

OPEN DRUG SCENES AND OVERDOSE MORTALITY – WHAT TO DO?

REPORT FROM FIVE EUROPEAN CITIES

Helge Waal, Linn Gjersing, Thomas Clausen

SERAF rapport nr 1/2011

ISBN: 978-82-93019-02-2

OPEN DRUG SCENES AND OVERDOSE MORTALITY – WHAT TO DO?	4
Introduction.....	4
Methods.....	5
AMSTERDAM - “ THE ORIGINS OF HARM REDUCTION ”	6
Netherlands	6
City characteristics.....	7
Development.....	7
Drug use situation	7
Treatment:	8
Control sector.....	10
Overdose mortality.....	11
Open drug scenes	12
Observations	12
FRANKFURT AM MAIN -”TAUNUSANLAGE AND USER ROOMS”	14
Germany.....	14
City characteristics.....	15
Development.....	15
Drug problems in Frankfurt	16
Contextual observations.....	16
Present treatment system.....	17
Control sector.....	17
Coordination	18
Overdose mortality.....	19
Open drug scenes	19
Observations	20
VIENNA- ”ZUSAMMENLEBEN” AND “ZONES OF TOLERANCE”.....	22
Austria.....	22
City characteristics.....	23
Development.....	23
Drug problems	23
Contextual observations.....	23
Treatment system	24
Control sector.....	25
Coordination	25
Overdose mortality.....	26
Open drug scene:.....	26
Observations	27
ZÜRICH - HEROIN TREATMENT?	29
Switzerland	29
City characteristics.....	31
Development.....	31
Contextual observations.....	32
Present drug situation.....	32
Present treatment situation.....	32
Control sector.....	33
Cooperation.....	34
Overdose mortality.....	35

Open drug scene.....	35
Observations	36
LISBON – DECRIMINALIZATION AS A SOLUTION?.....	37
Portugal	37
City characteristics.....	40
Development	40
Contextual observations.....	40
Drug situation.....	40
Treatment	41
Control sector.....	41
Cooperation.....	42
Overdose mortality.....	43
Open drug scenes	43
Observations	44
MESSAGES FROM 5 CITIES	46
General observations.....	46
Some common denominators.....	46
Harm reduction is a core approach	47
Assertive social service is a prerequisite	47
Health service should be low threshold but comprehensive	47
Non- shared traits.....	48
Shared characteristics.....	48
REFERENCES	49

OPEN DRUG SCENES AND OVERDOSE MORTALITY – WHAT TO DO?

INTRODUCTION

Problems related to use of illegal substances – in this report for convenience labeled “drugs” – is common in most European cities, in particular in larger cities and capitals. Some of these problems are drug related crimes, dissocial behavior, family disruptions and social misery. Others are health related such as malnutrition, infectious diseases and mortality, in particular overdose mortality. One particularly contentious issue is open drugs scenes; public city areas with open use of and usually also selling of drugs. This tends to cause call for immediate actions, both by control sector and treatment sector.

Several basic choices and principles have bearing on the understanding of these problems and the courses taken to meet the problems. One is whether the problems are inherent in the drugs use itself or whether the problems originate from the measures to meet them, i.e. are the problems partly or mainly caused by the control, the attempts at repression – so called control damages? Others are related to policy priorities. Basic here is the distinction between supply reduction and demand reduction. The first tend to inspire control measures and regulations. The second tend to prioritize preventive efforts through attitudinal campaigns, information and intervention in supposedly causative relations and settings. A third aspect relates to goal of therapy and other interventions. Abstinence oriented therapy and policy aim to stop drug use and basically to prevent any use. Harm reduction; on the other hand, build on the understanding that drug use is an unavoidable part of modern society. While it is a goal to reduce frequency, the primary aim is to reduce harms related to use, consenting that some types of use is less harmful and that it has a separate value to alleviate use related problems even though this might involve acceptance of the use itself.

This report does not intend to answer or take stance in these questions. The city of Oslo has troublesome drug problems, particularly related to number of overdose deaths and an open drugs scene in the vicinity of the central railway station – “Plata” and has commissioned Norwegian Centre for Addiction Research to analyze the problems and give advice on possible actions. One of the approaches is to investigate how other cities in Europe have addressed the issue of open drug scenes, in particular cities that seem to have solved or markedly reduced problems with drug scenes and high level mortality. Doing so, the different aspects and policy choices in the cities will as far as possible be clarified and the measures described. The development will be mapped out on basis of public statistics and discussions with researchers in each city, and most important; the practical and concrete

experiences discussed with relevant experts in each city. Amsterdam is chosen as the city that very early experienced problems and first developed a comprehensive harm reduction policy. Zurich and Frankfurt are particularly known for very large and destructive open drug scenes; Platzspitze in the first and Taunusanlage in the second. The development of heroin assisted treatment, HAT, is often associated with Zurich while injection rooms are associated with Frankfurt. Vienna is interesting because it has a reputation of a policy of coexistence with the drug using populations, and because of high level reliance on slow release morphine. Lisbon has lately been in focus because of regulatory changes with decriminalization of all drug use and possession of drugs for personal use.

METHODS

The basic approach is to study the development in some core European cities and to analyze and evaluate the measures taken. The first step was to make a profile for each city describing the cities drug use and drug policy development based on previous studies of the cities and on available literature. Second the present drug use situation, overdose numbers and drug scene problems were put into the profile on basis of EMCDDA-reports and other material. Thirdly a set of questions were prepared. We then established contact groups in each city with core informants from social service/health systems, from control sector and from research institutions. The profile and the questions were sent to the groups.

A study group from SERAF visited each city with core institutions and possible drug scenes autumn 2010. This group had members from Oslo police (Runa Bunæs in all the cities except Lisbon and Sveinung Sponheim (only Lisbon)) and from City of Oslo Alcohol and Drug Addiction Service (Lilleba (A- Kahtrine Fauske)). Willy Pedersen from Institute of Sociology, University of Oslo participated in Lisbon. The profile and the questions were discussed with the researcher groups and with relevant professionals from preventive, therapeutic and control sectors with the intention to discuss concrete experiences. Particularly relevant institutions and sites were visited. These observations and discussion is basis for reports from each city. The reports are sent to each city for corrections and supplementation. Finally shared and non shared traits and observations are analyzed to establish a basis for lessons and suggestions for Oslo.

The report from Amsterdam is reviewed by Professor Wim van der Brink, the report from Frankfurt by "Drug coordinator" Jürgen Weimer from the "Drug Policy Coordination Office" and Detective Chief & Drugs Liaison Officer Thomas Zosel, the report from Vienna by Project Coordinator Angelina Zenta from "Sucht und Drogenkoordination", the report from Zürich by Professor R. Stohler, from the Drug and Alcohol Department at the University Psychiatric Clinic and the report from Lisbon by coordinator and researcher Fernanda Feijão from Institute on Drugs and Drug Addiction. In addition the report is commented on by Klaudia Palczak and colleagues in EMCDDA.

AMSTERDAM - “ THE ORIGINS OF HARM REDUCTION ”

City profile is based on papers by Bless (1), Buning & van Brussel (2), Buster (3) Kalmthout(4). Reinaas et al 2000 (5), 3de Multi-city study (6), Waal (7) C van der Meer presentation at Pompidougroupp meeting, ref, EMCDDA national report 2000 (8).

Visit160910: Presentations by and discussions with Wvd Brink and M Buster .

NETHERLANDS

Some core socioeconomic features: 16, 5 mill inhabitants. Densely populated. High level public health care and social care systems, low but increased unemployment.

Core drug policy elements: Harm reduction policy was developed from 1970/80. Repression and abstinence-orientation were largely replaced by maintenance and tolerance. Special feature: Separation of hard and soft drugs policy. One element is that cannabis can be bought and used in “Coffee shops”. Use of drugs is generally tolerated but not legal. Selling is prohibited: Drug-related criminality 2008: 19269 felonies, 5894 for use/possession. There is a prominent use of administrative sanctions: ISD order: “Act on institution for prolific offenders” with the aim to reduce nuisance

Present development: a. Drug ranking with risk assessment as suggested basis for policy choices. B. Evaluation of policies. Advisory committee report on Drug Policy: Present drug policy proposals: “Use of drugs and alcohol by minors should be tackled far more rigorously (early detection) Coffee shops sale should be available for local users only. Measures against organized crimes should be strengthened.

Core treatment characteristics: There is a very high level of low threshold OMT. The municipal health care systems have a core role. GP’s are only involved in Amsterdam, not in the rest of Netherlands and mainly in treatment of non problematic users. Heroin treatment trials were initiated in 1998 with results presented in 2002. Heroin Assisted Treatment - HAT – became an accepted method in 2003. Currently there are HAT-centers in 15 cities with 700 patients constituting; 5 % of patients in OMT. Core trials:

- 1997-2001 Experiment High Dose MMT (n=225)
- 1998-2002 Experiment Heroin Assisted Treatment (HAT: n=549)
- 2001-2004 SOV: forced placement criminal addicts in Treatment prisons
- 2002-2009 Routine treatment with HAT (n=650 in NL)
- 2004-2009 ISD: forced placement revolving door criminals in Treatment prison
- 2006 Registration of heroin as a medicinal product
- 2007-2009 DV: forced placement homeless in closed MH institute
- 2009 Registration + reimbursement of Suboxone in NL

Drug use patterns: Lifetime use cannabis 15-34: 32%... High prevalence night scene, high prevalence deprived groups. Injection infrequent: 10 % heroin users, 1 % cocaine users.

Problem hard drug users: 1993: 28 000, 1996: 27 000, 1999: 29200, 2001: 33500 (2.2-4.3/1000).

Drug related deaths: fluctuates between around 100 and 130 (129 in 2008). In 2008, 52 drug-related deaths attributed to opiates, 22 cases to cocaine use.

CITY CHARACTERISTICS

Amsterdam is the administrative and financial center in North Netherlands. It has high level multiculturalism, especially by Surinamese descendants, and is well known for a culture of tolerance with Red light districts and cannabis cafes (separation of drugs policy). It has comparatively low level social problems often attributed to the policy of tolerance. Amsterdam is seen as trend setting city in Netherlands with mid-level prevalence of hard drug users (1/3 of Rotterdam)

DEVELOPMENT

→ 1965 Opium smoking Chinese, immigration of Surinamese subgroup (anti injection culture)

→ 1970 Flower Power (Provo) period, cannabis, alternative lifestyles largely tolerated,

1972 → Increasing use of heroin, increase of social problems, increase of repression. Abstinence oriented treatment.

→ 1980 Policy of harm reduction adopted with large scale methadone programs, coffee shops with cannabis. Increase in “drug tourists” → discouragement of foreigners policy

→ 1990 response a core responsibility for city health services with low threshold methadone, no preconditions and methadone bussing system. GP based treatment for non-problematic users. Enlargement of shelters and user rooms. None accept for public nuisance.

2000 →2010 largely stable situation. Development of HAT. Development of special measures for “difficult-to-treat” addicts. Integration of services. Continuing efforts against open scenes.-

2010 → there has earlier been a broad political consensus on drug policy. Presently right wing politicians are advocating closing down methadone treatment. However methadone treatment is the most cost-effective services.

Drug use situation

Hard drug users 1980/90 = 6000, 2004: 4000. 1500 “avoids” health care services. 500 extremely antisocial, 2008: 2913, 2010: about 3000. 50% Dutch citizens.

Group characteristics:

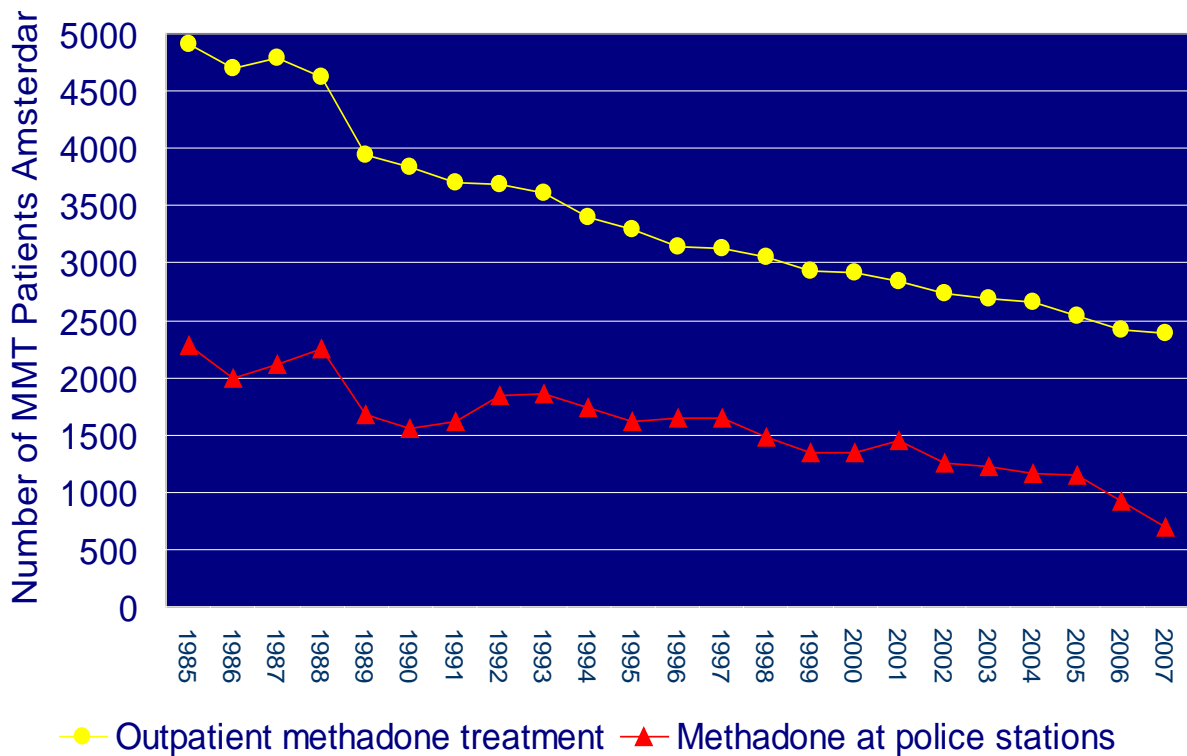
- 20-25% revolving door criminals (800-1.000)
- 80% cocaine dependent, 30% alcoholic, 95% nicotine dependent
- 80% HCV pos, 5-10% HIV pos
- 50% with psychiatric co morbidity, 25% IQ <80

By capture/recapture techniques it is established that the city has decreasing number of addicts with increasing average age.

Treatment:

The numbers in treatment was initially very high but has gradually decreased as shown in figure 1. By capture/recapture techniques it is established that the city has decreasing number of addicts with increasing average age.

Figure nr 1. Numbers in OMT in Amsterdam divided in outpatient in treatments system and treatment in police stations (by courtesy of W van der Brink)



80 % of heroin dependent individuals are in MMT. Type of treatment shown in table 1

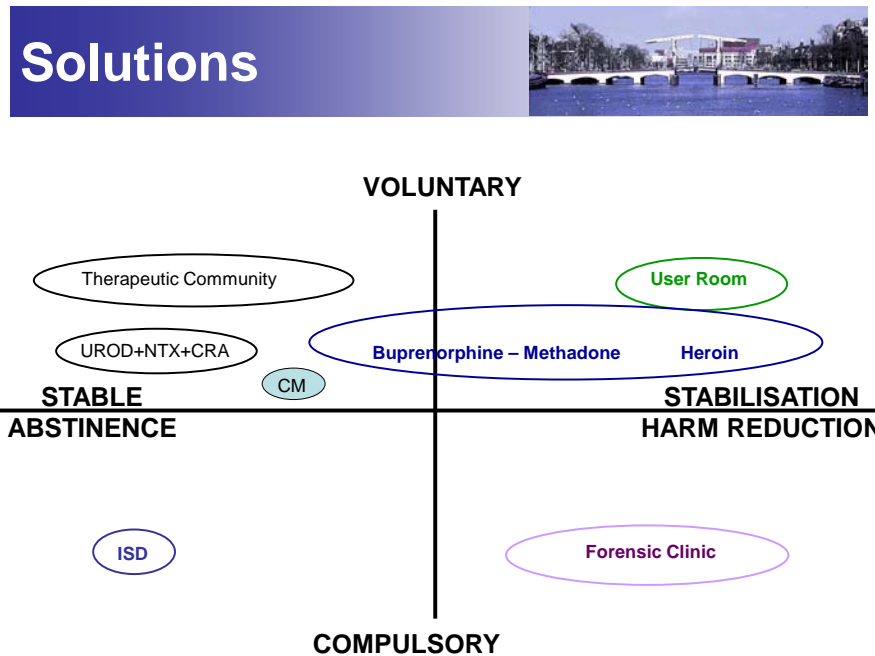
Table 1 Location and type of maintenance treatment in Amsterdam 2010 (courtesy of WvdBrink.)	
MMT	N = 2380 (80%)
HAT	N = 150 (5%)
ISD: revolving door criminals in Treatment prison	N = 150-250 (5-8%)
DV: homeless in closed MH institute	N = 50-100 (2-4%)
WF: Work Force	N = 500 (17%)
Total	N = 3000

OMT is continued at imprisonment and arrests. Methadone is available at core police stations. OMT might also be initiated within prisons.

Heroin assisted treatment is only indicated for a minority not benefitting from MMT. Neither overdose mortality nor open drug scenes have been seen as target problems in general. Treatment system should be seen according to two dimensions: voluntary vs. involuntary and abstinence oriented vs. harm reduction as seen in figure 2 (by courtesy of W v d Brink).

The core is OMT with methadone or buprenorphine. A minority is target group for abstinence oriented treatment and compulsory and quasi compulsory treatment should be available. Compulsory treatment should also be available in quasi compulsory setting within forensic clinics. Another important aspect is that there is sufficient capacity. Waiting lists are neither accepted nor necessary. Further there is a high emphasis on integration in any service site. Cooperation and collaboration is not dependent on the user. Out-reach teams, especially ACT-teams, connect to problematic, particularly with mentally ill addicts. It is also important that there is no delivery of services on street. Addicts are expected to meet in centers, especially as these have user facilities and often necessary other services.

Figure 2. A comprehensive overview of the treatment system (by courtesy of W van der Brink)



Control sector

The policy is one of systematic police interventions (no more than 4-5 users). Further, policy of cooperation police and health/social sector is established. When a problematic area develops for instance at the central station, a strategy is to establish joint team of Police/social affairs. Further health services and police have separate lists with files of problematic users. A joint central list of the most problematic users is based on these separate files with health care and police records.

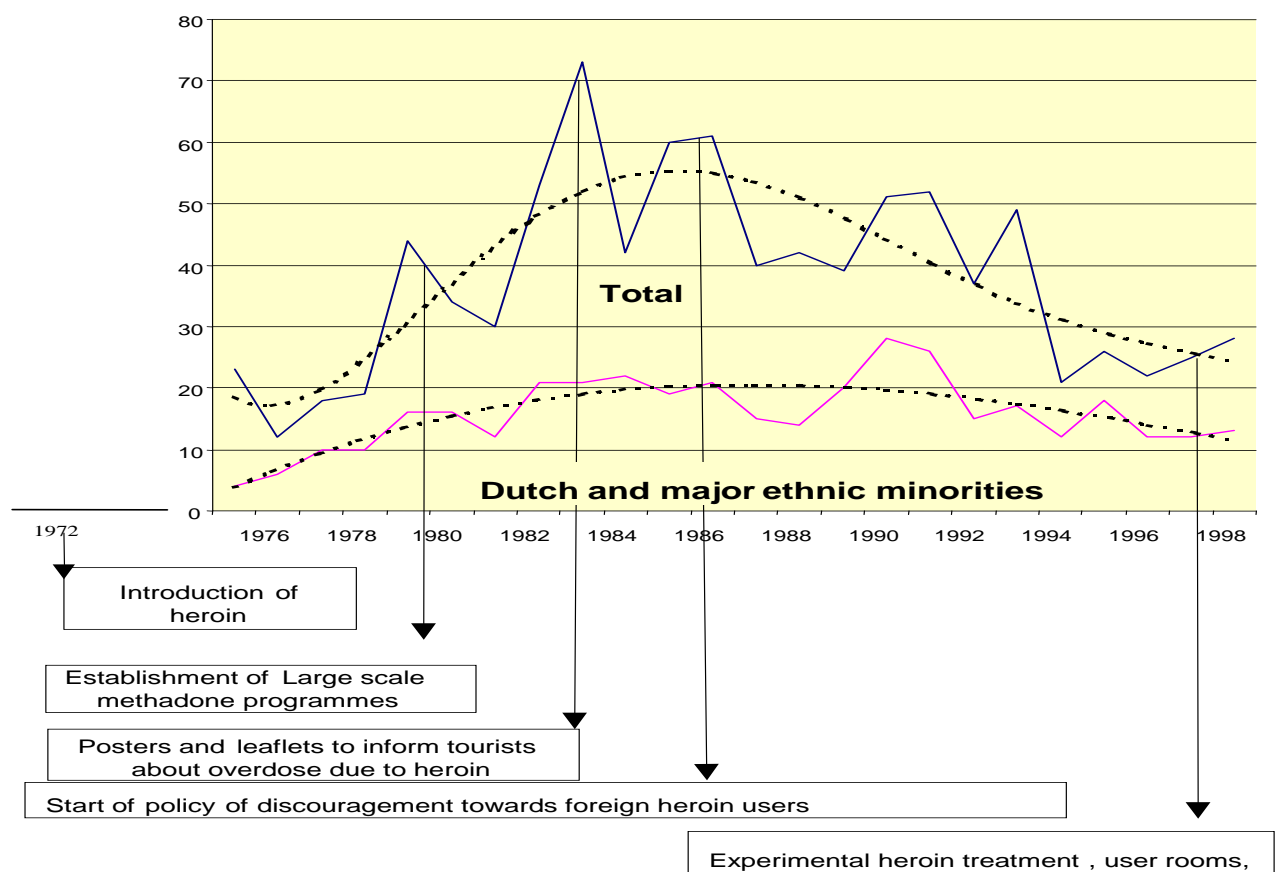
If problematic users defy police orders, they might be subjected to administrative proceedings by special courts. If they commit crimes, compulsory treatment within special prisons is an option. If mental disorders are present, compulsory treatment within mental health institutions is an option. Specific models are developed to deal with revolving door criminals. Previously they were sentenced according to their behavior. Many were in prisons for short period in times. At present they will be subject to proceedings in a civil court. They are not convicted according to the criminal law but get a legal measure. A person, who is found not responsible, can be sent to treatment for 2 years. One year might be decided as inpatient treatment (Quasi-compulsory treatment). The person has no choice, but those who adjust may be released earlier. Some is also allotted to longer term in treatment prisons. The offenders are not treated in health services but in “treatment prisons”. Another aspect is the service for

seriously disturbed and problematic users through a system for forced placement of homeless in closed mental health institutions.

OVERDOSE MORTALITY

The number of overdoses has never been very high in Amsterdam. Figure 3 shows the development until 1998. As can be seen, it is particularly non-Dutch individuals that die.

Fig 3 Overdose development in Amsterdam 1976-1998 (by courtesy of M Buster)



These are mainly intravenous users while the Dutch, both the majority and the minorities almost exclusively inhale heroin. It can also be seen that the decrease in overdose numbers came before the introduction of heroin treatment and user rooms. However, the harm reduction orientation and repression of user scenes came early, in particular the high level low threshold methadone program. Since 1998 the number of overdoses has been stable between 20 and 30 cases/year. Half is non Dutch individuals. This means that Amsterdam has slightly more than 10 overdose cases among citizens while Oslo has 60-70. Both cities have about 3000 heroin addicts.

Two major differences are obvious. The first is that Oslo has about 30% of the addicts in treatment while Amsterdam has 80%. Another is the prevalence of injection use. Oslo has

90% while Amsterdam has 10%. The high risk group for overdoses would accordingly be about 300 individuals.

One core question obviously concerns the origin of the drug use pattern with low level intravenous use. Following elements has been suggested

1. Early use among immigrants from Surinam culturally resistant to injections.
2. Opium smoking tradition in Chinese groups with long history in the city
3. High quality of heroin available (smoking affordable)
4. Never chased by the police (injection is much faster than smoking)
5. Surinamese were normal people without any major pathologies, no tendency to self destructive behavior
6. Users scare by high level transmission of HIV
7. Old using population (Mean age 47 yrs) have no veins anymore
8. Hardly any injectable cocaine and amphetamine available in Amsterdam

OPEN DRUG SCENES

Drugs scenes appeared early and were met with systematic prevention. Well known is problem development in the Zeedijk area, a deprived city area with demolished buildings and slum characteristics. This was met with policing and extensive redevelopment programs creating an area without narrow alleys, squatters and hidden porches of open drugs scenes.

At present there is no specific open drug scene even though users tend to gather in some areas causing repeated actions by the police and the outreach social services.

OBSERVATIONS

Problems in Amsterdam arose early with the typical development from cannabis use integrated in anti-establishment culture towards increasing use of heroin in disadvantaged groups. Initially these problems were met with measures of prevention and repression in Amsterdam as elsewhere. In spite of measures, the city experienced a growing group of drug users developing problematic and self-destructive behaviours. The Amsterdam City Council asked the Amsterdam Municipal Health Service to develop strategies to reach the “unmotivated drug users” and adopted a public health approach both to contain the “drug epidemic” and to meet the specific needs of the group.

These recommendations and trials were the origins of harm reduction as a systematic policy. One characteristic trait was attempts to separate “soft drugs” (i.e cannabis) from “hard drugs” (in particular heroin) (2;4). Drug use was not seen as a crime while professional selling was. Dependence is regarded as a disease to be met by health care measures.

Another trait was heavy investment in low threshold methadone dispensing from the Municipal Health Service (2). Mobile dispensing from busses was started in order to reach marginalised groups and to overcome resistance from unwilling neighbourhoods. Methadone dispensing from police stations was initiated to reach deviant and antisocial groups and to enable continuation of treatment at arrests and imprisonments. Needle dispensing was also a part of the picture as was shelters and contact centres. In this way the city almost from the beginning developed a systematic policy of harm reduction and survival policies. This is last ten years supplemented with heroin assisted treatment, compulsory treatment within mental health systems and quasi-compulsory treatment in special prisons.

Open drug scenes was from the beginning systematically met with policing and an extensive redevelopment programs in exposed areas (1). As the drug scenes increased, the policy shifted towards more emphasis on dispersion of scenes, urban safety programmes and application of intensified persuasive and compulsive measures towards street addicts. Any public gathering of more than 4-5 addicts is to be interrupted by the police with basis in administrative laws that authorise fines. If the users do not pay their fines, this might result in court verdicts followed by arrests. Users could also get law-enforced orders not to visit certain parts of the city. Bless (1) states: Amsterdam shows that a consequent and persistent approach along these lines can be quite effective to keep the scene on the move and prevent major concentration of drug users. One premise is that problematic drug users repeatedly causing nuisance, might be subjected to compulsory means, including choice between prison and treatment. The system is presently met with broad user satisfaction. There is an influential user organization, at present with no specific criticisms.

Another aspect is the tradition of “Red light districts”, areas with legal or semi legal prostitution and tolerance towards deviant behaviour. The Dutch tradition seems to contain a high tolerance for self-determination as long as there is no public nuisance. The police have traditions for the making of alliances with deviant groups and to find sorts of compromises where the law is practised leniently or adapted to situations where non-action might be sensible.

By combinations of these traditions, a well developed harm reduction strategy and systematic prevention of open drug scenes and public nuisance, the problems has been kept on tolerable levels. The scenes are there but in dispersed and only semi-open ways. Drug use is a problem, but a tolerable problem. At present the main emphasis is 1. To develop the heroin assisted treatment programs, 2. To increase integration with psychiatric treatments system, particularly with assertive community teams (ACT) 3. Strengthen comprehensive treatment in view of co morbidity problems and 4. Strengthen treatment within prisons and 5. To integrate health system based addiction services, social service systems and mental health systems.

FRANKFURT AM MAIN -"TAUNUSANLAGE AND USER ROOMS"

City profile is based on papers by Bless (1) Hedrich (9), Kemmesie (10;11), COST A 6 working group meeting in Frankfurt and visits. Reinaas et al (5), Waal (7). EMCDDA national report 2009 (12).

Visit 14092010: Presentations by and discussions with low threshold drug coordinator J Weimer, heads of public prosecution office: M Bechtel and Buchhold and Police Commissioner Thomas Zosel. Visit to East side contact centre and shelter, DCR contact centre and user room, Central railway station area.

GERMANY

Core socioeconomic factors: Germany has a population of 82 mill. The largest in Europe. The unemployment has traditionally been low and is still below average in Europe. North Germany has specific characteristics being dominantly protestant and traditionally high level industry with strong labour movement. South Germany is traditionally catholic and more conservative. Mid Germany is mixed both in religious and political affiliations. The nation is a federation of 16 federal states, each with parliament and federal government. Hessen is the largest state in Mid Germany and Frankfurt the largest city. Generally, there is high standard public health and social services, but there are large variations in organizing and in standards (public/private, type and coverage of insurance). There are also considerable variations in drug law understanding.

Core drug policy elements: Germany followed for a considerable period a restrictive drug policy with abstinence oriented treatment and active drug use restrictions. Harm reduction measures were increasingly enforced during the 1990's, particularly voiced by politicians, law enforcement, social service and socio-political pressure groups in Hamburg and Frankfurt. The "Frankfurter resolution" is a policy document adopted by several European cities in a meeting in Frankfurt. The main messages are that restrictive policies should be replaced by health oriented and to emphasize harm reduction more than abstinence in treatment. Since then MMT has taken a major role in treatment of heroin dependency. HAT has been tried in several cities and is presently a treatment option in 7 cities, among them Hamburg and Frankfurt. There are large differences between states and each state will have to be evaluated on its own premise. Of particular importance is German Narcotics Act §31a that provides possibility to discontinue prosecution for certain drug offences. This provides the public prosecutor with an instrument to decide proceeding without court approval. Act §31 originates from the office of the public prosecutor and the Faculty of Law in Frankfurt where it was elaborated as legal ground for reforms. At present this act is implemented in all German states but in differing understanding.

Drug use situation. Germany has roughly average drug use prevalence. The most used substance is as everywhere cannabis, particularly in the young and young adult population. As variations among states are very large and as several of the investigations are limited to one state, national statistics are difficult and unsure. Measured by use last 12 months and last

30 days, the increase in use has stopped and prevalence is somewhat lower. For comparisons state-wide statistics are recommendable. National estimates of number of problematic drug users is based on multiplier methods using drug related mortality and police contacts. The number calculated is in the range of 82000 – 156 000. This corresponds to a prevalence of 1.5-2.8/1000, unchanged from last years but lower than earlier (15-64 yrs of age). This estimate is on level with the Norwegian (1.6-2.5/1000).

CITY CHARACTERISTICS

Frankfurt is the main city in the federal state Hessen but not the capital. It is a banking city with European central bank. Population: Hessen: 6, 2 million. Frankfurt: 670 000 inhabitants. The city has 43 local city administrations. The Frankfurter resolution is a policy statement from a city conference in Frankfurt. Representatives from several cities opposed to the “fight against drugs” gathered and made a resolution advocating a harm reduction policy. This resolution influenced the city’s choice of policy and subsequent strategies to close open drugs scenes. The city was also among the first to invest in injection rooms/user rooms. On this background the city’s situation and experiences is of specific interest.

DEVELOPMENT

1960 → 1975 from student protests to open drug scenes. A “flower power” type use in “Haschwiese” developed into multi-problem scene around the central station. City measures: Abstinence orientation treatment and police repression

1975 → 1990: Period of chasing around with conflicts and changes (liberal-restrictive), increasing problems. A high level coordination and planning committee Montagsrunde was established in 1987 and a City coordination office in 1989.

1989 → 1992: In the late 1980’s the city experienced a dramatic increase in social deprivation, misery and overdose deaths, peaking in 1991 with 147 deaths. “Taunusanlage” was an open drug scene: in an inner city park belt visited by up to 1000 addicts per day. The availability of heroin rose and the prices fell. Outreach and low threshold consultation in vain, repression futile.

1991→1992: A working group established understanding for new policies. “Mit Drogenabhängigen leben”. This was adopted politically as policy document.

1992 Final closure of Taunusanlage with pre closure enlargement of harm reduction facilities: A new drug policy based on 1. Coordination of measures and administration, 2. Strengthening of harm reduction with OMT, user rooms, counselling services and 3. Zero tolerance for drug scenes. Non-city inhabitants were to be returned. First injection rooms were established in 1994.

1992→ present. Reduction of problems, drop in overdose deaths, reduction of drug offences, reduction in use, increase in satisfaction. Present situation is acceptable even if problems still present-

Drug problems in Frankfurt

Drug problems were among the main city problems growing until the closure of the Taunusanlage and introduction of new drug policies. Since then the number of users has stabilized and decreased. Table 2 shows the numbers of heroin users. The prevalence of injections was and is high. As can be seen, the number of users is higher than in Oslo.

Table 2 Number of problem heroin users in Frankfurt 1995-2005

1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
5.796	4.590	5.086	3.138	3.205	3.747	3.958	4.044	4.174	4.275	4.353

Contextual observations

The development in Frankfurt is characterized by increasing crisis until 1991-2 when the situation was experienced as intolerable and as a threat to the choice of Frankfurt as location for European central bank. This caused a combined willingness to finance changes and willingness to implement coordinated policies. The policy was based on a combination of

Fig 4 . Chart over drug policy in Frankfurt.

-

Drug policy City of Frankfurt



4 Column Model

1 Prevention

2 Crisis and Survival

3 drug free programs

4 Repression

aims:

- 1 prevent drug consumption
- 2 harm reduction; social (re)integration
- 3 kick on processes to lead a drug free life
- 4 fight criminality ; reduce public nuisance

target groups:

- 1 – young persons (up to 28 years)
- 2 – addicts and users with problematic patterns of consumption
- 3 – people who want to quit drug consumption
- 4 – dealers, addicts with criminal deviance and creators of public nuisance

03.09.2010

prevention, therapy, harm reduction and repression – the latter balanced to prevent marginalization of drug users. The initiator was the major of the city, the Police Commissioner and public prosecutor played a central role. As can be seen in figure 4, the policy is developed as a four pillar policy, very much in line with the other described cities. Crisis and survival measures are the harm reduction elements while the city also emphasises treatment after the model of abstinence oriented programs.

Present treatment system

The treatment system that was developed in the 1990's is largely the same today. There are 5 public MMT clinics with 470 places and in addition 3 centres with policy of maintenance to Abstinence (90 places). Further MMT is available in 10 clinics based on 19 GP's. Heroin assisted treatment is available in one of the clinics in a small program. Further the city has inpatient treatment both "drug free and methadone based, in all 260 places and special apartments for maintained patients (114) places. 1200 are in MMT and 100 in HAT, in all roughly 30%. In addition a substantial number is in MMT through GP-based treatment and abstinence oriented treatment. Roughly 55% of the heroin dependents are in some sort of treatment, 21% are homeless and more than 70% unemployed. The capacity in the MMT system is largely sufficient. Methadone treatment is provided as center-based treatment and no low threshold methadone treatment in bussing systems are available. However, the intake procedures are rather simple, mainly by medical examination.

Crisis and survival help is available in 5 contact centres with cafe, social interventions and medical care. There are 5 shelters with in total 155 beds and additional 20 emergency beds. Four injection rooms coined "consumer rooms) have a total capacity of 35 users at any time during opening hours.

Eastside is the largest contact center, also with injection room. It is presently well established and a well functioning system that now can be characterized as a social pedagogic treatment centre aiming to increase the patient's abilities. It also has crisis intervention facility for homelessness.

Control sector

Until 1991 Frankfurt had restrictive policies with heavy emphasis on demand reduction through prosecution of users. All use and possession of illegal drugs was subjected to obligatory prosecution and punishment. During the development of the Frankfurter policy, the office of the Prosecutor General developed amendments of the Drug Law, Act §31a. This states that even though all use and possession is forbidden, the reactions should be balanced according to the public interests. The public prosecutor has the authority to decide the case with a waiver not bringing the offender to court. This is extensively used. Minor offence is usually 5-15 g cannabis, 1 g cocaine, 1 g heroin and 1 g crack. The state prosecutor deals with between 7000 and 8000 drug related cases every year. And in most cases it is decided to give a waiver. Amount of drugs and frequency of arrests are emphasized. The names of those prosecuted are noted in a local registry, but not in the national criminal offence registry. All dealing and sales are, however, prosecuted and tried for court. Initially and by moderate quantities, the reactions are fine and by repeat offence and more serious offence, the verdict is imprisonment.

The police force and the prosecutor's office are divided in federal criminal police force with narcotic squad and city police with public order priorities. There are 20 police stations. The police cooperate both on call and by patrol with the contact centers and outreach social services to prevent open drug scenes and other types of public nuisance. They do not generally enter contact centers and consumption rooms unless called as crisis intervention, but might have access if suspects are believed to be on the premises.

Basic to the thinking of the police is that drug dependents are sick persons. The public health approach has priority and the disruption of scenes is seen both in a public health and in a public order perspective. The prison system is poorly integrated in the comprehensive treatment system. Treatment is dependent on prison doctors with varying competency. Individuals in MMT will usually have their treatment continued in short term admissions but will be subjected to detoxifications at long term. MMT is not initiated within prisons. Mortality upon release is a known problem. The topic is under discussion with several reforms planned.

Coordination

The strong tradition of cooperation is now an integral part of the day to day work, and as problems have decreased, coordination is reduced in frequency and geared more towards monitoring the situation and to meet consecutive problem. The “Monday round” was originally a city task force headed by city council comprising the heads of public prosecutor, the city police, the council for health and social administrations together with publicly elected members. This group met weekly securing continuity and comprehensiveness. As the city problems diminished, the Monday round is changed and meet every 2 weeks chaired by the drug policy coordination office that plan and implement target oriented sub teams according to concepts and reports and specific problems that might arise. The task forces are established through allocation of relevant resources and resolved when the task, the problem is resolved. The police representative forwards from the Monday round to a liaison officer that enables police task force and for instance at present directs at least 6 police officers at any time in the current drug scene at the central station area.

The “Monday round has been supplemented by the “Friday round” consisting of the leaders of control sector and clinical and social work facilities that used to meet weekly in order to establish contact and trust between police and social work. This yearlong process has been successful so this group currently meets four times a year. This round will adjust roles and direct relevant forces to problems that might arise and needs not met.

OVERDOSE MORTALITY

Figure 5. Drug related deaths and development of drug policy in Frankfurt am Main since 1985 (by courtesy of J Weimer)

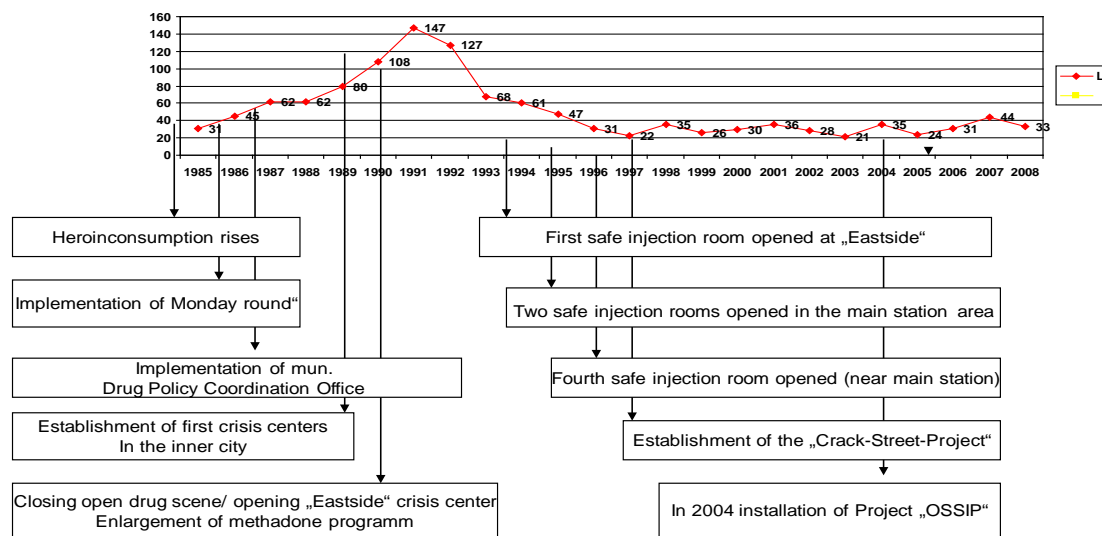


Figure 5 shows the number of overdose deaths in relation to city measures. The figure demonstrates that the number of deaths increased with the rise of heroin consumption until the combined efforts of closing the drug scene and implementing increased services in shelters and contact centres. This was based on cooperation of control sector and treatment sector with available methadone maintenance. The contact centres were supplemented with injections centres somewhat later. The last 10 years the number of overdose deaths has varied between 20 and 40, roughly 1/3 to 1/2 of the numbers in Oslo

OPEN DRUG SCENES

Frankfurt is often cited as a city that has succeeded in curbing a large open drug scene and in integrating users. As described in the overview, the open drugs scene relocated itself several times during the period of one-sided attempts at police suppression until a large scene with more than 1000 addicts grew in the Taunusanlage, a park area between the old and the new opera building. The park has large financial buildings on both sides. The scene grew in spite of several attempts on helping measures and periods with suppression, largely pushing the addicts towards a “red light” district in the vicinity of the central railway station. In 1992 the Mayor decided that the open drug scene in the Taunusanlage could no longer be tolerated, a decision met with opposition and demonstration. Harm reduction approach had been developed; contact centres and methadone slots were enlarged and decentralized, before the closure. A large shelter with cafe, shelter and methadone out patient clinic was opened in former industrial buildings remote from the city centre. Drug users not belonging to Frankfurt were expelled while helping facilities at the same time were established in their home communities. Users in the city centre and at the scenes were bussed to the contact

centre in the periphery. The first safe injection room was established in 1994 and three more in 1996.

The open drug scene is no longer a significant problem. The basic premise is claimed to be the effort for “living together”, accepting that drug users exist while at the same time preventing the gathering of open scenes and insisting on reduction of public nuisance. Emphasis is also put on positive experiences with the user rooms. Measures should be a combination of prevention, therapy, harm reduction and repression – the latter balanced to prevent marginalization of drug users. After several years of systematic work, the large scenes are presently of the past. However, there has been a continuous establishment of new drug scenes. These have been kept under control with continuous forces and follow up by police, health and social services. Tendencies to recurrence are systematically met by outreach social services in cooperation with city police.

Currently there are 4800 known drug users in the police registries, and the majority of these do not cause any trouble. There are approximately 200 to 300 who belong to the drug scene around the central train station in Frankfurt’s red-light district. However there is a small group of 30 to 50 persons who are “causing trouble and are viewed as unruly and with no respect for the police”. During summer 2010 these people have receive increased attention and there are increasing demands from shop owner and other stakeholders to clean up the area.

OBSERVATIONS

According to our impression, the present treatment system is well received, according to our information, both by the public and political system. Continued police interruptions at the central railway scene might cause aggressive reactions by a minority, but in general the evaluations are positive. During our visit we got the impression of friendly, but also of “non nonsense” attitudes in the shelter we visited, East side. The rooms were closed in day time, the rules for conduct quite explicit and exceptions were only accepted in very special cases; “This is a free country. If they do not want to stay here, they can leave”. One impression was a development of pedagogic and growth-related strategies. The consumption rooms gave similar impressions.

The original system of harm reduction and zero tolerance for public nuisance seems to be integrated in the city representatives and the different bodies. There is a strong emphasis on integration of user, but also an expectation of compliance. The original system of returning non-city citizens to their home places is not as effective as it was. Other regions and cities have often poorer facilities and low willingness to receive addicts for follow up. A return ticket to Frankfurt seems seldom to be the result.

The capacity in the health system and social services is relatively satisfactory and there are no waiting lists in MMT or shelters. However, capacity for long term rehabilitation seems

unclear, (650 places in the state of Hessen for drug free long time therapy, up to 6 months and more) and there is the relatively high level of homelessness and unemployment.

Users who sabotage or neglect rules are often asked to leave, if necessary with assistance of the police but this is not a large problem. Difficult and violent users are subjected to court proceedings according to possible crimes and might also be handled with administrative regulations. It is expected that the mental health system should take care of addicts with psychiatric disturbances, but it is not clear whether this functions. The HAT program is at present not structured to treat the most problematic users and of no specific avail for open drug scenes or overdose mortality.

Present situation is experienced as acceptable and planned to continue along the developed lines. It is partly felt that a certain level of problem should be expected and should be integrated in a city of Frankfurt size. However, long term perspective is emphasized. There are no fast solutions. Several years' perspective is necessary to deal with open drug scenes and continuing efforts important to prevent recurrence. Coordination of control and harm reduction sectors is mandatory with continuing willingness at problem solving and monitoring.

VIENNA- "ZUSAMMENLEBEN" AND "ZONES OF TOLERANCE"

City profile is based on Waal 2004 (7), interview with Michael Dressel 2004, discussions with Alfred Uhl and Alfred Springer 2004, reports Ludwig Boltzmann Institut für Drogforschung (13;14). 3de Multicity report Council of Europe 2000 (6). EMCDDA national report 2009 (15).

Visit 13092010: Presentation by and discussions with Professor A Springer and Dr med Hans A Haltmeyer from Verein Wiener Sozialprojekte (Viennese social projects), Drug Coordinator Michael Dressel, Drug Commissioner of Vienna, Dr Alexander David and project coordinator Angelina Zenta from Such und Drogenkoordination Stadt Wien. _Visit to the Karlsplatz police station discussions on practice and problems with major Dietmar Berger and police officers, "Viennese social projects" with the managing director Mag. Robert Öllinger and with head of out reach social worker team. Visit to Karlplatz area and to contact centers.

AUSTRIA

Some core socioeconomic factors: Austria is a German speaking border state with central European states in close contact with the Balkan region. The population is **8.3** million. Austria is a federation of 9 states, each with parliament and government. The police are organized federally, and there is no city police/local police.

Core drug policy elements: Austria had initially a restrictive supply reductions oriented policy. This was markedly changed in direction of harm reduction after problem increase with concomitant discussion in the 1990's. Drug policy has now a federal and state based coordination with federal and state drug coordinators. The policy is influenced by social democratic and social psychiatric thinking. This induces primacy of social problems and a need for integration. Austria is particularly known for the ideology of co existence and zones of tolerance – areas where drug use life should be observed and controlled but tolerated. Diversification is a general ideology. Problems should be spread and the user integrated. A national tradition is a high emphasis on sustained release morphine as maintenance drug (Substitol® and Compensan®).

Core treatment characteristics: 2008: 11119 in OST, 1570 first time, 9549 in continued. Present development is in direction of evaluation and diversification. A national documentations system, DOCLI, is established to monitor the system.

Drug use situation: Life time prevalence of use: 20 % cannabis at least once (up to 40% in young adults), other drugs 2-4%. 12 months prevalence: Smaller: use of illicit substances mostly experimental use in transient period. Problematic drug users: 2007: 22-33 000.

Drug related deaths: 2007: 175. 2008: 169 confirmed by autopsy, total number 201 drug related. There are almost no overdose deaths without opioids.

Drug related crimes increased until 2005 followed by a gradual decline. Status 2008: 1959 misdemeanors, 17121 felonies.

City characteristics

Vienna is the capital of Austria and by far the largest city with 1.7 million inhabitants; 20 % of all Austrians. The city has 23 districts with local administrations. Drug policy is organized with coordinating office subordinated to the city council, headed by a drug coordinator. A drug commissioner in the health administration monitors and plans treatment development. The city has long social democratic traditions and public housing is an important element in housing projects with 200 000 flats for rent. Social work is organized through non governmental organizations. The largest in the drug sector is Verein Wiener Sozialprojekte that is commissioned by the city for prevention; out-reach social work, contacts centres with low threshold, social work. There is traditionally high emphasis on vocational rehabilitation and a multitude of labour projects.

DEVELOPMENT

→ Late 1980's: Gradual increase from cannabis use to heavy opioid involvement, growing to public concern

1990 → 2000 drastic increase in problematic use with open drug scenes and heavy social problems. Mid nineties brought an experience of crisis. After extensive public and political discussions combined coordinated measures to containment and reduction of the problems were developed.

2000 → Stable period, strengthening of measures, continuing expansion of treatment, relative containments of problems but still high level. Ideology of conflict resolution and "zusammen Leben.

2004 → Increased emphasis on control of open drug scenes, the last closed in 2010.

Drug problems

Cannabis use (lifetime): 1993: 5%, 1997: 12%, 2001: 14%, 2005: 17%, 2007: 19%, 2009: 16%. At present estimate of cannabis smokers: 100000, mostly socially integrated, not in treatment.

Other drugs: 2-4%, top year 2007, except opiates: Top year 2009 (3 %)

Problematic poly drug use with opioids: 2001: 10000, 2004: 6-8000, 2010 10000 – 14000 (7000 in OMT). Roughly 40% of the heroin users inject.

Cocaine/i.v heroin users: 500-1000: mostly outside treatment system. Cocaine snorters: 30-40 000 (not in treatment). 10% of the users are Hiv+.

Contextual observations

Vienna has experienced the typical gradual problem increase from cannabis use to hard core problematic drug users, although somewhat later than the other cities described in the report. The societal reactions seem initially less repressive with development of a policy of tolerance and an understanding of dependency in light of social deprivation and mental health

problems. Drug related problems were seen as conflicts between the interests of the drug user and of the public and the approach was to negotiate the conflict and find acceptable solutions with the aim that the users and other inhabitants in the city should live together. “If they do not disturb us, we shall not disturb them”. Clear and shared limits were to be applied within setting of conflict management. This system was accepted by the police, the social workers and by the users as well as by politicians and general public as long as public nuisance was on a tolerable level.

For a sustained period this approach contained the problems on manageable levels even though with continuing political conflicts and critics. However, the policy of tolerance has presently lost support as the sustained problems became too high. At present there is the usual European attitude of harm reduction and zero tolerance for public nuisance. Present development emphasizes empirical evaluations, monitoring and diversification. Heroin dispensing is not planned but the possibility of injectable sustained morphine is launched. Injection rooms are not available. The principles are: all abuse should be rejected and interventions should be guided to minimize individual and societal damage, through punishing dealers, treating addicts and counselling users. Policy is developed with four pillars; prevention, health related measures, social measures and public safety. A leaflet advising on acceptable behaviours and treatment possibilities has wide distribution.

Treatment system

Opioid maintenance treatment based on methadone was officially introduced in 1987. Sustained release morphine and buprenorphine was made available in 1997. The numbers in treatment has increased. 4500 were in treatment in 2004 and 7000 in 2010. This is roughly 70 % of the problematic opioid users. Characteristic for Vienna is the high level use of sustained release morphine (SRM). SRM is more accepted by the users and also popular with the doctors. In 2010 60% of patients in OMT used SRM and 16% methadone. According to Austrian studies SRM has lower level side effects and higher level patient satisfaction. There has been a large national conflict on the subject of SRM with voices accusing SRM to be associated with high level diversion, to be used as introduction to opioid use, to be suited for and attractive in intravenous use with different types of complications. The data for this is scarce, but SRM is found in a high percentage of over dose death cases. Injections are well known.

OMT is generally initiated and monitored by general practitioners and some of the problems might be associated with insufficient competency by the average GP. As GP's are especially reimbursed for OMT in Vienna, the treatment is attractive for the general practitioner. A special commission, the *Vienna Expert Commission on Opioid Substitution Treatment*, has been appointed. At present new regulations state that 40 hours training program is necessary. The Ministry of Health has now decided that buprenorphine should be the first line drug, causing some decline in use of SRM.

The dominant pattern in Vienna is that GP's are responsible for OMT. In 2010 14% was treated in specialist centres and 10% by psychiatrists in private practice. One main problem is overprescribing of benzodiazepines, mirrored in the overdose numbers and also in selling patterns on drug scenes. Another problem is insufficient comprehensiveness in treatment. Half of the clients that seek drug help centres are in opioid substitution treatment.

A marker of the Viennese system is high availability of low threshold social care and counselling. This is mainly commissioned through contracted services from a non-profit organization “Verein Wiener Sozialprojekte”, originating from the cooperative movement. This manages a special division of out reach social services and 4 contact centres with counselling, dispensing of clean needles and utensils, cafe with very cheap food, services for laundry, vocational counselling etc. OMT might also be available. The outreach had 580 consultations each day in 2009. 2.6 million Needles and syringes was dispensed, 95% of these as exchange. It is also possible to exchange filters and tin to cook up the solution.

Housing is one of the preconditions in Vienna. It is decided to integrate drug users into the community. Presently there are enough housing facilities. The policy is that no one should live in the streets. The 200 000 flats belonging to Vienna ease integration. Additionally there are non-profit companies that provide apartments to people who do not earn enough to rent there own flat. The policy is that everyone should be made fit to be able to live in apartments. Sooner or later they have their own flat. Of special interest is an early warning system; if someone is kicked out of a flat, this are immediately reported to social services. Those that cannot live in an apartment by themselves will be provided with a cared facility and receive assistance. However, they have to keep to the rules to keep the flats. Additionally there are also low threshold facilities

Consequently, there is high availability of maintenance treatment and crisis interventions and high availability of low threshold medical and social services. User rooms are not seen as essential even though wished by some

Control sector

Austria has only federal police and no specific city police. The policing role is to investigate drug selling and bring dealers and especially organized drug crimes to court. On city level, the police participate particularly in maintaining public order and assist the social workers. All gatherings of users that may disturb others are interrupted. If necessary is users arrested and brought to court for misdemeanour resulting in fines. Courts have a variety of structured and differentiated penal measures at hand. The majority of the cases detected by police do not go to court. The majority of court cases do not go to prison but to treatment. Other control sector is mainly the health authority of the city e.g. control of OMT and pharmacies. OMT is available in all Austrian prisons, both judicial and police prisons, but there are problems with the period directly after release of prison with a high risk of overdoses

Coordination

Austria has built a nationwide system with federal drug coordinators and local coordinators. A close cooperation is established in Vienna with a drug coordinating agency under the supervision of the major and the city council. This agency coordinates all the activities for prevention and assistance for drug users in Vienna. The agency implements and finances most of the following measures: 1. Prevention of addiction, 2. Medical, psychological and social counseling, treatment and care for persons who are in danger of becoming addicted or who are addicted to drugs. 3.Rehabilitation and social integration for persons who are in danger of becoming addicted or who are addicted to drugs. The coordinator has regular meetings with the relevant police levels and the treatment and harm reductions institutions. Even as the policing system is strictly federally organized, the city level officers are

integrated in the coordination efforts based on a general agreement of cooperation with social sector.

Secrecy on information on individual level is maintained between control and treatment sector. Data on users in treatment e.g. users in OMT will for instance not be reported to police that controls driving license. However, there are specific regulations regarding special situations such as cooperation between drug institutions and youth office, school, or Austrian army.

OVERDOSE MORTALITY

Overdose deaths numbers have decreased since the period of crisis. In 2009 169 – 201 cases were reported drug related, 169 verified in Austria in total. In the period 2005-2007 there were in average 141 “drug related deaths” in Vienna. This is lower than expected from the share of heroin dependants in Austria. Most died by a combination of drugs, usually opioids and benzodiazepines. 75% was found with benzodiazepines and 20-25% with alcohol. Only 5% was found only with heroin as opioid drug while 58% was found only with morphine and 12% only with methadone. The message seems to be that the main overdose number presently originates from use of SRM or methadone combined with benzodiazepines and/or alcohol. Heroin-induced deaths are infrequent but deaths by substitution medication are a large problem. This would bring focus on the dominant role of the general practitioners with poor traditions in control and supervisions of patients. Possibly the routines for take-home dosages are somewhat liberal. Compared to Oslo the number of overdose deaths is roughly double but the number of opioid dependants is threefold.

OPEN DRUG SCENE:

As described the policy has been to combat user areas by diversion and “zones of tolerance”. Originally several small satellite drug scenes existed. But gradually these decreased and the last such zone was a part of the park at Karlplatz where 40-50 users were tolerated at one time. Roughly 1000 belonged to the scene. Outside the zone no more than 4 to 5 persons were allowed to gather, particularly not in the subway. If more than 10 users gathered outside the zone, they would be asked by the police to move and to spread or to go to the zone. The zone was under police surveillance and a scene for outreach social workers. There was otherwise no service at scene according to a strategy not to increase attraction. This constitutes a precarious balance between too much control and restrictions (repression) and too little (too much tolerance). Gradually this was judged to be difficult. The main problem with the open drug scene was the visibility of drugs and intoxication. There were no injections on the scene, but nearby toilets were used as injection rooms. Karlplatz was a very convenient place for an open drug scene with liquor sales, food stalls, malls and a centre for several subways and busses. The scene was primarily a centre for small scale dealings, and few foreigners and criminal organizations were in the place. As the problems continued and increased, the media focused the problems repeatedly. The status for the last years was that Karlplatz had become the main place for dealing with morphine and benzodiazepines. The

heroin peddling was not as visible and not so much a public nuisance. The heroin business is largely dominated by Nigerian groups peddling in a system using the subway stations.

Closing down on Karlplatz (the only place where more than 10 to 20 people were allowed to meet) was the last step in the action that started 7 yrs ago. As the station was to be reconstructed, this gave an opportunity to close down the scene completely. So far the park has been reconstructed with increased visibility and no areas to hide. The bus station will now be reconstructed without any mall. Although some shops are remaining, most will be removed. Prior to the closure of the scene social services increased counseling and shelter availability. Further cooperation between social services and the police were improved. A special task force was established to enforce the rules and new treatment places were opened. The staff in the contact centers was enlarged and 2 new places for needle exchange established. The capacity of the night shelter was doubled. The contact centre and needle exchange that had been located at Karlplatz were moved from the area while the street worker contact group remained.

A long debate preceded the closure with suggestions to make the area less attractive to users such as to reconstruct the scene into an art scene, to decrease shopping areas and so forth. But when it was decided to close Karlplatz down there was considerable time pressure. A new treatment centre was built in three months (Feb. 2010 to May 2010). In June the drug scene was closed down. Initially the changes caused unrest among social workers/street workers that complained that they lost the overview of the scenes and had decreased opportunity for contact establishments. At present there is general satisfaction. However, continuing intervention to prevent the reestablishment of the area is necessary. The earlier experience was that when the police stepped through the scene, the users parted and then they returned. At present the strategy is to enforce police authority and prevent any open scene. At least 2 police are always in sight. It is believed that this measure will have to be maintained at least for two to three yrs. There is currently no knowledge on how the black-market develops. The goal is to get drug users into the treatment system. No one should need to buy illegally on the black market.

OBSERVATIONS

The basic concept in Vienna is the consensus that addicts are sick people and primarily a responsibility for the health care and social care system. The principle is treatment for addicts and repression for dealers. Users are generally not imprisoned. Maintenance treatment shall be available, if necessary low threshold on demand. There is high emphasis on outreach and low threshold services.

The drug policy was designed in 1992 and 1999 and is still valid even though the policy of zones of tolerance is discarded. A huge increase of institutions and personnel in the last 20 years has been necessary. The main problem today is social reintegration of stabilized clients. One specific problem is the difficult situations on the labor market.

Most users can presently find treatment in variety of therapeutic settings: low threshold, measures of harm reduction, counseling centers, GPs and inpatient treatment. Only a minority is outside treatment system. User's satisfaction is reported to be high, but more psychiatric help is needed for poly-morbid users. Precondition for the system is a high level of health and social care. No drug users shall be without a home and the homeless care services encompass all users. Nearly 100% covered by health care system and social insurance.

According to the reports, there are only minor problem with difficult users. Users who sell drugs on premises, use violence against other clients or threaten personnel will be excluded. Nevertheless they can find treatment in any other institution. Further, continuation of drug use is no cause to be excluded from treatment. Violent users are very few and dealt with individually. As a last measure police is called in. Last years saw an increase of the role of psychiatrists in drug institutions. Psychiatric treatment has been specified to needs of mentally ill users.

In sum: the Vienna system seems to be a well functioning system without heroin dispensing and injection room facilities. The basis is high level social and health system operating on a harm reduction model concomitant with emphasis on prevention of public nuisance. An earlier policy of zones of tolerance, roles of conduct and conflict management is largely modified and zones are closed. The level of overdose mortality is acceptable, even though maintenance drugs seem to be the main opioid drug involved. Open drug scenes are presently prevented through continued police surveillance and out reach social service interventions. A concept of diversified OMT with several types of opioid agonists is interesting. The high level private GPs responsibility (all costs covered by national health insurance) and small level public health care might be suboptimal.

ZÜRICH - HEROIN TREATMENT?

Profile is based on Bless (1), Uchtenhagen A(1;16-18), Klingemann HK(19), Falcato (20), Fuchs et al (21), Huber C (22), Stohler R (23) (M Hertzog: 2004 How to prevent an open Drug Scene? The Zürich Experience.) 2004 Pompidou group report, Waal (8).

Visit 14092010: Presentations by R.Stohler/M. Liebrecht: The Swiss and the Zürich treatment system, A. Feller: The city municipality's strategy for a city-compatible consumption pattern of psychoactive substances, Captain Beat Rhyner Criminal Investigation division, Major Felix Lengwieler High Crime Areas division: Actions on a national and cantonal level and street level law enforcement: Some lessons and some accentuations: A. Moldovanyi: Special treatment initiatives to overcome the open drug scenes. Discussions. Visit in MMT treatment centre, HAT treatment centre, detention centre, drug testing office

SWITZERLAND

Some core socioeconomic factors: Federation of 26 cantons, each with parliament, government, judicial system. The administrative system is complex with high level decentralization from federal government to cantons and municipalities. Total population is 7.6 millions. Economy is sound and unemployment low level. Most cantons have high level health systems and social care. Systems are mostly public but there are differences between cantons.

Core drug policy characteristics: Switzerland has for several years based its policy on a health understanding of drug problems with public health responsibility. The first stage was a well developed drug free (abstinence oriented) treatment system. Subsequent on a national crisis a national program, the “Four pillar Drug policy” was developed in 1991:

Pillar I Prevention:

- Professionalised regional agencies for drug prevention
- National awareness campaigns
- Cantonal project „healthy schools“
- Evaluation of prevention projects and agencies
- National programme for targeted prevention
- Prevention activities and health promotion in prisons

Pillar II Harm reduction

- Syringe/needle exchange programmes in cities
- Syringe/needle exchange programmes in prisons. However, this is not the case in most prisons
- Supervised injection rooms in cities
- Health care for substance abusers (every Swiss resident must be insured by a health insurance company)
- Vaccination programmes for Hepatitis B
- Sheltered workshops and day programmes
- Supervised apartments
- Low-threshold contact centres
- Outreach work
- Low threshold substitution

- Low threshold medical care
- Safe injection kit
- Availability of bleach (also in prisons)
- Availability of condoms (also in prisons)
- HIV/Hep testing incl. counselling
- Safer sex counselling

Pillar III Treatment

- Increased availability of all approaches
- Documentation and evaluation of drug-free residential treatments (FOS); national register on internet (infozet-direct, see www.infodrog.ch)
- Implementation of quality standards (QuaTheDA)
- National study on detoxification methods
- National project on Heroin-assisted treatment (PROVE)
- National consensus conference and guidelines on substitution treatments (NASUKO/SSAM)
- National programme for continued education of professionals and curricula development

Pillar IV Control – law enforcement

- Increased police presence in cities
- Zero tolerance for open drug scenes
- Tolerance for hidden drug scenes without negative consequences for neighbourhood
- Zero tolerance for drug injecting in public
- Special police detention centres (assessment/placement/ repatriation) for drug users
- Compulsory treatment for alcohol dependency accepted but only in some cantons.

Drug use situation Number of heroin users: 1975: 3250, 1993/4: 33000, 2007: 30900.

Treatment: Numbers in treatment increased and now stabilized:

	1993	2000	2002	2004	2008
Drug-free residential	1250	1 390	1300	1100	1500
MMT	12100	16 000	18000	15300	17500
HAT	309	1 037	1087	980	1300

At present is 54% in treatment.

Overdose mortality (Data include foreigners unntil 1997)

1991	1993	1995	1997	1999	2001	2002	2003	2005	2006
405	353	361	241	181	197	167	194	211	193

CITY CHARACTERISTICS

Administrative city in canton of Zürich and a banking capital. Population (2004) 365 000, Population of canton: 1.2 million.

DEVELOPMENT

1960 → late 1970 “Flower power period”

- Slowly increasing drug problem
- Abstinence oriented treatment, first methadone programs
- Out-patient drop in, mobile emergency centers, self help groups, parents association

1980 → 1990 Development of crisis

- Political and social controversies – schismatic polarization
- Campaigns for youth autonomy – solidarity with users
- Drug scenes – Platzspitze from 1986 – attracting users from surrounding cantons and countries
- 3000 visitors on the scene – out of control
- Increasing criminality – drug related mortality tripled
- Increase in multitude of help and treatment
- Development of “aid for survival” (shelters, primary medical care, meals, work – offers and needle-exchange, no – preconditions methadone programmes “street rooms” – fixer cafeterias, drop-in centres with cheap meals, showers, toilets and Laundromats.)
- Problem: “strong pull-effect” , a “subcultural world of its own”

1990 → 1994/5: Towards a joint national policy

- Three leading political parties developed a joint drug policy platform
- 1992 Final closure of Platzspitze -
- Addicts moved to Letten area - (250 – 300 heavy users as core group, 2500 “passing clients”)
- “Citizen action group” , “doctors, dogs and private detectives”
- “Letten plan” of action, closure in October 1994

1994/5 → 2000

- Joint action by federal, cantonal and municipal authorities
- “Three step plan”: increased repression of dealers, decentralization” of users voluntary and non-voluntary (if necessary by arrest in a detention centre), massive investment in harm reduction
- Development of full capacity low threshold services (user rooms, health services, methadone dispensing).
- Trials with heroin dispensing, acceptance of HAT.
- Innovations and evidence based strengthening of all four pillars

2000 → to present

- Comprehensive treatments system; drug free, MMT and HAT
- Sufficient capacity of treatment and social services
- Harm reduction and zero tolerance for public nuisance

Contextual observations

The development in Switzerland involves the typical evolution from cannabis dominated use towards destructive heroin use in uncontrolled open drug scenes. It is noteworthy that a well built health system encompassing both abstinence oriented treatment and methadone dispensing did not hinder the development, and characteristic that the problem instigated strong political and professional conflicts blocking constructive societal response. Of especial interest is the experience that a rich flora of survival-help offers on the drug scene was in vain and seemed rather to increase the problems. A strong pull effect attracted not only on citizens from Zürich but also users from other cantons and neighbouring nations. The result was in Zürich as elsewhere, a socio-political crisis that in Switzerland reached national proportions. This crisis seems to have paved the way for a national, cantonal and citywide consensus resulting in comprehensive measures. Noteworthy here are massive low threshold services in collaboration with strong control efforts. From this solution there is developed a system of comprehensive treatment and social service efforts in close conjunction with police units and court systems. Detention of users is accepted but seems at present to be of limited significance. The prominent feature is harm reduction together with rehabilitation oriented services, and zero tolerance for public nuisance combined with efforts aimed at integration of deviant users. Heroin assisted treatment is at present a limited element as is user rooms, but these elements are positively evaluated.

Present drug situation

- 3000 – 5000 heroin users, decline in population: 4%/year
- Reduced police notifications for heroin use, increased for cannabis use
- Public acceptance of harm reduction policies, less concern of drug problems
- Incidence of new heroin users has declined (canton): 1975: N=80, 1990: N=850, 2002: N=202. Prevalence rates declines slowly as few ends all use.

Present treatment situation

- OMT are covered by obligatory health insurance. After addiction medicine course, any GP might prescribe. OMT is available in public OMT centers, 3 of these include HAT.
- Roughly 2000 users are in harm reduction OMT at any day, 10 % of these in HAT. 9500 are included in canton register.
- There are 4 contact centers with injection and smoking rooms (approx 800 users) for residents of Zürich (“visible” drug users, above 18 yrs of age), 2 contact centers from alcoholics and socially marginalized people
- Low threshold outpatient medical treatment
- Housing programs (1500 places, 400 low threshold places)
- Working programs for clients on welfare (approximate 450 person a year, 50% in OMT), Prevention for street prostitutes (500 clients a year), Street work- youth outreach counseling, drug checking at parties and at the drug information centre, case management approach
- Heroin assisted treatment – HAT. This report does not intend to evaluate HAT. The conclusion in the Suisse – and international - evaluation is that HAT is feasible and attractive to a minority of users. As such it is seen as an integral non-controversial part of a comprehensive treatment system. The typical HAT is based on two or three times a day

heroin administration, either orally or by injection supplemented by oral methadone to sustain the patient during the night. Differing centers have somewhat differing policies on take-home regulations and on other aspects of treatment. One centre in Zürich allows as many injections as the patients want - leaving a disturbing possibility of integration in a heroin dominated life style. Oral slow release preparations are presently available. The role and efficiency of oral heroin is however, not internationally accepted. It is not self evident that there is any special advantage compared to slow release morphine as the only substance reaching central nervous system is morphine derivatives. For the purpose of this report, it might be stated that the Suisse level of overdose mortality do not seem determined by the HAT treatment. Neither has HAT been instrumental in solving the problem of open drug scenes.

Control sector

Overview:

- Three level police: Federal criminal police, Zürich Canton Police, Zürich city police
- Police inter-agency coordination/cooperation on strategy, intelligence, information and coordination based on regular meetings.
- City drug use is mainly responsibility for city police. Objectives: Compatible/compliant drug use- not a drug free city. Public order. No public drug dealing and drug use (zero tolerance). Low drug-related crime rates (especially violent and property crimes)
- Criminal investigation division, target trafficking and dealers, Patrol/uniformed police divisions target public use and dealing (1200 officers working in the patrols), High crime area division target hot spot areas /public order issues, drug supply and demand reduction and preventing open drug scenes
- Methadone maintenance available in almost all prisons, Special units for drug-free treatment as an alternative to a regular prison regime in 7 prisons, 2 prisons with heroin assisted treatment
- Treatments on court order (sentences suspended) are as effective as voluntary treatments (Uchtenhagen 2007)

The policing role is developed as pro-active, problem-oriented policing to prevent drug dealing and use in public. Non-public (private) drug use that is not disturbing to anybody will be overlooked unless dealing is brought to attention. There is small risk of being caught by the police if a drug user buy their drugs in privacy and use it in privacy. Also, if someone for instance smokes cannabis in public place without disturbing anyone, the police will usually not interfere. The priority is to prevent problem development, and a core strategy is police patrols in the high risk areas. Here, the police are proactive and might at random, without obvious cause stop and search suspected drug users and traffickers and other offenders on public grounds. The aims is to make it unsafe to carry drugs, weapons etc due to high risk of being stopped by the police. On individual level communication and cooperation with other institutions are key factors. If for instance mentally deviant individuals are caught repeatedly, the patients will be placed in hospital for a few days. However, they will then be released to ambulatory services. A person cannot be hospitalized against his/her will. The aim is primarily a linking between different services. But as prevention of new open drug scenes has a high priority, any crowd of drug users will meet with massive police interventions. The

scenes pop up from time to time, generally at the same spots, depending on the season. The police will often – based on experience - park a patrol car at these locations. If that is not sufficient, active individual interventions are practiced.

Another measure is specific security/intervention/prevention project (ZIP Zürich). This is a project for streets social workers based on combination of social service and establishment of public order. ZIP was established in 2000 and consists of one division with 20 staff members. The model is outreach work with acceptance of repressive means. Public spaces are not to be monopolized by specific groups, and when the social workers see someone use drugs in public, they might call the police. ZIP wears uniforms but do not have repressive authorities. However, a system for information sharing with police is developed. ZIP also work with beggars and other problems in the public space.

Detention centers - “Relocation centers” were developed during the closure of the open drug scenes. The goal is that those who don’t belong to Zürich should be transported out if they do not leave voluntary. Those belonging should be integrated in a treatment system. When individuals with substance use or other drug related offences are arrested, they can either be kept by the police for 24 hours or be sent to the relocation centre. It is up to the police to make their own decisions and they may choose to give a warning and a referral. One option is to release a patient in the morning to obtain prescription from their doctor. But if a person returns several times to a drug scene or otherwise repeatedly is brought to notice, he or she will usually be put in the relocation centre. It is not “fun” to be in the relocation centre and people will avoid to be sent there.

One main reason for the relocation centers was to have users not belonging to Zürich, sent home. However it is increasingly difficult to return people as the other community is not obliged to take the person back. In the later years the system has also been used for Zürich citizens engaged in open drug use or otherwise repeatedly seen with offensive public behavior.

By visit, the relocations centre reminded of a remand centre with some additional staffing of health and social service personnel.

Cooperation

Particularly impressive in Zürich is the broad acceptance of systematic and obligatory cooperation between city, canton and country authorities and between control, social service and health professional. The general consensus is that isolated control actions without social and health back-up always are a failure and that social initiative without control backing is futile. Legalized consumption rooms and low threshold prescriptions are judged to be insufficient without maintenance of public order. Drug use is a health problem that should be seen within a public health policy integrating the need for maintenance of public order and respect for public nuisance. This is also a necessity according to the policy of integration of alienated users. It is generally accepted that multidisciplinary cooperation necessitates institutionalized systems of information transfer and coordination of action. Another important aspect is development of personal contact and trust between individuals in different

services. Mutual tasks and service situations on street and in different types of interventions seem to be valued. There is also reciprocal assistance in educational aspects both in basic training and graduate courses. A long process has been necessary to build up the trust between social workers and police, but presently there is high level cooperation, often reaching hard-to-reach, hard to-treat individuals. The police can join street workers on tour and see how a contact centre works. This improves collaboration.

OVERDOSE MORTALITY

From a low level of overdoses deaths in Zürich in 1978 (N=19), the numbers increased drastically towards the period of crisis reaching 116 in 1991. Then it started to decline reaching N=50 in 2002. The conclusion is that overdose mortality is decreased to a level judged acceptable. As roughly 50 % still inject, mortality is difficult to avoid. There is no mortality in HAT-centres, but the HAT population is too small for this to influence the mortality rate.

OPEN DRUG SCENE

The large drugs scenes were closed in the early nineties by comprehensive coordinated actions. As open drug scenes tended to recur, often at a level of about hundred participants; a continuous joint effort is established. Open drug scenes have now largely disappeared in cities. There are still trafficking but this is dislocated to private apartments. Drug injecting in public places infrequent with less visibility of drug users living unattended and in misery. User needles and Syringe in public places is not a large Problem.

Initially the police defined the drug scenes as social problems and the social workers as a public order problem. At present the understanding is of a joint responsibility. The essential change has developed through daily joint briefings on the street. A core concept is “Urban compatibility” - Stadtverträglichkeit. It is not the drug use in itself as much as social marginalization arising both from individual characteristics and from marginalization process that cause the drug scenes. The basic question is therefore how to integrate marginalized individuals. First: Homelessness is defined as unacceptable. Zürich has 1500 housing places for different target groups, about hundred places in temporary shelters and about 400 low threshold places for socially marginalized. The next is how to prevent gatherings of individuals creating a destructive and problematic milieu tending to reinforce marginalization. *Zero tolerance* is an operative means to “co-existence” in public areas – defining what types of behavior that is tolerated and the number users tolerated in a public place. Zero tolerance is strictly and systematically pursued. In addition Zürich has created a specific approach coined “SIP” (Security, intervention, prevention). This is outreach social services in close cooperation with the police with shared information systems. The intention is to educate marginalized people to social behavior and the aim is co-existence.

OBSERVATIONS

The Zürich situation is best understood on basis of a national and in particular a local crisis development with an unprecedented rapid increase in heroin use, large open drugs scene and closely related criminality and mortality. This crisis seems to have ended several years of conflict between liberal and conservative parties advocating different measures; treatment oriented and survival measures versus repressive control measures. Repeated shifts of policy were replaced by a systematically developed policy integrating prevention, harm reduction, treatment and control. During our discussions it was repeatedly underlined that all pillars have equal importance. The integration of control measures with treatment and harm reduction was especially prominent. Another important aspect was the coordination of national, canton-wise and municipal policies. Today the policies have broad general acceptance in the general population and the political parties accept and support the policies included the different harm reduction with exception of a rightwing extremist party.

Presently, the Suisse system seems nationally to be very well accepted. Further, user satisfaction reported to be high particularly in HAT projects. It seems substantiated that the control pillar is integrated within health and social services as is the helping and treating systems in the control sector. The acceptance of informal and formal regulations is possibly to be understood on background of the crisis situation that seems almost to have caused a national trauma. However, and perhaps at present more important: a well built system of coordination and planning, and even more, a system of interactions experienced fruitful for all parties strengthens a tradition of cooperation.

The capacity in health system/social services is reported to be sufficient and systems of quality control and monitoring as far as understood, well developed. Involuntary and quasi compulsory treatment is accepted. Treatment in prisons is well developed with differing models. The primary aim of Suisse treatment system is harm reduction. This means that treatment should adapt to the needs of the user. Nobody is therefore excluded for drug use or non-compliance. However, retention is often relatively short and a relatively high numbers leave treatment but might then return. Further; users who sabotage and continue public nuisance behavior, might be brought to relocation centers and also be met with quasi compulsory treatment. Violent users are judged to be a shared task for control and treatment sector. Mentally ill users are a clear responsibility for the public mental health system that has well developed traditions for OMT.

LISBON – DECRIMINALIZATION AS A SOLUTION?

City profile is based on Bless(6), Greenwald (24), EMCDDA(25), Hughes and Stevens 2010.

Visit 08-09092010: Presentations by and discussions with Dr. João Goulão, President of IDT and National Coordinator on Drugs and Ana Sofia Santos IDT and Paula Vale de Andrade IDT, Nadia Cardoso Simões, Lisbon Dissuasion Commission, Paul Griffiths, Dagmar Hedrich, Ignacio Vázquez Moliní, Klaudia Palczak, Jane Mounteney, Roland Simon from EMCDDA. Visit to treatment unit Centro das Taipas and discussions with Miguel Vasconcelos and Antonio Costa. Visit to shelter.

PORTUGAL

Some core socioeconomic factors: Portugal is a republic. There are 18 administrative districts, each with administrative centrums with limited influence. The dominant influential levels are the national level and the local level in 308 municipalities. Once a world power with colonies in South America and Africa, Portugal now has only two oversea territories; Azores and Madeira Islands. Population is 10616617 inhabitants (INE, May 2010). Portugal is dominantly catholic. The national language is Portuguese. The Lisbon area is the dominant industrial area with a population of almost 3.0 millions.

Drug policy development:

1926 -1974: Salazar regime; conservative dictatorship with heavy internal repression. Illegal drugs were a minor problem. The “carnation revolution” in 1974 brought downfall of the regime. The overseas regions in Africa became independent. A high number of soldiers deployed in cannabis growing regions returned, many to unemployment, many with cannabis habits. In addition the changes brought an immense curiosity to try everything that used to be forbidden.

1974- 1980: High level “hippie like sentiments”, freedom and no restrictions, increasing use of cannabis.

1980-1990: Level of cannabis use increased, and dramatic increase in heroin use and social misery, particularly close to shanty towns built because of the rapid increase in large city population (moving from the rural areas and overseas). Drug policy was largely restrictive based on suppression and abstinence oriented treatment. The first OMT was opened in 1987. According to some estimates there were 100 000 heroin dependants + 100 000 occasional users. This is by far the highest level described in Europe. The level of HIV infection became extremely high.

1990-2000: Massive social and health service crisis. Large open drugs scenes developed particularly in Lisbon and Porto. A high prevalence of “street addicts”, often with HIV, HCV and TBC resulted in massive public uproar as many families were affected. Addiction became a dominant subject in elections resulting in rapid development of treatment: Initially

foremost high level private service providers, mostly abstinence oriented with detoxification or self-help orientation.

1997: Introduction of large scale public low threshold methadone maintenance (methadone by bus – harm reduction) and high threshold treatment in institutions. Suppression of open drug scenes and imprisonment of drug dealers.

1998: The large open drug scenes were closed with destruction of buildings in decay. EU financed large rebuilding projects; European urban initiatives.

The appointment of a “Commission for a National Drug Strategy” initiated an intense public debate with participants from all layers of Portuguese society. The commission gave recommendation of decriminalization, harm reduction and increased treatment efforts. The suggestions were incorporated in new drug law.

2000: LAW 30/2000 (Decriminalization Law) on decriminalization of consumption and possession for own use.

2002: IDT - Institute of Drugs and Drug Addiction established

2010: National status

- 18 districts have at least one CDT’s established (appointments by Ministry of Justice and of health). All 18 districts have been subjected to “diagnoses” – investigations of unmet needs in the treatments system and in problem solution. The diagnosis has been guidelines for development in the respective districts.
- About 6000 CDT proceedings/year with 3-4000 rulings, 4-5000 misdemeanor cases
- No relaxation in anti-drug efforts, demand reduction policy
- National Plan against Drugs and Drug Addictions for 2005-2012
- Increase in prevention efforts – TRI - School based, help lines, a-mail/phone-based, PRI: specific intervention programs – risk groups, media campaigns (health promotion)

Drug use situation:

Problem drug use was latest estimated in 2005 by treatment demand indicators (27 685 registered at treatment sites, treatment rate: 0.52-0.59)

- Estimated number of problematic drug users: N= 44 653
- Primary drug: Heroin 60% , additionally: heroin and cocaine 11 %
- First treatment episode: Increasing average age, now above 30 yrs
- Mode of administration. Decreasing injection use according to first treatment episode. Overall prevalence: 30%.

Treatment data:

	2002	2008
Total:	31.800	38.500
In OMT:	36%	67 %

Waiting time 2008: OMT: 6, 7 days, detox: 11.6 days. TC: 17.1 days, all below target level.

Administrative sanctions (2008) drug use: 6543 processes (decrease 3 %) (Lisbon 19.8 %)

46 % referred by the “Public Security Police”, 34 % Republican Guards, 20 % by the courts. 68 % mainly cannabis, 14 % only heroin, 90% only one drug. 6% referred twice

Drug related crime: 2008: 1603 cases with 1771 individuals, trafficking, 70 % convicted, tendency to increase in number of individuals

Overdose deaths:

Portugal report overdose deaths both as a B-selection and a D-selection. The B-selection is based on the general mortality register, i.e. dependent on death certificates from a GP. The D-selection is based on reports from forensic institute toxicological reports of suspicious deaths.

Figure 6 Overdose deaths in Portugal by EMCDDA report 2009 (4) D –selection vs. B-selection

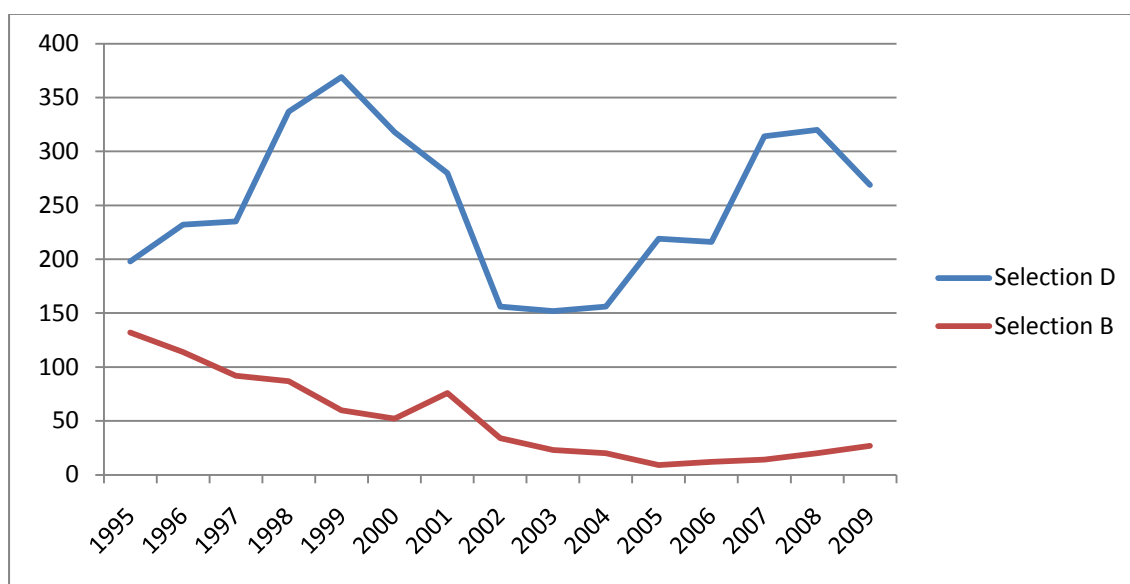


Figure 6 demonstrates marked differences between B- and D-type selections. The figures have been questioned and the 2010 EMCDDA report does not bring numbers of overdose from Portugal. The problem with the B-selection is that overdose deaths might have negative consequences. This might cause that the GP do not always reported the case as such. The problem with the D-selection dependent on forensic reports is that it might be questioned what part of these deaths that should be attributed to overdoses. By improved techniques the forensic institute has decided that 36 % of 320 deaths in 2008 and and 28 % of 269 in 2009 36 % should be attributed to overdoses. In any case it is problematic to attribute reductions in mortality to decriminalization in 2000 -2001. The number with B-selection was 27 in 2009 and this is a slight increase. Even with these insecurities taken in account, the figures indicate there was an increase in the period up to 1999 and a decrease from 2000. This decrease has stopped after 2003 and the present development is not clear. Both the decrease

and a possible later increase parallel general national changes and international trends. The causal link with decriminalization is weakly evidenced. The Cato report on Portugal (24) has attracted wide attention with its very positive evaluation of the changes in policies, but seems to exaggerate the evidence. Nevertheless, the policy changes seem overall to have brought definite improvements, and at least no worsening as prophesized by its opponents.

Other observations:

The prevalence of HIV has been extremely high. AIDS related mortality (indirect drug related mortality) is also high. Portugal had until 2008 in all 7273 deaths in AIDS. 51% of these were associated with drug addiction. In other words 3709 deaths were associated with drug use. The incidence is now considerably reduced and only 68 cases occurred in 2008.

According to reports a relatively high percentage of the users are employed, the level of education among users are high and a very high percentage live with their parents. These observations indicate that users are less deviant than often found in Norway and that the families are far more involved.

CITY CHARACTERISTICS

Lisbon is the capital of Portugal and a municipality of 479884 inhabitants (INE, May 2010). The surrounding administrative region (NU3) with the same name has – 18 municipalities with almost 3 million inhabitants, the capital inclusive.

DEVELOPMENT

Contextual observations

The development described for the country, is characteristic also for Lisbon. As in Portugal, the situation should be understood on background of Salazar's repressive regime that instigated obedience to police authority not necessarily found in other countries. Further a massive crisis caused a general willingness to investments and cooperation. The closure of the open drug scenes with concomitant harm reduction measures was part of a deep societal response. Thus several aspects of the situation changed even before the decriminalization laws. At present the combined efforts of societal reactions and measures have created a system that alleviates the drug problem to a tolerable level. The decriminalization has not caused any negative development and has saved high numbers from imprisonment and negative influences and at the same time lessened pressure on the control sector.

Drug situation

Precise information on present prevalence in Lisbon is not available, but as in Portugal in general, drug use is no longer experienced as a priority. National school surveys on drugs and

other psychoactive substances (1001 and 2006) indicate decreasing prevalence of drug use among adolescents and secondary/high school students. The treatment indicator survey finds that the average age of first treatment incident is increasing. The prevalence of injections is on decrease. Treatment indicator evidence is supported by decreasing numbers in needle dispensing. Number of overdose deaths is decreased as is incidence of HIV infections.

Treatment

The national model is that each of the 18 districts shall have treatment centers with detoxification, inpatient abstinence oriented treatment and high threshold treatment oriented OMT. Further, harm reduction shall be available in mobile outreach teams and the districts shall have city out reach social workers that approach users on street, contact teams and needle exchange. There are also shelters and rehabilitation institutions. Lisbon is well developed with three clinics, four harm reduction units and several contact centers. Waiting lists are generally not accepted.

Treatment is provided as high threshold methadone or low threshold methadone. In high threshold methadone the requirements are about the same as in Norway. Our group visited Centros des Taipas. This Centre had 9 psychiatrist, 12 psychologists and 4 social works in three teams serving detoxification unit, rehabilitation and OMT. The impression was one of a highly competent and efficient multidisciplinary clinic. We were also informed that harm reduction is available on short notice, both in terms of low threshold methadone and housing and day care centers.

Control sector

Use of all types of drugs are presently decriminalized but not legalized. Use, acquisition and possession for own consumption of enlisted substances constitute presently an administrative offence not a criminal offence. The limit is the quantity required for average individual consumption during 10 days. If the seizures are larger or if dealing is suspected, charges will be made. All offenders that are caught peddling or in possession of larger quantities are brought to court. Specific regulations specify that it is illegal to give drugs to minors and mentally ill people. The offence is punishable to imprisonment between 4 – 12 yrs.

- If within the describe limits, the person will be referred to the CDT - “Commissions for the Dissuasion of Drug Addiction” that are established to deal with minor use. The CDT handle all administrative offences- mostly brought to attention by visitations to the CDT from the police. The aim is to motivate drug users either to stop drug use or to treatment and improve social integration.
- The Dissuasion committee has three members, usually a psychologist who is in charge, a lawyer and a sociologist or social worker. A technical group comprised of 3 people with approximate the same back ground prepare the cases. This group can also be social workers. There are also 3 in the administrative group. These are all full time positions.
- An offender is usually referred to the DC by the police. Physicians can refer their patients but very seldom do. The typical proceeding is that the commission explains the law and inform on consequences of drug use. Then the person is heard on plans and prospects. Basically the DC’s function as “courts” with proceedings and consequences. The user is entered in a national registry. However, this registry is separate from the criminal

register. If the person follows the advices and rulings of the DC and is not caught a second time within 5 years, the registration is eliminated. The DC's are confidential.

- CDT decides treatment of addicts and “specialized interventions of those not addicted”. Treatment can't be decided compulsory. If an addict does not agree to go to treatment, alternative sanctions are administered (fines are not allowed to be applied to drug addicts) Registers are separate from crime registers.
- Special interventions: 1. fines (25€- minimum wage - suspendable without repeated use) 2. Warning 3. Agreement to treatment. Case closed if treatment is fulfilled, 4. Social behavior sanctions (suspension of professional licenses, ban on visits in high-risk areas/locals or on association with specific individuals, obligatory periodic report to the CDT, prohibition for travelling abroad, termination of public benefits and allowances).
- CDT has solitary discretion to determine, proceedings are confidential, privacy respected. Minors are aided by legal representative

Reactions and opinions within police towards this system have been divided in passive/negative (no use without indictment) and positive: these interventions are meaningful.

Cooperation

The unique feature in Lisbon is – as in whole Portugal – the “Dissuasion Committees”. If someone is caught with drugs, they are taken to the police station. The police confiscate the substances, but if the amount is within limits for 10 days consumption, no charges are brought. Instead the dissuasion committee (DC) is notified and the person has to present to the DC within 72 hours. It is a crime to disobey and the person may be charged if they do not turn up at the DC. Approximate 2000 people are presented each year at the Lisbon DC, 6-10 cases every day. When a person turns up at the DC, he or she has a preliminary interview with one from the technical staff who writes a psychosocial report. This information is given to the DC, and then there is a hearing. The person may bring a lawyer or counselors, but as there are no reimbursements, not all can afford this. When the offender is under 16 years, the person is registered and the family is informed. For those between 16 and 17 years, parents are notified and asked to be present during the hearing

The DC decides whether the person is a non-addict consumer or an addict, i.e. dependent user. A non-addict receives a warning and gets information about the consequences of their drug use. The commission might in addition decide on behavioral restrictions. He or she may also be sent to psychologist or to other type of treatment if the DC finds this appropriate. If the person is caught again, he or she may receive a fine ranging from 25 to 450 Euros.

Persons may appeal the DC's decision. If the DC establishes that the person is an addict, they are referred to treatment. If necessary they will also find housing facilities. If a person

does not turn up, the DC reaches a decision without the person present. However, if the person breaks the sanctions, the police might be involved. After the DC hearing and decision there is a new meeting in 3 to 9 months. The DC focus is on the health and social situation. Foreigners and tourists also have to meet in the DCs if caught using drugs. The DC's report to the Minister of Health.

According to our informants, the DC functions reasonably well. One reason might be that the history of heavy repression during the earlier Salazar regime has caused a rather ingrained respect for authorities. However, adequate function is unlikely unless most of the subjects experience the proceedings as meaningful, or at least preferable to ordinary police procedures.

OVERDOSE MORTALITY

Reliable statistics of overdose mortality in Lisbon was not available. The development is believed to parallel the Portuguese described above.

OPEN DRUG SCENES

Before the revolution the army and the navy had an important place in the Portuguese society and some neighborhoods were dependent on personnel and income related to navy activities. The changes brought hardships and drug trafficking became a possibility to supplement income. Three large areas/neighborhoods in Lisbon developed into open drug scenes coined "supermarkets". Casal Ventoso, the largest "supermarket", had approximately 5000 "visitors" everyday. 2000 people lived in the area and whole families were involved in trafficking. In this area there were conspicuous social misery, high numbers of individuals in poor health and open IV drug use. The emergency responses were developed in collaboration with the municipality. The "supermarket" areas were literally destroyed and rebuilt. At the same time treatment availability were increased and low threshold services such as methadone buses were established. Initially, the police complained according to our informants, that they lost overview of the trafficking and also that they lost the opportunity to establish contacts with drug networks. The drug seizures diminished, but after some time the police improved collaboration, number of drug seizures increased and the police operations became more efficient.

OBSERVATIONS

The far reaching changes suggested by “Commission for a National Drug Strategy” initially met with a heated debate with arguments for instance that Portugal would become “a paradise for drug addicts”, “everyone will be on drug” etc. This has clearly not occurred. Problems have diminished to the extent that drug use is not experienced as the main public problem. In 2009 polls drug use was on 13th place in public concern. Further, drug use is no longer a political issue. There were 3 elections last year and drug use was not mentioned in any of the elections. On the other hand, reports such as the Cato report (24) gives unrealistic positive evaluations.

The realities are difficult to evaluate. It seems convincingly established that the system presently is well accepted. It seems also clear that most users are positive to the CDT system as an alternative to court proceedings. The system is, however, not in any way legalization. On the contrary, in several ways this type of decriminalization might be a stricter societal response, at least compared to lenient systems where the police dissuade by passivity or by overlooking use. Accordingly, some users were irritated and felt they should have the right to judge by themselves. However, the system is at least in principle, a possibility to distinguish between experimental or initial use - clinically insignificant use - and “addiction” – use characterized by dependency and to structure the responses accordingly. Further, the system established policing roles that might be experienced fruitful.

Open drug scenes seem to be of the past, but drug use in cafes and on the party scene are prevalent, and peddling at least of cannabis is not uncommon in Lisbon and was observed by the group on several occasions. However, these scenes are small scale and not destructive uncontrolled scenes. Such open drugs scenes are constantly met with police presence, and the police might refer the users present on the scene to the CDT system. The police have authority to ransack users on street and obviously control some areas more than others to prevent open drug scenes. They will not crack down on a group of youngsters smoking at a bar on a Friday night. A laissez-faire attitude might be found in reactions to the formal rules.

The CDT system should be understood as a part of a comprehensive treatment system without waiting lists and with outreach social services that might continue motivation and problem solving. Further, repeat use and repeat referrals might increase levels of sanctions. Mental health problems should at least in theory be diagnosed and followed up within mental health services and the treatment systems are part of or in close cooperation with psychiatry.

There are no critical user's organizations and most of the negative reactions originate – according to our informants – from professionals involved in profit based programs losing support and money. However, Portugal experiences an economic crisis that might in future infringe upon budgets in a problematic way.

The lesson to Oslo is in particular that Portugal has changed a massive crisis situation with a unique combination of control and harm reduction measures. The crisis and the policy development seem to have established a shared understanding of drug use in a health context while use at the same time is confronted and alternatives offered.

As for planning, it is an interesting approach to diagnose problems and needs in a set of districts within a national plan. Further; the model of coordination on national governmental and district levels based on cooperation between control and social and health sectors seems fruitful. It should be noted that a continuing police presence is judged necessary to prevent the return of drug scenes. The possibility to use dissuasion and referral to CDT increases the police armamentarium. The decriminalization does not seem to cause any dramatic changes and is primarily associated with an overall positive change without increase in use. It might be that the DC-system is partly dependent on the specific Portuguese context of traditions from the Salazar regime. Nevertheless, the systematic non punitive confrontation of use is interesting and should be discussed.

MESSAGES FROM 5 CITIES

GENERAL OBSERVATIONS

Open drug scenes seem best understood as exacerbations of general tendencies in modern urban society. Individuals with varying patterns of social, behavioral or mental problems tend to experience difficulties in social integration and to drift towards urban center areas. These tendencies are exacerbated by use of legal and in particular illegal substances. Social reactions and sanctions tend to increase stigmatization and disintegration. The result is in the described cities open drug scenes that tend to grow out of control. These scenes are experienced as destructive to the individual and a problematic nuisance to society

All the cities have tried a range of measures to alleviate the problems. None of the cities has succeeded by treatment and survival measures. Increase in measures – more of the same – seems to meet with failure. Neither has the cities succeeded by repressive methods alone, not even by increase in control measures combined with crisis intervention and coercive interventions.

Only when the cities have developed a comprehensive policy integrating and coordinating treatment and helping measures with control measure have they, each along its own pattern, succeeded in alleviating their situation.

SOME COMMON DENOMINATORS

These comprehensive integrated policies seem to share some core traits.

1. Problematic substance use and dependency is first and foremost met as health care problems.
2. Even so drug use is seen as types of behavior, and the user has no right to be of nuisance to others.
3. But the user has the same inborn right to integration in society and the same set of individual rights as the general population.
4. One central mechanism is social stigmatization and isolation
5. Mental health problems are often at the core and should be diagnosed and treated
6. But problematic behavior is to be controlled and prevented and the relevant controlling measures have to be shared across different professions and service systems.
7. The basic premise for this is a shared responsibility and a commitment to cooperation between the police, the social services and the health care.
8. This commitment has to be binding and anchored at high political level.

HARM REDUCTION IS A CORE APPROACH

One of the core features of the cities is that harm reduction is adopted as a central strategy. The elements vary somewhat but the common traits are

1. A free of charge low threshold public health service – often at city service level.
2. An easily available low threshold opioid replacement therapy without waiting lists and without or with very short waiting periods.
3. Specific strategies to attract and contact "hard to reach" users, if necessary by combined outreach social service cooperating with police patrol or officers.
4. Easily available contact and crisis centers that have a range of social services – often incorporating needle dispensing and in some cities also user rooms.
5. Homelessness is unacceptable and met with a varied system of shelters and hospices, also with individual living quarters – but the services presuppose adequate behavior and the services have premises that is to be respected by the users.

ASSERTIVE SOCIAL SERVICE IS A PREREQUISITE

The cities have developed differing models. The shared traits are

1. Active assertive outreach to contact and motivate drug using individuals "on street".
2. This service is coordinated with or conjoint with police patrols or officers, in particular to prevent the development of drug scenes
3. A range of important services such as night shelters and other housing opportunities, contact centers as a place to be during the day and as opportunity for cheap food, washing, needle dispensing etc. The service should also serve as a gateway to low threshold health service and replacement therapy.
4. The services should not increase the attraction of the drug scenes and not be offered on scene.
5. The social workers accept to work in service both of the user and society and aim to promote social integration. Drug scenes are seen as destructive.

HEALTH SERVICE SHOULD BE LOW THRESHOLD BUT COMPREHENSIVE

Low threshold health service seems also to be a shared trait even though the organization varies. The important traits are

1. Availability of service also for behaviorally problematic individuals, usually within some type of contact possibility.
2. The services should not operate with written applications and time lists. Waiting lists and waiting time is reduced as far as possible and in principle not acceptable
3. The substance abuse service should be comprehensive and encompass
 - low threshold replacement, often methadone maintenance
 - rehabilitation oriented replacement therapy (high threshold)

- crisis intervention and detoxification within a longitudinal treatment perspective and possibility
- abstinence oriented treatment and treatment in TC-type institutions, possibly also to offer antagonist treatment as relapse prevention (naltrexone).

NON- SHARED TRAITS

Some elements were found in some but not in all the cities. They seem therefore not to be of core significance event though positively evaluated when established.

1. User rooms were integrated in Amsterdam, Frankfurt and Zürich. According to feedback they eased the integration of users, particularly those without own housing. These facilities seemed also to diminish public nuisance in areas with high prevalence drug use.
2. HAT – heroin assisted treatment was in particular developed in Zürich and Amsterdam while playing a more limited role in Frankfurt. The message was basically that HAT was valuable in the care for hard core users while the role for maladjusted behaviorally problematic users were limited. HAT was not seen as crucial to prevent open drug scenes or overdose deaths in any of the cities.
3. While low threshold methadone treatment was emphasized in all cities, the mobile service with dispensing in busses was only operating in Amsterdam and Lisbon.
4. Slow release morphine (Substitol) was only used in Vienna. In this city SRM had become the main agonist drug, valued by doctors and users, but seen as problematic by the police. SRM was obviously diverted and misused at relatively large scale as more than half of the overdose deaths were found related to use of SRM.

SHARED CHARACTERISTICS

The cities that have succeeded in reducing or eliminating the problem with open drug scenes had

- succeeded to combine restrictive and helping measures
- succeeded to change and adapt reciprocal roles for police, helpers and users
- everywhere developed high availability of low threshold maintenance treatment, most often by methadone
- everywhere effectively closed or actively prevented development of open drug scenes and continued active efforts to prevent recurrence
- preference for dispersion of drug use and selling in relation to concentration
- developed a basic accept of the users, also those who were unable or unwilling to stop the use of illegal drugs
- never let destructive behaviour continue and developed approaches to dialog that include demands on the users
- no tolerance for public nuisance
- But nevertheless developed appeasement, found approaches to coexistence between society and users of illegal substances.

REFERENCES

- (1) Bless R, Korff DJ, Freeman M. Open Drug Scenes: A Cross-National Comparison and Urban Strategies. *European Addiction Research* 1995;1:128-38.
- (2) Buning E, Brussel Gv. The Effects of Harm Reduction in Amsterdam. *European Addiction Research* 1995;1:92-8.
- (3) Buster M, Sluijs T. Drug overdoses and overdose deaths in Amsterdam. Oslo: Alcohol and Drug Addiction Service and the European Commission; 2002. Report No.: Strategic Choices for reducing Overdose Deaths in Four European Cities II.
- (4) Kalmthout Av. Some aspects of new Dutch drug policies: continuity and change. In: Waal H, editor. *Patterns on the European drug scene. An exploration of differences.* Oslo: National Institute for Alcohol and Drug Research; 1998. p. 11-6.
- (5) Reinås K, Waal H, Buster MC, Harbo M, Noller P, Müller O. Strategic Choices for Reducing Overdose Deaths in four European Cities Part I and II. Oslo and Brussels: Alcohol and Drug Addiction Services and European Commission; 2002.
- (6) Bless R. 3de Multi-City Study. Drug use trends in European Cities in the 1990s. 2000. Council of Europe Publishing.
- (7) Waal H. Comparative overview of public nuisance features with regard to open drug scenes and different approaches taken by European Countries to address them (Paper prepared to Pomidou group meeting Strasbourg November 18th -19th 2004). 2010. Report No.: SERAF rapport 2004/8.
- (8) National focal point. National Report 2009: Netherlands. Amsterdam; 2010.
- (9) Hedrich D. European report on drug consumption rooms. Luxembourg: Office for Official Publications of the European Communities; 2004.
- (10) Kemmesies UE. Offene Drogenszene und Druckräume. Ein empirische Beitrag. *Wiener Zeitschrift für Suchtforschung* 1996;19:17-31.
- (11) Kemmesies UW. Szenebefragung Frankfurt/aM 1995. Die "Offene Drogenszene" und das Gesundheitsraumangebot in FaM, ein erster "Erfahrungsbericht". Frankfurt am Main/wiesbaden: Institut zur Förderung qualitativer Drogenforschung, akzeptierender Drogenarbeit und rationaler Drogenpolitik; 1995.
- (12) National focal point. National Report 2009: Germany. EMCDDA; 2010.
- (13) Springer A. Konsumräume. Exxpertise im Auftrag des Fonds Soziales Wien. Vienna: Ludwig-Boltzmann-Institut für Suchtforschung; 2003.
- (14) Uhl A, Seidler D. Prevalence Estimate of Problematic Opiate Consumption in Austria. Vienna: Ludwig Boltzmann Institute for Addiction Research (LBISucht); 2001.
- (15) National focal point. National report 2008, Austria. EMCDDA; 2010.
- (16) Uchtenhagen A. Evaluation of Action against Drug Abuse in Europe: A COST Social Science Project. *European Addiction Research* 1995;1(1-2):68-70.
- (17) Uchtenhagen A. Harm Reduction: The Case of Switzerland. *European Addiction Research* 1995;1(3):86-91.
- (18) Uchtenhagen A. Heroin-assisted treatment in Switzerland: a case study in policy change. *Addiction* 2010 Jan;105(1):29-37.
- (19) Klingemann HK. Drug treatment in Switzerland: harm reduction, decentralization and community response. *Addiction* 1996;91:723-36.
- (20) Falcato L, Stohler R, Dursteler-Mac Farland KM, Eichenberger A, Eich D, Rossler W. Closure of an open drug scene - a case register-based analysis of the impact on the demand for methadone maintenance treatment. *Addiction* 2001 Apr;96(4):623-8.

- (21) Fuchs WJ, Grob PJ. Harm Reduction in an Open Drug Scene. *European Addiction Research* 1995;1:106-114.
- (22) Huber C. Needle Park: what can we learn from the Zurich experience? *Addiction* 1994 May;89(5):513-6.
- (23) Stohler R, Nordt C, Falcato L, Dursteler-MacFarland KM, Rossler W. [Is methadone maintenance provided by private practitioners effective?]. *Soz Praventivmed* 2004;49(4):276-80.
- (24) Greenwald G. *Drug Decriminalization in Portugal. Lessons for Creating Fair and Successful Drug Policies*. Washington: Cato Institute; 2009.
- (25) National focal point. *National Report 2009: Portugal*. Lisbon: EMCDDA; 2010.