WHO BECAME THE VICTIMS AND WHY?

Drug abuse as a phenomenon;

A retrospective and futurological overview on successful and non-successful approaches

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INTRODUCTION

Speaking to this congress it is only fair to express some reservations. Although I share the goal and the engagement in the struggle to reduce use of drugs and the plight to improve lives of

those victims to the use, I have for a long time felt uneasiness by rhetoric of war – war on drugs. The division in the good guys and bad guys compromises a rational understanding. I will in this essay try to establish that while it is reasonable to advocate a restrictive policy, all truths are found in a balance where the reductions of harms and acceptance of users needs has an equal footing with societies need to diminish use and use related problems.

BASIC CONCEPTS

First; The concepts "drug" and "abuse" are basically unclear as we have a high and increasing number of substances used in widely differing ways. Obviously some of the substances are highly valued by some users and often used in destructive manners. The substances belong to widely differing chemical groups and their effects vary dramatically. Some do for instance induce sleep while others keep the user alert. Further, some are generally accepted and integrated in most people's lives – such as alcohol. Others are accepted for some purposes but only when ordered by physicians - medical drugs – medicines. Others again are accepted and valued for technical purposes but not for intake – glues, solvents and gasolines. Some again – and this is the core theme for this conference – is illicit - illegal drugs seen as destructive forces that should be fought to protect society and vulnerable individuals.

The neutral "scientific" concept is "psychoactive dependence producing substances". What these substances have in common is that they have effects in the central nervous system that might cause drug-seeking behaviour; the individual tends to seek and prefer the effects of the drug over other utilities – sometimes even to detrimental consequences. This concept is neutral to the cultural history and societal status of the substance and focus on the behavioural changes consequential of repeated use.

The core properties of psychoactive drugs have been a central theme in neurobiological research the last decades. Presently we know that the common core effects are exerted in a phylogenetically old system in the brain, the motivational system that has regulatory influence on well-being, sense of meaning and motivation. The system secures sufficient frequency of biological necessary behaviours such as for instance nutrition and procreation. Repeated use of the substances induce new appetites; liking and wanting for the effects. Other effects concern the executive planning functions of the forebrain, and others again the stress mobilizing systems. Repeated use lead to neuroadaptation, downgrading of the affected neurons by intracellular changes.

On this basis the dependent user will have short-term abstinence reactions trying to abstain from the drugs differing by type of drug. More importantly, the user will for prolonged periods tend to feel dysphoric with increased wanting and often decreased liking of the effects, repeated instances with cue released craving coupled with weakened executive functioning and decreased stress-tolerance. In addition research points to the importance of changes in gene expression causing long-term changes in the intracellular processes. This means that the changes might remain for long periods.

At the bottom line; the individual develops impeded rationality; decreased competency in handling the choices and endurances in societal life – or some do. Use might therefore cause disruptive behaviour problematic for the individual and his or her social network. Obviously it is

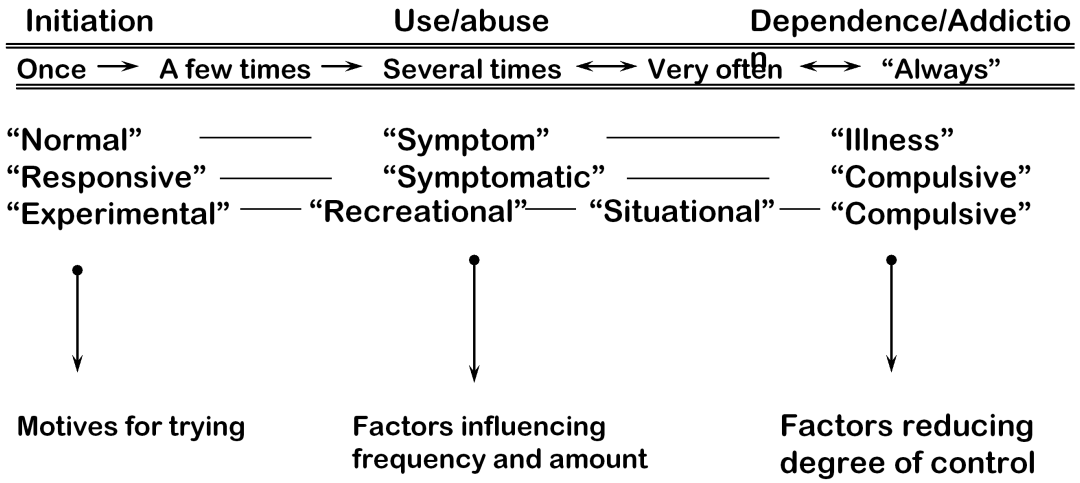
important to minimize the use and at least advocate patterns that are as harmless as possible. Those who advocate the individual's right freely to choose substances for pleasure, recreation or intoxication are therefore on slippery grounds. Society has both rights and duties to regulate drug use and drug availability. In this paper I will present current knowledge on which we know most often becomes the victims of substance use and discuss some societal measures and models in prevention of use and use related problems.

Types of use – severity of use

Abuse is of course basically a normative concept. The drug is used in a way not condoned by societal norms or regulations, the drug used is by itself not accepted in society so that all use is seen as abuse or the drug is used in amounts or ways that causes societal or health harms. In a somewhat futile attempt to avoid normative judgements, the WHO has chosen the concept "harmful use" because only use with negative consequences for health is thought to be a concern for health care.

Figure 1 presents a model of substance use illustrating types, frequency and severity of use. On the left side we have the phenomenon of experimenting, trying out of substances. The middle area illustrates established use of varying frequency, consequences and motivation. Some types of use is seen as recreational, more or less accepted use motivated to increase pleasure or induce recreation from the hardships and dreariness of everyday life. Other types are clearly more situational, caused by norms, expectancies and availability in certain situations. Other types of use should perhaps rightly be called symptomatic. This covers types of use motivated by the alleviation of mental, somatic or societal sufferings. The right hand side illustrates the area of diminished control often termed deviancy and illness. "Addiction is a chronic but treatable disease of the brain" as often stated.

Figur 1 Model of types and seriousness of use



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What is addiction – who are the addicts

The different types of understanding influence choice of measures. Figure 2 gives an overview.

Table 1 Models of addition and the corresponding understanding og the addict

MODELS OF ADDICTION THE ADDICT

- Moral & normative - have weakness of the will
- Chronic brain disease - obeys biology
- Psychosocial disease - self medicates
- Learned appetites - has learned helplessness
- Developmental - is deviant and stigmatized
- Choice - has impeded rationality

The traditional view is one of norms and moral as seen in the traditional concept of "acrasia" – the weakness of the will that Plato and Aristotle thought would render everybody helpless puppets in the powers of the pleasures of the body unless countered by proper upbringing and teaching. The present view of addiction as a chronic brain disease is in contrast outside the

scope of norms. Something has been changed in the brain to induce a state where the person follows the lures of the Sirens in terms of biological impulses powerless as Odysseus unless bound to the mast. In the psychosocial model the culprit is society or childhood traumas causing diseases with needs for self-medication. The behavioural model of learning focuses primarily ingrained cognitive and behavioural habits and patterns. The developmental or sociological model again focuses life situation and careers in society causing deviant and stigmatised destinies, often caused by or made worse by society's countermeasures. These different models describe more or less important aspects of drug use and addiction. The point to be taken is that they lead to differing views on who is to blame and on choice of measures.

Who are the victims?

Let us first consider the experimenters. It is often believed that drug experimenting is a signal of psychosocial difficulties or that innocent adolescents are tricked into use by evil-minded drug peddlers. Heaps of epidemiological research demonstrates this to be a simplification. When the used substances are accepted by society or by the surrounding milieus, the experimenting with use will be a sign of "normality" – of trying out behaviours available in the surrounding. When the use belongs to adult world, initiation of use is a part of growing up, ritualising the transition to adulthood. In most part of Europe adolescents who have never tried alcohol are most likely characterised by anxiety and social withdrawal more than by active choice. The same has been demonstrated in areas where use of cannabis is highly prevalent. The peddler is mostly the friends or the friend's friend.

But when it comes to unusually early initiation to use or to use of drugs not accepted or seen as deviant, the use signals a loading of social and personal problems. Increasing frequency of use and use of drugs judged to be part of deviant cultures correlates strongly with familial disruption and psychosocial disadvantages. The development of dependency correlates particularly strongly with severe family problems, social handicaps and mental health problems, often with child care interventions and institutional upbringing. Odds ratio of substance use disorders is increased for individual with psychiatric diseases, in particular severe affective disorders and schizophrenia spectrum disorders, but also for anxiety states and milder states of depression. Personality problems are in particular frequent among addicts. Further research demonstrates increasingly important influences from genetic vulnerability.

The message is clear. The prevalence of drug experimenting is first and foremost influenced by the degree of acceptance of use; psychological and social availability and by the concrete physical availability. The more the drug is used in different settings, the higher prevalence of experimenting and use development. Most will however reduce or stop use of drugs seen as deviant and integrate the use of socially accepted drugs. Some will increase use and use drugs in harmful ways, in particular those living in exposed milieus or those who feel that the drug effects alleviate sufferings. And some – and these are the real victims – develop lifestyles dominated by drug use and severe states of dependency – most often with illnesses and misery as close companions.

If measured by risk for dependency, some drugs are more dangerous than others. Rough estimates says that by repeated use at least one in two to three develops nicotine dependency, one in three to four dependency on cocaine or on heroin while one in eight-10 will become

alcoholics and one in nine to 11 will develop cannabis dependency. The propensity to addiction varies among the different substances but they have in common that the prevalence of experimenting is directly related to the prevalence of dependence.

Societal policies

All societies seem to regulate use of psychoactive substances. In more primitive societies, regulations are informal by rituals and customs. Sanctions might be harsh but not by formal punishment or procedures. In modern society we both have international regulatory conventions (table 2) and national laws (Table 3) with the intention of reduction in drug availability. This is also seen as a core responsibility in the declarations of the ECAD. The cities take on the commitment to partake in an international struggle.

Table 2 International regulations – The UN Conventions

- Preregulatory period
- National interest period (Opium war 1839-42)
- Period of international regulations (conventions)
    - Shanghai opium commission 1909
    - Opium convention 1912 (Haag-convention)
    - Single convention on narcotic drugs 1961 (First UN convention)
    - Convention on Psychotropic Substances 1971 (Second UN convention)
    - Convention against illicit traffic in narcotic drugs 1988 (Third UN convention - Vienna convention)

Historically, however, the national laws and regulations have changed in views on how to regulate differing drugs as is illustrated in table 3. Some has always been licit, some have had a period with prohibition and then made their way into acceptance, some have gained acceptance for specific purposes and some remain illicit, illegal drugs. One obvious fact is that it is the legal or licit drugs that take the heaviest tolls of lives and create the largest sums of social misery and family problems. Legalization is obviously not by itself an attractive solution.

The message here is that each societal definition leads to different measures and means to reduce the problems. The licit drugs – in most societies alcohol – is regulated by sales restrictions, prices, restrictions in where and when to use and by cultural patterns. The formerly illicit substances such as nicotine and caffeine are presently regulated by taxation (prices) and by restrictions on use.

Table 3. The national laws and regulations on different substances in a historical perspective

- "The legal drug" - alcohol
  - Alcohol policies; prohibition, monopoly, restrictions, cultural patterns
- Formerly illegal drugs - nicotine, caffeine
  - Restrictions, taxation, advice
- Illegal drugs - heroin, cocaine, cannabis, hallucinogens
  - Prohibitions, criminalization
- Prescription drugs - opiates, benzodiazepines etc
  - Physicians as control agents, retail pharmacies
- Consumer regulation - organic solvents, gasoline
  - Sales regulations, informal control

The use of licit and formerly illicit drugs has been extensively researched (WHO reports, Edwards et al 1994. Rossow et al 2004). The main message is that the most effective means to reduce consumption is to reduce availability and increase prices. Effective means might also be found within restrictions in places to use (no smoking at the work place, the public scenes). Public campaigns are mostly ineffective as are educational measures.

If one questions the feasibility of different measures, however, these give another type of message. Only measures backed by the public stand a chance to survive and be effectively implemented. One immanent danger is always the build up of illicit sales and another is neglect. Further, there is also strong influence from cultural traditions. The restrictive countries seem to have particularly destructive patterns of alcohol use. The Mediterranean countries on the other hand seem to have protecting traditions. Further reductions in use are presently seen in France and other Mediterranean countries without specific restrictive measures. On the other hand the public in the Nordic and other restrictive countries seem increasingly reluctant to accept the regulations and the alcohol consumption is on increase. .

The prescription drugs and the substances used for technical purposes have different types of regulations. The sales restrictions and cultural barriers work to a differing degree, and abuse – meaning use for intoxication – is to a varying degree a problem. Diversion from accepted use is considerable. One prerequisite for these types of regulations is that the substances have a clear definable purpose, a type of use that gives concrete and measurable benefits. It is sometimes suggested that one should regulate illicit drug as prescription drugs (Christie and Bruun). But this is obviously only possible if the substances have such beneficial defined purposes.

Drug policies

The core theme for this conference is the policies on the illicit drugs. Historically the origin is

often traced back to the first and second decades of the 20th century. Alarmed by the increase in the use of drugs such as opiates but also of cocaine and to a lesser extent marihuana, Europe and US developed legislation on medical drugs, laws on retail and wholesale trade of drugs and the authorization of professions and societal organizations responsible for the prevention of use. In the US, the Harrison Act of 1914 and later supplements largely defined drug use within the penal code with all non-medical acquisition of drugs as illegal behavior. In Great Britain, the Rollerstone Act of 1928, on the other hand, brought a medical point of view defining the addict within a health frame with a legal right to treatment – meaning opiates as medication. The Nordic attitude emphasized restrictions and reduction of availability on the one hand but defined the addict as a responsibility of the health care system on the other. Some countries resisted or overlooked the engagements and have gradually forwarded policies on harm reduction, but none so far the policy of legalizations advocated by some organizations and individuals (Nadelman 1991)

The development has been analyzed from different angles and theoretical frames. The drug policy positions are usually supposed to rest on a basis of science and concern for the welfare of people. From a historical point of view, the dominant belief systems, the professions and individuals in position and the cultural situations in the respective countries at the stages of decisions, might be more decisive (Berridge 1966, 1998, 1999). Within the traditions of social constructionism (see for instance Cohen 1990) the whole drug problem is seen as caused by the views and interests of the dominant actors influencing the policy choices.

The rise in use of illegal substances in the later decades of the 20th century brought a sharpening of the policies. In the UK, the Brain committee advocated strengthened regulations and restrictions within the British health-oriented policy. In the US the restrictive policy was sharpened by President Nixon and later on by President Reagan under the so-called "War on drugs". The policy of drug free societies was adopted in the northern regions of Europe, particularly in the Scandinavian countries. These types of policies emphasize supply reduction as a preventive measure and are therefore associated with criminalisation of use, high-level sentencing in drug cases, non-traditional police methods as for instance undercover operations, international co-operation on police and customs level. Concerning demand reduction, the focus is on preserving and strengthening attitudes against use. Drugs use should therefore be kept illegal or at least socially not acceptable. The focus of therapy tends to be put on abstinence-oriented treatment.

At the extreme end, drug use is seen to be an evil causing problems and suffering to the extent that even harsh preventive measures are justified. Proponents sometimes voice the view that the life of the drug user should not be eased too much as this might increase tendencies to use, or prevent motivation for abstinence. It should be borne in mind, however, that these types of views are definitely not inherent in the policy model. The basic trait is not one of police methods and harsh life conditions for the addict. The basic trait is the view that drug use itself is a destructive phenomenon that should be prevented or reduced as far as possible. The harm is seen to be primarily caused by the drugs and by drug use, and the success of policy is a reduction of prevalence and incidence of drug use.

The tide has to a large extent turned against these types of policies during the last two decades. The opposition has built the case with a range of arguments, and Dutch drug policy has often been seen as setting a successful example (See for instance Buning & van Brussel 1995). The

influential so-called Frankfurt declaration adopted by the "Konferenz: Europãische Stãdte im Zentrum des illegalen Drogenhandels" in Frankfurt 1990, proclaimed that the elimination of drugs and drug use is a failure. Therefore "The priorities of drug-policy have to be changed dramatically". Decriminalisation of use, free possession of small amounts of drugs, separation of some drugs such as cannabis from "hard drugs" such as heroin and a variety of measures aimed to alleviate problems for the user, should replace sanctions and policing.

Currently, these types of views have considerable support although there is also considerable opposition as for example through the organization arranging this congress – ECAD. In the extreme case, the problems of substance abuse are seen as primarily caused by the restrictions, not by the drugs. It is pointed out that some users can take drugs in a controlled way, and it is believed that most would be able to do so if not prevented or disturbed by criminalization and stigmatization. The destructive use patterns are seen as caused by the illegal status that creates criminal and harmful milieus. The drugs are made unsafe by the illegality that prevents knowledge on content, strength, purity and so forth. The solution is accordingly that one should make the drugs legally available and subjected to quality control. The use should be de-stigmatized or "normalized" and accordingly socially accepted (See for instance Nadelman 1990).

The liberal position that anybody should have the right to use drugs by their own choice is closely related to legalization. The arguments here are based on normative views on individual rights primacy in relation to the common good and often, but perhaps not necessarily, in contrast to a public health view. Proponents of this view are often also concerned with the consequences of criminalization and non-traditional methods of investigation that are seen to infringe upon the civil rights in modern society (See for instance Husak 1992, Hamaide 1995. For an evaluation see: Waal 1999)

The proponents of harm reduction have founded an organisation, IHRA - International harm reduction association. This organisation publishes a scientific journal; International Journal of Drug Policy. As can be read here, the concept of harm reduction covers a range of arguments and not all adhere to the more extreme positions. The core arguments are rather pragmatic. As drug use has been on the rise in all European countries and in the US, the fight against drugs is seen as a failure. While large resources are used in futile attempts to curb the use, insufficient are used to reduce the harm carried by use.

Table 1 DRUG POLICIES AS A CONTINUUM BETWEEN EXTREMES

War on drugs	The fight against drugs has absolute primacy. The dealer is an enemy. The addicts' interests are subordinated to the needs of the fight. The ultimate aim is victory over the enemy forces (drugs, drug dealers, and drug producers).

Drug free society	The common good has primacy. The dealer is a threat to the weak and to the community. The addict is a problem and a victim. The ultimate aim is to create a society where drugs are hard to get and not of interest to the large majority. The weak should be protected.
Public health policy	Prevention and cure has primacy. Often prevention is seen as cost effective and should be prioritized when possible. Cure is costly and often difficult. The dealer is a contaminant and a risk to others but might also be a victim. The addict has a disease and should have treatment. The aim of policy is to reduce the prevalence and incidence of drug use. Restrictions and decrease in availability are important as means to reach the goals of reduced total consumption and thereby even more the problem consumption.
Risk reduction	This might be seen as a subgroup of public health policy. Reduction of use might have primacy but reduction of risks connected with no prevented use, is also a focus. The dealer is seen as a threat to the public good but also as an individual at risk. Information on less risky, unwanted behaviour and advocacy on safe procedures are accepted. The aim is to reduce prevalence and incidence both of drug use and of illnesses and harm connected to use.
Harm reduction	Reduction of harm associated with drugs in society has primacy. Drug use is seen as unwanted and problematic but nevertheless an unavoidable element in modern society. The prevention of use is unrealistic and when seriously attempted, an independent cause of harm. Such harm should be minimised by decriminalisation and by acceptance of the drug user as a person with rights and interests. Nevertheless drug use prevalence should be decreased and kept low if possible. The aim is a total level of harm that is as low as possible.
Legalisation	Reduction in use of the penal code and imprisonment has primacy. Drug use might be a problematic phenomenon to be reduced but should not be a punishable behaviour. The prohibitive laws are unwarranted and the real cause of destructive behaviour and problems. Drugs should be supplied in ways that do not presuppose illegal acts such as through public offices or monopolies, prescriptions and pharmacies or registered and controlled, privatised, authorised shops.
Liberalism and consumer orientation	The rights and interests of the individual have primacy. Restrictions are seen as an infringement on the right to consume wherever that does not threaten the interests of others. As consumers the users have the right to consumer control and quality information. Drugs should be available as other goods through stores with competition securing low prices and competent services.

The restrictive measures are further judged to cause harms both to society and to the user. Drug use prevention by legal sanctions, is judged to endanger goal-directed measures to reduce specific harms such as overdose deaths, deteriorating health of users and social problems. Prohibitions and restrictions cause higher drug prices increase the use of incarceration and the criminal activities to afford the drug supply. It is, however, refuted by most that drug selling, particularly on a large scale and especially of drugs like heroin and cocaine, should be prohibited. Full-scale legalization is therefore not inherent in harm reduction even if proponents might be found within its adherents.

The controversies might for didactic reasons be sorted on a continuum from one ideological and political extreme to the other with the pragmatic positions in the middle as in table 1. To the extent that this didactic overview of policy positions is accepted, it can be seen that risk reduction and harm reduction constitute a sort of middle ground between two positions with opposite views on causes and measures. At the one end the drugs and their availability are seen as the ultimate problem. At the other the prohibitions, restrictions and the criminalization are the real culprit. At the one extreme the addict is a criminal or at least a victim of criminals. At the other, the addict is a consumer hindered in voluntary activities through unjustified laws and persecution. At the one end, the goal is to prevent use and establish abstinence through therapy. At the other, the goal is to alleviate drug use lifestyles and ensure safe drug use through consumer information and quality control.

More pragmatic aspects dominate the middle ground. The reduction of risks and harm are basically not controversial. The problem arises if the goals and attempts are seen to endanger other and more important goals. In table 1, risk reduction and harm reduction have been defined as different positions as in the definitions of concepts in part I. Again, this is a didactic division. It is intended here to draw a line between positions where the reduction of drug use is seen as a prioritised goal and those where the reduction of harm connected to non-preventable use, has the highest priority. Obviously these positions have considerable overlap. Some measures would therefore be acceptable for both types of views. Others would be important to one and less acceptable to the other.

WHAT ARE THE EVIDENCE?

Three aspects ill be considered; whether there is any clear correlation between drug policies and drug use prevalence, whether one can see any co variation policies and open drug scenes and between measures and overdose deaths.

Prevalence findings

Do restrictive countries have different development in drug use prevalence than liberal

countries? Evidence is found in statistics from the EMCDDA and from UN and US statistics even though reliability of data varies and more problematic; differing data selections are used.

In this paper only some crude findings will be touched. Cannabis is everywhere the most prevalent illicit drug. Particularly high prevalence is found in England, Ireland, Switzerland and Denmark. Low levels are found in Sweden, Finland, Greece and Portugal. High middle levels are found in Netherlands, Germany, Italy, France and Spain. Low middle level is found in Norway. Use of amphetamines follows much the same pattern even though here Sweden, Finland and Norway have high levels together with England and Netherlands. Use of heroin is everywhere a low frequency phenomenon without any clear pattern, except that some countries have had more obvious problems with amphetamines and less with amphetamines. Cocaine seems to be a rapidly increasing problem in most Europe, particularly so in Spain, Italy, France, Germany and the Netherlands, and less in Scandinavia.

If we try to measure the levels of "problematic drug user", we encounter different definitions with the Swedes including users of all types of drug, inclusive high-level cannabis. If we focus intravenous use, the problem is among others that some countries such as Netherlands have a population of users almost exclusively using heroin smoking. Further, the approaches used to measure the populations vary basically. The resultant picture is unclear, but there is no sign that liberal, harm oriented countries have higher numbers than restrictive.

If we look in particular at Central and Eastern Europe, the pattern is mostly one of a marked increase from a particularly low level after the break up from former Soviet Union control and influx of western ideas and goods. Here one might state that effective restrictions seem to have protected the populations, but within a regime that few of us would accept.

This picture is obviously composite. If we pinpoint Sweden and Norway as particularly restrictive countries, we might argue that drug use prevalence is lower, but we might also argue that the have had the same development only somewhat belated perhaps caused by the geographic position and other factors irrelevant to policies. If we take restrictive US into the discussion, this country have high prevalence of almost all types of use.

A stronger finding is that drug use everywhere is a minority phenomenon, that most adolescents have sceptical attitudes. The majority end the use of illicit drugs as they mature and grow into adult society. It is also obvious that the level of use is influence by cultural and historical factors. If that is the case, our power to influence the level of use is moderate. The general societal development will dominate. Reassuring then is the finding of problem limitation. The social matrix seems to be relatively resistant towards new drug, at least as long as they do no enter the field of marketing and demand for easy availability. But the need for harsh and effective methods seem small, and the evidence that one can feasibly approach towards a goal of "drug free society", is negligent. Defeatism seem closer if one measure success of policy by these types of goal. This is not the same as giving up. The Norwegian criminologist Nils Christie has expressed that "The war on drugs is over. The drugs won". This is clearly not precise. The populations remain anti drug, the growth of use stagnates and there are few sign of legalizations taking the majority positions in any country. A stalemate without final victories seems a more appropriate description. But the problem with high war costs, both in term of resources used and in pain inflicted by imprisonment and harassment of users, are nevertheless problematic. The lack of convincing results makes this worse. Perhaps should the concept of "war " be exchanged and

the goals of drug free societies be exchanged for more realistic ones. The decisive question is whether the drugs are "normalised" in the meaning accepted for every day use and legalized to the situation that consumer rights influence availability and an increasing number f situations is expected to involve drug use. The fight is therefore to a large extent a cultural one.

Open drug scenes

Seen in a historical perspective, the open drug scenes are a new form of an old phenomenon. A larger or smaller fraction of most populations drift from the local communities towards the city centres. Some seek new opportunities, others and escape from the control and scrutiny of tighter neighbourhoods. Some want to unfold personal preferences of various sorts, others to escape the stigmatisation from societies negative to their behaviour or appearance.

The aggregations of users of illegal psychoactive substances that have appeared in the large European cities the last decades obviously represent new aspects of this old phenomenon. Several reasons lie behind. One is the cultural and political opposition from discontented youths in a particular historic period. The second is ambivalence and split response from society. The third is the oppression of use of new drugs caused by both realistic and unrealistic fears. The fourth is individuals seeking refuge from increasing demands in production and education. The fifth is increasing numbers of immigrants and asylum seekers from countries with availability of drugs and high levels of misery. The sixth is the problems of illegal drugs; varying availability, high profits, attraction of hard-core criminal groups, alienation of drug users from health care, variable scenery of possibilities for profit and drugs mixed with defiance and desperation.

On this background several European cities have experienced an unparalleled growth of drug users in the city centres during the years from the end of 1970’s and the early 1980’s.

In the following I will describe five city cases with emphasis on developmental traits and societal measures and attempt to point out share and non-shared approaches. The aim is to elucidate fruitful and not so fruitful patterns (for closer analyses, see Waal 2004).

The two-sided face of harm reduction - The Netherlands - Amsterdam

The description is built on papers by Bless , Buning & van Brussel , Buster and Kalmthout (1988).

Drug problems arose earlier in Amsterdam than in most European cities. At that time the city had already experience with opium smoking Chinese immigrants and a population of Surnames from former colonies. Then in the late 196o’s came the Provos, the youthful protests mingled with cannabis and alternative lifestyles, a trend that was particularly prominent in Amsterdam. From these groups originated a growing heroin problem.

Initially these problems were met with measures of prevention and repression in Amsterdam as elsewhere. However, according to Bless , it was as early as in the late seventies decided that the response of primary prevention and drug free treatment was insufficient. 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.

One characteristic choice was attempts to separate "soft drugs" (i.e cannabis) from "hard drugs" (in particular heroin) . Cannabis use was seen as misdemeanours. The availability was separated from hard drug peddling by allowing "coffee shops" with sales of cannabis while sales of "hard drugs" were punished. Drug use was not seen as a crime while professional selling was. Further one choose heavy investment in low threshold methadone dispensing from the Municipal Health Service . In order to reach marginalized groups and to overcome resistance from unwilling neighbourhoods a program of mobile dispensing from busses was started. Methadone dispensing from police stations was initiated to reach deviant and antisocial groups. 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.

Another characteristic but less well-known trait was also prominent. When open drug scenes appeared, this was met with both policing and an extensive redevelopment programs . Further, as the drug scenes and drug problems 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 was to be interrupted by the police. Amsterdam applied administrative laws that authorised fines and used this to prevent gatherings. If the users did not pay their fines, this would result in court verdicts followed by arrests. Users could also get law-enforced orders not to visit certain parts of the city. As stated by Bless (1995), 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. Problematic drug users repeatedly causing nuisance, have been subjected to compulsory means, including choice between prison and treatment.

"Drug tourists" represented another problem. Amsterdam experienced an influx of drug users from neighbouring countries, in particular from Germany and Belgium. These groups tended to concentrate in specific areas and had often particularly destructive patterns of use. While Amsterdam from the beginning had a use pattern dominated by heroin smoking, the drug tourist, as of course also some of the Dutch were injectors. This was met with a policy of "discouragement", inducing the person to return to their home country by various means .

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 e 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. Some hopes are placed on heroin prescription. What presently causes concern is in particular a increasing use of cocaine.

From unsystematic tolerance to suppression and harm reduction – the Zurich and Frank furt experiences

The description of Zurich is based on papers by Klingemann Falcato et al Fuchs , Huber and Uchtenhagen and repeated visits. The description of Franfurt am Main is based on papers by Bless Hartnoll and Hedrich , Kemmesies , Schardt , COST A 6 working group meeting in Frankfurt and visits.

Zurich and Frankfurt am Main are both cities that seem to have solved the problems with open drug scenes; in Zurich the "Platzsptize" and the Letten area, in Frankfurt the "Taunusanlage". Their development has several common features. In both cities the development was first hippie-like adolescents gathering with guitars and cannabis in parks. In both cities the phenomenon was initially tolerated, then as problems grew ineffectively suppressed by policing methods with result of transfer to other places. An influx of more severe use followed and drug-related problems grew. Initally abstinence oriented treatment were offered, then came increasingly an emphasis on

"aid for survival" approaches, low threshold programmes with out reach teams including shelters, primary medical care, meals, work – offers and needle-exchange. drop-in centres with cheap meals, showers, toilets and Laundromats combined with medical services and needle exchange and in Zurich also low threshold methadone programs.

Both cities nevertheless experienced increasing problems and futile attempts to close of the scenes. The vicinity of the drug scene experienced ever increasing pressures of petty crimes and social nuisance, and "pull-effect" of the drug scenes.

In both cities the turning points seem to have come with full political and public responsibility for joint efforts. In Zurich a "Letten plan" was adopted by the federal, cantonal and municipal authorities, replacing a long controversy between cantonal and city administrations. According to a "three step plan" the raiding of dealers were sharply increased. Decentralization" was systematized. The non-Zürich citizens were obliged to have their treatment in their home districts, if necessary by arrest and use of detention centre followed by assignment to appropriate treatment and eventually out-transportation. The communes had funding for their helping and caring facilities from the Cantonal Government and "aid-for–survival" measures were increased. The harm reduction approach became a core aspect encompassing heroin dispensing.

The Letten site was closed in February- March 1995. In the wake the treatment system was expanded. Schätzle et al has found that the demand for methadone maintenance grew and that individuals that earlier had opioids from the illegal marked, now sought treatment. The low threshold approaches and harms reduction measures were thoroughly accepted. But as noted by Klingeman and Falcato , a prominent feature were also that open drug scenes not longer were tolerated.

In Frankfurt the first steps came in 1988 when a working group, Das Montagsrunde, was established on the initiative of the Frankfurt police. The group consists of all bodies and institutions engaged in drug related issues. In 1989 an integrated drug policy and with a coordinating office within the municipal public health department was decided. A policy document, "Mit Drogenabhängige zu leben" was adopted by the city council in 1991. The document advocated a joint effort built on a shift from repression towards reduction of drug harms both to the users and the public, focusing on survival help, crisis intervention centres, needle exchange and enlargement of methadone treatment. "Frankfurter Resolution" which is the core document for European Cites on Drug Policy was originates from this plan. Initially the problems continued even though the police repression was reduced. The number of overdose deaths peaked with 147 deaths in 1991 and the HIV prevalence among users on the scene grew up to 20 % in 1992.

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. But as an harm reduction approach had been developed, methadone slots were enlarged and decentralized, before the closure. Overnight places were opened and a large contact centre with cafe, shelter and methadone out patient clinic was opened in former police buildings remote from the city centre. Drug users not belonging to Frankfurt were expelled while helping facilities at the 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.

Living with – and curtailing the problem: Wien

The description is based on interview with the drug coordinator in Vienna, Michael Dressel MA, Fonds Soziales Wien and informal discussions with professor Alfred Uhl and professor Alfred Springer, both from Ludwig Bolzmann Institut für Drogforsuchung and two reports from the institute . The final version is revised after corrections by drug commissioner Dr Alexander David.

The drug problem in Vienna arose to public concern during the late 1980's. Public use of drugs became a problem in particular during the 1990's. The development was met with a set of treatment and harm reduction measures, and after 1995 the problem is contained and reduced. At present it is estimated that the city has 6-8000 regular opioid users. 4 500 of these are in maintenance treatment. A semi-open drug scene is located in the areas around the Karlplatz, partly in the underground areas connected to the subway, partly at the main railway stations and other areas. The scene is a meeting place of roughly 1000 drug users, up to one hundred persons might be present at the scene at any given time.

An important measure is the creation of an informal "zone of tolerance". This zone is marked by flowerboxes. Within this zone groups of 50 to 60 – up to hundred standing individuals are tolerated. Outside the zone, whenever more then 4 to 5 persons gather, particularly in the subway, they are expected to move. If more than 10 users gather outside the zone, they will be asked by the police to move and to spread or to go to the zone. There are no attempts to close down the scene, but the scene is under close surveillance both by uniformed police and by narcotic squad/criminal investigators in plain cloths.

At present the situation is experienced to be tolerable and under control. The rules and regulations are made very explicit and are known to the users. All open drug use will cause interference from the police. Drug dealing between users, is overlooked if it does not constitute a nuisance. All dealing by non-addicts will cause arrests and be brought to court.

Measures taken to meet the development:

1. Consensus has been reached that addicts are sick people and should be a responsibility for the health care system rather than criminal justice.

2. Maintenance treatment shall be and is available on low threshold and on demand. Every GP has the right to prescribe maintenance drugs on professional judgment. There shall be no waiting lists. Most GP's participate in training programs provided by the Viennese chamber of physicians.

3. High emphases is put on out-reach and low threshold services. The city has contracted services from a non-profit organization who operates a large contact centre with walk in services for *heal care, food,*

laundry, cheap clothing and sleep, needle dispensing, day job centre and out reach team.

4. Nobody shall have to sleep in the raw. Shelters have sufficient capacity and a bed for the night is always available. Substance use in the shelters is, however, not permitted.

5. Systematic prevention and repression of public nuisance. Diversification of drug scenes is judged important to make control possible.

The undecided policy – with increases in harm reduction. Oslo

Oslo as an ECAD member might be seen as an example of a city emphasizing the road of drug free societies. The development in Oslo has followed the traditional course seen in the other city examples – even though somewhat belated and definitely slower in development. The youthful protests and hippie ideology manifested itself in the last years of the 1960's with "flower power" youths smoking cannabis in the castle park. The park scene was initially tolerated but then met with various types of repression, and finally dispersed by active policing. The drug users moved down the main street of Oslo to Egertorget, a square outside the Parliament, and when followed by police restrictions, further to Bankplassen, another place downtown, and then to Kirkeristen, a church area before it finally settled in park area near the central railway station, Plata.

The city policy was one of repression combined with out reach contact and helping services, investment in different types of abstinence oriented treatment institutions, and finally when the problems grew in the nineties, with "Help- without- conditions"; increased availability of crisis and detoxification centres coupled with available resources to make treatment on demand possible . Methadone dispensing has been made available, but on a high threshold model with the goal of rehabilitation.

The Guardian brought July 27th 2002 a shocking reportage from Oslo . In sharp contrast to the then recent ranking of Norway as the top nation in living standards and health care, the journalist pointed to increasing number of fatal overdoses and a destructive open drugs scene to be seen at the "Plata", the drug scene by the Central railway station. A shooting gallery was found behind dock buildings near by. The open misery was disturbing and the helplessness of interviewed social workers and city officials, obvious.

The problem was not especially one of increasing overdoses even though the numbers were high. The peak period was in 1998 – 2000 with 134 overdose deaths. In 2002 the numbers were down to 76 and in 2003 to 52. The problem was one of increasing misery on the scene and of increasing public nuisance. Violence increased, as did openly destructive drug taking patterns and hard-core criminality. Attraction of adolescents was reported and public uproar became increasingly problematic.

In June last year, the police closed down the scene. Drug users were asked to move and were warned on fines if they disobeyed. According to plans, this action was supposed to be coordinated with new contact centres, injection room facility and offers of return for those belonging outside of Oslo. These preparations were only partly finalised.

The closure of the open scene was met with criticisms from the religious organizations active on the scene, from left wing political parties and from the press. There were reports on increased pressures on different care institutions and certain parts of the city. Some claimed increase in mortality, but actually the overdose mortality decreased from the month before closure. The users do, however, aggregate in the vicinity of the

former open scene, and the public nuisance is considerable. Claims are made for the need for a "zone of tolerance, an open scene where informal contacts and small scale selling can take place. Others claim involuntary treatment and/or more effective policing methods. Shop owners complain of thefts and disturbances, of loss of customers and financial problems. The parallel with experiences from Frankfurt and Zurich seems obvious.

Typical development

These five cities demonstrate both shared and non-shared traits. A shared trait is that the development seems to have originated in the late sixties or early seventies with young people gathering in parks or as squatters in non-traditional places. The scenes have attracted less resourceful groups. Initially the drug used has mainly been cannabis, but amphetamines and heroin have arrived and become the dominant drugs. Lately use of cocaine has increased in most scenes but not yet in Oslo. While the smoking of drugs has remained dominant in Amsterdam, injection has been dominant in the others. The milieu has grown harder with groups characterised by criminal patterns and professional dealing. Different ethic groups and asylum seekers have been reported to cause problems, but this seems to be poorly corroborated. A serious problem, however, is the influx of drug users and poorly adjusted individuals from the surroundings, from the neighbourhoods of the cities, from other parts of the country and from other nations. These traits have been particularly prominent in cities with surrounding countries with restrictive drug policy. The scenes have developed serious patterns with subgroups alienated from health care and often with severe social problems. The public nuisance has increased, both by open drug use and drug related morbidity and mortality and by drug crimes and drug use related crimes, in particular petty thefts, but also with violent crimes and mafia-type influence.

Typical measures

Two opposite types of responses are recognizable. One is the restrictive or repressive type reacting to the scenes from the point of law and public order. The scenes are seen to represent aggregations of forbidden behaviours, sometimes in open defiance of society’s rules and norms. In particular in the Nordic and perhaps North German areas, the view of drug use as an epidemic, strengthened the tendency to use repressive means to prevent the spread of what was seen as a disease. The US concept of war on drugs is another influence that inspires attempts to abolish the scenes with repressive means.

The other type is what might be called a liberal and humanistic, seeing the drug user as a victim of alienation and stigmatisation in repressive societies. The focus is partly on blaming the prohibitionist position, the restrictive drug policy, and partly on the sufferings and illnesses of the drug users on the scenes – and in prison if detained. The arrival of the HIV on the scenes has strongly supported these approaches.

One typical experience is the chasing around. In Oslo the drug users were chased from the Castle Park just to appear on other scenes until the chaser, the police and the city authorities finally seemed to resign and let the scene grow more or less restricted to the place near the central railway station. Here the scene was under close surveillance and partly contained. The same development was seen in Zurich where the chasing around ended up in Platzspitze. In Frankfurt the end station was the central station area and then the Taunusanlage. The drug users do not vanish even if driven out of one scene and will find ways to gather in other parts of the city. The vulnerable areas are according to Bless et al inner cities, traffic nodes and down-graded residential areas. One might experience as in Frankfurt an increasing weariness in the

police with the futility of the chase and a growth of the view that a concentrated scene is to be preferred as they can be surveyed cost-effectively. The same argument has been heard in Oslo.

But then again, what seems to happen is that sooner or later, the problems grow out of hand. The "pull" of the scene attracts users from far off and the burdens grow. The protests from local shop owners, from public and the passers-by, from the tourist office and from business interests – and from concerned citizens grow to the point that one once again decides to close the scene.

The initial response seems everywhere to have been to increase the offer of traditional treatment, detoxification and abstinence oriented treatment system. In Oslo this was systematised as the "help without conditions", measures granting all drug users immediate treatment according to their choice "regardless of cost", while the pressures on the scenes was increased. But a high number of users do not want the treatment offered or is out of reach.

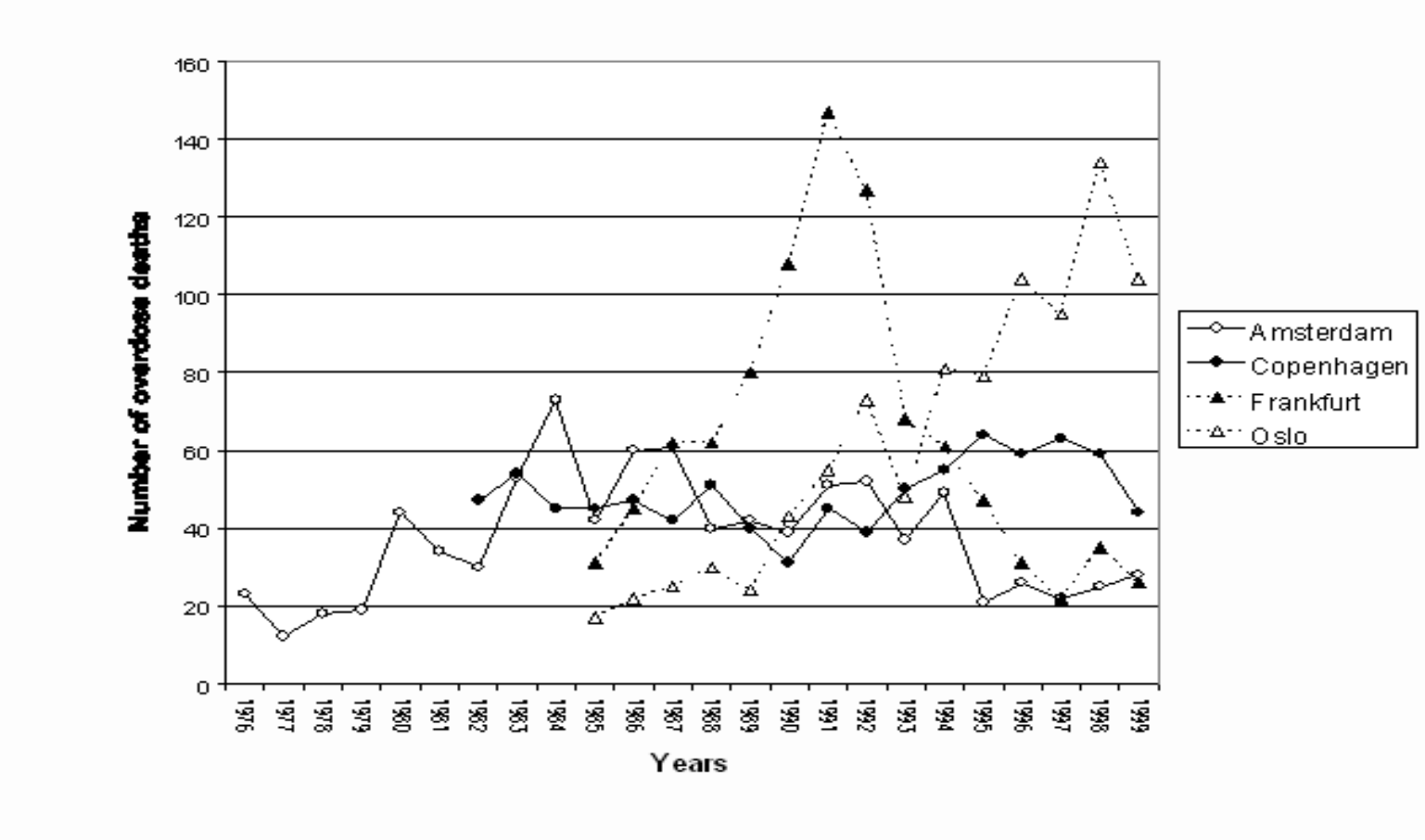
Another usual response is to build out-reach teams that partake on the scenes and make contacts and guide to treatment slots. A third attempt is to build crisis centres and low threshold health services, either in mobile units or with service at odd times and walk in policies. A fourth approach is non-judgemental preventive and risk-reducing measures such as the delivery of condoms, clean needles and user paraphernalia at low or no costs to diminish risks for infections and other diseases. A fifth element is different types of helping measures such as delivery of food, either without cost or to very low prices, shelters, contact centres and meeting places, free laundry automats and sometimes also availability of short time work opportunities. The last to be mentioned is a variety of religious and humanitarian groups offering their service from sermons to discussions, music or as in Oslo also fashion shows. The ideology might, as in Oslo, be one of "street" activism or "street approaches" – often in opposition to the surrounding society that might be viewed as oppressive and stigmatising.

Nevertheless, what seems to happen is that even though the misery on the scenes might be less intense, the measures do not prevent the destructiveness of the scenes, not even stop its increase. Some as Huber believes that the "pull-effect" of the scenes increases when attractive measures not available in the users home locations, are offered. When the expelling forces in the surroundings or the neighbouring countries remain unchanged, the influx of users often becomes devastating. The destructiveness of illegal drug trade, the possibility for income from illegal drug sales and a drug marked attracting both drug users integrated in society and problematic personalities causes serious, often intolerable problems. Only in Vienna one seems to have found a balance where the drug scene is tolerated and contained.

The example of overdose deaths

Drug use – in particular intravenous use of opiates such as heroin – brings serious harms such as increased morbidity and mortality. How does a city successfully fight these problems? Overdoses is here used as a case example built on a report to the City of Oslo and the European Union (Reinaas et al 2002). A study group gathered data on city situation, drug problems, measures undertaken and development in overdose deaths. The report examines the findings in a time sequence perspective. Figure 2 gives an overview of the development in overdose numbers.

Figure 2. Overdoses in four European cities in a time perspective



As can be seen from the figure, overdose deaths were initially registered in Amsterdam and peaked in this city in the mid-eighties. Thereafter one has seen a gradual decline towards a level of 20 to 30 deaths yearly. Next came Copenhagen with a relatively high level from the first registrations peaking after a roughly stable situation in the mid-nineties. Frankfurt fared well until the late 1980's when the city experienced a steep increase of deaths, which peaked in 1991 followed by a rapid decrease towards the level of Amsterdam. Oslo had the lowest number until the end of 1980's after which the city experienced an almost as steep increase as Frankfurt did, peaking in 1998 to 2001. After this there has been a decrease till 40 in 2003, the further development is not clear.

The cities are known for different choices. Amsterdam is known for harm reduction with emphasis on low threshold methadone, investment in health care measures, separation of soft and hard drugs, tolerance of drugs for personal use and heroin dispensing. Copenhagen is known for liberalism, tolerance for semi legal cannabis sales in Christiania, investment in low threshold methadone and a variety of low threshold institutions and day care centres. Frankfurt is in particular known for harm reduction meaning injections rooms within a system of contact centres, high availability of low threshold methadone and a decriminalisation of drugs for personal use. Oslo is known for a restrictive policy with high emphasis on abstinence-oriented treatment, out reach strategies and late and high threshold methadone programs.

The difficult question is what has caused the differential developments. One strategy was to interview representatives from users, professionals and city administrators on which measures that were regarded as important. The interesting thing was that the representatives from each city seemed to invest hopes and

importance in the most recent and most discussed measures. In Amsterdam the dispensing of heroin was particularly emphasised. In Frankfurt the "health rooms", the user rooms were brought forward and heroin dispensing was the hope of the future.

Obviously, to be essential in the explanation of the changes in development, a measure will have to be implemented before the reduction in problem severity. It can be seen that neither the injection rooms nor the heroin dispensing has been a precondition to harm reduction. The user rooms in Amsterdam were established in 1997 and the Dutch heroin program even later while the harm reduction program has been regarded as successful since the latter half of the 1980's. What all the cities have in common is that restrictive policies seem to have been in vain. All the cities have early invested in repression and increase in abstinence oriented therapy. Oslo in particular in what was called "on demand measures and crisis interventions. These measures do not seem to prevent the development. With increasing problems, the cities have turned to harm reduction measures, in particular methadone dispensing and low threshold health care and crisis and contact centres.

But while "harm reduction is more publicised, the cities also invested considerably in restrictive measures. Amsterdam invested systematically in prevention of nuisance by suppression of all drug scenes and with what was called the "discouragement of drug tourism", lessening the influx of drug users not belonging in the city. The same goes for Frankfurt. The measures of harm reduction were only effective in reducing the overdoses after the closure of the "Taunusanlage" and decentralization of the treatment, meaning that those not belonging in the city were sent home. Findings in Copenhagen are less clear. The city seems to have invested in harm reduction relatively early but not in a systematic way. This might have been an explanation for a relatively low peak in deaths, but also for a slow reduction.

PRINCIPLES FOR A COMPREHENSIVE POLICY

Consensus and cooperation

In the described cites a change for the better has only been attained after consensus on a coordinated policy. This consensus is dependent upon compromise between conservative or restrictive views and liberal or left wing views. The police must accept and support treatment and harm reduction but the social services and the voluntary organisations must also accept and support the need to diminish public nuisance and the destructiveness of illegal activities.

Acceptance of the drug user as a citizen

The attitude that drug use should simply be made to stop, will tend to isolate users from the health care system and social benefits tend to be made dependent upon change in drug using behaviour. Public space is to be spared from the sight of the deviant user. But drug use does not stop, and the users do not vanish. Repression tends to further alienation, destructive behaviour and misery. What is more, the necessary measures will be in contrast with basic human principles of our societies – and causes protests and conflicts. It is a prerequisite to change that the drug user is accepted in society's arenas – including public space. The society should make peace with the addict.

Harm reduction as an important principle

Originally a Dutch concept, harm reduction is at present accepted in most western countries. Drug use can

be stopped, if at all, only by absolutely unacceptable degrees of suppression. This means that the focus has to shift towards the aim to lessen the harms, both to the user and to society. It involves measures to diminish risk behaviour for infections and overdoses, and measures to protect the vulnerable user and give help and assistance also to users not able and willing to end the use.

But it also involves measures to avoid or reduce nuisance and "pull factors" – elements that attract potential users and vulnerable individuals to the scenes of use.

The almost undisputed measures are low threshold health care, shelters and other basic needs support, needle dispensing, free condoms and risk management education. This means program to increase competency in less risky drug use. Methadone maintenance – and maintenance by other opioid agonists, is by itself only partly a harm reduction measure. When coupled with demands for motivation to change behaviour and to rehabilitate from drug use and drug use behaviour, it might more precisely be seen as at treatment option. When seen as a low threshold measure where society makes agonist treatment available on the level that most users can accept, it is a core element in all approaches in harm reduction. However, also this measure might increase harms, if diversion of methadone causes overdoses in inexperienced users or given to users not really dependent.

Normalization is contraproductive. Legalization enlarges problems

Normalization of drug use is a concept adopted for attempts to make drug use a less deviant behaviour and the user less stigmatised. The normalized drug in use is alcohol and nicotine. As is well known these drugs causes definitely larger problems. It is considerable evidence that normalization and legalization will cause increase in use behaviour and increase in harms.

To curtail or limit drug scenes

To my knowledge, no city has ever succeeded in limiting the problems of drug use without curtailing or limiting the drug scenes. This involves by necessity restrictive measures that might be seen as infringement on the user’s rights to public spaces and feared to cause the user behaviour to go underground to less supervised situations. The closure of scenes was earlier hotly debated in cities such as Zurich, Hamburg and Rotterdam and is presently a core theme in the Oslo discussions. But as stated by Bless et al , this negative attitude to restrictive measures "could easily be interpreted as an excuse for non-intervention" which could lead to reactions and myths also disruptive to harm reduction facilities and to an increase in general feeling of security. If one believes that the criminalization of the user is the main cause of drug related problems, the restrictions might seem intolerable. But as stated by Bless (1995) .."although tolerating open drug scenes might seem logical and even imperative from the anti-prohibitionists or abolitionist view, we found strikingly little evidence for the assumption that such tolerance is a condition for a successful harm reduction approach". On the contrary the case of Amsterdam speaks in the opposite direction. Amsterdam seems to be the city that most successfully have reduced harms and contained a large drug problem effectively, and this city have curtailed development of open drug scenes from early in the period of increasing drug use.

Public nuisance is not a human right – but users do have rights

While it is true that curtailment of drug scenes seem to be essential, it is as true that it seem impossible to do this without feasible alternatives for the users. Users do have to stay somewhere, and also have the

possibility to meet each other. The Vienna model of zone of tolerance seems unique as it establishes a sort of semi open drug scene within limits known both to the users and those supposed to uphold the limits. The problem is seen as a sort of conflict between user's and public interests. The limits and rules should be clear and consistently guarded, but within a concept of respect for the user and for public nuisance. Other concepts are contact and service centres such as in Frankfurt and Zurich.

Premise for rational user behaviour

To ask the user to respect the problem of public nuisance is to expect rational behaviour. This expectation is only realistic if the opioid dependant user is in maintenance treatment. There is no example of successful closing of open drug scene without high availability of maintenance treatment. This was initially demonstrated in Amsterdam and is a core aspect of the Frankfurt and Zurich experiences. Also in Vienna the right to treatment more or less on demand is stressed as a core principle. In Oslo, maintenance treatment is increased but not in a harm reduction low threshold approach.

Premise for a tolerable and sustainable situation – the decentralization of treatment.

A core element in the description of all the cities is the influx of drug users not belonging in the city. This is a special case of a general phenomenon, the drifting towards the city centres. The phenomenon, however, becomes strongly aggravated when open drug scenes create a life space without restrictions and pressures in the society at large and at the same time offers opportunities not available locally. The result is pressure on the city finances, on scarce social care resources and increased difficulties in attempts to integrate the users in society. All the cities have, in varying degree and by varying methods, applied strategies to return users not belonging in the city. Amsterdam had its policy of discouragement of drug tourists, Frankfurt clearly expelled the non-Frankfurt users and Zurich detained and expelled users from other cantons and nations. In Oslo so far, one has tried a voluntary approach with different types of resources made available on condition of return to the user's home community.

SUMMING UP

All policy choices have to build on the obvious fact that the drugs are here to stay. It is wishful thinking and might lead to oppressive policies to attempt the impossible, to reach a drug free society. On the other hand, it seems to be as unrealistic to promote abolition of all restrictions and cause as destructive consequences when one enacts on the belief that the evil is the measures of society and that the drug user is only a sick patient to be cared and cured.

The present drug use patterns will strengthen tendencies to unhealthy and destructive aggregations in the city centres, creating drug scene of different types. The most destructive seem to be the open scenes as islands of permissiveness in a restrictive society. But also in more liberal societies, the dynamics of drug scenes are problematic, if permitted then kept on continuing surveillance and control. Dispersed and less open scenes seem to clearly to be a lesser evil.

But closure of drug scenes is only feasible within a frame of harm reduction. The basic preconditions are that the drug addict is recognized as a citizen with individual rights to be respected. But on the other hand, this is only realistic and possible if the users respect the need to diminish public nuisance and the rules of open public areas. This again, presupposes that the drug users are in a position where rationality is possible. This means that maintenance treatment must be available and places to live and stay must be in

reach.

FUTUROLOGICAL SPECULATIONS

Basically Europe has developed in a pragmatic direction. The strong views and ideologies are less prominent. Goals are more often expressed as integration of services, and as documentation and evaluation with results as guidelines. There is an increasing emphasis on biological models, diagnostics and differentiation of approaches. Drug use is accepted as a lasting if regrettable phenomenon, and harm reduction has become an important goal in most countries. Risk reduction is almost universally accepted.

Is this a "trend, movement or change of paradigm" as formulated in an editorial in European Addiction Research by Fuchs and Degwitz (1995)? These authors, as most others, point to the influence of the HIV epidemic that brought prevention of an epidemic into primacy from the mid 1980's. Abstinence could no longer be held as a precondition for treatment availability as the prevention and treatment of a potentially life threatening disease came into focus. Later on, drug deaths and other emergencies have become focus of intervention. Fuchs and Degwitz see this as basic changes and conclude that harm reduction is not only a change of emphasis but also a basic change of attitudes. "Society needs to accept limits to what can be changed and has to learn how to best live with what cannot be achieved". They see the need to give up the goal of solving the drug problem as inherent in the harm reduction position. The need is to find ways to live with it as a problem of modern society.

The contra argument would be that we do live with several types of problems without giving up the continual fight to reduce them. Pollution, traffic accidents, discrimination are examples of unavoidable problems that it is nevertheless judged worthwhile to fight.

This means that even though there may seem to be an unbridgeable controversy at the bottom, much of the practical controversies seem more caused by the "rhetoric of war" than by principal disagreement on policies and programs (Waal 1998). Opioid maintenance, needle dispensing and exchange, vaccination, most of the outreach health projects and measures to minimize stigmatization are accepted in most if not all countries with restrictive policies. Risk reduction and opioid maintenance in prisons and by outreach to high risk groups are also found, as are non-traditional approaches in information and projects to approach marginalized groups. On the other hand, no countries have today based their policy on legalization, and no countries seem to escape significant harm and social problems through drug use. According to the Dutch governmental report "Drug Policy in the Netherlands – continuity and change" a few thousands of addict cause intolerable social in spite of extensive harm reduction efforts. (Ministry of Health, Welfare and Sports 1995) Consequently legal sanctions should be used in the service of forced treatment. Some of the accepted police investigation methods are not allowed in Norway and Sweden

Those programs most controversial are those aiming at "normalization" of drug use and those that seem to increase acceptance of drug use in society as a whole and to increase availability of drugs. Examples are low threshold maintenance, particularly projects that seem to give out illegal substances without measures to influence behavior. Dispensing of heroin is often heatedly opposed as are project that are suspected to build on drug users principal right to have drugs on their own demand and by their own choice. Projects to ensure quality and safety control for drugs whether in red light areas or in youthful rave milieus are also controversial.

According to a thoughtful paper by Farrel et al 1999, the problems of consumption and dependence – both

of legal and illegal drugs are, and should be, a major concern of all modern societies. Consumption is a more important phenomenon than dependence, at least for drugs sufficiently researched such as alcohol and nicotine. The major elements influencing consumption are drug supply and drug demand. Harm reduction is a third element that might influence both level of supply and level of demand and the different measures taken should be judged not solely on the basis of changes in the level of harm but also through impact on the level of supply and demand.

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