

Comparative overview of public nuisance features with regard to open drug scenes and different approaches taken by European Countries to address them

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Helge Waal, Unit of Addiction Medicine, University of Oslo

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Introduction

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 stigmatization from societies negative to their behaviour or appearance.

A rich sociological literature deals with these aspects of modern society, partly with focus of society's incarceration and suppression of the mad, the wild and the misfits (1) and partly with focus on consequences of and solutions to processes arising from industrialization and modernisation of western societies (2). For this purpose, suffice it to point to some typical societal responses. On the one extreme we find the zero tolerance approach with heavy emphasis on criminalisation and incarceration, in particular consequently practised in authoritarian societies. On the other extreme we find the humanistic helping and sharing responses originating in particular from aspects of Christian traditions. In between we find the Nordic welfare state built on the idiom "do thy duty, demand thy right". Society has the duty to solve problems and furnish solutions, but the deviant citizen should fall in line or accept treatment and restrictions (3). We do also find societies where the families, the church and welfare organisations furnish a network disciplining and accommodating the deviants engulfed in informal, sometimes quite strict, rules and caring institutions. In the middle one might describe a sort of "red light district" approach where society accepts deviant forms of behaviour as long as this do not cause significant public nuisance. In formal and informal zones of tolerance deviancy is let alone. These societal responses are deeply ingrained in the thinking and problem solving behaviour, not only of the politicians and administrators, but also of the public, the police and treatment professionals. New problems are therefore met with responses typical for the respective society (4).

The open drug scenes are both a new and an old phenomenon. The city centres has long seen aggregations of individuals with alcohol problems, different types of deviancy and poor compliance with societies rules and often with problematic family histories. Most cities have found ways to meet the situations with a mixture of measures from society's traditions.

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 phenomena 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 increasing numbers of 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 in aggregation of drug users in the city centres during the years from the end of 1970's and the early 1980's. The phenomenon has often initiated in hippie type of adolescents characterised by opposition to societal norms, by guitars and cannabis. In others the pattern was more dominated by poverty, unemployment and bitterness. In both cases, the development grew in

seriousness with attraction of problematic personalities and persons with criminal behaviours and patterns.

The concept of open drug scene (5) covers differing elements. The term is used for meeting points where drugs are sold and for places where users aggregate and meet each other. It is also used in describing the problems of nuisance and public reactions to the scenes and the development of subcultures that might be experienced offensive. According to Bless et al (5), there is no generally accepted definition of a drug scene as locations, types of drugs and types of users might vary. The core concept is of course that several users meet and that drug are sold and used. The open drug scene is defined by Bless as “all situations where citizens are publicly confronted with drug use and drug dealing”. This definition will be used in this paper.

I do not profess any particular authority in the understanding or solving of these complex problems. My background is solely one of a psychiatrist in the field of substance abuse treatment in Norway, living thorough and partaking in the different attempts to lessen the problems. This paper is prepared on the background of participation in the COST A 6 project: Evaluation of Drugs in Europe (6), in particular in a working group on “Evaluation of Policies, Policy changes and Societal Responses to Politics”. This project, headed by Professor Ambrose Uchtenhagen brought several seminars and working groups with sharing of thoughts and experiences together with visits to some of the European scenes and discussions of some of the measures undertaken. Further, I have visited Frankfurt, Amsterdam, Zurich, Vienna and Copenhagen on several occasions, partly observing the scenes and partly discussing the development and the measures. I have also supervised a EU project evaluating the measures taken to meet the problem of overdoses in Amsterdam, Frankfurt, Copenhagen and Oslo (7). In the preparation this paper, I have made a database search of Medlin, PubMed, Psychlit and Sociological Abstracts with the search words “open drug scene”.

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.

Switzerland – the Zurich experience

The description is based on papers by Klingemann (8) Falcato et al (9) Fuchs (10), Huber (11) and Uchtenhagen (12) and repeated visits.

Development

During the late 1970'es the Zurich drug problem was minor and largely contained by increasing police repression. However, there was a steady rise in notified drug users and a growing illicit market. Therapeutic Communities, first Methadone maintenance programmes, specialised outpatient drop-in centres and a specialised mobile emergency service were set up to reach out to those in need for treatment. Social psychiatry coordinated these efforts and established links to self-help groups and parents associations. During the 1980'ies the situation changed with political and cultural controversies expressed through campaigns for autonomous youth centres, solidarity with marginal groups such as drug users. The users gathered in the city centre, finally settling in particular in a park in the city centre, the Platzspitz from 1986. This scenery became well known and attracted drug users, not only from different cantons in Switzerland but also from surrounding countries. According to

Klingemann (8) the scene was also infiltrated by international “drug mafia”. More than 3000 addicts visited the scene that rapidly grew out of supervision and control.

In parallel the city experienced rising problems. Drug related crimes increased in particular in the neighbourhood of the drug scene. Deteriorating conditions for the drug users on the scene caused serious concern. The drug related mortality tripled within 5 years. This development caused polarised debates and several policy shifts. Initially the predominant reaction was one of tolerance and increase of helping and therapeutic measures. The traditional approach with emphasis on motivation, selection from outpatient to in patient service with follow-up services aimed at abstinence was experienced as inadequate. The result was a growth in “aid for survival” approaches, low threshold programmes with outreach teams including shelters, primary medical care, meals, work – offers and needle-exchange. Special approaches such as no – preconditions methadone programmes, services for special needs such as “female sex workers” and “street rooms” – fixer cafeterias. The programs included drop-in centres with cheap meals, showers, toilets and Laundromats combined with medical services and needle exchange. The methadone programmes included a facility that offered computerized distribution of methadone where the users autonomously decided on the dosage preferred within a permitted range by use of a personal magnetic card (8). Three leading political parties formulated a joint drug policy platform, and in 1991 the Federal Government proclaimed the “4-pillar-drug-policy” (Prevention, Treatment, Harm Reduction and Law enforcement).

According Huber (11) the result were problematic. The vicinity of the drug scene experienced ever increasing pressures of petty crimes and social nuisance, and the “pull-effect” of the drug scene was a destructive element. According to Uchtenhagen (12) the “drug scene became a subcultural world of its own, attractive for all kinds of people who were not only looking for drugs but also for e.g. contact, suspense or easy sex. The social problems increased and the political pressures rose until the police closed the Zurich Platzspitze in the spring of 1992.

In the continuance the police activities increased – with an increase in recorded offences from 23 000 in 1991 to 40378 in 1994. Uchtenhagen (12) judges the result to be a disaster as the addicts and the pushers moved to neighbouring residential quarters and made backyards and playgrounds unsafe. A new, less open open drug scene established itself in the Letten station, a closed down railway station where a core group of 250 – 300 heavy users became a core group and 2500 “passing clients” belonged. The problems of increasing violence, gang wars caused public protests and reaction. A “citizen action group” called for tough and immediate actions and posed an ultimatum in October 1994; unless the authorities closed the drug scene within a time limit, concerted actions by “doctors, dogs and private detectives” would take action (8).

Then followed the adoption of a joint strategy in a “Letten plan” 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 to receive their treatment in their home districts, if necessary by arrest and medical check-up in a 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 with increase in heroin dispensing.

The Letten site was closed in February- March 1995. In the wake the treatment system was expanded. Schätzle et al (13) has found that the demand for methadone maintenance grew and that individuals that earlier had opioids from the illegal market, now sought treatment (9). There followed a period with controversies. Some advocated restrictions, incarcerations and involuntary treatment. Others advocated legalization with a state monopoly of drugs after a model of alcohol monopolies. The low threshold approaches and harms reduction measures were, however, thoroughly accepted. But as noted by Klingeman (8) and Falcato (9), a prominent feature were also that open drug scenes not longer were tolerated. Gradually, Switzerland has developed a well functioning system. A visitor to Zurich will experience a city without open drug scene. In the central park along the riverside, you might find addicts in use situations but not as crowds and the police will tell you, if you ask, “of course the city still has addicts and more closed drug scenes do exist. But the open scene problems are more or less solved, and even though there remains problems, they are not at the same level of destructiveness.

Austria - 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 Boltzmann Institut für Drogenforschung and two reports from the institute (14;15). The final version is revised after corrections by drug commissioner Dr Alexander David.

Drug problems in Vienna

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 measures, and after 1995 the problem is contained and reduced. The number of problematic opioid drug users in Vienna was estimated to 10 000 in 2001(15). The number is continually changing and at present 6-8000 are regular users. 4 500 of these are in maintenance treatment with methadone, slow release morphine or buprenorphine. The last couple of year's intravenous use of cocaine has increased steeply while the use of opioids has stagnated or diminished.

Open drug scene in Vienna

At present there is a semi-open drug scene 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.

This scene is supervised by a set of traditions and regulations. As stated by the “drug commissioner: “We do not want persons stay too long. When you arrange for comfortable situations, then more people will come. That is why there are no comfortable places to sit and no shelters from sun or rain. There are also watch rules for dogs and other measures to reduce nuisance. After a while the user will leave.

Further, public nuisance is not tolerated. Vienna is described as a tolerant and open city, and the presence of drug users in public places is to be accepted. This also means that the sight of intoxicated or deprived users is to be accepted. Crowds will however cause nuisance, might induce fear, hinder traffic or entrance to shops and public transportations.

An important measure is the creation of an informal “zone of tolerance” in the park at Karlplatz. 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 than 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. If shops are bothered by thefts and threats, the police will interfere. The aim is a vague sort of balance continually supervised in cooperation between police and social services.

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. Camera surveillance is not emphasized. Out reach social workers visit the scene regularly to secure contact with treatment and rehabilitation possibilities.

The changing drug patterns are obvious at the scene. Earlier the opioid users had one to three injections a day. Today use of cocaine increases rapidly with user taking up to 10 injections a day and may cause increased problems in planning of injections.

There is also an increase in refugee groups and problems with “false” asylum seekers. Particularly noticeable are Nigerians who allegedly are threatened by persecution in Nigeria. In reality they seem to be criminals and drug peddlers who earlier have been operating in Britain and then Germany before they arrived in Vienna.

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 emphasis is put on out-reach and low threshold services. The city has contracted services from a non-profit organization “Verein Wiener Soziale Projekte” (www.vws.or.at, www.drogenhilfe.at) who operates:

A. a large contact centre with walk in services for

- *health care* (doctors, nurses – treatment of ailment and infectious diseases) with referrals to GP. Fixed appointment for MMT is possible with a choice of agonist treatment. At present roughly 30 % is on methadone, 10 % on buprenorphine and 60 % use long acting morphine.
- *food, laundry, cheap clothing and sleep* (twelve beds)
- *needle dispensing* (exchange 90 % return, first needles are sold)

There is no injection room (divergent opinions), and dealing on the premises is not tolerated

B. day job centre. Users can have offers of jobs with pay daily. The public and firms contract persons for short term tasks

C. 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.

Basic principles:

1. *Close cooperation between police and social services* organised by the drug coordinator of the city of Vienna who operates under the order of the mayor. There are regular meetings between police and social services supervised by the city's drug coordinator and often the city counsellor of health heads this meeting. Representatives from the city traffic authorities and the outreach street workers also participate.

2. *Clear and consistent messages.*

Addiction should not be prosecuted. Every addict should have offer of treatment, but open drug use is not tolerated. Drug use is, however, overseen and dealing among users not investigated as long as these behaviours do not occur openly or to the nuisance of others. Public space is public property. Anybody who wants to stay in public places has to behave. Criminality is not tolerated; any criminal act on the scene should be prosecuted. Street dealing is prosecuted.

3. *Conflict management.*

It is seen as fruitful to define the drug related problems as conflicts between the interests of the drug user and of the public. The basic measure is to negotiate the conflict and find acceptable solutions. Limits to acceptable behaviours should be clear. The aim is that the users and other inhabitants in the city shall live together. "If they do not disturb us, we shall not disturb them".

4. *Public security*

It should be seen as a prioritized goal to take care of the public interests. In public places, it is proper to expect non-disturbing behaviour.

5. *The principles of balance.*

To manage the drug scene is to take care of a precarious balance between too much control and restrictions (repression) and too little (too much tolerance).

6. *Diversification*

A large scene is difficult to control and will often be followed by increase in criminality and public nuisance. The scene will also attract larger numbers of unstable or disadvantaged individuals.

Some comments:

Basic here seems to be a consensus of relative tolerance of drug use and acceptance of the users. 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 (14).

At the same time there is clear and shared rules and limits with consequent interference guided by the principles of conflict management. This system is accepted by the police, the social workers and by the users as well as by politicians and general public. Public nuisance is not accepted.

There is a sharp distinction between addicts seen as sick and non-addicted dealers seen as criminals. This distinction might be expected to be difficult to attain.

The result is an interesting approach to the problems of large cities adjusted to the traditions of Austria and the situation in Vienna.

Germany - Frankfurt am Main

The description based on papers by Bless (5) Hartnoll and Hedrich (16), Kemmesies (17;18), Schardt (19), COST A 6 working group meeting in Frankfurt and visits.

The development

The first visible drug scene appeared in the "Haschweise", a park belt in the inner city, during the period of student protests in the late 1960's. During the 1970's middle class dropouts and lower class adolescents increasingly gathered on the scene, and as heroin was introduced, the city experienced a rise in number of drug related deaths and an increase in social problems.

Alarmed by the development, the city authorities decided on repressive measures. In spite of protest from helping professions and liberal groups, the drug scene was closed in 1980. What followed was the chasing of drug users from one open scene to another until the scene settled in a deprived area around the main station by 1981. This was a sort of Red light district with cheap hostels and prevalent prostitution without social power to resist. As stated by Hartnoll and Hedrich (16), the development might be seen as a deliberate segregation, a way of using a space of the city to regulate a social problem.

What followed was an increase in problems. Visitors arriving in the station met and reacted to the sight of deprived, often begging, addicts. The police in neighbouring cities repressed drug scenes and drug milieus. This caused influx of large numbers of new addicts. The police invested to clean up the main station area but the scene appeared again in particular in the Taunusanlage, an inner city park belt. This scene grew rapidly and contained up to 1000 addicts. In the late 1980's the city experienced a dramatic increase in social deprivation, misery and overdose deaths, peaking in 1991 with 147 deaths. The availability of heroin rose and the prices fell.

Reactions to the Taunusanlage

The growing open drug scene met with conflicting responses. On one hand the pressure for repression grew, in particular as the city intended to become an international trade centre and the seat of the European Central Bank. On the other the leftwing parties and the social pressure groups advocated out-reach, needle exchange, and measures to reach the drug users with helping measures on the scene. At the same time the participants on the scene were largely alienated from society. The treatment system was mainly oriented towards abstinence, and users were largely met with negative attitudes in the health care system. According to Hartnoll and Hedrich (16), both the community leaders and the public wanted drugs and drug addiction removed from the view –out of sight.

A political shift – a shift in paradigms

In 1988 a working group, Das Montagsrunde, of all bodies and institutions engaged in drug related issues was established on the initiative of the Frankfurt police. Then the election came in 1989 that brought a coalition between the Social Democrats and the Greens to power. The new leadership decided to develop an integrated drug policy and establish a coordinating office within the municipal public health department. 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“ was a policy document passed in 1990 at the 1st Conference of European Cities at Centre of Illegal Trade in Drugs. European Cities on Drug Policy was established as a network with signatory member cities and a central office in Frankfurt.

Gradually the police repression was reduced, but the drug scene grew and the problems increased. 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 a 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 outpatient 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 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.

According to reports, the open drug scene is no longer a significant problem. Basic is claimed to be the effort to create premises 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.

The Netherlands - Amsterdam

The description is built on papers by Bless (5), Buning & van Brussel (20), Buster (21) and Kalmthout (22).

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 1960'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.

The development

Initially these problems were met with measures of prevention and repression in Amsterdam as elsewhere. However, according to Bless (5), 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.

Harm reduction as a systematic policy

One characteristic trait was attempts to separate “soft drugs” (i.e cannabis) from “hard drugs” (in particular heroin) (20;22). 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. 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 (20). In order to reach marginalised 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.

Prevention of open drug scenes

Another characteristic trait was, however, also prominent. When open drug scenes appeared in the Zeedijk area, this was met with both policing and an extensive redevelopment programs creating an area without narrow alleys, squatters and hidden porches (5). 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 (5), 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. It should, however, also be pointed out that 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 the drug infected 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, often with HCV, HIV and other diseases. This was met with a policy of “discouragement”, inducing the person to return to their home country by various means (20;21).

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 have 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.

Norway – Oslo

Norway belongs to the Nordic public health tradition where alcohol is seen as a potential threat to be regulated by monopoly sales and different types of regulations. The policy is influenced by total consumption theory. This states that the problem consumption is dependent on the total consumption in a given country by a multiplication factor. If the average consumption increases, the problem consumption increases even more. Use of prescription drugs is restrictive to diminishing prevalence of dependency. Illegal drug use is seen within an epidemiological context with the aim to prevent the spread of the use by diminishing availability, increasing prices and negative attitude to the use – but not necessarily to the user. The official goal of the national drug policy has been the vision of a “drug free society” even though this goal by the latest governmental papers is reformulated to be more a directional indicator than a goal to be attained. Oslo belongs to the ECAD, “European Cities Against Drugs”, a network of European cities organized partly in opposition to the network built on the Frankfurter resolution.

The development

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. Gradually the scene was invaded by youths with different types of problem situations, and in parallel the use of amphetamines and opiates increased. “A place to live” was an informal meeting place and centre formed by squatters and oppositional youth groups outside the control of policing and other authorities. Soon also these scenes had increasing drug problems.

The park scene was 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 response 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 (23). Methadone dispensing has been made available, but on a high threshold model with the goal of rehabilitation.

“Expensive Oslo is cheap fix capital”

The Guardian brought July 27th 2002 a shocking reportage from Oslo (24). 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.

What had happened? Some measures had been taken. A cooperation group was already established with representation of the city council, the substance abuse services, the social services and the health care. Methadone treatment was expanded but still in a high threshold level. Low threshold health care was made more available in four downtown centres and several contact centres was planned and partly in existence. The drug scene was closely supervised by police video cameras and police officers. There was established a cooperation between the childcare system, the police and the out reach system to react when new adolescents or children were observed. Petty dealing was more or less overlooked and open drug use tolerated. Several organisations had their day delivering of food, offering salvation and treatment, the city mission had sermons by a “street preacher” and even a “street doctor” and other street health personnel. A rock concert and a fashion show were arranged on the scene, all based on professed solidarity with the deprived.

The crisis

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 this 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 to meet and live. 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 increasingly prevalent in the others. The milieu has grown harder with groups characterised by criminal patterns and professional dealing. Different ethnic 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.

Bless et al (5), has pointed to divergent policy strategies in a three types model as illustrated in fig 1.

Figure 1 Policy strategies and types of drug scenes (5)

TYPE OF SCENE	POLICY	CITIES
Hidden scene	Preventive	Toulouse Tower Hamlet Kensington and Chelsea Munich
Dispersed open scene		Vienna Barcelona Amsterdam
Concentrated open scene	Corrective	Hamburg Rotterdam Zurich

The “chasing around”

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 (5) 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. This might as in Zurich cause a disaster (12). The users move in defiance and desperation once more and establish themselves without the support and control in worse situations – in Zurich in the Letten area followed by a sharp increase in nuisance and severe problems.

“Kindness is not enough”

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 (11) 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 (9) 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.

Some preconditions for a positive development

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. It might also involve attempts to counteract a development towards “normalization of drug use”, a concept adopted for attempts to make drug use less deviant behaviour and the user less stigmatised as this might be feared to cause increase in use behaviour and increase in harms.

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 a 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.

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 (5), 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 .."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

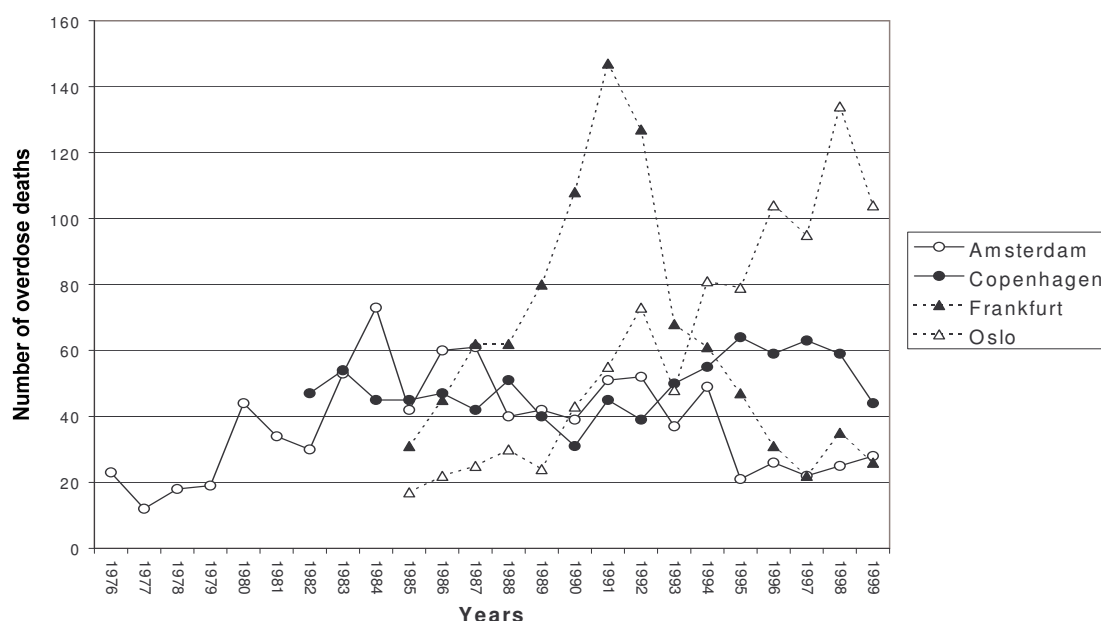
clearly expelled the non-Frankfurt users and Zurich detained and expelled users from other cantons and nations. In Oslo so far, one has tried a voluntary approach with different types of resources made available on condition of return to the user's home community.

Measures not generally accepted

Two measures are often brought forward; injection rooms and the medical dispensing of heroin. Frankfurt is in particular known for its emphasis on injection rooms and Zurich in addition for heroin dispensing. These measures are often seen as particularly offensive – or promising.

In the comparative project to study measures to reduce overdose deaths, one element was to interview representatives from users, professional and city administrators. One question was which measures that were regarded as important. The interesting thing was a pattern that the representatives from each city seemed to invest hopes and importance in the most recent 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.

Figure 2. Overdoses in four European cities in a time perspective (7)



This obviously means that these measures are experienced as valuable and that they are able to catch the imagination – as they can evoke fears and abhorrence in other cities. In figure 2 measures are placed in a time perspective related to the overdose development. To be essential, 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. Amsterdam seems to have managed without both for several years. Vienna has at present neither. Zurich on the other hand invested systematically in injection room facilities and in the enlargement of heroin dispensing in

parallel with the closing of the Letten scene. Here these measures might have been essential, but not without the closure of the open drug scene. According to the Hamburg experiences (25) injection rooms seem imperative in reducing public nuisance in the vicinity of existing open drug scenes. Through qualitative and quantitative data it is also substantiated that the rooms offer opportunity to influence the health consciousness and risk behaviour of the users – at least as long as the rooms are not overburdened by heavy numbers of users. It is also substantiated that drug injections within the user room is relatively safe. Some influence on number of overdose deaths is indicated but much less convincingly proven. Also in Canada there is some evidence that injection rooms might diminish public nuisance when an open or semi open drug scene exists (26). In an extensive overview (27) finds it substantiated that the rooms are particularly functional in service of the homeless and alienated subgroups. When located near by with low threshold policy, they are also important possibilities to reduce nuisance. The broader health effects are less well proven and depend both on numbers, policing cooperation and other factors. There is also solid evidence that heroin might give positive effects, but the necessity and primacy of this measure is disputed.

Some concluding remarks

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 care 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.

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