Strategic Choices for reducing Overdose Deaths in four European Cities

Part II: Appendix
to the final report from the project
STRATEGIC CHOICES FOR REDUCING
OVERDOSE DEATHS

A joint project of the cities Oslo, Amsterdam, Copenhagen, and Frankfurt am Main

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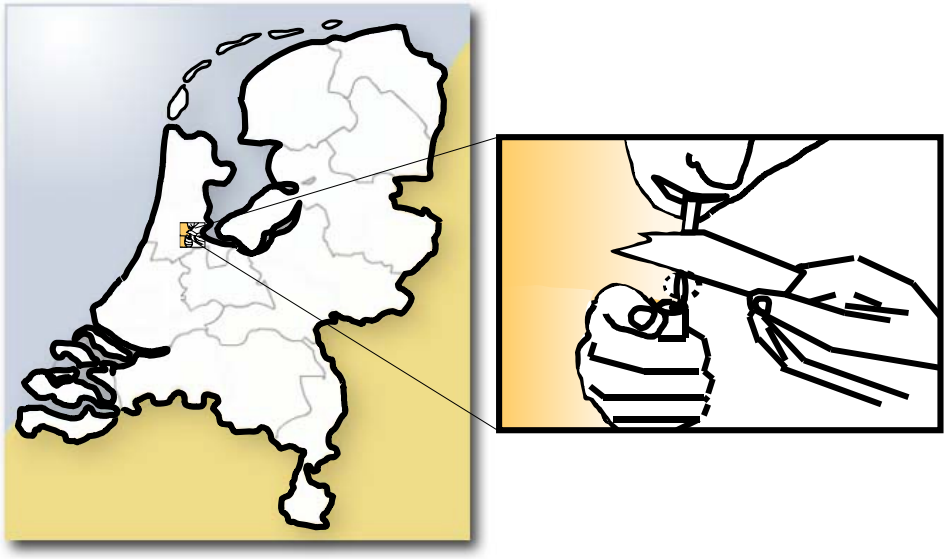
1 Drug overdoses and overdose deaths in Amsterdam



M Buster, T Sluijs, 2000

The city of Amsterdam

Amsterdam is a relatively small capital with its 727,000 inhabitants. However, it is a major cultural centre and has two universities. Activities of economic importance are; finance, conferences, tourism, transport (Schiphol airport and the Amsterdam Harbours) and Information / Communication Technology.

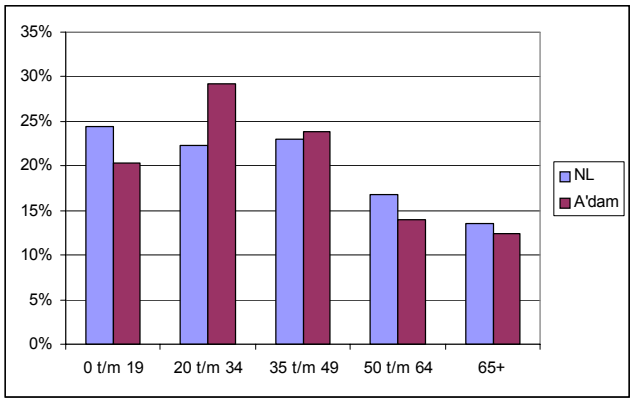
1.1 Demographics

The information of this chapter is based on reports of the Amsterdam Office for Research and Statistics (O+S) and the Central Bureau of Statistics (CBS) of the Netherlands.

- **Age-distribution**

Amsterdam has 727,095 (registered) inhabitants. Figure 1.1 shows the age distribution of Amsterdam compared to the Netherlands. Amsterdam has a relatively low number of people under the age of 20. The age group between 20 and 34 is over-represented. Many young people migrate to Amsterdam to attend universities, other educational institutions or start a new job in Amsterdam.

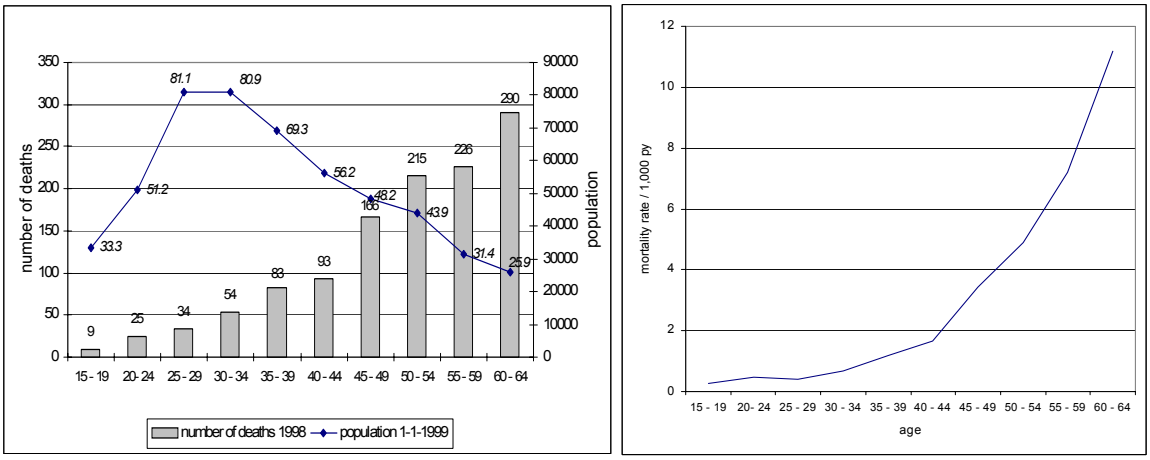
Figure 1.1: Age distribution of Amsterdam compared to the Netherlands



- **Number of deaths per age category**

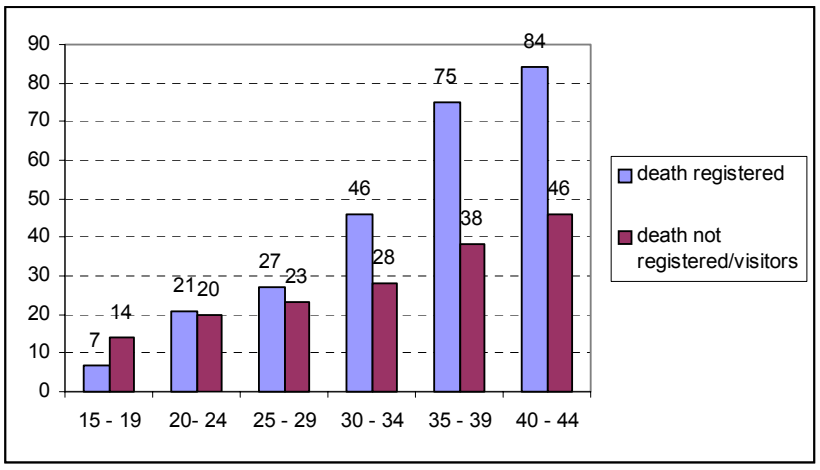
The number of deaths and size of the population are shown at figure 1.2. Mortality among the youngest age categories is rare. The incidence rates increase from 0.4 per 1,000 personyears (py) among the lowest until 11.2 / 1,000 py among oldest age category between 60 and 64.

Figure 1.2: Number of deaths, population size and mortality rate by age-category in Amsterdam



The number of deaths mentioned above are the figures of those people that are registered in Amsterdam. However, not all people that die in Amsterdam are official inhabitants of Amsterdam, and not all residents of Amsterdam die in Amsterdam. Some visited Amsterdam or are illegally living here, others came to one of the specialised hospitals (e.g. the cancer hospital Anthony van Leeuwenhoek). At 1999, 260 deaths of official residents and 169 of non residents between 15 and 45 were reported. Figure 1.3 shows the deaths occurring in Amsterdam at 1999.

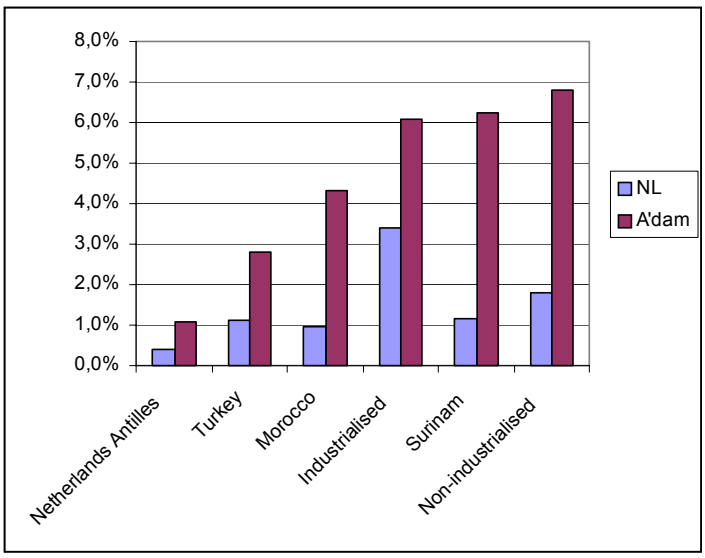
Figure 1.3: number of deaths <u>occurring in Amsterdam</u> (registered residents versus non residents)



- **Inhabitants by country of birth**

Twenty-seven percent of the inhabitants of Amsterdam is born in another country. In the Netherlands this is only nine percent. Differences between Amsterdam and the Netherlands are shown at figure 1.4. The foreign inhabitants mainly originate from Surinam, Morocco, Turkey and the Netherlands Antilles (52%). Another 22% originates from industrialised, mainly European, countries and 25% originates from the so called non-industrialised countries. Next to the 27% of the population that is born in another country, 17% of the population has at least one parent that originates from another country.

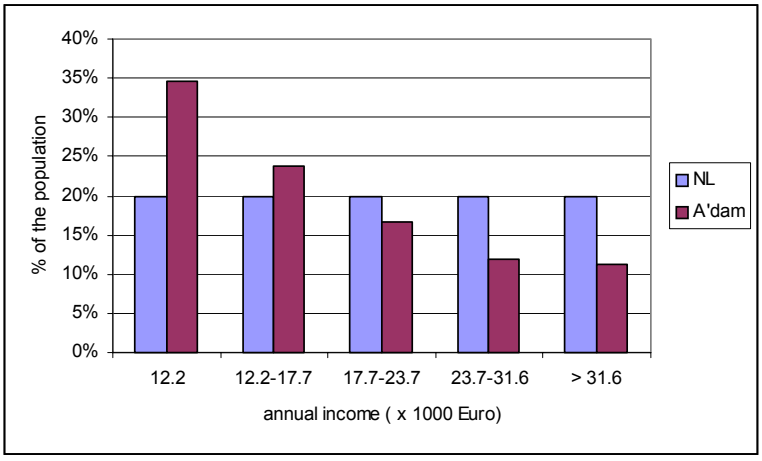
Figure 1.4: percentage of inhabitants born in outside the Netherlands, Amsterdam compared to the total Dutch population



- **Income**

Figure 1.5 shows that the income of the Amsterdam households is relatively low compared to the total Dutch population. The annual income of 35% of the Amsterdam households belongs to the poorest Dutch quintile, only 12% of the Amsterdam households belongs to the richest Dutch quintile.

Figure 1.5: Annual income per household in Amsterdam compared to the Netherlands



- **Social insurance**

The percentage of people that gets money from social insurance (unemployed or disabled) is higher in Amsterdam (24%) than it is in the Netherlands (16%). Figure 1.6 shows that the percentage of people that earns money by employment is lower among those between 18 and 24 years of age (presumable due to the high percentage of students). Between 25 and 64 differences are small. This is probably due to the lower number of people that depends on their partner. Almost half of the Amsterdam house holds consists of one person only.

1.2 Drug policy and History

The information of this chapter is mainly derived from the factsheets about the Dutch policy that are published by the Trimbos instituut. At http://www.trimbos.nl/indexuk.html more extensive information can be found.

1.2.1 General drug policy

The main aim of the Dutch drugs policy is to reduce the risks of drug use to the individual drug users, their immediate environment, as well as society in general. The reduction of supply and demand is also an important objective. With respect to the individual, the protection of their health is the key aim. In this context, prevention and care are core policy issues. With respect to the protection of society as a whole, measures in the field of public order and safety are important issues.
Responsibility for the Drugs Policy rests with both the Minister of Health, Welfare and Sports (HWS) Minister of Justice. The Minister of HWS bears the prime responsibility for policy on prevention and care, with the exception of administrative prevention. This is the task of the Ministry of the Interior. The Minister of Justice is responsible for the enforcement of the Opium Act. The Minister of HWS is responsible for the co-ordination of the government's drug policy.
The Opium Act is the main law in which regulations on drugs are laid down. Various other types of legislation may also be applied in investigation and prosecution which makes it possible to tackle money-laundering. The Public Prosecutors office has also issued directives for circumstances in which more severe sentences are to be used, such as selling to vulnerable groups (school children, psychiatric patients) and trade in the vicinity of schools and psychiatric hospitals. But the government policy is also based on the premise that criminal prosecution must be no more damaging to the drug users than the drug use itself.

- **'hard' and 'soft' drugs**

Since 1976 the Opium Act distinguishes between drugs that involve unacceptable risks ('hard drugs': heroin, cocaine, LSD and XTC) and cannabis products ('soft drugs' : hashish and marihuana). Drug possession, trafficking and production are illegal and punishable by law except for medical, scientific and instructional purposes, if a license has been provided. Penal provisions for hard drug offences are considerably more serious than those for soft drug offences. Moreover, the possession of drugs for trafficking are punished more severely than possession of drugs for individual consumption. In 1996, the Public Prosecutor established regulations for the investigation and prosecution of Opium Act offences. Investigation and prosecution of the import and export of hard drugs have the highest priority. The investigation and prosecution of hard and soft drugs possession for personal use (hard drugs up to 0.5 grams, soft drugs up to 5 grams) have the lowest priority.

1.2.2 History of drug use in Amsterdam

During the fifties amphetamine was used within small subgroups and a tradition of opium use existed within the Chinese community. During the sixties larger numbers of young people started to experiment with drugs, especially cannabis and LSD.
At the beginning of the seventies heroin was introduced and spread rapidly. The concordant influx of young Surinam people, vulnerable towards heroin addiction enforced the spread of the heroin epidemic in Amsterdam and street-trade was familiar to them.
At the end of the seventies heroin addiction was a major problem in Amsterdam that asked for a major intervention. This major intervention started at the beginning of the eighties with large scale methadone programmes and the famous methadone by bus project of the municipal health service. As Giel van Brussel, who developed these programmes, stated

twenty years later; “the Amsterdam programmes are founded on desperation and public health realism.” Soon treatment was available for all heroin addicts.

This “low threshold” approach however caused a cumulating number of German (and later Italian) heroin users that lacked this form of treatment in their own country. In contrast to the Surinam drug users, whose main route of administering drugs was oral (“chasing the dragon”), the vast majority of the German heroin users injected their drugs. In terms of drug deaths the situation got worse. Annually a three fold higher number of deaths was registered during the mid-eighties than during the end of the seventies.

Since the mid-eighties a policy of discouragement was introduced to decrease the influx of foreign heroin users. Access to treatment for those who were no official inhabitants of Amsterdam was limited. Treatment itself was more focused on the prevention of the HIV-infection that was spread among intravenous drug users. Besides information about HIV and AIDS, needle exchange and distribution of condoms was introduced.

During the nineties the number of foreign drug users decreased steadily. HIV-related mortality reached its peak and slowly declined afterwards. Due to the lower influx of young people the average age of the heroin users in methadone treatment has risen steadily and is about forty years right now. The percentage of injecting heroin users among them decreased until 15%. A sample of ± 200 chronic heroin users is treated with heroin experimentally. The (oral) use of base cocaine is getting more important within the scene of heroin users and other marginal groups (e.g. homeless youngsters). The target population of the municipal health service widens and includes all marginal groups that lack basic needs (home, income, medical support). Due to the low compliance of this population this implies an active role of this service.

Although the heroin using population is ageing and slowly decreasing. Young people still use drugs. The use of magic mushrooms, MDMA, Amphetamines, and cocaine is widespread. However, among those who use these drugs the frequency of use is generally low.

1.2.3 Budget of the municipality

The municipality is responsible for implementing the drug policy and drug aid services in Amsterdam. In Amsterdam the budget for drug aid services of the year 2000 is ε 14,500,000. The Jellinek and the municipal health service are the main institutions that carry out the prevention and treatment and receive a 38% and 31% of this Budget respectively. The Jellinek focuses on drug free treatment and drug prevention. The municipal health service on harm reduction and care co-ordination. Next to the Jellinek and the Municipal Health Service, 15% of the budget is spend on other organisations. The other organisations often contact the drug users at street level, give information and social care and may advise people to look for help at the Jellinek or Municipal Health Service. Some of these organisations (or institutions for homeless people) have users rooms. The number of user rooms will increase at 2000 and therefore ε 1,200,000 is reserved to build and start new user rooms. Another project in which different organisations co-operate is a 24 hour service project meant for crisis situations that may occur at any moment.

Table 2.1: Budget of the municipality of Amsterdam spent on drug-aid-services

Institution	ε
Jellinek	5,500,000
Municipal Health Service	4,500,000
All smaller services / organisations	2,200,000
user rooms*	1,600,000
24-hour service project†	700,000
Total amount of money spent	14,500,000

* *Half of which is incidental (building of new rooms)*
† *Shared organisations*

1.3 Drugs and Drug use

The information of this chapter is gathered from police information (laboratory) own observations and an article by Manja Abraham "places of drug purchase in the Netherlands" available at (http://www.frw.uva.nl/cedro/library/places.pdf). In this chapter the prevalence and incidence of the use of licit and illicit drugs in Amsterdam is described. This is reported by Manja D. Abraham, Peter D.A. Cohen, Roelf-Jan van Til en Marieke Langemeijer of the centre of drug research (CEDRO) of the university of Amsterdam the study *'Licit en illicit drug use in Amsterdam III, developments in drug use 1987-1997'* is available at http://www.frw.uva.nl/cedro/library/prvasd97.pdf Moreover, this chapter contains preliminary results derived from three projects that are part of a study in which "key indicators" of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) are studied (http://www.emcdda.org). These studies are conducted in co-operation with the university of Glasgow (local prevalence estimations of problematic opiate use), the university Tor Vergata of Rome (incidence of problematic opiate use) the Osservatorio Epidemiologico in Rome (mortality among opiate users).

1.3.1 Availability, price and quality of drugs

- **Alcohol and cigarettes**

Low alcoholic drinks (beer, wine, port) are available at supermarkets grocery shops and liquor stores. Drinks with higher concentrations of alcohol (liquor, wodka, whisky etc.) can be bought in liquor stores only. A look at the supermarket shows us that the cheapest tin of 0,5 l. beer is ε 0,40. Cigarettes can be bought at specialised tobacco shops, supermarkets, snack bars and pubs. One packet of cigarettes (20 cigarettes) is approximately ε 2.90. Cigarette smoking at public places is forbidden.

- **Cannabis**

Can be bought in coffee-shops. The main rules for coffee-shops are No advertisement, No nuisance, No Hard drugs, No sale to people younger than 18 years of age and no admission of youths to coffee shops, No sale of more than 5 g per transaction. Prices depend on the quality of the hashes or cannabis, 1 gram is approximately ε 5,00.

- **Magic Mushrooms, Smart and eco-drugs**

Different kinds of herbal drugs and magic mushrooms can be bought at the so called “smart drug shops”. One portion of magic mushrooms is ε 12,00

- **MDMA, Amphetamine**

These drugs can be bought at the “home-dealer” who sells MDMA or cocaine or may deliver drugs at home, at the discotheque or on the streets. The price MDMA is about ε 7,00, the dosage however, halved as well. Of the tested pills that were sold as MDMA 95% contained MDMA. The amount of MDMA varied widely from 5 to 195 mg (average 68 mg).

- **Cocaine chloride**

Purity of cocaine(-hydrochloride) is normally high, 90% till 100%. The adulterants normally used are manitol or linositol (kind of sugars). The price of cocaine is approximately ε 35,- a gram. The purity of base cocaine is high 90%-100%. What is left after turning the acid form of cocaine to the basic form is $NaHCO_3$, when ammonia is used generally no adulterants are found. The price of base-cocaine ε 35,- to ε 40,- a gram but it is possible to buy little pieces for ε 5,-

- **Methadone, Heroin**

Can be purchased at illegal dealers or on the street (Especially at the Red light district or South East Amsterdam) and “home dealers”. At the laboratory of the police in Amsterdam the purity of street-samples of heroin is studied. The percentage of pure heroin varies widely (10-60%) on average it is approximately 25%. Most important adulterants used are caffeine and paracetamol, caffein enhances the evaporation. The price of heroin is approximately ε 35,- a gram and is sold as “little balls of brown” of ¼ g. Methadone is sold for ε 1,20 per pill of 5 mg.

1.4 Prevalence of Drug use: Results of the House hold Survey

Table 3.1: selection of data from “*Licit and illicit drug use in Amsterdam III”*

	Prevalence			***Incidence***	***Age at onset***	***Trend***
	% ever	% ever and > 25 times	% last month	% start use last year	Median age start (all users)	Month prev. 1987-1997
Alcohol	88.1	77.1	70.9	1.7	16	-
Tabacco	71.4	62.8	41.8	1.2	16	↘
Cannabis	36.3	15.8	8.1	1.1	18	↗
Cocaine	9.3	2.6	1.0	0.6	23	-
Heroin	1.7	0.7	0.2	0.0	22	**X**
Amphetamin	5.9	1.9	0.3	0.4	20	-
XTC	6.9	1.2	1.1	1.3	25	↗
Hallucinogenics	9.2	1.0	0.6	2.1	22	↗
* magic mushrooms	6.6	0.4	0.5	2.0	21	↗
‘hard drugs'	14.1	-	2.0	1.3	22	↗

Hard drugs': heroin, cocaine, amphetamine, XTC, LSD
***X** :numbers too small to draw conclusions*

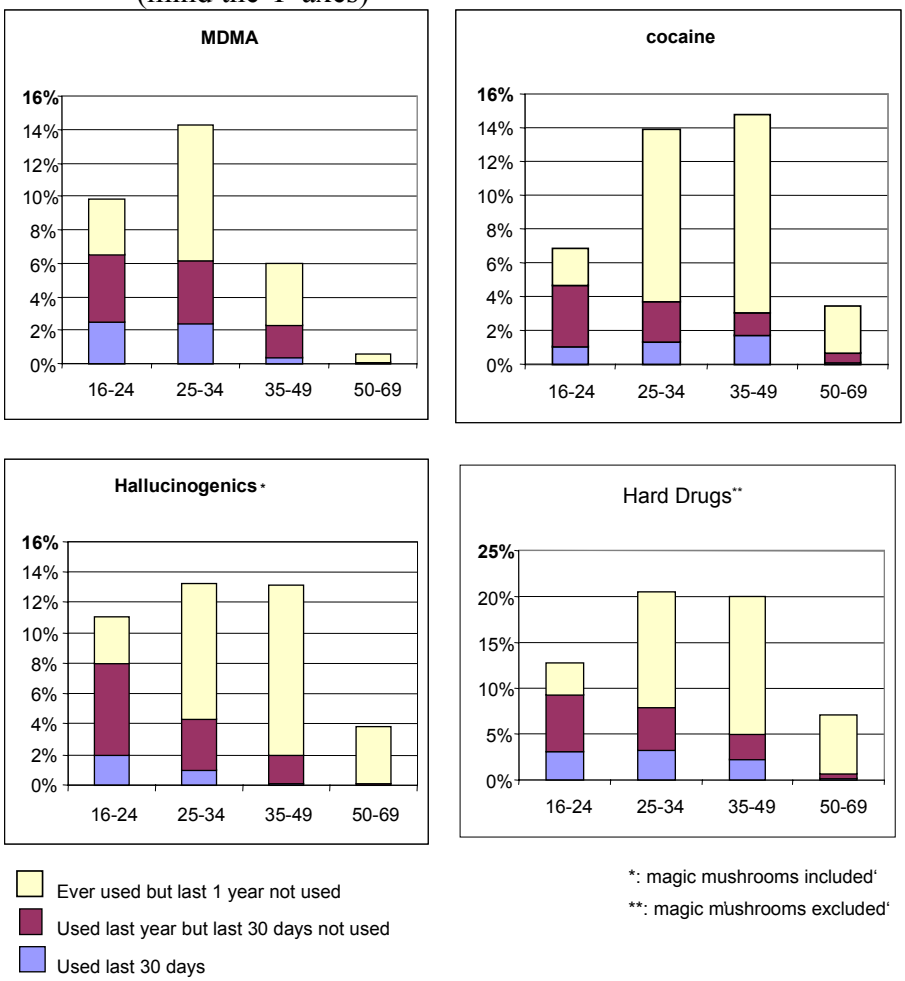
At table 3.1 a selection of data regarding the prevalence and incidence of drug use in Amsterdam is given. Considering illicit drugs, the percentage of experienced users (those who have used a certain drug at least 25 times) among the ever users is small. Less than half (44%) of the people that ever used cannabis, has used it more than 25 times in his life. Of the ever users 22% used cannabis during the month preceding the study. Still, there are people that use cannabis very regularly, 2% of the Amsterdam population used cannabis more than 20 days during last month.

Users of Hallucinogenic substances (LSD, magic mushrooms, mescaline, 2CB or Ayahuasca) are mostly experimental users, only 10% used it more than 25 times. Among the older age categories the proportion of actual users is very low. Figure 3.1 shows that the percentage 'ever users' by age is rather similar for cocaine en hallucinogenic substances. Only a small percentage of people above 50 years of age ever came in touch with these drugs. The highest percentage of (ever) cocaine use, is found among the age group between 35 and 49 years. Among this age group, last month prevalence of cocaine is highest too. However, current use of hallucinogenic substances is rare.

In Amsterdam the popularity of XTC started at the beginning of the nineties. Therefore ever use prevalence is highest among the age category between 25 and 34. Heroin use is rare among the general population of Amsterdam. People that just started using heroin are hard to find, only two out of the 3800 people questioned had his first experience with heroin during the year before the study. In comparison, 50 people used XTC and 77 used magic mushrooms for the first time.

Figure 3.1: prevalence of the use of XTC, cocaine, hallucinogenics en 'hard drugs' by age-category

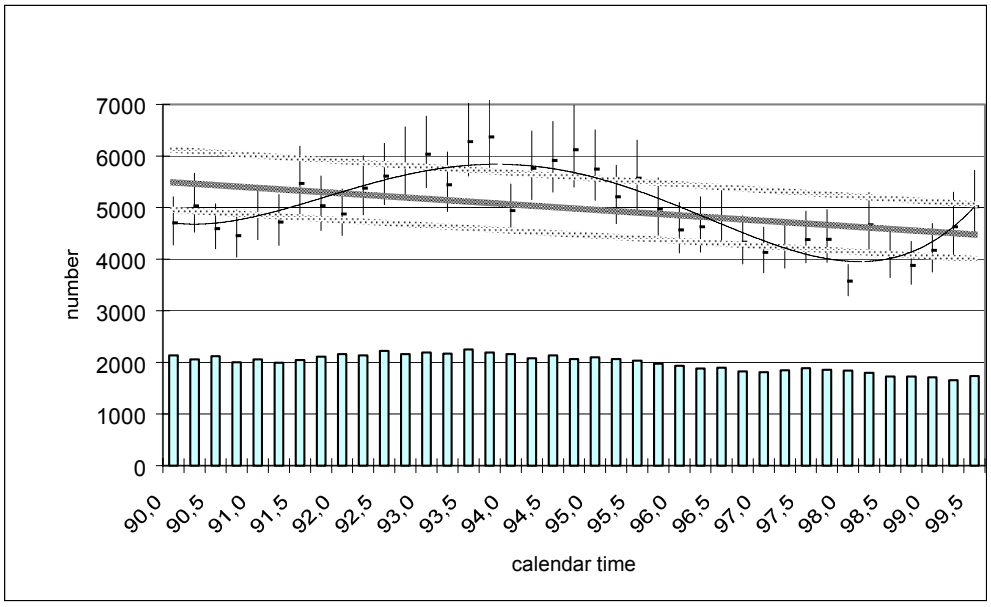
(mind the Y-axes)



1.4.1 Prevalence of problematic opiate use

House hold surveys are less reliable to estimate the prevalence of problematic opiate use. Therefore, the estimation of the prevalence of problematic opiate use is based on a three sample capture recapture method. Three quarterly registers; methadone treatment of the Municipal Health Service, methadone prescription at the police station to arrested drug users and contacts with drug users admitted in a hospital are used to estimate the size of the population that is not contacted by any of these programmes. These estimation is based on the amount of overlap between these three samples of problematic opiate users, analysed with general loglinear regression. Figure 3.2 shows the number of subjects that is used to estimate the total number of problematic opiate users. This is the number of opiate users that is in contact with the GG&GD within each three months periods (approximately 2000 opiate users).

Figure 3.2: The 3-sample capture recapture method: Based on the overlap between drug users that are registered at methadone treatment, police station or hospital the estimated number of problematic opiate users is calculated quarterly; the number quarterly observed by Municipal Health Service is shown as well.

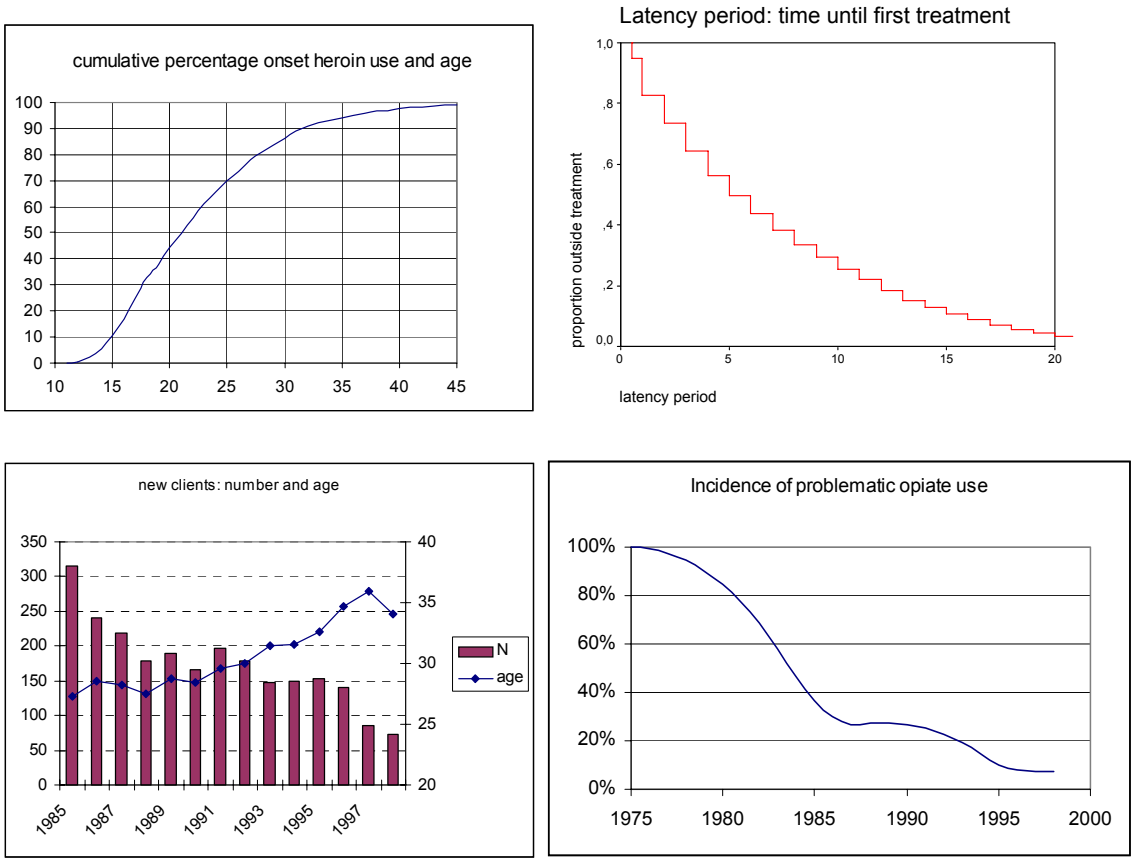


The prevalence of opiate use is slowly decreasing. A linear trend suggest an estimated number between five and six thousand at the 1990 and between four and five thousand at 1999.

1.4.2 Incidence of problematic opiate use

Incidence of problematic opiate use is calculated by using the "back-calculation method" that was applied within AIDS research. It is based on the idea that all AIDS cases are visible, the HIV positive people that have not developed AIDS yet, however, are hidden. When the latency of HIV-infection to AIDS is known, the development of the incidence of HIV-infection can be estimated by studying the development of the AIDS incidence.
Similar to the incidence of HIV infected the incidence of drug use can be studied. Drug users become visible when they start treatment. Before they start treatment many remain 'hidden'. The time between starting heroin use and starting treatment can be regarded as a latency period. The incidence can be calculated by combining information about the age distribution of starting heroin use, the latency time, the number of heroin users that start treatment and their age distribution. The back calculation method gives an estimation of the incidence of problematic opiate users that eventually will participate in treatment and is applied for the Dutch and major ethnic minorities only. The median age of starting heroin use was 21, the median latency period was 5 years. Although the capacity of methadone treatment remained stable, the number of new clients is decreasing since 1985. The average age of these clients increased from 27 to 35 years of age. This indicates that there is a decreasing incidence of problematic heroin users. This is confirmed by the results of the Back calculation method. According to these estimations the recent incidence of problematic heroin use is approximately ten percent of the incidence at 1975.

Figure 3.3: The back calculation method: based on the age of starting drug use, the latency time and the development of first treatment cases, the incidence of problematic drug use is calculated. (limited to the Dutch and major ethnic minorities)

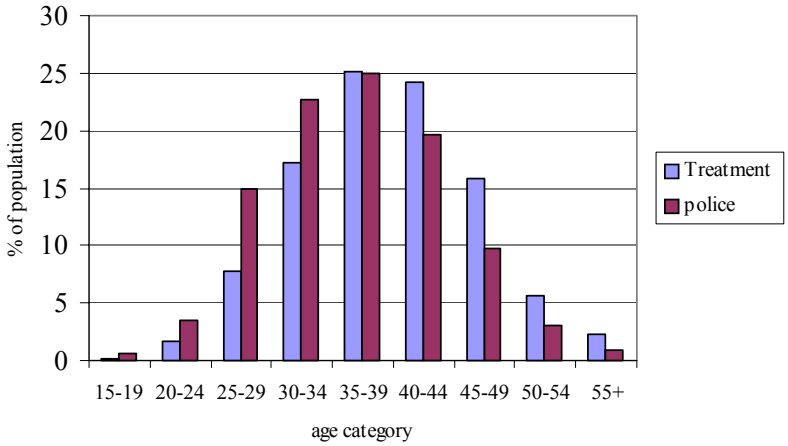


During the eighties, many opiate users form Germany and Italy migrated to Amsterdam. Due to the policy of discouragement (limited access to treatment for drug user who are not officially living in Amsterdam; except for foreign prostitutes and foreign drug users with serious health problems) and the gradual changing treatment policy in Germany and Italy the migration decreased and many of them repatriated.

1.4.3 Characteristics of methadone clients

The prevalence of opiate use is stable or slowly decreasing and the incidence has been decreasing since the late seventies. Therefore the population of opiate users is ageing. The average age of the clients at the Municipal Health Service at 1999 was 40 years (sd=7.5), the average age of the opiate users that were arrested and received methadone at the police station was 37 years (sd=7.3). Figure 3.4 shows the age distribution of GG&GD methadone treatment programme participants and arrested opiate users at 1999. Only very few young drug users are observed.

Figure 3.4: Age distribution of opiate users that received methadone at MHS treatment programme or police station (1999).



The proportion of female opiate users is 25% at the methadone treatment, the percentage of females contacted is higher at the hospital and lower at the police station.
A recent study at the methadone outpatient clinic showed that only 13% injected their heroin during the last month. Whereas 37% had ever injected heroin. The large majority 88% ever smoked their heroin and 53% did so during the last month. The average duration of smoking heroin (among those who ever smoked) was 21 years, the average duration of injecting was 10 years. Base-cocaine is widely used as well, 85% ever smoked base-cocaine and 53% did so during the last month.

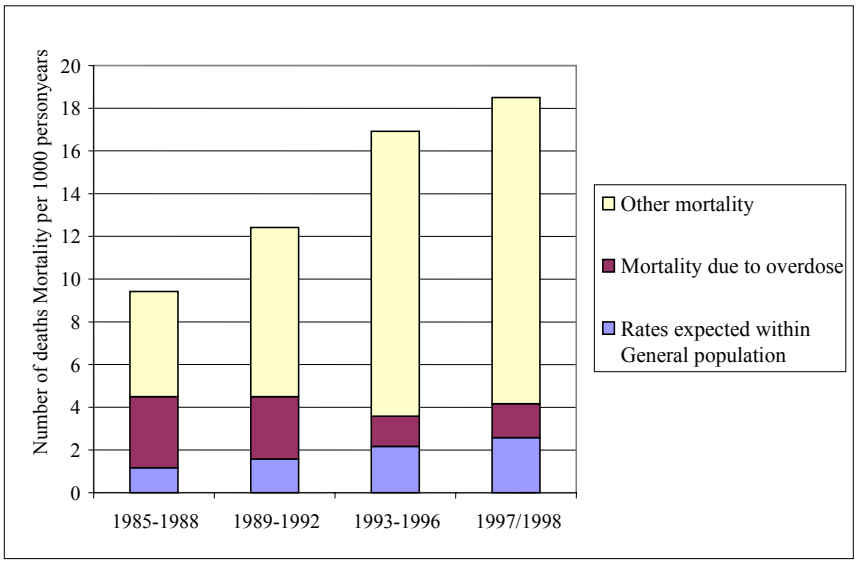
1.4.4 Mortality among opiate users in methadone treatment

In order to calculate the number of fatalities per 1,000 persons per year, the group that is known to live (legally) in Amsterdam and participates in methadone treatment is studied. To arrive at a valid calculation, the group has been restricted to the Dutch and ethnic group that has a known domicile in Amsterdam and has taken part in a methadone programme in the year in question.

Since 1985, mortality per 1,000 methadone clients has been calculated ever year. ‘Observation time is calculated from the first methadone prescription that year until the date of death or the end of the year. A distinction is made between basic mortality, overdose mortality and other fatalities related to drug-use. Basic mortality is what would be expected from a sample of the population of Amsterdam of the same age and sex. Because the group has aged considerably over the years, basic mortality in 1998 was higher than for 1985. The remaining mortality is associated with: drug-use itself (overdose but also cirrhosis of the liver as a result of alcohol abuse in combination with hepatitis C), with the manner of use (AIDS, hepatitis), with the characteristics of the addicts (psychopathology, suicide) and with the drugs-related lifestyle (violent death, infectious diseases). Because many of these diseases also occur among the ordinary population, in the case of an individual fatality, it is often impossible to determine whether the person would also have died had there not been a question of drug-use. An exception is acute drug related mortality due to an overdose of drugs. However, by comparing the occurrence of death in a group of drug-users with basic

mortality, the proportion of fatalities related to drug-use, lifestyle or background characteristics can be shown.

Figure 3.5: Mortality-rates among methadone clients (Dutch + largest ethnic minorities) 1985-1998



Each period mortality rates among these methadone clients are approximately seven times higher than the rates that would be expected in a general population. The rate differences doubled from 8 (1985-1988) to 16 deaths per 1,000 py (1997-1998). The overdose mortality rates however decreased from 3.3 to 1.6 /1,000 py. During the last period only 8,5% of the deaths is caused by an overdose.

1.5 Prevention / treatment facilities in Amsterdam

1.5.1 Prevention

The main goal of drug-prevention activities in Amsterdam is to make youngsters, people that are working with youngsters professionally (teachers, social workers) and parents aware of the potential dangers of alcohol and drug use. Most drug-prevention activities of Amsterdam are performed or initiated by the Jellinek (http://www.jellinek.nl). Several of their programmes are listed here.

- *Advice to the general public*

Lectures about alcohol and drug use are given on request. A telephone service to answer questions and give advice about drug use to the general public. Production and distribution of promotion materials about alcohol and drug use.

- *Consultation project for social workers and teachers*

Focuses on the questions: “how to differentiate recreational alcohol or drug use from problematic alcohol or drug use?” and “How to support youngsters with problematic alcohol and drug use?”

- *Healthy school and drugs*

Lectures about alcohol and drugs are given at secondary schools. Teachers are advised on how to support pupils that use drugs and how to implement school rules towards alcohol and drugs. This project if carried out by the Jellinek and Municipal Health Service.

- *XTC Project*

This project gives the possibility to test pills that are sold as XTC. It advises about drug use at dance clubs and house parties "peergroup-support-project".

- *Project cannabis*

This project is focussed on potentially problematic cannabis users. Distribution of health promotion material at coffee-shops. Training of social workers to make youngsters aware of the way that they are using cannabis.

- *Educational support for parents*

Course for parents to deal with alcohol and drug use when raising up the children.

- *Community project*

Combination of projects within one neighbourhood in order to increase the effect of health promotion.

- *Police at school project*

A police-officer and an arrested drug user visit primary schools and tell about their experiences. Initiated by the police.

- **Policy and prevention**

Next to prevention activities in the form of health promotion, the Dutch drug policy itself may have had a preventive effect towards hazardous drug use among youngsters. The policy of separation between the market for 'soft drugs' (cannabis products such as hashish and marijuana) and the market for 'hard drugs' (heroin, cocaine, amphetamine) is designed to prevent cannabis users from ending up in an illegal environment.
A side effect of the Dutch drug policy is that the priority of arresting drug traffickers rather than drug users leads to a higher visibility of drug users in the streets. The population of drug users is getting older and especially among those wandering in the streets the high prevalence of (psychiatric) morbidity is clear. The drug users of Amsterdam are not exactly role models were young people want to identify themselves with. This could be one of the reasons that heroin lost its popularity among young people in Amsterdam. Of course this is not a deliberate prevention measure.

- **Information and prevention**

In order to perform prevention activities knowledge of the prevalence and trends of drug use among (young) people and specific subcultures should be available. There are several Amsterdam studies or institutions that produce information on drug trends or subcultures:

- The annual study of the Jellinek (Antenna study); specially focused on young people (secondary school),
- The CEDRO (centre for drug research) of the University of Amsterdam; focuses on the general population with house-hold surveys and evaluates the effectiveness of the Dutch drug policy.
- The drug consultancy office (adviesburo drugs); focused on dance culture and XTC use.
- The Municipal Health Service; focused on opiate use.
- The Trimbos institute, monitors drugs and drug use on a national level

1.5.2 Treatment

The treatment section is mainly derived from the report "care for the future" of the municipal health service (GG&GD) of Amsterdam. This report can be found at http://www.gggd.amsterdam.nl/jggz/d/drugsjaarUK.pdf
Help for users has two directions: drug-free treatment focussing on kicking the habit, and social-medical help focusing on minimising risks.

- **Drug-free treatment**

The aim of drug-free treatment is that the addicted user should live without drugs. During therapy, the addicted client is advised how he can alter his addiction behaviour. Behavioural patterns are taught which aim at avoiding situations that are associated with drugs. People also learn how to cope with mood changes without resorting to consciousness altering substances. Several sorts of detoxification programmes have been developed, both clinical and ambulatory. The Jellinek Centre offers Clinical treatment (Klinische Behandeling Sarphatistraat) to ±100 people annually. A thousand drug users participate in different kind of treatment including methadone (reduction) treatment, psychotherapy, acupuncture, and family therapy. Recently, a special treatment project for female borderline patients started with 100 clients. An experimental treatment is the detoxification method under narcosis, combined with long-term follow-up treatment with an opiate antagonist (Naltrexon).

For each form of treatment, it is crucial to use careful diagnosis in order to match the individual client with the appropriate treatment programme. The treatment process for ensuring that an addict arrives at lasting (voluntary) abstinence takes a long time and demands a lot of motivation and support from the surrounding people. It's a process which consists of falling down and getting up again. Treatment concentrating on detoxification faces three sorts of problem:

- The right selection of suitable clients for the specific treatment method. This is a question of giving the client the right treatment at the right moment in his career of addiction. Intensive intake procedures have been developed to test motivation.
- Premature dropout from treatment in spite of preliminary selection. Clients who pass the intake procedure leave the treatment situation prematurely (with conflicts). They almost always return to active use.
- Fallback following successful treatment. Many clients who have concluded successful treatment fall back into addiction behaviour after one or more years.

- **Risk reduction**

A lot of drug addicts either do not want to or cannot withdraw from drugs. This is why drug help focussed on reducing risks has been developed. This concerns a cohesive system of social-medical methadone treatment in combination with social help. The latter focuses on rehabilitation and consists, among other things on day activities and nightly accommodation, social help and supervised living. Risk-reduction is a low-threshold form of care which reaches a lot of active drug-users in Amsterdam. First and foremost, this form of help succeeds to a considerable degree in preventing physical illness or treating it in such a way that death is avoided. The approach is effective for the control of infectious diseases such as TBC, STD and AIDS.
In addition to this, it seems that the aim of methadone treatment, namely providing a medical opiate substitute for heroin, is being approached reasonably well. Indeed, many methadone clients appear to be able to dispense with heroin to a large extent, as long as the doses are sufficiently high and administered within a tight structure of discipline and reward.

The activities of the GG&GD focus on reducing risks. The service acts as a social-medical safety net within drug-care in Amsterdam. In this respect, it particularly concentrates on drugs clients with discipline problems and criminal behaviour. These are clients who often have serious physical conditions. The GG&GD provides various sorts of methadone and heroin equivalent opiate programmes and function as a linking and regulation station. The help provided by the GG&GD focuses most of all on preventing and eliminating the medical and social complications of drug-use. We also attempt to refer the individual client to a care channel that fits in with what the person involved is able to do.

- **Police project**

Drug-users detained at Amsterdam police stations are visited seven days a week by drug doctors. During these consultations, an assessment is made of the physical and psychological condition of the addicted detainees. If opiate withdrawal is detected, or if the person involved is taking part in the methadone programme, the addicted detainee is treated with methadone. In 1998, a total of 1,507 addicted arrested opiate users received methadone at the various police stations. If there is no obvious indication of opiate withdrawal, no methadone is provided. This usually applies to criminal cocaine users who either take no opiates or take them only occasionally.

- **hospital project**

All drugs clients admitted in the Amsterdam hospitals are visited by the GG&GD in order to enable an orderly stay in the hospital, both for the hospitalised drug users and for the other patients. A part of this form of care co-ordination is arranging national health insurance where needed. Homeless drugs clients are also provided with sheltered accommodation with adequate after-care.

- **Prostitution project**

Wherever there is an epidemic of addictive drug-use, we may find the phenomenon of drugs prostitution. For female addicts, prostitution is a major, non-criminal source of income. Whereas, for many non-addicted women, prostitution is more or less an ordinary profession which they can handle in an emancipated way, this is less the case with drug prostitutes. Certainly when it comes to payment for sex without a condom, prostitution carries with it the risk of transmitting sexual diseases. Owing to this situation, there is intensive co-operation both internally and externally between the Sexually Transmitted Diseases Clinic and the GG&GD's Prostitutie en Passanten Polikliniek [Prostitution and Foreigners outpatients Clinic], known as the PPP. The latter provides social-medical care to boy and drug prostitutes, including methadone treatment, STD checks and contraceptive advice. The PPP provides social-medical help for addicted prostitutes. Besides care for prostitutes the PPP provides medical emergency help for illegal foreign drug-users.

- **care co-ordination**

Care is permanently arranged for problematic drug-users in hospitals and social care institutes. The GG&GD also co-ordinate care if drug-users come to the notice of the police and the justice system in connection with drug-related disorderly behaviour. Care co-ordination is needed in situations when the contact between clients and conventional care provision is easily broken, for example through the misbehaviour of clients with chronic adjustment problems.

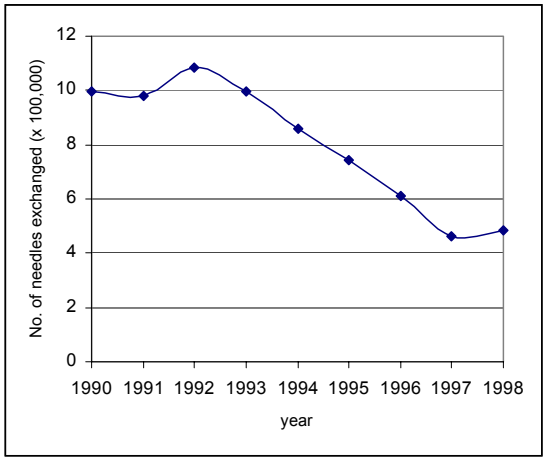
- **Users rooms**

Since 1998 seven users rooms are started throughout the city. Eventually fifteen of them are planned. These users rooms are meant for drug users that have no other place to use their drugs than the street. Every user room has its own (small group) of drug users who are permitted to enter, buying and selling of drugs is not allowed. On the one hand the aim of the users rooms is to reduce the nuisance caused by drug users and on the other to give the drug users a place were they can rest and use their drugs quietly under supervision. Most user rooms are a part of existing services for drug users or homeless people.

- **Needle exchange**

Intravenous use increases the risk for infection and overdose. To prevent the use of each others needles and thus the spread of viral infections, the needles can be exchanged anonymous at different organisations and locations in Amsterdam. Due to the decreasing number of injecting drug users (the possibilities of needle exchange remained equal) the number of needles exchanged decreased drastically during the period 1992 – 1997 which is shown at figure 4.1. Repatriation of foreign (injecting) drug users, higher mortality among injecting drug users and switching from injecting to smoking may explain the drop of the number of needles that were exchanged.

Figure 4.1: number of needles exchanged 1990-1998



- **Heroin experiment**

The GG&GD looks after heroin provision in Amsterdam as part of the national heroin experiment. In this experiment, a group of chronic heroin addicts who react unsatisfactorily to methadone treatment receive medical heroin seven days a week. The intention is that this will lead them to have more grip on their addiction (and therefore on their lives). The report of this experiment is being provided by the Central Commission for the Treatment of Heroin Addicts (CCBH).

- **Treatment in prison**

Heroin users with repeated police contacts can be forced by law to participate in an experimental, extensive treatment program in prison instead of incarceration as usual. The

goal of this treatment is to reach abstinence and social rehabilitation. This experiment will start in 2001 and treatment will be given to fifty heroin users.

Prison -policies differ; some prisons detoxify heroin users within a of two to four weeks in others methadone maintenance can be continued. The detoxification without a proper aftercare makes that heroin users run a higher risk of overdose mortality after they are released form prison.

- **Children of drug addicted parents**

The municipal health service (GG&GD) offers case management and psychosocial support for the children of drug-addicted parents and for the parents themselves.

- **Crisis Intervention**

Another form of risk reduction is the availability of an inpatient crisis intervention centre that offers support to heroin users in a state crisis due to mental problems and excessive drug use. Annually 700 people receive this inpatient support by the Jellinek Centre.

- **Methadone treatment data of 1998**

Table 4.1 gives the number of clients, methadone dosages and number of methadone prescriptions of the Municipal Health Service, General Practitioners and Jellinek. Treatment at the Municipal Health Service varies from daily contact (during the heroin experiment) to weekly contact. Most clients however come five, three or two times a week (during working days) the frequency is related to the degree that the client can control his addiction. Methadone clients with the highest state of control are treated at their own general practitioner. Like regular patients they receive their methadone at the pharmacy. The Jellinek treats methadone clients that are motivated to withdraw from drugs or those that are admitted because of a crisis-situation. At the municipal health service fluid methadone is given at every contact than it is checked whether somebody really drinks it or not. Take home dosages are always given in the form of tablets. Since the beginning of the nineties the methadone dosage has increased at the Municipal Health Service. At 1990, the average dosage of all daily prescriptions of the Municipal Health Service was 40.5 mg and at 1998 the average dosage increased to 63.4 mg.

Table 4.1 methadone treatment data of 1998

Treatment at:	Number of Dosages	Average Dosage	Annual number Of Clients	Average number Daily clients
Total	694145	53.2	3881	1902
MHS programme	377618	63.4	1942	1034
MHS police	6412	41.4	1507	18
General Practitioner	269174	41.6	1084	737
Jellinek	40941	36.6	311	112

Besides substitution treatment with oral methadone other substitutes are used: 70 people were treated with dextramoramide, 13 with morphine, 35 with injectable methadone and 31 with heroin on an experimental base.

- **XTC and risk reduction**

The municipal health service checks the safety of the larger dance parties (number of people, chill out room, water available, air conditioning). It is directed towards those who organise large dance parties.
To reduce the risk of intoxication with other substances than MDMA, pills sold as "XTC" can be tested at the Jellinek centre.

- **Other organisations**

Next to the large official treatment centres the Jellinek and the Municipal health Service (GG&GD) many other smaller independent organisations have been founded to improve the health and quality of live of the drug users. Most of these organisations have a very low threshold (access for all drug users or active outreaching fieldwork to reach drug users). Many offer daytime activities (or work projects). Most of them offer information. Several magazines or newsletters are published by these organisations mainline and MDHG ("the Junky Union"). Some have a user room or needle exchange services. One of the organisations is specially concerned with (illegal) foreign drug users that have no access to regular treatment. Others have special projects for certain groups like HIV-positive heroin users or female heroin users. The organisations are especially important to maintain a critical discussion about drug policy and drug treatment of Amsterdam.

Streetcornerwork	(http://www.streetcornerwork.demon.nl)
Mainline	(**http://www.mainline.org**)
AMOC	(http://www.amoc.demon.nl)

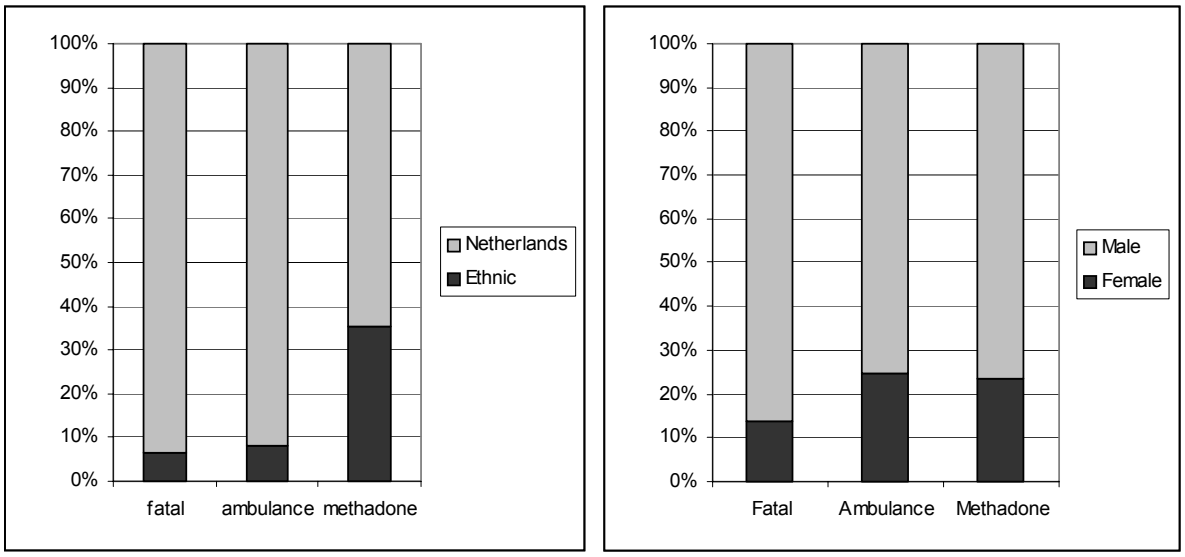
1.6 Non-fatal overdoses of drugs in Amsterdam

In 1998, 257 alarm calls concerned people who had become unwell following the use of heroin, cocaine, methadone and alcohol in combinations. Two thirds of them were taken away for treatment. The occurrence of overdosing has decreased in comparison with the 1980s. This is connected with the settling down of hard-drug-users. Most of all, the disappearance of barbiturates and methaqualone products as routinely prescribed medication in general practice is important in this respect.

1.6.1 Non-fatal versus fatal

Figure 5.1 shows the percentage of females and ethnic minorities in methadone, ambulance-register (after a non-fatal overdose) and register of fatal overdoses. Two major differences are visible, among the percentage of females with a non-fatal overdose is similar to the percentage of females receiving methadone, among the over dose deaths however, the percentage of females is much lower. The

Figure 5.1: percentage of females, ethnic minorities in treatment, ambulance (non-fatal od) and fatal overdoses



The percentage of ethnic minorities is lower among the non-fatal and fatal overdose cases if we compare this to the percentage that receives methadone. Obviously ethnic minorities are at lower risk to have an overdose and females are at lower risk to die when an overdose occurs. The lower risk of an overdose among the ethnic minorities will be related to the low percentage of injecting drug users among them. The lower risk to die among females may be related to the better social structure of females; a partner can call for help if something goes wrong.

1.7 Fatal overdoses of drugs in Amsterdam

1.7.1 Defining overdose deaths

In Amsterdam overdose deaths are defined as acute deaths after the use of illicit drugs and presumable caused by the toxic effect of this drug. Drugs are defined as heroin, methadone, cocaine, XTC (MDMA), Amphetamines or hallucinogenic substances. These drugs are often combined with alcohol, benzodiazepines or barbiturates, death after the use of these substances without any illicit drugs are not considered as drug overdose deaths.
If someone, after using heroin, falls in one of the canals of Amsterdam and drowns is not considered as a overdose death. Similar, if someone jumps out of the window after using LSD, this death is not considered as an overdose death. Both deaths would be defined as accidents.

If someone uses heroin, cocaine, XTC with the intention to feel euphoric, energetic or to forget the daily sorrow, and dies, this is an accidental overdose. Ideally we would limit the study to these cases. However, whether death is accidental or intentional is often hard to find out. Therefore all acute deaths after the use of drugs that are included in the definition of overdose deaths. If someone writes a good bye note and takes a fatal dose of heroin, he is defined as an overdose death. This person died after the use of drugs and his death was caused by the toxic effect of the heroin dosage. A special kind of overdose death occurs when cocaine is swallowed with the intent to transport it and one or more of these little packages break. This death is counted as an overdose death, although the victim did not intend to use the drugs.

In many occasions there are no witnesses, and the body may be found some time after the death occurred. When someone is known as a drug user, drugs will be detectable. However this does not prove that the drugs was causing the death. If this drug user is young other causes of death are rare. In Amsterdam however, the population of drug users is growing older and other causes of death are not unusual. Distinction between death due to the acute effect of drugs and death due to the chronic effect of drugs, alcohol and cigarettes and poor living conditions is more difficult.

1.7.2 Gathering information about overdose deaths

To count the number of overdose deaths all reports of the coroner are studied.
The following reports are laid aside:

- those with overdose of illicit drugs written as the cause of death
- those with suicide with illicit drugs or suicide with unknown drugs
- those with death due to the abdominal transport of cocaine
- those with a unknown cause of death and some indications of possible drug overdose. (e.g. someone who is known as a drug users, signs of drug use)

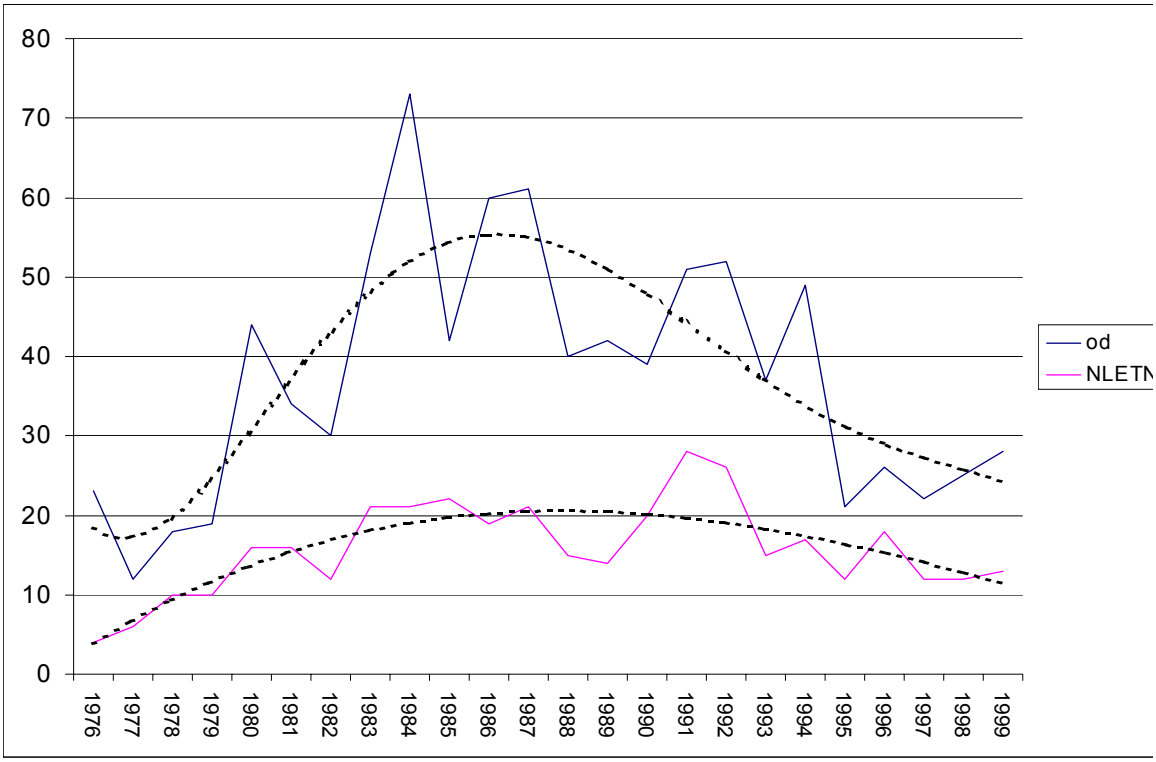
Of all potential drug deaths, name, gender, date of birth is recorded. The next step is to ask additional information at the police station or national forensic laboratory.

The coroner is a forensic medical doctor, he should tell the police whether a offence (in this case homicide) has occurred or not. So in case it is clear that the cause of death was not homicide, further investigation of the exact cause of death has no high priority. Therefore toxicological investigation is not generally done in the Netherlands.

1.7.3 Time trends

In Amsterdam 900 overdose deaths are recorded since 1976. Among the Dutch and Ethnic minorities the annual number increased slowly during the seventies and shows a small decrease during the nineties. The total number of overdose deaths, shows a sharp increase at the beginning of the eighties and shows a sharp decrease again during the nineties. During the total period 380 cases (42%) originated from the Netherlands, Surinam, Turkey, Morocco or the Dutch Antilles. The majority originated from other countries.

Figure 6.1: OD deaths 1976 – 1999 total and among the Dutch and ethnic minorities

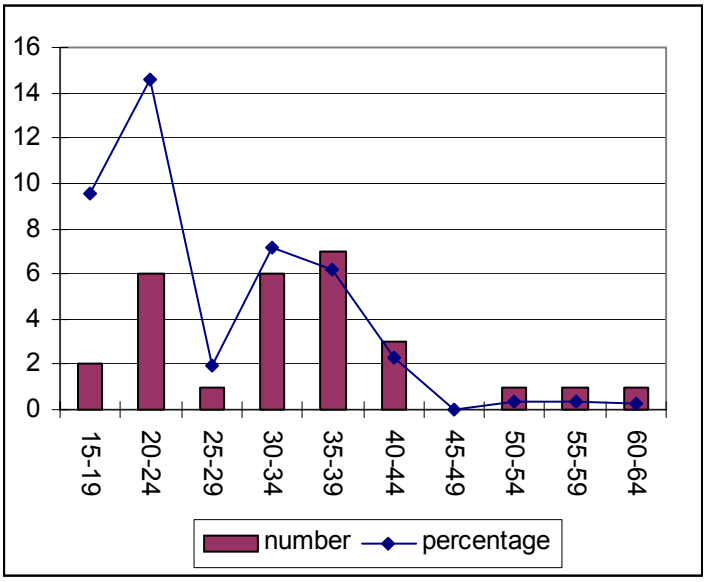


Several factors could explain the high incidence among foreign drug users. Their main route of administrating drugs was injecting, whereas among the Dutch many people smoked their heroin. At the beginning of the eighties, the Amsterdam heroin had a higher purity than the heroin they used at home. Moreover, they were not familiar in town and did not know were to go to when an overdose occurred.
During the nineties the number of overdose cases decreased rapidly. The decreasing number of opiate users could explain part of the decrease however, the estimated decrease of the population was approximately 20%. The selective decrease of the number of injecting drug users is expected to be higher. Although the capacity of the needle exchange remained equal, the number of needles exchanged dropped more than 50% since 1990.

1.7.4 Number of overdose deaths at 1999

The overdose deaths occurred within the age categories between 15 and 64 years. Eight of the 28 casualties were females. Among the age category of 15 until 44 years 6.2% of all deaths occurring in Amsterdam are presumed to be caused by an overdose.

Figure 6.2: Number of OD-deaths and percentage of all deaths occurring in Amsterdam by age category



Among the 28 overdose deaths only 13 were official residents of Amsterdam and 15 were not registered. The average age of the all overdose deaths of 1999 was 34 years. The average age of the Amsterdam residents was 38.5 years. Those not registered in Amsterdam were younger (28.5 years).

Eleven of them, were younger than 45 years. The absolute and relative contribution of these deaths to the total number of deaths occurring in Amsterdam is related to the age categories in figure 6.3. Among residents between 15 and 44 years of age 4.2% of the deaths were due to an overdose of drugs. The overdose mortality rate among the registered inhabitants of Amsterdam between 15 and 44 of age at 1999 is 11 / 372,000 = 3.0 per 100,000 inhabitants (95% CI 1.6 – 5.3).

Fourteen overdose deaths did not officially live in Amsterdam. Among non-residents between 15 and 44 years of age 9.4% of the deaths were due to an overdose of drugs. A mortality rate cannot be calculated. (The denominator is unknown)

1.8 Description of overdose deaths of 1999

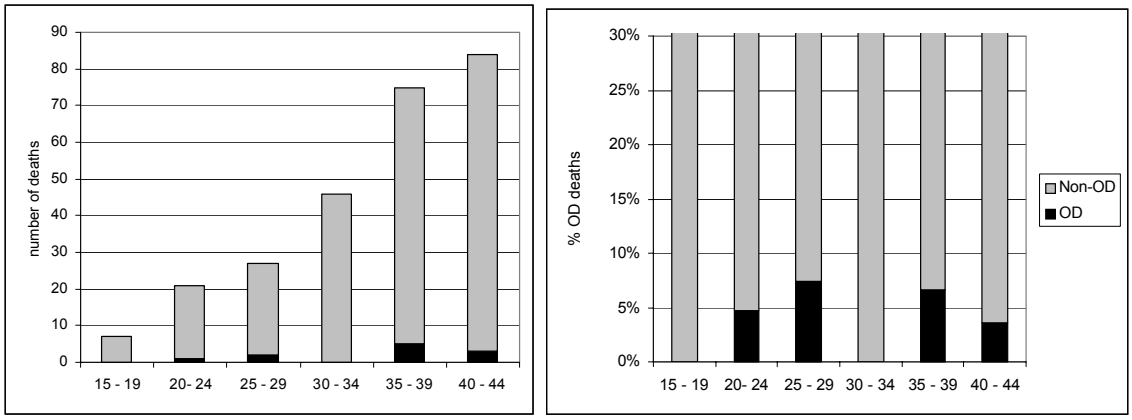
- **Circumstances residents versus non residents**

There is a difference between the 15 non residents and 13 residents regarding to the place of death. Many non-residents died in a hotel (8). They originated from Germany (2), USA (2), Great Britain (2), Italy and Slovakia. Five of them were obviously normal tourists whose death was presumed to be accidental. Four of them used heroin (mostly combined with cocaine) and one cocaine and alcohol only. One of them swallowed cocaine balls. A German couple of 30 and 31 years old committed suicide with methadone pills and were found death in each others arms. Probably, they went to Amsterdam specially for this purpose.
Two young people (a Swedish 20 years, a Dutch non-Amsterdam resident 20 years) died after visiting a house party and were probably only visiting Amsterdam as well. Four non residents died in private houses; these victims originated from Colombia, Morocco, and Lebanon

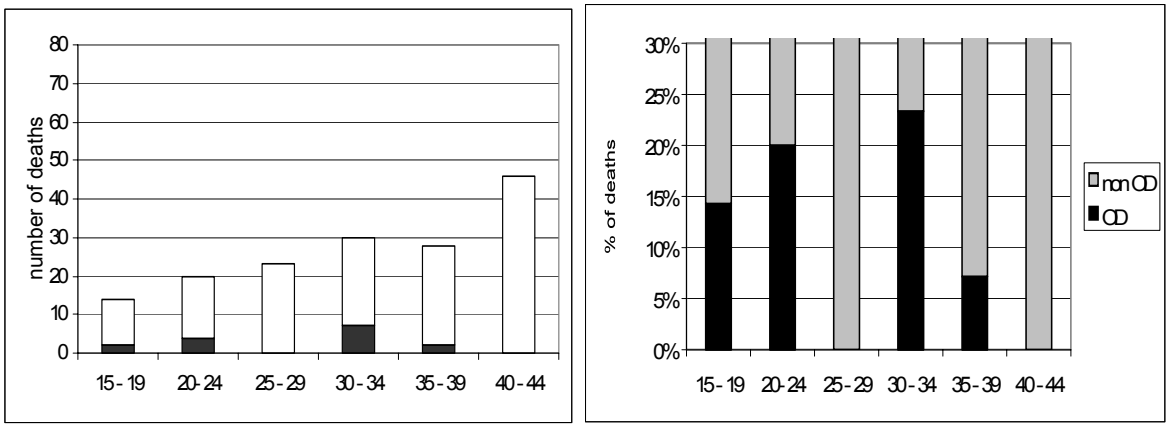
(country of brirth of one victim remained unknown). The Colombian (33 yr) and a male (± 30 yr) with the unknown of birth died after swallowing cocaine balls. The Lebanese

Figure 6.3: Absolute and relative number of OD deaths in relation to the total number of deaths occurring in Amsterdam at 1999, differentiated by residents and non-residents.

A) Residents



B) Non-residents



(30 yr) died from a heroin shot after he was released from prison. The Moroccan (35 yr) died after using too much alcohol and cocaine with friends. One male (35 yr) from Greece was found death in a little boat with a syringe in his arm. None of these people were known at the municipal health service.

Not all residents are born in the Netherlands, one is a Ethiopian refugee, one from Germany and two from Surinam. The residents often took their overdose in private house (11), their own (8) or of people they know (3) . One overdosed at the hospital (during an admission) and one in a park. Seven of them (6 at private houses and 1 at the park) probably died as a result of a suicide. This suspicion is based on the drugs that is used (often large doses of methadone in combination with psychopharmaca) former suicide attempts and psychiatric history. One died because of swallowing cocaine-balls (after the police entered the house). One elderly man (64 yrs) died after the consumption of large dose of cocaine. One died after the consumption of a combination of heroin, cocaine, hashes and alcohol, the report of the three died mentioned opiates (heroin) only.

- **Treatment**

Only, nine of the 28 overdose deaths were registered at the methadone treatment register. Five of them received treatment during the year preceding death and three received methadone treatment during the week they died. One participant however, was admitted in a hospital when he overdosed. Five of the drug users that were known at the treatment centre had also received methadone at a police station. Moreover, again five were also known at the hospital project (before the overdose occurred). Although we generally assume that the coverage of population of drug users is high, only one third is known at the municipal health service while they were alive. Among the non-residents nobody was known at the methadone registry or hospital project. This may be due to the fact that most non-residents visited Amsterdam only temporarily. An exception is the Lebanese drug user that was just released out of prison. As mentioned previously methadone maintenance treatment is generally not supplied in prison, detained opiate dependent person often get detoxified instead. Four of the residents were unknown at the Municipal Health Service. Two of them died because of a cocaine intoxication only, one was known to have a severe benzodiazepine addiction (by her GP), and one was a partner of a methadone treatment client. She used his methadone (among other pills) to commit suicide. Two out of the nine clients that were registered at the methadone register were known to be HIV positive. About the others no information was available. Information about psychiatric disorders was known for six residents. Former suicide attempts (3), depression (2) and psychosis (1) are mentioned.

- **Intention**

Not all casualties had the intention to use the drugs, four of them (14%) swallowed large quantities of cocaine in order to hide it during transportation. Others seem to have the intention to end their lives. Based on the circumstances (former suicide attempts, psychiatry) and drugs that were used ((large dose methadone + often combined with several other psychopharmica) we think that nine of the victims had a suicidal intention (32%). The fatal drug overdose of fifteen cases (54%) was presumed to be accidental. Two these cases consumed MDMA, amphetamine at a dance-party.

Besides the toxic effect of drugs dehydration due to dancing and vomiting may have caused death. She might be specially vulnerable (??) The toxicological report of the girl that died after the use of MDMA mentioned only low dosages of MDMA, and stated that this dosage was unlikely to cause death. One elderly man (64 years) used (a large amount of) cocaine and two combined cocaine with alcohol. The use of cocaine may lead to excessive alcohol use (you don't feel drunk), moreover a special metabolite (coca-ethylene) is produced that may have an independent toxic effect. Ten victims consumed opiates (heroin), mostly combined with cocaine.

Table 6.1: presumed intention of taking the drugs

Presumed intention	Number	%
Smuggling cocaine (no intention to use)	4	14%
Suicide attempt	9	32%
To experience the effect of the drugs	15	54%

Table 6.2: kinds of drugs that are used

Kind of drugs used	Number	Toxicological verification
Opiates (+ other substances)	19	2
(among which methadone)	(8)	(2)
Cocaine (+alcohol)	3	1
MDMA/amphetamine at dance party	2	2 (only low concentration MDMA)
Smuggling cocaine	4	1
Total number of overdose deaths at 1999	28	6

1.8.1 Toxicology

Only six of the overdose casualties were studied by the Forensic Laboratory of the Ministry of Justice. Analysis is performed in order to detect alcohol, amphetamine-like substances, cocaine, heroin/morphine Methadone and cannabis.

Company
The majority of the people (54%) was alone when the overdose occurred. They were found death. Two people with MDMA or Amphetamine intoxication were at a dance party and were both transported at the hospital. Two people committed suicide together they were each others company but did not call for help. Two out of three people that were smuggling cocaine were transported to the hospital but could not be helped (at one occasion the police entered, at the other, it is unknown whether there was company). Two people used cocaine and alcohol with friends, these friends however, noticed too late that they obviously had used too much. Two people who overdosed in a hotel and were found after they overdosed reanimation however, did not succeed anymore. One overdosed in a house of an acquaintance (pusher(?)), was transported but died at the hospital. One person overdosed during a hospital admission, was found unconscious and did not survive.

Company?	**Number**	**%**	**Transported To hospital**
Company	7	25%	2 (+1)
Double (intentional) overdose	2	7%	0
Alone	14	50%	0
Dance Party	2	7%	2
Unknown	3	10%	2
	28	100%	6 (+1)

(+1): was already admitted in a hospital

Among the fourteen cases that were alone, there are six presumed suicide cases, one cocaine smuggling case, one cocaine consuming case and seven opiate (+cocaine) overdose cases. One presumed suicide case was transported to the hospital (whether someone else or she herself alarmed an ambulance is not reported).

location of overdose

	Residents	Non-residents	Total
Private house (own house)	11 (8)	4 (3)	15
Hotel		8	8
Dance party		2	2
Outside	1	1	2
Hospital	1		1
	13	15	28

1.9 Issues for strategic choices

The number of overdose deaths in Amsterdam has decreased during the last ten years. However, we may still be able to limit the acute deaths after the use of drugs. The following issues are intended as a brainstorm of the possible strategic choices that could be made in Amsterdam (and possibly in Oslo, Frankfurt or Copenhagen too) in order to limit the number of overdose deaths.

1.9.1 Reducing prevalence of (risk-full) drug use

The incidence of heroin use is already very low, other drugs seem to be less risk-full regarding the risk of a fatal overdose. It is of major importance that the prevalence of intravenous drug use decreases and ongoing projects to persuade drug users to switch from injecting to smoking should be continued. Regarding the use of cocaine: the risks of the use of cocaine combined with alcohol should be stressed. Special efforts could be made to reduce the risk-full use of drugs by tourists (information at (low-budget) hotels).

- **Enhancing to call an ambulance**

The liberal drug policy in Amsterdam facilitates to call an ambulance when something goes wrong. Drug use itself will not be punished and there is no need to hesitate when an overdose occurs.
This could be stressed when information is given to non-residents.

- **Proper treatment in prison**

Still, drug users are detoxified in prison. In case people are motivated to start a detoxification treatment and intend to continue abstinence after they are released detoxification may be useful. However, if a drug users does not have this intention it may lead to an fatal overdose.

- **Supervision of large scale Dance Parties**

Some large scale dance parties are supervised by the municipal health service to make sure, there are chill out rooms, enough water, and proper ventilation. This should be maintained or extended.

- **Prevent intestinal drug traffic**

Swallowing cocaine seems to be a good way to smuggle cocaine. The risk of being caught be the police may be small, there is however, a risk of death when one or more of the packages breaks.
One way to decrease this form of transport is increasing the risk that cocaine is detected.

- **Psychiatric support to prevent suicide**

Although psychiatry is an important issue within drug treatment in Amsterdam, psychiatric support of drug user may be improved and the number of intentional overdose fatalities may decrease.

2 Drug overdoses and overdose deaths in Frankfurt am Main

Susanne Schardt

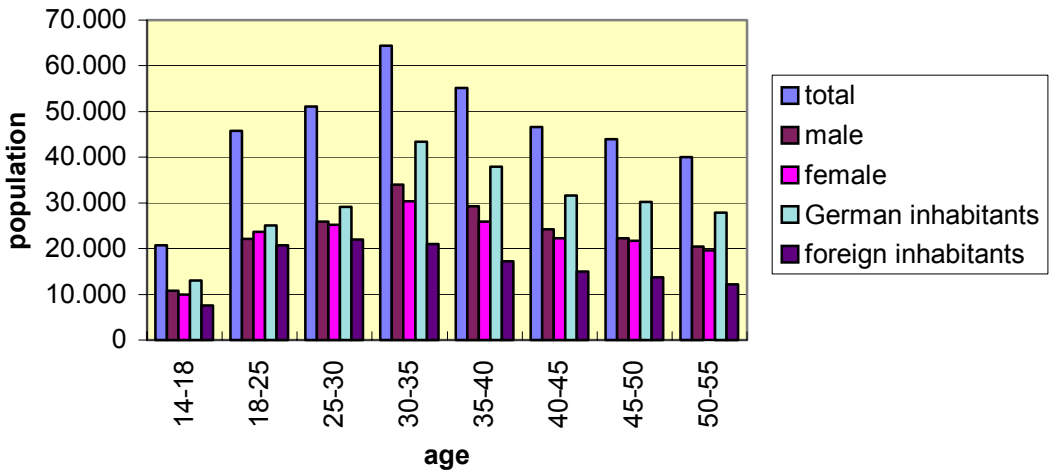
2.1 Brief general description of the city

Total number of inhabitants: 650.468 (in 1998)
Share of inhabitants of foreign origin 28,6% (in 1998)

Population of Frankfurt am Main by age, gender, age group, and origin in 1998

	14-18	18-25	25-30	30-35	35-40	40-45	45-50	50-55
total	20.677	45.781	51.086	64.416	55.207	46.601	43.899	40.065
male	10.797	22.122	25.913	33.997	29.263	24.290	22.225	20.502
female	9.880	23.659	25.173	30.419	25.944	22.311	21.674	19.563
German inhabitants	13.059	25.067	29.164	43.362	37.939	31.645	30.195	27.890
foreign inhabitants	7.618	20.714	21.922	21.054	17.268	14.956	13.704	12.175

Inhabitants of Frankfurt am Main, 31.12.1998



Unemployment rate: Approximately 10,7% (in 1998)

Characteristics: Frankfurt has the largest European cargo airport. Frankfurt is the largest city of Hessen 75% of employees working in Frankfurt are working in the services sector (agencies, banks, marketing etc.).

2.2 The history of drug policy developments in the city

The first visible drug scene in the city of Frankfurt am main emerged in the late 60s at the so-called *«Haschwiese»*, a park in the belt of parks that surrounds the old inner city area. At that time, the student's protests where in full flow in Frankfurt am Main and this drug scene was mainly associated with Cannabis users (especially students).

In the 1970s, new groups of users appeared on the drug scene, especially lower-class adolescents, but also middle-class «drop-outs»[1]. At this time, heroin was introduced on the Frankfurt drug scene and the first increase in drug related deaths lead to higher attention and concern about drug taking. Consequently, repressive measures were increased during this period, especially in 1980 when local authorities decided to close down the open drug scene which had, until then, not been large and controlled but not dissolved by the police. Although the (CDU) mayor's decision at that time resulted in protest, because it was feared that closing down the open drug scene would lead to rather less control and might make it more complicated for the helping system to get into contact with drug users, commercial and «image» interests in the city supported this decision which was finally put into action in 1980. Hartnoll and Hedrich describe the consequences of this decision as follows:

«The drug scene was then chased around the city by the police from one open space to the next, until by 1981 it had become largely established in and around the main station. At the time, this was an underdeveloped area with cheap hotels, a poor, multi-ethnic population, and a tradition of prostitution that had grown since the Second World War. The open drug scene was probably allowed to develop there because it did not threaten any powerful interests. From a police perspective, it was perhaps seen as preferable to contain the scene in one area. Some see it as a deliberate segregation, a way of managing the use of space in a city and of regulating social problems. A small scene continued to be visible in the park from time to time.»[2]

The large number of commuters coming to Frankfurt (more than 300,000 daily - and most of them coming through the main station) and the increasing number of complaints from shop owners and banks in the main station area were driving factors for intense repressive action from the police towards the drug scene. But despite the police endeavours to «clean up» the main station area, the open drug scene established itself in this area, especially in the *«Taunusanlage»*, another one of the parks that form the park belt around Frankfurt's ancient inner city area. Moreover, the drug scene began to expand considerably in numbers, comprising, at some times, up to 1,000 persons a day. When repressive measures also increased in other cities in the Rhein-Main Region as well as in the Federal State of Hessen and the surrounding Federal States (*Länder*), such as Bavaria and Rheinland-Pfalz, even more drug users were attracted by the Frankfurt drug scene. In the late 1980s, the city was confronted with a dramatic increase in physical and social depravation of drug addicts and a dramatic increase in drug mortality, which finally culminated in 147 deaths in 1991. At that time, about two thirds of the users on the Frankfurt drug scene were estimated to come from outside Frankfurt.

[1] See also: Hartnoll, Richard and Hedrich, Dagmar: «AIDS prevention and drug policy. Dillemas in the local invironment» in: Rhodes, Tim and Hartnoll, Richard (eds.): «AIDS, Drugs and Prevention», London 1996

[2] Hartnoll and Hedrich, ibid.

«From 1987, after a period of relative stability since the early 1980s, the prevalence of heroin use and addiction started to increase in many parts of Germany, including Frankfurt and nearby cities. The availability of heroin rose and prices fell. The fact that Frankfurt was a major commercial and financial centre with excellent local, national and international transport and communication links was very likely an important factor in stimulating the heroin market in the city.»[3]

In the second half of the 1980s, Frankfurt, like many other cities too, was confronted with an aggravation of serious problems relating to HIV and AIDS. In the meantime, the number of intravenous drug users had increased considerably. In the cities there was an increasing fear of possible infection of the remaining population attributable to the great spread of HIV among i.v. drug users who were also involved in prostitution to pay for their drugs. This fear triggered vehement discussions on new possibilities for intervention for i.v. drug users. One of the major measures to prevent the spread of HIV was to exchange free syringes and needles to i.v. drug users and free condoms to sex workers. Other options reflected upon to reduce the depravation, physical risks and to establish better contacts with the ever mobile drug users were the establishment of so-called low-threshold facilities, such as crisis centres, street work, and methadone prescription. But these views, expressed by some experts and newly developed self-help groups of drug users did not meet with much approval at the level of policy makers or even the «established» treatment system:

«... the attitudes of politicians, professionals and public alike were highly negative and moralistic. With few exceptions, physicians and psychiatrists were reluctant to treat addicts or to provide health care; the police, prosecutors and courts followed a severe and punitive line; community leaders and the public wanted drugs and drug addiction removed from view; and addicts were often rejected by their families and local communities.»[4]

2.2.1 A shift in the paradigm

In March 1989, municipal elections resulted in a coalition between Social Democrats and Greens. For the first time, a drug policy coordination office was established in the municipal department for public health and women. In the meantime, a working group consisting of representatives of all municipal bodies and institutions engaging in drug-related issues had been established (police, justice, all bodies and aid-services engaging in drug-related issues). This still existing *Montagsrunde* ("Monday´s Round") discusses and develops common local strategies to solve specific drug-related problems in the city.

The *Montagsrunde* was at first established as a working groups to enhance concerted action against drug-related crime by a decree from the Lord Mayor in 1988 upon the initiative of the Frankfurt police:

«Approaches to combat drug-related crime and to ensure a more effective system of care for drug addicts necessitate further intensification of coordination between police forces and the municipal agencies of the City of Frankfurt am Main. This is why I decree, as agreed upon with the president of police, that a meeting to discuss the situation is to be held at regular weekly intervals, uniting the head of the municipal office for public affairs and the head of the municipal health office on one hand, and representatives of the police on the other, with a

[3] Hartnoll and Hedrich, ibid.
[4] Hartnoll and Hedrich, ibid.

view to coordinating expedient measures. The municipal councillor for social welfare is requested to participate in these meetings. He is also obliged to come to an agreement and coordination of activities with the organisations carrying out drug help and counselling.»

Meanwhile, also the general prosecutors, the state attorney, the municipal department for youth, the department of legal affairs, the federal school department, and representatives of the drug helping organisations participate in these meetings. Since the municipal Drug policy coordination office (Drogenreferat) was established in 1989, it coordinates and administers the activities of the *Montagsrunde* which is chaired by the municipal councillor who also holds the health portfolio. One of the major activities in the beginning of this group was to develop a strategic recommendation paper to the municipal parliament under the title «To live with Drug Addicts» (*«Mit Drogenabhängigen leben»*), which was agreed in Aril 1991 by the city council after consultation with all political parties. This document drafted a comprehensive and new drug strategy for the city that would involve all concerned groups in the community and shift the focus of policy measures from mere repression towards the reduction of drug related harm both for drug users and the general population. The first step taken to initiate a new drug policy therefore consisted in focusing on the survival of drug consumers and establishing crisis intervention centres, needle exchange and the enlargement of methadone treatment, this approach enabling police forces to concentrate upon actions to combat trafficking and crime as well as on ensuring safety for citizens and commuters.

With this recognition, the document closely followed the *Frankfurt Resolution*, a policy document passed in Frankfurt in 1990 on the occasion of the *1st Conference of European Cities at the Centre of Illegal Trade in Drugs*. This conference was held by the municipal councillor for women and health and organised by the drug policy coordination office in November 1990, inviting European cities to share their experience with drug related problems on the local level and to exchange local strategies in drug policy. The first signatory cities of the *Frankfurt Resolution* were the cities Amsterdam, Frankfurt, Hamburg, and Zurich, who stated in the document:

«The attempt to eliminate both the supply and the consumption of drugs in our society has failed. The demand for drugs persists to this day, despite all educational efforts, and all the signs indicate that we shall have to continue to live with the existence of drugs and drug users in the future. (...)

A drug policy which attempts to combat drug addiction solely by criminal law and compulsion to abstinence and which makes motivation for abstinence the prerequisite for state aid has failed. (...)

A dramatic shift in priorities in drug policy is essential. Help for drug addicts must constitute together with preventive and educational measures an equally important objective of drug policy. The maximum amount of social and health assistance must be made available when dealing with drug addiction and drug users, and repressive interventions must be reduced to a minimum. Criminal prosecution should focus its priorities on combating illegal drug traffic. The protection of the population is, in particular, a task for the police. (...)

Anyone who wants to reduce suffering, misery and death must firstly free the drug addicts from the threat of prosecution simply because they use drugs. Secondly, offers of help must not be linked to the target of total drug abstinence. Help should not only be aimed at breaking away from dependence, but must also permit a life in dignity with drugs.»[5]

[5] European Cities on Drug Policy: «Frankfurt Resolution», Frankfurt am Main, 1990

The signatories of the *Frankfurt Resolution* decided also to become actively involved in an ongoing cooperation and exchange of experience and know-how with regard to tackling drug problems on a local level. From this initiative emerged the cities network *«European Cities on Drug Policy (ECDP)»* with its central office in Frankfurt am Main. Meanwhile, the Frankfurt Resolution and its follow-up document, the *«Declaration of the European Cities on Drug Policy»* of 1998 have 34 signatory cities in 9 European countries and in Israel.

ECDP also supported the city of Frankfurt in enlarging their methadone programme by sending a senior doctor from the Amsterdam methadone programme to the city for one year (in 1992) to train doctors in methadone prescription and help establish the outpatient clinics for methadone.

During 1990-1991, police interventions on the open drug scene in the *Taunusanlage* were reduced, although the scene was still closely monitored and raids were launched periodically to keep as much control as possible on the illegal drug market. Consequently, the size and intensity of the open drug scene increased and health, and social problems, violence, etc. became increasingly urgent. As mentioned before, drug related deaths rose to 147 in 1991 and a study conducted on the open scene in 1992 showed that HIV prevalence was up to 20%[6].

This situation coincided with Frankfurt's intentions to become an international trade centre and the seat of the European Central Bank as well as with a sharp increase in complaints from shop-owners and bank employees about public nuisance, shoplifting and street robbery. In 1992, the Mayor finally decided that the open drug scene in the *Taunusanlage* could no longer be tolerated and had to be closed down; a decision that met with opposition from the side of the police as well as the treatment system and the drug users themselves, who organised a demonstration in summer 1992. After intensive discussions, the *Montagsrunde* put forward a demand to establish alternatives to the drug scene before this place was being closed down for drug users. Several alternative measures were pushed through: methadone slots were decentralised and expanded to 200 places. Overnight places were offered by the municipality for drug users, and in autumn 1992 the largest crisis centre, including an overnight shelter, a contact café, a methadone out-patient clinic, and social counselling was opened in an area remote from the inner city. The organisation also provided transport for drug users from the main station area to the facility. In November 1992, the *Taunusanlage* was finally closed and in connection with this, also drug users not coming from Frankfurt were expelled from the city. In March 1993, a coordination office was established to enhance the cooperation between Frankfurt and its surrounding communities (*Kooperation Kommunale Drogenhilfe*) which also supported the establishment of helping facilities for drug users in their communities. Since that time, non-residents (or persons not registered within the Frankfurt social welfare system) can also use certain services (i.e. safe injection rooms, crisis centres, needle exchange), but are not allowed to partake in the Frankfurt methadone programme for instance, unless their home city takes over the expenses.

In 1993, the city of Frankfurt applied for a pilot project for the prescription of heroin to long-term heroin users at the Federal Office for Health, which had later been turned down, but was taken up again as a nation-wide scientifically evaluated model for the prescription of heroin by the red/green government newly elected in September 1998.

[6] Vogt, I. : «Offene Szene in Frankfurt am Main: Abschlußbericht», Frankfurt am Main, 1992

In 1994 the first safe injection room was established in Frankfurt with the active support of the *Montagsrunde* and the state attorney. Until 1996, three more safe injection rooms were opened up in the main station area.

In June, 1995, a new CDU Lord Mayor has been elected in the City of Frankfurt. This has been a direct election without exercising any influence on the political majority of Greens and Social Democrats. Some municipal departments have consequently been reorganised, drug policy then falling under the responsibility of the municipal department of economy and health (CDU). Harm reduction oriented drug policy however, continued to be a fundamental aspect of the municipality's policy with priority being laid on the so-called four pillar policy which is also followed in Switzerland and laid down in the *«Declaration of the European Cities on Drug Policy»*.

2.3 The four pillar policy

2.3.1 Prevention

Prevention is based on a comprehensive perception of health education which implies mental, physical and social aspects of health to be of equal ranking. Its goal is the active strengthening of children, adolescents, and adults and the various protective factors, comprising all measures of structural prevention in an attempt to prevent as many individuals as possible from harmfully using legal as well as illegal psycho-active substances.

2.3.2 Therapy

People encountering mental, social, and/or physical problems because of their use of any drug - whether legal or illegal - are entitled to proper professional treatment, counselling and help. It is the task of the helping system to ensure that no moral or other judgement toward drug users prevents them from gaining access to the same care as any other individual. Therapeutic and social interventions therefore aim at covering a large spectrum of available instruments with the aim of giving as many drug users as possible the chance of abandoning their addiction and harmful use and lead an integrated life in our communities. Treatment aiming at abstinence often is a long-term process. Abstinence-oriented treatment, consequently, is complemented with treatment setting intermediate aims, such as harm reduction and survival help.

2.3.3 Harm Reduction/ crisis intervention/survival help

The target envisaged by harm reduction consists in helping present drug users to survive and overcome acute health and social crisis. All measures contributing to the avoidance of serious menacing infections and other harm are suited to achieve this goal. Low-threshold services, syringe exchange, consumer rooms, and the administration of substitute and, if necessary, original drugs are existing examples of this pillar.

2.3.4 Repression/ law enforcement

> The major goal of repression in this context is to initiate concerted action of police and justice with a view to influence the availability of legal and illegal psycho-active substances in such a way that the availability is controlled and harmful use is minimised.
>
> It is the primary task of the police and judiciary system to combat the illegal drug market and to ensure security for the population of our communities while trying to avoid, wherever possible, the marginalisation of consumers which creates additional hazardous conditions for their health[7].

A crucial element of this policy is to achieve a balance and integration of various measures into an overall social and health care system. Harm reduction measures are, directly and indirectly, contributing to the reduction of criminality and the significant reduction of costs to be borne by society. The city of Frankfurt places great effort in multidisciplinary cooperation, the *Montagsrunde* being a crucial element for forming intersectoral alliances between all municipal bodies responsible for tackling various aspects of drug use, the police, judiciary system, as well as the drug and youth helping services.

[7] see also: «Declaration of the European Cities on Drug Policy», Frankfurt am Main, 1998

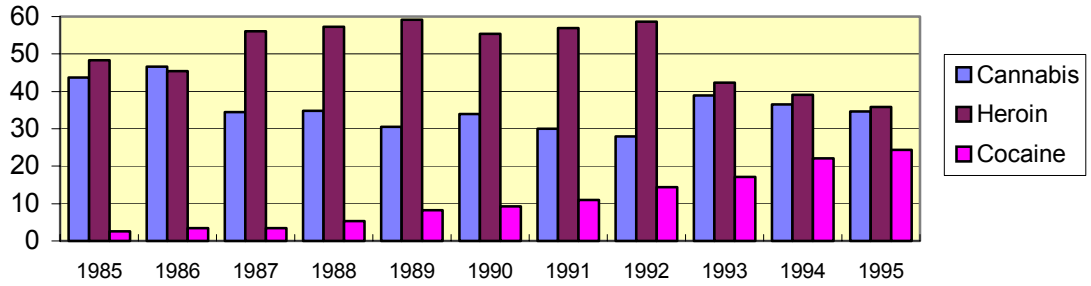
2.4 Drug-related problems and drug policy priorities

On account of the fact that the countryside surrounding Frankfurt (Rhein-Main Region) has an excellent network of railways, high-speed railways and subways ensuring very good connection to the city, Frankfurt has also a strong attraction for many drug users from the region, these people commuting to Frankfurt to buy and consume drugs. In general, 300.000 commuters come to the city every day - many of them by train. As such a large number of people comes through the main station area daily, this neighbourhood, which is, like in most large cities, also the red-light district and the centre of drug trafficking and consumption, is under constant public «surveillance». Many discussions have been going on for years about public order issues in the inner city, this aspect certainly being also an important factor when it came to offering low threshold services for drug users in this area.

From 1997 to 1999, according to the annual report of the municipal drug policy coordination office (Drogenreferat) for 1997-1999, 5.086 (1997), 3.138 (1998), and 3.205 (1999) users of illegal drugs have been registered by the police. In comparing these figures to the previous years, we have to take in account that during that last period police activities have been increased considerably and figures are often determined to a large extent by the modalities of registration. Therefore, figures of drug users registered by the police do not necessarily reflect the actual size, or increase/decrease of the drug scene in the city. The purity of heroin lies between 7% and 15% and the prize for a so-called «street-gram» (approximately 0.7 - 0.8 grams) is about 24€.

The drug mostly used during the early 90s was heroin, but cocaine and benzodiazepines were also used. Poly-drug use began to increase on the scene. As early as 1994/95, cocaine use had increased considerably on the open scene which was demonstrated by drug related offences dealt with at the Frankfurt courts:

Percentages of different drugs involved in all offences against §29 (purchase and possession) in 1995



source: Multi-City Study Frankfurt am Main 1995

As in previous years, we have to reckon with a considerable number of non-registered users of illegal drugs in the city. The drug policy coordination office of the city estimates that almost twice as many users purchase illegal drugs in the city: approximately 6.500 persons.

According to the report of the Frankfurt municipality, the obvious decrease of registered users of illegal drugs in 1998 (and the confirmation of this figure in 1999) has to do with changes in the electronic data file system of the police forces that ensures a more systematic counting of drug users.

As in Germany in general, also in the city of Frankfurt, we can observe in increasing trend towards poly-drug use. Also, cocaine and crack use has increased over the last 5 years. In 1997, the police has registered 200 crack users in the city. The municipal drug policy coordination office, however, estimates in its latest annual report that the actual number would most probably be twice as high. The characteristics of this group are a very high mobility and agitation which make it complicated to get them into contact with the helping system. Another problem seems to be - in our point of view - that measures developed during the last decade are targeted almost entirely towards heroin users and fail to provide effective services for this considerably different group of users. However, following a number of information exchanges and study visits to other cities in Europe, new strategies are currently being discussed by the local authorities in Frankfurt. The Crack-Street-Project, established in September 1997, was first initiated to collect in-depth information about this group and has been able to achieve considerable success in providing medical and social individual help through a unique combination of outreach work and medical treatment.

One of the best known measures in the field of survival help or harm reduction in Frankfurt am Main are the consumer rooms or safe injection rooms which have been established between 1994 and 1996. Together with the wide-spread needle exchange, and the methadone programme, these facilities comprise the core services in the field of harm reduction in the city.

Through the ECDP network, the city of Frankfurt, together with other German ECDP cities Hamburg, Hannover, Dortmund, and Karlsruhe, has promoted the establishment of better legal conditions for the establishments of consumer rooms, or safe injection rooms on the national level. The New German Government, elected in 1998, passed a change of the German narcotics laws in early 2000 that now enables all German cities to run safe injection rooms under certain conditions. One of them being the approval of the respective regional government for the implementation of such facilities.

In spite of all efforts aimed at offering alternatives to the open drug scene in Frankfurt there are estimates according to which 100 to 200 drug consumers - chiefly long-term addicts - continue consuming in the streets around the main station. There are ambitious efforts to integrate these drug addicts into a project of diamorphine (heroin) prescription with the aim of stabilising their physical condition and enable them to social reintegration. That is why the City of Frankfurt has contacted the Federal Ministry of Health already in 1993, making an application for approval of a project similar to the projects realised in Switzerland. Following the political change after the federal elections in 1998, the new red/green government of Germany has begun developing a nation-wide trial for the controlled prescription of heroin in several larger German cities, including Frankfurt, Hamburg, and Hannover. First implementation of local projects of that kind are, however, not expected before 2001.

2.4.1 Drug policy priorities

Drug policy is ranking high in municipal policy, the five main subjects most frequently discussed in drug policy by the City of Frankfurt are:

- Heroin prescription trials
- Establishing a network connecting youth welfare and drug-aid services
- Substitution and work programmes
- Synthetic drugs

- Prevention
- New drug trends (Crack/Cocaine use)

Since 1990, when the «Frankfurt Resolution» became one of the policy guides for the Frankfurt drug policy, survival help, crisis intervention, HIV prevention and substitution became major policy priorities in the city. This lead to the implementation of so-called harm reduction or low-threshold measures, such as needle exchange, crisis centres, methadone maintenance programmes, and later also safe injection rooms. During that time, the methadone programme was not only enlarged considerably, but also decentralised. Drug users are at first given methadone in several out-patient clinics around the city and are then referred to specially licenses general practitioners in the area where they live, as soon as they have stabilised.

2.4.2 Drug related deaths

In Frankfurt (as in all of Germany) the term includes all death cases that stand in a causal connection to the misuse of illegal drugs or other substances that are consumed to replace these illicit drugs. Therefore, it also includes methadone abuse or fatal mixtures of various drugs. As mentioned before, drug related deaths peaked in 1991 with an alarming number of 147 that also prompted the enlargement of the methadone programme and several other crisis intervention and «survival-help» measures.

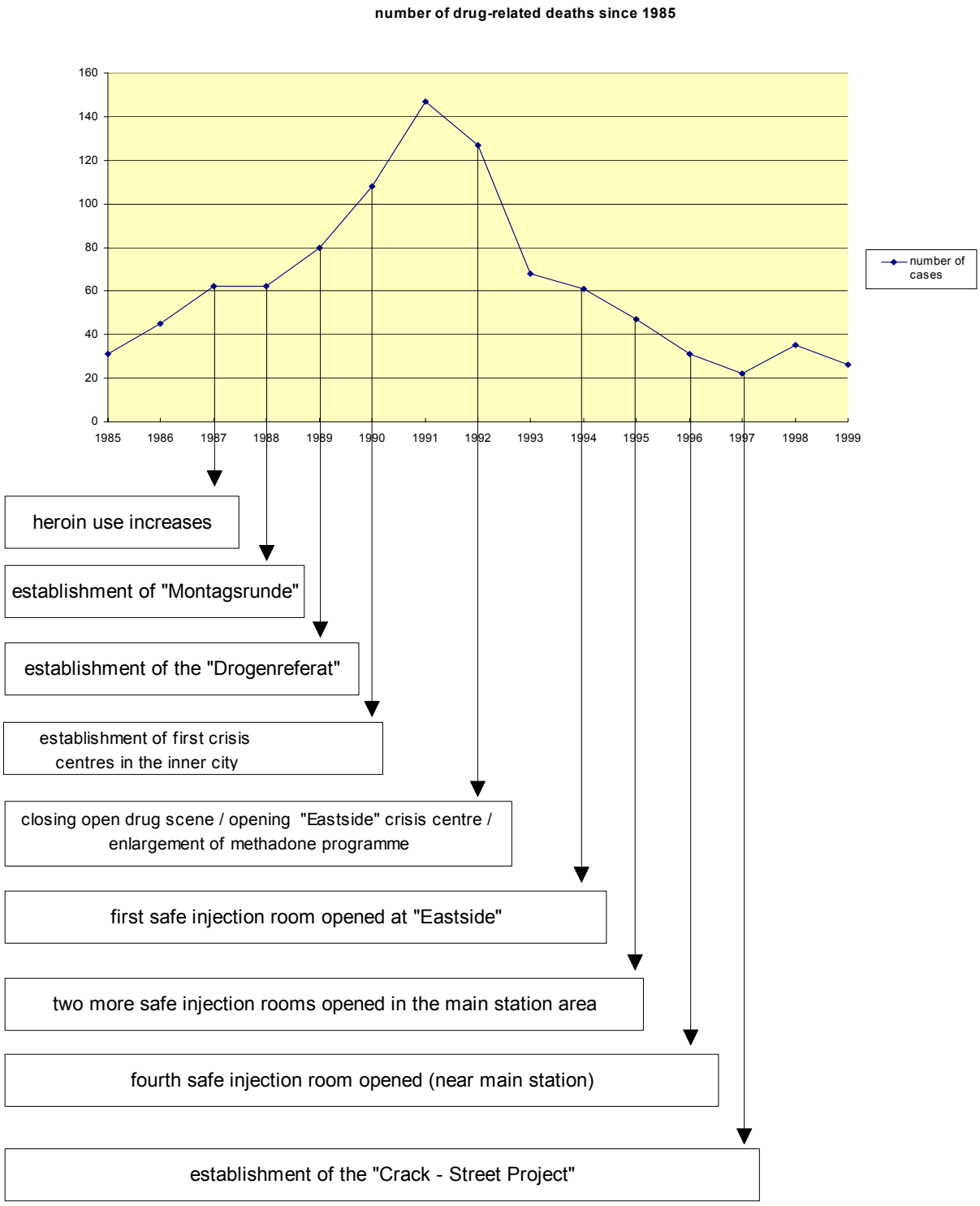
The number (and especially the increase during the late 80s/early90s) of drug related deaths has always been one of the strong motivations for drug policy decisions in the city. As the decision makers in Frankfurt aim at a balance between providing help for drug users and maintaining public order for the benefit of the general public, also drug-related crime is a driving factor for drug policy decisions in the city.

Drug-abuse related death cases in Frankfurt from 1985 to 1999

Year	Number
1985	31
1986	45
1987	62
1988	62
1989	80
1990	108
1991	147
1992	127
1993	68
1994	61
1995	47
1996	31
1997	22
1998	35
1999	26

Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000

Drug-related deaths and drug policy developments in Frankfurt am Main since 1985



2.5 Forms of services currently offered in the city of Frankfurt

2.5.1 Prevention

The City of Frankfurt is offering primary and secondary prevention. There are, at all Frankfurt schools, teachers specialised in drug counselling service. The municipal drug policy coordination office has published various brochures and conducted several special activities and campaigns on prevention, with a special impact on synthetic drugs (Ecstasy, speed, etc.). Currently, a major focus lies on the forming of cooperation alliances between youth welfare and drug helping measures and NGOs.

Since 1997, 4 services for youth and drug users have developed an additional focus on secondary prevention that include outreach-work in youth centres, various cooperation projects with youth centres and schools, training workshops and conceptual support for teachers and youth workers. Obviously, a considerable increase in the number of young persons in a phase of experimentation and beginning problematic use reached by the services could be achieved through this new prioritisation and cooperation.

Aims and objectives of measures in the field of prevention in Frankfurt:

- primary and secondary prevention
- training, workshops, seminars
- publication of information material - also in foreign languages
- peer- support and education activities
- cooperation between the youth and drug helping sectors
- use of Internet technologies for information
- specific information modules for parents and teachers or other multiplicators

Together with the cooperation circle on «new drugs» (Arbeitskreis neue Drogen), and the expert office on prevention, the police and other concerned official bodies, the municipal drugs policy coordination office plans to do a survey among experts to develop an «early warning system» on drug trends in youth scenes. First results are being expected in autumn 2000.

2.5.2 Detox/Therapy

The Federal Land of Hessen offers 74 places for inpatient detoxification and 703 places for inpatient therapy. There are 595 places, for long-term therapies, 50 places for psychiatric care 58 places for compact therapy and interim services which are mainly used by clients coming from Frankfurt. During the last five years, the number of Frankfurt clients admitted to this service has permanently dropped.

The aims and objectives of therapy and «help to abstinence» (Ausstiegshilfe) measures in Frankfurt:

- long-term abstinence
- regaining physical and psychological health

- social (re-)integration
- regaining the ability to work and earn money

Services offered in this sector:

- Detox wards at 2 clinics
- in-patient therapy
- long term therapy (between 6 and 18 months)
- after care (housing, education and work-training project)
- therapeutic communities (housing with counselling)
- psychological therapy
- specific medical and psychological help for drug addicts and AIDS patients with a psychiatric illness (Eschenbachhaus)

Statistics in the field of detox, therapy and abstinence oriented help cannot be given, because the data collection methods differ greatly from service to service.

Currently the price per bed/overnight stay in therapy is approximately 65 €.

No overdose deaths have yet occurred in treatment (including methadone treatment, safe injection rooms, crisis centres etc.). If people have died in treatment facilities (i.e. housing facilities / shelters) they died of AIDS or other diseases and not of an overdose. There are, of course, also hospices where AIDS patients may spend the last months/days of their lives with intense medical and psychological care.

2.5.3 Harm Reduction/crisis intervention/survival help

Aims and objectives of the Harm reduction measures in the city:

- An approach of «acceptance», that reduces the harm that drug users do to themselves and to society. This approach no longer makes abstinence the prerequisite for help. (Decriminalisation, social integration and reduction of physical or health related harm)
- survival help with a general aim to achieve abstinence
- offering help where it is needed or «picking up drug users where they are», without preconditions regarding abstinence.
- Adding another - low-threshold - entry into the general health care and helping system
- crisis intervention and survival help

Measures in the harm reduction field implemented in the city are:

- Needle exchange
- Consumer rooms or safe injection rooms
- Methadone maintenance
- Contact cafés/Crisis centres
- Crack-Street Project (medical care and outreach work)

NGOs in the drug helping sector in Frankfurt and their spectrum of services in the harm reduction area

- Integrative Drogenhilfe (IDH) e.V.
- Verein für Arbeits- und Erziehungshilfe (VAE) e.V.
- AIDS-Hilfe Frankfurt
- Jugendberatung und Jugendhilfe (JJ) e.V.
- Malteser Dienste (MD) (medical help/methadone)

Municipal offices involved in conducting harm reduction measures:

- Municipal Health office (MHO)
- «Walk Man» - outreach project for drug using minors of the municipal youth office (also part of the «Crack-Street-Project»)

Overview on harm reduction measures and the organisations providing them

	IDH e.V.	VAE e.V.	AIDS-Hilfe	JJ e.V.	Walk Man	MHO	MD
Contact Café	×	×	×	×			
sleeping facilities	×		×	×			
housing	×	×		×			
medical help	×			×		×	×
counselling	×		×	×			
Internet-councelling				×			
services for women		×		×			
services for minors		×		×	×		
secific services for drug users and their children	×			×			
services for drug users of foreign origin (migrants/minorities)				×			
needle exchange	×	×	×	×			
consumer room / safe injection room	×		×	×			
Methadone prescription	×	×		×		×	×
Streetwork		×	×	×	×		

Crisis Centres / Contact Cafés

There are three "crisis centres" established close to the drug scene (in the main station quarter), one is located in a neighbourhood close to the main station area and one at Osthafen - a neighbourhood with factories and warehouses. These centres offer low-threshold help like coffee and food at low prices in a contact café zone, shower facilities, a

clothing exchange service, a needle exchange service as well as medical care or counselling on demand. Some of these centres also offer sleeping facilities and one also work training programmes, most of these centres being connected to a clinic offering outpatient methadone treatment.

Safe injection rooms / consumer rooms

Three of the crisis centres have been combined with consumer rooms. 2 in the inner-city or main-station area (*«La Strada»* and *«Elbestrasse»*), one at *«Eastside»*, the largest crisis centre in Frankfurt, which offers a contact café, sleeping facilities, work-training projects, counselling, and an outpatient methadone clinic in a neighbourhood remote from the scene *(«Eastside»*). The fourth injection room is also located in the main station area (*«Druckraum Niddastrasse»*) where medical counselling and care is also provided twice a week. The last facility is a safe injection room only and not linked to a crisis centre. However, people are being referred to other services through this facility also.

The injection, or consumer rooms, established in 1994-1996 were the first facilities of this kind established in Germany. In 1999, an average of 778 consumptions of intravenous drugs has been counted in all four consumer rooms in Frankfurt (capacity: 35 places for all four facilities). In 1999, 642 emergency cases were reported in these facilities, but in only 50% of these cases it was necessary to call a doctor. The other half could be taken care of by the trained staff of the consumer rooms. Since their implementation in 1996, no lethal emergencies have occurred in any of these facilities.

Syringe/needle exchange

Syringes and needles may be exchanged in all crisis centres. There is also a mobile syringe exchange programme in the main station area. In addition, syringes may be bought at pharmacies. Approximately 1,5 million syringes and 2 million needles are being exchanged annually on a one-to-one basis.

Methadone prescription

In June, 1993, the numbers of doctors allowed to prescribe substitute drugs comprised 146 general practitioners and 30 hospital doctors. In 1994, already more than 800 addicts (long-term addicts) have undergone a methadone treatment offered by the City of Frankfurt. There, they have been administered methadone every day, this therapy being under permanent medical and psycho-social control. For clients whose prescriptions are being paid for by the general health insurance or the social welfare, there is a set of official indicators («NUB Richtlinien»). These indicators have often been criticised because they will not allow for methadone prescription as a preventive medical or psycho-social method. Currently, 984 places are offered for methadone treatment at 10 outpatient methadone clinics and through 22 general practitioners who need a special license to prescribe methadone to up to 10 clients. The drug policy coordination office states that there are several doctors who prescribe methadone without the official indications and license. It estimates that a total of 1.300-1.400 clients receive methadone in the city.

Cocaine/Crack

Recently, the discussion about how to tackle the problem of the increased use of cocaine and crack in the city has become another priority. In September 1997, the so-called «Crack-Street-Project» was started that combines street work, social work and medical care for crack users.

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2.7 Data Tables

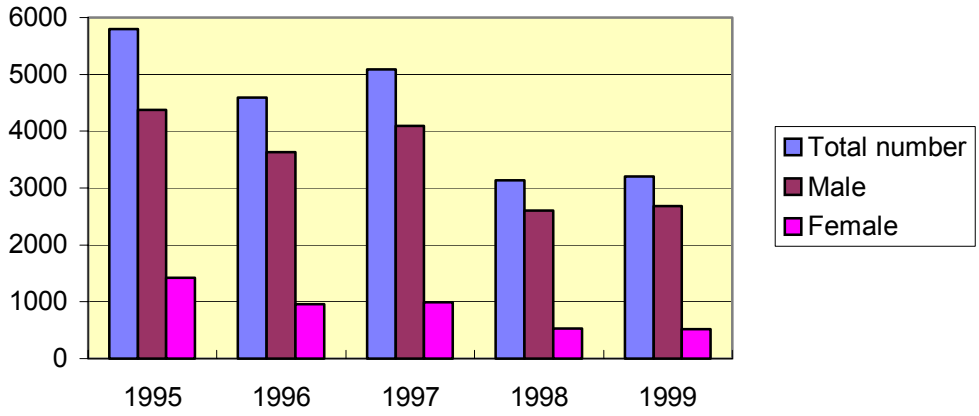
Registered users of illegal drugs

Registered drug users in Frankfurt from 1995 to 1999 (incl. breakdown by gender)

Year	Total Number	Male	Female
1995	5.796	4376	1420
1996	4.590	3636	954
1997	5.086	4089	997
1998	3.138	2607	531
1999	3.205	2681	524

Source:Police headquarters of the City of Frankfurt am Main

Registered drug users in Frankfurt 1995-1999 (including breakdown by gender)

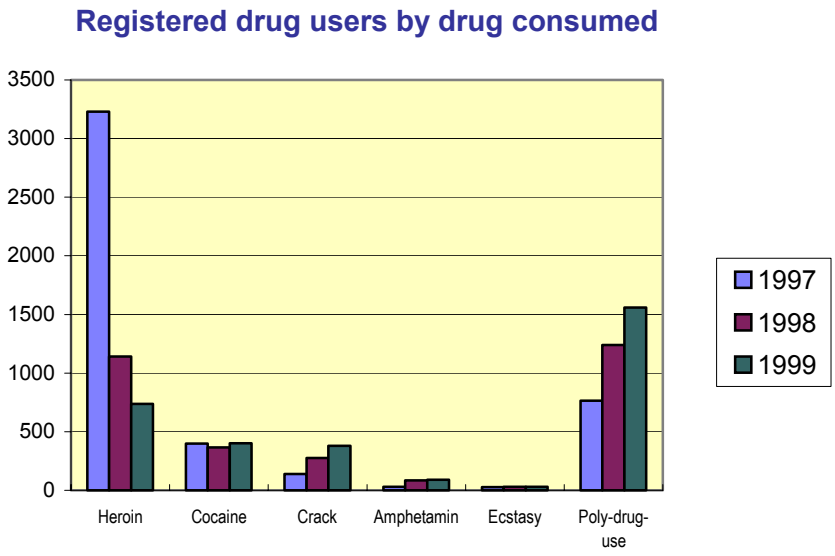


Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000

Registered Drug users in Frankfurt - breakdown by drugs consumed

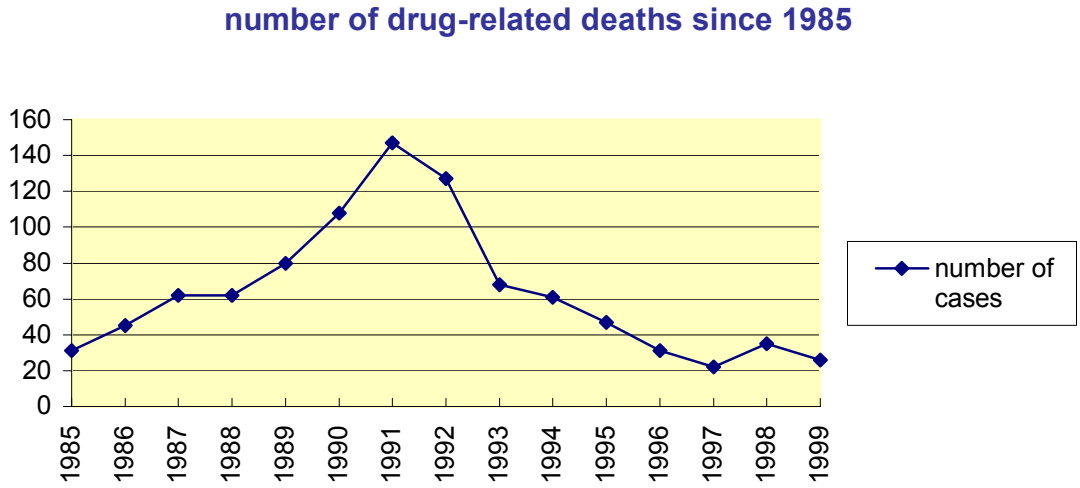
Year	Heroin	Cocaine	Crack	Amphetamines	Ecstasy	Poly-drug-use
1997	3231	399	140	30	26	764
1998	1142	366	275	85	31	1239
1999	738	401	379	90	30	1559

Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000



Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000

Drug abuse related deaths



Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000

Drug related deaths and drugs consumed

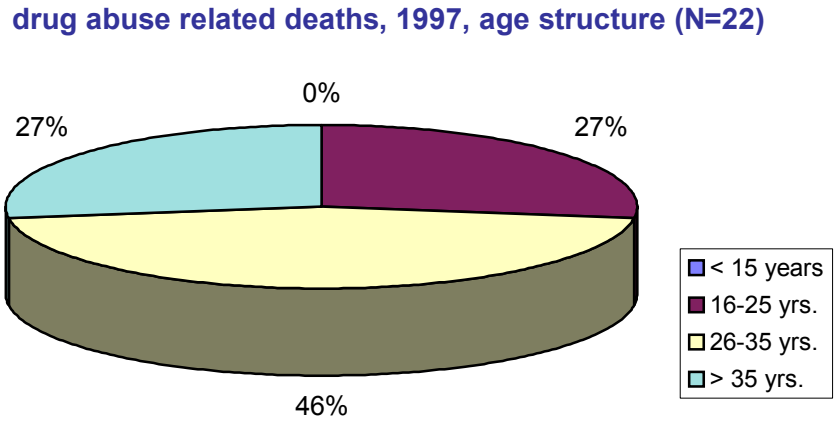
For a breakdown of drug related death cases by drugs consumed, please find data for 1996-1999 provided by the institute for forensic medicine (Institut für Rechtsmedizin, Prof. Kauert) in the Annex.

Age-structure of death cases in 1997 (N=22)

Age	number of cases	percentage
< 15 years	0	0,00%
16-25 yrs.	6	27,27%
26-35 yrs.	10	45,46%
> 35 yrs.	6	27,27%

Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000

N.B. this age structure is different from the ones made for the following two years. It was therefore not possible to compare them.



Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000

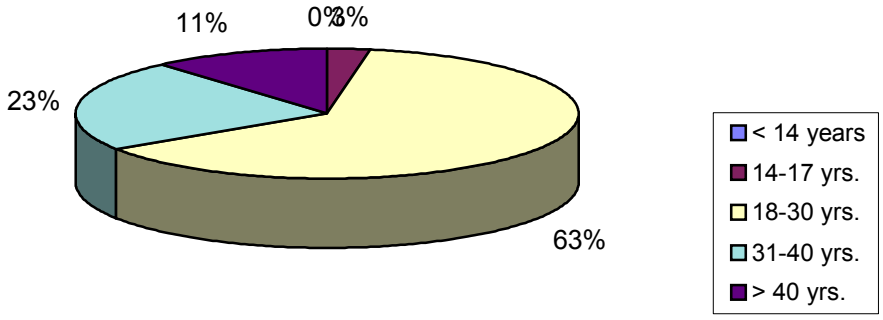
In 1997, the oldest person having died in relation with drug abuse was 50,
the youngest was 19 years old. The average age of drug victims in 1999 was 31,2 years.

Age-structure of death cases in 1998 (N=35)

Age	number of cases	percentage
< 14 years	0	0,00%
14-17 yrs.	1	2,86%
18-30 yrs.	22	62,86%
31-40 yrs.	8	22,86%
> 40 yrs.	4	11,42%

Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000

drug abuse related deaths, 1998, age structure (N=35)



Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000

In 1998, the oldest person having died in relation with drug abuse was 49, the youngest was 16 years old. The average age of drug victims in 1999 was 29,5 years.

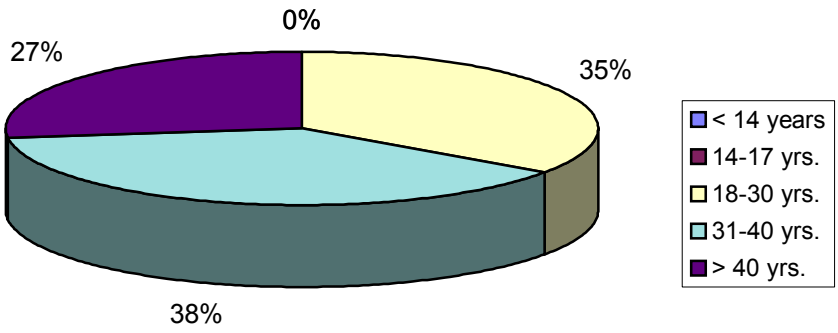
Age-structure of death cases in 1999 (N=26)

Age	number of cases	percentage
< 14 years	0	0,00%
14-17 yrs.	0	0,00%
18-30 yrs.	9	34,60%
31-40 yrs.	10	38,50%
> 40 yrs.	7	26,90%

Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000

N.B.: In 1999, the oldest person having died in relation with drug abuse was 45, the youngest was 18 years old. The average age of drug victims in 1999 was 34 years. Only 5 of the 26 registered drug deaths occurred in the inner city and in public. According to the police statistics the majority (16) of the registered drug deaths occurred in private homes (9) and hotel rooms (7).

drug abuse related death cases, 1999, age structure (N=26)



Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000

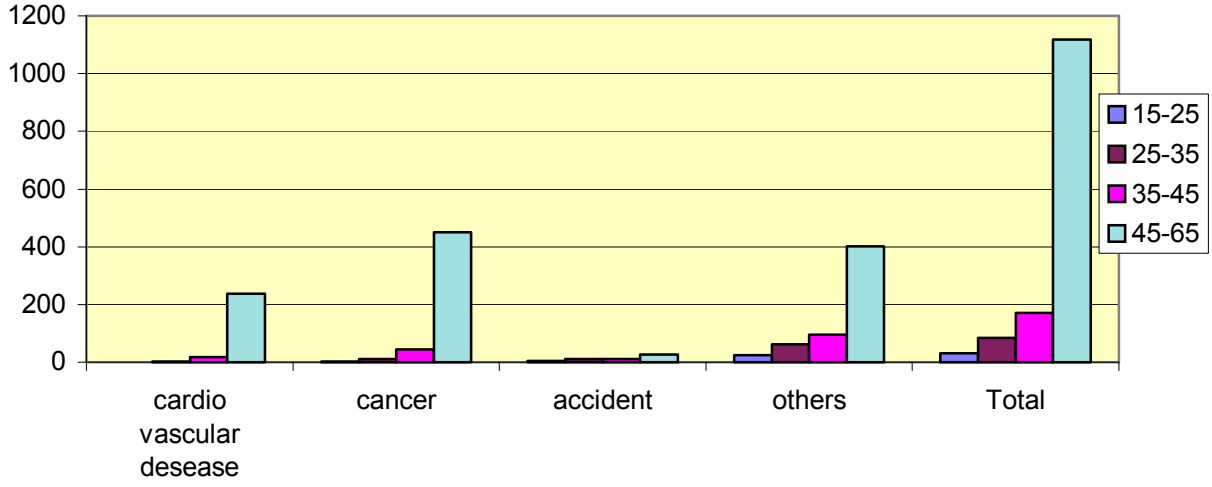
In comparison: **death cases in the general population in Frankfurt am Main**

Death cases in Frankfurt am Main by age groups and selected reasons

reason for death	15-25	25-35	35-45	45-65
cardio vascular disease		3	18	238
cancer	2	10	44	450
accident	5	10	12	27
others	24	62	96	402
Total	31	85	170	1.117

Source: Statistical yearbook of the city of Frankfurt am Main, 1999

death cases in Frankfurt am Main by age groups and selected reasons for death



Source: Statistical yearbook of the city of Frankfurt am Main, 1999

Consumption and emergencies in the safe injection rooms

Consumptions in the 4 injection rooms

Year	number of consumptions in all 4 injection rooms
1996	515 (daily average, in December 1996)*
1997	265.291
1998	288.291
1999	284.032

Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000

* in 1996, no complete data concerning the number of consumptions has been collected. Data collection only started in December 1996.

N.B: these figures are «consumptions». Considering the fact that many drug users use i.v. drugs several times a day, this does not relate to the actual number of persons coming to these facilities.

Emergency cases in the four injection rooms

Year	number of emergencies in all 4 injection rooms
1996	8 (in December)
1997	397
1998	651
1999	642

Source: Annual Report of the drug policy coordination office of the city of Frankfurt am Main 1997-1999, Frankfurt 2000

The annual Report of the drug policy coordination office of the city of Frankfurt for 1997-1999 states that in 50% of all cases, emergencies could be dealt with successfully by the staff of the injection rooms.

Unfortunately it was not possible to obtain any emergency-related data from the ambulance or emergency doctors services, because German law protects personal data. The only non-personalised data available would have been registrations of the street names where the ambulance was called to. According to the ambulance personnel, certain streets/places indicate that this could have been a drug-related emergency, but as there is no verification possible, we decided to leave these figures out of the report.

Detailed emergency statistics for the 4 consumer rooms

Emergency cases in the safe injection room «Elbestrasse» 1996-1999 by gender

	1996	1997	1998	1999
Total	5	188	228	294
Male				210
Female				85

Source: Drogennotdienst, Jugendberatung und Jugendhilfe e.V., 2000

N.B.: the safe injection room opened in August 1996 with reduced limited hours

Emergency cases from 1996-1999 by gender in the safe injection room «Eastside»

Year	**1996**	**1997**	**1998**	**1999**
Total	**29**	**15**	**11**	**18**
Male	**20**	**20**	**9**	**12**
Female	**9**	**5**	**2**	**6**

Source: «Eastside», Integrative Drogenhilfe e.V., 2000

Emergency cases in the consumer room "La Strada" from 1996 - 1999 by gender

	1996	1997	1998	1999
Total	76	44	45	102
Male	22.102	21.204	21.665	no data
Female	7.766	8.402	6.945	no data

Source: «La Strada», Aids-Hilfe Frankfurt., 2000

N.B.: the considerable rise in emergency cases in 1999 is due to the implementation of a new data collection system. Up to that time, only sever cases were registered, now also more moderate cases are being registered

Emergency cases in the consumer room "Niddastrasse" from 1995 - 1999

	1995	1996	1997	1998	1999
Visitors	35.382	84.122	108.793	140.759	138.268
ODs	68	172	150	297	342

Source: «Druckraum Niddastrasse», Integrative Drogenhilfe e.V., 2000

3 Drug overdoses and overdose deaths in Copenhagen

Mette Harbo

3.1 Introduction

Copenhagen in figures year 1999	
Total number of inhabitants	491,082
Population between 15 – 64 years	353,850
Share of inhabitants of foreign origin	11.7%
Unemployment rate approximately	7.1%
Shelters (beds per night)	1000
Homeless per night*	200

* any given day

Copenhagen is the capital of Denmark and is situated on the island of Zealand and Amager. At the beginning of 2000, it had 495,699 inhabitants living in an area of 88.3 square kilometres. The City of Copenhagen is surrounded by the County of Copenhagen and in the middle of the city lies the municipality of Frederiksberg. The City of Copenhagen is a part of Greater Copenhagen, which comprises the City of Copenhagen, Frederiksberg and the Counties of Copenhagen, Roskilde and Frederiksborg. The Copenhagen Region has a population of approximately 1.8 million, a third of the Danish population.

The City of Copenhagen is divided into fifteen districts with inhabitants of between 10,000 and 40,000. The City is in a process of administrative transition, with growing political autonomy in the individual districts, resembling to a wider extent the situation in municipalities in counties outside the City of Copenhagen.

3.2 Health in Denmark in comparison with other countries

In general terms, Denmark is experiencing relative deterioration in health development when compared with other countries. According to the OECD 1998 report providing, life expectancy in Denmark at birth was 78.0 years for women and 72.8 years for men.. Having been placed at the top of the health list in 1970, Danish women now occupy the 15th out of 15 places in the EU and Danish men the 14th. However, infant mortality ranks 8th from the top. When compared to other countries this means that the Danish population is experiencing a loss of life in middle age, particularly among women.

The Healthy Cities indicators, published in 1996, show that the Copenhagen Standard Mortality Rate (SMR) ranked no. 6 among the 23 Healthy Cities. Copenhagen was among the top ten as regards all cause-specific death rates while some other cities with high SMRs were high only in relation to some specific causes. The City of Copenhagen also exhibits high mortality rates from: “symptoms and ill-defined causes”, which to some extent are most likely attributable to alcohol and drug-related deaths.

3.2.1 The drug problem in the City of Copenhagen – historical background

In 1955, the first Euphoriants Act was passed in Denmark due to a minor group of “old type” drug addicts mainly supplied by doctors prescriptions. According to the law, a central register for prescriptions of strong opoids was established to prevent doctors from malpractice and to control them. Measures could be taken towards those who did not comply with the law. This smaller epidemic beginning in the late 40s eventually tapered off during and after the end of the Second World War.

In the middle of the 1960s, a new type of drug use among the young appeared and caused much anxiety because of its unprecedented implications. The drugs in question were mainly cannabis and psychodelics. In the late 1960s, amphetamine and shortly afterwards opium became popular as well. School surveys conducted in the 8th grades in Copenhagen in 1968 and 1970 showed an increase from 10% to 20% among those who had ever tried cannabis. The drug problem was mainly concentrated to the Copenhagen area and to the major cities in Denmark.

From1969 to 1971, the first treatment facilities appeared and the "phase model" for treatment was introduced (phases: detoxification, stabilization, after care and drug free life).
A national board was formed to monitor development. Later, in 1975, the board was transformed to The Council on Alcohol and Narcotics.

In 1970 heroin was introduced on the market as so called "Pakistan pills".

In 1973 guidelines for methadone treatment were issued, stating that this type of treatment should be considered an exception County councils were formed in 1975 to secure that the guidelines were observed. As a rule, methadone treatment was only handed out by general practitioners (GPs).

1975/1976 heroin chloride was introduced on the market.

From 1975 and onwards, treatment systems emerged throughout Denmark, still mainly implementing the phase model.

In 1976, the first attempt to record the number of drug addicts was made. It took place in the greater Copenhagen area. Approximately 3,000 drug addicts were found , i.e. approximately 2,000 in the City (Municipality) of Copenhagen. On the basis of drug related mortality rates, it was estimated that there were 5,000 to 10,000 drug addicts in Denmark.

In 1977, the polarisation between social workers and medical doctors regarding methadone treatment reached its peak. This antagonism has only recently tapered off.

In1983, the HIV infection (at the time known as AIDS) was put on the agenda.

In the mid 1980s, treatment goals were adjusted as it was officially accepted that some addicts could not be made drug free and had to be maintained on methadone.

In 1984, there was a debate in the Folketing regarding drug use prevention and treatment. The strategy pursued so far was essentially supported, although the ineffectiveness of the treatment was discussed critically.

In 1987, cocaine began to emerge on the market.

In the 1990s, the treatment system was criticised for being ineffective and the Ministry of Social Affairs began to show an interest in the field.

In 1990, the first reports on ecstasy surfaced.

In 1992, a law was passed on compulsory treatment. Compulsory treatment could only be carried out if: 1. the county agreed to establish necessary facilities and 2. the persons in question applied for it themselves. The law has never been in use.
In the 1990s the debate on legalised drug provision to drug addicts began. The Zurich experiment was monitored closely.
I
n the 1990s, heroin base smoking was becoming more and more widespread in Copenhagen. The organisation of former drug addicts in NA groups also began in the mid 1990s, and the movement rapidly spread throughout Denmark. Today, there are groups in every county.

In 1995, laws were passed, laying down that county authorities were responsible for all kinds of treatment, drug free as well as methadone maintenance treatment. A long dispute between municipalities and counties regarding the payment for treatment was thus finally resolved. It also meant that the methadone treatment was moved from the general practitioners to the county treatment authorities.

In 1996, the Government Council on Narcotics under the Ministry of Social Affairs was established.

In 1998, a capture-recapture study was conducted in the City of Copenhagen and it was estimated that in 1996 there were about 4,000 drug addicts in the City of Copenhagen.

3.2.2 Christiania

As something rather special near Copenhagen and the Copenhagen drugs scene, the city houses Christiania. Christiania is an approximately 10 hectare large area near the Copenhagen canals. Many years ago, the area was used as military barracks, but was deserted in the 1960s and lay idle. In 1971, a group of young people occupied the area and started to renovate the old buildings. After a few months, approximately 400-500 people lived in Christiania, and the area was labelled a social housing experiment. Today, Christiania provides accommodation to 650 adults and approximately 300 children (and 300 dogs). The area has been through turbulent times, given that the public authorities have tried several times to shut it down. The area has been subjected to much controversy both among politicians as well as the general population. Throughout the almost 30 years, Christiania has represented alternative living compared to the established society.. Principles of solidarity, ideology, autonomy have constituted some of the cornerstones on which Christiania is based, also today. And what has made Christiania internationally known is its liberal attitude towards cannabis. Christiania accounts for the highest and most concentrated cannabis sales figures in Copenhagen. In "Pusher Street" it is possible to buy all types of cannabis as well as pipes and other accessories from various booths. Naturally, this contributes to attracting individuals who need narcotic substances and therefore also attracts types of substances stronger than cannabis. At the end of the 1980s, this gave rise to much turmoil in Christiania, internally as well as between Christianites and the police. Today, the inhabitants of the area appear to take the law into their own hands to a higher degree, which means that the sale of hard drugs in Christiania has been reduced as compared to before. The police will raid the area for cannabis 2-4 times a year - the rest of the year, they will appear only for other causes. There are a variety of music clubs in Christiania offering musical functions several times a week. Approximately 1 million people visit Christiania on an annual basis. It is assumed that approximately one half of the visitors arrive to buy cannabis, the rest visit out of curiosity. In comparison, it is worth mentioning that Tivoli in Copenhagen, with its 3.2 million visitors each year, ranks number

three on the European scale. Christiania is thus a not insignificant tourist attraction to Copenhagen.

3.3 The actual situation - The drug using culture

3.3.1 Drug use trends/spread/new recruitment/preferred substances.

There has been a moderate increase in the estimated number of drug addicts in Denmark throughout recent years, from about 10,000 at the beginning of the 1990s to 14,000 today. About 5% leave the drug abusing population every year, which amounts to approximately 700 persons, and the incidence is probably somewhat higher.
Addiction is typically multiple drug use, but heroin is the dominant drug. Most addicts do benzodiazepines, cannabis and alcohol, while amphetamines and cocaine are less widespread. The use of heroin has probably increased in recent years, especially outside Copenhagen.

3.3.2 Age development in the main target group.

The mean age in different drug addiction populations is increasing. This applies to the population of dead addicts, those imprisoned and drug addicts seeking treatment. The reason for this is that drug dependency is a chronic or long lasting condition, and that the drug addiction debut arrives at a later age.
The actual mean age for those seeking treatment is 39 years.

3.3.3 The occurrence of abstaining periods/tolerance reduction due to imprisonment/detoxification/institutional treatment.

It is not known how many periods of abstinence drug addicts in Copenhagen do have as an average. However the number must be large due to frequent imprisonment and drug free in-care treatment episodes.

3.3.4 How widespread is intake of heroin by injection.

About half of all heroin addicts mainly take heroin by injection, while the other half mainly does smoking or sniffing. There is a clear age-related correlation increasing probability for injection with increasing age. Among those seeking treatment, about 80%, either inject or have been injecting drugs.

3.3.5 Availability of heroin

For some years now, all police districts throughout Denmark have seized heroin.. In this respect Denmark has become very homogenous. In 1999, heroin was the most frequently seized drug in all police districts, except in one. In 1999, almost three quarters of all heroin seized was heroin base, the rest being heroin chloride.

Drugs seized in Copenhagen in		
Substance	**Quantity**	**1999**
Heroin	Kg	24.5
Cocaine	Kg	19.8
Amphetamine	Kg	6.6
Cannabis	Kg	1,147.4
Ecstasy	Number of pills	7,563.5

Source: Drug Statistics, National Investigative Support Centre. (NEC).

Heroin chloride is generally more pure than the base with a median purity around 70%. The base revolves around 30%. As a general rule, the variation is very large. Caffeine and paracetamol are the most commonly used adulterants, but sugar is also frequently found. No really acute health threatening adulterants have ever been found.

3.3.6 Price development of heroin

Since 1995, the development on the market has been followed through a national project and a specific study was made in 1995 on the illegal drug market in the City of Århus. Rumours will have it that prices are falling but neither in the study nor in the past few years of surveillance has it been possible to demonstrate falling prices. The variation is, however, large and highly dependent on the amount purchased. For heroin base from DKK 500 to DKK 3000 per gram (60 € - 375 € per gram), heroin chloride being somewhat more expensive.

3.4 Documentation deaths caused by intoxication

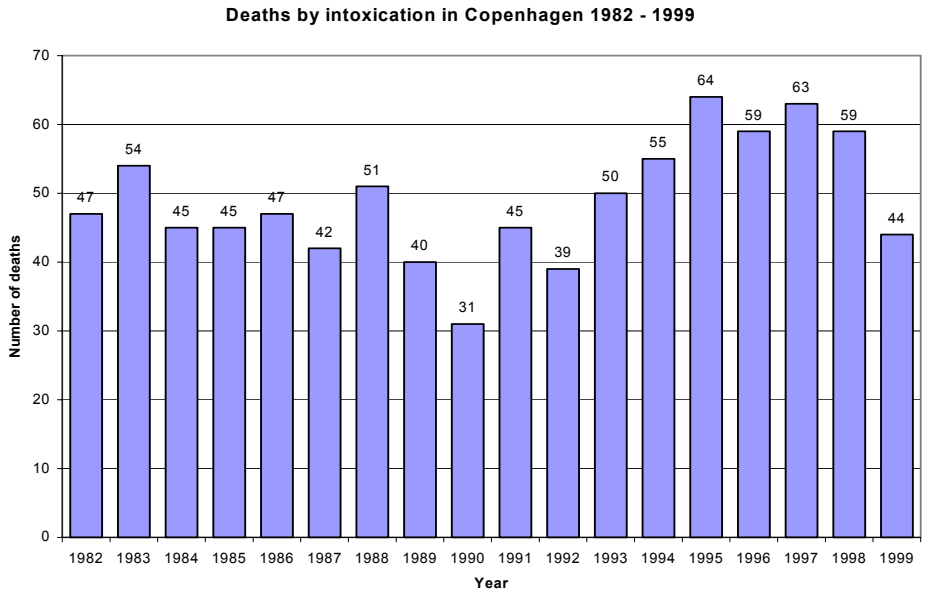
In Denmark, drug related deaths are registered by the police. In a circular letter issued by the National Commissioner of Police in 1976 an autopsy as well as a chemical drug analysis should be performed in connection with all deaths that by statuary regulation are caused by suspected drug addiction brought to the knowledge of the police and where drug abuse is suspected. .. The autopsies are financed by a national budget. The result, death certificate, autopsy report including chemical analyses, is then sent to the National Board of Health where the death is coded in accordance with ICD 10 rules (International Classification of Diseases, 10th revision). In the police register deaths are separated into deaths caused by intoxication and other.

According to statuary regulations the police only receives reports on deaths, where the individual is found dead, where an accident is the cause of the death or where some criminal act is suspected .

Natural causes of death, where, for instance, an addict or former addict dies from tuberculosis in a hospital, are not recorded as a drug related a death in the police register.
This means that almost all deaths caused by intoxication, when being considered as accidents, are reported to the police, and autopsy is performed and the death is included in the register.
There are no ICD codes in the police register.
When extraction is made from the national cause of death register on relevant codes there is not a 100% coherence with the police register.
In Copenhagen we are rather confident with the registration of deaths due to intoxication's among drug addicts as registered by the police.

3.4.1 Defined populations from which counts on deaths caused by intoxication's rates can be made

The problem of calculating death rates derives from the denominator problem.
In Copenhagen we are confident with the number of deaths due to intoxication but the denominator can be different populations: those seeking treatment or estimated populations of drug addicts in different areas or confined addicts.



The most reliable calculation is the one made by the National Board of Health on drug addicts seeking treatment. On the basis of their treatment registry, death rates are calculated year by year. This calculation can be done for Copenhagen separately as well as for the nation in general. The method includes all-cause death rates, but cause specific rates can also be made. The figure provides the number of deaths due to intoxication among people living in Copenhagen from the years 1982 – 1999. For the years of 1997, 98, and 99 the figures are also broken down by gender and by 5-year intervals. See table, below.

Deaths due to intoxication among people living in Copenhagen broken down by gender and age in 1997, 1998 and 1999						
	1997		**1998**		**1999**	
Age interval	Women n=12	Men n=51	Women n= 10	Men n= 49	Women n= 9	Men n=35
15-19			1	1		
20-24	1				1	2
25-29	1	4		8	1	8
30-34	3	11	3	12		6
35-39	5	16		8		7
40-44	1	13	3	9	4	5
45-49		6	2	4	2	4
50-54	1			7	1	3
55-59		1	1			
60-64						
>65						

3.4.2 Reliable surveys to assess the distribution of drug use among the general population

The National Board of Health plans to perform surveys every fourth year regarding drug use among school children. In Copenhagen there are plans for conduction surveys in high schools as well. The Danish Institute of Public Health (DICE) has just begun to include questions about drug use in their health surveys. These surveys are conducted about every fourth year and includes the population down to 16 years.
The actual survey data are reliable but are not yet a part of a specific periodical routine.

3.4.3 What is the overall mortality rate among known drug addicts

In 1999, the overall annual mortality rate in Denmark among those known in treatment was 2.4%. In January 2000, the rate for the same population was calculated to 2.2%. By the same method the mortality rate for Copenhagen in 1998 was calculated to 2.5% (National Board of Health).
According to the Forensic Institute in Copenhagen mortality rates due to intoxication are rather stable amounting to about 80% from 1982 through 1997. This number refers to the deaths due to intoxication as registered by the police in Copenhagen.

3.4.4 Where do deaths caused by intoxication occur

The table shows were deaths due to intoxication took place in 1997, 1998 and 1999 in Copenhagen.

Place of intoxication deaths for 1997, 1998 and 1999			
Place of death	**1997**	**1998**	**1999**
Own home	31	30	27
Friend	12	13	11
Hotel	1	1	0
Institution/hospital	6	2	1
Detention/prison	0	1	1
Public place (outdoor)	2	5	2
Public place (indoor)	5	5	1
Other	6	2	1

Circumstances related to death in 1997, 1998 and 1999			
	1997	**1998**	**1999**
Alone at time of death	41	32	21
Homeless	4	9	3

3.5 The treatment and rehabilitation system

3.5.1 Legislation

In 1995, new laws were passed concerning the treatment of drug addicts. The purpose of the laws were following:

1. to make one, and only one authority, responsible for the social as well as for the medical treatment of drug addicts. In the Municipality of Copenhagen, The City Council, in the rest of Denmark the County Council.
2. to secure better treatment by having the possibility to link methadone treatment directly to social work
3. to secure better control with methadone and to reduce methadone diversion.

3.5.2 The City Council

The Municipality of Copenhagen has, as similar to a County, the responsibility for the treatment of drug addicts in the municipality.
The City Council is the decision-making authority in the municipality, and its members are elected every fourth year. The City Council has the financial authority and is responsible for the economy of the municipality: budgets, collection of local taxes and the overall activities carried out in the municipality. There are seven standing committees, one committee for each administrative area. The City Council sets out the field of activity for each committee and approves annual budgets for the committees. Each Committee has its own administration and is in charge of administrative activities. The Social Committee is responsible for activities regarding treatment of drug addicts. The Committee identifies all goals for drug addiction treatment in the municipality and is responsible that costs are in balance with approved budgets. Remarks to the annual budget provide thorough details on how resources should be used. For instance, the number of in- and outpatient slots are stated in the budget together with the precise funding of different activities and projects, objectives and criteria for evaluation.

3.5.3 Overall treatment goal

The overall treatment goal can be divided into the following objectives:

- Drug free living – the stopping of illicit drug use and addiction.
- Social rehabilitation.
- Restrict and reduce the damage caused by drug addiction on both the individual addict and society.

These objectives are not mutually exclusive, and it is believed that the treatment for all clients should have the fulfilment of all objectives as the ultimate goal. Stopping or reducing addiction is the basis for further social and rehabilitation activities, including education or specific training aiming at jobs or job-like placements. On the other hand, social work and rehabilitation are preconditions for sustained reduction of drug addiction. And realisation of the two first objectives are prerequisites for damage reduction, even if some damage can be avoided with the two first objectives not achieved. The amount of damage reduction caused by the specific abuse will also determine how far the social rehabilitation process can be brought.

3.5.4 The Administration

The Social Administration secures that goals determined by the Committee are carried into effect, holds institutions operational, implements new ideas, evaluates activities and makes necessary adjustments on grounds of financial or factual reasons. The Social Administration

also plans future activities and forwards budgetary forecasts to the Committee. The municipal accounts are revised by a specific administrative department in the municipality, The Accountant Administration.

3.6 The effort for drug addicts

3.6.1 The overall budget for drug addiction treatment in Copenhagen in 1999.

Table 1 shows the budget for drug addiction treatment for the year of 1999. Social transfers, welfare aid, pensions and activities in other administrations with connection to drug addiction are not included. About 12% of total slots are in-care slots, amounting to almost 40% of total costs. It is estimated that there are 250 –300 in-care treatment episodes annually with drug free living as treatment the primary objective.

Table 1. Total expenditure for drug treatment , City of Copenhagen 1999.

	Number of slots	Per cent	Costs (€)	€ per slot	Per cent
In-patient* Facilities	96	6,2	3,759,000	39,000	24,8
Outpatient** facilities	1178	76,1	6,963,000	5,911	46,0
Special treatment***	175	11,3	2,396,000	-	15,8
Budget for buying slots in private treatment centres*	100	6,5	2,019,000	-	13,3
Total	1549	100,0	15,137,000	-	100,0

*Primarily drug free treatment
**Primarily substitution assisted treatment
***Drug free treatment and substitution assisted treatment

3.6.2 Treatment organisation

The number of clients has risen from 1,306 in 1996 to 2,387 in 1999. The treatment system in Copenhagen is the largest and most differentiated in Denmark. Every treatment institution has well defined tasks, but has within its field of work and budget extensive authorityto organise activities, compose its staff etc.
There are four central institutions, Counselling Centres (CC) (Amager, Indre, Vest and Nord), responsible for four districts of the municipality and the treatment of all drug addicts living there. All treatment begins in the centres and they administer all welfare aid, pensions and other social services for those seeking treatment. For the rest of the population social services are provided at Social Service Centres (15 in the city). The CCs register clients, distribute and refer them to specialised institutions and have the authority to buy treatment services in private institutions. Thus the CCs have the financial as well as the professional responsibility for all drug addicts in treatment, no matter the treatment they are referred to.

3.6.3 Social work and social rehabilitation

The professional social work consists of:
- The administration and payment of social welfare aid, pensions etc.
- An assessment of housing conditions, aid for appropriate housing and if necessary training in how to live on your own,
- An assessment of education, job skills and ability to work. Referral to further education, jobs, job training and job-related placements etc.

3.6.4 Drug treatment

The specific drug treatment can be summarised as follows:

- A social and medical professional examination of the needs of the client, hereby taking into account social conditions mentioned above, the character of the addiction in terms of length and severity, medical conditions as psychiatric or somatic diseases, need for blood testing and vaccination etc.
- The preparation of a treatment plan where social and more specific treatment needs are considered in an integrated manner. The timing of different elements in the plan should be stated, social as well as elements related to addiction or medical conditions.

Treatment takes place as purely out-patient treatment or as a combination of out-patient care combined with one or several in-patient episodes. The treatment will nearly always be supported by medication in shorter or longer periods, as treatment almost always is begun by a period of stabilising with methadone or buprenorphine. When drug free treatment is required there will be a period of tapering off medication and when maintenance is required , substitution treatment will be continued. Maintenance treatment is by far the most frequent, as 80% of clients receive this treatment.

There are specialised treatment services for families with children, hiv-positive clients and clients with severe somatic or psychiatric conditions.

Treatment integrated with methadone maintenance is organised as outpatient care differentiated according to the functional level of the client. Methadone delivery is in the same way differentiated to match stability and functional level. Methadone is normal given orally and is taken under supervision as well as take-home doses depending on professional assessment of the individual. Substitution medication includes methadone (50-120 mg daily), buprenorphine and LAAM. Heroin is not used. After medical evaluation, other psychoactive medication can also be given, such as benzodiazepines and psycholeptica, as well as other medication for somatic treatment.

According to the law on treatment of drug addiction, the County authority (Copenhagen) may delegate the medical maintenance part of treatment to general practitioners. In these cases, the client should be in a stable condition and the GP should agree on the delegation in advance. This delegation of responsibility does, however, not liberate the County (Copenhagen) of its fundamental responsibility for treatment, and there is thus an obligation for the CCs in Copenhagen to follow-up on the clients referred to GPs. In a case of referral, the CCs also continue to have the clients social files. Where disputes arise, the CCs are obliged to take over no later than within 14 days. The actual number of delegated clients is 230.

Drug-free treatment takes place in institutions owned by the municipality as well as in private institutions, where the CCs buy services. There is a specific budget for the purchase of private treatment services. All kinds of institutions are used: treatments inspired by AA and NA movements, therapeutic communities, institutions relying heavily on social programs, institutions inspired by Italian phase models and religious movements. Most clients require more than one treatment service and most of them have been subjected to two or more.

3.6.5 Reduce damage

Hand-out of syringes and needles.
Since 1986, the City of Copenhagen has dispensed syringes and needles free of charge. To begin with, this service was provided by the pharmacies, but since 1996, it has primarily been carried out from a bus parked in three different areas in Copenhagen each day. In addition to the variety of syringes and needles dispensed, the bus also hands out cleaning swabs, small cups, cotton wool, containers for used syringes and needles, informative material and condoms. The bus is paid by the City of Copenhagen the Municipality of Frederiksberg, but is run by the Copenhagen Fire Service which also runs the ambulance service. Each year, a total of between 400,000 and 500,000 needles are handed over the counter. This number has not changed significantly throughout all the years.

Pre-hospital medical treatment
The transport physician ambulance accounts for part of the services offered by the City of Copenhagen to reduce injuries and deaths among drug addicts. This is an extended emergency service, with doctors and special equipment being onboard the ambulance in case of a patient suffering from cardiac arrest. The transport physician ambulance also carries antidote to be administered on site so as to ensure that most intoxication cases are brought into hospital.

Nursing care
Since 1998 there has been a specific health service for those living in shelters in Copenhagen. This service relies mainly on nurses with access to obtaining advice from medical doctors at a centralized treatment unit. The service is added to regular primary health care, which is free and available for all with danish residence permit. The specific health service is supposed to focus on injury caused by injection behavior, treatment of ulcers, adherence to treatment with antibiotics (TB), relevant admissions to in-treatment etc.

Psychiatric patients who also are drug addicts (dual diagnosis)
It is a well known fact, that drug addicts who also suffer from major psychiatric disorders cause much trouble in drug treatment systems as well as in the psychiatric care. In Copenhagen there has been established a specialised out-patient clinic to remedy this problem. The clinic has capacity for 25 out-patients. Adding to this, treatment units in the drug treatment system and in the psychiatric care can have assessments and advice regarding treatment of their clients or patients with suspected psychiatric disorder or drug addiction.

The Police and prisons.
Since the beginning of the wave of drug use from the 1960´s the police activity in Copenhagen with regard to repression could be classified as ”middle repressive” in comparison with other relevant European cities. There has, however, been periods with intensive police activity directed against street addicts and culmination in 1996/97. Since then police involvement has mainly been directed towards more serious drug crime and not so much against every day street level trafficking.

In Danish prisons the prevalence of drug addicts has been constant about 30%, out of totally 4000 confinement slots.

3.7 List of references

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4 Drug overdoses and overdose deaths in Oslo

Knut T. Reinås, 2000

4.1 Some background demographic data of the city,

The city of Oslo is the capital of Norway, and offers employment and cultural services for people from 25 city districts and a rather densely populated area in the surrounding municipalities. Approximately half a million people live within the city border, and another half a million in the municipalities nearby.

Population in Oslo by 1st January 1999, by sex and age group (1)

Age	Males	Females	Total	Percent of the total Norwegian population
0-5 years	20 093	19 042	39 135	10.8
6-12 years	18 791	18 180	36 971	8.9
13-15 years	6 462	6 080	12 542	8.0
16-19 years	8 684	8 578	17 262	8.1
20-44 years	107 195	107 050	214 245	13.3
45-66 years	55 451	56 515	111 966	10.5
67-79 years	19 049	27 978	47 027	10.9
80 years +	6 503	17 216	23 719	12.6
Total	242 228	260 639	502 867	11.3

30.2 percent of the population is concentrated in the 6 central city districts. The percentage of immigrants and persons of foreign heritage sums up to 89 742, 17.8 percent of the total population. Of those approximately 75 percent have a non-western background. About 22 percent were born in Norway. The largest immigrant groups stem from Asia (43,8 percent), Africa (14.7 percent), Eastern Europe (14.0 percent) and other Nordic countries (14.0 percent).

Homelessness in a strict sense is a limited problem. 861 persons are registered as being without a permanent home, whereof 685 were males and 176 were females. 177 were immigrants.

In the age group 25-64 years 57.3 percent of the males and 56.1 percent of the females were unmarried, widowers/ widows, separated or divorced. The degree of singleness is somewhat higher than in the rest of Norway. Great mobility and several one person-households render a looser social network than in more rural districts. Weakened social and weakened informal social control may be expected from this situation.

By August 1999 8 825 persons were registered as unemployed in Oslo in the age groups 16 years and older. The unemployment rate was 3 percent. More than half of the unemployed persons were in the age group 30-49 years. The unemployment rate among persons with Non-Western citizenship was 9.4 percent for the total age group 16 years and older.

Individuals at risk for developing a criminal career and a drug using pattern often migrates to Oslo from other parts of Norway. Estimates from The community street work in Oslo say that approximately 20-25 percent of adolescents with a problematic life style belongs to other parts of the country. The same goes for established addicts. In a survey among users of three shelters for homeless people during the winter 1998/99 it turned out that a little less than 1/3 of the visitors had their place of birth outside Oslo (2).

Since the late sixties there has been a more or less open drug scene in some parts of Oslo, mainly in parks and streets in the centre of town. This open drug scene has moved a little around through the years. For the time being, most street drug users tend to gather on the eastern side of the central station, and the lower parts of the Karl Johan Street, which runs from the Central station to the Royal Castle.

4.1.1 Brief general outline of the historical background for the drug problem in the city.

The modern drug history in Oslo started in the mid sixties. A small group of young people settled in the park behind the Royal Castle and spent their time there, playing guitar and smoking cannabis. This occurrence must probably be seen as an extension of the international hippie phenomenon. They considered themselves a protest movement, and had the usage of cannabis and LSD both as a marker of revolt against the established society, and as a means of achieving insight in "cosmic truths". Many of the participants gradually developed a more or less criminal life style pattern. Many of the ideologically dominating characters in this group were from the beginning strong-minded and gifted young persons from affluent homes. The group attracted by and by deviant youngsters from surrounding city districts and young visitors from other regions.

As the drug use and the criminal lifestyle pattern made its marks in this drug scene, many of the founders withdrew from the scene. The general radicalisation of Norwegian youth from the end of the sixties to the middle of the seventies offered other possibilities to channel the desire for revolt and criticism of the society. But many young individuals had become dependent on illegal drugs, not only cannabis, but also other substances.

Several preventive measures have been developed since the late sixties. Youth clubs, Community Street Work, psychiatric youth teams, school programs, and special drug measures within police and customs, in addition to all the private and voluntary initiatives that were taken from organisations, churches and individuals.

Initially injection was infrequent. Amphetamine was the most common injectable substance, partly due to contacts in Sweden, where amphetamine since the sixties had been the dominant illicit drug, which also at one time had been legally prescribed there. Opiates however gradually replaced amphetamine as the most preferred injectable drug, at first in the form of illegally acquired morphine, then as heroin.

In the first half of the eighties HIV came into focus. Preventing drug use was not only an important aim on its own grounds, but also important to prevent spread of AIDS. This perspective dominated from the middle of the eighties. For the drug policy this had three consequences: Firstly the public awareness was somewhat diverted from primary prevention. Secondly the establishing of treatment facilities for drug addicts was stepped up. Thirdly it resulted in a greater interest for measures that could prevent HIV-infection in established drug users. The outreach services and detoxification units distributed syringes, needles and condoms, and vending machines were discussed and even deployed on a couple of locations. "The syringe bus" was established in 1988 under name of "The AIDS information bus".

The middle of the 1980's the HIV-epidemic brought about great fear, not only within the care system, but this fear was also conveyed to the general public and not least to the youth. The

recruitment to injecting drug use was reduced to about one third and gradually turned into a refuge for middle aged, weary, heroin dependent people (3).

In the 90-ies two new developmental traits have dominated the drug debate:
1. The number of overdose deaths has increased to unacceptable levels. This caused backing for treatment and rehabilitation measures, such as new treatment institutions and measures within the prison system. Several types of "immediate measures" were also made available. As soon as a client reported willingness, treatment should be bought wherever available, with minimal bureaucratic procedures. For this purpose an extended co-operation between police, social service and institutions was created. A methadone project for 50 AIDS-sick drug addicts was established in 1991 and a trial project for 50 hard core opiate addicts in 1994.
2. Substances like cannabis and LSD gained new popularity. New intoxicants that earlier hadn't been in the picture now appeared on the scene. That goes first and foremost for Ecstasy (MDMA), but also other "designer drugs". And even amphetamine seems to have had its revival.

4.2 The distribution of drug use in the general population

The National Institute for Alcohol and Drug Research conducts postal surveys over drug use. These are reliable as far as the general population is concerned, more so for drugs like cannabis, than for heroin and injecting drug use.

The survey in 1994 and 1999 among the Norwegian population over 15 years of age, showed the following results:

Percentage (15 years +) who reported use of different drugs ever, last 12 months and last 30 days in two SIFA surveys among the general Norwegian population(4).

		1994	1999
Cannabis	Ever	10,8	13,2
	Last 12 months	2,7	4,4
	Last 30 days	1,6	2,1
Amphetamine	Ever	2,6	3,8
	Last 12 months	0,9	1,5
	Last 30 days	0,4	0,3
Cocaine/Crack	Ever	1,3	2,3
	Last 12 months	0,7	1,0
	Last 30 days	0,2	0,1
Ecstasy	Ever		1,7
	Last 12 months		0,9
	Last 30 days		0,2
Heroin	Ever	1,0	1,7
	Last 12 months	0,6	0,9
	Last 30 days	0,1	0,2

Source: The National Institute for Alcohol and Drug Research

Similar figures for Oslo for the year 1994 showed that the general population in Oslo had a higher level of use of the different substances than the Norwegian population in general (5). The Oslo sample is too small to give reliable information about the level of drug use, but the

tendency is an increase, compared to the 1994 figures. That means that Oslo figures would show a higher level of drug use than the figures for the whole Norwegian population do.

4.2.1 Epidemiological development

In 1968 the National Institute for Alcohol and Drug Research (SIFA) conducted the first survey among youth in Oslo in the age group 15-20 years. The method was enquete by mail in a sample of about 1000 adolescents, and 5,3 percent answered that they had ever used cannabis. This survey has been repeated annually, and from 1970 even other illicit drugs were included. The development is illustrated in the table below.

Drug use prevalence in the age group 15-20 years in Oslo (ever used)

Year	Cannabis	Sniffed solvents	Ampheta-mines	Cocaine or crack	LSD	Ecstasy	Heroin and similar substances	Injected drugs	Total number of respon-dents
1968	**5.3**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**793**
1969	**5.1**								**1027**
1970	**8.0**	**6.0**	**1.9**	**-**	**0,8**	**-**	**-**	**0.8**	**910**
1971	**15.1**	**9.0**	**2.2**		**1.5**			**0.9**	**878**
1972	**18.8**	**9.1**	**2.7**	**-**	**2.5**	**-**	**-**	**1.0**	**785**
1973	**18.3**	**8.5**	**4.0**		**2.4**			**0.9**	**800**
1974	**20.2**	**10.4**	**6.4**	**-**	**4.0**	**-**	**-**	**1.7**	**805**
1975	**18.7**	**8.0**	**5.9**		**3.4**			**1.9**	**785**
1976	**16.5**	**6.4**	**4.8**	**-**	**2.2**	**-**	**-**	**1.5**	**775**
1977	**18.1**	**10.3**	**3.9**		**1.2**		**1.4**	**0.6**	**771**
1978	**17.5**	**9.3**	**3.2**	**-**	**1.6**	**-**	**1.2**	**0.4**	**739**
1979	**22.2**	**12.8**	**4.1**		**2.3**		**2.2**	**1.8**	**729**
1980	**19.5**	**12.4**	**3.1**	**-**	**0.6**	**-**	**1,7**	**0.7**	**707**
1981	**22.5**	**9.9**	**3.0**		**1.2**		**1.2**	**0.8**	**770**
1982	**21.5**	**10.9**	**3.4**	**-**	**1.4**	**-**	**1.3**	**1.1**	**743**
1983	**19.8**	**9.7**	**2.4**		**0.9**		**1.6**	**0.9**	**681**
1984	**21.8**	**13.2**	**4.0**	**-**	**0.6**	**-**	**1.4**	**0.7**	**695**
1985	**19.5**	**10.3**	**1.8**		**0.7**		**1.3**	**1.2**	**678**
1986	**16.5**	**9.8**	**2.2**	**-**	**0.6**	**-**	**0.5**	**0.5**	**623**
1987	**17.3**	**11.2**	**3.3**		**0.7**		**1.6**	**0.9**	**578**
1988	**16.0**	**9.8**	**2.5**	**1.5**	**0.5**	**-**	**1.0**	**0.7**	**1257**
1989	**18.1**	**8.0**	**2.3**	**1.5**	**0.3**	**-**	**1.4**	**0.6**	**1260**
1991	**16.6**	**5.8**	**2.3**	**0.8**	**-**	**-**	**0.6**	**0.7**	**829**
1992	**17.3**	**4.8**	**2.2**	**0.7**	**-**	**-**	**1.4**	**0.9**	**765**
1993	**20.4**	**5.8**	**3.9**	**0.9**	**-**	**-**	**2.5**	**1.0**	**686**
1994	**18.1**	**7.7**	**4.4**	**1.7**	**1.9**	**2.1**	**1.3**	**0.6**	**481**
1995	**20.8**	**7.0**	**3.5**	**1.1**	**1.3**	**1.5**	**0.9**	**0.0**	**457**
1996	**23.7**	**5.9**	**5.5**	**2.5**	**1.7**	**4.2**	**0.9**	**0.1**	**768**
1997	**25.7**	**6.6**	**7.1**	**3.9**	**2.8**	**5.1**	**1.2**	**0.4**	**808**
1998	**24.7**	**4.4**	**7.6**	**4.2**	**2.8**	**4.9**	**1.2**	**1.3**	**822**
1999	**27.0**	**7.4**	**7.0**	**4.2**	**2.8**	**4.6**	**1.2**	**1.3**	**1146**

Source: The National Institute for Alcohol and Drug Research (SIFA)

As can be seen, the cannabis use was modest before 1970, but increased during the first years after that, and reached a peak of 20,2 percent in 1974. But much of the increase during those years was probably due to a cumulative effect. From the late seventies and up to the middle of the nineties the situation was relatively stable with a cannabis lifetime experience rate around 20 percent. During the years after 1995 there has been an increase in cannabis use.
The increase in the ever used-rate is confirmed by the figures for usage during the latest 6 months, which from 1994 to 1999 have increased substantially, from around 10 percent in 1994 to about 16 percent in 1999(6).

There has most of the time been a substantial percentage that reports ever to have used amphetamines. Cocaine was for the first time recorded in 1988, and the use has increased, so that it now competes with ecstasy to have the highest ever used-rate.

Heroin was recorded for the first time in 1976, but in the beginning the opiate available was morphine. From the late eighties however heroin has been the dominant opiate on the illegal drug market in Oslo. The heroin situation seems quite stable according to the table above. The figures reporting use of heroin and injected drugs however, are probably less reliable than the figures for cannabis, as heavy drug users are probably less inclined to answer this kind of inquiries. Estimates of heavy use of drugs like heroin will have to be approached by other methods.

In 1990 there was made an estimate of injecting drug users in Norway (7). On a background of statistical data for mortality causes, the police registers and data from the yearly surveys by SIFA, it was estimated that the number of active drug users in Norway should be 4-5000. If the number of persons who ever had tried injecting, or who had quitted, was added, then the total number of persons with drug injecting experience at that time was calculated to about 7-9000 persons. About half of the active drug users and the persons with drug injecting experience was estimated to live in Oslo, or about 2000-2500 active injecting drug users, and 3500-4500 with drug injecting experience.

There was conducted a new estimate by the National Institute for Alcohol and Drug Research in 1999 (8). By use of a so called "mortality multiplier method", using data from the registration of drug related deaths by the police and Statistics Norway, the researchers estimate the number of active injecting drug users in Norway to be 9-12 000 people. About half of those persons live in Oslo. That means that there in Oslo should be 4500-6000 active injecting drug users. The recruitment in the younger age groups seems to have been relatively stable, while there has been some influx of older drug users who start injecting at a grown up age.

4.2.2 The drug using culture in Oslo

Cannabis and the party dope culture are no doubt predominant, but there is also a culture of heavy drug use.The dominating mode of heroin use is injecting. An inquiry at the six detoxification centres in Oslo in 1998, covering all admitted clients during one week, revealed that 96 percent of the clients who considered themselves as "regular drug users" reported to be injectors, while 56 percent of the occasional drug users reported the same(9).
As the epidemiological data have already shown, the use of amphetamine is also more widespread than the use of heroin. But there has been a change within the drug injecting population. In 1987 a research project in prison showed that 53 percent of the injectors used opiates, 35 percent used amphetamine and 12 percent used both substances(9). Recent data

from "The Syringe Bus" indicate that the share of drug injectors who mainly inject amphetamine now is reduced to 10 percent, while the rest either inject heroin or combinations(10). An even higher percentage of heroin users among the intravenous drug users was detected in the detoxification study.

4.2.3 Age development in the main target group.

Several studies indicate that the average age in the target group has been rising. An inquiry among "The syringe bus" clients in 1992 revealed an average age of 29 years, which was two years more than a similar inquiry in 1990(11). At a new inquiry in 1994 the average age had risen to 31 years(12). An evaluation of "The syringe bus" from 1998 states that the average age among the clients in 1997 was 32 years, and that the figure had risen 5 years since 1990(13). A recent report, however, states that the younger drug users may be underrepresented at "The syringe bus" as well as in the police registers. A rude estimate would indicate that the distribution of age among injecting drug users in Norway is as follows(14):
<= 20 years: 10 percent
21-30 years: 45 percent
>= 31 years: 45 percent

Even if the Norwegian figures are partly derived from Oslo populations, it is reason to believe that the average age for Oslo would be somewhat higher than the above age distribution for Norway.

4.2.4 The occurrence of abstaining periods/tolerance reduction due to imprisonment/detoxification/institutional treatment

Detoxification and abstinence while in treatment or in prison reduces tolerance. Consequently the addict is more vulnerable just after release from prison or discharge from institution.
In Oslo drug addicts relatively often go into that kind of detoxification period, with an ensuing lowering of tolerance as a result. A working group that considered the overdose deaths problem in Oslo in 1998 concluded that 10 percent of the deceased from overdose regularly come directly from stays at institutions, while 10 percent have newly been released from prison(15).

4.2.5 Availability

The number of police seizures of heroin in Oslo has increased during the nineties, with a peak in 1997-1998. In 1999 there could be seen a reduction of 21 percent in the seizures of heroin, while there was a substantial increase in seizures of ecstasy as well as cocaine. In the first half of the year 2000 the police reports an unexpected and strong increase in seizures, with 1268 seizures, which is all time high.
While the Oslo share of seizures had diminished from 72 percent in 1995 to 38 percent in the first half of 1999, this percentage has increased again to 45 percent during the first half of 2000.

The police registered for the first time a price fall on heroin in the summer of 1991, and since then the price has fallen, probably by more than 50 percent. Price elasticity calculations in Norway indicate that a 10 percent drop in heroin price results in a 10 percent increase in consumption(16). Data from clients at the "Syringe bus" indicate that the consumption of heroin per dose has increased by 60 percent from 1993 to 1997. In addition the number of

injection days increased from 22.3 to 26.9, and the number of injections per day had increased from 3.4 to 3.9(17). All differences are significant.
Oslo police district assesses the street price for heroin in this way(18):

Heroin street price in Oslo 1999/2000(EURO)

	Userdose	**1 gram**
Heroin	43-48 EURO (0,2 gram)	96-220 EURO

Source: Oslo Police District

During the seventies, the average purity in the police seizures of heroin could be between 40 and 50 percent, even though there were seizures with both lower and higher purity.
During the eighties, the purity of most of the heroin seizures ranged between 35-55 percent, with an average of about 40-45 percent.
In 1998 the police measured the average purity to be 45 percent, while there was a reduction in average purity in 1999 to 33 percent. The average is calculated on the basis of number of seizures tested, but there may be a great bias if some big seizures deviate considerably from the average. In 1999 there were some big seizures, which were measured to have a purity of no more than 7 percent, and the average of all seizures bigger than 1 kilogram was 29 percent. The conclusion is that there was a substantial over all reduction in purity in 1999. In the first half of the year 2000 the average purity again has increased to 41 percent.

The Criminal Police Laboratory judges that the lowering in purity in 1999 may be due to a temporary change in the raw opium quality, which again might depend on variations in climatic and fertilising conditions in the producing countries from one harvest to another. To assess the purity of heroin in small user doses, the police would have to test every seizure they have done. But consultations with representatives from the police indicate that there are small differences between the average purity in small seizures and bigger seizures. The police made rather elaborate recordings of user doses and bigger seizures in the 70ies and 80ies, and they found relatively small differences among those two categories. Today they don't do that kind of comparable measuring any more, due to lack of resources.

What significance does the availability have for the consumption of heroin and for the overdose death rate? As must be remembered, there was a reduction in the number of drug-related deaths in Oslo in 1999 and a new increase in the first half of 2000. It is tempting to suggest a close correlation between the number of police seizures and the number of fatal overdoses. High numbers of police seizures could then be taken as an indication of high degree of availability. But some caution should be exercised, as changes in the number of seizures might also mirror a change in the police routines or policy. There are some indications that the Oslo police during 1999 concentrated much of their efforts on the party dope environments, with the result that the traditional drug scene got less attention

Studies of price elasticity indicate an influence from the price reduction of heroin in the beginning of the nineties. Cheaper heroin implies higher consumption, more heroin used per injection, more injections per day and more injection days per month. However, there was not recorded any great price variation during 1999, and it is difficult to connect price variations to the temporary reduction in overdose deaths.

The purity of street heroin is obviously a very important variable. Whatever the reason, it seems that the reduction in purity also suits neatly into the pattern of reduced drug related mortality in 1999, and the corresponding increase in drug related deaths in the first half of the

year 2000. In conclusion the data indicate that variations in availability and purity could account for, or had an impact on, the temporary reduction and ensuing increase in the overdose death mortality during 1999 and the first half of the year 2000. As there were recorded no price variations in that period, it is not easy to assess what significance the heroin price has. But the price reduction in the beginning of the last decade seems to have contributed to the increase in heroin use and thereby also in the increase in overdose deaths.

4.2.6 The occurrence of adulterants

According to the police laboratory there has not been detected any adulterants in the heroin in an extent that would influence its toxicity. There have from time to time been detected strychnine, but then used as a means to make the mixture taste bitterly, and the concentration to low to be toxic. Other adulterants are caffeine or paracetamole.

4.2.7 How do we document the overdose and drug related mortality?

The first drug related deaths were registered in Norway in 1976. Then the Statistical Central Bureau recorded 8 such deaths(19). By 1984 the figures had risen to 40. Those recordings were not registered on county or municipality level. But from 1980 one has been able to separate the Oslo figures from the rest. They show a relatively stable rate of overdose deaths up to 1990, but after that the increase has been rather dramatic, with more than a tripling of the overdose deaths figures up to 1998, according to statistics from the Criminal Police.

Number of drug-related deaths in Oslo and in Norway 1980-1999

	Oslo	Outside Oslo	Men	Women	Total
1980	25	18			43
1981	17	27			44
1982	5	20			25
1983	14	17			31
1984	22	18			40
1985	17	36			53
1986	22	33			55
1987	25	35			60
1988	30	33			63
1989	24	40			64
1990	43	32			75
1991	55	41	84	22	96
1992	73	24	78	19	97
1993	48	47	77	18	95
1994	81	43	102	22	124
1995	79	53	108	24	132
1996	104	81	159	26	185
1997	95	82	149	28	177
1998	134	136	226	44	270
1999	104	116	181	39	220

Source: The Criminal Police Central. The figures are built on reports from the police districts.

There is also a set of statistics provided by the Central Bureau of Statistics. The Central Bureau of Statistics use the definition "dependence of medical drugs", and the basis for their recordings is death certificates. The figures are often delayed by two-three years. Hence most commentaries are based on the statistics from the police.

The statistics from the police are based on deaths reported from the various police districts in the country. The medical doctors have the duty to notify the police in cases of unnatural deaths, and one of the unnatural death causes is drug use. Having been notified about an unnatural death, the police then request a medicolegal autopsy according to the following regulations:

1. Medicolegal examination is mandatory when it is suspected that a person's death is caused by a punishable act.
2. Medicolegal examination ought to be performed when an accident is suspected, when a suicide is suspected and when death occurred unexpectedly and suddenly, and information about manner of death is insufficient or the person was alone at time of death(20).

As a result of these instructions and regulations a heroin death is therefore most likely subjected to medicolegal and toxicological examination. Data from the Institute for Forensic Medicine, University of Oslo (21) show that about 90 percent of all examined "overdose" deaths are heroin deaths.

There might however be a small change during the last years in the police inclination to ordain an autopsy when a known drug user is dead, based on a change in the budget routines, which now require that the autopsy expenses be covered on local police budgets. Hence it is believable that deaths among known drug users will be characterised as "drug related death" or "overdose death" even if an autopsy has not been carried out.
If known drug addicts die from illnesses in hospital, they will probably not be recorded as "overdose death" or "heroin death" or "drug related death"(22).

In the year 2000 the number of fatal overdoses in Oslo increased again up to 132, which means that the number is still at the same high level as in 1998.

4.2.8 Is there a defined population of drug users, from which to count drug related deaths rate?

There are no registers from which one can count drug-related deaths directly. In its nature drug use and drug position is an illegal act in Norway, and as the protection of privacy is a very high-ranking value, it has not been thinkable to establish registers for these purposes. But the police registers have been of some use in calculating the total number of injecting drug users. The total death rate among drug users is calculated in different follow up studies, where a group has been followed over time. The characteristics of the studied group may have varied from study to study, and so has the death rate outcome.

When Ole-Jørgen Skog made his calculation of the injecting drug using population in 1990, he assumed an average yearly death rate of 2.0-2.5. He calculated that half of the deaths in the group could not be diagnosed according to ICD code 304 (drug dependence). Accidents, suicides, and infections constituted the other half(23). When Bretteville-Jensen and Ødegård recently made their calculation of the injecting drug using population, they found that the studies conducted in Norway during the 90ies indicated a yearly death rate among IDUs of 3-4 percent(24). They estimated, on the grounds of two studies, that the percentage of overdose deaths should be 65 percent of the total number of deaths among injecting drug users.

Even if the rest of the deaths were not due to overdoses, there is reason to believe that most of them were drug-related.

4.2.9 How many overdose deaths are counted from different drugs

In principle it should be possible to discern the overdose deaths due to different drugs from each other, but in practice it is not that easy. The police statistics definitely do not separate fatalities due to heroin, from fatalities due to other substances or sudden deaths from unknown cause. However most of drug related deaths in Norway happen in connection to heroin use, and the share of heroin deaths in percent of all drug related deaths seems to have increased during the recent years. In 1997 The Institute for Forensic Medicine found morphine in the blood in 96 percent of all examined cases of drug related deaths(25). If morphine is found in the blood, the death is most likely to be defined as a heroin death.

But it is also shown that the post mortal concentrations of morphine in the blood in autopsies are relatively low, and other substances have often contributed more to the poisoning. During the period 1977-1995 there was, in addition to morphine, found alcohol and/or benzodiazephines in the blood of 70 percent of the examined heroin cases at the Institute for Forensic Medicine (26).

The working group, which considered the drug-related mortality in Oslo, summed up that 25 percent of the women and 50 percent of the men, who die from overdoses, have alcohol in their blood. And 60 percent of the women and 40 percent of the men have benzodiazephines in their blood (27).

There are reported a few overdose deaths due to methadone, while there are no known overdose deaths due to buprenorphine in Oslo.

There are also recorded a few deaths due to acute poisoning of amphetamines, cocaine or party drugs. But some of the deaths in that category would be defined as overdose deaths due to mixtures of different drugs, while others would not be defined as overdose deaths at all, but rather as deaths due to cardiac arrest or brain stroke.

4.2.10 Age and gender of the deceased

Most studies show a female share of the drug using population of about 1/3. But 15-20 percent of the overdose deaths are women, which indicates that women have a reduced risk to die from an overdose, compared to men. In 1998 there were 109 (81%) men and 25 (19%) women who died due to drug related causes. Among the deceased in the year 2000 the percentage of women were 22.

The spread in age groups among the deceased from drug related deaths in Oslo in 1998 was as follows on the next page:

Drug related deaths in Oslo 1998 divided into age groups and sex (%)

Age group	Women	Men	Total
<20	0	1	1
20-24	12	8	9
25-29	12	19	18
30-34	36	24	26
35-39	28	17	19
40-44	8	21	19
45-49	4	7	7
>50	0	3	2
Total	100 N=25	100 N=109	101 N=134

As can be seen 10 percent of the total number were under 25 years. But the percentage for women in the youngest age groups was slightly higher than for men, 12 percent compared to 8 percent.

We don't know much about the deceased's marital status, educational status, housing situation or actual treatment status. Nor do we have information on their mental health.
About their belonging to the city, The Alcohol and Drug Addiction Service has examined police data from the 50 first victims of drug related deaths in Oslo in 2000, and it was found that 26 % were registered in an other municipality than Oslo. Only 4 percent were not known by the police. This figure is low, and it remains to see whether this will be confirmed by new examinations.

4.2.11 Where do the overdoses occur?

The drug related deaths in 1998, 1999 and 2000 have been recorded by the ambulance service.

The place where the deceased were found, drug deaths in Oslo 1998, 1999 and 2000

	1998	**1999**	**2000**
Public place	33	19	26
Public toilet	10	6	2
At home	36	30	44
In apartment	18	20	23
Institution	9	7	8
Night shelter/hospice	14	11	18
Tramcar/bus/train	1	0	
Other	6	7	11
Unknown	8	2	
Sum	134	102	132

As can be seen, most of the deaths occurred in private surroundings, while 32 percent in 1998 and 25 percent in 1999 occurred in what we could call "public surroundings". In the year 2000 this figure had declined to 21 percent.

4.2.12 Situation when they died:

There are no systematic studies of the overdose situations. Some are alone. Overdoses have also occurred where several people have used drugs together. Some have survived and some have died.

Most drug users have a mobile phone. Usually ambulance is called by peers. In 1998 the ambulance service performed 2208 overdose missions and in 1999 there were 1577 such missions. Most of the times the ambulance service was called by fellow drug users.
The intervention usually done is giving an injection with the opioid antagonist naloxone.

4.3 Which authorities are involved in the drug treatment system?

In Norway there are divided responsibilities between the national level, the county level and the municipal level. In Oslo, the county and municipal functions are joint.

Very roughly one can say that the state is responsible for funding, and for legal framework. The state also is wholly responsible for the police activities, which are important elements in the drug policy. On the government side the Ministry of Social Welfare and Health is the responsible body. Most of the drug prevention, as well as treatment and care are carried out within the framework of the social welfare act of 1993.

4.3.1 Political bodies

In Oslo the City Government is e responsible. In great and principal matters in the alcohol and drug field approval from the Standing Committee on Health and Social Welfare and the City Parliament is needed. Presently Oslo has a minority City Government, with the Conservative Party in dominating position. The Commissioner for Primary Health Care and Social Affairs is responsible for the drug policy in Oslo. The commissioner is assisted by the Department for Primary Health Care and Social Affairs, and the drug matters are handled by the Section for Social Services, according to the Social Welfare Act. The above mentioned bodies are politically responsible for the drug policy in the City of Oslo.

4.3.2 Within what limits do this/these body/-ies give directives for the direction of the development within the drug field?

The drug problem is a matter of great concern to the political establishment in Oslo. That means that parties in position, as well as in opposition, will engage in debates on the topic, as well as in different propositions to reduce the problem, control the problem or prevent it. The present city government released a white paper to the city parliament in the autumn of 1997, "Measures against alcohol- and drug abuse in Oslo"(28). The following debate revealed a broad consensus about the main lines in the drug policy. The white paper didn't go deeply into the topic of law enforcement though, as that is considered to be a national state responsibility. The need for co-operation between the municipal authorities and the police was nevertheless underlined. The white paper was mainly occupied with the treatment and care systems for alcohol and drug addicts, and what could be done in the respect of prevention. The limits within which the municipal political bodies give directives for the drug policy are the Social Welfare Act of 1993, and the budgetary situation.

4.3.3 Administrative bodies

The responsibility for carrying out the city parliament's and the city government's drug policies is divided. On one hand the 25 city districts, have, through the social welfare offices and the primary health service, the responsibility for receiving, and providing care and/or treatment for, persons with alcohol or drug problems. On the other hand The Alcohol and Drug Addiction Service (Rusmiddeletaten) has the responsibility for running institutions and outpatient facilities for alcohol and drug addicts. The agency also runs the methadone assisted treatment programs and the Field Health Care service.

4.3.4 Within what limits do this/these body/-ies give directives for the direction of the development within the drug field?

The city district councils decide their policy within the limits of the Social Welfare Act and the social welfare budget that every city district receives in the beginning of each year. The city districts are also instructed to provide a plan for their alcohol and drug policy concerning prevention as well as treatment and care.

The Alcohol and Drug Addiction Service also runs its institutions and outpatient facilities within the framework of the Social Welfare Act, except for one institution, which is run according to the Hospital Act. The Alcohol and Drug Addiction Service is expected to co-operate with the city districts, as well as with the psychiatry and the secondary health services. The agency also receives a budget at the beginning of every year, which is relatively detailed. That's the general basis on which the activities are carried out, with a relatively strict budget control from the city districts themselves, towards their services, as well as from the city government towards the city districts and the Alcohol and Drug Addiction Service.

4.3.5 How big is the overall budget for the drug field in the city?

The part of the budget for the 25 local administrations which is used for prevention, treatment and care of alcohol and drug addicts is difficult to assess, because it is integrated in the overall budgets of the city districts. A qualified "guesstimate" would be about NOK 500 millions, or about 61 million EURO.

The budget for the Alcohol and Drug Addiction Service for the year 2000 is NOK 584 millions, or about 71 million EURO, of which national government grants comprise 7,2 percent.

4.3.6 Who decide the total budget of the field, and how detailed is this budget?

The city parliament decides on a total budget for the city. This also means a total budget for each city district, and each municipal agency, with some allocations of budget chapters, so as money for social services and primary health care. This takes place after a budget process, where each city district and municipal agency has sent propositions to the city government about their budget plans and expectations, and their needs for investments, maintenance and salaries

4.3.7 Which agencies are involved, on the health side, on the social welfare side, on the psychiatric side and on the voluntary organisations' side?

On the health side the hospitals' emergency rooms are involved, primarily the central emergency room, Legevakten, run by the Ullevaal Hospital, and the communication centre for emergency medicine, AMK, which also co-ordinates the ambulance service. The ambulance service is called on nearly every occasion of overdose in the city.

The primary health care service, for which the city districts are responsible, also receives drug users for ordinary consultations about illnesses, as well as conditions connected to their drug use. The primary health service in the city districts is partly municipal and partly private. There are municipal health stations for children 0-5 years, health stations for youth (6-15 years), which are attached to the school health service, private health care centres and private practising GPs. There are other professions like midwives and school health nurses, as well.

The psychiatric health care system, receive only psychiatric patients and addicts who have even a psychiatric problem. So the alcohol and drug problem is well known even within the psychiatric system. There is established one treatment unit for patients with dual diagnosis. Three psychiatric youth teams are connected to three of the psychiatric hospitals. These teams take the responsibility for much of the outpatient treatment and consultation activity directed towards drug users. Many of their clients are not that young any more, however.

There are some facilities in between the health and social sector, as for example the Social Emergency Service, a kind of social services located in the same facility as the central emergency room. Another example is the Field Health Care Service, a service located in 5 contact centres and night shelters for drug users in Oslo. These offer education and on the spot aid to drug users with abscesses and wounds, and when needed, refer them into the ordinary health service. The Alcohol and Drug Addiction Service (see below) run the Field Health Care Service. So is the case with the "syringe bus", which has a prominent position among Oslo's health oriented measures towards drug users. It delivers clean needles and condoms and gives advice about HIV-testing and where to seek help.

The social sector has the primary responsibility for giving help and assistance to alcohol- and drug addicts and intoxicated people in Oslo. The social service offices are responsible for social security money, offer advice and guidance, and, if needed, try to provide beds for persons in treatment or care institutions, or refer clients to self help groups, and, if needed, try to solve housing problems. The Social Welfare Act authorises compulsory admission to institutions for addicts with their life and health at risk, or who are pregnant and the baby's life and wellbeing may be endangered due to the expectant mother's drug use.

The Alcohol and Drug Addiction Service was established in 1994 as a part of the social sector, working under the Social Welfare Act, but with the task to run institutions, outpatient and low threshold facilities for addicts over 18 years of age. The reasons why this agency was established as a special alcohol and drug unit, were that the services offered were too comprehensive and required too much specialised competence to be integrated in the overall health, psychiatric, social or child care systems.

Besides running institutions, this agency also runs the Outreach and Co-ordinating Service, which offers help to people by street work, transportation to detoxification or treatment units or back home, for intoxicated and homeless people. Likewise the agency runs The community

street Work (An outreach youth support team), which is an agency aiming at youth astray, and which carries out a kind of secondary prevention by persuading young people to return to their homes, offering a lift home and so on.

4.3.8 How comprehensive are the services of these agencies?

The ambulance service covers about 44 000 calls out a year, of which 1577 were overdose emergencies in 1999. The number of overdose emergencies had declined considerably compared to the year before when the number was 2208.

The syringe bus delivered about 1,7 million clean needles in 1999, spread over 108 000 visits, and received about 70 percent of the syringes back. It is not known how many clients the syringe bus has, as there is no registration, and one can utilise its services anonymously.

There are in Oslo a total of 43 doctors in municipal primary health care facilities and 261 GPs, working in the city districts. The number of health personnel was in 1998 1 for every 238 children 0-5 years, 1 for every 788 school children 6-15 years, and there were one primary health care doctor for every 1927 inhabitant(29). Number of patients in the primary health care service is not known.

There are no good statistics for the activities of the psychiatric system towards addicts. One dual diagnosis facility has a capacity of 10 beds, and as the stay there generally lasts very long, the number of admitted patients is not very high. That means that many dual diagnosis clients must be treated elsewhere, and they are probably a group with a lack of treatment possibilities.

The primary social services have very comprehensive activities towards different segments of the population. There are no overall statistics for all kinds of clients, but in 1998 there were registered 22 371 clients receiving social security money(30). As many of these receivers also have children to support, and sometimes even other persons, the number of people depending on social security money is higher, 37 466 persons (31). The share of the population who is affected by social security varies greatly between the city districts, from 1,8 percent in one city district to 21,3 percent in another. But there are no good figures for how many of the social security receivers that suffer from alcohol and drug problems, or for whom intoxicant use is the main problem. There is no new research available, but in 1995 there was carried out a mapping in eight city districts, comprising 16 of totally 38 social services offices, in order to find out which clients had intoxicant problems and psychic problems. The figures in these eight city districts turned out to be 3738 clients "in need of care", out of whom 2402 were said to have intoxicant problems. The intoxicant clients comprised 18 percent of the total client number in these city districts. Among those 23,9 percent were women(32). Applied to the social security figures of 1998 for the whole city, and assuming that those percentages have not changed much since that time, one risky "guesstimate" would be a number of clients with intoxicant problems of about 4 000, and the number of persons involved would be about 6 700. Of course this doesn't necessarily involve people who are applying for help at the primary health care centres, at the child welfare offices, at the crisis centres for women, at the emergency rooms or at the detoxification units or other facilities for addicted people. Many of those do not require reports back to the social welfare offices.

The Alcohol and Drug Addiction Service runs 4 municipal detoxification centres, and buys in addition beds at two similar private institutions, so that the agency totally have 103

detoxification beds at its disposal at any time. In addition there are 21 acute low threshold beds at rehabilitation and care institutions.

Moreover the agency runs 3 municipal treatment institutions, and buys beds at 15 similar private institutions. Totally this represents 422 full time treatment beds available for the agency. Out of these institutions there grows of course a great deal of outpatient treatment as well.

Finally the agency runs 20 municipal institutions for rehabilitation and care, and buys beds at 9 more private institutions. Totally the agency has 700 rehabilitation and care beds available. Some of these institutions have, during the recent years, developed a low threshold profile, with tolerance for deviant behaviour and intoxication.
The agency has established Field Care Service at 5 different rehabilitation institutions and contact centres, to improve the health services for drug addicts.

The Reach-out and co-ordinating service, and The community street work, two outpatient facilities, both run by the Alcohol and Drug Addiction Service, conduct reach-out activities days and evenings. Totally there are about 65 employees.

The administration of the Alcohol and Drug Addiction Service has 42 employees. In the different institutions there are approximately 615 municipal job positions with a total of about 1000 employees. In the private institutions the numbers of employees are about the same. That means that the alcohol and drug sector employs something like 2000 persons in about 1200 job positions.

There are not yet a good documentation system for the detoxification, treatment, rehabilitation and outpatient work carried out by all these institutions and facilities. But one mapping system can account for most of the admissions at most of the inpatient facilities. In 1999 the number of admissions was as follows:

\ddmissions in 1999 to the institutions run by the Alcohol and Drug Addiction Service by sex.

	Frequency	Percent	Valid Percent
Women	1913	26,8	27,4
Men	5075	71,0	72,6
Total	6988	97,8	100,0
Missing	159	2,2	
Total	7147	100,0	

As can be seen, there were about 7000 admissions at the institutions controlled by The Alcohol and Drug Addiction Service. The number of persons is much smaller, as one person may have visited one institution several times, and more than one institution during a year. About one fourth of the admissions were made up by women.

4.3.9 How do they co-operate?

Basically there is a "chain thinking", implying that there ought to be a co-operation between the city district-based social and primary health services, often called "the first line", and the different institutions and outpatient facilities, organised by the Alcohol and Drug Addiction Service, often called "The second line". And there ought to be a co-operation between the central health sector, including the psychiatric system, and the various measures and offers within the intoxicant sector, mainly run or controlled by the Alcohol and Drug Addiction Service.

But in many cases this expected co-operation does not work well enough. That's especially true when the client drops out of the institution or program he is connected to, or he or she is going to be discharged from treatment and is expected to go on more or less unsupported, or to be followed up by the first line social service. There are difficulties attached to reporting between facilities, and between the first and the second line. The Alcohol and Drug Addiction Service has up to this date not the permission to provide data on a client identity base. The concern for privacy is a very high-ranking value in Norway, although in most cases this obstacle is to be overcome by some kind of informed consent by the client. That means that the client gives his consent that information about him or her may be given to other named instances. To prevent co-operation problems, there are also formed working groups around many of the clients. These groups often consist of representatives for different public agencies which might be responsible for some part of the client's treatment or rehabilitation or follow up, including the first line, the institution or program, self help groups, outreach street workers and some times even the police.

4.4 Drug-free treatment

Up to the beginning of the 1990ies the official policy in Norway was that treatment of drug addicts should be drug-free. The policy concerning relief of withdrawal symptoms could differ between institutions, but generally one was reluctant to use drugs in treatment, and even under detoxification. In the beginning of the 90-ies there was established a small scale methadone program in Oslo for 50 drug addicts with an HIV-infection, and in 1994 an other methadone program for 50 drug users from the street addicts group. This number have since then been enlarged, and now about 450 persons have been admitted into the methadone programs in Oslo. Contrary to the methadone programs in many other countries, it was decided that the follow up treatment of these clients partly should be integrated in the existing institutions and programs. That means that institutions, which formerly used to be drug-free in a strict sense of the word, now might have some methadone clients among their otherwise drug-free clientele. Some institutions have been more reluctant than others have, though, to admit methadone users into their programs. And still there are some treatment institutions that don't admit methadone users. But as a whole one can not speak of a drug-free treatment apparatus in Oslo, but well of treatment programs that aim towards drug-freedom. In that sense of the term one could say that the greater part of the drug treatment institutions in Oslo work abstinence-oriented.

4.4.1 Which systems/actors offer drug-free treatment?

Besides that many institutions with drug-free programs offer outpatient treatment as well, this is particularly true for the alcohol clinics, which have much more outpatient treatment than

treatment of clients in beds. This is also true for the three Psychiatric Youth Teams, which especially offer drug-free treatment to young addicts. Historically the inpatient facilities have grown up partly through private initiatives, and partly through municipal or even national governmental initiatives. The alcohol treatment institutions and rehabilitation- and care institutions for old, sick and weary problem drinkers have the longest history. From the seventies and especially the eighties there also grew up several drug treatment institutions. Those were primarily aimed at treating and rehabilitating young drug addicts back to a drug-free life. But drug addicts grew older, and it became evident that the treatment optimism from the eighties had failed, and that this group also had needs for care and housing, not necessarily followed by total abstinence from drugs and/or alcohol. Through the last half of the nineties the authorities in Oslo, as in Norway elsewhere, have tried to merge the traditions of the institutions admitting alcohol or drug clients respectively. The biggest actors in the institution field, besides of the Alcohol and Drug Addiction Service itself, is The Church City Mission, The Blue Cross (Christian Temperance Organisation), The Salvation Army, and different smaller organisations and Foundations, some with an affiliation to the AA-movement or to smaller Christian groups.

4.4.2 Possibilities to take part in drug-free treatment several times

In Oslo there is always a possibility to get into a drug-free treatment program if the client is motivated. There have at times been waiting lists, especially in the eighties and nineties, and there still are. But the demand is beginning to ease, and that is probably an effect of the growing methadone programs. From 1999 the Alcohol and Drug Addiction Service have recorded waiting lists centrally. As Oslo have many different inpatient and also outpatient treatment facilities, there are clients who have a long history of repeated institutional and outpatient treatment admissions and dropouts. The policy has been that there is always a chance for recovery and rehabilitation, that a new institutional admission may be more successful than the last one, and that there is a process of growing even in clients with several institutional failures behind them.

4.4.3 How are the expenses of drug-free treatment covered?

The municipality pays all the expenses for drug-free treatment. The Alcohol and Drug Addiction Service covers the costs of the running of all the municipal institutions and outpatient facilities, and covers the cost of the services that are run by private organisations and foundations according to the formal agreement that are made with every private actor. The city districts have to pay a cost of NOK 200 every day (24.4 EURO) to have a client, for whom they are responsible, admitted to a treatment institution.

4.4.4 How many beds/places for drug-free treatment are available?

For drug-free treatment there are available 376 beds at the end of July 2000. Of those 236 are assigned drug users. In addition there are 64 treatment places available on daytime basis. The outpatient activity conducted by the three psychiatric youth teams is not included here.

4.4.5 What amounts of money are spent on drug-free treatment?

On institutions especially meant for drug users there was spent NOK 110,6 millions (13.5 Million EURO) in 1999. A few years ago the total amount would have been spent on drug-free treatment alone. But now one has to count a small percentage at some institutions for

methadone treatment, because of the integration. But this is still a very small part of the expenditure at 4 out of 12 institutions. In addition comes the treatment activity conducted by the psychiatric youth teams, but the economic costs of this are not easy to assess.

4.4.6 From whom are these money obtained?

All the money that is to be spent on drug-free treatment is contributed from the municipality. That means that the city districts and the Alcohol and Drug Addiction Service get their budgets from the City Parliament. It also means that the private actors get their expenses for drug-free treatment covered by municipal contributions. To get the costs of treatment covered from the municipality, the private actors have to have a formal contract with the Alcohol and Drug Addiction Services.

4.5 Individual health oriented measures

In Oslo there has been a long tradition for taking steps to maintain and improve the social situation and the health conditions for people who are sick, weary and dependent on intoxicants. This tradition was developed through many years, especially in the alcohol field, like offering feeding, night shelters and temporary housing. The detoxification units for alcoholics were also developed in that spirit at the beginning of the 70ies. As the drug using population grew older and more exhausted, and treatment attempts failed, it was natural to look for similar measures in that field, or to try to integrate measures for alcohol and drug addicts, so that both groups could benefit from it.

Nevertheless, the drug using population deteriorated in health condition, due to illnesses like hepatitis and HIV-infections, abscesses and wounds and psychiatric problems made it urgent to provide health oriented measures that could prevent the spread of HIV and hepatitis, and improve the general health conditions of the drug users.

4.5.1 Methadone assisted treatment – high threshold

The methadone programs in Oslo have a short history. The first program, for HIV-infected, injecting drug users was introduced in Oslo in 1991, and was up to 1995 limited to 50 clients. In 1994 a trial project for "ordinary" injecting drug users was introduced. This also was confined to 50 clients. In June 1997 the Norwegian Parliament decided that the programs had to be extended to a much larger number of drug users, and that such programs also had to be made available for drug users in the rest of Norway, since the results from these two projects were so promising. In Oslo there was established a national and regional competence centre, The centre for Methadone-Assisted Rehabilitation in Oslo (MARIO). The demand for admissions to this centre, which has been divided into four locations, has been higher than expected. By the end of 1999 had 275 Oslo-clients been admitted, and totally 440 from the Health region east, which is to be served by MARIO. The total number of applications to MARIO by the end of 1999 was 388.

Admittance to the methadone program in Oslo presupposes that the client should be 25 years or older, have a drug using career of several years standing, several of the last being heroin dominated. Drug-free treatment should have been tried to a reasonable extent. There ought to be an individual plan of rehabilitation, signed by the client, the municipal social welfare service and other co-operating actors.

The methadone program in Oslo is a typical high dose methadone treatment, with doses varying between 70 - 130 milligrams a day, taken in juice.

Control measures are urine tests, initially twice a week, reduced according to client progress. In the beginning, the patient has to meet on a daily basis, take- home dosage also according to progress. Individual agreements are agreed upon on occasions like travels and long holidays. Included in the Oslo programs is also one program with a capacity of 100 clients, especially meant for physically ill drug users, like people with HIV-infection, hepatitis, diabetes, endocarditis and other chronic conditions that are to be under continuous treatment. The criteria of admittance differ from the other programs, but the rest of the regime is similar. . There is of course some reluctance to exclude these people from the program, and the acceptance for irregularities, like use of additional intoxicants, may be somewhat higher than in the other programs.

In addition to the MARIO clients, there are "external" methadone clients, where one institution or psychiatric unit or GP takes the main responsibility for the methadone treatment of the patient. Here the applicant is taken in through the MARIO system and the treatment contract is signed, according to the MARIO routines. By the end of 1999 there were 17 such patients in Oslo.

4.5.2 Methadone assisted treatment – low threshold

There are at present no methadone assisted treatment in Oslo that could be characterised as "low threshold". But there is a debate whether such programs should be established, based on the fact that 10-20 percent of the clients at MARIO doesn't succeed in achieving an acceptable level of intoxicant control.

4.5.3 Medicament assisted treatment including other substances than methadone.

There was a trial project with buprenorphine in Oslo, started in 2000 and with 100 clients. These clients were recruited from the waiting list to MARIO, and results from the project showed that these clients made better than clients who did not get buprenorphine while waiting for methadone treatment.

4.5.4 Prescription of heroin

There has been a debate also on the topic of heroin prescription, especially after impulses from the Swiss trials. But so far there is no plan to establish such a measure in Oslo.

4.5.5 Percentage of drug users taking part in medicament assisted treatment.

It is a question of definition whom we are talking about as drug users. A recent estimate conducted by the National Institute for Alcohol and Drug Research assesses the number of intravenous drug users in Norway to 9-12 000, whereof about 10 percent by preference inject amphetamines. A little less than half of those belong to Oslo(33). That implies that the number of IDU's in Oslo should be 4500-6000. The intravenous heroin users should then be 4050-5400. The percentage of IDU's participating in medicament assisted treatment - about 450 persons, roughly 10 %.

4.5.6 Needle exchange programs.

There is one needle exchange program in Oslo, "the syringe bus". The bus collects used needles and delivers new ones, as well as condoms. There is no distribution of sponges, distilled water, spoons or other paraphernalia by the syringe bus. It is also possible to buy clean needles at most of the pharmacies in Oslo in their opening hours. In the beginning of the 90ies there was set up a few wending machines which also distributed clean needles. But the experiences from this were not good, and there are no such machines in Oslo today.

4.5.7 Users' room/injection rooms

There has been a debate whether to establish one or more users' rooms or not. The summer of 2001 the City Parliament made a decision to establish a trial with users' rooms in Oslo, provided this was found in accordance with the law by the national government. This has not been finally decided yet.

4.5.8 General health care measures directed towards the drug addicts

The street addicts have often proved not to be welcome in the ordinary health care system, and they are not easily adjustable to the rules that reign there. Therefore there is established a Field Health Care Service at 5 different rehabilitation institutions and contact centres, where drug users regularly show up anyway, to improve the health services for this group.

4.5.9 Street work towards the drug addicts

The Alcohol and Drug Addiction Service runs the Outreach and Co-ordinating Service, which has as its responsibility to keep an eye on the drug scene in the city, in order to make contact, to offer contact, and with a mandate to follow up overdose-threatened persons. In this work the service makes home visits, and carries out transportation home or to detoxification in response to calls from the public or from the police or other co-operating instances. The service also refers people to treatment facilities or gives advice. They have the possibility of using some mobile money resources to support institutions in taking in some of those often very difficult clients. The Outreach and Co-ordinating Service have 26.5 job positions, and carried in 1999 out 5902 missions on totally 1381 persons.

4.5.10 Aftercare for people who have survived overdoses

The Outreach and Co-ordinating Service carries out some kind of follow-up of drug users who have survived overdose. But for the time being the routines for messages from the ambulance service are not good enough, and the Outreach and Co-ordinating service only receive messages on a small part of the overdose missions carried out by the ambulance service. In 1999 The Outreach and Co-ordinating Service had 265 overdose missions, whereof some were missions on the spot, but some also were follow up after overdose survival.

4.5.11 First aid courses

There have been carried out some first aid courses, with the drug users themselves as target group. The same goes for employees attached to shops, public toilets, restaurants, central train station and subway staff, and other categories of people who at intervals come in close contact with drug users.

4.5.12 Testing of the purity of drugs

There has been some discussion about testing drugs for the users, for example at raves and big house parties, but for the time being there is no plan to start such activities.

4.5.13 What amounts of money are spent on individual health oriented measures?

It is very difficult to calculate in detail how much is spent, but the main related activity of the Alcohol and Drug Addiction Service, the methadone program, had an expenditure in 1999 of NOK 35.2 millions (4.3 million EURO). The Field Health Care Service had an expenditure in the year 2000 of NOK 4.2 millions (0.5 million EURO). Both those activities are increasing. In addition the "syringe bus" spends about NOK 3 millions (0.37 million EURO) a year(34).

4.5.14 From whom are these money obtained.

In principle all these money are obtained from the municipality, even though the national government stimulates the establishing of new measures by transferring money in an initial phase.

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5 What can we learn from literature!

By Marcel Buster

This part of the report on strategic choices to reduce overdose deaths will give a short overview of the scientific literature. Although deaths due to cocaine and ecstasy have also been reported, heroin is the most important cause of overdose deaths in this study. Therefore, the literature study is predominantly focussed on (the prevention of) fatal heroin overdoses.

Heroin affects the centre of the brain that controls breathing. This may lead to a fatal respiratory failure. Although heroin is a prime cause of overdose mortality, the complex personal and social context has to be taken into reckoning if we are to build intelligent prevention policies. In summary, the most important findings of the literature study are that:

1) Some forms of heroin use are more dangerous than others. Intravenous use of heroin and combined use of heroin and alcohol, barbiturates or benzodiazepines increases the risk of overdose mortality.
2) Some heroin users are at higher risk than others. Heroin users that appear to be at higher risk are single, homeless, those suffering a mental disorder, those with a HIV infection and those that have suffered a non-fatal overdose before.
3) The amount of heroin leading to an overdose may vary over time because the individual user may gain or lose tolerance to heroin. A stable high tolerance may prevent an overdose, loss of tolerance (after detoxification) may increase the risk of overdose in case of relapse.
4) In case of an overdose of heroin an effective intervention (the injection of naloxone) is available. If an overdose occurs, the presence of a witness who calls for an ambulance immediately, is most important to prevent an heroin overdose to be fatal.

5.1 Toxic effects of drugs, mode of administration and combining drugs

Heroin causes a depression of respiration, by a specific mechanism, such as depression of the centre of the brain that controls respiration. Moreover, when consciousness and cough reflex are depressed, blockage of saliva, mucus or vomit can lead to a reduction of the respiratory capacity. Pulmonary oedema is a possible but uncommon cause of acute heroin-related fatality. (White & Rodney 1999)

The toxic effect of cocaine concentrates on heart and blood vessels. The lethal effect is most commonly cardiac depression which may be aggravated by exertion or arousal . Severe toxicity is also accompanied by convulsions which may also aggravate the potential for heart toxicity by depletion of oxygen in the body. Chronic cocaine use appears to predispose patients with incidental or genetically determined abnormalities (aneurysms) in the blood vessels of the brain, to present with problems at an earlier age than non-cocaine users. Fatal cocaine overdoses have occurred in smugglers who have sought to secrete the drugs by packing it in condoms and swallowing it.

The commonest acute complication of Ecstasy is a hyperthermic collapse (overheating) due to dancing for long periods in a hot environment without adequate fluid replacement. The drug enables the user to dance continuously without any feeling of tiredness or exhaustion, while at the same time suppressing the sensation of thirst. (advisory council on the misuse of drugs, 2000) The Swedish Ecstasy victim occurring in Amsterdam was thought to be caused by a water intoxication, in this case excess fluid ingestion is compounded with inappropriate secretion of the antidiuretic hormone which is due to the pharmacological effect of the drug (Braback & Humble 2001).

Heroin may be taken by injection, smoking (chasing the dragon), snorting or swallowing. Gossop (1995) examined non fatal overdose among 313 heroin injectors and 125 heroin smokers in London. An overdose had been experienced by 2% of the heroin smokers compared to 31% of the injectors. Among heroin users during and (less than one year) after leaving methadone treatment in Amsterdam an overdose mortality rate of 2 per 1000 personyears has been reported (Buster *et al.* 2001); whereas among injecting heroin users of Amsterdam an overdose mortality rate of 6 per 1000 personyears has been found (van Haastrecht *et al*. 1996). IV drug users are at higher risk but there is no absolutely safe way to administer heroin; overdoses after snorting, smoking or swallowing are reported as well (Darke & Ross 2000).

Several studies suggest that a lower dose of heroin is needed to cause a fatal overdose if heroin is combined with alcohol, barbiturates or benzodiazepines. These drugs themselves are relatively weak respiratory depressants but combined with opiates they can augment the effects of the latter drug. (White & Irvine 1999). Ruttenber *et al.* (1990) found higher levels of alcohol in those subjects with lower levels of morphine, suggesting that alcohol enhances the

toxicity of heroin. If benzodiazepines are ground up and injected the risk of an overdose is found to be higher. (Ross J *et al.* 1997, Powis *et al.* 1999). The combination of alcohol and cocaine is also thought to increase the risk of a fatal overdose. Combining Alcohol and cocaine results in the formation of cocaethylene in the human liver. This substance intensifies the euphoric effect of cocaine but may also increase the risk of sudden death.

Studies on the effect of (changes in) purity of the heroin or contamination of the drug as the cause of overdose mortality give mixed results. In Atlanta, USA, Huber *et al.* (1974) found a positive association between the purity of heroin and the number of heroin related deaths. Others did not find any relationship between purity of street level heroin samples and temporal clustering of heroin overdoses (Kalter *et al.* 1989) or rise of heroin related death (Risser *et al*. 2000). These findings however, do not rule out that some heroin-related deaths occurred because addicts purchased heroin with an unexpectedly high purity. Main detected adulterants were caffeine, sugars (particularly lactose), paracetamol and methaqualon. Impurity (like strychnine) may play a role in a proportion of heroin deaths, however, it is expected that this role may be relatively minor and subject to regional variation.

Hyatt & Rhodes (1995) reported an increasing medical emergencies and deaths due to the use of cocaine with a decreasing price of the drugs and vice versa. Drug users will probably increase their drug use if prices decreases, which may lead to an increasing number of overdose deaths. Changes in price may be more important than the price level itself. The differences in price level between cities merely reflect the relation between supply and demand of a certain drug.

Considering the effect of the drug scene (open scene, dispersed scene or hidden scene) on overdose mortality the scientific evidence of either negative or positive effects of open drug scenes is rather spurious. Open scene is thought to attract new drug users and result in a accumulation of health problems (for example transmission of HIV, HepC) but drug users are easier to reach by health workers. Bless *et al.* (1995) suggest that on the one hand tolerating an open drug scene is counterproductive to the aims of harm reduction and, on the other hand, harm reduction interventions cannot be successful under strong prohibitionist conditions. In this study dispersion of the open drug scene in Amsterdam and Frankfurt may have contributed to a decrease of overdose mortality (this study).

5.2 Risk groups

Some heroin users are at higher risk than others. The identification of risk groups is of special importance. Interventions designed to reduce the risk of overdose may be more effective if they are differentially targeted on drug users with the highest risk. However, Given that those who probably are most at risk of a premature death also seem to be the most poorly integrated, it is understandable that attempts to reduce mortality often seem inadequate. The

high risk group will probably have minimal motivation to follow the routines and demands of services being followed (Rossow & Lauritzen 1999).

Males are typically over-represented in fatalities attributed to overdose. This is not surprising given the over-representation of males among heroin user throughout the world. Within heroin users the higher risk of males is less outspoken. In Amsterdam the risk of an overdose itself does not seem to be higher among males, but the risk to die due to an overdose is (appendix; Amsterdam city report).

It is wrong to assume that it is only or specially the novice user who is at risk. Given that the average age of death reported in most studies is approximately 30 years and that heroin careers typically start in the late teens most fatal cases have been using heroin for a considerable amount of time prior to their death.
Homeless are found to be at a high risk for both non fatal and fatal overdose (Rossow & Lauritzen 1999, Langendam et al. 2000). The injection of drugs in public places was identified as a risk factor in causing overdose in Paris. The risk for toxic accidents would be increased because the drug would have to be injected quickly and without caution (Ingold, 1986).

The relationship between overdose and suicide remains unclear. Almost half (49%) of the Glasgow drug users attending hospitals because of a non fatal overdose reported suicidal thoughts or feelings immediately prior to overdose (Neale 2000). Kosten & Rounsaville (1988) did not find any relationship between overdose and suicide attempts. Darke & Ross (2001) conclude overdose and suicide are different clinical problems, and will require different responses. Poor mental health, particularly depression, is a key factor predisposing individuals to suicide. The Advisory council on the misuse of drugs (2000) states that drug users deserve full access to help with mental health and any barriers relating to stigma should be overcome.

Some interviewees thought that risk of overdose mortality is higher if people are ill or tired. Infections are known to affect drug metabolism (Monshouwer & Witkamp, 2000). Warner-Smith et al. (2001) mention is evidence that systemic diseases may be more prevalent in users at greatest risk of overdose and hypothesize that pulmonary and hepatic dysfunction resulting from such disease may increase susceptibility to both fatal and non-fatal overdose.

Furthermore, he suggests that consequences of non-fatal overdoses makes heroin users more vulnerable for a future fatal overdose. The event of an overdose may be an opportunity to persuade a drug user to enter treatment. Neale (200) states that in the hours following an illicit drug overdose, many drug users are emotionally vulnerable, willing to talk and anxious for assistance.

Eskild (1993) reports HIV-positive drug users are at higher risk to die due to an overdose than HIV-negative drug users. Next to a causal relation it is concluded that a selection of high frequent users in the HIV positive group may explain this association. Those drug users who a show a risk behaviour leading to HIV also show a risk behaviour leading to overdose (Rossow & Lauritzen).

5.3 Tolerance

A fatal overdose is the result of using a quantity of heroin in excess of the person's current tolerance of the drugs. Tagliaro *et al.* (1998) found that the concentration of morphine in hair of victims of a fatal overdose was lower than those found in hair of active drug users, and more comparable with ex-drug users.

Although some people may benefit from detoxification treatment, the majority of detoxified addicts rapidly relapse to heroin/opiate use. Release from prison constitutes a high-risk period for overdose among heroin users. This high risk period is likely to be related to abstinence or infrequent heroin use in prison resulting in a reduced opioid tolerance. Relapse after detoxification in prison is common. Seaman *et al.* (1998) reported a 34 higher risks among HIV positive IV heroin users during the first two weeks after release compared to other moments in time.

Tolerance is also modified by learning. In the presence of cues previously associated with drug administration tolerance is markedly enhanced, compared to the tolerance observed in a novel environment. Thus, administration of an opioid in an environment not previously associated with administration of the drugs is associated with lesser tolerance and hence higher risk of overdose (Siegel *et al.*1984) Consistent with this argument, Gutierrez-Cebollada *et al.* (1994), found that the self-injection of heroin in an unusual place was a risk factor for heroin overdose in Barcelona.

By using methadone as a replacement of heroin, methadone treatment intends to prevent withdrawal symptoms, relief drug hunger and helps the patient to move away from injecting use. This and the frequent contact with nurses and social workers at the treatment centres will improve their social functioning, and heroin users may take advantage of wider aspects of treatment and rehabilitation (Advisory council on the misuse of drugs 2000). Methadone treatment is associated with lower overdose mortality rates (Caplehorn *et al.* 1996). Treatment retention is a thought to be of the utmost importance (Caplehorn *et al.* 1994); regular maintenance treatment enhances the tolerance towards opiates. Leaving methadone treatment is often associated with higher mortality rates. Outcomes have generally been poor in abstinence oriented methadone treatment; large percentages of detoxified addicts rapidly relapse to heroin use (Magura & Rosenblum, 2001).

Methadone maintenance treatment has been shown to result in a substantial reduction of the overdose deaths among IV drug users. However, methadone may not only prevent overdose death but also be the cause of it. (Zador & Sunjic, 2000) This can be accidental due to misjudgement of a client's tolerance by the physician or misjudgement by the opiate user buying methadone at the black market. Methadone can also be used as a means to commit suicide. Two recent studies indicate, however, that the number of deaths prevented exceeds the number of deaths caused by methadone treatment (Caplehorn & Drummer 1999, Perret, 2000). The challenge is to continue developing accessible and effective services, thereby reducing the risks of all opiate related deaths, balanced against measures to reduce treatment related individual and community risks. (Gabbay, 2001)

5.4 Intervention in case of an overdose

The reactions of drug users to overdose is particularly important in view of the finding that many drug related deaths occur in company of other drug users. (Darke *et al.* 1996, Zador *et al.* 1996, Walsh 1991). Possibly connected with this finding, Davoli (1993) reports single drug users are at higher risk of a fatal overdose. Moreover, Instant mortality does not appear to be the norm Manning & Ingraham (1983) reported that 23% collapsed immediately after injection and only 14% of the cases in the study by Zador *et al.* (1996) were classified as

instant. The fact that most heroin related fatalities appear to occur over a period of time presents an important opportunity for interventions.

However, not every witness calls for medical help. Bennet & Higgins (1999) reported that although most witnesses of an overdose (71%) had thought that emergency help should be sought, n only 44% emergency help was actually sought. In only 10% of the *fatal* overdoses reported by Zador *et al.* (1996) medical assistance was sought prior to death: there was no intervention before death in 79% of the cases.

During emergency resuscitation after opiate overdose, doctors or paramedics routinely give naloxone. It is a specific and effective but short acting antidote to opioid overdose. Schulz-Schaeffer & Puschel (1995) reported "Often they leave the ambulance against medical advice. In these situations, the consumption of respiratory depressive substances either narcotics or additional consumption – is highly dangerous. wrote Several times we observed life threatening situations in intoxicated patients and fatalities after remorphinization following naloxone administration." Still, in order to prevent overdose deaths naloxone could be made more widely available to those that are likely to be a witness of an overdose, or it could be distributed among drug users. Although no evidence of effect of naloxone distribution among drug users on overdose mortality is published yet, first results of pilot studies show no adverse effects. (Dettmer *et al.* 2001)

5.5 Conclusions

Although the prevention of heroin use itself is most important to reduce the number of overdose deaths, the literature study provides clues for preventive measures that can be taken in order to reduce overdose mortality among heroin users. To prevent overdose deaths among heroin users effectively, a preventive measure should:

1) Enhance the heroin users' tolerance towards opiates
2) Decrease the concurrent use of alcohol, barbiturates or benzodiazepines
3) Decrease injecting heroin use
4) Prevent or reduce social deterioration (homelessness)
5) Treat psychiatric disorders.
6) Create a safe environment to use heroin

7) Enhance calling for medical assistance in case of emergency

8) Manage to reach a large proportion of the high risk groups (such as homeless, drug users with psychiatric co-morbidity, HIV infected, active injecting drug users, heroin users with a history of overdose)

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6 Estimated effects of various measures on overdose mortality

By Marcel Buster

The following estimations are an attempt to quantify possible effects of various interventions. The goal of these estimations is to increase awareness of the possibilities and limitations of certain strategies to reduce overdose mortality. The estimations are not 'correct'; they are based on different assumptions. The results will change if assumed values of the variables change. These estimations however are performed with simple calculations and alternative calculations (based on different values of the assumptions) can be processed. The values of these variables could also be adapted to the city of interest.

In these assumptions three main principles are important:

1) The effect of the intervention.
2) The proportion of the target population that is reached.
3) Coverage of the measure among specific high risk groups

Effects of certain actions will be different in each city. For example: in a situation in which background overdose mortality rates are low (e.g. because of a non-injecting drug culture) facilities like methadone treatment or users' rooms will save less lives than facilities implemented in a situation in with a high general overdose mortality rate.

The proportion of the target population that is reached depends on the nature of the intervention. To spread a health message to prevent OD, drug users do not have to be reached every day. Considering safe injection rooms however, the beneficial effect will only be limited to those injections actually occurring in the room. Methadone maintenance treatment will be beneficial only for those drug users who actually participate in treatment (daily number of clients).

The proportion of the target population reached will always be limited by budget and the willingness of the drug users to participate and stay in the programmes. In practice the most problematic addicts will be at highest risk and will be the most difficult to reach as well. Every restriction, rules and obligations will lower the accessibility of the services and

decrease the effectiveness of these services on a population level. Restrictions, rules and obligations should be limited to those necessary to reach the goals of the programme safely.

The effects of the following interventions are given:

1) Low threshold methadone maintenance.
2) Safe injection rooms.
3) First aid courses, distribution of Naloxone.
4) Incarceration, methadone maintenance during incarceration.
5) Inpatient abstinence oriented treatment.

Imaginary population

The examples are based on an imaginary population of 5000 injecting heroin users. A stationary population, meaning that the number of drug users entering the population is equal to the number of drug users leaving the population (mortality, recovery, moving). Although it is likely that, due to methadone treatment, incarceration or abstinence oriented treatment, a higher proportion of people would be remain drug free than without these measures or facilities, this aspect is not taken into account. It would make the calculations more complicated and confusing. Considering a situation without interventions the annual number of overdose deaths in the imaginary population would be 100. Hence, the overdose mortality rate is 2 per 100 heroin-users per year. Additional assumptions are made in the individual examples.

6.1 Estimation of the effect of safe injection rooms:

Assumption 1: the general risk of a drug user to die because of an OD is 2%
Assumption 2: this risk is 4% among 1000 homeless drug users, 1,5% among 4000 other drug users.
Assumption 3: 10 safe injection rooms will be established, serving 50% of homeless drug users (N=500).
Assumption 4: (according to assumption 1 and 2) 20 OD deaths are expected within this group.
Assumption 4: 50 % of injections in the target group take place inside the safe injection room.
Assumption 5: No overdose fatalities will occur inside safe injection rooms

Calculation of prevented OD deaths:

0,04 (expected OD mortality rate) * 500 (number of people reached) * 0,5 (proportion of injections) = 10

Old situation 100 deaths

New situation 90 deaths (10 (=0,04*500*0,5) of them were allowed to enter safe injection rooms.

6.2 Estimation of the effect of low threshold methadone maintenance treatment:

Assumption 1: the general risk of a drug user to die because of an OD is 2%

Assumption 2: this risk of an overdose death during methadone treatment is 0.5%.

Assumption 3: 40% (N=2000) of the population of heroin users can be reached (daily)

Assumption 4: population in treatment does not differ from population outside treatment.

OD deaths expected: 2000 (number of drug users reached) *0,02 (OD mortality rate) = 40 OD deaths

OD deaths observed: 2000 (number of drug users reached) *0,05 (OD mortality rate) = 10 OD deaths

Old situation: 100 OD deaths
New situation: 70 OD deaths : 10 of them die during methadone treatment (possibly due to methadone)

6.3 Estimation of the effect of first aid course

Assumption 1.1: 75% of OD cases with a witness, the witness knows how to handle.

Assumption 1.2: 67% of OD cases with a witness, witness acts appropriate.

Assumption 2.1: 60 of OD deaths dies without witnesses.

Assumption 2.2: 7 of OD deaths is witnessed but almost instantaneous.

Assumption 2.3: 33 of OD deaths dies due to inappropriate actions of witness.

Assumption 3.1: information campaign increases witness with knowledge to 90% of cases.

Assumption 3.2: information campaign increases witness with appropriate acting to 75% of cases.

In this situation the number of fatal OD cases due to inappropriate acting would decrease from 33 to 25. The total number of deaths would decrease from 100 to 93.

6.4 Estimation of the additional effect of naloxone distribution

Assumption 4.1: after distribution of naloxone, 40% of the witnesses carries naloxone at the time and place of emergency.

Due to naloxone an additional 3 (of 7 almost instantaneous) and 10 (of 25 inappropriate actions) lives could be saved in addition to the first aid courses. Due to large spread of naloxone and first aid courses together the number of overdoses decreased from 100 to 80.

6.5 Estimation of the effect of incarceration:

Assumption 1: 10% of population is in prison, average term of imprisonment is 3 months
Assumption 2: during first two weeks after release people have a ten times higher risk.
Assumption 3: there are no fatalities during incarceration
Assumption 4: 10% of ex-prisoners remains drug free during that year.

Every three months 500 people are released and spend two weeks at a high risk period.
500 (quarterly number) * 4 (annually) * 2 (weeks period)= 4000 high risk weeks
4000 (high risk weeks) / 52 (weeks in a year) = 73 high risk years.

Expected mortality without incarceration: (73*0.02)+(500*0.02) = 11,5
Observed mortality with incarceration: (73*0.02*10) + (500 * 0) = 14,6

Old situation: 100 overdose deaths
New situation: 103.1 OD deaths 14.6 after incarceration.

6.6 Estimation of the possible effect of methadone treatment in prison.

Assumption 4: with methadone maintenance treatment and additional methadone treatment after release from prison, OD mortality rate during the first two weeks are three times as high instead of ten times as high (increase due to suicide and drug use)
Assumption 5: No OD mortality in prison.

Observed mortality with incarceration:
(73*0.02*10)+(500*0) = 14.6

Observed mortality with incarceration and methadone treatment in prison:
(73*0.02*3)+(500*0) = 4.4

Old situation: 103.1 OD deaths 14.6 after release from prison.
New situation: 92,9 OD deaths 4.4 after release from prison.

6.7 Estimation of deaths due to abstinence oriented treatment

Assumption 1: Daily 15% (N=750) of population is in inpatient treatment, average term of treatment is 3 months.
Assumption 2: These patients have a average risk of mortality, (2/100 per person per year)
Assumption 2: Halve of the people relapse and have a ten times higher risk for a period of 2 weeks.
Assumption 3: There are no fatalities during inpatient treatment

Every three months 750 people are released and halve of them spend two weeks at a high risk period.
Annually there are 750 (quarterly) *0,5 * (relapse) *4 (annually) *2 (weeks) = 3000 high risk weeks
3000 (high risk weeks) / 52 (weeks in a year) = 58 high risk years

Expected mortality without inpatient treatment:
(116 normal risk years *0.02 OD mortality rate)+(750 years outside treatment *0.02 OD mortality rate) = 17.3

Observed mortality with inpatient treatment:
(58 high risk years *0.02 OD mortality rate *10 higher risk) + (750 years inpatient * 0 OD mortality rate inpatient) = 11.6

Although (in this calculation) 11.6 drug users are expected to die when they relapse after detoxification, detoxification treatment could still has a (5.7 OD deaths) preventive effect.

Old situation: 100 OD deaths
New situation:94,3 OD deaths (11.6 of them after relapse)

Looking at the deceased only it seems abstinence oriented treatment caused 11.6 deaths
Looking at the population this measure prevented at least 5.7 deaths.

6.8 Discussion/conclusion

None of the measures will lead to a zero number of OD deaths. If all of these measures would be applied together, the number of OD deaths could possibly be more than halved. Large scale low threshold methadone maintenance treatment seems to be the most effective and feasible measure.

Measures like methadone treatment, abstinence oriented treatment and incarceration may cause deaths. However, these measures may also prevent deaths. Studying the OD fatalities only tells us something about the deaths caused by these measures, or OD deaths occurring despite of these measures. The OD fatalities don't tell us anything about the number of deaths prevented and may result in misleading conclusions.
Therefore, efforts should be made to evaluate the measures. For example, the effect of an intervention such as methadone treatment in prison is easy to study but not described in literature yet. Of course, efforts should be made to prevent the overdose deaths after detoxification or deaths caused by methadone without decreasing the effectiveness of the programme (for example by a different treatment approach towards different kind of heroin addicts).

Studying OD fatalities may tell us something about the maximum effect of specific interventions, for example methadone treatment in prison prevent those people that die after they leave prison. If this number is low we can say beforehand that the effect of this intervention will be low too. Naloxone distribution can only prevent those OD deaths that are witnessed by others, if all OD deaths occur without witnesses, Naloxone distribution will not have any effect. On the contrary, if all heroin OD deaths are witnessed by people who acted appropriate but could not prevent death, Naloxone distribution would be the measure of first choice. Before starting first aid courses the need for doing this, can be checked by interviewing drug users about their knowledge concerning first aid in case of an overdose and about their behaviour while they witnessed a overdose.

The effectiveness of user rooms largely depends on the coverage of the target population. (number of user rooms, number of visitors, opening hours). OD mortality is only one of the reasons to start a user room additional reasons are: improving the quality of life of drug users, providing information, building a bridge to other services, reducing nuisance and to disperse the open drug scene. Similarly the contacts with drug users in methadone treatment create opportunities for all kind of additional interventions that may prevent or reduce social physical and mental problems.

7 The questionnaires

7.1 The drug users' questionnaire:

- In order to get a picture of the person the information comes from; I would like you to tell something about yourself. (During the answer to this question, the following data should be registered: Gender, age, years of schooling, place of living, source of income, belonging to the city)

- History of drug use, where and with whom do you generally use drugs? (Including the answer to our former questions: For how long time have you been a drug user? What kinds of drugs do you usually use? How do you take your drugs (mode of use)? Where do you usually take your preferred drug?)

- What kind of treatment (if any) do you receive at the moment?

- Have you yourself ever experienced critical or life-threatening situations in connection with drug use?
- If yes, can you tell me something about it?
- How have these situations usually happened?
- What kinds of drugs have been used?
- With whom did this last experience happen?
- What do you think was the reasons why this incident happened at that moment?
- Could you say it was mainly accidental or intentional?
- What was the action in these situations (when you yourself experienced a life-threatening situation in connection with drug use?)
- Have you been in treatment during any of the situations?

- Have you ever been witness to a life-threatening situation in connection with drug use?
- How and where have this (these) situation(s) (usually) happened?
- What kinds of drugs have been used?
- With whom did this last experience happen?
- What do you think was the reasons why this incident happened at that moment?
- Could you say it was mainly accidental or intentional?
- What was the action in these situations (when you witnessed a life-threatening situation in connection with drug use)?
- Did the person(s) survive?

If you think about the problem with overdoses and life-threatening situations in connection with drug use:
- What do you think goes wrong when people die?
- What could you yourself do in such a situation?
- The number of overdose deaths has been rising in some cities (Copenhagen, Oslo) and decreasing in others (Frankfurt, Amsterdam). What do you think could be the reason behind those differences?
- Can you mention some facilities or measures of (name of the city) that
  - possibly prevent fatalities
  - possibly increase the risk of fatalities

- Looking back on your long-term carrier as a drug user, what do you think about what has been done to prevent overdoses and life-threatening situations among drug users in this city? What has been good and what has been bad?
- If the politicians should ask you to advise them concerning this topic, what advice would you give them?

7.2 Questionnaire for professionals in the street level survey

- Some information about background, as gender, age, level of education, profession
- How long have you been working in situations where OD's occur, and what type of work have you been doing?
- Have you experienced life-threatening situations among drug users, and what drugs have been involved?
- What modes of administration of drugs do you generally observe in your work?
- What do you perceive as risk factors?
- When you think of the measures that have been taken to avoid overdose deaths, what has been helpful, and have there been measures taken with risk-enhancing effect?
- Have the situation changed during your time of service, and what has changed? (Types of drugs used, mode of administration, types of people, types of circumstances)
- what is usually done in an overdose situation,
- What is generally recommended to do in such a situation in your profession?
- What could by your opinion be done to prevent overdose deaths?

7.3 The study of officials

Interview form

This project is trying to map and define the political goals and strategies in drug policy, in order to prevent and reduce the overdose mortality in the four cities of Amsterdam, Frankfurt, Copenhagen and Oslo. When speaking about "drugs" in this interview we primarily think of drugs like heroin, amphetamine, cocaine. In order to carry out this mapping, we would like you, in your position as a ……
to help us understand by answering a few questions.

1. (For politicians) What are by your opinion the most important political goals in this city?
   (Please rank the following items into three categories, with 3 items in each category: 1.Top priority, 2. High priority, and 3. Medium high priority)

Rank

- To improve public care for the elderly
- To improve public child care
- To improve housing for the homeless
- To reduce pollution problems
- To reduce traffic problems
- To reduce alcohol problems
- To reduce drug problems
- To improve treatment of psychiatric disorders
- To improve the education system

Please comment on your ranking on drug problems.

(For administrators/police people:)

1a. What has been the major philosophy and goals concerning drugs in your organisation during the past 10 years ?

1b. What have been the major obstacles that your organisation has encountered in its practise?

1c. Imagine you could have changed something in this society's drug policy in the past ten years, what changes would that have been?

2. What was the most important political goals in this city's policy in the drugs field ten years ago? Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

Rank

- To strive for a drug-free society
- To reduce harm caused by drug use
- To reduce drug use related crime
- To reduce public nuisance associated with drug use
- To prevent drug use among youngsters
- To secure or improve the coverage of treatment for drug addicts
- To reduce drug dealing
- To prevent the spread of diseases like HIV and Hepatitis C among drug users
- To prevent overdose deaths among drug users
- To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade

Could you please comment on your ranking on these items.

3. What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?
   Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Rank
• To strive for a drug-free society	
• To reduce harm caused by drug use	
• To reduce drug use related crime	
• To reduce public nuisance associated with drug use	
• To prevent drug use among youngsters	
• To secure or improve the coverage of treatment for drug addicts	
• To reduce drug dealing	
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	
• To prevent the overdose deaths among drug users	
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	

If any changes, compared to ten years ago, please comment on the reasons for these changes in priorities.

4. Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms			
In police strategies less focus on users towards more focus on larger scale dealing			
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)			
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)			
Housing for people with drug problems			
First aid education			
Sufficient capacity of methadone programs			
Low threshold methadone programs (allowing side use during treatment)			
Methadone programs in prisons			
Heroin prescription programs			
Interventions in order to change the main route of heroin administration from injecting to smoking			
Distribution of naloxone (narcanti) to drug users			

Could you please comment on your ranking and explain why some interventions are not feasible in this city, if any.

5. Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think, to reduce or forbid the distribution of these pharmaceuticals is one way?

6. Do you think, that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

7. Do you have any other suggestions about how to reduce the overdose deaths in our city?

8. When evaluating this city's drug policy in total:
   a. In what aspects do you think the policy has successfully reached its goals, and why?
   b. In what aspects do you think the policy has failed to reach its goals, and why?

Thank you very much that you took your time to answer these questions.

8 Interviews from Amsterdam

8.1 Drug users in Amsterdam

I conducted the first three interviews at the treatment centre of the municipal health service. I asked the head nurse of the outpatient clinic to approach two clients who had an experience with overdose themselves, or as a witness, and who would like and would be able to talk about these experiences. The two clients she had in mind agreed to talk with me *(interview 1, 2)*. Next, I approached the head nurse of the outpatient clinic for prostitutes and foreigners with the same question, the two female drug users she had in mind were participating in the experimental heroin treatment at the "Medical Substitution Unit". I approached these drug users via the nurses of this unit, the first however, refused to participate, the second did agree with an interview (*interview 3*). To be able to talk with people outside the treatment centre I approached the centre that focuses on the help of foreign (originally German) drug users (AMOC/DHV) with the same question. The man that runs the user room brought me into contact with two drug users that had experienced an overdose *(interview 4 and 5)*.

It is clear that drug users I interviewed are specially selected for the purpose of this study. They all had a history of injecting drug use, although the majority of the Amsterdam drug users does not inject. They all experienced one or more life threatening situations, they all witnessed one or more of these situations. Moreover, they were all able to add information that will be of great value for the purpose of this study. Two of interviews (*interview 3 and 5*) were conducted right after heroin use. Although these people were able to understand and answer the questions appropriately, the interviews were less lively and I felt some reluctance bothering them with too many questions.

8.1.1 Interview 1: 36 year old Dutch male.

I grew up in a small town near by the sea and came to Amsterdam to study. After I had finished my university study (economics) I started working. Together with my yuppie friends I snorted cocaine for the first time when I was 27.

After this first use, the frequency of cocaine use increased, I started to buy cocaine for myself and eventually started to smoke cocaine. Smoking of cocaine was an experience that is not comparable with snorting , if you feel ill, tired and down at one moment, you will feel happy and strong one moment later. However, if you use it too much, you start feeling too speedy and you need something to slow you down. Heroin is a perfect drug to slow you down. So when I was 31 I started using heroin (chasing the dragon) to reduce the effect of the cocaine. At that time I already lost my job and my girl friend. After a few years I got my first shot of heroin. Or better, someone else did it, because I was to afraid to look at it. After a while you get used to it. After my overdose experiences I am reducing my intravenous use of heroin and cocaine. On Average I inject once a day. When there is money available, I use more; when there is no money, less. Alcohol is a serious problem for me right now. I start shaking if I don't drink beer. Alcohol is the worst addiction and I will go to the detox. (treatment facility).

Nowadays I live at a 'social pension' that is specially meant for homeless drug users. In this pension I can stay as long as needed and meals are included. I pay the pension with the social benefit I receive. They give me pocket money several times a week.

Five years ago I demanded for treatment at the Jellinek. They are focussed on abstinence at this treatment centre, they tested my urine daily and the test turned out to be positive much

too often. So I was expelled. Nowadays I receive methadone treatment at the municipal health service.

Normally, I use my cocaine and heroin at my room and most times someone joins me. After I use drugs it's like my temperature rises and I ask my mate to sprinkle water in my face. There is a users room connected to the pension, but this is merely for those who smoke heroin and cocaine. They don't appreciate people that use their heroin intravenously, especially drug users originating from Surinam don't like needles and blood.

I had two overdose experiences, at the first experience I used a mixture of white and brown (*cocaine and heroin MB*). I bought this at a dealer who I know well and who always informs me when the purity of the drugs he is selling has changed. This time however, the dealer forgot. After I shot, I had the feeling that a thousand needles were sticking into my face. I fainted and woke up one our later, dizzy and tired and terrified.

The second time I had a syringe full of dope. After I shot halve of it I thought, this is good, I only want a quarter more. Instead of shooting one quarter I accidentally shot it all. I may be distracted because of some noise or something. I felt like I was paralysed, could not move anymore and slowly I was falling from my bed. Although I couldn't move I could talk, perhaps I shouted my neighbours name. This guy who lived upstairs was alarmed and entered my room. He was too drunk to do something and although he realised it was serious, he left. Suddenly I found myself in a forest, although I knew I was right in my room. I thought I was dying. When I woke up next day I felt quite normal again.

Two times I have been a witness of an overdose. At night I saw a man on the corner of the street (at the Zeedijk) he was crawling and biting on his teeth, it looked like he had an epileptic attack, but there was a needle and he had blood on his arm. I think that when he prepared his shot he couldn't exactly see what he was doing because it was dark and he may have accidentally taken too much. I tried to clean the blood with a T-shirt and stayed with him to make sure that he would not quilt in his vomit or swallow his tongue. Some policemen passed, they told me that they knew this guy very well, that it often happens and that he will be all right. They had been taken him to their police station for ten times. I understand that their attitude is getting tougher when this happens a lot.

A second time was during the winter. It was minus three. I saw a girl who prostituted herself, I had some dope and proposed her that we should use it together at my place. After we used some dope she asked for some tranquillisers and she swallowed nine of these at once. I told her that was a stupid thing to do. She started to make strange sudden movements with her head, I smashed her in the face, threw cold water on her and tried to keep her conscious, her breath and hart beat was normal. I wanted to call an ambulance but everything seemed to be stable and I just kept an eye on her. Only after 18 hours she woke up again.

If you talk about why people die due to an overdose of drugs, you have to distinguish those that want to die and those that don't want to die. Just use four or five grams of pretty strong coke and your heart will fail. Overconfidence, if people have money and are using drugs for a few days without sleep and their last flash was not exactly what they want it to be, people turn to be overconfident. I think overconfidence is more important than inaccuracy or a dealer selling bad drugs. Most people try a little bit of drugs and feel what it is like before they inject a dosage in order to get the flash. I think the emergency services are all right here, there's

nothing wrong with it, the ambulance will come within fifteen minutes. Except if you are alone or when your buddy is too stoned to act.

If someone gets an overdose of drugs, you have to make sure that he stays awake, to smash him in the face or to throw cold water in his face. Make sure that someone doesn't quilt in his vomit and if someone makes strange sounds or spastic movements call 112 (the alarm-number) immediately.

I think the number of overdoses is lower in Amsterdam because 80% is inhaling drugs. I don't know about Denmark or Norway but I hung around with a Swedish guy and he was telling me that injecting is a normal way using drugs out there. Here, drug users look down upon you if you are injecting, as a 'shotter' you are treated as an out-law. Since the base coke was introduced the number of injectors decreased. Although in my opinion it is stabilising right now and the taboo on injecting is getting less. It takes a lot of effort if you want to die due to an overdose by smoking. Another thing that may be important is that the syringes we get from the needle exchange are rather small, that guy from Sweden had a very large one with him.

In my opinion facilities that could have prevented overdose casualties in Amsterdam are the user rooms. There you are warm, there is enough light to see what you are doing, you can clean your arm and use clean needles. There you have time enough to prepare your shot.

Measures that may cause overdose deaths is the policy of the police to chase people away. Last time I was at a dealers place and a girl entered panting, she was arrested by the police because she was soliciting behind Central Station. She was totally stressed and although it seemed she already had more than enough, she asked for another ball of coke. Because she was stressed she didn't give a shit of the possible dangers.

My advice to the policy makers? That is a question I want to think about more profoundly, if you give me your number I will call you to give an answer to this question.

8.1.2 Interview 2: 34 year old Dutch male, born in Amsterdam.

I'm born in Amsterdam, as I child I lived in Friesland, but returned to Amsterdam in a few years. I finished my high school and I conducted a few years of middle level retail trade school. I worked as a bicycle-repairman. Now I'm living in a pension for the homeless and receive social benefit.

My drug career started as a dealer. I think I started to use my own cocaine when I was 24. After a while, I started to snort the coke more and more frequently and I stayed awake at night. The use of hasisch was insufficient to get me down and I started to use heroin. First chasing the dragon, later intravenously. I get a daily dosage of 140 mg of injectable methadone from the municipal health service. I started treatment four years ago at that time I had a job and I used before and after work but sometimes I was dope-sick during working-hours. Now I stopped using heroin but inject cocaine approximately once a week. I buy base coke and use ascorbine to make a cocaine solution to inject. When I use, I mostly share coke with others.

I haven't experienced an overdose with heroin. One time I had a bad experience with coke, I had administered a lot at a time, and the flash that normally goes down again continued. I started to worry, I was alone and tried to open the window and I almost fell out of this

window I couldn't really control my muscles anymore. I did not loose consciousness but it was a scary.

I lost a friend of mine because of an overdose. I met him at the methadone outpost and he just came out of jail. He had no place to go and I took him with me. We used some cocaine and he had heroin. We did a lot together, and I thought that he could take what I take. We shot the heroin. He was complaining that he was so tired. He fell a bit to the front and I thought he fell asleep. I put him in a bed and went to sleep myself as well. When I woke up he was lying in exactly the same position and I thought… this is bad news! While I thought he wanted to sleep and while I put the blankets right he was actually dying! The day after the police came. They were all right. They cleaned my room and they approached me well. I could have murdered him this way. When I'm thinking of this right now I think it was just a stupid thing to do, but I don't think he did it on purpose. I'm also wondering why this had to happen to him, he was a good guy, a friend. I think there are multiple reasons why he died; he was already tired, he was detoxified during his incarceration and I just didn't notice that he was dying.

I have been a witness of an overdose two other times. They were both not very regular users, not participating in methadone treatment and… they were just too greedy. If you are sharing the dope they feel cheated if you give them less. They want to take as much as I do but they just can't handle it. Once, I tried how far I could go, and that is more than 1 gram (I couldn't dissolve it anymore). The first time, this guy had the needle in his arm when he collapsed, than I did something stupid, I put him under a cold shower in order to wake him up again. He laid down I could hardly notice his heart beat or breath. He laid there quite some time on one side and afterwards I noticed a red mark on his cheek, this mark stayed there for several days When this didn't work I called the ambulance, and the gave him Naloxone. The other time went quickly. That guy lost consciousness before he had injected all the dope. His face turned pale and his lips turned blue. I called the ambulance as well and tried to give him pain stimulants, by putting a wet towel on his head and sticking a needle under his nails. In the beginning this had some effect but after some time this effect diminished. The Narcan that the people from the ambulance gave him, worked like a miracle and he survived as well.

I think an overdose may be lethal when people are alone, when their company is not aware of what's happening or if the reaction of their company is too slow. The most important thing is calling an ambulance immediately.

I know some drug users from Norway and they shoot a lot. If there is an increasing number of overdose deaths over there it's because heroin is new, and people have to learn how to deal with it by falling down and coming up again. I think we had a period like this in Amsterdam as well. I think in Amsterdam people know how to react and they may react faster because you don't have to be scared for the police. Another thing is that heroin has become unpopular, some dealers do not sell it anymore. Base coke is more important, heroin is of matter of secondary importance. Moreover, I think in other cities a larger part of the drug users injects their heroin.

On my question about facilities or measures taken to reduce overdose deaths he was surprised and asked me what kind of facilities there are. I explained that some facilities are not explicitly meant to reduce overdose mortality, but some facilities like methadone programmes may prevent overdose mortality. User rooms may prevent deaths, somebody dies

when he is alone and when he has to use on a spot where it is not allowed. Then things go fast, in that case mistakes are easily made and you are more likely to take too much.

Things that may be counterproductive. Forced detoxification during incarceration, they start with 40 mg of methadone and every other day you'll get 5 mg less. People are fixated on their drugs and start using as soon as they are released.

An advice to the policy makers. We have a lot in Amsterdam, even heroin treatment. I think nowadays most Dutch drug users know what they are doing. They don't need to be informed. If a Dutch drug user dies I would call it stupidity.

What I would advice is methadone treatment in prison, although I heard that there are more possibilities to receive treatment in prison recently. Especially if people are doing only a short time, they will be focussed on drugs. After they are released they start using the amount they used to take. If people are doing more time, they will think about their situation after incarceration more profoundly. If you are in jail for a longer time, you will start to think about your situation and methadone alone is no fun. So I think that many drug users who are in jail for a longer period with methadone maintenance will make the decision to reduce their methadone themselves which may be more effective.

8.1.3 Interview 3: 32 years old Dutch Female

I'm born out at sea but I grew up in a town in the north of Holland. After primary school I visited a low degree professional education. I started using heroin by chasing the dragon when I was 14 and I started to shoot cocaine when I was 17. Since a few years I don't inject cocaine anymore but I've been smoking base-coke. A few years after I started using drugs, I moved to Amsterdam. Nowadays I rent a house together with my boy-friend but I had a period of homelessness before. That time I lived in one of the boxes underneath the flats. I always used inside the house (or box); the dealer came to our place when we wanted to buy dope. I'm a participant of the experimental heroin treatment now, so now I smoke my heroin at the municipal health service.

I had experienced more than 13 overdoses, most of them intentional. My friends hands are quite loose. When we had a fight and he had hit me I got totally upset. Than I started to use heroin and swallowed all pills that I got. That time I used barbiturates. Once a week I bought them, so when I had just bought them I had quite a lot of them. It was an impulsive act. At most occasions my friend found me and he called an ambulance, at other occasions other people called the ambulance. At the end, my friend just waited until he heard the sirens of the ambulance, followed them and found me that way. Sometimes I tried to hide me, but it is hard to hide if you are outside in the streets. I guess people at the treatment centre did not believe that I would be able to quit with this excessive use of barbiturates but since a few years I stopped the use of these pills and I didn't take an overdoses anymore.

I experienced an overdose of cocaine as well. I was very scared. I could not talk anymore and I did not recognise anybody. People that were standing around me are worried but in my imagination they were mean and wanted to hurt me. One time I experienced an overdose of heroin, afterwards my face was puffy. That time I injected the heroin. I don't think that it is

possible to get an overdose of heroin by smoking it, the heroin is too slow, but it is possible with coke, smoking coke is much faster.

I was a witness of a cocaine overdose once, this person was crawling with convulsive movements. He was scared to death and could not talk anymore. I prevented that he would bite his tongue off and I put a wet cloth on his forehead. I yelled at him and slowly he returned to a normal state of consciousness and I did not need to call an ambulance.

If a person dies he has taken too much dope but this can be accidental or intentional.

In case of an overdoses of cocaine you should prevent that the person hurts himself. Try to put something in his mouth (not your fingers; I almost bit off my boy-friends fingers) the best is to put your bag of tobacco in his mouth. You have to prevent that someone looses his consciousness and to make sure that he can not smash his head into pieces.

The difference between other countries and Amsterdam is the quality of the dope. Elsewhere, dope is highly impure, the quality is bad and there are many adulterants added to it. People die because they are using polluted heroin.

To prevent overdose fatalities there should be some place were you can run to in times of excessive stress, when you are really upset. A friend of mine did not want to talk to her boy friend on the phone, and a few days later she received his death announcement. He did not know were to go to and hung himself.

My advice to the politicians would be to distribute heroin in a controlled way. Than you are sure the quality of the heroin is good. In my opinion, this heroin treatment is beneficial for many people, they are spending less time on the streets to use drugs or to get money in order to buy drugs.

8.1.4 Interview 4: A 28 years old English male

Five years ago, I arrived in Amsterdam with a classic Truck, which was my house as well. I had problems with this truck, got stuck on the road and the police dragged it away. Although I think the car was easy to fix, I could not afford paying the money for parking and I stayed here. Nowadays I'm homeless, I live in squads or empty houses and earn a living by shoplifting.

I started to use heroin at the age of 15 at the techno-parties in England and I did not pass the secondary school that I was attending. I was smoking heroin but when I arrived in Amsterdam I started shooting, the quality of the dope is poor and only when you shoot it, it has an instant effect. Nowadays I shoot cocktails of heroin and cocaine. Normally I use at the users room, because it's practical and clean.

About my overdose experiences I can tell you it was the best high that I ever experienced. The strange thing is that is does not scare you nor it will put you off using dope. These overdoses happen when I'm very tired, when I've been using a lot of drugs without sleeping properly. Your body just can't take it anymore. I think I always felt the same degree of tiredness before the overdose occurred. When it happened, I used a cocktail of heroin and cocaine, in fact it was more like an epileptic insult. Two times it happened at the toilette of McDonalds, people found me and started shouting, by the time the ambulance arrives I was all right again.

Something similar happened to me at the user room. That time I was just released from jail (and I received methadone there) and I passed out after shooting the cocktail, again, after a few minutes, when the ambulance arrived, I was all right and I did not understand why they had called the ambulance. I don't participate in a methadone programme. I don't have any intention to stop using. In that case I would have two habits (heroin and methadone) and in case you go to jail you feel a lot worse. In fact it's the same, going to get your methadone at the treatment centre everyday or buying your dope everyday. Only in case of emergency (to prevent withdrawal) I take some methadone.
I've been a witness of an overdose. I was downtown nearby the University. I sold some dope to a guy, I told him it was strong (it was from my private dealer). He was greedy, and wanted to buy for five guilders more. As soon as he had used it he fainted, I shouted at him, he stopped breathing and I gave him mouth to mouth. He vomited, it was disgusting but you have to, if you want to keep someone alive. Although thirty people watched me (they were standing on the bridge) an I'm sure at least ten of them must have had a mobile phone, none of them rang an ambulance. So a ran into a cafe to ring. I returned and continued mouth to mouth. He started breathing again and I stopped. When the ambulance was close I ran away. Only than these people tried to chase me and I told them: "if it wasn't for me he would be death by now." I was worried about him, did not know whether he survived or not. One and a halve week later I saw him again, he talked in a strange way. I think the lack of oxygen caused some sort of brain-damage.

I think people are dying because of an overdose when the dope is unexpectedly strong, when they have a different dealer for instance. When someone has an OD you must give him mouth to mouth until the ambulance arrives, in order to bring oxygen to the brain. In Amsterdam the ambulance is quick.

Differences between Amsterdam and other cities…. I can tell you about the difference with England. When you get an OD in someone else his house, they will put you on the street and call an ambulance afterwards. They won't try to keep you awake or to give mouth to mouth because the are too afraid for criminal charges from the police. If you gave him the dope and he dies you will be arrested for man slaughter.

Another difference of importance is the high proportion of people in methadone treatment and that the number of shooters is constantly dropping. Moreover, I think drug users in Amsterdam have more education and know what to do in case of an emergency.

In Amsterdam the quality of the heroine is poor and if there is good dope available it may cause an OD to a lot of people. Dealers want to make more money and put more and more adulterants in it.

An advice to the policy-makers in case of a high OD prevalence would be to organise a paramedic ambulance with a specially trained medical staff at different locations in the city. This ambulance should be able to reach an emergency case within 7 / 8 minutes. Moreover, I would advise to educate drug users; organise first aid nights.

8.1.5 Interview 5: A 33 years old German male

I was born in Germany and I've been a electrician, a carpenter and a painter. A sleep on the street, actually I don't mind sleeping on the street, even if its very cold. I ask people for money, I have a special technique. I won't tell you the details, but it is nothing criminal.

I started injecting heroin in Amsterdam 18 years ago. That time I stayed here about two months. I was clean for three years; after a cold turkey in Spain. I went to prison in Germany for eight and a halve years and I was using heroin, in prison it is very easy to get heroin. Four and a halve years ago a returned to Amsterdam and I have lived here since than. Normally I use my drugs right here at AMOC, I'm in methadone treatment at the outpatient clinic for prostitutes and foreigners.

I think it was November 1999, I wasn't in treatment that time. It happened right here, I had bought Thai heroin. My shoulder hurt so I asked someone else to put the needle in my arm. I think that person thought it was cocaine because Thai heroin is white as well. He shot the total amount of heroin in my veins…too quickly. The last word that I said was "fantastic" after that I fainted. I didn't breath anymore and did not have any pulse either. The ambulance was alarmed and arrived very soon. They gave me Naloxone and I got my conscience back. They wanted me to stay there for a few days. It may return but I did not want to, I was stoned during the whole week.

I was very grateful that they saved my live and later I got the opportunity to save someone else his life and in fact I'm very proud of that. After my period in jail I followed an security course 'Objecten und personen schutz'. It was proposed to me by the police, they needed people like me that spent a long time in jail and think in a different way. After this course I did not start working in this field, though.
A drug user came to me and told me there was an emergency case. I went there and I found six people smashing this unconscious drug user in the face. I dragged him up with my arms underneath the armpits and shuddered him in order to get the blood back into his body. I checked his pulse and breath and made sure he couldn't swallow his tongue and while the ambulance was on its way I tried to reanimate him. He survived.

The risk that things may go wrong is higher when people are already stoned. They may not notice the air bubbles within the syringe. Sometimes it happens to me. The quality of the heroin is important as well, the heroin here is ten times stronger than what you buy in Germany. If you are not aware of that you may easily get an OD. However, there may be a lot of other stuff in the heroin, especially when you shoot you are vulnerable for that.

What you should do in case of an overdose? Call an ambulance, check pulse breath and tongue. Drag the person up and shudder, check the pulse again, put a pillow underneath his neck, and perform mouth to mouth and heart-massage. Check the breathing once a while, until the Ambulance arrives.

I think in Amsterdam the drug policy is all right there are many facilities, for example this users room. And there is a special OD alarm number 5555.555 seven times five anyone can remember this. I don't know about any measures in Amsterdam that may be counter-effective regarding OD-deaths.

My advise to the politicians would be to make more user rooms, here I know the people and it's save. If you don't know the people and dealers they can sell you shit which may turn out badly. I think the police is chasing too much after the drug users. If I'm caught they will keep me for the night, whereas three hours after they catch a dealer you can see them selling their shit on the same spot again. Important is the possibility to buy drugs at the same dealer, with a stable quality and purity. Especially when you inject this is of major importance.

8.1.6 Some conclusions that I could draw from these interviews:

Several things of importance can be derived form this interviews:

The people I interviewed did all inject their heroin at the time they had a overdose. Moreover, they were all homeless at the time of interview or when they experienced this fatal overdose. On the one hand this has to do with the user room that I visited. User rooms are especially meant for people who don't have a place to go to use their drugs. On the other hand homeless people will be especially at risk because of their way of living and the circumstances under which drugs are used.

8.1.7 The heroin users' view on the problem:

Among heroin injectors an (accidental) fatal overdose is not likely to happen:
People use their heroin regularly (or use a constant amount of methadone).
People use heroin with a constant purity.
People can take their time in preparing their injection and using drugs.
Have a place to go, where they can get some rest without being treated as outcasts of society.
People are surrounded by people that know what to do in case of emergency.

The risk of a fatal overdose increases may if:
People start using (the same amount of) heroin again after a drug free period (after detoxification).
they are ignorant of the quality of heroin they are using.
they combine heroin with benzodiazepine or barbiturates
they can not pay enough attention to the injecting practice (darkness, stoned or stressed)
there is nobody (able) to help.
people are greedy.
People are tired.

In Amsterdam the number of fatal overdoses is low because:
The majority of the drug users does not inject and number of injectors is dropping.
A high proportion is on methadone treatment.
Heroin is less popular, use of base coke is increasing.
The syringes that are dispensed are small.
Establishment of user rooms: here it's warm, light, hygienic, relaxed
Drug users know what to do ion case of emergencies.
No police involvement when you alarm an ambulance.

The number of fatalities could decrease more if:
Forced detoxification during incarceration would stop.
Heroin treatment would be enlarged.
Special ambulance for overdoses would be established.
First aid training of heroin users would be introduced.

8.2 Street workers in Amsterdam

8.2.1 Police officer, male, 46 years, head of the police-team at the Amsterdam red light district.

I have worked at this police station for eighteen years now. Especially at this district we are confronted with drugs, drug-related crime and overdose mortality. We used to see overdose deaths with the regularity of a clock and (non-fatal) overdose cases on a daily base. Often, we are the first to see the victim. After the coroner concludes that the deceased did not die naturally, the criminal investigation department investigates whether it is a criminal offence (murder or man-slaughter) or not. However, specially when the victim is a real junky this is very hard to tell. I think any evidence of murder is seldom found.

I think the situation concerning overdose deaths was worst at 1987, if I remember rightly, we had 57 overdose deaths during that year. Now it is much better, actually, I can't remember any death that occurred last year. In the past we saw overdose casualties at the most impossible places, in the most impossible positions. We saw both people neatly lying next to each other in their hotel room and we saw the most bloody scenes as well. Sometimes it is so dirty that you feel the need to be disinfected…a horrible idea that the same (hotel)room is going to be used by somebody else that night. Many deaths were found at buildings were lots of drug users lived and/or used their drugs during the eighties there were quite a lot of them, the circumstances under which these people lived were degrading and a public health danger (e.g. toilets full of shit). In our district we only have one building like that nowadays and there is a procedure going on to clear this building as well. Moreover, we put more pressure on the owners of low budget hotels, if they tolerate dealing or use of hard drugs, they know we will close down their premises.

If we encounter an overdose case, the first thing we do is warn the municipal health service (ambulance). In the mean time we make sure a persons remains alive or start resuscitation (not in case of rigor mortis). There are special breathing masks to give mouth to mouth. The old ones did not have any solution for the vomiting that may occur, later we used masks with special valves. Sometimes it's dirty, but in these occasions, you do what you have to do, although I had another picture of the job when I started working at the police. When the ambulance arrives they will give the patient Narcan, which is a miraculous drug, once I saw a victim jumping out of the ambulance after Narcan was administered to him.

Times have changed, I think nowadays the police acts more realistic, we used to denied that we have to accept that there are drug users. Now we know that it is an utopia to think that we get rid of them totally. We used to consider the possession of a single boll of heroin as a criminal offence, we drove to the laboratory with it and the lab analysed it in order to find out where the dope came from. Actually, this took us more time than it took for the drug user that we caught. All this massive, time consuming work appeared to be nonsense. Nowadays, once in a while we catch a 50 kg of heroin. This will appear in the newspaper the other day, but still, it does not make much sense, eventually the users will get their drugs anyway. Overdose mortality may be quite low in Amsterdam because of the increased openness, for example, the Municipal Health Service warned the German and Italian tourists to be aware of the higher purity of the heroin in Amsterdam. The route of administration is important as well. Suriname drug users can not stand pain, and therefore do not inject. The use of heroin itself is decreasing as well, cocaine and crack are more widely used. As a consequence drug users are much more active, they can walk on the streets for 24 hours a day and show a more aggressive

behaviour. After use of heroin only, they are just standing somewhere. Furthermore, I think the way people use drugs is changing, I guess people use drugs in a more sensible way. In the eighties they used rohypnol combined with alcohol, under influence of these drugs people were still able to inject but were not able to fix the right amount of heroin.

I think methadone treatment has reduced the amount of drugs that is consumed and increased the hygiene because of the aligned needle exchange. Prevention is important; the youth is doing all right, they do not use heroin. Many however, use XTC instead but accidents with XTC only happen sporadically .

Many drug users are incarcerated and methadone is reduced in prison. However, I don't think that this results in a lower number of deaths. Even at the Amsterdam prison good quality heroin is available.

Sometimes I ask myself; where is this fuss about drugs all about?
I'm in favour of the prescription of heroin to the kind of drug users we are dealing with here; drug users that have been addicted for many years now. We have to accept their addiction, heroin prescription will give them more rest. To be clear, I don't want heroin to be available at the supermarket but it should be available in a controlled way. The users rooms that have been established are not a sufficient alternative, their scale is too small and drug users still have to go somewhere else in order to buy their drugs. As long as we do not prescribe the drugs, drug users will keep on wandering around on the streets.

At this moment, in Amsterdam, I don't think death due to overdose is a problem anymore. It won't be possible to reduce the number of overdose deaths to zero. Prevention can not prevent everything, there will always be some people that start experimenting with drugs.

8.2.2 Interview with a 44 year old male ambulant nurse

I have worked at the Amsterdam ambulance since 1990. I worked at the ambulance in Utrecht and at the Intensive Care. I attended nursing school, special education to intensive care nurse (both children and adult) and ambulance nurse. My work consist of emergency cases for about 60% and regular transportation between hospitals for about 40% of the time. I'm working four days a week. We have a weekly schedule for day, evening or night shifts that repeats itself every nine weeks.

I think I encounter a severe heroin overdose about two or three times a year. This means someone stopped breathing, has a low heart rate and a low oxygen level in his blood. Most overdose cases are tourists, they are experimenting without good advises and shoot themselves to an overdose. Actually, all heroin overdoses are injecting drug users. Moreover, you find people with an overdose of cocaine, mostly very agitated. I encounter overdoses of hashish two or three times a month. Again mostly tourists. They start eating space cake *(cake with hashish in it, you start noticing an effect after approximately one hour* MB) and if they don't feel anything after twenty minutes they will take another piece. However, these cases are never life threatening, except if someone starts panicking and jumps in front of a car.

There are different stages of overdose, if someone is breathing but drowsy and you don't know how long ago he injected, you don't know whether this person is going up or down. To be sure we take them to the hospital. Often it is not really necessary to take a person to the hospital, if somebody else keeps an eye on this person it's safe enough. However, if the

company consists of fellow drug users, I'm often not sure whether they really stay or leave to buy drugs and we will transport the victim as well.

In case of a severe heroin overdose we use Narcan, in that case it is important to give just enough: the person should start breathing but should not regain his full consciousness. When you give too much, people feel better at once and don't want to go to the hospital anymore. This may be dangerous because the half life time of Narcan is shorter than that of heroin. So when Narcan looses its function people are at risk to get an overdose again with the heroin that is left. Especially if someone starts using heroin immediately after waking up this is a very dangerous situation. I think they made these kind of mistakes in the eighties and it may have caused some lethal overdoses.

If we use Narcan people will survive. The last severe OD that I encountered was that of a American guy, he was in a coma. In fact it was a suicide. He has written a good bye note. Although we used Narcan his breathing stayed low. Probably he has made it though, but he may have some neurological damage due to a lack of oxygen.

I think if heroin users are in a general bad condition, with abscesses, HIV infection etc. they are more vulnerable to die, especially if the OD occurs outside on the pavement when it's cold. Besides suffering from an overdose they suffer from hypothermia. I think the Dutch heroin users are generally really experienced and are using heroin quite sensible. There is also some solidarity among them. Tourists however, usually haven't eaten a lot of cheese from it. (Dutch expression meaning: "they don't know what they are doing if they are using drugs").

I have the impression that when I started working here ten years ago it happened more often than today. Sometimes there are some periods with an increased number of cases, probably connected with differences in purity.

I think in Amsterdam there are less fatal overdoses because heroin users feel free to alarm an ambulance in case something happens. Here you are no criminal when you take an overdose of heroin (you only have to go to the criminal circuit to buy it). Drunk driving is a criminal offence, when people have a car accident after the use of alcohol, they may hesitate to call an ambulance. Another thing is that most inhabitants of Amsterdam recognise when someone has taken too much heroin and realise they have to alarm an ambulance. Moreover, the quality if the heroin is quite good in Amsterdam.

At the alarm centre, people are instructed not to sent the police in case of an overdose. However, if we feel threatened we do call for police assistance. Heroin users are mostly well to handle but cocaine users are not always that pleasant. But the police won't bother drug users only because they are using drugs. Foreigners often do not know that the police won't come. I notice they hesitate to tell you exactly what has happened. Last time we went to someone with the symptoms of excessive heroin use, he had very small pupils but denied that he used it. I had to convince him that the police would not come. Slowly he started trusting me and told me his story.

8.2.3 Street corner worker,

I've been working since 1988 at a drug aid service (mostly AIDS prevention, needle exchange etc.) in a Deventer (town in the east o the Netherlands)). I came to Amsterdam in 1993 and

have worked in different districts for Street Corner Work foundation. Now I'm working at the centre, and since 1997 I've been working with young drug users, we try to contact young drug users who are hanging about central station and the red light district. If they are homeless we can offer them a postal address and can arrange income. We don't always succeed in this but at least we talk about risks and we learn to know something about quality of the drugs and trends of use.

I've seen an overdose of an German injecting drug user, he was almost unconscious so we slapped him in the face and tried to keep him active, to keep him awake until the ambulance came. He had taken the same amount of drugs as he did in Germany, but the quality of the drugs is better here so it was too much. Actually that was the only overdose that I ever witnessed.

I think the main risk factor is a difference of purity. This is especially dangerous for foreigners, if you are used to shoot half a gram each time and you do a similar thing right here, you are at risk of an overdose. Other risk factors…you hear stories of users that when they feel depressed they try to overdose, but I guess that this is a way to draw attention. Similar to the people who show me that they have cut themselves and say they wanted to kill themselves. If you really want to you kill yourself you don't talk about it, you just do it. However, if this kind of situation goes on for a long time I start to worry. There may be some moment that they will succeed. But than it's not in the form of an overdose of drugs but with cutting or tablets like benzodiazepines.

I think that it's important to give information about the quality of the drugs, especially to foreigners. There are differences between Amsterdam and Rotterdam and even in Amsterdam you see differences between the quality of the drugs in the centre and in the South East part of Amsterdam. The Amsterdam drug users often go to the South East to get their drugs. Tourist will get it at the centre. We take samples regularly and go to the police to analyse it. I think information about the quality is the only way. And if you don't inject it is hard to get an OD, at least I've never heard that someone killed himself by smoking heroin. I think they will jump in front of a train instead.

In Rotterdam they have a quality label for drugs that is sold in the so called basements. If you buy your drugs there you know that the quality is good. Of course you can still buy it on the street with the risk that what you buy is not trustworthy. In Amsterdam people tell each other were they can buy good dope but that is just for the moment, tomorrow it can be different. But still,… if people really want to commit suicide they will succeed and this kind of prevention won't help.

Changes over time…on the streets the atmosphere is getting more aggressive, the techniques to sell drugs are more aggressive, people get intimidated, everything gets tougher. There are sixteen year old boys that use forty year old drug users to sell their drugs.

The police is chasing more nowadays, therefore everything needs to go faster, people tell me "we smoke a lot but we don't have any time to enjoy. There they (the Police) are again on their horses or mountain bikes." They buy drugs to get high, and to get high you should lay down and smoke it. They have to buy more drugs but don't enjoy, they used to make their base coke themselves. That took a while but after that they could enjoy, now they sell coke in a ready to use form. Everything is fast, fast, fast, they watch out for the police while they are smoking and don't enjoy. That worries me.

I don’t know if there is a relation with overdose… I hear very little about overdoses.

Users rooms are not a solution for everybody, because a certain group doesn’t want to go there, they don’t want to go to any kind of drug aid service. The want to do it their own way, this may be the highest risk group, they should organise a place where more people can enjoy their drugs. Heroin treatment has a similar problem, dope is more than a powder, it’s about all the surrounding things: it’s about the people, the rituals, you know it’s about buildings. For some people it may be a solution but there will always be a group that prefers wandering through the city looking for dope.

There are different drug scenes in the city, lately I’m trying to do something for the North African users. They are from a Muslim culture with a different perception, different codes, morals and values differ from the Surinamese group, they will develop into a problematic group.

Coke is important at the start but people start using heroin get into balance an you see that gradually heroin is getting more important for them because of the physical withdrawal syndrome. Some even inject. There are also different places for different scenes, at the red light district, the food plaza or the central stations show different patterns of use.

I can't think of anything that is typical for Amsterdam that has a risk inducing effect. But perhaps some things can improve: we should advise tourists about what to do in case of an OD, with brochures at the hotels for instance. Furthermore, in my opinion, further enlargement of the heroin treatment would solve a lot of problems.

8.3 Officials in Amsterdam

8.3.1 Cees van der Meer; senior policy co-worker, department of welfare, municipality of Amsterdam.

"Important is stabilisation and social participation of drug users."

" At a certain moment drug aid services started to do everything; taking care of income, housing, work etc and therefore, other institutions that were specially created to take care of income housing work etc., refrained from paying attention to the drug users."

"I think it is good that we consider heroin addiction as a medical problem, with nurses instead of social workers"

"A drug free society is an Utopia, we are not going to work on that."

"The stereotype chronic drug user is an endangered species, which will disappear in pensions for homeless or elderly and will receive heroin and methadone over there."

"it sounds old fashion but I think 'rest and hygiene' are important."

"I guess we are moralistic in the right way, moralistic but realistic. We are not acting hysterically."

"There is a awful lot of boozing and sniffing going on."

Goals of drug policy during the last ten years

A professional drug aid service developed when the municipality of Amsterdam started financing this at 1978. This drug aid service was predominantly focussed on public health and the harm reduction policy. Next to health, we started paying attention to nuisance and criminality during the early eighties. During the mid-eighties the term integral drug-policy was introduced. Next to health, nuisance and criminality, we started to concentrate on social recovery, interpreted as activities focussed on housing, income and work. During the nineties we decided not to focus on abstinence anymore, we don't think that is important. Important is stabilisation and social participation of drug users. All institutions that are experienced in these fields (income, housing, work, health, criminality) have to co-operate to make this work.

Because we realised that we could not talk about the addict and the drug aid service, we started a policy focussed on different target groups. You have to know which substances are used, who is using these substances, in what frequency and what the consequences are. We started thinking about tailor made solutions. Next to the chronic drug users, we paid special attention to youngsters and differentiated between recreational use and excessive use. You have to reach youngster both in a family, school and at leisure situations. We have projects to support the parents with raising their kids. At school there is the "healthy school and drugs project." At bars and discotheques you have to do with other kinds of drugs (such as XTC) and other parties (such as owners of the discotheques). It's about alcohol and drugs in relation to violence. Finally, we distinguished criminal drug users, who are frequently arrested by the police. For them projects of compulsory treatment (instead of imprisonment) are developed.

Obstacles

A major obstacle was lack of policy. At a certain moment drug aid services started to do everything; taking care of income, housing, work etc and therefore, other institutions that were specially created to take care of income housing work etc., refrained from paying attention to the drug users. The social service did not do anything for drug users, at mental health institutions drug addiction is a contra-indication and drug users were not even welcome at the institutions for the homeless). We decided that other departments of the municipality (economic affairs and social affairs) should pay special attention to the weaker groups of society, among which the group of drug users. Nowadays, at least one third of the beds at some pensions for homeless should be occupied by drug users. Moreover, we are spending a lot of money to find a job or activity for those people with the largest distance to the labour market (among which many drug users). Another obstacle was the lack of co-operation between the different institutions of the drug aid services, next to the municipal health service (the medical part) and the Jellinek (abstinence oriented treatment) there are some other unattached clubs. However, they didn't have anything to do with each other, we changed this and are forcing them to co-operate.

Things you would have changed?

The municipality should have chosen much earlier to take responsibility and built up something solid, meaning developing a policy and invest. This in contrast to divide the care in different categories (mental health, homeless, drugs). If you take a look in the town you see people who booze, are mentally ill and are homeless at the same time. Different areas of care should co-operate.

I think that is the only thing I would like to change. I think the Amsterdam policy (and this sounds extremely arrogant, but luckily I didn't develop it on my own) has been functioning very well. At least well if you look at the methadone treatment of the Municipal Health Service. I think it is good that we consider heroin addiction as a medical problem, with nurses instead of social workers. If only social workers are dealing with addicts, there is no knowledge of all the medical problems (such as abscesses) and they don't have any knowledge about mental health care. In a situation in which drug use is a contra-indication for psychiatric treatment there is not much what you can do with these social workers. We have constructed a more solid fundament by looking at the problem from a medical point of view.

What were the most important political goals in this city's policy in the drugs field ten years ago and what is your opinion about the goals in the near future? Please rank the following items into three categories,
(with no more than four items in each category):
High priority, 2. Medium priority, 3. Low priority.

	Previous 10 years	Future policy
• To strive for a drug-free society	3	3
• To reduce harm caused by drug use	1	1
• To reduce drug use related crime	2	2
• To reduce public nuisance associated with drug use	1	1
• To prevent drug use among youngsters	1	1
• To secure or improve the coverage of treatment for drug addicts	1	1
• To reduce drug dealing	3	3
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	2	2
• To prevent overdose deaths among drug users	2	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3	3

A drug free society is an Utopia we are not going to work on that.
Trade of drugs and prevention of money laundry is national policy, so this has a low priority for the municipality. Looking at the late onset of our needle exchange programmes to prevent HIV infection I don't think there is a reason to be really proud of this policy.
I think that our future goals are similar. The stereotype chronic drug user is an endangered species, which will disappear in pensions for the homeless or elderly and will receive their heroin and methadone over there. We hardly have any influx of young people and the addictive behaviour as we know this from the older junky will disappear. This however does not mean that there is not a enormous amount of drugs that is sniffed an swallowed these days. If you are going to a discotheque and swallow some pills, of course you have to make sure that you're not poisoning yourself. For us however, it is only an issue if you loose your job, get great debts and end up in the street. This however, does not happen, otherwise we already should have noticed it. This means that the term addiction will get a totally different contents, and that there will be some fundamental changes of the drug aid services or we may (and this sounds really bad) discontinue these services. Another option is to integrate it with public mental health care, because not the substance but the consequences of use will be the central issue.

		feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	2	x	
In police strategies less focus on users towards more focus on larger scale dealing	2	x	
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	3	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	1	x	
Housing for people with drug problems	3	x	
First aid education	1	x	
Sufficient capacity of methadone programs	2	x	
Low threshold methadone programs (allowing side use during treatment)	1	x	
Methadone programs in prisons	3	x	
Heroin prescription programs	1	x	
Interventions in order to change the main route of heroin administration from injecting to smoking	2	x	
Distribution of naloxone (narcan) to drug users	3		x

In user rooms people can use their drugs at ease and can more enjoy and I am told people start using less drugs, the opposite situation is there when the police is chasing drug users.
Sufficient capacity and low threshold methadone programmes are somehow connected but if I have to choose I think low threshold is more important. Methadone in prisons… I don't think there are many OD's in prison.
First Aid courses, I was charmed by the course developed by mainline (organisation for drug users), to give health promotion and learn them what things they can do themselves, it was also good for the drug users' self-esteem which is generally low.
Furthermore, I'm a supporter of the heroin prescription
…to distribute Narcan, I don't think that's a good idea, I think it will be difficult because drug users have to administer each other medication ..and they might misuse it.

Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk?

If there are alternatives you'd better use these alternatives. At most, the municipality may support a campaign to reach this goal.

Do you think that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

You have to take the drug users inside, not predominantly to reduce nuisance but also to create rest for the them. It appears to lead to less drug use. Moreover, think it is important to spread drug users throughout the city. You have to make sure there are no large groups at one spot, you should try to keep it small-scale. I think basic facilities such as showers should be available in user rooms or drop-in-centres, how do you call it, it sounds old fashion but I think 'rest and hygiene' are important. Of course there should be an opportunity to use drugs; there could also be two rooms, one to rest and the other to use drugs.
When evaluating this city's drug policy in total:

a) In what aspects do you think the policy has successfully reached its goals, and why?
b) In what aspects do you think the policy has failed to reach its goals, and why?

A
What is successful is the low prevalence of heroin use, surely if you compare it with our neighbour countries. In this respect I think the separation between soft and hard-drugs was very important. Moreover, I think that we (although we may have been too late sometime) set up a reasonable basic health care for these people. I guess we are moralistic in the right way, moralistic but realistic. We are not acting hysterically. Drugs are there and it's better not to use them but if you use them, use them sensible, that's a good starting point. Another good thing is differentiation, what kind of drugs is used, who is using it, where is it used. If you treat all alike you are a scare-monger. I think our policy is pragmatic, we don't ignore the problem, and don't put the blame on the drug users.

B
More in general, but I don't know if the municipality is able to do something against it, we notice that, although addiction problems are changing, there is a awful lot of boozing and sniffing going on. The variety of drugs at the moment is enormous. Apparently there is a need for this. It may be a symptom that something is wrong in society, perhaps the increasing individualisation, the high appeal of society to everybody. (You may skip this part, it sounds like a good story but you can't do anything with it, perhaps we are not even able to influence these things.) You cannot say, let's prohibit all drug, increase the punishments and the problem is solved. Those drugs will come anyway. We'd better make sure that we monitor the developments, intervene if things go wrong, and built up a strategic prevention.

8.3.2 Codrington: Green left at the moment an opposition party.

1 What are by your opinion the most important political goals in this city?
(Please rank the following items)

- To improve public care for the elderly 3 (already good)
- To improve public child care 1 (should be improved)
- To improve housing for the homeless 2
- To reduce pollution problems 3
- To reduce traffic problems 2
- To reduce alcohol problems 1
- To reduce drug problems 1
- To improve treatment of psychiatric disorders 2
- To improve the education system 1

Youth care and education are very important, you want to hold people responsible for their behaviour, health, drug use and traffic you need to educate them, otherwise you are combating symptoms. With XTC we were to late, only after it went wrong, a few people got unwell during a party, we started to improve the education and started to create conditions to prevent accidents. I think at the primary school before children start experimenting with alcohol and drugs you should inform them, and I think prevention is an important task for the government. Housing for homeless, this very important from our left wing perspective, it is a duty of the authorities to make sure that there are places where these people can stay, in Amsterdam we are striving for a situation that nobody has to sleep on the streets against his will.

Alcohol and drugs problems has also to do with youth care, you have to start early with education. Psychiatric diseases I think in the Netherlands and in Amsterdam in particular, the treatment is good, however, housing for homeless with a psychiatric disease needs some improvement.

What were the most important political goals in this city's policy in the drugs field ten years ago and what is your opinion about the goals in the near future*?*
Please rank the following items into three categories,(with no more than four items in each category): 1 High priority, 2. Medium priority, 3. Low priority.

	10 yrs ago	*Future*
• To strive after a drug-free society	1	3
• To reduce harm caused by drug use	2	1
• To reduce drug use related crime	1	1
• To reduce public nuisance associated with drug use	1	1
• To prevent drug use among youngsters	2	2
• To secure or improve the coverage of treatment for drug addicts	3	3
• To reduce drug dealing	2	1
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	1	2
• To prevent overdose deaths among drug users	3	3
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3	2

Ten years ago striving after a drug-free society was very strong. People closed their eyes for reality and focussed on prevention and not using drugs and acted like drugs were not there. Harm reduction wasn't the first priority that time, I think there was a high focus on reduction of nuisance and criminality. It may seem paradoxal but I think the priority for prevention wasn't that high. Improving the coverage was not that important, the prevention of the spread of viruses like HIV was important. Overdoses was not an issue. At the moment striving to a drug free society is not under discussion anymore. It became a fact. Harm reduction is much more important, reduction of nuisance and criminality is still important. Prevention of drug use. I don't know if that is enough, at least we don't encourage them to use drugs. Reduction in drug dealing is an important item at the moment at least if you see how serious they are combating it. Money laundering is quite important for the political agenda too. Prevention of OD deaths, I don't hear much about that.

		feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	1	x	
In police strategies less focus on users towards more focus on larger scale dealing	1	x	
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	3	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	2	x	
Housing for people with drug problems	2	x	
First aid education	3	x	
Sufficient capacity of methadone programs	1	x	
Low threshold methadone programs (allowing side use during treatment)	1	x	
Methadone programs in prisons	2	x	
Heroin prescription programs	1	x	
Interventions in order to change the main route of heroin administration from injecting to smoking	2	x	
Distribution of naloxone (narcanti) to drug users	3	x	

I think more people should benefit from users rooms. At the moment the capacity is still quite small, often it is hard to implement because of resistance of the neighbourhood. I think it is a very good facility.

I think at the moment the police is focussing too much on the small dealers and not on the guys with the big cars. I think methadone treatment is one of the reasons we have a low number of overdose deaths, together with methadone contact is important to give education. It's not very clever to expel drug users from a methadone programme if they use drugs. I don't know whether you can influence the route of administration.

Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think to reduce or forbid the distribution of these pharmaceuticals is one way?

I thought that a pharmaceutical as Rohypnol is not easy to get, I think we have made some strict agreements with physicians. Although, when I walk around, I get the impression other

benzodiazepines are still quite easy to get. I don't know whether there is an European agreement about these substances. Perhaps there should come something like that.

Do you think that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

In some countries where drug use exists underground and people hardly talked about the problem, the number of drug users rose spectacularly. I think it's good to have an open atmosphere but course you have to combat nuisance. I don't think the visibility of drug users will encourage drug use. I live in Amsterdam South East and there I regularly come in contact with the boys (some of the boys I know for more than twenty years) and what you see is nothing good, you will see a process of decay at the margins of society. If young people realise that this can be their future I think it will be a deterrent. Amsterdam is a European capital which attracts many foreign people to experiment with drugs who could have the impression that it's easy to obtain and use drugs and for whom the threshold to use is lower but I think the opposite effect is stronger.

Facilities with a low threshold, where people can drop in, relax and use their drugs with supervision.

Do you have any other suggestions about how to reduce the overdose deaths?

If I talk with drug users they know quite well about the dangers. I think the government could make some stronger effort to educate young people, who are experimenting with drugs, about the dangers of towards health. Not to make a taboo
of it, but to talk about it freely and at the right time; when children start experimenting.
Than the number might decrease even more.

When evaluating this city's drug policy in total:

a) In what aspects do you think the policy has successfully reached its goals, and why?

I think it's successful in creating an open atmosphere and all the possibilities there are to talk and discuss about it in a normal way. It's of great value that we as the local government sit around the table with pressure groups and drug aid services and come to agreements. Only if a government or society admits that the drug problem is a fact that can not be denied there are possibilities to find and organise ways to solve the problems (nuisance and problems of drug users themselves).

b) In what aspects do you think the policy has failed to reach its goals, and why?

At the same time, of course we wanted a drug free society at the start, and I still think it's a pity that we didn't reach that. Moreover we couldn't really re-socialise the drug users (with or without use) to get work and integrate them in society. Especially the older Surinam boys are still in the margins of society. If they leave prison for example there is no safety net that prevents their problems getting worse. In this respect I think that the drug aid services and the government failed.

8.3.3 Jesse van der Linden Liberal Democrats (right-wing party)

"If I look at my own youth experience I think only little has been done to prevent drug use among youngsters."

"Excuse me for your study but I don't think death due to overdose is a problem in Amsterdam. Please convince me if it is important."

".. the topic of stability, of course that is a major topic, the more stable you are the better it is."

"they told me 'look what I can get at the pharmacist'. Than I wonder who is crazy right here, why is a physician doing this?"

"Sweeping clean the red light district like what is happening now, I don’t know whether this is an option, it is difficult. I think you need alternatives in the sense of housing and normal day-activities (not these frøbel-clubs such as we have right now)."

"the users rooms are very successful, especially for the neighbourhood."

"It strikes me that everything is focussed on heroin addiction; we are 'unbelievable successful' in this. In the mean time in the South East of Amsterdam the users of base coke are forgotten because it is too difficult to do something about it."

"I'm not talking about those who use cocaine in a controlled way but about those who are developing an uncontrollable behaviour and who are a danger to themselves and society (and than I actually care more about the danger to society)."

1 What are by your opinion the most important political goals in this city? (Please rank the following items)

- To improve public care for the elderly 1
- To improve public child care 3
- To improve housing for the homeless 2
- To reduce pollution problems *(and safety)* 1
- To reduce traffic problems 3
- To reduce alcohol problems 3
- To reduce drug problems 2
- To improve treatment of psychiatric disorders 2
- To improve the education system 1

Please comment on your ranking on drug problems.

There are no unimportant items on your list and therefore it is a matter of priority. The absolute spearhead of the liberal democratic party is to improve education; the future of the city depends on this. Another important issue is improvement of housing for the homeless, recently we visited some of the homeless shelters and we decided that something had to be done, the way it is right now is unworthy of man. Care for the elderly is another spearhead of our party but the municipality doesn't carry out the health care for the elderly. We have nothing to say about that, what we do however, is visiting the elderly, showing them the way and tell them what they may claim. For us elderly are very important.
Then there are a few overlapping topics. I would tend to consider alcohol and drugs problem as one problem. Moreover, I am very much involved with the topic of involuntary admission of psychiatric patients.
Then we have discussed the most important problems, traffic problems are important and, pollution is important. For us pollution is very much connected with safety (but this is not on your list) in case you consider pollution and (the sense of) safety together, it is very important. Youth health care is going well, and therefore it is not a priority at a moment. Care for the homeless is not a general priority, but this item is a priority for me at this moment (so you may write a '2' for this) and I think alcohol has less priority than drugs so this could be a number three.

What were the most important political goals in this city's policy in the drugs field ten years ago and what is your opinion about the goals in the near future?

Please rank the following items into three categories, (with no more than four items in each category): 1 High priority, 2. Medium priority, 3. Low priority.

	10 yrs ago	*Future*
• To strive after a drug-free society	3	3
• To reduce harm caused by drug use	1	2
• To reduce drug use related crime	2	1
• To reduce public nuisance associated with drug use	2	1
• To prevent drug use among youngsters	3	1
• To secure or improve the coverage of treatment for drug addicts	1	2
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	1	2
• To prevent overdose deaths among drug users	3	3
• To reduce drug dealing and prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade ***(together)***	2	1

I will give the perspective of the liberal party. As far as I now, the VVD has never strived after a drug free society. Reduction of health damage has been very important. If I look at my own youth experience I think only little has been done to prevent drug use among youngsters. Efforts to reduce criminality and nuisance has been to little, should have been more and now it already has a very high priority.

In the past we focussed on health (exchanging syringes etc.) and how to reduce health damage. I assume that we will continue the way we are working right now, so the prevention of viruses will not have a high priority anymore.

When we talk about treatment of drug users and coverage of treatment do you include base-coke users as well? Talking about treatment is fine when we talk about heroin but there is no treatment for those who are addicted to base coke. That's one of my questions to the municipal health service; what are you doing or what are you planning to do with this group? I think the largest problems will develop in this group. I'm not talking about those who use cocaine in a controlled way but those who are developing an uncontrollable behaviour and who are a danger to themselves and society (and actually I care more about the danger to society). That should be a priority.

I would like to consider drug dealing and money laundry as one. I think criminality is getting more important after the story of 'van Traa' (report about police strategies in relation to organised crime MB).

Excuse me for your study but I don't think overdose deaths is a problem in Amsterdam, please convince me if it is important, because than we should do something about it. If you consider how much drugs people are using, I think the overdose problem is very modest, at least I never got any signals that it is a problem.

		feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	2	X	
In police strategies less focus on users towards more focus on larger scale dealing	3		x
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	3	X	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	1	X	
Housing for people with drug problems	2	X	
First aid education	3	X	
Sufficient capacity of methadone programs	2	X	
Low threshold methadone programs (allowing side use during treatment)	2	X	
Methadone programs in prisons	3	X	
Heroin prescription programs	1	X	
Interventions in order to change the main route of heroin administration from injecting to smoking	1	X	
Distribution of naloxone (narcanti) to drug users	1	X	

I haven't thought much about reduction of overdose deaths, if certain problems are increasing you start thinking about what to do about it but as I said I never got any signals that it is a problem.
But OK, users rooms. I think that it helps, may help. More focus on drug dealing, we believe in a market mechanism, so as long as there are drug users there will be demand and as soon as you catch one dealer the dope will be more expensive and there will be another one. You won't get less drug users. OD after imprisonment… I heard a story of a drug user who could save some money during imprisonment (social benefits), so after being released the first thing he always did was buying drugs. First Aid training isn't really necessary I think. I've got the feeling that methadone programmes are helping as well, and I'm also supporting the heroin project. If overdose deaths mainly occur among IV drug users interventions to change the route could be helpful. By the way, I'm just guessing I don't know much about it. And than, the topic of stability (work etc MB), of course that is a major topic, the more stable you are the better it is. Narcan may be helpful, and than drug users would need a first aid course for that.
Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think to reduce or forbid the distribution of these pharmaceuticals is one way?

I think physicians are very important in this respect. The junkies were I've been talking to all have a certain relation with their physician, I think that they get a stupidly large amount of pharmaceutics, some had a whole bunch of prescriptions, and they told me 'look what I can get at the pharmacist'. Than I ask myself 'who is crazy right here, why is a physician doing this?' Sometimes they get multiple prescriptions; some general practitioners and other care providers act like they are the only one who sees this patient. I hope that this 'support' project will lead to a better co-ordination of care, will eventually lead to a patient follow up system, that care providers know who is doing what and that this will decrease 'shopping'.

Do you think that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

Sweeping clean the red light district like what is happening now, I don't know whether this is an option, it is difficult. I think you need alternatives in the sense of housing and normal day-activities (not these frøbel-clubs such as we have right now). This is the same for homeless people many of these day activities don't make any sense, a homeless asked me 'would you feel like doing a bit of painting all days'. I wouldn't like that either, again the support project in which they try to tackle the different social problems at the same time may result in a disintegration of the drug scenes. However, actually, I don't know, I have great doubt about the successfulness because it is such a tight scene; everybody knows each other (and everybody knows the care providers). I visited the street prostitutes and somehow they all know where everybody is, they always know to find each other, I don't know exactly what you could do about this.

Do you have any other suggestions about how to reduce the overdose deaths?
No, ...I think people are allowed to do what they want to do.

When evaluating this city's drug policy in total:

c) In what aspects do you think the policy has successfully reached its goals, and why?

I think the Junky union is a good organisation, we made an exception for subsidising them. With other patient organisations the amount of money is related to related to the number of members that are supporting them but for a Junky union this is quite difficult.
Moreover It looks like the heroin prescription will be successful and of course the users rooms are very successful, especially for the neighbourhood. Moreover, we have to wait and see what the involuntary treatment for criminal drug users (instead of imprisonment) will bring us.

d) In what aspects do you think the policy has failed to reach its goals, and why?

It strikes me that everything is focussed on heroin addiction; we are 'unbelievable successful' in this, sometimes there are foreign delegations, to whom we are telling the successfulness of our policy and that it is absolutely fabulous. But in the mean time in the South East of Amsterdam the users of base coke are forgotten because it is too difficult to do something about it. That's what I think about the Amsterdam policy. Another problem might be the sexual exploitation of young addicted girls (I heard some rumours about this, I know the police has been looking for it but couldn't find anything). We went to Berlin and saw young girls prostituting themselves on the streets and I can't believe Amsterdam is really free of that, perhaps a similar thing is happening but than in a more hidden way. If it is really the case I think it will be far more important than these deaths due to overdose.

8.3.4 Giel van Brussel Head of the department of social and mental health of the municipal health service.

"The most important obstacle is the political perception of drugs as forbidden fruit."

"What really should have been done was an earlier warning against the dangers of AIDS and earlier start of needle-exchange"

"We live in a drugs infested society, this means we shouldn't emphasise the prevention of drug use but we should emphasise save drug use and avoid heroin."

"You have to make clear that when somebody calls for help it won't be a police affair."

"Overdose mortality is connected with chaos and that is exactly what an open drug scene generates."

"The solution to finish an open drug scene is to send the police to stop it. As simple as that. It is the first thing I advise, absolutely."

"Many people remain stuck in poverty, strange deviant patterns, nuisance and I don't know what. It is a downright sad affair."

Focus during the previous ten years:
Since 1991, it has been clear that drugs past their prime and a stabilisation of heroin use was going on. Furthermore, it has been clear that people suffering a heroin addiction, had a chronic addiction. The most important thing that had to be done was the prevention of AIDS, that really came to the front. We have succeeded in this (in the sense that it happened) accompanied by the change from injecting to smoking This decade people went ill and died. The idea of drugs as a health crisis consolidated.

Obstacles during the previous ten years:
The most important obstacle is the political perception of drugs as forbidden fruit. Because of this perception, there is a kind of holy duty, a holy war, directed to abstinence. It is clear this does not work, is not possible but this doesn't matter because it has to be done. We had to row up against the image of drugs as a disorder that should be forbidden and should be cured. In our professional view we consider heroin addiction as a chronic disorder for which a proper treatment (at least curative) is lacking. This is very much in contrast to the political drive and pressure towards prohibition. What strikes me is that that perception has been knocked over during the previous years. Things have been changed now and it is clear that for those addicted to heroin nowadays their addiction is a chronic disorder. Treatment (methadone maintenance treatment, MB) is judged by it's true merits; it is considered good if it gives people the opportunity to function on a reasonable level in society. If they do not cause to much nuisance and, preferably, survive. This perception has been there for a relatively short period, perhaps five years.

If you could do it again: what would you change?
The most important point that fails is the linkage of care within the judicial system and care outside the judicial system. That was bad ten years ago and it still bad right now. A good linkage is most important because so many of those people come in contact with the judicial system. The after-care of discharged prisoners should be integrated in the regular care and the goals of this after-care should be realistic.

But history goes much further back and what really should have been done was an earlier warning against the dangers of AIDS and earlier start of needle-exchange but then I'm talking about eighteen twenty years ago.

What were the most important political goals in this city's policy in the drugs
field ten years ago and what is your opinion about the goals in the near future? Please rank the following items into three categories, (with no more than four items in each category):

1. ***High priority, 2. Medium priority, 3. Low priority.***

	10 yrs ago	*Future*
• To strive for a drug-free society	2	3
• To reduce harm caused by drug use	1	1
• To reduce drug use related crime	1	1
• To reduce public nuisance associated with drug use	1	2
• To prevent drug use among youngsters	2	3
• To secure or improve the coverage of treatment for drug addicts	2	3
• To reduce drug dealing	3	3
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	1	1
• To prevent overdose deaths among drug users	3	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3	2

We live in a drugs society, this means we shouldn't emphasise the prevention of drug use but we should emphasise to use drugs safely and to avoid heroin. That is something that is missing in this table, but which is most important. By differentiating between risks people will start to be more conscious about their responsibility.

Health risks will remain important and will be associated with a large coverage of the drug treatment centres. Again, not considering all drug users but especially those with a heroin dependence. I don't need to see XTC or Cocaine users, I want to reach the heroin users. Furthermore, prevention of criminality and nuisance is important in order to have a liveable society.

Prevention of overdose deaths isn't of political importance now and that wasn't the case ten years ago. That time it already stabilised to a lower level. Personally I think it remains an important issue.

		feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	2	x	
In police strategies less focus on users towards more focus on larger scale dealing	2		X
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	3	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	1	x	
Housing for people with drug problems	3	x	
First aid education	1	x	
Sufficient capacity of methadone programs	1	x	
Low threshold methadone programs (allowing side use during treatment)	1	x	
Methadone programs in prisons	3	x	
Heroin prescription programs	3	x	
Interventions in order to change the main route of heroin administration from injecting to smoking	2		X
Distribution of naloxone (narcanti) to drug users	2	x	

I don't think that we are able to reduce the number of overdose deaths much because it is already very low right now. If you talk about other cities I think you are right if you say user rooms are important. It is important that the police focuses less on drug users. According to

me, sufficient capacity of methadone programmes and low threshold programmes is actually the same thing.
Police actions concerns a policy that is much broader than the municipal policy and I don't think that you can influence the mode of administration. It just happens or not.
Narcan may be a good idea, an article about the use of it has been published recently (BMJ).

Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think to reduce or forbid the distribution of these pharmaceuticals is one way?

It's about information to the drug users and to the general practitioners. That way we managed to put barbiturates and rohypnol off the market. We succeeded because the GPs listened, that really depends on the message and the status of the people who give the message. In Amsterdam the municipal health service did it.

Do you think that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

I think there is an association between the open drug scene and overdose mortality. Overdose mortality is connected with chaos and that is exactly what an open drug scene generates. An open drug scene attracts all kind of vulnerable people to a place with lots of dope and a high level of anti-social situations. An open drug scene attracts people with deviant behaviour and excessive drug use. It stimulates the use of drugs and not only because it is more or less tolerated. Cities with open drug scenes generally have large numbers of overdose deaths (Zürich or Frankfurt in the past). A solution to finish an open drug scene is to send the police to stop it. That is the first thing I advise, absolutely. Even if the drug users are just spread out over town it's a progression.

Do you have any other suggestions about how to reduce the overdose deaths?

In Amsterdam we noticed that ODs mostly occurred in the vicinity of someone else and that mostly there is sufficient time between taking drugs and dying. It is very important that drug users recognise if somebody else suffers an overdose. The one who suffers the OD is not aware of that; he is almost death. If somebody sits in the same position for a long time and breaths strangely, a low frequency and snoring sound, it should be recognised. People should call for an ambulance and don't leave the person alone. You have to make clear that when somebody calls for help it won't be a police affair. Nor for the one suffering an OD, nor for the one that accompanied the person, even if he gave or sold the drugs to the victim. That is what I mean with first aid courses among drug users. It was the content of the campaign we had in the eighties when many German heroin users died.

When evaluating this city's drug policy in total:
In what aspects do you think the policy has successfully reached its goals, and why?
In what aspects do you think the policy has failed to reach its goals, and why?

It was successful in creating the image of a heroin user as a chronic patient, a looser of society. It has been successful in the sense that there is a strong taboo on the use of heroin, not only among people who use heroin but also among non users even if they are anti-social and

at risk for addiction. Successful is that drug users survive a long period of addiction. They take the role of patients and let us take care of them. Not everybody but the majority, and the coverage of the treatment facilities is high.

The backside of this success is the chronic situation, if people cure it is because of the natural recovery and not because of treatment. Moreover, only a marginal improvement of functioning in society is possible. Many people remain stuck in poverty, strange deviant patterns, nuisance and I don't know what. It is a downright sad affair.

8.3.5 Jules Somers, Police: Regional officer excessive nuisance,

Focus during the previous ten years

The police doesn't chase after the users themselves as long as they are not involved in any criminal act. I'm convinced that chasing after drug users won't stop their drug use, they will get their drugs one way or the other.
We are combating drug trade and nuisance caused by drug users. If users cause nuisance they are not allowed to enter the red light district for a certain period, this way we spread the drug users. Although I doubt whether this solves anything.

What are the major obstacles.
We would like to have a continuous action; to be everywhere all the time. This, however, is not possible, we don't have enough manpower for that. Therefore we have to prioritise.

If you could have: what would you change?
I don't really know if any other strategy of the police could have given better results.
The whole policy has been developed in many years. Perhaps we should have started the implementation of the user rooms a few years earlier. The heroin project should have started a few years earlier as well.

What were the most important political goals in this city's policy in the drugs?
please rank the following items into three categories
(with no more than four items in each category)

1. High priority, 2. Medium priority, 3. Low priority.

	10 yrs ago
• To strive for a drug-free society	3
• To reduce health damage caused by drug use	1
• To reduce drug use related crime	1
• To reduce public nuisance associated with drug use	1
• To prevent drug use among youngsters	2
• To secure or improve the coverage of treatment for drug addicts	2
• To reduce drug dealing	2
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	3
• To prevent overdose deaths among drug users	3
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	2

I don't know much about the political situation 10 years ago, so I don't think I can fill out both forms. Striving for a drug free society is not an option, it can not be a serious goal because it's a Utopia. It is just as impossible as striving for a totally alcohol free society.

I think the reduction of health damage among drug users has had the highest priority. And the two topics on your list, the prevention of the spread of HIV and HepC and the prevention of overdose deaths, are important parts of this broader policy, and so I don't have to mention them again as an important objective.

To reduce nuisance and drug related criminality is also very important. There are different kinds of nuisance, people bother about shouting or fights on the street but also about people who are using drugs in public. Although it is not a real threat it may give people an awkward and unsafe feeling.

Reducing drug dealing; there are a few ongoing networks were quite some people work on for a long time, but the big guys are hard to get, they don't touch any drugs they are sitting in their chair earning money. If we catch them we try to get all the money and possessions owned with drug trade as well.

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	1	x	
In police strategies less focus on users towards more focus on larger scale dealing	3	x	
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	1	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	1	x	
Housing for people with drug problems	1	x	
First aid education	2	x	
Sufficient capacity of methadone programs	2	x	
Low threshold methadone programs (allowing side use during treatment)	2	x	
Methadone programs in prisons	2	x	
Heroin prescription programs	3	x	
Interventions in order to change the main route of heroin administration from injecting to smoking	3	x	
Distribution of naloxone (narcanti) to drug users	3	x	

When I worked on the street as a police officer I have encountered overdose fatalities, but lately I don't hear about overdose deaths anymore.

Looking at your list there are a few other thinks I would like to add, this is a possibility to test the quality of the drugs (what is already possible with XTC) and the distribution of clean needles. This saves lives as well.

I think user rooms are important but not exactly to reduce overdose deaths, although if they can use their drugs quietly under supervision it is better than when they are using on the street quickly and dark. I think there are nine of these in Amsterdam right now and we are planning to implement fifteen of them. People usually support the users room as long as it is not in their neighborhood, therefore it's difficult to find places where you can start these facilities. When these facilities are there people find out that the drug users don't cause any nuisance for the neighborhood; there is no benefit for a drug user in causing nuisance in front of a users room which may result in closing the facility.

I think housing is important but a house alone is not enough. You should make sure they have a regular income, and for some people, this money should not be given once a month, cause otherwise it is finished at once. Moreover, you need day activities.

The heroin prescription program is not very useful to prevent overdose deaths, it is on a low scale and it is meant for chronic drug users they have been using drugs for years and years and didn't die all these years. I think it's unlikely overdoses are prevented in this group. This doesn't mean that I don't think that it is not a good idea to give these people their heroin, that they don't need to go on running after drugs and stealing etc.

To change the route from injecting to smoking, it's better to smoke you'll get less infections infection and spread of viruses, but I don't know whether it's possible to change this behavior. If distribution of naloxone would be a necessary and useful intervention we would already have implemented this.

I think its important to educate the drug users about the dangers such as the danger of an overdose after a period of abstinence. A first aid course could also be a part of a form health promotion. We do have methadone programs in prison but I don't think it is very important to prevent the number of overdose cases.

Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think to reduce or forbid the distribution of these pharmaceuticals is one way?

It depends whether there is a illicit trade of pharmaceuticals it is very difficult to do something about it. As long as there is trade somebody will supply the drugs. If the problem is mainly caused by prescribed pharmaceutics than you have to control the prescription of these drugs. You have to prevent that people are collecting these pharmaceutics and sell them.

Do you think that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

I doubt whether people are at higher risk in an open drug scene opposed to a situation when drug users are not visible. I think that a comprehensive set of measures that we implement together makes the difference. In my opinion, needle exchange, drug aid services lead to a lower number of deaths. To reduce the open drug scene you have to make sure people have a place to go to such as the users rooms.

When evaluating this city's drug policy in total:

In what aspects do you think the policy has successfully reached its goals, and why?

I think our policy is quite successful. You see that slowly more and more other European countries (such as Switzerland, Germany and France) are adopting this kind of policy.
It is successful in the sense that the health of the users is relatively good, they are growing older and there is only low number of new drug users.

In what aspects do you think the policy has failed to reach its goals, and why?

I think we have been less successful in combating nuisance and drug related criminality. We developed two methods to reduce this. On the one hand there is the support project where

police and drug aid services co-operate in trying to improve the situation of these people on five different aspects (income, housing, work, health & criminality). This is a voluntarily way to reduce nuisance.

Next, there is an involuntarily experimental form of treatment which is meant for about 75 drug users who belong to the top regarding causing drug related (minor) criminality. Since April drug users are selected for this and tomorrow the official opening will take place. Some of them asked for this compulsory treatment, they are using drugs and committing crimes for many years, they are too old to commit crimes but still they don't stop.
Many people are sceptical about the results of it and I don't dare to give a prediction of the outcome but… if you don't try you won't win and only after 6 years we will know whether these people turned into decent citizens or not. At least they are outside society for ¾ year and the will keep themselves quit for another year (because otherwise will go to prison). Another experiment among drug addicted women who were given the choice; abstinence oriented treatment or prison, did not work. It was voluntary and none of the women finished the whole treatment; obviously more means of coercion are needed.

9 Interviews from Frankfurt

9.1 Drug users in Frankfurt

The questions:

The interviews with the drug users focused on the question: what are the reasons for an overdose in connection with the consumption of illegal drugs and what the possibilities are to prevent or reduce overdose deaths.

The questionnaire:

We used a questionnaire that comprised a broad set of questions (standardised, partly standardised, and open questions). It was divided into four sections: The first section asked for „social standard - questions“ (social, regional background, education etc.). In the following sections questions concerning the development of drug use (sequence of consumption, intensity of use etc.). The final part focused upon open questions concerning the problems of overdose experience. The interview partners were asked to speak about both their own overdose experiences and those of others they had observed. In addition, they were invited to express their opinion on the issue of overdose. It was therefore considered necessary to keep this section as an open questions section to ensure a focusing on the core issue of the over-all study and to leave ample space for the subjective/personal experience and descriptions which also underlines the expert-position of the interview partners.

The interview-situation:

Four of the five interviews with drug users were conducted in service facilities that offer sleeping facilities, working possibilities, a safe-injection room, and methadone administration in the vicinity. The interview partners in this service were all mainly relaxed and calm, which might also be due to the fact that the were not exposed to the „stress“ of the street-level drug scene.
The fifth interview was also conducted in a drug helping service facility - a safe-injection room without any further offers in the premises that is located in the „drug scene“. The interview partner was approached close to this facility. The atmosphere of the interview was therefore also less relaxed than the others.
All interviews were conducted in a separate room and a calm atmosphere. No other people were present during the interviews and thus the interviews were not influenced by other people.
All interview partners gave the impression of being basically calm and concentrated. The first four seeming to be only mildly under the influence of drugs while the fifth interview partner seemed to be considerably more under the influence of drugs.
Two women and three men were interviewed. The oldest was 34 years old, the youngest 24. All interview partners were not married and of German nationality. Of the five interview partners three were currently living in sleeping facilities, two lived in apartments together with other drug users.

Two of the interview partners had finished extended elementary school (Hauptschule), one finished secondary school and two had not finished their school education at all.
Two of the interview partners had finished their professional training or apprenticeship, three did not.
All interview partners expressed that they were not involved in a continuous job.
All interview partners were asked to give themselves a code-name if they wanted - which is also the name they will be given in the transcripts.

9.1.1 Thomas, 29 years old, German

Thomas lives in an apartment together with other drug users in Frankfurt. He finished extended elementary school (Hauptschule), but not his professional training and is currently unemployed.
Thomas started smoking cigarettes when he was 9 years old and currently smokes about 15 cigarettes per day. With 12 he drank alcohol for the first time and currently consumes some alcohol a couple of times a week.
When he was 23, Thomas tried heroin for the first time. At the moment he uses heroin less than once a month. He uses it i.v. and preferably as a „cocktail“ together with cocaine. He pays about 90 DM (46 €) per gram and estimates that the purity is about 12%. He thinks the quality is „good“ and according to his experience and estimations neither the price nor the purity of the heroin have changed over the past year.
Thomas consumed cocaine for the first time when he was 18 and currently uses cocaine less than once a month. The quality is stable and he pays about 90 DM (46 €) for a gram. To ensure he uses cocaine of continuous quality, Thomas only buys at his long-term dealer.
Occasionally, he also consumes crack and cannabis, but less than every three months.
He finances his living mostly through the social welfare money and from money his girl-friend gives him.
Thomas is on methadone since four months. The main reason for joining the programme was that he wanted to escape illegality. He thinks the possibilities to join the methadone programme in Frankfurt are sufficient, but he would personally prefer a methadone bus, like in the Netherlands, because he feels it would enhance the possibilities to access the methadone programme for him and others. He does not want to enter therapy at the moment, because he does not feel this is necessary at the moment. However, he feels that the possibilities to enter therapy in Frankfurt are sufficient.
Thomas feels his health status is good and he has neither attracted HepC nor HIV.

Thomas' OD experiences:

I (Interviewer): Have you ever encountered a critical or life-threatening situation in connection with your drug use?
P (interview partner): Yes, 5 times.
I: How did this happen?
P: That was more like panic attacks, so it was more a subjective feeling when I had the feeling that I had taken too much cocaine, but I don't know whether I really had taken too much.
I: What drugs did you consume in the situations?
P: Speed and cocaine
I: Were there also other people present during these situations?
P: Yes, staff of the safe injection room. But help was not really required.
I: What do you think were the reasons for these incidents in these situations?

P: I think there are different physical conditions and sometimes you are not in the condition to cope with the substances. But it might also have been that there was speed in the drug or the purity was higher than usual.
I: Have these life-threatening situations also occurred because you wanted to commit suicide?
P: No, that was not the reason. It was more by accident.
I: How did you react in such situations?
P: I put water in my face and try to move around to keep my blood circulation going.
I: Have you been in treatment when any of these incidents occurred?
P: No.
I: Have you ever witnessed a life-threatening situation of others in connection with an overdose?
P: Yes, once in front of the safe injection room; once at a friend's place and once in a toilet at the main station.
I: What drugs have been consumed there?
P: Heroin in all cases
I: And who was it that you were with at the time they had the OD?
P: The person in front of the safe injection room I did not know, but the others have been friends of mine
I: What do you think were the reasons for the incidences?
P: The one in front of the safe injection room had taken pills and heroin together. The friend who had an OD in his own place had to vomit, because the drugs were too pure and his body rejected them. And the guy at the toilet in the main station had an OD because it was the first time he took heroin after detox.
I: Did they try to commit suicide?
P: No, I think it all happened by accident
I: What did you do in these situations (when you witnessed an OD)
P: The one in front of the safe injection room I just observed. At my friend's place, I called help and did some First Aid measures - and the at the main station toilet I also called help.
I: Did these people survive?
P: Not the guy in front of the safe injection room - it was too late for help, but the others have survived.
I: If you think about the problems of overdose and life-threatening situations in connection with drug use: what do you think are the main reasons why these incidents may become fatal?
P: I think it has mainly to do with a misconception of the purity of the drugs, or a misconception of your own physical conditions.
I: What can you do in such a situation?
P: Basically just give some First Aid.
I: In some cities the number of fatal ODs is rising (Copenhagen, Oslo) while it declines in others (Frankfurt and Amsterdam). What do you think could be the reasons for this?
P: I think the drug policy in these cities is different. In Frankfurt for instance you have the safe injection rooms, which ensure better hygienic conditions and help on the spot. Frankfurt also has a large methadone programme, but it would still be better to have Polamidon because it satisfies your greed. The methadone programme helps, because you have to take the drug under medical observation and because the substance is of a continuously good quality.
I: Could you mention some facilities or measures in your city that may have

helped to reduce the risk of fatal ODs?

P: Yes, methadone programmes and safe injection rooms

I: Could you mention some facilities or measures in your city that may possibly increase the risk of fatal ODs?

P: No.

I: Looking back on your drug using career, what - in you opinion - has happened that helped reduce the risk of fatal ODs?

P: The safe injection rooms

I: And what have been negative factors?

P: I can't think of anything at the moment.

I: If the policy makers would ask you to give them some advice on this issue - what would that be?

P: Well, first of all an unbiased information about drugs, then also an enhancement of the safe injection rooms offers and the methadone programme. A quality control of drugs would also not be bad. Perhaps also the prescription of heroin to addicts.

9.1.2 Friedrich, 34 years old, German

Friedrich currently lives in one of the sleeping facilities in the city of Frankfurt. He has not finished school, but his apprenticeship and is currently unemployed.
Friedrich started smoking cigarettes when he was 11 and currently smokes about 35 cigarettes per day. At 11 he also drank alcohol for the first time and currently consumes alcohol daily. When he was 14, Friedrich tried heroin for the first time. At the moment he uses heroin about once a week. He uses about 1 gram i.v. a week and preferably as a „cocktail" together with cocaine. He pays about 80 DM (41 €) per gram and estimates that the purity is about 9%. He thinks the quality is „less good" and according to his experience and estimations neither the price nor the purity of the heroin have changed over the past year.
Friedrich consumed cocaine for the first time when he was 16 and currently uses cocaine about twice a day. He thinks the price has risen during the past year and he now pays 130 DM (66€) per gram. Friedrich buys from various dealers.
In addition, he also consumes crack and cannabis about once a week.
He finances his living mostly through the social welfare money and from occasional jobs. As an additional source of financing he mentions drug dealing and other illegal activities, such as stealing.
Friedrich is on methadone since one year. The main reason for joining the programme was that he wanted to escape a life in illegality and be relieved from the pressure of having to steal and conduct other illegal activities for purchasing drugs. He thinks the possibilities to join the methadone programme in Frankfurt are sufficient, but he would personally prefer to have more tolerance towards side consumption. He thinks this would help to develop a more individual strategy to overcome addiction - perhaps also in a combination of methadone and other substances He is not interested in entering therapy at the moment, because he feels it would not help him - however, he feels that the possibilities to enter therapy in Frankfurt are sufficient.
Friedrich states that his health status is not so good at the moment - he had a prolapsed disc, suffers from HepC and has problems with his stomach and bowels. But he is HIV negative.

Friedrich's OD experiences:

I (Interviewer): Have you ever encountered a critical or life-threatening situation in connection with your drug use?
P (interview partner): Yes, 5 times.
I: How did this happen?
P: The first time I took too much cocaine, the second time too many tablets and alcohol; the last three times it was too much heroin
I: What drugs did you consume in the situations?
P: cocaine, tablets and alcohol, but mostly heroin.
I: Were there also other people present during these situations?
P: Not the first time, but in the other situations yes.
I: What do you think were the reasons for these incidents in these situations?
P: I wanted to commit suicide
I: How did you react in such situations?
P: I tried to keep my blood circulation going.
I: Have you been in treatment when any of these incidents occurred?

P: No.
I: Have you ever witnessed a life-threatening situation of others in connection with an overdose?
P: Yes, three times.
I: What drugs have been consumed there?
P: Heroin in two cases, cocaine in one.
I: And who was it that you were with at the time they had the OD?
P: The persons have all been friends of mine
I: What do you think were the reasons for the incidences?
P: In one case, my friend wanted more heroin - he was just greedy. The second had taken too much cocaine - also a case of having been too greedy. And the third time the heroin was simply too strong.
I: Did they try to commit suicide?
P: No, it all happened by accident
I: What did you do in these situations (when you witnessed an OD)
P: With the first one, I did some first Aid measures - and we gave him a salt injection. In the second case I also did some First Aid measures and we pulled a plastic bag over his head because of the hyperventilation. The third case was more complicated and we had to try all kinds of things - heart massage, putting him under the shower and mouth to mouth respiration.
I: Did these people survive?
P: Yes, they have all survived.
I: If you think about the problems of overdose and life-threatening situations in connection with drug use: what do you think are the main reasons why these incidents may become fatal?
P: Well, it is mostly the bad purity of the heroin. You don't have any control over the quality of the drugs from the streets.
I: What can you do in such a situation?
P: Mouth to mouth respiration, inject salt and try to get the blood circulation going again.
I: In some cities the number of fatal ODs is rising (Copenhagen, Oslo) while it declines in others (Frankfurt and Amsterdam). What do you think could be the reasons for this?
P: In Frankfurt and Amsterdam you have the safe injection rooms and methadone programmes - in other cities you probably don't
I: Could you mention some facilities or measures in your city that have may have helped to reduce the risk of fatal ODs?
P: Yes, safe injection rooms and methadone programmes. The safe injection rooms are clean and you have some control and thus also some help, if you need it. Methadone also helps, because the quality is stable. But the helping services also take better care of you nowadays. With sleeping facilities, for instance, this also helps.
I: Could you mention some facilities or measures in your city that may possibly increase the risk of fatal ODs?
P: No.
I: Looking back on your drug using career, what - in you opinion - has happened that helped reduce the risk of fatal ODs?
P: The safe injection rooms, the methadone programme and the work-training possibilities for people on methadone.
I: And what have been negative factors?

P: I don’t know of anything.
I: If the policy makers would ask you to give them some advice on this issue - what would that be?
P: They should install safe injection rooms and possibilities for the prescription of heroin to long-term users.

9.1.3 Simone, 24 years old, German

Simone currently lives in one of the sleeping facilities in the city of Frankfurt. She has finished secondary school, but not her apprenticeship and is currently unemployed.
Simone started smoking cigarettes when she was 24 and currently smokes about 50 cigarettes per day. At 14 she drank alcohol for the first time and currently consumes some alcohol once a week.
When she was 15, Simone tried heroin for the first time. At the moment she uses heroin less than once a week. She uses i.v. and preferably as a „cocktail“ together with cocaine. She pays about 80 DM (41 €) per gram and estimates that the purity is about 15%. Simone thinks the quality of the heroin is „good“ and according to her the price and purity of the heroin have decreased over the past year.
Simone consumed cocaine for the first time when she was 16 and currently uses cocaine about twice a day. She thinks the price has risen during the past year and currently pays 150 DM (77€) per gram. Simone buys from one dealer only to make sure she receives stable quality. In addition, she also consumes crack once a week.
Simone finances her living mostly through prostitution and social welfare money.
Simone is on methadone since 4 months. It is important for her that drugs don't determine her life any more and that she can decide for herself how to handle the drug now. Also, she does not want to prostitute herself any more. Simone thinks the possibilities to join the methadone programme in Frankfurt are not good enough, because care and accompanying measures are lacking. She does not want to enter therapy at the moment, because she is afraid of failing.
Simone says her health status is bad at the moment - she suffers from HepC and depressions. But she is HIV negative.

Simone's OD experiences:

I (Interviewer): Have you ever encountered a critical or life-threatening situation in connection with your drug use?
P (interview partner): Yes, 8 times.
I: How did this happen?
P: The first 5 times it was due to the too good or too bad quality of the drugs. I had purchased the drug on the street and it was simply of unknown quality. The last three times I tried to commit suicide.
I: What drugs did you consume in the situations?
P: The first 5 times it was a mixture of cocaine and heroin. The suicide attempts were only with heroin.
I: Were there also other people present during these situations?
P: The first 5 times it was either in or in front of a safe injection room and the staff of the facility were there to help. The last three times no one was there with me.
I: What do you think were the reasons for these incidents in these situations?
P: The first 5 times it was due to the too good or too bad quality of the drugs. When I wanted to commit suicide, it was because I had lost all lust for life and had a quarrel with my boy friend or my parents.
I: How did you react in such situations?
P: The first 5 times I was incapable of doing anything. The last three time I received help from passers-by or from the police and they gave me Narcanti.
I: Have you been in treatment when any of these incidents occurred?
P: No.

I: Have you ever witnessed a life-threatening situation of others in connection with an overdose?
P: Yes, 9 times. The first time, my boy-friend just collapsed in the street after an injection. The other times it happened in or in front of a safe injection room.
I: What drugs have been consumed there?
P: My boy-friend had taken heroin, the others heroin and cocaine, I think.
I: And who was it that you were with at the time they had the OD?
P: As I said: the first time it was my boy-friend and the others I did not know.
I: What do you think were the reasons for the incidences?
P: My boy-friend had taken too pure heroin. The others had either estimated the quality wrongly or had consumed too much after detox.
I: Did they try to commit suicide?
P: No, I think it all happened by accident
I: What did you do in these situations (when you witnessed an OD)
P: With the first one, when my boy-friend collapsed, I called an ambulance and called for help. In the other cases I also called for help in the safe injection room.
I: Did these people survive?
P: Yes, I think they all survived.
I: If you think about the problems of overdose and life-threatening situations in connection with drug use: what do you think are the main reasons why these incidents may become fatal?
P: It is either bad drugs or you try to commit suicide or you over-estimate yourself after a detox.
I: What can you do in such a situation?
P: Heart massage, call for help; mouth to mouth respiration, or trying to talk to people who had an OD - take care of them basically.
I: In some cities the number of fatal ODs is rising (Copenhagen, Oslo) while it declines in others (Frankfurt and Amsterdam). What do you think could be the reasons for this?
P: Frankfurt has the safe injection rooms and more social workers who can also offer you a perspective - for instance through work-training programmes, sleeping facilities, crisis centres etc.
I: Could you mention some facilities or measures in your city that may have helped to reduce the risk of fatal ODs?
P: Safe injection rooms in general and the helping facilities and sleeping shelters. They offer some perspective and space for alternative action which make an integration possible again. You are simply taken seriously as a human being and then you don't have to attempt suicide any more.
I: Could you mention some facilities or measures in your city that may possibly increase the risk of fatal ODs?
P: No.
I: Looking back on your drug using career, what - in you opinion - has happened that helped reduce the risk of fatal ODs?
P: My family accepted that drugs are being taken and that I take drugs, which reduces the risk of suicide. Also the implementation of safe injection rooms.
I: And what have been negative factors?
P: I don't know.
I: If the policy makers would ask you to give them some advice on this issue - what would that be?
P: There should be a better acceptance of drug addicts in our society, to enable

integration and reintegration. Also safe injection rooms and crisis centres or drop in centres should be installed. And there should be more tolerance towards drug users among the police.

9.1.4 Micha, 32 years old, German

Micha currently lives in one of the sleeping facilities in the city of Frankfurt. He has finished extended elementary school (Hauptschule), but not his apprenticeship and is currently unemployed.
Micha started smoking cigarettes when he was 10 and currently smokes about 30 cigarettes per day. At 10 he drank alcohol for the first time and currently consumes some alcohol once a week.
When he was 20, Micha tried heroin for the first time. At the moment he uses heroin a couple of times a week. He uses about 2 grams i.v. a week and preferably as a „cocktail" together with cocaine. He pays about 120 DM (61 €) per gram and estimates that the purity is about 10%. He thinks the quality had improved over the past year, but also the price has risen.
Micha consumed cocaine for the first time when he was 22 and currently uses cocaine daily. He currently pays 160 DM (82 €) per gram and thinks the price has risen during the past year. Micha buys from the same dealer every time.
In addition, he also consumes crack about once a week.
He finances his living mostly through the social welfare money and from occasional jobs. As an additional source of financing he mentions drug dealing.
Micha is on methadone since 6 years. The main reason for joining the programme was that he wanted to escape the pressure of having to commit acquisitive crimes. He thinks the possibilities to join the methadone programme in Frankfurt are sufficient, but he is principally not interested in entering therapy, because he sees no perspective in a drug-free life. Micha thinks that the possibilities to enter therapy in Frankfurt are sufficient.
Micha states his health status is not so good at the moment - during the last three months he suffered from HepC, problems with his stomach and bowels, his lungs and problems with colds and flu, tooth aches and depressions. But he is HIV negative.

Micha's OD experiences:

I (Interviewer): Have you ever encountered a critical or life-threatening situation in connection with your drug use?
P (interview partner): Yes, 4 times.
I: How did this happen?
P: The first two times I had an OD because I had had cravings for quite some time before taking the drug. I guess the quality of the stuff was just too good for me then. The third time I received the drugs as a gift and they had obviously been mixed with strychnine. The last time it was a mixture of heroin and tablets.
I: What drugs did you consume in the situations?
P: The first two times heroin, then - as I said - heroin and strychnine and the last time heroin and tablets.
I: Were there also other people present during these situations?
P: Yes, every time - the last one happened in a safe injection room.
I: What do you think were the reasons for these incidents in these situations?
P: As I said: the first time the quality was too good and I was brought back with electro-shocks. Then there was the strychnine thing and the last time it was just the greed for more, so that I took also tablets along with the heroin.
I: Have these life-threatening situations also occurred because you wanted to commit suicide?

P: No, never
I: How did you react in such situations?
P: The first three times I tried to keep moving and to keep my blood circulation going. The last time I received help at the safe injection room.
I: Have you been in treatment when any of these incidents occurred?
P: No.
I: Have you ever witnessed a life-threatening situation of others in connection with an overdose?
P: Yes.
I: What drugs have been consumed there?
P: Heroin.
I: And who was it that you were with at the time they had the OD?
P: Other users I did not know
I: What do you think were the reasons for the incidences?
P: It was simply too much heroin - a case of having been too greedy for the kick and then maybe even after detox, that is simply too much then.
I: Did they try to commit suicide?
P: No, I don't think any one of them tried to commit suicide
I: What did you do in these situations (when you witnessed an OD)
P: I did some first Aid measures, mouth to mouth respiration and trying to keep the blood circulation going.
I: Did these people survive?
P: Yes.
I: If you think about the problems of overdose and life-threatening situations in connection with drug use: what do you think are the main reasons why these incidents may become fatal?
P: When you take too much drugs after a clean-phase or when you underestimate the quality of the drug. Or when the quality is just too bad.
I: What can you do in such a situation?
P: First Aid measures, shout at the person, move the person around, put water in the face, call help and mouth to mouth respiration.
I: In some cities the number of fatal ODs is rising (Copenhagen, Oslo) while it declines in others (Frankfurt and Amsterdam). What do you think could be the reasons for this?
P: Maybe they just have a different quality of drugs, or help comes too late, because you don't dare to call an ambulance - because of the marginalisation of drug users.
I: Could you mention some facilities or measures in your city that may have helped to reduce the risk of fatal ODs?
P: Yes, the safe injection rooms. There the works are clean and you have some surveillance and help.
I: Could you mention some facilities or measures in your city that may possibly increase the risk of fatal ODs?
P: No.
I: Looking back on your drug using career, what - in your opinion - has happened that helped reduce the risk of fatal ODs?
P: Mobile syringe exchange, sleeping facilities, the safe injection rooms - basically everything that enhances the situation for drug users.
I: And what have been negative factors?
P: Crack users are often marginalised, you are being forced to inject because of that.
I: If the policy makers would ask you to give them some advice on this issue - what

would that be?

P: They should install safe injection rooms and needle exchange because of the hygiene, offer more possibilities for substitution - generally more help and space for new activities and perspectives. You should also install more possibilities for housing. Generally you may say: less repression and more acceptance.

9.1.5 Sadie, 24 years old, German

Sadie currently lives in an apartment together with her boy-friend who is also a drug user. She did not finish school or her apprenticeship and is currently unemployed.
Sadie started smoking cigarettes when she was 12 and currently smokes about 15 cigarettes per day. At 12 she drank alcohol for the first time and currently consumes alcohol daily.
When she was 14, Sadie tried heroin for the first time. At the moment she uses half a gram of heroin daily. She uses it i.v. and seldom as a „cocktail" together with cocaine. She pays about 100 DM (51 €) per gram and estimates that the purity is about 15%. Sadie thinks the quality of the heroin is „good" and according to her the price has been stable, but the purity of the heroin decreased over the past year.
Sadie consumed cocaine for the first time when she was 14 and currently uses cocaine a couple of times a week. She states the price has not changed during the past year and currently pays 130 DM (66€) per gram. Sadie buys from one dealer only to make sure she receives stable quality.
In addition, she also consumes crack approximately once a day.
Sadie finances her living mostly through drug dealing and social welfare money. Her boy-friend also supports her financially.
Sadie is not in the methadone programme, because she is not interested at the moment. She says she is not well informed about the possibilities to join the methadone programme in Frankfurt. She recently interrupted therapy and does not see any possibility to stand through a therapy at the moment. However, she thinks, possibilities to enter therapy are sufficient.
Sadie says her health status is currently not so good - she suffers from heart and blood circulation problems, abscesses, epileptic fits and depression. But she is HIV negative.

Sadie's OD experiences:

I (Interviewer): Have you ever encountered a critical or life-threatening situation in connection with your drug use?
P (interview partner): Yes, 5 times.
I: How did this happen?
P: Once I tried to end my life, but the other times, I guess it happened because of my bad health condition. I think my liver does not work as good as it used to.
I: What drugs did you consume in the situations?
P: Heroin and tablets in combination.
I: Were there also other people present during these situations?
P: Yes, my boy-friend was with me.
I: What do you think were the reasons for these incidents in these situations?
P: As I said - one time it was a suicide attempt, the other time my body did not cope well with the heroin any more. I think I have problems with my liver.
I: How did you react in such situations?
P: I can't remember.
I: Have you been in treatment when any of these incidents occurred?
P: No.
I: Have you ever witnessed a life-threatening situation of others in connection with an overdose?
P: Yes, about 10 times.
I: What drugs have been consumed there?

P: Heroin, I think.
I: And who was it that you were with at the time they had the OD?
P: Other users whom I don't know.
I: What do you think were the reasons for the incidences?
P: Either because the body does not function right any more, the liver, or because the heroin was too good or too bad.
I: Did they try to commit suicide?
P: I don't know.
I: What did you do in these situations (when you witnessed an OD)
P: I called for help when it was necessary.
I: Did these people survive?
P: Yes, I think they all survived. But I'm not sure.
I: If you think about the problems of overdose and life-threatening situations in connection with drug use: what do you think are the main reasons why these incidents may become fatal?
P: Because the body does not function well any more.
I: What can you do in such a situation?
P: First Aid and call for help.
I: In some cities the number of fatal ODs is rising (Copenhagen, Oslo) while it declines in others (Frankfurt and Amsterdam). What do you think could be the reasons for this?
P: Perhaps Frankfurt and Amsterdam are just more advanced in drug policy, for instance with the safe injection rooms.
I: Could you mention some facilities or measures in your city that may have helped to reduce the risk of fatal ODs?
P: Safe injection rooms and methadone programmes.
I: Could you mention some facilities or measures in your city that may possibly increase the risk of fatal ODs?
P: No.
I: Looking back on your drug using career, what - in you opinion - has happened that helped reduce the risk of fatal ODs?
P: The installation of safe injection rooms.
I: And what have been negative factors?
P: I can't think of anything.
I: If the policy makers would ask you to give them some advice on this issue - what would that be?
P: They should enhance methadone prescription and install safe injection rooms.

9.2 Street workers in Frankfurt

9.2.1 Social worker

The Interview-partner had been selected because of is expertise in the street level. He has a diploma in social pedagogics, is 34 years old and works as a social worker since ten years. Since 6 years he is working in a safe injection room in the main station area of Frankfurt. According to his estimates, he witnessed about 300 emergencies during that time. About 299 of these 300 people have survived these emergencies.

I (=interviewer)
P (= interview partner)

I: Could you please tell me a bit about your work and what you do?
P: We are a safe injection room, in the Niddastrasse, main station area. It is run by Integrative Drogenhilfe. We are open from Monday until Sunday between 9.00 in the morning and midnight. We offer clean consumption facilities and are also the largest needle exchange in Frankfurt. Our target group are the so-called heavily addicted drug users who would otherwise be forced to consume in the street.
I: Since when does the safe injection room exist?
P: The first one was opened in 1994 and after that three more were implemented. This facility exists since summer 1997 and it is the follow-up project of the safe injection room in Moselstrasse which had been opened there in May 1995.
I: Have you ever experienced overdose emergencies of drug users - and what were they like?
P: A classical emergency - or at least here in our facility about 90% of the emergencies - would be an overdose of opiates. These are simply people who lie on the floor and don't breathe anymore. People who have a severe breathing depression, but - in 99% of the cases - still a heartbeat. As we are always in the vicinity of these people, we don't need much time and find them while their heart is still beating, although they already have stopped breathing.
P: Are these emergencies sometimes also suicide attempts?
I: Certainly. But when you try to take your life in our facility you will be quickly disappointed, because you will be saved. The next time you try to commit suicide you would do it somewhere else. You can hardly say how many of the overdose deaths are suicides.
I: What kind of a consumption situation could you observe in these cases?
P: In principle there's everything. Those who have simply estimated falsely, but it is interesting how this is defined afterwards: some say „I have taken too much" and others say „the substance was simply too strong". Although, of course, this is the same one part of the people blame themselves and another part blames whoever. Then there are people who are simply not in an intellectual condition any more to clearly, cleanly and safely find the right dosage. Then there are also people who go to their limit on purpose every time, usually these are men, or it is people who have consumed a lot of alcohol and then continue consuming heroin virtually up to their limits. It is absolutely hard to generalise about this. There are no significant signs . which makes the issue so complicated. Everybody collapses - the well versed ones as well as the non versed ones, the healthy and the unhealthy, those who have had clean phases and those who are completely active. At any time, in any weather.

I: What do you think are the risk factors?

P: Changes in the quality of the material, changes in the physical condition. It is seldom that someone has an OD who did not consume anything the day before, so there is some cumulation of drugs.

I: Could you mention some facilities or measures in your city that may have helped to reduce the risk of ODs?

P: All safe injection rooms, because they can actively stop the results of an OD. In addition also facilities that are located c lose to the drug scene and can also provide First Aid on the street if necessary. In Frankfurt we have the advantage that the open drug scene is located in a very small area and there is no spreading of the scene throughout the city. So, every emergency case can be reached by foot in a couple of minutes and almost all the staff members of the drug helping agencies - not only in the safe injection rooms - are being trained in First Aid measures. That makes it easy.

I: Could you mention some facilities or measures in your city that may possibly increase the risk of ODs?

P: No.

I: Has the situation of the drug users with regard to ODs during the time of your work - and if so, what has changed?

P: During the last ten years almost everything has changed: the drugs have changed, the consumption, the helping measures. There is hardly anything still as it where at that time, apart from the fact that there is still a lot of intravenous consumption. Although people know more about drug consumption, although needle exchange, safer use etc. have been an increasing issue you have more - let me call them „Kamikaze - users". Above all we have a much faster scene nowadays because cocaine has been established massively, whereas it had been a rather slow scene earlier which had been characterised by opiates with all its consequences. The locations for consumptions have changed. While toilets and parks had been the main places for consumption, it is now the safe injection rooms and their immediate vicinity, the pavement in front of the safe injection rooms. There are surely just as many ODs as before, but less with a lethal result, because they occur closer to the system and can be reached earlier. We still have a number of severe ODs. So it is hard to say whether there has been a learning process as we had hoped for, or that people consume more clever because of the safe injection rooms. We are very close and see a lot of idiots who just cannot cope with their consumption. But I suppose you are hinting towards the decreasing numbers of ODs and there are several factors: as I said, we have an advantage of the location that makes it easier for us to react towards emergency cases. The other factor is that there are simply much less opiates You don't' die from cocaine that easily and if you do, it is different. Also, the quality of the heroin is so bad that it is not easy to die from it in Frankfurt. In the meantime we have also strongly enlarged the methadone project. That is a huge factor and people are more in contact through the methadone programme and are i.e. sent into hospital much earlier. This also leads to the fact that they do not run around in the streets in a physically weak condition- something that would endanger them even further. So, there are simply several factors that cumulate here.

I: And why don't you die so easily from cocaine - or differently?

P: Cocaine just damages the body differently. A drug death is usually simply a normal death of someone who dies of a breathing deficiency and this won't happen with

cocaine. A cocaine user would - if at all - die from heart failure or from resulting problems, like a general loss of physical force.

I: What do you usually do when an OD occurs?

P: Usually the most important thing is respiration. And then, of course, all life-saving measures, like checking the pulse, putting the person in a stable position etc. But in my facility, the most important thing is usually respiration.

I: What is usually recommended to be done in such situations in your job?

P: In a case of emergency, the most important thing for our staff workers is to ensure self protection. To see that no needle is still sticking in the person or lying around in its vicinity. And then you just have to conduct the standard procedure. We have determined very clearly, how many people have to help, what positions they have to take and that in such a case there is absolutely nothing else going on in the facility - so that is the scheme that has to be followed. But apart from that an emergency is a completely banal thing and it usually doe not take much at all to treat the classical emergency. It is no more than any First Aid help would do - social workers are not allowed to do more than checking the pulse, try to speak to the person and find out what he or she has taken, respiration either. You may technically improve this, for instance with oxygen, but the question is how far are you allowed to go.

I: When you think about the problem of overdose and life threatening situations in connection with drug use - what do you think are the main reasons why people die from an overdose?

P: Because they consume in places where there is no help. Either because the people they are using with don't call for help or cannot help themselves. They simply suffocate then. OK, there has also been experience that the calmer the setting is the less risk you have of an overdose. But I would be careful there. On the other hand there is the experience from the Frankfurt sleeping facilities where also a lot of consumption is going on and still they do have relatively few emergencies. So, apparently stress is not a small factor for the risk of estimating wrongly. But stress is always there when you are consuming in an illegal framework and are in danger of losing your expensive and hard earned drug again before you could put it into your vein and I think that is one of the major factors in the street. In apartments there are other factors, like the other substances people might have in their blood, whether they use alone or in a group, how the others behave, whether they believe in this myth of injecting salt instead of doing some respiratory measures first. This myth is still rather popular with our clients. It depends on how the drug policy is, whether you can even dare to call an ambulance, because you never know whether the y will be accompanied by the police, etc.

I: In some cities the number of fatal ODs is rising (Copenhagen, Oslo) while it declines in others (Frankfurt and Amsterdam). What do you think could be the reasons for this?

P: Well. You should be careful about this, In Frankfurt the numbers of drug deaths have decreased only until 1999. But there is a better over-all condition because of the methadone, the compact scene, the short ways to reach an emergency victim, good cooperation with the ambulance nurses. But in the end the short time you need to get to an emergency victim is most important and there we simply have an enormous advantage compared to other cities because our scene is not so wide-spread. But it is difficult. This is now the second in year in which the numbers of drug deaths are rising again and right now we have twice as many drug deaths as in the same period during last year and it is still unclear who these people are. The seem to be people from outside Frankfurt. But this is just being evaluated and therefore you have to be a

bit careful about how far you lean out of the window. In the end you die fast, if you only have a couple of dozens in a city and percentages are extremely variable. But still I believe that the bad general conditions we now get because of the massive cocaine use also contributes to this considerably. It is also possible that people just feel too safe and then use in a Kamikaze manner. There you have to scrutinise your own work critically, because the people who come to us have made the experience that no matter how much they consume they will always be saved. Of course, it is them tempting to use more and more, because you want to check out your limits. And if you take this attitude home, where the help is not available, you may easily end up in trouble.

I: What else could be done - in your opinion - to avoid ODs?

P: What is being done already. But there will always be people dying from an overdose, because the substance opiate is simply far to potent. Of course you may say you should go further towards sniffing or smoking of opiates because it simply reduces the danger of an OD. Then you should also think more about peer-group support and giving Narcanti and educate drug users more in First Aid measures. But this all sound more euphoric than it would be in practice. You simply have to put up with a certain number of drug deaths.

9.2.2 Police officer

The Interview-partner had been selected because of is expertise in the street level. He has finished the poly-technical University and has the two diplomas for being a policeman after his professional training at the police. He has also attended numerous workshops and educational trainings in drug related issues and also works as an educator in this field now. He is 37 years old and works as a police officer in the area of drug related crime in Frankfurt since 17 years. According to his estimates, he witnessed about 100 emergencies during that time. 95 of these 100 people have survived these emergencies.

I (=interviewer)
P (= interview partner)

I: Could you please tell me a bit about your work and what you do?
P: I work here at the direction of special services and I am head of the special branch 2 which comprises a lot of issues. It begins with the main task of coordinating the theft and narcotics issues, the division of tasks in the field of focus monitoring and the coordination of the various offices. It also includes the evaluation of arrests, seizures, criminal charges, etc. as well as the planning of action-days within the framework of focus monitoring or actions against certain groups of delinquents, the planning of operations when there is a demonstration, the coordination of object protection, the coordination of observations. My main task is to lead an operational unit, a special force, that conducts mostly plain clothes activities.
I: Have you ever experienced overdose emergencies of drug users - and what were they like?
P: Well, I have been working in the drug scene for 17 years now and worked on the street since April last. I have seen relatively much, especially as far as ODs or the use of bad drugs are concerned. Also that sometimes there is some aggression against me or my colleagues after the consumption of crack, but this is only seldom the case. There was one incident which I found really extreme when a female drug addict stood in front of the Café M (contact Café). She had probably used a lot of cocaine that day and tried to strangle herself - her face was already blue. I will not forget this in my whole life.
I: Can you say something about the drugs that were involved in these overdose incidents?
P: Let me put it this way: if an outfall symptom makes the person a bit slower, I would say there was heroin involved, but if they symptoms were more like being pushed, I would guess that was due to cocaine or crack.
I: What kind of a consumption situation could you observe in these cases?
P: Well, all I usually saw was the result, so I cannot really say anything about what drugs were involved or how they had been used.
I: What do you think are the risk factors?
P: I think, one of the factors is that the quality of the drugs changes. At times you have good drugs on the scene, most of the time you have bad drugs. And if there's sometimes a substance that has been packed very well - I mean there are less additives in it, people of course simply drop like flies, because they are not used to this. I remember a case in Bremen where they suddenly had drugs of 20% purity and people just dropped like flies. I think, something similar has also happened in Frankfurt once, but I think there it was more the fact that some crack was added.
I: Could you mention some facilities or measures in your city that may have

helped to reduce the risk of ODs?

P: I think, certainly the helping services, the safe injection room in Niddastrasse, the Café Elbestrasse, the Schielestrasse, La Strada - definitely.

I: And why?

P: Because they take care of the people relatively well, because they see relatively much of what is happening on the street level through their clients. And because they immediately can pass on information that they obtain. I think they also have the confidence.

I: Could you mention some facilities or measures in your city that may possibly increase the risk of ODs?

P: Not that I could think of anything at the moment.

I: Has the situation of the drug users with regard to ODs during the time of your work - and if so, what has changed?

P: Well, I have the impression that through the helping services and especially the safe injection rooms we see a lot less, that the ODs in the streets have decreased or that we had helpless people anywhere else, whether in the streets or at the main station or in any of the hotels. On the contrary: I do think that these facilities are being visited and used and that there is relatively much controlled injection and not too much. They watch that there and I do think this has helped.

I: What do you usually do when an OD occurs?

P: I do not dare to take any First Aid measures. Of course, I do try to perform the absolute basic measures of First Aid. Otherwise I would - depending on the location, try to call an ambulance for the person in need. When I am lucky and find someone in the vicinity of a drug helping facility, they do really have the competence and I have often observed that they were able to get someone back who had already been quite far, because they simply have the experience and medical know-how. Then I would call them for help.

I: What is usually recommended to be done in such situations in your job?

P: I think this is the best chance and that's also what we tell our new staff. And we have relatively many of them here in this house - we are also supported by the stand-by units and they are also being told that they should call an ambulance via the central coordination office of the police or to call an emergency doctor. They should try to help - put the person in a stable position, but it may also be an epileptic fit - you never know - and you have to decide out of the situation. The cooperation with the helping agencies is really good, it has grown over the years. But, I think, it also depends very much on the persons, both at the services and here at the police. We look for contacts and we have it. So, when we are out in the streets we always go there, we have also telephone contacts and that is the same from the other side. We are not opponents, on the contrary. We really work together with one common goal and drug addiction or drug related crime cannot be coped with by the police alone. On the contrary, the municipality has to do something, the justice system has to do something and that's how this grew.

I: When you think about the problem of overdose and life threatening situations in connection with drug use - what do you think are the main reasons why people die from an overdose?

P: Lack of knowledge and experience or temporary abstinence. We had that quite often that people who have just come out of jail have done themselves a large quantity and then could not cope with it - yes, I would say that is one of the main reasons.

I: In some cities the number of fatal ODs is rising (Copenhagen, Oslo) while it

declines in others (Frankfurt and Amsterdam). What do you think could be the reasons for this?

P: A decent drug policy - that really covers it all. It starts with a very liberal police work, very liberal work from the municipality, the health office, drug policy coordination office etc. But this does not mean we are not following criminal offences, on the contrary, when we recognise a criminal offence we prosecute it. What we do not do is, i.e. to chase junkies around town without any reason or something like that. So, it all makes sense. So, i.e. if there are people in front of a helping facility wanting to get in, we will not chase them away or control everyone who goes in, because it is pretty clear that everyone who wants to get in to inject will also have drugs on him.

I: What about small quantities - are they being taken away?

P: We take them away. We call this a simplified procedure and these cases are also brought to the prosecutors but according to our experience they will hardly put the case into court. That is because of the recommendations for enforcement on the narcotics laws that make it possible to drop cases when small quantities are involved and usually this is what is being done also. But when an offender has been caught several times and the court just waits for a case to get this person - i.e. because he is on a long probation or something, then that is going to be a big blast.

I: What else could be done - in your opinion - to avoid ODs?

P: Most of all decent information. What has become an issue recently is the prescription of heroin that might even come this year. We from the police see this a bit critically, I admit, but it may also be another step to minimise the problem a bit more.

I: Do you have any other remarks about ODs?

P: What else comes to my mind? I think, the police has not so much to do with this. We are more like a little piece in the over-all puzzle. I think that especially the police has sought for linking up with others in the past years - of course also here in the house. But also further to the top, with the chief constables for instance. Like through the Monday-Round. Then there are a lot of talks with the justice system and also a close cooperation. We are setting some signs, not against junkies, but against the dealers. If you think about how they are being prosecuted and charged in court - you don’t have that in other German cities. There you get - according to §35 of the narcotics laws - a punishment to work, but here in Frankfurt, after the second time, you will get one year in jail without probation.

9.2.3 Ambulance nurse

The Interview-partner had been selected because of is expertise in the street level. He has finished his training in a training-life saving assistant. He now works as an ambulance assistant and teacher in life-saving services. He is 33 years old and has been working in his job since 14 years. Since 7 years he has been working in his current area of work in Frankfurt am Main. He estimates that he has experience with about 3000 ODs. Of these 3000 people, about 2990 have survived the OD.

I (=interviewer)
P (= interview partner)

I: Could you please tell me a bit about your work and what you do?
P: After my formal qualification I became a teacher in the life-saving services, this is a nurse, not a doctor, based upon the training for the state examination in life-saving services for non-doctors. Currently I am head of the training section at the second largest life-saving service in Frankfurt. As far as the issue of drugs is concerned, I have started with heading an out-patient clinic for drug addicts in Frankfurt - with a focus on medical issues. In addition also accompanying work in prison, substitution etc. Then I changed to a drop in centre for drug users and there I did drug work only for three years. Then I went back as the head of the training section in life saving services where I worked at an ambulance station for several years which is mainly active in the main station area.
I: Have you ever experienced overdose emergencies of drug users - and what were they like?
P: According to a statistical evaluation of our ambulance station I was involved in about 3000 OD emergencies. Then there are also re-animations in the area of the ambulance services which amount to about 2-10 OD emergencies per day, depending on the size of the drug scene which grew smaller over the years. As far as life-threatening situations are concerned, the main issue is the heroin overdose, respiratory dysfunction, and increasingly also intoxications from cocaine and crack. Benzodiazepines and barbiturates, that is sleeping pills, also play a considerable role, because most of the clients have poly drug use.
P: What is a cocaine overdose like?
I: In short, there are two different facets of the nervous system. One agitates - is more about stress - and the other is about relaxation and metabolism. Drugs have different effects on these two facets of the nervous system. They can enhance them, combine them with the distribution of happiness hormones. Heroin has a strong sedative effect. You have problems with your conscience and - what is also life threatening - with breathing. Usually the heartbeat continues, though. So, the drug user dies from suffocation which means that it takes some time until he dies and death can be avoided relatively safely if respiration is ensured within a relatively short time. Or, if the emergency is recognised quickly and an ambulance is called as fast as possible. A cocaine intoxication enhances the stress component, combined with happiness hormones. So, people are usually agitated, tend to have sometimes life-threatening cerebral cramp attacks or their heart beat stops. It is unusual, but theoretically possible.
I: What kind of a consumption situation could you observe in these cases?
P: The open drug scene in Frankfurt, which I would continue to call an open scene, because it usually takes place in the streets, used to be in the Taunusanlage with a couple of thousand of people who consumed drugs completely freely. Nowadays this

takes place to a large extent in the safe injection rooms and because these are still overburdened, also in the streets. The emergencies are usually like this: a patient collapses, is being robbed by his fellow drug users which often prolongs the time until the ambulance is being called. And after the ambulance comes, the drug use still continues.

I: What do you think are the risk factors?

P: One risk factor with heroin use is the first consumption. People may react with an OD easily to that. The drug is also mixed with other substances to maximise the earnings for the dealers. That makes the dosage hard to estimate by the users. You may estimate a quality of something between 7 and 13%. You may also by at the same dealer every time and use the same amount every time. If the purity of the drug varies greatly - let's say to about 40%, you are more or less helplessly doomed to have an OD. Another risk factor is when people come out of jail or detox where your body has been weaned off the drugs for some time. Of course, drugs are also being used in jail, but not that much. Epileptics react to cocaine with epileptic fits which is a great danger. Then there is poly drug use with all its accompanying diseases that a life at the verge of society entails: HIV, sometimes open TBC, abscesses, lymphagitis, that's enflamed lymph channels, that can lead to a weakening of the organism, etc.

I: Could you mention some facilities or measures in your city that may have helped to reduce the risk of ODs?

P: It is an over-all concept when I compare the scene today with that of the Taunusanlage and the measures that have been taken to minimise this problem. It all goes hand in hand and you cannot just take one factor out. On the one hand, there is the closing of the open scene, of course, with some police action, combined with a system of social measures and detox for people from outside Frankfurt or for those who have not been registered as homeless in the city since one year. This has already pushed a large group of users into the surrounding communities and cities. Of course, it has not solved the problem, just minimised the group that Frankfurt has to take care of and established new problems for the surrounding communities. All that was combined with the safe injection room services and an enlargement of the social services, for instance Polamidon-programmes. With these programs, the doctor has the possibility to see the client every day and to look what physical condition he is in. With the pressure to receive your Polamidon - or not - there is also some pressure to seek medical care. This already decreases the risk that people simply die of standard diseases. For the acute situations of an OD, the safe injection rooms are a wonderful facility. If a client uses and collapses there, help can be given or called for immediately. All that, combined with a focus on safe injection rooms is able to reduce the whole thing.

I: Could you mention some facilities or measures in your city that may possibly increase the risk of ODs?

P: In my point of view, facilities that are run badly, i.e. those who do not do enough against drug dealing and don't have control in their facilities to prevent drug use if that is not foreseen. At the safe injection rooms it is foreseen that you use drugs, but if this is also tolerated i.e. in a sleeping facility in an uncontrolled manner at the rooms and you simply don't check that regularly whether your clients are still alive, this is really a death trap. Or toilets in a normal contact service. Users go to the toilet , consume drugs there - illegally really - and then you don'' check this for a longer period - whether this client is still alive or in danger. A well-kept helping facility that is also controlled regularly, where the staff is trained in respiratory First Aid and has the right

equipment and knows also how to use it and how to call help in case of an emergency, minimises the risk.

I: What do you usually do when an OD occurs?

P: It depends on the drug. Let's take a heroin overdose, because this is still the major reason for deaths. The most important measure is respiration with oxygen. You may also leave the oxygen aside - so, for an injection room, simple respiration is enough to prevent that the patient has a toxic brain damage. Then the ambulance services usually use Narcanti. We give at first 1ml intra-muscular to achieve some kind of a depot that prevents the patient from falling back into the heroin-intoxication for some time. Then we use the same dosage i.v. to get the patient back into a state of consciousness as soon as possible. Usually patients become clear quite quickly, are being checked again briefly and then stay within the area of the safe injection rooms with their trained staff. In case the heroin has been smoked - which seems to be quite usual in Amsterdam, but rather unusual in Frankfurt, because the drug is simply not pure enough for that here, you also have to control whether people develop a toxic lung oedema, that is to say that the lung is not filled with water.

I: What is usually recommended to be done in such situations in your job?

P: Of course you have to be skilled in working with the areas that are on the margins of society. It is certainly not for people who do this the first time and you have to know a bit about this, how to deal with the clients and how to protect a client from being robbed without making a complete fool of yourself. You need a certain strictness in your appearance and, I guess, also a pretty high social competence to deal with the problematic patients. Most drug users have very limited social skills, which is also partly due to the drugs. For the component of helping in an emergency, you have to be versed in he area of drugs and be prepared for the special clients you have to deal with. In our training there are special fields of crisis intervention and the training of social skills, but this is certainly not enough. If you work at such a ward in such an area, you have to look very closely at who you are putting there. That is a question of staff management on the spot or also of moral competencies. It is always the question whether people are simply there to earn some money or whether they are interested in doing something practical. You should also make sure that regular supervision is ensures in such an area, because people burn out rather easily. You may have to exchange staff frequently. The problem then is that you always have amateurs working there. Professionals who also do their job well and are able to judge the situation well, are also respected a bit by the junkies, simply burn out quickly within 2 or 3 years. It would be ideal to stress these people relatively little and then see that they can stay on for longer in this area of work.

I: Has the situation of the drug users with regard to ODs during the time of your work - and if so, what has changed?

P: Considerably, from our point of view. The peak was clearly on heroin during the mid 90ies. Cocaine was emerging at that time, the existence of crack was denied, but already present at that time. Nowadays it has become clear that heroin use still continues with older junkies of about 25 years of age and older, connected with poly drug use. Younger people, from 13 years upwards, very often consume only cocaine or crack, not heroin at first, which comes later, through the contact with the hard-drug scene.

I: When you think about the problem of overdose and life threatening situations in connection with drug use - what do you think are the main reasons why people die from an overdose?

P: You have to differentiate this according to the drugs consumed. If I take heroin intoxication as the main reason for drug deaths, the main reason for that is, of course, that the emergency is not recognised. If respiration is given in time, the danger is relatively low, unless other complicated factors also add onto that, i.e. a structure, in which the drug user is being forced onto the margins of society and drug addiction is being lived in main station toilets or in private apartments where you have to fear that the police comas along with the ambulance when you call them. Then, drug users would rather let someone die than take the risk to receive a penal charge - that also results in many drug deaths. You marginalise a problem, close your eyes, and get a bad image in the press, because drug death figures rise at the same time. Within the context of the safe injection rooms for instance, drug related emergencies are being recognised relatively quickly, are being treated relatively quickly, and although the emergencies are more or less stable, the fatal overdose cases decrease remarkably, because the critical gap of ten minutes can simply be filled. Of course, people still die in apartments or in toilets, but the general risk is being minimised.

I: In some cities the number of fatal ODs is rising (Copenhagen, Oslo) while it declines in others (Frankfurt and Amsterdam). What do you think could be the reasons for this?

P: I think, a linked safety-system, in cooperation with the police, the drug helping services, and the ambulances. On the one hand, police increases the pressure on dealers, dissolves collection points of drug users and thus makes sure that relatively little consumption is going on there - and relatively little deaths occur. At the same time, a possibility to consume drugs in a legal or rather semi-legal setting with skilled personnel that is able to give First Aid. A fast working ambulance service that si skilled accordingly and an accompanying helping system, working projects etc. So that the scene is a bit controlled and canalised - that will certainly be successful or lead to success. I have no idea about the situation in Oslo or Copenhagen, but I guess the problem is being dealt with in a different way there and then you are bound to have an increase. Perhaps they think people will stop using drugs by themselves, but that is in contradiction to reality.

I: What else could be done - in your opinion - to avoid ODs?

P: From the point of view of emergency medicine almost everything is being covered already and e have reached a limit at the moment. We have established the safe injection rooms to an extent that students who work there are able to give First Aid, who know the way to call an ambulance. And the life-saving services are fast in the inner city. The are instructed accordingly and I don’t think, help could be provided any faster than that.

9.3 Officials in Frankfurt

9.3.1 Head of the Office for order of the municipality of Frankfurt

This project is trying to map and define the political goals and strategies in drug policy, in order to prevent and reduce the overdose mortality in the four cities of Amsterdam, Frankfurt, Copenhagen and Oslo. When speaking about "drugs" in this interview we primarily think of drugs like heroin, amphetamine, cocaine. In order to carry out this mapping, we would like you, in your position as head of the Office for order of the municipality of Frankfurt to help us understand by answering a few questions.

1a. What has been the major philosophy and goals concerning drugs in your organisation during the past 10 years ?

For one thing we wanted to improve „order“ with regard to addicts in public areas. I don’t want to say reinstall, but we did plan to achieve a sustainable improvement. That was one of our goals. The other one was to offer ill drug users help in order to improve their situation, health wise, but actually in all respects.

1b. What have been the major obstacles that your organisation has encountered in its practise?

First of all there have been problems in our heads. I have used the term „ill drug user“ deliberately, because not everybody perceived drug addicts as ill people. But we have worked systematically on this perception and up to a certain point we also succeeded in implementing this philosophy in politics and also, if you like, in the public opinion which has to play an important role in this process. If I say „we“, I am usually referring to the Monday round table group, because the original cards played by the public affairs office of the municipality are relatively low. The Public affairs office is involved in this issue, especially under the aspect of the public order and public safety services - that is the colleagues that work in uniform in public areas and who have a large number of tasks to fulfil. When the open drug scene was dissolved, these colleagues worked together with the police, o rather supported the police’s activities by going into certain parks and trying to convince drug users to leave the area and go to helping services etc. This was one of the cornerstones of the whole story after all, that we have only seriously began to dissolve the open drug scene in the parks after alternative offers of help to drug addicts had been established. That is to say he whole range of services from sleeping facilities to medical care etc.

1c. Imagine you could have changed something in this society's drug policy in the past ten years, what changes would that have been?

I don’t know really, whether you could have done something very different from what we did. For one thing, we tried to distribute the burden - and after all the whole story cost a lot of money - a bit. Frankfurt plays a very special role in the Federal Republic and that has to do with traffic that meets in Frankfurt. The consequence was that there was always a lot of dope on the market, Frankfurt was easy to reach and that lead to the fact that many addicts came to Frankfurt to purchase their drugs and sometimes they also got stuck here. We have tried to

concentrate the network of help that had established over the years on those who „lived“ in Frankfurt. We did not want to offer our help to anyone just coming through the city as we did with the people who lived here, because this would have a dimension that we could not have fulfilled. In a later phase the safe injection rooms were added and it does make a difference whether a thousand people want or have to use theses facilities or whether it is only half that number. And this is, as I said, the reason who we were rather strict in a certain phase on whether these were people from Frankfurt or from outside the city we offered our help to.

2. **What was the most important political goals in this city's policy in the drugs field ten years ago? Please rank the following items into three categories, with three items in each category: 1. High priority, 2. Medium priority, 3. Low priority.**

	Ranking
To strive for a drug-free society	3
To reduce harm caused by drug use	2
To reduce drug use related crime	1
To reduce public nuisance associated with drug use	1
To prevent drug use among youngsters	2
To secure or improve the coverage of treatment for drug addicts	1
To reduce drug dealing	3
To prevent the spread of diseases like HIV and HepC among drug users	2
To prevent overdose deaths among drug users	1
To prevent money laundering and economical destabilisation through the investment of large sums of money from drug deals	3

Could you please comment on your ranking of these items.

The reduction of the drug market actually had a middle priority also - of course, this is not actually a task of the public affairs office, but a task of the police. But „opportunity makes the thief“ and the easier it is to purchase drugs, the higher the danger that someone who has not yet come into contact with drugs will be brought into contact with them - perhaps even on purpose. There was an intense discussion at one time and reality has often been quite different. It was always around the issue that in the vicinity of schools school kids were being offered drugs and turned into drug users. As far as my experience goes this has certainly happened, but in a much smaller extent than anxious parents or parents’ representatives sometimes carried forward.
And you have to be clear about one thing: there will never be a drug-free society. The substances may change - and they already have from 1990 until today. At that time there was no Crack around, only little cocaine and there was almost only heroin. Today we have a

crack-problem. And I don't even want to speak about alcohol and so on, because this doe not strictly belong into this term.

3. **What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?**
   Please rank the following items into three categories, with three items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Ranking
To strive for a drug-free society	3
To reduce harm caused by drug use	2
To reduce drug use related crime	1
To reduce public nuisance associated with drug use	1
To prevent drug use among youngsters	2
To secure or improve the coverage of treatment for drug addicts	1
To reduce drug dealing	3
To prevent the spread of diseases like HIV and HepC among drug users	2
To prevent overdose deaths among drug users	1
To prevent money laundering and economical destabilisation through the investment of large sums of money from drug deals	3

If any changes, compared to ten years ago, please comment on the reasons for these changes in priorities.

The priorities have not changed.

4. **Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.**

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	1	X	
In police strategies less focus on users towards more focus on larger scale dealing	3	X	
Rehabilitation opportunities (housing, education, social network etc.) Vocational opportunities (work, work training)	3	X	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	2	X	
Housing for people with drug problems	1	X	
First aid education	3	X	
Sufficient capacity of methadone programs	2	X	
Low threshold methadone programs (allowing side use during treatment)	3	X	
Methadone programs in prisons	1	X	
Heroin prescription programs	1	X	
Measures aimed at changing application forms, such as smoking instead of injecting	2		X
Distribution of naloxone (narcanti) to drug users	2		X

Could you please comment on your ranking and explain why some interventions are not feasible in this city, if any.

Concentrating police strategies on bigger dealers rather than on consumers, well that is a strategy the police follows anyway - it is part of their original task. But that has nothing to do with overdose deaths - well of course, if there are no more drugs there won't be any more drug related deaths, but that's unrealistic.
The Rehabilitation and vocational opportunities are, of course, a very crucial step in the development of a drug addict. But, before you can speak about vocational measures the person must get in a position where it is actually possible to educate or train him or her. But in connection with overdose deaths this only plays a secondary role in comparison to the other four points I have mentioned.
I cannot comprehend why you should train addicts in First Aid to enable them to help themselves. Everyone else dealing with drug addicts however should of course be trained in First Aid, because it may prevent collapsing if it is applied at the right time etc.
With regard to lowering the threshold to the methadone programs that is allowing side use during treatment, well that's basically practice already. I don't think anyone is being kicked out of the methadone program if he or she has a certain side consumption. The participation in the methadone program should, of course, not become some kind of an alibi only. About changing application forms I have to say that I don't think it can be our task to bring someone from one drug consumption into the next and it is a fact that today application forms have established themselves that create new problems - keyword „Crack".
About applying or providing Naloxone, I can't really say anything, because I simply don't know enough about it.

5a. Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose.

5b. What are your thoughts about the possibilities to reduce or forbid the distribution of these pharmaceuticals?

Well, Rohypnol is a substance, of course, which is also being abused as a drug, but I don't feel competent here.

6a. Open drug scenes may increase the spread of heroin addiction, cause nuisance etc.
6b. What are your thoughts (experience) about how to prevent or reduce open drug scenes?

I think this has been proven. If I think back to the nineties it was completely uncomplicated for anyone - even the most naive person - to show up there, to be drawn into it and to get hooked on the needle faster than anyone could see. The supply of dope - that was a supermarket and if you had the necessary money you could get whatever you could wish there in no time.
In Frankfurt we have shown rather clearly that it is well possible to reduce the pen drug scene and how it can be done. You have to proved some facilities to those people who simply *have* to shoot up and where they can do this under hygienically indisputable conditions, AIDS prevention, without anyone having the possibility to watch or without the unpleasant consequences on the pavement or wherever else. That business-people are not being hindered, because their clients say: „No, I really don't want to step over three rug addicts before I enter your store" - we have had this for quite a while in Frankfurt.

7. Do you have any other suggestions about how to reduce the overdose deaths in our city?

Well, I don't have a recipe for that. I have just raised the issue again today, because currently we have an increase in people dying from drugs and we have not yet analysed the circumstances. It seems that there is a certain number of drug addicts who have died in a private setting - in a hotel room or somewhere else. And there the helping network has practically no chance to bring help to the people in the right time. I believe there has not been one single fatality in any of the helping services. They have always happened at other places where help cannot be provided in time and I can't think of anything to prevent that. I mean, if someone comes to Frankfurt and gets himself some dope and then rents a hotel room somewhere to inject himself and maybe he gets the wrong dosage, then that's that. The only thing, but that is also a field which has not yet been analysed one hundred percent, is whether an how the consumption of methadone in combination with other substances plays a role. This should be thoroughly looked at, but it is only possible with a considerable time delay because a post-mortem has to made on the deceased. All the circumstances around every single person dying from drugs must be recorded in detail, so you can put theses things next to each other and see whether there are some parallels between the cases that may provide some kind of pattern to prevent . I am really a bit concerned now, because we had a slight increase last year but this year it does not seem to be so insignificant any more in my eyes. If I take the low basic numbers from 1998 and 1999 as a comparison then it is a startling increase although, as I said, we don't have a patent remedy at hand. But it is also a bit early to judge this.

8. When evaluating this city's drug policy in total:
a. In what aspects do you think the policy has successfully reached its goals, and why?
b. In what aspects do you think the policy has failed to reach its goals, and why?

We have certainly achieved that the consciousness regarding this topic has changed, positively. We achieved that drug addiction is no longer one of the topics number one in the

public areas. The police have succeeded in reducing the drug related crime by intensive measures. If we can believe the statistics, theft in the streets, property theft and all theses things have been forced back considerably. I think you may also say that through the methadone programme on one side and the installation of safe injection rooms, sleeping facilities etc. it became possible to improve the situation for people suffering from drug addiction, at least for those who are willing and able to accept such help. We have not succeeded completely so that you would not see any more drug users in the streets and squares who inject themselves, there is always a corner where you can observe this. Maybe this also has partly to do with the fact that some, I cannot give you the exact number, have been ordered to stay away from the safe injection rooms and cannot go there any more. We have also not yet succeeded in damming up the Crack Problem in the way that we would wish to. There is certainly something here ore there which I cannot think of right now. Of course we do not have a paradise here in Frankfurt with regard to this issue, but if I compare it to the situation we once had, we have achieved a lot.

Thank you very much that you took your time to answer these questions.

9.3.2 Staff member of the drug policy co-ordination office of the municipality of Frankfurt

This project is trying to map and define the political goals and strategies in drug policy, in order to prevent and reduce the overdose mortality in the four cities of Amsterdam, Frankfurt, Copenhagen and Oslo. When speaking about "drugs" in this interview we primarily think of drugs like heroin, amphetamine, cocaine. In order to carry out this mapping, we would like you, in your position as a staff member of the drug policy co-ordination office of the municipality of Frankfurt to help us understand by answering a few questions.

1a. What has been the major philosophy and goals concerning drugs in your organisation during the past 10 years ?

I think, the most important goal in drug policy was to implement the policy of harm reduction in Frankfurt and the respective measures, such as safe injection rooms, crisis centres, methadone maintenance, sleeping facilities etc. to realise this policy of harm reduction in practice. And it was necessary to fill the Monday Round table group with life, that is to combine and form into one entity the repression on one side and help on the other side of this group to ensure that what is called harm reduction is secured within all levels and institutions that are concerned with drug policy. The policy of harm reduction in connection with the Monday round table was important for Frankfurt, because harm reduction and all measures following it were the only adequate possibility to dissolve the drug scene and to provide an actual alternative for people who had lived in the open drug scene.

1b. What have been the major obstacles that your organisation has encountered in its practise?

There have not really been any major obstacles to this policy in Frankfurt, apart maybe from the necessity to convince the city parliament and the council that implementing this programme would cost a few million. It took some time to do this work, but it was not really difficult. Of course, there have been the usual difficulties in implementing the programme and new measures. Drug dealers then try to expand their market activities also into areas where they cannot be tolerated. But these are market mechanisms, if you like, and you have to cope with them whether you like it or not.

The police has not made any difficulties at all during the time of adapting the measures. Three years before they had larger difficulties, if you like, in accepting the philosophy of harm reduction and all the entailing measures, such as safe injection rooms, for instance. But this is , in the end, also something for the benefit of the police, in the sense that they have to undertake less useless operations. Of course there had to be a dialogue with the police, through the whole hierarchy down to the police officers in the streets. But all this was more a time problem than a problem of issues, because the officers who were doing their job in the open drug scene were well aware of the futility of their daily actions and were demanding different things themselves.

You can definitely say that the Monday Round table group has played an important role in this process. If you look at this group and the participation of the police and state attorneys in it, it also represents the whole range of society, that is reflected in the various political parties.

If such serious partners as the police president or the state attorney of Hessen, such authorities, are supporters of harm reduction policy themselves, convincing the politically responsible people, the Frankfurt city council, becomes much more easy than if this approach would be *only* supported by the helping system. They are seen as people with a larger commitment, but not given credit to represent also the regulative powers, such as the police or justice system.

1c. Imagine you could have changed something in this society's drug policy in the past ten years, what changes would that have been?

Of course it would have been much better if essential parts of the harm reduction policy had been safeguarded by the national government. This would have been a chance to go beyond the borders of the city for the benefit of the whole drug using population in Germany. Especially when you consider that there are still only four cities in Germany that actually have safe injection rooms - you could have had that 8 years ago already. You could also have implemented a lot of other things at an earlier state - think about the heroin project, for instance. We are now in 2001 and it will be 2002 before we have the first heroin trials in practice. If we had had the safe injection room laws 8 years ago, most probably also the heroin trials would have come about 4-5 years earlier - as a consequence of the safe injection rooms, if you like. And this would also have meant something for other cities, as much as for Frankfurt, that in this case also the crack problem would probably not have had such a dimension in a drug scene that would have been left then.

2. What was the most important political goals in this city's policy in the drugs field ten years ago? Please rank the following items into three categories, with three items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Ranking
To strive for a drug-free society	3
To reduce harm caused by drug use	1
To reduce drug use related crime	2
To reduce public nuisance associated with drug use	1
To prevent drug use among youngsters	3
To secure or improve the coverage of treatment for drug addicts	1
To reduce drug dealing	2
To prevent the spread of diseases like HIV and HepC among drug users	2
To prevent overdose deaths among drug users	1
To prevent money laundering and economical destabilisation through the investment of large sums of money from drug deals	3

Could you please comment on your ranking of these items.

There has been the enormous public problem of an open drug scene which we had to respond to with a new drug philosophy, if you like, that is called harm reduction. Harm reduction is about reducing harms, reducing the public nuisance, secure help for addicts and to prevent as much as possible overdoes deaths.

3. What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?
Please rank the following items into three categories, with three items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Ranking
To strive for a drug-free society	3
To reduce harm caused by drug use	1
To reduce drug use related crime	2
To reduce public nuisance associated with drug use	1
To prevent drug use among youngsters	3
To secure or improve the coverage of treatment for drug addicts	1
To reduce drug dealing	2
To prevent the spread of diseases like HIV and HepC among drug users	2
To prevent overdose deaths among drug users	1
To prevent money laundering and economical destabilisation through the investment of large sums of money from drug deals	3

If any changes, compared to ten years ago, please comment on the reasons for these changes in priorities.

The problem in answering to these categories is that many of the mentioned measures have been implemented during the past 10-12 years. Of course you have to stick to them, therefore reducing the harm caused by drugs naturally continues to have a high priority ,because you cannot simply give up safe injection rooms now, you cannot give up needle exchange and this also goes for other points that I have mentioned as a priority. In addition, you also have to respond to new challenges. For Frankfurt that means the crack scene, the crack users or better the poly drug users in this city. And because this is now a fairly large group of people in the city, you have to look for responses to this problem. In Frankfurt we have also done something about this: i.e. the Crack street project. But we do not yet have an over-all harm reduction approach with regard to the crack problem, as it had been for the heroin problem,

where it became a conclusive concept. There is simply a large open question and we have not yet found an answer to it.

4. **Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.**

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	1	x	
In police strategies less focus on users towards more focus on larger scale dealing	3	x	
Rehabilitation opportunities (housing, education, social network etc.) Vocational opportunities (work, work training)	2	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	2	x	
Housing for people with drug problems	2	x	
First aid education	3	x	
Sufficient capacity of methadone programs	1	x	
Low threshold methadone programs (allowing side use during treatment)	1		x
Methadone programs in prisons	2	x	
Heroin prescription programs	1	x	
Measures aimed at changing application forms, such as smoking instead of injecting	3		X
Distribution of naloxone (narcanti) to drug users	3		x

Could you please comment on your ranking and explain why some interventions are not feasible in this city, if any.

We do have a number of rehabilitation and education measures in Frankfurt, but the quantity is not enough. Especially also qualitatively it is not sufficient, where we see the necessity to enable people to get used to working life in a job, at least in a limited way and to develop qualitative and quantitative measures building on this that would also offer a certain opportunity to re enter the first job market for the people undergoing these steps. The whole thing is complicated because it would mean bringing different financial budgets together that are available at different offices of the municipality. Then there is the employment office with a number of problems and also the regional, national and European level. It is extremely difficult to develop a concept on that basis, it will take a long time and you have to face the resentments of the people involved. Lower threshold for entering the methadone programme are also not possible, because - as you can read in the papers every day - the costs for the health system are exploding in a way that such unloved costs, that do not bring a positive image to the health insurance companies can hardly be pushed through. You rather have to fight that the number of clients in the methadone projects that already exist are not being cut down.

With regard to the measures that aim at a change of consumption forms - away from injection and towards smoking - I think the major problem is to achieve a socio-cultural change of paradigm with the individual user. I think this cannot be realised.
Giving naltrexone to drug users must be left to doctors and not to Junkies who have enough stuff on the great bazaar, the street. When they need Naloxon or Narcanti, they can get it from the emergency or from other doctors if this should be indicated. There should not be even more drugs for self-medication in the hands of drug users.

5a. Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose.
5b. What are your thoughts about the possibilities to reduce or forbid the distribution of these pharmaceuticals?

Well, it is not just that the combination of heroin and Rohypnol is problematic. The combination of methadone and Rohypnol or also problematic and it should therefore not happen. I think that in the course of our heroin trial we will be able to gather more knowledge about what kinds of sedatives in what dosages and situations can be prescribed to heroin users in the future and which not in order to prevent risks, such as respiratory problems, and I think we should await the outcomes.
Forbidding Rohypnol would not help in the least, because thousands of other drugs are on the market today and there are always enough opportunities to get these drugs on the market.

6a. Open drug scenes may increase the spread of heroin addiction, cause nuisance etc.
6b. What are your thoughts (experience) about how to prevent or reduce open drug scenes?

I am strongly convinced that an open drugs scene increases the risk of an overdose. In Frankfurt you can also prove this with figures: At the time when the open drug scene still existed, we had about 10-15 ambulance operations there daily. Today there are about 7 or 8 a week. I think, this really speaks for itself and also speaks in favour of the safe injection rooms too, because a large number of these emergency situations can be handled by the staff of the safe injection rooms without calling an ambulance. I do not believe that the open drug scene promotes the spread of heroin addiction. People become addicted for completely other reasons and out of completely other social connections. The heroin scene in Frankfurt has never been so attractive, that anyone would have consumed heroin because of that.
The open drug scene an be reduced or prevented by offering the whole palette of helping measures, such as safe injection rooms, needle exchange, methadone, sleeping facilities, crisis intervention etc. - as it is being done in Frankfurt and other cities. Trying to dissolve and open drug scene without offering alternatives at the same time means nothing else but burdening a whole city with a drug problem instead of just some places or facilities where the „open drug scene“ is located now.

7. Do you have any other suggestions about how to reduce the overdose deaths in our city?

No.

8. When evaluating this city's drug policy in total:

a. In what aspects do you think the policy has successfully reached its goals, and why?

b. In what aspects do you think the policy has failed to reach its goals, and why?

I think that the major goals in drug policy have been achieved, such as bringing as many drug users into the helping system as possible and thus to bring them into contact with treatment possibilities. You also have to state that there is a number of drug users who do not become abstinent despite undergoing treatment - as old as they might get. That is one dilemma, but that's the way it is in our society: you cannot cure people completely over and over again - that's an illusion and it also applies to addicts. The other thing is that there are new developments with new drugs, such as XTC and that there will probably other chemical derivatives in the future which you cannot respond to yet, because you cannot anticipate what kinds of drugs we are going to have.

Thank you very much that you took your time to answer these questions.

9.3.3 The health-policy speaker of the Greens

This project is trying to map and define the political goals and strategies in drug policy, in order to prevent and reduce the overdose mortality in the four cities of Amsterdam, Frankfurt, Copenhagen and Oslo. When speaking about "drugs" in this interview we primarily think of drugs like heroin, amphetamine, cocaine. In order to carry out this mapping, we would like you, in your position as the health-policy speaker of the Greens to help us understand by answering a few questions.

1. **(For politicians) What are - in you opinion - the most important political goals in your city? Please rank the following items into three categories, with three items in each category: 1. High priority, 2. Medium priority, 3. Low priority.**

	Ranking
To improve the public aid for seniors	1
To improve public welfare for young people	2
improve the housing situations of homeless people	3
reduce environmental problems	2
reduce traffic related problems	1
reduce alcohol related problems	3
reduce problems in connection with illegal drugs	2
improve the care for people with psychiatric problems	3
improve the educational offers in the city	1

Could you please explain your ranking?

The reduction of problems that occur in connection with illegal drugs don't have the highest priority any more, only a high priority. On various levels - such as certain health issues or within the framework of safety issues they used to have top priority in the city, because the earlier responses had proven to lead into a blind alley. Those were the reasons why the topic had such high priority. You can also see this from the fact that both the former municipal councillor for health and the Lord major had taken up a personal responsibility or this issue and also linked their public image to it. These are the main reasons with which you may describe the situation. A blind alley plus a really dramatically high drug problem as far as drug related deaths are concerned. Also regarding the issue of safety with a completely uncontrollable „open drug scene" etc. At that time I worked for one of the helping services myself that was active in the field, so I have also seen the problem from another angle, also in connection with the whole HIV/AIDS topic etc. This came on top of everything and it was really a catastrophe.

2. What were the most important political goals in this city's policy in the drugs field ten years ago? Please rank the following items into three categories, with three items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Ranking
To strive for a drug-free society	3
To reduce harm caused by drug use	1
To reduce drug use related crime	1
To reduce public nuisance associated with drug use	1
To prevent drug use among youngsters	2
To secure or improve the coverage of treatment for drug addicts	1
To reduce drug dealing	3
To prevent the spread of diseases like HIV and HepC among drug users	2
To prevent overdose deaths among drug users	2
To prevent money laundering and economical destabilisation through the investment of large sums of money from drug deals	3

Could you please comment on your ranking of these items.

The goals of drug policy in the past ten years have always been based upon two pillars: public order policy and health policy. In that context the aspect of harm reduction and everything that goes with it has always been important, as well as improving the situation for the benefit of the general population. It is interesting that these two goals have merged into one. That was also characteristic for the discussions where health policy makers and police often have taken over the part of the other side. The best people to represent this approach in discussions also with the public - for instance about why we do not have a drug-free society - have always been the police.
There have been different lines of arguments, but they all resulted in one effect. And this was not a foul compromise either - not like you get this and the others get that. The police noticed that reducing the open drug scene presupposes that you have a place where you can actually send people to. On the other hand, it was also very clear that for an offer like the safe injection rooms for instance, we would first have to define certain rules and regulations - also in public. And it had to become clear: you cannot occupy the park, we offer you other premises.
There have been two prominent cuts as far as the attitude of the Frankfurt police is concerned. The first was the new orientation in 1989 when such a concept for drug policy was consciously drawn up and the second was in 1995, when the Christian Democrats, who were opposing this response until then, joined our approach. Until today, I find it fascinating to see that an approach that is considered as the number one safety risk in other cities is being pursued very naturally.

3. What are by your opinion be the most important political goals in this city's policy in the drugs field in the near future?
Please rank the following items into three categories, with three items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Ranking
To strive for a drug-free society	3
To reduce harm caused by drug use	1
To reduce drug use related crime	2
To reduce public nuisance associated with drug use	1
To prevent drug use among youngsters	1
To secure or improve the coverage of treatment for drug addicts	1
To reduce drug dealing	3
To prevent the spread of diseases like HIV and HepC among drug users	2
To prevent overdose deaths among drug users	2
To prevent money laundering and economical destabilisation through the investment of large sums of money from drug deals	3

If any changes, compared to ten years ago, please comment on the reasons for these changes in priorities.

I have not given the reduction of drug related criminality the highest priority for the future any more, because this goal has already been achieved relatively widely. Also, because I think that as soon as the situation has stabilised it is necessary to take the next step and go into prevention - as experts put it, into secondary and primary prevention. This is the local necessary step although, of course, it is much more complicated. But there has also been a change in addiction prevention in schools which had formerly been oriented very much towards achieving a drug free society and has been re-oriented. The cooperation with youth facilities, street work - especially also in the field of crack - are all issues that oscillate somewhere between preventing and accompanying drug use. In fact, a category between these two is somehow lacking. Work as it is being done by the Safe-Party-People for instance. These are things that fall out of every category here. OK, harm reduction is always top priority and that goes for all objectives. If I should pick out one, I would always mention this. But if I combine harm reduction with preventing drug use among young people, then you have a shift. First of all you have to prevent that people simply croak in the streets somewhere but then you can also say, we nor have a situation where we can actually reach people, or where we can also stabilise people who may be experimenting with drugs.

4. **Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.**

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	1	x	
In police strategies less focus on users towards more focus on larger scale dealing	3	x	
Rehabilitation opportunities (housing, education, social network etc.) Vocational opportunities (work, work training)	2	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	2	x	
Housing for people with drug problems	2	x	
First aid education	3	x	
Sufficient capacity of methadone programs	2	x	
Low threshold methadone programs (allowing side use during treatment)	1	x	
Methadone programs in prisons	1		x
Heroin prescription programs	1	x	
measures aimed at a change of forms of consumption - from injecting towards smoking	3		x
Distribution of naloxone (narcanti) to drug users	3		x

Could you please comment on your ranking and explain why some interventions are less feasible than others.

Regarding the lower threshold for access to methadone programmes, a certain side consumption is being tolerated meanwhile, something that was quite unthinkable in the beginning. Based upon the information I have, however, I would wish this to be even more flexible.
The possibilities for rehabilitation and education and training are really useful in preventing overdose deaths and in stabilising people. People are the offered a true alternative and they are not left alone with their stabilisation. I have the experience that there are a number of programmes in that field today, but they are by far too little.
The heroin prescription programmes have the problem that in fact they are behind the development of drug use. When you speak about prescribing original substances, you are now only able to target this on a small fraction of the over-all use. I have tried a few years ago to open up the discussion about cocaine and how to respond to this issue for the following reason: how do I explain to people who use a variety of substances that I will only take out one substance and concentrate on that. This substance you may receive from the state but for the rest we will leave you alone as we did before. I don't that that is consistent. It is also not logical - but I did not find any support for these thoughts in the city.

5a. **Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose.**

5b. What are your thoughts about the possibilities to reduce or forbid the distribution of these pharmaceuticals?

Well, I think that the most important thing is to make heroin prescription possible at first, to bring it into a medical setting where it is also controllable. My view on the medical and pharmaceutical market is too sober to make me say that taking Rohypnol off the market would solve the problem, this is an illusion. As long as the substance is on the market somewhere, people will have access to it. I would rather begin at the other end and I imagine that the organisation of licensed practitioners (Kassenärztliche Vereinigung) is being asked for here. They should be thinking more intensively about ensuring quality among their people and that there are certainly still some things to do, because there are, of course, doctors who follow dubious individual paths in this field. But I would not want to follow the restrictive path either.

6a. Open drug scenes may increase the spread of heroin addiction, cause nuisance etc.
6b. What are your thoughts (experience) about how to prevent or reduce open drug scenes?

I would say so, yes, and the open drug scene can be prevented and reduced by following approaches as we have done here, where alternative spaces were offered for drug use and not only alternative premises, but also alternatives in forms of consumption. But, looking back, I would on the other hand also say clearly at this point only if you also have an equivalent public order approach - even if we had been warned about that massively in the past. Especially during the time the „open drug scene“ was dissolved, massive political agitation came against that. But because of this extreme public attention the police has been rather careful in their activities compared to the times before. What is much more problematic in the work the police does with drug users is the every-day violence somewhere in the „B-Ebenen“ (subway and railway areas, underground shopping areas) where people are being picked up suddenly and then taken into these famous rooms there that don’t even have a window. But in my point of view looking back, dissolving the „open drug scene“ has been an important accompanying measure. At least my personal experience with drug addicts has shown that it is equally important to offer help and to say clearly: folks, not here. And you have to make this clear in all strictness. Strictness in this respect does not mean the truncheon, but for me it is to make clear that it cannot be that a junkie can just do what the rest of the population can not.

7. Do you have any other suggestions about how to reduce the overdose deaths in our city?

One thing we have tried a couple of times already is a programme like the one running in the Netherlands „Antenne“ - some kind of an early-warning system, about changes and developments in the drug scene, changes in use, changes in the composition of substances and that even goes as far as drug-checking. The police has information about these developments also, of course, but I think it would be worthwhile to develop a special measure out of this that would be located between police, medicine and socio-political research. People have to know what happens in the street. There could be a lot of information that could be useful for the people working in the helping system to steer the system. Maybe the whole stories about Crack would have been clearer at an earlier stage. I don’t know how much it would actually have changed, but it would be an additional constituent.

8. When evaluating this city's drug policy in total:

a. In what aspects do you think the policy has successfully reached its goals, and why?

b. In what aspects do you think the policy has failed to reach its goals, and why?

Drug policy has achieved two things, it achieved a double harm reduction - for the drug addicts themselves, their health up to the issue of survival, and it achieved harm reduction with regard to the consequences for the rest of society and which they are entitled to. I do think that people who live in the main station area are entitled to be able to enter their apartments etc. And these two goals of harm reduction have been achieved provably to a very high extent.

What has not been achieved and still remains an open question to me is the area of primary prevention to reach people. Not to prevent that they experiment with the issue of drugs and addiction, I think that is illusory, but to provide as much information and communication possibilities to them as possible. But for that you have to develop structures where you can prevent as much as possible that the user or others are being harmed as a result. A lot has been achieved in this field, but it is difficult to say what can be achieved. On this path you have to take other issues into account also i.e. the whole border zone to other addictions and to discuss this really thoroughly with young people. This is not just about saying that if they go into a disco and take Ecstasy once it is a catastrophe while all kinds of other addictions - also in the family - are absolutely natural. The second issue lies at the other side of the spectrum: offering people a way back into society. But this has a lot to do with the problem that passages from unemployment into the first labour market or into social life are still quite tight as far as my experience goes. But that is probably only logical in a society that has somehow put up with 4 million unemployed people and thinks it is great to be down to 3.5 million can, of course, always just offer a drop in the ocean for drug addicts or offer a second or third labour market to some extent.

These are the two issues. The third one, which I had mentioned before and which has not been achieved is a change in forms of consumption and embedding it in the prescription of original substances. You simply have to state that both in the prescription of substitute and of original drugs there are restrictions in thinking and this is the reason why we lack in concepts ranging from the field of cocaine to party drugs. With regard to party drugs I personally have a lack of answers too, but there are obvious deficits. You have to start thinking about a person with a very high Ecstasy use. Sometimes social work in schools my be not enough: But I don’t have the solution either.

Thank you very much that you took your time to answer these questions.

9.3.4 The health-policy speaker of the SPD

This project is trying to map and define the political goals and strategies in drug policy, in order to prevent and reduce the overdose mortality in the four cities of Amsterdam, Frankfurt, Copenhagen and Oslo. When speaking about "drugs" in this interview we primarily think of drugs like heroin, amphetamine, cocaine. In order to carry out this mapping, we would like you, in your position as the health-policy speaker of the SPD to help us understand by answering a few questions.

1. **(For politicians) What are - in you opinion - the most important political goals in your city? Please rank the following items into three categories, with three items in each category: 1. High priority, 2. Medium priority, 3. Low priority.**

	Ranking
To improve the public aid for seniors	2
To improve public welfare for young people	1
improve the housing situations of homeless people	3
reduce environmental problems	2
reduce traffic related problems	1
reduce alcohol related problems	3
reduce problems in connection with illegal drugs	1
improve the care for people with psychiatric problems	3
improve the educational offers in the city	2

Could you please explain your ranking?

It should be criticised that the category of order and the picture of the city in the public was not included here. This is not about improvement of public welfare for young people, but about implementing sufficient projects for young people and adolescents. I think, all in all these categories have only little to do with the whole complex.

2. **What were the most important political goals in this city's policy in the drugs field ten years ago? Please rank the following items into three categories, with three items in each category: 1. High priority, 2. Medium priority, 3. Low priority.**

	Ranking
To strive for a drug-free society	3
To reduce harm caused by drug use	1
To reduce drug use related crime	1
To reduce public nuisance associated with drug use	2
To prevent drug use among youngsters	2
To secure or improve the coverage of treatment for drug addicts	1
To reduce drug dealing	1
To prevent the spread of diseases like HIV and HepC among drug users	2
To prevent overdose deaths among drug users	3
To prevent money laundering and economical destabilisation through the investment of large sums of money from drug deals	3

Could you please comment on your ranking of these items.

When we opened the discussion in 1989, Frankfurt had an „open drug scene“ and it was clear that the debate in the city was whether we wanted to keep this „open drug scene“. And it was the opinion of the majority that we did not want to accept this any longer. We wanted to break up the open drug scene and offer many services at the same time. That meant developing a broad public offer of help and a system of drug helping services with different pillars. For the first time also with an approach in help that focused very much on acceptance. At that time this was really new, meaning that you did not just let things run, but to set limits on one side and to accept it as part of our society. This is only possible if the helping services are being expanded. But on the other side the city does not do this just because they want to help drug addicts, which is pretty clear. Public safety and public order have always played an important role in this field. To prevent hold-ups in the city, to say it cannot be that people feel insecure in the city because of drug related crime. This was actually the most important issue in that respect.
One thing that is always part of it, of course, is the fact that at that time the number of drug related deaths was extremely high. The question what can be done to prevent young people coming into the drug scene and what could be the different helping measures, syringe exchange etc. It is being taken as a matter of course today, but at that time it was not natural at all, it had to be pushed through with great difficulty. This was also a tough political discussion in the political parties. In 1989 we had a red-green coalition for the first time and there were hefty discussions between the SPD and the Greens on that issue.

3. **What are by your opinion be the most important political goals in this city's policy in the drugs field in the near future?**
   Please rank the following items into three categories, with three items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Ranking
To strive for a drug-free society	3
To reduce harm caused by drug use	1
To reduce drug use related crime	2
To reduce public nuisance associated with drug use	1
To prevent drug use among youngsters	1
To secure or improve the coverage of treatment for drug addicts	1
To reduce drug dealing	2
To prevent the spread of diseases like HIV and HepC among drug users	2
To prevent overdose deaths among drug users	3
To prevent money laundering and economical destabilisation through the investment of large sums of money from drug deals	3

If any changes, compared to ten years ago, please comment on the reasons for these changes in priorities.

I think for the last ten years we have made the right drug policy, but today we have reached a point where we have to think about whether the helping offers are still being accepted. We have implemented a lot of measures and made also some mistakes. In methadone prescription there had been demands in the beginning to have also an accompanying psycho-social counselling and care. This has only happened to a small extent. In the meantime we have installed the safe injection rooms and we observe that the number of consumptions in theses facilities have gone down considerably. We have to think about why certain offers are not being accepted the way we planned in this city. What happens in connection with crack use for instance is that many people don't go into the injection rooms any more, that cannot speak to them any more in the facilities and don't want to either. The staff of the safe injection rooms also reports that many people just come in to make an injection and they are not willing or capable of waiting for their turn. If they cannot make an injection there immediately, they simply go out in the street and do it there and they simply do not want to talks about any further helping measures any more. It is also interesting that the personnel thinks about being more proactive in their work - to go out and speak to people. But we also have the situation that there are less and less social workers and there is no more personnel to get. Almost all the staff members of the safe injection rooms are students and I find that very difficult, and only one social worker who is no longer capable of contacting people and motivating them to think about becoming clean, reducing the consumption or going into detox.
On the other hand it is not very helpful to simply put people into detox. We know that too, it doesn't help. They are back on the street 3 weeks later at the latest. And then we have another problem we have to think about much more: we hardly have people in youth helping services who do not have some kind of experience with drugs. But there is no link between youth care

and drug help to do more in the field of prevention. Looking at the consumptions it is also interesting that the over-all number has declined, but only in some of the facilities, in others not, and you have to think about the reasons for that too. But the number of exchanged syringes did not decline, it is higher than before.
Back to the categories: I think the strife for a drug-free society is a complete illusion. If I could, I would not even rank this issue with the lowest priority, I would not give it a priority at all. I think, in Frankfurt no one has given himself into this illusion any more for the past years - at least not from the drug policy sector. The reduction of drug related crime is still an important issue. Safeguarding the possibilities for therapy would have highest priority too. Preventing money laundering does not play a role in Frankfurt, that is to say it never was a point for public discussion in politics. I think it is also not so important. It may be an issue to discuss on the federal level, but not on the local level.

4. **Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.**

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	1	x	
In police strategies less focus on users towards more focus on larger scale dealing	1	x	
Rehabilitation opportunities (housing, education, social network etc.) Vocational opportunities (work, work training)	1	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	3	x	
Housing for people with drug problems	2	x	
First aid education	3	x	
Sufficient capacity of methadone programs	1	x	
Low threshold methadone programs (allowing side use during treatment)	2	x	
Methadone programs in prisons	3	x	
Heroin prescription programs	2	x	
measures aimed at a change of forms of consumption - from injecting towards smoking	2		x
Distribution of naloxone (narcanti) to drug users	3		x

Could you please comment on your ranking and explain why some interventions are less feasible than others.

We have implemented very many measures in Frankfurt even though the legal regulations do not exist yet, i.e. with the safe injection rooms. And this proved to be very good, after all there are more that 20.000 consumptions taking place in these facilities. The police strategies are really a success of the Monday round. It was always the political aim not to put pressure on the users, but on the dealers. With the Frankfurt police there is always a problem when young police officers coming from the northern part of Hessen are

somehow overburdened with the situation in Frankfurt. That means we need permanent training for these police officers. The sleeping facilities have also been a very important part within the over-all system of „accepting“ helping offers in the city. The emergency shelters are being taken on very well and although they should only be a temporary measure, reality is often different. Lowering the threshold for access to methadone programmes is an objective I consider important. In Frankfurt we have different opportunities because of the different service providers from very low thresholds to higher thresholds and I think it is the right way to look at how far the clients are and to separate things a little. The next thing, which really was not a controversial issue in Frankfurt and where we found consensus very quickly was the prescription of heroin for those who can not be reached by the methadone programme. Another problem is that clients who are being delivered to a hospital are often not receiving the substitution they should. The medical treatment simply is not quite right yet and hospitals are often not willing to take in clients. I also find it exciting that abstinence and detoxification hardly play a role in the public debate any more although all helping services say that this is working very well nowadays.

5a. Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose.
5b. What are your thoughts about the possibilities to reduce or forbid the distribution of these pharmaceuticals?

I must say it is, indeed, difficult to say something about these medical things, because it was never an issue with us. It belongs to the medical field and I don't think that politics can or should decide this. If the doctors can justify this, it should lie in their responsibility. If it makes sense to prescribe it from the viewpoint of the doctors, it must be prescribed. But I would rather not interfere here, because it is really not our business.

6a. Open drug scenes may increase the spread of heroin addiction, cause nuisance etc.
6b. What are your thoughts (experience) about how to prevent or reduce open drug scenes?

The risk of an overdose in an open drug scene is guaranteed. Wherever you have helping offers and control, the risk can surely be reduced to a certain extent. You cannot prevent an open drug scene at all and it is not the goal of the Frankfurt drug policy to prevent it. We only want it to stay within controlled limits. The only means to reduce an open drug scene is to offer services, there is no alternative to that. I think it is an illusion to think you could get rid of the problem. Strangely enough we have far less discussions about a shift of the open drug scene into certain neighbourhoods, when the open drug scene was dissolved there had been very fierce discussions in the neighbourhoods. It comes up in the neighbourhood councils, but when you look at the proposals from the neighbourhood councils today you see that drug policy plays a far smaller role than in previous years.
There is still visible drug use, but I don't recognise the open drug scenes in neighbourhoods as an issue in the public debate any more. I think it has to do with the improvement of the services. People may not feel so threatened any more, not that it has vanished completely. The feeling of being threatened occurs when people inject openly. And it is also interesting that when people have crack stones, so it is the injecting that scares people when they see it and you cannot really cope with it.

7. Do you have any other suggestions about how to reduce the overdose deaths in our city?

Thank god the number of overdose deaths has gone down considerably during the past years. Although it is always difficult to count a an overdose as a drug related death, because what is being recognised is when someone dies in his room etc. and suicide is not counted as a drug related death if it is not recognised as being linked to an overdose. The only possibility I see is to try again to enhance street-work. The social workers say they try to send out street workers increasingly so that they really just spend part of their working hours in the facility and try to reach out to people again. I think that is the only possibility and they have to be trained accordingly in medical issues. It is fatal though that we have the situation that many services have a lack of personnel and sometimes they cannot even open because of that. The services say they are afraid that they will have to close facilities down because of a lack of staff in this year or next. But if people stand in front of a safe injection rooms and cannot get in - what should they do? Then, of course, you will have a public scene outside.

8. When evaluating this city's drug policy in total:

a. **a. In what aspects do you think the policy has successfully reached its goals, and why?**

b. In what aspects do you think the policy has failed to reach its goals, and why?

It definitely achieved a considerable reduction of the harm done to this group of people. The whole concept of harm reduction has worked to a very large extent. People have much better chances for survival nowadays and better chances to get into detox easily. I think it is positive that drug policy does not attempt to simply force people into help but to accept also that people live the way they do. Nonetheless, policy cannot just say: well that's the way it is - it has to continue making offers, but it must also accept that sometimes these offers are not being used. I think this is the crucial point. I think the city of Frankfurt has done a good job here, although, of course, it must think about how to reach young people now and do much more proactively than before. And it must think about whether the financial means are still adequate and sufficient. That will be difficult, we have a very tight budget situation, but I still believe that there are certain health issues where you simply cannot think about budget cuts. Think about that the costs will be much higher in the end if you do not work proactively. What did not work out finally is the Illusion that people would not be visible in the city any more because they are simply not recognised any more. Another problem we have not solved is the increasing violence in the drug scene that is also reflected in the service facilities, of course. And then you have to think about what happens if no one wants to work in this field any more.

Thank you very much that you took your time to answer these questions.

9.3.5 The head of the drug department of the Frankfurt police

This project is trying to map and define the political goals and strategies in drug policy, in order to prevent and reduce the overdose mortality in the four cities of Amsterdam, Frankfurt, Copenhagen and Oslo. When speaking about "drugs" in this interview we primarily think of drugs like heroin, amphetamine, cocaine. In order to carry out this mapping, we would like you, in your position as the head of the drug department of the Frankfurt police to help us understand by answering a few questions.

1a. What has been the major philosophy and goals concerning drugs in your organisation during the past 10 years ?

In principle, it was the recognition - and not just among our part of the organisation, it was basically the same in all organisational units that had to deal with repression - that repression in the field of drug related crime is not the ultimate wisdom and that also from our side we had to go into this more with means of prevention. In that respect we were pleased to find partners here and that it came to a consensus which could be implemented in the Monday round. A group of experts where the police could bring in their expertise and their demands and where we found partners easily. Here we could bring in new developments that were recognised and here in this competent round they were translated into action.

1b. What have been the major obstacles that your organisation has encountered in its practise?

I really cannot tell you, because I just came here a few months ago. As far as I know this development was supported by a broad consensus. The concrete background - no matter on which side - I personally do not know about.

1c. Imagine you could have changed something in this society's drug policy in the past ten years, what changes would that have been?

I can only look at this in retrospective. In 1991 we have started the substitution programme, then in 1992 we continued with measures for reducing the open drug scene which is to say that we tried to dam up the „open area“. This was flanked two years later by the instalment of the safe injection rooms and the continuous expansion of services. Perhaps one could have wished that all this would have happened faster than it did - but maybe this was not possible, because it needs development. However, I think we are on the right path. When enter new paths you walk them step by step - rightly - you evaluate whether the path is the right one and then you develop on from that stage. It is easy for me to say that I look back 10 years from the green table and it ally could have happened faster, but this would not be serious.

2. What was the most important political goals in this city's policy in the drugs field ten years ago? Please rank the following items into three categories, with three items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Ranking
To strive for a drug-free society	3
To reduce harm caused by drug use	2
To reduce drug use related crime	1
To reduce public nuisance associated with drug use	2
To prevent drug use among youngsters	2
To secure or improve the coverage of treatment for drug addicts	3
To reduce drug dealing	1
To prevent the spread of diseases like HIV and HepC among drug users	3
To prevent overdose deaths among drug users	1
To prevent money laundering and economical destabilisation through the investment of large sums of money from drug deals	1

Could you please comment on your ranking of these items.

This ranking has been made upon the basis of our tasks. As we have a predominantly repressive task and are an organisation unit that fights against drug related crime but also organised crime, we are therefore necessarily asked to dam up all the delinquent areas with a major priority, such as money laundering, drug dealing and acquisitive criminality. Nonetheless, we have always tried to get these activities in line with the street, also by looking beyond our limited horizon, with the societal consequences, also concretely with the health policy consequences, although, of course, there are limits to our possibilities. We can stimulate, we can emphasise, but we cannot always put something into action immediately.

3. **What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?**
   Please rank the following items into three categories, with three items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Ranking
To strive for a drug-free society	3
To reduce harm caused by drug use	2
To reduce drug use related crime	2
To reduce public nuisance associated with drug use	1
To prevent drug use among youngsters	2
To secure or improve the coverage of treatment for drug addicts	3
To reduce drug dealing	1
To prevent the spread of diseases like HIV and HepC among drug users	3
To prevent overdose deaths among drug users	1
To prevent money laundering and economical destabilisation through the investment of large sums of money from drug deals	1

If any changes, compared to ten years ago, please comment on the reasons for these changes in priorities.

The goals have not changed, because our tasks have remained the same. I have to orient this according to our tasks at first. That is to say, the prosecution is determined by the legality principle there and we have this order, I can't give it a lower priority. Our intention to combine this with a preventive philosophy oriented towards the addict has remained the same. I think, a drug-free society would be a beautiful goal, but from my point of vie it is not realistic.
Therefore, I don't see a change in the future from the point of view of this organisation.

4. **Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.**

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	1	x	
In police strategies less focus on users towards more focus on larger scale dealing	3	x	
Rehabilitation opportunities (housing, education, social network etc.) Vocational opportunities (work, work training)	1	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	3	x	
Housing for people with drug problems	1	x	
First aid education	2	x	
Sufficient capacity of methadone programs	2	x	
Low threshold methadone programs (allowing side use during treatment)	2	x	
Methadone programs in prisons	2	x	
Heroin prescription programs	1	x	
measures to change habits of consumption - from injecting towards smoking	3	x	
Distribution of naloxone (narcanti) to drug users	3	?	?

Could you please comment on your ranking and explain why some interventions are not feasible in this city, if any.

I cannot judge upon giving naloxone, I don't know this. With regard to measures aiming at a change of habits of consumption - from injecting towards smoking - if this refers to crack, it is not a goal worth striving for. Apart from that I think that most of the issues mentioned are feasible, many things have already been - at least partly - achieved here.
I have given a high priority to the Rehabilitation and vocational opportunities as well as to housing, because I think the most crucial point in this is to stabilise the social surrounding, get them out there. To end this situation of depravation in which they find themselves and perhaps having also a little control over what they consume. This is easier, if you have competent contact persons there and in such services also failures or pathological developments become apparent probably faster and better or at all, then if they are living somewhere out in the scene. So, I do see a great priority there, and of course I also link this with the hope that the chance will be there again - at least in parts - to live some kind of a „normal" life.
Police strategies are - in consultancy with the public prosecutor's office - less concentrated on the consumer than on the large scale dealer.
I think this is right, but from my point of view I don't necessarily see the connection with the problem of overdose deaths.

5a. Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose.
5b. What are your thoughts about the possibilities to reduce or forbid the distribution of these pharmaceuticals?

I cannot give any definite judgement whether this is so from the toxicological or medical point of view. In my view, the problem could be reduced by information that this could

proably be a dangerous combination according to current knowledge. Forbidding the prescription will not help much, because it will be offered on the market anyway.

6a. Open drug scenes may increase the spread of heroin addiction, cause nuisance etc.
6b. What are your thoughts (experience) about how to prevent or reduce open drug scenes?

We do not have an „open" drug scene in Frankfurt any more.
It is a fact that the numbers of the drug deaths to be mourned have decreased drastically after its closing.
I would not want to state that this was mostly due to police measures alone. Here you need a number of supporting measures. On a big, mostly uncontrollable open scene you also find a large variety of drugs to purchase.

7. Do you have any other suggestions about how to reduce the overdose deaths in our city?

In my view, we are on the right path. Well-targeted repressive activities against the level of the dealers combined with supporting measures of counselling, medical and psychological care, the substitution programmes as well as the safe injection rooms for the addicts. This approach of a multi-dimensional, multi-organisation cooperation should be followed on consequently and perhaps also supplemented, i.e. with the controlled prescription of heroin. In the end, however, we will all not be able to prevent drug use related deaths completely. Neither the municipal drug policy co-ordination office nor the police can stand behind a user and keep an eye on him.
If I look back upon the last years since 1993, we actually had a continuous decline, then a relatively stable level with some minor fluctuation, which is very good if you look at the over-all German average.
I don't want to sound cynical if speak about deceased people and a good average, but I am only giving figures now.
When you evaluate what the reasons for the increase in drug deaths were, we are often at a loss and ask ourselves what was it? We must not forget that behind this problem are people and their habits. We can try to influence these positively, we can try to offer help, but we will not reach everybody, we cannot reach everybody. But, I believe the work that is being done here is good and I would be happy if especially the heroin prescription model would fulfil our expectations. I see a chance there and therefore I am optimistic.

8. When evaluating this city's drug policy in total:
a. In what aspects do you think the policy has successfully reached its goals, and why?
b. In what aspects do you think the policy has failed to reach its goals, and why?

What we have achieved - and I think compared to the rest of Germany - there is already quite a lot. We have achieved quite a lot for the users, we have achieved mostly that users are conceived as what they really are - by all bodies involved, including the police - as ill people. We have made help possible as much as we could. In a broad consensus with the helping services, local policy makers, the justice and law enforcement system. I am convinced that

heroin prescription will supplement this approach in the future. I think it is sensible and it should be followed.
It is hard to say what we have not been able to achieve. There is an optimum, more. Of course, you can always say we need more services, we need more safe injection rooms, but all this has to be feasible, also from a financial point of view, which is unfortunately a very crucial point theses days.

Thank you very much that you took your time to answer these questions.

10 Interviews from Copenhagen

10.1 Drug users in Copenhagen

10.1.1 Male, 31 years (Camping village)

I am 31 years old and started to take drugs as a 12-year-old. I have hepatitis B and C and I'm HIV positive and live in a trailer now. On Thursday I have been offered to move into a flat for a while, and I have accepted this, mostly because of my dog and of course also to look after myself. At some point in time, I might catch a cold and I can't afford that right now. I have no education whatsoever. I started smoking cannabis. Before that I played on gambling machines, then I started smoking, then on to cannabis and finally I tried speed. I was a skinhead when I was young and needed to be self-confident. It was a tough environment. Then came the dope and the pills, because you needed something to relax on. I was almost going crazy after three years on speed. But I continued to take all kinds of different drugs. At present I take 80 mg of methadone a day and once in a while, I smoke cannabis. I have been clean for three years and been living in Jutland. I have been treated for my addiction and have been in family care, I have had a wife who was not HIV-infected. However, we had too many problems and it didn't work out for us. So I ended up going back to Copenhagen and instead of playing Superman and walking around with the belief that I could conquer the world, where there was a chance that I might relapse into heroin or painkillers, I went up to my old centre and asked them for methadone again. And that was no problem. They just gave it to me.

I myself have been through three or four experiences with an overdose. The last time was in the men's room at Nørreport station. This happened several years ago. I was in the middle of my methadone treatment at the time. I was alone, and I really don't remember that much. All I remember is that I was eating painkillers (Ketobebidon) and walking around without making much sense and I thought I was somewhere else. You walk around with a lot of ideas in your head. I fell asleep on a bench. The ambulance men tried to wake me up, but they couldn't. They had also given me an antidote, and that made me really mad. So I started yelling and screaming that they had pulled me down from the sky, and now I had to go out and get some more, but all they had done really was to save my life. I don't remember who called the ambulance. Why I had an overdose on that particular day was probably because I didn't have anywhere to stay and I was pretty stressed. When you need a shot, you have to go to the men's room at the subway. The lights in these rooms are special and it is hard to see and find your veins, and the painkiller (Ketobebidon) needs to be filtered through cotton and a 20 ml pump. A real ordeal.

I simply think that I had too many and was too stressed out and I needed to get a full shot before I was thrown out. I was standing with a lighter and had to find the veins in my groin without missing. The lights in there are so dim you can't see squat. You might even say that the low lights in the men's room are the reason why some people lose an arm or a leg.

I had my first OD when I was 18 years in Sundholm (a shelter). It was during one of my first shots. Once when I was staying at Sundholm, I shared a room with a guy called Harley. That wasn't his real name, and he wasn't very nice to me. In fact he was a real bastard, and I didn't like him. When he had drugs, he never shared them with me. In the beginning, I shared my drugs with him, because I'm a nice guy. Then I found out what kind of a jerk he was, so of course I stopped sharing drugs with him. Then one night around midnight when we were living in the same room I woke up and found him lying halfway out his bed and he had

thrown up a little. I thought that it was his own problem. Fuck him, and the next day he had thrown up even more. The next morning when I woke up, I found out that he had choked on his own vomit, and I felt a bit guilty. I should have walked over to him and kicked him back into bed again, but then again, he might as well have rolled out of bed once more. Those things happen. Of course I felt bad about it. This was the last time I had been so close to an OD.

People end in OD situations because they don't know when to stop. Stress, out and make money and if you have been without drugs for more than 24 hours and you need to go into the "street" to get the drug, it is sometimes difficult to buy anything, because you are afraid that the police might turn up after you've bought it. They keep an eye on you everywhere and it really makes you nervous. Maybe you don't have any place to live or a regular place to take hit the needle and there are people all over the place. Then you end up taking it all in one shot, because then you are certain that it is all gone and the police can't take it away from you. The police make the whole thing more difficult because they are constantly on your back and have a policy of harassing drug addicts around the Central Station.

If the politicians really wanted to do something to help us they should build injecting rooms, if possible in some of the outpatient clinics and primarily for those injecting methadone. A new substance on the market is the concentrated methadone, specially designed for injection purposes. The politicians are the real stumbling block. Shooting drugs is a disease, a mental thing going on in your head. So I hope that injecting rooms will be introduced and make people relax more when shooting. Our situation today is filled with running around the corner and hiding behind a bush when shooting methadone. Your 20 ml pump is filled with old blood, and bacteria just love the juice. It's shot into your veins, perhaps with a few blood clots that fly up to your heart and stay there, or they sit in your arm in a blood clot. Either the clots stay in your arm or in your brain.

Injecting rooms and more lenient legislation for the small fish, give them what they want - this is my advice to the politicians.

10.1.2 Male, 42 years (Maria Church)

I am 42 years old and live outside Copenhagen. I have been an IDU since I was 13 years. I started with smoking a bit cannabis, but then went straight on to heroin. I have an education as a paint dealer, but live as a pensioner today. I take methadone, cocaine and benzodiazepines in huge quantities. The heroin can't win over the volume of methadone I take. A waste of money.

Once I was in drug free treatment for 1 month.

I don't remember anymore how many ODs I have lived through. My first OD was when I was 16-17 years or something like that. 14 years perhaps. I remember the last one better than the first. This happened almost 3 weeks ago. I had been taking some drugs in my apartment and woke up 36 hours later in my basement, so I don't know what happened. I had taken a mixture of coke and methadone. I rarely experience an OD. I am mentally stable, but my body sometimes shuts down. I also had a double pneumonia and an abscess in the lungs. Of course that didn't make things better. I was alone when it happened and also when I woke up. I knew that I was touching the limit, but I am also suicidal. I normally take it all the way to the edge.

My wife has also experienced an overdose a thousand times while I've been there. I have blown life into her (resuscitation) so many times that I can't remember it anymore. I never call the ambulance when it happens because there is no time once they start having cramps. The only thing to do is to keep them down.

Many of the ODs in Copenhagen are probably because of strong drugs, and those taking them don't know how much they can take. You don't feel the drug to begin with, at least nothing that really kicks you into space, and then you quadruple the dose and you stop breathing.

If you don't want to experience an overdose, you shouldn't do drugs. Otherwise you should try and shoot half and see what happens and then wait 10 seconds so you can feel how you're responding. The only problem with this method is that you don't get that same kick out of it.

If our situation is improved, politicians should do what they are doing at the moment. We are a few addicts who are going to try pure methadone. I'm sure that's a good thing. I could imagine that it would stir some attention. Another thing is that they should legalise drug taking in certain controlled areas. If you can walk in there and you know there's a nurse on the other side who will help you if you start to "tilt". Many of those who are overdosed are young people who are inexperienced with drugs. People like me know how to stay out it.

Another problem is that if you see a police officer, then you take the whole works in one shot or swallow what you had hidden in your mouth. That may cause an OD and you may die, so my advice to the politicians of the City of Copenhagen is: Stop chasing us.

10.1.3 Male, 38 years (Project "Udenfor")

I am 38 years old. I live in the north west part of Copenhagen and have been a drug addict since I was around 12 1/2 years. I was born in Jutland, but arrived in Copenhagen the first time when I was 17/18 years. My parents were drug addicts and I smoked cannabis the first time when I was 9 years old and took heroin the first time when I was around 12 1/2 - 13 years. When I take drugs I am either alone or together with others. But primarily, I do white heroin. I may shoot drugs down at Maria Church square, or in the street. I may also do it at home or when I'm at my friends. I am in methadone treatment at present.

I have had an OD seven times. The first time was when I was 16 years. I have had three ODs in Copenhagen and four in Jutland. The last time was probably 1 1/2 years ago. I had bought heroin in the street, because my private pusher was out of town, and I can imagine that I had bought impure heroin which lead to complications and then to an OD situation. I hadn't taken anything else or more than I was used to. I had my OD near the Maria Church. I really don't know what happened. Somebody must have called an ambulance, because the ambulance came and so did the police and the people from the church. I had a respiratory aggregate and saltwater, ie antidote. They didn't take me to hospital. I had to get up and walk around while I threw up like crazy.

The typical OD person is one who has just been thrown out of treatment or been discharged from drug-free treatment. Then they are back in the street after their treatment, and then they are more prone to an overdose, because they start out with taking the same quantity as the one they took before they started treatment.

The last time I saw an overdose was around 1 1/2 month ago. In the street leading up to Maria Church. We were standing there a lot of people, then a guy showed up and bought some packages and shortly after we were told that he was all blue in the face. Then we rushed into the church and asked the staff to call the ambulance. This is a very unpleasant situation. I can only talk from my own experience, but I get all sweaty when I get near an OD. Most people say that it is his/her own fault. But sometimes I have seen that the ones selling the drug leading to an overdose walk away for an hour or two and then come back with the same strong drug and just keep on selling. This means that none of us really do anything to stop this kind of traffic. And I simply don't know what the reason is.

Another time it hit one of my good friends; we bought two grammes of white cocaine, and then he took around half a gram. A real rock. I warned him and told him that it would kill him. Fortunately, he didn't die, because they got there in time. I called the ambulance in Svendborg, and the police showed up as the first and the ambulance came afterwards. The police kept us away, so we couldn't help him. They searched us and had our money confiscated together with the drugs that we were carrying and while this was going on, my friend was lying there without anybody being able to help him, because we couldn't help him before the ambulance came and gave him an antidote. He survived, but he died four months later of another overdose.

It is important that you stay away from mixing the drugs and that you try with a small dose to begin with. This is the best thing one can do to try to avoid an overdose.

It is my impression that it isn't the old drug addicts who die. Many of them I have seen in the street the past three years are young people. They have been drug addicts for only two or three

years. Perhaps they have been under treatment for the first time and then they need to come down and wave the flag, show that they are still in control of things, and then they get a real kick in the head, which may turn out to be 100 mg too much.

My advice is to carry out heroin studies. This is the only way to stop the OD deaths. If people wish to take heroin, they have been hooked by a drug, and there is nothing to stop them. So I believe that the only proper drugs policy is one that allows for monitored trials. That means controlled quantities and drugs that are pure. The politicians should leave their desks and come into the street and see how life really is.

But it is complicated. I don't really know what good treatment is. Giving information to the drug addicts is worthless, because they know already what it's all about. Perhaps make some information campaigns on how the drugs affect the body when mixing substances, because many addicts don't know enough about that. Information could be given on various ways to take the drugs, if they take different kinds of drugs. However, no information will cause an addict to stop taking drugs. Once an addict, always an addict.

10.1.4 Female, 28 years (Women's shelter)

I am 28 years and have been injecting drugs for 16 years since I was 12 years old. I didn't start out smoothly. I just started - wham! I have been a prostitute for 16 years too. I have been under methadone treatment for the past 10 years and sometimes I take some other drugs in connection with my methadone, and this is mostly cocaine and pills. I have also been really hooked on heroin. Moreover, my parents were also addicts, and I was born with withdrawal symptoms. Today, I'm homeless. I have lived for 8 years in Copenhagen. I started with raw opium which I prepared myself and took from the fields. I cut off poppies, boiled them and all that jazz - you know. When I was 12 years old.

When I inject drugs, I normally do it in the public restroom. Mostly when I'm alone, because I take cocaine and I like doing it on my own. I inject in the groin and do the injection myself. I have no other spots on my body where I can find veins. I can't stand noises when I take cocaine. It seems to me that other people make a lot of noise. They don't know when to keep quiet. I like holding hands when I'm high, but people don't know that they should be quiet when their noise makes me feel sick. That's why I would rather be alone when I take drugs, even though I know that it is more dangerous. It's a lonely affair, getting the money, but I don't want to share and I don't want to be together with people. It's lonely being a drug addict when you walk the streets (for prostitution). Of course, there are a few times when you take the drugs together with some friends, but mostly I do it on my own. It's a one-man show, doing it in a backyard somewhere, public restroom or stairway. I do nothing to try to avoid getting an overdose, even though I inject on my own. Right now, I am in methadone treatment, but that's not really treatment. That's just maintenance.

The first time, I suffered from an overdose was when I was 16 years old. I think I had been taking drugs for around four years. I overdosed on painkillers (Ketobebidon) and my throat just clogged. The people I was together with dragged me around and threw me into a cold shower and beat the daylights into me. I have also overdosed on cocaine, when I started getting cramps and almost bit my tongue off. That really scares you. If you suffer from a cocaine overdose, there's nothing much you can do - you simply get a massive stroke. I have had many near-death experiences with nosebleeds and stuff like that. If it's heroin, all you need is an antidote. Nevertheless, many addicts choose not to get an antidote, because they get sick. They get withdrawal symptoms after an antidote.

The last time I overdosed was not far from here, in a stairway in Helgolandsgade. I shot cocaine and had too much, and then I lost my sight. Bells were ringing in my ears and I couldn't breathe. Some of the other girls had to drag me down to the shelter, where I wasn't allowed to come, but I stayed there anyway until I stopped shaking. I had been sitting in a corner and injected my drugs, but luckily others saw what I was doing. This was on the night of 1 December 2000. I was also in methadone treatment at that time. There was a short period when I was completely clean and didn't take drugs for almost three years. But in total I've been 10 years on methadone.

Once I was together with a friend who overdosed on cocaine. She had cramps, pink foam and lost consciousness. This was in Amager, not far from where I lived. At that time I had a place to live. I rented a room there at the time. I called an ambulance, but had already managed to wake her up when they came. They didn't give her anything. She should have had a sedative, but they won't give sedatives to drug addicts. Later she died from bacteria in her heart valves

You often suffer from an overdose when you have been taking coke for a long time. I knew that the drugs I had bought were stronger than the ones I normally buy, but I really needed something that could lift me off my feet, because it was such a long time ago. So I was greedy. And my greediness almost killed med. I wasn't quite sure about the dose I took, but my greed conquered my brain. I didn't intend to overdose, but I knew that it could happen, and I didn't really care. After many days on cocaine, where you haven't been sleeping, you don't care very much about anything else. You keep on going, because you want that final kick. This, and the fact that you don't know the concentration, and then all of a sudden, there's something good. If you could go somewhere, for instance to injecting rooms or something like that, it wouldn't always end so dramatically. It's difficult to get help when you are sitting in a backyard. Chances that someone will pass by and find you are low. Or you may use the public lavatories. The places that are monitored are better, because you will automatically be found there, but there aren't many places like that. There are lots of stairways, really slimy places, where only few people come. Of course, nobody is there to save you. The most logical solution would be injecting rooms.

What you can do is take a smaller dose. However, I would never do that myself, because it's very difficult for me to inject, because I have no veins and I don't want to sit and inject twice if one dose is enough. That's what I often do: I take a larger dose than I'm sure I can handle. If I split up the dose in two, it would be easier for me to handle. And it isn't always the dose that kills you. You may also be physically down, and then your airways can't handle the situation.

The police are also the reason why people die because the police sit on our backs. And it's the wrong people they are harassing. They lean on the small fish. This doesn't reduce crime - it increases it. Each time they relieve a street junkie of a package, he has to crack another crib, and I have to get myself a new customer. So all the police do is to keep them selves busy. It has the opposite effect, and they know it. Or at least they should know it. I don't understand what kind of logic they are pursuing. However, I'll never admit that heroin should be liberalised. The addicts will get bored. And then they need more. So, if junk is served to you, you'll still go out and do crazy things, because people on drugs are very restless people. They are bored and a junkie can never get enough, even though he would be able to go to the clinic six times a day - that just wouldn't be enough. You will never ever be able to make a drug addict happy. It is one big black hole. You can't get enough.

I don't know what kind of help we need. Perhaps the injecting rooms, another more safe environment to shoot drugs. Otherwise, I don't know what could help.

I think it is wrong that some people feel chased. I can't see that filming junkies and spending millions of Kroner will help, because they will never get to the bottom of things. The only thing is that they will ruin life even more for this group of people, and I don't understand why they want to spend money on that kind of activity.

10.1.5 Female, 32 (House for the homeless)

I am 32 years and have lived in Copenhagen since I was 17-18 years old. I have been an addict since I was 26 years. I have graduated with an HF exam and have been enrolled in the university for a short period. I started with heroin, which I smoked to begin with. Today I do heroin and cocaine, but I inject it now. I am also in methadone treatment.

I have never tried an overdose, but I have been close to trying one. I'm a Heavy Biter, which means that if I take too much, I just fall asleep.

Once I was in Hamburg when I saw one suffer from an overdose. It was an overdose from strychnine. It looks really strange, with the eyes rolling upwards. They lose balance and it's clear that they're about to kick the bucket. It was right outside an injecting joint in Hamburg. Nobody did anything. Nobody called an ambulance. I forced the person to walk around. I leaned forward and held him, and then forced him to walk. It was an accident, he just had too much.

I think there's a lot of strychnine in the dope. I think that basically it's everything else than clean dope. I don't believe the police when they say that the dope in the streets in Denmark is almost 8% clean. Then when something stronger arrives in the streets, people die from overdoses, but I don't believe that. I think that the dope is mixed with rats poison, or strychnine. It's got nothing to do with the concentration, because I have taken very clean concentrations, and I didn't die from that. In Holland and Germany, it's possible to have your dope checked in labs. I mean, how clean the dope is. Legalise heroin. I am certain it would help. And then it wouldn't be possible to mix all kinds of strange things into it, and you could get a clean cut every day.

I think that many of the overdose deaths in Copenhagen are covered up executions. This is what is often told in the street - that if you are already lying down, they drag you into the nearest secluded area and leave you there to die. I've heard that lots of times.

The more restrictive the police is the worse it gets. That is also one of the reasons why people die. If they feel chased. What they do is when they have bought the drugs, they have to take it immediately or they risk being stopped by the police and having it seized. So they don't think twice, use dirty needles and unhygienic conditions. Less stress results in fewer deaths.

However, drugs aren't going to go away. They're here to stay, and fighting them the way they do is stupid. It only produces more junkies.

10.1.6 Headlines - summary

- The reasons for overdoses are purported to be stress, caused in particular by police strategies, drug concentration, including genetic differences and adjustment , general condition of health. Each of them has a contributory effect, where only one of them may cause the death of a person and each of them may individually boost the other.
- As something rather special for Denmark, the drug Ketobebidon, which affects the respiratory system, is in great demand. It should be investigated whether there is a correlation between deaths in Copenhagen and Ketobebidon (strong painkillers).
- Most of the interviewees agree that injecting rooms and a changed attitude by the police would have a favourable impact on overdose deaths. However, there appears to be some disagreement on several other initiatives, whether or not heroine should be handed over the counter, for instance.
- From a prevention perspective it is interesting to observe that more or less all of them are aware of and can provide a description of safe injecting techniques, but this is rejected by several of them as an actual option. In other words, they know what is right, but fail to act accordingly.
- Furthermore, the interviews reflect that the lives as drug addicts imply that they cannot live up to expectations in terms of solidarity, care for each other, self-justice vis-à-vis bad pushers, etc.

10.2 Street workers in Copenhagen

10.2.1 Street nurse, Maria Church

I graduated as a nurse in November 1998 and was then directly assigned to the area around the Maria Church as a street nurse. I am 27 years old.

The Maria Church is located right behind the Copenhagen Central Station. In this area, hard drugs are being traded, and this is also the location, where the drugs are taken in front of everybody.

Basically, this is a place where all the drug addicts gather, deal and take drugs, but other groups also hang out there, alcoholics and people who have been unable to assimilate into the surrounding society. As it appears, it is a broad spectred group of outcast from society, but primarily the area is the home of drug trafficking and drug taking. The Maria Church has then opened its doors and operates as a shelter during the daytime from 12-16 and from 19.30-23.00 in the evening. During opening hours, people will walk in and out and have coffee, but the key activities are carried out in the open space in front of the church, and this area receives many visitors during the daytime - those who just show up to buy drugs and then leave again instantly, and those who simply use it as their main haven where they stand all day long and make social contacts.

In addition to our general training as nurses, we have received a special course in first aid, primarily with a focus on observation of overdose symptoms and how to intervene with ventilation, ie artificial respiration with a balloon.

We are not authorised to administer the antidote which may prove necessary, so what we do is observe whether the patient has overdose symptoms; this is a special talent one develops gradually. We constantly observe the group and notice when, woops, one is about to "tilt" as we call it. We are then able to intervene with ventilation without having to call the ambulance, but in most cases, when we are dealing with the classical overdose, we need to call ambulance and wait for the rapid response vehicle crewed by a doctor to arrive and administer the antidote. In the period up to his arrival, we start to subject the patient to ventilation whereby we sustain life. Some days we rush to as much as 5 overdoses per day, and sometimes a full week may pass without any overdose events. However, we must keep in mind that we are only talking about the area around Maria Church, to which the overdose situations are by no means confined. There are many other areas in Copenhagen where overdose symptoms occur.

I have once had to deal with a cocaine overdose reaction which is something quite different, and it is a very rare phenomenon. The classical overdose situation is when a person has taken too much heroin, and in combination with drinking beer, taking methadone and sedatives, it is difficult to say what causes the overdose reaction. It could be the heroin that is the "last straw", but often it is just the combination of various substances. I have never seen anyone with overdose symptoms who has not been injecting drugs. It is very difficult, I would almost say impossible to take an overdose by smoking heroin, simply because you fall asleep before you get that far. Although it is a somewhat bold statement, I would maintain that smoking-related overdose symptoms are hardly ever seen, because the clientele at the Maria Church are primarily injecting drug users.

The typical overdose is suffered from those who have been in drug free treatment and who return to the environment if they have not been able to drop the habit completely. Their body is not used to the dose they took previously. This group of people may, for instance, be those who have been in prison. If they have not been taking heroin while they were in prison, and the period need not be of long duration, they will not be able to cope with the quantities taken prior to their imprisonment. Then we have the weekend-junkies who are the ones who only take drugs perhaps once a month, turning into binge abuse for a weekend or so. No doubt we are dealing with people who are not participating in any kind of treatment program or who have just been released from prison, or who may have been receiving Minnesota treatment - or - well - who have just not been taking drugs on a daily basis. Of course, there are also the cases with addicts who simply do not know the right concentration of the drugs. Overdose events are often a result of more strong drugs circulating on the market.

When I see new faces and notice that their eyes wander uneasily because they are not quite familiar with the area, I always keep a closer eye on them. If I find that I should go over and talk to them, I say "try to be careful and shoot only half or less than half – and do it slowly so you know the strength". Because even though they only shoot half, they still might have an overdose if their body is not used to it.

What is really distinctive and the reason why we see fewer deaths in Copenhagen without being able to give any exact figures in relation to other cities and town, is of course that we have the street nurses, which is the secondary reason. The primary being that the rapid response vehicle crewed by a doctor and paramedics gets to the scene so quickly. The people in the area meet with each other and instantly spot an overdose underway. These factors are contributory to distinguishing us from other towns and cities in Denmark. What should also be considered is whether or not the firemen should be allowed to administer intramuscular antidotes. We also try to provide useful information such as instructing the addicts in injection techniques: when injecting, do it slowly. However, it is sometimes difficult in practice when the police walk the streets and the unclean drugs are being dealt without anybody knowing of the quality of such drugs.

When viewing the problem throughout a longer period, there is no doubt that the intensified police work with activities being launched to remove the drug addicts from the streets during city renovation and similar projects has been instrumental in increasing death figures and injuries which have been experienced by the addicts as a result of being under stress and being chased.

In order to bring down the number of overdose accidents, the users must first and foremost be informed of drug concentrations for that particular drug. Another remedy would be that although a group of addicts still would be unaware of drug concentrations and how much their body could take, this group should be able to go to a place manned by nurses who were trained to make observations. If nothing else, this group of people would be able to perform their abuse in quiet surroundings instead of shooting drugs immediately in order to get away from the area and avoiding a fine. The users should learn how to help each other. The fact is that overdoses are being taken many other places in Denmark than at Maria Church, also at home, where they should be able to help each other. It would be brilliant if they had tablets themselves that they could place under the tongue in order for a person to be able to wake up. It should also be possible for the paramedics, ie nurses and firemen, to administer the antidote. I also find that we need to embark on a constant dialogue with these people. Give them information because many of them (I was rather startled to learn this) did not even know

what an overdose was and the reasons for it. They simply think the heart stops beating, which eventually it does. Still it is important that they receive ample information, because the more information they get, the better they understand that they there is no point in shooting the drug all in one time. Opiates in general obstruct respiration, and excess quantities will cause breathing to stop and the body receives no oxygen. However, providing targeted information requires that you move about in the environment. The other activities are very specific, but filling them with information which they may pass on to others and to new-comers will perhaps cause the death rate to drop or be avoided altogether.

10.2.2 Copenhagen Police, Station 1

I am a policeman after four years of training and education.
In addition to my formal training, I have taken a number of courses in drug problems and investigation. I have almost 22 years' experience, of which 18-19 of them have been spent in Vesterbro. When talking about drugs, we have a central department referred to as the drugs and license department. This is a consolidation of the drugs department, the drug and license squads. Each police station is obliged to oversee drugs traffic or drugs crime going on in the district in question, cf our drugs strategy. Vi have six police districts in Copenhagen, and we are district - or station - 1. What is characteristic of station 1 is that we have a great deal of drugs traffic in out streets. To deal with this, we have set up a task force. We also have a group working as civilian officers. We make up strategies of how we should combat drugs trafficking in the streets and how we will cover the area. Our task is rather simple at present, given that the drugs population have chosen to settle down in the area surrounding Maria Church and the back entrance of the Copenhagen Central Station. These are the two areas, in which we encounter the problems of drugs trafficking in the street.

The police at Station 1, who deal with the narcotic problems, are divided in two sections. One works as a civilian group one works in uniform. The latter operates primarily from a bus[8] circling the area at Vesterbro making contacts with drug addicts, who are hanging around this area (the open drug scene of Copenhagen). The bus operates according to the Danish Administration of Justice Act and police regulations. The Danish Administration of Justice Act states that the police have an obligation to secure law and order and they have legislative as well as executive means to punish those people (addicts and alcoholics) who, just by being there, disturb others. The punishment can be a fine (€ 70 each time) or expulsion from the area. Our main goal here is to remove groups of addicts form squares and sidewalks because they obstruct or harass other citizens who walk by.

In addition to the Fine Bus, we have a department of civilians dealing in drugs traffic. They keep people under surveillance from hidden stakeouts, keeping an eye on those who sell and those who buy. Once a deal has been made, they apprehend the buyer, locate the drugs on him and get a hold of the dealer. In accordance with the new drugs legislation adopted in 1996, such a situation gives grounds for an arrest and for the person being punished. If he has done time for drugs trafficking before, he goes to jail the first time, which is something new. Before, the dealer needed to have 10 counts for drugs trafficking before punishment was ordered. But today, punishment sets in the first time after a sentence has been passed.

The first time, the dealer receives a conditional sentence for his offence. The second time, he may be sentenced to one to three months' imprisonment, even though he has only been sentenced the first time for a small package (0.05 grammes). If he is caught numerous times, he will be sentenced to one year's imprisonment, even though the deal has been of a minor nature. This is a reasonably hard punishment.

The basic training of Danish policemen includes first aid courses, which also train in the problem of overdoses. In addition, they soon acquire a great deal of experience by being coached by an elder colleague who has most likely been through this situation before. They then know what to do or, perhaps more aptly, not to do. Here at station 1 in Copenhagen, we

[8] A minibus driven by police in uniforms. From this bus, a majority of the drug addicts are fined for illegal activities in the street. The bus is also nicknamed the "Fine Bus".

have a response time of two to five minutes from the point when we have made a callout to a rapid response vehicle crewed with a doctor, until the ambulance arrives. So, we only have very little time. And what we know is that most drug addicts are infected with some kind of infectious disease. We provide acute first aid, which means that we place people in Nato position if it is necessary. Very few colleagues only do using mouth-to-mouth resuscitation. I am aware that we have masks that we could use, but it takes time before the mask is on and resuscitation starts, and by then the ambulance crewed by a doctor has arrived. Sometimes, however, they arrive too late and the person in question dies before reaching the hospital. But in most cases, the patient is brought back to life. Not by us, but by the doctor.

The majority of all overdoses are predominantly brought on by heroin. However, some of them report to us later that they had been mixing the drugs. We cannot be quite sure that what they are telling us is the truth, and we cannot be certain that they know what they have been taking. Throughout the past 25 years, analyses have been conducted on the mixture of substances in drugs. Often it turns out that the concentration of heroin has just been stronger than the one they are used to.

What is typical for them who suffer from an overdose is that the person has been imprisoned for some time, gets out and buys the usual quantity of drug. One way or the other, they have managed to phase out their abuse during imprisonment or the place where they have been staying, and then they get too much and lights go out. If they are not offered treatment within very short time, they die. Most of them respond favourably to resuscitation if we had them under surveillance while taking the drug. We would then be able to step in and administer some antidote, but the fact is that they die because nobody is watching them.

In order to curb the number of overdoses, the users should be told what is in the package they are about to buy. This means that we would have to analyse illegal drugs bought in the street, and we cannot do that. This is impossible for us to organise properly, and our legislation does not provide for this situation. And our legislation ought to. It should be possible for the drug addicts to receive over-the-counter drugs. Another question is then whether we would be interested in having a group of people subjected to permanent aid of this kind. Another solution to avoiding the deaths is to get to the addict quickly after an overdose has been identified. If we could achieve this, the greater the chance would be for them to survive. The people we find dead from an overdose are those who have accidentally placed themselves in an isolated spot. This is one of the reasons why the addicts take their injections at Maria Church. Many of them do in fact have a place to live and we ask them "why don't you go home?". Those who are willing to answer that question tell us that the reason why they hang around there and inject themselves in the groin and in the neck is that they are afraid of dying at home alone. All people are afraid of dying. So are drug addicts, even though they inject several times a day.

When we find somebody in the process of injecting him/herself, we ask them to finish the job in a hurry. However, there is an ethical problem in this approach. We do not know whether we are asking the individual to inject himself with a lethal dose and he subsequently drops dead in front of us. However, the risk of him dying is lower when we are standing there watching him than if he were sitting alone.

We may have seen a number of assassins that have been covered up as being caused by an overdose. However, since this has never been established in certainty, I cannot say that this is the case. There are only two ways to stop the problem of ODs. One is to keep them under

surveillance, the other is to hand out a drug with a concentration which we are certain will not harm them. A combination of the two measures would naturally be the optimum solution, but as I have pointed out earlier, there are a number of ethical aspects, which need to be considered. I am in favour of drug-free treatment. I am in favour of people being liberated from their addiction in order for them to be able to act on their own free will. This is not possible when you are a drug addict, and you are still a drug addict even though your drugs are dispensed free of charge.

10.2.3 Ambulance driver at the Copenhagen Fire Brigade

I am 39 years old, trained as a fireman, ambulance driver and paramedic assistant in the rapid response vehicle. I have received callouts to ODs regularly throughout the past 14 years and also work as the Copenhagen Fire Brigade coordinator for the needle exchange bus in Copenhagen.

We are given special training in connection with overdose accidents, because what we do in reality is grant first aid to people who are unconscious, ie we make sure that the airways are free, and this is work we do in connection with all types of accidents. So we are not specially trained, but during our educational program of new instructors, we teach them about various substances, what these substances do to people, whether the patients stop breathing or whether they get a psychosis or cramps, etc. We teach specifically in the side-effects of the drugs.

In Copenhagen, primarily the rapid response vehicle is used in cases of overdoses. This vehicle also brings along a fireman who is trained as a paramedic and a medical assistant, which means that he has supplemented his training as a paramedic. The vehicle is also crewed by a doctor who is an anaesthesiologist and has a minimum rank as deputy superintendent. This type of doctor is used to giving priority to the airways and carried equipment and antidote to initiate on site treatment. Most often it is not necessary to bring the person to the hospital.

Previously the antidote administered was so concentrated that the addicts woke up from their overdose full of withdrawal symptoms and aggression, because they felt that the ambulance personnel had bereaved them of their shot. After the needle bus has been introduced, the parties have entered into a dialogue. We have tried to tell them what we do when we get to the scene, that they had stopped breathing, and that they have been close to dying, that they have been seconds from a cardiac arrest. And then we have tried to reduce the dose a little to make sure that they have no withdrawal symptoms when they wake up.

In 95% of the cases, we arrive at the scene in the nick of time - the situation is indeed life-threatening. Most of the times the addict has taken heroin, perhaps in combination with other drugs, intravenous drugs bought in the streets. Emergency calls to an overdose of cocaine or amphetamine involving cramps are rare.

A typical overdose emergency is often at Maria Church square in Copenhagen where we are frequent visitors as this is the place where the drug addicts sit at the back of the church in the shelter of numerous others. Often they need to speed up their activity, because police are heading for the square in their Fine Bus. But the addicts are unaware of the quality of the drug, whether it is a strong or a mild concentration, or what it contains altogether, but nevertheless they inject the substance and an overdose situation is imminent when it turns out that it is stronger than they are used to; the respiratory system is paralysed, the patient turns blue, and it is clear for everybody that something is wrong, and then they send for us. It is often stress that triggers the call.

Although there is an unwritten code that says that if the needle is in your arm, the police will not intervene, the drug addicts will still hurry to finish off the injection.

As something relatively new, we have started to appear in apartments housing drug joints as a result of the stress campaigns launched by the police. Before, we were practically only called to outdoor emergencies.

Another typical overdose situation is the drug addict being discharged from treatment, returning to the environment, and taking the same dose as he/she was used to before. This causes an overdose reaction, because their body is unable to take the same dose as it could when they stopped and were subjected to treatment.

We are really busy when the socalled "killer heroin" hits the streets. When the drug in circulation for one reason or the other has not been diluted. Normally, many of the addicts have the same dealer, which means that they know the quality and the drug they get and therefore are in the safe. However, those who get back from rehabilitation or those who are more erratic buyers are more exposed to this type of heroin.

The only initiative that I can think of having a favourable effect on the reduction of overdoses in Copenhagen is the rapid response vehicle crewed with paramedics and a doctor. This is the vehicle that saves lives.

Within the past 4-5 years, there has been no significant changes. The same type of people are the ones we know of. We are not called out to beginners. Those we see are people who have used the drugs for many years. It is the same type of users and the same type of drugs we see in connection with ODs.

The best way to bring down the number of lethal ODs in Copenhagen is to build "injecting rooms", where the users may take their drugs under the control of medical staff. This is the best way, in my opinion, to change the situation.

10.2.4 Headlines

According to the three street workers, the reasons for the lethal overdoses in Copenhagen are drug concentration, drug nature and interim dose reduction as the most significant factors.

Specific solutions for bringing down the number of lethal overdoses include the rapid response vehicle already in action and over-the-counter antidote to an additional number of medical groups.

The three street workers mention two political solutions such as injecting rooms and a slowdown of police harassment towards drug addicts in the streets.

10.3 Officials in Copenhagen

10.3.1 Interview with the Mayor of Copenhagen Social Administration, Winnie Larsen-Jensen (Famile- og Arbejdsmarkedsforvaltningen)

Question no. 1 the prioritising went as following:

What are by your opinion the most important political goals in this city?
(Please rank the following items into three categories, with 3 items in each category: 1.Top priority, 2. High priority, and 3. Medium high priority)

	Rank
• To improve public care for the elderly	1
• To improve public child care	1
• To improve housing for the homeless	2
• To reduce pollution problems	2
• To reduce traffic problems	3
• To reduce alcohol problems	3
• To reduce drug problems	3
• To improve treatment of psychiatric disorders	2
• To improve the education system	1

Winnie Larsen-Jensen begins:

The important thing in this kind of categorisation is to know that you have to make a distinction between public service towards the general population and intensive care for the socially disadvantaged minority groups. The way that I see it, my role is to be the social conscience of Copenhagen and look after the disadvantaged. For many years there has been a greater focus on drugs in Copenhagen not only in the media but also in public awareness and among politicians. Then there is another perspective as well. Personally what I might find most important or top priority has not only a political angle, but also a financial one. However I find that there is only a very small readiness for initiating new things and especially spending money on this, money that has to be taken from somewhere else.

The three items that I have ranked number one are care for elderly, childcare and the education system. They reflect the political and public agenda in Copenhagen. All three items play a very important role in the awareness of the general population's opinion of the social welfare system. There are a lot of resources and interest groups to speak up for the cause and of course, a lot of people also benefit from these important topics.

Priority number two is also of great importance. I believe that housing for the homeless and treatment facilities for psychiatrically disturbed people should be put in focus. It is necessary for me to feel safe, also when my daughter bicycles around the city at night. That means, that these topics should be attended to so that people don't have to hang around in the streets and be very visible. Unless they are taken care of, nobody else would want to live in Copenhagen or take part of the life in a big city.

In the third category drug problems come first. Copenhagen does not have a traffic problem. Personally, I find drug problems very interesting. But compared with the other policies on the list not the same numbers of people are affected by them and that's why they can only be a third priority. I think, that whatever we do for drug addicts, it's very important to be visible with our interventions. Addicts outside treatment are frightening to people and they feel frustrated that "nothing" is done. All those in treatment we send away to other parts of Denmark, or get them on methadone programmes, stabilise their life, making them (almost) invisible or "disappear" in the crowds of Copenhagen. We need to show people in Copenhagen, that helping addicts makes a difference.

Question no. 2 the prioritising went as following:
What were the most important political goals in this city's policy in the drugs ***field ten years ago? Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.***

Rank
Blank
3
1
1
1
2
1
2
3
3

- To strive for a drug-free society
- To reduce harm caused by drug use
- To reduce drug use related crime
- To reduce public nuisance associated with drug use
- To prevent drug use among youngsters
- To secure or improve the coverage of treatment for drug addicts
- To reduce drug dealing
- To prevent the spread of diseases like HIV and Hepatitis C among drug users
- To prevent overdose deaths among drug users
- To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade

When I think back we were less focused on the real issues and had a more narrow view on the problems. We believed that less dealing and better border control could solve most of the problems. Drug related crime and public nuisance was in focus as well. Whatever makes the public worry always gets political priority. Of course drug use among youngsters always has

to be on everybody's list. Worried parents are a very strong pressure group and it is the right place to start! Prevention is always preferable to treatment.

My number 2 priority reflects two things. We knew back then that we had to treat or help some of the drug users, but we still didn't quite know how. In one way I think you could say that we were experimenting more with methods and options than we are today, because we hadn't found out what could and what couldn't help. At the same time, we started to talk about prevention and prevention strategies, but it took several years before we actually did something concrete. HIV and AIDS was a big thing during the 80's. Everybody was worried and 10 years ago we knew that iv drug users were a serious risk group and prevention was necessary among this group of people. There were already several initiatives especially taking care of HIV infected persons. But none of these places were willing to take HIV positive drug users into their care at that time. That means that it was a prioritised issue but not an unproblematic one.

I can comment on my number three priorities briefly. None of these items were issues on the public or on the political agenda 10 years ago. And to strive for a drug-free society is a utopian ideal that would be unrealistic to prioritise - ever.

Question no. 3 the prioritising went as following:

What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?
Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Rank
• To strive for a drug-free society	Blank
• To reduce harm caused by drug use	1
• To reduce drug use related crime	2
• To reduce public nuisance associated with drug use	2
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	1
• To reduce drug dealing	3
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	1
• To prevent the overdose deaths among drug users	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3

I find it most important to reduce harm, prevent youngsters from starting to take drugs and prevent spread of diseases like HIV and Hepatitis. The whole prevention issue among youngsters also gets a lot of attention among social workers, researchers, politicians and of

course parents. In the matter of reducing harm caused by drug use I think we have come a long way. Personally my attitude towards what is tolerable has moved a lot. For example we have just started a new project with an injectable methadone programme in Copenhagen. This would have been unthinkable just a few years ago. According to improvement of treatment we just have to keep on trying to get these people out of their drug abuse. Whenever they get motivated there should be a wide range of attractive alternatives. This might be the most important issue at all.

My number 2 category all has to do with safety and making the general population feel safe. Drug related crime and public nuisance sort of speak for them selves but to me prevention of OD deaths is also related to being safe. To reduce OD deaths means less stress in the environment. Giving them no rest, moving them around makes them unpredictable and violent and that of course causes uncertainty among the general population.

The number three issues are all beyond our control, things we can't help. Our job and our force are to focus on the human being and try to reduce harm for the surroundings and for the drug user.

Question no. 4 the prioritising went as following:

Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	2	x	
In police strategies less focus on users towards more focus on larger scale dealing	1	x	
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	1	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	2	x	
Housing for people with drug problems	2	x	
First aid education	3	x	
Sufficient capacity of methadone programmes	1	x	
Low threshold methadone programmes (allowing side use during treatment)	2	x	
Methadone programmes in prisons	1		x
Heroin prescription programmes	2	x	
Interventions in order to change the main route of heroin administration from injecting to smoking	3	x	
Distribution of naloxone (narcanti) to drug users	3		x

In order to reduce OD deaths stress is one of the most important factors together with rehabilitation opportunities. The latter we already do but the first issue could still be improved. I have added sufficient capacity of methadone programmes to this no. 1 ranking. Knowing it is not a question of methadone programmes alone, but also of sufficient capacity

in a broader sense on all treatment and rehabilitation offers. Methadone in prison is only offered to those who already are in treatment, which is unsatisfactory but unfortunately out of our jurisdiction and, I am afraid, beyond what is feasible as things are at the moment.

To category number two I add injecting room, information on dangers after periods of abstinence, housing and heroin prescription programmes. The first and the last are the most controversial and have been discussed now for more than a year politically and in the media. Personally I am against both of them, but I'm convinced that they will both be feasible within the next few years. I sense that more and more of my younger party colleagues are much more open to this kind of thinking than I am. Housing for homeless is already a priority and being dealt with. Information is good, but I am not sure whether it works, as it should?

I think training drug users in first aid is a bad way to spend our money, but definitely it's feasible. Interventions in order to change the main route of heroin administration from injecting to smoking are a trend that we already see. I don't think we can do much to help it, it's one of those things that will happen automatically. Distribution of an antidote (narcanti) to drug users is a bad idea and not likely to be feasible either.

Question no. 5:
Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think to reduce or forbid the distribution of these pharmaceuticals is one way?

Since March 1996 these kinds of pharmaceuticals have been registered when prescribed and have since dropped to a very low level. However, I still think that we could be a bit stricter with the GP's, and try to impose restrictions on those who still over-prescribe. The best thing of course would be if we could come up with alternative pharmaceuticals that would be of no interest to drug users. I don't think it is an option to completely forbid pharmaceuticals. Strong forces would work against a total prohibition, such as GP's and pharmaceutical firms.

Question no. 6:
Do you think that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

This has been the policy for the last 10 years. The police chase them around from one corner to another and the only thing we achieve is to make drug users more stressed, more aggressive and the overall negative attitude that we end up with means more deaths and illness. Furthermore, it makes it a lot harder for our social workers to have positive interaction with people in the environment. If the drug users are stressed they seem to hide more always changing location, that's not in anybody's interest.

Instead of closing down the open drug scene, it would be a lot better to help them first through our social workers and secondly with some rehabilitation programmes.

Question no.7:
Do you have any other suggestions about how to reduce the overdose deaths in our city?

Even though it's not on my personal agenda I do think that prescribed heroin programmes and user rooms would reduce the number of overdose deaths in Copenhagen and I think we should look more into a broad variety of treatment offers. It should be through treatment and rehabilitation that we prevent drug users from overdosing, not by giving them all they want including drugs. I don't think that making them change their patterns in drug use, would have a very big impact on OD deaths.

Question no. 8:
When evaluating this city's drug policy in total:
a. In what aspects do you think the policy has successfully reached its goals, and why?
b. In what aspects do you think the policy has failed to reach its goals, and why?

I think that one of the reasons that we have been so successful is our decentralisation of the organisation. The presence of outpatient clinics in the local community makes us visible and gives a much better dialog and creativity among social workers, doctors and drug users. We put the human being into focus, and our personal knowledge of each person allows us to consider new perspectives.

I would love it if we could get even better in preventing youngsters from ending up in this horrible environment of drugs and prostitution. This should get our utmost focus and interest. Another worrying issue is young, pregnant mothers with unborn as well as new born babies suffering from withdrawal symptoms. I think we ought to give these women and children even more attention than we do today and maybe use other methods as well.

10.3.2 Interview with the Deputy Director of Copenhagen Social Administration, Carsten Stæhr Nielsen (Famile- og Arbejdsmarkedsforvaltningen)

Question no. 1a:
What has been the major philosophy and goals concerning drugs in your organisation during the past 10 years?

Previous the main aim has been to strive for treatment methods that will lead to a drug free situation for the addicts. That means that the main focus and priorities has been on treatment facilities and less on drugs in society. This of course was not done only by the work of this administration but as a joined effort with many players. We have had many addicts in treatment over the years, but only very few end up being drug free. Since 1996 there has been a change in our way of thinking. We asked ourselves if drugs and being drug free was the right parameter to look at when trying to improve living standards among drug users. Today we try to look more dialectic at problems. A drug addicts primary obstacle is lag of socialisation not the drug it selves. However, drugs do seem very conspicuous in relation with addicts, but we have to force ourselves to rethink our approach and look at the social contest a lot more than we used to. What we must do in order to help these people, is to teach them social skills and through that, they will more easily be able to stay clean or stay on a lower dose of methadone. This might sound like the perfect solution, *but* to obtain better social skills when drugs intoxicate you is very difficult. This vicious circle makes it very challenging to work in this line of work. The focus from purely drug free treatment has also changed so that we now look at treatment and harm reduction interventions as a whole.

Question no. 1b:
What have been the major obstacles that your organisation has encountered in its practise?

Methodically we are behind, we need better tools, better directories. Things end up with too much maintenance of (methadone) treatment and to little development within the field. Because drug free or substitution treatment is what we already know, we end up binding us to these approaches instead of searching for new. That means that we keep focusing on drugs and abuse instead of seeing the problems in a more balanced way within a social context. The way I see it, our obstacles are more tided to the professionals than to the politicians because the professionals do not have clear aims and results for the purpose of there treatment. If they did I am sure the politicians would not hesitate to spend more money on this area. But bear in mind that it would take a very big economic effort to really deal with this problem, money this area will only get if we know it would work as intended.

Question no. 1c:
Imagine you could have changed something in this society's drug policy in the past ten years, what changes would that have been?

I would have liked if we earlier had changed our view upon drug addicts, so that we saw the whole person with all it's problems and not just blamed the drug abuse on society or on the addicts themselves. There aren't any drug addicts that do not have a very good explanation (if you know their life story) on why they have ended up like this. That also means that we should have been better to, earlier see signs and help children and youngsters in badly functioning families and have helped and supported them, so that drug abuse did not become there final choice in life.

Also we have been slow on changing our treatment policies from a very restrict to a more progressive. Only to offer drug free treatment or not accepting side abuse with substitution treatment is just closing our eyes from reality. I believe that restrictions only lead to denial and don't do anybody any good.

Question no. 2 the prioritising went as following:
What were the most important political goals in this city's policy in the drugs ***field ten years ago? Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.***

Rank
1
2
3
2
1
2
3
1
2
3

- To strive for a drug-free society
- To reduce harm caused by drug use
- To reduce drug use related crime
- To reduce public nuisance associated with drug use
- To prevent drug use among youngsters
- To secure or improve the coverage of treatment for drug addicts
- To reduce drug dealing
- To prevent the spread of diseases like HIV and Hepatitis C among drug users
- To prevent overdose deaths among drug users
- To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade

To strive for a drug-free society is a very strong political message that speaks to the sense of justice in ordinary people. And you could argue it is also a very "cheap" massage. 10 years ago drugs wasn't really on anybody's agenda, especially when it came to spending money. To prevent youngsters from taking drugs is always important, it did then as today get a very strong political focus and again it sounds good, that you want to prevent youngsters from start taking drugs but it is not very binding or concrete. HIV also got a lot of attention not really out of concern for the drug users but because of fear of a global epidemic in the general population. My number two, reduce harm caused by drug use, reduce public nuisance associated with drug use, improve the coverage of treatment for drug addicts and prevent overdose deaths among drug users were all on the political agenda. But the whole area did not hold a very high priority and the few money spend on it, was spend on treatment facilities before harm reduction interventions. Priority number three are all police assignments and that leave them out of our focus and give them low priority.

Question no. 3 the prioritising went as following:

What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?
Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Rank
• To strive for a drug-free society	2
• To reduce harm caused by drug use	1
• To reduce drug use related crime	3
• To reduce public nuisance associated with drug use	1
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	2
• To reduce drug dealing	3
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	1-2
• To prevent the overdose deaths among drug users	1-2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3

I think the main changes here are, and that's also reflected in my ranking, that we now look more dualistic on this whole area. 10 years ago it was drug free treatment and all solutions were bounded with drugs. Today we see treatment, drug free and substitution, together with harm reduction interventions, prevention strategies and social rehabilitation.

Question no. 4 the prioritising went as following:

Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	1	x	
In police strategies less focus on users towards more focus on larger scale dealing	3		x
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	1	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	3	x	
Housing for people with drug problems	2	x	
First aid education	2	x	
Sufficient capacity of methadone programmes	2		x
Low threshold methadone programmes (allowing side use during treatment)	2	x	
Methadone programmes in prisons	3		x
Heroin prescription programmes	3	x	
Interventions in order to change the main route of heroin administration from injecting to smoking			
Distribution of naloxone (narcanti) to drug users			

It is very hard to say what might be feasible within the next two years on the political scene. Some things could get feasible because they get to be part of a compromise, I think that could be very likely for users room contra prescribed heroin treatment for example. Changed police strategies and methadone programmes in prisons I do not think is feasible, just because the police simply do not want to, and it is there jurisdiction, so they make the policies for it. Sufficient capacity of methadone programmes isn't feasible either, mainly because of financially difficulties. I think the two most important issues in order to reduce overdose deaths are user rooms and rehabilitation. The latter we already do in a larger scale the first is more controversial and politically discussed. I think that being more pragmatic i.e. legalise user rooms in larger scale than today, prescribe heroin in treatment for those wanting or needing it would help the weakest and prevent some of our overdose deaths, but lets ask ourselves if this is the road we want to take. We do maintain these people in their drug abuse by offering them more drugs and places to take them. If we improved treatment with better psycho-socially support we might end up with a better outcome not only for society but also for the drug addicts.

I can't answer the two last suggestions on the list I do not know enough of it to qualify my answers properly.

Question no. 5:
Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think to reduce or forbid the distribution of these pharmaceuticals is one way?

Knowing how little it is prescribed already prohibition seems very radical. Furthermore you'll have to be very sure that a prohibition really would do some different. That it won't get illegally imported from other counties instead or something likes that. Besides pharmaceutical firms most likely would object strongly to a prohibition as well.

Question no. 6:
Do you think that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

A few years back the police did try to close down the open drug scene in Copenhagen, but only with very little success. I think it is the wrong approach to try and shut down the open drug scene. Instead of closing it, it should be accepted under some controlled conditions. The police should be allowed to react to nuisance and illegal activity, but giving the area as much privacy that the drug abusers feel quite safe. If that becomes the case our social workers are able to work the area and do a much better job, useful not only to the drug addicts but to the police and everybody else. This is a better way to deal with an open drug scene, compered to chasing addicts around.

Question no.7:
Do you have any other suggestions about how to reduce the overdose deaths in our city?

No, not really. I am not the right person to ask this question.

Question no. 8:
When evaluating this city's drug policy in total:
a. In what aspects do you think the policy has successfully reached its goals, and why?
b. In what aspects do you think the policy has failed to reach its goals, and why?

I think we have been successful in keeping the balance between harm reduction and drug free treatment. Furthermore our treatment facilities are very well functioning. They have become much better, working from a development perspective and not just maintain the drug addict in their drug abuse.

I do not know if we have completely failed anywhere, but we still haven't become good enough with developing new tools and strategies within the treatment system. I believe that we still are too medical and not enough socially orientated in our treatment. This is what we shall keep focusing on in the next few years.

10.3.3 Interview with the Detective Chief Superintendent of Copenhagen Police Force, Erik Bjørn

Question no. 1a:
What has been the major philosophy and goals concerning drugs in your organisation during the past 10 years?

In the 80's our over all focus was on the street drug user. We tried to harass them, moving them around always stopping them on the street searching for drugs or stolen goods, simply trying to make them disappear by chasing them. During the 90's we changed that strategy. I think, what happened was that not just the police but also politicians and others started to see the addicts as human with a social problem instead of seeing a group of trouble makers that should be removed. We stopped chasing the addicts around and we stopped caring so much about the crimes that they committed, knowing that they are just going to steal even more if we keep taking their drugs. It became a vicious circle getting us nowhere. Today we focus on dealing and dealers, leaving the addicts to social service. We are interested in all kinds of dealing from international trade, those smuggling drugs into Denmark, those distributing drugs around Denmark and those selling on the streets of Copenhagen in that order.

As part of the political strategy it has been made possible to convict all dealers no matter how much they sell or have on them. That means that the second time you are convicted for selling drugs no matter if it is 1 gram or 10 grams you will be sentenced to prison. That tightens the focus on dealing itself not so much on the quantities.

Question no. 1b:
What have been the major obstacles that your organisation has encountered in its practise?

I think that one of the major obstacles has been to realise that being a drug addict is not a police problem, it is a general problem for the society. It took a while before politicians and others accepted that even though the police could and did move them around, chasing them away from Vesterbro and The Maria Church the problem continued, just somewhere else. Having drug addicts in a society is a social responsibility much more than a task for the police.

Question no. 1c:
Imagine you could have changed something in this society's drug policy in the past ten years, what changes would that have been?

I think that there are three things that are important in drug prevention strategies. In prioritised order comes preventing more people from start using drugs even if it means interventions from as early as birth. Secondly we should create proper conditions for those already living with drug addiction. Not just in order to be nice to them but because crime and public nuisance are of great importance for the common citizen. It is therefore important that addicts live under conditions where this is avoidable. This should be done with aggressive, casework interventions making sure nobody is on their own, feeling miserable. Thirdly we need to prevent drugs coming into the country and this is where the police should concentrate their attention.

This is how I see our overall drug prevention strategy and if you should change something it would be that, all relevant authorities much sooner should join forces and make united effort, as we have a common goal.

Question no. 2 the prioritising went as following:
What were the most important political goals in this city's policy in the drugs ***field ten years ago? Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.***

	Rank
• To strive for a drug-free society	1
• To reduce harm caused by drug use	3
• To reduce drug use related crime	2
• To reduce public nuisance associated with drug use	1
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	3
• To reduce drug dealing	2
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	3
• To prevent overdose deaths among drug users	3
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3

Those I ranked no 1 all reflect the fact that we 10 years ago saw drug problems as a phenomenon that would go away. We just wanted drug users out of the way, so we did not have to look at them. The focus was on what problems the drug user caused for everybody else, not what problems the actually drug user had or why he/she started using drugs.

To reduce drug related crime and to prevent drug dealing were both prioritised as no 2. They are connected with no 1. We just would not accept what they did, regardless why they did it.

All the other items on the list are ranked no. 3. I just do not think anybody was looking at any of these matters. That would imply that we saw things from a drug user perspective, which we didn't.

Question no. 3 the prioritising went as following:

What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?
Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Rank
• To strive for a drug-free society	3
• To reduce harm caused by drug use	2
• To reduce drug use related crime	1
• To reduce public nuisance associated with drug use	1
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	1
• To reduce drug dealing	2
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	2
• To prevent the overdose deaths among drug users	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	1

Today it is almost the opposite. Today it is the drug user and their living conditions that are the starting point. Now the question is how society can live together with drug users in a way that minimises the inconvenience among the general population and is tolerable for the drug user as well. That means that we should concentrate on reducing drug related crime and reduce public nuisance associated with drug use by removing dealers or breaking up larger groups of addicts in the streets but without searching them for drugs first. This actually works quite well. We have the "Fine bus" that goes around in the area making sure that the drug users are relatively calm and that they do not seem frighten to other people living in the area. The drug users know this policy and accept it. I believe we now have a situation that is tolerable for everybody - a situation under control.

Prevention of money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade has become a very important aim. After changing our strategies away from the drug user and towards dealing, this is one of the main things that we have to concentrate on. However, it is more a priority within the police force than an issue on the public agenda. Old ladies will be absolutely terrified if her purse gets stolen by an addict in the streets but if we confiscate 4 kg of heroin in the airport it's just something she reads about in the papers. It won't upset her the same way.

To strive for a drug free society is simply naïve. I do not think anybody believes that it is a realistic prioritisation.

Question no. 4 the prioritising went as following:
Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	2	x	
In police strategies less focus on users towards more focus on larger scale dealing	1	x	
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	3	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	3	x	
Housing for people with drug problems	1	x	
First aid education	3	x	
Sufficient capacity of methadone programmes	1	x	
Low threshold methadone programmes (allowing side use during treatment)	?		
Methadone programmes in prisons	3	x	
Heroin prescription programmes	2	x	
Interventions in order to change the main route of heroin administration from injecting to smoking			x
Distribution of naloxone (narcanti) to drug users	3	x	

As far as injection rooms are considered we have to make clear what it is that we gain by establishing them. I am very sure that it will make lots of them disappear from the streets and that means less nuisance for the public and less trouble in public areas. Besides, I believe that it is feasible and will come within the next few years as a natural development as a result of our harm reduction and treatment strategy. However, it won't be without problems for the staff and not without problems for the police. The way our legislation works today it won't be possible to create user rooms, especially not because we know there will be dealing inside, and as a police force we cannot accept that.

It is important with regard to overdose mortality rates that there is less focus on the addicts and more on dealing, which we consider high priority. However I believe that this is already the case and I do not think that we can come any further without neglecting the public order.

Rehabilitation is already done in a larger scale in Copenhagen and is of course important, but I'm not sure whether it would have an influence on overdoses. More information about how to use drugs just won't have any effect. These people know all there is to know about taking drugs and how much they can cope with. The problem is that they just don't care about themselves as long as they get their drugs. Housing is very important, that means they have somewhere to relax and won't be bothered by police or some of their own people. I am not sure whether they can benefit from first aid, even if we teach it to them.

Treatment offers should be top priority, we need to help these people with their problems and we need to get hold of them in a way so that they won't cause too much trouble elsewhere. I

know nothing about low threshold methadone programmes and methadone in prison won't prevent them from dying of overdoses later on.

With regard to prescribed heroin treatment it is very hard to say what impact it would have on the overdose mortality. In my opinion we should implement prescribed heroin if two things are fulfilled. First it should mean a better life for the addicts, give them more self-respect because they do not have to prostitute or steal in order to get drugs. Second it must lower the crime related to drugs especially offences against property among the general population. If these two things become a direct effect of giving them heroin, I think it's worth trying. Also you would presume it to have a positive effect on the mortality rate. The drugs are pure and at the same intensity and would be given under clean and proper conditions, most likely in an injecting room. Injecting rooms and heroin treatment complement each other, if we do one we should do both.

Interventions in order to change the main route of heroin administration from injecting to smoking are not feasible at all. You cannot teach a drug user with 25 years of drug history to change his way of doing his drugs. They just won't do it, so there isn't any point in trying. To distribute narcanti to drug users is feasible but I doubt they can make it work even if we teach them how. It's a lot better to have a quick and skilled ambulance service as we do to day.

Question no. 5:
Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think to reduce or forbid the distribution of these pharmaceuticals is one way?

The prescription of Rohypnol has already been drastically reduced after the GPs were put under surveillance to monitor how much each of them prescribed. However, we have not seen any reduction of availability on the streets, nor have the prices gone up. That strongly implies and we also now this for a fact that after the prescription went down a large scale of import started mainly from Athens, Prague and Sophia.

Question no. 6:
Do you think that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

I don't believe in closing down the open drug scene, but I do believe in controlling it. They are allowed, if they do not become a public nuisance or if they do not gather in larger groups that can seem frightening. We control this by making ourselves visible in the streets - it does have a preventive effect on most of them. But it is still important that they do not feel stressed if they comply with these simple rules. For example, they do not need to run away every time we show up or worry that their drugs will be confiscated - we won't search them just out of the blue. If we choose to search them anyhow, it will be as part of another operation most likely dealing or proving that they just bought from a dealer we are after. Then we will confiscate their drugs, but we won't charge them with possession.

Question no.7:
Do you have any other suggestions about how to reduce the overdose deaths in our city?

The way I see this, it's important to acknowledge that we do have a problem with drugs and that it is not the drug user alone that has it. We need to deal with drugs and their side effects from a broader perspective in order to maintain security among the general population as well as tolerable conditions for the drug user. That is why we need to make a total plan for how to solve problems related to drugs. This goes not only for the police, but it means that everybody has to get in on it. Politicians, treatment facilities, doctors, social workers, addicts and of course the police as well. Then and only then can we make a real change.

Question no. 8:
When evaluating this city's drug policy in total:

a. In what aspects do you think the policy has successfully reached its goals, and why?
b. In what aspects do you think the policy has failed to reach its goals, and why?

The good thing is that we have started this process working together as a unit and we are moving in the right direction. The bad thing is that it has taken us too long to get started, we have been fumbling around hoping that this problem eventually would go away or solve itself.

This is an ongoing process where we need to learn and to recognise new problems as we go along.

10.3.4 Interview with the Medical Director of Copenhagen Social Administration, Peter Ege (Famile- og Arbejdsmarkedsforvaltningen)

Question no. 1a:
What has been the major philosophy and goals concerning drugs in your organisation during the past 10 years?

First I would like to state that from where I sit (Famile- og Arbejdsmarkedsforvaltningen) we only deal with the treatment system. This administration does not have prevention strategies etc. as part of our jurisdiction. This is the position from where I will speak.

Within treatment we work with two different kinds of perspectives. One is to help the drug addict to get a better life. That can be by offering them either drug free treatment or substitution treatment in different programmes. The other is to reduce harm proportional to the addicts situation for instance by offering drug users treatment when whey want it (no waiting list) or prescribe them methadone so that they wont have to get a lot more other drugs all the time.

I think that we see a new development, which is to focus less on the goal of having drug free addicts and instead to focus on social skills and rehabilitation. Of course using drugs has a lot to do with the capability of learning new social skills and adjusting to the more established part of society, but just focusing on getting them drug free won't get us very far. This is a new development just starting especially within the treatment system, but still I believe the political focus is on drugs and drug users being drug free.

Question no. 1b:
What have been the major obstacles that your organisation has encountered in its practise?

The overall problem has been lack of sufficient capacity. This field has not been given as much money as required in order to offer everybody treatment whenever motivated to seek it. This also means that the treatment facilities have been overcrowded for so long that it's been wearing out staff and facilities. When your routine work gets pushed to the limit you tend to do only the necessary work and not create new methods or improve routines.

Another obstacle has been that the treatment institutions have focused on drug free treatment. That made us work in a defensive context. Introducing larger scale substitution treatment (1996) we were given the opportunity to not only try and reduce harm, but to work with a more innovative perspective. Methadone programmes should not just be a way to passivate the drug addicts but to get us started working with their social skills and try to reintegrate them in society and in the labour marked. This has become better over the last years but we still have a long way to go before it becomes part of the ordinary routine and not something out of the ordinary.

Question no. 1c:
Imagine you could have changed something in this society's drug policy in the past ten years, what changes would that have been?

Again this is a bit as mention above. I think we should have been more reflective on what we wanted, when we introduced larger scale methadone programmes, what our intentions were in

1996. We just went ahead and did it without being to clear about it. This is probably why it has been used more as a defensive, maintenance drug strategy rather than a possibility for innovation of living conditions among drug users.

Question no. 2 the prioritising went as following:
What were the most important political goals in this city's policy in the drugs ***field ten years ago? Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.***

	Rank
• To strive for a drug-free society	1
• To reduce harm caused by drug use	3
• To reduce drug use related crime	2
• To reduce public nuisance associated with drug use	1
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	3
• To reduce drug dealing	3
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	3
• To prevent overdose deaths among drug users	3
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3

To strive for a drug-free society was very important 10 years ago. It was a declared, political aim and methadone treatment was only seen as a last option for those out of reach. I ranked reducing public nuisance associated with drug use and to prevent drug use among youngsters I ranked number 1 as well. I think my first group of priorities reflects a political view. All three of them are very important political issues that will win votes among the general population but is not necessarily in the best interest of the drug users.

Drug related crime was an issue 10 years ago especially to keep people safe but it's not a task for the municipality and therefore not the highest priority. To reduce harm caused by drug use is not easy to rank because nobody was thinking in those terms at that time. The rest of my 3rd priorities were on the agenda, but because drug abuse in a broad sense wasn't highly prioritised, those were not really issues that anybody cared about. I guess you could say that our perspective wasn't as varied as it is today.

Question no. 3 the prioritising went as following:
What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future? Please rank the following items into three categories, with no more than four

items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Rank
• To strive for a drug-free society	3
• To reduce harm caused by drug use	1
• To reduce drug use related crime	1
• To reduce public nuisance associated with drug use	1
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	2
• To reduce drug dealing	3
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	2
• To prevent the overdose deaths among drug users	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3

I think that one of the most glaring things is a changed focus on harm reduction interventions. The term harm reduction in a broader sense implies innovation and changed living conditions for the drug user. My number 2 group of rankings are also a result of a stronger focus on harm reduction strategies. Harm reduction is now a part of the political and the organisations discourse. We are spending money on all these matters knowing that in order to treat people and make their living conditions better we need to keep them alive. Furthermore if we want more money and more resources in this area we need to be more skilled in producing measures and data within the treatment system to prove that what we do really matters.

To strive for a drug-free society is no longer a realistic aim. I do not think that anybody believes in it anymore. Moreover, it had some very unintentional side affects both on street level and in the treatment system. To reduce drug dealing and to prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade are both issues out of our jurisdiction.

Question no. 4 the prioritising went as following:

Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	3	(x)	
In police strategies less focus on users towards more focus on larger scale dealing	1	x	
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	1	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	2	x	
Housing for people with drug problems	2	x	
First aid education	2	x	
Sufficient capacity of methadone programmes	1	x	
Low threshold methadone programmes (allowing side use during treatment)	1	x	
Methadone programmes in prisons	2	x	
Heroin prescription programmes	3	x	
Interventions in order to change the main route of heroin administration from injecting to smoking	1	x	
Distribution of naloxone (narcanti) to drug users	2-3	x	

I believe that injecting rooms have only very little influence if any on the overdose mortality rate. That's why I'll only priorities it third. Furthermore, it's hard to say whether it's feasible or not. During the last few years there has been a lot of political debate about this topic, ending with the national government clearly saying no to injecting rooms, arguing it's against UN conventions. Nevertheless, we already do have a few officially acknowledged user rooms in Copenhagen at different locations, but creation of injecting rooms as part of the general drug strategy in Copenhagen is most unlikely as long as the governmental level disapproves.

The police focus is of great importance for the overdose mortality in Copenhagen, and the way it is handled to day is one of the main reasons for the high numbers of overdose deaths in Copenhagen. If a drug user is stopped in the streets they get their drugs confiscated on the spot, that's why they never carry anything. As soon as they buy anything, they will shot up the whole amount at once, which often is a rather large quantity. To change this pattern we need the justice department on the governmental level to make up its mind about this, but that is well out of our jurisdiction.

Social rehabilitation is one of the most important things as well. We need to change their self-confidence and give them the ability to care for themselves. These people do not die because they don't have an injecting room they die of social marginalisation.

Information on dangers after periods of abstinence, housing and first aid education are not anything that directly influence the mortality rate and the impact would probably be small. However, we do have a moral obligation to initiate harm reduction measures like this in our society, that's why it should be prioritised second.

Sufficient capacity and low threshold programmes with methadone are both very important. Being in a programme protects them from severe marginalisation and they get a high tolerance that protects them from random qualities of different drugs. Prescribed heroin only would have a small impact on the mortality rate, but it would satisfy many of the addicts.

To change the main route of heroin administration from injecting to smoking would be fantastic for the mortality rate. It is very hard to overdose from smoking, but I very much doubt whether it would be possible to change this behaviour. To give them self-administered narcanti is feasible, but it would only be the well functioning that could benefit form it, and they are not really the ones at high risk.

Question no. 5:
Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think to reduce or forbid the distribution of these pharmaceuticals is one way?

It is already illegal in the U.S. so it's not completely out of the question. However it is not very likely to happened in Europe within the next 10 years. There are too many strong interest groups that would work against it. But it would be very good and have a big impact on overdoses if we could remove Benzodiazepine completely.

Question no. 6:
Do you think that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

The way I see it, the open drug scene is mainly a nuisance problem. It becomes a question of public order, which should be taken care of by the police not by us. I believe that the open drug scene can be reduced, moved around or divided, but not completely closed down. It is too much a (social) marketplace to disappear. Our administration does social work in the open drug scene and therefore has an influence to lowering the level of noise and decrease drug dealing.

Question no.7:
Do you have any other suggestions about how to reduce the overdose deaths in our city?

Some of the most important issues are to increase the capacity and improve the quality in the treatment system. We need to be more on the offensive in our work and strategies in order to increase the addict's self-confidence and ability to care for themselves. We have been struggling with some heavy capacity problems, everything is over-booked and that is not honouring the above mention strategy. To me it is more a question of money in order to deal with our capacity problems, not a question of better planning or education among the treatment workers. They do have the right expertise and the right knowledge to yield better treatment than they do today.

Question no. 8:
When evaluating this city's drug policy in total:
a. In what aspects do you think the policy has successfully reached its goals, and why?
b. In what aspects do you think the policy has failed to reach its goals, and why?

From 1996, since we changed the whole treatment system, we have been very good at increasing capacity within the treatment system in order to avoid having people on waiting lists. We have come a long way since then, and the way that we have implemented substitution treatment as a supplement has been very successful. On the other hand we still

need to take full economic responsibility for the goals that we put up. Goals such as treatment available to all who seek it (preferably early in their drug history) and no waiting lists are all very expensive. So in order to achieve this, the field should get a better priority on the political agenda. Besides, some of these goals lack a systematic plan on how to carry them through even with the extra money.

11 Interviews from Oslo

11.1 Drug users in Oslo

11.1.1 Interview with a 33 year-old man (In methadone treatment)

Attended nine years of primary and lower secondary school. Lives in Oslo. Born and raised at Lambertseter in Oslo. Receives medical rehabilitation benefits.

Has used drugs since he was 14 years old. Started with alcohol and hash. For the past five months I've been on methadone. In addition to methadone, I use pills (Rohypnol), amphetamines and smoke some hash. I seldom use heroin. Before I started with heroin I injected drugs. But I've completely stopped that now. It's a relief.

Where did you normally use drugs before starting with methadone? Everywhere, mostly outside, but you usually have a place to live right? Lately I've been living in a rooming house. So it mainly happened there then.

Before the methadone treatment, I spent two periods in collectives, at Fossumkollektivet and Veiviseren. I really haven't been around that much. I was committed the first time pursuant to Section 11 of the Child Welfare Act to Fossumkollektivet when I was 16-17 years old. I was there for about a year. I have also been at Veiviseren for about four months. I decided to quit when I had been there for four months.

I have managed not to overdose for a very long time. But last summer I overdosed twice in fourteen days, but not so serious that an ambulance came. My girlfriend managed to revive me. I have not needed any antidote. The first time was when I had fixed a dose of heroin combined with Rohypnol. I guess it was just too much. People who overdose are mostly those who mix heroin with pills. You hardly ever overdose when using pure heroin. But it really gets serious when you mix it with alcohol and pills. It's the worst combination you can take. I mixed heroin and pills to get a stronger dose, it's a good feeling. It gives you a better quality of high, you get a double effect. It's a different good feeling than just heroin alone. It was my girlfriend who revived me on both occasions when I overdosed. The reason was that Rohypnol intensifies the effects of the heroin. But I had done this many times before. Perhaps it was purer than usual. Perhaps I was tired. I hadn't slept for several days. It was when I had been using amphetamines, and then you don't sleep. When you cut out amphetamines you try to come down a bit, and then you take heroin. In this case I took heroin and Rohypnol, right? There can be several reasons, lack of sleep, food and things like that. But it was definitely an accident and nothing that was planned. My girlfriend gave me mouth-to-mouth and threw water on me. It wasn't one of those really heavy overdoses, so it was possible to revive me. I got oxygen, so I kind of breathed, and then she got me up on my feet so that my body started to function again. I wasn't in any treatment programme when I had these overdoses. I've experienced many overdose situations with other people. This has occurred in connection with the use of heroin and pills. That's mostly the combination that people use. People get scared and desperate when things like that happen. It's really not a pretty sight. You see the person getting blue around the mouth, then they get blue in the rest of their face, and just continue getting bluer and bluer. There were a lot of people there the last time. The cause was heroin

and pills. It was an accident. There was a whole bunch of us sitting there, and we had a lot of heroin and pills. There were three of us who were active, the rest just sat there and stared. We laid him down on his side and put a pillow under his head, and tried to revive him by mouth-to-mouth resuscitation, but it didn't work. Then we tried heart compression, but time passed and he just got bluer and bluer. We didn't call an ambulance. Then someone came and gave him a shot of amphetamine. This is extremely dangerous you know. But after five minutes we continued with heart compression and mouth-to-mouth, and finally managed to revive him. I think this was more due to our efforts, and not because of the amphetamine injection. People do a lot of strange things, they just haven't got a clue. What you're supposed to do is to lay the person down, give him mouth-to-mouth and heart compression. If it takes a long time you just have to call an ambulance, it's as simple as that. However, we didn't call for an ambulance this time. The tragic reason people don't call an ambulance is that people carry a lot of drugs in their pockets. One time a friend of mine and another guy were in a hospice room, my friend took an overdose, his buddy didn't tell anyone or call an ambulance because if the manager of the hospice found out that drugs had been used in the room, they would have been kicked out. My friend could have died, because his buddy would have been kicked out if he called. So they continued blowing air into his lungs for two hours. So what happened was that he got double pneumonia and ended up in the hospital, where he stayed for half a year. He was in a respirator for a long time. In the end he died. This happens quite often, they don't phone because then the police would come. Maybe you have stolen goods or drugs and stuff in your apartment. If you call the casualty clinic the police often show up as well. People have most likely died because of this fear. Would you say that if someone has taken an overdose, people would most likely not call for an ambulance? It varies. I think for the most part people do phone. Many people who experience overdoses do not want to be recognised by the police. That's why they are so reserved. The person I helped, survived.

What goes wrong when people die? There can be several reasons. But people are worn down. People that die don't use large doses. Half a quarter, half a gram, but their bodies are worn down. It might be the lack of food and sleep, you're tired and then you are more vulnerable. I find the casualty clinic is fairly quick to respond when they are called. But more people could have been saved if people weren't so afraid of being exposed.

What should one do in a situation like that? You should start resuscitating and phone the casualty clinic regardless. It's better to phone one time too many. If you're alone, then phone first and start resuscitating. I haven't had any first aid training or received any training offers. I have taught myself.

I don't know what the differences are from town to town, but they say that the drugs in Norway are generally better than in other countries. But the pattern of use is also important. In Norway it's common to use Rohypnol in shots.

I've tried smoking as well, and took a large dose, but it didn't give the same effect. You don't get that extra buzz or kick.

What has been done to prevent overdose deaths? Not much, just some lectures at schools and such. I can't think of anything else, but it's clear that institutions are preventative. But no new preventative measures. Of course Subutex and methadone are some of the more positive preventative programmes the municipality has established. I feel that everyone that has a drug problem should be offered methadone. It's tragic that up to 600 people are currently on a waiting list for methadone. They say Norway is a rich country, so what's the problem? Do

they have a problem hiring people? Or building methadone houses or centres? I just don't understand, it should have happened much sooner.

Has the municipality done anything that could increase the risk of an overdose? All drug users have been labelled, their lifestyle. The municipality helps drug users live a hard life. It's illegal to use drugs, you have to steal and hide away. It's degrading for the drug user. People should be allowed to use drugs as much as they like, they should legalise it. I think they should be given a place where they could shoot up under controlled conditions. They have continued the same drug policy for the past 20-30 years. But they have started with methadone treatment programmes, which shows at least that there is some new thinking. They have to start to understand that they have to make the best out of the situation, not just continue the way they've always done.

Do you have any opinion on what they've done that has been positive? They haven't only done bad things. The first collectives appeared many years ago. This is good, but they also develop into money-making machines. A lot of things get done because of money. I know that Veiviseren costs NOK 37,000 a month and that Tyrili costs NOK 45,000 a month. The more money involved, the less serious it gets. Of course it's good for a person to get into such a place, to get away from drugs and Oslo for three years, but what happens after that? The failure of after-care has always been a topic of discussion. Medicine treatment programmes are also good. But I wouldn't want to stay at Fossumkollektivet forever. You have to choose if you want to use drugs, to be addicted to heroin, roam the streets without having a place to go, live a life filled with crime, or you can choose to live in a collective for the rest of your life. Of course it's better to live in a collective. But that isn't any proper life, to stay there and peel potatoes together with twenty other people. It's all right for a while, but not in the long run.

What would you like to say to the politicians? I'm very satisfied with the methadone treatment programmes, so I would tell them to get more people into the programme and shorten the waiting lists. I think that is the way to go. I know this from my own experiences. I have 24 sentences, served over ten years in jail. I am a super criminal when I'm hooked on heroin. I now function very well. I don't use drugs daily, maybe not even every week. You can see it in the people who have been needle addicts for 20-30 years, suddenly they have a much better lifestyle. They have cigarettes and food, and contact with their families. They have a job and begin to exercise, some still engage in supplementary use, but so what, it's a lot better than being hooked on heroin. To have a place to go to and to avoid jail.

What are you going to do in the near future? I live in a rooming house. My fiancée lives there as well. I have taken a computer course and would like to continue with that. My girlfriend is also on methadone. So we can back each other up. I think that low threshold methadone is a good thing. There are three categories of methadone users here. There are those who manage. Then there are those who get high every once in a while, and there are also those who use methadone but really don't give a damn. I think, however, that low threshold methadone is good. I think everything over 40-50 milligrams prevents overdoses. But if you take heroin and pills, then the methadone loses its effect. I use 105 milligrams myself.

Perhaps they don't stop being criminals, but at least it prevents deaths. Why should we suffer when we can have it better? Drug use becomes a disease after a while. It costs very little to give people methadone, compared to the alternatives. The people who sit and govern really haven't got a clue. There are several shortcomings, but we're on the right track. The needle room at the PRO centre is of course preventative. I would have gone and taken a lot of my

injections there. Many people go home alone and do it there, and if they overdose, well, then they die. Cleanliness and control are important. On the whole I think the access to clean syringes is good in Oslo. I've used the Needle Bus many times. But I've also used the same syringe that others have used. I've even used a syringe that a HIV positive user had used first. That was when I was in jail. I didn't use chlorine, I used soap, these are the chances one takes, but you can understand how desperate one can get. But for the most part I used the Needle Bus, or I went to the pharmacy and bought them.

11.1.2 Interview with a drug addict, a 29-year-old woman (staying at M3 - a detox institution)

Lives in a hospice in St. Olavsgate in Oslo. Born and raised in Oslo. Completed nine years of primary and lower secondary school, plus a couple of years of upper secondary school. Has been a single mother for many years. Has one child. Makes her living by stealing, prostitution and drug pushing.

I started with alcohol when I was 12, then started smoking hash in primary and lower secondary school when I was about 13-14 years old. Continued with hash until I was about 18. I had tried amphetamines and heroin, but wasn't a regular user of these substances. My life as a heroin user actually started after I became a mother and I had every other weekend and other days free from my child. I quickly got involved with other amphetamine users when I went out on the town in connection with alcohol, and it didn't take long before I started using heroin as well, something I took when I was on my way down. The first time I tried heroin, I went looking for it myself. At Plata. I knew where to go. During that time I stuck, for the most part, to amphetamines and heroin.

I now use heroin and Rohypnol. I inject heroin together with Rohypnol. I don't use these drugs in combination with alcohol. I don't like the effect it has, I lose control and feel very unwell. I function poorly on alcohol. I can be anywhere from a solarium cubicle or bus terminal to a hospice room when I shoot up. I take most of it in my hospice room, at least lately. I can also buy my dope there. It's kind of like a little world in there, a kind of drug world. I've lived in two hospices from May (2000) up until now (March 2001).

I usually take drugs alone. The reason is that it's better to knock about and do things on my own, then it becomes kind of like an ego trip. Everything revolves around getting hold of money. I'm not afraid of sharing with others. I've shared with others on many occasions. It just "happened" that I now knock about on my own. I've overdosed some times as well. I am now in detoxification in preparation for Arken (a small institution for women). Before coming here (M3) I was at P22 (another treatment institution) for four days. I'm here now (at M3) because I left P22. Because I wanted to get high.

I was at Tyrili(a treatment institution at Lillehammer, 200 kilometers from Oslo) from 1996 to 1998, and I worked there afterwards. I got high when I was there as well, approximately every third month the first year, so-called one-day lapses. After that I was there for a year and a half without using anything, until I gradually started again, with cocaine. I have also eaten and injected ecstasy and GHB. I've overdosed on GHB as well. You sort of just tune out the same way as with heroin.

Knows what it's like to overdose

Yes, I've experienced several critical situations, several overdoses. I wonder why it actually happened, since the doses were sometimes smaller than what I normally used. It could have been because I was very tired, extremely stressed or had been awake for a long time on amphetamines, or something like that, maybe I hadn't eaten, but I find it hard to explain why it happened then and there. My overdoses have been on heroin, except for that one time I overdosed on GHB. I've overdosed three to four times where an ambulance was called, and I

have been shaken back to life by others on many other occasions. Probably ten times. I would have overdosed if it hadn't been for them.
This has happened at all kinds of places, from just outside the train station to hospices, by security personnel in parking garages, and during the summer it's happened in parks etc. It was just a coincidence that I was found. If not, I would have been dead. But I've never tried to take my own life, it has always been an accident. People, casual passers-by and other drug addicts, have called the overdose team (ambulance). Others have mobile telephones and have called. I also overdosed while I was under treatment at Tyrili. I just left. I wasn't under any treatment on the other occasions. I've also seen others who have overdosed. On one occasion there was a guy who came and asked if anyone had any wads of cotton wool. No one had any, a while later he came back and asked if anyone had a telephone. Can you just stay here and wait for the ambulance, he said, and I'll go back. It was near the stock exchange. Suddenly I see the guy running away, just as the ambulance arrived. Instead of giving the overdose victim first aid, he had robbed him. His heart had already stopped, there was no hope, so he died. We don't know what he took. The guy who had taken off said that he didn't dare to stay there since he was carrying drugs, so he just snuck away. The guy who died had taken heroin. I have also been in several situations where I've called 113 (ambulance) and tried to keep the victims alive, without knowing if they would survive. For example, one time I bought a ready mixed dose that I thought was supposed to be amphetamine, which turned out to be strong Thai, so the person who took it thought it was amphetamine. This happened at home at my father's. It was just by coincidence that my father heard a thud on the bathroom door, and when we broke the door open my daughter's father lay there and was completely blue in the face, the overdose team wasn't sure either if they could save him, but they were successful. I was the one who called 113. The reason was that he thought it was amphetamine and it turned out to be white Thai. I've done the same thing myself, thought it was cocaine and it turned out to be white Thai. I sniffed it, became drowsy and almost fell asleep at the dinner table. What I'm telling you now was also an accident and not an attempt at suicide. I haven't been in any other situations where somebody wanted to take their own life either. The last time I experienced this I used mouth-to-mouth resuscitation and heart compression. I wasn't sure how I was supposed to do it, but I kept at it until the ambulance arrived. The person survived. I've never had any instructions on how to do it here in town. There was, however, a whole day of first-aid training when I was at Tyrili. I don't know anyone in town who has had any first-aid courses either, except the ones I know from Tyrili.

I don't think people really want to take their own life, even though it can happen. On the other hand, I believe that people get killed. Some want revenge, some have money owed to them that they haven't received. If I ever get into a similar situation again, I will check for a pulse, check if he's breathing and then use mouth-to-mouth resuscitation, in addition to phoning 113 of course. I would also do this if it happened in my own hospice room.

I don't know much about the narcotics policies in other countries. But it would be nice if there was a safe place where we could go and shoot up. But I don't know the reason why the number of drug overdoses has decreased in other countries.

As for preventative measures in Oslo, it is important that people know what they should do when someone takes an overdose, first-aid training. Giving people methadone is of course such a measure.

I can't think of any special measures that actually increase the risk of an overdose.

The overdose team has saved many lives. But it obviously hasn't helped.

I've tried smoking heroin. I did this for about a year, because I sort of thought I kept myself a lot straighter then. But it's a lot more expensive to smoke. I smoked the same preparation that I normally injected. I haven't seen any special heroin for smoking. I had contacts who could get hold of good smoking dope, so I got that. Some of the stuff you inject is not good to smoke, but during the period when I smoked I got hold of smoking dope, and this is exactly the same as what I also inject. You have to be a bit of a chemist to inject heroin as well, it has to be filtered and boiled etc.

Many people die near the train station, they die alone there. It would probably be good to have a place where people could go and shoot up, a place where there were other people around. I could probably go on heroin for a long time, as long as I had clean syringes and a place to shoot up. But I don't know if I could do it for several years.

11.1.3 Interview with a drug user, male, 41 years old (M3)

Has completed primary and secondary school, a foundation course in computer science, and a number of other university courses. Has his own flat in Oslo. Is a native of Oslo. Receives disablement benefits.

I've been a drug user since the seventh grade, when I was around 13-14. I started with hash then. Since both my parents were teachers, I felt I had to prove that I wasn't such a good boy and so obedient. That's how I ended up in the wrong crowd. Still, the drug use didn't interfere with anything else I was involved with. I had some experience drinking before I started with hash. But, it really wasn't much fun being dead drunk and ready to throw up. It was a lot more fun to smoke hash. I went to hockey and soccer practice, and could be stoned at school, but this was not a problem. No one noticed anything.

I use heroin now. I inject. Nine times out of ten I'll use it together with Rohypnol. I've also tried to smoke it, but you need more of it in order to smoke, by injecting it straight into your veins you get your money's worth after just a few seconds. This is why I prefer needles instead of smoking. It's just as much the syringe and the rituals surrounding the actual drug, because you get very sick of it in the end, you just need it to function. You don't get high at all from smoking. I have no interest it in at any more. One of the reasons I'm sitting here is because I've managed to keep it hidden from the people around me. Perhaps I'm kind of an atypical user. It's the first time I'm here. I've talked to the health and social welfare office, as well as the social security office.

I usually use drugs at home. Most times I'm alone.

I've been treated in institutions twice, for one and a half years at Renåvangen and Ullvin.

Yes, I've had several overdoses. It has to do with how much nourishment you have in your body, what shape you're in that day. However, the times it happened I had been drinking alcohol. I was lying unawares in a coma, and was saved on at least three occasions by ambulance personnel. I wasn't living in Oslo at the time, and I had locked myself in a toilet downtown. I don't know how close I have come, whether or not I just fell asleep or if it was a near death experience. My memory isn't so good right now, but I think I've had eight to ten overdoses. This has of course something to do with mixing different drugs together. It's dangerous to mix Rohypnol in your shot. The antidote doesn't work then. I've either been alone or together with other students when I have taken overdoses. The last time was on a drinking trip together with a classmate. When we got off the boat from Denmark, we had drunk five bottles of Pernod. I shot up when I got ashore. But it was an accident. I am not suicidal. But I've been so depressed at times that I just wished I would never wake up again. I'm no longer as down as I used to be. You can be anything, from being a closet-junkie to showing your face to the whole world, getting filmed by the cameras down at Plata and tailed by the police. I have been so low that I've decided not to go there again. But now I sit at home and make dinner every day, take a daily walk, take vitamins and cod-liver oil pills and try to live a healthy life, besides the drug use of course.

I've been saved several times from an overdose, I don't remember too much from those situations now. I haven't slept more that four-five hours the last few days. But I have a fair idea of what you are getting at: Why are there so many overdoses in Oslo? They have had the

same drug policy in Norway and used the same methods with the same lousy results for the past 30 years. The only hint of any kind of liberalism is the introduction of a methadone programme in this country, but it's hell to get hold of it, that is, to get into a treatment programme. I eventually managed to get hold of it, but I've been out of the programme for half a year. This was because of supplemental use of both heroin and pills. This heroin use was really just a waste of money and time, I just fell asleep, and I experienced no euphoria. But the ritual surrounding the whole business is also important. I also think that the heroin is weaker than before. There is a lot of it, people practically throw it at you, but it's weaker. The people down at Plata now use maybe 1.5 grams in a shot. But I always test it first. You never know when you might get hold of stronger stuff. I take only very little at first. And I also get hints from my suppliers about how strong it is. It is often mixed with baby formula.

I have no idea of how many people I've saved. I have been in those kinds of situations at least two hundred times. The most common situations are those where people get out of a rehabilitation programme, jail or institution and, since they are drug users at heart, they take no precautions when they get out. Some friends of mine have experienced these kinds of overdose situations. But the typical overdose situations here in town occur because the people are in poor health. They spend the whole day trying to get money, constantly on the move and their mind constantly working out new plans. They get no nourishment. They forget to eat. They are just plain tired and worn out. My friends have all used a combination of heroin and Rohypnol. The last time I saved someone was someone that came knocking on my door. It was someone who I had been in an institution together with. I have of course learned a few tricks. I know first aid for example. I've learned this myself, not through any courses the Alcohol and Drug Addiction Service has arranged though. The first symptom is getting blue around the mouth. When you raise their eyelids and see that they just have a blank stare, you realise that the game is almost over. One technique I've used is just to pound them. I pulled him into the shower and just kept spraying him with increasingly colder water, and I slapped him in the face. He survived. If I hadn't done this he would have died. I would have called for an ambulance if I didn't think that I could manage myself. One dirty trick is to box them over the ears with your palms. You may burst their eardrums, but this is better than the person dying. But I didn't want to phone for an ambulance since it was in my own home, and it's never nice to have someone overdose in your own flat. But I still feel that dialling 113 is the least you can do.

What doesn't work? There is no political willingness in Norway to do something about this situation. They say a lot of things, but for the most part it's just bullshit. Nothing gets done. The concept of "injury reduction" is not accepted here in Norway, the only exception being the methadone programme. People seem to have a need to see drug addicts as outcasts, the same way they need to see Blitzers, Bootboys, Bandidos, motorcycle gangs, the Pakistani and other immigrants as outcasts. Drug users are a good enemy to have, so that people have something to measure their own excellence by. It's not generally accepted that drug addicts can have some human worth, this has been taken from them. They have been labelled and stigmatised as thieves, scoundrels, self-destructive individuals - you name it.

What could you do yourself? They say there is a drug user association in Norway. The only organisation that actively works with drug user related problems is the PRO centre (a centre for prostitutes). They've understood that these are human beings, and they treat drug addicts with a completely different attitude. The users don't have time to organise themselves. We have no representatives who understand us, who can sit down in the cafeteria of the parliament and sell ideas. I don't know any one in this user association, and I don't know

whether I would want to draw attention to myself by being there. But the day I do get out of this situation, then I'll be there. People have to understand that we are dealing with human beings. Your children or grandchildren can be drug addicts without you knowing about it. A lot of people think that you are born a drug addict, and that if your mother or father drink or use drugs, then you will also do the same. But you don't become a drug addict overnight. This is a gradual process. Suddenly you wake up one day and think: "Hey, I am no longer in control".

What is the reason for the difference between the various towns? I think there is a lack of injury-reducing measures in Oslo. You have to make sure that people are healthy and have food. The religious organisations hand out food at fixed times. I'm ashamed to live in a backward country that shuts down programmes like the needle room at the PRO centre. It's also good to have contact centres like they have at the Salvation Army and Blue Cross. I have used these, but I haven't used the field service.

Are there any measures that increase the risk of overdoses? You should be with somebody. There should be someone who walks around in the milieu and checks up on things. People are so exhausted, they just don't have any more resources, and at the same time they're on the waiting list for methadone for the fifth or sixth year in a row! I am thinking of things like a needle room with health care personnel present and heroin prescriptions. I wouldn't use one of these needle rooms, since I have my own apartment. Perhaps I would have gone there just out of curiosity.

What advice would you give?
Firstly: It revolves around money. They need to have the will to find money to do something about the situation. As soon as they have the money, they should set up needle rooms, where people can come and go without the police being present. They should be staffed with health care workers who can check your health and distribute food twenty-four hours a day. It's not the heroin that kills, but the lack of food and being burnt out. If I had food and health care I could have used heroin for another 200 years. It's not dangerous in a controlled environment. I think most people use about NOK 1000 a day. But you can get it cheaper if you buy in larger quantities. NOK 5-700 a gram. I get mine fairly cheap because of good suppliers, so I don't have to steal in order to obtain money. But this is an exception.

11.1.4 Interview with a drug user (Mario), 44 years old

He is a native of Oslo and lives here. Lives off of disablement benefits. Attended eight years of elementary school and one year of vocational school.

I have used needles for 29 years. Started using hash when I was 14 years old, and I injected morphine for the first time when I was 16. Heroin didn't arrive before 1978. The very first injection I took was a dose with amphetamine, but I quickly found out that morphine was a lot better. I've smoked hash for thirty years, but I don't consider this a drug. I have cirrhosis of the liver, hepatitis A, B and C and everything else that can go wrong. I'm now using methadone. I have had some relapses with benzodiazepines, but it has actually worked well beyond all expectations. Even though I have some supplemental use, everyone is really satisfied with my progress. I haven't taken a shot of heroin since May (ten months ago). I haven't had it this good in thirty years. But they do pester me about school and work though, voluntary work and things like that, but I have no interest in this. I've had disablement benefits for two and a half years, and have no problems passing the time, so why should I take a cooking course or something like that. During the summer I go out fishing, and I ski during the winter months. The caretaker where I live gives me some odd jobs to do, so I'm never bored.

Before I got into the methadone programme, I spent ten months on 1000 mg Dolcontin, a kind of quota. This was far too much and I almost died. I received this from Aker hospital. I'd had thirty abscesses that they had operated on since 1994, and Dolcontin could be perceived as a kind of lifesaver. I got the doses for a month at a time, and this is why it went wrong. I was supposed to take doses of 500 mg, but I took more than that. I didn't overdose on Dolcontin. I think they use it to gradually reduce people's intake of drugs.

I haven't been in any treatment programme, except for a day and a half at M3 and the one time I spent five days at M3. I've been through a lot of illnesses and withdrawal symptoms on my own. I didn't want to admit myself anywhere. I had no plans of cutting out drugs until I could get methadone. But I have of course been in contact with the welfare and social security offices. I have received disablement benefits for the past two and a half years.

I have never had any overdoses where it has been necessary to call for an ambulance. I've woken up on my own. Of course other people have tried to revive me, but never by using mouth-to-mouth or heart compression. The last time I almost experienced an overdose happened so long ago that I can't remember anything about the episode. But I had used heroin and Rohypnol in these situations. But I never mixed Rohypnol with the heroin in the actual shot, I took pills on the side. As far as I can remember, I was with some other people the last time I took an overdose. I woke up ten hours later, without any recollection of what had happened.

One of the times was because of an unhappy love affair. But the primary reason that I've taken too much has been the simple fact that I've been addicted to drugs.

I've experienced 20-30 overdoses by others in the flat I used to live in. They had taken a bit too much. They had shot up and either fallen down right away on the bathroom floor, or just passed out on the sofa. I have always managed to revive them. I have called for an ambulance, then given them mouth-to-mouth and heart compression until the ambulance arrived. I know

first aid. I learned this at school. There has never been any suicide attempt. It's always been an accident. But I've lost 20-30 friends from overdoses during the time I have been a user.

One reason that things go wrong sometimes is because people have been too long in institutions or jail and then used the same doses as before. Perhaps they also take 5 Rohypnol in addition, thereby doubling the effect, and then it's just good night.

You could commit people to institutions or rehabilitation centres. Or you could warn them. I have a 24 year-old daughter who is a drug addict. I've warned her, but it doesn't help any. It's like talking to a wall. She has been in jail for one and a half years, so now she mainly just uses hash and ecstasy.

The main reason there are fewer overdoses in places like Amsterdam, for example, is because you can go into a coffee shop there and smoke a pipe of hash without being labelled as a needle addict. If heroin had been available in the same type of setting, then it would be a lot easier to go over to using heroin.

Otherwise, when people have an alcohol level of 3 per thousand, there are many people who feel that it might be cool to shoot up. And maybe they don't drink more than two to three times a year. They underestimate the alcohol.

Measures to prevent overdoses. I feel that the measures implemented here in Oslo have been ineffective. I also think that people who haven't been using heroin for more than two years lie perhaps about having used it for a lot longer in order to get into some form of treatment programme. Half of those who are on methadone treatments have no business being there, since they haven't been on opiates long enough. Those who have sniffed, drunk and used amphetamines, get high on methadone, right? For me the methadone just takes away the craving for heroin. It doesn't diminish the craving for alcohol or pills.

What measures are counterproductive? I think everyone knows that medicine-free treatment programmes decrease your tolerance level. But I definitely feel we should keep the institutions we already have. But the physicians in private practice are so lax about prescribing Valium and Rohypnol. These are substances that should simply be illegal. But there is also a lot of Rohypnol that comes to Norway because of the war in the Balkans. It comes in boxes and crates. It costs NOK 40 for a tablet now.

Good and poor measures? We had nothing before. I feel that the measures that have been initiated now are good, except I don't feel that you should have had to have been on opiates for ten years to qualify for methadone. I spoke to the chief physician here and told him that only "acid heads" and "whores" are running around here. But the doctor felt that if someone has been addicted to heroin for two or three years, then this was good enough reason to be admitted. But why is the requirement ten years then? - Do you think that the requirement should not be ten years? Yes, it should be at least ten years, or at least five years. But it should be documented then that they have been addicted for that long. And you know that pills are never sold here (at the methadone centre) on weekdays. But on Saturdays and Sundays, the ones who can't get any methadone home with them on the weekends come here, and the whole place is overflowing with pills. I've even been offered to buy pills on credit. But I get really pissed off and tell them, "If you ask me one more time, I'll tell them about you". I've told them that it happens, but I've never given them any names.

What would you say to a politician? One thing that definitely doesn't help is to be strict with those who have relapses with pills. If I have relapses with pills, then these relapses tend to last for a month or two. The last time I used pills every day for two months. You don't think you're high yourself, but everyone else notices it. I don't notice anything before I get really unwell, and that's when I feel it. - Have you taken any pills today? No, but I had some yesterday.

I feel they could've thrown out half the people in here. The ones who have only been on amphetamines and things like that. That way they could admit the ones who have been addicts for 20 years. The ones they don't have any room for today. I have been living in the heroin milieu for 40 years, and if there is someone I don't know here, then it's the ones who are under 30.

They've talked about establishing a needle room. What do you think about this? I think it is very important, instead of having people shooting up alone in a toilet. But I would personally have gone straight home and shot up there, like I've always done. I'm not really afraid of being alone, because I know I wouldn't take an overdose.

11.1.5 Interview with a drug user, a 37 year-old man (Interviewed at M3)

Have been on drugs since I was 11 years old. I live in Oslo, born and raised here, come originally from Grorud section. I currently have no place to live, so I have been sent back and forth now between the various social welfare offices in Oslo. In spite of all this, I have actually managed to work as a taxi driver at night, up until three years ago. I have more or less lived a kind of double life, combined with amphetamines and heroin. I live off of social assistance and have no other income. I have completed primary and lower secondary school and one year of trade and commerce courses at the upper secondary schools.

In 1972-1973, when I was in third grade, I moved to a new suburb. There are a lot of different people in a suburb like that. Perhaps because of my curiosity and the need for excitement, I have always had a tendency to get into contact with the wrong people for some strange reason. I have done very well at school and in sports.

On one occasion I managed to get hold of liquor at home, I stole it. There was never any form of drunkenness at home. I had of course to tell some white lies about spending the night with some friends and things like that, where there was even more drink and other stuff going on. If they knew this at home, I would never have been allowed to go. I told them it was OK to be there, but it was also where the casual drinking started, by trying the hooch, for example. In the third or fourth grade, I smoked a little hash, etc. This was all I used for a few years. We looked down on those who used heroin, amphetamines and things, couldn't figure out that it could be any fun. But managed to get a pancreatic infection because of the drinking before I turned 30, 20 years earlier than normal. This was awfully painful and scared the hell out of me. So if I buy a half bottle of something now, I can just phone the hospital and go lie down. I can drink some beer without any major problems. The need to get high has always been there. At one time I tried using some amphetamines, and thought this was great for a while. But I grew tired of this after a while, and I had some friends that used both amphetamines and heroin. It happened one time when I had been drinking a bit, someone offered me some heroin to try, and since then it's become the strongest drug when it comes to taking control of your life. My friend remarked afterwards that he felt bad that he had gotten me hooked on heroin, but I said it was alright since I felt I had complete control of the situation. But it took hold of something in my head. I've had everything, and I've lost everything. I've also seen people who have had everything and been off drugs for 10-12 years, and manage nevertheless to lose everything again. I was almost 30 years old when I tried heroin.

Now I mainly use heroin. I can smoke a bit of hash, but heroin is my major drug. I need a little Rohypnol in my doses though. I dissolve it and mix it together with the heroin. The purpose of this is to become more well. I don't use heroin in other forms than in injections. Something I've done since the first day I started using heroin. People can stand around down at Plata and be almost fatally ill, but they won't go home and shoot up before getting hold of some Rohypnol, because it doesn't work otherwise, they say. I think this is just a load of psychological nonsense. But I've never heard of anyone on methadone say the same thing.

I have to inject the heroin into muscle, since I have no veins left, so I suffer from abscesses and other crap like that. The difference is that it takes longer before the effects start when you inject into muscle, and you don't get the added kick you get if you shoot it straight into your veins. But I get a high that is almost just as good, and after a while the actual high doesn't play that large a role anymore, the most important thing is to get well again, your withdrawal

symptoms disappear and you begin to function normally again. In order for me to get high, I need half a gram of heroin, something I just can't afford. I have used as much as a gram and even a gram and a half because I was involved in drug pushing. There was also one occasion when I shot up into my triceps and hit a nerve. I got so-called "drop-hand" then, where your hand is more or less paralysed. That's when I realised that I had reached a rather high dosage level and that I'd get fatally ill if I went to my room and lay down. You don't get any help if you're stuck in one of these hospice rooms. That's when I decided to admit myself. Should, however, the price of heroin go down, both myself and others would most likely use more. You know, when you approach forty years old, it also gets more and more difficult to be a criminal, either committing burglary or shoplifting, and the moral objections also start taking their toll, possibly because of my background as an alcoholic. The poor attitudes that are present in the drug milieu today, compared with the attitudes in the alcohol milieu, still shock me. In the drug milieu you always need money, otherwise you have nothing. In the alcohol milieu you can at least get a drink if you arrive and are hung over. Other drug addicts rob people when they are dying, instead of resuscitating them or calling for help.

I don't smoke heroin, but I know others people that do. Quite a few immigrants do it, but also several Norwegians. But not that many people do. But I have sniffed heroin. This worked fine, it was just as good as injecting it. However, this also takes a few minutes before it takes effect, and you don't get the added kick you get if you inject it straight into your veins, then your brain starts to boil after just five seconds.

I'm usually in my hospice room when I shoot up. When I haven't had a place to live, I've had to do it outside. I'm usually alone when I shoot up. I've heard the warnings about not shooting up alone, but I have such a high tolerance level that I would be surprised if I injected heroin that was so pure that I would die from it. It would have to be Thai or something like that, but this I would have noticed, and taken it a bit easier, since it's totally white and you don't have to boil it. You should be able to smoke and inject good heroin.

I am now trying to get into Veslelien (a treatment centre). I'm 1.82 m tall and weigh 65 kilos. I can't take it anymore. I weighed 87 kilos the last time I was in an institution. It is very physically and psychologically exhausting. I've been here ten days and will be ready for Veslelien soon, but it's fully booked up there.

I've also been treated at Mørk gård (a rehabilitation institution). This was two years ago. I was there for seven months and thought it was fine. But it was a rather unhealthy environment, since there were three of us who were older than the rest, and we more or less formed a gang. We stole some spare car keys and drove into town at night, and since we had received around NOK 20,000 in social security benefits between the three of us, we got hold of a lot of heroin. I took three overdoses while I was at Mørk gård. On one occasion it took them three quarters of an hour to revive me. I've been fairly close a few times. One time I woke up in the casualty clinic after breaking into a restaurant and stealing a lot of liquor, which I drank in combination with drugs. I also had a lot of drugs that I was preparing at home. While I was doing this, I took another injection, and didn't remember anything before waking up at the casualty clinic. I was living in a hospice at the time and was saved by a neighbour who happened to drop by. He said it was the worst case he had ever seen, because I also had convulsive fits and pupils the size of eggs. I woke up in the casualty clinic and noticed I had something in my sock, it turned out to be three syringes. So I took one of them and went straight into a new overdose. Since I was in the casualty clinic I was luckily saved.

But every time I have taken an overdose has been in connection with alcohol. I think I've had a total of eight or ten overdoses.
I've also taken overdoses on the streets. And one time in a hospice I received some cotton balls from someone, they were so fat that it resulted in a huge overdose. (Cotton balls that you filter the heroin through before shooting up. Many people put a few extra drops on the cotton balls in order to have something to fall back on in bad times. You boil them and put them in the syringe in order to withdraw the heroin). On one occasion I had drunk a litre of vodka and they had to give me five shots of Narcanti in order to revive me. I remember waking up that time with pain in my legs. The reason was that I had bought some drugs from someone on the third floor, while I was living on the ground floor. So he dragged me out from his room on the third floor and down to my room, so that the heroin couldn't be traced back to him. And he just left me there. Someone else called for the ambulance, not him. They had resuscitated me and pounded my chest, so when I woke up it felt like I'd been in a drunken brawl.

In summary, it has been heroin and alcohol that I, for the most part, have used when I've overdosed. I had no intention of taking my own life. The last time was outside. I wasn't together with anyone.

The reason was that I had drunk alcohol in addition to the heroin. Sometimes you just don't give a damn. When I'm under the influence I become careless. It was unintentional, even though I often think of taking my own life.

Overdose situations with other people. Yes, I've seen many overdoses involving other people and given mouth-to-mouth to even more. This has mostly occurred in people's homes. They have perhaps been in detoxification programmes, something we wouldn't know about, and then they take the same dose as everyone else. And suddenly they are just lying flat out. Heroin and Rohypnol. The last time this happened was together with a buddy and his friend. His friend had just been in a rehabilitation programme. He took the same dose as us. We tried to resuscitate him and called for an ambulance. He did survive.

I think that people often take overdoses deliberately so that they will die. The ambulance service is very effective. Something else that also goes wrong is that many people don't say anything when an overdose situation occurs.

I feel I know enough about resuscitation, however, I haven't been taught this by the Alcohol and Drug Addiction Service.

I've heard that other cities have clinics and places where you can go and shoot up. And in Switzerland you can actually get heroin. I think this is quite positive. This is a more liberal practice than other places. Not too many hassles with the police all the time.

What measures have you noticed in Oslo that could prevent overdoses? I haven't noticed any particular measures. Nothing besides the ambulance driving around town.

What can increase the risk of overdoses in Oslo? I don't really have any particular comments. But detoxification and institutionalisation can reduce the tolerance levels. So people have to be careful when they get out.

What do you think about the things that have been done? I only know about the ambulance service.

What advice would you give to the politicians? I would demand some health centres where you could shoot up in peace and quiet. I think you have to start from the bottom up, with, for example, needle rooms. I would have used these. But when you are in a hurry, you just shoot up in the nearest alley. Otherwise, I've used the needle bus a number of times. I keep my paraphernalia clean. I use sponges with alcohol for cleaning. But I've also had abscesses.

11.2 Street workers in Oslo

11.2.1 Interview with a representative from the Psychiatric Team for Youths (Ullevål), male, 59 years old

I am a psychologist and have worked in this field for approximately 30 years. Worked at one time in an outreach programme at Bjølsen. There was a user milieu there, and the drug use ranged from sniffing to morphine. We experienced overdoses, and this was in the early 70s. Morphine is what was used then, but syringes were also used, and there were two overdose related deaths. Since then I've worked out in the field, and from the middle of the 80s I've worked at Uteseksjonen and have seen the overdose problems at close hand. Indirectly, I've experienced overdoses and overdose related deaths through methadone treatment programmes. I ended my work with the methadone programme a year ago. Had worked there since the summer of 1994. I now work on the psychiatric team for youths, which is a polyclinical offer for people up to the age of 35, who have a combination of drug and psychological problems. We have approximately five interviews per day. Some of those who have appointments don't show. I also worked on the Needle bus in 1988, and I was part of the first syringe distribution from Uteseksjonen as well. We started before the Needle Bus, which subsequently became a permanent programme. I've also been on an overdose team, from the beginning there as well. It was after I conducted among other things an interview survey of drug users on the street, which revolved around overdoses, syringe use and suggestions for programmes, etc. This was about the same time that POHT (the outreach health team project) was established. I interviewed around thirty drug users. The statistical material was of course limited, but at least it showed a certain trend. This was the starting point for the reduction in injuries in Oslo involving needles, and the goal was to develop risk prevention measures in relation to overdoses, if possible. I saw a high level of commitment and people going far in deviating from the official drug policy goals when it came to the ultimate goal of achieving a drug free society, with reference to the HIV epidemic. I suppose I took a rather high moral line, because I saw a great deal of tolerance with regard to distributing information on the use of syringes and infection paths, with regard to handing out syringes, since I felt that part of this tolerance stemmed from the fact that this was something that could affect anyone, while overdose deaths didn't concern anyone other than the drug users themselves. So on one hand they were willing to go quite far, and stretch their aims, but when similar measures were suggested for overdoses, there was no response, which is something I became quite angry about. I suppose I said something like if they were so very worried about everyone who died, then maybe they could just go out and tell them how to use needles without dying from them, evaluate health programmes and fulfil the needs of the users somewhat with regard to these sort of things. This resulted in an uproar. I felt for example that we could have had talks with the clients about the risk of death from overdoses before their discharge. But many people in the field opposed this.

Question 1: My work situation now is such that I don't see these kinds of situations much any more, but I have been involved with them earlier. The typical cases are the individuals who have managed quite well for a while, but then experienced a relapse. It's very often these individuals who have the toughest time, besides the newly released ones, in toilets and places like that. I have given assistance and picked up people who have taken overdoses, they were given an antidote and woke up feeling disoriented, frustrated, suffering from abstinence and generally felt very poorly. And there haven't been many words of thanks for this assistance. It's been more frustration over what had happened. So they feel betrayed and aggressive

towards those who have revived them and gave them an antidote. As a member of the health team, I also worked in the observation room at the casualty clinic, and have experienced some rather wild incidents. I remember one time when I think we had five people in a small room, more or less in a coma. A couple of them who were heavily under the influence took turns giving mouth-to-mouth resuscitation to the other. I suppose one of them was a bit more "awake" than the other. In any case, they stopped breathing. But they took care of each other. But I also remember, something that made quite an impression. An older nurse came in, surveyed the situation and started to argue with a younger doctor about whether or not they should give an antidote to one of them who was sitting there constantly on the verge of passing out. She felt that here was a poor young man who had used a lot of money to get into this state, she knew from earlier experiences with antidote injections that the person would wake up in a state of abstinence and feel awful, so she argued that they should wait as long as possible before administrating the antidote in order to preserve as much of his high as possible, so that he could have an opportunity to recover on his own. A very pragmatic solution from a medical perspective, and we were in control then and there. Otherwise my experience is from the street, and as soon as someone started turning blue you called an ambulance, and tried to keep them awake. We were often the first ones they would contact.

Patterns of use. I believe there are some pure heroin users. And these users are the ones who sort of don't like this borderline existence, where you are apt to cross the line. They want to be in control and find it uncomfortable to find themselves in such a borderline situation. When you combine heroin with Rohypnol, you quickly fall into such a borderline state. However, there are some users who combine heroin with other drugs and don't like to lose control, while others just have to fall into this borderline situation and stay there, and I suppose they are well aware of the fact that when they are this close to an unconscious state, that something can go wrong. It's hard to say whether it's a question of indifference or if they trust the emergency services. For some it might be indifference, but for others it's probably the experience of lying there in a state of borderline existence. This is what they find attractive, and it is experienced as a good high, floating out of their own body, perhaps it's a type of near-death experience. The ones who use pure heroin and don't like this borderline existence, run a much lower risk of taking overdoses. I remember one of them who got into the methadone programme. He was one of the stars there, and everything went fine. No supplemental drug use.

Smoking heroin was a rather exotic affair in its day, something you hardly ever heard about, but you could see it in places like Amsterdam and in Spain. But now it is coming here, there are more people who smoke now and stay with it. There is a new user group that has appeared in connection with the new synthetic drugs, and they don't consider themselves drug addicts. One of the reasons is that they don't use needles. They feel they really shouldn't use heroin, but some of them do, and then they smoke it. These are people who have set a limit for themselves when it comes to injections, and not past syringe users who have graduated to smoking. For a long time I thought this was fairly safe in relation to overdoses. But I have seen a report confirming that there are also several cases of people dying from overdoses after smoking heroin. The risk is of course less, but there is still a risk. I remember talking to people about it, but I had to find something else to say, because it actually isn't as safe as I had thought. At least it's more difficult to smoke heroin in combination with other medications. I suppose you could smoke yourself towards a heroin overdose, but I have always thought that when the heroin smoker's respiration stopped, then the intake of heroin stopped, thereby stopping the process. But I suppose it depends on how much they've already had and how deeply they have inhaled. In conclusion I think that, among the new recruits at least, there is a tendency not to start with needles, and just smoke instead. However, there are a number of

people who start with party dope and then start using needles. They inject amphetamines, and when they've crossed that boundary, they start injecting heroin. Risk factors. There is of course a greater risk of overdosing, if you inject it rather than smoke it. If you inject, the risk of dying from an overdose is greater if you combine it with alcohol, Rohypnol, benzodiazepines or other medicines, instead of using pure heroin. But there is no safe way to use heroin. However, what state you wish to achieve is also important. If you want to reach this borderline situation, then this is a dangerous goal. Rohypnol is easily dissolved and has some peculiar effects, but other medicines should not be forgotten either. They can also be mixed in. This also applies to central stimulants. The policy. I really can't see any sensible measures of any importance that haven't been discussed or tried. Of those that have been implemented, I feel that information is a necessary, but insufficient condition. We need to publish information, and it should be prepared in cooperation with the users themselves. I'm thinking about measures like joining some users together in connection with a common situation or problems that they have in common and want to do something about. I believe in all the measures that involve the users, such as first aid training, teaching them simple steps to take and what numbers to call etc. This has been implemented earlier at a high level, but it appears that these efforts are somewhat on the decline again. I'm also a firm believer in dialogue groups in connection with discharges from institutions and prisons. I am sure that the efforts made here vary, since how the client actually fares afterwards doesn't really concern these establishments. The client is out of sight and mind then. It's a difficult balancing act. On the one hand you want to wish the client good luck with a new drug free life, and tell them that you believe they will succeed, but then on the other hand you let them know that you are aware that they have been looking forward to taking a really heavy dose now, and then start lecturing them on the dangers etc. The so-called immediate measures we had in the beginning of the 90s shocked many people. This involved sending people away for treatment as soon as they showed any interest in getting treated. The drug users just weren't prepared for these quick responses, and some of them left very quickly. However, for some it appeared that if they first entered an institution and started a treatment programme, that they stayed there, and maybe even managed to start a new life. During this period the street users were taken very seriously, and for a while they had to be careful not to mention anything about wanting to enter a treatment programme. They risked being shipped off on a plane the following week. Otherwise, I am a firm believer in any kind of health oriented measures. I see that this is growing trend, and the field care service is of course a proposal we've had for many years now at Uteseksjonen. We saw the need for a central meeting point that would include the health services and the possibility of distributing information in the downtown area. A place where we could discuss their health situation, abscesses, yesterday's overdose, their HIV status, etc. And it is a good opportunity to talk to the users about overdoses, find out what their understanding of the situation is and what solutions they would suggest. With regard to methadone, it can also help prevent overdoses, as long as it's used in the proper manner. But we don't want a situation like they had in Denmark some years ago, where methadone was involved in approximately a third of the overdose deaths. If we get a situation where we have a lot of drug use combined with methadone during treatment programmes, or the leakage of methadone to the black marked, then we must be prepared for a situation where autopsy reports will show a lot of methadone among the overdose victims. So then we would have to reassess methadone as an overdose preventative medicine again. We risk losing track of our objectives. I don't know to what extent the methadone programmes are being evaluated now. I feel we should register and stay alert so we don't get off track. We shouldn't focus so much on methadone saving lives. It happens under certain conditions, but not in all circumstances. I know there is a great difference between the share of methadone users in Oslo and Amsterdam, for example. Less than ten percent of the needle addicts here use methadone. I

don't think there is any standard for the percentage that are on methadone or for the offers people receive in addition to methadone. I know there was a lot of methadone on the street in Copenhagen, and that this contributed to the overdose deaths there. The use of low threshold methadone for a small and select group must be evaluated in relation to the help they've received with regard to improving their quality of life. And if the agencies helping them can prove that they have actually improved their lives by using methadone, then I believe this might be a possible form of treatment for a select few. Stopping methadone treatment for this group can increase the risk of overdose related deaths and worsen their quality of life. So for this group it is conceivable that a less ambitious methadone programme might be feasible, provided there is some form of control that the methadone actually goes where it is supposed to go. The goal then is to consolidate a function level that is optimal for the individual in question, which also includes getting high, where their quality of life is better with methadone than without.

Counter-productive measures. I can't think of any measures that we have implemented that have increased the overdose risk. We have a large number of medicine-free treatment programmes, and this is good. But we must bear in mind that in many cases there is a great likelihood for a relapse, and we must take precautions here. But the dramatic tolerance reduction in connection with the use of opiates could perhaps be emphasised even more. We should, however, be aware that the objectives in the Norwegian methadone regulations, which state that the applicants must try medicine-free treatment programmes "to a reasonable extent" first, are not worth the paper they're written on. People who have been in and out of prison and reformatories for many years, also receive methadone. A prison background is considered to be equivalent to a medicine-free treatment programme here. I do not think that people institutionalise themselves for medicine-free treatment programmes in order to qualify for methadone either. We attach importance to the overall situation with regard to the intake.

What has changed? There really isn't that much that has changed in the culture. Heroin has become less expensive and more readily available. It's a buyers' market. This change came about in 1992-1993. That is when the sellers suddenly found themselves wandering around not being able to sell their goods. The price reductions are attributed to the enormous volume smuggled in. I believe that the injection culture has always been here. When it comes to the heroin milieu, however, there has been an increase in the recruitment, and younger people have now arrived on the scene. Several old alcoholics have also joined the milieu and started to use heroin. It is the market that rules, like the New Hampshire people say, and you do not choose your drug or what condition you want self-medication for. You use the drugs that are available and you can afford. We are starting to get old, worn-out alcoholics in our methadone programmes. Young heroin users seem to make a point of the fact that they don't use alcohol. For the ecstasy users the picture is somewhat different. Here alcohol is present. But the party dope people also wind up using heroin afterwards, and alcohol may be a factor in these cases. They either start by injecting amphetamines, then start to inject heroin, or they start smoking heroin and then start to inject it. Heroin is the last resort for drug users. Ecstasy users often come to us after just a year. So this happens very quickly. They also tell us that they don't want to go back to using ecstasy. The classical development a heroin user used to be four to five years using amphetamines before they wound up using heroin. With regard to methadone treatment programmes I've felt that there hasn't been any need for other types of medicines. We should concentrate on establishing a good methadone treatment programme. I have, however, noticed that as soon as we are close to achieving this, other medicines, like Subutex for example, are pushed. I feel that this is rather unreasonable. But I am open to suggestions. When we have the necessary experience with methadone, we could perhaps consider whether

a small group should be evaluated in relation to other drugs such as heroin. But this can never be a form of treatment, since this would be for the people who have fallen through everything. Before getting to this stage, I feel there are a lot of other things we should work on with regard to treatment. I feel that Subutex has been forced upon us. I don't know who has lobbied whom for this drug, or what offices they have been in, but there is a great deal of capital backing it, which influences the development of medical treatment, in addition to populism and the fact that the media set the agenda. And we can of course fear that as soon as we start to establish Subutex, there will be a new push in relation to heroin, for example.

11.2.2 Interview with a female outreach social worker on the streets, 42 years old

Nurse working as a charge nurse at OKT. I have worked in the field since 1984, approximately 16-17 years. Worked as a freelancer for many years, while doing other things. I currently work in a half-time position. The acute part of my work is very exciting and gives me an opportunity to act on my own.

We go out on assignments when we are called, when someone needs help, in acute cases such as overdoses or excessive drunkenness, and when people are incapable of taking care of themselves. Home visits can also be just as dramatic when people have been drinking at home alone over a long period of time and are actually in need of acute help. These are the kind of assignments we have. They are often of an acute nature, and we have to find a temporary solution, which includes everything from admitting them to the casualty clinic and acute care institutions to information and referral to other assistance agencies. We also follow up people, sometimes over long periods of time. We stop when we have managed to establish contact with the proper organisation. We don't have any mobile resources at our disposal.

We are summoned in cases involving all kinds of drugs, although less often in cases where the new drugs used by teenagers, such as ecstasy and GHB, are involved. Uteseksjonen is contacted more often in these cases. But we do get summoned in these cases from time to time. For ecstasy abstinence for example, and we do a lot of information work over the telephone. There are a lot of teenagers and relatives who ask questions about the drugs and their effects. Otherwise we are in involved in every aspect of these drugs, primarily alcohol, amphetamines and heroin. But now I'm forgetting something very important, and that is the abundant use of pills. This includes people who just use pills, such as benzodiazepines, tranquilizers and sedatives, and the many people who also mix pills with alcohol. There are also very many heroin addicts who also use pills. They have taken so many pills, especially Rohypnol, over a number of years that it has become a problem for them. But this problem is totally underestimated by the treatment programmes. When heroin abstinence has been achieved, then the pill abstinence starts. This is something they just can't cope with, because it's awfully tough. It's the toughest form of abstinence. Is there something that can be done to alleviate the pill abstinence? There are programmes at several of the clinics here in town that treat pill addicts, where they gradually reduce their intake. They don't make use of cold turkey, as you have to do when you admit yourself to an acute care institution. The pill clinics are a long-term programme, perhaps more than a year, where they gradually reduce the addict's intake and follow him/her up closely. Should heroin and alcohol addicts also undergo this kind of long-term reduction programme? I think that the acute care institutions that run detoxification programmes for heroin addicts should absolutely consider the problems associated with pill addiction in the detoxification phase. So far very little has been done.

With regard to overdoses, is it generally the heroin overdoses that are the classic examples. Most often in connection with a mixture of Rohypnol or alcohol. The person stops breathing, goes into respiratory arrest, or he has extremely reduced respiration. Then we have to administer artificial respiration, initiate life-saving first aid measures and call for an ambulance. The only equipment we have with us is our breath and hands, i.e. we have a breathing mask and give heart compression, we're very well-trained in first aid. This is something we have had good use for on several occasions. It is often enough just to breathe for the person to keep his/her circulation going. But an ambulance has often arrived on the scene by the time we arrive.

What can you tell us about the patterns of use you see? The heroin users generally inject. This is something that we have observed. We know where they usually shoot up, and we go to these places three times a day since this is where overdoses occur. They inject heroin and Rohypnol, and they take of course pills. The hygiene standards are of course deplorable. There are no suitable conditions for shooting up safely under a motorway. When they get clean syringes, it is really only half of what they need. They don't get clean water, nothing to boil them in and no swabs. Infections occur just as often there as elsewhere. They should give them everything, not just half of what they need. They should decentralise the distribution of syringes to the field care service. That way we can perform other tasks such as counselling. The Needle Bus can, however, be helpful in identifying weekend junkies, teenagers, etc. They haven't had the capacity to do anything about their observations. It's quite possible that they should keep the bus, but that they should expand their services.

We know too little about the risk factors associated with overdoses. But reduced tolerance in connection with imprisonment or medicine-free treatment for example increases the risk. So does mixing alcohol with Rohypnol. It is also thought that poor mental health may also be a problem. The same applies to poor physical health. If, for example, you've been on amphetamines for a week, your heroin tolerance has already been greatly reduced. So if you then try to cut down on a week's use of amphetamines and fix the same heroin dose as before, you are already in the danger zone. This is maybe more important than being physically worn down, even though the lack of sleep, food and the effects of amphetamine use may also influence their resistance.

Do you think they underestimate the significance of combination use? When it comes to alcohol it is definitely underestimated. We have interviewed some people who have overdosed. They clearly play down their alcohol use. We have much more knowledge when it comes to Rohypnol. It's a calculated risk and a devil-may-care attitude when they use these combinations. They get to a point where they really don't care if they risk taking an overdose. It's not a suicidal attitude, rather one of indifference. Many of them say they don't give a damn, even though they aren't suicidal.

Death wishes are not widespread among the individuals I've spoken to. On the other hand, stress factors are widespread in the lives of these people. Poor living conditions, friends dying, disputes, threats, people after them, violence, having to steal, they have an incredibly stressful life. They score very high for stress factors in our surveys, and this doesn't exactly give them any stable frame of mind. A life filled with harassment and struggle influences perhaps the overdose situation.

What measures have been successful? There are a lot of measures that have been initiated to prevent overdoses, and that's a good thing. Our field work is good, even though it is difficult to say whether it has had any effect on overdoses. But it's a good initiative. It does something with the state of their health, and their quality of life and sense of dignity is strengthened. It is speculated whether the state of their health has any significance in relation to their overdose resistance, but these are just speculations. There is no single reason.

OKT had a project at the Bredtvedt women's prison. This involved discharge talks, where we talked to them about overdoses and the importance of being careful. So it was basically preventative talks about overdoses. I and another nurse at OKT ran this project. These girls knew an awful lot about the subject. We did this for a year and a half, and we visited the

prison every third or fourth week. The way it worked was that we would prepare a topic for the day, one and a half hours, and then a conversation would start. The girls had answers to the questions we asked. Everyone involved in the project became very knowledgeable after a while. But we weren't allowed to continue. Some big shots thought it should be done in a different way. I met some of these girls later. Some of them managed quite well for a while, while others went back to their old ways immediately. Discharge preparations on the part of the prison authorities are not always that good, and it isn't always easy for the girls themselves to follow through even though the plans have been laid in advance. But we had no way of measuring the effects of what we did.

POHT was established in order to prevent overdoses. They did a lot of good work. But it's difficult to say what effect it had on the overdose rates. Follow-up and information in relation to overdoses was offered. After-care in relation to overdoses and preventative care in relation to the next overdose. But even though this work helped, especially first aid training for users, there are of course new groups all the time. A lot of them come back for refresher courses every summer.

Recruitment? It's hard to say, but from what I can see it seems that there are new groups in our society who have started to use heroin, the weekend junkies. They are perhaps university students who have been out on the town and had a few beers, then they go home and inject a dose of heroin. It might not be the first time, but they haven't done it very often either. Their level of knowledge is lousy. They don't know that it's dangerous to drink alcohol before injecting themselves with heroin. This is a group that has become more visible these past few years. They are more difficult to reach. We don't have too much information about Plata, but we have observed teenagers and young adults that drop by with their satchels on their backs after school, and they are so quick that we hardly see them, they get their drugs and are off again. And these are the so-called well-functioning, decent teenagers. This is increasing. I don't really know if it is heroin they buy, since these are groups who also use amphetamines, ecstasy and pills. Plata is the marketplace for drugs. This is the big marketplace in town. The older alcoholics have also started to use heroin, some use it all the time, others just occasionally. There are quite a few overdoses here as well. But they often hang out in larger groups, so they often get saved by the others.

Someone has mentioned that you can also get hold of drugs in pubs and bars. Some say that drugs abound in pubs and bars. They are readily available. But we don't get called out on assignment to pubs and bars. If we do, it's usually because of excessive drunkenness.

The fact that we have many medicine-free treatment programmes can of course lead to many detoxifications. But it's good to have such programmes. The poor follow-up after being discharged is a continuously recurring question.

Methadone. There has never been so many people in methadone programmes as now. However, there has never been so many overdose related deaths either. But it's so new in Norway that's it's difficult to say what kind of impact it will have.

We've met people on the street who have been on methadone, and they've almost been unconscious or extremely uninhibited. There have been hospital admissions and other dramatic situations. People use alcohol and Rohypnol as well. When you take Rohypnol together with methadone, the effects of the Rohypnol are intensified, and then you get a kind

of counter effect, you get high instead of being sedated by it. Alcohol is also very dangerous when taken with methadone.

Would you say that the situation has changed since you started working here? Yes, when I started in 1984, it was of course the traditional alcoholics that were predominant. But now, there is a lot more heroin and pills. This has actually increased. Pure alcoholics don't exist anymore. I also feel that there is a greater share who visit now, without actually belonging to any particular group in central Oslo.

We perform artificial respiration, heart compression and call if we get there before the ambulance. Even though the ambulance personnel has been there and given the victim Narcanti, it is still important to keep the patient active, by, for example, taking the patient for a walk in order to get his circulation flowing again.

This is also what is recommended to do. Naturally it is also recommended to follow up the individual through information and perhaps to contact him/her later on.

I feel there is too much focus now on the overdose deaths, one should have more of an overall perspective and take the entire drug policy into consideration.

11.2.3 Interview with a police officer from the URO patrol, male, 36 years old

I graduated from the police academy in 1988 and have worked in the narcotics section, URO patrol, for the past 8-9 years, except for a short period working undercover. I have always worked in situations where overdoses occur. The first three years I worked out on the streets every single day. This was the time when the drug milieu was concentrated around the upper part of Kirkerista near the Narvesen kiosk at Egertorget, and I've followed this milieu as it has moved down to what we now call Plata. Our instructions are to first survey the milieus and gather information on the user and dealer milieus. We are supposed to disrupt these milieus and arrest people there, in addition to obtaining information from sources so that we can identify individuals who are higher up in the distribution chain. What is not regulated in our instructions can almost be described as our function as social workers, and this has become a significant part of our job. We have become a point of contact for those who haven't had any contact with adults since they were 8-10 years old, because they have doped their entire adolescence away. They don't know how to act when they go to the cinema, they don't know how to go to a restaurant, and they don't know how to approach the opposite sex in a normal manner if they want to initiate a relationship. All of the things that other people learn while growing up have just passed them by. I have also experienced that many of them contact us simply to have someone to talk to about things other than buying and selling narcotics. They come to me. I've obtained a reputation down there. They know who I am and what I stand for. My philosophy is to do my job. I have to arrest people there. But we have to be able to talk to each other, to break boundaries. I don't believe in this cops and robbers scenario. My philosophy is that you don't have to push people further down in the mud than they already are. They know very well where they already are. By giving a little of yourself, you get much more back, not only professionally, you also get a lot of information and knowledge about people and how they live and think. I feel this has strengthened me as a person and made me a better police officer. You are not only interviewing a police officer, but also a kind of social worker. We aren't trigger happy and action oriented. There are a lot of myths about our department. We aren't down there as often as we used to be. But I'm sure that if I was down there and someone tried to attack me I could just yell for help and someone would come and help me, I'm convinced of this. The way I describe myself also applies to most of my colleagues. We are the ones who set the limits for the drug users, something that can seem a bit strange in this kind of environment, but those who have been drug addicts for a long time have as a rule managed to avoid most kinds of limits. They sort of become slippery eels after a while. But as soon as someone starts to set limits for them, they actually seem to appreciate it. In spite of the fact that they get caught, they seem to feel that it's all right.

I don't actually see that they shoot up in overdose situations, but from their appearance it's obvious that heroin is involved, possibly in combination with something else. Heroin is the strongest poison they take when they overdose. What other drugs they've taken is something they have to answer themselves, but I haven't noticed any other drugs. Now we see that they shoot up in public, so that we can observe it. They started this three or four years ago, and it became possible for the general public to see it. It's really crazy now. They sit on this "pin cushion" as they call it, just next to the ToTo kiosk, preparing their dose and shooting up. It's become a much more common thing to do, it's not so mystical anymore. They don't hide. They're not afraid that others might see them or that the police might come. This is because there are so many of them now. There has been an incredibly enormous recruitment of new people. And there is a greater supply of drugs. And this is precisely because we haven't been

down there as much as we used to be. The police have not changed their policy, but there has been a change in our presence.

Our department had a lot more time to work in this environment before. We don't have the time anymore. We have so many other things to do. We get so much information about what is happening around us. We have so many cases that we just have to grab the hottest item of the day. If we have an opportunity where we may be able to confiscate three kilos of heroin, then we will concentrate on this instead of working down at Plata. We have to prioritise, and since there are so many of these other big jobs we have to concentrate on, we prioritise these jobs instead of working down at Plata. Consequently there is less contact. We don't find out as much about what is happening down there. There are actually fewer police officers working this patrol today than when the patrol was established, so obviously we cannot manage to do everything. If we had 50 officers instead of the 13 we have today, we could have two or three teams that could work down there, and that could help keep the recruitment in check and control the milieu. Then we could also concentrate on our other jobs, like the immigrant milieus and the restaurant and bar businesses, etc.

Risk factors. The risk is of course the way the drugs are used, that they are injected. Of course there is the risk that they get hold of drugs that they haven't tried before. They have more or less regular suppliers. The uncertainty is introduced when the suppliers get some new drugs. And then it's what they mix the stuff with, like Rohypnol and things like that. Tolerance is important. There is a lack of follow-up after prison, institutions or hospitals. They think and feel they are fit and in good shape, and then they set the same doses as before. Some of the overdoses are taken on purpose. I'm quite sure of this. They have phases when they are really low. It's not necessarily the ones who tell you they will do it who actually do it. I don't have any proof, but this is how I have interpreted the situation, based on how the individual has behaved during the period before the overdose, what sort of problems they've had, if they owed money or people were after them. Suicide can be a solution, or they do something so drastic that they get caught for it and manage to escape in that way. This is also an escape route. We've also heard that murders have been committed by means of overdoses, but this is difficult to prove.

The police have standing instructions to order autopsies for all suspicious deaths, and all the costs associated with this are charged against the police budget. This is not at all favourable, and this applies to many other incidents besides overdoses. But I have no grounds to say that there are suspicious deaths that should have been examined, that have not been. But what can you find from an autopsy of an overdose victim? You find out that the person is dead from an overdose, right? You don't find out why. The tactical part of the investigation is lacking. On the other hand, if you find out something related to murder, then you have to make use of much more resources. I worked for a while in the violent crime sector and remember a discussion about having autopsies performed. The conclusion, however, was that there wasn't any way to cut costs, this was something one just had to do.

What measures have been successful? My understanding is that syringes are one of the risk factors. This is a major factor, and it doesn't become less by handing out several thousand syringes a day downtown. But I understand why they do it, because of the risk of infection. Perhaps we would have had an AIDS epidemic instead? But I think that syringe distribution has been a contributing factor, especially when you think of the new recruits. In order to overcome the overdoses we must try to minimise the recruitment. They stand there and hand out syringes to just anyone who comes and asks for one, without any discretion or questions

about what they need them for. My neighbour could go downtown and get a syringe without being asked a single question. If you're going to have a Needle Bus, then you should at least have some kind of support organisation for this activity in order to identify the people who are on their way into a life of heavy drug abuse. My criticism isn't therefore just about distributing syringes. It is about how they do it. Of course you have to weigh this up against the possibility of infection, whether or not to do it, but I think this helps promote the syringe culture.

There is the field service of course? It's possible that those who use this service do obtain a better quality of life, at least they get the feeling that someone cares about them. The feeling that no one cares about what they do, that it doesn't make any difference to anyone, that can, be a contributing factor to the hopelessness of their situation. So, whether or not the field service has been helpful with regard to overdoses, is not known. Last year, after the field service started, they spoke out a little too soon, exclaiming this was the solution, but this was clearly a contributing factor in improving the situation for the users. But then again, these are programmes that have been implemented for the heaviest user groups. I think if you want to get anywhere, you have to start at the other end, with the new recruits and people who are on their way into heavy drug use. Like I said when the house milieu started and gathered supporters, give them five years and you'll see them on the street. And this is what we see today. We see them on the street. Not everyone of course, but those who had a predisposition, they are there now. They are the biggest recruitment groups for heroin use. They would never have ended up there otherwise, but it's because of their participation in the house culture.

Immediate measures: – HUB. When the HUB project was initiated the first time, we saw that the relapse rate was fairly high. There weren't many, if any at all, who eventually landed with their feet on the ground. Perhaps they went three months without drugs, which is in itself positive. However, the second time they implemented it, it seemed to be more well-thought-out. This worked better, but after we brought a client to them and the next step had been completed, it was difficult to find places for them. Anyway, this was the feedback we received. We had to slow down a bit because they had problems finding places for them. Maybe it isn't so stupid not to send people away the same day, because we see that their motivation shifts enormously, and that many users aren't motivated after all. So maybe it isn't any use to send them away. One thing that has changed considerably is the desire to admit oneself, to start a drug-free life. After the introduction of methadone, this is now non-existent. You hear about people that entered treatment programmes time and time again, and that there is no use in trying to make them drug free anymore. In reality there are many who have never tried. They don't want to get out. They don't want to experience anything different.

What has changed? There are a lot more drugs. This is important – the supply is almost equal to the sales. They take whatever they can get a hold of. If they have a lot, they use a lot. The blockade at the borders is not noticeable in this connection (expanded customs inspections were implemented at the borders due to foot and mouth disease in Europe during the period prior to this interview, and more narcotics seizures were reported in this connection). There was no noticeable difference in the supply situation after the seizure of 36 kg the other day. Before, when you seized 300 grams, the market dried up. There are some days when there are no pushers at Plata, simply because they all happen to have other things to do at the same time, but not because of a shortage of drugs. There are also many more drug users now. A few years ago I knew the names of everyone on the street, now I have no idea who anyone is anymore. This is because there are so many more of them. Many people from other parts of the country also come to town. It used to be just a summer phenomenon, but now it's year

round. There has also been a kind of unwritten law not to sell to minors. It's been like that, and maybe it still is, and everyone says it's like that. But if you drive two blocks away and look back in your binoculars, you see them selling to anyone.

At the end of the 80s they said that the recruitment had stopped completely, and that the average age of the users increased by one year for every year. But this has definitely changed now. There are new users, not necessarily just young ones, but there are also adults who have been recruited into this milieu, 25 to 30 year olds, who really don't have any previous drug background. It has something to do with the fact that it is more commonplace now and the supply of drugs. Everyone knows where to get hold of drugs.

What about dispersing this milieu to other areas? Well, the police have never been the reason why the areas where they congregate have shifted. These areas can be anywhere. But no one has the guts to tell us where they should be. If need be, we could move the whole group to the middle of Ullevål stadium. What we have done on Karl Johan was simply a way to distribute the burden. When we decided to do something about Viking-torget we saw that the shops there were about to go bankrupt. Tell us where you want the drug users and we'll send them there, it'll take us two weeks. So there isn't any real problem for us to move this milieu. But why should we have to move them all the time, when no thought is given to it? They've said that it's better to have them concentrated in one area, that way we will know where we have them and can control them, but they've always been in one area, they've just moved. But now there are so many more of them.

What do you do in the event of an overdose? The first thing we do is to call an ambulance. Then we perform life-saving first aid. This is considered the normal good practice. It has never been discussed whether the police should carry Narcanti. They have discussed whether or not to distribute Narcanti to the drug users.

You should first try to find out why the overdoses occur. I think the most important thing to do is to make an effort to stop the recruitment. There would still be a period of continued overdoses among those already in the milieu, but you could initiate follow-up programmes for those who have been discharged from institutions. Someone to function more or less as a babysitter. But this would require resources. It's no use to just stand there and hand out pamphlets. I'm not talking about continuous supervision, but an agreement that has to be signed before they are released or discharged. They can enter into a follow-up agreement at that time. They have to have a place to live, a transitional arrangement, a halfway house, with some form of control over where they go. It's not a loss of liberty, but a voluntary contract. It's their life and their choice. But the contract must be agreed on before the discharge, because as soon as a relapse has occurred they are no longer free, then it's the drugs that make all the decisions.

We should be given additional resources, more people. We are not a stress factor for the milieu. I can't take those who say this seriously, since they don't know how we actually work. What are the chances of being caught by the police in Oslo, when 13 people work in this type of job? These 13 people work for the most part with other jobs, rather than going into the milieu to arrest users. The users know this. In some cases when we come across someone who has bought something and is on his way to shoot up, then we have no choice. We have to confiscate the drugs, that's the law. But we don't follow the users like hawks hovering over the area and swooping down for the kill. But with more people we could have better control over the situation. And in addition, there is of course everything that happens in flats and private

homes. By being present down there we could confiscate more drugs. This would most likely have a minimal effect. We would gain knowledge about what was going on. We could give advice. We could be a point of contact for very many people down there, and this in turn would mean that if someone starts to think about taking an overdose, someone else may make a telephone call to a police officer they know. This is something I've experienced many times. Many times I've spent half an hour or an hour at home on my sofa talking to a distraught drug addict. And I know that we are very good at this. We know very well how they live, because we see them in very many situations. I know that they will contact us if there is something they want to talk about, a possibility they should have, and this requires that we are present. And then I give them my name and a telephone number.

11.3 Officials in Oslo

11.3.1 Interview with Erling Lae, Chief Commissioner of Oslo

1. (For politicians) What are by your opinion the most important political goals in this city? (Please rank the following items into three categories, with 3 items in each category: 1.Top priority, 2. High priority, and 3. Medium high priority

	Rank
• To improve public care for the elderly	2
• To improve public child care	2
• To improve housing for the homeless	1
• To reduce pollution problems	3
• To reduce traffic problems	3
• To reduce alcohol problems	3
• To reduce drug problems	1
• To improve treatment of psychiatric disorders	1
• To improve the education system	2

Please comment on your ranking on drug problems.

- It's difficult to rank these items, all of them are important. But I would like to start with what we have been the most successful with in the past, so that we don't have to concentrate as much on the areas where we already have achieved a lot. If you had asked me a few years ago I would have placed care for the elderly as a top priority, but here I feel that so much has been done that it is no longer a top priority. Since we have almost complete day-care coverage and declining birth rates, I would also give this a 2, fairly high but not a top priority. We still do a poor job of providing housing for the homeless, so this I would rank as a 1. Regarding problems with pollution, I feel we have achieved so much that I would rank this as a 3. I would also rank traffic problems as a 3, simply because some of these items must be placed in this category. Problems with narcotics are clearly ranked as a top priority. Improving the treatment of psychological problems is also a definite 1. The education system is a 2, and then we are left with a 3 for problems associated with alcohol.

I am evaluating all these areas, not just based on where we have the greatest problems, but on where we have the greatest gap in relation to our goals and what we manage to achieve, as well as where we are the most helpless in relation to the measures available to us, so I have given a 1 where I've found this gap to be the greatest. With regard to narcotics, I don't think we have been very successful. The problem just increases. With regard to alcoholism care, we have more or less had a programme in place for a long time, so I feel it isn't a problem that is increasing in the same manner as narcotics. The City Government's policy reflects that the

drug problem is a top priority, with regard to financing, for example, since it is the sector that has increased the most during the last five years. But I don't necessarily see any correlation between the increase in expenditures and results. Our philosophy and main goal has been to achieve a drug-free society. But one of the main obstacles that I face as a politician is the strong ideologies in this field. This crosses over into politics. Sometimes it impedes the free discussion of what measures should be taken.

2. **What was the most important political goals in this city's policy in the drugs field ten years ago? Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.**

	Rank
• To strive for a drug-free society	1
• To reduce harm caused by drug use	1
• To reduce drug use related crime	3
• To reduce public nuisance associated with drug use	2
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	2
• To reduce drug dealing	3
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	1
• To prevent overdose deaths among drug users	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3

Could you please comment on your ranking on these items.

This is not easy since there is a kind of gap between the goals and what one actually chooses to do. To work towards a drug-free society was the highest priority at that time, and it still is. But the greatest efforts ten years ago concentrated on reducing the harmful effects on heavy drug users and preventing the spread of Hepatitis C and HIV. I must therefore give these two items a 1. For the police it was important to reduce drug-related crime, but for the politicians this didn't have the same priority. So I would give this the lowest priority. On the other hand we focused more on reducing the level of public nuisance by chasing these groups away, so this I would give medium high priority. The prevention of drug use among young people was also given top priority. Securing the availability of treatment capacity has also been given high priority, so I gave this a 2. On the other hand, drug dealing was not focused on that much, so this is a 3. Preventing overdose deaths had medium high priority ten years ago,

while money laundering is a crime policy area that was not given very high priority in local politics.

3. What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?
Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Rank
• To strive for a drug-free society	2
• To reduce harm caused by drug use	1
• To reduce drug use related crime	3
• To reduce public nuisance associated with drug use	3
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	1
• To reduce drug dealing	2
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	2
• To prevent the overdose deaths among drug users	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3

If any changes, compared to ten years ago, please comment on the reasons for these changes in priorities.

- We all support a drug-free society as an ideal goal, but we are realistic at the same time, so I would give this a 2. I still feel that this should be our goal, so I won't give it low priority, but I think we had greater expectations of achieving this ten years ago than today. However, when it comes to reducing the harmful effects of drug use, we give higher priority to this now than before, so I would give this a 1. The reduction of drug related crime is still a task that does more or less not concern local politics that much, so I would rank this a 3. The same applies to the item related to reducing the level of public nuisance.

The reduction of the level of public nuisance is also given lower priority today. Here I don't have much to og on other than how we acted in relation to the open drug scenes. Today we have a much more accepting attitude. Whether or not it should be like this, I can't say. On the other hand, the prevention of drug use is now definitely a top priority. Securing treatment for drug addicts is also a top priority. The reduction of drug dealing is of medium high priority today, while preventing the spread of HIV and Hepatitis C is less important today than ten years ago, so I would give this medium high priority. The prevention of overdose deaths is definitely a top priority today, while the prevention of money laundering has low priority in local politics.

4. **Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.**

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	3		x
In police strategies less focus on users towards more focus on larger scale dealing	2	x	
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	1	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	1	x	
Housing for people with drug problems	3	x	
First aid education	2	x	
Sufficient capacity of methadone programs	1	x	
Low threshold methadone programs (allowing side use during treatment)	2	x	
Methadone programs in prisons	2	x	
Heroin prescription programs	3		x
Interventions in order to change the main route of heroin administration from injecting to smoking	1		x
Distribution of naloxone (narcanti) to drug users	3		x

Could you please comment on your ranking and explain why some interventions are not feasible in this city, if any.

- I would rank injecting rooms/user rooms as low as possible. I give police strategies a 2. This means that I agree that one should focus on large-scale dealing. But I don't agree that the street users should be left alone when they are high. Rehabilitation and vocational opportunities are of course important so that an individual can function in society, even so, they can still die from an overdose. I do, however, feel that a more comprehensive programme is important in order to prevent overdoses, and I give this a 1. Housing is also a general measure, so I would give this a 3, since an overdose can just as well happen at home. The debate on housing is often used as an excuse, but people are just fooling themselves. First aid training is a so-called acute one-time measure that should be given medium high priority. When it comes to establishing an adequate methadone programme capacity, I feel that this should be given top priority. I am a more in doubt when it comes to low threshold methadone, at least with regard to the deaths. In relation to human dignity, I can understand that this can

function as an alternative to injecting rooms, for example, but I wouldn't give this top priority, so I give this medium high priority. We haven't discussed methadone programmes in prisons that much. But it seems sensible to have such a programme for the inmates that are already involved in such a programme; they should be able to continue. Active drug users should of course not get drugs in prison at all, but they do of course get drugs. So I would give this a 2. I disagree with heroin prescription programmes, so I give this low priority. When it comes to trying to get people to smoke heroin instead of injecting it, you can't just ask them: "Would you be so kind as to smoke your heroin?". Of course there is a point to be made here, but the fact that they should rather smoke it should not be made into propaganda either. Nevertheless, I would give this high priority. I won't comment any more on all the measures that I feel we could implement, but I don't think that it is politically possible to implement injecting rooms or heroin prescriptions in Norway. Even though I've ranked changing the main method of heroin administration from injection to smoking as a 1, I don't think that this can be implemented. This applies also to the distribution of naloxone to drug users.

5. Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think, to reduce or forbid the distribution of these pharmaceuticals is one way?

Answer: - Yes, I think so.

6. Do you think, that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

- Yes, open drug scenes become well known places for the distribution of drugs, and thus they may increase the propagation of drug use and addiction, and also lead indirectly to drug related deaths. I feel that we should restrict or close the open drug scene around the Oslo S train station, for example, but this would mean that we would have to come up with alternatives for the people that already frequent this area today.

7. Do you have any other suggestions about how to reduce the overdose deaths in our city?

- I think we should change the distribution of clean needles, so that we can have better control, by having the needles distributed by the field service and making it less offensive, for example. I also feel that we should use forced treatment to a greater extent in order to help the most obviously vulnerable individuals.

8. When evaluating this city's drug policy in total:

a. In what aspects do you think the policy has successfully reached its goals, and why?

b. In what aspects do you think the policy has failed to reach its goals, and why?

- I feel that I've already answered this question in my introductory comments.

11.3.2 Interview with Marianne Borgen, member of the Committee on Health and Social Welfare, member of the Oslo City Council and representative of the Socialist Left Party (SV).

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1. (For politicians) What are by your opinion the most important political goals in this city?
(Please rank the following items into three categories, with 3 items in each category: 1.Top priority, 2. High priority, and 3. Medium high priority)

	Rank
• To improve public care for the elderly	3
• To improve public child care	1
• To improve housing for the homeless	1
• To reduce pollution problems	2
• To reduce traffic problems	2
• To reduce alcohol problems	2
• To reduce drug problems	3
• To improve treatment of psychiatric disorders	3
• To improve the education system	1

Please comment on your ranking on drug problems.

Improving the housing opportunities for the homeless is one of the areas I have assigned top priority. I think that the problems associated with narcotics can also be improved in this manner. With regard to people with psychological, alcohol and drug problems, I find that the housing conditions for them are so poor in this city that there is a correlation between improving the housing conditions and improving the conditions for drug addicts. There are a number of assistance measures that do not work today, because the conditions the heavy drug users live under are so extremely poor. As a politician, I am also very concerned about preventative measures, and I think that the most important way to prevent a number of our problems with violence and narcotics is to concentrate on improving the conditions for children while they are growing up and families that are not so well off. That is why the education system and childcare are other important top priority areas for me. In the long run this will also improve the conditions in the area of narcotics and alcohol. This of course does not mean that there are not many challenges in this area as well. But I've noted that regardless of whether we are discussing drug and alcohol problems or other social problems we often end up talking about housing. It is often said that if we had more sheltered housing and a better education system, then we wouldn't have the same queues in the psychiatric sector. We would then be able to get more people out of institutions and into intermediate stations, such is often the case with sheltered housing. We wouldn't have as many relapses requiring institutionalisation then. Preventative measures in relation to education, local community problems and children are frequent topics of discussion. But we have experienced a lack of

willingness in certain political parties to take the consequences of what has been agreed on. When it comes to prioritisation we just can't make a go of it, or some people are just not willing. So I feel that the discussion should not revolve only around overdoses. For example, in discussions concerning hospices, it is often mentioned that the people we are talking about, those who actually live there, are people with major drug and psychological problems. It is said that many of them could never manage to live in normal housing, that they need sheltered housing. But then nothing is done to try to provide them with such housing. This is a debate I've participated in for at least 20 years. The arguments that are used today are actually the same arguments that were used in the 1980's. I'm not saying that the drug problem isn't a major issue, or that special measures are not required, but when I am asked to prioritise, I choose to put the general measures first.

2. **What was the most important political goals in this city's policy in the drugs field ten years ago? Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.**

Rank
1
3
2
3
1
2
1
1
2
3

- To strive for a drug-free society
- To reduce harm caused by drug use
- To reduce drug use related crime
- To reduce public nuisance associated with drug use
- To prevent drug use among youngsters
- To secure or improve the coverage of treatment for drug addicts
- To reduce drug dealing
- To prevent the spread of diseases like HIV and Hepatitis C among drug users
- To prevent overdose deaths among drug users
- To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade

Could you please comment on your ranking on these items.

We talked a lot about preventing diseases such as HIV and Hepatitis C. There was a different type of concern about HIV-AIDS; there was concern that this was a risk to the general population. It was felt that there was a general threat, not just primarily a threat to the drug users. We talked a lot about preventing drug use among young people. There was also talk of striving for a drug free society. I can't remember that there was much discussion about reducing the harm caused by drug use, so I would rank this as a 3. There was also some discussion about improving treatment programmes, so I would rank this as a 2. There was, however, a great deal of focus on reducing drug dealing, so I would give this a 1. Overdose deaths weren't that important in the debate as they are now, so that I would give a 2. Money laundering was not highly prioritised, so I would give this a 3. There was no focus on public nuisance, so I would give this a 3. A number of new drugs appeared on the scene around that time. There were a number of problems that were felt to be a threat to the innocent society one thought Norway had, and it was therefore important to prevent the use of drugs among young people to reduce drug dealing.

3. **What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?**
   Please rank the following items into three categories, with no more than four

items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Rank
• To strive for a drug-free society	3
• To reduce harm caused by drug use	2
• To reduce drug use related crime	2
• To reduce public nuisance associated with drug use	3
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	1
• To reduce drug dealing	1
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	3
• To prevent the overdose deaths among drug users	1
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	2

If any changes, compared to ten years ago, please comment on the reasons for these changes in priorities.

Twenty years ago I thought it was possible to achieve a drug-free society, but I suppose I've become a bit more disillusioned now. I still wish it were possible, but if I were to prioritise what is the most important in the near future, I would give that category low priority. But I would give high priority to preventing drug use among young people. I would also give high priority to the reduction of drug dealing. If we could manage that, then we would solve a lot of problems. I am also concerned about securing or improving the coverage of treatment, but I would also like to point out in this connection that medicine-free treatment alternatives should be available. I would also give priority to the prevention of overdose deaths. Since we have made some progress with HIV-AIDS, I would give medium high priority to reducing harm caused by drug use, so I would give this a 3. I would also give medium high priority to reducing drug related crime. The prevention of money laundering I would give a 2, so the remaining categories would then receive a 3. The difference between the goals ten years ago and now is primarily due to the fact that the more recent assessment of the situation represents my personal views, while the historical assessment is of a more general nature. But the difference may also be due to the fact that we have given up somewhat in the battle against narcotics, or that there are so many new drugs now that we have to realize that some of these drugs we just won't be able to get rid of, so we have to concentrate on getting rid of the worst ones. Perhaps we should start looking at the drug problem in much the same way as alcohol problems, which I think I ruin many lives, and which, from a socio-political point of view, represent a much bigger problem when it comes to the number of people who are affected. And there is an extremely high number of children living in families where one or both of the

parents have alcohol problems. And alcohol is something we must be prepared to live with. I think we have to start evaluating narcotics in the same way now, even though I personally feel it would be nice to have a drug-free society. Even though we acknowledge that we will never be able to get rid of these drugs, this doesn't mean, however, that they are accepted or that there will be any kind of legalisation of such drugs. I don't think one should legalise cannabis, but I don't feel that the debate is clear-cut either. There is, for example, the relationship between hash and alcohol to consider. I find that the debate on the problems associated with narcotics overshadows much of the general substance abuse problems in our society, primarily the problems associated with alcohol. And I don't think it will be possible to ban alcohol. Therefore the idea of achieving a society free from any substance abuse problems is doomed from the start.

Today I prioritise reducing the harm caused by drug use slightly higher than I did ten years ago. The harmful effects are greater today and we are more aware of them now. Ten years ago I didn't participate in this debate as a politician, so I am more familiar with these problems now. I also prioritise treatment higher now than I did then, due to some of the same reasons. I also find that access to help for many of the drug addicts is inadequate. I return again in this connection to what I pointed out earlier about better housing facilities. We won't be able to have a successful treatment programme until we do something about the housing situation. I also find that much of the focus placed on methadone has been important and necessary, but at the same time there has been a tendency in political circles to think of this as some kind of miracle cure that one should concentrate wholeheartedly on. Because I want everyone who has a drug problem to be able to get help and have an opportunity to become completely drug free, I see that what is offered today is not enough and that the quality is too poor. So I wish that the City of Oslo, in addition to methadone and low threshold treatments, would adopt an offensive strategy for people who want to become drug free, and that Oslo could also be a bit more daring with regard to the development of alternative methods. We are too traditional and not brave enough. I think it's a scary development when the debates in recent years have revolved around low threshold treatments and methadone, both of which are important, but the socio-political follow-up has failed, and therefore many of the prerequisites for methadone treatment have not been met. I think one should focus more on the measurement and development of quality, for the medicine-free treatment programmes as well, so that we can find out more about what works and what does not. Thus we could concentrate on good programmes and get rid of the bad programmes. We don't know enough about how the traditional treatment programmes work and how they will work in the long run. Overdose deaths are important, but they are a symptom that something is fundamentally wrong. The cause of this can be debated, but when people take their own lives in this way, either on purpose or by accident, is tragic, and this is something that politicians such as myself must take very seriously.

4. **Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.**

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	3	x	
In police strategies less focus on users towards more focus on larger scale dealing	2	x	
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	1	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	1	x	
Housing for people with drug problems	3	x	
First aid education	1	x	
Sufficient capacity of methadone programs	2	x	
Low threshold methadone programs (allowing side use during treatment)	3		x
Methadone programs in prisons	1	x	
Heroin prescription programs	3		x
Interventions in order to change the main route of heroin administration from injecting to smoking	2	x	
Distribution of naloxone (narcanti) to drug users	2	x	

Could you please comment on your ranking and explain why some interventions are not feasible in this city, if any.

I don't think injection rooms are important in preventing deaths from drug overdoses, so I rank that the lowest, but I think it would be possible to implement this. I think I would prioritise a change in the strategies of the police towards apprehending more large-scale dealers as medium high, I think it might be very difficult but not impossible to implement. But the public and politicians are mainly concerned about what is visible, so there will probably always be some focus on the users, also because of the public nuisance factor. Rehabilitation and vocational opportunities I feel are very important, so this is something I would prioritise the highest. And this is of course something that can be achieved. Information to users after long periods of abstinence is something I would also prioritise highly, and this is something I feel we can do much more systematically and better than what is being done today. Housing is important, but I don't know if it is so important in relation to overdoses. Some people say that overdoses mainly occur in people's homes. I'll give this a 3. But it is of course possible to offer better housing to people with drug problems than is the case today. First aid training is probably very important to reduce the number of overdoses, so I will give this my highest priority, and this is something that is very easy to implement. I'm a bit unsure about the item concerning adequate methadone programme capacity. It is conceivable that adequate capacity and competence in other programmes could also have a preventative effect. But I'll give this medium high priority, and this is something that can definitely be implemented. Low threshold methadone programmes that allow supplemental use is something I know little about. But I would probably be a bit hesitant and give this a low priority. Moreover, I don't think this would be easy to implement in relation to public opinion and the political climate. Methadone can of course cause overdoses if it is taken in combination with other drugs. We already have methadone programmes in prisons, so this can obviously be implemented and it is something that I would prioritise highly. Heroin prescription programmes is something I would give a 3, and I don't think something like this could be implemented in Norway today. To change the main method of heroin administration from injection to smoking I would give medium high priority, and I think it could be implemented if one really worked hard at it. To distribute naloxone (narcanti) to drug users is

something I would give medium high priority, provided this drug does not have any properties that I am not aware of. This would have to come in addition to other programmes, you can't just assign responsibility for taking care of drug users to other drug users. But you could for example establish a trial project to test this out. To me it sounds like we should look a bit more closely at this.

5. **Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think, to reduce or forbid the distribution of these pharmaceuticals is one way?**

I really don't think I have enough expertise to take a stand on this. But I suppose Rohypnol also has some positive effects, so if we prohibit this, what kind of problems would we have then? So in these instances, we as politicians must rely on recommendations from experts. If we get unequivocal recommendations from them, it would most likely not be difficult to get support from us politicians either. Nevertheless, it must also be proper in this connection to approach the medical profession to make sure that the doctors use caution when prescribing this drug.

6. **Do you think, that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?**

This is also difficult. Open drug scenes give us a degree of insight and control. But it can also lead to easier accessibility. On the other hand, I think that the accessibility would be there anyway. The Committee on Health and Social Welfare was in Zürich and saw how they cleared the streets. But we didn't get any impression that this reduced the use of narcotics. It just made it more comfortable for the more respectable citizens to walk around the city without being confronted with *Les Miserables*. So I think that the open drug scenes can be an advantage. In most city districts drugs are readily available, even though there aren't any openly declared drug scenes. I ride my bicycle or walk past the scene in Oslo fairly often, and it is not a pleasant sight. I don't feel threatened by it, but it does make me sad, and I am provoked by it to a certain degree. You are reminded that it exists, and that is rather unpleasant. This unpleasantness can also have a positive effect, in the sense that you start to think that there must be something we should do to help these people. It would be wonderful not to have to witness it, but I'm not sure that it would be very wise. I am not sure either if it increases the overdose risk, I don't know enough about it, but most of the overdoses do not occur in open drug scenes. But that is where many users get their drugs. If one can get rid of this scene, then the whole drug scene would go under ground, and this too has its disadvantages. But perhaps it could have a preventative effect in relation to children and young people. I don't think I can take a stand, for or against, unless I get a thorough expert study as a basis for my stand.

7. **Do you have any other suggestions about how to reduce the overdose deaths in our city?**

I am a firm believer of increasing the availability of low threshold treatment programmes. I believe in the implementation of low threshold treatment programmes in combination with the establishment of housing with support and care. This may be one way. I believe in support and care, I believe that people should be seen and I believe in dialogue. Find programmes that can give those who need it a feeling that they receive support and care, and give them a feeling that they exist. When people receive a little care, with few requirements, then this can help establish a relationship with assistance agencies.

8. When evaluating this city's drug policy in total:
a. In what aspects do you think the policy has successfully reached its goals, and why?
b. In what aspects do you think the policy has failed to reach its goals, and why?

Well, we have a problem since we haven't managed to reduce the overdose figures, and we haven't managed to reduce the use of narcotics. But there are some sub-goals here where we've managed to be somewhat successful. We have implemented some low threshold programmes, such as the field service. We have a methadone programme that is functioning. So we have done a lot. We have also talked a lot about measuring quality, quality criteria, etc. This has progressed very slowly. But we should try to implement more long-term studies of what works over time. So establishing methods for measuring quality is a goal that we have not reached. And as long as the number of drug users is increasing, we cannot say that we have succeeded in alleviating our narcotics problem. It is also unsatisfactory that we don't have any figures on how many people are in our institutions and participate in various programmes each year. The Socialist Left Party has often pointed out the need for these kinds of facts. Moreover, we do not know how many people are shuttled from one system to the other, between for example the Alcohol and Drug Addiction Services, psychiatric institutions, and somatic hospitals, so this is definitely not good enough. So then the question is whether it is the political leadership or the experts who aren't doing their job good enough. I think the fault lies with both parties. If the experts had a greater need for more resources to analyse the effects in order to determine what clients are shuttled between the systems, then it would be strange if I as a health politician didn't feel them breathing down my neck more. I don't feel that the experts have taken many initiatives in relation to us politicians with regard to making a contribution to increasing and improving the quality.

11.3.3 Interview with Tom Pape, Labour Party, Chairman of the Committee on Health and Social Welfare, Oslo City Council

1. (For politicians) What are by your opinion the most important political goals in this city?
(Please rank the following items into three categories, with 3 items in each category: 1.Top priority, 2. High priority, and 3. Medium high priority)

	Rank
• To improve public care for the elderly	1
• To improve public child care	2
• To improve housing for the homeless	1
• To reduce pollution problems	3
• To reduce traffic problems	3
• To reduce alcohol problems	2
• To reduce drug problems	3
• To improve treatment of psychiatric disorders	1
• To improve the education system	2

Please comment on your ranking on drug problems.

I would have to say that we still have many important tasks with regard to care for the elderly that need to be improved, so this would have to get top priority. There are also many important tasks with regard to improving the treatment of psychiatric disorders that we haven't completed. There is some connection here with drug problems, but also other problems, so I would also give this top priority. Improving housing for the homeless is the third category I would give top priority. In a way there is a relationship between care for substance abusers and psychiatry. Of high priority I would rank improving the education system, reducing alcohol problems and improving public child care. Of medium high priority I would place traffic problems, drug problems and pollution problems. These are of course still important, but I would have to rank them as such. This means that I have ranked drug problems as medium high priority. But since I've ranked psychiatric disorders highest, then this will also encompass many of the same problems. Moreover, I would have to say, from a general point of view, that alcohol is a more comprehensive problem than the drug problem, it touches more people, is a lot more harmful than most people are aware of, and I think it reduces the quality of life and health for a lot more people than drugs do. From a social point of view I find that the drug debate receives far too much attention compared with problems with alcohol and abuse of over the counter medicines. I think that alcohol injuries and wrongly prescribed medication are greater challenges than drugs. The reason that drugs have gained such a large role in this debate is maybe because drugs are a more visible problem. It's the sort of problem that is newsworthy for the tabloids, in the sense that the users die suddenly, the victims are most often young and because the harmful effects often happen

rapidly. People can daily consume alcohol at home all their lives without anyone noticing the injuries they have received. So the brutality in the problems with drugs, and that it most often affects younger people, is an important reason for all this focus. The social acceptance of alcohol is also so great that there are limits on how far we can continue with this debate without feeling that our attitude towards alcohol is perceived as illegitimate, our society is just not ready to accept this. This does not apply to the drug scene and its problems.

2. **What was the most important political goals in this city's policy in the drugs field ten years ago? Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.**

	Rank
• To strive for a drug-free society	1
• To reduce harm caused by drug use	2
• To reduce drug use related crime	3
• To reduce public nuisance associated with drug use	1
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	3
• To reduce drug dealing	2
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	1
• To prevent overdose deaths among drug users	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3

Could you please comment on your ranking on these items.

A common denominator for caring for substance abusers has been, and still is, to work towards achieving a drug-free society. Highest priority was also to prevent drug use among youngsters. We worked hard in preventing the spread of diseases like HIV and Hepatitis C among drug users. To reduce public nuisance associated with drug use also had high priority. Not primarily the municipality's policy, but from the police, my perception is that the police have been working with this for the past ten years. Money laundering is something I would give lowest priority. I don't think that this has been especially noticeable. We have definitely not been successful in securing treatment for drug addicts, so I would give this a 3. I don't know enough about what was done in reducing drug related crime, but it doesn't seem like we have done a lot to combat this problem. I live in an area where it is relatively widespread, and feel that it has had low priority. As I see it the remaining three items then receive medium priority, for example reducing the harmful effects caused by drug use. There are some

initiatives now, but it wasn't very prominent ten years ago. The same applies for reducing drug dealing and preventing overdose deaths among drug users. One reason I can give for ranking the work to achieve a drug-free society as a top priority is that it is only in the past three to five years that the perspective, to reduce the harm associated with drugs, has been made known. What has characterised the Norwegian care for substance abusers, is to understand what came about during the prohibition period between the labour movement and various organisations within the Church. Since then it has been a tradition to strive for a drug-free society, and this is something I feel has characterised this caring for substance abusers far too much. I don't mean that it is unimportant, but sometimes I feel that the goals for a drug-free society have almost taken on a religious nature. This goal has been strong in both of these groups since the same people were often active participants on both sides. It is only now that we are starting to think differently, not as an alternative to a drug-free society, but we are now looking into measures of reducing the harm that is done, something that doesn't necessarily have total abstinence for the individual as its primary goal.

My impression of the police is that they haven't been characterised by empathy or understanding of the problem, I have observed one policeman that has looked upon this as a public nuisance problem and consequently treated it as such. But I suppose in some way this can be a legitimate reasoning.

Preventing drug use among youngsters I feel has been, and still is, an objective that has persevered, although to a varying degree. Of course there is a political topic of how much we should focus on this, but there are very few politicians in Norway that feel it is insignificant. Most of them feel it is very important. But there is some disagreement on how to achieve this, and to what degree. There was also a strong focus on preventing the spread of HIV and Hepatitis C. It was very dominating and a lot of resources were put into this, especially in the assistance services. Preventing the spread of disease has been important for the assistance services for a very long time.

One matter that comes to mind is the Needle Bus, it probably didn't cost that much but it was the actual concept that has become dominant. The reason for this was perhaps that this was something we could easily carry out, and a lot of people felt this as a major accomplishment.

The prevention of money laundering has never been a goal, it is only lately that the police find themselves capable of handling this problem. I don't know too much about this, but the way I perceive it is that it hasn't been any major focal point for the work done in the narcotics sector in Oslo. We have all talked a lot about treatment for drug addicts, all political parties have said that this has top priority. But if we look at the development in the number of treatment places during this time, it is regrettably my feeling that the people needing these places have increased, but the actual number of places have more or less remained constant. So even though it is said that this is prioritised highly, we must, on the basis of the results, conclude that it hasn't been given any high priority.

3. What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?

Please rank the following items into three categories, with no more than four

items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Rank
• To strive for a drug-free society	1
• To reduce harm caused by drug use	1
• To reduce drug use related crime	2
• To reduce public nuisance associated with drug use	3
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	1
• To reduce drug dealing	2
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	3
• To prevent the overdose deaths among drug users	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3

If any changes, compared to ten years ago, please comment on the reasons for these changes in priorities.

I would have to say that working towards a drug-free society is still of top priority. I still think this goal is important but it needs to be adapted and supplemented further. The common denominator for our work must still be that we wish to achieve a society where people don't have to run away and hide to get high in order to forget and get away from the reality we live in. I also feel it is important to constantly remind the youngsters of the difficult and dangerous areas they will encounter while growing up, so-called preventative measures, in other words preventing drug use among youngsters is very important. And we must be able to do something in the area of treatment, so I give this top priority. We must manage to improve the accessibility for treatment. I would also give top priority in reducing the harm caused by drug use. It is difficult to say what is actually meant by this, but unfortunately we now have a drug user culture where people establish long lasting addiction and consequently develop serious injuries. But they somehow manage to keep going. In the long run we cannot just sit and watch the awful sufferings that these people have to deal with. We have to do something with them. To reduce the public nuisance associated with drug use is something I would give lowest priority. I should probably have ranked reducing drug dealing as a top priority, but I haven't because I don't think we can manage to achieve this. So I would give this a 2. The other medium prioritised categories are preventing overdose deaths among drug users and reducing drug related crime. The lowest prioritised categories are then reducing public nuisances that are also associated with crime, preventing the spread of diseases like HIV and Hepatitis C and preventing money laundering. If you compare today's priorities the way they were ten years ago I think that securing treatment centres for drug users now has to be placed in the top priority category. One of the main problems today is that people today receive

treatment too late, and the treatment they get is often not good enough. The treatment concept we have inherited is perhaps one of the weaknesses of the drug-free paradigm, it's not very treatment oriented, the treatments are something you receive from specific people at a specific place over a certain period and perhaps assisted by medicines of some kind. But the treatment programmes should be more extensive and comprehensive and should include housing, daily work and the total aspect of what they need. I am sure that half of the money spent in treatment-oriented programmes is just wasted because we place these people in hospices when they are discharged. These settings are so discouraging that the chances of dropping out are so great that it is comparable to throwing hundreds of millions of Kroner right out the window, simply because we can't see the entirety or are willing to take the consequences of it. If we look at who is succeeding in care for substance abusers, we must look at AA. This is the "chain gang". They are the ones who manage to create stability, the framework and continuity, without a penny in public support, and they don't even want any! I'm not a supporter of their philosophy. But their underestimated success is due to the fact that they have understood that this is probably a type of behaviour that once they are in this mess, you just have to accept that this is the way it is and take the subsequent precautions. I think that in the care for substance abusers in Oslo they should concentrate more on the various manned housing programmes as a permanent offer, where there are resources that deal with the inhabitants, not for four weeks but for the rest of their lives. Up until now we have far too easily accepted the fact that people with drug problems is supposed to live in a kind of yo-yo existence. In summary, I think we should concentrate more on treatment, and we have to think of new ways in what we perceive as "treatment". I would also like to comment on my ranking of prevention of diseases as lower than what was the norm ten years ago, we will of course continue focusing on this, but seen in total context it becomes less important. This is something that will get picked up by way of the other priorities.

4. **Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.**

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	3	x	
In police strategies less focus on users towards more focus on larger scale dealing	2	x	
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	1	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	2	x	
Housing for people with drug problems	1	x	
First aid education	1	x	
Sufficient capacity of methadone programs	1	x	
Low threshold methadone programs (allowing side use during treatment)	3		x
Methadone programs in prisons	2	x	
Heroin prescription programs	3		x
Interventions in order to change the main route of heroin administration from injecting to smoking	2		x
Distribution of naloxone (narcanti) to drug users	3	x	

Could you please comment on your ranking and explain why some interventions are not feasible in this city, if any.

I would have to say that rehabilitation and employee opportunities combined with housing for people with drug problems are probably the two most important categories. This is derived from the basis that drug use is a form of risk taking where one of the consequences is that you can simply die from it. If you look at it like this and not as a long-term suicide it is evident that you need to have venues where you can manage to capture and do something about these risk factors. For this you need to be associated with these people in many different circumstances. And this is where I think it is important that proper housing situations exist where the clients are professionally followed up, and one can manage to maintain contact with them over a period of time. This could perhaps minimise that risk factor. I would also like to mention sufficient capacity of methadone programmes as a top priority area. I think many of those that die waiting in line for methadone treatments are people that have this risk I mentioned earlier. I don't think we should have low threshold methadone programmes in Norway, I think it works well with strict entrance criteria of the methadone programmes we already have. What has irritated me is the socio-professional follow-up. We are on the verge of losing our grip. Something I think is unwise. But when I say that I want sufficient capacity I mean that I want sufficient capacity in the type of methadone programmes we have had, I don't want them to reduce the criteria for entering such a programme to any extent. The only thing I think they should do, and what they have already done, is to be more flexible in the evaluation of the combination of age and years of drug use. I think we have to accept the fact that people may have been drug users for ten years already by the time they turn 25. Now they've reduced the age limits and there is no longer an absolute age limit. The evaluation that has been made of the Norwegian methadone programmes shows that there are elements with this programme, such as the entrance criteria, and the weight of the socio-professional follow-up, that give better results than the low threshold programmes in Switzerland or other countries. And the fact that it is high dosage methadone is important in order to prevent side usage. The last category I would give top priority is first aid education. But I would like to emphasise that there are a lot of other categories on this list that are important. But I am puzzled by some of the categories. For example distributing nalaxone to drug users, I am sceptical to how they will manage to administer this. If we look at how overdose deaths happen then most of them happen at home, alone. When an overdose occurs you only have a few minutes before you die. If you were alone an antidote would be of little use. But it could be useful in those cases when they were together with other drug users. But I am doubtful as to whether they would be able to administer it, or to carry it with them at all times. I don't place much faith in this.

Changing the main route of heroin administration from injecting to smoking is important and I would give this a 2. I feel it's important but I can't really see how we should implement this. This is something we could use the field services, injecting rooms, the Needle Bus and ambulance to implement, to reach them in the areas where the users are in the process of shooting up. But then you get into this strange discussion you also get when discussing injecting rooms, you need employees that are willing to go out and spread the message. It's less risky to smoke heroin than to inject it. After all, they do it in Copenhagen. The assistance services claim that they have managed to shift this trend, although I can't say that they've documented this very convincingly. They are quite adamant on this point, and they actually do have fewer users that inject than what we have.

Heroin prescription programmes are something I don't believe in. I give this a 3. I thought we already had methadone programmes in prison, and that they have actually managed to administrate areas of this in parts of the Oslo Regional Prison. But sure, under certain circumstances it's not such a bad idea. It would inhibit part of the operations that supply the prisons with drugs. So if a number of the heavy users there use methadone and manage to stick to that, then I think it could influence the whole prison environment. But this would also have to be based on a philosophy and evaluation of the whole programme. Although I know little of how it would be implemented or what people think of it. A low threshold methadone programme that also allows side use is something I would prioritise the lowest, as a 3. I think that the methadone programmes we have now work well enough, but we just don't have enough capacity. This is our main problem, and especially the socio-professional follow-up and other categories such as housing and general rehabilitation. I would have to give a 2 in the category on information on the overdose dangers in prisons and institutions. I actually thought that the police already had top priority when it comes to catching the large scale dealers. I will give this a 2, but I do think it is important to capture the big dealers and to maintain zero tolerance on drug use.

5. **Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think, to reduce or forbid the distribution of these pharmaceuticals is one way?**

Yes, I think we should re-evaluate this. But the way I have understood the problem is that the share of illegal Rohypnol, not through our legal pharmaceutical channels, is greatly increasing. So far we've been talking of a combination of drug use, and both of these drugs have been smuggled into the country. If this picture is correct then banning legal Rohypnol will really be of little use. It could perhaps be easier to confiscate Rohypnol if it was only found illegally. I do however think it's pretty senseless to say that a ban would deprive patients of their sleeping medicine. There are acceptable medicines that could fill this void. And if the losses aren't serious, if we can show improvement, and if the professionals feel that it could be useful, then I think we should be willing to consider a ban.

6. **Do you think, that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?**

On Platsspitz in Zürich I got the impression that this was a place where injections and overdoses occurred, while "Plata" in Oslo is more a place for dealing. The open drug scenes in Zürich, which was a dealer and user venue, would have to be considered differently from what is considered as simply a dealer venue in Oslo. According to statistics for Oslo, the main problem is that people take overdoses and are alone. If they are together with others they will usually get help. So ironically it could be that an open drug scene, where they also shoot up, could reduce the risks for overdoses. There are instances where they also shoot up in the area around "Plata". And the fact that it is an open and accessible drug scene can be tempting for new recruits, so in that way one can say that they do contribute to new users. So you can argue differently concerning the open drug scenes. But in Zürich they obviously feel that they have had good results in limiting this environment. So all in all I would say that we shouldn't

have these open scenes in Oslo either. The alternative in Oslo, where the police once tried to force the scene into Gamle Oslo District and establish mini-scenes with drug users in residential areas, is not a good idea. It is after all better that the business areas struggle with this problem than the people have them roaming around in their neighbourhoods. If we only had these two alternatives, I would prefer to have them where they are now. I remember we had our own mini-"Plata" on the corner by the post office when I moved to Grünerløkka. It was one of the City's largest venues for dealing. That environment also found its way into our back yard. I have personally picked out 10-15 needles from the children's' sandboxes every morning over several years. In the choice between having this scene down town, where the police have good control of the situation, and having them in residential areas, I would say that a centrally located area is after all better. But when the situation becomes as extreme as it was in Zürich I feel it was correct to disperse this scene completely.

7. Do you have any other suggestions about how to reduce the overdose deaths in our city?

The most important factor is to maintain the capacity of the ambulance personnel, protect and develop it, since they save over 90 per cent of the overdose cases they are called out on today. Further, it is important to expand the services for the field services, so that one can get drug users into dialogue relating to their health problems. Even though the number of users of this service cannot be used as an evaluation, it is my opinion and from those that work there, that this works. And of course it will be a challenge to get them to smoke heroin instead of injecting it. I think this would be a great improvement but I don't quite know how we should go about doing this. We also have greater challenges to contend with, in this context it is too simplified to say that if they only had a place to live then they wouldn't end up as overdose victims. But I still would like to say that the development would have been different if we could manage to look at the problem as a whole, something I don't think we are doing today. We should have managed to implement treatment programmes that included housing opportunities then the problem would have appeared differently and we could have managed to concentrate on other areas, areas that are not evident today. Follow-up is definitely the keyword. But I don't think there is any Columbi egg in the prevention of overdoses. We should do more of what we are currently doing.

8. When evaluating this city's drug policy in total:
a In what aspects do you think the policy has successfully reached its goals, and why?
b In what aspects do you think the policy has failed to reach its goals, and why?

Yes, we have reached our goals in some areas but I'm not satisfied. The goal we had of implementing a fairly decent and justifiable methadone programme is something we have managed to achieve, even though I find several faults with it and things I would have done differently. We have totally failed when it comes to increasing treatment capacity. The fact that the number of heavy drug addicts seems to increase, rather than decrease, proves that we have not been successful in the category of prevention. You could of course ask yourself how the situation would have been if we hadn't done what we had, but this is something that is impossible to answer. But I feel that we have a society where you see that the drug problem seems to increase so dramatically you can question whether or not we are doing the right thing, and whether they have any influence. And the development seems so gloomy that it doesn't seem fair to say that we have done all that we should. But I wouldn't say that we

haven't done something. Here we have a social problem that is so complex and where the measures are also so complex that it becomes difficult to differentiate the areas where we have been successful or have failed. But I would like to come back to housing, something which I think is totally inadequate. I feel that there are too many agencies that share the responsibilities for assistance measures, and I feel that the resources in the social services must be increased drastically. Experience shows that the city's districts that have their own people that deal with drug problems generally have better offers for drug addicts than those that don't.

11.3.4 Interview with Bjørg Månum Andersson, Director General of Primary Health Care and Social Affairs

1a. What has been the major philosophy and goals concerning drugs in your organisation during the past 10 years ?

In general, emphasis has been placed on work towards achieving a drug-free society. Even though we realise that this is perhaps difficult to attain, our main philosophy, both politically and professionally, has been that if we don't fight this problem, the situation would have been still worse. One principal goal has been to provide treatment programmes that can help individuals who have problems. Prevention has also been a goal. It has also been important to coordinate the services, so that the resources are utilised in the best possible manner.

1b. What have been the major obstacles that your organisation has encountered in its practise?

The greatest obstacle has been the fact that the drug problem just keeps increasing, so that the need for relief services has increased faster than we have managed to develop the programmes, even though the contribution of resources has increased twofold. And even though there has been a consensus on the primary goals, the fact that there has been no uniform perception neither politically nor the service agencies on how the services and policies should be developed has in particular been an obstacle. It can also take a long time after a political decision has been reached until it is implemented, because a decision may meet resistance in the service agencies. One example is the implementation of a more common use of compulsory treatment another is when the city parliament decided to go for methadone treatment.

1c. Imagine you could have changed something in this society's drug policy in the past ten years, what changes would that have been?

The abuse of drugs is increasing among youngsters and in new adolescent groups.
I would have intensified some of the areas in the ECAD plan of action that deal with prevention. The schools, police, parents and teachers should have worked together to develop a drug-free school environment in Oslo. I think in this connection that we should work more on intensifying the information activities in the schools, and that we should also keep the school environment drug free. Narcotics are a problem in Oslo's schools. I see this, since I live next to one of the largest primary and lower secondary schools, and I have on several occasions stood at my kitchen window and observed drug dealing at the entrance to the school without the scool doing anything to prevent it. Ten years ago it would have been difficult to prove that drug dealing and use took place during recess periods, but today we know that it happens. I feel that the schools are the most important arenas for prevention measures, so this is where we have to work much more systematically. If we had had any extra resources or could reorganise some of our current resources, then I would use these for prevention measures in the schools. We should have a type of "drug contact teacher" at every school, who could coordinate the prevention measures and information work. I would say that 10-15 percent of the resources we currently use on treatment and assistance measures should be used on prevention measures, where we really could mobilise our efforts against narcotics. We have declared now that the Oslo schools should be racism free. Why not also declare that the

schools should be drug free, and try to achieve this through cooperation among teachers, students, parents, the police and the local community.

2. **Which were the most important political goals in this city's policy in the drugs field ten years ago? Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.**

	Rank
• To strive for a drug-free society	1
• To reduce harm caused by drug use	1
• To reduce drug use related crime	2
• To reduce public nuisance associated with drug use	3
• To prevent drug use among youngsters	2
• To secure or improve the coverage of treatment for drug addicts	1
• To reduce drug dealing	3
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	1
• To prevent overdose deaths among drug users	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3

Could you please comment on your ranking on these items.

Striving for a drug-free society clearly had the highest priority 10 years ago. The same is true of the goal to reduce harm caused by drug use. I think reducing drug use related crime was of medium priority, since the politicians in Oslo felt that this should be left up to the police, as a government agency. Reduction of public nuisance associated with drug use had, as far as I can remember, a fairly low priority 10 years ago. The prevention of drug use among young people had medium priority. If this had been given higher priority, then they would have done more in the schools. I believe that the goal to secure and improve the coverage of treatment for drug addicts had high priority, but I don't feel they managed to achieve this. They were probably interested in reducing drug dealing, but here in Oslo this was more a question of asking the government agencies, such as the customs authorities and the police, to make a greater effort. However, the Oslo politicians placed high priority on preventing the spread of disease. This is why the Needle Bus was introduced and established close to the Ullevål Hospital. I don't think the prevention of overdose deaths among drug users was given very high priority. The situation was completely different then than it is now, so it was probably not given more than medium priority at that time. I don't remember anyone giving money laundering any priority at all. If I were to comment beyond this, then I would have to say that it was tragic that so

much importance was attached to the Needle Bus. It is possible that it has reduced the spread of diseases like HIV and Hepatitis C, but I am also convinced that it has strengthened the tendency for individuals to become and remain injection users, which has in turn surely contributed to increasing the number of overdose deaths. If the goal is to achieve a drug-free society, then handing out syringes to drug addicts for the illegal use of drugs represents a double standard. I really hope we can make some constructive changes regarding the Needle Bus. Ten years ago the problem of sharing needles and the spread of HIV was defined primarily as a health problem. This was the reason why the Needle Bus was established. If they had also considered the social and epidemiological effects of this, then I'm not so sure that it would have been introduced. However, in today's situation, we cannot just stop handing out syringes over night, this would be extremely dangerous, but we could perhaps find a method of distributing syringes that was less offensive. I perceive the distribution of syringes as an ethical problem, but I also see that it is ethically unsound to suddenly discontinue the established Needle Bus programme.

3. **What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?**
   Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Rank
• To strive for a drug-free society	1
• To reduce harm caused by drug use	1
• To reduce drug use related crime	3
• To reduce public nuisance associated with drug use	3
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	2
• To reduce drug dealing	1
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	2
• To prevent the overdose deaths among drug users	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3

If any changes, compared to ten years ago, please comment on the reasons for these changes in priorities.

I would still give highest priority to striving for a drug-free society, together with , reducing harm caused by drug use and preventing overdose deaths among drug users. I would also give highest priority to preventing drug use among young people, securing treatment for drug

addicts and reducing drug dealing. I would give medium priority to preventing the spread of diseases like HIV and Hepatitis C. The prevention of money laundering, reducing drug use related crime and reducing public nuisance associated with drug use would then be given lowest priority, although I don't consider these unimportant. Concerning the changes from 10 years ago to the present, I now place higher priority on reducing drug dealing. There are a number of new drugs on the market now, and I feel that the authorities have lost control of the situation. I wish therefore to give this work higher priority in order to reduce the recruitment of new users. Ten years ago I thought we could control recruitment, but we see now that students and other young people, who one would assume should know better, now pop pills and take other drugs as if it they were candy.

4. Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	3		
In police strategies less focus on users towards more focus on larger scale dealing	2		
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	1		
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	1		
Housing for people with drug problems	1		
First aid education	1		
Sufficient capacity of methadone programs	2		
Low threshold methadone programs (allowing side use during treatment)	3		
Methadone programs in prisons	2		
Heroin prescription programs	3		
Interventions in order to change the main route of heroin administration from injecting to smoking	2		
Distribution of naloxone (narcanti) to drug users	3		

Could you please comment on your ranking and explain why some interventions are not feasible in this city, if any.

I rank injection rooms lowest, but I think that they might be feasible in Oslo, since a majority of the politicians might support them. I don't think they would contribute to reducing overdose deaths either, since most of the deaths occur in private areas. I would rank housing for people with drug problems and first aid education as very important. I would give heroin prescription programmes a 3. I would give medium priority to having sufficient methadone programme capacity. I think that the increase in the number of people using methadone has happened too quickly, but I do feel that it prevents some overdose deaths. But I don't necessarily think that low threshold methadone programmes that allow supplementary use can reduce overdoses, so I would give this the lowest priority. I don't think methadone

programmes in prisons reduce overdoses either, at least not inside the prisons, but they could perhaps have a certain preventative effect when the prisoners are released. So I would give this medium priority. I think perhaps it might be difficult to teach people to smoke heroin instead of injecting it, but perhaps I could rank this as a 2. I know too little about naloxone in order to take a stand on this, but I don't have any high expectations, so I give this the lowest ranking. I would like to rank rehabilitation and vocational opportunities as high as possible, and the same goes for information on the dangers of overdoses after long periods of abstinence. Less focus on drug users in police strategies is something I would give medium priority. I am more concerned about the prevention of recruitment, since this is what will reduce the market demand. New dealers will otherwise quickly replace any large-scale dealers who are caught by the police as long as the market and opportunity for profit is there. Sufficient methadone programme capacity is feasible, and this also goes for the other methadone proposals, even though I am sceptical about implementing them. Heroin prescription programmes are not feasible, due to prohibition by law. I don't think it is very feasible to get heroin users to switch to smoking instead of injecting. The users' addiction and use patterns indicate that they will continue to inject once they have started to inject. I don't think that antidote distribution is feasible, but I really don't know enough about this.

5 Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think, to reduce or forbid the distribution of these pharmaceuticals is one way?

I don't believe in banning it, but the doctors must be much more restrictive. The distribution occurs both legally and illegally, and much of the illegal distribution occurs via channels other than the doctors. It is clear that doctors far too readily prescribe sleeping medications, so many people use them too often and become addicted. However, it is also clear that a number of the recipients of Rohypnol prescriptions, resell the drug to others. It is also probable that if Rohypnol was banned, then they would just start mixing other drugs. We have seen now that epilepsy medications have been mixed with heroin and caused overdoses.

6. Do you think, that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

I don't believe that open drug scenes are the largest contributor to overdoses, since most of the users inject their overdoses privately behind closed doors. I think rather that the risk lies in the fact that the open drug scenes attract persons seeking contact, who find a sense of belonging and excitement in this environment. I've travelled a lot throughout the world, and I have yet to experience a large city that doesn't have an area where drug users congregate. So I really don't see how we could go about eliminating these open drug scenes. In Oslo we have seen that as soon as you shut down one area, the drug users just reappear somewhere else. I have discussed this a lot with the police. They can create unrest in the environment. We should get the minors away from these areas, since this something we can do. However, we should also ensure that they get back to their homes, if they do not live in Oslo, or ensure that they will be taken care of. If the police were more visible, then perhaps we could prevent that the drug dealing took place so openly. It seems, however, like the dealers have lost all respect for the police. They deal drugs even when the police are standing right beside them. So the police are definitely not active enough. But what should the police do with the people they apprehend?

We could establish some form of low threshold programme to follow up on this, for example in co-operation with woluntary organisations.

7. Do you have any other suggestions about how to reduce the overdose deaths in our city?

I have thought hard about what we can do about this problem in relation to where they live. Some of the overdose deaths occur in hospices. By increasing staffing and expanding the field service, in addition to following up, motivating and initiating activities in these places, we could perhaps reduce the overdose risk to some extent. But so few of the deaths occur in these places, so we should perhaps consider how we can enter into their private domain without violating their privacy. It has been mentioned that increasing the methadone share could be a method of preventing overdose deaths, but this would require active follow-up on the part of the community. Otherwise we would have overdose deaths from methadone like other cities also have experienced. If you have a proper rehabilitation scheme for those who live in private homes as well, then I think we will be able to reduce the overdoses here as well. I have also been concerned that we don't have enough information on this group, and I wish that we could improve our knowledge here. I also think it is important, as a starting point, to gather more information on overdose deaths in the party drug environments, since I feel we will find some contributions to the negative statistics there.

8. When evaluating this city's drug policy in total:
a In what aspects do you think the policy has successfully reached its goals, and why?

The establishment of the Alcohol and Drug Addiction Service has allowed us to join all our forces together, and we have also managed to increase our resources in this field. This has been a prerequisite for success in this field.

b In what aspects do you think the policy has failed to reach its goals, and why?

We have not been successful with regard to prevention. Our weak and unsystematic efforts in this area have contributed to legitimising the use of drugs, and this has resulted in increased use, as well as increased drug related injuries and deaths.

11.3.5 Interview with Christine Fossen, head of the narcotics division, Oslo Police District

1a. What has been the major philosophy and goals concerning drugs in your organisation during the past 10 years ?

There is zero tolerance for narcotics, and we have worked on limiting the use of drugs and uncovering criminal acts. We have seen over time that the problems are so great that we now give priority to the youngest users, in cooperation, for example, with the Alcohol and Drug Addiction Service, and to serious organised crime. It is important to uncover the import and sales of narcotics. We simply don't have enough resources to apprehend everyone. We could have uncovered more crime and made more arrests if the entire criminal prosecution process had had more resources of both a human and financial nature. In the current situation, a greater effort on the part of the police with the existing resource situation would entail that other duties the police are responsible for would not be carried out. In recent years, the police have worked to a greater degree in accordance with objectives, budgets and activity plans. We were more incident oriented before. We went out and dealt with whatever we found. Now we are more organised and work deliberately in relation to specific groups and tasks. I must also stress that it isn't just the unrest patrol that works with narcotics in Oslo. District stations, the intelligence section and other units within the police also work with young people and narcotics. We are trying to create a common understanding of what goals we should give priority to. The uniformed police also uncover large narcotics cases at times.

1b. What have been the major obstacles that your organisation has encountered in its practise?

Our main obstacle has been the fact that we are restricted by our resources, both our human and financial resources. This places certain restrictions on those who work here. Many of them are so involved in their work that they would gladly work around the clock. Cooperation with other agencies can also prove to be challenging. We have, however, made a great deal of progress in this area, but there is still room for improvement. One obstacle in this connection is our obligation to observe professional secrecy. This is a very high barrier against cooperating across the various sectors for some. I don't think is unique just for the police. It applies to other public agencies such as hospitals, the child welfare service, etc. We now have a very good relationship with the Alcohol and Drug Addiction Service in Oslo through "Uteseksjonen", and professional secrecy hasn't been any problem here. It would also be nice if we had more people to work in the unrest patrol. But then we would have to strengthen the entire chain at the same time, since more unrest patrolmen would create more cases. Our investigators have more than enough to do already. At any given time we have between 75-100 people in custody in the narcotics section, and many of them are foreigners. In addition, the lawyers must handle all the cases. Cooperation between the lawyers (who are responsible for prosecution) and the investigators is very close throughout the entire investigation process. If we doubled the number of officers in the unrest patrol, then we would have to triple our administrative organisation in order to handle all the new cases.

I would also like to mention that Oslo should have an emergency receiving facility, so that the police would have somewhere to take people who cannot take care of themselves due to their

intoxication. People usually call the police when they find someone lying in the street, but we often have nowhere to take them if they don't end up in hospital or police custody. We would gladly take care of people, but we should have some place to take them.

1c. Imagine you could have changed something in this society's drug policy in the past ten years, what changes would that have been?

- I would like to see much more focus on preventative work in the schools. We should try to reach the young people in a much more systematic manner than we do at present, preferably in cooperation with the Alcohol and Drug Addiction Service, the child welfare service, police, etc. There are several agencies that could share this responsibility. Using the schools as an arena for reaching both parents and children is important. This should be the school's responsibility, while the police could be one of several agencies that could offer support to the schools. We should build a network for all the students/classes based on the schools. Parents should spend more of their free time with their children. It is important to identify the children who need help at an early stage, especially children who do perhaps not have such resourceful parents who can back them up. The development among young people is frightening. Research has shown that young people who start to smoke and drink alcohol at an early age also start to use drugs at an early age. It is important to prevent this, and to delay their introduction to tobacco and alcohol as long as possible. Many parents allow their children stay home alone on weekends. I would like to see a mobilisation of parental responsibility in preventative work. It's important to prevent early experimentation with narcotics. The child welfare service should also be more involved in some cases and take action in relation to families where the children are being raised under difficult conditions. Some of them have little chance later on in life when their childhood is deficient or has been taken away from them. Children's rights should be given higher priority than parents' rights.

- Of course the general drug policy is also responsible for creating an environment for young people's experimentation with drugs, regardless of what sort of childhood they have. I feel that an active drug policy has more or less been non-existent for many years. But it seems that we are now starting to wake up, now that we are experiencing an explosive increase in narcotics abuse. The younger generation in our society thinks that it is perfectly all right to pop a couple of ecstasy pills. We had an active drug policy many years ago when the drug problem was relatively new. Public interest in this policy was not very visible and many people "thought" that the police would fix this problem. But it is very nice to see that we now have a renewed public interest in our drug policies. It's important to take a clear and well-defined stand.

- I think we must ask ourselves: "Why do young people use more drugs now than before." Perhaps there is something about our society that leads to a constant desire for new and more profound experiences. These experiences simply have to be enhanced, whether it be through base jumping or attending house parties and dancing to techno music. We don't go on holiday to our cottages anymore. We travel half way around the world in order to experience something special. Perhaps this is part of the reason why there is an increased use of central stimulants. There is a never-ending search for new experiences and an enhancement of these experiences.

2. What was the most important political goals in this city's policy in the drugs field ten years ago? Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

Rank
1
2
2
3
1
2
3
1
1
3

- To strive for a drug-free society
- To reduce harm caused by drug use
- To reduce drug use related crime
- To reduce public nuisance associated with drug use
- To prevent drug use among youngsters
- To secure or improve the coverage of treatment for drug addicts
- To reduce drug dealing
- To prevent the spread of diseases like HIV and Hepatitis C among drug users
- To prevent overdose deaths among drug users
- To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade

Could you please comment on your ranking on these items.

Preventing public nuisances has traditionally been assigned low priority. We have simply moved these environments. It hasn't been a particularly important political goal to get rid of this problem, so I would give it a 3. On the other hand, the prevention of drug use among young people has been a high priority political goal. Even though we haven't managed to achieve this in practice, I would rank this as a 1. I also think that there has been a great deal of concern about reducing overdose deaths, so I rank this as a 1 as well. Striving for a drug-free society has been our goal all along, so I rank this as a 1. The prevention of money laundering has also been given low priority in Oslo's policies in the drug area. The fact that drug dealing is so well organised and that such large sums of money are involved is something we've only realised in the past few years. The Needle Bus shows for example that preventing the spread of HIV and Hepatitis C has had high priority. Treatment was probably important, but I would rank this as a 2. The same applies to drug related crime. We have at the same time been more concerned about reducing theft and other crimes of gain than reducing the actual drug dealing. It has had low priority, at least in Oslo's local politics I think.

In summary, I would say that a drug-free society became an important political goal when the use of drugs was introduced as a problem in Norway. But when overdose deaths began to increase in the beginning of the nineties, this was given high priority. It is a very visible phenomenon, and an extreme consequence of drug use. I also think that preventing disease

has been something we have always been very concerned about. This is perhaps because contagious diseases can also affect those who don't use drugs. We have been more concerned about this than increasing the capacity of the treatment centres for example. We have also been very concerned about young people. This is something that we've always given high priority.

3 What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?
Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Rank
• To strive for a drug-free society	3
• To reduce harm caused by drug use	3
• To reduce drug use related crime	2
• To reduce public nuisance associated with drug use	2
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	3
• To reduce drug dealing	1
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	1
• To prevent the overdose deaths among drug users	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	1

If any changes, compared to ten years ago, please comment on the reasons for these changes in priorities.

All the goals have in principle been very important, but if I must rank what should be an important goal for the City of Oslo as I see fit, from my own point of view, then I would rank them as follows. I would rank striving for a drug-free society as the lowest priority, simply because this is a utopian goal. We can of course work towards coming as close as possible to this goal as we can. In this context, however, I would rank this at the bottom. I would rank the prevention of drug use among young people as the most important. We must also reduce drug dealing, so I would rank this as a 1 as well. The prevention of overdose deaths is of course important, but I cannot rank this higher than a 2. On the other hand, I think our society should concentrate more on money laundering, so I would give this the highest priority. Some people earn a lot of money on other people's suffering. Reducing the harmful effects caused by drug use is something I would give low priority. Public nuisances, such as open drug scenes, lead

to the recruitment of new users, so I think this is something we should at least give medium high priority. Treatment is something I feel we should give less priority. Preventing the spread of HIV and Hepatitis C should still be a high priority, since this can also affect others, not just the drug users. I also feel that reducing drug related crime should at least be given medium high priority. If the City of Oslo sees this as a problem and it is possible to shut pubs and bars where narcotics are sold or money is laundered, then the city should be tough enough to actually shut them down, provided of course that we have legal grounds to do so. Taking from them the places where they launder money, sell drugs or recruit new users is very important in relation to supporting the work of the police to try to apprehend those who are behind these operations. Many people involved in this business earn a lot of money from selling and smuggling narcotics. They build vast fortunes on other people's suffering.

Striving for a drug-free society has gone from a 1 to a 3. It's very naive to believe that we will ever attain a drug-free society. This should therefore not be ranked as a primary goal. All the other goals that have been listed here, however, support the goal of creating a drug-free society. So, when all is said and done, this goal is actually important.

The priority assigned to reducing the harm caused by drug use has gone from a 2 to a 3. I feel that drug users must take more responsibility themselves here. Politically, I feel that we should first and foremost concentrate on recruitment. Here the goals before and now are still the same. Public nuisances, i.e. the drug scene, must be given higher priority, since this is associated with recruitment.

The priority assigned to treatment has declined, since the results have shown that many people do not benefit from the treatments they are offered and the dropout figures are very high. On the other hand, the priority assigned to the prevention of drug dealing has been greatly increased, and this is something that is first and foremost a job for the police. But it is also very important to get the relevant municipal agencies to support shutting down venues where the police have registered drug use and dealing and when the police recommend that they are closed. There are of course political considerations to take into account, and I know that it is very unpopular to revoke a pub's or bar's alcohol licence. But places that tolerate drug use and house parties are recruitment centres for new users. I think that this is very different today than ten years ago. There are a lot more young people out on the town, a lot more pubs, restaurants and bars, and a lot more drugs on the market. Therefore a lot more young people are introduced to drugs now than before. Maybe Oslo should have its own restaurant police, so that they could keep the restaurant business better under control in cooperation with the municipal authorities, county tax office, employee register, tax office and other agencies, etc. This would be similar to the measures that have been implemented in Copenhagen and Stockholm.

4. **Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.**

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	2	x	
In police strategies less focus on users towards more focus on larger scale dealing	2	x	
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	1	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	1	x	
Housing for people with drug problems	3		x
First aid education	3	x	
Sufficient capacity of methadone programs	1	x	
Low threshold methadone programs (allowing side use during treatment)	2	x	
Methadone programs in prisons	1	x	
Heroin prescription programs	3		x
Interventions in order to change the main route of heroin administration from injecting to smoking	2		x
Distribution of naloxone (narcanti) to drug users	3		x

Could you please comment on your ranking and explain why some interventions are not feasible in this city, if any.

I think that less focus on the drug users and more focus on the big drug dealers is important, even though we have to focus on both. But we must catch the small-scale users as well in order to set an example that it is illegal. We must have zero tolerance for narcotics. The unrest patrol visits the "Plata" scene daily, but we deliberately use a lot of resources on young people at the places they frequent. "Plata" is an open drug scene, which can function as a recruitment venue. It has become a very unpleasant area. There is a lot of trouble there, and it is also used for the recruitment of new users. It is important that we spend some time there since this allows the police to gather important information. But we cannot be there all the time, even though a lot of people wish we could. We must give more priority to the environments where there are young people, and we must also apprehend those who are responsible. The unrest patrol could have covered the entire city, but there are only 17 officers and they work shifts. We have to spend enough time at "Plata", so that we have some form of control. This environment knows the police. Often there is little point to bringing exhausted heroin users to the police station in order to report them, charge them for use or possession, and then just release them again. The unrest patrol says that they have the situation under control. They know who is there, and who is ill and exhausted. Sometimes a few of them are just picked up and driven home.

I am a firm believer of rehabilitation and employment opportunities, and this is something that we should be able to implement far more than is the case today. I don't feel I have enough knowledge of methadone in order to give a detailed description of what should be done, but I have ranked this according to what I do know. I would give adequate methadone programme capacity the highest priority. This is something that we should be able to implement. But I'm more sceptical about low threshold methadone programmes, even though this is probably possible to implement. Prescribing heroin is something I do not like at all, and I really don't think this is something we can implement in Oslo. I have more faith in methadone programmes in prison, since we have them under control there, as opposed to low threshold

methadone programmes. With regard to getting people to smoke instead of inject, I would give this a 2. However, I don't think we can implement it, and I don't think it's a good solution either. I do not think that it is feasible to start handing out naloxone (narcanti) to drug users. They really aren't capable of taking care of anything at all.

I don't have any faith in housing for people with drug problems. It can't be implemented either. They are incapable of living properly. It must be combined with rehabilitation and employment opportunities. And then you really have to control them so that they are taken care of to such an extent that you can reel them in if they start to slip.

With regard to first aid training, I would give this low priority, and I really don't think it would be easy to implement. From my experience with the people at "Plata", I don't think it would be wise to give them too much responsibility. Most of them have enough problems taking care of their own lives.

I would rank injection rooms as a 2. I don't support this, but if the politicians decide to implement it, then I suppose it can be implemented.

Information to drug users in prison and when they are discharged from institutions is something I would give the highest priority, and this is something that can be achieved. We can of course always talk to people, but I really don't think it helps much.

I feel that the debate on overdoses gets a bit "intense" sometimes. The deaths are after all caused by something they do of their own free will. The figures vary from year to year, and as long as there is enough heroin on the market, addicts will die from it. A lot more people die in traffic accidents, and many more die from alcohol. We also have child abuse and domestic violence, etc., etc. There are so many deaths in our society, and I just can't seem to get too enthusiastic about this debate on overdoses. It is of course tragic that someone dies of an overdose, but I don't think our society can prevent this from happening. Many of the overdoses occur at home and upon release from custody/prison, or after rehabilitation.

5. Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think, to reduce or forbid the distribution of these pharmaceuticals is one way?

No, I don't think that is the way to go, since so much gets imported illegally. Most of the drugs such as Rohypnol and Valium that we confiscate on the streets are illegally imported. They don't come from domestic pharmacies. They are smuggled in from the Czech Republic, Poland and the Baltic states.

6. Do you think, that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?

- Yes, I think open drug scenes like this increase the spread of heroin addiction and that they indirectly increase the overdose mortality. You can reduce these environments by keeping them under control and keeping an eye on recruitment. If there are a lot of young people, then

this is a good reason for the police to have a greater presence there. This is something we have learned through a joint project the police have carried out in cooperation with "Uteseksjonen". Future/"Uteseksjonen" and the child welfare service have been responsible for following up the people we bring in. We have said that the police can of course help move the environment away from "Plata", but we have to really think about this. Where do we really want to have them? They will band together somewhere no matter what. But one thing is certain, having an environment like that in the heart of Oslo is undesirable. We also see that not only young people buy drugs at "Plata". We also see adults from "respectable homes" who find their way there in order to get the ingredients they need for their "party packs".

7. Do you have any other suggestions about how to reduce the overdose deaths in our city?

No, I think we must build up the various assistance agencies to greatest possible extent. I think we should be able to use more forced treatment. We must also have treatment space that is available at all times, so that there is always room when they are exhausted or ready for treatment. Waiting for an opening I think kills their motivation for treatment. HUB is an example of a joint project between central municipal agencies and the police. I also feel that a central liaison committee between the police and central municipal agencies should be revitalised and expanded to include the battle against drugs in general and not just overdose deaths.

8. When evaluating this city's drug policy in total:
a. In what aspects do you think the policy has successfully reached its goals, and why?

We have done a lot, and surveyed the overdose situation quite well. Here we have established relevant measures, such as the field service. We have also done a lot when it comes to prevention in Oslo, more than many other places, because the police in Oslo have a great deal of expertise in this area for example.

b. In what aspects do you think the policy has failed to reach its goals, and why?

The policies have not managed to achieve their goals with regard to new recruitment. Oslo is the worst city in Norway with regard to recruitment. But this is a consequence of being a large city, so I don't think all the blame can be placed with Oslo. Our preventative measures aimed at young people have not been good enough. But as long as the police and customs officials are unable to prevent all the illegal import of drugs to this country, I am not sure how much this would have helped anyway. We think that approximately one tonne or more of heroin finds its way to Norway every year. We only manage to seize 50-100 kilos of this volume. I also think that cooperation between the police and other agencies has improved. At least now we are speaking the same language. The development of the drug trade (import, trafficking and use) is controlled by many factors other than those that the City of Oslo or the police have control over. The drug trade is managed by market forces, buying and selling generates profits, big profits for some. I think therefore that our expectations should not be too high with regard to controlling the overdose mortality, as it will always fluctuate.

11.3.6 Interview with Lilleba Fauske, Director of the Alcohol and Drug Addiction Service, City of Oslo

1a. What has been the major philosophy and goals concerning drugs in your organisation during the past 10 years ?

The creation of a drug-free society has been our main philosophy and goal, as a great vision. Prevention, relief and treatment have also been part of this and given priority. Relief is perhaps stressed more now. Prevention has, however, been written and talked about more than what has perhaps been demonstrated in practice, since all the money has been used for treatment, and relatively little has been left over for prevention. Prevention has, however, always been one of our goals. We could have probably done a lot more if we had been tougher in our prioritisation.

1b. What have been the major obstacles that your organisation has encountered in its practise?

Our main obstacle is course the lives that are being lived out there. We just can't use the money the way we want, since it has been necessary to build up treatment programmes to a much greater degree than we had hoped. Prevention has been given less priority in practice as a result of this. The acute nature of the drug problem and political pressure after stories in the mass media dictate many of our priorities. We haven't been tough enough either when it comes to saying that we are going to give priority to prevention. The Alcohol and Drug Addiction Service is engaged for example in tertiary prevention at best. In general, however, more money should be used in Oslo on kindergartens, schools and various other measures in the city districts. This is where something can really be done. Social problems do after all always have a cause. Sometimes you can see that children need help when they are just two to three years old.
The drug problem is also big business, and many people earn a lot of money from dealing in drugs. There is so much money involved in this business that it is perhaps naïve to think that we can fight it unless the rest of the world supports somehow a common effort. The forces behind this business are so far ahead of us when it comes to their sales strategies. This is the world's second largest industry after the weapons' industry. Therefore it is very limited what little Oslo can do about this situation. But strategies to limit the influence of the market forces must be developed. As a result of these forces, the drug prices have fallen in Norway in recent years, and the availability of drugs has increased. So if anyone wants to experiment with drugs, it is a lot easier to do experiment now than it was one or two generations ago. Today, all my daughter has to do is say the word outside her school and a dealer will be there. These young people are also very acceptant of these drugs, like hash for example. Smoking hash is totally acceptable. We have not been very good at disseminating counter-argumentation. We should probably have spent millions on advertising and information campaigns over many years in order to stop this. Denmark is reporting good results from their information campaigns against ecstasy and party drugs. These campaigns were condemned by professionals since they contained elements of fear and death. But if this is what it takes to reach the younger generation, then we should perhaps be willing to try.

I would also like to point out that the professional secrecy attitudes in our society also affect the Alcohol and Drug Addiction Service's ability to document how many clients we have in our institutions or what their problems or backgrounds are. Today we have no authority to

keep records of any personally identifiable information. I feel that this prevents our organisation from performing its duties in the most appropriate manner.

1c. Imagine you could have changed something in this society's drug policy in the past ten years, what changes would that have been?

With regard to the police, we see that there is much more international cooperation now. I feel that this is of vital importance in order to restrict the market forces. Here I think that the Oslo police have been a forerunner with regard to cooperation with Eastern Europe and Russia, in addition to training and joint intelligence. Cooperation between the police and social workers should of course be much closer, and this is an area that we have managed to improve in recent years. Everyone is satisfied with the organised cooperation between the police, outreach service and the child welfare services, and this is something we should have implemented much earlier. But there has been a lot of resistance to this, especially among social workers, because of professional secrecy issues. Luckily this has changed for the better, and I don't think there are many individuals in the outreach service who have problems cooperating with the police. There has been a great improvement on this front. I would also like to see better cooperation between the Alcohol and Drug Addiction Service and the politicians, for example, so that they could be more up-to-date on developments in this field. I feel that the distance is too great, the way Oslo is organised now, in order to keep the politicians abreast of the developments in this field. I am not just thinking about the City Government politicians here, it is just as applicable to City Council politicians as well. I also think that some of the initiatives taken by professionals throw the politicians off balance, resulting in hasty decisions. There should be better contact with the specialist agency to give the City Council a better professional basis for making certain political decisions. This would make it easier to maintain our long-term goals. I envision for example a work model where experts could be present and speak freely at consultation meetings arranged by the politicians themselves. I know that this has been done in Denmark- Experts with different opinions have made their views known, and then the politicians have been able to draw their own conclusions at their own pace, instead of basing their decisions on random statements from some expert who only represents perhaps a small portion of the entire professional community. But like I mentioned earlier, I would like to have far greater resources for primary prevention. I think that our society loses out when resources are not deployed at an early stage in families where anyone can see that the situation is difficult. Why don't we deploy resources when we see that a four year-old already has massive problems? Why don't we provide them with support? A respite home - it costs almost nothing. Even though we stress the parents' rights, I think many parents would accept help if this help wasn't looked upon as "dangerous". I know of many measures that are perfectly harmless, such as substitute grandparents or extra personnel in schools or other institutions. Imagine what an extra teacher in school could mean to an individual child! When I first started working at the Alcohol and Drug Addiction Services, I remember stating that if we got a lot of money I would invest this in preventative measures in the city districts. Someone got very angry then, since there are many other institutions that need more personnel as well. This is probably true, but you get a far greater return in the long-term if you invest in preventive measures. This is something that the politicians probably know as well. But the reality of life always gets in the way in the form of acute needs. And suddenly you find that you've used what little extra that could have been used for preventative measures. Our efforts are too dependent on budgets. When weighing between the elderly who require nursing home care and preventative measures for children, it is always easy to prioritise care for the elderly over care for children, even though

it entails far greater expenses for the city district in the long term. Unfortunately, however, the results of preventative work cannot be documented, its just not possible.

2. What was the most important political goals in this city's policy in the drugs field ten years ago? Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Rank
• To strive for a drug-free society	1
• To reduce harm caused by drug use	3
• To reduce drug use related crime	1
• To reduce public nuisance associated with drug use	1
• To prevent drug use among youngsters	2
• To secure or improve the coverage of treatment for drug addicts	2
• To reduce drug dealing	2
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	1
• To prevent overdose deaths among drug users	3
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	3

Could you please comment on your ranking on these items.

I think that striving for a drug-free society has been ranked as no. 1 This applies also to the reduction of drug related crime, reduction of public nuisance and preventing the spread of HIV, and not so much Hepatitis C perhaps. Preventing drug use among young people has been of medium high priority. The same applies to securing or improving the availability of treatment programmes and the reduction of drug dealing. I think the prevention of overdose deaths and the prevention of money laundering has been given low priority. The reduction of harm caused by drug use was also given low priority, simply because they had such high ambitions of creating a drug-free society through prevention and treatment, that they just didn't think much about measures to reduce the level of harm caused to active drug users.

If I were to comment on these priorities, I would have to say that there has always been a great deal of focus on zero tolerance of drugs and that the goal of creating a drug-free society has always been firmly entrenched in the national politics and locally in Oslo. HIV was also focused on a great deal when it first arrived, and it quickly became one of the top priorities. This became a big fright for politicians and the general public, they just didn't know what it was and imagined that people would start dying like flies from HIV! It was regarded as some

kind of plague. No one had any experience with epidemics, such as tuberculosis, and they basically panicked. I have ranked drug related crime as a top priority, primarily with a view to the prioritisation, since the small dealers were arrested and the intention was to get rid of it and restore order on the streets. And the drug users were moved from the park around the palace to "Plata". What's next, the Oslo Fjord?

So this is connected somewhat to the next item, reducing the public nuisance associated with drugs, something I also gave top priority. I feel that this has been very important. After all we do have harsh penalties for drug-related crimes in Norway, and we have taken a fairly hard stance. We have talked a lot about preventing drug use among young people, although there hasn't been much money to back the words. But Oslo has managed to maintain a high level of support for young people. I don't think that there are all that many large cities left that allocate as many resources to preventative measures. There has, however, been a decline in the resources for combating this situation at the national level.

High priority has also been assigned to improving treatment programmes. There were, however, budget cuts when the institutions were the responsibility of the city districts, ten years ago, but they have gradually been built up again during the last 6-7 years. Ten years ago overdose deaths were given low priority, it's only during the last few years that this has been focused on. And I don't think they hardly thought about money laundering!

3. What should by your opinion be the most important political goals in this city's policy in the drugs field in the near future?
Please rank the following items into three categories, with no more than four items in each category: 1. High priority, 2. Medium priority, 3. Low priority.

	Rank
• To strive for a drug-free society	3
• To reduce harm caused by drug use	2
• To reduce drug use related crime	2
• To reduce public nuisance associated with drug use	3
• To prevent drug use among youngsters	1
• To secure or improve the coverage of treatment for drug addicts	1
• To reduce drug dealing	3
• To prevent the spread of diseases like HIV and Hepatitis C among drug users	1
• To prevent the overdose deaths among drug users	2
• To prevent money laundering and economic destabilisation due to investments of large amounts of money earned from drug trade	1

If any changes, compared to ten years ago, please comment on the reasons for these changes in priorities.

Beginning with the top ranked priorities, I feel that the prevention of money laundering is so important in order to be able to gain a reasonable degree of control over the drug marked that it should be given top priority. The prevention of HIV and Hepatitis C should also have top priority, especially Hepatitis C, since it is a very serious and resource demanding disease, especially with regard to our hospital capacity. I would also give top priority to securing and improving the coverage of treatment for drug addicts. The same applies for the prevention of drug use among young people. I also think it is important to reduce the harm caused by drug use, and the same applies to the reduction of drug related crime and prevention of overdose deaths. I give all of this medium high priority. The lowest priority is thus given to the reduction of the public nuisance associated with drug use and reduction of drug dealing, because I assume that this applies to small-scale drug dealing on the streets. I would also rank striving for a drug-free society as an area with the lowest ranked priority.

As a comment as to why I gave medium high priority to overdose deaths, I would have to say that this is a result of the type of lifestyle they lead on the streets. Unless they stop injecting, we can never rid ourselves of this problem. It must be more important to use resources to prevent more people from getting into a situation where they are at a high risk of dying from an overdose. And this is why I also give high priority to money laundering. We need to get at the root of the problem with regard to the professional distribution system. And we must also view this in the context of an international chain that starts with poor farmers in developing countries who should be given alternatives to growing opium poppies or cocaine.

4. **Drug users and street level workers in all the four cities have been asked about what they thought could help prevent overdose deaths. (In all these cities the ambulance service were found efficient and good) Below you'll find a list of the most common suggestions. Please rank the items by importance (into three categories, with 4 items in each category: 1. Very important, 2. Important, 3. Not that important,), and note for each of them whether they are feasible or not.**

		Feasible	
Measure to reduce overdose deaths	**Rank**	**Yes**	**No**
Injecting rooms/user rooms	3		x
In police strategies less focus on users towards more focus on larger scale dealing	2	x	
Rehabilitation and vocational opportunities (housing, education, social network work, work training etc.)	1	x	
Information on dangers after periods of abstinence (release from prisons, discharge from drug free treatment institutions)	2	x	
Housing for people with drug problems	1	x	
First aid education	2	x	
Sufficient capacity of methadone programs	1	x	
Low threshold methadone programs (allowing side use during treatment)	1	x	
Methadone programs in prisons	2	x	
Heroin prescription programs	3		x
Interventions in order to change the main route of heroin administration from injecting to smoking	3		x
Distribution of naloxone (narcanti) to drug users	3		x

Could you please comment on your ranking and explain why some interventions are not feasible in this city, if any.

I would rank injecting rooms low. I perceive this as a measure to reduce overdose deaths, and I really don't see how injecting rooms will be of any benefit. I don't think this can be implemented either. It would, in any case, require some changes in our law. I feel, however, that there might very well be some political support for this. With regard to the police strategies, I have given medium high priority to changing the focus from small-scale users to big dealers. Such a change can be implemented, and this is something I think we are already in the process of doing. It is common now to impose fines instead of prosecuting people in possession of small quantities for their own use. But the drug users themselves claim that the police stress them, and if they were left alone more, there would be fewer deaths from overdoses. I have given top priority to rehabilitation and vocational opportunities. More provisions have been made in places other than Oslo for more or less complicated employment. It is said that work is good for the soul, and if you have somewhere to go on a regular basis, then you will have a better life. But you have to make sure that the work is suited to the ability of these people, so that they don't suffer any more defeats. With a little creativity and good cooperation between the central authorities and the local government, I feel this it should definitely be possible to implement this.

I have given information to drug users as a 2, since I think they know a lot about this themselves. They might not know that much about injecting, but they do know that it is dangerous to inject right after they are released from prison.

I have ranked housing as a top priority, and it should be possible to implement this. The reason we are not successful today is due to the fact that the city districts, who have the clients, don't have the money or resources. With Oslo's new organisation the districts will be given their own apartments. And then it would be easier for them say "No, we have 200 apartments, and we are going to give priority now to giving housing to 50 drug addicts". But then we have to consider task number 2, which is to follow up these clients once they have a place to live. And this requires actually flexibility and an understanding of working in the local community, which some people have forgotten. In my experience, people who have been classified as unhousable can nevertheless be housed as long as they are given a suitable offer. You have to have a social worker there, and you have to train them. "You plant flowers there, and you don't throw garbage there". This is possible, because everyone wants to have a good life. This applies to drug addicts as well. But you can't spread these people around in various housing cooperatives. You have to establish smaller housing units, because very few people want to have these people as their nearest neighbours. This is something we just have to accept. These units must therefore be more isolated and offer follow-up from social workers, as well as volunteers, perhaps, like someone from the Church City Mission, various congregations, etc., who could cooperate and share the tasks. This would work great. This is something they are already working with in the city districts today. But this requires resources, and it requires the employment of social workers, who must also be given training and followed up. First aid training is important, so I have given this medium high priority. This is something we can implement, and we are in the process of doing so. I would give adequate methadone programme capacity the highest priority. This is possible, and we have increased the capacity a great deal since we first started. We will attain the desired level in time. The big question here is, what is the desired level? Should all the clients who the social welfare offices recommend to start with methadone be accepted by the programme? I don't

think so. I do, however, believe in a gradual expansion of the methadone programme in the future. I think, however, that it is just as important to ensure that the systems surrounding each individual client are functioning, so that the programme can work according to its intentions. Low threshold methadone programmes are something that we should have, so I would rank this as a 1. And this is of course something that can be achieved. But this will involve a number of criteria. We must have very strict regulations for this in order to keep it under control, so that we don't end up with everyone being in a low threshold methadone programme. We have to choose people who have actually made an effort, but have failed, and where we see there is an imminent risk of dying. You have to be a bit pragmatic in this situation. This measure is first and foremost aimed at reducing and preventing overdose deaths. The situation here is such that if this person is not allowed to take methadone, then this person will die. There are a few such individuals out there. I have given medium high priority to methadone programmes in prison, and this is something that can be implemented. I have given low priority to heroin prescription programmes. This cannot be implemented, since it is completely illegal, as well as totally unacceptable, both politically and socially. In order to obtain this heroin one would also have to seek out criminal environments. I think that this would be going too far in order to prevent overdoses. To change the method of taking heroin from injecting to smoking is something I have also given low priority, I don't think we can manage to implement this, at least not for the people who have already started to inject. On the other hand it could perhaps be easier to convince those who have started to think about shooting up that they should smoke it instead. But I think this would be a complicated message to get across, so I really don't place much faith in this. I have also given low priority to the distribution of naloxone to drug users, and I don't think this is feasible.

5. **Combining heroin with other pharmaceuticals (especially Rohypnol) seems to increase the risk of an overdose. What are your thoughts about the possibilities to reduce this risk? Do you think, to reduce or forbid the distribution of these pharmaceuticals is one way?**

The Alcohol and Drug Addiction Service has tried to remove Rohypnol from the market, but the Board of Health would not allow this. They reported back, however, that they had coloured the pills blue and made them less soluble in order to help us a little. But the main reason for not removing it from the market was the fact that the supply of Rohypnol from the former East-Block countries was so great that even if we managed to reduce the legal prescriptions, illegally smuggled goods would flood in to replace any reduction. I do know that it has been removed from the market in the US. But I don't think this is the right way to go for Norway. I don't know if there are any other ways of approaching this problem either. The drug users know that this drug is especially dangerous in combination with heroin. But they also know that using it gives them a special kick, which is of course what they want. I think they are well-informed of this risk, but they still do it.

6. **Do you think, that open drug scenes increase risk of overdose or even the spread of heroin addiction (causing nuisance etc). What are your thoughts (experience) about how to prevent or reduce open drug scenes?**

don't think that the open drug scenes increase the risks of overdoses, they probably has the opposite effect. But I do think that they may increase the risk of heroin addiction, since new users have a much greater opportunity to get into contact with the market when these scenes are larger and more defined. Moreover, it has a negative effect on the general public. It signals

in public that it is perfectly all right to have a lot of people openly dealing in drugs to passers-by and anyone who is there. If you don't do anything about this situation, then you are saying indirectly that this is perfectly all right. In order to prevent the growth of these environments, you need to have more police resources in order to break them up, and then move them to more sheltered surroundings that are easier to keep under control. I am not quite sure exactly what this alternative should be. You have to create congregation areas with a little employment, some activities, some food and an opportunity to get some rest. And the cooperation between the police and other agencies would have to be better. I also think we should use more forced treatment under the Social Services Act for a number of people who live in these environments. I know that social services use these laws for a number of older addicts who are about to perish. The dilemma is, however, that forced treatment is clearly far more successful with younger people who haven't gotten that far in their addiction careers. It looks, however, that younger people, especially girls, are being treated now under these laws, as compared to when the Act was first introduced. I am a supporter of a greater degree of force, but a prerequisite here is that these forced treatment programmes must have a content that includes follow up. This would signal respect for the individual in the same way that you set limits for children when raising them.

7. Do you have any other suggestions about how to reduce the overdose deaths in our city?

Professional secrecy is an obstacle to the prevention of overdoses and documentation. We must be better at reporting overdose accidents to social services or when something goes wrong with clients on the street. It is the duty of social services to follow up their sick clients in a proper manner. I think that social services have the competence required for this follow-up, as long as we don't destroy this by constantly depriving them of employees, something that has happened in a number of the city districts. Decreasing the number of employees in some districts is the same as sawing off the branch you are sitting on. Otherwise groups should be appointed for the neediest clients to a far greater degree than is the case today. Each social services centre could select their ten neediest clients and work specifically around them. Showing interest from the public sector in relation to people with problems can be of great benefit to the client in many ways. By utilising case management principles to a greater extent, we could also stretch the capacity of social services further, by having other agencies take over primary responsibility for some of the clients. The follow-up of drug users who are not undergoing any treatment is part of the key to better results and survival.

It is also a problem that the health services and social services don't cooperate enough. This has something to do with their cultures and professions. I am a firm believer in breaking down these professional secrecy barriers and the unwillingness to inform each other across the various sectors. I would also like to see solutions where social assistance was distributed from some of the addiction institutions. I know that there are social services representatives at some senior centres in the city districts who are responsible for payments and handling applications. The same could be done in our institutions.

8. When evaluating this city's drug policy in total:
a In what aspects do you think the policy has successfully reached its goals, and why?

We haven't achieved any of our main goals. Oslo is not a drug-free city. At the same time we can ask ourselves, where would we be if no effort was made during these years? At least we've managed to coordinate things a little better administratively, professionally and with regard to cooperation by establishing the service. I feel that we are slowly but surely restructuring, adapting and changing our programmes so that we can have a possibility of getting these problems under a reasonable degree of control. This would not have been possible if the responsibility for drug related problems was left solely with the various city districts. We have also had a project aimed at the "party-drug" environments, and the expertise gained from this will be useful when we start to implement programmes for these groups. We have an organisation that is down to earth and relatively adaptable.

b In what aspects do you think the policy has failed to reach its goals, and why?

The problems have increased and more people are dying. But these are factors that are to a large extent beyond the control of the City of Oslo, such as market forces and the increased availability. The buildup of the assistance organisation in Oslo must be regarded as our society' reaction to the fact that this problem has been increasing. Now there is a young generation with completely different drug and alcohol patterns , and this is something we haven't managed to identify yet. There is also an increased need for care and treatment for a large number of drug users, and it is not clear whether the Alcohol and Drug Addiction Service will be responsible for this at all. Moreover, we have not managed to successfully build up a strong enough prioritisation of our efforts in relation to people with drug problems in our city districts. This is of course related, for example to the resource situation, while the social worker turnover in city districts is too high and the level of expertise is too low at the same time. I also feel that the City of Oslo in general has not been successful in assigning adequate priority to drug problems. We do not sit at the head of the table.

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