety of sources for this cooperation. Some are institutional, others historical, and several are cultural. A source that some respondents found was quite effective in fostering cooperation was the fact that the harm reduction approach was simply the best alternative.

One of these respondents was a drug coordinator within the federal bureaucracy. He believed that cooperation stemmed from the universal realization that harm reduction works: "Safe injection sites and heroin maintenance were both political at the beginning, but their merit pulled them through and politicians realized that they were not producing nuisances; but were in fact effective." A member of the Christian Democrat party felt that "one cause of cooperation is that most CDA who spend one week learning about the drug issue come around and recognize the utility of harm reduction". Some believe that cooperation comes from the absence of conflict. Illustrating this, a respondent from within the Health Ministry explained that that no conflict occurred between harm reduction and law enforcement advocates in Netherlands because everyone acknowledges that we must take a health approach.

More common explanations of cooperation in drug policy were institutional in nature. Several respondents referred to the Polder model of consensus-building that has dominated in Netherlands for many years. Others weren't quite sure of their nation's political bargaining history, but knew that cooperation was a very necessary element of policymaking. Illustrating this was a Labour Party Member of Parliament: "There's so many groups that we all end up

being minorities. As such, we can't afford to have a big debate on ideology because no one is big enough to win. We have to be practical and get along".

Of those respondents who were more familiar with political structures of Netherlands, the responses of two in particular stuck out from the rest. The first was from a former health director: "The biggest cause of cooperation between actors comes from the pillarization of our political system that has been in place since WWII…[D]ivided by religious pillars, society operated on the acceptance that the country could only operate if the leaders from each pillar worked together through compromise and consensus. While cooperation came from this, so did tolerance for alternative lifestyles and habits."

Another respondent who offered a more detailed explanation of cooperation focused her attention on expectations: "Cooperation in Dutch policymaking comes through the sharing of expectations. It is expectations which help us deal with uncertainty. In earlier years we had different pillars with different viewpoints. At the very top of these pillars was a pacification policy which means that we must share expectations so that uncertainty does not drive us apart. It was through the sharing of expectations that helped us avoid battles and build coalitions".

Though most respondents who offered institutional explanations of cooperation in Dutch policymaking focused on corporatism, some spoke about proportional representation and Holland's multi-party system. One of these individuals was a high level advisor in the Ministry of Justice. This respondent believed that in Dutch politics there is a general tendency to reach compromises. This is mainly due to the fact that Netherlands is accustomed to governing coalitions that are made of numerous political parties. According to the policy advisor, "this stimulates cooperation between the people involved in the process".

Another respondent who spoke about electoral design was a member of the People's Party for Freedom and Democracy: "Proportional voting creates a need for parties to form coalitions. Coalitions are always based on a contractual agreement which parties are bound to. Cooperation and compromise are needed to uphold this agreement. There are very few open quarrels about drug policy because of the coalitions system".

Very much related to the institutional explanations of the cooperative policymaking environment in Netherlands are cultural and historical explanations. While these types of explanations were only offered by a few respondents, they did touch on issues that are very important to the understanding of Dutch policymaking. A former drug policy advisor at the Ministry of Health explained that "one of the reasons we don't fight much in Netherlands is because we try not to panic. We break things down to effective parts that count. We focus on the end product of policy—not the morals behind it. This allows us to deal with issues rationally and come up with the best solution that works and that gets good results and minimizes harms".

Another respondent who offered a cultural explanation believed that Dutch people are non-hierarchical and more informal—which means it is easier to consider and include opinions from different groups. One very unique historical explanation came from a municipal drug coordinator: "Anyone who was a sailor and didn't want to travel anymore stayed in Netherlands. We were a small country with lots of diversity. The only way to get along was to accept differences and cooperate".

These explanations of cooperation provide a more thorough understanding of the factors which have led to the harm reduction status quo in Netherlands. Though competition could be the likely result of policymaking activities in drug policy, cooperation is almost always the end product. Too many respondents, this is the best possible outcome for all actors. Illustrating the

importance of cooperation in policymaking is a Dutch parliamentarian who entered politics after spending several years as a scholar: "Cooperation comes from necessity. In academics I learned that critique and conflict advance knowledge. However as a politician I learned that you have to cooperate to get anywhere".

On the topic of cooperation, the majority of respondents who I discussed this topic with focused on politicians. One of the beliefs held by many people I interviewed in Netherlands was that once cooperation occurred between political actors, it was easier for actors from the health venue to become involved in guiding Holland's drug policy. The largest group of public health actors is those within the civil service. They, along with their counterparts in the fields of justice and policing, have played a tremendous role in the formation of Dutch drug policy.

The Role of Bureaucrats in Dutch Drug Policy

As in the other three case countries studied in this research, Netherlands has a high involvement of bureaucrats in its drug policy. The literature on drug policy, as well as the interviews I conducted, suggests that the involvement of health bureaucrats has led to a policy of harm reduction in Netherlands. The interviews in particular, revealed that their expertise in science and policy making are one of the factors which enabled them to play a big part of the policymaking process.

On the topic of bureaucrat expertise, a former policy advisor with the Ministry of Justice explained that "drug policy in Netherlands has largely been driven by very educated bureaucrats who used science to drive their solution building—particularly in the early years". Another respondent explained that bureaucrats and service providers in the non-government sector have been very instrumental in helping policymakers come to terms with things. The advice they give is based on evidence, and on expert opinion that on most occasions weighs much more than the

moral opinions of politicians. This observation was echoed by a researcher from Justice who confessed that her research often served as the expert opinion in policy backgrounders that she would write.

Once the skills and expertise of bureaucrats wins them an opportunity to affect policymaking, no time is wasted on many other options. Several respondents revealed that a large majority of policy ideas come from within the bureaucracy. One respondent to mention this worked as a long-time policy director in the Justice Ministry. He explained that, "We [bureaucrats] play a big role in that we approach ministers with ideas and make suggestions on which ones we favor. Policymaking happens mostly within the ministry". Another advisor had the same experience in the civil service: "Half the time I'm making policy plans and sorting out the direction of policy, the other half the time I am providing information to parliament".

An interesting thing that came out of some of the discussions was that bureaucrats and politicians are very aware of one another's activities, as well as each other's interests and abilities. A team coordinator within one of the federal ministries described how for many years the health ministry had to provide annual reports to parliament on drug policy. Eventually, they became familiar and accepting of the bureaucrat handling of the issue and informed the health ministry that they no longer had to provide annual reports—"just keep doing what you're doing". This ultimately strengthened the autonomy and capacity of the Health Ministry to make policy in the drug area.

In a reversed illustration, one respondent from the Justice Ministry explained that bureaucrats constantly scope out their ministers and make choices based on their anticipations of the minister's response. Some ministers even take total control of the issue away from bureaucrats. As she explains, "Bureaucrats are very careful to offer advice within their

ministries. They also don't try to push ministers towards choices that fall outside of the coalition agreement. Our Justice Minister has personal views on drug policy and has taken the lead. However the Health Minister is preoccupied with health care and so depends on civil servants to manage the file".

Another respondent who mentioned that bureaucrats are acutely aware of the politicians they serve added that the level of governance also plays a big part. A parliamentarian for the People's Party for Freedom and Democracy explained that most of the time bureaucrats push their own agenda. However the direction of their agenda is largely a function of their politicians. To summarize, the respondent found that on a local level politicians see the everyday problems of drug use and want their bureaucrats to come up with solutions. On a national level however, politicians are further removed from the drug problem, and consequently are more conservative and less likely to change the status quo. Although the status quo is guided by the principles of harm reduction, intensifying that commitment is also seen as changing the status quo. This, according to the respondent, is why we only see advancements in harm reduction at the local level.

The end result of the discussions I had with respondents on the role of bureaucrats was that the latter are definitely influential in the policy process. In the case of Netherlands, it seems that civil servants from the health venue had a major influence. What brought Dutch drug policy what it is today, was the right combination of bureaucrats and politicians who worked together to reach their desired end. The dynamics of their relationships are often hidden. It is only through field research like this that we can learn about the relationships between different policy actors and the joint effect they have on public policy. Offering a very illustrative example of this is a former drug coordinator within the Ministry of Health:

> "In the 80s the parliamentary secretary I worked for was very liberal in thinking. He knew that I had a social democrat agenda. He asked why I kept putting tones into speeches. I told him that policymaking takes 100 speeches. Though an asshole, he did push through with harm reduction, normalization, and pragmatic policies we proposed. When he became minister he made a speech in Canada that made students cry. They were so amazed that a government minister would admit the pragmatic truth. He was well liked, and in the end he didn't care if he pissed people off. It was largely this minister and the work in our branch that allowed for scientists and anti-prohibitionists to have some poignant moments in the 1980s".

Problems Caused by Politics and the Bureaucracy

Though there have been some real successes in Netherlands that have come from the work of bureaucrats and politicians, there are some troubles that these groups have caused. When talking to respondents about this topic, one of the immediate observations I made was that the Dutch interviews revealed very few direct problems with these groups. When contrasting their answers to those given by the North American respondents, it seems as if the Dutch almost have no concerns with politics or the bureaucracy surrounding drug policy. In absolute terms however, there were a few issues that respondents felt was affecting the issue area.

The first set of problems concerned shortfalls of both bureaucrats and politicians. One issue that was revealed through these discussions was disconnection between politicians and bureaucrats at the federal level and their counterparts at the local level. A bureaucrat from the law enforcement venue explained that the federal government develops policies with the intent of them being implemented and enforced by the local levels of government. Unfortunately, as he explained, "there is little room for municipalities to tailor these policies to fit their needs".

While problems of disconnect can occur between levels of government, there can also occur a communication barrier between bureaucrats and politicians. A political staffer within the Tweedekamer revealed that politicians create laws on drugs that are not enforced by the bureaucracy. He believed that "having something illegal on paper but not in practice undermines

the credibility of government. Government should not permit the use of drugs ever! It sends the wrong message".

A third problem involving both bureaucrats and politicians is the management and distribution of resources within Holland's justice system. A Christian Democrat Member of Parliament believed that the country's justice system often becomes too busy to deal with drugs. Since the focus in Netherlands is on harm reduction, there are often not enough drug resources for law enforcement. On a political level, a problem arises whenever more funding is requested: "We more money is asked for law enforcement it turns into a big political debate over legalization. Nothing is ever resolved".

When analyzing the answers of respondents who talked only about problems caused by politics, it was difficult to find a common theme in their responses. It seemed that each respondent who discussed this topic had his or her own specific concerns with politics. One individual pointed out that the city council in Den Haag voted for an experiment that consisted of opening the back doors of coffee shops. Unfortunately the Minister of Justice had a good relationship with the mayor. The result was that the mayor overruled the motion.

Another specific concern was provided by a psychiatrist who claimed that "politicians get involved in discussions over drug policy when they really shouldn't. You never see them fighting over cancer. They should leave the discussion up to experts. It's a brain disease". This concern was raised by a few other respondents, though they felt that in the end politicians in Netherlands did respond to the advice of experts.

The one commonality I was able to find among answers of a few respondents was a concern regarding the way that coalitions affect governing. Some respondents felt that the need to form a consensus in coalitions slows down the policy process, and forces policymakers to

settle on alternatives that they may not be entirely supportive of. Others felt that coalitions work to maintain the status quo and provide little opportunity for new ideas to surface.

Illustrating this, a respondent from the People's Party for Freedom and Democracy felt that the development of coalition of diverse actors made it hard for a uniform view to develop: "We never have one party in charge of government. As such, we end up having to form coalitions; which make compromises and sacrifice some opinions for bargaining sake. It is difficult to make developments when views are so diverse". Another respondent felt even more strongly that coalitions thwart developments in policymaking: "Coalitions allow other parties—even minorities—to hold us hostage and we can't push for regulation and increased harm reduction".

As for problems that stem from the bureaucracy, it appears that a majority derive not so much from the behavior of bureaucratic actors but from the structure of the bureaucracy. One respondent claimed that the government is having a problem addressing the drug issue because it involves so many different issues (housing, welfare, healthcare). The bureaucracy is having trouble tackling this issue because it is not designed to work together on one particular issue. A different respondent shared a similar complaint: "The bureaucracy is too complex—every one argues over who should pay for what and no one ever considers a group effort".

Of those who felt that structure was a problem in the bureaucracy, it seemed that no one agency in particular was excluded. A complaint of the law enforcement bureaucracy was that it is too cooperative with its counterparts in other countries: "The police are a much more natural fit for cross border cooperation—it's all about the toys, equipment, and helicopters. Because other countries send their police to drug conferences, the Dutch police are also invited. This has elevated them to a spokesperson status in Netherlands drug policy". A concern from another

respondent focused on the health sector. The respondent complained that the original health bureaucracy was not organized in a way that prevented drug addicts from dropping out. He continued by saying that, "there are too many gaps between services. Everyone expects that the other guy is taking care of things".

A final set of problems concerning bureaucratic structure involves an element of federalism that was not often discussed by respondents. The problem to some was that criminal justice is organized nationally while harm reduction and treatment are organized locally. To a few, this gives law enforcement an unfair advantage. To other respondents however, it was the regionalization of the public health sector which led to harm reduction in the first place. One problem that no respondent refuted was the fact that larger cities get much of the harm reduction and treatment resources while smaller towns are left with very few resources in these areas.

A final problem of bureaucratic structure that is related to federalism came from a Labour Party parliamentarian who felt that it was important for government to solve problems in drug policy at the federal level before there can be progress developed at the local level. Apparently some municipal leaders want to move forward in their drug strategies but are being held back because the federal ministry has not yet sorted out its position on the issue.

As mentioned, there were not so many problems that respondents identified as stemming from politics or the bureaucracy. There were a great number of respondents however that talked about other factors that cause problems in drug policy. These include problems inherent to drug policy, problems regarding the actual drug policy of Netherlands, and problems caused by international actors.

For those who believed that a few problems inherent to drug policy existed, some found something wrong with the actual policy, while others found something wrong with what resulted

in the implementation of that policy. A Christian Democrat Member of Parliament explained that "some of the tools used in harm reduction led to problems because they don't necessarily stop drug use. We have normalized marijuana use which has allowed us to ignore the risks. We know that heroin experiments are wrong—however for particular people they should be used temporarily. All of this is very contradictory". A criminology professor complained that "the problem of hard drugs being illegal is that we're constantly forcing prices up and quality down. Even with big busts, the market bounces back".

A unique consequence of Netherlands' drug policy, according to one respondent, is that it has been so successful that people are beginning to ignore the utility of harm reduction. The former head of drug policy within the Ministry of Heath reported that "we've become the victims of our own success. We implemented harm reduction; which has lowered death, HIV, and overdose. The result is that people thought things were good and so nobody focused on the issue anymore. People didn't maintain drug policy with updates. This allowed for a weakening of the status quo—which is why we now face opposition when we try to develop new harm reduction instruments."

A related concern raised by a different respondent was that Dutch policymakers have relied so heavily on harm reduction that law enforcement and prevention have been left behind. To fix this problem, some actors are trying to fix these venues and rebuild the balance. Naturally however, they face fierce criticism from harm reduction advocates.

One of the most discussed problems that stems from drug policy itself is the controversy surrounding the back door of coffee shops. As mentioned throughout this research, it is legal to buy marijuana from a coffee shop, but it is illegal for coffee shop owners to buy marijuana in order to stock their shelves. One respondent who commented on this was a parliamentarian from

Lijst Pim Fortuyn: “it’s a paradoxical law which does nothing but cause problems and confusion”. Another former policy researcher in the Justice Ministry explained that “politicians have allowed us to liberalize the demand side but not the supply side. This contradiction causes a lot of uncertainty—which leads to problems”.

In trying to determine why this problem has continued in Netherlands, I asked a few respondents to share their understanding of the issue. Most of the answers brought us back to a discussion on problems caused by politics. To illustrate, one respondent claimed that “the only reason the back door debate exists is because of political parties; not because of different understandings of the issue”. Another respondent explained that the problem persists because while most parliamentarians say yes to back door experimenting, those in the cabinet are against it. The main reason why they are against it is because of international pressure.

Alas we come to the most mentioned problem in drug policy—those which stem from actors situated outside of Netherlands. Many respondents throughout the interviews identified some problem or set of problems which stem from the fact that Dutch politicians are often forced by outside actors to refrain from liberalizing Holland’s drug policy any further. Some felt that the pressure from outside politicians was forcing a divide between members of the federal cabinet and all other policymakers in Netherlands.

Illustrating this, a Member of Parliament for the Labour Party explained that as soon as a parliamentarian becomes a minister, they focus on international pressure rather than domestic concerns. The result of this is that the higher a politician’s focus of power is the more conservative they become on this matter. The parliamentarian added that this phenomenon is not limited to any one party: “It’s not like we’re all left-leaning long-haired friends of Jesus who

support this. Right-wingers even say that regulating the market is best. But as soon as someone gets into a cabinet seat they forget about this all".

A municipal policy advisor described there to be a unique situation in Netherlands. According to the respondent, "municipalities and the Tweedekamer think pragmatically; however ministers feel the pressures of colleagues in other countries and don't allow for certain developments to begin in Netherlands. The Economic and Foreign Affairs Ministers are really against liberalization because of consequences they will pay in other sectors". A similar response came from a legal scholar who claimed that, "we've been held back in a lot of ways because of international factors. In the 1970s we experienced an oil boycott on Holland for supporting Israel. We then became dependent on Germany, Belgium, and France. This forced us to tighten up our drug policy—among other policies—so we could get oil".

Not all respondents of course were convinced that international actors are as much of a threat as other policy actors believe they are. A Labour Party Member of Parliament confessed to having an interesting discussion with a major player in Dutch drug policy: "In discussions I had with the Minister of Justice over back door regulation, he said Netherlands could not experiment with this because of international law. I informed him that we were already breaking international law by having the front door open for consumers".

Though the focus of this research is on domestic effects on policymaking, there is a lot that international factors can explain about Dutch drug policy; particularly in recent years. Some respondents found that the effectiveness or ineffectiveness of Netherlands' drug policy. One was a Christian Democrat parliamentarian who believed that Dutch drug policy is only effective if other countries have the same policy. According to the respondent, "drug tourism is making our efforts counterproductive. When other countries look at our approach to the drug problem they

only point out the bad stuff". A similar response came from a fellow caucus member: "We either need to get other countries to legalize or we need to stop ourselves. It is silly for us to pretend we're an island that knows everything. Our drug strategy will not work if other states do not liberalize."

The problems of drug tourism, as well as pressure from neighboring countries, are not going unnoticed by drug policy actors in Netherlands. Some respondents even within this sample have had experiences in dealing with international factors that affect Dutch drug policy. A former bureaucrat from the Health Ministry complained that the Dutch government wanted to legalize and regulate marijuana sold at the back door but the European Union, United Nations, United States, and France put a stop to that. The municipal policy advisor to a city mayor explained that in his city, they feel more repercussions from other cities in neighboring countries than they do from their fellow cities in Netherlands. The response of this individual was that "drugs should be dealt with regionally instead of stopping at the border because drugs and crime don't stop at the border".

In dealing with these pressures, some policy actors have taken a proactive approach at stemming the pressure before it reaches Netherlands. A team leader within the Ministry of Health explained that his group has had to spend a lot of time at international conferences and government-sponsored events to defend the criticisms of other countries. After doing so, they often have to deal with these fallouts domestically. The respondent described one of these consequences: "In earlier years most Dutch weren't bothered by our drug policy. But with globalization it's tougher for people to defend our drug policy knowing how much they depend on the outside world".

Another respondent with international experience explained that it is really hard to get others to see the benefits of harm reduction. Apparently, many outside actors do not want to accept that there is an alternative outside of the law enforcement status quo. Describing his personal experiences in these types of encounters, the respondent claimed that "In the international sphere I often feel like donkey shit because nobody wants to hear from you unless you sing in tune with others or you are an official representative of the government [not just a bureaucrat]. Most people in the international arena don't want to listen to experts, practitioners, and volunteers. Little do they know that the professional opinion of these people really matter in Netherlands".

As a growing number of respondents complained of the limitations that the international system places on Dutch policymakers, I became curious as to what those on the giving end of such *pressures* felt about these matters. At the U.S. Embassy in Den Haag I interviewed an agent of the U.S. Drug Enforcement Administration. His interpretation of the relationship the U.S. has with Netherlands on drug policy was a bit different: "We don't tell them how to run drug policy. We stay out of the prohibition-harm reduction debate because we're just visitors. We're here for advice and training, and to take information from the DEA and package it in a way that is acceptable to the Dutch. I have great respect for the Dutch because despite major trafficking that goes on here, they have very few users. The U.S. has a lot to learn from these people".

In summary, the problems in Dutch drug policy that stem from the bureaucracy or politics are far fewer than those mentioned by respondents in any other country. Perhaps the element of cooperation in the policy formulation stage, combined with a consensus on the utility of harm reduction has led to relatively few problems in Dutch drug policy. Those problems which do exist tend to be the result of bureaucratic structures, as opposed to bureaucratic

behavior. A major political problem in Netherlands stems not so much from the parties but from the different levels of government. As several respondents described, there is a strong disconnect between the federal and local governments. This grows wider when international actors pressure the Dutch government to refrain from liberalizing their drug laws any further.

The Politics of Drug Policy

In the discussions on problems within drug policy, few respondents pointed to issues that stem from politics. Some of this may have to do with the fact that drug policy is not as politicized in Netherlands as it is in other countries. Of course, this is not to say that drug policy does not become political at times. While some respondents described how Dutch drug policy is not political, others explained how it was.

Speaking from the former perspective, those who thought it was not political believed this to be the case because of a variety of reasons. Some respondents believed that the nature of politics in Netherlands was not conducive to politicizing issues. As one parliamentarian described, "party discipline is strong, and it is very rare that someone will stand up on their own and talk out of line". Other respondents felt that the coalition building required in a system of proportional representation with corporatist political bargaining minimizes the opportunity to polarize issues and exploit them for votes. One such respondent was an elected member of Lijst Pim Fortuyn: "The Polder model prevents politicization of crime and drugs. Cooperation has led to more incremental steps that are made in a stable political environment". A different parliamentarian felt that the small size of parliament allowed for people to talk about issues and keep politics out of it.

Another explanation for why drug policy was not a political issue focused on the widely-held agreement that harm reduction was a good thing. A civil servant from the Ministry of

Justice believed that no one politicizes drug policy because there is a consensus around the harm reduction status quo. A mayoral assistant believed that it was not politically exploited because of the way the original policy was formulated: "From the start, we included everybody and [collectively] agreed that harm reduction should be the status quo".

Aiding in this collective process may be the fact that morality was largely left out of the policymaking process surrounding illegal drugs. According to a justice researcher, drugs are not a political issue because people do not treat it as a moral issue. The respondent believed that "once you add moral beliefs into an issue area conflict is inevitable". Another believer in this line of thought was an Amsterdam city councilor: "It's not political because the public won't respond to politicalization or dogmatization of addictions. If anyone in Netherlands suggested that we start a "war on drugs" they would be asked if they needed medical assistance".

The final reason for why politics may be largely absent from discussion on drug policy is because the issue lacks sufficient salience to merit the attention of politicians. Several respondents identified that it is not an issue which gains much attention of the public or media. Consequently, as one bureaucrat proposed, "Drug policy is not a social problem that is high on the political agenda". One politician even went so far as to conclude that more political debate on Dutch drug policy occurs outside of Netherlands than in the county's own political circles.

Though most respondents believe that drug policy is far from a political issue in Netherlands, a solid number of respondents believed that it is—particularly in recent years. The reasons for why drug policy has become politicized range from strategic positioning during elections, exploitation for votes, problem specific politicization, and attachment of the drug issue to immigrants.

For those politicians who exploit a certain position on drug policy for votes, the benefits are not that tremendous. According to one federal politician, the public is never concerned about it enough to base their vote on it. A politician from the Christian Democrat party took a milder stance: "Some people in our party have benefited from our more strict position on drug policy because that's what some people want. I do think that other parties are more liberal on drug policy than their voters are." Another respondent found that in recent years the morals of some groups have led a few politicians to take a position on drugs in order to gain electoral support. As this observer notes however, "this occurs mostly in Christian parties".

When drug policy becomes exploited for votes, it often occurs more at election time than any other time. To some respondents, this is when the drug issue becomes most salient. A cannabis policy advisor in the federal bureaucracy revealed that marijuana policy often becomes a political issue at election time. The reason for this is because people are somewhat concerned about coffee shops and whether the government should close them down. This is the time when exploiters of drug policy work the hardest. A senator and part time professor also believed that drug policy becomes politicized near election time—but only to a limited extent; largely because there are so many other issues to address during the campaign.

The most common reason for drug policy to become political is when specific problems surface in the media or in certain communities. One respondent claimed that drug policy becomes political when the media focuses the public's attention on nuisances and harassment caused by drug dealers. Another respondent observed that politics enters discussions on drug policy when the public shows that they are fed up with drug users and want them locked up. According to this respondent, though public tolerance for coffee shops may be shrinking, it is difficult for political actors to exploit and exaggerate drug policy outcomes because there are

plenty of supportive facts on coffee shops. “It is almost impossible for them to refute this evidence”.

A recent development that has troubled drug policy makers in Holland is the problems associated with immigrant drug dealers and users. Whereas drug policy was always focused on helping addicts who suffer from an illness, the problems caused foreign users and traffickers have changed things: “The immigrant issue has really taken drugs off the public agenda. Drugs are now brought up when it’s tied with the mafia and organized crime; not public health.” Another respondent found that drugs have been increasingly linked with immigrants after the assassination of Pim Fortuyn—who was a political leader that fought against immigration, drug trafficking, and social disorder.

No matter the reason for the politicization of drugs, for those who believe it occurs in Netherlands, there is a definite impact on public policy. This impact comes from the influence that politics of the drug issue can have on certain actors. The coordinator of an outreach center in Rotterdam provided this illustration: “Politics definitely affects the behavior of actors. The former mayor of Rotterdam used to support me in my endeavors. He came and looked at our facilities; I even introduced him to several users and dealers. For years we had his support. When the coalition changed however, he got stuck between the governing parties and turned on me. I called him on it and he apologized”.

The difficulty of analyzing field research is finding a balance between what some respondents believe and what others actually describe. While it seemed that more respondents denied there being any politicization of drug policy in Netherlands, quite a few had some very real examples which showed the opposite. I believe it is best to assume that there does exist some politics surrounding the drug issue because it is an issue that is very contentious—no matter the

policymaking environment one observes it in. A more important question is not so much whether politicization of the drug issue exists, but to what extent it has an effect on the decisions of policy makers. A good discussion to learn more about this is the balance between public opinion and science.

Public Opinion versus Science

As one respondent described in the above analysis, political exploitation of the drug issue does not happen all that often because of the large amount of data that scientists keep on Holland's drug strategy. According to respondents, the involvement of scientists and scholars in decision-making has been a constant occurrence since the 1970s. As a result, public opinion has played less of a role in Dutch drug policy.

Many respondents who felt that decisions in drug policy were based on science as opposed to opinion believed that the country's entire drug policy is the product of politicians actually listening to the scientific researchers they hired. A civil servant in the Ministry of Health stated that "the only reason we have the drug policy that we have is because we actually took the advice of committees that examined the drug problem. Canada had Le Dain and the U.S. had Schaffer—but neither of them went beyond that". A different respondent explained that Dutch politicians use science because they need to back up their reasons for using policies that other countries are not using.

Of course being able to produce scientific knowledge didn't always guarantee that social researchers in Netherlands were able to influence policymakers. As some respondents described, there was a need for strategy even among the experts within the civil service. One of these individuals was a long time policy advisor in a federal ministry: "Sometimes science has to be framed in ways that parallel the views of politicians. When Lijst Pim Fortuyn ruled Rotterdam

they wanted to get rid of the drug nuisance. We in the health community knew we couldn't fight them so we framed our strategy in their language and told them that we were going to fight their war on nuisance and provide care. To us, nuisance is caused by those who dropped out of the health care system and have no where to go. Eventually, they bought it."

Another respondent who has spent a number of years providing expert testimony to various governments also felt that packaging was important: "The easiest way to get through to politicians is not to fight with them. Just show them you're good and that you can do it. Then they'll believe you."

Of those respondents who have experience in trying to inform political actors through the use of scientific knowledge, some revealed important things about the role of science in policymaking. One believed that "science is the driving factor when things are taken out of moral context. Some things are just too important to be decided by politicians". Another felt that science and knowledge were very important in that they "have the ability to change the opinions of people".

Over the years, scientists have managed to maintain their role in drug policy. The desire for this—as one retired researcher explained—was that "it was as if they wanted to make sure their ideas were protected". One respondent explained that the best way for a scientist to maintain their presence among political circles is to make sure the public knows what they are saying. Since it is very seldom that experts try and educate the public directly, alternative steps must be taken. As the psychiatrist described, "you explain it to a politician; then they explain it to the media, who in turn inform the public. Once the public is educated, they'll be on your side of the issue". Once the public is on the same side of an issue as scientists, it becomes that much

easier for them to shape policymaking—for as an Amsterdam city councilor described—politicians know they have to get the proper information and represent the people.

While most believed that Dutch policymaking concerning illegal drugs involved the advice of scientific experts, some were more confident that public opinion weighed in. The reasons they gave for this centered on the argument that politicians are rational actors who know that votes can maintain or increase their power. One respondent cautioned that both understandings are true. Generally, politicians side with science until and issue becomes political. The Christian Democrat parliamentarian concluded that "when an issue becomes political there is no room for facts anymore. People can no longer identify what the problem really is. They end up fighting over their different perceptions of reality".

When discussing with respondents some of the reasons why science has played a part in drug policy, they mentioned a lot of the same things they did when I asked them why the drug issue was not politicized. They also brought up a lot of the same reasons for why harm reduction was the status quo drug policy if Netherlands. These reasons include cooperation, consensus, coalition building, and compromise. When identifying the sources of these factors, many of them offered cultural, historical, and political explanations—most of which have been discussed throughout this analysis. Another major factor in developing the cooperative conditions necessary of the harm reduction status quo was political institutions.

Political Institutions and Drug Policy

Dutch respondents seemed to be more familiar with the effect of institutions on drug policy than those respondents from the three other case countries. Within the sample there was a general consensus that Holland's institutional structures played a part in creating the cooperative policymaking environment needed for the harm reduction venue to become the status quo. In fact

with the exception of cameralism, almost of the understandings of how these structures lead to harm reduction were similar.

Though I did not get the opportunity to speak with all respondents about this issue, of the large majority that I did receive responses from, only one felt that political institutions did not matter in policymaking. The Christian Democrat parliamentarian believed that "Institutions don't play much of a role—it's mostly culture. Our tradition of being traders has made us very tolerant of differences. In Holland we try to avoid conflict. Instead of saying *no* to someone we say *let's discuss this*".

The remarks of this respondent are not in total contrast to those of other respondents who felt that institutions do matter. One respondent agreed that culture did matter in drug policy, however institutions matter because culture exists within institutions: "Society develops institutions, so culture is embedded in the political structures of a country". Another respondent explained that the reason our political institutions have helped in the formation of drug policy is only because Dutch culture is a part of its political system: "Our political system is based on taking care of the weakest. America's is based upon praising the strongest. Hence why they focus on parading their policemen around after a bust instead of providing addicts the services they need". A third respondent also felt that a strong connection between institutions and culture made a difference in Dutch drug policy: "Political institutions make certain distinctions possible. It allows people to define themselves in comparison to others. On an international level, the difference between us and America is that we don't think users should be punished for drug use."

Of the five different political institutions mentioned by respondents, political bargaining and electoral design were mentioned the most. Intergovernmental relations and cameralism were

also discussed, but to a more limited extent. Executive type was only mentioned by a few respondents—all of which who spoke on corporatism and proportional representation as well.

The general understanding on corporatism and proportional representation was that they both minimized conflict, fostered cooperation, and prevented the drug issue from becoming politicized. Whereas corporatism allowed for various actors to be a part of the policy process, proportional representation—by providing the necessity of coalition building—made sure that all parties had a shared understanding of harm reduction and the benefits it provides.

In discussing political bargaining, a few respondents pointed to the fact that corporatism promoted consensus and cooperation within the group of actors responsible for drug policy. A former drug policy advisor in the Ministry of Health shared that his agency was allowed to play a role in drug policy because the Polder model fostered a need for group consensus; which meant everyone had to be equally included. A municipal policy advisor explained that "corporatism promotes consensus on an issue. The Polder model makes sure that we include others and work together towards a consensus. While the Polder model has faded a bit, the roots are still there and it has definitely affected social policies like addiction".

This equal involvement of different actors in drug policy has created a dependence on professionals within the addictions field. As some respondents pointed out, this heavy involvement on experts and scientific knowledge—combined with the goal of consensus building—has managed to exclude morality from discussions in drug policy. However to other respondents, this entry of science into policymaking as opposed to morality has something more to do with Dutch culture than the practicality of science.

Describing this, a Justice bureaucrat explained that "Dutch society is split into pillars. On a political level no one has a majority so the leaders knew that to have an effective government

they would have to make compromises. Collectively, they agreed that a moral-dogmatic view was not good. Thus they had to use pragmatism in decision-making".

A very similar pair of responses was offered by two different respondents. These individuals drew a connection between religion and morality. As such, their answers focused on the separation of church and state. A policy advisor in the Justice Ministry believed that: "The pillar model of decision-making is based on the idea that religious and moral values have little place in politics. Policies must be pragmatic". A legal scholar claimed that "Pillarization of Dutch society kept law enforcement out of drug policy because people didn't think that government should prohibit drugs because doing so was the church's job. Separation of church from state means that government doesn't do religious-type things like prohibiting drug use".

The various things that corporatism does, which lead to a cooperative decision making environment, have also played a part in minimizing the politicization of drug policy. An elected member of Lijst Pim Fortuyn believed that corporatism has allowed a variety of policy actors to work together and design drug policy in a non-political manner: "The Polder model has allowed politicians, municipalities, and bureaucrats to come up with rational pragmatic policy without politicalization."

Although most respondents believed that corporatism promotes consensus-building within policymaking, one respondent found a drawback that is quite contradictory to what others have reported. According to a senator, while corporatism does allow for policy to work towards consensus, it excludes certain groups. By having consensus as the goal, it sometimes becomes necessary to exclude those that are seeking changes to the status quo. The senator concluded that "cooperation and consensus building are what allowed liberal thinkers into drug policy, but now they're keeping others out".

As previously mentioned, another common institution discussed by respondents was electoral design. According to respondents, proportional representation had an effect on Dutch drug policy that was very similar to corporatism. The coalition building that stems from this type of electoral design forces political actors to be cooperative, consensus-oriented, and open to alternative ideas. The end result of course is less politicization of the drug issue.

Illustrating some of these dynamics are several respondents from different areas of Netherlands' drug policy network. A Labour Party parliamentarian believed that "the PR system minimizes conflict and politicization because politicians are not fighting for a majority of the votes". A political consultant explained that "the proportional system forces government to form coalitions; which creates a large opportunity for science and pragmatism". A civil servant from the Ministry of Justice held that "coalitions help foster cooperation and pragmatism in policymaking. Also, because there are so many parties people are forced to make compromises". Finally, a Justice researcher proposed that "proportional representation has allowed for cooperation to develop between parties who strive for a coalition. The result is pragmatic policies in many contentious issue areas".

Another component of proportional representation that was discussed by a Christian Democrat politician was party discipline. The respondent believed that strong leadership in the parties led to a more focused discussion of the drug issue: "Having no constituencies makes parties stronger and more centered around their leadership; which means a discussion on drug policy is less fragmented".

Like the discussions I had with respondents on corporatism, there was one respondent who believed that proportional representation made things more difficult in drug policy. A Member of Parliament for the People's Party for Freedom and Democracy claimed that

"proportional representation has forced cooperation. The drawback of this is that there are no dramatic changes—mainly because one of the governing parties will always be in the following coalition. This carry over from term to term is what contributes to the consistency between coalitions that depoliticizes things".

Turning to intergovernmental relations, a common position taken by many respondents was that the decentralization of health care in Holland led to regional innovations in drug policy. These developments have not only influenced developments in other regions of the country, but also in national policymaking circles. Taking this position was a Christian Democrat who explained that "because of the small size of Netherlands, what appears to be good at a municipal level very easily becomes what is good at a national level". A respondent from the public health venue provided a similar explanation: "the regionalization of drug policy allowed for innovation. Much of the instruments started locally and spread across the country."

To some respondents, the decentralization of certain policy areas has delivered some strong benefits to drug policy. A municipal policy advisor believed that "it allows municipalities to see what's happening on the streets, which allows them to form a lot of initiatives and experiments". Another respondent also believed that it fostered experimentation in drug policy, and developed a bottom-up approach to the drug problem. A third respondent felt that decentralization is very important to issue areas like drug policy because "you only get consensus democracy, cooperation, and compromise when government is ran at a local level. This allows government a chance to talk with people".

A very influential individual in Dutch drug policy felt that the unitary governance of this issue area, combined with its decentralized implementation, has allowed drug policy to become what it is today. Using a comparative example of Holland and France, he illustrates how

policymakers are better able to make decisions when they are familiar with a variety of options: "Regionalization has led to well-informed drug policy in Netherlands. France has a strong centralized state. When law is applied across the entire country, people end up believing it is right. Drug policy in Netherlands is regionalized; which brings people closer to laws and allows them to realize that laws aren't superior and do not last forever. Because of this, decentralization causes people to put more thought and time into the laws they make".

While most supported the idea that regionalization breeds innovation, not all respondents believed that the municipal governments in Holland were fully responsible for the country's harm reduction approach to the problem. One respondent believed that the support of the national government for this approach has made a real difference in drug policy outcomes: "The decentralization of health care allows municipalities to have control over drug policy and tailor it to meet local needs. If we have a strict and repressive national policy, many cities would have more drug problems than they already have."

Other respondents shared differences on the extent to which power was balanced between the two levels of government. A senator believed that regional governments really had no power in Holland. Apparently the European Union, national government, and municipal governments were the only ones with any say. This response was echoed by a member of parliament who believed that the provinces play no role in drug policy, for the real decision-making power in the matter was at the national and local levels. In contrast to these observations, one bureaucrat from the Health Ministry believed that the decentralization of drug policy has allowed for the national government to lose power over what goes on. Because of this he believed that "it is difficult to get one broad idea across the country".

The fourth institutional structure I discussed with respondents was cameralism. Of the few who discussed this structure, there appeared to be two understandings of how drug policy is affected. On the one side are respondents who believe that the Eerste Kamer plays no role in policymaking. A drug policy researcher reported that the senate never says no to the house in drug policy. He felt that "it's as if they are not even there, and when they do say something everyone is surprised". Other respondents reported that the senate "is not really a major player"; and "they check for errors in laws but don't really make any".

One respondent who felt that the upper chamber in Holland's parliament plays much less of a role than the lower chamber was a long time legal scholar. To summarize his comments, the Tweedekamer is really the only legislative body. The Eerste Kamer deals more with the second reading of bills, but they do not get involved in issue definition, agenda setting, or policy formulation. Their lack of influence allows the Dutch parliament to run more efficiently than other bicameral legislatures.

On the other side of the issue was a group of respondents who did believe that the senate played a role in Dutch drug policy. Speaking from experience, a senator from the People's Party for Freedom and Democracy explained that "With my position in the chamber I have been able to access the drug policy agenda on three occasions. With cooperation from the Labour Party, my colleagues and I were able to influence several policy outcomes in this area. Senators are here not because of their admiration for politics but because of their chosen profession and ability to review policy originating from the Tweedekamer".

A different senator also believed that the Eerste Kamer played a reviewing role in drug policy: "The senate chamber is one of reflection. We try not to act on details—but in fundamentals. Out role is to reject or accept. Ninety-five percent of the time we accept." A

respondent from the Tweedekamer had similar remarks about her colleagues in the upper chamber: "They have a limited role because of their lack of power. They are important however because they help to ensure the quality and conciseness of the policy".

The final political institution discussed was the executive. Very few respondents discussed how regime type affected the dynamics of policymaking as it relates to illegal drugs. Some points that were raised however tell us something about the way that executive policymakers behave. One respondent pointed out that mayors of municipalities are appointed by the national government. The respondent's assessment of this was that this "alleviates them from the problems that elected policymakers deal with". Another respondent offered a more detailed account of the impact that mayoral appointments have on the behavior of policy actors:

> Much of drug policy is driven by the mayor and council of cities and towns. Mayors in big cities are appointed by the national cabinet while mayors of small towns are appointed by the provincial cabinet. Each body is advised by a multi-partisan group of city politicians. The effect on drug policy is uncertain. However we do know that mayors are far more willing to advocate new developments in harm reduction—even those who belong to more right-wing parties".

At the national level, the respondents who discussed executive powers revealed that Holland's prime minister is seldom involved in drug policy. According to one parliamentarian, this occurs because "the Prime Minister does the day to day administration of the nation but is strongly guided by the coalition agreement he made with the other governing parties. As a result, there is little room for dramatic interventions by the Prime Minister". Another respondent felt that the influence of the prime minister in drug policy largely depends up his interest in the subject and his strength—for he is still only the first among equals.

In close, the respondents in the Dutch sample were very keen on the idea that institutions have an impact on policymaking. Through several examples and illustrations, the respondents provided a detailed account of how the behaviors of actors in drug policy are affected by political

institutions. It was nearly unanimous that Holland's institutional structures created a cooperative policymaking environment; one that has led to a drug policy based on harm reduction.

While corporatism fosters a consensus-style decision making that leads to pragmatic drug policies, proportional representation and the resulting need for coalition-building foster discussion on drug policy that is free from politics. The centralized formulation of Dutch drug policy, combined with its regionalized implementation, has allowed for several harm reduction innovations to take place. According to respondents, this has both intensified and strengthened the harm reduction status quo—not to mention it has also helped drug policy decision-makers become well-informed. While the Dutch sample's discussions on the executive did not reveal any support for or against the arguments explored in this research, they did inform us of how the appointment of mayors has alleviated some of the political stress that comes with proposing new ideas to the status quo.

Netherlands Overview

The qualitative data I gathered in Netherlands are very useful in that they offer a very thorough explanation of the processes involved in Dutch drug policymaking. According to respondents, the harm reduction status quo was a product of multiple things. The first was the entrance of professionals and experts into government discussions on drug policy. The Polder model of decision-making; which has long been a tradition in Holland, reduced many barriers for the public health venue to define drug users as ill persons.

The second was that the consensus driven policies which came from the Dutch government were largely shaped by health bureaucrats who were safe to work in an environment that was free from politicizations of the drug issue. This opportunity was afforded to them by the necessity of coalition-building that is inherent to an electoral system based on proportional

representation. As many respondents described, morality and ideological battles were left out of the discussions on drug policy; which helped everyone in the long run.

Another strong determinant of Dutch drug policy was the ability of municipalities to implement their own drug policies within guidelines that were loosely set by the federal government. Many respondents expressed how important it was for the harm reduction movement, that cities were able to develop the services they believed their citizens needed. The cooperation between policy actors—at both levels of government—certainly was an asset to those in favor of liberalizing Holland's approach to the drug problem.

One factor that seemed to affect drug policy in Netherlands more than in any of the other case countries was pressure from outside the country. Constant monitoring and demands placed upon the Dutch government from the international sphere have made it difficult for liberalization to occur in Holland. In fact, some respondents claimed that pressure from outside countries and organizations has created a divide between the federal cabinet and the rest of the country—including elected members of parliament. The result is that while a majority of Dutch drug policy actors want to experiment with further innovations in harm reduction, members of the federal cabinet—regardless of party and ideology—prevent them from doing so.

5.4 Qualitative Summary

Data collected for the qualitative portion of this research reveal important findings regarding bureaucratic dominance, political institutions, and drug policy. Respondents in each country told a collective story of how their country's drug policy came to be, what it entailed, how it has changed, who the main actors were, how politics and public opinion affected drug policy, and how political institutions influenced all of the above. The most important realization I had after completing this field research was that policy actors are forward-driven players whose

behavior is commandeered by factors outside of their immediate control. These factors include institutional, political, cultural, historical, and international conditions—all of which were thoroughly discussed by the respondents who participated in this research.

The four case countries chosen for the qualitative portion of this project delivered an easy opportunity for me to compare and contrast different types of drug policy in a variety of political, cultural, and institutional settings. While bureaucrats played a major role in the formation of drug policy in all four countries, the type of bureaucrat who became involved was largely a function of politics.

In more competitive policymaking environments—like the United States and Canada—it was difficult for treatment, prevention, and harm reduction advocates to mobilize reform efforts against the law enforcement status quo. Those bureaucrats in advisor roles often gave politicians the sense that prohibition and deterrence are the most important tactics to use in dealing with the drug problem.

In more cooperative policymaking environments, political actors—for various reasons—put politics and morality aside to consider what science had to offer in the search for an effective solution to the drug problem. Treatment and harm reduction professionals were able to dominate drug policy formulation in Austria, while Dutch drug policy became controlled by the harm reduction venue. The result was that politicians saw the drug problem as one of public health, rather than safety.

United States

The main theme deriving from interviews with American respondents was that competition characterized the policymaking process. Whereas politicians competed for votes, bureaucrats competed for resources. The result of this was that more dominant actors tended to

control the drug policy agenda. Politicization of the drug issue, law enforcement dominance, and strong public opinion have worked against any reforms to the law enforcement status quo. Findings from the field interviews suggest that one source of these interactions is America's political institutions. Federalism, the majoritarian electoral process, bicameralism, presidentialism, and pluralism force all policy actors to compete with one another for decision-making power. When this occurs, drug policy becomes a game of power brokers instead of problem solvers.

Canada

The major problem revealed by the Canadian sample was that there is a discrepancy between how balanced the country's national drug strategy really is. While the federal government claims that the health venue is in control of a four-pillar approach to the drug problem, existing legislation makes it difficult for the law enforcement venue to not be in charge. One indication from the interviews is that there is a slight sense of change within the drug policy network. Canada's pro-bureaucrat polity eases cabinet hesitation to rely on the civil service rather than public opinion for answers. The difficulty in summarizing respondent views of institutions is that there is a split between those who believe that competitive institutional structures (pluralism, majoritarian electoral system, federalism, bicameralism) lead to new actors entering the system—by way of overpowering other actors; and those who believe that cooperative institutional structures (parliamentary executive) lead to new actors entering the system—by having less barriers to overcome.

Austria

If one thing can evoke broad discussion on the institutional, historic, and cultural explanations of Austrian drug policy it is the famed *social partnership*. Corporatism in Austria

has affected the behavior of policy actors by creating the need for consensus in decision-making. To a lesser extent, the coalitions which derive from Austria's proportional representation electoral system have enabled harm reduction advocates to be heard in the right decision-making circles. One factor which takes away from the bureaucrat dominance theory of this research is the 30 year tenure of the Social Democrats in Austria's parliament. Developments of harm reduction and treatment that occurred during this era were entrenched into the minds of politicians and bureaucrats. In recent years however, the *treatment first, punishment second* approach to drug policy is being threatened. A newly constructed nexus between immigrants and drug trafficking, the fading social partnership, and the fact that harm reduction is losing some of its hype means that some policy actors are sneaking subtle changes to the public health status quo.

Netherlands

As described by many Dutch respondents, the near 40 year history of harm reduction in Netherlands is the result of a wide-spread pragmatic, non-political view of drugs. One of the four main sources of this norm is Dutch culture; which to many has a strong element of tolerance and diversity. Another is the Polder model of decision-making; which allows for all actors to play an equal part in forming a consensus. The third is proportional representation and its necessary coalitions that lead to cooperation and minimal politicization of the drug issue. Finally the regionalization of drug policy implementation has allowed for a steady development of harm reduction throughout this small nation. The only real challenge to the consensus-style decision making that has dominated Dutch drug policy for so many years comes from the international sphere. Pressure from other countries and transnational organizations has created a divide between the federal cabinet and as one individual put—"everyone else".

5.5 Qualitative Limitations

After conducting the field interviews for this research, then analyzing the data that were collected, it was easy to identify several shortcomings in this project's qualitative section. Though most were nearly impossible to overcome, I put an earnest effort into protecting my research from any harm that these limitations may have caused.

The first was the fact that data I gathered were nothing more than a compilation of experiences from different actors in the policy process. By using open-ended discussions on drug policy, there was no way to limit the range of what respondents were talking about. Leaving the window of time and political space open allowed for respondents to share their understandings of events that happened in different decades, political jurisdictions, and even drug policy areas. To some degree, this makes the job of drawing comparisons and similarities very difficult—even within the same country nonetheless between different countries.

While it would have been nice to compare respondent observations on the same policy event—and in the same time and political space—that luxury was not available. While troublesome, this limitation is not entirely detrimental to this work because of the fact that drug policy is such a narrow policy area. Because the events that occur in drug policy (such as the introduction of needle exchange), and the relationships that occur between actors (harm reduction vs. law enforcement) are quite similar, I was able to make the necessary comparisons for this research.

The second limitation to this research obviously regards sampling. While the snowballing effect that I employed gained me access to several important policy players in each country, there is no real way to compare the caliber of my respondents across the four countries. To explain, since I was lucky enough to access almost every important player in the Netherlands, I

spent less time with street-level bureaucrats and service providers. In contrast, my access to the *higher-ups* in Austria and Canada was not all that robust. As such, I focused my interviews more on policy actors who were responsible for the implementation and localization of drug policy rather than its original formulation[21].

A difficult limitation to overcome in cross-national qualitative research is the timing of each field expedition. While I would have enjoyed switching locations every week—to make sure I was approaching the discussions in the same way—that was not an option. As such, while going over my extensive stack of field notes I found that to some degree there was variation in the focus of my follow-up questions across all four countries. Though I used the same open-ended questionnaire on all 155 respondents, the nature of the discussions outside of the questionnaire were different. At times it seemed like I was in search of something new as I entered each different country. I do believe that in part this a function of the environment in which I was conducting the interviews.

America seemed to be so political, so cautious. As such I felt that I needed to find out what was behind it. Even though I finished up the second half of my American interviews after I had already visited the three other countries, those same feelings of strategic competition dominated most interviews.

Canada felt deathly bureaucratic. Not just because the government collapsed while I was in Ottawa, but because even the politicians acted like civil servants instead of free-spirited policymakers. Because of this, I found myself becoming more interested in the relationships between the different venues as opposed to the politics that prioritize the venues.

[21] While in the USA—out of complete fluke I'm sure—I managed to gain access to a few key actors who were either once in a position of power or who were close to someone in a position of power. Since I was also able to interview a healthy number of service professionals and bureaucrats, I believe that my American sample is in fair shape.

While in Austria, I sensed that underneath all the talk about the *social partnership*, there was definitely more tones of competition than cooperation. It seemed that even civil servants had a political hate on for somebody. My focus naturally fell on that.

In Netherlands, I felt like I arrived 30 years too late. The direction of Dutch drug policy was entrenched long before any of the other countries started to examine different options. Thankfully, most respondents were well versed in their history. Some were even old enough to remember what went on in the formation years—they were there.

The final limitation that merits discussion is bias on a part of the researcher and the respondents. While there is an assumption that most respondents are accurate in their descriptions of drug policy, there is a tremendous potential for them to be wrong. This becomes quite clear when two different respondents offer contradictory answers to a question. On the researcher side, while I made every effort to record exactly what respondents were saying, there is always a chance that I may have introduced language from my own profession; which in turn may have had an effect on responses given to me.

I do trust that for the most part the information provided to me was accurate, and very little of it was a regurgitation of any question or comments that I shared with the respondents. Holding this assumption does present certain risks, however the benefits of accepting this assumption and the rich data that accompany it far outweigh the costs associated with including a few biased answers in the analysis.

CHAPTER SIX

6.0 DISCUSSION

In trying to determine the reason for variation in the drug policies of democracies, it quickly became clear that completing such a task would not be simple. Other studies (Wilensky, 2002) on public policy show that a variety of domestic, international, institutional, and bureaucratic factors can influence policymaking. Some of the domestic factors observed by other scholars include media (Lambeth, 1978), public opinion (Page & Shapiro, 1983), partisan conditions (Mainwaring, 1993), political culture (Verba, 1963), party discipline (Satori, 1994), and political ideology (Inglehart & Klingemann, 1976). Some of the international factors studied by other scholars include international institutions (Gourevitch, 1978) and diplomatic pressure (Meernik, Krueger & Poe, 1998; Walsh, 2004). In the current research, both quantitative and qualitative findings reveal that international pressure and political ideology are two domestic/international factors that have an influence on drug policy.

In the area of political institutions, some research was has shown how such factors affect public policy. Past researchers of institutional explanations (Hicks & Swank, 1992) argue that the design of a country's political structures can influence policy outcomes by affecting the behavior of policy actors within the political system. In the area of bureaucratic dominance, other scholars (Breton & Wintrobe, 1982; Meier, 2002) explain that the control over problem definition allows bureaucrats the ability to monopolize discussions of a given issue because of the expertise afforded to them by their role in the civil service. Studies on drug policy have confirmed that indeed, bureaucratic dominance is real, and it affects decision making in this issue area (Betram et al., 1996; Isralowitz, 2002).

Of all four explanations of the drug problem, the latter two seemed to be the most interesting, yet also the most understudied. To fill that void I looked closely at bureaucratic dominance, then political institutions, and then the mediating effect that institutions have on bureaucrats within the formation of drug policy.

When I first examined bureaucratic dominance, the role of bureaucrats in policymaking came across as quite strong. It's as if political leaders cared about the problem but let civil servants manage the solutions. I soon realized that it would useful to determine the extent to which bureaucrats actually influence policymaking concerning illegal drugs. Much of the literature (Dunn, 1982; Meier, 2002) on this topic proposes that resource-driven bureaucrats will continue to define a problem to politicians in a way that benefits them. At the government level, vote-minded politicians will try their best to defend the status quo and paint their opponents to be deviators from this (Edelman, 1988). Combined, these policy actors will then work to control the *image* of the problem; which will in term determine the *venue* in which it is dealt with (Baumgartner & Jones, 1993).

The problem with these arguments however, is that they are limited to policymaking in competitive policymaking environments like the United States. This means that in their raw form, the explaining power of these theories in other democracies is limited. The one thing which separates democracies from one another is the design of their political system. I then turned to the role of institutions in policymaking and tried to estimate the merit of studying how political institutions shape the behavior of policy actors; which in turn affects policy outcomes.

Other scholars have investigated the extent to which political systems are defined by their political institutions (Crepaz, 1998). Others (Tsebelis, 1995) argued that different institutional structures create different conditions for policymaking. A few scholars actually went to the

extent of testing these types of arguments and found that when it comes to policymaking, institutions do matter (Huber, Ragin, & Stevens, 1993).

The current research attempts to build upon the public policy and comparative politics studies that have tried to inform us of the relationship between political institutions and public policy. Specific to this study is the affect that political institutions and bureaucratic dominance—whether jointly or in sync—have on drug policy. The hypotheses tested in this research are that bureaucrats play a major role in drug policymaking. However the venue from which dominant bureaucrats work is dependent upon the image of illegal drugs. Who controls the image of drug use has a lot to do with a country's policymaking environment.

In countries with more cooperative policymaking environments it is easier for minority opinions to be heard, morality to be left out of decision-making and pragmatic policies to be the result. In countries with more competitive policymaking environments it is much more difficult for alternatives to the status quo to be considered—particularly if the drug issue is politicized and morality is able to play a part.

The quantitative results of this research reveal some strength in the hypotheses proposed. Strong relationships were found between competitive institutional structures like single member districts and more repressive approaches like law enforcement and deterrence-based prevention. In contrast, cooperative institutional structures like proportional representation were found to explain variation in the index scores of substitution treatment, education-based prevention, and harm reduction.

The qualitative results also brought some support to the hypotheses. A majority of the respondents found that bureaucrats played a major role in drug policy. They also reported that certain political institutions fostered conditions in their policymaking environment that were

either competitive or cooperative. Of those policy actors I interviewed in Austria and Netherlands, the harm reduction and treatment bureaucrats were able to dominate because of consensus-based decision-making (that came from corporatism) and the non-politicization of drug policy (that came from proportional representation). Several respondents in Canada and the United States explained that the law enforcement status quo was perpetuated by politicians who constantly politicized the issue, turned to criminal justice professionals for advice, and based their decisions on public opinion instead of science.

The qualitative findings also showed several ways in which drug policy is affected by the domestic and international factors explored in the literature review of this research. Depending on the country, public opinion, the media, partisan conditions, party discipline, political culture, and political ideology all have some sort of an impact on drug policy. With the exception of the United States, respondents in the other three countries expressed a concern that their nation's drug policy was affected by international institutions and diplomatic pressure. Of these three, respondents in Netherlands discussed these factors the most.

To no surprise, not all the findings revealed in this research were expected. Empirical relationships showed up between federalism and several drug policy instruments that I had originally associated with unitary governance. The same occurred for bicameralism. These flip flops indicate that perhaps there is more ways to explain the role of political institutions in policymaking than through theories based solely upon the veto point argument. As some of the respondents explained, federalism breeds innovation in all types of drug policies and bicameralism allows for a second chamber to take the proper time to discover new solutions to old problems.

Unique findings also appeared in the qualitative results. As I predicted, many respondents in Canada and the United States complained that actors within the law enforcement venue made it nearly impossible for actors from other venues to intervene and change the status quo. My theory was that the competitive policymaking environment of these two countries allows for this. However in Netherlands—and to a lesser extent Austria, I had complaints from prohibition advocates who informed me that actors from the harm reduction venue were blocking their access to the drug policy agenda. While the cooperative policymaking thesis proposed in this research explains how harm reduction became the status quo drug policy in these countries, it does not completely explain why they are now keeping other actors out.

The only explanation I can offer for this is that in order for the theories proposed in this research to be close to the truth, one must assume that harm reduction and treatment are the best alternatives to use in drug policy. In the context of Netherlands and Austria, the reason that prohibition advocates are locked out of decision-making is because politicians, bureaucrats, and the general public believe it is the wrong solution.

CONCLUSION

This research borrows methodology and theory from a variety of political science subfields to deliver a thorough and conclusive cross-national analysis of drug policy. From public policy theory (Baumgartner & Jones, 1993; Kingdon, 1995; Sabatier & Jenkins-Smith, 1999), this research supports the idea that policy actors try to dominate the problem definition stage of the policymaking process. If successful, bureaucrats end up influencing the implementation stage that they are directly responsible for. Likewise, politicians heroically defend/alter the status quo they promised to maintain/change.

From the comparative politics literature, this project builds upon the idea that institutional structures largely determine a nation's policymaking environment (Cameron, 1978; Crepaz, 1998; Hicks & Swank, 1992). As Lijphart (19SAS) and Tsebelis (SSS) have argued before me, the policymaking environment in which actors behave is largely shaped by the political institutions of a given political system. Lijphart's description of *consociational* and *majoritarian* democracies, as well as Tsebelis' *veto point* argument suggest that a country's political institutions—combined with other factors—shapes the behavior of actors which ultimately affects their decisions (policy outcomes). Similarly, the current research has shown that when controlling for several domestic and international factors, the presence or absence of certain institutional structures determines how some policy actors are able to dominate over others also trying to control the policy process.

The mixed methodology that I employ in this research offers a very thorough investigation into the interactions of institutional structure, policy actors, and policy outcomes. The empirical analysis offered a valid test of the relationships between the variables. It also enabled me to compare institutions and their influence on the policymaking environment. The

interviews with policy elites provided a very reliable source of in-depth and experience-based knowledge on bureaucrats and the political institutions within which they operate. Together, these two separate methodologies have provides a strong set of findings from which to build further research from.

In terms of contributions to the field of political science, it is easy to see how the use of theories from comparative politics and public policy can become easily complex. However, careful theorizing and thorough testing of hypotheses should alleviate some of the difficulties that are inherent to answering questions from the perspective of two different subfields. I believe that this research can be used to help scholars of public policy and comparative politics better understand one another—in terms of their methods, theory, and application of both.

Outside of academia, this research benefits the government and non-profit sector by illustrating how the politics of drug control can largely be a function of conditions that fall outside the control of elected policymakers. While the partisanship of government matters, the relations of that government to other parts of the political system are largely determined by institutional design and bureaucratic dominance—something *real life* policymakers are not often aware of. As for the average dissertation enthusiast who is oblivious to what we study in political science, this dissertation shows how government works, why it works in the ways that it does, and how the lives of people can be affected by things often greater than policy actors themselves.

Future attempts to answer the questions explored in this work should consider a number of alternatives. One is to include case study and interviews on additional democracies. The most promising, in terms of institutional design and approaches to the drug problem, are Sweden, Switzerland, Germany and Australia. In terms of quantitative methodology, future researchers may want to consider one of two approaches to determining the effect of institutions on drug

policy. The first is to isolate each institutional structure explored in this research and spend more time identifying the direct affect of that institution on drug policy actors (ie: case study). The second is to develop additional indicators of how cooperative or competitive a given policymaking environment is. Using these variables in place or along side some of the variables used in this research may strengthen the arguments made throughout this dissertation.

In all, this research has examined four different approaches to the drug problem. The findings, as well as those of others, show that domestic and international political factors can explain variance in drug policy. In particular, this research has demonstrated the importance of examining the role of political institutions and bureaucratic dominance in the formation of public policy concerning illegal drugs. Drug policymakers are guided as much by political will as they are by the bureaucrats who define problems and the institutions that mediate the behavior of these people. This research concludes that the rules of the political game and the relationships between players in the game are a major determining factor in whether a government approaches the problem of illegal drugs with handcuffs or stethoscopes.

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APPENDICES

Table A.1
Drug Policy Data Sources Table

Variable	Country	Data Source
buprenorphine substitution-treatment, needle exchange	Argentina	Inchaurrga (2003)
heroin maintenance, needle exchange, outreach, outpatient treatment	Iran	Nissaramanesh, Trace & Roberts (2005)
education-based prevention, health curricula in schools, methadone substitution treatment, deterrence-based campaigns, health education-based campaigns, needle exchanges,	Ukraine, Slovenia, Russia, Romania, Lithuania, Poland, Latvia, Hungary, Czech Republic, Slovenia, Slovakia, Romania, Serbia/Montenegro, Macedonia, Moldova, Kazakhstan, Georgia, Estonia, Croatia, Bulgaria, Bosnia, Belarus, Albania	CEEHRN (2003)
needle exchanges, methadone substitution treatment	Paraguay, Argentina, Uruguay, Brazil, Russia	Intercambiando (2004)
inpatient and outpatient services (private)	Spain, Italy, Netherlands, Czech Republic, Croatia, Macedonia, Sweden, South Africa, Israel, Slovakia, Cyprus, Switzerland, Denmark, Hungary, Mexico, Argentina, Columbia, Brazil, Australia, Taiwan, Russia, Ukraine	Narconon (2007)
inpatient, outpatient, 12-step, prison treatment	Mauritius	United Nations Office for Drug Control and Crime Prevention (2001)
needle exchanges, prison sentences for possession	Paraguay, Uruguay, Argentina, Brazil	Bastos et. al. (2007)
treatment in prisons, harm reduction outreach	Russia	AIDS Foundation East-West (2007)
mandatory treatment	South Korea	Drug War Chronicle (2005)
needle exchange, substitution treatment, harm reduction outreach, inpatient, outpatient	Taiwan	Sung (2007)
detox	Thailand	Supawitkul (2000)
needle exchange, methadone substitution treatment	Thailand	Natpratan (no date)
methadone substitution treatment, detox, prison treatment	Albania	ENDIPP (2007)

methadone, morphine, and buprenorphine substitution-based treatment	Norway	Solberg, Burkhart, & Nilson (2002)
needle exchange	Bulgaria	Hagen, et. al. (2004)
needle exchange, detox	Romania	Drug Law and Health Policy Resource Network (2002b)
needle exchange, harm reduction outreach, prison treatment	Poland, Russian, Estonia, Moldova,	Open Society Institute (2007)
needle exchange, harm reduction outreach, skills training, prevention outreach	Moldova, Burundi, Sri Lanka, Philippines,	UNAIDS (2007)
tolerance zone	Denmark	Cannabis Social Clubs (2007)
de facto decriminalization	Denmark	Drug War Facts (no date)
reintegration	Slovenia	EMCDDA (2001)
skill-building, school-curricula, heroin maintenance, buprenorphine, workplace testing, social reintegration	Austria, Belgium, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxemburg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, United Kingdom, Norway	EMCDDA (2005)
prison for possession of soft drugs, prison for possession of hard drugs, decriminalization	Russia	Schreck, cited in Drug War Facts (no date); Stop the Drug War (2004); Senlis Council (2004b)
all variables	Armenia, Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxemburg, Malta, Moldova, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Ukraine, United Kingdom	EMCDDA (2007)
mandatory minimums, prison for soft drug possession, prison for hard drug possession, stiffer sentence for trafficking, civil asset forfeiture, drug courts	all countries	U.S. Bureau of Justice Statistics (2007)
all variables	all countries	U.S. State Department (2007)

prison for hard drugs, prison for soft drugs, civil asset forfeiture, stiff sentence for trafficking, police-based education, fear campaigning, reintegration, outpatient treatment, inpatient treatment, health curriculum, health campaign, decriminalization,	Moldova, Japan, Jamaica, Iceland, Columbia, Antigua and Barbuda, Brazil, Botswana, Barbados, Albania, Bangladesh, Dominica, France, Ghana, Israel, Italy, Mexico, Spain, Switzerland	Winslow (1999)
school testing	Mexico	Reuters (2007)
mandatory treatment, prison treatment, health curriculum, prevention outreach, fear tactics, drug court	Georgia	Drug Law and Health Policy Resource Network (2002a)
inpatient treatment, outpatient treatment	New Zealand	Care NZ (2007)
prison for possession of soft drugs, prison for possession of hard drugs	New Zealand	New Zealand Police (2007)
drug courts	New Zealand	New Zealand Ministry of Justice (2007)
decriminalization, de facto decriminalization	Australia	Drug Policy Alliance (2007)
de facto decriminalization	New Zealand	Scoop (2004)
health curriculum, health campaign	New Zealand	New Zealand Ministry of Youth Development (2004)
school drug testing, workplace drug testing	New Zealand	NORML New Zealand (2007)
health curriculum	Nicaragua	United Nations General Assembly (1995)
treatment in prison	New Zealand	New Zealand Department of Corrections (2007)
safe injection site	Portugal	Drug War Chronicle (2006); Senlis Council (2004)
methadone treatment, buprenorphine treatment, other substitution treatments	South Africa, Albania, Argentina, Armenia, Bahamas, Bangladesh, Barbados, Benin, Bolivia, Brazil, Burundi, Chile, Columbia, Costa Rica, Haiti, Honduras, Iceland, India, Israel, Mauritius, Mexico, Macedonia, Mozambique, Nicaragua, Panama, Papua New Guinea, Peru, Philippines,	INDRO (2007)

	St. Kitts and Nevis, St. Vincent and the Grenadines, Sao Tome and Principe, Senegal, South Korea, Sri Lanka, Suriname, Taiwan, Thailand, Trinidad and Tobago, Ukraine, Uruguay, Venezuela, Zambia	
needle exchange, harm reduction outreach	Mozambique	IRIN (2007)
civil asset forfeiture	South Africa	Redpath (2000)
prison for soft drugs, prison for hard drugs, mandatory minimum sentences, stiff sentences for trafficking	Mozambique, Bahamas, Bulgaria, Burundi, Benin, Barbados, Chile, Costa Rica, Croatia, Cyprus, Dominica, Dominican Republic, El Salvador, Ghana, Greece, Guatemala, Panama, Macedonia, Madagascar, Panama, St. Kitts and Nevis, St. Lucia, St. Vincent and Grenadines, Samoa, Sao Tome and Principe, Senegal, Serbia, Sierra Leone, Sri Lanka, Suriname, Taiwan, Thailand, Trinidad and Tobago, Turkey, Tuvalu, Vanuatu, Venezuela, Zambia	Australian Government Department of Foreign Affairs and Trade (2007); Foreign Affairs and International Trade Canada (2007)
decriminalization	Spain	van het Loo et al. (no date)
drug courts, mandatory treatment	South Korea	Stop the Drug War (2005)
needle exchange	Sri Lanka	Legal Action Center (2005)
reintegration, health campaign	Sri Lanka	Government of Sri Lanka (2007)
reintegration, inpatient treatment, outpatient treatment, prison treatment	Sri Lanka	United Nations Office on Drugs and Crime (2005)
drug courts	Switzerland	Grichting et. al (2002)
prison treatment	Switzerland	Klingemann (2006)
prison treatment	Taiwan	Jou, Chen, & Huang (2006); Taoyuan Women's Prison (2007)
mandatory treatment	Taiwan	Taitung Prison (2007)
health curriculum, health campaign, prevention outreach	Trinidad and Tobago	Trinidad and Tobago Ministry of Social Development (2007)
mandatory minimum sentencing	Turkey	Embassy of the United States in Ankara (2007)

prison for soft drugs, prison for hard drugs, stiff sentence for trafficking	Ukraine	Skala (2007)
medical marijuana	United Kingdom	NORML (2002)
pill testing	United Kingdom	Green Party Drugs Group (2007)
needle exchange, harm reduction outreach	Argentina, Brazil, Columbia	AIDS Coalition to Unleash Power (2002)
prevention outreach	Ghana	Narconon International (2007)
prison sentences for soft drugs, prison sentences for hard drugs, stiff sentences for trafficking, police education, fear tactics, student testing, workplace testing	Philippines	Stop the Drug War (2002)
detoxification, outpatient treatment, inpatient treatment	Philippines, Thailand, South Korea	National Rehabilitation Center for the Disabled (2001)
civil asset forfeiture	Philippines	Simser (2006)
inpatient treatment, outpatient treatment, low threshold treatment	Peru	Knowlton et. al. (2002)
needle exchange, harm reduction outreach, safe injection sites, de facto decriminalization, decriminalization, pill testing, reintegration, detoxification	Japan	CEEHRN (2005); TAIMA (2007)
decriminalization	Belgium	NORML New Zealand (2003)
pill testing	Australia	Camilleri & Caldicott (2005)
pill testing	Netherlands, Switzerland, Austria, Spain, Germany, France, Belgium, Australia, Czech Republic, Canada, United States	Enlighten (2007); EMCDDA cited in EROWID (2001); Winstock, Wolff, & Ramsey (2001); DanceSafe (2007)
underground pill testing	South Africa, Philippines, Thailand, Denmark, Estonia, Finland, France, Hungary, Norway, Poland, Portugal, Ukraine, Russia, Sweden, United Kingdom	Enlighten (2007); Winstock, Wolff, & Ramsey (2001)
fear campaigning, health	Slovakia	Drug Law and Health Policy

campaign, mandatory treatment, reintegration, needle exchange		Resource Network (2002c)
fear campaigning, mandatory treatment, inpatient treatment, outpatient treatment, decriminalization, stiff sentence for trafficking, methadone maintenance	Poland	Drug Law and Health Policy Resource Network (2002d)
detoxification, needle exchange	Hungary	Drug Law and Health Policy Resource Network (2002e)
mandatory treatment	Ukraine	Drug Law and Health Policy Resource Network (2002f)
detoxification, mandatory treatment, harm reduction outreach, needle exchange	Albania	Drug Law and Health Policy Resource Network (2002g)
needle exchange, prison treatment	Latvia	Drug Law and Health Policy Resource Network (2002h)
de facto decriminalization	Lithuania	Drug Law and Health Policy Resource Network (2002i)
needle exchange	Bulgaria	Drug Law and Health Policy Resource Network (2002j)
outpatient treatment	St. Kitts and Nevis	Inter-American Drug Abuse Control Commission (2005)
police education, fear campaigning, prevention outreach, health campaign, inpatient treatment, outpatient treatment	St. Kitts and Nevis	National Council on Drug Abuse Prevention (2003)
civil asset forfeiture, inpatient treatment, outpatient treatment, police education, low threshold treatment, detoxification	St. Lucia	National Anti-Drug and Substance Abuse Strategy of Saint Lucia (2000)
mandatory treatment	Russia	OSI International Harm Reduction Development Program (2007)
civil asset forfeiture, health curriculum, workplace drug testing, school drug testing, prevention outreach	St. Vincent and Grenadines	Organization of American States (2000)
prison treatment	Samoa	Radio New Zealand

		International (2006)
mandatory treatment, fear campaign, treatment outreach, inpatient treatment, outpatient treatment, detox, prison treatment	San Marino	United Nations Office on Drugs and Crime (2007a)
health campaign	Senegal	Sarr (1998)
workplace drug testing	Japan	Brooke Screening (2007)
all variables	all countries	U.S. Bureau of International Narcotics and Law Enforcement Affairs (2007)

Table A.2
Countries Used in Quantitative Analysis

Countries		
Albania	Greece	Romania
Antigua	Grenada	Russia
Argentina	Guatemala	St. Kitts
Armenia	Haiti	St. Lucia
Australia	Honduras	St. Vincent
Austria	Hungary	Samoa
Bahamas	Iceland	San Marino
Bangladesh	India	Sao Tome
Barbados	Iran	Senegal
Belgium	Ireland	Serbia
Benin	Israel	Seychelles
Bolivia	Italy	Sierra Leone
Bostswana	Jamaica	Slovakia
Brazil	Japan	Slovenia
Bulgaria	Latvia	South Africa
Burundi	Lithuaniua	South Korea
Canada	Luxembourg	Spain
Chile	Macedonia	Sri Lanka
Colombia	Madagascar	Suriname
Costa Rica	Malta	Sweden
Croatia	Mauritius	Switzerland
Cyprus	Mexico	Taiwan
Czech Republic	Moldova	Thailand
Denmark	Mozambique	Trinidad
Dominica	Netherlands	Turkey
Dominican Republic	New Zealand	Tuvalu
Ecuador	Nicaragua	Ukraine
El Salvador	Norway	United Kingdom
Estonia	Panama	United States
Finland	Paraguay	Uruguay
France	Peru	Vanuatu
Georgia	Philippines	Venezuela
Germany	Poland	Zambia
Ghana	Portugal	

ELITE INTERVIEW SURVEY INSTRUMENT

Respondent Information

1) What is your involvement or role in your country's drug policy?

2) How many years have you spent in government/bureaucracy? How many years of that were spent in matters relating to illegal drug policy?

3) Were you appointed, elected, or hired to your current position?

4) What level of influence would you say a person in your position has on the formation or maintenance of drug policies in your country?

5) Should the level of influence your position has be greater/lesser than it already is?

Drug Policy

6) Tell me about your country's national drug strategy (or overall approach to illicit drugs)?

7) How did the current drug strategy come to be?

7b) Have there been any dramatic changes over the years? If so, what caused those changes to occur?

8) Do you feel that your country's drug control policy has been
   a) highly effective
   b) somewhat effective
   c) somewhat not effective
   d) not effective at all

9) Regarding drug users only, do you believe harm reduction or law enforcement should be *your country's* first choice in drug control? What about treatment and prevention?

10) Are your country's drug sentencing laws for possession
   a) too strict
   b) just right
   c) not strict enough

11) Is there something about politics or the bureaucracy that cause problems in drug policy?

12) If you could design a successful drug strategy, what would it entail?

Policy Subsystems

13) Who are the main actors involved in your country's drug policy?

14) Can you provide examples of cooperation or competition between these actors?

15) What is the role of bureaucrats in drug policy? What efforts have they made towards/against changes in drug policy?

16) Can you please describe the relationship between all actors in your country's drug policy subsystem—governmental and nongovernmental?

Institutions

17) Why are the relationships that you have just described the way that they are?

17b) How political would you say drug policy is in your country? Would you say it is an issue that your public has great concerns about? Is it exploited for votes?

17c) While making decisions pertaining to public policy in general, do politicians in your country lean towards science or public opinion? How about in drug policy?

18) Democracies exist in many forms. The cause in variation between different democracies is attributable to different institutional designs (ie: federalism/ unitary intergovernmental relations, pluralism/corporatism, majoritarian/proportional representation, etc.). Do you see institutional design—or the rules of the game—as playing a role? Explain.

19) Envision your country's drug policy subsystem under a different set of political rules and institutional structures. What do you see?

20) On matters pertaining to drug policy, what is the biggest cause of cooperation between the parties?

Table A.3
Agencies and Organizations of Respondents by Type*

Country	Government	Bureaucracy	Interest Group/Political Party	Non-profit Organization
USA	U.S. House of Representatives; U.S. House of Representatives-House Committee on Criminal Justice and Drug Policy; United States Senate; U.S. Congress-Speaker's Task Force on Drugs; U.S. House of Representatives-International Relations Committee	U.S. Department of Education-Safe and Drug Free Schools; Office of National Drug Control Policy; Drug Enforcement Administration-Headquarters; Drug Enforcement Administration-Strategic Planning; National Institute on Drug Abuse; U.S. Bureau of Prisons-Psychology Services; Substance Abuse and Mental Health Services Administration; Food and Drug Administration; Partnership for a Drug-Free America; Columbia University-National Center on Addictions and Substance Abuse	Families Against Mandatory Minimums; Legal Action Center-Drug Unit; Criminal Justice Policy Foundation; Marijuana Policy Project; Crime and Justice Institute; Drug Policy Alliance; Harm Reduction Coalition; North American Syringe Exchange Network; Community Anti-drug Coalition of America; Women's Alliance for Medical Marijuana; U.S. Democrat Party; U.S. Republican Party	National Association of Drug Court Professionals; Civil Air Patrol-Demand Reduction Services; National Association of State Alcohol and Drug Addiction Directors; National Association for Addictions Professionals
CAN	Government of Canada-House of Commons; Government of Canada-Senate; City of Vancouver	Canadian Centre on Substance Abuse; University of Toronto-Department of Criminology; Royal Canadian Mounted Police (RCMP)-Drug and Organized Crime; Vancouver Police Service; Health Canada-Research and Surveillance; Health Canada-Drug Strategy and Controlled Substances Programme; Canada Border Services Agency; Corrections Canada; Public Safety and Emergency Preparedness Canada; University of Toronto-Centre for Addictions	Canadian Foundation for Drug Policy; Liberal Party of Canada; Conservative Party of Canada; New Democrat Party of Canada	Canadian Association of Chiefs of Police; Addictions Foundation of Manitoba

		and Mental Health; Office of Privy Council-Machinery of Government; Solicitor General of Canada		
AUS	Parliament of Austria-Nationalrat; Parliament of Austria-Bundesrat; Tirol Parliament	Ministry of Interior-Drug Coordination; Vienna Drug Policy Programme; Medical University of Vienna; Austrian Health Institute; Institution for Addictions Research; Ministry of Justice-Drug Coordination; Ministry of Health-Drug Coordination; University of Innsbruck-Law Department; Innsbruck City Hospital; Tirol Provincial Police-Drug Affairs	Austrian People's Party; Green Party; Tirol People's Party; Social Democrat Party of Tirol; Freedom Party; Social Democratic Party	Caritas Social Catholic Agency Innsbruck; Verein Wiener Sozialprojekte - Ganslwirt Low Threshold Drop-in; Austria Association for Drugs Professionals
NETH	Parliament of Netherlands-Tweedekamer; Parliament of Netherlands-Eerste Kamer; City of Maastricht; City of Amsterdam; City of Venlo; City of Den Haag	Ministry of Interior-Cannabis Unit; Ministry of Health; University of Utrecht-Law School; Ministry of Justice-International Drug Policy; Ministry of Justice-Alcohol, Drugs & Tobacco; Leiden University-Law School; Ministry of Justice; University of Amsterdam-Criminology School; Vrije Universiteit-Department of Political Science; Utrecht Municipal Health District; U.S. Embassy-Den Haag; Bouman Mental Health Institute Rotterdam; Netherlands National Police-Intelligence; U.S. Drug Enforcement Administration-Intelligence		Trimbos Institute; Rotterdam Outreach Services; Centum Maliebaan

* Agencies/organizations listed above refer to the most direct part of each agency/organization that respondents were affiliated with.

VITA

Chad Nilson was born in Prince Albert, Saskatchewan, Canada. He received his Diploma in criminal justice with an emphasis in law enforcement from Lethbridge Community College in Alberta. He then received a B.S. in criminal justice from the University of Great Falls in Montana and a M.A. in criminal justice from Radford University in Virginia. While working on his PhD at the University of New Orleans he obtained a M.S. in political science. Nilson's doctoral coursework focused on public policy, international relations, and comparative politics. During graduate school he participated and presented at several national and international conferences in the fields of political science, drug policy, criminal justice, and criminology. His publications are on a variety of topics, including police effectiveness, eco-terrorism, and drug policy. He has been a visiting researcher at the American University School of Public Affairs, the Centre on Governance at the University of Ottawa, University of Toronto's Centre for Criminology, University of Innsbruck's Canada Studies Centre, the Social Studies Institute in Den Haag, and Vrije Universiteit in Amsterdam. He has taught various courses on comparative public policy, governance and policy analysis. He currently professes for the Department of Political Studies at the University of Saskatchewan and is a research consultant for various non-profit organizations and government agencies in Canada.