Drug use, front line services and local policies

Guidelines for
elected officials at the local level

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EUROPEAN FORUM FOR URBAN SAFETY
Democracy, Cities & Drugs project

Drug use, front line services and local policies

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Preface

Among the different institutional levels, the cities should be one of the major front-line responses to drug use and misuse. They are responsible for, or have the potential to organise a co-ordinated response between the various agencies and stakeholders involved in the area of drug use. These include the social and health care fields, the various social justice agencies, the police force, the non-statutory and non-profit sector, i.e. NGOs, other community members and users, the club owners…

In order to share their practices regarding local and integrated responses to the issue of drugs use, European cites, together with EU civil society networks, created the Democracy, Cities & Drugs network (DC&D). The partners of the first DC&D project (2005-2007), co-financed by the European Commission, have shared their experiences on topics such as the role of elected officials as regards the municipal drugs strategies, the local "safer dance" projects, the integration of the drug services in the neighbourhood, the involvement within the local coalitions of the medical and scientific fields, of the minorities, of the specific groups...

This guide is the output of the "network of partner cities" working group, carried out by the European Forum for Urban Safety (EFUS) and involving the cities of Charleroi (Belgium), Enschede (Netherlands), La Spezia (Italy), Ljubljana (Slovenia), Matosinhos (Portugal), Prague (Czech republic) and Saint Gilles (Belgium). This guide complements the guides[1] issued from the other DC&D working groups by giving a general overview of the subject.

Any choice in terms of policy must take into account the obvious fact that drugs are there to remain. It is thus necessary to set up sustainable responses able to adapt to the evolutions of the situations. The development of the local participative democracy meets this need and the most important challenge for a city is to set up partnerships involving the drug users as well as the inhabitants. The implementation of integrated and participative policies to tackle the local drug-related problems, should thus contribute to the development of new forms of local governance, and the practice sharing among EU cities should strengthen the European drug policy model, based on a balanced approach between supply, demand and drug-related harm reduction strategies.

For any information regarding the DC&D network, please visit the website http://www.democitydrug.org

(1) Guides available at *www.democitydrug.org*

01 Introduction

1.1. Drugs and European cities

Many European cities have been experiencing problems related to drug use and drug trafficking for over 20 years. From Barcelona to Frankfurt, and London to Rotterdam, many cities have been engaged in the development of initiatives with varying resources and capabilities, differing histories and jurisdictions. Some initiatives remain within the criminal justice system, while others are part of public health policies. Some cities have developed more integrated drug policies which include prevention, treatment and harm reduction as well as criminal justice responses to drug use and trafficking.

While all major cities in Central, Western and Eastern Europe now face problems related to the consequences of drug use (for the individual drug users themselves as well as for society as a whole), it would be unrealistic for us to propose a model that could be systematically reproduced across all cities. Each city will have its own unique social, legal and policy context as well as differing drug issues.

The aim of this guide is to identify common characteristics amongst the varying methods employed by local communities in dealing with drug problems. This approach is based on principles common to all urban policies:

[·] To promote an integrated policy (public health, law enforcement, social cohesion)

[·] To develop responses that can be adapted to local problems and available resources

[·] To strengthen cooperation amongst key actors (local councils, county councils, national government, public services and the private sector, NGOs and citizens).

1.2. Harm reduction strategies amongst law enforcement and public health

Citizens often become motivated to take action when they are faced with problematic drug use where they live. Local authorities sometimes take action when they become aware of the consequences of such problematic drug use on the community. The police may take action to detect and arrest dealers yet many escape police detection. Furthermore, in terms of public health, large numbers of drug users are not in contact with any drug agencies that could offer them any kind of support. In many instances, public health policies have not been concerned with protecting the health of drug users themselves other than in terms of the threat they may pose in the spread of AIDS.

However, there are now a range of measures that have been introduced to help drug users in the context of their everyday lives.

Outreach services are able to reach drug users on the streets and in places such as squats, or in clubs or the party scene. Drop-in centres may offer services around the

clock, and can be adapted to every target group. In addition, networks of professionals can intervene in places where drug users can be contacted, such as through hospitals, emergency services, prisons or through social housing contexts.

Harm reduction is a public health policy. The objective of harm reduction agencies is to protect the health of individual drug users. As they address problematic drug users, these services can also contribute to community safety and social cohesion.

The results obtained demonstrate that protecting the health and well being of drug users and working towards community safety are compatible aims, because those involved in local programmes may no longer live on the streets or pose a threat to the local community in any way. Drug treatment agencies provide opportunities for problematic drug users to reduce the level of their addictions thus reducing the anti-social consequences of their drug use. With the support of drug agencies and workers, many users are able to reintegrate back into society.

Whilst traditionally the fields of public health, law enforcement, and social cohesion have each had their own objectives and have worked independently, in this guide we argue for a more integrated approach.

This guide concerns frontline services for drug users. The adopted approach is part of a larger integrated drug policy.

[·] Harm reduction complements prevention and treatment.

[·] Harm reduction also complements police services: police services are no longer the only agency on the frontline (such as in deprived areas or places where there is an open drug scene).

It is imperative to have an integrated drug policy at the local level: partnerships can make effective interventions in areas affected by problematic drug use, whilst adapting their interventions to particular target groups such as minors, immigrants, mothers and children, drug users in prison or facing release, or sex workers.

1.3. The need for taking an experimental and negotiated approach

Expansion of services depends on national and regional drug policies. Some projects are experimental, others are established. Some are in the voluntary sector. Others are placed within statutory sectors.

The establishment of drop-in centres for drug users has often given rise to negative public debate across many European cities. Residents' initial reaction can often be 'not in my back yard' (so-called NIMBYism). However, where the siting of facilities has been negotiated with local citizens (as in Germany, Switzerland and the Netherlands), public opinion has been found to be more positive. A national study carried out in Switzerland has shown that local residents accept such projects if they can be shown to have an impact on community safety.

The provision of facilities for drug users raises other questions that are open to public debate:

> Which services should be provided for drug users? To what extent should they be funded?

> What does 'accepting drug use mean? Should we tolerate people consuming illegal drugs in some specific areas? What status should drug users have as citizens and residents in the city?

> What collaboration should there be between health care services and law enforcement agencies? What information should be exchanged?

Whilst keeping a balance between public safety and individual freedom, new strategies on drugs require participation from all key actors, such as professionals, policy makers, elected officials and representatives, NGOs, citizens and, in particular, drug users themselves. Many cities across Europe have witnessed an increase in projects dealing with drugs as elected officials have been led to take action in recognition of their responsibility for promoting the health and well being of the people they represent. Such projects are not possible, however, without funding from health and social care services, having access to the expertise of professionals, or the involvement of NGOs. New models for drug policy have been developed by taking such a collaborative approach which is in line with requirements for urban policy in other areas.

This guide is accompanies guidelines on delinquency and crime prevention, as well as other guidelines on drugs.[2]

(2) See list of European Forum for Urban Safety's publications available at *www.fesu.org*
See methodological guidelines at www.who.int and *www.emcdda.europa.eu*

02

The role of locally elected officials

2.1. Locally elected officials and community demands

There is often a public outcry when there are rumours of drug use or drug trafficking in squats or public places, or when drug users become visible on the streets. Residents may turn to their locally elected officials to deal with the issues they face. It may be that they have concerns over community safety, or they may be concerned about rumours to do with drugs in their children's schools, or they may have heard about deaths due to overdoses or accidents.

Whatever the nature of their concerns or their demands, citizens often expect repressive measures to be taken, such as driving known drug users out of specific neighbourhoods, or increasing rates of arrest, conviction and imprisonment for drug use. Such measures appear to be what citizens demand and what many cities are continually striving for.

The police may be immediately effective, and may remove drug users from some public areas, but experience shows that drug users will often resurface in another neighbourhood. When there are no public areas they can use, they will go to private properties that they can easily access, such as entrance halls to buildings or car parks. The question is, by taking such an approach, are we not privileging one neighbourhood at the expense of another? The more deprived an area is, the less explicit the community's demands - but it is the lack of complaints that is more worrying. It may represent a serious crisis of confidence in institutions or in democracy itself. Are authorities becoming powerless in the fight against drugs?

Community demands about drugs have to be taken seriously without heeding to prejudicial attitudes or emotional responses. Whilst it is clearly important to take action based on local assessment of needs, such work faces many difficulties. For example, there is:

[·] A lack of adequate provision for problematic users - current European legislation promotes treatment for drug addiction, but treatment services traditionally require users to show some self-motivation. The difficulty is, of course, that problematic drug users are not, by definition, necessarily in a position to take responsibility and be self-motivated.

[·] A lack of public knowledge on addiction and drug trafficking - citizens faced with drug-related problems want an immediate and effective response to the problems they are facing, be they repressive or treatment orientated. But neither treatment nor fighting trafficking can lead to immediate and systematic results. Drug addiction cannot be treated like tuberculosis, by simple hospitalisation. The fight against drug trafficking requires long and difficult investigations to achieve even partial success.

[·] A lack of a co-ordinated response from agencies – this is evidenced by the actions of law enforcement agencies who simply release drug users after arrest and imprisonment without referral to health and social care agencies. Sometimes there is no

co-working even if a drug user has had contact with treatment agencies. In such situations, we would be entitled to believe that law enforcement and /or health care agencies are ineffective.

When community demands for public safety are not taken into consideration, residents may doubt the effectiveness of institutions and services to deal with problems, and this lack of trust increases conflicts between drug users and other citizens. These conflicts are fuelled by other factors such as intergenerational misunderstanding, prejudicial relations with ethnic minorities or with marginalised communities. Continuing communication and dialogue between local authorities and residents is, therefore, very important and necessary work. Since many citizens now have some experience of the consequences of drug use in their communities, it is possible to achieve a resolution that is beneficial to all through discussion and debate. The detrimental consequences of drug abuse, as in alcohol abuse, are known to be very serious for society as a whole, as well as for drug users themselves and whilst acknowledging that there are no quick fixes, we do need to find responses that benefit drug users as well as the wider community.

2.2. Roles and responsibilities of locally elected officials

The first obstacle faced by local councils is the division of responsibilities and jurisdictions. Arrangements differ in each country at every level (at national, regional, municipal, and neighbourhood levels). Agencies at each level may share responsibility for community safety, health, education, housing and town planning, as well as for drug policy.

In some countries, local authorities are responsible for drug policy often divided between regions and cities (e.g. in Spain, Italy and Belgium, or the Lander in Germany). In these countries, the capacity of locally elected officials to respond to drug issues rests on their responsibilities for other issues connected with drugs, such as community safety, health policy, or education.

It is common practice for both the state and municipal governments to share responsibility for drug, health and community safety policies. The state might be responsible for tackling drug dealers, whilst locally elected officials might be in charge of every day issues related to community safety. Harm reduction and prevention often fall under the competence of municipalities, while treatment and/or law enforcement might be within national jurisdiction.

Where drug policy is decided upon at national level, such as in the UK and in France, the role of locally elected officials can vary. In the UK, councillors (who are the elected officials) are involved in decisions about drugs strategies at the local level, but in France, a project manager is appointed by the state that is responsible for the whole policy. S/he negotiates with relevant services regarding what projects are needed at the local level.

Understandably, in European cities where drug policies were initially developed, such as those in Switzerland, Germany and the Netherlands, local authorities had jurisdiction to do so. But regardless of jurisdictions around drug policy, locally elected officials are obliged to work within inter-agency and multi-agency partnerships which bring together a range of services and agencies, NGOs, the private sector, and community representatives.

Whatever their official jurisdictions, elected officials are required to become more involved in issues relating to drugs for the following reasons:

[·] Even though they may not be responsible for local drug policy or for drugs services, elected officials are responsible for community safety and well being of the people they represent. Problems such as drug dealing, violence, delinquency, marginalisation and social exclusion, infectious diseases, risk behaviour in young people, and breakdown of families, all threaten social relations in people's daily lives. Elected officials have to look for ways of improving quality of life, promoting community safety and protecting the health and well being of local inhabitants. The question of drugs cannot be excluded from public health or community safety debates. The serious impacts of the spread of the AIDS virus made many people aware of the risks associated with injecting and the sharing of needles / syringes, but lack of treatment options has also had serious consequences, and not only for the spread of AIDS itself. The first drugs projects were set up to respond to open drug scenes where users meet each other in public spaces to buy and consume drugs. But residents also have concerns about encountering drug users in private areas such as stairwells, lifts, or car parks, i.e. spaces which may not be covered by strategies for public spaces. Lack of treatment options in a particular locality also impact on community safety.

[·] Interventions aimed at drug abuse must be adapted to local conditions in terms of both needs and resources. To be effective, these schemes have to be specific to the local context. It is imperative to involve elected officials because they have close contact with the public, as well as having an understanding of local issues, how services work, and what the relations between different agencies are. For these reasons, they would be in a good position to evaluate the quality of services being offered.

[·] Effectiveness of interventions depends on the reliability of key actors. Professionals working in the criminal justice system, and those in health and social care services all differ in their perceptions of what the problem may be. Furthermore, no two professionals may share the same views as to what may be effective solutions to the drug problem. There may be differing opinions amongst professionals from the same sector (such as between GPs and consultants, or the police and magistrates) or there may be differences between sectors (such as between the health professions and social care agencies).

Everyone defines the problem in their own way. Whatever their differences, however, agencies need to establish common objectives based on local assessments and audits. There may inevitably be conflicts of opinion amongst different partners, and in such cases, the Mayor or leader of the Council may be in the best position to drive the process forward in order to reach positions of commonality.

2.3. The need for integrated policies

Local councils may hesitate in becoming involved in harm reduction policies for drug users, because they might fear how citizens will react. Authorities might think that they are supposed to choose between "chasing drug users out of the area" and supplying needle exchange facilities. Contrary to prejudice, these simplistic dichotomies are not necessary. An integrated approach can work but it needs to be clearly explained and negotiated. The provision of clean needles and syringes has generally been accepted as a necessary facility since the medical profession confirmed their absolute necessity against the spread of AIDS and hepatitis. Citizens are now aware that hunting out drug users from one neighbourhood to another is not an adequate response to the problems they face in their local communities. The situation requires different strategies, depending on whether it is related to children and young people, homeless drug users, party or festival goers, clubbers, or drug dealers on the streets.

Taking a harm reduction approach has implications for every aspect of drug policy, including prevention, treatment and law enforcement.

[·] Prevention: young people who are not addicted or in need of treatment services can be offered information about different drugs, the effects they have and the risks associated with methods of use;

[·] Treatment: links are established with drug users in the context of their everyday lives to improve access to treatment. This link needs to be re-established if broken.

[·] Law enforcement: the police and harm reduction projects intervene in the same area. Cooperation should be deepened. The Police services should not arrest injecting drug users when they reach a needle exchange programme. When drug users are arrested, the police should refer on to appropriate services.

An integrated drug policy has to work with all urban policies such as education, town planning, and community programmes. This is particularly important for social policy, such as housing and re-integration.

Increasing treatment options reduces crime and delinquency. In methadone-substitution programmes, the reduction is evaluated to be 70% on average (see Ch. 6 Evaluation). Delivering needles provides opportunities for workers to make contact with previously unknown drug users. It can contribute to reducing social disturbance if workers can support drug users to access rehabilitation programmes, shelters and work opportunities.

For example, in Frankfurt, a drop-in centre for drug users operates from a former factory and opens its doors anywhere from a few hours a day to round the clock. There are facilities for cooking as well as many opportunities for getting involved or participating in activities. There are also training opportunities provided by programme partners from the business sector.

The issue of drugs is one of the numerous problems that European cities have to face, but tackling it is no less difficult than any other social issue. Local councils may need to integrate drug policy into existing initiatives in order to find ways of managing new responsibilities.

European experience shows that without the involvement of locally elected officials, harm reduction programmes are not carried out or their effectiveness is limited, as there is no one to harmonise the actions of partner services. The more locally elected officials are involved, the more the project is accepted and the more effective it is.

03 Building partnerships

3.1. Multi-agency partnerships, a necessity for action

The first stage of any local programme must be to identify partners and build partnership working. Partners need to be involved in initial auditing of needs and services, as well as in the development of aims and objectives of the partnership.

To initiate such a project, city councils need to:

[·] Identify relevant actors - relevant actors or organizations are in contact with drug users whether they are specifically commissioned or not.

[·] Build partnerships - Councils must decide which partners to involve and what responsibilities they should have.

Partnerships evolve at every stage of the project - on-going development of the project can lead to new partners being identified and involved. Different levels have to be organized, depending on the responsibilities of the partners (street level, administrative level, political level). Specific work groups might be necessary for precise objectives, such as preventing re-offending, providing housing and protecting mothers and children. Some of the partners will be involved in only certain stages, whereas others will be involved throughout the whole project.

Building partnerships as part of a strategy for change: Each service realises the impact of its actions on other services.

> For example, if a drug agency excludes a drug user for violent behaviour, this exclusion compromises his or her chances of obtaining social housing because referrals won't be able to be made. This forces the problematic drug user back onto the street, which in turn causes problems for people in the community. When the police arrest a drug user, treatment and reintegration are often interrupted. Health and social professionals therefore feel that their time has been wasted, and subsequent crime becomes more likely.

Lack of access to treatment primarily affects drug users themselves; their health deteriorates and their life expectancy drops by up to 70% (see Ch. 6 Evaluation). Citizens will also be affected, as drug users who do not receive treatment often go back onto the streets. As it is organised within the framework of the city council, drug partnerships need to introduce a new actor - the citizen. The partnership makes services act in the general interest, which includes the interests of both drug users and other citizens.

When partnerships work well, all partners learn equally from each other: everyone understands how other partners work; they make joint evaluations and work together to develop solutions to the problems they face. But achieving this requires a determination to maintain open dialogue and communication between all partners, while

remaining mindful of the tendency for agencies to revert to their own internal regulations without taking into account the impacts of their actions.

Bringing together all institutional actors runs the risk of making the partnership very formal. Building partnerships requires choices: local decision makers must decide which partners need to be part of the whole project, and which should only be involved at specific stages.

The city council is faced with other choices: it must choose whether to tackle certain issues immediately, or at a later stage in the process. Indeed, is the City Council ready to confront the difficulties, or will it bypass them? Are the decisions made in the general public interest or do they favour a minority? The credibility of the project depends on these kinds of decisions.

Building partnerships requires a considerable amount of effort, but their effectiveness rests on how successfully each partner's viewpoint, interests and ways of working can be integrated into the whole. Each partner holds its own information; each has its own expertise. Using knowledge gained across all sectors will lead to the development of new practices and new expertise that can be adapted to the specific local situation.

3.2. Services in contact with drug users

Whatever the context, key actors in contact with drug users include:

[·] Law enforcement: This primarily refers to policing interventions in problematic areas. However, different branches of a police force do not always work together. Specialized services in drug trafficking depend on specific hierarchical systems that are different from the local police force. An integrated policy also involves judiciary-police collaboration, which is often problematic. The participation of magistrates, probation services or child protection agencies may be decided at the beginning of the partnership, but in sensitive or particularly problematic cases, confidential case work meetings might be necessary.

[·] Professionals working with drug users: the participation of drug agencies is obviously a pre-requisite to the partnership, but there are other agencies that have contact with drug users, such as non-specialized health professionals like GPs, hospital staff, psychiatrists, doctors, or pharmacists. The private sector may also need to be represented as some rehabilitation centres are run independently. Emergency services can be key actors. They may be the only service in contact with drug users who are not being treated. The relationship between specialists and GPs, between public and private initiatives or between treatment and harm reduction services can either be effective or conflicting, depending on local conditions but no relevant agency should be excluded, whatever the relations.

[·] Professionals or members of civil society with personal relationships to drug users: involvement of these individuals could be critical in local projects. These individuals may come from outreach services, humanitarian NGOs, AIDS projects, parents or friends of drug users, organizations working within party, festival or club scenes. Their participation is particularly important as involvement from drug users themselves is unlikely (see Chap. 3.4.).

[·] Other agencies that provide services and facilities to drug users: these can include social services, employment, housing and voluntary care, sports facilities, schools, prevention clubs, probation service, prison etc. Youth services have to be involved even if drug use is not obvious. Professionals or volunteers will be aware of risk behaviour and will be able to help problematic young drug users as soon as possible.

[·] In small towns where the issue of drugs is recent, few people are in contact with drug users in the area. In the absence of drug agencies, individuals may offer help and support to drug users. These people must be identified and integrated into the partnership. On the other hand, in large cities, many partners are in contact with drug users. In most cases, there may already be networks of professionals working to bring together actors from a specific field (for example, health professionals or law enforcement officers). The existing networks must become part of the city council partnership, but it must also include frontline workers.

3.3. Citizen participation

..... 3.3.1. Why participation?

Citizen participation on drugs has the same requirements as participation in other areas of social policy:

[·] It must re-establish confidence in the authorities and public services. By involving citizens in the project, the authorities show that their demand for safety is being taken seriously. By becoming better informed about the reality of problems faced by drug users and agencies, citizens can begin to appreciate the aims and objectives of service providers and become aware of the resource limitations within which these services operate..

[·] It must contribute to social cohesion: citizens may realize that there is no simple solution; that it is neither desirable nor possible for all drug users to be sent to prison or rehabilitation centres. Citizens are provided with opportunities for discussing what the relationship with drug users should be and what their status should be in their city. This participation should lead to a reduction in conflicts not only with drug users, but with the social groups they belong to, in terms of age, ethnicity, cultural practice and so on.

[·] By changing their relationship with politicians, citizen participation changes their role within the community: citizens are no longer passive. Political decisions are no longer imposed from the outside but are developed in the knowledge that lo-

cal residents are the experts of their own lives and of the places they reside in. Citizens are seen as 'co-producers' of local policies.

Responses to drug use are a matter for the community because it is only through public debate and citizen engagement that we can effectively determine what our response to drugs ought to be. Furthermore, citizens can be partners in that response and therefore need to be involved in decisions that affect them. Making choices requires making compromises between different interests, and between the demands for public security and individual freedom. These issues need public discussion and debate.

..... 3.3.2. A process of re-establishing confidence

The involvement of citizens may be a common aim in drug policy as in other areas of social policy. However, when local authorities ask for participation, citizens are often reluctant to respond. And when citizens mobilise spontaneously, local authorities are often reluctant to involve them in any action they may be taking. The paradox is seemingly obvious: participation calls for citizens to have political responsibilities. It tests public confidence in institutions and their policies. Those who protest have often lost all confidence in public services and politicians. They are convinced that police forces are not doing their job, treatment services are ineffective, and politicians are indifferent to their fate. Participation is often perceived to mean agreeing with choices made by politicians. Public confidence in institutions and democratic process needs to be restored and this is often an outcome of participative processes, rather than the other way round.

Participation requires a change in community beliefs. Not only will citizens have to change, but so too will local authorities and services. Citizens are often considered to be obstacles to the development of rational and fair policies, as their fears are regarded as irrational and their beliefs tainted with racist and discriminatory prejudices. They are accused of favouring their specific interests instead of the public good. These beliefs overlook the fact that citizens, including those who protest the most, are often ambivalent to drug use and addiction. Opinion polls in different European countries show that most citizens do not think that imprisonment is the best response to drug abuse. Drug users are no longer viewed as distant mythical beings but as real people, often young people known to the community since their childhood.

Citizens are not a homogeneous group. The most deprived citizens, immigrants, young people and families are rarely represented, even though they may have daily contact with drug users. Within the framework of the Democracies, Cities and Drugs project, the network T3E-UK produced a guide[3] on race equality focusing on the involvement of the ethnic minorities in the partnerships. This project also identified a specific action targeting the Romanian population developed by the city of Prague within the framework of its municipal strategy as regards drugs.[4]

A study carried out in Switzerland has shown that residents who protest the most live in city centres and are not the most disadvantaged citizens. People living in deprived communities do not always have means for collective organisation, as does the business community for example. While residents of such neighbourhoods suffer the consequences of drug use and trafficking, they do not feel their concerns will be taken seriously and are less likely to want to organise a protest group. What's more, 'drug users' are often are real people who may be known in the community, such as a neighbour's son or a cousin.

Experience shows that the more citizens' own interests are considered, the more they are in a position to look for fair responses which consider every one else's needs.

..... 3.3.3. Different forms of participation

Citizens can be involved at different levels and at different points in the development of drug projects. The provision of information, consultation projects and conflict management can be organised at neighbourhood level. Citizen organizations may be asked to participate in city-led projects and where this is the case, it is important to involve enough organisations to adequately cover the diversity of views and interests that exist in the community. Organizations need not necessarily be directly linked to the local problem and citizens might be represented by neighbourhood committees or community NGOs. It is important for these organizations to be known and respected in the community as the credibility of the project depends to a large degree on the credibility of the participants. It could also be beneficial to involve individuals with a particular point of view, such as families of drug users, young people, or immigrants. The terms of such engagement need to be clearly defined and negotiated between each member, and regulated by a reliable institutional body.

How citizens are involved in projects depends on local traditions for participation, how the locally elected officials relate to the citizens within the political system, and the broader political context. In northern European cities, citizens are very much involved in decisions that affect their lives and negotiation is standard practice.

(3) Guide available at *www.democitydrug.org*

(4) See fiche available at *www.democitydrug.org*

In the 70s, the City of Amsterdam facilitated meetings between the local business community and drug users around the city's main railway station. Drug users themselves had already formed a peer-support organization which the city council decided to support. Discussions with the peer-support organization, the 'junkiebonden', led to the creation of a mobile service providing methadone and this was one of the first harm reduction projects that took place in the city.

The success of citizen participation depends on the range of actors who are engaged in the debate. Residents' mobilization against a facility placed in their street is motivated by their own interests or NIMBYism ('not in my back yard'). But beyond having private interests to protect their own area, citizens may in reality have views about drug policy and citizen engagement which may be at odds with the views of authorities. Recognising that there is always a diversity of opinions is a pre-requisite for effective participation, and without this understanding conflicts cannot be resolved. Conflict resolution requires transparent rules of engagement and consideration of everyone's points of view. In such instances, experimental projects, such as injecting rooms, can be accepted by residents, even though they may have been rejected many times elsewhere.

3.4. Drug user participation

No one is more involved than the drug users themselves, but their participation appears to be difficult to achieve. Drug users are seen as people who have lost control of themselves, although, faced with the threat of AIDS, they have been able to protect their health. Harm reduction policies have provided opportunities for using sterile needles and syringes, stopping injecting or not using drugs altogether. Most injecting drug users have responded to these opportunities, as evidenced by the decrease in the number of AIDS cases (see Ch. 6.3). Drug users are not only responsible for themselves; they also often play an important role in projects that impact on drug use in many ways:

[·] Autonomous drug user self-help organizations work to prevent the spread of HIV and other infectious diseases and to minimize risk behaviour. These organizations might intervene in different contexts (such as open drug scenes or party scenes).

[·] Community health programmes bring together health professionals and drug users. Residents may also be part of the project.

[·] Individual drug users also take part in various projects aimed at users (e.g. outreach services, needle exchange programs, drop-in centres, treatment services, peer prevention programmes). Drug users are also involved with organizations working in different fields (such as around HIV, with sex workers, or lesbian, gay and transgender people).

The alliance with drug users is often informal. In addition, ex-users or close relations such as parents or friends may be involved. Doctors or social workers might play a role as mediators, drawing on their relationships of trust that they have been able to develop with individual users.

The involvement of drug users is critical in reaching the hidden population of users because they already have access to that world. Drugs are hidden from anyone on the outside. The alliance with drug users is not only useful for reaching other users but is also important for understanding their needs in terms of health protection. Users have personal knowledge about the drugs they are taking, how to take them, and what the risks of consumption are. Personal decisions are made about using condoms or sterile syringes, or whether to stop injecting altogether and seek treatment.

Drug users must be involved in the assessment of the risks linked to drug use. They must be consulted on defining their own needs. They must also be consulted, as service users, to evaluate the quality of initiatives provided for them.

It remains to be seen how they will be exactly involved, at what level and with which formal or informal status. Most drug user organizations have expanded in the field of health. Some serve as a pressure group to combat against stigmatisation and repression but they rarely have any official status in council projects. There are many reasons for this:

[·] Drug users are less concerned about reducing anti-social behaviour than protecting their own health but respect for their local communities can be obtained through the provision of services they consider useful. Not respecting their immediate environment (for example, leaving syringes in public places) would be damaging for drop-in centres or needle exchange programmes that may exist in the community. Often syringes and needles have to be returned for a user to receive some more. Some projects have also initiated teams of users to patrol the streets and collect any discarded needles and syringes.[5]

[·] Those who take part in drug user organizations are rarely those who cause trouble. There are, however, many examples of successful conflict resolution or mediation in European cities. Some cities have held discussions between young people suspected of dealing cannabis and adults. Mediation such as this is rarer with hard drugs such as heroin or cocaine but there are some examples of participative democratic processes. For example, in Burnley, in the north west of England, a citizens' jury was held on the issue of drug related crime and the jury was comprised of local residents, some of whom were drug users and / or burglars.

[·] There are not many existing drug user organizations in existence. These organizations have to be set up but the process needs to be managed sensitively and with care.

(5) See the example from Lille in publication: European Forum for Urban Safety, *Local participation in strategies for the prevention and control of drug abuse*, 1998

Relations between local authorities and small local organizations must be managed by someone who knows the individuals involved and their links with drugs.

If it is not possible to involve drug users directly, then it may be necessary to develop different means of engagement:

[·] Through services in close contact with drug users in community health programmes (for example through services for sex workers, or public health projects relating to the prevention of AIDS);

[·] By inviting national drug user organizations or organizations from another town as experts.

[·] By consulting other services that represent or consult drug users

[·] By supporting projects that encourage participation (such as in young people's rehabilitation projects).

3.5. Building leadership and coordination

..... 3.5.1. A steering committee has to be set up

The job of the steering committee is to define the aims and objectives of the project. A coordinator must be appointed at management level. This is not merely an administrative role but one that requires many skills and devoted hours. Coordinating a multi-agency group requires knowledge of local services and drug issues facing the community.

The steering committee has to identify the level of existing resources and apply for additional resources that may be necessary in implementing agreed actions, in the short or longer term. The coordinator's role is to mobilize project partners. S/he has to be able to oversee the whole project, taking into account the diverse range of opinions and practices without favouring one approach. Appointing a new member of staff may be beneficial, especially in dealing with disagreements or conflicts among partners.

His or her tasks have to be carefully defined. For example, would s/he be in charge of local evaluation or would the partnership bring in an outside expert for this purpose?

..... 3.5.2. Each partners' responsibilities must be defined.

Organizing the partnership is part of the action: it is the partnership that contributes to the development of a strategy for change. There is a need for a steering committee to oversee the project as well as specific work groups to implement actions decided upon. The steering group needs to be made up of decision makers and individuals who know the local drug situation.

All partners have to be made aware of their functions and responsibilities. They must be clear in their role within the group i.e. can they take decisions for their organisation or are they merely there as a representative who needs to feedback and negotiate any proposed action with others in their organisation. Time devoted to building the partnership must be seen as recognised and evaluated.

..... 3.5.3. Implementation working groups

This follow-up committee brings together professionals in direct contact with drug users as well as local residents. These meetings have to be regular, in order to maintain the effectiveness of the project. It may be useful to have daily meetings.

Everyone's role must be defined. Everyone must be informed of the different elements of the project and should inform the partnership when they are facing difficulties. Informing the partnership of any difficulties has its own obstacles. For the professionals, a service that hasn't got sufficient resources cannot achieve satisfactory results. But for the public, a service which doesn't achieve good results is not doing its job. For this reason, when services are questioned, professionals are often driven to hide any problems that they have to face. Within the framework of a local partnership, however, communicating about difficulties is essential; all partners need to be made aware of others' progress in order to act collectively. In that way they can support each other through difficult times. Conflicts over roles or territories strain relationships between all the different services.

Managing relations between different services is not a waste of time: it is in itself part of the project. Some cities such as Saint Gilles in Belgium use very detailed conventions to define the involvement of each partner in the project.[6]

..... 3.5.4. Building leadership

Developing and sustaining a multi-agency approach requires leadership from an organisation whose authority is accepted by all partners. City councils have democratic authority but decision making within the partnership must be based on the consensus emerging from discussions amongst partners. The Mayor (or other municipal leader) must affirm his / her leadership for the whole project as s/he represents the general interest. His/her leadership will be better recognised if s/he:

[·] Explains why s/he is involved in the project. S/he has to clearly define his/her role.

[·] Accepts the reality of problems raised by partners: conflicts must be confronted, not hidden away

(6) See fiche at *www.democitydrug.org*

[·] Provides the partnership with the resources it needs

The involvement of locally elected officials is necessary for the partnership to work well. Working together is not a prerequisite: an efficient networking is part of the project outcome.

04 Local assessment

The local assessment[7] that we are proposing here deals specifically with drug abuse and its consequences at the local level. It deals with building a profile of users, the drug scene and patterns of use, risk behaviour associated with each drug and method of consumption, access to services, law enforcement responses, and relations between drug users and their environment. For projects that target trafficking, delinquency and public nuisance more directly, see the works published by the European Forum.

4.1. A necessary process

Residents may contact locally elected officials in situations such as these:

[·] There is a rumour of drug trafficking within a public place or a school, or when certain families are suspected.

[·] An accident, an overdose or drug-related psychiatric issue creates a public disturbance in a particular locality.

[·] Drug users take over private areas at night, such as entrances, cellars or car parks.

Problems seem to be similar in each city, but the local realities may greatly differ:

[·] The reputation of a particular neighbourhood as having problems with drugs may be recent or it may have existed for a long time.

[·] The social context may be homogeneous or there may be differences in terms of social class or ethnic origins which may provoke situations of conflict.

[·] High profile cases may lead to residents speaking out on drug issues in their communities but they may also protest because of local conflicts, fear of ring leaders or bad service provision.

[·] Drug users may be known to health care services or they may be young users unknown to any service. In such cases it would not be possible to make effective assessments about what drugs they use or their risk behaviour.

When a problem occurs in a neighbourhood, repression appears to be the more immediate and effective response. Analysing health and social needs might be considered as a waste of time. The question of young drug users is an example of a pressing issue. Purely repressive measures might contribute to reinforce social exclusion. Access to treatment raises other questions: what drugs do they actually use? Is treatment necessary? Is treatment adapted to the new pattern of drug use?

Many initiatives are started by local individuals who have identified a specific need but they do not always have a global assessment of available resources. These initiatives, which are often innovative, make the most of local facilities. They also have limitations:

(7) See SANSFACON Daniel, *Guide méthodologique sur le diagnostic des nuisances relatives aux drogues et la prostitution, Centre international pour la prévention de la criminalité,* March 2006
EMMANUELLI Julien, *Contribution à l'évaluation de la politique de réduction des risques*, SIAMOIS, Institut de Veille Sanitaire, Tome 1. november 2000

[·] These new services might be additional to existing services or it may be that the problem could have been better addressed by partnership working.

[·] Locally mobilized individuals might be tempted to replace existing services, for example with by patrolling the streets themselves to ensure community safety or by providing emergency services for marginalized people when the access to public services is not satisfactory.

Changing existing services to accommodate these needs would be a better approach.

Each region, city and neighbourhood has its own unique drug history. The history of drugs in a city or neighbourhood depends on when drugs were first introduced there, the profile of users and the community response. In one area, cocaine may be considered a drug for the wealthy, in another it can be bought on the streets. Understanding the meaning of drug use and its social context is critical for effective assessment.

Awareness of critical issues is also variable between cities. In most cities, drug use remains invisible and on the face of it, it may look like there are no tensions between drug users and the community. When problems are ignored, the health or social needs of users are not identified or even linked to drug abuse. Drug abuse may be linked to school failure or to suicide attempts, and denying the problem means there will be no attempt at providing harm reduction interventions.

The diversity of problems posed by drug abuse requires specific targeted analysis of local needs and resources.

4.2. A pragmatic approach

Although local assessment is always recommended in urban policy, it is not always put into practice. The complexity of the issue must be considered as the first obstacle. The fact that drug consumption and dealing is illegal makes assessment more difficult. However, important progress has been made over the last few years. The European Monitoring Centre for Drugs and Drug Addiction gathers national statistics in all European countries which are becoming more and more standardised. Data provided from many sources is analysed and new trends are identified. Access to information, however, remains difficult at the local level.

[·] Sources of information are limited and statistics gathered in local services are not standardised.

[·] The main sources of information are statistics from drug and law enforcement agencies. This information is not sufficient to fully understand the local situation.

[·] Each type of problem (risks linked to drug abuse, drug trafficking, delinquency and anti-social behaviour) needs a specific approach. Detailed studies need both financial and human resources, which are lacking at the local level.

[·] Evaluation of available resources is part of assessment but evaluating services is not only complex, it also tackles institutional processes, which are often in situations of conflict themselves.

Local assessment must consider all dimensions of the problem, but not all research has the same objectives. The information that needs to be gathered is that which is necessary for effective decision making.

When a problem appears in a neighbourhood, the assessment will begin by:

[·] Gathering existing information, and

[·] Consulting those involved in the conflict

The assessment will need to address commonly held assumptions about the problem - for example, are there any drug users living in a particular neighbourhood, are they foreigners, immigrants, are they homeless?

For example, in thinking about young drug users, we may ask, do young drug users have addictions that need treatment? And are services adapted to new patterns of drug use? These questions would be asked of all key professionals, doctors, social workers, addiction experts and harm reduction workers. Interviewing young users is also essential to know their opinion or personal experience of health care services. Services may be adapted to benefit the needs of young users based on this research and the service would be re-evaluated during the course of the project according to results it obtains.

Local assessment is necessary for deciding on priorities and must be an on-going process through every stage of project development.

In large European cities, assessments may already have been carried out and it may be necessary to provide additional evidence to justify the development of new projects. While the programme is running, more precise analysis could prove to be necessary in order to understand new users and new risks, or for the service to be extended to new target groups.

Knowledge of the local situation deepens as projects are developed. For example, through Safer Nightlife projects, knowledge about patterns of party drugs and risks associated with it is increased. Similarly, the provision of accessible facilities such as drop-in centres highlights the obstacles many users face in accessing other health care services. Monitoring projects on an on-going basis will identify issues which need further assessment.

The methodology has to be flexible, and must use all available data.

[·] The process of assessment has to give some rapid first results

[·] The data gathered has to be summarised to build up a picture of the local situation.

[·] This background context has to be submitted to the partnership and must result in indicators which aid future monitoring and evaluation.

4.3. Shared assessment

Taking time to consider all dimensions of the situation and the need for quick action may appear to be contradictory goals. The partnership offers a framework in which diverse views about the problem or associated needs can be discussed, and this is crucial if the assessment is to accurately reflect the local situation. Cities, such as la Spezia in Italy, carried out shared assessment with all the concerned actors leading to a report gathering all the collected data.[8]

When authorities ask for local assessment, they want to have an objective analysis of the situation. They usually ask for quantitative data. Quantitative indicators are necessary but to select the right indicators, you must first understand the local situation. This requires consultation with all key actors. Doctors, the police, residents and drug users themselves have different experiences and different opinions. They all contribute to what sociologists call 'building the problem', that is to say the way in which the community interprets the issue and what the consequences are.

The first source of information is the experience of each partner. Professionals know what problems arise from dealing with drug users. Drug users know why they use or refuse to use a service. Residents know what they fear. The partners know what the relationship between the services is.

Interpreting statistics from partner services requires the participation of professionals working in those services. Health professionals, for example, would know whether the increase or decrease in the number of patients is due to a change in resources, a change of practice, or if the number of drug users affected by a problem has increased or decreased. The same can be said for analysing number of arrests or convictions.

Evaluation of institutional resources demands participation from professionals. Professionals are in the best position to know the limitations of their organizations. It might be necessary to appeal to external research, especially if there are any conflicts. The participation of professionals is required to identify the resources that services could make available. They are also in a position to identify obstacles for accessing others services.

(8) See fiche at *www.democitydrug.org*

When citizen organizations take part in assessment, they provide insights into every day life. They require authorities to look into anti-social behaviour which leads to a feeling of insecurity. In addition, participants in the assessment process will become aware of how services function, they will learn what results may be obtained by law enforcement agencies, or by drug agencies. They can understand theirs limitations. They will understand the usefulness of developing experimental projects, adapted to their local setting.

A shared assessment requires the collation of data from all available sources. It requires negotiations between partners to share the same analysis. Co-operation to gather information is a pre-requisite to co-operation in action. Shared assessment is required for partners to develop common aims.

4.4. Defining the objectives of assessment

A pre-assessment may be necessary in order to identify:

[·] What the partners do agree or disagree on, and

[·] What is known and what needs more detailed research

Objectives resulting from the assessment phase will be based on this pre-assessment. Knowledge of the issue is cumulative. It is based on professional and personal experiences and on other research that may already have been carried out.

When little is known about a city's drug users, local assessment should have modest ambitions. The objective must be realistic, for example:

[·] To identify target groups

[·] To identify services able to reach drug users

[·] To identify individuals or facilities in contact with problematic drug users, i.e. the police, emergency services, residents, parents, close relatives, harm reduction projects

[·] To identify patterns of anti-social behaviour and crimes linked to drug issues.

Pre-assessment may lead to:

[·] The creation of new sources of data collection, such as:

>> An outreach service, which will intervene in the problematic area, or

>> A mediation service between residents and drug users.

[·] Analysis of quantitative and qualitative data within services

>> Collecting and analysing complaints;

>> Analysing reasons of admissions to emergency services.

[·] Summary of sources which bring together all the data:

>> A local drug use observatory;

>> Development of a warning system to identify new trends in drug use;

>> Monthly reports to monitor projects and evaluate their effects and impacts.

[·] Research with specific aims:

>> Observing a particular site, a target group or the relationship between different groups;

>> Research on risk behaviour linked to drug use in the local setting;

>> Study of the judicial process; the impact of measures on minors;

>> Public opinion surveys.

The aims of the assessment depend on resources which can be mobilized:

[·] A warning system, a local observatory, or a monthly report to monitor projects need substantial investment. Public opinion polls also require investments that have to be discussed according to the priorities of the local council.

[·] Analysing existing data within services is always useful. The partnership co-ordinator might support a working group within a service.

[·] When additional research is needed, it may be necessary to develop a working relationship with national or regional research centres, universities, or professional training centres (i.e. for social and health workers).

[·] Learning from experience within other European cities is critical. Exchanges and visits between cities need to be encouraged, resourced and developed. A city such as Charleroi in Belgium knew to develop this type of exchanges on a European scale and to benefit from it.[9]

4.5. Background information on drug use

Information on a given area, town or neighbourhood, must take into account the background to the drug problem:

..... 4.5.1. Economic, social and cultural background of the area

Drug use has different characteristics depending on whether it occurs in towns hit by unemployment or on the contrary within a town which is developing economically. Social and demographic characteristics, family relations, social mobility and migration affect the meaning of drug use. The particular setting, such as whether the problem

(9) See fiche at *www.democitydrug.org*

is in a tourist town, a port or a border town, will affect the context. Trafficking routes also affect the local situation.

Data might have been collected from fields not specifically relating to drugs such as community safety, social housing, truancy, teenage suicides or delinquency.

..... 4.5.2. National or regional characteristics of drug use

In Europe, much information regarding drugs is collected at national level within five information centres at national focus points. This is part of the REITOX Network. This information is often collected by national focal points able to evaluate the extent of the problem and its development.[10]

This information includes:

[·] Statistics from law enforcement and health care services

[·] Drug use surveys of the general population

[·] Specific research dealing with types of drug use and risk behaviour

[·] Crimes linked to drug use, drug trafficking rings and imprisonment of drug users.

National or regional research creates a framework which allows local conditions to be identified. For example: are deaths caused by overdoses increasing? Is there an increase or decrease in the number of users in healthcare settings? Which drugs are being seized?

..... 4.5.3. History of drugs in the area

The city's drug history is another factor which determines the context in which the relevant measures should be introduced. This local history partly determines opinions and attitudes, and it also determines current resources as well as those which could be mobilized.

In Western Europe, there are few cities that don't have a long history with drugs. If the precise history of illegal drug use is not known, at least it is possible to know when the problem became public, which event created a scandal, and what the context was (for example, was it a rave, a squat or a school). The local media will have evidence of this. Official papers from locally elected officials or complaints to the police may provide clues as to the extent or nature of the problem. It may be possible to investigate the debates which preceded the setting up of drugs projects, and their successes and failures.

(10) See information on the European Monitoring Centre for Drugs and Drug-addiction's website at *www.emcdda.europa.eu*

It's important to carry out background research (using, for example, newspaper articles, reports from city meetings, previous initiatives by NGOs) as part of the assessment process.

4.6. Quantitative Evaluation

How many drug users are there in a given city? How many are not receiving treatment? How many young drug users are injecting drugs? What petty crimes are associated with drugs? How often are they committed? How many citizens are victims of such crimes? In principal, a quantitative evaluation is necessary to make decisions. Quantitative data is also important in informing public debates. But there must be clarity about what is being measured. Surveys of drug use in the general population or in a specific group, such as students, do not show the number of problematic users in the area. Furthermore, a user who may be problematic for the community may not necessarily be presenting as having problematic health concerns.

Evaluation based on measurable data is not impossible, but would require a large number of services in contact with drug users. It also requires a reliable data collection system. Statistics from law enforcement and drug agencies are not sufficient to carry out a satisfactory assessment. Additional data is required.

> The majority of Western European cities have undertaken evaluations relating to the number of problematic drug users. Considerable progress has been made over the last ten years on this issue.[11] Different techniques have been experimented with. One example is the "capture/recapture" technique.[12] This technique is based on data collected in all services in contact with drug users (such as hospitals, emergency services, the police, NGOs etc). The problem is that the data is not standardised. It is also possible to evaluate the number of drug users in an open drug scene but it needs specific research. The city of Rotterdam has estimated that there are 700 problematic drug users in the city, but this estimate has only been possible after years of intervention and research.

A quantitative evaluation of an open drug scene should not be a prerequisite for the implementation of a local programme but is necessary for improving statistics on drug use. It is critical to identify quantitative indicators to aid the monitoring of local programmes. Statistics are important in increasing our knowledge of the context as well as in being critical for evaluation and monitoring purposes (see Ch.6).

(11) See European Cities Comparison, Ruud BLESS, Multi-city study, Pompidou Group, 2002 [P-PG/Epid (2002)11]

(12) For France, see the multi-centre study of Lens, Lille, Marseille, Nice, Toulouse, Observatoire Français des Drogues et Toxicomanies, 2001 – www.ofdt.fr

Currently, the main sources of information are:

[·] Statistics from specialized services: Caution must be exercised in using such data as it will only relate to drug users with whom the service comes into contact - most drug users are unknown to law enforcement or drug agencies. Increases or decreases in numbers from one year to the next may be due to changes in resources. Resources need to be stabilised before conclusions can be drawn from such data.

Non-specialist services such as general hospitals and social services may also have some data (such as the number of HIV patients), but most of the time, the collection of data has to be improved, which could be part of the objective of the programme.

[·] Health research: AIDS and hepatitis led to many studies being carried out. In Western Europe, risk behaviour has also been studied (for injecting or inhaling, for example). Other health issues are not so well studied. Psychiatric issues are only evaluated in a few clinical research projects. Overdoses are not recorded in the same way across European countries. Very few research projects concern other drug-related causes of death. Indirect indicators, such as the sale of syringes and substitution treatment might be useful data for quantitative evaluation.

[·] Drug use surveys of the general population: many surveys are carried out in European countries on alcohol, tobacco and cannabis (within the general population and or within specific groups (e.g. youth aged 15-29). Surveys of the general population do not deal with illegal drugs such as cocaine or heroin. Qualitative data are essential to understand the meaning and the social context of drugs, particularly underground drugs. Qualitative data contribute to the analysis of quantitative statistics from specialized services such as law enforcement or drug agencies. Qualitative data might be collected in certain areas by outreach services or ethnographic research.[13]

4.7. Analysis of needs and resources

Which drug users are related to services? What is their socio-demographic profile? What drugs do they use, what are the patterns of use? What are the risk behaviours? Which services are offered? How are services accessed? How can the quality of services be measured? At the local level, information is derived from annual reports of existing services.

Analysing information from services has a dual role:

[·] It brings together all relevant information available on known drug users, and identifies gaps in the information.

(13) See the TREND programme in France: *www.ofdt.fr*

[·] It identifies services and their limitations (difficulties in accessing care services, referrals not being made, reasons for dropping out of programmes etc).

Each service is in contact with particular drug users in a given area. Little may be known on risk behaviour, and information on their needs is incomplete. Analysing statistics from each service requires an understanding of their remit and operational premises.

Drug users are better known where harm reduction services intervene. Outreach services reach hidden populations in various settings such as in deprived areas, open drug scenes or in party contexts. Despite their work, knowledge gained through harm reduction services often remains incomplete, depending on what kind of services are offered. Many questions remain to be answered. Syringe exchange programmes are often in contact with drug users aged 30 and above. Do younger users no longer inject or do they not want to be identified as 'drug addicts'?

It might be difficult to identify drug users in services that are not specialised in drug addiction, such as a general hospital, an emergency service, institutions for street workers or young people. But these services might be in contact with drug users unknown to drug agencies. Their experience could be very useful.

4.8. Additional exploratory research

These exploratory research projects are carried out after existing information has been analysed. They have to be time-specific (from a few weeks to a few months). The information gathered is inevitably incomplete but needs to be sufficient for the process of developing the programme's objectives.

This additional research might tackle drug users' relations with services or with their environment, for example:

[·] Profile of drug users in emergency services; needs and responses

[·] Analysing conflicts within services (housing, rehabilitation, hospitals etc)

[·] Profile of users in prison, reasons for imprisonment, causes of subsequent offending, success or failure of rehabilitation

[·] Experience of families; relationship between young users and non-users

[·] Conflict analysis

Additional research is specially aimed at identifying the hidden population of drug users in the community and not just in relation to services.

Qualitative research is necessary for this purpose. Field researchers are able to establish trust relationships with drug users. The skills, knowledge and practice within harm reduction work well with ethnographic research methodologies.

The public health emergency regarding HIV and injecting drug use has highlighted the need for understanding the social context of drug use and risk behaviours, as well as needing to respond with pragmatic recommendations for intervention and policy development. Carrying out assessments has been necessary for the implementation of services in very different national contexts across the world. A methodology for 'quick assessment' has been developed with questions such as: How do we access and maintain contact with hard-to-reach drug users? Which services would respond to their needs? What health needs should be given priority? This methodology is promoted by WHO and the UN AIDS programmes to adapt AIDS prevention strategies to the various international contexts.[14]

Research projects must have the co-operation of key actors.

Key actors are in a position to provide specific and certified information on drug users in a given area. They have to be familiar with the lifestyle of the target group These key informants could be professionals, volunteers or indigenous workers or peers, users or former users. The quality of information collected will be particularly improved if drug users living in the community are integrated into the project.

Key informants can be trained to interview drug users or their families, close relatives, and neighbours. They can be trained to explore a specific question, for example, access to treatment, crisis situations, or relations between drug users and residents.

These key informants could later become involved in monitoring and evaluation of the local programme.

4.9. From local assessment to priority setting

Analysis often shows:

A lack of coherence between health care and criminal agencies.

[·] The police are often alone in dealing with drug issues on the streets; they may have no appropriate agency to refer to other than rehabs.

[·] Drug users who use public spaces or private areas are often socially excluded; they may not have accommodation or access to treatment.

[·] Problematic drug users are also often rejected by health care services.

[·] There are serious gaps in service provision for dual diagnosis cases (ie those where there are psychiatric issues as well as problematic drug use).

[·] The lack of socio-medical responses for those leaving prison leads to re-offending.

(14) See WHO Rapid Assessment and Responses guides at www.who.int

[·] Fear of repression makes users not bold enough to contact emergency services during crisis situations such as an overdose.

[·] Fear of closure by the council is an obstacle to prevention in night-clubs.

[·] A lack of cooperation between health agencies and social services - There are no social responses for users undergoing medical treatment. There are no appropriate responses during crises. Drug users are not referred to appropriate services after admission into emergency services.

[·] A lack of consultation with citizens - lack of information is part of the problem. Citizens don't understand how services operate. They don't understand why all drug users are not being treated or sent to prison. The fear of drugs might be sustained by the media or television programmes but it is important to not underestimate the reality many residents face on a daily basis. The safety of vulnerable people, for example isolated, elderly or disabled people, would need particular attention.

[·] A lack of measures addressing young drug users- in part, the difficulty is the different expectations of key actors. The status of cannabis is a key issue in the debate and alcohol abuse is often overlooked. Using cannabis is seen as normal for young drug users, but it worries their families. Responses to cannabis use are often purely repressive. In the context of the party scene, responses to risk behaviour have been developed but these responses have not been adapted to the social context of everyday lives. Groups of young people suspected of cannabis trafficking could also be the cause of conflicts within communities. Treatment is not adapted to polydrug use mixing alcohol, cannabis, and stimulants such as cocaine (which is being increasingly consumed within most European cities - see Appendix 1).

[·] Minority groups do not have full access to care - marginalised drug users, immigrants, homeless young people, minors, prostitutes. Girls and women of each of these target groups require specific measures.

[·] Events or particular contexts change the supply and demand of drugs - Cultural events, such as festivals, concerts, a "teknival" or periodical changes due to tourism (beaches in the summer and winter sports) would require selective interventions. Cities on national borders and ports on drug trafficking routes require specific research programmes and adapted policies.[15]

Local assessment provides the information needed for problems and available resources. It lays the foundations for a discussion on the priorities of the local programmes. Choices depend on the importance attached to law enforcement, health and social cohesion. An integrated programme articulates the priorities of each field.

(15) See publication: European Forum for Urban Safety, *Drug-related cross-border traffic patterns*, 1998

05 Building a local strategy

5.1. Integrating the aims of social cohesion

Law enforcement, on the one hand, and health on the other hand, have their own indicators to evaluate the extent of the problems. Taking social cohesion into consideration modifies the priorities in each field:

[·] The impacts of juvenile anti-social behaviour often go beyond the seriousness of the specific acts that are committed because they de-stabilise relations between generations which is at the heart of social cohesion.

[·] Public health policies are based on the rates of death and morbidity but the lack of access to care for marginalized groups or people suffering from mental disorders could have important consequences for the community despite the very few numbers concerned.

Programmes have to take into account the effects and impacts of health and law enforcement issues on social cohesion. The aims of social cohesion policies have been defined by the Council of Europe with the following indicators: an equal access to available resources, a respect for diversity, autonomous groups and citizen participation.[16]

Taking social cohesion into consideration has shown to be particularly important in local programmes confronting public conflicts. In Oslo, Frankfurt and London, the fight against crime and drug trafficking has been strengthened, but in all of these cities, law enforcement services are associated with social measures and policies. In Amsterdam, alternatives to prison are offered to arrested drug addicts in rehabilitation services. In Zurich, evaluation of the city's programme reached the conclusion that "any action taken solely by the police without the support of the health care and social services is doomed to failure." Finding a balance between individual freedoms and community safety has to be negotiated with citizens. Mechanisms for conflict management, dialogue between professionals and service users, cooperation between police, health care and social services, and community programmes are key factors of success.[17]

The aims of social cohesion have to be taken into account in harm reduction programmes:

[·] Social needs must be considered: access to housing can lead to drug users not squatting in private areas at night. Finding a job gives marginalized drug users a real alternative to exclusion or prison.

[·] There must be easy access to substitution programmes. Once stabilised, drug users can re-establish good relationships with their families and the wider community.

(16) See publication Pompidou Group, *Concerted development of social cohesion indicators - Methodological guide*, 2005

(17) See conclusions: Johnny Connoly, *Responding to open drug scenes and drug-related crime and public nuisance – Towards a partnership approach,* Pompidou Group, 2006

[·] Responses have to be adapted to individual situations and particular target groups such as young pregnant women or mothers, ethnic minorities, male and female prostitutes, homeless young people, squatters etc.

5.2. Objectives of harm reduction at each stage of a programme

Harm reduction is a public health policy. Drug users have to protect their health, which means both access to prevention (HIV and hepatitis transmission, risks linked to drug use) and access to health care services (for physical and mental health problems).

These public health objectives may contribute to greater community safety and social cohesion when the relation established with drug users in the context of their everyday lives provides opportunities for referral to health and social care services. Experience shows that most drug users are willing to be reintegrated back into the wider community when services are adapted to their individual situation.

Each stage of a harm reduction programme has its own objectives:

[·] Improving knowledge of the context: adapting health responses to current risks involves knowing users' backgrounds. A local programme adapted to the context would involve knowing the individuals themselves as well as their relationship to the wider community.

[·] Improving service provision: this includes improving access to, and quality of, services, developing professional skills, sharing resources through networking between different services.

[·] Developing new services: new services have to be commissioned to complement existing services. These may need to be exploratory projects in the first instance.

[·] Developing responsibility and citizen participation: families, young people, neighbours and citizens' local organizations. For example, the city of Ljubljana (Slovenia) proposes to parents training seminars in order to help them in managing risky behaviours.[18]

The general aims must result in precise and measurable objectives.

European cities responding to open drug scenes have developed local programmes with set targets for each dimension of the programme. For example, preventing new drug users from getting involved in the drug scene (Oslo), ensuring community programmes do not have negative impacts on neighbouring areas (the railway station in Heerlen, the Netherlands), protecting schools from drugs (Vienna), increasing the number of patients in treatment and reducing the number of young people receiving custodial sentences (Leeds). These objectives can be evaluated with key performance indicators.[19] The city of Matosinhos (Portugal) involves the inhabitants in the designing of their Municipal Drug Action Plan.[20]

5.3. Harm reduction services in the local context

Depending on the context, a local programme may favour one particular approach to intervention, but all the different approaches need their own resources, and this financial planning need to be built into the project form the outset.

Harm reduction services initiated by individuals or civil society organizations often respond with limited aims: access to sterile syringes, looking after patients in hospitals, self-help or civil rights of drug users, protecting mothers with children. When the action is part of a city council programme, these services could be broadened.

An outreach service whose primary role is to improve knowledge of the local situation has to propose services that establish trust and adapt to risk behaviour in context. When investigating anti-social behaviour, for example, the team has to play a mediatory role between residents and drug users. Barriers to access to services will be identified by the team accompanying drug users into services.

Easily accessible facilities such as outreach teams are defined as 'low threshold' (originally from the Netherlands) as they address drug users without demanding detoxification. These harm reduction facilities respond to immediate health needs and responses are adapted to manifesting risk behaviour (AIDS, hepatitis, STDs, blood poisoning, overdoses, etc).

According to the European Monitoring Centre for Drugs and Drug-Addiction's glossary, the aims of a harm reduction approach are to reduce the incidence of drug use-related infections and overdose, and encourage active drug users to contact health and social service.

The aim is to enable drug users to take control over their own health - users are responsible of making their own choices relating to drug use as well as to social integration. Services have to be user friendly, i.e. users are respected in the same way as any other citizen, and each person's case is individually considered. In return, drug users are asked to respect the local community. Responsibility and solidarity are the basis for the exchange.

(18) See fiche at *www.democitydrug.org*

(19) Connoly, 2006, op. cit.

(20) See fiche at *www.democitydrug.org*

A range of services have been tried in many different contexts such as housing for active users (shelters and hostels), low threshold prescribing treatments without demanding abstinence, mobile bus or van delivering sterile syringes or methadone treatment in the community. The range of services could include experimental initiatives, for example heroin prescription, injecting rooms or drug use rooms, which are proposed in Spain, Germany and the Netherlands.

Two types of facilities are in a position to play a key part in local programmes:

[·] Outreach services: these services are aimed at the hidden population of drug users, not served by existing drug agencies. These services intervene in an informal manner where drug users are living, on the streets, in squats or in night clubs, during 'teknivals', and concerts.

[·] Drop-in centres: these facilities offer a range of different services linked to risk behaviour, such as needle exchanges or provision of condoms, or they target socially marginalized users. Centre visitors can have something to eat and drink, and hygienic facilities and nursing care are often provided. Some emergency treatments might also be provided including referral possibilities to health care services or re-integration programmes.

These two types of service are often the first actions to be carried out in local programmes because they are able to identify specific needs and could result in new experimental initiatives.

Outreach services and drop-in centres often work in an integrated way. For example, the needle exchange can be part of an outreach service on a mobile bus or van, or a drop-in can be a safe space at parties or festivals, a 'chill out' room with gentle music, where drug users can relax, drink water and cool down. These services can be used day or night, in a given area or for a particular target group.

5.4. Managing integrated facilities

Integrating the objectives of public health, law enforcement and social cohesion has several consequences:

..... 5.4.1. Implications for service provision

service commissioners need to decide whether to provide an integrated service in one place or to operate on the basis of referrals to other agencies and programmes. Resources and existing work practices will determine which approach is adopted. However, from the perspective of drug users, such choices have to further opportunities for their empowerment and re-integration into society. Access to city-wide services contributes to drug users' reintegration but drug agencies need to play an intermediary role between drug users and existing services in order to make the best use of existing skills and resources. Harm reduction facilities have proved to be helpful in developing bridges between established services and marginalized minorities.[21]

Faced with a housing problem, social services can be called upon to define under what conditions drug users could be accepted, for example in dedicated programmes. But in some areas, there is no possibility of negotiating any housing for drug users. A specific project such as a temporary shelter or hostel would be the right response. It is important to disseminate information about new projects to other partners.

Barriers to accessing treatment centres and health care services must be identified and relayed to other partners. Certain issues are recurrent. Access to treatment is particularly hindered by:

[·] Psychiatric issues

[·] Alcohol problems and / or polydrug use

[·] Injecting

[·] Crack, cocaine and other stimulant drug use

Experimental projects are required to respond to the constant evolution of patterns of drug use and risk behaviour. Harm reduction projects require a pro-active, responsive and flexible organization, aware of the local environment, able to develop new projects with new target groups which present new risk behaviour. The team must be prepared to re-evaluate objectives and means at regular intervals, as local circumstances may quickly change.

..... 5.4.2. Staff recruitment

Working in an integrated programme requires a multi-agency team. All harm reduction activities require accurate knowledge on the patterns of drug use, the mode of administration, the risks and protective factors, the context of drug use and the local street culture. An integrated local programme stresses knowledge of the wider social and cultural context, relationships between groups of residents, family structures etc. Networking requires other specific knowledge, such as the roles and responsibilities of different services, professional practices and work cultures. Knowledge is partly gained from personal or professional experience and partly from empirical, technical and scientific sources.

Skills such as managing behavioural change, counselling, managing crisis situations and violent behaviour are specially required in frontline services but working in an

(21) See guide available at *www.democitydrug.org*

integrated service also emphasises skills such as communication and advocacy, networking and involving people and organizations, developing self-empowerment and community development.

In order for agencies to work together efficiently, it is important to be willing to learn from each other's experience. It is also necessary to have shared goals regarding how services need to be reformed.

Within the framework of the Democracies, Cities and Drugs project, the T3E-UK network produced a guide on race equality in the local drugs policies which takes into account the importance for the teams to be representative of the ethnic minorities.

Incorporating workers with different cultural and professional backgrounds also requires particular attention to:

[·] Time allocated to meetings: essential in frontline services, from a minimum of once weekly for the whole staff team to a daily basis for partners

[·] Working groups: these may relate to difficult situations, problematic behaviours, particular target groups. They may be specific to staff or in co-operation with partners

[·] Supervision: team support, empowerment, conflict management are essential

[·] Training session: these are important not only to gain knowledge but also because they act as a space for exchange and dissemination of good practice. These need to be open to

[·] Partners working in different fields (psychiatric, addiction, doctors, counsellors, social workers) and experienced volunteers (AIDS, self-help organization of drug users, parents, young organizations etc)

Harm reduction activities demand personal commitment and a large range of skills, as teams are working with people who are often in distress or in chaotic and unpredictable situations. Career planning and support must be part of the management of the project to prevent resentment, conflicts and 'burn out' of staff. This is frequent in frontline services and is not only detrimental for the health and well being of the individual but also compromises continuity and relations of trust within community projects.

[·] Management of the change agenda

Establishing viable working practices requires the identification of tasks with agreed timescales and adequate resources. The main tasks are:

..... 5.4.3. Collecting and analysing information

Disseminating messages and delivering information on prevention

> Counselling and support

> Making referrals and accompanying users to appointments

> Dedicating time for meetings

> Training

> Co-ordinating the partnership

> Mediation

> Developing initiatives and self-help projects

> Communication

Frontline services often underestimate the time and resources needed for all these tasks and may make use of volunteers or 'indigenous' workers with no professional qualification (such as local residents or drug users themselves). To successfully fulfil these tasks, frontline services have to be managed in such a way as to provide:

[·] Clear lines of responsibility and accountability

[·] Visible management structures and well-informed managers

[·] Realistic time-scales to match the objectives and targets

[·] Results evaluated against key performance indicators.

The programme must be regularly monitored. Difficulties must be identified. Good practice and success must be recognised and promoted.

5.5. Sharing information

Sharing information enhances the effectiveness of partnerships. It enables commissioners to make effective decisions about future financial support to projects, and allows services to be adapted to the needs of marginalized people. It allows for an open communication and exchange between services, citizens and drugs users. Drug users may be able to draw on their own experience and gain valuable skills through their involvement. However, there are many barriers to effective exchange.

..... 5.5.1. Technical difficulties

There needs to be a unified approach to the collection and analysis of data, and guidance on the kinds of information that is required by the partnership. Those working in frontline services acquire experiences that they are not always able to pass on. Indigenous workers may fail to note essential points that are so obvious to them that seem unnecessary to pass on. Another obstacle is linked to the kind of service that is offered. In frontline services, relationships with users are often limited. Contact may be brief, the user may not want to be identified, or hasn't got the time. Information on individual cases is confidential. Stigmatization and illegal activities would clearly be an issue in gathering information. Formalizing the collation of new knowledge raises specific difficulties which require experienced professional or research experts.

Experts may need to be called upon in particular stages of the local programme, for example, when developing projects in new settings, with new target groups, or with new risk behaviour. Researchers may also be needed in evaluations.

..... 5.5.2. Organizational difficulties

These obstacles relate to the internal functioning of each service and to communication between services. Health professionals and social workers are not always willing to treat drug users due to fear of facing high-risk conflicts or tensions. The Police service fear information leaks; the medical profession deals with medical secrets, ethnographic research on underground activities requires confidentiality to be guaranteed. Circulating information between different agencies breaks the tradition of every service which has traditionally tightly guarded information gained through its work.

..... 5.5.3. Political and ethical debates

Information sharing has to take into account the different aims and objectives of partner agencies. Community safety is a common objective that needs shared assessment but sharing information on individual cases has to be negotiated as there are civil liberty and human rights implications.

> When dealing with youth crime, drug-related crime, and violence, some cities, such as Rotterdam in the Netherlands and Leeds in the UK, have developed local programmes combining law enforcement and health care responses. Files of personal data have been set up for each i ndividual offender, or for addicted persistent offenders. The main source of data is through law enforcement agencies and health care services but other sources are used, such as residents' complaints or problematic users identified in the education system.[22]

The aims of monitoring have to be discussed and agreed with each partner agency. Ethical rules need to be defined: drug users have to be considered as any other citizen; their human rights have to be respected.

Partners and clients (drug users, families and residents) have to be informed of the data collected, who has access to the information, and how the data will be used.

Human and technical resources have to be identified.

[·] Training of personnel who will be responsible for collecting the information.

(22) See: Thierry Charlois, *Workshop Report "Drugs & Insecurity"*, Urbact Programme, SecurCity project, 2005

[·] Amount of time allocated, and

[·] Requirements for expert evaluation

5.6. Mobilizing resources

Cooperation between facilities is neither easy nor spontaneous. It is a long term process. Working together requires:

[·] Understanding the aims and objectives, practices and professional cultures of each partner.

[·] Accepting the consequent changes of organizational and professional practice.

Cooperation between law enforcement agencies and health and social care agencies raise particular issues that need addressing.

..... 5.6.1. Partnerships with law enforcement agencies

Local programmes may decide upon their common objectives based on issues identified through the local drugs partnership but reducing drug-related crime, community safety and dealing with anti-social behaviour are all key aspects of the police's role. For the police, working with health and social care agencies is beneficial because their work contributes to public safety. However, some times there are tensions between policing aims and those of health and social care agencies.

Cooperation between the police and harm reduction services is more direct than with the judiciary as both services make interventions at the frontline (for example, in neighbourhoods, in party scenes and so on). Precise objectives and means of cooperation depend on the context:

[·] In proximity of harm reduction services:: the safety of everyone must be guaranteed. Users have to be able to reach harm reduction services without being arrested because they are using drugs. The team has to call the police when crimes and drug dealing put people in danger (residents, the team and drug users).

[·] In police stations: medical consultations have to be allowed. The police must refer arrested users to appropriate health and social care services. In crisis situations, such as family violence or psychiatric problems, the police have to be in a position to call in appropriate professionals.

[·] In neighbourhoods: specific police actions, such as dispersing a group of drug users in a given area, should be organized with health and social care services, such as emergency housing, low threshold treatment, referrals and support.

[·] In nightlife settings: all dimensions of safety for young people must be considered. Transport issues must be considered for every one, including clubbers, emergency

and harm reduction services. The health and welfare of young people must be considered by establishing responsibilities for each service.

New national and local regulations are increasingly being developed which regulate the actions of enforcement agencies on the one hand and health, youth and social care services on the other. These new regulations, particularly focused on minors, are at the heart of public debate about whether children and young people should be given support and diverted from the criminal justice system or whether demands for community safety require further and further repressive measures. Violent or anti-social behaviour, petty crimes, as well as the involvement of minors in drug trafficking has led to a demand for greater repressive responses. This demand is further fuelled by failure to provide adequate funding of children and youth services, lack of adequate monitoring, and a succession of measures which do not allow for integrated responses[23] to individual children or young persons.

Law enforcement and health and social care services have several aims in common which should aid co-working. These are:

[·] Guaranteeing the safety of workers and clients on a daily basis

[·] Offering alternatives to prison

[·] Reducing the level of re-offending

[·] Offering support and care as early as possible

Each of these aims needs to be adequately resourced.

Reducing re-offending rates requires the development of shared-care arrangements with individual rehabilitation projects for sentenced drug users (For example Operation Heartbeat, Heerlen, a partnership between institutions, transport companies, the army and the prison service). Some cities have launched specific projects in order to offer treatment services to the most problematic users (For example Rotterdam, the PGA 700 project aimed at the most problematic users).

..... 5.6.2. Partnerships with health and social care services

Partnerships with health or social care workers can be difficult because on the one hand, there is a generalised fear of, and prejudicial attitudes towards, drug addicts and drug addiction. On the other hand, some drug users do present problematic behaviour for health and social care staff and their attitudes and beliefs may be based on such experience. Drug users are believed to not tell the truth, not follow rules, and always have urgent demands.

Drug users generally avoid health and social care services as they are afraid of being identified as a user. The consequences of being identified are different in each country depending on the national drugs legislation and on common professional practice. In the least, when there are no legal consequences, drug users will fear stigmatization and exclusion. Minors, pregnant women or mothers and prostitutes particularly fear social controls.

Harm reduction workers play a crucial role in acting as intermediaries between users and services. Staff has to facilitate access to treatment and rehabilitation services but they have to develop relationships of trust with drug users. Situations must be treated case by case, according to service aims and professional practice. Workers must inform drug users of the aims of the service and how it operates.

There are different models for improving access to health and social care services:

[·] Individuals may be accompanied for referrals to other services

[·] Joint care packages may be initiated with doctors and/or social workers

[·] "Bridge" schemes can be set up e.g. reserved hospital beds, specific projects to inform users of service provision etc

[·] Walk-in surgeries or case-work sessions with social workers based in harm reduction services

[·] Joint case management for difficult cases and/or crisis situations

..... 5.6.3. Networking as an effective tool for action

Developing good personal relationships is a pre-requisite to effective networking.

[·] Networking creates a common culture: working together is the first step to building a common culture on drugs. Because health professionals understand what drug users may be experiencing, they may be in a position to develop trusting relationships and may even be able to propose changes to the service based on their understanding. A common culture must be built upon a common base of knowledge. Networking will help partners gain a better understanding of each other's jurisdictions, roles and responsibilities.

> Objective: harmonizing the knowledge base amongst key actors:

> Means:

>> Training: Common training sessions with all key partners will eventually develop a common culture and shared practice around drug users. Each agency can communicate about its way of working with other partners.

>> Communication: the network has to provide existing information on drugs to

(23) See publication: European Forum for Urban Safety, *Local approach to organised crime*, 2000

all participants and to produce up-to-date harm reduction materials. Specific projects may be launched: information centres, call centres.

[·] Each of the partners must have an interest in the network: the network has to benefit each of its members. It must make current information available on the programme being carried out and on the existing resources in that area. It must offer a framework in which professionals can be called upon for their expertise.

> Objective: sharing resources

> Means:

>> Managing the network: updating and selecting useful information, identifying a link worker between the partnership and each agency

>> Making available local expertise: consultations organized within existing services (hospitals, social services, psychiatric services). Joint care and referrals for difficult patients.

>> Inviting experts from different fields (harm reduction, drug dependency, psychiatry, education and welfare).

>> Making available materials and human resources: office staff, communication resources.

[·] The network's actions must be valued: Locally elected officials have to support the development of the network. They are responsible for providing sufficient and adequate resources for the functioning of the network. There may be additional funding from all services that benefit from the network through capital support (e.g. local materials, equipment), human resources (time), or providing information.

> Objective: emphasis on good practice

> Means:

>> Information on action being carried out by the network as part of the partnership approach; inclusion of the network's actions in the partners' activity reports.

>> Public communication of actions. Organizing meeting or debates.

5.7. From information to participation

Ways of tackling the consequences of social exclusion may not be obvious at first glance. It requires reliable information and evidence. Repressive laws do not altogether address the public's demands for increased community safety. Furthermore, community safety is reliant on many other policies, from education to town planning.

The aims of policies on social cohesion not only determine choices about projects and facilities, but also about how to implement them, how to mobilize resources and which strategies to choose for communication. Local programmes need to use arrangements for local democracy in their areas. These are:

[·] Public information: information on action carried out is a prerequisite for citizens' participation. All means of communication are required: the local media, newspapers, press releases, internal and external communication channels of individual agencies, and organizations such as neighbourhood committees.

[·] Consultation: Citizens may be consulted by existing organizations such as neighbourhood committees. Bodies such as residents groups, youth councils and user groups within public agencies may be contacted. Consultation can lead to the development of policy around drugs as well as to specific work groups and commissions. Some countries or regions may also decide to hold referenda.

[·] Public debate: debates may be held at different stages of the development of programmes in order to inform residents of the progress that has been made in terms of analysis of local problems, choice of priorities, and effects and impacts of the programme (See example of the Forum organised by a Foundation in Haarlem, the Netherlands[25])

[·] Mediation: mediation may or may not be particular to the issue of drugs (Liege, mediation within a local community safety contract; health mediators in Roubaix[26]), and is responsive to different mechanisms for neighbourhood feedback. Organizations can take on a mediatory role between locally elected officials and residents. Specific organizations can take on this role for a particular group of residents (immigrants, youth or family organizations).

[·] Negotiation: negotiation can affect priorities for the whole programme or for targeted action such as the launch of a reception centre. Projects have to be negotiated in exchange for guarantees. Negotiation takes place in a more or less formal framework but must recognise the range of opinions on any one issue. Citizens' juries have been successfully used as a means of bringing together diverse viewpoints (For example in Burnley in UK or in Paris-Stalingrad in France[27]).

(25) See publication: European Forum for Urban Safety, *Local participation in strategies for the prevention and control of drug abuse*, 1998

(26) See publication: European Forum for Urban Safety, *Urban crime prevention policies in Europe: towards a common culture?* 1998

(27) See newsletter CRIPS-IDF, 56ème rencontre du CRIPS-IDF *"Démocratie participative et réduction des risques"*, 2004

06 Evaluation of local initiatives

6.1. Evaluating national drugs policies

Evaluating results in the field of drugs policy is a recent requirement. Up until the mid-90s, there was no valid reason to expect any improvements. Year after year, all countries experienced increasing indicators; increases in the number of arrests of drug users, increases in the quantity of drugs seized, and increases in the number of lethal overdoses. This continual increase generated a feeling of powerlessness. There was a willingness from politicians to tackle the issue of drugs but many knew they could not expect positive outcomes for their efforts. Initial harm reduction projects that provided clean needles and syringes seemed to be at odds with 'the fight against drugs'. Such measures had to prove to be efficient in fighting AIDS and in protecting drug users' health but one of the first concerns of evaluation was to demonstrate that such initiatives do not result in encouraging drug consumption. Needle exchange programmes could be developed because it could be proven that improving access to clean syringes does not increase the number of injecting drug users in the city.

The development of harm reduction policies has been heavily based on evidence. Two outcomes of such policies has been the decrease in lethal overdoses and AIDS cases.

> In France, changes were particularly rapid and important. Harm reduction policy has been evaluated by the National Institute for Health Monitoring since 1994. The evidence shows that there has been a reduction of 80% in lethal overdoses and a reduction of two-thirds in AIDS-related deaths. In 2004, injecting was responsible for 3% of Aids infection, compared to 30% in 1991. Beyond the concerns with health, there has been a decrease of 67% in the arrest of heroin users. This result is correlated to the number of users in treatment.

These results have led the European Monitoring Centre for Drugs and Drug Addiction to recommend the adoption of such public health policy. There are nevertheless specific limitations to what can be expected from this policy:[28]

[·] The most interesting results come from substitution therapies: these treatments are only available for heroin users. There are no substitution treatments for other drugs. Treatments for stimulants use as cocaine or polydrug use are less successful.

[·] The most problematic users would require specific care: referring problematic users to care services is a key issue for local programmes but the drug users with concurrent needs would require a broader project that is able to take all dimensions into account, such as their drug dependency, psychiatric problems, social need and legal issues. Such projects require a multi-agency case work intervention.

(28) European Monitoring Centre for Drugs and Drug-Addiction, *Annual report on the state of the drugs problem in Europe*, 2007 - www.emcdda.europa.eu

[·] Harm reduction policy is limited to protecting drug users' health: prevention of use has more problematic results. In some European countries, prevention programmes have been successful in stabilizing the number of cannabis users, but good practice has not spread across Europe. Most prevention programmes are never evaluated.

National drug policies always have to deal with a rising number of users on the one hand and the development of drug trafficking on the other. European countries face some common features:

[·] In the field of drug use: Heroin injection has been and always is a central element of drug problems, even though some western countries show a decrease. Opioids (largely heroin) remain the principal drugs for which clients seek treatment. In recent years, new patterns of drug use and abuse have been observed all over Europe. One of the main features of these new trends is the spread of recreational drug use. Polydrug users and users of stimulants such as cocaine have increased in all European countries. Alcohol abuse is often the basis of polydrug use. Cannabis, the most frequently used, gives rise to a growing concern for social and health outcomes. Though access to services has to be available as early as possible, very few young people seek treatment: only 7% of patients are aged under 20. The latest European report emphasizes the increasing need to develop responses that are sensitive to the complex and multi-faced nature of today's drug problem.[29]

[·] In the field of drug trafficking: international development of organized criminal gangs and drug traffickers is one of the major concerns at international and European level. Since the Treaty of Amsterdam, a European policy on drug trafficking has been in place. Arrests of drug traffickers and seizures of drugs are improving but these indirect indicators are dependant on resources allocated to law enforcement services. The results are always limited to specific areas and there is no consensus on global results on drug trafficking. There is interplay between repressive actions and organizations, affected areas and links between petty and major crimes.

These acknowledgments determine what can be expected from local programmes:

[·] It is possible to limit the negative consequences of use both for the environment and for the drug users themselves.

[·] It is possible to exercise greater control over a given area, to successfully fight against drug trafficking on the streets, and to reduce anti-social behaviour and community conflict associated with drug trafficking.

Whilst it is also possible to have successful impacts on drug use, local strategies need to recognise that drug use and drug users are here to stay. Drug-related problems are similar to other social problems which cities have to deal with in that they require continual assessment and evaluation.

(29) European Monitoring Centre for Drugs and Drug-Addiction, *Annual report on the state of the drugs problem in Europe*, 2007 - www.emcdda.europa.eu

6.2. Qualitative and quantitative indicators

Evaluation has to be planned at the very beginning of implementation process. Some cities in Northern Europe have plans with precise definitions of aims with quantitative indicators, databases for information gathered and some times qualitative as well as quantitative data.

The choice of data depends on the aims of the programme, but the feasibility of collecting information has to be taken into account:

[·] Few indicators have to be selected: each sector involved (the police, the courts, health care service, harm reduction services) have to choose their own indicators

[·] The information must be simple to collect: data should be collected from within each partner agency, as much as possible.

[·] The information must be significant: and relations established between different services will lead to a more whole analysis of outcomes.

..... 6.2.1. Indicators have to be defined for two different objectives

For the purposes of programme management, and for monitoring results, outcomes and impacts.

[·] Indicators for programme management: Management of local projects requires both quantitative and qualitative data in order to review aims and objectives, to mobilize new resources, or to call upon necessary expertise. The same question has to be asked at each stage of the programme:

[·] Does each partner benefit from the partnership? Is there effective cooperation between partners? What are the obstacles?

[·] Are the organisational choices justified? Do the regularity of meetings, the participants and the subjects considered correspond with the tasks in hand?

[·] Are the necessary decisions taken on time? Have they been discussed? Does every partner own the objectives? Has practice been adapted to meet the objectives?

[·] Have services defined quality indicators? Is access to services facilitated? Have staff benefited from training?

[·] Is the programme sufficiently funded? Have the objectives been redefined in accordance with the available resources?

[·] Has the involvement of local people been encouraged? Have people volunteered? Are new initiatives proposed?

Where there are difficulties or barriers that need addressing, it may be more productive to use qualitative data to gain an understanding of the issues in hand.

Partnerships become purely formal when there is no more debate, when those in charge are represented by more junior staff who cannot take decisions, or when absenteeism is increasing. Difficulties such as these can appear at the beginning but may continue as partners revert to previous patterns of engagement: there may be conflicts between different police services, or between the police and the courts, there may be a lack of co-ordination between social services and health care services, there may be territorial and political conflicts between decision makers.

Those charged with the management of such partnerships need to develop effective strategies for bringing about change. It is up to the co-ordinator to call upon partners when difficulties appear. The steering group needs to be made aware of such difficulties, and must support the role of the co-ordinator. When conflicts between partners cannot be resolved, decisions may fall on the shoulders of locally elected officials.

..... 6.2.2. Indicators for actions, outcomes and impacts

All services have to record their activities such as number of arrests, number of sentenced users, or number of patients being treated. It is important to distinguish between indicators of activity and indicators for outcomes.

Depending on the local situation, an increase in the number of drug users arrested could be considered a good or a bad result. The same applies for the number of complaints. Depending on the context, an increase could show an improvement in public confidence in the police. It could also show an increase in problems in neighbourhoods.

Indicators for service activity and those for outcomes are not used for the same purpose. Services have to provide evidence of their action. A high level of activity justifies greater human resources but quantitative indicators may have unpredictable and undesirable impacts.

Health care services may be tempted to exclude difficult patients, who demand a long time to achieve lower results. The same is true for Police forces: it is easier to arrest users known for a long time than breaking up a new ring of drug dealers demanding a long and difficult investigation.

The number of activities carried out does not equate with indicators for outcomes and impacts. Indicators have to be defined according to the desired results. Specific indicators have to be built to the analysis. Crime and social disturbance linked to drugs have to be identified and recorded specifically. Significant indicators have to be collected and provided across the different sectors involved.

For example in Leeds, UK, one of the aims is an increase in the number of drug users that are arrested. Specific indicators for the partnership have been defined: the number of users who have been referred to treatment agencies, the proportion of those referrals which have been retained in treatment, and those that have achieved completion of the care plan.

Projects need to be monitored according to a set of measurable variables collected through different sectors.

..... 6.2.3. Evaluative research

A number of projects require specific means to be developed:

[·] Reducing the number of re-offending drug users: evaluation depends on the information already collected in the courts or in the prison service. Evaluation should complement the existing data but individual trajectory research might be useful.

[·] Reducing drop out: it could require a dossier that can be passed from one service to the other. Evaluation on medical professional practice may be required to understand the reasons for success or failure.

[·] Changing drug users' behaviour: behaviours have to be identified in the setting of everyday life. Understanding such results requires identifying factors for protection and change.

[·] Changes to professional practice: changes of perceptions and beliefs, integrated approaches, support and counselling for behaviour change; development of a framework for cooperation and networking.

[·] Development of community health programmes: increasing participation and membership, key actors involved in the local programme; development of new independent initiatives.

Some of the variables may be integrated into a database, for example re-offending users or patients who drop-out of treatment services. Other indicators may be unique to a specific aim.

When the City of Rotterdam developed a partnership programme for the most problematic 700 drug users, it called upon expertise from specialists in all fields: psychiatrists, criminologists, addiction specialists and sociologists. Understanding individual trajectories with criminal backgrounds and treatment histories required joint research, better knowledge on the drug market and population of the open drug scene. The project developed a multi-agency approach to individual care. Evaluation will require an individual follow-up but understanding the results should also require qualitative research on professional networking practices.[30]

Whilst outcomes are judged against indicators, such as a reduction in drug-related crime and anti-social behaviour, it is imperative to understand why such results have or have not been obtained in the context of project delivery. Good professional practice requires qualitative research to identify the 'know-how', which determines the context for dissemination and training.

Qualitative analysis is required to select significant quantitative indicators. Qualitative analysis will take into account the complexity of the different variables in order to select few quantitative indicators that are significant for a strategy to bring about change.

6.3. Results and impacts

Most local programmes have been implemented to respond to open drug scenes and associated problems, such as violence between participants in illicit drug markets, street prostitution, public drug-taking, drug-related petty crime etc. Some European cities have now got much experience in responding to such issues and have developed different strategies. Levels of tolerance show considerable variation but whatever the societal choices, the most experienced cities of Western Europe have made attempts at assessment and have drawn up common guidelines (See Pompidou group report on open drug scenes, 2006, Appendix).

The first point is that good results can be obtained. 'Good results' means that open drug scenes are closed down or that the open scenes are in small places which are under control. Over the last few years, public concern on open drug scenes has been growing and cities such as Zurich, Frankfurt, and Amsterdam have responded to this through lessons learnt. These results show that:

[·] Very large scenes have negative consequences both for residents and for drug users. They must not be permitted to develop. Misunderstanding of the situation has numerous personal, societal and political consequences: open drug scenes are viewed as a terrible failure and powerlessness of authorities. The consequences for drug users themselves are no less acceptable. Drug users can be subjected to violence, social marginalization and health deterioration. They may feel trapped in the scene while young people are continually attracted.

Very large drug scenes cannot be controlled but some cities show a 'conditional tolerance' for small manageable drug scenes rather than driving drug users underground, which might be an obstacle for low threshold services as well as monitoring by the police. The 'conditional tolerance' is based on one principle: the monopolisation of public space by one group is not to be tolerated. Drug users can meet as long as it does not create a 'no-go' area, i.e. a public place residents would fear to go through.

[·] An isolated action by the police without backup from health and social care services is bound to fail: simple repression is not the answer. Partnership working offers the most sustainable method. In the first instance, this partnership requires collaboration between law enforcement, and health and social care services but it can be widened to other partners such as other services or residents. The partnership between law enforcement agencies and health and social care services must be based on a multi-faceted approach which involves a balance between repressive measures and the needs of drug users.

Working together is not easy: it requires a change of attitudes and practices by every one involved. Police authorities must move beyond strict law enforcement towards more problem-oriented policing. Social and health care professionals have to take into account the objectives of each service. Residents also have to accept the establishment of drug treatment facilities in the setting of open drug scenes. Overcoming these challenges is mainly dependent of the partnership functioning in terms of coordination, decision-making and communication practices.

[·] Harm reduction strategies must be part of the response: The needs of individual drug users and available support services are a crucial component of the efficiency of local programmes. Responses to drug users must not be limited to detoxification. Taking into account social and health needs requires a global strategy with:

> Immediate responses to urgent needs with low threshold services

> Widening treatment options

> Iimproving access to existing health and social care services

The importance of harm reduction strategies depends on the context. In Frankfurt, Zurich, Oslo, Dublin and Heerlen, developing services for drug users was systematic with 'low threshold' reception centres, rooms for injecting and taking drugs and easy access to treatment. Each facility was discussed and the extent to which they were accepted depended on three factors, public reaction and the level of tolerance in relation to drug use, human and financial resources that could be mobilized, and the legal status of each facility. Needle and syringe programmes and substitution treatments are now largely accepted in European countries. Injecting rooms and heroin prescriptions are the most controversial issues and still need debate and discussion.

[·] Good results can be obtained:

These results concern residents as well as drug users:

> A significant reduction in the quantity of drugs dealt on the street and the petty crimes and disturbances associated with drugs

> A significant reduction of mortality and a significant improvement of health for drug users

Measuring outcomes has an important role within partnerships as well as for citizens and authorities, but it requires specific attention and resources. Partnerships estab-

(30) See Thierry Charlois, 2005, op. cit.

lished in most European cities have identified specific needs and promote projects such as reception centres, housing for drug users, or information centres to meet those needs. Each of these projects can be evaluated with internal indicators, such as the number of clients or the number of actions taken, but it is difficult to evaluate their impact on the city as a whole.

> In Hamburg, a reduction in the number of petty crimes linked to drug use has been observed while at the same time access to methadone treatment has been made easier. Police forces are convinced of the indirect link between these two factors but evaluative research demonstrates the complexity of different variables.[31]

Results such as reduction in mortality rates have been observed but how those figures correlate with local programmes have rarely been established. Calculating a reduction in petty crime or anti-social behaviour presuppose that this was in fact an initial objective. Indicators demonstrating success have to be identified and agreed upon from the outset.

Over the last few years, there have been considerable improvements in providing analyses which take into account different factors that may impact on an outcome. Lessons learnt form such experience have modified national policy in the UK with an annual Tackling Drug Supply Conference. Measuring outcomes have become a key principle for drug policies

> The pilot scheme in the City of Leeds is an example of a partnership project. It was developed as part of the legislation adopted nationwide on anti-social behaviour (from The Crime & Disorder Act 1998). The evaluation deals with the effectiveness of measures such as the injunction of or the obligation to receive treatment for people who have committed crimes linked to drugs. 60% of people who commit drug-related crimes have been referred to treatment agencies, a proportion which is still considered unsatisfactory. On the other hand, the reduction in delinquency is testified. From March 2004 to May 2005, there was a reduction in burglary of 54%, a reduction in car crime of 40%, and a drastic reduction in drug-related crime of 89.5%.[32]

The three key principles that have emerged from this project for the City of Leeds are that:

[·] There is a need for effective project management from the outset, with clear objectives and achievable targets. This requires recruitment of qualified and effective leaders from the outset who are committed to the task at hand.

[·] Working partnerships as the key to success for any multi-agency project, so long as they are able to acknowledge the differences in working practices between partners. Effective partnerships take time to evolve and mature - they cannot be made overnight.

[·] Recruitment and employment of dedicated workers who are skilled in their areas of expertise is crucial. The success, to date, of this project has been solely due to the Herculean efforts of the people involved in its delivery. The role of individuals is not always pointed out. It is however their mobilization which ultimately determines the outcome of the programme.

(31) See publication European Forum for Urban Safety, *Local approach of organised crime*, 2000
(32) See Thierry Charlois, 2005, op. cit.

07 For a strategy of change

7.1. Changing attitudes, changing practice

Harm reduction programmes are founded on the basis that whatever prevention or repressive strategies there are, some people will always take drugs. Drug policies must not simply aim at reducing the level of drug use, but must also adopt a holistic approach that addresses the impacts of each approach on other aspects of the problem.

Harm reduction strategies widen the range of responses to drug use, and have several aims:

[·] To prevent drug users' health worsening in the short term

[·] To make access to treatment easier for dependant drug users

[·] To fight against social exclusion.

The approach must respond to problems as they appear in the field; responses must be adapted to the diversity of drug use and problems associated with it. A pragmatic approach is required with realistic objectives. Health promotion encompasses a large range of measures aimed at reducing the adverse consequences of drug abuse at individual and collective level with low threshold facilities. These facilities are based on two main principles:

[·] Drug users have to be able to protect their health, even if they continue taking drugs;

[·] Drug users' needs are not limited to detoxification; they have the same needs as any other citizen.

Harm reduction policies lead to a cultural change of beliefs and images on drug addiction. Changing attitudes involves a change of professional practice and relations with drug users:

[·] Drug users are held to be responsible: projects must promote users becoming more aware. As well as being responsible for their own health, drug users must also exercise responsible for the consequences of their drug use in their local environment.

[·] A range of problems is considered: responses must be adapted to different patterns of drug use and target groups: casual drug users, marginalized users, minors, migrants, women, prostitutes etc

[·] Information given must be credible: it must be based on the real risks of each drug and associated patterns of use. Dramatisation must be avoided.

This cultural change affects every one: professionals, drug users, families and the wider community. The project helps bring about change when it takes into account all the different needs, calls upon every one to be responsible and promotes social cohesion through negotiation between different parties.

The issue of drugs must lose its exceptional status; it must be treated like every other problem that modern society has to deal with.

7.2. Promoting medium and long term change

Problems are not always specific to drugs. For example, one may be faced with rigid organisations, or the lack of interaction between service delivery staff and managers.

In frontline services, workers are particularly vulnerable. They have to face the consequences of social exclusion, violent behaviour and conflict situations. Frontline workers are not welcome in health and social care settings because they represent problematic users who nobody wants to take care of. This role requires knowledge and many skills but these are often poorly identified. 'Burn out' is a frequent problem with serious consequences not only for the worker but also for the projects, which lose their credibility.

Changing perceptions, attitudes and behaviour requires an investment in the medium or long term.

Programmes are often funded for 2 - 3 years. This is the minimum time required to observe changes in attitudes or behaviour, but these changes must be shown to have become permanent. Furthermore, 2 – 3 years is not enough time for cities that have not had any experience in this kind of work. Acquiring knowledge and expertise requires long term investment.

A strategy for mid-long term change needs to tackle many different issues:

[·] Support for innovative practice: projects must adapt to changing patterns of consumption, changing drug user profiles and changing risk behaviour. Development of new innovative projects must be on-going.

[·] Responsibility: community health projects have to be promoted, be it through self-help organizations or in projects which bring together drug users, professionals and citizens.

[·] Recognising the value of good practice: good practice must be identified and supported. Participant's involvement in the medium and long term depends on the support and recognition they receive.

[·] Training key actors in the programme: training should be offered to everyone involved, professionals, as well as decision makers, residents and drug users. Training is the basis for promoting a common culture with regards to drugs and drug addiction.

[·] Recognising the importance of a qualified workforce: required practices and knowledges must be identified (drug use and risk behaviour, institutional resources, experience of mediation and negotiation). Frontline workers must be qualified.

[·] Communication at each stage of the programme: All of the communication resources should be called upon, from internal communication mechanisms to the marketing departments of city councils to use of the media. The public must be kept informed - public meetings, open debates, internet sources etc. Successful projects must receive sufficient publicity. Difficulties should be recognised and lead to a public debate.

[·] Mobilising the media: the media' role is often to report on scandals. This can increase awareness of an issue or increase fears and stigmatization. The media must be used from the outset. Keeping the public informed contributes to the development of effective responses, to the development of innovative projects and, above all, to the value of all good results.

[·] Using expertise: Lessons learnt need to be disseminated. Regular exchanges must be organised. The existing resources at the European level must be made available to everyone involved.

7.3. Limites of the action

Developing actions aimed at drug users often meets with the following difficulties:

The legislative framework: the European Union favours development of actions that protect the health of drug-users (see references…), but these often require adaptation of the legislative framework. For example, while WHO has recognised the effectiveness of substitution treatments at European as well as international levels, some European countries still have no legal framework for such treatments. Substitution programmes often operate in limited contexts. For example, they often have small budget allocations which result in small numbers of users in treatment. The public health benefits and community safety would clearly be enhanced if larger numbers of users were able to access such treatments. Additionally, some programmes (such as heroin prescription under medical supervision) are still only considered to be of an experimental nature and are not offered on a wide basis across the region. Some of these treatment options may be more widespread with better evaluation and dissemination by practitioners at national and international levels.

Public support: the level of public support for interventions often depends on the specific context. The development of day centres and other facilities for drug users has given rise to numerous debates. Consumption rooms remain unacceptable to the public in a number of European cities, even where such services are able to be offered within the legislative framework. Such experimentation requires a change in public perception and attitude. Interventions must respond to clearly identified objectives and be informed by a process of on-going evaluation.

Competing paradigms: curbing drug trafficking versus promoting public health: a local policy that sets integration as an objective must identify the contradictions which exist within public policy and practice at the local level. Drug dealing can develop wherever users gather, whether it is in the context of their daily lives or in an institutional context (such as in shelters). The problems posed by this will differ according to the context. For example whether the dealing is taking place in an open scene in an urban environment, in a syringe exchange programme, in a treatment centre or

in clubs and parties. Experience has shown that large open scenes in urban areas should not be tolerated, for public safety as much as for health protection and integration of drug-users. On the other hand, young people's cultural practices must be accepted and even encouraged, and the young must be able to benefit from information adapted to risk-taking. Each time, it is a matter of evaluating to what degree, and with what professional practices, trafficking can be controlled, the safety of residents and drug-users can be ensured, and health protection guaranteed.

Heightened demand for security: the demand for security leads to increased measures of social control. These measures can run counter to principles that underly professional practice and policy formation in a range of areas (such as health, youth protection, family services and so on). For example, there is a consensus amongst experts against the provision of obligatory treatment orders that equate treatment with punishment (some countries such as the UK allow such orders to be made by criminal courts in place of custodial sentences). Furthermore, treatment for serious psychiatric disorders can be imposed as a legal measure. In such cases, treatment for drug dependence is combined with treatment for the psychiatric disorder. Similarly, the reintegration of repeat-offenders who are drug users must take their addictions into account. Must treatment in this context be imposed on the offender? Furthermore, how do we define 'repeat-offenders'? Is it a matter of thefts, hold-ups or drug possession, and necessarily combined with consumption? Use of tests (such as urine samples or hair analysis) can also, depending on national laws on the legal status of drug consumption, run counter to the interests of civil liberties. Public debates ought to focus on achieving a balance between the means with which we want to ensure security on the one hand, with what we want to achieve as an outcome on the other.

Three principles must guide the handling of these different contradictions:

[·] Experimentation

[·] Evaluation of results

[·] Negotiation

These three principles are constituents of risk-reduction policies: Initiating new interventions is almost always somewhat experimental in nature but maintaining an experimental approach is a necessity in the drugs field: interventions need to be continually adapted to reflect changes in drug use, customs, and risk-taking, and their consequences for users and society at large.

Experimentation requires evaluation of results, effects and impacts. The results in question may have been obtained from interventions carried out previously or in other locations but they must form the basis of decision-making processes about service provision. Additionally, decisions must be informed by expert opinion as well as public needs. Whilst access to sterile syringes is a non-negotiable intervention necessary for the prevention of infectious diseases, AIDS, and hepatitis, the way in which services are provided may be a matter for negotiation. It is important to steer away from knee-jerk responses to public outcries and demands for increased security. Such measures are short-sighted and lead to an escalation of repressive measures, which, far from reassuring the public, will feed the demand for more security because they are insufficient for resolving the problem. Breaking this vicious circle requires taking time for consultation and debate with all parties concerned, including professionals from all the various sectors as well as representatives from relevant organisations (relating to drug-users, young people, families, ethnic groups, community groups and so on). Tackling drug use is not merely a matter for public debate or just one that can be answered by experts and investigators - not least since every field of investigation, from biology to anthropology, by way of psychological or psychoanalytical theories, has its own approach to drug addiction and responses needed. As in all social issues, it is important to distinguish between what is a matter for experts and what is a mater for public debate.

08 Conclusions

Frontline services play a crucial role in local urban policies since they are directly in touch with the communities they serve. Police forces have long been - and often still are - the only agency to make interventions on the ground. But increasingly we are seeing the development of outreach teams on the streets, in squats or clubs and parties, who provide a range of health and social services as an alternative to the purely repressive response which had previously been in place.

These services are developed within the ambit of 'harm reduction' (i.e. aiming to reduce the risks associated with drug use). The objective of these actions is, in the first instance, to avoid deterioration in health, facilitate access to treatment and fight against processes which lead to social exclusion. Harm reduction policies also contribute to security and social cohesion. A number of European cities (especially in northern Europe) have developed a range of frontline services which meet such needs and are integrated into local urban policy.

Drugs policies in the European Union promote reduction of supply and reduction of demand as complementary goals but, the 'repression' versus 'treatment' argument is no longer sufficient for responding to problems arising from drug use. Users who are engaged in anti-social behaviour in neighbourhoods are precisely those who resist institutional responses. Risk-reduction or harm reduction interventions are both necessary and effective in supporting such users. Their effectiveness can be demonstrated by an improvement in the health and well being of users as well as a reduction in incidents of public nuisance, violence or criminal acts associated with drug use.

Cooperation between services is never easy. Each service has its own missions and rationales, but local officials are in a position to negotiate between these differing approaches in the public interest. Locally elected officials are, after all, responsible for promoting social cohesion, which includes the well-being of all, equal access to available resources, respect for diversity, personal autonomy and citizen participation. Thus, regardless of the complex and multi-faceted response to problems associated with drugs and drug use, the commitment of local officials is a determining factor in the development of integrated and coherent strategies at the local level. This is true of drug policy as with all urban policies: the results depend on whose involved and to what extent.

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