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European Monitoring Centre
for Drugs and Drug Addiction

# ANNUAL REPORT 2005

## SELECTED ISSUES

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for Drugs and Drug Addiction

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# Contents

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### Reitox national focal points

Reitox is the European information network on drugs and drug addiction. The network comprises national focal points in the EU Member States, Norway, the candidate countries and at the European Commission. Under the responsibility of their governments, the focal points are the national authorities providing drug information to the EMCDDA.

The contact details of the national focal points may be found at:
http://www.emcdda.eu.int/?nnodeid=1596

# Introductory note

This volume contains the selected issues of the annual report.

The annual report is based on information provided to the EMCDDA by the EU Member States and candidate countries and Norway (participating in the work of the EMCDDA since 2001) in the form of a national report.

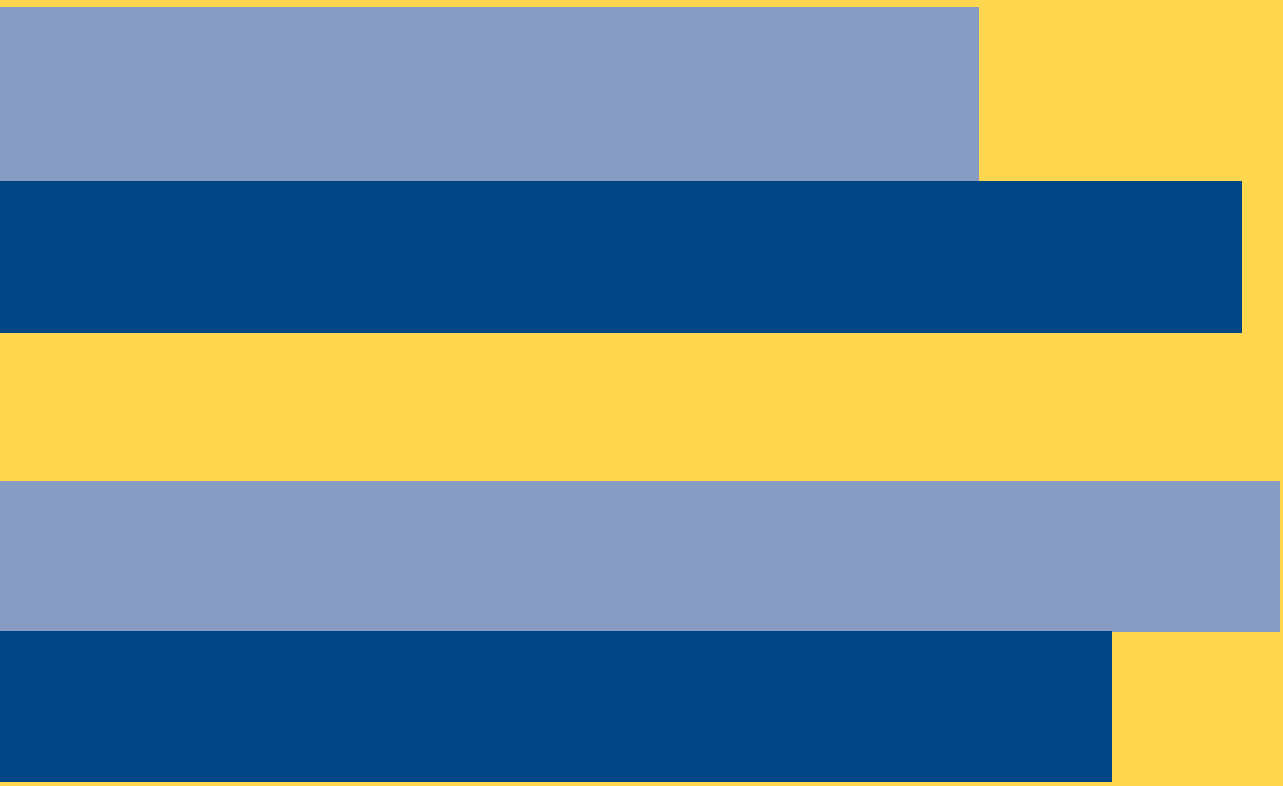
The national reports of the Reitox focal points are available on the EMCDDA website (http://www.emcdda.eu.int/?nnodeid=435).

An online version of the selected issues is available in English and may be found at http://issues05.emcdda.eu.int

An online version of the annual report is available in 22 languages and may be found at http://annualreport.emcdda.eu.int

The 2005 statistical bulletin (http://stats05.emcdda.eu.int) provides the full set of source tables on which the statistical analysis is based. It also provides further detail on the methodology used.

Country data profiles (http://dataprofiles05.emcdda.eu.int) provide a top-level, graphical summary of key aspects of the drug situation for each country.



Selected issue 1

# Drug-related public nuisance — trends in policy and preventive measures

This selected issue is not intended to present a systematic and exhaustive review either of all possible definitions of drug-related public nuisance or of all measures, provisions and policies aimed at reducing the problem in the European Union, nor does it aim to reflect precisely the situation regarding public nuisance in each of the countries concerned. Rather, it seeks to contribute to our understanding of the issues and problems related to a new — and somewhat still limited — area for intervention in Member States, candidate countries and Norway.
This document aims to present the first EMCDDA qualitative insight into an emerging concern within drug policy debate, at both national and European levels. The individual behaviours and activities usually covered by the term 'drug-related public nuisance' have long existed in most of the countries reporting to the EMCDDA, and therefore we are not talking about a response to new phenomena. What is new is the tendency among policy-makers, apparent in some countries, to categorise these phenomena under the same umbrella and to make the reduction in their occurrence a key objective of their national drug strategy ([1]) — and/or to develop specific interventions to tackle those issues.

To what extent is this tendency shared among European countries? Is there a consensual definition of this concept? How are the nature and extent of the phenomena to be assessed? What are the policies aiming to achieve and what are the types of interventions implemented, whether or not they are explicitly designed to reduce drug-related public nuisance? Are there any results from evaluations already available and have quality standards for intervention been established? All these are among the core questions that this selected issue aims to address.

## Definition, genesis and extent of the phenomenon

### Definition

#### A concept covering elements of different nature and extent

Drug-related public nuisance is a catch-all concept, an eclectic mix of elements differing in nature, substance and extent: in this respect, it can include situations, behaviours or activities. To add to this complexity, certain behaviours generally included in the definition of drug-related public nuisance are crimes. However, drug-related public nuisance cannot simply be reduced to drug-related crime. Drug-related public nuisance actually refers to a very wide range of 'deviant behaviours linked either to very codified and highly institutionalised rules, such as those of the criminal code, or to less explicit social norms and values' (quoted in the French national report). Some activities are deemed to be relatively minor in their effect; others, in contrast, are considered 'as causing extreme distress and misery to people' (Irish national report). Moreover, depending on the viewpoint taken, certain situations (a harm reduction facility, for instance) may be seen either as a cause of public nuisance or as a response to it.

Perception is a crucial element in the issue of public nuisance that makes it even more complicated for two reasons. First, as Garretsen et al. (1996) put it, 'nuisance is defined in terms of a wide range of human behaviours that are either inadmissible according to objective norms or subjectively inconveniencing. Yet the subjective inconvenience of behaviours is partly influenced by the varying levels of tolerance in society as a whole' (Dutch national report). This is also true within an individual country, 'where it is not easy to categorise nationally what all citizens consider to be nuisance behaviour' (United Kingdom national report). None of this helps to set a common definition that covers domestic and international differences.

Second, although a given area may be said to experience a lot of public nuisance problems, this statement may be based on public perception, which is not necessarily a function of the objective existence, nature and extent of behaviours and activities in the area. In other words, the fear and feelings of insecurity in a given area are not strictly proportional to the objective levels of criminality, delinquency, occupation of public space, vandalism, etc. that actually exist in that area. For example, a study in Estonia found that parents perceived their children to be at greater risk of harm from drug addicts close to their school than in the vicinity of their home, although the risk was the

([1]) The term 'national drug strategy' is defined, by convention, as any official document adopted, agreed or endorsed by the government or part of it (such as a ministry), planning future activities in the field of drugs. It could equally be called a drug strategy, drug plan or policy programme, or it could take the form of a letter or note to parliament or some similar format. To fit within this definition any document will have to fulfil three main conditions: (1) it must be a written document; (2) it must be agreed by public authorities; and (3) it must describe and plan future activities in the field of drugs, or at least in a related area.

same in both locations. In Finland, it is reported that the public perception of danger from drug users is far in excess of the actual levels of risk, and in Norway, the predominance of alcohol-related public nuisance problems is eclipsed by the public's perception of drug problems.

### A first definition from national reports

It is not an easy task to find well established and operational criteria which can be used to distinguish what clearly is or is not a public nuisance. However, a non-exhaustive review of the impressive range of literature on this issue allows us to put forward a tentative definition. Professor Helge Waal of the University of Oslo, in the context of the expert forum on criminal justice of the Pompidou Group, emphasises that the public nuisance concept includes a set of drug-related behaviours and situations that are a source of real concern for communities; these are undesirable and, in some cases, unacceptable to the general population, the civic authorities and local businesses (Waal, 2004). He also points out that such behaviour is also harmful to individual drug users themselves. Finally, he observes that public nuisance exhibits hybrid characteristics of both private torts and public laws — as we have seen above.

Responses provided by Member States to the EMCDDA's request for information on this issue mirror the equivocal nature of the concept but at the same time reveal quite a commonsense understanding of what is and what is not public nuisance. According to these responses, public nuisance encompasses crimes, disturbances and antisocial behaviours that disrupt the safety, security, health and tidiness of a community or neighbourhood and which jeopardise the quality and enjoyment of life of the inhabitants of a street, a neighbourhood or a community. Public nuisance refers, therefore, to behaviours, activities and situations that 'are perceived as undesirable, unpleasant, annoying, threatening or harmful by a person or a community, which consider [themselves] not to be involved in its generation process' (Luxembourg national report).

Public nuisance, as variously defined in the national reports, covers numerous actions, of which the most often quoted examples (Table 1) range from crime and delinquency to various types of perceived threats. Any engagement in these activities or behaviours resulting from or linked to drug consumption, possession or dealing can be considered as a drug-related public nuisance.

As argued in the United Kingdom's national report, all drug-related activities (ranging from use to trafficking) may also be included. According to the Reitox national reports, the most commonly reported drug-related activities/behaviours/situations having a negative impact on people's feeling of personal safety and on community stability and integrity include public drug-taking, and in particular public injecting; obvious drug-related intoxication; street dealing and crime committed under the influence of drugs; discarding used injecting equipment; annexation of space for dealing and/or consumption (open drug scenes) ([2]); vulnerability of children in relation to addicts and drug dealers; and intrusive verbal exchanges with drug users and dealers.

**Table 1: Acts and situations commonly included in definitions of public nuisance**

| |
|---|
| Annexation of public space |
| Urinating in public |
| Noise |
| Verbal aggression |
| Hindrance |
| Bothering other people |
| Damage to property |
| Decay of moral principles and corruption |
| Violence or intimidation of citizens |
| Threat to the individual or to social institutions |
| Threat to public health |
| Intrusive verbal contact |
| Aggressive begging |
| Causing citizens to take the law into their own hands |
| Prostitution |
| Riding/cycling on footpaths |
| Vandalism and damaging/destruction of public or private property |
| Graffiti |
| General harassment (including racist and homophobic incidents) |
| Rubbish dumping and misuse of communal areas |
| Uncontrolled pets and animals |
| Delinquency and criminality |
| Intimidating gatherings of young people in public places |
| Nuisance from vehicles (including parking and abandonment) |
| Rowdy behaviour |

## National genesis of the concept

### The link with individual countries' cultural traditions and socioeconomic status

There is not enough information to describe systematically how public nuisance has become established as a key or even core objective of certain national drug policies, but it is instructive to consider the way in which this issue has

([2]) The term 'open drug scene' is defined as a 'meeting point where drugs are sold and places where users gather and meet each other'. It is also used to describe the problems of nuisance and public reactions to the scenes and the development of subcultures that might be experienced as offensive by the general public (Waal, 2004).

emerged within the public sphere and drug policy debate in certain countries. It is apparent that the establishment of public nuisance as a key policy category depends on the state and the nature of the political debate concerning drug policy and public order issues at a given time in an individual country. It is also obvious that the categorisation of certain acts and situations as public nuisance varies according to an individual country's cultural traditions and socioeconomic status. The following examples may illustrate these two very general assumptions.

In Ireland, the development of a public nuisance policy appears to be the result of the conjunction of different factors, both structural and contingent. Indeed, in the mid-1990s, communities began to respond on their own initiative. Despite the fears generated by drug dealers, one consequence of the development of local drug markets and related antisocial behaviour has been that, on many occasions throughout the history of Dublin's drug problem, community-based groups and individuals have reacted by engaging in various types of action against drugs including community self-policing, informal justice and vigilante-type activities. Such anti-drug activity has highlighted the nature of the problems being confronted in these communities, thereby raising general public consciousness, which, in turn, has brought pressure to bear on those in authority to respond. These developments at a local level have coincided with major policy developments at a national level, which led to the establishment of local drug task forces. A major catalyst in bringing the issue to a larger public, and thus in exhorting policy-makers to tackle the issue effectively, was the murder of journalist Veronica Guerin in July 1996 by members of a drug gang. The media outcry led to an immediate government reaction and put the drug issue to the forefront of national policy. The issue of nuisance was one of those to be tackled on the wave of this action.

In the Netherlands, the public nuisance policy is reportedly the consequence of developments arising from a focus on harm reduction in the mid-1970s (Dutch national report). At that time, increasing numbers of heroin users of Dutch and foreign origin, including heroin-addicted prostitutes, began to cause inconvenience in the cities of Amsterdam and Rotterdam. The local-level drug policy of the day focused on the health and well-being of users, for example by setting up programmes for needle exchange and methadone supply and arranging streetwalking zones. Many municipalities started to develop projects against public nuisance and some kind of public nuisance policy. The publication of the White Paper on the subject of policy aiming at reducing nuisance caused by addicts in 1993 was the start of national policy-making against drug nuisance. In 1995, drugs policy received a new impetus as a result of the document *Drugs policy: continuity and change* by the Ministry of Public Health. In fact, a major reason for national government involvement was that drug-related nuisance was undermining public support for drug policies. And, since the 1990s, repressive measures have taken increasing priority on the political agenda. But in both documents, citizens' reactions and local community-based commitment are reported to have been central in raising awareness among authorities on this issue.

In countries where the drug-related public nuisance concept has not been established as a key issue in the drug policy debate and/or as an overarching objective of the national drug strategy, it is nevertheless interesting to study the situations that have attracted attention and policy change over the years. In general, they have been a function of what people have perceived as threatening or problematic behaviour, partly determined by descriptions in the mass media.

Norway is a good example of this phenomenon as the type of drug user in the public focus has varied greatly over time, as has the type of behaviour specifically targeted by control measures. In the 1960s and the first half of the 1970s, the use of drugs, especially cannabis, among young people was perceived to be the most serious problem. In the second half of the 1970s and the early 1980s, attention shifted to the somewhat older intravenous drug users and to problems relating to crimes against property and other forms of antisocial behaviour in this group. In the second half of the 1980s — after the human immunodeficiency virus (HIV) became widespread among needle users — the fight against infection became central, resulting in a redefinition of this group as care clients rather than antisocial and criminal cases. In the 1990s, with the eruption of the acid house scene, attention turned to the teenagers who were part of this scene. Today, now that the house scene has more or less died out, the focus of attention is once again on public order problems among those in an advanced phase of drug abuse, in the form of both violence and drug pushing within the drug milieu and the nuisance caused thereby to the public, who are exposed to begging and congregations of addicts in the city centres.

**Role of the media**

Several countries support the idea that media attention to the problem appears to play a key role (in addition to other important factors that have been touched on above) in the way that the problems linked to drug-related public nuisance have emerged and been constructed and thus are perceived by the public, and sometimes even by policy-makers. In Sweden, for instance, despite the fact that ordinary people, professionals and others are irritated by

public nuisance caused by alcohol and drug abusers, public nuisance problems have not received a lot of political attention, though they remain a topic in letters to the press. In Luxembourg, too, as the phenomenon of problematic drug use has become the subject of more research and has been given more prominence in media reports since the beginning of the 1990s, public awareness and concern have increased. Reports from officially recognised authorities declaring that the prevalence of problem drug use and drug-related petty crime has increased have contributed to this. Research, information and the media have played a major role in the appearance of public nuisance within the drug policy debate.

Nevertheless, the role of the media, its capacity to construct the issue at stake, and its ability to influence citizens' opinions, should not be overestimated. In every country, public nuisance issues and problems that have triggered policy involvement and commitment have also had a lot to do with the epidemiological patterns that actually exist ([3]). For example, in the Nordic countries, public nuisance problems have been identified as being mainly alcohol related. In Finland, public disturbances have traditionally been linked to alcohol use, whereas drug-related disturbances have been fairly rare. Custodies, violence and robberies are mainly related to alcohol use and not so much to drugs. The most significant drug-related public disturbances are experienced in blocks of flats where one flat is used for dealing drugs. On the other hand, alcohol use in public places leads to an annual toll of 100 000 arrests (custodies) for drunkenness. Drug use resulting in custodies has not been studied, but it is presumed to be rare. For example in 2002 only 56 cases in which public order and safety had been disturbed by a drug user were reported to the Helsinki police. These cases usually involved intravenous use on the street, sleeping on the street, going through rubbish bins or behaving in a threatening way. In Norway, too, until the mid-1960s most public nuisance in connection with drugs and alcohol abuse had been related to alcohol, resulting in the enactment of several laws empowering the police to intervene to uphold public order. Sweden presents the same noticeable characteristics: public nuisance is much more associated with alcohol than with drug abuse. Public nuisance caused by the drinking of alcohol in public has also recently become an issue in Spain.

As in any other policy analysis, the factors that might explain the emergence of drug-related public nuisance as an issue in the public agenda are varied and include the state of the debate concerning public order and drug policy issues, the role of community-based groups and local initiatives, the involvement of the media, contingent events that act as catalysts, epidemiological patterns, and issues of national politics and political windows of opportunity. Nevertheless, there is not enough information available to establish one of these factors as being more important than the others.

## Gauging the extent of the phenomenon

Gauging the nature and extent of drug-related public nuisance is a very difficult, not to say complicated, task. How do you assess the extent of public nuisance? Through opinion polls, victim surveys or ethnographic studies, for instance, which may bring information concerning feelings and representations, or through statistics, if any, on situations covered by the definition above, but knowing, conversely, that the objective existence of problems does not necessarily result in proportional feelings of insecurity? Both types of data should be combined to get a better picture of the subject.

### Drug-related crime statistics

Even within the wider definition of public nuisance, reliable information and data in the form of statistics and indicators do not seem to exist (national reports). The first and most obvious reason for this is the lack of a generally accepted definition of public nuisance in most countries. When data are available, and this is not the case for every country, they are generally statistics on drug-related crimes, which grasp only part of the phenomenon. The various types of nuisance are not generally included in descriptions of criminal acts and are rarely the subject of formal complaints to the authorities (French national report). For example, the police can record that an offender is intoxicated, but drug intoxication is more difficult to detect than alcohol intoxication. Furthermore, experience of public nuisance is often a regional or local one, with some areas and suburbs, generally poor and deprived, massively exposed to the phenomenon and others much more protected from it. This experience is also reflected in the willingness of local residents of such areas to cooperate with law enforcement responses. A local survey conducted in an area of Dublin with a severe drug problem found that the most common reason why people would not report drug-related crimes to the police was the fear of reprisal from those locally involved in drug-related crime (Connolly, 2003, cited in the Irish national report). Similar fears were not expressed in national crime surveys in response to the same question.

([3]) This is not because the feeling of insecurity, for instance, is not strictly proportional to the objective reality of crime. They are, so to speak, loosely coupled.

### Opinion polls, victim surveys and other quantitative instruments

Member States also report using opinion polls, victim surveys and other quantitative instruments, including short and focused questionnaires as well as qualitative methodologies, originating from social science disciplines such as sociology and ethnography, as tools for assessing the existence, nature and diffusion of such feelings among the community. Some countries have a strong tradition of gauging the extent and nature of the phenomenon, generally linked to a well-established policy and being the result of endeavours to define precisely what the concept should cover. For instance, since 1996 repeated surveys have been carried out to assess trends in drug-related nuisance in Dutch cities (Dutch national report). This is also the case in Ireland, where, since the onset of Ireland's serious drug problem in the late 1970s, a number of local studies have sought to highlight the impact of drug markets and associated drug-related crime.

In that context, it is worth quoting the study by Fahey (1999) which used a variety of research techniques to assess the living conditions in seven local authority housing estates in Ireland. Data were gathered primarily using ethnographic methods such as interaction in the everyday life of residents of the estates, participant observation and in-depth interviewing. Problems of social disorder were found to be central factors affecting the quality of life of the residents of all the housing estates studied. The authors concluded: 'Social disorder has the greatest impact on residents' quality of life, through direct experience of antisocial behaviour, a general loss of communal space and a sense of personal safety, and negative labelling of estates in the wider community' (Fahey, 1999). In Finland, according to a 2003 population survey, some 40 % of the population reported being scared of assault by someone involved with drug use. According to population studies, the proportion of those who deemed drugs an important problem in their own neighbourhood grew strongly between 1998 and 2002. The share of those who have actually experienced problems was approximately 11 % in the 2002 study. The percentage is typically much higher in cities than it is in rural areas.

In Verona, Italy, a non-governmental organisation (Il Corallo) has developed a project called 'Itineraries of social safety' (Itinerari di Sicurezza Sociale), which has been specifically concerned with identifying security and public nuisance problems associated with drug dependence and seeking resolution of the identified problems. As one phase of the project, a survey has been undertaken involving interviews with traders and the general population and travelling with outreach workers and interviews with privileged observers. In total some 1 000 interviews were conducted, around 75 % with traders and 25 % with the general population. In terms of the problems seen as being associated with drug misuse, discarded syringes and drug dealing are direct consequences. A French study in the 18th *arrondissement* of Paris came to similar conclusions: in this district, 87 % of residents had noticed drug users and 73 % cited these users as a general nuisance. Incidents considered to be the main nuisances were, first, drug use in public (94.5 %), then abandonment of syringes (94 %), and finally the presence of drug users in the entrances of apartment blocks (93.3 %).

### Eurobarometer opinion surveys

The feelings of insecurity experienced by EU citizens and their perception of drug-related problems (and perceived availability of drugs) at the neighbourhood level have been measured in the Eurobarometer opinion surveys since 1996. The report *Public safety, exposure to drug-related problems and crime* (EORG, 2003) highlighted the fact that, across the EU-15, the proportion of those feeling 'very unsafe' in the streets rose to 12 % in 2002, compared with 10 % in 2000 and 8 % in 1996. Overall, in the EU-15, when combining the results from respondents choosing the 'often' and the 'from time to time' options for exposure to drug-related problems, we can see a steady growth in exposure from 14 % in 1996 to 17 % in 2000 and to 19 % in 2002. It also appears that the majority of young people tend to agree that it is easy to get drugs. Indeed, according to the special standard Eurobarometer ([4]), the perceived availability of drugs among young people appears to have increased slightly between 2002 and 2004. An analysis of the survey results shows that 62 % (2002) and 63 % (2004) of respondents tend to agree that it is easy to procure drugs near where they live. Similarly, 55 % (2002) and 57 % (2004) of respondents consider that it is easy to get drugs in or near school or college. While bearing in mind that these Eurobarometer surveys reflect only opinions (perceptions) and not the real situation, they indirectly reveal the pressure of the drug scene on this target group.

### Drug-related public nuisance in the context of street crime, delinquency, and fear of crime

In all these studies and surveys it is clear that street crime and delinquency and fear of crime and delinquent behaviours are major concerns, even if the fear of crime is disproportionate to the actual risk ([5]). However, it is not

([4]) Flash EB 158, *Young people and drugs* (19.4.2004–13.5.2004).

([5]) Review of scientifically evaluated good practices for reducing feeling of insecurity in Member States, Building Research Establishment Ltd, 2005, for the European Commission.

always easy to separate clearly in representations and feelings of insecurity those that are linked primarily with crime and delinquency in general from those that are linked directly to drugs and drug-related activities. This is confirmed by a study carried out in Belgium by Decorte et al. (2004), who studied the impact of a quite exhaustive list of phenomena identified as public nuisance over a period of 12 months ([6]). This research showed that drug-related nuisance does not appear to be a separate phenomenon but exists in a context of general nuisance such as urban degeneration and vandalism. Information on crime or perceived risk of crime and delinquency often do not isolate the role of drug use in the perceived threats. For example, in Finland victim surveys are used to garner information about the prevalence of violence and the fears of violence among the population but with no reference to the role of drug use in the violence experienced or feared. All these should be considered as constraints that further complicate a precise assessment of the drug public nuisance situation.

**Main reported causes of drug-related public nuisance**

According to research on these issues and the information found in national reports from Member States, three types of populations, which often overlap each other, are often identified as the main producers of public nuisance: (a) polydrug users, regularly consuming alcoholic beverages; (b) problematic users, in particular public injectors; (c) users with comorbidities (reported by Sweden).

Similarly, two different settings are reported as the main generators of drug-related public nuisance. First, open drug scenes, such as occur in France, where it was found that nuisances perceived by residents were closely linked to the visibility of 'open scenes'. In Germany, too, problems related to public nuisance are to be found in the surroundings of open drug scenes. There are only a few German cities with a large open drug scene causing problems for residents living nearby. In Berlin, it is assumed that there are several small meeting points scattered over the city and frequented by a maximum of 40 drug users each. The total number of drug users frequenting these locations is estimated to be below 800 persons. Drug trafficking, too, is limited to a few 'hot zones', so that general nuisance for the population is assumed to be quite low and locally restricted. There are relatively large open drug scenes in Hamburg and Frankfurt. In Luxembourg, too, drug-related nuisance is most felt in surroundings where drug use and trafficking occur simultaneously, such as the central railway station or isolated lots near the dealers' scenes. In Sweden, drug-related public nuisance is mostly restricted to Stockholm and its downtown drug scene.

The importance of the open drug scene as a major generator of public nuisance can also be inferred from the cases of countries where drug-related public nuisance concerns have been limited because of the very secretive nature of the drug market. In Finland, the situation is reported to be not as severe as it can be in other countries, and this is thought to be a direct consequence of the characteristics of the Finnish drug market, which is said to be of a secretive nature. In comparison with other countries, a particular feature of the Finnish drug market is that there are no open drug parks or market places and selling drugs on the street is fairly uncommon. The drug market is hidden in private residences.

Drug treatment centres and low-threshold interventions have also been presented in national reports as being — or at least perceived as being — sources of drug-related public nuisance, which threaten the quality and peaceful enjoyment of life in a district and which have thereby triggered off public demonstrations, hostile attitudes by citizens, and, in certain cases, reaction from ad hoc community-based groups (in English, the NIMBY syndrome: 'not in my back yard'). Some examples of this syndrome are reported in France, while in Cyprus many centres report such an initial reaction. In Germany, there are low-threshold facilities where occupants of adjacent buildings, shopkeepers and passers-by feel that their security and quality of life is threatened. Similar difficulties arise particularly when low-threshold services for drug users are being newly set up. The German national report also refers to this as an unsolved problem in the case of drug consumption rooms, especially if the facilities are located in residential areas. The situation has been particularly complicated in Greece, where since 2002 organised public reaction (including sit-ins and demonstrations) against the launching of a Kethea treatment unit in Evros in northern Greece has had such an effect that, at the time of writing, the unit has not been able to open. Reaction against hosting substitution programmes in hospitals is also a problem throughout Greece.

This tendency to identify drug treatment centres and low-threshold interventions as drug public nuisance generators also exists in Norway, where in view of the then rapidly increasing number of HIV-positive drug addicts, the executive committee of Oslo city council decided in 1989

([6]) Traffic noise, animal droppings, theft of or from or vandalism of vehicles, refuse on the street, illegal dumping, aggressive conduct in traffic, traffic accidents, exhaust fumes from street traffic, vandalism of and graffiti on public property and private residences, dilapidation of buildings, odour from street litter and rubbish bins, urinating in public, noise at night caused by people on the streets, noise caused by pets or domestic animals, noise caused by children playing outside, noise caused by television or music from the neighbours, noise caused by neighbours quarrelling, noise caused by bars and discotheques, burglary, robbery and aggressive theft, brawls on the street, bag snatchers and pickpockets, street prostitution.

to establish a needle bus, which would distribute clean needles and provide information about how to prevent the transmission of HIV. However, drug addicts soon began to congregate in large numbers around the needle bus, many of them injecting their drugs in the surrounding area. This led to protests from local residents and the bus had to be moved regularly. The bus was eventually closed down in 2003 and needles are now distributed from a fixed location in Oslo city centre in connection with a low-threshold health station.

Finally, as stressed in the Luxembourg national report, the implementation of new infrastructures such as drop-in centres, consumption rooms or night shelters for drug addicts is often perceived as contributing to the causes of public nuisance, as they are said to attract problematic drug users and thus degrade the quality of life in the local area. However, as we will see below, it is ironic that these facilities may be established specifically, in certain countries, to counter issues of public nuisance — and with some success.

Thus, though the definition of drug-related public nuisance remains elusive, a greater understanding of the issue shows that it has slowly but surely been building up over the last 30 years at different rates in different countries. Nevertheless, improved identification of the problem may well be a factor in the growing number of reports of such nuisance as it grows in the public consciousness. However, with such a variety of methods of measurement, it is difficult to say objectively how much the phenomenon has actually increased — and this will influence the issue of how to define the effectiveness of the responses to it, which we shall now go on to examine.

## Policy and measures

### From public order to public nuisance

We have already seen that countries do not share a common definition of drug-related public nuisance, which makes the task of comparison between countries and attempts to group them somewhat challenging. Nevertheless, to help us understand the phenomenon, we have identified a rudimentary/preliminary typology, which divides the countries into two main groups: countries with an integrated and coordinated policy dedicated to drug-related public nuisance and countries without drug-related public nuisance as a central objective.

#### Countries with a policy dedicated to drug-related public nuisance

The first group of countries set reduction in drug-related public nuisance as a key objective of their drug policy as a whole and thus implement a more or less integrated and coordinated policy dedicated to drug-related public nuisance ([7]). They report a clear reference to the concept in official documents (laws, national drug strategy), in some cases accompanied by a precise definition. In this first cluster, we see Belgium, Ireland, Luxembourg, the Netherlands and the United Kingdom ([8]).

In Belgium, drug-related public nuisance first appeared in 2000 in the federal security and detention plan — as a result of its attracting a lot of attention in local police security plans — and, more specifically, in the federal drug policy note in 2001, where an important objective is the 'reduction in the negative consequences of the drug issue on society (including public nuisance)'. The new drug law passed in 2003 also contained references to public nuisance, whereby it is considered to be a matter of aggravating circumstances: existence of nuisance influences the reaction of the public prosecutor on all drug-related infractions and always aggravates the punishments. As such, public nuisance has become a key concept of Belgium's drug policy.

As part of a wide-ranging legislative response to the drug crisis in Ireland, specific measures were included in the Housing (Miscellaneous Provisions) Act 1997 to, *inter alia*, facilitate the exchange of information between Dublin Corporation and the police in relation to antisocial behaviour. This act provides for a range of measures giving local authorities the powers to deal with problems arising on housing estates, from antisocial behaviour, namely drug dealing, to violence and intimidation.

The Netherlands also implements an integrated policy against public nuisance, whereby health-related interventions, public order enforcement and supply reduction measures are addressed together, associating all actors involved at a local level in drug policy-making. In 1995, the national government launched a policy for making the cities vital, safe and habitable: the large cities policy (*grotestedenbeleid*). Large city problems called for a joint effort from public and private partners. By mid-2004, the national government had entered into covenants with 30 medium-sized and large cities. Participating cities are urged to adopt an approach that is result oriented (agreeing on concrete targets in advance and collecting data to realise these) and integrated (gearing activities of local municipalities and sector-oriented

([7]) In the rest of the text, we will distinguish between a drug-specific public nuisance policy and a broader public order policy, not specific to drugs.

([8]) Subgroups may be identified within this first cluster. Some argue, for instance, that the philosophy and the principles behind the drug-related public nuisance policies of the UK and the Netherlands are quite different. However, there was not enough information of that kind in national reports for us to be able to elucidate such clusters.

institutions towards one another). The national government has responsibility for formulating and monitoring policy lines and providing additional funds. During the first phase of the large cities policy (1994–98), the nuisance reduction steering committee (SVO) worked with municipalities in pushing back drug-related public nuisance. To improve coherence in the policy against (drug) nuisance and related problems, priority is given to an integrated or chain approach, in which prevention, repression and assistance are geared to supplement one another. This means that, in practice, the various actors, such as outpatient addiction care, social relief services, community health services (GGD) and the police and judiciary, have to work together.

The United Kingdom has also adopted this kind of integrated approach to the problem, based on the principle that, as the problem of nuisance includes so many different types of behaviours, the range of responses should be equally broad. UK policy therefore seeks to help persons who cause street problems and community disorder through their drug use by directing them into treatment and to safer methods of using while they regain control. Tackling public nuisance involves an integrated approach involving drug specialists and police working in partnership. Building 'bottom-up' community responses to drugs is a major strand in drug policy. As such, local drug and alcohol action teams (DAATs), working with crime reduction partnerships, seek to provide a balance between treatment and enforcement. As part of this, 'Communities against drugs' (CAD; 2001–03) enabled many community groups and organisations to engage in developing innovative responses to their local problems. The Home Office has published a number of guidance manuals for local partnerships that manage such problems (°), all recommending an approach comprising a mixture of enforcement, treatment and support.

Finally, we can include Luxembourg in this first cluster, since the new Luxembourg drug strategy (2005–09) introduces interesting elements in connection with the concept of public nuisance. The reduction of drug-related public nuisance, together with the reduction of risks and harm, is considered to be complementary, addressing, as in the other countries mentioned above, activities not only in the field of demand reduction (as in the previous drug strategy, 2000–04) but also in that of supply reduction.

The fact that drug-related public nuisance is often considered to be a local community problem seems to be recognised by the above strategies, all of which provide responses that are steered to a large extent by local community groups.

**Countries without drug-related public nuisance as a central policy objective**

The majority of countries do not report public nuisance (labelled as such) as being a central, or even a key objective of their national drug strategy. Rather, these countries address most of the acts and situations that have been described here as public nuisance within a broader safety and public order policy, even though they may also have developed ad hoc targeted interventions to cope with some of the drug-related public nuisance problems.

It is true that in many countries, for instance Cyprus, the national drug strategy may be seen to implicitly recognise the potential for public nuisance due to drug use and drug-related activities and to underline the need for action and interventions to cope with it. Yet, in most of those countries, the debate on the problems listed above has rarely been focused on any *systematic* way of resolving those issues; most of the time, a case-by-case approach is preferred. In other words, in this group of countries, there does not seem to be a single, consistent attitude within a country towards the problem of public nuisance.

In countries such as Hungary, there is no specific policy or legislation against drug-related public nuisance, and no separate legal category has been created for the classification of drug-related offences against public order, outside the scope of drug-related crime (excluding the offence of misuse of narcotic drugs). Legal responses are to be sporadically found among the criminal and administrative rules of law, penal rules of misdemeanour and internal regulations of the authorities.

The problems and issues that are labelled as drug-related public nuisance include variously: problems falling within the remit of the safety policy and the drug policy as a whole (Czech Republic); problems being close to 'disturbance of the public order' (Germany); problems being linked to a broad concept of public safety and security, which covers a range of community issues (Italy); or within 'public order disturbance' or 'juvenile criminality' categories (Slovenia) — to give just a few examples.

This group includes rather heterogeneous forms of policy reactions to drug-related public nuisance, and it may be worth dividing it into two subgroups. The first one would include countries such as Germany, France and Greece that have developed ad hoc interventions (as opposed to a full policy) with explicit reference to targeting a reduction in drug-related public nuisance. The second subgroup would comprise countries, including the majority of new Member States, which address most types of public nuisance with existing non-specific interventions and laws, with no reference to the concept at all (for some countries

(°) The crime reduction toolkit is available online (http://www.crimereduction.gov.uk/toolkits/as03.htm).

the concept of drug-related public nuisance does not even seem to exist).

## Responses and interventions

Surveying the most commonly reported responses and interventions implemented against public nuisance problems, it will be seen that some of them are targeted primarily at tackling the issue and some others have many objectives, among which the reduction in public nuisance could be just one, and not necessarily an explicit one. They may include different types of legislation, security policy and supply reduction activities, and harm reduction interventions.

### Legislation

Three main types of legislation may be distinguished: (a) general legislation concerning public order and public nuisance that does not target drug-specific public nuisance; (b) legislation that focuses on drug-specific public nuisance; (c) drug laws regulating use, possession, transportation, selling, etc. that are considered in certain countries to be a key instrument in combating drug-related public nuisance.

#### *General legislation concerning public order and public nuisance*

General public order legislation, which covers, more or less systematically, some of the behaviours that have been identified as public nuisance, is the key approach to drug-related public nuisance taken by many countries. In Cyprus, behaviours usually identified as causes of public nuisance are addressed by various laws and regulations, such the one considering the use of violence and intimidation. The general 1994 Law Concerning Violence in the Family and Protection of Victims 47(1) covers the abuse and neglect of children of drug users. There is no particular law addressing drug-related recruitment into crime, but Article 20 of the Penal Code stipulates that persons are held responsible for any assistance offered to any criminal activity. There is no legal provision regarding the annexation of public space by drug users, but the formation of illegal meetings, rioting, public disturbance and disturbance of the peace constitute offences. Intrusive verbal contact is considered an offence in the case of defamatory use of insults, irrespective of whether or not the perpetrator is a drug user, according to the penal code, provided the committing of a criminal offence is intentional. Thus non-drug-specific regulations can cover public nuisance problems, or at least some of them, empowering public authorities to act and respond. Other countries taking a public order approach to combating public nuisance include Denmark and Hungary.

Regulations adopted by authorities at the level of municipalities or regions should also be considered, in addition to the national legislation, as being of key importance in the fight against drug-related public nuisance, but they are outside the scope of this short overview. They should not, however, be omitted by those who want to get a more comprehensive and precise picture of the legal responses to the phenomenon. Indeed, with nuisance often being felt on a local level, it may well be addressed by local legislation.

#### *Legislation that focuses on drug-specific public nuisance*

Some countries have passed legislation against drug-specific public nuisance or, at least, against some categories of drug-related public nuisance. In the United Kingdom, the Anti-Social Behaviour Act 2003 tackles a problem that has emerged over the past few years: properties used for the sale and use of crack cocaine and other Class A drugs, which are associated with serious nuisance. The act is part of both (a) the national strategy on antisocial behaviour, which extends more widely than drug-related behaviour, and (b) the national crack cocaine strategy, a subset of the national drugs strategy. The act makes an explicit link, for the first time, between penalties and powers to control drug-related behaviour resulting in nuisance. Previously, the only punishable act was that of possessing or supplying (or producing or trafficking) the drug itself. The new act criminalises the subsequent nuisance arising from such offences. Its powers are targeted against properties as well as people, as the act enables the closure of premises used in connection with the production, supply or use of Class A drugs and which are associated with disorder or serious nuisance. The act also contains other powers against nuisance, none of which are defined as drug-related, even though they may be caused by drug use.

Spain's Constitutional Act 1/1992 of 21 February on the Protection of Public Safety does not mention the term 'drug-related public nuisance' as such but may be said to target some of the behaviours and situations identified as public nuisance. It provides for: (1) the prohibition of the illegal use and traffic of narcotics and psychotropic substances in public premises or establishments, or of failure to apply due diligence in preventing such use and traffic, referring to the owners or managers of such establishments; and (2) the classification of the following behaviour as serious infringements of public safety: (a) use of narcotics and psychotropic substances in public places, thoroughfares, establishments or transportation; (b) the illegal possession of such substances, provided that they are not intended for traffic (in which case, this behaviour would be a criminal offence); and (c) littering such places with paraphernalia or instruments used to administer drugs.

Anti-rave party legislation can also be considered as legislation against drug-specific public nuisance. In France, after action was taken by some prefects and mayors against events that were part of the techno movement, especially large 'teknivals' involving more than 20 000 people, an amendment to the law on security to regulate these gatherings was adopted in autumn 2001. Article 53 of the Law on Everyday Security (LSQ) ([10]) therefore gives a legal framework for the gatherings currently known as 'rave parties'. The same law on everyday security prohibits occupation of common areas in residential buildings (Article 52 amending Article 126-1 and 126-2 of the Building and Housing Code).

### *Drug laws*

Finally, there are countries where the primary drug control laws that regulate use, possession, dealing, transportation, etc. are considered to be key resources in the fight against drug-related public nuisance. For Norway, the most important provision is the one making any association with substances classified by international conventions as narcotic or psychotropic a criminal offence — including use and possession for personal use. Although this provision permits arrest and criminal prosecution of drug users, in practice it is implemented with some restraint. This criminalising of drug use is reported to facilitate surveillance and undercover work by the police in areas and public premises where they suspect that drugs are being used. In Sweden, too, it is considered that as use of drugs is criminalised, an investigation regarding violation of the penal law on narcotics can take place when a drug abuser is seized, even if he or she fulfils the necessary conditions for public nuisance defined in LOB, the law normally used to counter public nuisance.

## Security policy and supply reduction activities

Security policy and supply reduction activities are considered to be key elements of the reduction in public nuisance in many countries that report no legislation or measures specifically addressing the phenomenon of public nuisance linked to drug use and drug-related activities.

### *A decisive role for police forces at local level*

Police forces, with both national and local remits, and law enforcement agencies are key actors. In Cyprus, the overall management of and responsibility for combating drugs and drug-related issues such as public nuisance rests with the courts and police, and specifically the drugs law enforcement unit (DLEU). In Finland, according to the police anti-drug strategy (2002), local police must organise sufficient and efficient street supervision in order to prevent the sale and use of drugs, to obstruct the propagation of the drug culture and to reduce the recruitment of new users. It has been deemed important that local drug distribution channels must be disrupted and that encounters between dealers and users are made more difficult. In Germany, mayors, authorities and city councils are all involved. In Ireland, the Dublin North Inner City Community Policing Forum is a good example, as it shows that the forum had an encouraging effect on the willingness of the local communities to cooperate with public authorities in order to reduce drug-related incidents.

However, in practice, the police mainly assume the role of an executive organ. In Greece, the anti-drug subdivision of Attica (Attica Police Directorate) aims at reducing criminality, drug trafficking and drug use in public places. This service, which is part of the legal framework for the establishment of the anti-drug subdivision of the Hellenic police, has been further strengthened since September 2003 by means of a greater number of police officers and resources (cars, radios, computers and a telephone hotline number (109) for public reporting of drug-related crimes), in response to an increase in the number of users gathering in the open drug scenes in the centre of Athens. The work of the service, based on the zero tolerance concept, involves the following: (a) road checks on the open drug scenes in the centre of Athens, outside the premises of OKANA low-threshold services and the emergency pharmacies in the area, as well as road checks across the wider area of Attica; (b) arresting drug users and dealers; (c) taking dealers into custody; and (d) keeping suspects under surveillance following public complaints against them through the telephone hotline. The target group of this particular action was said to be traffickers of small drug quantities.

Many countries draw attention to local innovations and initiatives in their national reports. In both Greece and Cyprus, the concept of the neighbourhood police officer has been adopted as an important measure in the abatement of public nuisance.

In the United Kingdom, where a specific policy has been established to combat drug-related nuisance, a new police plan defines the way in which police forces should take account of this issue. Police forces are required to meet certain key objectives: to reduce crime, but also to tackle criminality, and to reduce antisocial behaviour and the fear of crime. In response to antisocial behaviour and disorder, chief constables and police authorities are expected to include in their local plans a strategy for tackling youth nuisance and antisocial behaviour.
To implement this, forces should work closely with crime and disorder reduction partnerships and make the best use of all the tools available to them, including antisocial behaviour orders (ASBOs), antisocial behaviour contracts,

([10]) Law No 2001-1062 of 15 November 2001/NOR: INTX0100032L.

fixed-penalty notices, the power to seize vehicles being used in a manner causing alarm, and the power to take action against badly run pubs and clubs.

In Italy, the approach to the issue is not drug-specific and is deemed to be broader, as can be illustrated by its focusing more on public safety than on local security. The concept of public safety began in relation to criminal behaviour and both actual crime and fear of crime. As such, the starting point was the rule of law and ensuring that the rule of law was more effectively enforced. The concept of urban security was extended to include a much wider range of activities than traditional law enforcement tasks and included programmes and projects aimed at reducing, and where possible preventing, criminality and behaviours causing social alarm. The genesis of the present approach to public safety, including security issues, has thus come from the need to ensure the proper upkeep of public facilities and improvement of the physical and social environment and the safety and security of the general public, as well as crime prevention and detection. The measures taken in Italy are extensive, although relatively few are specifically focused on drug-related issues. Instead they are focused on ways of improving local situations as a means of preventing future harm, rather than on a specific issue that might represent one part of a larger problem. In Italy, in every region and in most communes there are specific projects concerned with public security and safety.

### *Elimination of open drug scenes: a key target*

The elimination of open drug scenes appears to receive a lot of attention from Member States. This should be understood to be a consequence of open drug scenes being seen to be major contributors to public nuisance in general (see the first part of this special issue, 'Definition, genesis and extent of the phenomenon'). In Germany, open drug scenes are not tolerated and are prevented as far as possible by increased police presence and regular controls as well as through offering shelter and alternative meeting places as part of harm reduction interventions (see next section). This is notable in the state of Bavaria but also in the cities of Hamburg and Frankfurt, where relatively large drug scenes have shrunk significantly in recent years as a result of various measures, including a high control density. In Denmark, the normalisation of the area in Copenhagen known as Christiania (an autonomous community), where overt cannabis trading has been going on for a number of years, has been considered a key target by the government. Among the implications of normalising the area would be the stopping of overt cannabis trafficking. Denmark has also recently adopted legislation against 'cannabis clubs' (defined as a room from which cannabis is sold and/or in which cannabis is smoked), which allows the police, after advance warning, to issue a three-month injunction against the owner of such premises, prohibiting visitors from arriving or staying there.

### Harm reduction interventions

In addition to the various legislations and security and supply reduction policies, another reported response to public nuisance is in the form of harm reduction interventions. Harm reduction centres and low-impact interventions often receive considerable resistance from local communities, as they are perceived to be attracting problematic drug users. However, many countries report that this initial resistance to the establishment of such centres is often followed by a normalisation in the relationships between the community and the professionals involved. The reason for this change in attitude may be linked to the fact that such interventions contribute to the reduction of public nuisance in the area in which they are located. Treatment, harm reduction interventions and outreach work are often presented as effective responses to drug public nuisance and considered as a necessary accompaniment to law enforcement and supply reduction policies in many countries. This conclusion was underlined clearly by the forum on criminal justice of the Pompidou Group, which argued that the proactive offer of treatment and harm reduction measures is essential to complement actions against street level supply of illicit drugs.

In Hungary, harm reduction programmes are also considered to be responses to drug-related offences. In Luxembourg, drug-related harm reduction measures, which were implemented in response to a growing concern about the alarmingly poor health of problematic drug users and the spread of infectious diseases, have indirectly targeted the prevention of petty crime and other drug-related nuisance. The fact that in 2002 (Hungary) and 2003 (Luxembourg) those measures have been given a legal framework in these countries, and that other measures such as consumption rooms and heroin distribution programmes are retained as priorities by their governments, shows that health promotion and nuisance prevention/reduction continue to be strongly linked. In Austria, demand-oriented low-threshold measures are also considered to play an active role in preventing public nuisance.

### *Needle and syringe exchange programmes*

Exchange programmes are regularly quoted as one of the harm reduction measures that greatly contribute to the reduction of public nuisance, as discarded syringes found in parks and in children's playgrounds have attracted a lot of negative community and media attention. In that respect, many countries quote high return rates as an

indicator of effectiveness, for example in the Netherlands, or in Austria, which reached a return rate of 95 %, with the consequence that the number of syringes left lying about has decreased considerably.

***Consumption rooms***

Consumption rooms, similarly, are presented in some countries as having reduction in public nuisance either as a key objective, for example in Germany and the Netherlands or, by experts in Austria, as a possible outcome. In Norway, although reducing public nuisance is not the principal reason for deciding to establish an injection room, which opened in February 2005, the expected reduction in drug injection and discarding of needles in public places was listed among the desired outcomes of the intervention. Similarly, Luxembourg, where a consumption room was opened in July 2005, also cited the impact on public nuisance as one of the reasons for this type of intervention.

**Coordination, mediation, communication and information campaigns, and training**

National reports show that one of the key success factors for the smooth and effective establishment of any drug-specific interventions, and in particular harm reduction measures, in the community is consultation with and coordination between all actors involved in local drug policy, including community-based groups and individual citizens. In this respect, for the creation of new consumption rooms in Berlin, a cooperation agreement was reached, thus ensuring a regular exchange of information between the organisations running the facilities: police, judiciary and authorities. Such agreements are, in general, standard for drug consumption rooms. Collaboration between these authorities is legally mandatory under §10a BtMG. As part of this agreement, the responsible organisation must establish contact and communicate with the neighbourhood.

The same conclusions are reported in Luxembourg on the effectiveness of a night shelter opened in December 2003 in reducing public nuisance. For this shelter there had been (a) a consensual need analysis involving both service demanders and service providers; (b) early involvement of and constructive collaboration with local police and municipal authorities; and (c) early and reliable provision of information to local residents and the setting up of a nuisance reporting line. The subsequent success of the project is believed to be primarily the result of these factors among others ([11]); it is reported that after eight months of functioning, there were no major problems in terms of public nuisance and that, on the contrary, the night shelter contributed to reducing the incidence of people sleeping rough in the streets and squatting and late night disturbances caused by problem drug users.

This kind of consultation and coordination activity can also take a more institutionalised form, as for example in Greece, where the persons responsible for the street work programme contacted NGOs providing support to socially excluded groups (i.e. Kethea Multiple Intervention Centre, ACT UP, KEEL, ARSIS, Médecins Sans Frontières, Médecins du Monde) in order to create a network of services for dependent users. As such, networking and coordination activities between those at the political level and police and drug help centres are considered as a means, as in Austria, of avoiding controversy, and it means that issues are taken into the public sphere and addressed by competent institutions. This can contribute to the reduction of public nuisance to a certain extent.

Mediation is another term that describes similar processes and initiatives by which we can bridge the gaps between different institutions and the community. For instance, in Vienna, since 2003, monthly meetings of representatives of the police, Vienna's public transport system and social workers have been organised to develop a joint policy for coping with the drug scene and related problems. Since 1993, attempts have been made too by TEAM Focus to obtain a comprehensive, neutral overview of the background, causes and actors in conflict situations. In France, the 1999–2001 three-year 'Plan against drugs and for the prevention of dependencies' (MILDT, 1999, later extended to 2002) acknowledged that treatment and drop-in centres in areas where there are marginalised drug users 'are often not welcomed by local residents who are often poorly informed' and recommended the creation of mobile neighbourhood teams in the districts where there are most problems. Five teams have been created so far. Their objectives are first to improve the treatment of active, marginalised users and second to make the risk and harm reduction policies more acceptable to residents through information and dialogue.

Communication campaigns are also a key tool in improving the level of social acceptance of drug users by citizens, and thus in reducing their feelings of insecurity. In Austria, the authorities have put a lot of effort into having drug dependency defined as an illness rather than as a criminal act. This has led to a better understanding of addiction-related measures. Public relations work in Austria by drug aid institutions has raised public understanding of addiction patients and helped to create a general awareness that addiction has structural, social causes. It has thus contributed to overcoming fear, negative expectations and prejudice against drugs by

([11]) Another factor is seen as having contributed to the success of this night shelter, namely the involvement of clients in the nuisance prevention process.

means of specific educational campaigns. Similarly, in Greece, the concept of the so-called OKANA Campaign was that drug addicts should be regarded as patients who need treatment and support. The information and awareness-raising campaign of Kethea not only appeased reactionary voices but also shifted attitudes in favour of the programme and fostered better acceptance of drug users.

### Indicators and evaluation

#### Evaluation of a specific intervention

Comprehensive and overarching evaluations of an entire public nuisance policy or strategy, even in countries which have such a strategy, are quite rare. This is perhaps not surprising, given our opening assertion that the concept itself may be difficult to define and quantify. Instead, the culture of evaluation of a specific intervention predominates. In France, for instance, 'Coordination 18' was set up in 1999 with the objective of ensuring social mediation between the parties concerned with nuisance linked to drug addiction (drug users, local residents, traders, etc.) and the police. Between 2000 and 2001, one year after it was set up, the functioning and actions of this structure were evaluated. In Ireland, the Dublin North Inner City Community Policing Forum was evaluated positively (see last year's Irish national report). In Finland, too, a few specific studies have assessed the effectiveness of activities against drug-related disturbances. Police operations to prevent such disturbances in residential buildings have been evaluated in the Greater Helsinki area, and in Tampere cooperation between the police and social services in preventing the social exclusion of young drug users has been evaluated.

In Germany, a survey to evaluate the effects of a drug consumption room in Hamburg reported that during the opening hours of the facility, the number of drug users in the street was reduced by 47.5 % (Prinzleve and Martens, 2003 and 2004, cited in the German national report). A European study involving experts from Rotterdam, Innsbruck and Hamburg found that drug consumption rooms had positive effects on public nuisance, which were mainly attributed to a reduction in drug use taking place in public. However, in one case, police reported continual conflicts and complaints about a consumption room situated in the middle of a residential area.

#### Indicators

The indicators used to assess the level of success of the interventions to reduce public nuisance are those that also serve to assess the nature and extent of the phenomenon, namely indicators on drug-related crimes, together with opinion polls, victim surveys or ethnographic studies.

Austria reports that, in Vienna, the feeling of threat in connection with the open drug scene markedly declined between 1997 and 2001. As an indicator of social acceptance, only one fifth of the population of Vienna would feel very negative if a drug counselling centre were opened in their immediate vicinity. The Pompidou Group stresses that, ideally, the success of an intervention against public nuisance, and in particular in managing open drug scenes, should be assessed through a combination of indicators such as a reduction in the occurrence of public nuisance behaviours, satisfaction of the general public, and health and social gains (Burgess, 2004).

The Netherlands is one Member State that has launched quite broad evaluation programmes to assess the effectiveness of its actions against public nuisance. In that respect, it was found that, between 1996 and 2002, drug nuisance figures in the larger cities showed evidence of a downward trend. In the years 1998–2000, subjective inconvenience decreased, particularly in residential areas with the most severe (category I) level of nuisance. After 2000, however, the reduction did not continue. In residential areas with comparatively low drug-related nuisance, rates were stabilising or slightly increasing. Over the years 2002–04, the 2004 'police monitor Dutch population' ([12]) reports an almost constant drug nuisance rate of well over 6 % in residential areas. In 2004, compared with drug nuisance, slightly more respondents mentioned 'drunken people' as an important cause of nuisance, while 'nuisance by groups of youngsters' was on top of the list with 13 %.

Despite the above examples, evaluation of public nuisance policy or interventions appears to be underdeveloped. Nevertheless, in countries that deem public nuisance to be a key concern, the development of appropriate and specific indicators and improvement of other data collection instruments is essential if evaluation is to be achieved.

## Conclusions

#### Public nuisances, new phenomena?

Behaviours, situations and activities that are now usually categorised as drug-related public nuisance are not totally new entities. What may be new is the growing labelling of and concern over this issue in the public sphere and in the drug policy debate in certain European countries and at European or international levels. In those countries, drug-related public nuisance has become established as a key focus for national drug strategy, and the reduction in public nuisance has become one of the guiding principles for interventions.

([12]) www.politie.nl/Overige/Documentatie/politiemonitor_bevolking.asp

Is the relative success of this concept as a new drug policy category the consequence of a real increase in the extent of these phenomena in modern society in certain European countries? Or is this, conversely, the result of a growing feeling of intolerance towards drug users and drug-related activities in local communities, in particular in poor and deprived inner city areas? There is no evidence, or at least not enough in this chapter, for scientifically testing either of these two hypotheses, nor apparently is there in the national reports given to the EMCDDA. Far more research is needed to be able to give a more satisfactory answer.

The fact remains that, in Europe, a growing number of countries have decided to adopt the reduction in drug-related public nuisance as a central objective of their drug policy and developed overarching and multidisciplinary perspectives to address this issue, which may foster coordination and cooperation between institutions, agencies and stakeholders, including representatives of civil society. They have also designed a wide range of specific and targeted interventions to this end. In those countries, public nuisance policy should not be regarded as the sum of individual interventions of different natures, be they demand or supply reduction oriented, but as the result of a carefully thought through, coordinated and integrated approach that combines (or aims to combine) health, social, public security and environmental components.

However, most European countries have not adopted such categorisation, at least in their official drug policy documents and legislation, and have therefore not implemented any specific policy against drug-related public nuisance. Those countries appear to consider that the problems can be satisfactorily addressed within the framework of a broader safety and security policy, even though some of them have elaborated ad hoc responses to the phenomena as they arose, in particular in the field of health and social interventions.

How to explain this dichotomy? Some argue that the level of formalisation of the concept and the extent to which public nuisance has been defined as a central policy objective of a given drug policy and intervention, would be linked — though loosely — to the level of seniority of a drug policy, that is, the length of time a policy has been in place, and, in particular, to that of harm reduction. Even though this hypothesis has still to be proven by further research, we can see that the clustering of countries presented in this chapter is more or less consistent with this criterion.

We have also shown how miscellaneous and diverse are the interventions that can contribute to reducing public nuisance in the community. This diversity could be taken to be the result of a shapeless definition that may encompass, according to how this concept is interpreted, many drug-related activities, behaviours and situations. It could also be understood as the consequence of a tendency to present *any* intervention or regulation in the drug field as aimed at reducing public nuisance, among other things, particularly in the countries that have not developed a devoted policy. Thus, to avoid the risk of diluting this idea, some conceptual work would be desirable. Furthermore, initiatives to exchange experiences on good practice in this policy field, such as those of the representatives to the Pompidou Group and those within the framework of the European Union crime prevention network (EUCPN), could be further developed.

### Ethical issues

Implementation of public nuisance policies raises ethical issues. In some national reports and in the dedicated literature, the need to find a proper balance between the rights to safety and the enjoyment of a peaceful life and respect for human rights is underlined. An example of this kind of normative debate comes from a study commissioned by the authorities in Dublin focusing on those who were evicted from Dublin Corporation housing units in 1997 and 1998 for antisocial behaviour using two particular legal provisions. The report expressed concern that the application of the legislation was an 'overly "blunt instrument" which serves to penalise innocent parties (adult family members who are not engaged in antisocial behaviour and/or children) as well as targeting the identified culprit/offender' (Irish national report). This justifies the importance of developing evaluation studies that can reveal both positive achievements and unexpected side-effects of those interventions.

If we sum up some of the considerations we have just reviewed above, it could be said that the design and implementation of drug-related public nuisance policies involves striking at least two different kinds of balance: (i) law enforcement must be balanced against health and social interventions; (ii) rights to security must be balanced against other human rights, perhaps seen as balancing community rights and individual rights.

### Public nuisance policy concerns in a wider context

Finally, in some respects, the growing concern over drug-related public nuisance can be seen in the context of a shift in the emphasis of drug control policies away from simply reducing the use of drugs to targeting drug-related behaviours that have a negative impact on the community as a whole. In this context, as well as an increase in

concern over problems of public nuisance, there is a growing interest in addressing the issue of drugs and driving and increasing emphasis on the issue of drugs in the workplace, including consideration of extended drug testing in some areas. Yet at the same time, in some EU countries in the last five years or so, there has been a tendency to de-emphasise criminal punishment of the individual drug user, acknowledging that severe sanctions, such as imprisonment, may be counterproductive or simply unjustified for minor drug offences and especially for possession for personal use. In some respects, at least in the EU-15 Member States, it is almost as if criminal sanctions have been reduced (particularly imprisonment) for the individual user in a private setting but increased for the behaviours and situations that are public or that may affect community or society as a whole (EMCDDA, 2005). However, there is little evidence to establish that the two trends are related to each other.

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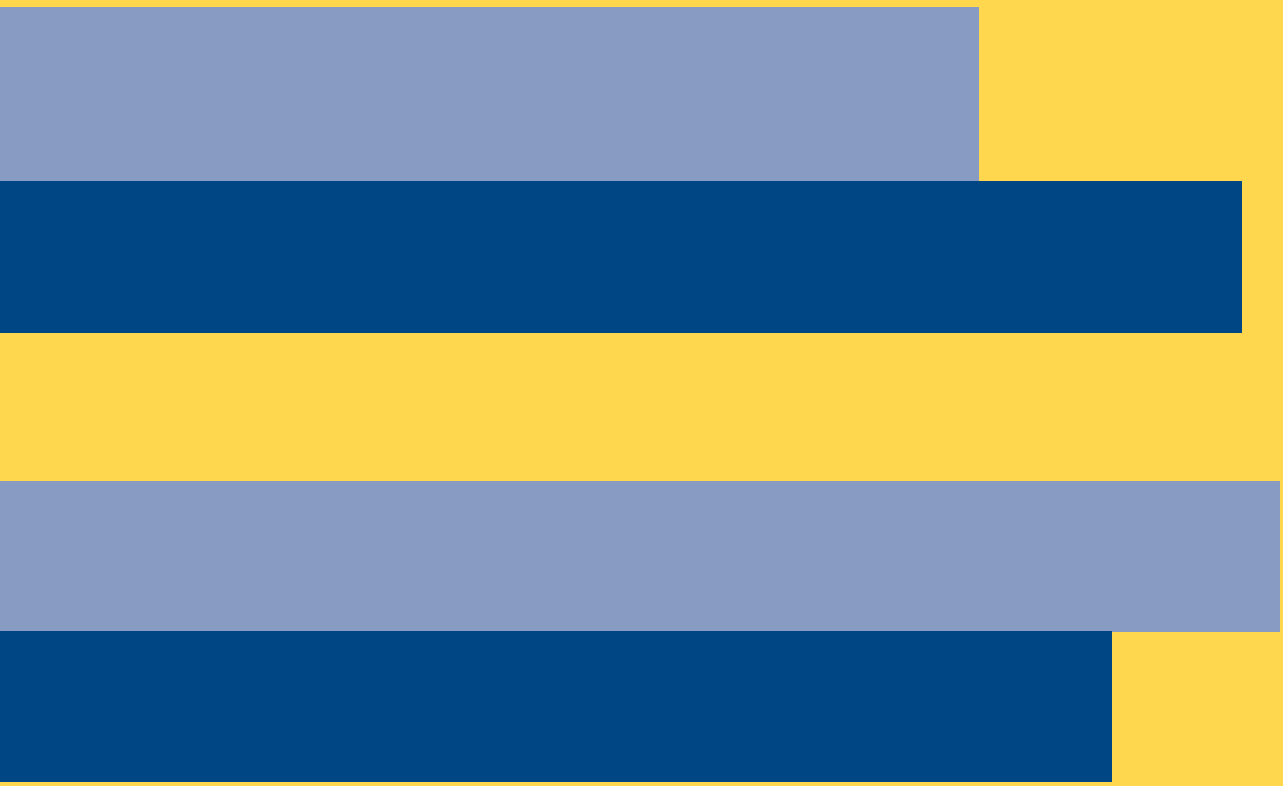


Selected issue 2

# Alternatives to imprisonment — targeting offending problem drug users in the EU

## Introduction

The alternatives to prison that may be offered to drug-using offenders cover a range of sanctions that may delay, avoid, replace or complement prison sentences for those drug users who have committed an offence normally sanctioned with imprisonment under national law. In this chapter, the focus will be on those measures that have a drug-related treatment component. It will describe the political and legal background, the application and implementation, including common problems, and the effects of treatment as an alternative to imprisonment.

Alternatives to imprisonment can be related to the aim of 'rehabilitative justice', that is, a focus on rehabilitation for the long-term benefit of both offenders and the community. Like the eighteenth-century change from physical punishment to moral rehabilitation, rehabilitative justice can be seen as an extension of longstanding attempts to increase the efficiency of sentencing (see, for example, Foucault, 1975). Mediation, community work and administrative and monetary sanctions are some examples of injunctions that are used as alternatives to imprisonment or, more generally, alternatives to punishment. A review of international research conducted between 1982 and 2002 revealed widespread support for restorative sentencing options, particularly for young offenders (Roberts and Stalans, 2004).

Alternatives to imprisonment cannot be viewed separately from the marked increase in drug-related crime, a phenomenon that has been ongoing since the 1960s, and developments in criminal legislation in the EU countries (see *Annual report 2005: the state of the drugs problem in Europe,* Chapter 7 and www.emcdda.eu.int).

For offenders in the EU, the most severe consequence of crime is imprisonment. However, prison is a particularly detrimental environment for problem drug users (EMCDDA, 2003). Prisons are overcrowded in many countries, and economic reasons for promoting alternatives to prison should not be underestimated because they are generally less expensive than incarceration.

As an alternative to prison, drug-related treatment that is linked to the penalty has been progressively introduced over recent decades for problem drug users. This development is consistent with the evolution of more humanitarian paradigms in legislation and criminal justice systems as well as with more advanced psychosocial and medical models of addiction. In the EU today, problem drug users are increasingly considered as having a medical and psychosocial disorder and not merely as criminals. At the same time, it has been shown scientifically that drug-related treatment can be effective in breaking the vicious and costly circle of crime and drug use.

## Policy and legal developments

### International developments

The UN Single Convention on Narcotic Drugs of 1961, signed and ratified by the countries of the EU, was the first international document endorsing the principle of providing measures of treatment, education, aftercare, rehabilitation and social reintegration as an alternative to, or in addition to, conviction or punishment (Article 36 (b)) for drug-related offences. In the intervening 40 years, the principle has been reaffirmed and strengthened several times by UN and EU agreements, strategies and action plans and by interpretation of the UN conventions as proposed by the International Narcotic Control Board (INCB) ([1]).

In its 2004 report, the INCB, which is the control organ for the implementation of UN drug conventions, favoured treatment as an alternative to prison:

> 'Drug prevention efforts, coupled with accessible treatment programmes offering psychosocial support and pharmacological therapy, supported by local law enforcement efforts that target the drug trafficking activities of addicts, may have a synergistic effect: reducing both the supply of and the demand for illicit drugs. Programmes that offer alternatives to prison and combine both law enforcement and individual recovery components have proved to be effective both in treating health conditions associated with drug abuse and in reducing crime; they may also prevent young drug

([1]) UN comprehensive multidisciplinary outline (1987); UN Convention Against Drug Trafficking (1988); UNGASS declaration on the guiding principles of drug demand reduction (1998); UNGASS action plan (1999); EU drugs strategy (2000–04); EU action plan on drugs (2000–04); United Nations General Assembly's special session 8–10 June 1988: *Political declaration guiding principles of drug demand reduction and measures to enhance international cooperation to counter the world drug problem*; and INCB, *Annual report 1996,* Chapter 1: Drug abuse and the criminal justice system, paragraph D. Effective use of criminal justice systems, sub-para 23 and 26 (at http://www.incb.org/incb/en/index.htm).

abusers from coming into contact with the criminal culture in prison. Consequently, demand reduction activities such as treatment alternatives that provide choices for drug abusers outside drug distribution networks may affect drug trafficking organizations and reduce their ability to supply illicit drugs.'
(United Nations, 2005)

The EU action plan on drugs 2000–04 (Council of the European Union, 2000) proposed that Member States set up concrete mechanisms to provide alternatives to prison, especially for young drug offenders. The subsequent evaluation of the action plan stated that, in all Member States, more attention was being paid to drug-using offenders, as illustrated by the increase in community-based alternatives to incarceration (European Commission, 2004a).

Changes in the national legislation of several countries reflect this development. Laws enacted in Portugal in 2000, Luxembourg in 2001, Belgium and Greece in 2003 and, to a lesser extent, the United Kingdom in 2004 removed or reduced prison sentences for certain drug use or possession offences, ostensibly for all adults although this would include young adults (and minors) as well. In 1999, a circular in France recommended custody as a last resort for young offenders. The Children Act of Ireland makes the same recommendation, and emphasises prevention and the diversion of young offenders from prosecution. To this end, as well as raising the age of criminal responsibility, it also enshrines the Garda Juvenile Diversion Scheme in statutory law. A law on the criminal responsibility of minors in Spain in January 2000 applies to those minors aged between 14 and 18 years who were fully intoxicated, or suffering severe withdrawal symptoms, at the time of committing an offence, and offers a variety of penalties, both including and excluding custodial measures (EMCDDA, 2004).

The new EU action plan on drugs 2005–08 (adopted by the European Commission and sent to the Council of the EU and the European Parliament at the time of writing) asks Member States to 'make effective use and develop further alternatives to prison for drug addicts who commit drug-related offences' (European Commission, 2005).

## National legislation

The first European references to alternatives to prison for drug users date from around the beginning of the 1970s. For example, the concept of alternatives to prison for drug users was mentioned in a Danish government report in 1969. France included the concept in its penal code when the French law of 31 December 1970 linked the principle of treatment order to all stages of the criminal procedure from referral to the public prosecutor to final judgment. Subsequently, all EU Member States have modified their legislation and their criminal justice system as well as their health and social services systems in order to assist offending problem drug users to improve their health and their social situation and to reduce crime and other harm to society.

## Legal situation — treatment alternatives to prison

An ELDD (European legal database on drugs) survey of the main treatment alternatives to prison or prosecution offered by the criminal justice systems throughout the Member States shows a primary focus on addicts or problem

### Three stages of the legal proceedings

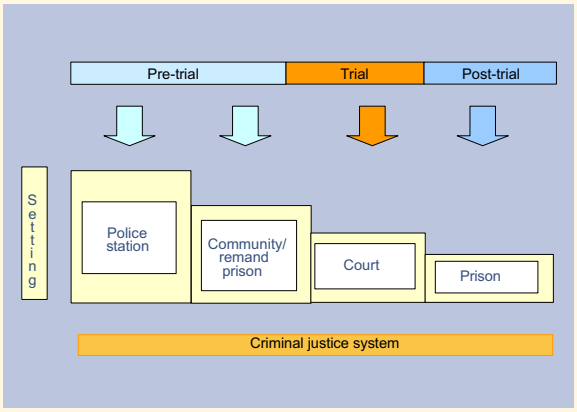
Generally, treatment as an alternative to imprisonment can be applied at three distinct stages of the legal proceedings (Werdenich and Waidner, 2003).

**Pre-trial stage:** Custody and pre-trial detention can be suspended for treatment. Decisions on diversion to treatment are made by the police, prosecutor or remand judge. Client, probation service and drug treatment providers are included in the decision-making procedure.

**Trial/court stage:** The judge can decide to suspend proceedings for a certain period to allow the offender to access treatment, or the sentence can be fully or partly suspended conditional on the client entering a particular treatment programme. Client, judge, probation service and drug treatment provider are included in the decision-making procedure.

**Post-trial stage:** After serving part of the prison term, inmates can be placed in a residential clinic outside the prison. This can also be an option for conditional release. This decision is made with the consent of the client and is taken by the judge.

#### Criminal justice settings and referral to treatment for drug-using offenders



users ([2]). The number of treatment alternatives that the laws specify for addicts is approximately twice as many as those available for the wider category of 'drug users', that is, those found in possession of drugs. This may suggest that addicts are somehow viewed as the more appropriate recipients of rehabilitative justice and that punishment is viewed as perhaps less appropriate than for the casual drug user. It reflects the view that addiction is a medical problem that can be successfully treated, whereas drug use by non-addicts is, apparently, still seen as responsive to legal sanctions.

The survey also shows that, in many countries, the offer of treatment alternatives is not only limited to an accused charged with an offence against the drug laws (e.g. drug use, possession, trafficking). If an addict is charged with a non-drug offence, such as a property offence — with acquisitive crimes, carried out to support a drug habit, being among the principal non-drug law offences committed by drug users — there is a considerable number of treatment options available to the court or prosecutor. This shows a legislative will to avoid prison for the offender, increasing the chances of successful treatment and limiting the chances of recidivism.

Otherwise, the various treatment options share similar characteristics, with occasional differences. The majority are options for the judiciary to choose from instead of a penalty, with a few that must be awarded in certain situations: either first-time offence or, conversely, when the addiction appears to be extremely strong. The treatment options are generally alternatives to prosecution or a sentence, although a few actually are the sentence and some are given in addition to the sentence rather than as an alternative. The 'alternative' status is usually conditional on the successful completion of the treatment programme, in that failure to complete the treatment to the standard required will result in the prosecution or sentence being reinstated. Finally, only a few laws specify the particular setting where the treatment should take place, such as a closed institution. Most are to be carried out in authorised treatment settings, with the option of inpatient or outpatient treatment presumably left to the judge or advisors; a number of laws do not even mention the setting where the treatment option should take place.

### Political and public consensus

There is a broad political consensus on the principle of treatment as an alternative to prison, which seems to be backed by citizens' attitudes (Reitox national reports). For example, a survey in Vienna found that the approval for imprisonment for drug use declined from 27 % to 21 % between 1995 and 2003, and in Ireland, in a recent survey of public perceptions of crime, nearly three quarters (73 %) of respondents believed that non-custodial sanctions, such as fines and community service, would be more fitting than custodial sanctions for certain crimes. In Finland, however, almost two thirds of the adult population considered severe punishment to be an important aspect of drug policy. In particular, the opinions of 15- to 24-year-old males towards anti-drug work were in favour of control measures at the expense of preventive work and, especially, treatment. Recently, public debate in Bulgaria has dealt with the drug problems encountered by delinquents, their needs and the problems related to their treatment.

Investigations by the French Parliament focused public attention on overcrowding and other harmful conditions in prisons, and influenced public opinion in favour of expanding alternatives to imprisonment. The 2003 Warsmann parliamentary report concluded that imprisonment 'should be reserved for the most serious offences'. Consequently, new legislation to adapt the legal system to developments in criminal behaviour listed alternatives to imprisonment as one of the relevant methods for the prevention of reoffending.

## Organisation and administration

### Inherent conflict between systems

The implementation of alternative measures to imprisonment entails an inherent source of conflict between the different administrative systems involved: the criminal justice system and the health and social services systems.

Legislative and executive decisions in the field of criminal justice are taken at national level in most EU Member States, except in federal states such as Germany and Spain where the decision-making powers are divided between the central and the regional levels. Legal and regulatory decisions relating to the health and social services systems are generally also taken centrally, whereas executive power tends to lie in the hands of the respective regional or local authorities. It seems evident that the need to coordinate decision-making and the action taken between two systems with such substantial differences in their respective degrees of decentralisation makes it more difficult to develop coherent policies for dealing with drug-using offenders (EMCDDA/University of Deusto, 1999).

Justice systems play a central role in the final decision-making process concerning the diversion or not of an offender to treatment. Generally, these decisions involve

([2]) For more detailed information, the full survey can be seen at http://eldd.emcdda.eu.int/?nnodeid=5036.

the prosecutor or the judge (court proceedings) and/or prison officials (execution of detention sentence).

A key obstacle to the judiciary system making full use of the option for treatment as an alternative to prison would be insufficient knowledge of the options provided for by law. A 'Green Paper on the approximation, mutual recognition and enforcement of criminal sanctions in the European Union', presented by the European Commission in 2004, stresses the importance of alternative sanctions in crime prevention and proposes that the acceptance of such sanctions by judges could be improved by setting up a mechanism at EU level to disseminate information, pool experience and promote good practice in this area.

O'Donnell (2002) lists the following possible reasons why progress can be slow in criminal justice reforms even when a consensus appears to be established such as treatment as an alternative to prison: institutional pessimism; bureaucratic inertia; problems of definition and measurement; political and moral considerations; and poorly designed evaluations from which generalisation is difficult.

The available evidence indicates that drug-using offenders who are able to control their addiction are less likely to break the law again than those who are unable to control their addiction (e.g. Gossop et al., 2001). However, treatment professionals traditionally regard personal commitment and free will as basic criteria for drug-related treatment and many consider that coercion is not very favourable to the success of drug treatment. Many stress the difficulty of creating a relationship of trust and motivation with the patient in a court-ordered context, where the client is in treatment because of a criminal sentence and the therapist may feel in the position of an auxiliary of the court.

An early German evaluation study (Kurze and Egg, 1989) questioned workers from treatment centres about problems with clients who were admitted for treatment under the drugs law. Complaints included a lack of insight by the clients into the illness and a lack of willingness to adhere to regulations. Workers believed that successful treatment was obtained only by using extensive motivational therapy to transform external motivation into self-motivation. In this study, as in many others, workers reported on the negative effect of these clients on the rest of the group. Behavioural patterns acquired while in prison were transferred to the therapy group, thereby considerably aggravating the atmosphere in the centre as well as impairing the motivation of other patients (Heckmann et al., 2003).

However, not all addicts choose treatment over imprisonment: the threshold for treatment might be perceived as too high, the threat of a sentence is not sufficient or realistic enough or the addict is not motivated (Van Ooyen-Houben, 2004a).

### Cooperation made possible

Efforts are made to bridge the gap between the judicial and the health and social service systems through coordination structures and initiatives. Often, informal cooperation mechanisms at local level have been forerunners to more stable institutionalised forms. Small countries and regions with some autonomy in justice matters are often in a more advanced phase in the coordination process than larger centralised nations.

In Belgium, an interministerial group was created to coordinate these efforts (Law of 3 May 2003). The therapeutic advice given by independent experts has grown from an informal contribution to a formal one — 'justice case managers' — although it is still in the implementation phase. In the German *Land* of Berlin, there is an agreement between the prosecution, justice and drugs services to facilitate the continuity of treatment for drug users who are under warrant for arrest. In France, an institutional coordination framework was created to try to improve welfare and health referral for substance users brought before the court. This was extended to all subregional areas (*départements*) in 1999 in the form of local service agreements signed between departmental authorities and treatment establishments responsible for providing treatment to those referred to them by the courts. Evaluation of this system showed that it allowed better determination of the health of those people who come to the notice of the courts, a greater range of treatment options and entry into a reinforced network of court and health authorities. These improvements were most visible in the pre-sentencing phase. In Italy, each region is now responsible for health and social care, including prisons. This has led to closer ties and improved capacity to provide appropriate alternatives to prison and to provide support for reintegration of offenders on completion of their sentence.

In Denmark, Ireland, Malta and the Netherlands, for example, probation services act as a bridge between the following different systems: justice, social welfare and health. The United Kingdom possesses a wide range of services, which cooperate nationally and locally in making treatment accessible to drug-using offenders. Among these are arrest referral schemes, drug treatment and testing orders (DTTO) and the criminal justice interventions programme (CJIP), introduced in 2003, which takes advantage of all opportunities to identify offenders with drug problems within the criminal justice system

(i.e. in police custody, with the courts, on probation and in prison) and to engage them in treatment using a case management approach. This led to an increase of 47 % in uptake of treatment in the CJIP areas and a reduction in the number of people on waiting lists.

### Funding and provision

Judicial sanctioning practice may be determined not only by penal law but also by financial considerations. For example, in the USA, the average cost for one full year of methadone maintenance treatment is approximately USD 4 700 per patient, whereas one full year of imprisonment costs approximately USD 18 400 per person (NIDA, 1999). The cost of an English DTTO is estimated to be between GBP 25 (EUR 36) and GBP 37 (EUR 54) per day, compared with GBP 100 (EUR 145) per day for imprisonment ([3]).

Usually, the mainstream drug treatment system is called on to ensure that offenders with drug problems receive treatment. The funding of treatment as an alternative to imprisonment for problematic drug users reflects the political–administrative structure of each Member State and may be rather complex. However, whereas treatment in prisons is funded by the justice services in most countries, treatment as an alternative to prison is usually funded by health or social welfare and security sources, with contributions made by the justice system in some cases. Local authorities play a central role in the national schemes in many countries (Denmark, France, Ireland, the Netherlands, Austria) because they are responsible for the care and treatment of drug users. As for drug treatment in general, funding is often channelled to NGO-managed drug services.

The extended possibilities for drug-related treatment as an alternative to imprisonment have greatly increased the workload of the treatment services. In some countries, this has led to waiting lists or a partial breakdown in the capacity of such services. In Ireland, Hungary, the Netherlands, Austria, Poland and Norway, convicted drug addicts who are willing to begin treatment are reported sometimes to have difficulties in finding a place in a treatment centre. In Sweden, the local welfare authorities that are responsible for drug care and the probation service sometimes have problems when negotiating treatment costs for sentenced offenders because the need for residential treatment is not acknowledged at local authority level. Denmark introduced a treatment guarantee for drug users in 2002 and, since then, the prison and probation services have not had any problems finding treatment slots for drug-using offenders who wish to be placed in treatment.

## Implementation

### Growing recourse to alternatives

Although recourse to alternatives to prison has increased during recent decades in the EU-15 Member States, in some countries this development has stagnated during the last five years. One of the consequences of increased recourse to alternatives to prison has been 'net widening' (Cohen, 1985), whereby the number of people falling under the supervision of the criminal justice system has increased, often without reducing the number of drug users in prison. In addition, it is not always clear from the data whether the alternatives are applied to problem drug users, or to recreational users 'encouraged' to take counselling.

In Germany, of approximately 20 000 offenders diagnosed as addicted to illegal drugs, 55 % had their sentence deferred in 2003 (although more than half of the deferrals were later revoked, see below). In Spain, the proportion of drug addicts appearing before the courts who are referred to treatment has increased since the 1995 penal code came into force. In Sweden, the proportion of drug users sentenced to prison who were diverted to treatment was about 17 % in 2003, the same as in the previous five years. In Norway, the use of partial sentences, that is, replacing part of the prison sentence with treatment in the case of serious drug crimes, has increased from about 5 % 10 years ago to 20 % in 2003. Cases of offenders referred to treatment instead of imprisonment grew from 1 200 cases in Austria in 1981 to 9 000 in 2003, although in recent years the proportion of the recourse to alternatives has diminished. Only 1.4 % of all drug users who began treatment in Greece in 2003 were referred to therapeutic services by the police or the criminal justice system. However, the percentage for adolescent drug users under 18 rose to almost 11 %. In France, it is estimated that the number of prison sentences for drug-using offenders is almost as high as that for alternatives to detention with a treatment component, but both convictions with imprisonment and referrals to treatment diminished considerably during the last decade. In Ireland, both sentences to community supervision (including those with obligation of treatment) and imprisonment increased by half.

Legislation and implementation of alternatives to prison began later in the 'new' Member States. The Czech Republic reports only a few cases of convicted drug-using offenders being diverted to community-based treatment instead of imprisonment. In Hungary, recourse to treatment

([3]) http://www.nao.org.uk/publications/nao_reports/03-04/0304366.pdf.

as an alternative to prison was rather low until new legislation was issued in 2003. It then grew dramatically from around 700 to 2 300 cases between 2002 and 2003. A Polish local study revealed that about half of convicted drug addicts were referred to treatment.

### Treatment modalities

In most countries, problem drug users usually undergo treatment as an alternative to prison in residential drug-free treatment centres. This is the case in, for example, Denmark, Germany, the Netherlands, Poland, Finland, Sweden and Norway. In Spain, in 2002, half of the offenders who were treated by alternative measures to imprisonment stayed in therapeutic communities.

The proportion of clients in therapeutic communities and other residential services coming directly from court has increased significantly and has reversed the falling numbers in inpatient treatment services registered in recent years in many countries.

The theoretical or practical possibility also exists to follow outpatient treatment programmes, for example community-based substitution treatment, in some cases combined with drug-testing obligations (e.g. the United Kingdom) or community work (e.g. France). Judges may prefer inpatient services in order to safeguard the retention in treatment, whereas other considerations, such as the motivation and stability of the drug user and the availability of specialised outpatient services or particular programmes for drug-using offenders (e.g. DTTOs), may favour outpatient treatment. In Belgium, drug users are able to have electronic surveillance, for example while following outpatient drug treatment.

### Timely decision

Rates of relapse into criminality vary significantly between drug users who start treatment before having contact with prison and those who enrol in treatment after serving some time in prison. A Danish study showed that those who started treatment directly after being sentenced had a repeat offence rate of 44 %, whereas the repeat offence rate of those who came from prison was 65 %. In Italy, the same tendency was observed, and sending offenders directly from court to treatment without going through prison is encouraged. A pioneering model of this practice is the programme 'La cura vale la pena' ('Cure is worth the effort'), to which the central court of Milan refers cases of drug-using offenders; treatment is then carried out in prearranged therapeutic communities. This programme has been replicated in other Italian cities. In other countries, including Ireland, Malta and the United Kingdom, different types of arrest referral schemes have been implemented. In the Nordic countries, however, drug-using offenders often first serve a term in prison while their treatment needs are assessed and, by request, they can serve the last part of their prison term in a treatment centre.

In the Netherlands, the practice of referring arrested drug addicts to treatment centres was developed in police stations. However, problems emerged, including a high drop-out rate and delays in referral caused by difficulties in finding adequate treatment facilities. To improve the referral process, the police focused on monitoring cases of multiple criminality while these offenders were remanded in custody awaiting trial. At this point, the drug user was better prepared to follow treatment and a wider range of treatments was available. Mechanisms to match the needs of the individual with the treatment offer, and vice versa, became more flexible (Van Duijvenbooden, 2002).

### A special case: juveniles and alternatives to prison

Over the last 20 years, most western European countries have experienced contrasting trends in the rates of conviction of juvenile delinquents, which have decreased, and the numbers of young people being registered by the criminal justice system, which have increased. Swedish researchers report that prison sentences are very rarely applied to people aged under 18, whereas the number of young people in institutions increased in the years following the introduction of new legislation in 1999 (Sarnecki and Estrada, 2004).

Young drug users are especially vulnerable to getting into a vicious circle of drugs and crime. In line with common legal principles, there is a strong determination among legislators and in the criminal justice systems in the EU to avoid imprisonment for young and very young offenders. Justice systems are particularly concerned about underage offenders and those who have committed a first offence. Several Member States have passed legislation to provide alternatives to prison, especially for young drug offenders. One of the main objectives is to impose educational and psychosocial measures, including, for example, mediation.

In Spain, 14- to 18-year-old offenders are judged under Act 5/2000 on the Liability of Minors, which is an act aiming to impose sanctions of a social and educational nature including substance abuse treatment. Youth courts in France may order treatment for problem drug users under the age of 18, but in practice courts favour them being taken into care at an earlier stage in the proceedings at the initiative of the public prosecutor. Paradoxically, the concern for the medical and psychological well-being of minors has resulted in the procedures becoming more

rigorous. New legislation in Hungary explicitly aims to secure diversion to treatment for offenders committing drug crimes for the first time. In Luxembourg, youth courts may order treatment or counselling for underage drug law offenders.

In Cyprus, the law provides for the treatment of addicted minors and they may be detained in treatment centres, although only after an application by the guardian or others close to the minor. In Poland, drug-dependent minors can be subjected to compulsory treatment if they are unwilling to undergo treatment voluntarily ([4]). The basic legal act in this respect states that drug use by a minor and becoming intoxicated constitute the basis for instigating legal proceedings.

In Malta, the police aim to work with the treatment centres and probation services in order for young people to benefit from alternatives to sentencing and from arrest referrals. Currently under debate is the implementation of a first offenders programme, which should give first-time drug-law offenders the option to attend a drug rehabilitation programme as an alternative to sentencing by the courts. Arrest referral schemes targeting drug-using offenders aged under 18 years have been established in 10 pilot areas in the United Kingdom, and a similar scheme is being tested in Dublin. By testing young people for class A drugs (e.g. heroin) at arrest, treatment needs will be identified as early as possible (Home Office, 2004).

However, there are few specific treatment programmes that are real alternatives to sanctions under the criminal law for this group. Young offenders, who are often mainly cannabis consumers, usually do not feel motivated to enter and follow drug treatment since the available services may not meet their needs. Some Member States (e.g. Germany, Luxembourg, Hungary, Austria and the United Kingdom) have established selective prevention programmes for first offenders, generally cannabis users, that offer psychosocial support, training and counselling (see Prevention in *Annual report 2005: the state of the drugs problem in Europe*, Chapter 2).

## Evaluation and research

### Investigation efforts

European evaluation studies of treatment as an alternative to prison are rare and partly inconclusive. No comprehensive major national or European studies are available. Research is usually linked to pilot projects and/or specific services, that is, with particular, selected populations, a short-term perspective and often without control groups (Van Ooyen-Houben, 2004b), and random assignment is exceptional. The three-year project 'Quasi-compulsory and compulsory treatment in Europe' (QCT Europe), co-funded by the European Commission within the fifth framework research programme, aims to remedy part of this research gap. The study will compare clients referred to treatment by the criminal justice system and those who enter treatment voluntarily. It will look at the effects of quasi-compulsory and compulsory treatment courses (QCT) on the drug use, criminality and socialisation of the people who go through them, and it will investigate the determinants for a positive outcome of the various types of QCT. It is planned that results will be presented by the end of 2005 ([5]).

### Retention essential

As other treatment research consistently shows, retention in treatment is a key indicator of success (for a review of the literature, see Stevens, 2003). A study in Catalonia found that, for prisoners who initiated treatment in a prison therapeutic community or in a drug-free centre outside prison, between 1990 and 1995 the rate of criminality was 32 % for those who progressed well in treatment whereas 55 % of dropouts relapsed. Of drug users treated outside prison, 37 % relapsed compared with 41 % of those treated inside prison. Similarly, the main finding of an evaluation of the first year of the Dublin drug court was that the rate at which participants were rearrested, charged and had their bail revoked declined the longer they stayed in the treatment programme. The proportion of those testing negative for opiates increased from 42 % over the first three months to 82 % in the last three months. Compliance improved significantly and 11 out of the 37 participants (30 %) were clean of all illicit drugs by the end of the period.

Dropout rates are one of the biggest problems in drug treatment in general and particularly so in treatment undertaken as an alternative to prison, since these drug users face imprisonment if they fail to complete their treatment programme. A review of Dutch research reveals that dropout rates range from 20 % to 100 %, and mostly lie between 50 % and 60 % (Van Ooyen-Houben, 2004c). Similarly, the German experience is that alternatives are revoked in 30–50 % of cases for a variety of reasons, including refusal to start or abandonment of therapy, desertion of the facility and relapse, disciplinary discharge from the facility or committing serious offences. A United Kingdom two-year follow-up study on reconviction in a population receiving DTTOs showed that 53 % of those who completed their order (only 30 % of the total) were

([4]) Article 13 of the Act on Countering Drug Addiction.
([5]) See http://www.kent.ac.uk/eiss/.

convicted of a crime within two years compared with 91 % of those whose orders were revoked (Hough et al., 2003).

A Danish study found no significant differences in treatment completion between inpatient clients who had been referred by the prison authorities and clients in inpatient drug treatment in general. Spain reports successful application of alternatives, in which only 8 % of the total number of such measures applied in 2003 were repealed because of failure to continue treatment; in Italy, the comparable figure was 10 %. Austrian research concluded that clients in treatment as a result of a court order have a lower drop-out rate than clients in voluntary treatment: 30 % vs. 50 %. Norway reports that while 786 sentences to treatment were registered as fully served in 2003, requests were made for only 89 cases to be converted to imprisonment owing to non-compliance with the conditions and/or new criminal acts.

### Quality and consistency

Some studies have suggested that it is the characteristics of the treatment provided, and not of the patient or of their route into treatment, that is important in predicting success in treatment (e.g. Fiorentine et al., 1999; Millar et al., 2004). Treatment as an alternative to prison seems to work best if the addicts are motivated for treatment, if they are actively and intensively approached and advised to go into treatment, if care facilities follow clinical standards and have enough and qualified staff, if there is a feeling of a real threat of punishment, if there is close cooperation between judicial authorities and care programmes and if sufficient aftercare is available (Van Ooyen-Houben, 2004c). The key to success in DTTOs lies in retention, strong interagency cooperation, appropriate staffing, good referral and assessment, effective monitoring and review of offenders and streamlining breach procedures (United Kingdom national report, p. 77).

However, in Hungary, among several negative indicators of achievement for treatment as an alternative to prison were an excess of officials involved in the process, excessive costs of proceedings and administrative complexity. The same report also identified the deficit of treatment centres in neighbourhoods and exceeding the capacity of the services with the extra workload as negative indicators of achievement.

A good relationship with the 'key stakeholders', clear vision, good non-bureaucratic management, control and quality improvement mechanisms, reduction of the waiting time to begin treatment, adaptation of the treatment offer to the necessities of the client, a good relationship between referral and treatment services and cooperation with local authorities to encourage reintegration in the community are some of the success factors related to the more organisational aspects of alternatives to imprisonment (Nacro and DrugScope, 2003).

## Conclusions

National legislation acknowledging international and European agreements and guidelines is the first prerequisite for the appropriate use of drug-related treatment as an alternative to imprisonment for drug-using offenders. Most EU Member States have legislation in place or are in the process of defining it. Nevertheless, the existing legislation must be implemented in a manner that benefits both the drug user and society. Knowledge, both about the legal possibilities and their implementation and about the drug-related treatment options that are available, is required of police, prosecutors and judges.

The criminal justice system and the health and social service systems have different points of departure and different deontological paradigms. Trust, cooperation and effective coordination at all levels are essential in order to successfully implement drug-related treatment as an alternative to imprisonment. Much can still be done in terms of attitudes, knowledge and practical management to facilitate resource-saving cooperation and coordination.

The availability and differentiation of drug-related treatment has increased over recent years. But many regions of the EU still lack the necessary variety and quality of drug services, and drug treatment services do not always have sufficient resources. In particular, drug-related treatment services for young people need to be expanded and diversified. Drug treatment staff must counter prejudices against clients referred from the criminal justice system. The staff must also have the necessary knowledge and skills to work with these clients in order to keep them motivated to take up and continue treatment.

Although scientific evidence suggests that drug-related treatment is a better and more cost-effective option for offenders with drug problems than imprisonment, research is still too scarce and too disparate to establish what works, how, when and for whom. Reduction of crime, improved health and social well-being are success indicators that benefit not only the individual drug user but society as a whole.

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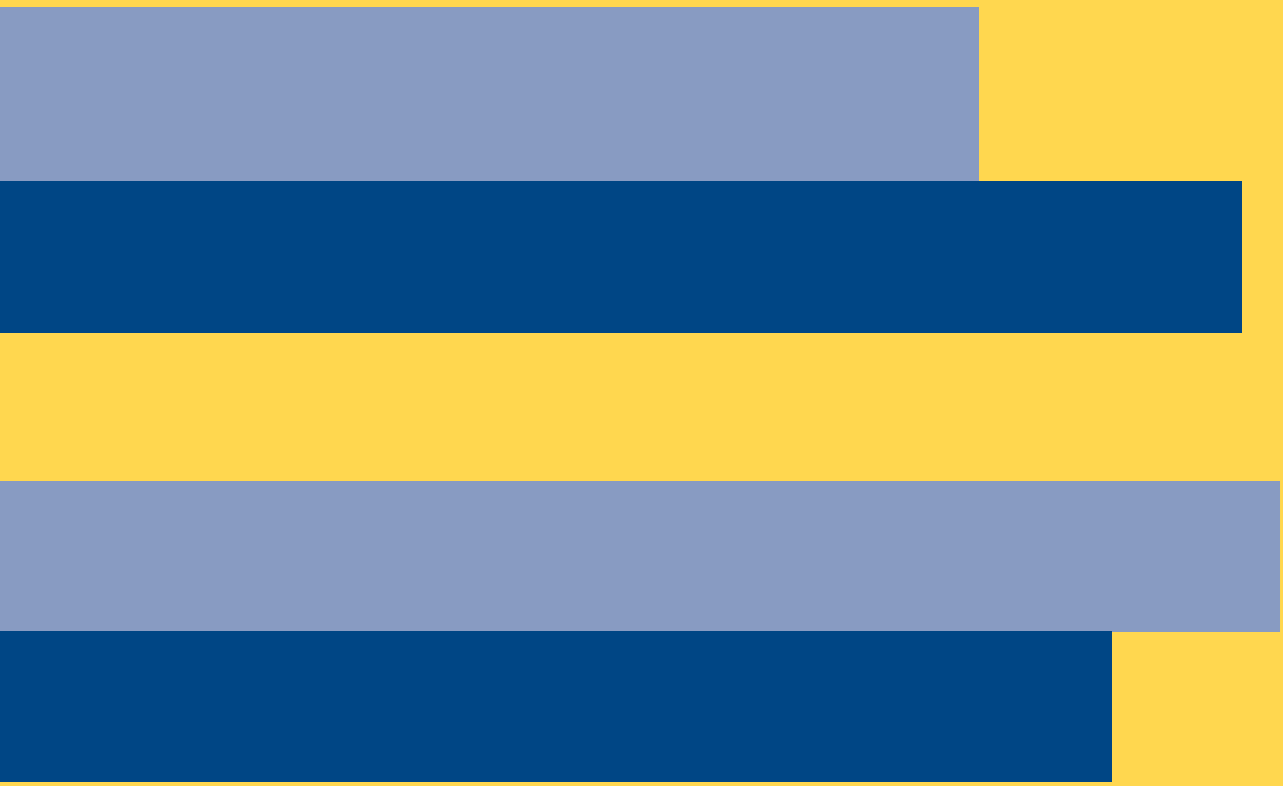


Selected issue 3

# Buprenorphine — treatment, misuse and prescription practices

## Overview

The use of pharmacological agents is one of the most common approaches in the treatment of opiate dependence. Early in the 20th century (Ministry of Health, 1926), authorities in some European countries realised the value of prescribing an opioid drug either as an aid to withdrawal or as a substitution medicine for patients who were addicted to heroin, morphine or opium. Today the most commonly used opioid substitution drug in Europe and the developed world is methadone, which was first introduced in the USA. A number of factors make this drug a popular therapeutic agent: it has a relatively long half-life (22 to 36 hours); it can be administered orally; and there is a strong scientific evidence base for its therapeutic efficacy. However, despite its popularity, the use of methadone continues to cause some concern, for example regarding the potential for it to be diverted to the illicit market, the level of withdrawal distress associated with cessation of the drug and the potential for overdose when used outside therapeutic settings. These concerns have been partly responsible for the development of interest in other withdrawal agents that can provide the same benefits as methadone but which may be more appropriate to some clinical settings or better suited to the needs of some client groups.

One drug that appears to deliver some of these benefits is buprenorphine. This mixed agonist/antagonist has historically been used for the short-term treatment of moderate to severe pain. Since the mid-1990s, buprenorphine has increasingly become available in Europe as an alternative to methadone for the treatment of opiate dependence. In this special issue, the reasons why clinicians are attracted to this drug, as well as the costs and benefits of buprenorphine in comparison with other treatment options, are explored in detail, and, for the first time, the increasing popularity of buprenorphine for the treatment of opiate dependence in many European countries is documented.

## Introduction: legislation and pharmacological action

Buprenorphine is classified under Schedule III of the United Nations Convention of Psychotropic Substances of 1971, requiring all countries to place it under control. By comparison, methadone is classified under Schedule I of the 1961 Convention, which places more restrictive measures on its control, distribution and use.

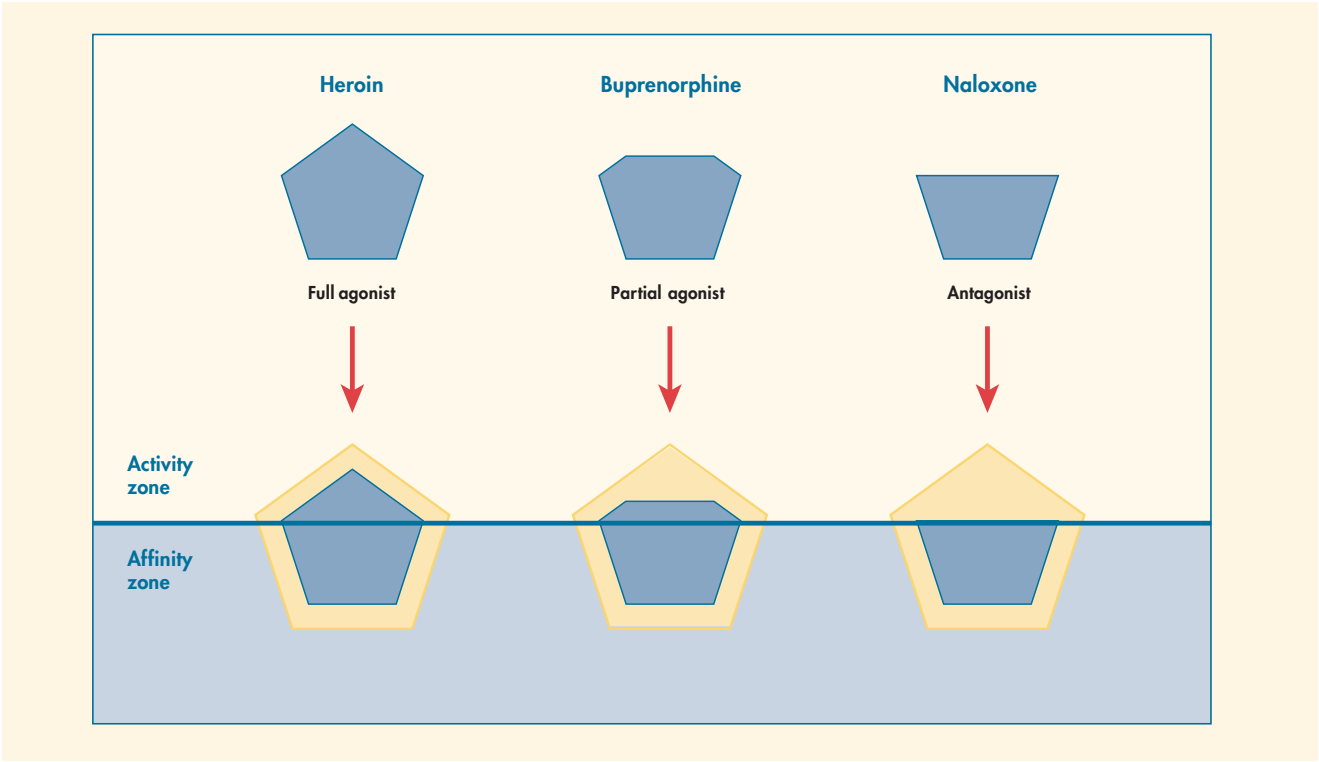
Buprenorphine is a derivate of the morphine alkaloid thebaine and, in contrast to methadone, which is a full opiate agonist, it is a mixed agonist/antagonist. This means that buprenorphine only partially activates the opiate receptors within the nervous system, producing a milder effect with both less euphoria and less sedation (Ridge et al., 2004).

Buprenorphine is often described as a partial agonist (receptor stimulator)/antagonist (prevents receptor stimulation) (Jones, 2004) (Figure 1) because it has important actions on two types of opiate receptors in the brain. Many of the most common opioid effects, such as euphoria, respiratory effects and reduced pain sensation, are caused by stimulation of the mu receptor. Buprenorphine produces these effects because it stimulates the mu receptor, albeit at lower intensity than other opiates such as heroin or methadone. Additionally, however, as buprenorphine binds more strongly to the receptor than these drugs, it can displace them. As a result, an individual who takes buprenorphine while dependent on another opioid risks the development of withdrawal symptoms due to a reduction in stimulation of the receptor. In addition, disassociation of buprenorphine from the receptor is slow, accounting for the drug's long duration of action, one of the factors that makes it a versatile treatment option.

Buprenorphine is also an antagonist of another receptor associated with opioid effects. The kappa opioid receptor is associated with some of the negative effects experienced in withdrawal, particularly depression. As buprenorphine inhibits stimulation of this receptor it may produce feelings of well-being.

Studies have shown that buprenorphine can be effective for the treatment of opiate dependence. In addition, it has been argued that the pharmacology of buprenorphine provides a number of benefits: its mixed opioid stimulating/blocking action makes it a relatively safer option in terms of the risk of overdose; its properties make it a less attractive drug to the illicit user and it may therefore be less likely than other opiates to be diverted onto the illicit market; cessation of the drug is associated with milder levels of withdrawal distress; and the long duration of its action permits more flexible dispensing options. Taken together, these factors may make

**Figure 1:** Effects of buprenorphine, heroin and naloxone on the mu opioid receptor




NB: The mu receptor is one of the primary sites for the reward effects of opiate drugs in the brain. The opiate binds to the affinity zone of the receptor and stimulates the activity zone, thereby producing an effect. In the diagram, heroin, buprenorphine and naloxone are represented by blue polygons, and the receptors by yellow polygons. The stimulatory effect of each chemical is related to how it interacts with the affinity zone (represented here as filling a proportion of the affinity zone). Heroin, classified as a full receptor agonist (stimulator), almost fills the activity zone while buprenorphine, a partial receptor agonist, fills a smaller proportion of it and naloxone does not stimulate the receptor at all. The substances also differ in how strongly they bind to the receptors. A substance that binds more strongly to the receptor can displace a substance that binds less strongly. Thus, buprenorphine can displace both naloxone and heroin, and naloxone can displace heroin.

*Source*: Adapted from Jones, H. E. (2004), 'Practical considerations for the clinical use of buprenorphine', *Science and Practice Perspectives* 2, No 2, pp. 4–20.

buprenorphine a versatile therapeutic agent and provide clinicians with an important additional prescribing option, although questions about which client groups are best treated with buprenorphine and which clients may be better suited to a different treatment option remain unanswered. In particular, it has been suggested that the pharmacological action of buprenorphine may make it less attractive to some client groups and that other benefits have to be weighed carefully against the cost of the drug.

## Common formulations

Buprenorphine is available as tablets to be taken sublingually (allowed to dissolve under the tongue), or as ampoules for intramuscular or subcutaneous injection. Low-dose tablets, containing 0.2–0.4 mg of the drug, are sold under the brand name Temgesic and are normally used for analgesic purposes, for relief from moderate to severe pain.

The most common formulation of buprenorphine used for the treatment of opiate dependence is high-dose tablets containing 8–16 mg buprenorphine hydrochloride and available under the brand name Subutex. These tablets are specifically intended for the treatment of problem drug use in clients who are being maintained in medically assisted treatment; in the case of clients undergoing withdrawal treatment, they are administered in a gradually reducing dose. Low-dose tablets are sometimes used for the treatment of opiate dependence, in which case multiple tablets are prescribed in order to achieve the desired dose.

In some countries buprenorphine is also available in another formulation, under the brand name Suboxone; in this case, buprenorphine is combined in a 4:1 ratio with the opiate antagonist naloxone. Suboxone was developed to reduce the abuse and diversion potential of buprenorphine by making its injection undesirable (Chiang and Hawks, 2003). Naloxone, in contrast to buprenorphine, has little effect when taken sublingually. However, when injected, the antagonist properties of naloxone can precipitate a withdrawal syndrome in anyone who is opiate dependent. Not surprisingly, this is thought to make the drug less attractive to those who inject

drugs and thus lower the risk of diversion onto the illicit drug market. However, many problem opiate users in Europe do not inject drugs, and studies of illicit drug users have reported the use of non-prescribed Temgesic and Subutex tablets.

## Treatment efficacy

Although the research literature is still developing, and questions remain regarding which patients are best suited to treatment with buprenorphine compared with other treatment options, a number of studies have suggested that buprenorphine can be effective in the treatment of opiate dependence. It should be remembered that prescribing for substitution or withdrawal management is likely to be only one part of a therapeutic intervention, and overall success rates are likely to be influenced by the overall package of care provided. Nonetheless, studies have suggested that buprenorphine can have a positive effect on a number of outcome measures, including reduced drug use, increased treatment retention rates and improved health status (Strain et al., 1994). Clinical approval of the drug also appears high. Studies have also shown that client acceptance of the drug is good, although questions remain about its attractiveness to all client groups and whether this has an effect on treatment uptake or retention (Schottenfeld et al., 1997). The question of which client groups are best suited to buprenorphine therefore remains an important one for further research.

Contraindications to buprenorphine treatment include a number of medical conditions (Jones, 2004) such as respiratory, kidney or gall bladder problems, mental disorders, head injury, adrenal or thyroid dysfunction, enlarged prostate and urination problems. Caution is also required in patients with hepatitis or impaired liver function as the impact of the drug on the liver requires further study. The suitability of buprenorphine for use by pregnant women remains open to debate. One study reported that the neonatal abstinence syndrome was less intense with buprenorphine than with methadone (Johnson et al., 2003), but again this is an area in which further studies are required.

Table 1 describes the pharmacological properties of buprenorphine and their clinical implications (Lintzeris et al., 2001).

The suitability of buprenorphine for use by pregnant women remains open to debate and the scientific evidence for the effects of buprenorphine use during pregnancy remains incomplete. In the USA, clinicians are currently advised to switch pregnant women from buprenorphine to a methadone prescription, partly because it seems clear that the therapeutic benefits of methadone are likely to outweigh any potential risks to the unborn child and this evidence base for buprenorphine is less complete. There are some concerns that, compared with methadone,

**Table 1: Summary of the pharmacological and clinical properties of buprenorphine**

| Property | Clinical implication |
|---|---|
| Produces opioid effects | Reduces cravings for heroin and enhances treatment retention<br>Less sedating than full agonists (heroin, morphine, methadone) |
| Prevents or alleviates heroin withdrawal symptoms | Can be used for maintenance or withdrawal treatment |
| Diminishes the effects of additional opioid use (e.g. heroin) | Diminishes psychological reinforcement of continued heroin use<br>May complicate attempts at analgesia with other opioid (e.g. morphine) |
| Long duration of action | Allows for once-a-day to three-times-a-week dosing schedules |
| Ceiling on dose–response effect | Higher doses (e.g. >16 mg) may not increase the opioid agonist effects, while prolonging the duration of action<br>Safer in overdose, as high doses in isolation rarely result in fatal respiratory depression |
| Sublingual preparation | Safer in accidental overdose (e.g. children) as poorly absorbed orally<br>More time involved in supervised dispensing |
| No severe withdrawal precipitated by opioid antagonists | Treatment with naltrexone can be commenced within days of buprenorphine<br>May complicate management of heroin overdose requiring high naloxone doses |
| Side-effect profile similar to that of the opioids | Generally well tolerated, with most effects transient |

*Source*: Lintzeris et al. (2001).

buprenorphine may be more likely to induce abstinence syndrome in the neonate and it is thought to cause higher neonatal toxicity during breast feeding (Lintzeris et al., 2001). However, some studies have shown buprenorphine to be both effective and well tolerated by mother and foetus, and one study reported that the neonatal abstinence syndrome was less intense with buprenorphine than with methadone (Johnson et al., 2003). Clearly, further research in this area is required.

Buprenorphine costs considerably more than methadone but some economic analysis has suggested that the relative costs of methadone and buprenorphine treatment can be similar. This rests on the assumption that buprenorphine may allow the possibility for less frequent administration. As the total cost of the intervention will consist of both the drug cost and the cost of clinical resources necessary to administer the drug (staff time, use of facilities, etc.) this may generate savings in terms of the input of clinical staff and other resources. For example, Ridge et al. (2004) estimated the cost of buprenorphine treatment to be around 1.3 times higher than that of methadone treatment. However, the extent to which available studies are relevant to the European situation as a whole is unclear. Clinical costs vary considerably between countries and prescribing costs may be difficult to separate out in practice from other elements of the care package provided. Methadone prescribing practices also vary considerably between countries and may also differ according to patient characteristics. The extent to which buprenorphine costs are similar to or exceed methadone costs are therefore likely to vary according to both local factors as well as the extent to which different prescribing regimes are implemented for each drug. However, both methadone and buprenorphine are generally assessed as being cheaper than other pharmacological substitution options, such as lofexidine.

Although there appears to be a growing consensus that the overall attractiveness of buprenorphine as a drug on the illicit European market is likely to be limited, and therefore diversion is potentially a smaller problem than with other opiates, this contention remains to a large extent speculative because of the limited evidence currently available. Buprenorphine, like all opiates, has the potential for misuse. Sources of harm include injection and combined use with other substances, in particular benzodiazepines and alcohol. As it is a relatively new substance in Europe, in many countries few data are yet available to inform a discussion on buprenorphine misuse and further research is therefore a priority.

### Comparison with methadone

Some studies have compared the effectiveness of buprenorphine and methadone and found similar outcomes in terms of retention rates and reduction in drug use (Strain et al., 1994; Schottenfeld et al., 1997). Some specific advantages of buprenorphine in the treatment of opiate dependence have also been reported. Compared with methadone, buprenorphine causes less sedation and users are more clear-headed; administration is also more flexible, which is useful in primary care settings (Fiellin et al., 2002) or at home, and the drug is well tolerated at high doses and has a safer profile. On the other hand, it has been suggested that methadone may be a more attractive drug (see, for example, Conférence de Consensus, 2004) to some client groups, especially those with long-term problems or a poor record of treatment compliance. This remains an important question for further study and should be seen as part of a broader debate on prescribing options for those with problems related to opioid dependence.

It remains unclear whether buprenorphine is superior to methadone regarding retention of clients in treatment and reduction of clients' additional consumption of illicit drugs. Some studies concluded that methadone is more effective than buprenorphine in retaining clients in treatment (Kosten et al., 1993; Ling et al., 1996), others have found no significant differences in retention rates (Strain et al., 1994; Schottenfeld et al., 1997). Similarly, claims that buprenorphine-maintained clients consumed significantly less additional opioids and cocaine than methadone-maintained clients (Giacomuzzi et al., 2003) must be weighed against research that found no significant differences between clients maintained on these two substances (Strain et al., 1994).

As buprenorphine is less hepatotoxic than methadone and is less likely than the latter to cause cardiac arrhythmias, renal disease and aggravate affective and psychotic disorders, buprenorphine may be particularly suitable for the following groups of patients:

- those with a short addiction history and good motivation (Kastelic and Scott, 1998);
- those with heart or renal disease;
- those with psychotic and affective disorders.

### Historical development

American experts first suggested in 1980 that there was a scientific basis for the use of buprenorphine in the treatment of opiate dependence (Jasinski et al., 1978; Mello and Mendelson, 1980). Research work followed, and the drug was approved by the US Food and Drug Administration (FDA) as a narcotic for use in treating opioid dependence in men and non-pregnant women in 2002.

Buprenorphine had been used as an analgesic in Australia and Europe since the mid-1980s, but its role in the treatment of dependence came somewhat later. Typically in European countries, formal recognition of the drug as an approved approach in the treatment of opioid dependence followed a successful small experimental or ad hoc trial. For example, France, in the early 1990s, was one of the first European countries to use buprenorphine to any significant extent for the treatment of opiate dependence, but it was not until 1996 that a formal legal framework for its use was adopted. Similarly in Belgium, limited use of buprenorphine can be traced back as far as 1984, but the legal basis for its use was only put in place in 2004. More recently, the period between experimental and formal use appears to be decreasing as the evidence base for the effectiveness of the drug has grown; for example, Finland reports some limited use from around 1997 and a legal basis being put in place in place in 1999.

Substitution treatment in general increased in popularity in Europe during the 1990s, but for the most part the drug of choice for clinicians was methadone. Although high-dosage buprenorphine treatment was available in eight Member States by the year 2000, availability continued to be limited in comparison with methadone treatment ([1]).

By 2004, all of the old 15 Member States, except Ireland, reported some use of high-dosage buprenorphine treatment (HDBT) for opioid dependence — in Ireland, buprenorphine use is restricted to withdrawal treatment. Among the new Member States, the Czech Republic, Estonia and Lithuania reported the launch of HDBT in 2004, and in Slovenia it was implemented in 2005. In the Czech Republic, there are now more clients in HDBT than in methadone treatment.

In addition to scientific evidence for the effectiveness of buprenorphine in the treatment of opiate dependence, other contextual factors contributed to its introduction in the European countries: insufficient availability of methadone treatment to meet the increased demand; irregular coverage of substitution treatment at national level in several countries; the spread of AIDS; and, finally, political debates on alternatives to methadone ([2]).

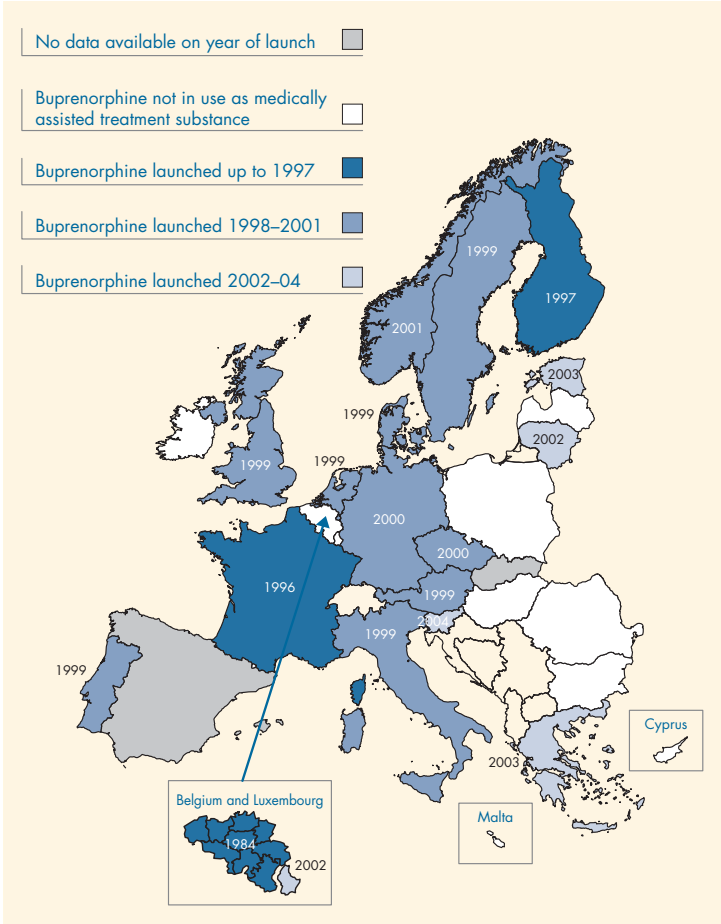
## Treatment provision of buprenorphine

Figure 2 shows which countries use high-dosage buprenorphine treatment (HDBT), and when it was introduced, but it does not reveal anything about the extent or effectiveness of HDBT (for an overview of clients in HDBT see the section on opiate treatment in *Annual report 2005: the state of the drugs problem in Europe*, Chapter 6).

The majority of Member States report the use of HDBT, mostly the old Member States. Thirteen of the old Member States (all but Ireland and Spain) report modest to extensive use of HDBT. Ireland uses buprenorphine only in withdrawal treatment, and Spain reports extremely low use, with a mere 36 clients receiving HDBT compared with 88 678 clients in methadone treatment, constituting a mere 0.04 % of the total treatment population.

Four of the 10 new Member States (the Czech Republic, Estonia, Lithuania and Slovenia) report use, or planned use, of HDBT but to a very limited extent (13 clients in Estonia in 2003, very modest use in Lithuania and no current clients in Slovenia). Only the Czech Republic reports relatively extensive use, with an estimated 1 400 buprenorphine clients being treated either in specialised units or at general practitioners.

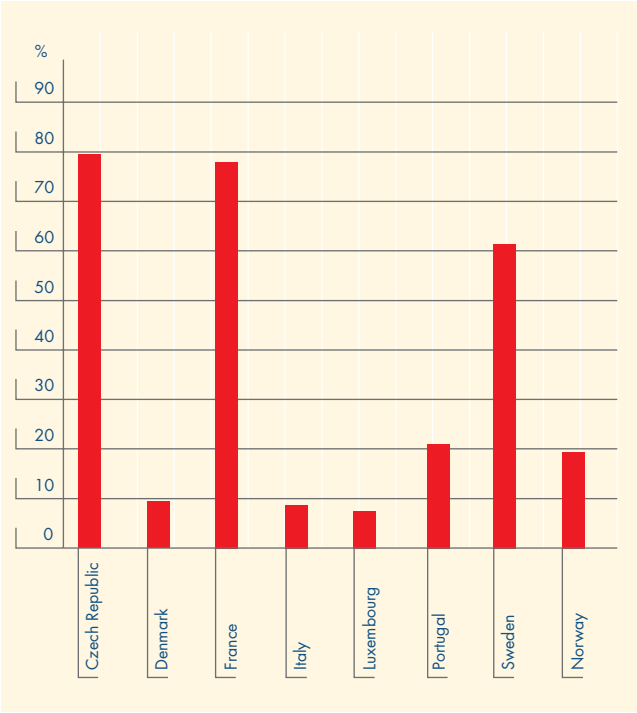
**Figure 2:** High-dosage buprenorphine treatment in Europe (EU Member States, Bulgaria, Romania and Norway)




*Source*: Standard table on drug-related treatment availability.

([1]) Belgium, Denmark, France, Germany, Italy, Austria and the UK (EMCDDA, 2000).
([2]) http://www.anit.asso.fr/docs/subutex_1.php.

**Figure 3:** Buprenorphine clients as a percentage of all medically assisted treatment clients




*Source:* Standard table on drug treatment.

Neither of the candidate countries, Romania and Bulgaria, reports the use of buprenorphine, although it has been allowed in Romania since 2000.

## Clients and coverage of high-dosage buprenorphine treatment (HDBT)

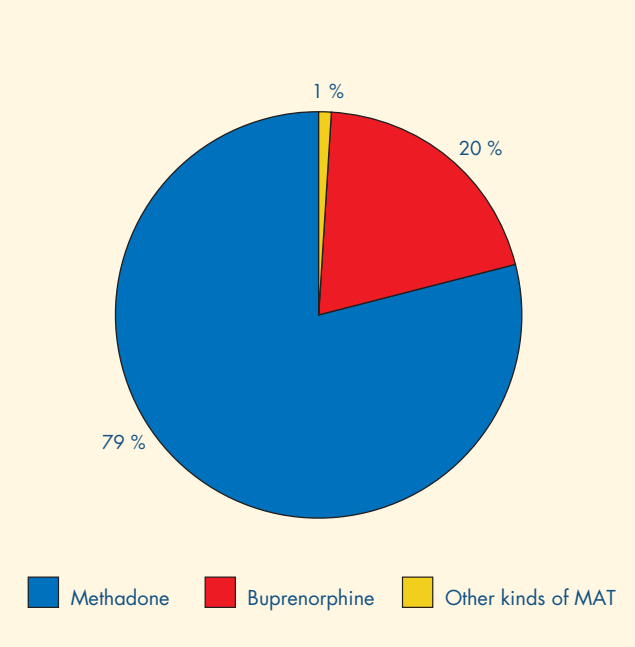
Analysis of the proportion of clients being treated with buprenorphine out of the total number of clients in medically assisted treatment (MAT) reveals two distinct groups of countries (Figure 3). In the first group (which comprises the Czech Republic, France and Sweden), clients receiving HDBT account for more than 60 % of the national aggregated number of clients in MAT. In France, in particular, buprenorphine treatment spread quite rapidly, because of some restrictions in methadone access (strict requirement for access, few places, reluctance of doctors in providing methadone) and because buprenorphine was judged as a safer and effective alternative to methadone. The second category comprises countries where HDBT accounts for less than 25 % of the total MAT (Denmark, Italy, Luxembourg, Norway). In both cases, it must be kept in mind that these figures are only relative and reveal nothing about the overall national provision of MAT or HDBT.

Taking the countries in the first group (>60 % in HDBT), the detailed figures are as follows. France reports 13 000 clients being treated with HDBT in specialised units and 70 000 at general practitioners, a total of 83 000 HDBT clients. The most recent prevalence estimate of problem drug use in France is around 180 000, giving a coverage rate for HDBT of about 46 % (there are also clients in methadone treatment). The same calculation for the Czech Republic gives an HDBT coverage rate of between 10.8 and 15.6 % (1 400 clients in HDBT divided by somewhere between 9 000 and 13 000 opiate problem drug users).

Out of the second group of countries, Norway aims to have buprenorphine on 'equal terms' with methadone, but this has not yet been achieved.

Looking at an aggregated European level, the following picture of HDBT clients as a proportion of MAT emerges. Overall, around 20 % of clients in MAT in the EU today receive buprenorphine (Figure 4). However, around 77 % (83 000 of 107 156) of these clients are in France. After subtracting the figures for France, the number of clients in HDBT constitutes a mere 5 % of the total (24 156 of 441 046). Thus, although buprenorphine treatment is now available in many EU countries, in the vast majority of Member States the actual number of HDBT clients is still very small. The expansion of HDBT is in fact very 'superficial' and its geographical distribution very uneven. Even in France, the geographic distribution of HDBT is rather unequal (Feroni et al., 2004).

**Figure 4:** Breakdown of medically assisted treatment (MAT) including high-dosage buprenorphine treatment in Europe (EU Member States, Bulgaria, Romania and Norway)




*Source:* Standard table on drug treatment.

### Prescription practices, admission criteria and guidelines for treatment

Although prescription practices are complex and can vary considerably even within a Member State, some common features can be identified. HDBT will typically be provided through two main channels: specialised units (which can be independent units or wards linked to a mental health centre or hospital) and general practitioners. Very often complete and fully reliable quantitative data regarding the provision of HDBT are not available, but reports from Member States suggest the following general trends.

In some countries (Denmark, Estonia, Greece, Spain, Italy, Finland, Sweden, Norway) HDBT is provided predominantly, if not exclusively, by specialised units, whereas in other countries (the Czech Republic, Germany, France, Luxembourg) HDBT is provided mainly by general practitioners. In a third group of countries (Belgium, Lithuania, Austria) it is not possible to establish the main provision channel. The role of general practitioners varies greatly among Member States; in some countries (Denmark, Greece, Sweden) general practitioners have no involvement while in others (Czech Republic, France) they are the main provider.

Admission criteria and/or rules related to the prescription and delivery of HDBT also vary among Member States. For example, the minimum age for treatment is 16 years in the UK, 18 years in Portugal, 20 years in Greece and Sweden, and 25 years in Norway.

Other admission criteria for the provision of buprenorphine include the following: buprenorphine should not be given to heroin injectors (Belgium), clients should be more motivated than others to quit drugs (Italy), the user should be dependent on opiates (France), users must meet the criteria of WHO's ICD-10 (Denmark). As discussed earlier, no clear consensus exists on the prescription of buprenorphine during pregnancy. The clinical practice in Belgium, the Netherlands and Portugal is to avoid prescribing buprenorphine to pregnant women while in contrast, in Austria and Norway, it is recommended.

## Misuse of buprenorphine

Buprenorphine, like all opiates, has the potential to be misused and, despite its relatively safer profile (Greenstein et al., 1997), cases of buprenorphine misuse have been reported. The combination of buprenorphine and other sedatives (such as alcohol, benzodiazepines, barbiturates, tricyclic antidepressants or major tranquillisers) can cause serious interactions that can result in respiratory depression and overdose.

Buprenorphine is readily injected if the tablets are crushed and dissolved in water, with the related risks of viral contamination; in addition, since it is not completely soluble in water (Guichard et al., 2003), injection is associated with specific risks such as skin infections, abscesses, oedema and vascular infections. Finally, injection of buprenorphine that has already been in the mouth can result in systemic fungal or bacterial infections (Lintzeris et al., 2001).

### Prevalence of buprenorphine misuse

Data on buprenorphine misuse are scarce and not harmonised at European level. In 2004, the EU Member States provided specific information on buprenorphine misuse ([3]): out of 17 countries where buprenorphine treatment is available, 12 reported some misuse of buprenorphine, albeit often extremely rare.

The two countries where the problem is most visible are Finland and France. In Finland, 28 % of persons entering drug treatment and 90 % of opiate users reported that they had buprenorphine as a primary drug leading to treatment; in France the corresponding figures were 5.8 % and 8.3 %.

Elsewhere, the number of buprenorphine misusers is much lower; in the Czech Republic, Denmark, Germany and Sweden, buprenorphine misuse is referred to only in informal sources; in the other countries, misuse is reported to be extremely rare (close to zero).

Very little information is available on trends in buprenorphine misuse in European countries, although there are some indications of a recent increase. The prevalence of buprenorphine misuse is highest in Finland, which has reported a steady increase of drug clients among persons entering drug treatment over the last four years (+170 %).

Studies carried out among specific populations have revealed that the proportion of buprenorphine misusers is higher among patients of low-threshold services (up to 41 % in France), among substitution treatment clients (Norway) and among disadvantaged and marginalised young people. Misuse of high-dose buprenorphine is also reported to be quite common among homeless people living in urban regions, partly because the combination of greater flexibility of administration and easy access to the substance can play a role in attracting users who

([3]) The TDI European protocol on people demanding treatment for their drug use provides information on clients using opiates as substitution treatment or as a primary and secondary drug of abuse; buprenorphine is included in the 'other opiates' category and only occasionally is the type of opiate specified. Specifications and qualitative information on buprenorphine were requested from the EU Member States in the 2004 Reitox national reports.

do not want a regular setting for care and partly because drug users who have received buprenorphine treatment sometimes switch to misusing the drug (Blanchon et al., 2003).

According to the available information, buprenorphine misusers seem to differ from other opiate users in several respects: they are reported to be younger, enter treatment earlier, start injecting sooner, and inject more often (Reitox national reports, 2004).

Two distinct groups of buprenorphine misusers are reported:

- those who self-medicate with the aim of stopping using other opiates; reasons for this type of misuse might be insufficient availability of substitution treatment or the desire to remain anonymous and keep away from the public health system (OFDT, 2004);
- drug addicts who use buprenorphine as drug of abuse, either as replacement for heroin (if heroin is not available or as a breakdown product) or as a primary drug of choice; reasons for this type of misuse may include the specific desirable effects of the substance, its accessibility and the opportunity to evade urine analysis in countries where it is not possible to measure buprenorphine in urine samples (e.g. Denmark).

Younger people are reported to use the drug more often as the primary drug of choice, whereas older users more often use buprenorphine as 'self-medication' (Table 2).

## Patterns and consequences of buprenorphine misuse

When buprenorphine is misused, it is often injected in combination with other substances, particularly benzodiazepines and other sedatives, alcohol and, to a lesser extent, cocaine and other stimulants.

**Table 2: Frequency of reasons for use of HDB in the past month, in 2003, among participants in the '2003 low-threshold' survey by age group in France**

| Reason for use | Age (years) | | | |
|---|---|---|---|---|
| | 15–24 (%) | 25–34 (%) | 35 and over (%) | All (%) |
| As treatment | 47 | 50 | 66 | 54 |
| To 'get high' | 20 | 10 | 13 | 13 |
| Both | 33 | 40 | 21 | 34 |
| Total | 100 ($n$ = 80) | 100 ($n$ = 209) | 100 ($n$ = 100) | 100 ($n$ = 389) |

*Sources:* TREND/OFDT (Escots and Fahet, 2004).

**Table 3: Frequencies and odds ratios (ORs) of risks associated with the injection of Subutex or other substances during the past month in France**

| | Subutex injectors (%) | Injectors of other substances (%) | OR and 95 % confidence interval | |
|---|---|---|---|---|
| Abscess | 31 | 19 | 1.9 | [1.2–3.1] |
| Injection difficulties | 68 | 55 | 1.7 | [1.1–2.6] |
| Blocked vein, thrombosis, phlebitis | 42 | 30 | 1.7 | [1.1–2.5] |
| Swelling of hands or forearms | 44 | 26 | 2.3 | [1.5–3.5] |
| Febrile episodes | 27 | 22 | 1.4 | [0.9–2.1] |
| Haematoma | 44 | 36 | 1.4 | [0.9–2.1] |

*Sources:* TREND/OFDT (Escots and Fahet, 2004).

Data on route of administration of buprenorphine misuse are very limited; in Finland and France, where the problem is more common, most buprenorphine misusers inject the substance (90 % of Finnish drug clients). In France, it is reported that injection is more common among less socially integrated people. Nevertheless, indications of a decrease in buprenorphine injection in recent years are reported.

French studies reveal that buprenorphine injection increases the risk of respiratory depression, overdose, skin and vascular infections and is more likely than some other drugs to cause abscess, thrombosis and haematomas (Table 3) (Escots and Fahet, 2004; OFDT, 2004).

Specific risk factors for buprenorphine injection are reported to be polydrug use, precarious economic conditions and insufficient doses of buprenorphine for people in treatment setting (Vidal-Trecan et al., 2003).

## Deaths

Deaths due to buprenorphine misuse are very rare, and it is thought that the risk of overdose is lower with buprenorphine than with other opioids because of its agonist/antagonist pharmacological characteristics (i.e. beyond a certain dose a further increase does not result in any further increase in effect) and because its usual administration is sublingual (see also the introduction).

Despite this, some deaths have been reported in the scientific literature and by some European countries. However, data are very limited and in most cases buprenorphine is detected in the blood together with other substances, often benzodiazepines or alcohol. It is thought

that the risk of overdose is highest with intravenous injection and concomitant use of alcohol and sedatives.

Five European Member States in 2003 reported post-mortem findings of buprenorphine in the blood. Eight reported cases in France, and 44 in Finland, were linked to Subutex. The difference between the two countries is striking given that in France between 72 000 and 85 000 people were receiving buprenorphine substitution treatment, whereas in Finland 460 patients were treated in 2004 with buprenorphine. In Finland, buprenorphine is frequently used as a substance of abuse, and in 2003 90 % of users entering treatment were injecting it. But in France too about one third of those using buprenorphine outside a protocol injected the substance. Finally, two deaths associated with buprenorphine were reported in Luxembourg and two in Sweden ([4]).

Comparing data on the number of deaths related to methadone misuse and the number of deaths related to buprenorphine misuse, buprenorphine appears to be associated with a lower risk than methadone. For instance, in France in 2003, eight deaths related to buprenorphine were reported, out of 72 000 to 85 000 people receiving buprenorphine substitution treatment; by comparison, there were also eight deaths related to methadone, out of a total of 11 000 to 17 000 treatment clients (French national report). However, data limitations should be taken into account (Pirnay et al., 2004).

Very little information is available on the measures adopted by European countries to reduce harm from buprenorphine misuse. Generic measures targeted at all drug users, but especially those who use opiates, including buprenorphine, include counselling, needle exchange and the use of filters.

The use of naloxone combined with buprenorphine (Suboxone) is mentioned as a specific measure to prevent overdoses, decreasing the likelihood of abuse (CESAR Fax, 2003).

### Illicit market

Information on the availability of buprenorphine on the black market is also very limited. Diversion of buprenorphine to the illegal market is reported in Austria (where it is very rare), the Czech Republic, Estonia, France and Finland. In the last four countries, there seems to be an inverse relation between the legal availability of the drug, which depends on the nature of national regulations, and diversion to the illegal market.

A tightening of national regulations in the Czech Republic and national importing regulations of pharmaceuticals in Finland resulted in a decrease in the availability of buprenorphine on the legal market; as demand for buprenorphine remained stable or even increased (e.g. Finland), this appears to have contributed to an increase in availability of the substance on the black market.

In contrast, in Estonia and France, ease of access to buprenorphine through doctors' prescriptions or pharmacies has contributed to a generally increased availability on the legal and illegal market. In France, clients can obtain several prescriptions by going from one doctor to another (so-called 'doctor shopping'), while Estonian users supply the Finnish illegal market. In Estonia, specific measures have now been adopted, and political agreements with Finland negotiated, to prevent the diversion of buprenorphine.

In addition, in Finland, a decrease in the availability of heroin, resulting from a reduction in heroin production in Afghanistan, is reported to be a crucial factor in the increase in buprenorphine availability in the illegal market (Nordic studies on alcohol and drugs, 2004).

Another element which has contributed to the increase in buprenorphine demand and availability is the low cost of the drug in the illegal market. In Finland, an 8 mg tablet of buprenorphine costs EUR 30–35, whereas the price of heroin is around EUR 60–350 per gram; in France, the price of an 8 mg buprenorphine tablet varies from EUR 1 to 4. Indications of a current decrease in the price of buprenorphine on the illegal market are also reported.

## Conclusions

Buprenorphine appears to represent a valuable additional prescribing option for clinicians treating opiate dependence. The pharmacology of this drug may also help in making medically assisted treatment more widely available and more easily accessible, if it results in more flexibility in prescribing options. In particular, this could be the case if buprenorphine were to be considered as a particularly suitable treatment option for prescribing by non-specialist general practitioners. Largely, any increased flexibility in prescribing options will be dependent on existing national guidelines and practice on methadone distribution. And to some extent, those countries where buprenorphine provision is currently most common, historically have tended to have a fairly restrictive approach to methadone provision. This may be changing as several countries appear to be developing a flexible approach in this area, where buprenorphine

([4]) The 112 (119) cases in France occurred between 1996 and 2001 (there were only eight deaths in 2003), and the two cases in Luxembourg between 1992 and 2003, whereas the 40 cases in Finland occurred in a single year. The relative risk is very different.

is available alongside methadone as a possible treatment option. In this respect, buprenorphine can be seen as a valuable additional element to the options available to clinicians and may provide some useful benefits in treating some groups of patients or prescribing in some settings. On the other hand, drawing conclusions about the relative costs and benefits of this drug in comparison to other treatment options is not a simple question. Certainly, it would be a concern if the use of buprenorphine meant that overall access to treatment became more limited due to cost constraints. Additionally, there are still questions about which groups of clients are likely to benefit most from which prescribing option and this remains an important area for future research.

That said, with some notable exceptions, most Member States report that the use of buprenorphine treatment appears to be low to modest and it would appear that there is considerable scope to improve availability to this treatment option. Compared with methadone, buprenorphine has advantages and disadvantages, but it can be viewed as an alternative and relatively safe drug that has proved efficient in both withdrawal and maintenance treatment. Although there are reasons why buprenorphine may be not a particularly attractive drug to illicit opiate users, a risk of diversion to the illicit market still exists and therefore measures to diminish diversion and misuse are necessary. It may be that the introduction of new formulations of the drug may reduce this risk further but, again, questions of cost and benefits will need to be carefully elaborated. Finally, information and data on use of buprenorphine in the treatment of opiate dependence and buprenorphine misuse in the EU Member States are still insufficient, and more research and investigation are needed although the current evidence base does suggest that the drug may represent a valuable addition to the clinical arsenal for treating opiate dependence.

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