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Second Multi-City Study on Quantities and Financing of Illicit Drug Consumption

Revised and Extended Version

Irmgard Eisenbach-Stangl / Ricardo Rodrigues (Eds.)

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EUROPEAN CENTRE FOR SOCIAL WELFARE POLICY AND RESEARCH

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Use of Drugs: Use of an Ordinary Commodity?

Introduction to the Second Multi-City Study

Irmgard Eisenbach-Stangl

Estimates of the size of drug markets are a prominent part of the knowledge base of drug controls and a valuable tool, e.g. for the legitimization as well as for the critique of drug-political activities (Hakkarainen et al., 2007). The concept of the drug market covers production, trafficking and sale of controlled substances and deals with a chain of activities including growing of psychoactive plants as well as acquisition of drugs for consumption. In the economic concept of the drug market, purchase and consumption of drugs are the last link in the chain, they are the site where demand meets supply and becomes measurable on the level of the individual consumer. Despite increasing interest in research on drug markets, the last link of the chain remained widely neglected.

Drugs – as widely known – are not ordinary commodities

Drugs – as widely known – are not ordinary commodities satisfying everyday needs of average citizens. Drugs are intoxicants as alcoholic beverages which were classified as luxury goods. Use of intoxicants can alter mood and within some consumers urges demand for immediate continuation – a state of mind also called craving – and leads to dependency (Uchtenhagen and Zieglgänsberger, 2000). Contrary to alcohol – an intoxicant with effects comparable to "hard" drugs – drugs were worldwide prohibited. Although few decades ago drug-political goals in most European countries were reformulated to reduce stigmatisation and social exclusion of drug users, which accompanied criminalisation, their status did not change remarkably (Levine, 2001). Drugs, drug consumption and drug users remained burdened with a negative image and submitted to so manifold controls that economic concepts of commodities, consumption and consumer are seldom applied. Research on drugs, drug consumption and drug consumers under economic signs thus is a delicate and cumbersome undertaking that requires numerous virtues of the researcher as well as of the drug users including patience, respect, sustainability, containment and many more.

The Second Multi-City Study on Quantities and Amounts of Illicit Drug Consumption was dedicated to the assessment of quantitative parameters of drug consumption. As the First Multi-City Study, it was part of a comprehensive effort of UNODC to construct "a policy relevant illicit drug index" per country aggregat-

ing “drug production, drug trafficking and drug consumption into a single composite activity” (Chawla, 2007). Both studies were carried out by the European Centre for Social Welfare Policy and Research in Vienna on behalf of the United Nations Office on Drugs and Crime (UNODC). Research was generously subsidized by the Permanent Mission of Austria to the United Nations (Vienna) and accompanied by an observer of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon. The First Multi-City Study was published in 2009 (Eisenbach-Stangl et al.), the revised Final Report of the second study is presented here.

The focus was on the assessment of amounts of drugs consumed by individual drug users per consumption occasion and respective expenditures

Research questions and cornerstones of the research design were the same in both multi-city studies and predefined by UNODC: The focus was on the assessment of amounts of drugs consumed by individual drug users per consumption occasion and respective expenditures and frequencies of drug consumption occasions in selected European cities. Five illicit drugs were of interest: *cannabis* – herb and resin, *heroin* – brown and white, *cocaine* including crack, *amphetamine* including metamphetamine, and *ecstasy*. The categories lack system – ecstasy is considered separately though it is related to amphetamines – and they deviate from categories used by main European organisations: The first report on European drug markets jointly published by the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) and Europol distinguishes not only ecstasy and amphetmaine but additonally metamphetamine. The categorisation of EMCDDA obviously was based on other premises. Did the selection of the big five of the present study consider chemical ingredients but also conspicous consumption such as the use of ecstasy by the clubbing and dancing scene peaking in 2002, claimed EMCDDA and Europol to have built on diversifications of the drug market. The different signs of categorisation also affected heroin and other opioids and opiates which in the EMCDDA report of 2013 were lumped.

Though opioids (any substance producing opiate-like body effects – Uchtenhagen and Zieglgänsberger, 2000) prescribed in substitution therapy and in addiction treatment are also sold and purchased illegally and though their share in the drug markets is continuously growing and concerns UNODC (e.g. Eisenbach-Stangl, 2013), they were not considered as illicit drugs by the multi-city studies for a simple reason: Opioids approved for the treatment of addicts and mostly submitted to strict controls are not prohibited substances but legal medicines that keep their legal status when illicitly purchased and consumed. Other opiates than heroin (substances produced of opium – Uchtenhagen and Zieglgänsberger, 2000) were disregarded because of their diffuse status. They mostly are crude local preparations of low quality and low purity such as e.g. “braun” and “kompot” produced of poppy straw, which because of their varying and dubious, mostly semi-legal status are not sold on drug markets.

In other words: illicit heroin is substituted by officially approved and professionally administered opioids as well as by self-administered mostly semi-licit local opiates of low quality. Substitution therefore is to be considered as a strategy of desire management by which a preferred commodity is replaced by

another, be it an illicit by a licit or vice versa, be it by state services for political reasons or by individuals for personal desires. Seen from the backside, substitution is a strategy to deal with restricted availability and thus also an effort to manage prohibition, poverty and loss. Drug users of more privileged background are in the position to navigate their state of mind with the drugs of their choice whenever they desire to reduce frustration, to strengthen concentration and to relax (Parin, 2001; also Reuband, 1989; Kemmesis, 2000; Hakkarainen, 2005; Eisenbach-Stangl and Spirig, 2010).

Substitution keeps drug use moving and is one of the main difficulties of quantitative drug research.

Substitution keeps drug use moving and is one of the main difficulties of quantitative drug research. Another research problem associated with drug prohibition is that illicit activities mostly are hidden and that special strategies to identify, contact and inquire or observe hidden persons have to be developed. Since the problem has been widely discussed in the literature (classical: Jahoda, 1938/1995; Cohen and Short, 1958) there is no need to repeat the debate but there is need to report on the strategies applied in the present study.

A further prohibition-related obstacle for a study on economic aspects of drug use is the varying and unknown quality and purity of the substances purchased on the street level. The research problem "unknown purity", which for drug users is an existential threat, was neither overcome by the First nor by the Second Multi-City Study. In the first study drug users were addressed as informants, in the second study they were also interviewed as experts – both approaches failed as will be discussed in more detail in the introductions to Part 1 and Part 2.

Both multi-city studies explored the limits of the drug markets in looking at other sources of drugs than professional dealers. Especially cannabis – as widely known – which like alcoholic beverages is perceived to be a "social drug" (Schulz, 1975), is shared among friends. As other interesting issues turning up in the course of the study also acquisition could not be studied in more detail: Research was limited by the time frame and the budget as well as by the research questions and by the predefined research design, which required the construction of a questionnaire filled in by the interviewer.

The Second Multi-City Study was carried out in seven European capitals

The Second Multi-City Study was carried out in seven European capitals: In the three Nordic cities of Copenhagen, Stockholm and Helsinki, in the two Eastern cities Moscow and Bucharest and in Belgrade and Sarajevo in South-Eastern Europe. The seven cities are capitals of countries of remarkably different political and economic structures since about hundred years: The three Nordic cities are capitals of extended welfare states and "old" Member States of the European Union. The other four cities are capitals of countries with markets in transition, with restricted resources and hardly-developed welfare structures and with a less established relationship to the EU: Romania a young EU member, Serbia an access country, Bosnia and Herzegovina a country administered by the EU, and Russia that could be addressed as a trade partner of the common market as an economic empire of its own. The city sample of the Second Multi-City Study complements the sample of the first one, which represented Western and Central Europe and the EU with the cities of London, Amsterdam, Torino, Prague, Vienna and Warsaw.

The Nordic cities and countries traditionally are not the home of main drug markets and within the drug policy frame of the EU they combine strict drug controls (Denmark aggravated drug controls shortly after the turn of the Millennium – see Kolind and Olsson in this report) with, in particular, extensive social care for drug users. Serbia and Bosnia-Herzegovina are countries nearby the main production area of cannabis herb in Europe and additionally are crossed by the main trade route for heroin. But whereas Bosnia-Herzegovina adapted to EU drug policy and adopted harm reduction as drug-political goal Serbia remained abstinence-oriented and stuck to strict controls and medical treatment with a high threshold. Romania – another country with poor resources – in drug policy follows harm reduction oriented EU strategies, which are openly rejected by Russia. Russia, which is well supplied with cannabis resin and with heroin from bordering Afghanistan – the worldwide largest producer country of this drug –since many years struggles with drug-related infections but refuses to introduce substitution treatment. Stricter as in Serbia, drug controls in Russia remained abstinence-oriented and treatment restricted to few hospitals with a high threshold.

The predefined research design provided for a survey of two ideal-typically constructed user groups

The predefined research design provided for a survey of two ideal-typically constructed user groups by face-to-face interviews and a questionnaire filled in on the spot. The research team of the Second Multi-City Study refined the instrument developed by the team of the first study, added few new questions and when necessary adapted it to the situation of the new cities.

The two ideal-typically constructed user groups as in the first study were addressed as “socially integrated” and “marginalized drug users”. The selection of respondents considered consumption patterns as well as background variables. Though sampling was oriented on research findings with regard to age, gender and drug use, it was more opportunistic than purposive and did not generate findings, which were representative for the variety of user populations in the cities. To locate and weight the data collected by the interviews, a report on the drug situation in the city was requested presenting, among other things, information on drug use and its development over the last decade. According to the guidelines developed in the course of the first multi-city study and refined at the beginning of the second one, the city reports also include information on drug policy and drug markets including purity and prices of the substances sold.

The research team of the Second Multi-City Study that consisted of seven research teams on city level and the coordinating team of the European Centre met four times to discuss and decide on design, instruments and proceedings, to exchange experiences with fieldwork and to develop a common understanding of the data collected. Fieldwork was carried out from 2009 to 2011. Coordinator of the study was Irmgard Eisenbach-Stangl – Senior Researcher at the European Centre and project leader of the First Multi-City Study. She was supported by Ricardo Rodrigues who was responsible for estimates of amounts and expenditures on aggregate level.

The seven city reports are presented in Part 1, the comparative analysis of the survey data in Part 2. The data analysis was carried out by the research team of the European Centre, in collaboration with the city teams. Part 3 is devoted to city estimates on amounts and expenditures for last month consumption. Part 4 was added after delivery of the final report to UNODC. It was conceived to broaden, differentiate and systematize the understanding of drivers of drug consumption by comments from neighbouring social sciences other than (economic) drug research: The invited experts analysed the data of the current study from the viewpoint of welfare state research and cultural studies, the criminological expert commented on both multi-city studies.

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PART 1

City Reports

Edited by Irmgard Eisenbach-Stangl

Drug Use and Social Contexts

Introduction to Part 1

Irmgard Eisenbach-Stangl

The city reports describe the drug situation in the seven research sites as "dense" as possible

The city reports describe the drug situation in the seven research sites as "dense" (Geertz, 1973) as available information allowed. The reports are based on a collection of data governed by guidelines, which had been constructed in the course of the first multi-city study and at the beginning of the second adapted to the peculiarities of the new city sample. The guidelines addressed sources of information on the local drug situation, local drug policy during the last 5 to 10 years, the development of drug consumption and drug subcultures in the same period, and purity and prices of drugs. A final task requested was a short comparison of the drug situation in the city and the country.

In the first multi-city study expert interviews had been successfully used to fill gaps in the database, in the second study they became an important part of data collection and were also taken into service for the assessment of purity and prices of local street drugs. The interview partners were chosen among professionals working in relevant organisations such as drug services, drug administration, law enforcement agencies like the police and the courts and last but not least, in hemp stores. Up to 20 key persons per city were interviewed; one interview was obligatory: One expert of the forensic laboratory for drug analysis had to be contacted.

Up to 20 key persons per city were interviewed

At this point it is useful to anticipate the results of the key person interviews in regard to purity on street level: The results were largely dissatisfying but at closer sight had to be expected. In Moscow the forensic expert refused the interview. The Swedish expert addressed the inaccuracy of the purity figures derived from thorough analysis of heterogeneous samples of unknown origin and relevance. In Helsinki small seizures (mostly of street drugs) and seizures of selected substances were not analysed at all. In Belgrade only large seizures were analysed, others only on request by the juridical system. In other words: the forensic experts demonstrated the incomparability of their data on the spot. The information collected in interviews with representatives of the police was hardly better. The common denominator of all expert interviews was the decline of purity of almost all substances since many years, approaching zero

(Sarajevo), that prices in some cites also dropped continuously but did increase in others and that availability was mostly higher in the capitals of the countries but not in all.

The city teams were free to follow key themes, themes which they conceived to be important for the construction of a city drug profile

In regard to the structure of the report, the city teams were free to follow key themes, themes which they conceived to be important for the construction of a city drug profile. Most local teams chose forces at work beyond the city borders such as war and displacement in Sarajevo; drug traffic and drug markets in Belgrade; drug imports and an extended drug market in Moscow; poverty and social exclusion in Bucharest; contradictious – strict and caring – state responses in Stockholm; contradictious – swinging – drug policy in Copenhagen; the entanglement of illicit drug use with consumption cultures of licit substances (mainly alcohol but also psycho-pharmaceuticals) in Helsinki.

The social forces associated with the drug situation in the city by the local research teams were well chosen and their impact on drug consumption would deserve further and more detailed analysis. Some of the forces generate fast and visibly effects such as drug markets, whereas the impact of others – e.g. of ambivalent attitudes towards intoxication and dependence – is slow and hidden but might be more sustainable. The effects of forces vary with contexts: The impact of the drug market on consumption patterns in Sarajevo seemed to be weaker than in Belgrade due to intact family structures. The city reports also include fine examples of ambiguous forces burdening the life of drug users and in an extreme case even endangering the life of other citizens: Drug policy in Stockholm, which at the same time excluded and cared for drug users, seemed to promote the development of a new subculture of elderly and educated but isolated and stigmatised drug users. And drug policy in Moscow which rejected maintenance therapy and favoured cure by abstention treatment contributed to the continuous increase of HIV-infected drug users that spread the infection among all.

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Copenhagen City Report

Torsten Kolind

1 The city

Copenhagen is the capital and with approximately 530,000 inhabitants in 2010 the largest city in Denmark. It is situated on the islands of Zealand and Amager and covers 88.2 km^2. The city constitutes an autonomous municipality called Copenhagen Municipality. Together with a wide array of adjoining municipalities it constitutes *Greater Copenhagen* with about 1.1 million inhabitants. This report focuses solely on the municipality of Copenhagen.

Copenhagen Municipality is composed of different quarters, most notably Nørrebro, Vesterbro, Østerbro and City. Nørrebro is characterized by being an old working class quarter, now housing many immigrants from various Middle Eastern and African countries and many students. Vesterbro is like Nørrebro an old working class quarter, which as Nørrebro has undergone a large-scale urban renewal in the past 5-10 years. Parts of the area have become trendy and therefore also rather expensive. Many of the cheap student apartments have been turned into larger, more expensive apartments and old "Vesterbroians", who belong to the lower social classes, have moved to other parts of Copenhagen. At the same time Vesterbro is also an area where socially marginalized people live. One part of Vesterbro is close to the central station, which is known for its open drug scene as well as different kinds of harm-reducing initiatives such as shelters, drop-in centres, needle exchange, and street-level nursing. Østerbro was and still is an old bourgeois quarter and the city hosts the main shopping centres, many offices, restaurants, bars and discos.

Copenhagen is a student city with a wide range of different educational institutions including several universities

Copenhagen is a student city with a wide range of different educational institutions including several universities. The percentage of young people between 20 and 29 years is high compared to national figures: 23% versus 11%. Immigrants and descendants of immigrants make up 28% of the population in Copenhagen, whereas for the whole country the figure is 11% (Statistics Denmark, 2011). Many of the immigrants live in Nørrebro, which also is the most densely populated area (179 per 10,000 m^2).

The mean life expectancy of the inhabitants of the Municipality of Copenhagen was 74.7 years for men and 80 for women in 2009. This comes close to the mean life expectancy of the general Danish population (Statistics Denmark, 2011).

2 Drug policy and drug treatment in Copenhagen

There is no officially stated drug policy for Copenhagen

There is no officially stated drug policy for Copenhagen. However, some of the recent years' tightening of the Danish drug policy stems from problems primarily related to the Copenhagen area. Looking at the *de facto* drug policy of Copenhagen compared to other regions in Denmark it can be seen as being somewhat more liberal. For instance, the outpatient treatment institutions in Copenhagen were the first in the country to ease the mandatory abstention for drug users in abstention treatment. In most other cities in the 1990s drug users were discharged from treatment if additional drug use was detected, e.g. by use of urine control (Jöhncke, 1997; Dahl, 2005). Copenhagen was also the first place in Denmark to experiment with drug users injecting methadone (Pedersen, 2003). Also, in some way Copenhagen's drug policy has been activist. For instance, in 2009 a majority of the city councillors suggested legalizing cannabis in Copenhagen, though this was not approved of by the central government. Moreover, Copenhagen offers a range of low-threshold services which partly have been established by initiatives of civil society such as: so-called street-lawyers ("gadejurister") offering legal advises and other kind of help to marginalized people, mainly drug users (Gadejuristen, 2011); street nurses; drop-in centres such as shelters targeting marginalized drug-using women with experiences of prostitution (Reden, 2011), and an engaged user organization, "The Danish Drug User's Union", founded in 1993. The union is an organization for active drug users, which for instance organized a bus collecting needles in open drug scenes, carried out drug-preventive work in schools and informed on and advocated for drug users' rights on a political level (Jepsen, 2004; Anker et al., 2006; Brugerforeningen, 2011). Not least to be mentioned is DUGNAD, a former private organization working on drug-related problems in Vesterbro now taken over by Copenhagen Municipality (see: www.dugnad.dk).

Since the turn of the millennium, Denmark has embarked on an increasingly repressive drug policy

Denmark has traditionally been seen as a liberal country, especially when it comes to cannabis (Storgaard, 2000). But since the turn of the millennium, Denmark has embarked on an increasingly repressive drug policy (Jepsen, 2008; Storgaard, 2005). In 2001, an act against cannabis clubs was issued, enabling the police to forbid access to what they suspect are cannabis clubs, without providing for evidence to the judge, which is otherwise normal practice in Denmark. In 2003, the scope for the police's use of agents in drug investigation was expanded, and reverse presentation of evidence was introduced in cases of seizures of money or valuables. In 2004, the maximum penalty for organized drug crimes was raised from 10 to 16 years (Møller, 2008; Jepsen, 2008). And with the governmental drug action plan from 2004 (Regeringen, 2003), which was the first drug action plan, the whole rhetoric was hardened, illustrated by the US-inspired title of the action plan: *The fight against drugs*, and with the official

goal of zero-tolerance in relation to all drugs. As a consequence the penalty for possession of cannabis was raised from a warning to a fine, also for first-time possession. The size of the fine was raised in 2007 and is today a minimum 2000 DKK (ca. 270 €). In October 2010 the Danish government launched a new drug action plan: *Fight against drugs II* (Regeringen, 2010), which proceeds along the same line as the previous one with a focus on zero-tolerance. One reason for launching a new action plan was the increase in drug-related deaths in Denmark, from 239 in 2008 to 276 in 2009.

Alongside the increased repressive drug policy, the Danish government has improved users' access to drug service programmes

Alongside the increased repressive drug policy, the Danish government has improved users' access to drug service programmes. In 2003 a treatment guarantee was introduced meaning that drug users have the right to receive drug treatment within two weeks of their first enquiry to a municipal treatment service agency and counselors became obliged to draw up an individual written action plan for each individual in treatment. In 2007 the Danish municipalities became responsible for drug treatment (Pedersen and Nielsen, 2007) and the treatment guarantee was extended to drug users in Danish prisons (Asmussen and Kolind, 2008).

Drug treatment in Denmark consists mostly of outpatient treatment, ranging from long-term psychosocial therapy individually or in groups, to loose contacts less than once every second month (Pedersen and Nielsen, 2007). Treatment can also be substitution treatment either with methadone – the traditional substitution drug in Denmark (Dahl, 2005) – or buprenophin. Since 2009, also heroin is offered. According to estimates of the National Board of Health about 300 drug users received heroin in 2009/2010, most of them lived in Copenhagen. Residential care is declining: in 2009, 1,259 users were treated residentially, in 2010, it were only 1,010 (DanRIS, 2010; 2011). Few treatment places are free, mostly in facilities working with the so-called "Minnesota Model", a programme developed on the basis of the 12 steps of Alcoholics Anonymous.

The last figures for the year 2009 show that in Denmark 13,700 persons are treated in drug services (Sundhedsstyrelsen, 2010). This figure has increased markedly since 1996 – the first year drug clients were registered by the National Board of Health – due to the introduction of the treatment guarantee and to increased treatment capacity. In addition to psychosocial treatment in drug services, more than half of the drug clients (7,750) are in substitution treatment.

Copenhagen additionally got special services, mostly targeting young people and cannabis users. There is for example *SMASH*, a sms-based prevention initiative founded in 2005 aiming at young cannabis users (15-25 years of age) and offering anonymous information and advice how to reduce harm. Today, the programme operates a website and has extended its counselling and information to cocaine, amphetamine and ecstasy users. An evaluation has proved that the programme reaches young people experimenting with cannabis and other drugs, who otherwise could be hardly contacted, as they do not perceive their use as a problem (Laursen, 2007). The project U-Turn offers anonymous

face-to-face counselling to young persons below 25 years, its programme includes individual and group counselling to users as well as their friends and families. U-Turn is additionally running preventive programmes in schools and other institutions (U-Turn, 2011). The third example is a project run by the Municipality of Copenhagen itself: *The cannabis and cocaine project* aims at the development of therapy for users who never had contacts with professional care (Soholt, 2008). The Copenhagen Municipality also cares for marginalized drug users by a variety of low-threshold services offering food, a shelter and drop-in centres.

Due to a visible and disturbing drug scene, which had established close to the Copenhagen Central Station, a debate on an injection room has been raised. So far the national government has solely permitted a so-called health room, run by the former private association DUGNAD, where drug users can be seen by medical practitioners and nurses, and get supplied with safe injection kits and other 'tools', but are not permitted to inject their drugs. The health room got established after a study had shown to what extent marginalized drug users were excluded from the national public health system and after it had been decided to initiate respective health measures (Pedersen, 2009).

The numerous and diversified drug services in Copenhagen allow a high coverage of regular users

The numerous and diversified drug services in Copenhagen allow a high coverage of regular users. In 2007 almost one half of the regular drug users were in treatment (2,700 from 6,000 – Københavns Kommune, 2011). Drug clients in Copenhagen on average are older than in the country as a whole, due to the early arrival of the international drug wave in the capital and the early establishment of drug services (Københavns Kommune, 2006; Houborg, 2008).

In 2005 drug treatment got established in Danish prisons. In 2001 approximately 30,000 € were spent on drug treatment in prisons, in 2009 it was already 8.7 million €. Treatment within prison includes motivational programmes, day treatment, cannabis and cocaine treatment, treatment in isolated wings, in drug-free wings, and in after-treatment wings (Kolind et al., 2010).

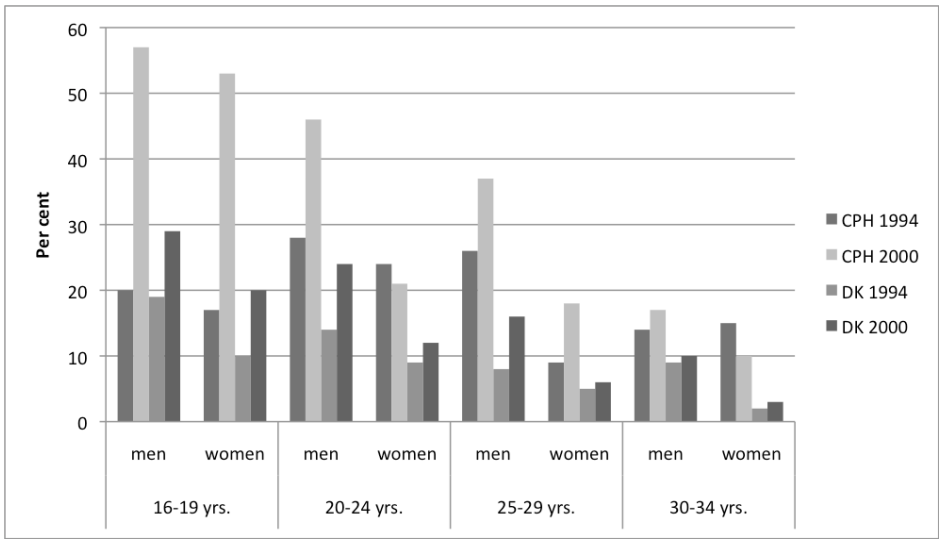
3 Consumption and consumers

Figures on drug use in Copenhagen are scarce: the most recent ones are from 2000. However, national surveys show that even though in the 1990s young people's (15-30 years of age) drug use increased markedly it has flattened since then and that it also did not increase among the elder population. Therefore, the 2000 figures might still be of use. Looking at young Danes in general, cannabis and cocaine use have increased probably related to a general European trend (Parker et al., 1998). Cannabis use is especially widespread In Copenhagen. Figure 1 shows that in Copenhagen more than half of all young men

Cannabis and cocaine use have increased probably related to a general European trend

between 14 and 24 years have smoked cannabis within the last year, whereas in Denmark as a whole it was only about one quarter. The cannabis users are mostly young people from the upper middle class as well as from broken families (Sundhedsstyrelsen, 2003).

Figure 1: Last year cannabis use of men and women in different age groups, in Copenhagen and Denmark as a whole, 1994 and 2000; in percentages



Source: Københavns Kommune, 2006.

Also, the use of other drugs than cannabis is presumably markedly higher in the capital. Figure 2 shows that in 2000 about twice as many Copenhageners have used cocaine and amphetamine than Danes living in other regions. In Copenhagen the percentage of young and middle-aged men (14-44 years old) who have tried other drugs than cannabis amounted to 16% (Københavns Kommune, 2005).

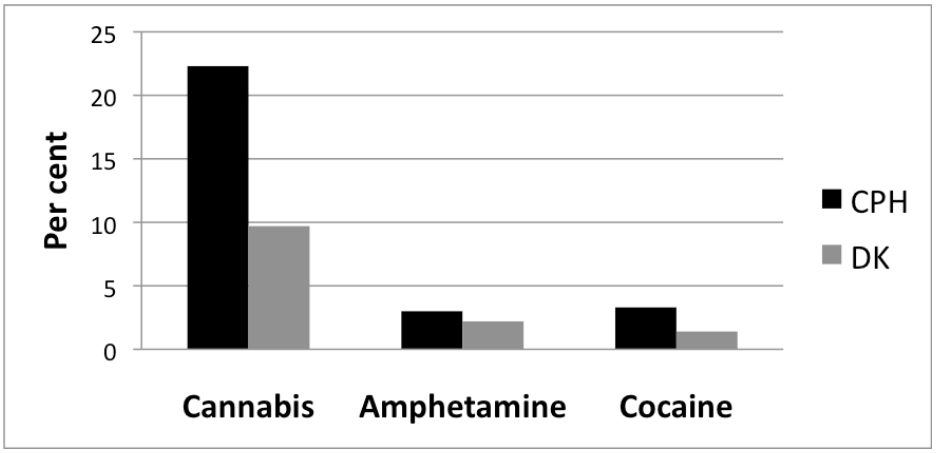
According to estimates of the National Board of Health in 2005 the number of regular drug users amounted to ca. 27,000 in Denmark, which is about the same size as in 2001. It includes only regular drug users suffering of physical, psychological and/or social harm such as users in substitution treatment but also regular users of central stimulants and cannabis (National Board of Health, 2006). About one fourth of all regular drug users lived in Copenhagen, meaning that the capital had roughly two and half times as many regular drug users than the rest of the country (Sundhedsstyrelsen, 2003).

The percentage of cannabis users increased at the expense of heroin users

In 2009 the number of regular drug users increased to about 33,000 and their composition changed. The percentage of cannabis users increased at the expense of heroin users: Whereas in 2005 29% of the regular users consumed cannabis, their share increased to one third in 2009. More than another third

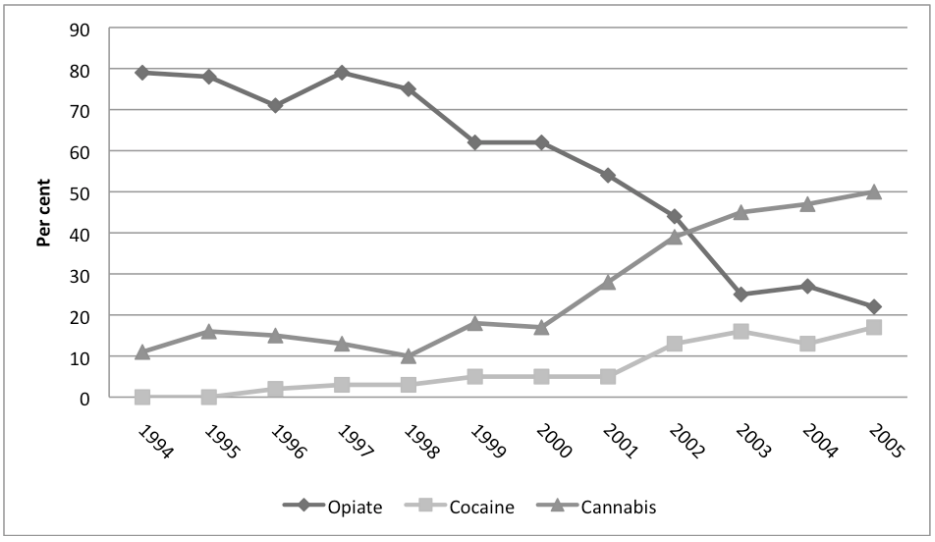
(13,000) were injecting drug users, half of whom lived on Zealand, the isle on which Copenhagen is located (Sundhedsstyrelsen, 2010). The percentage of injecting drug users corresponds to figures for other EU countries (EMCDDA, 2010).

Figure 2: Last year use of cannabis, amphetamine and cocaine among men 16 to 44 years old, Copenhagen and Denmark, 2000, in percentages



Source: Københavns Kommune, 2006.

Figure 3: Main drug among users admitted for the first time to a drug service, 1994-2005, in percentages



Source: Københavns Kommune, 2006.

Drug treatment data reinforce the picture drawn by the estimates. If drug preferences of drug clients who for the first time were admitted to a drug service are considered, cannabis has become the drug of choice (see Figure 3):

Though in 2005 only 11% of clients had been admitted for the first time because of cannabis problems, half of them preferred cannabis. And though the vast majority (70%) had been admitted because of opioid problems, only one fifth (22%) preferred opiates (Københavns Kommune, 2006).

4 Drug scenes

There are two open drug scenes in Copenhagen

There are two open drug scenes in Copenhagen (Dahl, 2008). The most known is Christiania, or The Free Town. It is located in a quarter called Christianshavn, covers about 32 square kilometres and is inhabited by approximately 900 dwellers. The area was occupied by squatters in 1971 and has since then been ruled as a kind of commune where cannabis is not perceived as an illegal intoxicant, but where hard drugs are not tolerated. Christiania is known for Pusher Street where cannabis previously has been sold openly. To some extent Christiana functioned as the cannabis redistribution centre between Europe and Scandinavia, and in the early 1990s the annual turnover was estimated to be 40 million €. Because of the unveiled cannabis market, but also because of the inhabitants' alternative lifestyle Christiania attracted many drug tourists from both Denmark and other European countries. Traditionally it was attacked by the political parties of the right wing and defended by those of the left (Møller, 2008).

The sale of cannabis has led to several conflicts with the police and also some round-ups by the police, in which larger amounts of money have been confiscated. Political responses have changed repeatedly. In the 1990s police was instructed to restrict prosecution of small-scale dealers (Møller, 2008: 127) but in 2004, in the course of the Government's generally harder response towards drugs, the police turned to a zero-tolerance policy also in Christiania and carried out a range of round-ups. One consequence was the spread of the sale of cannabis to other parts of Copenhagen, where it had to be hidden. The fight for the control over the dispersed cannabis market in 2010 seems to have resulted in a war between a biker gang and second-generation immigrants, in which the police reacted so harshly that several complaints were lodged. Parts of the cannabis market have moved to southern Sweden, but other parts remained and Pusher Street is still at work, though in a more covert manner.

The second open drug scene is Copenhagen Central Railway Station and Maria Church Square, two places so close that they can be portrayed as one. As in other large cities the station in Copenhagen is a place where drug users meet, and where drugs are consumed and sold. It is an important meeting point to socialize and contact the drug market. The drug users are, however, continuously chased away by the police and fined because their presence at the station

is interpreted as a disruption of the public order. To make them leave, classical music is used at the eastern entrance where drug users meet. Close to the railway station is another open drug scene around Maria Church. Contrary to Christiania, all kinds of drugs are sold here and injected openly. The residents feel disturbed because of the tragic scenery, the availability of drugs and the needles scattered. The police patrols the area regularly and frequently fines drug users, who cannot pay and therefore go to jail. Contrary to the police, Maria Church welcomes the drug users and offers a refuge during opening hours. A non-spoken informal agreement between the parties guarantees that the police only exceptionally enters the church; that the church refrains from getting active in the public and thus attracts more drug users; and that drug users do neither inject nor sell drugs in the church (Frantzsen, 2003).

Copenhagen has had a variety of cannabis clubs

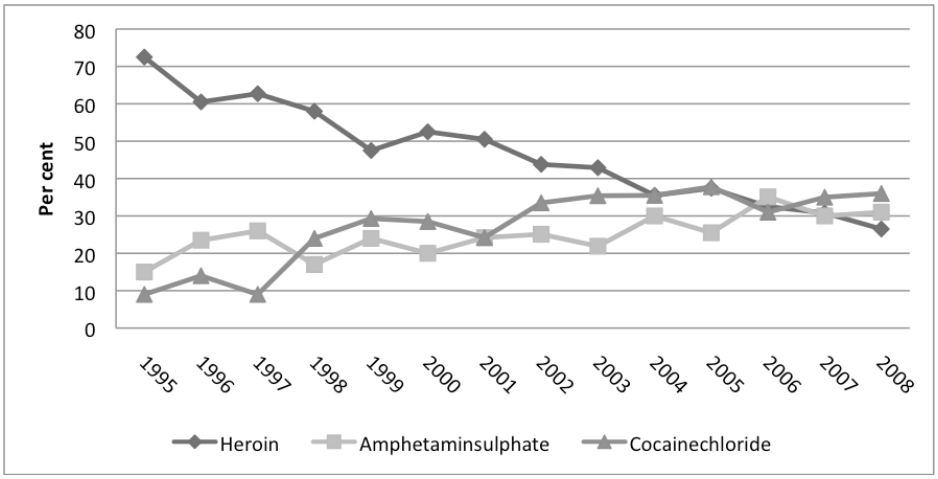
Copenhagen has had a variety of cannabis clubs. Some focused on sale of cannabis, others were mainly meeting spots, places where cannabis users socialized and smoked. Research has shown that the social aspect was prevailing in cannabis clubs in Copenhagen, and that they in regard to their function therefore are comparable to pubs where visitors have a beer and a chat (Asmussen and Moesby-Johansen, 2004). In 2000, the police registered 60 cannabis clubs, 2 years later – after a new law had tightened up controls – only 34 were left over. In 2009, the police counted 2, a figure which is too low because the foundation of new clubs is not taken into account (Møller, 2008).

5 Drugs, markets, purity and prices

Two statistics inform on drugs seizures and drug purity in Copenhagen. The police statistics on seizures of illegal substances established in 1999 (Narkotikastatistik, 2008) is to be used with caution: The area served by the Copenhagen Police is bigger than Copenhagen Municipality and the drug categories used have changed frequently. Especially to keep in mind is that police statistics mirror the priorities and activities of the police and far less systematically reflect drug scenes and drug markets.

The other statistic is an outcome of a research project on the purity of drugs seized in the five largest cities in Denmark including Copenhagen (Sundhedsstyrelsen, 2009a). The project started in 1995 and is financed by the Danish National Board of Health. The initial intention to investigate the relation between purity and prices had to be dropped, because the reports on prices had been too inaccurate. But Figure 4 shows at least the number of seizures of selected drugs in Denmark during the last decade:

Figure 4: Number of seizures of heroin, amphetaminesulphat and cocainechloride in Denmark, 1995-2008; in percentages



Source: Sundhedsstyrelsen, 2009a.

Figure 4 shows that the share of seizures of heroin has been continually declining since 1995, and that cocaine was the drug most often seized in 2008. As with cocaine the percentage of amphetamine seizures has been rising from 1995-2008. Cocaine and amphetamine made up 2/3 of all seizures in 2008.

The volume of seizures is higher in Copenhagen, due to higher availability and consumption in the capital, but presumably also due to more intensive police activities. According to the data presented in Table 1 the volume of heroin and cocaine seizures is especially high indicating the higher prevalence of "hard drug" use in the capital.

Table 1: Volume of seizures of selected substances, Denmark as a whole and Copenhagen, absolute numbers and percentages, 2008

		Copenhagen police district	Denmark	Per cent
Cannabis	Kg	937,21	2.914,46	32.2
Amphetamine	Kg	59,50	119,83	49.7
Heroin	Kg	38,67	43,94	88.0
Cocaine	Kg	34,58	56,09	61.7
Ecstasy	Piece	3050,00	17.631,00	17.3

Source: Narkotikastatistik, 2008.

Table 2 presents more data on the regional differences of drug seizures. Seizures in Copenhagen mostly concern cocaine and heroin, in the countryside amphetamine. Seizures of ecstasy were monitored separately: they decreased remarkably in 2008 and were only found in three cities including Copenhagen (Sundhedsstyrelsen, 2009b).

Table 2: Number of seizures in regard to drugs, in the five largest cities, 2008; in percentages

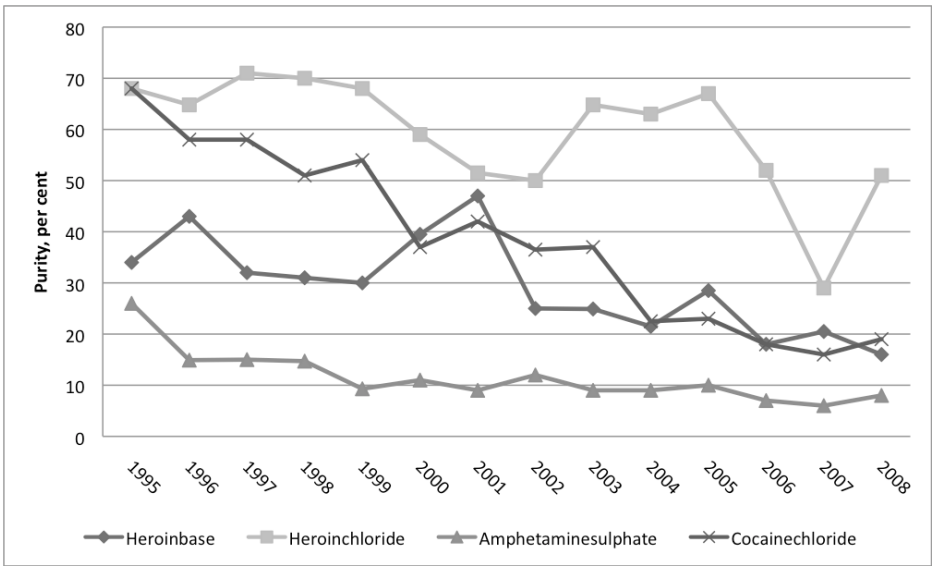
Police district	Copen-hagen	Århus	Odense	Ålborg	Esbjerg	All
	N=52	N=52	N=39	N=26	N=26	N=195
Heroin	40	27	28	4	19	29
Cocaine	42	33	28	50	19	35
Amphetamine	10	35	38	42	46	31
Metamphetamine			3		15	3
Other drugs		6	3	4		3
Non drugs	8					2

Source: Sundhedsstyrelsen, 2009a.

Purity of heroin, cocaine and amphetamine has declined continuously in Denmark since 1995

Purity of heroin, cocaine and amphetamine has declined continuously in Denmark since 1995, on user level as well as in other respects (Figure 5). With heroinchloride und cocaine purity is significantly higher in the capital where most regular users of these substances live (Sundhedsstyrelsen, 2009b).

Figure 5: Purity of drugs on user level, 1995-2008; in percentages



Source: Sundhedsstyrelsen, 2009a.

6 Conclusion

Drug policy in Copenhagen Municipality is somewhat more liberal and activist than Danish drug policy in general, which has become increasingly repressive since 2000. But Danish drug policy since the turn of the millennium also included the extension and diversification of drug services, among other things the establishment of low-threshold facilities within the governmental as well as the private sector. Drug services were especially extended and diversified in the capital where they mostly targeted new consumer groups – young users – and new problems – risks related to recreational use – both more prevalent in Copenhagen than elsewhere in Denmark. Due to this development Danish drug policy has become more ambivalent during the last 10 years, focused on control and the penal system on the one hand, on treatment, advice and on risk harm reduction, on the other hand.

Danish drug policy has become more ambivalent during the last 10 years

Copenhagen has two open drug scenes, the better-known one in Christiania, where mostly Cannabis is taken and which has suffered several crackdowns by the police. The "Central Railway Station and Maria Church" scene where harder drugs are sold and injected is under permanent police control. The responses to the open scenes make the double face of Danish drug policy very well visible: In the neighbourhood of the Central Railway Station, marginalized drug users are stressed and penalized by the police (Frantzsen, 2005) and at the same time targeted by harm reduction initiatives as the health room or drop-in centres.

All types of substances are more frequently used in Copenhagen. These conclusions based on survey data are reinforced by figures on drug seizures and on clients of drug services, which both are significantly higher for the capital. With regard to drugs of preference, Denmark moved from heroin towards cocaine and amphetamine, as figures on seizures and drug service data indicate. However, in Copenhagen, heroin is still an important substance: in the capital heroin seizures are the highest, and numerous heroin users can be found among the older clients of drug services. But with all substances purity has declined during the last 10 to 15 years, though that of heroin and cocaine remained significantly higher in Copenhagen, where regular use of these substances is relatively widespread.

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The Two Faces of Drug Consumption: Experimentation, Marginalization and the Swedish Drug Policy

Filip Roumeliotis

1 Stockholm

Stockholm county is the county with the highest population and is the youngest county in Sweden

Stockholm is the capital of Sweden. With a population of 2,019,182 (ca. 21% of the nation's population) in 2009, Stockholm county is the county with the highest population. The total population in Sweden is approximately 9,380,000 and the average age is 41 years, making Stockholm the youngest county in Sweden with an average age of 39 years. The county counts the smallest number of inhabitants aged 65 and over (14% compared to 18% for the whole country). The age composition in Stockholm for the year 2009 was as follows: 0-15 years: 19%, 16-30 years: 19.8%, 31-45 years: 23% and 46-60 years: 18%.

In the 1960s and -70s Sweden began receiving high numbers of labour immigrants, mostly from Finland. In the 1990s and 2000s immigration was mostly connected to the wars in former Yugoslavia and Iraq. The highest recorded figure of 101,200 persons with 168 nationalities migrated to Sweden in 2008 and the immigration surplus accounted for 76% of the population increase that year on a national level. Persons born in Finland make up the largest number of foreign-born inhabitants in Sweden followed by persons born in Iraq and former Yugoslavia. 14% of the Swedish population is born in a foreign country and in Stockholm this figure is 20% making Stockholm the county with the highest share of foreign-born inhabitants.

Of all employed persons in Stockholm county (1,054,255 in 2009), 259,530 persons were employed in business services and financial intermediation, 222,410 persons were employed in trade and communications, and 127,590 persons were employed in health and social work, making them the three largest branches in the county. In comparison, the three largest branches in the whole of Sweden are trade and communications, with 813,578 employees, health and social work with 708,860 employees, and manufacturing, mining

and quarrying with 695,845 employees. The total amount of persons employed in Sweden in 2009 was 4,406,789. In the same year, 6.7% of the available workforce in Stockholm county was unemployed, which is lower than the unemployment rate for the whole nation (8.3%).

2 Swedish drug policy

Sweden has a history of highly restrictive drug policies

Sweden has a history of highly restrictive drug policies. Since the 1960s, when the drug issue became a major public concern, Swedish drug policy has become increasingly repressive. In 1978 "a drug free society" was adopted as an ultimate goal, as well as a principle for the handling of the drug situation, and the maximum penalties for drug offences were continuously raised. This highly restrictive view on drugs means that, officially, no distinction is made between "soft" and "hard" drugs, all non-prescribed use of substances classified as narcotics is criminalized, and, in 1988, the consumption of illicit drugs was criminalized with fines imposed on consumers. The criminalization of consumption was, however, criticized due to its inefficiency since the police was not allowed to conduct blood- or urine tests in order to acquire evidence of consumption. So, to make the criminalization more efficient, prison sentences up to six months were introduced for consumption of illicit drugs in 1993, giving the police the right to take blood- and urine samples in suspected cases of consumption (Blomqvist et al., 2009; CAN, 2009b).

Harm reduction measures, such as methadone maintenance and needle exchange, have historically been conceived of as negative since they contradicted the main goal of a "drug free society" and, furthermore, would send wrong signals about society's view on drugs. Even during the HIV epidemic in the mid-1980s Sweden chose not to employ harm reduction strategies to limit the epidemic. Instead, it spent hundreds of millions of SEK on what was called an "offensive drug care", offering drug users treatment with the aim of total abstinence from drugs.

This highly restrictive view on drugs with an emphasis on control and sanctions can historically be traced back to the influence of the Swedish temperance movement and its main representative, the physician Nils Bejerot. He was one of the most central debaters on drug issues during the 1970s and 1980s and was a strong proponent of an 'epidemic' perspective, with a focus on the drug users and the use of drugs instead of social factors (Törnqvist, 2011: 189f).

Also the police belonged to some of the most influential early actors in drug policy (Lenke and Olsson, 1999). Nevertheless, during the past ten years a slight shift in favour of harm reduction measures can be observed – this issue will be taken up later.

In 2005 a new action plan was presented by the government. It consists of a balanced mix of preventive, treatment and repressive measures

In 2005 a new action plan was presented by the government (Prop. 2005/06:30) whose main targets for the work towards a "drug free society" were: To prevent the recruitment of new users, to help individuals overcome their addiction and to decrease the availability of drugs, meaning that drug policy should consist of a balanced mix of preventive, treatment and repressive measures. In this regard, the new drug policy did not differ from previous policies and their ultimate goal of a "drug free society". In this action plan, the government stated that the county councils, the municipalities and the state all share responsibility in the work to reach the goal of a "drug free society". The government earmarked 250,000,000 SEK (cap. 26,500,000 € in 2010 currency) for the enforcement of the action plan for the year 2006, and 260,000,000 SEK for each following year. Since the action plan covers both alcohol and drugs, however, these sums are meant to cover both areas.

In 2008 the work of the national drug coordinator was taken over by the National Board of Health and Welfare and the Swedish National Institute of Public Health, with the mission to support and develop prevention work on municipal and local level, where it is mainly done. Local drug prevention is most often formulated in a municipal programme. In 2008 about 90% of all municipalities had a programme for the prevention of problems connected to alcohol and drugs and 80% had an appointed drug coordinator (FHI, 2008a).

Much of the preventive work is carried out in schools, and focuses on risk behaviour of students, supporting parents and the school environment through programmes such as Social Emotional Training (SET), which aims at developing the social and emotional capacities in children and youth (FHI, 2009). Treatment is provided by the municipal social services – that are responsible for long-term treatment and care –, and healthcare-based drug services, but since the 1990s it is to an increasing degree also offered by voluntary organizations and especially private care providers. Apart from this, treatment is provided at specific departments within the prison and parole system (non-custodial treatment), and in Stockholm by the Addiction Centre Stockholm, which also offers information, counselling, and rehabilitation.

Policies and practice do not always match

Policies and practice do not always match. During the financial crisis in the 1990s the balance of preventive-, treatment-, and repressive measures shifted and the latter gained weight at the expense of treatment- and preventive measures (BRÅ, 2003). And despite ambitious national guidelines for an evidence-based practice and the ambition to make treatment more uniform and, above all, rational, practitioners working in Stockholm reported on never-ending reorganizations, short-term projects with no effects and lack of individually adjusted treatment and evaluation. In their view availability of treatment is too limited, treatment duration too long, and the collaboration between treatment organizations does not seem to work at all, leaving patients in a vacuum or to being handed over from unit to unit, mainly because of disagreement on payment responsibilities. They also complained about the barriers to attractive

lifestyles consisting of a home, employment and a meaningful social context, which could function as incentives to enter treatment and to comply with therapy. Drug policy, finally, was perceived by the interviewed practitioners as waging a war against drug users, in which symptoms and not causes were treated (Christophs, 2009).

A shift towards a somewhat increased acceptance of harm reduction measures that aim at "care" rather than "cure"

The critical remarks made by the practitioners could be seen against the background of the shift mentioned above. There seems to have occurred a shift from the traditionally restrictive official stance against any use of drugs, including substitution treatment which was often said to contradict the main goal of a "drug free society", towards a somewhat increased acceptance of harm reduction measures that aim at "care" rather than "cure" of drug users. This includes an increased focus on substitution treatment and low-threshold activities. This shift has, however, not put the main goal of a "drug free society" into question or even passed it by unquestioned, it has rather been reformulated as a medical question and thus integrated into the drug policy. Although the acceptance of harm reduction measures has been welcomed by many as a much needed change in the handling of the Swedish drug problem, there is a concern that drug users to an increasing extent get offered medication and shelter on behalf of solutions aiming at social re-integration. This involves the risk that the drug problem might be reformulated as a question of public nuisance in which marginalized drug users are simply kept out of view of the "normal" population (Blomqvist et al., 2009; Olsson, 2011). This shift in many ways illustrates the complex and sometimes contradictory relationship between written programmes, their enforcement and consequences.

3 Sources of information

One of the main sources of information on drug consumption is the school survey conducted annually since 1971. The survey targets students in grade 9 and (since 2004) students in grade 11, and is conducted by the Swedish Council for Information on Alcohol and Other Drugs (CAN). CAN also collects information and statistics from the customs, the police and the courts on drug prices at street level, drug seizures and offences, and drug-related deaths.

Another major source on drug consumption is the national health survey conducted by the Swedish National Institute of Public Health (FHI) covering various health-related topics, including cannabis and alcohol consumption for ages 16-84.

For Stockholm, the Prevention Centre Stockholm (PC) conducts annual "Stockholm surveys" similar to the school surveys conducted by CAN.

In 2007/2008, a "base-line" study was conducted in Stockholm to assess the HIV/Hepatitis B situation among intravenous drug users. The study included 720

persons defined as “active intravenous drug users” (having injected drugs during the last 12 months) and provides information on socio-demographic factors as well as consumption patterns for intravenous drug users.

In addition to these studies, key informants have been interviewed for the current report, in cases where no information was found in the mentioned surveys and studies.

4 Trends in drug consumption

The consumption of illicit drugs seems to be fairly stable in Sweden with relatively low consumption levels

The consumption of illicit drugs seems to be fairly stable in Sweden with relatively low consumption levels. In the school survey conducted in 2008 on a national level, 7% of the boys and 5% of the girls in grade 9 stated that they had experimented with drugs at some point in their life. This is a decline compared to 1971 when about 15% of the students in grade 9 reported life experience with drugs (CAN, 2009a). The figures for Stockholm in 2008 are somewhat higher with 13% of the boys and 12% of the girls reporting life experience with illicit substances (PC, 2009). This is also a decline, viewed from the perspective of 1967, with a lifetime prevalence of 17% for the girls and 23% for the boys in grade 9 (CAN, 2009b). The most common illicit drug consumed is cannabis and the share of students in grade 9 who had tried another drug varies between 0-1% since 2000 (CAN, 2009a).

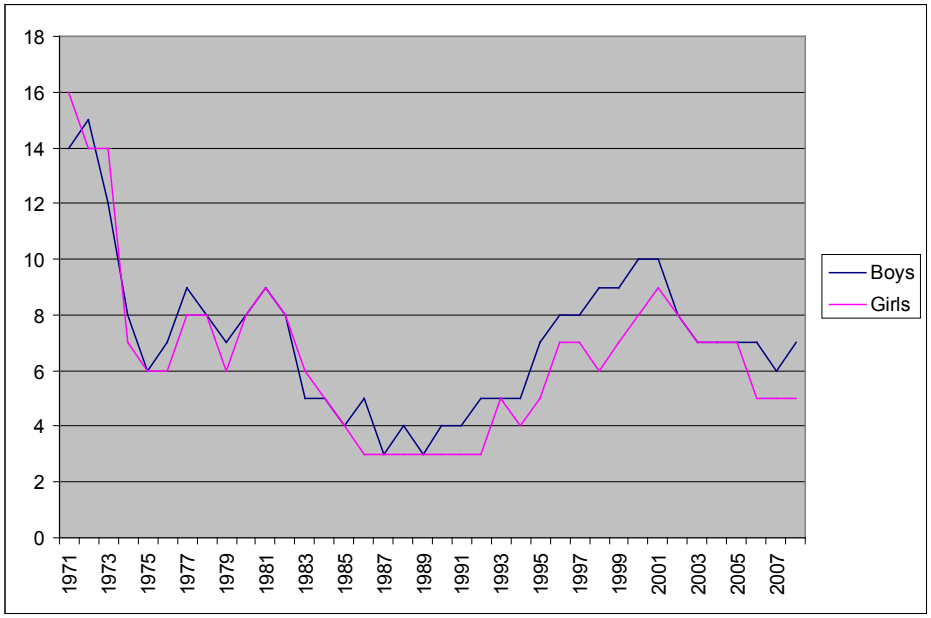
But school surveys do not necessarily reflect the drug consumption of the total population, and certainly not the frequency of heavy drug use – they mostly concern one or two age categories. Therefore a decline in the drug experiences of 15-year-old schoolchildren could indicate a delayed introduction to drugs that does not reflect the frequency of drug use of the total population (Lenke and Olsson, 1999). Furthermore, drug use trends should be interpreted against the backdrop of contextual factors such as the general decrease in juvenile delinquency and alcohol intoxication (ibid.). Finally the high numbers of drug-experienced youth at the beginning of the 1970s have to be seen in the light of the still ongoing “youth revolution” for which cannabis was a symbol for peace, freedom and love (Olsson, 2011).

The national health survey is one of the few studies on the drug consumption of the adult population: But it only measures cannabis use since it is the most common illicit drug.

Respective results show a lifetime prevalence for cannabis use of about 14.9% for all males and 8.4% for all females, 16-84 years old, in 2004. Of those aged 16-29 years, 22% had at least once in their life experimented with this substance. The lifetime prevalence has been fairly stable over the last 6 years; it was 15.3% for males and 8.7% for females in 2010 (FHI). The survey data for

the years 2007-2010 also show that cannabis experiences are more frequent in Stockholm than in the country as a whole: In the capital it was 20% of the male and 12% of the female respondents, in the country 14% of the male and 8% of the female respondents (ibid.).

Figure 1: Lifetime prevalence of drugs for students in grade 9 (15-16 years) in Sweden, 1971-2008, in percentages



Source: CAN, 2008a.

Few studies have been conducted on "heavy" drug consumption, except for the years 1979, 1992 and 1998, when studies were carried out on national level. In these studies, information was gathered from professionals working with drug users on local level. On the basis of their reports on problem users the number of non-registered drug users was estimated. Heavy drug consumption was defined as injection of drugs at least once during the last 12 months or drug use on a nearly daily basis during the last 4 weeks (CAN, 2009b). In 1979 the number of problem users was estimated to be 15,000, by 1992 it had risen to 19,000, in 1998 the figure was up to 26,000, amphetamine, heroin and cannabis being the main drugs. Later estimates – in 2001, 2004 and 2007 – arrive at 28,000, 26,000 and 29,500 "heavy" users, but their definition of "problematic drug consumption" differs from the earlier studies since it is based on drug-related problems instead of mode and frequency of use (ibid.). The only available estimated figures on heavy drug consumption in Stockholm cover the years 1979, 1992 and 1998.

Table 1: Estimated numbers of heavy and problematic drug users, Sweden and Stockholm county

Year	Total	Stockholm county
1979	15,000	3,481
1992	19,000	4,944
1998	26,000	8,723
2001	28,000	***
2004	26,000	***
2007	29,500	***

Source: CAN, 2010; Olsson et al., 2001.

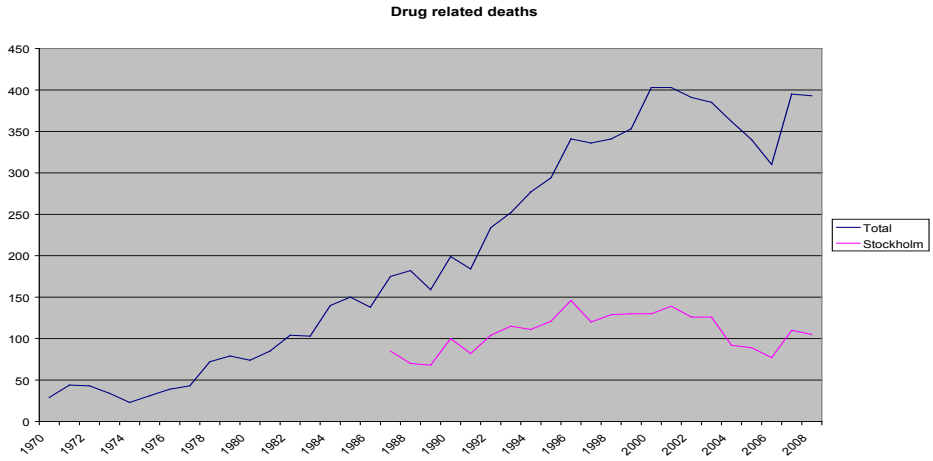
Two times as many problem users per inhabitant live in Stockholm compared to the rest of the country

According to some estimates two times as many problem users per inhabitant live in Stockholm compared to the rest of the country but the size of the intravenous drug using population today remains unknown. The shares of problem users who live in large cities and the rest of the nation have evened out somewhat but the available information indicates that drug consumption is still concentrated in urban settings (KI, 2008).

Stockholm holds about one third of all drug-related deaths, drug users entering treatment and drug-related offences in Sweden, but it is difficult up to impossible to use these figures as indicators of the size of the heavy drug-using population since they depend on changes in legislation, structure and offers of drug services and priorities in law enforcement as well as police resources. The development in drug-related deaths shows that almost 60% of all drug-related deaths in Sweden occurred in Stockholm during 1987-1995, but that the share has decreased to about 30% during the last few years. The number of drug-related deaths in 2008 was 393 persons at a national level and 105 persons in Stockholm. In comparison to other EU Member States, the Swedish figures on drug-related deaths are about twice as high as the average (Olsson, 2011: 38). This can in part be explained by the strong marginalization of heavy drug users, their life situation and the lack – or late introduction – of harm reduction measures such as e.g. substitution treatment programmes (ibid.).

The rising problems with HIV in the second half of the 1980s and early 1990s were responded to by an “offensive drug care” – a broad and extensive focus on drug care. Most of the care at this time consisted in institutional, long-time treatment aiming at abstinence, although a shift could be observed toward short-term, outpatient treatment, partly due to the financial crisis in the beginning of the 1990s. Regarding intravenous HIV-cases in Sweden, Stockholm stands for about 70% of the reported cases between the years 2000-2008 (CAN, 2009b).

Figure 2: Drug-related deaths in Stockholm and in Sweden as a whole, 1970-2008, absolute numbers



Source: CAN, 2008a.

5 Drug users

It is more common for men than women to use cannabis, and the largest group in this population is between ages 16-29 (FHI, 2008b). For students in grade 9 in Stockholm, a similar distribution can be seen, with more boys than girls having used drugs (14% and 13% respectively) and the average age for first-time use is 14 years for both groups (PC, 2009).

Lifetime experience as well as regular use of drugs was three times as common for persons who neither worked nor studied

There are more social dimensions in regard to drug experiences than gender dimensions. Among conscripts, lifetime experience as well as regular use of drugs was three times as common for persons who neither worked nor studied compared to persons who studied in 2005 (CAN, 2010). According to a study on 15-64 year olds, experience with drugs was more common for unemployed persons, persons with economic problems, homeless persons and persons with weak social networks (CAN, 2010).

Studies have shown that most of those who experiment with drugs do it out of curiosity and that this is constricted to a few experiences. This means that the majority of those who have experimented with drugs have only used drugs (read: cannabis) a few times (Olsson, 2011: 40f). Thus, the prevalence of heavy drug use cannot be directly explained by the prevalence of experimental use as one of the basic assumptions of the Swedish drug policy holds. Rather, the prevalence of heavy drug use should be seen as complex, involving combinations of properties in the individual, the substances and the environment (ibid.).

Regarding heavy drug users, they often show signs of early and accentuated social problems and negative experiences during their upbringing. In addition

to this, persons from socially and economically weak and vulnerable groups are overrepresented among problematic drug users (CAN, 2009b; CAN, 2010; Olsson, 2011: 38).

According to the mentioned baseline study on intravenous drug users (KI, 2008), 83% of the heavy users were born in Sweden, are 40 years old on average and mostly male (73%). Somewhat less than half of the "grave users" have no address and 43% are unemployed. 83% have been in custody once or more often and 62% have been in jail several times. The onset of drug use is on average 15 years of age, and for quite many (9%) even below 12 years. Among intravenous drug users, amphetamine is the most common drug – almost half had used it during the last 12 months – followed by heroin, used by 22%. The drug-using population mostly consists of poly-drug users: use of amphetamine mostly goes along with alcohol and THC consumption (31 resp. 30%) whereas heroin as main drug is most often combined with benzodiazepines (40%), amphetamine (26%) and THC (15%).

6 Drug crimes and drug control

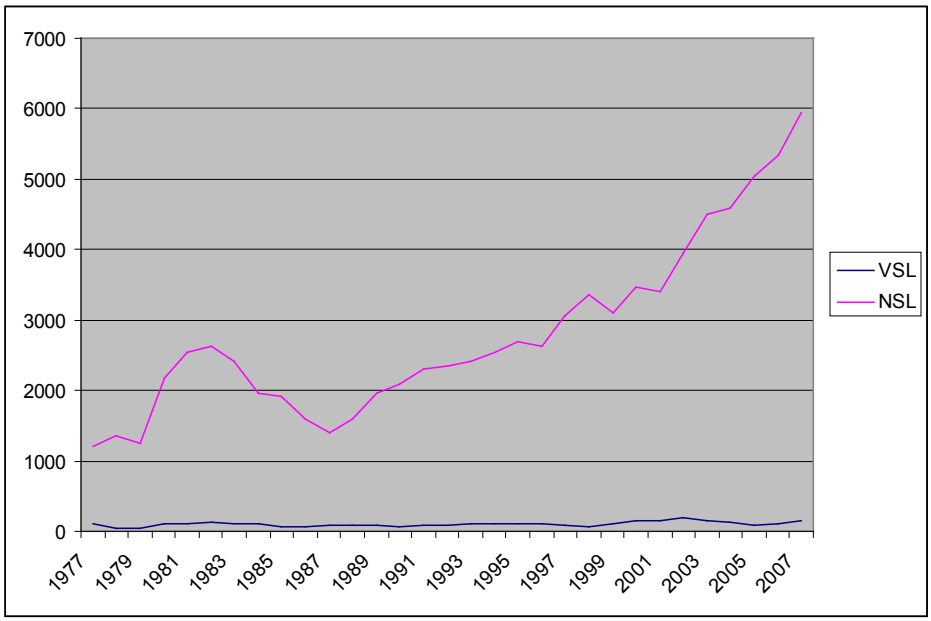
As mentioned above, Sweden holds a highly restrictive policy on drugs, criminalizing possession, sales and consumption of all non-prescribed substances classified as narcotics

As mentioned above, Sweden holds a highly restrictive policy on drugs, criminalizing possession, sales and consumption of all non-prescribed substances classified as narcotics. From 1988 to 2008 the number of hours spent by the police on drug crimes has tripled and the yearly number of persons convicted for drug crimes has increased from 4,971 to 21,253 from 1988 to 2009 (CAN, 2009b; CAN, 2010).

There are two main drug-related laws; one on smuggling (VSL) and one on possession, sales and consumption of narcotics classified as substances (NSL). As for smuggling, the number of reported drug-related crimes has been fairly stable and partly even declining during the 1990s, but the crimes reported under the NSL-law have been rising and have more than tripled between 1990 and 2008 (from 26,496 to 78,188). The increase is mainly due to rising reports of minor offences such as possession for own consumption and consumption itself; offences on "middle level" have declined and major offences have been fairly stable. The development reflects the shift of controls from the suppliers to the users, made possible by the criminalization of consumption that took place 1988 to 1993. The increasing emphasis on police controls is also to be considered as a shift of Swedish drug policy towards more repressive measures carried out by the police and the judicial system at the expense of social, treatment and preventive measures (BRÅ, 2003; CAN, 2009b). Taken together, the increasing emphasis on repressive measures coupled with a newly-found acceptance for harm reduction measures, such as drug maintenance programmes

and low-threshold activities, indicates that Sweden might be adopting a "public nuisance" approach toward drug problems in which the traditional focus on social re-integration is to a large extent left behind (Blomqvist et al., 2009; Olsson, 2011).

Figure 3: Number of persons suspected of drug-related crimes defined by the VSL and NSL, 1977-2007



Source: CAN, 2008a.

In 2008, more than 10,000 persons were imprisoned of which 58% were assessed to be drug users of which three quarters were characterized as "grave drug users". At present drug offences are the most common offence among prisoners (CAN, 2009b).

7 Drug markets

The drug market in general, ..., has been expanding steadily since the 1970s

The drug market in general, seen as physical and economic availability, has been expanding steadily since the 1970s as indicated by increasing numbers of seizures and simultaneously dropping prices. The four most common types of drugs in Sweden are cannabis, amphetamine, cocaine and heroin. *Cannabis*, and especially *hashish* has been the most common drug and its availability has increased in the 1990s. It seems that *marihuana* has been spreading during the last few years and there are indications of a higher demand for it (CAN, 2009c). Availability of *amphetamine*, traditionally the main "heavy" drug, has steadily increased since the 1970s and *methamphetamine* has become more common since the turn of the century.

When seizures are measured by weight, those of methamphetamine increased their share from 2% in 2000 to 15% today. *Cocaine* started to spread in the 1980s and is becoming more common (CAN, 2008b). Heroin entered the drug market in the 1970s, its availability increased until 2000 and stabilized after that. *Brown heroin*, which makes up 75% of all confiscated heroin, is the dominating form and *white heroin* might be becoming less available.

Seen from a geographical perspective, *white heroin* is more common in the regions surrounding Stockholm and less common in the south of Sweden, where *brown heroin* is more common. *Synthetic drugs* (apart from amphetamine) gained some popularity during the 1990s, being connected to nightlife and clubbing, with ecstasy being the most famous. There was an increase in ecstasy use among 18-year-old men from 1 to 4% between 1994-2002 although its popularity has waned since then and there are indications that ecstasy use is becoming more and more rare.

A similar development can be observed for LSD, GHB and *"magic mushrooms"* – an increase in popularity in the 1990s has been supplanted by a decrease in both popularity and availability between the years 2000-2006. *Kat* was classified as a narcotic substance in 1989, it has spread somewhat since then and is presumably mostly used by persons stemming from regions where it grows (CAN, 2009b).

Finally, drugs classified as pharmaceuticals have increased in availability – mainly benzodiazepines, methadone, subutex and similar substances. Substances called *"internet drugs"* – drugs not yet prohibited but with similar effects to illicit ones – raised some public awareness although it is unknown whether availability has increased.

8 Drug prices and purity

CAN has been gathering information on drug prices on street level for the most common drugs since 1988. It is based on 30 police reports sent to CAN twice a year. The data depict a marked decrease in drug prices since 1988, levelling off during the last years, except for cocaine for which the price has continued to drop. The price of hashish on national level has, since 1988, dropped by 50%, of amphetamine by 70%, of cocaine by 40%, of brown heroin by 65% (CAN, 2008b). The price of ecstasy has dropped by about 40% between 2000-2005, while the price of LSD seems to have remained stable (CAN 2009c). Today the most expensive drugs are white and brown heroin followed by cocaine. The decline of heroin and cocaine prices seems to correspond to a trend observed in Western Europe and the USA (CAN, 2008b).

The price of hashish on national level has, since 1988, dropped by 50%, of amphetamine by 70%, of cocaine by 40%, of brown heroin by 65%

Prices do not differ remarkably on regional level, but they are lower in southern Sweden than in the north, probably due to the southern part's proximity to continental Europe.

Figure 4: Median drug prices in Stockholm and Sweden as a whole, 2005-2009, in Euro

Drug*	Stockholm	Sweden
Hashish	8	8
Marijuana	10	9
White heroin	186	160
Brown heroin	138	106
Amphetamine	21	26
Cocaine	85	85
Ecstasy	10	10
LSD	10	10
Kat**	-	21
GHB	4	3

Notes: * Prices are indicated per gram except for LSD (per trip), kat (per bunch) and GHB (per cl). ** Prices for Stockholm are not available. Source: CAN, 2009c.

There are no accurate figures on the purity of drugs

There are no accurate figures on the purity of drugs. According to a key informant at the Swedish National Laboratory of Forensic Science, due to the heterogeneous samples of drugs, analysed purity cannot be calculated at the moment. The National Laboratory analyses all drugs confiscated in Sweden and is the only body carrying out this work. The analysed drugs range from small seizures with low purity on street level to large ones from customs with high levels of purity. Currently, there is an attempt to collect information on purity in collaboration with state attorneys.

9 Conclusion

Sweden upholds one of the most restrictive drug policies in the world

Seen from an international perspective, Sweden differs in many ways in respect to the handling of the drug situation. First of all, the Swedish drug policy by far exceeds the outlines of the conventions laid down by the United Nations and the European Union (Träskman, 2011), meaning that Sweden upholds one of the most restrictive drug policies in the world. Secondly, with a view to which actors have been central to the formulation of the drug policy, Sweden differs from most countries due to the strong influence from the temperance movement and the police on drug policy formulations. Finally, the strong position of the temperance movement, along with the goal to achieve a 'drug free society' has meant that harm reduction measures are poorly developed, and in cases where they have been implemented, have come about only recently.

As for drug consumption, seen from an international perspective, experimental drug use in Sweden is stable and low, with about 1% 16-64 year olds reporting to have used drugs last month, compared to an average of 4% in the European Union (CAN, 2010). In regard to heavy drug use, however, Sweden is similar to most other European countries, and drug-related deaths show that Sweden is worse off than the average EU-country (ibid.). This, in many ways, reflects how problematic drug consumption and experimental drug use in Sweden develop in different ways and independently of each other, have different outcomes, and that the causes for the two forms of consumption differ (Olsson, 2011). It might also be interpreted as reflecting the strong marginalization that problematic drug users experience due to the Swedish drug policy as it seems that processes of marginalization are accentuated by the repressive aspects of the policy implemented.

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Drug Market and Drug Consumption in Helsinki

Jussi Perälä / Tuukka Tammi / Pekka Hakkarainen

1 Helsinki

Helsinki is classified as one of the fastest growing metropolises in the European Union and the GDP per capita is one of the highest of any city in the world

Helsinki is the capital of Finland as well as its major political, educational, financial, and cultural centre. Helsinki is classified as one of the fastest growing metropolises in the European Union and the GDP per capita is one of the highest of any city in the world. Compared to other Finnish cities, there are less industry jobs in Helsinki but plenty of jobs in the service and business sector. More than 68,000 jobs are related to information and information technology. Approximately 70% of foreign companies operating in Finland have settled in the Helsinki region.

Today Finland has a population of 5,326,314 and Helsinki 568,484. In the greater Helsinki area, there are over one million inhabitants. The proportion of people under 15 years old is 14% and of those 65 years and older 14.3%. Approximately 53% of the population are women. The working population is 63% and the unemployment rate is about 8%. The immigrants' unemployment rate is 2.5-fold compared to that of inhabitants with Finnish background.

The majority (i.e. 84.3%) of the population speaks Finnish as native language. The second-biggest language group is Swedish, 6.1%. Helsinki is also a multicultural city: 6.4% of the population are foreign citizens. The main ethnic minority groups are immigrants from Estonia, Russia, Somalia, China and Thailand. One third of Finland's immigrants live in Helsinki. In younger age groups the immigrants' share is bigger than in the parent generation. In the group of the 7-15 year olds, 12% of citizens speak another language than Finnish or Swedish.

2 National and local drug policy

Before the 1990s, Finnish drug policy was mainly law enforcement oriented

Before the 1990s, Finnish drug policy was mainly law enforcement oriented and only minimal attention was given to the treatment of drug abuse until the turn of the millennium. From the mid-1990s, however, the prevalence of drugs, the ways they were used, health hazards, crime, popular opinion and public debate on drugs, and also the strategies and measures of drug policy changed. At that time, the rapid increase in drug use and related harm opened the debate on including welfare and health policy as part of drug policy. The strongest disagreements amongst professionals and policy makers concerned harm reduction measures, such as needle exchange and substitution treatment. Today, these measures are established and expanded, and with the help of these methods, the formal drug policy also aims at protecting individual and public health. At the same time, however, there are no signs that Finland would concurrently downgrade the repression of drug users: quite the contrary, fining of drug users has been systematic and increasing from the millennium onwards. The Finnish drug policy has moved onto a dual track of both increased user repression and increased welfare and health policy (Hakkarainen et al., 2007; Tammi, 2007).

The Finnish drug policy has moved onto a dual track of both increased user repression and increased welfare and health policy

The bigger cities in Finland have their own drug strategies and local practices vary to some extent. As drug use and users are largely concentrated in Helsinki, there are also more policy responses in the area than in smaller cities: with the total number of drug users visiting needle exchange programmes being 13,000 in Finland, over 9,000 of them come from the Helsinki metropolitan area (Rönkä and Virtanen, 2009: 95). The great majority of users in substitution treatment are in the greater Helsinki area: 600 out of 1,700 patients altogether in Finland. In 2010, a combination preparation containing buprenorphine and naloxon accounted for about 60% of substitution treatment, and methadone for the remaining 40% (Forsell et al., 2010). Also the criminal control of drug users (surveillance, fining etc.) is intensive in the metropolitan area; with regard to use and possession it is not more permissive than in the rest of Finland (Kainulainen, 2009).

3 Trends in drug consumption and drug markets

3.1 Consumption trends on national and local level

Basic data on drug use are obtained from population surveys conducted since 1992 (Hakkarainen et al., 2009). To get a picture of young people's drug use ESPAD has been the survey used. It has been conducted in Finland every

four years since 1995. According to these surveys drug use increased in the 1990s. It is reflected in young people's increased experimentation with cannabis, which began in the Helsinki region amongst the children of highly-educated parents, then spread to other cities and the countryside, regionally from south to west, north and east, and into lower social levels of education. However, at the turn of the millennium, experimentation with cannabis began to decrease in the younger age groups (Metso et al., 2009).

According to the newest ESPAD results the adolescents living in the capital area have used more drugs than adolescents living in other parts of Finland. In 2007 15% of boys and 12% of girls living in Helsinki had tried some illegal drug during their life: 14% of boys and 11% of girls cannabis, 3% of boys and 5% of girls some other drug. 4% of boys and 16% of girls in the capital area had tried alcohol and pills together. During the whole survey period, there was less drug use among adolescents in Finland than in many other European countries (Metso et al., 2009).

In 2002 the sharpest increase in the numbers trying drugs was seen in the age group 20-29. Back then, around one in three men and around one in four women in this age group reported having tried cannabis at some stage in their life. In the age group under 40 the use of amphetamine and ecstasy also showed a statistically significant increase. Non-medical use of psychoactive prescription drugs had also increased. In the metropolitan Helsinki region and in larger cities with a population of more than 100,000, drug use was much more common than elsewhere in the country. In a study published three years later the drug situation seemed to have calmed down (Hakkarainen and Metso, 2003; Hakkarainen and Metso, 2007 and 2009).

According to the most recent estimate, some 450,000 adult Finns have tried cannabis at some time in their life and, annually, some 100,000 Finns use it. Last-month users number about 40,000. In 2004 users increased their consumption from 1,697 to 4,255 kilos of cannabis products. Although the number of daily users of cannabis is the lowest, they use most of the available cannabis. Traditionally the cannabis consumed has been imported resin mainly from Morocco. However, at the turn of the millennium the home growing of cannabis started to gain more popularity among cannabis consumers (Hakkarainen et al., 2009).

After cannabis, amphetamine is the most popular illegal substance. Amphetamines have been very popular in Finland already since World War II

After cannabis, amphetamine is the most popular illegal substance. Amphetamines have been very popular in Finland already since World War II, partly because of its massive import and medical use during the war. Since the 1950s the intravenous use of amphetamine has been dominant among problem users. Amphetamine is followed in popularity by ecstasy, cocaine, LSD and different kinds of mushrooms. Heroin, which in the 1920s and 1930s had been frequently used as cough medicine and to an extent surmounting any other Western nation (Ylikangas, 2009), at present is almost missing on the Finnish drug markets. It was replaced in the beginning of the 2000s by the maintenance substance

buprenorphine, usually subutex, which currently is the seventh most-used illegal substance. Some 10,000 to 30,000 Finns have tried subutex at least once in their life. During the same time 25,000 to 50,000 Finns have tried cocaine (Hakkarainen and Metso, 2007).

Finnish drug culture is tied in closely with alcohol culture

Finnish drug culture is tied in closely with alcohol culture. According to Hakkarainen and Metso (2009) drug use is most common among the heaviest drinkers. Drinking to inebriation is most common among cannabis users. In the urban lifestyles of younger people the use of cannabis is interwoven with frequent clubbing and party-style drinking patterns. Another indication of the intertwining of drug and alcohol cultures is found among mixed users, who not only drink heavily but also use various drugs and medicines (Hakkarainen and Metso, 2009).

3.2 Problem drug users

Amphetamine has traditionally been the predominant drug among marginalized drug users for decades and it is still widespread. The vast majority of problem users – about 75 to 80% – have used amphetamine as their primary drug. It should be mentioned that treatment for amphetamine addiction is not available (Arponen et al., 2008).

In the 2000s buprenorphine has become almost as common as amphetamines among marginalized drug users

In the 2000s buprenorphine has become almost as common as amphetamines among marginalized drug users and also psychoactive prescription drugs got used as intoxicants (Partanen et al., 2007.) Heroin vanished almost totally from the drug markets in the mid-2000s. Buprenorphine, usually subutex 8 mg pills, has taken over former heroin markets and now it is the main opiate among problem users. The combined use of subutex, alcohol and pharmaceuticals typically forms part of the culture of problem substance abuse in Finland. Problem users of subutex are using simultaneously and intravenously also prescription pills to get a "heroin kind of feeling" although many of them have never even tried heroin (Finland Drug Situation, 2009; Perälä, 2011). Joint substance abuse is also indicated by the death cases, in which particularly benzodiazepines and alcohol play an important role (Salasuo et al., 2009). Also the increasing number of amphetamine findings in forensic autopsies (51 in 2003, 94 in 2007 – Department of Forensic Medicine, 2008), indicate poly-drug use.

According to the 2008 data from the drug treatment information system, opiates were the primary problem substance of half of the clients entering drug treatment, for as many as 34% it was buprenorphine. The opiates were followed by amphetamines (16%) and alcohol (18%), and at a distance cannabis (9%) and pharmaceuticals (7%).

The majority of problem users inject the substances, i.e. mostly amphetamines and buprenorphine. Currently, 82% of the clients of substance abuse services take their drugs intravenously. Of those who at some point in their lives

have taken drugs intravenously, 82% admitted to share needles and/or syringes (Ruuth and Väänänen, 2009).

According to the last estimate in 2005 Finland had 14,500 to 19,000 problem users of amphetamine and opiates. This accounts for approximately 0.5 to 0.7% of the total 15-55 years old age group. The proportion of men was 80%, while the majority of problem drug users belonged to the 25-34 years old age group. Of all problem drug users, an estimated 50 to 60% live in Southern Finland and over half in the Greater Helsinki area, where the estimated number of problem amphetamine users was between 4,000 and 6,000 in the mid-2000s (Partanen et al., 2007). According to the data from 2005, the upward trend in the number of problem users in Southern Finland has stopped, and the number of problem users has even dropped outside the Greater Helsinki area. The proportion of women among problem users seems to be on a constant decline everywhere in Finland, possibly excluding the Greater Helsinki area. The ageing trend among users is most evident in the Greater Helsinki area. In the light of data from 2005, it seems possible that the drug problem as well as specialized treatment services (substitution treatment, health counselling) will be concentrated in the Greater Helsinki area and possibly some other larger cities (ibid.).

Table 1: Number of problem users with amphetamine and opiate as primary drug, Finland and Helsinki, 1997–2005, absolute numbers

	1997	1998	1999	2001	2002	2005
Finland	9400-14700	11500-16400	11100-14000	13700-17500	16100-21100	14500-19100
Opiate users	1500-3300	1800-2700	2500-3300	3900-4900	4200-5900	3700-4900
Amphetamine users	6800-11600	7600-13000	8300-12400	10100-15400	10900-18500	12000-22000
Greater Helsinki	4000-7400	4200-6000	4100-5400	4900-6600	5300-7800	5100-8200
Opiate users	900-2000	1000-1600	1200-1900	1800-2700	2000-3200	1300-2400
Amphetamine users	2800-7400	2600-6000	2500-5000	3200-6900	3300-6000	4000-6000

Source: Partanen et al., 2007.

Users of amphetamine may take 0.5 to 5 grams a day, depending on purity and personal tolerance levels, opiate users one or two subutex pills. The information that some users take 3-5 pills a day, has to be taken critically. Cannabis users take up to several grams a day, which might be explained by their setting, the large group (Kinnunen et al., 2005; Kinnunen, 2008; Perälä, 2011).

Table 2: Summary on the problem drug scene in Helsinki

Main drug(s) / drug combinations	Amphetamines, buprenorphine, prescription pills (benzodiazepines and opiate-based drugs)
Size / number of problem drug users	5,100 – 8,200
Frequency of consumption of main drugs (per drug)	Several times a day / week depending on user
Mode of consumption of main drugs (i.v., oral, sniff, smoke)	Intravenous use of amphetamines and opiates (mainly buprenorphine)
Amounts (per main drug): dose per use, daily dose	0.5-5 g amphetamine daily 1-2 pills buprenorphine (subutex 8mg) daily
Gender: proportion of males	80% males (whole Finland)
Ethnicity: proportions	Mainly Finns
Age: available categories or averages	Biggest age group 25-34 years (whole of Finland)
Main consumption setting: public, private	Private; no open drug scenes in Helsinki
Treatment capture: proportion	600 in substitution treatment (metropolitan Helsinki area), 70% of users reached by health counselling services (estimate)
Police capture: proportion	Police controls targets repeatedly with the same users

The prevalence of HIV among intravenous drug users has never exceeded 5% (Arponen et al., 2008) and decreased during the last years. An HIV epidemic among intravenous drug users in the Greater Helsinki area in 1998 took a downward turn already in 2000. HIV infections are concentrated in poverty areas (Kivelä, 2007).

3.3 Drug markets

Finnish drug markets are described in several studies, additional information can be found in police reports. For the following description also key informants were interviewed along guidelines used for the other participants in this study, too.

No truly open drug market exists in Helsinki

No truly open drug market exists in Helsinki, most sales take place in private residences; concentrations in city quarters, therefore, remain hidden (Kinnunen, 2008). In certain bars, clubs and parks in the Greater Helsinki area there is

a relatively open trade of cannabis by the gram, mainly by immigrants. Cannabis prices in these places are generally higher than in private residences (Perälä, 2011.)

The Finnish drug market does not seem very organized at least with regard to cannabis resin, allowing free entry into the market for newcomers. Dealers generally focus on the use and sale of one main drug. Some drug dealers are 'devout resin men', who do not supply other substances, as a matter of principle. Others specialize on some other drug, but also supply resin (Kinnunen, 1996; Junninen, 2006; Hakkarainen et al., 2009). The number of marijuana and cannabis plant seizures has grown in the 2000s, which indicates that small-scale cultivation of drugs has become more common (Finland Drug Situation, 2009; Hakkarainen and Perälä, 2010). It has to be mentioned that cannabis home-growers also got more targeted by the police (Kainulainen, 2009).

On the Helsinki drug market three groups of actors can be identified: "importers", "wholesalers" and "retailers"

On the Helsinki drug market three groups of actors can be identified: "importers", "wholesalers" and "retailers". The few importers are scarcely professionalized and organized; they consume their own products and compete with a competent police on a small market. There is only one wholesale dealer working with his "court", a bunch of friends, also using their own products. The dealers at retail level are all users, whose earnings hardly cover the costs of their habit (Perälä, 2011).

Police reports draw a contrary picture: They describe a professional drug trade, which is dominated by organized crime groups often consisting of foreigners, mostly Estonians and Russians, partly living in Estonia (NBI, 2009). According to police reports amphetamines indeed are imported from or via the Baltic states and the Russian Federation and to some extent this is also true for cannabis resin.

Finland has a unique situation with regard to opiates. Buprenorphine, mainly subutex (8 mg pills), has almost totally replaced heroin on the markets. Earlier, subutex was trafficked in small quantities mainly from Estonia, acquired by prescriptions signed there. When the Estonian "pharmaceutical tourism" was terminated (NBI, 2009; Finnish Customs, 2009.), imports had to rely on France. But due to the constantly changing buprenorphine markets currently more of the substance is imported from the UK, as well as from Sweden and Norway, where it is cheaper than in Helsinki (Finnish Customs, 2009.)

Custom authorities fear that supply of heroin might increase when subutex supply declines. They are especially afraid of heroin from Russia (Finnish Customs, 2009.) and that ethnic minority groups who do not use drugs themselves take over Helsinki's drug markets. At present, immigrants import only cannabis herb from The Netherlands. Though cocaine is trafficked more and more, the established amphetamine culture prevents its settlement. However, the constantly changing nightlife and upcoming restaurants might likely be building a breeding ground for this substance.

4 Purity and prices

The purity of confiscated drugs is analysed by the Crime Laboratory of the National Bureau of Investigation and by the Customs Laboratory. According to key informants amphetamine and methamphetamine are only analysed if the seized quantity exceeds 10 grams, with heroin 2 grams. Cannabis plants are analysed only on request and if the seized amount exceeds 150 grams. Other drugs and dilution substances are not analysed at all (Finland Drug Situation, 2009).

The purity at wholesale level varies remarkably

The purity at wholesale level varies remarkably: with cannabis herb between 0.1-15% (average 4.9%), with heroin 11-69% (average 36%), with cocaine between 11-81%, (average 30%). Amphetamines seem to be more diluted than other substances (e.g. with caffeine), their purity oscillates between 0.1 and 68% (average 24%); the purity of metamphetamines reaches similar minima and maxima with 3-53% (average 30% – NBI, 2009).

Purity varies remarkably and can be determined by one large seizure. In general purity dropped since 2005, with e.g. cannabis resin as well as with amphetamines. Was the purity of the latter about 90% in the 1990s, it was recently only 12-20%. Though purity drops, dilutions of drugs remain the same for a long time, which indicates unchanged sources. Drug users may get accustomed to low-quality drugs, producing special desired effects (Perälä, 2011).

The police also observe the development of drug prices on wholesale level through information from informants, crime suspects and experts in various fields and through documents seized and investigations. As drug use in the Helsinki area is more common than in other parts of Finland, prices are lower than in smaller cities where cannabis resin, amphetamines and subutex may well cost the double (NBI, 2009). There is one exception: Prices of home-grown cannabis seem to be the same all over Finland (NBI, 2009). According to police estimates, one kilogram of cultivated inflorescence sells for 9 € and one gram for 10-20 € (NBI, 2009).

The price of one kg cannabis resin bought in Helsinki varies between 2,000-3,500 €, 100 gram batches are sold for 400-600 €, one gram for 5-20 € (on average 13 € – NBI, 2009; Perälä, 2011). Rare white heroin is between 120-200 €, subutex 8 mg pills between 25-100 €, one gram of cocaine 60-150 €, ecstasy tablets 10-20 €. The average street price per gram amphetamine is between 15-50 €, methamphetamine is sold at the same price (NBI, 2009; Seppälä, 2010). Drug prices are almost the same in different settings. In private settings heroin is sold for 80-130 € per gram, cocaine for 60-120 €, amphetamine for between 20-25 € per gram, ecstasy pills are around 10 €.

Due to reduced supply, the street price of subutex seems to have increased up to 50-70 € for one 8 mg pill (Perälä, 2011). On the other hand, prescription pills used together with buprenorphine do not seem to have much market value. Pills are sold for 1-2 €, prices vary with the number of pills (Perälä, 2011).

All in all, street market prices seem to have increased a little during the last years

All in all, street market prices seem to have increased a little during the last years (Finland Drug Situation, 2009). The price increase was accompanied by a decrease in quality.

For importers – especially of amphetamine – the drug trade may be a profitable business. According to police estimates, it is possible to make a profit of 6,000 € per kg. (NBI, 2009). Key informants observed that Estonian amphetamine traffickers turned to imports from The Netherlands, where they bought the substances at a lower price. A successful wholesaler might be able to sell 1-2 kilos of amphetamine in a week. He will spend at least 20% of his profit for his own consumption and that of his companions. For retailers who sell amphetamine per gram, the business is not profitable. Personal use, bad purity of their product, severe controls of authorities and selling on credit are factors that erode their profit (Perälä, 2011).

Table 3: Summary on purity and prices; prices in Euro / gram

	HW	OO	CP	AmMeth	E	C
Purity according to forensic laboratories	11-69% av. 36%	100%	11-81% av. 30%	Amph.: 0.1-68% av. 24% Met amph.: 3-53% av. 30%	NA	resin NA herb 0.1-15% av. 4.9%
Purity according to other key informants	9-12% (2006-2008)	100%	30%	12-40%	NA	NA
Prices according to forensic laboratories	NA	NA	NA	NA	NA	NA
Prices according to other key informants	80-130	20-70/ subut. 15-30/ subox.	60-120	20-25	10/pill	5-10/ resin 5-25/ herb
Prices according to NBI statistics	120-200	25-100/ subutex 8 mg	60-150	15-50	10-20/ pill	6-20/ resin 10-20/ herb

HW = Heroin white; OO = Other opiates subutex / Suboxone 8 mg; CP = Cocainepowder; AmMeth = Amphetamine & Methamphetamine; E= Ecstasy; C = Cannabis resin & herb.
Note: * Purity and prices of methamphetamine per mg MDMA.

5 Conclusion

Helsinki is the rapidly growing capital of Finland. It is also its drug capital: drug users and markets are concentrated in the metropolitan Helsinki area. The drug situation of Helsinki is illustrated by studies on juvenile drug consumption and estimates of problem users, which prove that adolescents in the capital area use more drugs than those in other parts of Finland and that 50 to 60% of all problem users live in Southern Finland and over half in the Greater Helsinki area.

Herbal cannabis has become the most popular drug and has replaced cannabis resin, which traditionally had dominated the market (Hakkarainen et al., 2011). According to the most recent drug surveys, drug use is slightly increasing, especially use of cannabis by young adults. Men in this age group were the most active cannabis users. The attitudes of Finnish people indicate a shift in the cultural position of the drug: Almost half of the population considers the risks of trying cannabis to be minor; among young men three quarters. The increasing tolerance also concerns irregular cannabis use whose risks are estimated to be low. The shift in attitudes and the increase of cannabis use among young adult men can be seen as an indicator of a trend towards "normalization" of cannabis (Hakkarainen et al., 2011).

After cannabis, amphetamine is the most popular illegal substance. Heroin was never widespread and was replaced by buprenorphine during the last decade, mostly subutex. Subutex at present is the seventh most frequently used illegal substance in the overall population. Among marginalized drug users, who traditionally mainly use amphetamine, subutex became almost as common as their primary substance. Additionally, the use of psychoactive prescription drugs such as intoxicants became common. Ecstasy, cocaine, LSD and different kinds of mushrooms are relatively seldom used.

Among treated drug users opioids are the primary drug: Drug users admitted to a drug service in 2008 for the first time and representing 50% of all drug treatment clients reported opioids as their primary drug, followed by amphetamines (16%), alcohol (18%), cannabis (9%) and pharmaceuticals (7%). These results also reflect the provision of treatment, since opioid users are provided with substitution treatment, which is not available for amphetamine users. Moreover, most opioid users (about two thirds) are substituted with their drug of choice, i.e. with buprenorphine.

Drug surveys also show, how closely drinking and drug use are intertwined

Drug surveys also show, how closely drinking and drug use are intertwined, and how prominent medical substances are within poly-drug use patterns (Hakkarainen et al., 2011). The culture of problem substance use is nowadays also characterized by a combined use of various narcotic substances, often alcohol and pharmaceuticals, particularly benzodiazepines that play an important role in drug deaths. Problem drug use concentrates in eastern parts of Helsinki where drug treatment is mostly offered.

With the penalization of drug use at the end of the 1960s the drug markets went underground. Sales and consumption of cannabis, as well as of other illegal drugs, take place in private residences. According to research, the drug market and especially the cannabis market is not very professionalized and organized: dealers mostly only sell one drug. Contrary to the picture drawn by research the police suggest that the drug trade is professionalized and dominated by organized criminal groups often from foreign countries, mostly from Estonia and the Russian Federation. All in all drug prices seem to have gone up but purity, especially of amphetamines, went down.

Seizures of cannabis plants increased in the 2000s, which indicates a change in the small-scale cultivation of the plant initially not cultivated for commercial purpose. Also designer drugs have entered the drug market of the capital during the last years and pharmaceuticals acquired a more prominent market position: The quantity of pharmaceuticals seized in 2008 – mainly of buprenorphine and benzodiazepines – was markedly higher than in the previous year.

Regardless of the changes in attitudes towards drugs and drug consumption all drug use is still a crime. The Finnish police are very active in prosecuting Finnish drug criminals. In prison health care units, the use of stimulants prevails (Kuussaari and Ruuth, 2008). Next to buprenorphine (subutex), amphetamine is the second most common intoxicant used in prison (Perälä, 2011).

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The Drug Situation in Moscow

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1 General information about the city of Moscow

Moscow is the capital of the Russian Federation, the city where Russia's supreme legislative and executive authorities are based

Moscow is the capital of the Russian Federation, the city where Russia's supreme legislative and executive authorities are based. Moscow is an autonomous region in the federal structure of the country, one of two federal-level cities (the second one is Saint Petersburg), and at the time of data collection it included 10 administrative districts, which were further divided into 125 municipalities. Moscow will expand in the nearest future and it will become accordingly reorganized.

Moscow is the largest city of Russia. According to the 2002 census, the permanent population of the city was 10,382,754 inhabitants; by 2009 it reached 10.5 millions. The proportion of men (47.5%) and that of women (52.5%) remained the same. If immigration is disregarded, the population growth becomes negative: in 2004 due to a birth rate of 8.9 per 1,000 and a mortality rate of 12.6 it shrunk by about 3.7 per 1,000. The population of Moscow shrunk somewhat less than that of Russia as a whole, which in the same year shrunk by 5.5 per 1,000. The youth population (15-20 years) was about 600,000 in 2009, during the last five years it kept gradually decreasing. In regard to their ethnical composition, the majority of the residents of Moscow are Russians (84.8%), only small proportions belong to other ethnicities: Ukrainians 2.4%, Tatars 1.6%, Armenians 1.2%, etc.

Despite this negative growth of population, due to immigration the actual number of permanent inhabitants is constantly increasing: 1.8 million are officially registered as temporary migrants (work migrants, students) and according to estimates there are also no less than 1 million unregistered migrants in Moscow, including illegal ones. Each year 50-55 thousand are officially receiving the right to work or study in Moscow. According to the Ministry of the Interior the overall number of persons who reside during daytime in the city, including pulse migrants from surrounding territories as well as visitors, transit passengers and tourists occasionally exceeds 20 million.

Moscow is the financial and industrial centre of Russia, based on extensive highly qualified labour resources. The leading role in the industrial production sector is played by the food industry, machine building, metal-working, manufacturing and building. There are more than 1,000 large and 13,000 small industrial enterprises in Moscow. As of August 2009 about 3,054,700 people were working in state, private or mixed establishments, companies or public organizations. According to Rosstat (http://www.gks.ru/gis/tables/urov-7.htm), the average monthly salary in 2009 made up 33,339 roubles (about 750 Euro).

Moscow is an urban centre open for passenger transit and tourism, both in-country and international. It has nine major railway stations and four airports, and it is the largest auto, railway and air route junction for passenger and freight flows (*Russia in Figures*, 2004 and 2005).

2 Drug policy

The present drug situation in the Russian Federation can best be characterised by the increasing trafficking and abuse of highly-active illicit drugs

The present drug situation in the Russian Federation can best be characterised by the increasing trafficking and abuse of highly-active illicit drugs, such as heroin, cocaine, amphetamine-type stimulants, as well as of pharmaceuticals with the potential to provide similar effects. In December 2009 a draft of the Russian Federation State Anti-Drug Policy was prepared by federal and regional legislative and executive authorities as well as by representatives of civil society, and it was forwarded for approval to the President of the Russian Federation. According to the abovementioned Strategy, decisions and measures undertaken by state authorities in the field of combating drugs should be based on principles of rule of law and constitutional rights – mainly equity, inevitability of punishment, as well as on an integral approach to prevention.

The reduction of illicit drug supply in the city is within the responsibility of the Moscow Department of the Federal Drug Control Service, as well as of the Moscow Department of Internal Affairs. The main responsibility to reduce drug demand (prevention, treatment and rehabilitation) is with the “narcotic” (“substance dependency” or “alcohol and drug treatment”) facilities of the Department of Healthcare, as well as the Department of Education of the Moscow city (Brun et al., 2008; Koshkina et al., 2008 and 2009). Prevention of drug and other psychoactive substances abuse has to be carried out by educational facilities, in accordance with the Decree of the Ministry of Education No. 619 “About the concept of psychoactive substances misuse prevention in the educational environment” of 28/02/2000.

The narcotic facilities observe, treat and rehabilitate patients suffering of drug dependency (not only drug dependency, also alcohol and other psychoactive substances). Dependency treatment includes coping with the withdrawal syndrome; treating the pathological craving syndrome; treating other disorders,

both pre-morbid and substance use-related; treating somatic and neurological consequences of past use; anti-relapse treatment; psychotherapy and psychological correction of personality disorders. Medical and social rehabilitation of unlimited duration is the final part of treatment interventions.

Medical and social rehabilitation of unlimited duration is the final part of treatment interventions

The narcotic facilities are coordinated by the Moscow Department of Healthcare. During 2008, outpatient care was offered by 14 narcotic dispensaries, 9 narcotic consultation rooms for teenagers, and 2 laboratories analysing substance intoxication. Inpatient treatment was provided by special departments of three hospitals with altogether 3,527 beds for patients with narcotic disorders whose numbers have insignificantly decreased over the last five years mainly due to budget restraints and medical service re-organizations. There are 741 medical doctors specialized in addiction treatment work in the state-supported narcotic services, as well as 141 specialised medical psychologists, 35 psychotherapists and more than 50 social workers – partly specialized, partly not. The narcotic services include 427 rehabilitation beds. Rehabilitation work is also done by outpatient units, by social rehabilitation clubs for dysfunctional families, and by anonymous mutual help groups. It is assumed that the effectiveness of the narcotic services could be improved by the establishment of specialized rehabilitation centres providing support after medical treatment. Besides the state sector, a network of private centres and clinics, as well as licensed private practice physicians offer care for drug dependents.

Substitution treatment is prohibited

Substitution treatment is prohibited for persons addicted to substances on List I and II of the Narcotic Drugs and Psychotropic Substances and their Precursors, which are subject to national as well as international controls. And also the legalization of the non-medical use of drugs is forbidden by Russian Law.

Prevention and social support for drug users are offered by the Moscow Department of Social Care and by the Committee on Family and Youth. The Committee on Telecommunication and Mass Media provides information and educational activities. An active role in drug use prevention is also taken by the Committee on Physical Culture and Sports, the Committee on Culture, the Committee on Relations with Religious Organizations, and the Moscow Federation of Trade Unions. The city parliament – the Moscow City Duma – provides the legislative basis for the anti-drug programmes.

All measures are enforced on city level. The central coordination is provided by the Interdisciplinary Council to combat illicit drug trafficking, the coordination in the districts is taken care of by local interdisciplinary committees.

3 Sources of information

The following sources were used to describe the drug situation in Moscow:

- Statistics of medical facilities collected, analysed and published on annual basis by the National Research Centre on Addictions of the Russian Federation Ministry of Health and Social Development.
- The European School Project on Alcohol and Other Drugs (ESPAD), report 2007 (Koshkina et al., 2009). The Russian Federation and Moscow component of the survey was carried out by the National Research Centre on Addictions with the technical support from the UNODC Russian Federation office.
- The report "Knowledge for Action Against HIV/AIDS in the Russian Federation" (Renton et al., 2006).
- Analytical report of the Federal Targeted Programme "Integral Measures to Combat Drug Abuse and Trafficking for 2004-2009" (Koshkina et al., 2009).

Patients with substance dependency treated in state-supported narcotic facilities are statistically assessed in the Russian Federation by special forms containing the diagnoses of the International Classification of Diseases (ICD-10). Each narcotic treatment facility prepares an annual report in accordance with the requirements of the State Statistical Committee. The largest group of drug-using clients of narcotic facilities are patients with a drug dependency syndrome. The so-called "preventions group" does not yet suffer of dependency; according to ICD they are classified as drug users or users with harmful consequences. During the last few years, guidelines have been introduced on how to report.

The statistics allow trend analyses as well as comparisons of Russian provinces. They, however, do not reflect patterns of drug use among the general population. The patients treated in narcotic facilities suffer from severe problems; recreational users commonly do not get admitted. But recreational users are assessed by surveys among specific population groups such as e.g. youth – by estimates (nominative techniques, capture – recapture) as well as by qualitative studies (key informant interviews, focus groups, etc.).

4 The drug situation in Moscow

4.1 Drug users in narcotic treatment

During the last five years the number of drug-dependent patients has constantly increased

By the end of 2008 the state-supported narcotic facilities registered 24,809 drug-dependent patients, i.e. 237 per 100,000 persons. During the last five years the number of drug-dependent patients has constantly increased (Table 1). The numbers of drug-dependent patients in Moscow are somewhat lower than the average numbers for Russia due to the greater availability of treatment in private narcotic clinics or by private narcotic specialists (Koshkina et al., 2000 and 2007).

Table 1: Number of drug-dependent patients registered in state-supported narcotic clinics, Moscow and Russian Federation, 2004-2008, per 100,000 and absolute

	2004	2005	2006	2007	2008
Russia (per 100,000)	240.2	242.0	245.8	250.6	252.2
Moscow (per 100,000)	219.6	222.2	228.1	234.4	237.0
Moscow (absolute)	22,838	23,146	23,803	24,511	24,809

The overwhelming majority of the registered drug-dependent patients of Moscow (81.6%) suffered of opiate dependency; their percentage has been increasing by 1.3-1.5% during the last 2 years. About one fifth of the registered drug dependents in Moscow were women (96.0 per 100,000 female population), a percentage higher than in Russia as a whole (Table 2). The number of female patients of state-supported narcotic clinics has been increasing; most of them (85.5%) were dependent on opiates.

Table 2: Number of drug-dependent female patients registered in state-supported narcotic clinics, Moscow and Russian Federation, 2004-2008, per 100,000

	2004	2005	2006	2007	2008
Russia	70.2	72.5	75.1	78.3	80.3
Moscow	84.0	84.9	89.1	93.1	96.0

The number of newly registered drug addicts per 100,000 of the general population between 2004 and 2008 was much lower in Moscow than in Russia, though it increased since 2006. The majority of firstly admitted patients (79.0%) were opiate dependents.

Admission to narcotic hospitals and emergency rooms of drug users irrespective of a dependency increased by almost 3 times from 4,496 in 2004 to 12,681 in 2008, that is from 43.2 to 121.1 per 100,000 of the population (Table 3). But most drug users admitted to hospitals take opiates intravenously, are more severely dependent than those treated at outpatient narcotic units, and get registered as drug addict at a state-supported narcotic clinic. The increasing numbers of hospital patients is related to increasing severity of addiction in the Russian capital which forces drug users to seek treatment.

Table 3: Hospital admissions of drug dependents in Moscow, 2004-2008, absolute and per 100,000

	2004	2005	2006	2007	2008
per 100,000	43.2	63.5	103.0	120.5	121.1
absolute	4,496	6,616	10,742	12,597	12,681

4.2 Injecting drug users (IDUs)

Treatment does not reach all drug dependents, not even those injecting intravenously

Treatment does not reach all drug dependents, not even those injecting intravenously. A trial to estimate the number of injecting users (IDUs) was therefore undertaken in 2006 in Moscow and in 8 further Russian regions. IDUs treated residentially were interviewed (in Moscow, 213) and additionally they were asked to provide anonymous information on acquaintances that regularly used drugs. Among the acquaintances in Moscow were 626 additional IDUs of whom only 76 had been treated at a state-supported narcotic clinic.

Finally the size of the IDU population in Moscow was calculated by the benchmark-multiplier approach. It was estimated that there were 2,149 per 100,000 of the population or somewhat more than 220,000 IDUs in Moscow in 2006 and that the overwhelming majority of them (about 88%) was not registered. Or in other words: that per one registered IDU, seven IDUs were “hidden”.

In order to study the behavioural, medical and social consequences of intravenous drug use in Moscow, anonymous interviews were conducted among active drug injectors in 2003. The first interview partners were selected by social workers in street settings, additional interviewees were found by “snowballing”; in total 499 IDUs were interviewed. The questionnaire included information on drug use, sexual behaviour, social settings and treatment. Along with interviews, saliva samples were collected and tested for HIV, HCV and syphilis antibodies.

The results show that Moscow’s IDUs prefer heroin (63.6%), at great distance followed by metamphetamine (20.4%), other amphetamines (7.4%) and methadone (4.3%). Drug combinations were common; the most frequent one was heroin with psycho-stimulants, i.e. methamphetamine, amphetamines or cocaine. The mean age of first injection was 18.4 years.

The frequency of injection varied remarkably: 39.5% had injected 1-4 times during the last 4 weeks, 22.2% 10-14 times, 5.3% 15-19 times, 4.5% 20-24 times. 17.6% had been using and injecting drugs daily or almost daily (25-30 injections during the last 4 weeks). The risks are related to the use of other people's needles and syringes (lifetime, 65.2%) and to injecting paraphernalia. Two third of the interviewees reported an overdose with loss of consciousness at least once in their life, one quarter during the last 12 months.

Sexual behaviour of IDUs was another risk factor of blood-borne infections

Sexual behaviour of IDUs was another risk factor of blood-borne infections. 44.3% of the interviewees reported sexual contacts with occasional sexual partners during the last year, a quarter of IDUs had never used condoms. Criminal activity was less remarkable. Though every fourth IDU had been in prison, only 6.1% of the respondents reported to live mainly from drug dealing, and a further 5.7% made money by other criminal activities such as theft or robbery.

According to the tests, the prevalence of HIV infection among the Moscow IDUs was high, i.e. about 12.4%. Prevalence of HCV was much higher and reached 63.6%. Thus, the injecting behaviour of Moscow's IDUs proved to be a risk factor of bloodborne infections with the potential of further spreading.

4.3 Drug experiences among youth

The European School Project on Alcohol and Drugs (ESPAD) is carried out in Moscow every four years, starting with 1999 (Koshkina et al., 2004; Hibell et al., 2009). The target group are 15-16 years old students of various educational facilities, who are asked to fill out a standardized questionnaire anonymously in a classroom setting. The questionnaire includes questions about tobacco smoking, alcohol use and drug use.

Lifetime experiences with illicit drugs of Moscow students have slightly increased

According to the surveys of 1999, 2003 and 2007 lifetime experiences with illicit drugs of Moscow students have slightly increased (Table 4).

Table 4: Lifetime use of illicit drugs, 15-16 year old students in Moscow, 1999, 2003, 2007, in percentages

1999	2003	2007
24.2	23.4	26.5

Cannabis (marijuana or hashish) has always been the most frequently used illicit drug among the Moscow students. Lifetime experiences with cannabis increased slightly between 1999 and 2003, but more frequent use (more than 10 times) did not (Table 5).

The lifetime use of ecstasy, ranked second in 2007, of "magic mushrooms" and of amphetamine were also increasing during the period of observation. Lifetime use of heroin, of LSD, of inhalants and of tranquillizers dropped. And with all ESPAD surveys in Moscow, use was higher among boys than among girls.

The results prove that experimental use of illicit drugs and other psychoactive substances remains an important problematic issue among Moscow students.

Table 5: Lifetime use of illicit and licit drugs, 15-16 years old students in Moscow, 1999, 2003, 2007, in percentages

	1999	2003	2007
Cannabis	22.4	21.8	25.6
cannabis more than 10 times	5.1	4.5	5.6
Heroin	5.8	0.3	0.8
LSD	3.8	1.4	4.2
Ecstasy	2.4	2.6	5.7
Amphetamines	0.9	0.8	2.8
"Magic mushrooms'	1.2	2.6	4.5
Inhalants	9.4	6.6	4.4
Tranquillizers	6.5	2.8	3.3

5 Interviews with key informants

To complement the description of the drug situation in Moscow, 20 key person interviews along guidelines developed in the course of the current study were carried out. The guidelines focussed on the current drug situation, on consumption trends, on drug markets, prices and purity.

The selection of the most relevant drug professionals in the city was difficult: on the one hand, their awareness of specific issues, such as drug purity and prices was requested, on the other hand, they should be able to provide an overall description of the drug situation. To facilitate selection the Moscow research team approached the organisations responsible for drug policies (e.g. the Federal Drug Control Service and the Ministry of Health), asked for proposals and finally selected 20 experts expected to provide the most detailed answers to questions of interest. One organisation of central interest for the current project refused to nominate an interview partner: the laboratories responsible for the analysis of seized drugs that are in command of the most accurate knowledge on purities and prices.

Table 6: The key informants

Background	Organization type	Number
Sociologists	Non-governmental organization	2
Social workers	Rehabilitation centres	5
Psychologists	Rehabilitation centres	3
Analyst	Russian Federation Federal Drug Control Service; Moscow Department	3
Jurists	Ministry of Internal Affairs, Moscow Department	2
Addiction psychiatrists	narcotic clinic	3
General practitioners	City hospital	2

As planned, the interviewed key persons were of different professional background, and worked in different areas. They therefore emphasized different dimensions of the problem and sometimes had difficulties to respond to all the questions. Thus, some treatment professionals argued that they cared for drug dependents but not for drug prices or purities. But all would agree that the drugs situation in Moscow, as well as in Russia as a whole, still gives ground for widespread concern.

5.1 Drug use and drug users

Drug abuse in Russia remains on a high level

According to the view shared by all key informants, drug abuse in Russia remains on a high level, not least because of the well-developed market where a wide variety of illicit drugs can be acquired easily. Within the high level of overall consumption drug preferences change and drugs of "natural" plant origin are steadily giving way to synthetic ones. Additionally, a shift towards heroin is observed.

As regards the numbers, key informants spoke about 537,000 registered addicts and drug abusers in Russia and estimated 2.5 million drug users, the majority being 18 to 39 years of age. The increase of HIV cases was explained by the high number of drug injectors. Some professionals estimated that up to 70% of Russia's IDUs are HIV-infected. They also mentioned other consequences of injection such as blood-borne infectious heavy somatic diseases.

The drug professionals distinguished between subgroups of drug users according to preferred substances and consumption modes.

- "Street users": Young people who prefer cannabis (hashish or marihuana) and smoke almost openly in the public – on staircases and in playgrounds, and in other places where young people are gathering.
- "Clubber groups": youth who meet in clubs, at parties, discos and other youth vacation spots and who mainly use ecstasy, amphetamines, "magic mushrooms", and sometimes heroin or cocaine.

- "Users of homemade opiates": Small groups of drug users around a so-called "cooker" preparing opiate solutions for intravenous injection from precursors. The size of the group depends on the capacity of the cooker.
- "Heroin users" who prefer intravenous injection and might take pharmaceuticals additionally.

The number of drug-experimenting youth is increasing; a part of them turns to "occasional use" and of those few to regular use. The older adolescents become, the more "club drugs" – amphetamine, methamphetamine, ecstasy – they use besides marihuana and hashish. Club drug users are usually 18-25 years old; four fifth are male. In the club setting also large amounts of alcohol are drunken. Women often start drug use under the influence of their partner.

Heroin remains the "drug of choice" of regular users

Heroin remains the "drug of choice" of regular users, it is taken intravenously, mostly daily, and the daily dose is between 0.5 to 3 grams. Actual heroin users in earlier years often used homemade opiates or "pervitin" (homemade methamphetamine), and they often combine heroin with synthetic and "pharmacy" drugs. Narcotic specialists, who more or less exclusively meet drug users with developed addiction, described the typical heroin users best. They are mostly men between 23-35 years old, many of them work as managers and/or in trade, in the service sector or in the show business. Hedonistic lifestyles are not rare and poly-drug use is frequent, though heroin remains the main drug.

Narcotic specialists are also concerned about the spread of the so-called "pharmacy" drugs, such as Coaxil, an antidepressant sold in pharmacies without prescription. It is taken orally or injected intravenously, one to two times daily, 15 to 30 tablets. Also the use of the substances Buterfenol, Zaldiar, Kodterpine, Kodesan and Tramadol is increasing.

Amphetamine and its derivatives are mostly ingested or sniffed, less often injected, they are either occasionally taken or during so-called "marathons", lasting between 3 days to several weeks. As a rule the "marathon" is followed by a drug-free period with pronounced withdrawal.

Compared to cannabis and amphetamine, cocaine and crack are seldom used. Cocaine is considered to be an "upmarket" drug for the rich and it is hardly available. Its price seems to go up continuously whereas purity decreases.

A list with the most common drug combinations might look as follows – all combinations go along with the smoking of marihuana or hashish:

1. amphetamine + heroin (sequentially);
2. amphetamine + MDMA (simultaneously);
3. heroin + marihuana;
4. heroin + methadone;
5. heroin + coaxil;
6. amphetamine + phenazepam or other tranquilizers;
7. alcohol + dimedrolum (diphenhydramine, a first-generation antihistamine, also used recreationally as a potentiator of alcohol).

5.2 The drug market

Key informants perceive Moscow's drug market as highly professionalized and well structured

Key informants perceive Moscow's drug market as highly professionalized and well structured. The distribution of drugs takes place via a network of dealers and sales points. The market share of synthetic drugs is growing, and since they are popular among youth they are available almost everywhere: in clubs, discos and other entertainment venues as well as in recreational areas and even in some schools and training centres though they are not main market places. They either come from EU countries such as Poland and the Baltic States, or from Southeast Asia where industrial-type laboratories are producing enormous quantities of methamphetamine in tablets, crystalline methamphetamine and substances such as ketamine. But all types of synthetic drugs are also produced in large laboratories in Moscow and in the Moscow Region, and distributed in the city.

Poppy straw and acetylated opium are sold at opium dens, by resellers, and also in some kiosks under the counter. Heroin, marihuana, hashish can be purchased at private apartments, from street dealers or via drug users. Experienced users usually have well-tried dealers, most likely well-known acquaintances or friends. Drugs can also be bought by entrusted people with whom time and meeting point are arranged. It is even possible to avoid seeing the dealer face to face: money is left in a pre-agreed secure place; it is taken after some time and replaced by the respective amount of drugs.

Internet retail of so-called "smoking blends" with an effect similar to marihuana and hashish but not prohibited got very popular during the last years. "Pharmacy" drugs are bought in drugstores without prescription, above or under the counter. Besides special sources, street "drug markets" are to be found in many districts offering a wide variety of substances. Three well-known street markets are close to one narcotic clinic, which is known "for being located in a drugstore". The doctors are well informed, but helpless.

According to key informants, two thirds of the dealers are drug users themselves. The majority are small "street" dealers who sell directly to drug users. More professional and higher-educated dealers do not use drugs themselves.

5.3 Purity and prices

The key informants interviewed estimated the purity of drugs to be low

The key informants interviewed estimated the purity of drugs to be low. According to their knowledge few dealers with good reputation sell higher-quality drugs at a higher price.

Street *heroin* is most likely brown and its purity does not exceed 5-7%. Brown heroin bought at small wholesale parties has a somewhat higher purity of 0-12%. White heroin with a purity of 15-20% is rare. *Amphetamines*, mostly methamphatemine, are either homemade ("inside a kitchen, in a basin or in a pan") or produced by illegal laboratories; purity in these cases is no matter.

Cocaine is rarely available, very expensive and of low quality when bought "in the street". "Up-market" dealers sell cocaine of higher quality. *Ecstasy* if manufactured "industrially" has a purity as high as 90-100%, if homemade it has significantly less. *Cannabis* is often adulterated and diluted with other herbs such as green tee.

The key persons were less informed about drug prices and not surprising, law enforcement professionals were informed best. They estimate the profit of the drug mafia as high as 300% to 2000%. The reported street drug retail prices vary enormously, but remain in a range that does not only depend on the purity, but also on factors such as place of production, route of delivery, number of "hands" through which the lot passes before it reaches the consumer.

Key informants thought that so-called "systematic" use of opiates requires significant amounts of money. A heavy heroin user today needs about 6,000 roubles (about 150 €) on a daily basis for his/her drug. It is obvious that in the majority of cases there are no legal opportunities to earn such money.

A specific feature of Moscow compared to the rest of Russia is that the major part of the most expensive drugs, such as heroin, cocaine, amphetamines, is sold in the capital where a significant part is distributed within the criminalised population but increasingly reaches customers from business and the artist elite.

Representatives of NGOs who work in rehabilitation of drug addicts were best informed about the actual drug prices. Here are the prices for the main drugs in roubles and Euro (calculated on the average rate for August 2009) according to their information:

- The average price for heroin is around 1,500-2,000 roubles per gram (35 to 45 €).
- Street cocaine starts from 6,000 roubles per gram (135 € and more).
- Amphetamines sell between 1,000 and 1,200 roubles per gram (22-27 €).
- An ecstasy tablet costs between 500 and 650 roubles (from 11 €).
- Cannabis costs 600-800 roubles for a matchbox of 5 grams (13-18 €).
- A dose of pharmacy drugs for injection sells for 200 to 1,200 roubles (from 4.5 to 27 €).

5.4 Trends

Drug use in Moscow is getting worse

Drug use in Moscow is getting worse. On the one hand drug users become younger, on the other hand the number of drug users in older age groups is increasing, too. Increasing are also the numbers of female drug users and those of "experimenters". Synthetic and "pharmacy" drugs having effects similar to opiates (such as Coaxil) have become popular, and also amphetamines as a substance "to increase work performance".

The drug market becomes diversified and offers additional substances such as for instance methadone; it also becomes more concealed, and pharmacies get increasingly involved in the drug business. Drug prices are rising, but quality drops.

5.5 Moscow and the Russian Federation

Availability of drugs in the capital is higher than in the country as a whole: it is possible to get any drug of choice. But although drug consumption is more spread, the negative social consequences are milder due to the higher living standards in the city. Consumption of all kinds of illicit substances is higher: of soft drugs such as marihuana, of expensive drugs such as cocaine and of party drugs. Consumption of synthetic drugs in large quantities is not only prominent in Moscow but also in Saint Petersburg, i.e. in the big cities. Contrary to that, cheap heroin of high quality dominates the drug markets in the regions of Siberia, Baikal, the Volga region, the Far East of Russia, which results in increasing numbers of opiate users and addicts in these areas.

5.6 Drug issues to be focussed on

The main focus of drug policy should be the improvement of drug-related responses and their evaluation

The main focus of drug policy should be the improvement of drug-related responses and their evaluation, according to the opinion of the key informants. Another main issue is corruption that undermines any drug-related measure. A third problem are measures against legal substances with higher risks than “street” drugs, which did not get respective attention. But the most urgent and up-to-date problem is the improvement of the quality of medical care and the rehabilitation services, as well as the quality of drug abuse prevention.

6 Conclusion

The drug situation in Moscow and in Russia as a whole is still tense: The abuse of various narcotic drugs and psychoactive substances continues to spread among population groups. And narcotic services report that the numbers of male and female drug patients keep increasing. But the number of drug users by far exceeds the number of drug addicts registered by narcotic facilities, presumably by seven times. Drugs are used in various combinations and intravenous injection is still a popular mode of consumption, though it is associated with numerous health risks.

The drug market is well-developed and professionalised in respect to its activities such as, for instance, the selection of places where drugs are sold. Drugs are trafficked to Moscow from other countries and produced in local laborato-

ries. At present the share of synthetic drugs at the Moscow drug market is increasing and also "pharmacy" drugs get more popular and widely used though their availability was reduced by sale restrictions for pharmacies. Drug prices keep increasing along with the decrease of drug quality; purity of drugs remains low, especially in the "retail network".

The drug problem never had such a high social significance; however, over the last years society's reaction has become especially painful. There are no final solutions found in the international experience of combating drug problems that can be directly copy-pasted into Russia's situation; each country has to develop a drug policy on the basis of its unique social and cultural features, to prevent the use of drugs and minimize the harm caused by them.

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Bucharest – New Faces of the Drug Issue

Andrei Botescu / Paula Frusinoiu

1 The city during the last 5 to 10 years

Bucharest, Romania's capital and at the same time its largest city – had about 1,944,367 inhabitants in 2009, that is almost 9% of the inhabitants of Romania. It has more than 2.2 million if the 280,307 inhabitants of the outskirts are added. Unofficially, the city attracts more than 3 million per day and according to estimates 4 million in the coming years.

Bucharest is relatively rich: With almost 9% of Romanian citizens it generates almost 19% of the national GDP. Also, the unemployment rate is much lower than in Romania as a whole: in 2009 the respective numbers were 2.3% versus 7.8% (INSSE, 2009). About 10% of the inhabitants are students, which reflects the higher education of those living in the capital compared to Romania as a whole, but the percentage of the younger generation – younger than 20 years – is lower.

Bucharest has a high density of inhabitants and is very homogeneous

Bucharest has a high density of inhabitants and is very homogeneous: In the 2002 census, 97% declared to be Romanians. According to self-declaration 1.4% are Roma and thus belong to the largest ethnical minority in Bucharest, but the number is underestimated: self-declaration was impaired by discrimination (Bădescu and Grigoraş, 2007), which even might be on the increase at present. In common, ethnic communities in Bucharest are growing – such as the Hungarian (0.32%) and the German community (0.1%) – or get established – such as the Chinese, Jewish and Arab communities.

Bucharest is Romania's economic centre, hosting the major part of the most important economic branches as there are: services, construction industry and real estate business. During the last years the IT industry, the financial sector, research and education have fuelled the economic development in the city.

Bucharest is at the crossroads of the main railways, roads and air routes. It spreads on 228 km^2, within 6 administrative districts in a radial layout so that each has a part of the city centre. The districts lost their characteristics during the major social changes: the central and north parts, which traditionally were

inhabited by people with high incomes got transformed into an "oasis" of luxury surrounded by poor areas with infrastructure problems during the transition period when Romania changed from a totalitarian state with strict supervision to a democratic one. The districts are also characterized by the leftovers of the pre-revolution period, several central areas being in a state of continuous decay, at present inhabited by people without personal documents and regular incomes, mainly Roma.

2 Romania's drug policy

Drugs became a public issue after the revolution in 1989, during the period of transition of economy, organisations and values

Drugs became a public issue after the revolution in 1989, during the period of transition of economy, organisations and values. In the communist area drugs had not been of any interest and drug use was *de facto* low. But after 1991 drug use and drug supply increased immediately. And also policy changed, due to EU requirements. Organisations responsible for the enforcement of drug measures were coordinated across areas and coordination was also built up with international bodies. Prevention and care were extended – under supervision of a self-chosen EU Member State that was Spain. The adoption of European drug policy standards reached a first peak in 2002 with the establishment of the National Anti-drug Agency at the Ministry of Administration and Interior under the lead of a national drug coordinator in the position of a secretary of state – an act by which the Spanish drug policy model was transferred to Romania. At the same time the National Focal Point got established, the Romanian counterpart of the European Monitoring Centre of Drugs and Drugs Addiction (EMCDDA). The foundation of organisations responsible for drug issues resulted in the formulation of the first key document: the National Anti-drug Strategy 2003-2004, which was followed by the National Anti-drug Strategy 2005-2012, both accompanied by subsequent Action Plans.

The new national drug policy is based on 4 pillars

The new national drug policy, which has to be enforced by the mentioned centralised organisations also caring for continuity, is based on 4 pillars, i.e. drug demand and drug supply reduction, drug monitoring and international cooperation. The lead position given to demand reduction was also underlined by the drug-political objectives defined: reduction of incidence of drug use and the stabilisation of drug use on a low level are on the top of the list. Demand reduction measures are widely accepted as could be observed when five new drug prevention, evaluation and counselling centres were established in 2007 and when in the same year three integrated addiction care centres of the Mental Health Institute were founded providing substitution treatment among other offers. Within a few years Romanian drug policy changed from a prohibitive policy (as defined by Newcombe, 2004) criminalizing possession and trafficking and fa-

vouring abstention treatment to an addiction policy accepting harm reduction and diversified multi-disciplinary models of care, cure and rehabilitation.

Prevention is carried out by numerous agencies – among them several NGOs – and it mostly addresses schools and focuses on information and communication skills as protective factors. Integrated care is a multi-disciplinary approach and is organised on 3 levels: (1) primary medical assistance for drug users at emergency rooms, and within general social services; (2) care for drug users within public health services such as e.g. psychiatric facilities; (3) specialized care, including detoxification and therapeutic communities.

Substitution treatment is mainly based on methadone though since 2007 also other substances as suboxone and naltrexone are prescribed. Between 2000 and 2006 only about 600 drug users were substituted, but the number doubled between 2006 and 2008 and increased further to about 1,600 in 2009 – a comparable number to other European cities. Almost one half of the drug clients are handed over by the system of justice or brought in by the police.

When drug users become clients they get registered in the records of the drug facilities. According to these records most of the clients inject brown heroin but many are also poly-drug users, taking illegally acquired methadone, benzodiazepines, neuroleptics, barbiturates, painkillers and opiates such as tramadol and experimenting with cocaine. The drug services that traditionally focussed on heroin addiction became more and more open for problems related to other substances.

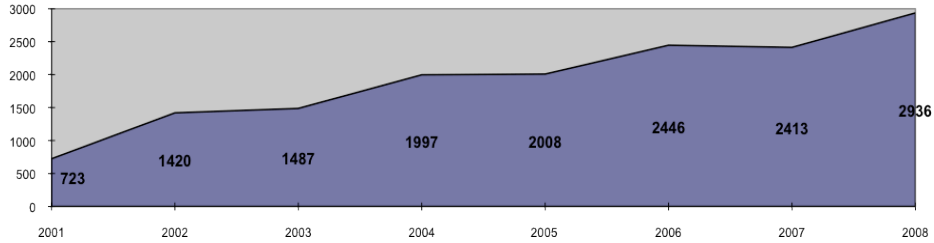
The national drug policy aims at a balance between demand and supply reduction

The national drug policy aims at a balance between demand and supply reduction. But due to its high number of problem users and especially of drug injectors, the city of Bucharest developed its own approach, relying even stronger on demand reduction by preventive interventions and integrated care for addicted users and implementing the measures by pilot projects. The result is that most drug services are located in Bucharest and that almost three quarters of all drug clients live in the capital.

Drug use is not an offence, but possession is. Penalties for possession distinguish between “risk” and “high risk” substances according to an amendment to the drug law in 2004. Another diversification not yet enforced is that between “user” and “addicted user”, allowing voluntary treatment for the latter instead of imprisonment.

The number of drug offenders registered by the police increased fourfold between 2001 and 2008 (see Figure 1): In 2008, 2,936 persons were registered, 1,865 of whom – 63.2% – had violated the drug law relating to their own drug consumption. More than half of the offenders are registered in Bucharest where a higher percentage – three quarters – was registered in connection with their drug use.

Figure 1: Drug offenders registered in Romania (including Bucharest), 2001-2008



Source: National Anti-drug Agency, National Report on the Drug Situation, 2009.

Bucharest, as the largest urban agglomeration, has a well-developed drug market with professional dealers

Bucharest, as the largest urban agglomeration, has a well-developed drug market with professional dealers. But high prices and low purchasing power keep the numbers of regular users at a low level. Heroin had a "promo" price when it appeared first, but it attracted dealers – more than all other substances, crossing the country on one of its important drug trafficking routes. At present heroin has a low price and is easily available in all poor areas of the city. Heroin was taken orally or smoked in the beginning, but with the professionalization of the drug market, users switched to injection. The city responded by the establishment of a detoxification centre in 1992 and the introduction of substitution in 1996.

3 Sources of information on the local drug situation and local drug markets

Drug research was initiated and partly also financed by the new state organisation – the Anti-Drug Agency – and it served as the basis for the new key document, the National Anti-Drug Strategy. Research started late, but developed well though there are remarkable gaps left: research, for instance, is dominated by prevalence studies and lacks evaluation of interventions.

The main sources of information on drug use in Romania and in Bucharest are two international/European surveys, which are regularly repeated for monitoring reasons: the "General population survey on knowledge, attitudes, practices regarding drug use (GPS)" and the "European School Project on Alcohol and other Drugs (ESPAD)". Additional information is provided by projects carried out in special settings such as prisons, recreational milieus and harm reduction services. Some more details on the main sources of information are presented below.

- The "General population survey on knowledge, attitudes, practices regarding drug use (GPS)" was carried out in 2004 and 2007 by the National An-

ti-Drug Agency. The survey is representative and comparative – it is carried out in 41 countries – capturing the general population between 15 and 64 years.

- The "European School Project on Alcohol and other Drugs (ESPAD)" was carried out in 1999, 2003 and 2007 in most European but also in non-European countries. The responsible Romanian organisation was the National School for Health Management. The survey is carried out in 116 schools, the target group are up to 3,000 pupils from the 9th and 10th grade, about 16 years old, who are asked to fill in a questionnaire on knowledge, attitudes and practices in regard to licit and illicit drugs.
- The "Study on drug use among prison inmates" was carried out in 2006 by the National Anti-Drug Agency in 35 penitentiaries, among 3,218 prisoners and 1,088 staff members between 15 and 60 years old.
- "Drug use injecting behaviour and sexual conduct" was carried out in 2004 by the "Romanian Harm Reduction Network (RHRN)" among 501 visitors of the syringe exchange services in Bucharest.
- "Marginalisation and social exclusion of youth: problem drug users" was carried out in 2007 by the National Agency of Youth Initiative Support in one prison in Bucharest among injecting drug users. This is the only qualitative study in the field.
- "Drug use in recreational settings" was carried out in 2008 by the National Anti-Drug Agency among party visitors, of whom 1,500 were interviewed online, 300 face-to-face. Of interest was the social background of the target group, which was approached by quantitative as well as qualitative methods.
- The "Study on the prevalence of HIV and/or VHC among injecting drug users in Bucharest", carried out in 2007 by the National Anti-Drug Agency in treatment centres and syringe exchange programmes in Bucharest. More than 300 15-59 years old drug injectors were asked about their view on the drug services.

The discussion on drug use in Bucharest presented in the following sections is based on the mentioned sources. Additionally information provided by 20 key informants was used, who were interviewed in the course of the present study along given guidelines. All key informants were familiar with drug questions but differed in regard to their profession: among them were psychiatrists, psychologists, social workers and physicians working in various drug services such as substitution, outreach programmes, private and state-run clinics for intravenous drug users and social and medical assistance for imprisoned injectors,

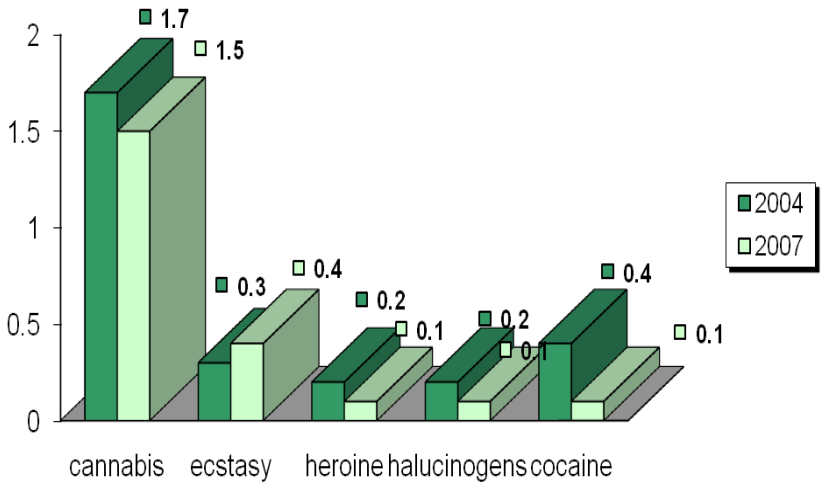
as well as experts from the forensic laboratory, police officers from the supply reduction department and representatives of NGOs involved in harm reduction campaigns.

4 Drug consumption, drugs and drug-related problems in Bucharest

4.1 Drug use

According to the most recent GPS of 2007, lifetime prevalence of illicit drug use is 1.7% in the general population (15-64 years). That is, almost 300,000 people have used at least once in their life marijuana and/or ecstasy, inhalants, cocaine, crack, amphetamine, hallucinogens, heroin, opiates. Compared to the GPS of 2004 lifetime prevalence has slightly dropped. Bucharest has a higher consumption and cocaine is only used in the capital (see Figure 2).

Figure 2: Lifetime prevalence of selected drugs in the general population, Romania, 2004-2007, in percentages



Source: National Report on the Drug Situation, 2008.

The ESPAD Studies confirm the low lifetime prevalence

The ESPAD Studies confirm the low lifetime prevalence found in the GPS but contrary to the latter show an upward trend for experiences with cannabis, ecstasy, cocaine, amphetamine and any injecting drug as Table 1 illustrates.

The nationwide prison study of 2006 (National Report on the Drug Situation, 2007) indicated that drug use was higher among inmates who lived in the

capital prior to detention, and that also drug preferences differed: in Bucharest heroin is the preferred substance, followed by cocaine, whereas elsewhere in the country it is marihuana followed by hashish and cocaine.

Table 1: Lifetime prevalence of selected drugs of 16-year olds, Romania, 1999, 2004, 2007, in percentages

Drug	1999	2003	2007
Tobacco	57.3	63.8	54.0
Alcoholic drinks	85.5	88.0	80
Alcohol and pills	3.8	3.2	4.0
Cannabis	1.2	2.6	3.0
Inhalants	1.3	1.7	4.0
Ecstasy	0.2	0.6	2.0
Cocaine	0	0.7	2.0
Amphetamine	0.2	0.2	2.0

Source: ESPAD, 2007.

In 2008 visitors of recreational settings in Bucharest were investigated. According to the results visitors differ along various variables such as, for instance, age, preferred music style and preferred substance, though cannabis is the drug of choice everywhere: Almost one third of all visitors aged 15 to 34 had experiences with hashish or marihuana, about one sixth had used it in the last year, 7% in the last month, and 3.5% were regular users (used it several times per month). In other words: drug use in recreational settings is mostly experimental, even that of cannabis, i.e. the most established and "socially integrated" illicit substance.

4.2 Main drugs, drug combinations, frequencies, amounts and modes

Heroin: As mentioned, heroin use is concentrated in Bucharest. It is mainly injected, but occasionally also inhaled – "melted on a tinfoil" – and smoked, commonly by beginners. It is mostly brown heroin adulterated with various substances whose health risks are either high or unknown. According to several sources, consumption patterns did not change during the last years: The onset is between 15 to 19 years, use takes place in small groups of 3-5 people and is part of a poly-drug use pattern. But heroin use is declining: "Heroin is not in line with the society vibes anymore. Heroin gives you a kind of inner peace that is in contradiction with the permanent need of energy, shake-up that the actual

But heroin use is declining

speedy life in Bucharest requires. The trendy electro music rhythms, the night-life, the chase for money demand an energetic, restless personality and heroin can prevent one from doing that" (National Anti-drug Agency, 2009).

Key informants from the police confirm this trend and observe dealers who switch from heroin and cocaine to cannabis, synthetic drugs and methadone, not at least due to lower sentences for comparable profits in the case they are caught.

Neuroleptics, barbiturates, painkillers and opiates illegally acquired on the street market: Among the best-known drugs are tramadol, carbamazepine, fenobarbital, benzodiazepines, levopromazin, and codeine, which sometimes are taken as substitute or together with heroin. But the most frequently misused opiate is methadone.

Cannabis: Students in the historical centre of Bucharest use it, mainly as marijuana. It is very seldom home-grown.

Cocaine: Also known in Bucharest as "dava", it is mostly used experimentally or occasionally because of its high price. The users are mainly young people of privileged background. The simultaneous consumption of heroin and cocaine ("speed ball") only recently came to Bucharest (National Anti-drug Agency, 2009).

Ecstasy: As with cannabis, ecstasy is perceived as a recreational drug for weekend use among socially integrated scholars and students. The popularity of the rave scene promoted the long-term use of the substance (36-48 hours).

Amphetamine was first synthesized in 1887 by the Romanian chemist Lazar Edeleanu in Berlin. But it is only since recently offered as "speed" on the Bucharest drug market. More often than speed, the police seizes regenon, a licit substance for weight loss, which in large amounts (10-20 pills) combined with alcohol and coffee is appreciated by drug users seeking low-cost amphetamine-type stimulants.

Aurolac in Romanian language is the name for a volatile inhalant

Glue: Aurolac in Romanian language is the name for a volatile inhalant sold as silver/golden powder, which is put in a bag and "sniffed" through openings. It is the substance almost daily used by the homeless, who therefore are also called "*aurolaci*". This term was taken up for homeless adults and street children in general, because they are perceived as the largest risk group in regard to drugs beside school dropouts and children of problem families. In 2004 the number of children working and living in the streets of Bucharest, but mainly around the Railway Station, amounted to 400-500. They are already the second generation of sniffers with serious social and mental disorders. Beside glue abuse they are exposed to heroin abuse but also to prostitution and paedophilia. They are supplied by a "glue black market" and its young adult dealers. The number of "glue sniffers" had already been declining, but with the economic crisis it increased again. Glue is also used by heroin users if they do not have the means to buy other drugs (Salvați copiii, 2003).

"Legal highs" have became popular

"*Legal highs*", i.e. mostly plants and herbal mixtures, mixed with research designer drugs which do not contain controlled substances and are sold in so-called "weed shops", have became popular in Bucharest in 2008. Since then their number has increased rapidly and retail has been established on the internet. According to a study in 17 European countries in 2009, 7% of the online retailers were based in Romania (EMCDDA, 2010). The shops partly also offer mood-evoking and energizing pills and powders containing amphetamine-type stimulants (mephedrone and other cathinones, MDPV, naphyrone) mixed with known stimulants like caffeine, kreatine and others.

Alcohol is mainly used in combination with ecstasy and/or cannabis in recreational settings, but according to key informants also taken in small amounts by regular heroin users.

Consumption patterns vary by the drug

As the presentation in the table shows, consumption patterns vary by the drug: Frequency, for instance, is higher with opiate consumption than with cannabis and consumption of stimulants. Table 2 summarizes the main findings for frequencies in numbers and shows the percentage of daily users of selected drugs between 2004 and 2008:

Table 2: Daily users of selected drugs, 2004-2008, in percentages

Drug	2004	2005	2006	2007	2008
Methadone	87.5	100	100	75	100
Heroin	88.6	90.6	98.7	95.3	96.4
Cocaine	33.3	20	0	0	50
hypnotics and painkillers	74.4	52.3	62.8	53.0	43.8
Other substances	63.3	88.7	70.1	73.3	34.0
hallucinogens	0	0	0	0	33.3
Inhalants	29.2	55	46.2	21.1	30
Cannabis	21.2	8.6	14.3	14.1	25
Stimulants	20	31.25	8.3	10.5	12.5

Source: National Report on the Drug Situation, 2008.

Also according to the key informants from low-threshold services and the *National Report on the Drug Situation 2008*, amounts vary by substance. Heroin users mostly inject 1-2 grams of street heroin in doses of 0.25 and 0.5 grams administered 2 to 3 times per day. If heroin is not available, it is mostly replaced by a combination of tranquilizers, barbiturates and eventually light alcoholic beverages. Regular cannabis users smoke 1-3 marijuana cigars daily and 4-5 during the weekend. Regular ecstasy and amphetamine users take 1-2 pills daily on weekdays and 4-5 pills during special events, parties, or clubbings.

Finally, modes of consumption differ by drug and additionally change with consumption practices and fashions over time: Drug clients, for example, at present mainly inject heroin, and the percentage of injectors has increased from about half in 2004 to about three quarters in 2008. Oral use of heroin is preferred by far less opiate users, i.e. about one quarter, and smoking and inhaling are rare. Oral as well as nasal use have declined during the last five years (National Report on the Drug Situation, 2008).

4.3 Drug users: social background, health and problem use

Drug users are mostly men, as the data of the drug services indicate: The syringe exchange programme, for instance, is visited by three times as many male than female drug users, the substitution programme by six times as many. According to the documentation of the public health units, between 2002 and 2008 the gender rate of admitted clients has stabilized at 3.5 to 1. Only recently, women have become more present in drug services (National Anti-Drug Agency, 2009).

The majority of the drug users are Romanians, but a noteworthy percentage is of Roma origin

The majority of the drug users are Romanians, but a noteworthy percentage is of Roma origin. The first small dealers have partly been Roma, but it is a myth that they – due to their conservative values – are only involved in the drug business and not in drug use: According to available data about 30-40% of the injecting drug users are Roma.

The average age of the injecting drug users in Bucharest is at present 25 years with a range of 20 to 30 years. It is increasing but at the same time broadening, a change which is partly due to a shift of drug preferences away from heroin towards stimulants and cannabis. The ageing of drug users can also be observed with the clients of state health units, but only with marginalized drug users: Socially integrated drug users become younger due to new substances offered and less intensive controls (*key informants from drug treatment facilities and low-threshold services*).

According to figures for 2008 (*National Report on the Drug Situation 2009*) two thirds of the problem drug users live with their parents, one fifth with their partner/partners and children, about 7% alone and about 5% under unspecified “housing” conditions. According to the key informants from drug treatment services, the housing situation of problem users is in general poor: the majority lives in overcrowded flats with larger families, and a part lives on the street – in the sewage system, the subway, abandoned houses, and places where prostitution takes place.

According to the documentation of the state health clinics most treatment needs are associated with heroin: more than two thirds of the patients are heroin users, other substances play a minor role (National Report on the Drug

Situation, 2009). An analysis of drug-related deaths between 2001 and 2007 confirms the dominant position of opiates in regard to health problems: 57 of 72 deaths or four fifths of the deaths were related to heroin, codeine, tramadol or other opioids.

Infectious diseases partly have a low prevalence such as HIV (1 % of injecting drug users in 2008), partly a high one such as HCV (73% of injecting drug users in the same year), some seem to be underreported such as HBV (12% of injecting drug users).

The number of problem users – who are mostly injectors – seems to have slightly dropped between 2003/04 and 2007/08 according to estimates (National Report on the Drug Situation, 2009). The decrease could have been caused by the migration of problem users – who are often Roma – to other European countries made possible by the accession of Romania to the EU in 2007, by a decline of the popularity and consumption of heroin and by effects of extended and diversified prevention and treatment, or by more than one of these factors. Drug treatment statistics also indicate a decrease of heroin use by the dropping number of heroin clients between 2001 and 2008, from 1,598 to 1,096. But it has to be kept in mind that the drug services had been tailored for heroin addiction treatment and drug addicts started to change their drug preferences during this period. The treatment service network has not been able to adapt so quickly to the new drug problems.

Key informants observe an alarming increase of cannabis users seeking psychiatric care because of disorders generated by long-term use. But it is difficult to estimate the number of problem cannabis users. Few key informants from the treatment and low-threshold services assumed on the basis of their personal observations that the ratio of problem users who prefer either heroin or cannabis is one to one.

The number of problem cocaine users is low; their share in the problem drug users is about 3-5%. The numbers of problem glue users and problem amphetamine users are without doubt higher though unknown.

4.4 Settings and scenes

Drugs are only cautiously used in public places

Drugs are only cautiously used in public places because drug users otherwise run the risk to get recorded by the police. Though the police intensively attacked retail networks during the last 3 to 4 years, dealers still offer their merchandise in certain areas. But they also hide and can only be reached via recommendations of “reliable persons” according to key informants from low-threshold services

Hard drugs are used in secluded places such as parks and abandoned houses in the outskirts of the city. Contrary to that, cocaine and amphetamine are used in the centre of the city. In regard to drug use, Bucharest’s 6 districts can be subsumed to several diversified “drug areas”, which developed only since 2008:

- "Heroin areas" – Districts 2,4, and 5, the belt of the city.
  Some streets in these districts come close to an open drug scene and consequently are sources of permanent conflicts between drug users and dealers, neighbours and the police. They belong to areas inhabited by marginalized and deviant young people, among them many Roma without personal documents and job, some of whom are heroin injectors with a long drug career with regard to use as well as to dealing. Injecting in small groups can be observed (key informants from low-threshold drug services and police). In the central roads of the belt of the city there dwell sex workers who also use mainly heroin.
- "Ecstasy and stimulants areas" – Districts 1, 3, the North and South of Bucharest.
- "Cannabis area" – District 6, an area inhabited by students.
- "Everything and all" – the historical centre, among whose heterogeneous inhabitants and visitors, homeless hard-drug users without personal documents can be found as well as fashionable users of "legal highs" and small dealers and users of cannabis and stimulants.

4.5 Financing sources

Heavy drug users are in need of about 170 Lei daily that is about 52 Euro

Heavy drug users are in need of about 170 Lei daily that is about 52 Euro according to a study on injecting drug users in treatment and syringe exchange programmes in Bucharest (National Report on the Drug Situation, 2008) but according to a key informant they "do not succeed in getting important amounts to finance drug use". They therefore combine all available sources – legal, semi-legal and "light" illegal ones – such as: to drive a taxi, to dress hairs, to unload merchandise, to wash windshields, to manage ownerless parking places, sale of syringes provided by syringe exchange programmes, sale of methadone provided for by the substitution programme, dilution and sale of small quantities of drugs currently not needed, to deceive customers when selling goods at the vegetable market, prostitution, to procure prostitutes, to extort protection charges, theft of goods later sold on the black market, car theft and, if the withdrawal symptoms are heavy, burglary. Drug users with a long drug career might also sell their knowledge where to get "better quality" at "special prices", a trade that is also associated with gratifications of the dealers – mostly drugs for free.

A recent study (National Report on the Drug Situation, 2008) of injecting drug users shows that almost one half lived mainly from own work, about 40% on the expense of parents, relatives and partners and about one tenth from semi-legal and illegal activities.

4.6 Retail networks

Drug trafficking is organized in several layers

Drug trafficking is organized in several layers. Wholesale networks of mainly Turks, Arabs, Ukrainians and Moldavians transit large quantities of drugs along the Balkan routes, which only partly are destined for Bucharest. The retail in the capital is controlled by clans of mostly Roma, known in the criminal milieu not only for drug trade. Street dealers, who are also involved in other small deviant business such as prostitution and stolen goods, get active one layer below them. Drugs are also being sold by users themselves, which mostly consume since long and have developed contacts to dealers, specializing on newcomers not familiar with the market.

5 Purity and prices

Heroin according to key informants has a purity of 5-10% to 30% at street level. This estimate is based on statements of drug addicts newly admitted to the substitution programme. "If somebody comes and says he/she used 2 grams per day, I am supposed to give him 200 mg of methadone (for 2 g of pure heroin – *the authors*), but I give him 60 mg and I see it's usually working". About 10% of the seizures – mostly of heroin offered at a higher retail level – are analysed, the purity is up to 43% with a recorded maximum of 65%. Most key informants thought that purity of heroin on the street market was varying from one dealer to the other and was "generally decreasing".

Most key informants thought that purity of heroin was "generally decreasing"

Heroin is sold in small doses of 0.25 g ("bile" in Romanian language) for 7 to 12 euro and in large ones – 0.5 g – for 14 to 24 euro. Key informants thought that the heroin price on street level had increased by 30-35% over the last year, mainly due to the exchange rate of Lei and Euro. On the wholesale level, the price had increased from 12,000-15,000 to 15,000-16,000 € and the medium retail price from 30-35 to 40-45 €.

Hashish has a medium purity of 8.3% ranging between 4 and 16% and it can be bought on the drug market of Bucharest for 9 to 12 € per gram. Marijuana is sold for 10-12 € per gram, which is more expensive than during the last years when it could be acquired for 6-7 €.

Cocaine can reach a purity of 62%, but the police also seized samples with 18%. Low-purity cocaine is thought to come from Spain. The price for one gram on average is 100 €, the range is between 80-120 or even 160 €.

Ecstasy with an average purity of 40 mg/pill is sold in Bucharest for 8 € – range: 6 to 10 €. The price has decreased by 50-70% over the last 5 years.

Amphetamine, which is sold as pills and powder, has an average purity of 22.5%. The average price is 12 € per dose and pill.

For comparison, the prices of some other substances: a blotter (a piece of paper that looks like a stamp) of LSD is 30 € at street level, one gram of ketamine 25 €, one gram of spice 8 €.

Summary Table 3a: Average price of selected drugs at street level in Euro, 2005-2009

Type of drug	2005	2006	2007	2008	2009
Cannabis resin	6	6	7	9	9-12
Cannabis herb	7	4	10	14	8-12
Heroin	40	60	35	30-35	35-45
Cocaine	120	50	120	120	100
Amphetamine	13	50	10	10	12
Ecstasy	15	15	12	8	9

Source: Key informants from Combating Organised Crime Units and NGOs.

Summary Table 3b: Purity of selected drugs in percentages, 2009

	Cannabis Resin	Cannabis herb	Brown Heroin	Cocaine	Amphet-amine	Ecstasy
Purity acc. to forensic laborato-ries	8.3% Min 4% Max 16%	8%	Street level 21% Wholesale 43% Max 63%	Street level 62% Wholesale 87% Min 18%	22.5% previous years	40mg/ cp 40%
Purity acc. to other key inf.			Street level 5-15% Wholesale 20-30%	Street level 68-70%		

Source: Key informants of Drug analysis lab of Criminal Police, from Combating Organised Crime Units and from NGOs.

6 Conclusion

Low purchasing power of Bucharest's inhabitants

Like other urban agglomerations, Bucharest with its numerous actual and potential drug users represents a prolific market place for drug traffickers. But drug use only appeared in Romania and especially in Bucharest after the revolution in 1989 and during the transition from a totalitarian regime to a democratic state, transforming economy, institutions and values. And it appeared slowly due to the low purchasing power of Bucharest's inhabitants.

Heroin, which was an exception in the beginning, is nowadays the substance most often used by marginalized drug users, who mainly inject it and not at least therefore suffer of various medical and social problems. Problem drug users have always concentrated in the poorest areas of the city, though heroin spread socially as well as geographically during the last two years. Cocaine and amphetamine, the expensive substances, are mostly used in the centre of the city on an experimental and occasional basis – though since few years, they are also taken by marginalized users from time to time and mixed with heroin. Cannabis and ecstasy, finally, are perceived as weekend drugs and mostly used by scholars and students, i.e. by socially integrated persons living in the inner quarters close to the city centre.

Drug services mostly cover heroin users: about 70-80% of the clients are admitted because of heroin-related problems. Most of the drug services in Romania are located in the capital where the majority of the Romanian heroin users live. The drug services in Bucharest are also the most diversified in the country including the most developed harm reduction offers such as substitution treatment and syringe exchange.

The drug situation in Bucharest is also characterised by the abuse of "Aurolac" – a glue sniffed by the most disadvantaged among those living in the streets. Sniffing has decreased significantly during the last 7-10 years, but it has been revived by the economic crisis: Aurolac is taken by injecting heroin users when they lack the resources to buy heroin, methadone, barbiturates or other substances sold on the drug market.

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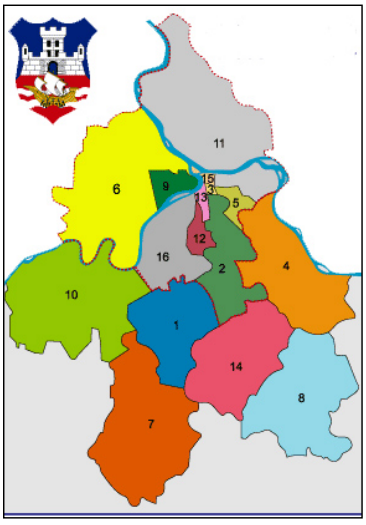
Drug Consumption in Belgrade

Svetlana Vučetić-Arsić

1 The city

Belgrade is the capital of the Republic of Serbia and with a population of 1,710,000 inhabitants its largest city. It lies at the confluence of Sava and Danube, where Central Europe's Pannonian Plain meets the South European Balkans (Serbia-Belgrade, 2009). It is one of the oldest cities in Europe and it has been an important crossroad between the West and the Orient for centuries. Belgrade has had many different names throughout history, and in most languages the name translates as "the white city".

The city has an urban area of 360 km², while together with its metropolitan area it covers 3,223 km². Belgrade has an autonomous government and is divided into 17 municipalities (Territory, 2009).



1.BARAJEVO	5.ZVEZDARA
2.VOZDOVAC	6.ZEMUN
3.VRACAR	SURČIN
4.GROCKA	7.LAZAREVAC
	8.MLADENOVAC
9.NOVI BEOGRAD	13.SAVSKIVENAC
10.OBRENOVAC	14.SOPOT
11.PALILULA	15.STARI GRAD
12.RAKOVICA	16.ČUKARICA

Recent polls (2007) show that Belgrade's population has increased by 400,000 persons in just five years since the last official Census has been undertaken. 27.5% of the population were young or of middle age, more than 25% were older than 60 and the gender ratio was 1:1.12 for males compared to females (Statistical Yearbook of Belgrade, 2007).

As a result of its tumultuous history, Belgrade has been home to many denominations for centuries. Today the composition is rather homogeneous: According to the 2002 Census, there are 90.7% Belgrade citizens of Orthodox confession, about 1.3% of Islamic and 1% of Roman Catholic belief, while 3% are declared as atheists (Census, 2002).

Belgrade is home to many ethnicities. Only recently up to 100,000 persons arrived as refugees or expatriates from Croatia, Bosnia-Herzegovina and Kosovo, as a result of the Yugoslav wars between 1990 and 1999.According to the Census 2002, the main nationality groups in Belgrade are Serbs (89.9%), then Yugoslavs (1.4%), Montenegrins (1.3%), Roma (1.2%), Croats (0.7%), Macedonians (0.5%), and Muslims as a national minority (0.3%).*

Today, over 35% of Serbia's gross domestic product is generated by the city, which has 31.4% of Serbia's employed population. The average gross salary per month in September 2010 was 46.4 Serbian dinars (RSD, about 437 €), while net income in Belgrade amounted to 34.6 Serbian dinars (about 323 €) per month, which is the highest average net salary in the country. In December 2009, the employment rate in Serbia was 13.5% or 726,465 persons, i.e. the same as in Belgrade where it was 13.8% according to the National Employment Office.

2 National and local drug policies

At the beginning of the 1980s, when larger amounts of illicit drugs had passed its borders, former Yugoslavia responded with a variety of legal actions, one of them being the adoption of the most important international agreements on narcotic drugs. Another step was the foundation of the Federal Commission for Addictions by the Ministry of Health in response to growing numbers of cannabis, opiate and heroin users. In 1987 the Institute for Addictions was founded in Belgrade, whose responsibility was care for addicts from the whole of Yugoslavia. The initial strategy was guided by European protocols on the treatment of addicts, and it especially relied on a substitution programme with methadone.

During the 1990s, due to civil wars on ex-Yugoslav territory, country borders became vulnerable to drug trafficking

During the 1990s, due to civil wars on ex-Yugoslav territory, country borders became vulnerable to drug trafficking, and in 1999 Serbia has lost the custom control of its southern province, Kosovo and Metohija, which led to an easier penetration of illicit drugs from the Middle East. According to State Department sources Serbia, but especially the Kosovo, serve as passages for drugs designated for the drug markets of other European countries and only a small percent-

* A number of 15,869 Muslims as a matriculation form minority live in Serbia, and they are proclaimed as a national minority since 1971. In the Socialist Federal Republic of Yugoslavia they had a position as constitutive nation in the Republic of Bosnia and Herzegovina. After 1992, when the state Bosnia was formed, the majority of Muslims adopted a new name as ethnicity: Bosniak. Nevertheless one part of the citizens kept their old name, thus according to the Census 2002, in Serbia there were 135,670 Bosniaks and 15,869 Muslims as national minority.

age remains within the country for the 60,000 to 80,000 Serbian drug users (Bureau of International Narcotics and Law Enforcement Affairs, 2007). Heroin, cannabis and stimulants coming from Afghanistan, Myanmar and Turkey, cross Bulgaria and the FR of Macedonia to Central and West European countries, cocaine coming from Columbia and Bolivia crosses ports in Spain, Montenegro, Italy and Greece.

The political transition and social-economic crisis have triggered drug misuse to become a crucial social-medical problem

The political transition and social-economic crisis have triggered drug misuse to become a crucial social-medical problem. As a response to the drastic increase of opioid users, further steps were taken at the turn of the millennium to improve legal, health and prevention activities. The penal law was amended, the training of the police reorganized and medical treatment and rehabilitation of drug users were modernized: a programme with the opioid antagonist naltrexone was established and buprenorphine was registered as a substance for detoxification and substitution of opiate addicts.

Since 2005 a national drug strategy, including a respective action plan, was developed and adopted in February 2009. It is based on the following principles: respect for laws, strengthening of institutional capacities, protection of citizens and local communities, protection of human rights, multidisciplinarity, appropriate information, availability of treatment for all drug users, decentralization, ethics and reduction of stigmatization. At the same time also the National Strategy for the fight against HIV/AIDS was approved by the Serbian Government.

Today primary health care services are the first step in the treatment system for substance use disorders

Today primary health care services are the first step in the treatment system for substance use disorders. The main steps are offered within a specialized system for alcohol and drug use disorders but also within the mental healthcare system. The treatment for substance use disorders – including detoxification, maintenance therapy, inpatient treatment of drug dependence and treatment of drug-induced psychoses – is financed through social and health insurance. A basic level of healthcare is provided by law for those who are not insured. Substitution treatment can be initiated by doctors in specialist treatment centres. In September 2010 detoxification and maintenance with buprenorphin were introduced at the Institute for Addiction and three other regional centres in Novi Sad, Kragujevac and Nis. Some treatment is financed through external subsidies (Ministry of Health of the Republic of Serbia and Global Fund, 2010), and some NGOs provide for additional treatment services such as psychosocial intervention and therapeutic communities. In Belgrade, medical treatment of addiction is provided by the Institute for Addictions (also Special Hospital for Addictions), the Institute for Mental Health, the Institute for Psychiatry, the University of Medicine and by specialized private health centres.

In 2008, the Ministry of Health allocated a specific budget for prevention of substance use disorders. Serbia has a tradition of conducting preventive programmes of illicit drug abuse. Many institutions are active in the field of prevention, including healthcare services, the police, the community, and institutions from the educational sector.

3 Sources of information

The following studies were used to assess drug consumption in Belgrade:

- *Socio-demographic features of drug users*. Retrospective study, 1987-1995. It surveyed 2,450 patients treated in the Institute for Addictions. (Veljković et al., 1995).
- *Prevention of psychoactive drug abuse in the local community 2001*. Random samples of 1,871 high-school and gymnasium students, 282 teachers and 107 parents from 16 Belgrade municipalities were studied (Ćirić et al., 2001).
- *School survey project on the use of alcohol and other drugs among youth in Serbia 2005*. This is a pilot study based on the European School Survey Project on Alcohol and other Drugs (ESPAD) surveying young people's abuse of alcohol and other drugs. The samples taken in Belgrade, Niš and Novi Sad consisted of 1,600 secondary school students aged 16 (Manzoni et al., 2005).
- *Drug use among the general population and young people 2006*. A stratified two-stage representative sample of 10,690 people was investigated by a self-administered questionnaire to assess the prevalence of drug use among the general population (aged 15-59) (Strategic Marketing, 2006)
- *Health investigation among inhabitants of Serbia, Annual Report*. A random sample of 6,156 households with 15,563 adults and 1,725 children from 12 to 19 years from all Serbian regions was interviewed. The main topics were social-demographic characteristics, health status, lifestyle, health control, early disclosure of illnesses, and satisfaction with own life (Ministry of Health and Institute of Public Health, 2006).
- *ESPAD 2008*. 6,500 students aged 16 from urban and rural areas were interviewed (Ministry of Health and Institute of Public Health, 2009).
- *The surveys among high-risk populations and people living with HIV. Basic results 2009-2010*. Bio-behavioural study among 964 intravenous drug users in Belgrade, Novi Sad and Niš as well as among sex workers in Belgrade (Ministry of Health and Global Fund, 2010).
- *HIV, HCV and syphilis prevalence assessment: risk behaviour and use of services in the population of injecting drug users in Belgrade and Niš*. Bio-behavioural cross-sectional study with a target population of 571 intravenous drug users of ages 18 or over who have temporarily or continuously injected psychoactive substances during the last month (Ministry of Health and Institute of Public Health, 2010).

- *Correlation between impulsiveness and overdose occurrence in the population of intravenous opioid users*. Evaluation of medical protocol and incidence of complications in 3,758 patients with an acute opiate or multidrug co-intoxication treated on the medical emergency department in the Special Hospital of Addictions, Belgrade, between march 2003-2008 (Vučetić-Arsić, 2010).

Most of the available information on drugs, regular drug use and drug users is coming from Drug Health Services or the Ministry of Police. These results are respectable, but not complete. For the description of the drug situation in Belgrade, therefore, interviews with key persons were carried out in the course of the current study along a given questionnaire. 24 experts were interviewed, among them psychiatrists who are specialized in addiction (6 persons); experts from the Federal Commission for Addictions and the City's Federal Commission for Addictions (4 persons); police officials from the Ministry of Police Belgrade City, Department of Drug Control Administration (2 persons); experts from the Ministry of Interior, Criminal Investigations Directorate, Service for Combating Organized Crime (2 persons); experts from the Serbian Customs Administration (2 persons); experts from the Special Hospital of Central Prison (2 persons); the Head of the Forensic Department from the National Criminology Center (1 person); one District Attorney (1 person), psychologist, epidemiologist and social workers in the addiction field from Health Services (3 persons) and an expert from an NGO (1 person).

4 Drug consumption: Results of the literature review and interviews with key persons

4.1 Prevalence and incidence

The drug survey of 2006 provides data on lifetime prevalence of illegal drugs: 10.9% of respondents 15-59 years old reported to have experiences with illegal drugs, most of them with cannabis (10.7%), few with other substances (e.g. 1.9% with ecstasy, 1.3% with cocaine).

Lifetime and last year experiences were almost double in the younger generations (15-34 years) and experiences were higher for males

3.8% of all respondents had used a drug during the last year. Lifetime and last year experiences were almost double in the younger generations (15-34 years) and experiences were higher for males apart from sedatives, which had been used more frequently by females. The average age of first-time illegal drug use was 18.6. In 2005, a pilot study based on the European School Survey Project on Alcohol and other Drugs (ESPAD) methodology explored young people's abuse of alcohol and other drugs. It surveyed 1,600 secondary school students

aged 16 from the cities of Belgrade, Niš and Novi Sad. Cannabis lifetime prevalence was 12.9 % and reported lifetime use of non-prescribed medicines was 11.3 % (Manzoni et al., 2005).

The results of the ESPAD study from 2008 complement those of the study of 2006. Also adolescents prefer cannabis and (non-prescribed) sedatives (benzodiazepines). The latter are not just used by the elderly; they are widely used as intoxicants – the rising sales of the public pharmacies indicate an upward trend. Lifetime experiences with psychoactive drugs (excluding alcohol and tobacco) are reported by 15.1% of first-grade secondary school students, boys as well as girls, in Belgrade somewhat more often (ESPAD, 2008). Other substances than cannabis and sedatives play a minor role – see Table 1.

Among students who reported experimental cannabis use at least once, most tried it at age 15 (48.8%) and 16 (19.8%), while 3% of the students who had smoked cannabis did so before age 9. The use of cannabis 40 times or more was reported by 0.5% of the students.

Table 1: Lifetime experiences of students 16-years-old with illicit drugs, Serbian regions, 2008; in percentages

Region	Belgrade (N=1160)	Vojvodina (N=1491)	Central Serbia (N=3504)	Total (N=6155)
Any illicit drug	17.1	15.8	14.1	15.1
Cannabis, herb and raisin	9.1	8.8	5.0	6.7
Ecstasy	2.0	1.9	1.3	1.6
LSD & other halucinogens	1.2	0.7	0.7	0.8
Amphetamines (speed)	2.5	1.5	1.2	1.5
Cocaine	1.0	0.9	0.9	0.9
Heroin	0.8	0.7	0.9	0.8
Tramadol	1.3	1.2	1.5	1.4
Inhalants	2.2	2.8	3.2	2.9
Alcohol with pills	2.3	3.9	2.4	2.7
Sedatives without prescription	8.3	6.2	7.9	7.6
IDU of any illicit drug	0.4	0.3	0.5	0.4

Source: ESPAD, 2008.

Data from the Drug Health Services indicate that opiate addicts are the main beneficiaries of the drug services in Belgrade, and that users of cannabis, cocaine or amphetamine rarely make use of them. They additionally indicate that the number of patients of the health services registered as drug addicts (diagnosed as ICD/ F10 to F19) is increasing: Prevalence increased (from 437.3 per 100,000 inhabitants in 2008 to 470.4 in 2009) as well as incidence (Table 2). The registered drug addicts mainly belonged to the age group of 25-29 years old, the gender ratio was 3 males on 1 female.

Some more figures on drug users in treatment: In 2007 the Special Hospital for Addictions treated more than 1,000 new patients and cared for 1,200 patients residentially, for 200 by the maintenance programme. In 2008 24,000 drug addicts underwent acute detoxification at the Department for Toxicology, Military Medical Academy. In 2008, 45 deaths caused by illicit drugs (mostly a fatal heroin overdose in combination with benzodiazepine or alcohol intoxication) were counted, but 106 fatal heroin overdosed persons were registered by the Police Department. A similar pattern of heroin overdoses was documented among patients in the Emergency Centre of the Institute of Addictions (Vučetić-Arsić et al., 2009).

Table 2: Registered drug addicts in Belgrade, 1998-2009, absolute and per 100,000 inhabitants

		1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
A	N	288	151	467	393	444	497	625	954	773	630	772	463
	p.HT	18.27	9.58	29.63	24.93	28.17	31.53	39.65	60.53	49.04	39.97	48.98	29.00
B	N	1,633	1,748	2,173	2,516	2,932	3,412	4,013	4,926	5,618	6,196	6,893	7,414
	p.HT	103.61	110.90	137.87	159.63	186.03	216.48	254.61	312.54	356.44	393.12	437.34	470.4

A = *INCIDENCE* of patients with a drug addiction diagnosis;
B = *PREVALENCE* of patients with an addiction diagnosis
p.HT = per 100,000 inhabitants

Source: Institute for Public Health, 2008.

4.2 Drugs, regular and occasional users, groups of users

During the last two decades the drug situation in Serbia has changed

During the last two decades the drug situation in Serbia has changed. According to the survey of 1987-1995, which investigated 2,450 patients of the Institute for Addictions, drug addicts were: mostly young males (79.8%), with high school education (67.9%), who were unemployed (64.6%), lived in Belgrade (63.9%), in residence with both parents (38.3%) or alone (23%). Users were single (66.7%) or married with 1 or 2 children (22.6%), they tried illicit drugs for the first time when 14-18 years old (53.1%). When they were 19-23 years old one third of them had become registered as drug addict by a health service (35.5%).

The first drug consumed was mostly cannabis (40.9%), followed by poppy tea (30.1%) or heroin (30.0%). 92.1% of all registered drug addicts consumed heroin (Socio-demographic Features of Drug Users, 1987-1995).

Today illicit drug use has spread to all social classes

Today illicit drug use has spread to all social classes. But heroin is still the most preferred substance (90.5%) of registered drug users in Belgrade followed by amphetamines, benzodiazepines and ecstasy (about 7%). According to the database of the Special Hospital for Addictions (Database for Treatment Demand Indicator, Pompidou questionnaire, 2010) also other characteristics of regular drugs did not change substantially over the years: the present drug patients mostly have secondary school education (69.1%), are unemployed (78.5%) and live with their parents (75.1%), some of them with a family member using illicit drugs or alcohol (17.5%) (TDI, Special Hospital for Addictions, 2010).

Stimulants such as speed and cocaine have gained popularity, and LSD, which had lost its attraction since the 1970s, recently had a comeback. Some amphetamine users are former heroin addicts or young addicts who temporarily use speed. Others are occasional users of ecstasy and cocaine. To mention are further ketamin, which arrived shortly ago, GHB, solvents and glues. Occasional users are mostly not reached by research. Probably most of them use cannabis herb such as marijuana or skunk (contains high levels of the psychoactive ingredient THC), and among them are some well-known cocaine users.

At present four consumer groups can be identified

At present four consumer groups can be identified: (1) regular heroin drug users from all classes and education levels, (2) a small number of socially privileged and accordingly well-hidden cocaine users mostly from business, from the criminal milieu or from the “rich and famous”, (3) young amphetamine users, who formerly used heroin, and (4) invisible socially integrated cannabis users of all age groups.

There is no drug scene in Belgrade and drugs are consumed across the whole city. But there are clubs where ecstasy and amphetamine users meet (rave clubs) and others where cocaine is used (float clubs). Smoking marijuana in public is becoming more frequent.

4.3 Consumption patterns, mode of consumption and substance combinations

Consumption patterns change with trafficking routes – mainly of heroin. During the last 15 years the mode of heroin consumption has changed: Previously, heroin was mainly consumed by intravenous injection (called “slamming” or “shooting up”) because users expected additional pleasurable effects. Nowadays only older heroin users stick to injection as data of the Institute of Addiction indicate: in 1987 90.6% of the patients injected, in 2010 it were only 39.8%.

Younger and recreational users frequently snort drugs or smoke them by inhaling their vapours when heated, either with tobacco in a rolled cigarette or

by heating the drug on aluminium foil from underneath. This method of administration is known as “chasing the dragon”, when it concerns methamphetamine it is called “chasing the white dragon”. According to data from the Special Hospital for Addictions 44.2% of the younger heroin users sniffed and 14% inhaled their drug (TDI, Special Hospital for Addictions, 2010).

Estimates on the basis of police sources arrive at 12,500-25,000 injecting drug users (IDUs) in Serbia, one third of them in Belgrade. The majority is male – one woman per seven men –, one fifth is 15-24 years old. Prevalence of HIV infection is as low as 2.4% but prevalence of hepatitis C infection is 77.4% in Belgrade and Niš (Ministry of Health and Institute of Public Health of Serbia, 2010).

Poly-drug use often includes alcohol, not at least because of its good availability

Poly-drug use often includes alcohol, not at least because of its good availability. The most common drug combinations during the last five years were sedatives and alcohol; tramadol and alcohol; sedatives, heroin and sleeping pills; cannabis and alcohol; cocaine with alcohol, heroin and cannabis. A growing popularity of drug combinations including alcoholic beverages can be observed among the youth (ESPAD, 2008). And the prominence of alcohol is also indicated by data of the Emergency Department of the Institute for Addictions: the majority of admissions because of intoxication are alcohol-related (Table 3). Admissions because of alcohol intoxication amounted to 9.9% of all admissions between 2003 and 2008; because of intoxication with illicit drugs it was only 5.6% (Vucetic-Arsic et al., 2009).

Table 3: Emergency admissions because of alcohol and multi-drug intoxication, 2003-2008, absolute numbers

	2003	2004	2005	2006	2007	2008
Alcohol intoxication (N = 760)	99	183	192	180	244	234
Multi-drug intoxication (N = 338)	43	10	98	66	58	63

Sources: Special Hospital for Addictions, 2010.

4.4 Summary on drug consumption patterns in Belgrade

Table 4 is based on all epidemiological data and statistical reports quoted at the beginning of this chapter as well as on the interviews with key persons, who added important information and explanations:

Table 4: Summary table on main drug scenes in the city

	Scene 1	Scene 2	Scene 3	Scene 4
Main drug(s)	Heroin	Cannabis	Cocaine	Amphetamine
Size / number of drug users	> 6,500 IDUs > 6,893 registered addicts ~ 40,000 police estimates	Unknown	Unknown	Unknown
Frequency of consumption of main drugs	Daily, seldom, less frequently or occasionally	Regularly or occasionally	Occasionally	Occasionally
Mode of consumption of main drugs	Intranasal, i.v. injection, inhaling, smoking	Smoking	Intranasal	Intranasal, i.v. injection
Amounts of daily dose	0,5-1,5 g	Few breaths, 1 joint	0,5-1 g	1 g
	Scene 1	**Scene 2**	**Scene 3**	**Scene 4**
Gender: Men:Women	3:1	3:1	4:1	4:1
Ethnicity estimates	97% Serbian	95% Serbian	95% Serbian	98% Serbian
Age: averages	28 years	14-50 years	20-45 years	19-45 years
Socio-economic status	All classes	All classes	Middle and upper class	All classes
Main consumption setting:	Private	Private and public	Private and public	Private and public
Treatment capture:	90-95%	2-3%	2%<	2%<
Police capture:	95%	Unknown	Unknown	Unknown
Main financing source:	Also criminal activity	Mostly legal	Also criminal activity	Also criminal activity

5 Drug markets

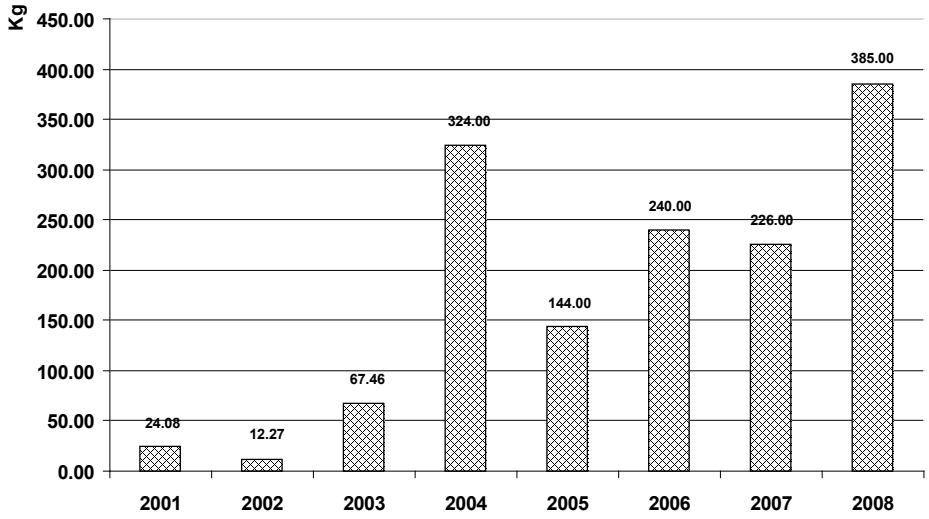
The illegal drug market in Belgrade spreads to all municipalities of the city and is well organized

The illegal drug market in Belgrade spreads to all municipalities of the city and is well organized. Since illicit drugs are even sold in schoolyards, also students get involved in drug markets. Many heroin dealers are recruited from 14-16 year olds who therewith often start a deviant career.

On Serbian drug markets also pharmaceuticals can be acquired, mostly the synthetic opioid analgesic tramadol or other painkillers, analgesics containing codeine and other active agents, and digestives of diverse composition. During the last five years, illicit laboratories started to produce amphetamines, in the Belgrade vicinity faster than elsewhere. The laboratories seem to produce more than drug addicts in Serbia use. The production is set up and organized by Serbians who cooperate with foreign citizens.

Delivery services called “pizza service” have become popular, but also Internet sales developed, though the offered quantities of cocaine, LSD and GHB are mostly small. And sometimes even public bodies as the Fast Post Services are involved in the drug trade. This was revealed by the customs administration, which as the health and police administration has set up a monitoring system for trends and changes on the drug market. Additionally, an early warning system has been established at the county as well as city level to provide timely information on drug issues, where several administrative departments cooperate. Also seizures indicate that the drug market is prospering though their increase is partly due to improved police equipment (see Figure 1).

Figure 1: Drug seizures in Serbia, 2001-2008, in kg



Source: Serbian Customs Administration.

The most often seized drugs are, not surprisingly, those most often used and sold. Table 5 also shows that the share of seizures made in Belgrade is relatively high.

Table 5: Seizures of illicit drugs in Serbia and Belgrade, 2008-2009, in grams and pills

	SERBIA		BELGRADE	
	2008	**2009**	**2008**	**2009**
Marijuana (g)	1,420,313	1,083,239	124,524	146,880
Hashish (g)	1,084	16,094	137	10,826
Heroin (g)	181,922	169,207	55,737	57,591
Cocaine (g)	10,292	19,225	5,814	2,618
Ecstasy (g)	207	5,408	-	-
Ecstasy (pills)	1,045	2,512	513	257
Amphetamine (g)	16,435	7,181	5,602	7,600
Amphetamine (pills)	547	239	-	-

Source: Ministry of the Interior of the Republic of Serbia, 2010 ; Ministry of Police of Belgrade City, 2010.

6 Purity, prices, expenditures and financing behaviour

To improve law enforcement, laboratories have been established to identify illicit drugs and analyze their quality, to identify manufacturing methods and countries/regions of origin and to identify retail and consumption patterns and trends. The Forensic Department of the National Criminology Centre in Belgrade was established in 2000, its equipment was renewed in 2006 and it receives supervision from the Bundeskriminalamt in Wiesbaden, Germany.

The laboratories analyse large seizures of illicit and licit substances, among the latter are anabolics, sedatives, methadone or tramadol and they are only analysed upon request of the juridical system.

Purity of street drugs varies with place and time

Purity of street drugs varies with place and time. Purity of street heroin may be up to 10% but is more commonly less than 5-15% with some samples as low as 3%. Varying purity has often been connected to a fatal overdose, because users do not expect substances of high purity. Typical admixtures for heroin are paracetamol, caffeine, keratin, lidocain, bezamine, powder, brown sugar and pudding dust.

Purity of cocaine has dropped remarkably to about 40-50%, but its price has gone up to about 60-70 € per g. Amphetamine sulphate and amphetamine phosphate found on Belgrade streets are often cut with sugar, caffeine and/or ephedrine and sometimes with paracetamol, Vitamin C, and talcum powder.

Purity varies between 10-30% with an average of 20%. The amount of MDMA in one ecstasy tablet on average is 20%. Many ecstasy tablets also contain other drugs – ketamine, amphetamine, caffeine, ephedrine have been found.

According to experts' opinion regular heroin users daily spend 20-25 € on drugs, 175-200 € weekly and 600-700 € monthly. Financing behaviour of heroin drug users depends on length and pattern of drug use. In the beginning of their drug career users spend own or parents' resources, later they borrow from relatives and friends, finally they commit criminal acts.

Table 6: Current purity (in percentages) and prices (in Euro/g or pill) in Belgrade

Source	BH	PT	C	Amph.	E	C / THC	
						herb	resin
Purity Acc. to forensic laboratories		(8%-14% morphine)					
street	3-17%	70-80%	30-50%	10-50%	10-15%	10-12%	15%
small seizure	35%	80%	60%	50-80%	20%	5-10%	15-20%
large seizure	17-40%	80-100%	50-70%	80%	20-25%	15-22%	30-40%
Purity Acc. to other key informants	5-15%	90-20%	20-30%	30%	20%	20%	10-15%
Purity Acc. to police dep. of Belgrade	8-10%	60-80%	20-30%	20-70%	5-15%	10-20%	10-15%
street	80%	100%	80-100%	60-80%	10-20%	20-40%	10-30%
Prices Acc. to forensic laboratories	20-40**	4.5-5/ bag of 300 g	50-60	10-12	4.5-10	3-4.5	5-7
Prices Acc. to other key informants	20 40-60** 70-125/ 5g**	4-5 €/ bag of 300 g 8-10 €/ bag of 5-8 g	50-70	7.5-10	2-3 (6-8 retail)	1.5-5	6-7
Prices Acc. to police dep. of Belgrade	20-50 **	4.5-5 €/ bag of 300 g	50-70	10	5-10	2.5-5	6-8

BH = Brown heroin; PT = Poppy tea; C = Cocaine; Amph. = Amphetamine, sulfate and phosphate; E = Ecstasy; C / THC = Cannabis, THC content.
Notes: *Purity and prices of methamphetamine per g * MDMA; ** White heroin.
Source: Criminology Centre, Belgrade Police Department and other key informants.

7 Differences between the drug situation in Belgrade and in Serbia as a whole

More problem users are living in Belgrade than in the other parts of the country

The school survey of 2008 found that 6.7% of all students had tried cannabis at least once; in Belgrade it was 9.1%, but only 5% in Central Serbia. Also last year consumption of cannabis and hashish and regular use of these drugs was significantly higher in the capital (Table 7). Besides these findings no remarkable differences in regard to the patterns of drug use in Serbia and its capital were observed. But the higher prevalence and incidence rates of drug clients indicate that more problem users are living in Belgrade than in the other parts of the country.

Table 7: Illicit drug use in Belgrade, in big cities and in Serbia, students, 16 years old, 2005 and 2008, in percentages

Illicit drug	Big cities 2005*	Belgrade 2008	Serbia 2008
Cannabis, lifetime prevalence	12.9	9.1	6.7
Cannabis, use in last 12 months	9.1	7.0	4.9
Cannabis, use in last 30 days	4.7	3.0	2.3
Ecstasy, lifetime prevalence	2.3	1.7	1.6
Sedatives without doctor's prescription, lifetime prevalence	11.3	9.3	7.6
Amphetamines, lifetime prevalence	1.7	2.5	1.5
Cocaine, lifetime prevalence	0.9	0.9	1.0
Heroin, lifetime prevalence	1.2	0.8	0.9
Inhalants, lifetime prevalence	2.8	2.3	2.9

* = Belgrade, Novi Sad and Nis. Source: ESPAD 2005 and 2008.

8 Conclusion

The presented data suggest changing drug use patterns among young people in Belgrade: especially remarkable is the increase of psycho-stimulant consumption (sedatives and tranquilizers) as well as that of amphetamines. As the key persons interviewed observed, psycho-stimulants as well as amphetamines are often combined with alcoholic beverages. It is reasonable to assume that the psycho-stimulants come from licit sources but are acquired illicitly. Though the use of amphetamine and psycho-stimulants is increasing, cannabis remains the most popular illicit drug among young people.

All these substances can have serious physiological effects and negative psychological and social consequences. Knowledge on the chemical composition of the substances as well as on drug abuse trends is therefore valuable and indispensable for the development of appropriate responses such as e.g. treatment strategies. In Serbia consensus could be reached that the changing drug situation does not require a new treatment system but the further development of existing approaches. Sound knowledge on the drug situation is also indispensable for law enforcement and the criminal justice system must have access to results of research as well as drug analysis. Monitoring of drug consumption of young people should be continued: Especially the ESPAD surveys carried out every four years provide for knowledge on drug use and abuse trends and support planning of preventive activities. The results of the surveys do not only allow to assess the drug situation in Serbia, but also to compare it to that of 42 other countries and thus to depict it within an international context.

Current knowledge is restricted due to a lack of research and due to limited quality, available data do not allow to identify drug problems properly and to assess drug trends with accuracy

Current knowledge is unfortunately restricted due to a lack of research in the epidemiological, pharmacological, clinical and therapeutic field. And due to limited quality, available data do not allow to identify drug problems properly and to assess drug trends with accuracy. More and better data would support the public discussion in the media – press and television – which today is openly carried out by politicians and professionals who work with drug abusers. But more and better research would also support the favoured drug-political responses aiming at “care” and in need of development of knowledge on treatment, risk reduction and prevention.

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State of the Drugs Problem in Sarajevo

Darko Datzer / Almir Maljević

1 Overall picture of Bosnia and Herzegovina and Sarajevo

Bosnia and Herzegovina is a small country situated in the South-East of Europe. Its multiethnic society is composed of three major ethnic communities: Bosniaks (mainly Muslims), Serbs (mainly Orthodox), and Croats (mainly Roman Catholic). The country gained its independence from the Yugoslav Federation in 1992; at present it is applying for membership in the EU. The conditions for membership include the reform of state administration, the unification of the economic space, the strengthening of democracy and the rule of law, and the protection of minorities. Due to its weak economy, distorted interpersonal relations and a lack of political consensus concerning major state issues these conditions are difficult to fulfil.

The country consists of two entities: the Federation of Bosnia and Herzegovina and the Republic of Srpska, and one district: Brčko District of Bosnia and Herzegovina, each with its own legislative, executive and judicial powers. The Federation of Bosnia and Herzegovina is further divided into ten administrative units – the cantons – also with own legislative, executive and judicial powers. Sarajevo is a canton of the Federation of Bosnia and Herzegovina, a city of this canton, and the national capital.

Unfortunately Bosnia and Herzegovina is known for the calamity associated with the war of 1992-1995, which devastated the country, left dead and wounded, stimulated migration and ruined the economy and human relations. Even today, 15 years after the war, nation and ethnicity are dominant political categories, preventing the lamentable past to be left behind.

Sarajevo was especially hit by the war

Sarajevo was especially hit by the war. The three-year siege took over 14,000 lives, 40% (5,601) of them were civilians. Due to the population density and inability of the citizens to leave, 2-3% of the inhabitants died. But war did not only reduce the number of inhabitants, it also changed the demographic composition of the city.

Refugees appeared and became new citizens, and the city was no longer represented by those who had lived in it for a long time – http://www.sarajevo.ba/en/stream.php?kat=142

According to the data provided by the Agency for Statistics of Bosnia and Herzegovina (2011), in June 2010 3,843,126 people lived in Bosnia and Herzegovina. The canton Sarajevo – one of the most populated regions in the country, had 423,645 inhabitants (Federal Office of Statistics, 2009), and 72% of them lived in 4 of the 9 canton's municipalities. The data quoted in the following chapters refer to this urban core of the country, which will be called Sarajevo or Sarajevo city.

Sarajevo is the most densely populated city in Bosnia and Herzegovina, with 2,101 people per square kilometre. Children under the age of 14 make up one sixth of the population, those who are 65 and older have about the same percentage. The "economically active" between 15 and 65 make up the "rest".

The employment rate in Sarajevo is around 45% of the economically active population and the economic sectors with the largest numbers of employees are trade, public administration and processing industry. The average salary is 482 € net (Federal Office of Statistics, 2009) compared to 414 € in the whole of Bosnia and Herzegovina. Less than 20% of Sarajevo's economically active population are unemployed, which is less than the Bosnian-Herzegovinian average of 24% (Agency for Statistics of Bosnia and Herzegovina, 2010; Federal Office of Statistics, 2009). The GDP per capita is 3,300 € (Agency for Statistics of Bosnia and Herzegovina, 2011), which is several times less than in the EU-27 area.

2 National and local drug policies

The country suffers of poverty, disorganized economy and dysfunctional families. These characteristics are reliable predictors of various forms of crime and social pathology, including drug abuse

In 2008 the Annual Report of the United Nations Development Programme (UNDP) reported a continuous decline of political, economic and social stability in Bosnia and Herzegovina on the basis of public polls. But also according to other sources the country suffers of poverty, disorganized economy and dysfunctional families. These characteristics are reliable predictors of various forms of crime and social pathology, including drug abuse. Extended drug trade adds to the vulnerability of Bosnia and Herzegovina for drug use. The country is crossed by the Balkan route, which is still the main path for smuggling heroin into Western Europe. Drugs are widely available, the numbers of young drug users are increasing, traffic accidents as well as suicides, crime and violence associated with drug use are growing; large and well-established risk groups – disabled and displaced persons, children without parents, demobilized soldiers – become active in the drug field; and the funds allocated for prevention, education, repression and treatment are too small (United Nations Office on Drugs and Crime, 2009; EUROPOL, 2009; Commission of the European Communities, 2009: 58).

Today, drug use is recognised as an issue in Bosnia and Herzegovina

Today, drug use is recognised as an issue in Bosnia and Herzegovina. Among other issues, public discussion picks up the impact of war experiences on drug use, on the societal as well as on the individual level where it is often associated with depression (Conner et al., 2008).

The public was particularly alarmed by 15 heroin deaths and the government became interested in the increasing numbers of heroin addicts, who often are involved in criminal activities. As a result, a National Strategy on Supervision over Narcotic Drugs, Prevention and Suppression of the Abuse of Narcotic Drugs in Bosnia and Herzegovina for the period 2009-2013 was adopted in March 2009, which for the first time assigned responsibilities for drug issues to a special organisation.

It aims at primary prevention, harm reduction, treatment and supply reduction – goals that require collaboration on national and local level.

2.1 Prevention, harm reduction and treatment

law and the national strategy distinguish three levels of prevention

The Law on Prevention and Combat of the Abuse of Narcotics in Bosnia-Herzegovina (Peck and Plant, 1986; Hammer, 1992; March et al., 2006) regulates, among others, "framework measures for reduction of illicit drug consumption" (Art. 2, Par. 2) and on state level establishes procedures and bodies responsible for the reduction of illicit drug consumption. This law and the national strategy distinguish three levels of prevention:

- Primary prevention addresses the general population, aims at healthy life styles and includes a wide range of activities in health and social care.
- Secondary prevention aims at early detection of drug addicts, tertiary prevention by treatment and rehabilitation of diagnosed addicts. Since drug addiction is considered as a recurrent disease, treatment aims at the reduction of illicit drug consumption.
- Harm reduction and treatment services are organised on all levels, those of entities, cantons, and districts.

Treatment includes medical, psychiatric and social interventions. Inpatient treatment in Sarajevo is mainly offered at the institute for alcoholism and substance abuse where detoxification, maintenance as well as drug-free treatment are carried out. Mental disorders caused by drug abuse are treated at the Canton Sarajevo Psychiatric Hospital.

According to EMCDDA (2011), there are 11 therapeutic communities in Bosnia and Herzegovina, few of them in Sarajevo. One of them is the only community funded by the state, called Campus. Campus has 30 places and offers socio- and psychotherapy as well as vocational training and recreational activities to heavy drug users.

Harm reduction measures are the task of outreach services. But only one of those based in Sarajevo provides reliable support for drug users: the private "Citizen's association for the support, treatment and re-socialization of drug-addicted and recovered persons (UG PROI Sarajevo). It proved to be a safe facility since its establishment several years ago, and gained the trust of its regular, occasional and potential clients. Besides harm reduction interventions such as needle and syringe exchange and maintenance, UG PROI runs a therapeutic community in the countryside for heavy drug users.

There are no exact data on addicts in treatment

There are no exact data on addicts in treatment, though the law requires registration. According to UNODC (2009), it were 653 in the country as a whole in 2007, most of them opiate addicts, also using cannabis. Psychostimulants are hardly used: 0.7% of the patients had used cocaine, 1.7% amphetamines and 1% ecstasy. It is further estimated (EMCDDA, 2011) that about 700 drug users are in methadone maintenance in the whole country, 250 of them – more than one third – in Sarajevo, due to its concentration of users as well as of drug services.

2.2 Supply reduction – policing the illegal market

The combat of supply at national level, among other things, included the establishment of toxicological laboratories for analysis, research, monitoring and information (Ministry of Security of Bosnia and Herzegovina, 2009).

According to UNODC (2009), in 2006 193 drug-use related offences were recorded in Bosnia and Herzegovina – mostly possession – and 1,322 drug-trafficking offences. These figures are low compared to other European countries although not an indicator for a quiet drug situation. They on the contrary indicate that domestic law enforcement agencies are not very effective, as also a report of the EU Commission complains:

"Operational police units have received new inspection equipment. Bilateral police cooperation with countries of the region in the fight against drugs has improved. Bosnia and Herzegovina law enforcement has performed a number of operations, including via international cooperation, aimed at disrupting drugs trafficking as well as production and sales. However, compared to its importance as a transit country, the quantity of drugs seized at the border remained low. Domestic inter-agency information exchange and cooperation in the fight against drugs needs to be stepped up. Specialised law enforcement units are in need of training and equipment to make the fight against drug trafficking more effective" (Commission of the European Communities, 2009: 59).

Compared to its importance as a transit country, the quantity of drugs seized at the border remained low

More recent data for the year 2009 reconfirm this picture: Only 1,722 drug-related offences have been registered on state level in the whole of Bosnia and Herzegovina in the course of this year (Table 1). The small number of drug-related offences (ca. 1.6%) dealt with by the Prosecutor's office of Bosnia and Herzegovina and the Court of Bosnia and Herzegovina (data related to Ar-

ticle 195 of the Criminal Code of BiH,) is to be explained by the fact that these institutions on state level are in charge of drug-related offences only if they involve an international element such as international sale, purchase, transport or transfer. Other drug-related offences are dealt with at the level of the entity and canton courts. With regard to drug-related offences dealt with on state level, their vast majority (ca. 83%) is processed by the prosecutors' offices and courts of the Federation of Bosnia and Herzegovina. In the Republic of Srpska, only 13.65% of drug-related offences are processed by the prosecutors' offices and courts. The large number of offences in the Federation of Bosnia and Herzegovina (Article 239) and inversely, the small number of such offences in the Republic of Srpska (Article 225), is to be explained by the fact that possessing narcotic drugs is a criminal offence in the Federation of Bosnia and Herzegovina whereas it is only a misdemeanour in the Republic of Srpska.

Table 1: Number of reported/investigated/indicted/convicted drug-related offences in BiH in 2009, absolute numbers

Number of ... drug-related offences	Reported	Investigated	Indicted	Convicted
Article 195 of the Criminal Code of BiH – Illicit Trafficking in Narcotic Drugs	28	19	12	8
Article 238 of the Criminal Code of FBiH – Unauthorized Production and Sale of Narcotic Drugs	341	284	212	150
Article 239 of the Criminal Code of FBiH – Possessing and Enabling Enjoyment of Narcotic Drugs	1,088	862	759	692
Article 224 of the Criminal Code of RS – Unauthorized Production and Sale of Intoxicating Drugs	202	137	75	54
Article 225 of the Criminal Code of RS – Enabling Another to Enjoy Narcotics	33	3 3	17	15
Article 232 of the Criminal Code of BDBiH – Unauthorised Production and Distribution of Narcotics	20	18	14	10
Article 233 of the Criminal Code of BDBiH – Possessing and Enabling the Consumation of Narcotics	10	10	9	10

Source: High Judicial and Prosecutorial Council of Bosnia and Herzegovina, 2010.

Higher numbers of drug-related offences are reported for the canton Sarajevo: in 2009 57 cases of unauthorized production and sale of narcotic drugs were reported and 260 cases of possession (Ministry of the Interior of Sarajevo Canton, 2009).

Table 2 depicts the seizures and the progress made between 2008 and 2009 – though it was not appreciated by the EU Commission that concluded in the abovementioned report: "the fragmented structure of the police and the judi-

ciary continues to provide a favourable environment for drugs trafficking and related violations" (Commission of the European Communities , 2009: 59).

Table 2: Drug seizures of the Canton Sarajevo police in 2008 and 2009

Type of illegal drug	Quantities seized	
	In 2008	In 2009
Marijuana (in grams)	2.148,33	4.762,019
Marijuana (packs)	331	223
Marijuana (joint)	96	32
Heroin (packs)	689	286
Heroin (in grams)	1.591,596	3.746,426
Amphetamine (packs)	178	106
Amphetamine (in grams)	1.340,335	1.795,25
Amphetamine (tablets)	38	50
Hashish (packs)	5	0
Hashish (in grams)	120	0,5
Ecstasy (tablets)	170,5	308
Cocaine (in grams)	49,419	39,830
Cocaine (packs)	44	9
Heptanone /Methadone (tablets)	148	60

Source: Ministry of the Interior of Sarajevo Canton, 2009.

3 Illicit drug consumption

3.1 On national level

Data on national level are restricted to the European School Survey Project on Alcohol and Other Drugs (ESPAD), which for the first time was carried out in 2008 in Bosnia and Herzegovina. The data are only published at the website of EMCDDA, the current presentation has therefore to stick to this publication.

Cannabis is the most common drug among Bosnian youth

With regard to preferred substances cannabis is the most common drug among Bosnian youth, but also inhalants are astonishingly popular in the Federation as well as in the Republic of Srpska (Tables 3 and 4). Remarkable are also the spread of the experiences with heroin and the relatively frequent use

among adolescents. Though similar, the consumption patterns of youth living in the Federation and the Republic of Srpska differ in an interesting way. Experiences and use are higher in the Federation, the variety of substances is bigger in the Republic. But the differences might as well be due to different sampling procedures or analyses.

Table 3: Lifetime, last year and last month use of young people 15 to 16 years old, Federation of Bosnia and Herzegovina

Drug	Lifetime prevalence (%)			Last 12 months (%)			Last 30 days (%)		
	Male	Fem.	Total	Male	Fem.	Total	Male	Fem.	Total
Cannabis	20.3	9.6	14.6	16.1	6.3	10.9	8.9	3.6	6.1
Ecstasy	8.5	4.4	6.4	5.7	2.3	3.9	3.2	1.3	2.2
Inhalants	12.4	10.4	11.3	7.4	6.1	6.3	4.9	4.0	4.4

Source: EMCDDA, 2011.

Table 4: Lifetime, last year and last month use of young people 15 to 16 years old, Republic of Srpska

Drug	Lifetime prevalence (%)			Last 12 months (%)			Last 30 days (%)		
	Male	Fem.	Total	Male	Fem.	Total	Male	Fem.	Total
Cannabis	11.5	7.5	11.6	11.6	5.0	7.9	7.0	2.7	5.4
Heroin	4.0	1.1	2.8	—	—	—	—	—	—
Other opiates – inhalants	11.7	7.8	9.9	6.9	4.0	5.5	4.8	2.5	3.6
Cocaine (total)	4.5	1.5	3.0	—	—	—	—	—	—
Crack cocaine	3.7	1.1	2.4	—	—	—	—	—	—
Amphetamines	6.4	2.3	4.4	—	—	—	—	—	—
Ecstasy	6.9	3.1	5.1	4.8	1.8	3.5	3.1	1.3	2.2
GHB	2.8	0.4	1.6	—	—	—	—	—	—
LSD	3.6	1.6	2.7	—	—	—	—	—	—
Benzodiaze-pines	9.1	11.1	10.0	—	—	—	—	—	—
Medicaments and alcohol	5.8	4.3	5.0	—	—	—	—	—	—
Steroids	3.2	0.6	2.0	—	—	—	—	—	—
Magic mushrooms	2.4	0.6	1.6	—	—	—	—	—	—
Any illegal drug injecting	2.7	0.7	1.8	—	—	—	—	—	—

Source: EMCDDA, 2011.

UNICEF Bosnia and Herzegovina (2008b) commissioned a study in 2008 on the prevalence and dispersion of health risk behaviour among adolescents liv-

ing in institutions for parentless children and in a kind of boarding schools. 392 young people between 12 and 20 years old were interviewed, about 5% had drug experiences, mostly with cannabis.

The data on drug experiences of youth indicate a drug consumption in Bosnia and Herzegovina below European average

The data on drug experiences of youth indicate a drug consumption in Bosnia and Herzegovina below European average. This assumption is confirmed by data presented by UNODC in 2010 as part of its assessment of global drug problems. Among the whole population aged 15 to 64 years, annual prevalence of opiate use was 0.3%, annual prevalence of use of cocaine 0.6%, of cannabis 2.8%, of amphetamines 1.0%, and of ecstasy 1.4%.

Finally, there are few estimates on problem users: Estimates on national level arrived at 3,000-8,000 injecting drug users in 2009 (EMCDDA , 2011), on the level of Sarajevo it was 889 intravenous users in 2010, with a range from 703 to 1,075 (UNICEF/UNDP Bosna i Hercegovina, 2010).

3.2 In Sarajevo

If drug consumption was assessed it was mostly studied as part of a more general issue. The first study to be mentioned in this context is the International Self-Report Delinquency Study 2 (ISRD 2), which was carried out in 2005/06 in selected cities including the capital. It studied drug use and juvenile delinquent behaviour. Lifetime experiences with any illicit drug among the 1,756 pupils between 12 and 16 years old were rare, and in Sarajevo interestingly enough even more rare than in the other cities (Budimlić et al., 2007).

A study of the Clinical Centre of the University of Sarajevo carried out at about the same time showed comparable results. The majority of 462 pupils of primary and secondary schools hardly had any experiences with drugs, and if they had, they had mostly taken cannabis (Hadžić and Kudumović, 2007).

In 2007, the Research Group on Youth Groups and Gangs in Europe – the Eurogang Network – conducted a study on juvenile delinquent behaviour in five cities; Sarajevo was one of them. Here again, less than 5% of the 2, 206 respondents who were between 13 and 17 years old reported drug experiences, and – as in the other studies – alcohol experiences were many times more frequent.

UNICEF and UNDP Bosnia and Herzegovina commissioned research on injecting drug users in 2007 and 2009. 260 respondents (in each of the surveys) were recruited via respondent-driven sampling methods, they were between 29 (mean 2007) and 30 (mean 2009) years old, unemployed, not married and had high-school education. At the onset of drug injection the age was 20 to 21; one third (2007) to one half (2009) had used drugs for more than one year, most of them used several drugs two to three times a day. Injection usually takes place in private apartments at meetings with other users. Table 5 shows that all injectors use heroin and that all other substances are much less frequently taken (see Table 5).

Table 5: Drugs used by drug injectors (multiple responses)

	%
Heroin	100
Cocaine	9.3
Heroin and cocaine combined	14.7
Amphetamine	2.8
Morphine	3.0
Opium	0.3
Methadone in ampoules	1.4
Liquid methadone	7.7
Liquid throdone (tramadol)	11.2
Ecstasy	4.3
Other	3.8

Source: UNICEF Bosna i Hercegovina, 2008a.

3.3 User groups and drug-related characteristics of the capital

To fill the gaps of the description of the drug situation in Sarajevo because of scarce information sources, interviews with two key informants have been carried out in the course of the present study along given guidelines: One interviewee was a representative of the Criminalist Expertise Sector within the Centre for Forensics and Support in the Federal Police Department, the other a crime investigator in the Cantonal Ministry of Internal Affairs specialized on drugs.

One of the key informants estimated 5,000 current drug users in the Sarajevo Area, 3,500 of them being occasional users mostly consuming cannabis, and 1,500 being risky users injecting heroin daily.

Another differentiation developed by the key informants used different drugs, frequencies and amounts

Another differentiation developed by the key informants used different drugs, frequencies and amounts: Cannabis users are usually younger (16-24 years), they sometimes get involved with heavier drugs such as heroin. If used for occasional purposes, one local measure (2-3 grams) of cannabis can suffice up to three days. If they use it on a more regular basis, the typical amount used is 1 gram per day. Cannabis is mostly smoked. The cannabis users strongly overlap with users of ecstasy, a substance used only on weekends, on average 1-2 pills.

Cocaine users are older, approximately 35-50 years. They mostly have a better social status and money and in many cases are well known by the public. Cocaine is mainly sniffed and rarely injected; the typical dose is 0,5 g, used three to four times a day.

Heroin users are the most heterogeneous group: They are between 18 and 50 years old and come from all social strata. Heroin is mostly injected, only beginners prefer sniffing or smoking. Heroin users are often poly-drug users: most of them like cannabis. The usual amount of drugs taken per day is 1 or 2 packages; one package weighs one quarter of a gram.

Occasional amphetamine and ecstasy users are younger, between 18 and 21 years old. They commonly use drugs at parties with electronic music, according to one key person as "part of the ritual of this kind of fun". The typical amount taken is one to two local "paketić", together about 0,5 g.

Drug use in Sarajevo is much higher compared to other cities in Bosnia and Herzegovina

Drug use in Sarajevo is much higher compared to other cities in Bosnia and Herzegovina. The continuously rising number of heroin-related deaths is an indicator; at present there occur 10-12 deaths per year. Sarajevo has no open drug scene, presumably due to a "clean streets policy", i.e. intensified efforts to keep use away from the streets, parks and other public places. The police assume that drug use also of heavy drug consumers moved to places such as ruins.

4 Purity and prices of drugs

Purity of heroin estimated on the basis of 21 heroin seizures in Bosnia and Herzegovina oscillates between 10 and 67% (Hajdar, 2002). It is therefore to be assumed that most of the heroin in Bosnia and Herzegovina is of low quality and effectiveness, due to dilution and adulteration with "fillers" such as caffeine, paracetamol, procaine and sucrose. Low quality is a main reason of heroin-related deaths – users might die if they come across substances with higher concentration. The heroin available in Bosnia and Herzegovina according to chemical analysis comes from Middle or Southeast Asia, most likely Afghanistan.

The quality of heroin and cannabis herb is on average at the European level, but prices are below

According to the assessment of global drug problems by UNODC, the quality of heroin and cannabis herb is on average at the European level, but prices are below. The data for Bosnia and Herzegovina for 2009 and 2010 are presented in Table 6. Low prices for average quality indicate the benefits for the local drug market of the geographic position of Bosnia and Herzegovina on the Balkan route.

The key persons assess the purity of drugs as low and perceive a decrease over the years. At present – so the key informants – purity of heroin can be as low as 0.5% per gram, so that in some cases the acquired drugs only provide a clue. The key persons' approximations of the purity of the main drugs are summarized in Table 7.

Table 6: Typical retail and wholesale prices (in USD), and purity levels of drugs in Bosnia and Herzegovina

Type of drug	Retail price	Wholesale price	Purity per gram (%) at retail level
Heroin	48 (per gram)* 37 (per gram)**	15,072 (per kg)* 19,1 (per kg)**	5-33.8* 5-34**
Cocaine	82,2 (per gram)* 88 (per gram)**	41,107 (per kg)* 73,5 (per kg)**	-
Cannabis herb	2 (per gram)* 2,2 (per gram)**	685 (per kg)* 1,3**	0.6-4.1* 0.2-9**
Cannabis resin	8,2 (per gram)* 7,4 (per gram)**	-	5.5-11
Amphetamine	7 (per gram)* 11 (per gram)**	4,204* 9,8**	-
Ecstasy	13,7 (per tablet)* 5,3 (per tablet)**	2,740 (per 1,000 tablets)* 3 (per 1,000 tablets)**	

Note: * 2009 data; ** 2010 data.
Source: United Nations Office on Drugs and Crime, 2009 & 2010.

Table 7: Purity of drugs according to key informants, in percentages

Purity		Brown heroin	Morphine	Cocaine	Amphetamines	Ecstasy	Cannabis herb
Forensic expert	Gen. level	50-70%	50-70%	50-90%	70-90%	Up to 90%	-
	Street level	5-10%	5-20%	10-20%	10-40%	Up to 90%	-
Police investigator	Gen. level	20%	-	20%	70%	Unknown	20-80%
	Street level	0.2-0.5%	-	10%	50%	Unknown	Unknown

Also in the case of cannabis drug dealers dominate the drug market

Also in the case of cannabis drug dealers dominate the drug market, less than 1% is home grown. The market – so the key persons – sells mostly brown heroin. A market for speed was developed by adulterations of cannabis with a speed solution and there is at least one laboratory in the area of Sarajevo, which produces speed. One of the respondents distinguishes between street, quarter, city and state traders. Those on higher levels of the supply chain are well connected with regional crime networks, mostly organized in neighbouring countries. Street dealers of heroin are increasingly middle-aged professionals who do not use drugs and who are able to supply with up to 200 grams. The expensive cocaine is delivered discretely on-the-call. Dealers of amphetamines are usually younger; they sell their drugs near bars and schools. If drug users sell drugs, they are frequently in methadone substitution and deal to earn a living. The information given by the key persons on prices is presented in Table 8.

Table 8: Prices of drugs (in USD) according to key informants

Purity		Brown heroin	Morphine	Cocaine	Amphetamines	Ecstasy	Cannabis herb
Forensic expert	Gen. level	29,000/ 1kg	11-15,000/ 1kg	22-36,000/ 1kg	-	0,7 / 1 pill*	2-4,40 / 1kg
	Street level	44-88 / 1g	-	44-88 / 1g	7 / 0,2g	2-7 / 1 pill	2-7 / 1g
Police investigator	Gen. level	15,000 / 1 kg	-	25,000 / 1 kg	4-6,000 / 1kg	0,7 / 1 pill*	1,600 / 1 kg
	Street level	29 / 1g	-	73 / 1g	15 / 1g	4-7 / 1g	7 / local measure**

Notes: *General level means purchase of at least 100 pills. ** "Little bag", equalling 3 g.

5 Conclusion

The drug used most in Sarajevo as in the country as a whole is cannabis. But lifetime experiences as well as current use are low compared to other European countries. Low cannabis consumption cannot be explained by low availability of the drug and remains an issue for speculation, for instance of fashions.

The most consumed "heavier" drug is heroin whose consumption does not change dramatically. Heroin users are mostly poly-drug users who typically take also cannabis and cocaine. Their consumption patterns, their social background as well as their current marginalized social position to a large extent correspond to that of heroin users in other European countries (Eisenbach-Stangl et al., 2009; March et al., 2006). With one exception: the higher educational status which seems to be attributable to the high level of education in Sarajevo and Bosnia and Herzegovina as a whole – according to the Labour Force Survey 2010, close to 60% of all working age population have attained secondary (high-school) education or more (Agency for Statistics of Bosnia and Herzegovina, 2010).

The use of stimulants – of cocaine, amphetamines, and ecstasy – in Bosnia and Herzegovina and its capital compared to that of other European countries is similarly rare. Amphetamine and ecstasy use are restricted to special events in the little developed recreational scene. Cocaine use is restricted to special occasions probably due to financial reasons. But as with the consumption of other drugs further research is needed to assess consumption patterns and to understand consumption trends.

Drug use was not a novelty after the war of 1992 to 1995, but war itself and the transitional period following it probably have promoted drug consumption

Drug use was not a novelty after the war of 1992 to 1995, but war itself and the transitional period following it probably have promoted drug consumption, as they brought about political instability, high rates of unemployment and social disorganization. But even if drug use increased it did not change dramati-

cally. Among the reasons for the modest spread of illicit drugs in general might be the traditional and well-established use of licit substances, especially that of alcoholic beverages, which conforms better with the Bosnian-Herzegovinian society.

Problem use is considered to be a chronic disease, and is dealt with accordingly by medical treatment and psychotherapy. The resources allocated to inpatient treatment are scarce and are reserved for those whose recovery would be at risk in an outpatient programme due to exposure to a social setting where drug use is common. Prevention includes a wide spectrum of activities and actors from professional and lay groups.

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PART 2

Comparative Survey on Consumption Patterns and Expenditures

Irmgard Eisenbach-Stangl / Ricardo Rodrigues

Drug Use and Drug Users

Introduction to Part 2

Irmgard Eisenbach-Stangl

The empirical core of the predefined design of the Second Multi-City Study was the assessment of quantitative aspects of drug consumption patterns and expenditures of two samples of ideal-typically constructed drug users in each of the seven sites: of occasional drug users and of frequent or regular users. Research on quantitative aspects of individual consumption and expenditures is a delicate matter in general and even more if the commodities in question are prohibited substances The research interest in the individual drug economy, therefore, was complemented by few questions on the social position of the drug user and aspects of his / her attitudes towards his / her life and actual living conditions ("set" and "setting" in Zinbergs's terminology – Zinberg, 1921/1984). The data collected consequently shed light on a range of interesting aspects of consumption and purchase patterns, which will be presented in the next chapters.

The second drug wave was carried by a new generation of drug users who were pleasure- and consumption-oriented and developed new – experimental – consumption patterns

The two ideal-typically constructed types of drugs users are offspring's of the "second drug wave" in the 1990s, which by some authors is understood as a generational phenomenon (Hakkarainen, 2005). The second drug wave was carried by drug users who were pleasure- and consumption-oriented and developed new – experimental – consumption patterns preferably with cannabis and ecstasy but also with cocaine and a variety of "new" psychoactive substances. They were different from the "old problem users" of the 1980s who – due to expanding substitution treatment – replaced heroin by licit as well as illicit use of opioids. Problem users were the target group of harm reduction policies, the "new recreational" users inspired the development of risk-reduction strategies. The construction of two ideal types of drug users thus was supported by their distinct social background and gender composition, but also by drug policies and last but not least by the media (Demant et al., 2011). Occasional and regular frequent drug use *de facto* are not distinct habits but represent the two poles of a continuum on which consumers change position during the course of their life (Klingemann, 1994 and 2000).

The construction of ideal-typical consumption patterns in the current project was based on substances taken and on consumption frequencies: In accordance with the construction of drug policies occasional use was defined as mostly exclusive use of cannabis whereas heavy use was associated with heroin. Both consumption patterns could include use of any other substances of interest – ecstasy, amphetamine and cocaine – as also of any other psychoactive drug. Frequency considered any consumption event that is also more than one per day. Thus occasional drug use was finally defined as consumption of cannabis (herb and resin) and/or ecstasy and/or amphetamine (incl. methamphetamine) and/or cocaine (incl. crack) and/or any other drug during the year prior to the interview and at least once in the month prior to the interview. The consumption of heroin did not qualify for the definition as occasional drug use pattern but it did also not exclude and was explored. Regular heavy consumption was defined as at least monthly and last month consumption of heroin and/or other opiates (including substitution drugs and psycho-pharmaceuticals sold on the drug market) and/or cocaine and/or crack and/or amphetamine and/or methamphetamine. The consumption of cannabis and ecstasy did not count but also not exclude.

Occasional user is just one – rather technical – name for the first ideal-typically constructed consumption pattern. More colourful are e.g. “recreational user” (Calafat et al., 1998) providing consumption with a predefined psychological function, and “hedonistic use” (Uhl and Springer, 1997) associating drug use with predefined psychological motives. The research team of the First Multi-City Study prioritised societal categories and decided to address occasional consumption patterns as “socially integrated drug use”, emphasizing their compatibility with regular work and continuous social relationships. Heavy drug use patterns, which as a result as well as a cause are associated with numerous problems, and on top of them with societal stigmatisation and marginalisation, were addressed as “marginalised drug use”.

Considering research budget and organisation, sampling of drug users was preferable to sampling of drug use patterns. Drug users with comparable consumption patterns tend to meet (and consume) in special places: Occasional users were looked for in leisure time facilities such as discotheques and bars and at events such as raves, whereas heavy users were identified in drug control organisations, i.e. drug services as well as prisons. The size of the sample per research site was hundred occasional and hundred heavy users. The age and gender composition of both samples should reflect age and gender composition of respective drug users in individual cities.

The recruitment of socially integrated drug users proved to be more difficult than that of marginalised drug users

The recruitment of socially integrated drug users proved to be more difficult than that of marginalised drug users. It was most difficult in Stockholm where less than half as many drug users could be motivated to participate in the study (48 instead of 100). Though the research team had modified the study as e-sur-

vey, allowing the drug users to answer the questions in anonymity in the privacy of their home, it was perceived as part of the strict Swedish drug controls, among other things as an effort to map users. Strict drug laws were also an obstacle in Sarajevo and Moscow, which in both sites induced cautious responses and numerous refusals. In most sites it was difficult to establish contacts to social milieus known for socially integrated drug consumption, especially if the substance in question was cocaine or amphetamine. To overcome the difficulties the local research teams reacted with "special approaches" – for instance by building up contacts to close friends of users. Snowballing only proofed to be a successful strategy in the recruitment of socially integrated users in Helsinki and Bucharest.

Most of the socially integrated respondents were contacted and interviewed in leisure time facilities, at events and in private environments, but in one site also health and security services served as starting point for contacts: Ecstasy users delivering their urine test as well as drug users known by police and by private securities were approached in a drug facility in Belgrade. The remarkable number of 25 refusals underlines the negative relationship of strict controls, free expression of opinions and (social) research – issues taken up in many field notes.

In most sites, incentives were offered to drug users: money – 4 Euro in Moscow, up to 12 Euro in Helsinki; vouchers for prepaid telephone cards in Sarajevo; fruit juice and snacks as well as tickets for rave or rock concerts in Bucharest; prepaid telephone cards in Sarajevo; movie tickets and ice cream in Helsinki. In Helsinki few respondents rejected the incentives and were proud to get interviewed as "recreational users". The interviewers had drug and/or field experiences and extended contacts to integrated drug users. They were hired, trained and in few cities also supervised by the research team. The number of interviewers in one site amounted to 11 persons, in another city (Stockholm) the lead researcher carried out all interviews himself.

The recruitment of marginalised drug users via drug services was less time-consuming with one exception: In Stockholm the study had to pass a "board of ethics" at first and then to get the permission of the single services – all in all a time-consuming process delaying the interviews in this site. With few exceptions recruitment via drug services was easier and faster, but it also was associated with many biases: Services are usually tailored to a special clientele and they respectively earmark the samples recruited (Magnani et al., 2005). Studies carried out in different cultures such as the Multi-City Study have to deal with far more complex "biases" provided by the legal, economic, political and professional differences of the structure to which the services selected for recruitment belong to: The Swedish services as mentioned were part of the social welfare sector, the services in Moscow and Belgrade were state hospitals, the Finnish facility was a private NGO organisation.

Responses to the questionnaire were among other things shaped by the authority given to the client to agree with or to refuse participation in the study and by the setting chosen for the interview: Most interviews took place within facilities and in few cases interviewers belonged to the staff of the facility.

Though or because of blurred borders between research and treatment the rate of refusals among marginalised drug users was low

Though or because of blurred borders between research and treatment the rate of refusals among marginalised drug users was low and interviews could be carried out without notable disturbances – with the exception of few interviews at Nordic sites where some interviewees were intoxicated and became violent.

The interview instrument – a questionnaire developed in the course of the First Multi-City Study – used different types of questions: single and multi-response questions, open questions and Likert scales. It opened with few demographic topics, continued with consumption patterns including substitution drugs, turned to expenditures for drug consumption and closed with subjective ratings of aspects of life. It was designed to be filled in by an interviewer putting in writing the responses of the interviewee, a work located on the gateway from (qualitative) documentation of everyday life (events) to systematic research aiming to translate the observed into (quantitative) distinct categories.

The questionnaire was revised by the research team of the Second Multi-City Study, few of the questions got modified and a new question was added. One of the modified questions concerned purity. The respondents were asked to provide purity by accurate percentages instead of ranking it on a crude scale low – medium – high as in the First Multi-City Study.

To come to the point, the respondents were overburdened by the new question about purity and the results were so poor that calculation of last month amounts and expenditures as with the First Multi-City Study had to rely on the purity of street drugs.

The new question aimed at the assessment of consumption during the last 12 months. Drug users do not consume regularly and as any other consumption drug use is determined by seasons (by heat and cold), by contexts (being at home or abroad), by structures of every day life (weekends and festivities) and by individual events. Drug users also reduce consumption to decrease expenses, sometimes by individual sometimes by professionally accompanied detoxification. Also this question overburdened respondents and led to so poor results that calculations on amounts consumed had to rely on last month consumption.

Few other questions raised resistance – they “raised eyebrows” as the Swedish team put it – especially among socially integrated users in Nordic countries: The interviewees disliked the association of drug consumption issues with illegal resources of income as much as with drug addiction (“regular use”) and drug treatment (drug services).

The interviews took place between summer 2009 and summer 2011; at all sites marginalised users were interviewed first. Because of budget problems the research team in Copenhagen participated only in the comparison of socially

integrated users and modified target group as well as questionnaire. The questionnaire became self-administered and occasionally was filled in by groups discussing single questions. The Danish research team observed the groups and became convinced that the discussions rendered the answers more honest. Though the Danish study concentrated on a target group different from those of the Second Multi-City Study – young adults, socially integrated but recognizable as drug users – it was carried out in close collaboration and was not excluded from presentation in this report.

The results are presented in four chapters, which do not strictly follow the questionnaire. The first chapter deals with the social position of the respondents, measured by "objective" indicators such as education, police contacts and working situation, as well as by "subjective" indicators: the respondents' perception of health, working situation and access to services. The following two chapters discuss the consumption patterns of socially integrated and marginalised drug users separately. They focus on drug preferences and drug combinations – on poly-drug use – and on frequency of consumption. The last chapter presents the findings on amounts consumed per month and on expenditures. The tables and figures exclude results below 5% – a number that almost always is equivalent to 5 respondents. And each chapter is concluded by a city comparison.

The Social Position of Socially Integrated and Marginalized Drug Users from an Objective and Subjective Perspective

1 Objective indicators of the societal position of drug users

The questions opening the interview aimed at the assessment of the social position of the respondents. The assessment focussed on "objective" indicators, but the responses inevitably were also shaped by the subjective view of the respondents and influenced by further "distracting" factors as for instance those of the interview setting. Therefore efforts were undertaken to systematise assessment as much as possible and to raise comprehensibility of the questions. The "subjective perspective" was of interest in itself – that is the way drug users perceive their social position. The questionnaire included a respective set of questions in the end. This chapter deals with the results of objective and subjective indicators.

The first questions were "easy", they dealt with gender and age. They were followed by more "difficult" questions on social networks and very difficult ones on education and income, as well as on measures of social (re)integration. The term "difficult" in this context refers to questions which according to the experiences of interviewers were misunderstood, misinterpreted or not understood by the interviewed drug users.

Demography

The rules of recruitment agreed on by the research teams excluded drug users below 18 years. Some adolescents contacted erroneously were kept in the sample. The adolescents presumably contributed to the wide range of age in both samples: Socially integrated as well as marginalised drug users were on average between 20 and 30 years old (Table 1). Due to recruitment, the first sample was somewhat younger in most of the sites: The marginalised drug users were contacted via drug services and the socially integrated users mostly via private networks of students. One sample of marginalised drug users – the one

in Stockholm – was outstanding old and homogeneous: It represented a special Swedish subgroup of drug users, members of a deviant subculture who already in the 1950s had gotten in touch with drugs, mainly with amphetamine. These early drug users had became early clients of Swedish welfare services and had survived due to their compact and extensive care. The higher age of socially integrated drug users in the same city had other reasons and presumably was an effect of the strict Swedish drug policy. Only experienced and dedicated and thus older drug users agreed to participate in the current study and to answer the questionnaire. The risk to become officially identified as drug user was perceived to be high.

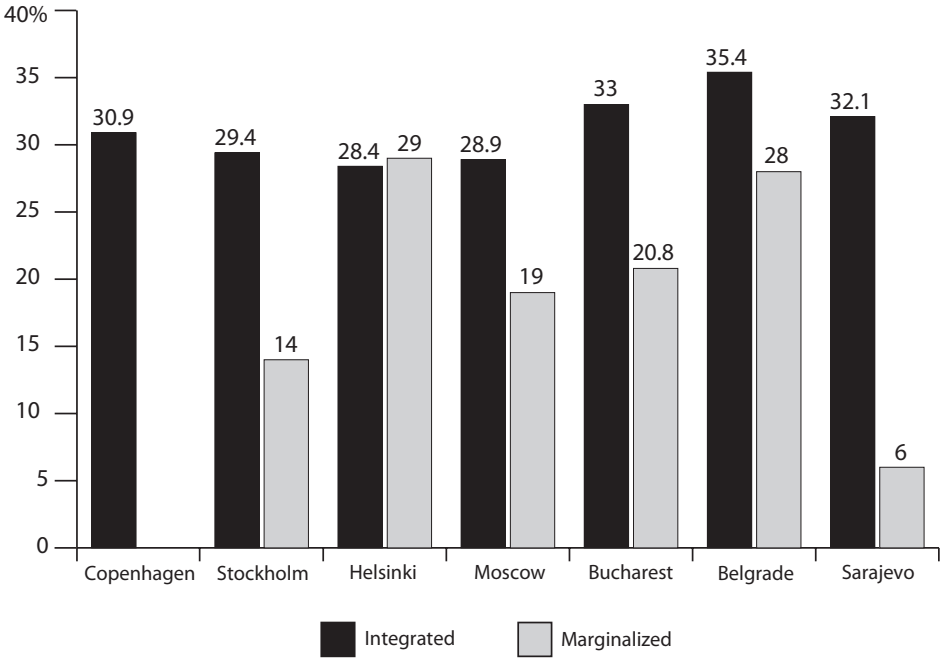
Table 1: Age composition of socially integrated and marginalized drug users: mean and minima and maxima

	Socially integrated	Marginalized
Copenhagen	N = 165	
Mean	25	
Min/max	13/55	
Stockholm	N = 48	N= 100
Mean	31	48
Min/max	22/65	31/65
Helsinki	N = 102	N= 100
Mean	29	29
Min/max	19/49	18/47
Moscow	N = 114	N= 100
Mean	29	28
Min/max	17/46	17/51
Bucharest	N = 100	N= 101
Mean	24	27
Min/max	17/32	14/52
Belgrade	N = 113	N= 100
Mean	28	28
Min/max	16/46	14/52
Sarajevo	N = 112	N= 100
Mean	25	30
Min/max	16/42	18/47

The percentage of females in the samples of socially integrated drug users in all cities was about one third and corresponded well to the percentage of female drug uses in society

The percentage of females in the samples of socially integrated drug users in all cities was about one third and corresponded well to the percentage of female drug uses in society (Figure 1). The lower percentage of females in the samples of marginalised drug users in most of the cities also was in accordance with the percentage of females in the drug scene and among clients of drug services (Eisenbach-Stangl, 2005, 2011). The variations of the gender distribution of the samples have to be seen as effects of sampling procedures: In some cities they were guided by findings of most recent surveys as in Helsinki and Moscow, in others – where survey data were not available – by expert knowledge and assumptions on the social context. In the case of Sarajevo and its Islamic culture few women were to be expected among marginalised drug users, and the percentages of females in the second sample were respectively low.

Figure 1: Percentage of females among socially integrated and marginalized drug users



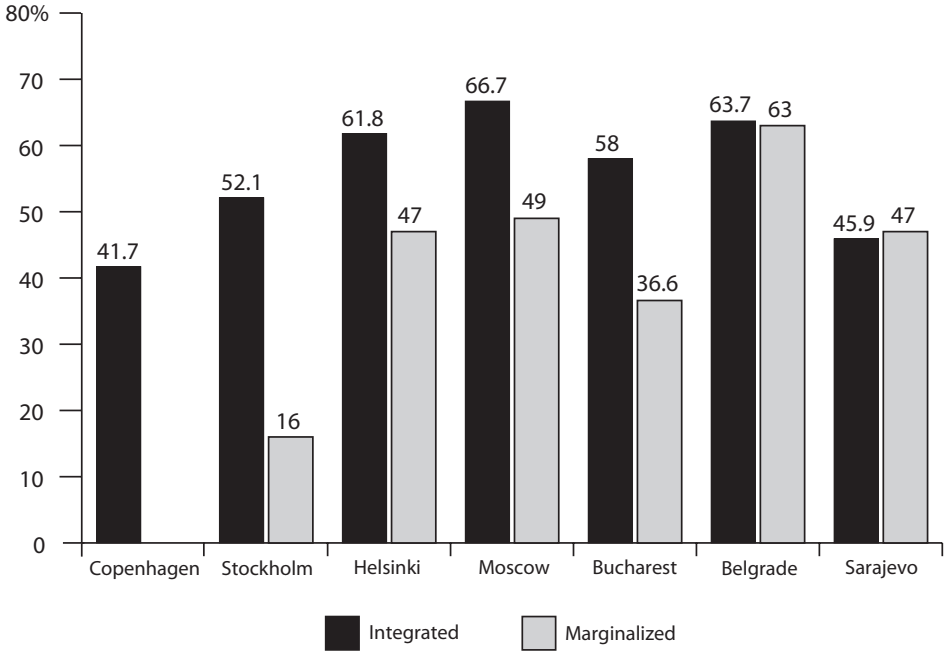
Social network

Socially integrated drug users had a denser social network compared to marginalised users

As could be expected, socially integrated drug users had a denser social network compared to marginalised users, indicated by a permanent partner, by friends and by the number of close friends (Figures 2-4). With the exception of Copenhagen half to two thirds of the socially integrated drug users had a partner whereas the proportion dropped to less than half in the case of marginalised users (see Figure 2). The percentage of marginalised users with partners was exceptionally high in Belgrade with its sample of clients of high-threshold

drug services, and especially low in Stockholm with its sample of elderly long-term drug users that, although being cared for by drug services, seemed to be extremely isolated.

Figure 2: Percentage of respondents having a partner; socially integrated and marginalized drug users



Social contacts as measured by having "friends" were similarly well developed in both groups of drug users, though socially integrated consumers also in this regard were better embedded (see Figure 3). Especially many marginalised users in Bucharest had dropped out of the social net, possibly due to their ethnic background – many were Roma – and/or due to their legal status – also prisoners were interviewed. In other words, marginalised users in Bucharest were more often socially isolated than in other cities because of their double or even triple exclusion.

Most marginalised users in Bucharest were isolated, but few reported a denser network (a higher number of "close friends") than all other marginalised users and also than socially integrated users living in the same city (Figure 4). Possibly also this phenomenon was associated with ethnicity and intensive drug consumption is not always a reason of exclusion.

Figure 3: Percentage of socially integrated and marginalized drug users having friends

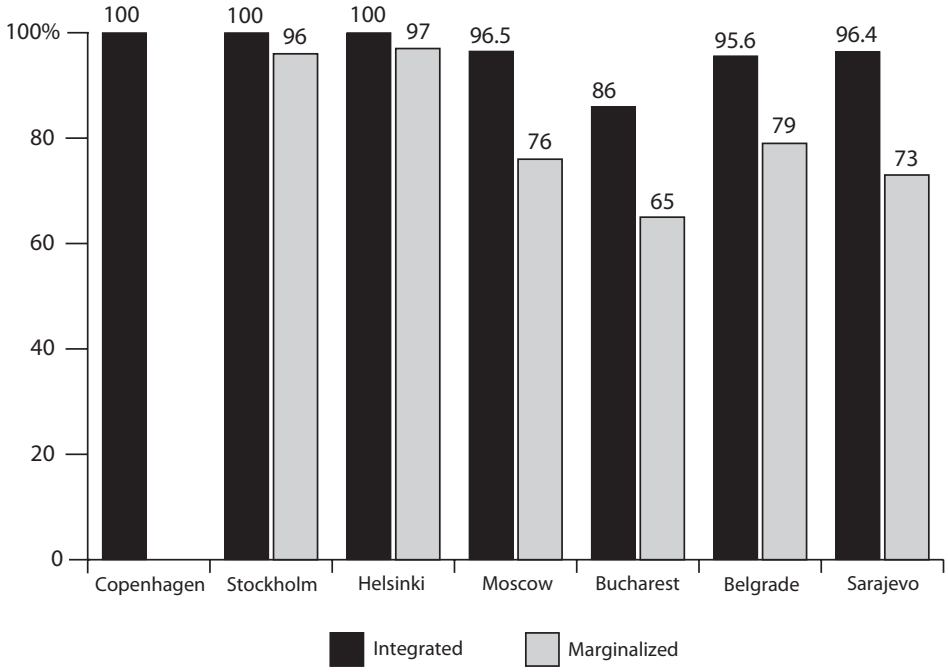
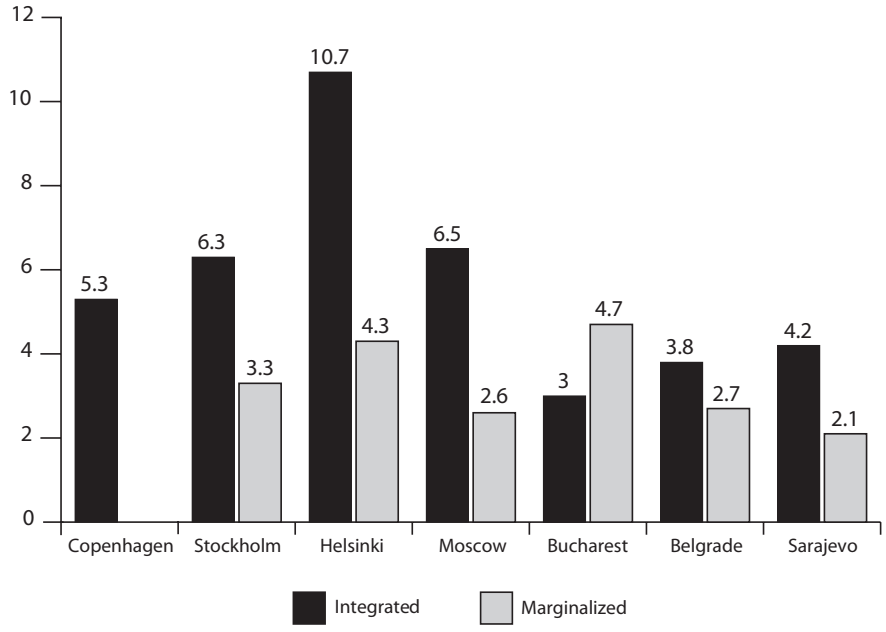


Figure 4: Number of close friends, socially integrated and marginalized drug users, mean

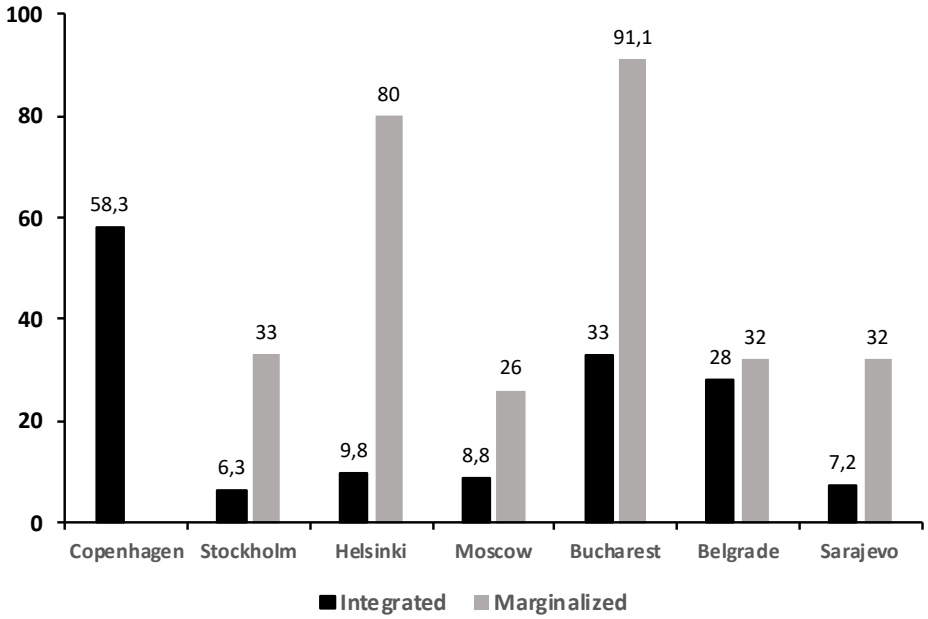


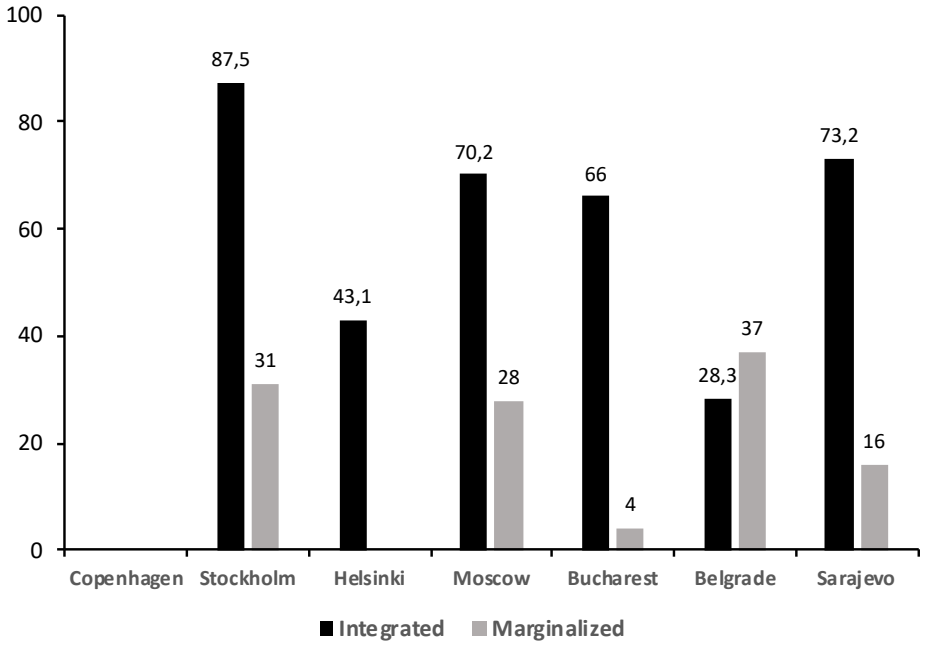
Position in the societal hierarchy and compensatory welfare and drug policy measures

Integrated drug use was associated with dense social contacts and networks as well as with higher education

Integrated drug use was associated with dense social contacts and networks (providing for dense informal controls) as well as with higher education (promoting the development of self-control). Copenhagen was the exception where due to special sampling socially integrated drug users had the least education (Figure 5a). In all other cities, more socially integrated than marginalised drug users had acquired a qualification for university, in most cities the difference was high with the exception of Belgrade. The educational level of the second sample was lower and varied considerably among the cities (Figure 5b). In Stockholm, Moscow and Belgrade as many as one third of the marginalised users had a qualification for university, in Helsinki and Bucharest it was close to zero. The differences had varying reasons: the high educational level of many elderly marginalized users in Stockholm was the result of the extended welfare measures for the socially excluded whereas in Moscow and Belgrade it mirrors their more privileged social background and the high educational level of the whole population. The university of Bucharest, finally, is shielded by an examination and by the requirement of vocational training for many years.

Figure 5: (5a) Socially integrated and marginalised drug users who finished compulsory school and (5b) with qualification for university





Socially integrated users mostly lived in their own flat and in the capitals of former communist countries also in the flats of partners, friends or their family of origin (see Table 2). In the former communist capitals the dependency of marginalised users on their social net was even higher due to the restricted housing situation, in which young adults in general were forced to live with their family of origin during a substantial part of their life. In the Nordic cities – and thus in countries with a more developed market economy – socially integrated users mostly had a flat of their own and rarely depended on family and friends. The sample in Copenhagen was an exception due to sampling. It included mostly risky cannabis users who obviously had left their family, did not have the resources to buy or rent a flat and could not or did not want to live with friends. In the Nordic cities also marginalised users did not live with partners and families; to a substantial part (one quarter in Helsinki, three quarters in Stockholm) they are provided with shelters and homes by the state or by privately funded welfare organisations. The prominent position of special, mostly professional welfare organisations in the care for drug addicts indicated the advanced stage of welfare extension in developed market economies, which are constructed to compensate for shortcomings on individual level – besides accommodation, e.g. offering education for deprived drug users.

Table 2: Accommodation among socially integrated and marginalised drug users, in percentages

	Socially integrated	Marginalized
Copenhagen	**N = 164**	
Own flat	3.7	
Partner/family/friends	15.2	
Public shelter/ homeless	81.2	
Stockholm	**N = 48**	**N= 100**
Own flat	75	11
Partner/family/friends	16.7	11
Public shelter/ homeless	2.1	78
Helsinki	**N = 102**	**N= 100**
Own flat	84.3	54
Partner/family/friends	11.8	21
Public shelter/ homeless	1	25
Moscow	**N = 114**	**N= 100**
Own flat	57	30
Partner/family/friends	42.1	61
Public shelter/ homeless	0.9	8
Bucharest	**N = 100**	**N= 101**
Own flat	57	18.8
Partner/family/friends	36	66.3
Public shelter/ homeless	-	14.9
Belgrade	**N = 113**	**N= 100**
Own flat	36.3	32
Partner/family/friends	61.9	65
Public shelter/ homeless	0.9	3
Sarajevo	**N = 111**	**N= 100**
Own flat	40.5	29
Partner/family/friends	55	66
Public shelter/ homeless	0.9	5

Occasional users in all cities were better integrated in the labour market

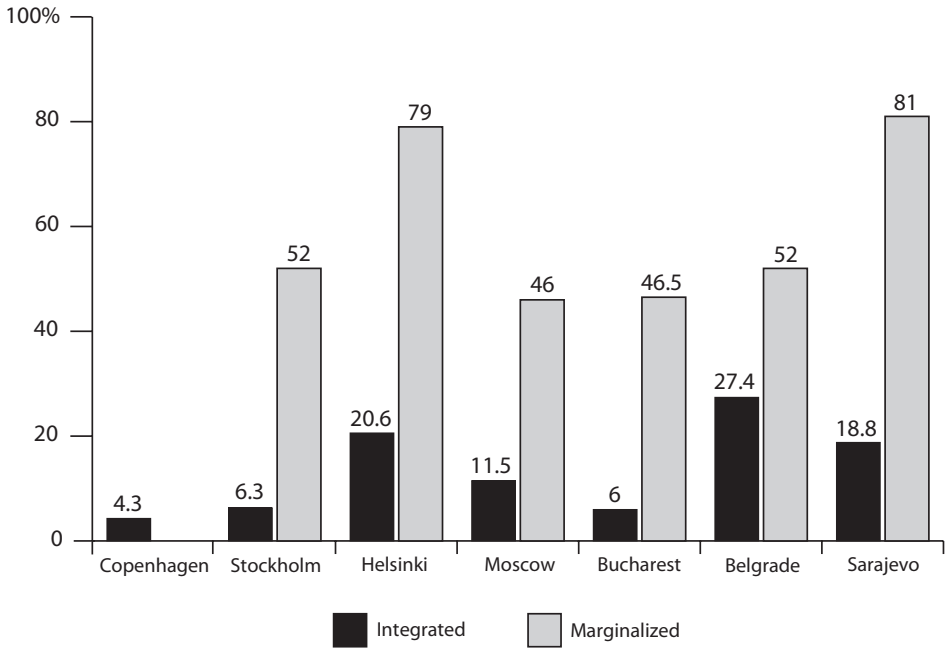
Occasional users in all cities were better integrated in the labour market – in a preparatory stage as students, as part-time employees or, most frequently, as full-time employees. Marginalised users were much less integrated, and if they worked part- or full-time they often had a variety of occasional jobs.

Consequently, unemployment was much higher among marginalised users and it surmounted to 50% in Stockholm, Helsinki, Belgrade and Sarajevo where up to four fifths of the respondents were without work. But in the same cities also unemployment among socially integrated users was higher (see Figure 6). Unemployment probably had a different socio-economic background: in Nordic countries it was mostly a consequence of social exclusion/stigmatisation of drug users whereas in former communist cities it was rooted in the weak economy and the associated general high unemployment rate.

Corresponding to their integration in the labour market, most socially integrated users had a regular income

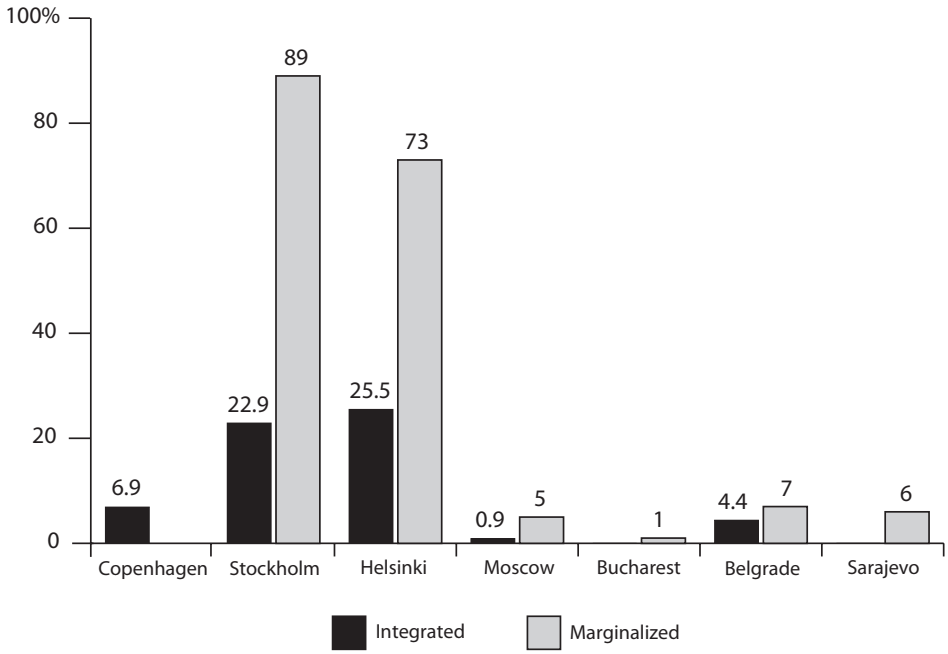
Corresponding to their integration in the labour market, most socially integrated users had a regular income. Otherwise they were financially supported by their families as in former communist countries (17% in Bucharest and 38% in Sarajevo) or lived on social welfare as in countries with extended market economies (almost one quarter in Stockholm and Helsinki). Marginalised users who mostly had dropped out of the labour market and less often had a regular income, were to a much higher percentage financially supported by their families in former communist countries (one quarter in Bucharest, one half in Sarajevo), or lived on welfare in capitalist countries (three quarters in Helsinki, nine tenths in Stockholm).

Figure 6: Unemployment of socially integrated and marginalised drug users, in percentages



To summarize: in former communist cities marginalized users were less disintegrated in regard to education and occupation, but also in regard to accommodation and financial resources due to the support of their family of origin. Marginalized users in countries with an advanced market economy suffered of stronger isolation and deprivation, and as clients of social welfare organisations became the target of compensatory measures (Figure 7).

Figure 7: Social security as main income, in percentages



Irrespective of the source of support drug clients also lived from deviant activities

Irrespective of the source of support drug clients also lived from deviant activities especially in former communist countries (about one quarter in Moscow, Bucharest and Sarajevo): mostly prostitution (9% in Bucharest), begging (9% in Sarajevo, 6% in Moscow) and dealing (see Figure 8.). Little surprising, integrated users were far less involved in deviant activities with the exception of Belgrade, presumably due to a peculiar sampling process. The data did not allow to distinguish between monetary needs and deviant lifestyles but the deviance they depict might also be rooted in both and more factors.

Contacts with the police at first sight seem to be closely associated to deviant activities: Socially integrated drug users in all cities reported fewer deviant activities and fewer encounters with the security forces. Socially integrated drug users in Belgrade and Sarajevo were more frequently involved in deviant activities and had closer acquaintance with the police. But the picture changed with marginalised users: The marginalised users in Stockholm that were the least deviant reported most police contacts. Also in Helsinki only a small percentage of marginalised users reported deviant activities but a larger percentage than in most former communist cities had had encounters with the police. Thus, the police did not only react to deviance but becomes active by itself – it is pro-ac-

tive particularly in respect to drug-related offences as with other so-called victimless offences. The data presented further indicate that pro-activeness is a police strategy mostly applied by the security forces of welfare societies (Eisenbach-Stangl, 2004) and is part of the stigmatisation and exclusion of drug use and drug users.

Figure 8: Deviant sources of income among socially integrated and marginalized drug users, in percentages

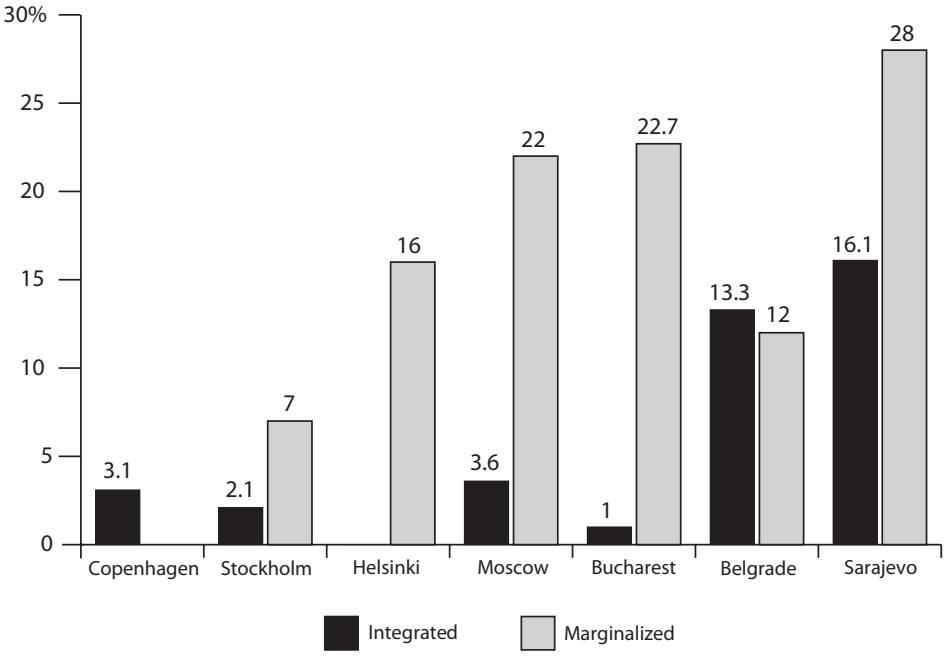


Table 3: One and more than one problem with the police, socially integrated and marginalised drug users, in percentages

Socially integrated	**CH (N=161)**	**SH (N=48)**	**HS (N=102)**	**MC (N=114)**	**BR (N=100)**	**BG (N=113)**	**SJ (N=112)**
one problem	13	6.3	8.8	11.4	14	25.7	18.8
More than one problem	9.3	4.2	5.8	10.5	3	10.4	20.5
Marginalised		N=100	N=100	N=100	N=101	N=100	N=100
One problem		15	17	34	15.8	41	29
More than one problem		41	65	26	33	9	31

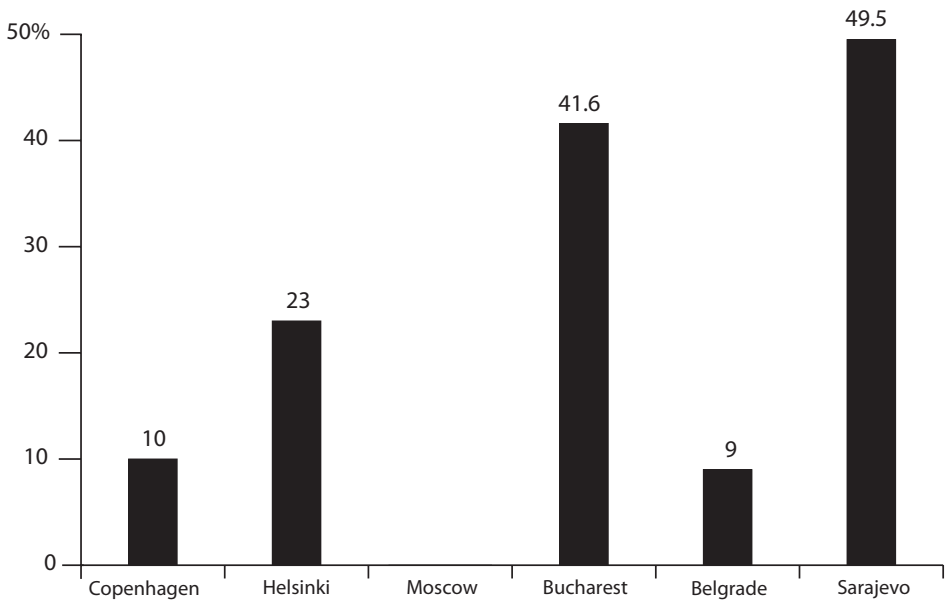
The welfare system of countries with advanced market economy provides drug users with non-specific compensation such as education, accommodation and (most regularly) a steady income. As these compensations, contrary to e.g. unemployment benefits, do not aim at integration in the ("first") labour market and consequently are conceived as long term measures, they are discussed as "secondary compensation" and "secondary integration" by Land and Willisch (2008). In continuation of their discussion, substitution treatment can be under-

stood as “tertiary compensation” which contrary to “secondary compensation and integration” via special measures aims at the prevention of health damages to others and to the drug user himself – especially of infectious diseases such as HIV and AIDS – and at the reduction of special undesirable activities such as drug-related crime. “Tertiary compensation” via substitution and via further “harm reduction” interventions is a cheap and low-threshold strategy that spread since the 1990s. Substitution was propagated by the EU and introduced in most Member States at the turn of the century (Hedrich et al., 2008).

The maintenance programmes established in the countries investigated at the time of the study only covered subgroups of problem users. If percentages of respondents in substitution are taken as indicator for the extension, the access country Bosnia and Herzegovina had the most extended programme, followed by the EU member Romania (see Figure 9). In Helsinki about one quarter of the marginalized users was in substitution, in Stockholm and Belgrade it was only one tenth; in Russia substitution was prohibited. In other words: In half of the cities investigated tertiary integration was impaired by abstention and temperance ideologies cutting through socio-economic and political positions.

To summarize: the data presented show that the Nordic cities Stockholm and Helsinki – both capitals of older EU Member States – invested mostly in expensive secondary integration but limited special tertiary compensation on lower threshold and therefore integration on a lower – tertiary – level; that in Bucharest and Sarajevo – capitals of a younger EU Member State and of an access country – (cheaper) special compensation aiming at tertiary integration was the first choice; and that the second access country (Serbia) and the Russian capital mostly offered traditional medical and psychiatric treatment widely disregarding social exclusion and stigmatisation.

Figure 9: Marginalized drug users in substitution treatment, in percentages



2 Subjective indicators of the societal position of drug users

Self-assessment of the social position was based on "subjective" indicators targeting generic aspects of life such as health status, feeling secure, quality of subsistence such as housing, the financial situation and availability of adequate health and social services. Each indicator was to be rated on a five-point scale from minus 2, the most negative value, to plus 2, the highest or most positive value.

Generic aspects of life

In all cities socially integrated drug users evaluated the selected aspects of quality of life more positively than marginalised drug users

In all cities socially integrated drug users evaluated the selected aspects of quality of life more positively than marginalised drug users, be it health status, feeling secure and impact on own life (Figures 10-12). But integrated drug users in Nordic capitals differed from those in capitals of former communist countries: not so much in the evaluation of their health status – which was thought to be rather good in all investigated sites – but mostly in their ratings of feeling secure and of impact on own life. Marginalized users mostly responded in the opposite way: Their ratings on security and impact on own life were more positive and their evaluation approached that of the socially integrated drug users of their home town. In other words: Integrated and marginalised drug users in capitals of former communist countries resemble each other to a greater extent, and marginalized users feel more secure and influential than in Nordic capitals.

Figure 10: Health status, socially integrated and marginalised drug users, means

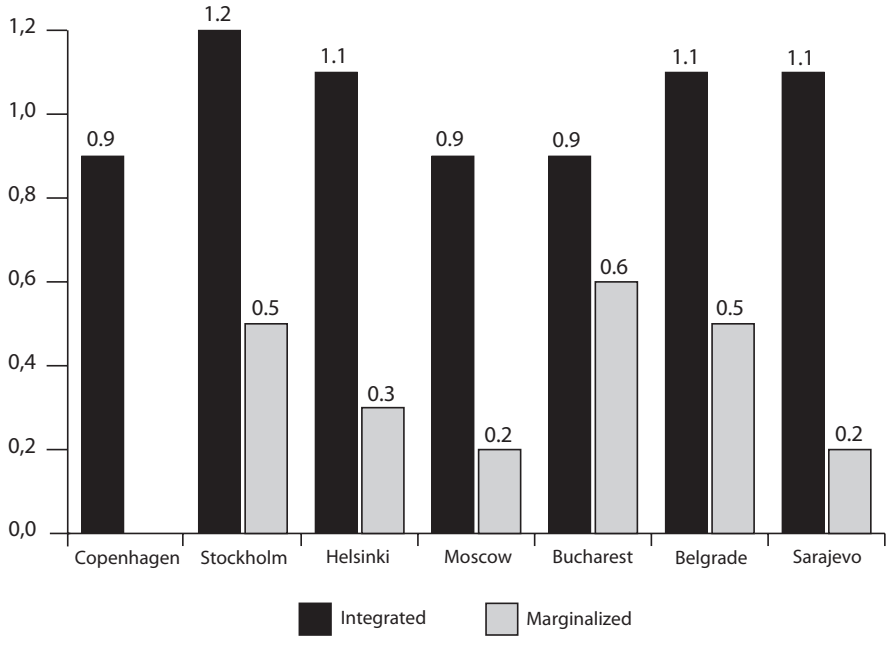


Figure 11: Feeling secure, socially integrated and marginalised drug users, means

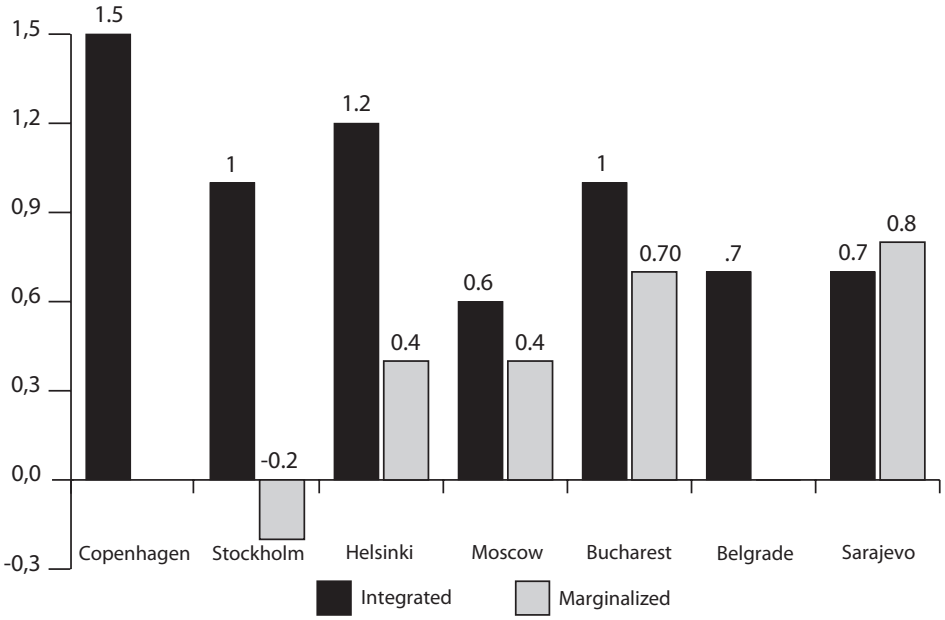
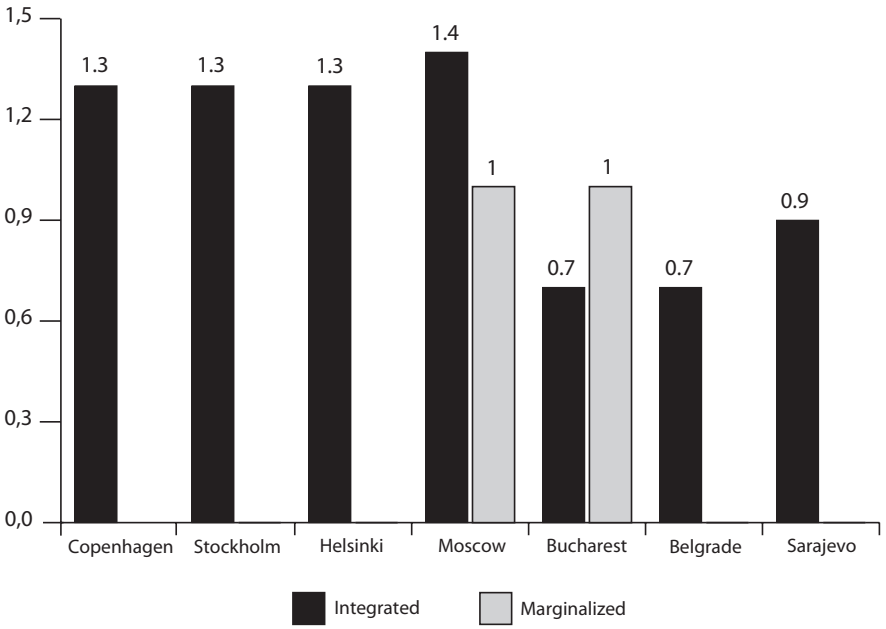


Figure 12: Influence on own life, socially integrated and marginalised drug users, means



Quality of subsistence

A second group of indicators assessed the perceived quality of the housing situation, of the opportunities on the labour market and of the financial situation. Integrated drug users again rated all indicators more positively than marginalised users, but their response patterns differed among Nordic and East-South-Eastern cities: The Nordic group evaluated its housing situation and position on the labour market quite well and more positive than socially integrated drug users in former communist cities, but its financial situation rather bad and worse than their counterparts in Eastern and South-Eastern European cities. Integrated drug users in former communist cities were especially negative in regard to their position on the labour market (see Figures 13-15).

Marginalised users in Nordic cities differed the most from socially integrated drug users

Marginalised users in Nordic cities differed the most from socially integrated drug users and expressed the strongest dissatisfaction with housing, work and money, responses of marginalised drug users in former communist cities only show a more uniform opinion in regard to their financial situation which is rated negative but less negative than by the socially integrated drug users in the same cities.

Figure 13: Housing situation, socially integrated and marginalised drug users, means

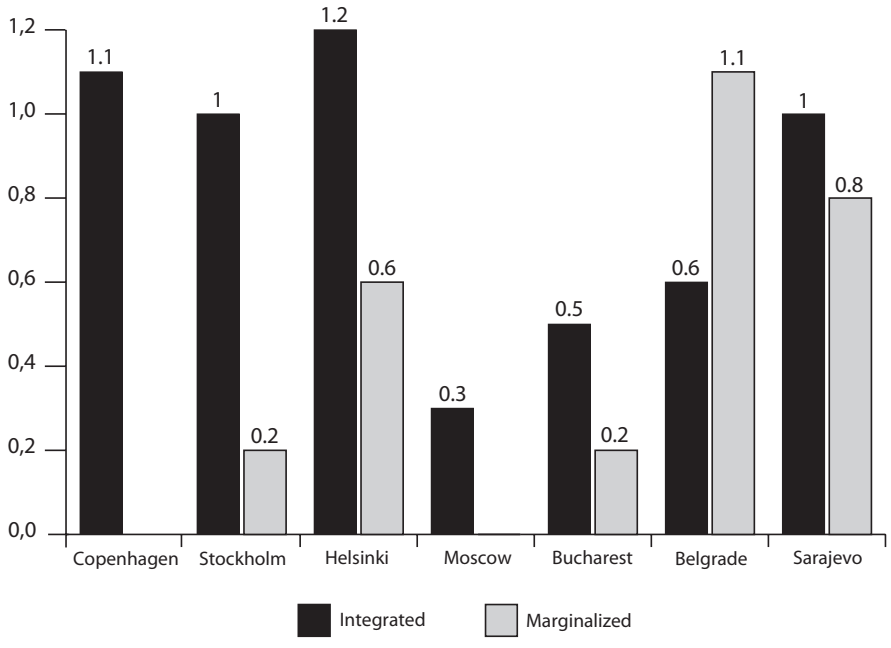


Figure 14: Position on the labour market, socially integrated and marginalised drug users, means

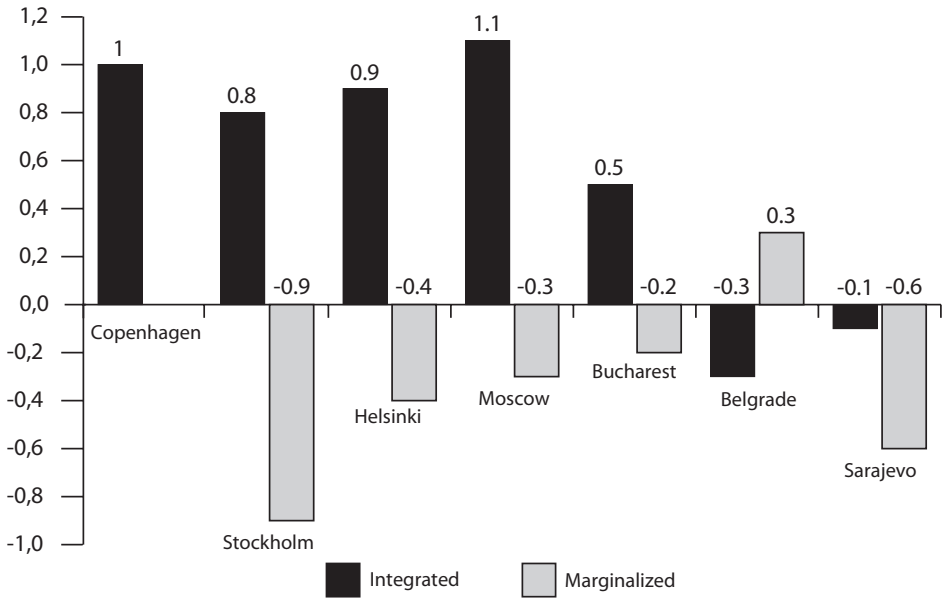
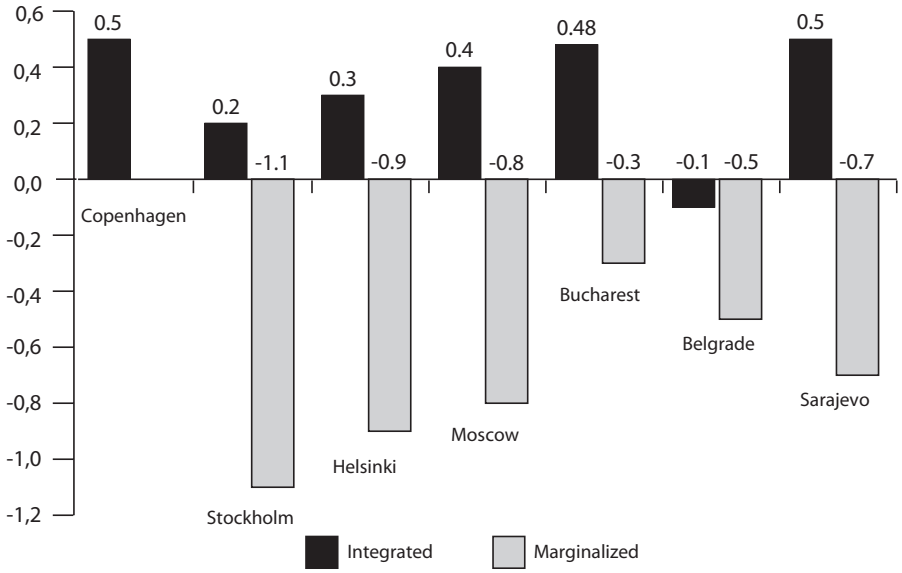


Figure 15: Financial situation, socially integrated and marginalised drug users, means



Access to health and drug services

The evaluation of access to health and drug services as well as that on housing, on the position on the labour market and on the financial situation, was obviously determined by a multitude of factors. As in the former sections discussion is restricted to the most plausible explanations.

Eye-catching is the positive rating of health services by socially integrated drug users in Nordic cities (Figure 17) possibly indicating concrete experiences and the high quality of health facilities in the extended welfare states. Similarly, the positive rating of the access to health and drug services by marginalised users might indicate frequent needs for professional aid and support and satisfaction with successful usage. But the reason for the positive evaluation might also be looked for in the role these services played for recruitment and interviews of the second sample. The exception of Helsinki – where marginalised drug users rated the access to health and drug services worse than in any other city sample – in the opinion of the local research team was to be explained by the high percentage of females in the second sample and by the pronounced male design of the services.

Higher rating of the health services in comparison to the drug services

The higher rating of the health services in comparison to the drug services might be associated with the stigmatising character of the latter or with expectations of becoming stigmatised by usage.

Figure 16: Access to health services, socially integrated and marginalised drug users, means

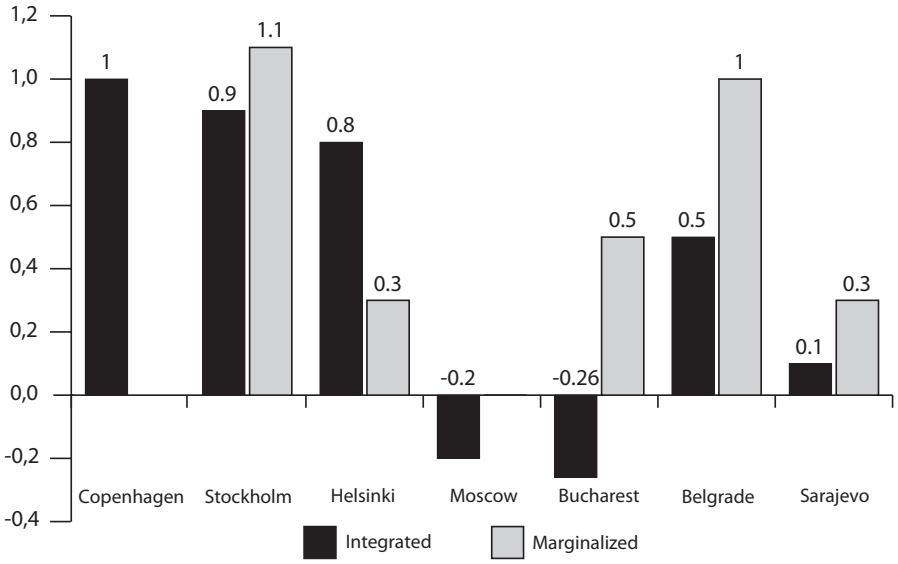
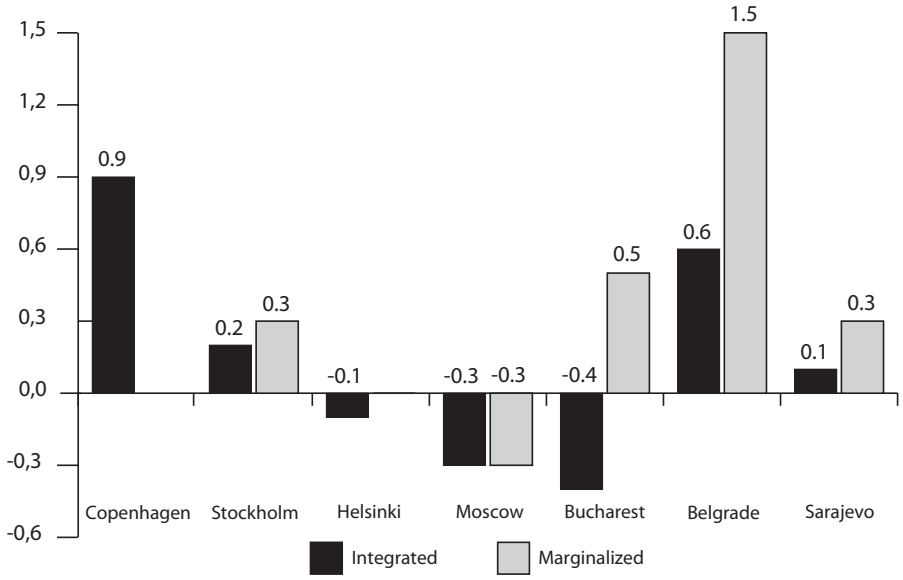


Figure 17: Access to drug services, socially integrated and marginalised drug services, means



3 Summary

Multifold factors are responsible for the differences in social position among and between both groups of drug users in the selected sites

Multifold factors are responsible for the differences in social position among and between both groups of drug users in the selected sites. Though only selected dimensions could be considered and important dimensions had to be neglected – such as convictions, diseases and own family – or could not be sufficiently assessed – such as the "subjective" perception of own position – the data allow to draw rough city profiles of drug users and consumption patterns.

The interviewees in Stockholm were the oldest and probably also the most experienced drug users: The marginalised users were survivors of a drug scene that was established soon after World War II, thanks to extended general welfare measures including a restricted maintenance programme. The welfare services were effective in respect to their health, education and financial situation – and probably also in regard to the reduction of offences –, but not in regard to everyday life: Most of the almost exclusively male drug users were socially isolated, lived in public shelters and had frequent contacts with the police. The "subjective" assessment matched the "objective": the elderly drug users ranked their health status and their access to services relatively high, but did neither feel satisfied nor secure or influential on their own life.

Occasional drug users in Stockholm mostly refused to participate in the study because they were afraid of being identified by state agents. Those interviewed were likely experienced drug users who knew how to hide their consumption habits. Their embedment in a social net, their integration in the workforce and their satisfying housing situation protected them against social disintegration

and stigmatisation. Accordingly, the integrated users were most positive on health status and impact on their own life, rather satisfied with their living conditions and their access to services and only dissatisfied with their financial resources.

The socially integrated drug users in Helsinki were younger and had a weaker position in the workforce than their Swedish counterparts. Despite their more marginal position their subjective perception did not differ remarkably from that of their Nordic neighbours.

The Finnish sample of marginalised users – to one third consisting of women – stood out for low education, but not for low-key accommodation. Though marginalised users also stood out for contacts with the police, they felt more secure than their Nordic neighbours. Consequently they were satisfied with their living conditions, but rated access to health and drug services almost as badly as marginalised users in Moscow where services were the least extended and diversified. According to the local research team the negative evaluation of the services was to be explained by their gender design: The services target "heavy" drug users who in Finland are mostly male following the culturally deeply rooted understanding that intoxication is a "male matter" (Sulkunen, 1986).

Due to special sampling the integrated drug users of Copenhagen differed remarkably from all others. The sample included adolescents whose fragmented education and accommodation resembled that of the marginalised drug users in other cities. But the interviewees, on the other hand, did not deviate in regard to (legal) sources of income and (rare) police contacts. The Danish drug users therefore have to be considered as sample "in between", and among other things served as reminder that the two groups of drug users investigated did not represent drug users in general.

Moscow was the only city without substitution programme and with two samples of respondents in a relatively comfortable social position. The socially integrated users had a dense social net, were economically well integrated and had an acceptable housing situation. They nevertheless had frequent contacts with the police and felt the least secure. Health was thought to be very good, but health and drug services were evaluated as badly as by their marginalised counterparts.

The marginalised drug users in Moscow were relatively privileged. They mostly were socially integrated and many had a higher education, a job and a regular income. But many respondents also reported illegal sources of income and frequent contacts with the police. The contradictory data indicate a heterogeneous drug subculture in the Russian capital attracting drug users of privileged as well as of deprived social milieus.

The Rumanian samples were the youngest and of similar age, but differed in many other respects. The socially integrated users had a weaker social net than those in other sites, and also their economic position was fragile. But accommodation was better than in other former communist countries and they could rely on their families. Though they did not depend on illicit sources of income,

contacts with the police were frequent. They had a pessimistic view on general aspects of life such as health and security and they were dissatisfied with their living situation and their access to health and drug services.

The marginalised drug users in Bucharest were the most excluded sample though many were reached by the extended substitution programme. The main reason for their outstanding social exclusion was their ethnic background – many of the respondents being Roma – and their civil status – many were imprisoned at the time of the interview. Both factors characterise heavy drug users in Romania in general. In accordance with their excluded position they were socially rather isolated, and – due to their fragmented education – had a disastrous economic position. Consequently, a high percentage of the marginalised drug users depended on their family of origin and/or on deviant sources of income such as prostitution. Not surprising were the frequent contacts with the police but rather the optimistic perception of their living situation: health, security and social influence as well as chances on the labour market and access to health and drug services were rated high.

Moving West to Belgrade meant to approach the main drug traffic route to Central Europe and diversified drug consumption habits. As in Moscow marginalised users in Belgrade had a dense social net and were well-educated, which did not protect them from unemployment. The unemployed were supported by their families and few (also) lived of deviant sources. Contacts with the police were frequent. Their optimism in regard to social position and their enthusiasm in regard to drug services probably were the consequences of their recruitment.

Socially integrated drug users in Belgrade – who to a high percentage were female – were less educated, frequently unemployed but socially integrated and financially supported. Only few of the respondents made use of deviant sources of income, but conflicts with the police were frequent, which shows presence in response to strong drug traffic. The respondents were very positive about the health and drug services and moderate in regard to other issues.

Sarajevo in many respects was peculiar. Outstanding were the high rate of unemployment among marginalised users, and the high percentage of those who mainly lived on deviant sources – mostly begging. Many were involved in the drug traffic – contacts with the police were more frequent than elsewhere. Marginalised users frequently lived with their families and got financially supported – a situation which was highly appreciated and probably contributed to their feeling of being secure. State support mostly consisted of a substitution programme which reached half of the respondents but was badly rated.

Also the socially integrated drug users – that in Sarajevo were female above average – lived in a dense social net, mainly due to their families who made up their bad economic situation. As with the marginalised users a high percentage of socially integrated users reported deviant sources of income and police contacts. Their subjective opinion on their social position was startlingly positive, pessimistic was only the perception of their position on the labour market.

Consumption Patterns among Socially Integrated Drug Users

1 Recruitment

Socially integrated drug users were mostly recruited by friends

Socially integrated drug users were mostly recruited by friends which were students and (actual or former) users themselves (Table 1). In Moscow integrated users additionally were contacted at leisure time venues and on the street. Recruitment in Belgrade deviated the most: drug users who had to undergo urine controls were contacted in respective health and drug services.

Table 1: Strategies applied to recruit respondents/drug user groups/approach milieus and number of drug users reached per strategy/group

	CH (N=165)	SH (N=48)	HS (N=102)	MC (N=114)	BR (N=100)	BG (N=113) – overlapping	SJ (N=111)
1st strategy/ group		48 snowballing by friends	102 private contacts	94 private contacts	100 network of social work students	85 cannabis users	90 private contacts via students
2nd strategy/ group				14 at parties, raves, discos, bars + pub		48 (meth) amph. users via young users	17 contacts with "the scene" by former addicts working in harm reduction facilities
3rd strategy/ group				6 on the street		28 cocaine users via close friends	4 "other"
4th strategy/ group						14 ecstasy users via health and social services and school	

2 The social background of the users

To commemorate: The interviewed socially integrated users were on average between 24 (Bucharest) and 31 years (Stockholm) old, the youngest was 13 years old, the oldest 65. Less than one third was female. In regard to age and gender the samples were roughly representative, but they were not in regard to a third basic variable, i.e. the length of consumption. Respondents on average reported 3 to more than 13 years of regular use of illicit substances including cannabis (Table 2). The regular users with the shortest "drug career" (Becker, 1973) was the youngest sample interviewed in Bucharest, those with the longest drug career the oldest sample interviewed in Stockholm.

Table 2: Years of drug use, means, minima and maxima

	CH (N=149)	SH (N=48)	HS (N=102)	MC (N=111)	BR (N=100)	BG (N=113)	SJ (N=112)
Mean	6,5	13,4	9,4	10,3	3,2	7,8	6,7
Min/ Max	0-40	4-40	0,3-30	1-26	1-8	0,4-30	1-25

3 The drugs preferred

The names of the substances selected for investigation – and those of their most important derivates, preparations and adulterations – varied from one city to the other, as did the units sold, probably also quality and least but not last prices mostly paid in local currencies. In Table 3 examples of local variations are presented, which were collected in interviews with integrated as well as marginalised users.

The local substance parameters had to be transmitted to parameters used by the research team, a cumbersome procedure that highlighted shortcomings of the quantitative approach.

The data confirm that cannabis was the most frequently used drug both in Nordic and Eastern/South Eastern cities

Table 4 distinguishes lifetime-, last year- and last month prevalence and depicts the changing position of single drugs in consumption patterns (Wouters et al., 2009). The data confirm that cannabis was the most frequently used drug both in Nordic and Eastern/South Eastern cities – more than half of the respondents used cannabis during the last month. Cannabis was mostly consumed as herb (up to 96% in Helsinki), in the Nordic cities including Moscow also as resin. In Stockholm and Moscow resin consumption was even higher than herb use (85 and 60% in Stockholm, 79% and 56% in Moscow). In four cities amphetamines were taken to a remarkable extent (about one fifth of the respondents in Stockholm, Helsinki and Sarajevo, in Belgrade more than one third), at three sites cocaine (more than one fifth in Helsinki and Belgrade, in Sarajevo 40%) and

at one site ecstasy (one fifth in Helsinki). Current methamphetamine use was negligible, few respondents in Stockholm and Belgrade reported that they had tried or used the substance earlier. To summarize: Cannabis was the first choice in actual consumption patterns, stimulating substances were second, in most cities amphetamines, but in almost one half cocaine. Actual consumption of other substances was insignificant – if due to disinterests of users or to restricted market supply has to remain an open question.

Table 3: Examples of local names and measures of drugs preferred by socially integrated and marginalised drug users

	Local names of substances	Local measures and weights
Belgrade		
Amphetamine sulphate + phosphate Metamphetamine	Uppers, bennies, glass Speed, meth, crystal meth, ice	
Moscow		
Cannabis resin	Plujschka (spots)	1 plujschka = 1g matchbox = 5g circle = 0,05g
LSD	sakhar (sugar)	Marka (stamp) kaplya (drop)
Sarajevo		
Heroin cocaine amphetamines cannabis		Paketic' = 0,25g Crta (line) = 0,05g Su't (shot) =0,5g Joint =1g, paketc'= 2-3g
Stockholm		
Cannabis resin		Puffs per 0,03g

Ecstasy was the drug most often ever tried or used

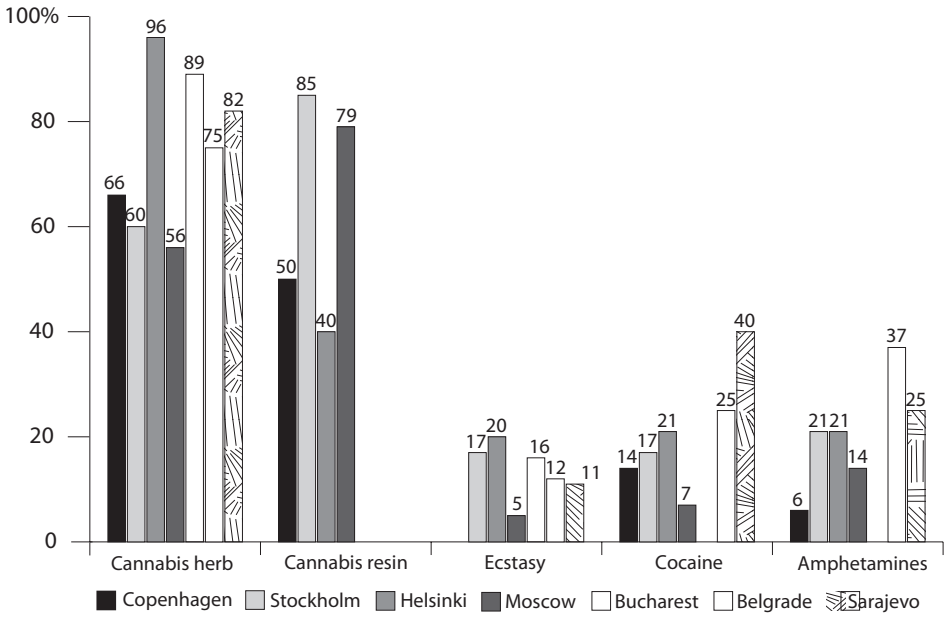
A comparison of lifetime and last year prevalence reminds of the "second drug wave" and its most popular substance ecstasy which peaked in 2002 and dropped sharply after that: The popularity of ecstasy at the turn of the century is pictured in Table 4: Ecstasy was the drug most often ever tried or used, with the exception of Helsinki where amphetamine was the most popular substance in regard to lifetime experiences. In "last year consumption" ecstasy did not longer play any role. "Last year consumption" in two cities focussed on the new "glamorous" drug cocaine and in the others turned to the problematic (but established?) amphetamine (Demant et al., 2011).

Table 4: Experiences and consumption of cannabis herb and resin, ecstasy, cocaine and amphetamines, in percentages

	CH (N=149)	SH (N=48)	HS (N=102)	MC (N=111)	BR (N=100)	BG (N=113)	SJ (N=112)
Cannabis herb							
Last Month	66	60	96	56	89	75	82
Last year	7	25	-	7	7	10	8
> one year ago	-	15	-	-	-	13	6
Cannabis resin							
Last Month	50	85	40	79	-	-	-
Last year	12	13	31	-	10	9	
> one year ago	-	-	5	-	13	22	
Ecstasy							
Last Month	-	17	20	5	16	12	11
Last year	6	17	11	11	10	12	11
> one year ago	12	35	39	40	15	45	14
Cocaine							
Last Month	14	17	21	7	-	25	40
Last year	18	29	21	6	5	14	5
> one year ago	12	33	25	25	-	19	6
Amphetamine							
Last Month	6	21	21	14	-	37	25
Last year	7	15	27	19	-	16	8
> one year ago	14	27	20	30	-	18	6

Figure 1 summarizes the findings on last month prevalence within another format. Socially integrated drug users favoured cannabis, mostly as herb in the Nordic cities, including Moscow also as resin. Amphetamine and cocaine were used by a remarkable percentage of respondents only in the cities on the drug route Belgrade and Sarajevo.

Figure 1: Last month prevalence of use of cannabis herb and resin, ecstasy, cocaine and amphetamines per city, in percentages



Substances not considered in the presentation of prevalence such as e.g. heroin were rarely taken by socially integrated drug users and if consumed, consumption was restricted to few cities: Especially Belgrade, where socially integrated users with comparable risky consumption patterns had been recruited, stood out for comparable high heroin and nicotine consumption.

The responses again underlined the top position of cannabis

Another way to measure the position of a substance within the drug menu of drug users was the open question on "The drug, most difficult to go without ...". The responses again underlined the top position of cannabis (Table 5) but highlighted also its close relationship to nicotine. Besides that only cocaine seemed to be of some importance for socially integrated drug users in Belgrade and Sarajevo.

Table 5: "The drug, most difficult to go without ...", socially integrated users, in percentages

	CH (N=165)	SH (N=48)	HS (N=102)	MC (N=114)	BR (N=100)	BG (N=113)	SJ (N=112)
Cannabis herb & resin	22	-	34	26	48	16	28
Nicotine	9	38	22	17	21	-	18
Cocaine	-	-	-	-	-	10	14

4 Modes of consumption and frequency

Consumption modes varied among the substances but were mostly uniform across the seven cities

Consumption modes varied among the substances but were mostly uniform across the seven cities: Cannabis herb and resin were smoked or inhaled; ecstasy was mostly taken orally and only in Moscow injected by half of the users; cocaine was sniffed. Amphetamine consumption was the exception and varied among cities possibly because of its prominent history in many of the sites. The substance was mainly sniffed in five of the cities, in Stockholm and Moscow it was mostly taken orally, and occasionally it was also inhaled.

Drugs were differently administered and they were taken with different frequency. Frequency was approached by two questions. One asked for the number of consumption days during the last month, the second more experimental one extended the time frame to consumption days within the last 12 months. The first question allowed to calculate an average number of consumption days per last month per drug and per city, the second the average number of consumption days per average month of the last year. By the extension of the time frame from last month to last year it was intended to control consumption cycles peaking at festivities such as Christmas and New Year's Eve and in the warmth of summer, and dropping in lonely winter days, sometimes even to abstention (Eisenbach-Stangl et al., 2011). Table 6 combines the responses to both questions: average number of days per last month at first and in parentheses the average number of days per average month during the last year. The presentation focuses on the drugs taken by most respondents of the first sample.

As was to be expected the responses to both questions differed remarkably, but also not systematically. Since last month' memory on consumption days without doubt is more reliable it was chosen as basis for discussion and further calculations.

Table 6: Days of drug use per last month (and average month of last year) by type of substance and by city, socially integrated drug users, means

	CH (N=165)	SH (N=48)	HS (N=102)	MC (N=114)	BR (N=100)	BG (N=113)	SJ (N=112)
Cannabis herb	5,3	7,5 (8,0)	16,6 (6,3)	10,6 (14,0)	5,7 (1,6)	9,4 (0,9)	13,3 (3,5)
Cannabis resin	8,1	6,8 (5,5)	5,6 (13,8)	18,3 (8,9)	- (4,6)	- (6,7)	- (11,2)
Ecstasy	-	3 (1,8)	2,8 (2,4)	1,7 (0,1)	3,4 (1,9)	2,3 (0,7)	1,8 (2,3)
Cocaine	1,4	1,1 (2,0)	2,5 (2,5)	5,5 (0,3)	- (0,9)	3,7 (1,6)	7,1
Amphetamine (Methamph.)	2,3	1,3 (2,6)	5,5 (2,5)	5 (1,8)	- (2,6)	4,3 (1,4)	7

Last month's consumption frequencies presented in Table 6 illustrate that by trend the substances preferred were taken more intensively: Cannabis herb was taken most intensively, followed by cannabis resin with the exception of Stockholm where the preferred herb as well as resin were taken at about every fourth day. Also the intensity of stimulant use roughly corresponded to the position of the substance in the drug menu: Amphetamine was taken somewhat more frequently than ecstasy and cocaine. But all in all the frequencies of any drug consumption were moderate and as consumption modes they did not vary remarkably among the cities.

5 Poly drug use and drug combinations

Most drug users take more than one substance

Most drug users take more than one substance. Though poly-drug use only recently received more attention, it is not a new phenomenon, also when it comes to mixtures with legal substances (Olsson, 1981; Eisenbach-Stangl, 1983). Table 7 presents the number of illicit drugs used during the month prior to the interview. The calculation was restricted to substances used by more than 5% of respondents in at least three cities: To cannabis herb and resin (this time taken together), to ecstasy, cocaine and amphetamine. Legal drugs were not included.

Table 8 shows that the overwhelming majority of socially integrated users concentrated on one illicit substance – that is cannabis. "Mono drug consumption" of socially integrated users was more common in the Second Multi-City Study than in the first one which was carried out in Western and Central European cities and thus in the political and economic centre of Europe.

Table 7: Number of drugs used during the last month, integrated drug users, in percentages

	CH (N=165)	SH (N=48)	HS (N=102)	MC (N=114)	BR (N=100)	BG (N=113)	SJ (N=112)
1	89	67	71	79	88	58	55
2	8	21	11	19	10	35	33
3 and more	-	13	19	-	-	7	12

Table 8 presents the main combinations of the considered (illicit) drugs; it is restricted to combinations taken by at least 10% of a city sample. Since illicit poly-drug use is not common among the socially integrated users in the investigated cities, Table 8 resembles Table 7.

Rare combinations concerned the use of cannabis and one stimulant and were mostly observed in Belgrade and Sarajevo. The stimulants combined with cannabis were amphetamine and cocaine, i.e. substances seldom chosen in mono drug use patterns. More exceptional combinations were only observed in Stockholm and Helsinki.

Table 8: Main drug combinations, last month, integrated drug users, in percentages

	CH (N=165)	SH (N=48)	HS (N=102)	MC (N=114)	BR (N=100)	BG (N=113)	SJ (N=112)
Cannabis	83	67	69	79	83	37	38
Ecstasy	-	-	-	-	5	-	-
Cocaine	-	-	-	-	-	10	16
Amphetamine	-	-	-	-	-	10	-
Cannabis + Ecstasy	-	-	-	-	8	6	-
Cannabis + Cocaine	-	6	-	-	-	-	15
Cannabis + Amphetamine	-	10	-	11	-	18	13
Cannabis + Ecstasy + Cocaine + Amphetamine	-	8	9	-	-	-	-

6 Summary

Patterns of drug consumption of socially integrated users did not vary remarkably across the seven cities

Patterns of drug consumption of socially integrated users did not vary remarkably across the seven cities: Conformities in consumption preferences and modes on the one hand and moderate consumption intensity of any substance on the other indicate unifying forces effective on a transnational – European – level. Despite all differences in the social position of the socially integrated users in the seven sites depicted in the previous chapter, their life circumstances and lifestyles equally provided for drug-related attitudes that kept consumption moderate and at low risk.

Though the sample of socially integrated drug users in Copenhagen consisted of younger and conspicuous users with shorter drug careers, their drug consumption was not outstanding: they were mostly “mono drug users” and preferred cannabis – herb somewhat more than resin. Few used also cocaine. Cannabis use was comparably infrequent and by itself did not qualify the users as problem group.

Because of the tight formal and informal drug controls integrated drug users in Stockholm were eager to keep their consumption hidden. Tight drug controls had not succeeded to deter them from using illicit substances for many years of their life. They favoured cannabis resin but also smoked herb and few also consumed ecstasy, amphetamines and cocaine. In other words: socially integrated drug users in Stockholm seldom were “only cannabis users”, many were multi-drug users, and their drug range probably, among other legal substances, included nicotine as the drug “most difficult to go without”.

In Helsinki, socially integrated users had a strong preference for cannabis herb but more frequently than in any other cities additionally consumed cannabis resin, ecstasy, other amphetamines as well as cocaine. The Finnish sample did not only rank first in regard to multi-drug use, it also stood out for frequent drug consumption.

Just as the socially integrated drug users living in Stockholm, their counterparts in Moscow favoured cannabis resin, which together with nicotine was the "drug the most difficult to go without". Like the Swedes the Russians additionally consumed cannabis herb, but besides cannabis only used amphetamine, which they more frequently had taken in the past. Both substances were taken frequently and probably in a more risky manner rooted in a local tradition of use of intoxicants.

The Bucharest sample of socially integrated users was rather young, educated and used drugs only since few years. They favoured cannabis herb and some additionally took ecstasy, which had been popular across Europe but had vanished out of the drug menus of socially integrated users at the other sites. Frequency of drug consumption was rather low – the Romanian socially integrated users kept consumption risks low.

The socially integrated drug users in Belgrade were again experienced and more risky drug users. They preferred cannabis herb and additionally used amphetamine and cocaine rather frequently. Thus they were pronounced multi-drug users but they did not consume with outstanding frequency. Despite – or because? – of their status as clients of drug services the occasional drug uses in Belgrade more seldom than all their counterparts were concerned about substance-related dependencies.

With regard to socially integrated drug users Sarajevo was a "herb city". But as in neighbouring Belgrade they did not stick to cannabis herb but also took cocaine and amphetamine and therefore were to be addressed as poly-drug users. Since many used amphetamine and cocaine and since both substances were consumed most frequently, the socially integrated users in Sarajevo were considered to be the most risky consumers among the first samples. But contrary to their Serbian counterparts they were sensitive for the risks associated to their consumption patterns: More than in other cities they felt to depend on drugs, mainly cannabis, nicotine and cocaine.

Consumption Patterns among Marginalised Drug Users

1 Recruitment

Most marginalized drug users were approached in drug services, they were "drug patients" or "drug clients"

Most marginalized drug users were approached in drug services, they were "drug patients" or "drug clients". The percentage of respondents recruited in drug services was 90-100% in Stockholm and Moscow and 80% at the other sites (see Table 1). The samples recruited by this procedure were neither homogeneous nor representative: The drug facilities varied in regard to target groups and to services offered, to professional orientation and to their administrative and legal frame within and among the cities.

Table 1: Drug services used for the recruitment of respondents

	SH (N= 100)	HS (N=100)	MC (N=100)	BR (N=101)	BG (N=100)	SJ (N=100)
Low threshold services (partly + subst.)	90 (outreach + day centres, shelters for homeless)	67	42 (run by NGO, partly outreach)	40 (run by NGO)	1 (outreach)	67 (run by NGO)
Substitution programme	10			15 (low threshold run by state)	9	4
Outpatient service (s)		15	58 (run by state, partly detox.)	28 (partly run by state)	42 (treatment and emergency)	
Residential treatment					31	4 (therapeutic community run by NGO)
Prison, police station, probation				18	7	2
In the street					10	23
Other		20 (users' home)				

In Stockholm respondents mostly were approached via facilities that offered non-specialized care to all subgroups of marginalized persons; in Helsinki, Bucharest and Sarajevo recruitment mostly took place via low-threshold services for drug users. Though respondents in Moscow were also contacted in low-threshold services, the majority was recruited in the high-threshold in- and outpatient facilities for drug addicts belonging to the state health services attracting drug users from higher strata. The special addiction facilities of the state health services were also the main source of recruitment in Belgrade: one third of the respondents were patients of a residential unit.

2 The social background of the users

The marginalised drug users interviewed were between 27 and 30 years old and thus not remarkably older than the first sample. With one exception: In Stockholm they were 48 years on average, the youngest was 31 years old, the oldest was a senior of 65 years. The second Stockholm sample included many drug veterans with first contacts with drugs dating back to the 1950s.

The second sample differed from the first one in regard to percentages of females. The sample in Sarajevo had the lowest percentage with 6% female interviewees, the sample in Helsinki the highest with 29%. The heterogeneous percentages of female respondents among the "marginalised sample" corresponded roughly to the gender composition of drug clients in the respective city.

Drug careers of marginalised users were longer than those of socially integrated users

Drug careers of marginalised users were longer than those of socially integrated users, especially in Nordic cities, indicating an earlier onset of drug use and/or a better and more effective provision with health and social services.

Table 2: Years of drug use, mean, minima and maxima

	SH (N=100)	HS (N=100)	MC (N=100)	BR (N=101)	BG (N=100)	SJ (N=99)
Mean	28,5	13,0	8,9	7,7	8,7	10,7
Min/max	10-50	3-35	1-46	1-17	0,5-30	2,5-27

3 Substitution drugs

Substitution therapy aims at the replacement of heroin as well as other opioid and opiate consumption by licit opioid use, thus at the reduction of illicit opioid and opiate consumption on the individual level. Substitution therapy intervenes in consumption patterns and amounts consumed and therefore is of interest in the context of the current study. Though substitution treatment expanded in Europe since the 1960s, it is not equally developed across the coun-

tries and remained a controversially discussed measure (Thom et al., 2013). Consequently the percentage of substituted drug users varied among the cities investigated from zero in Moscow where maintenance treatment is prohibited, to (almost) 50% in Bucharest and Sarajevo. Table 3 shows that methadone was the substitution drug of choice in all cities except Helsinki where Buprenorphine was widely prescribed.

Table 3: Substitution substances prescribed

	SH (N=10)	HS (N=23)	BR (N=42)	BG (N=9)	SJ (N=47)
Methadon	50	47,8	83,3	100	100
Subuxone	-	47,8	16,7	-	-
Subutex	-	4,3	-	-	-

Substitution programmes are effective within limits

Substitution programmes are effective within limits: Most clients continue with the consumption of "street drugs" and/or additionally acquire substitution drugs on the drug market. Concomitant use was submitted to sanctions and therefore underreporting was to be expected. But despite severe sanctions almost all substituted respondents in Stockholm and Helsinki (about 90%) reported concomitant use of street drugs – mostly illegally acquired substitution substances (Bubrenorphin). In Bucharest and Belgrade two thirds of the interviewees admitted concomitant use, in Sarajevo it was a minority of 13%.

Substitution drugs were also taken by drug users that were not clients of a maintenance programme, the respective percentages varied between zero in Bucharest and Sarajevo and 65% in Helsinki. In other words: substitution substances added to the list of goods sold on local drug markets as well as to the drug menu of individual drug users and local drug cultures. Substitution substances in few cases were promoted and became the drug of preference of marginalised users – as in Helsinki and in Vienna – in one of the cities investigated in the First Multi-City Study (Eisenbach-Stangl et al., 2009).

The picture is further complicated when consumption of other opioid-containing prescription drugs is considered. They are prescribed to substituted as well as to non-substituted drug users and also become available at illicit drug markets. Tramadol was the most prominent prescription drug in this study, which especially in Moscow and Belgrade was frequently prescribed to drug users by medical doctors but also frequently acquired illegally .

4 The drugs preferred

Table 4 presents lifetime-, last year- and last month prevalence of selected drugs and per city. The table differentiates between brown and white heroin, cannabis herb and resin as well as between amphetamine and metamphetamine; but it does not include crack, which is almost unknown in the sites investigated.

Heroin was the leading drug of all marginalised drug users in former communist cities

In regard to actual "last month" consumption heroin was the leading drug of all marginalised drug users in former communist cities: Brown heroin in Bucharest, Belgrade and Sarajevo, mostly white heroin in Moscow. Marginalised drug users in Nordic cities actually favoured amphetamine, in Stockholm methamphetamine.

With the first choice in Eastern and South-Eastern cities being heroin and in Nordic cities amphetamine/metamphetamine, the second choice in all cities was the same: cannabis herb, in Stockholm resin. The percentages of cannabis users reached "European level" (about one half in Belgrade and Sarajevo and up to two thirds in Stockholm – EMCDDA, 2011). The exception was Bucharest were only brown heroin seemed to count.

Drug preferences in the past – assessed by lifetime and last year prevalence – were different: In both Nordic cities about one third of the marginalised metamphetamine/amphetamine users had taken heroin whereas a comparable percentage of the heroin users living in Belgrade and Sarajevo had experiences with amphetamine and/or ecstasy or still used these substances (Belgrade). Table 4 further shows that the "ecstasy fashion" also affected marginalised drug users and that cocaine underwent a less distinct career: it was widely used in the past in Stockholm and Sarajevo, but actually of no importance in the drug menu of marginalised drug users. In Belgrade, cocaine use was low in the past but actually rising. The status of cocaine therefore was diffuse, also in respect to the users: cocaine was a drug of socially integrated as well as marginalised users.

Table 4: Experiences and consumption of heroin, cocaine, amphetamine, metamphetamine, ecstasy and cannabis; in percentages

	SH (N=100)	HS (N=100)	MC (N=100)	BR (N=101)	BG (N=100)	SJ (N=100)
Heroin, brown						
Last month	9	0	31	96	80	98
Last year	-	15	0	1	12	-
More than one year ago	39	45	-	-	6	0
Heroin, white						
Last month	9	-	56	0	5	0
Last year	-	9	6	0	-	0
More than one year ago	33	33	-	0	11	0
Cocaine						
Last month	9	-	-	7	41	8
Last year	9	17	-	-	23	17
More than one year ago	68	42	0	7	17	42
Amphetamine						
Last month	91	58	11	-	29	6
Last year						
More than one year ago						
Methamphetamine						
Last month	53	5	0	0	8	0
Last year	36	20	0	0	12	0
More than one year ago	8	0	-	0	27	0
Ecstasy						
Last month	-	_	-	-	13	-
Last year	9	15	6	-	21	16
More than one year ago	36	65	0	6	30	47
Cann. Herb						
Last month	28	50	27	8	36	41
Last year	36	11	10	4	18	23
More than one year ago	32	-		7	30	15
Cann. Resin						
Last month	64	42	10	-	6	0
Last year	15	12	0	-	-	0
More than one year ago	17	-	0	-	24	0

Figure 1 presents the findings on last month prevalence of heroin consumption in another format and complemented by consumption of “other opiates ” a category which also includes the consumption of opioids. The category “substitution drugs” covers any illicit use of substitution substances, such as e.g. use of illicitly acquired substitution drugs as well as consumption of substitution drugs in another but the prescribed way. All opioid- and opiate-related categories add up to the summarizing category “any opiates”.

Figure 1 confirms the extensive consumption of (white and brown) heroin in Eastern and South-Eastern cities, and it also demonstrates that the percentage of opiate and opioid users can but must not increase if "other opiates and opioids" and "substitution drugs" are considered. Since the categories overlap, a rough addition must suffice for illustration. Though none of the respondents in Helsinki reported consumption of brown or white heroin, 98 of 100 respondents reported consumption of "any opiate" during the month prior to the interview: 23% were substituted, 12 had taken "other opiates", 88% had consumed licit or illicit substitution substances. In Sarajevo on the other hand – the site with a high availability of heroin – substitution substances had no appeal.

Widespread amphetamine/ methamphetamine consumption in Nordic cities and especially in Stockholm

Figure 2 focuses on last month use of stimulants and cannabis – amphetamine and methamphetamine as well as cannabis herb and resin taken together. The graph confirms the widespread amphetamine/methamphetamine consumption in Nordic cities and especially in Stockholm, and the low consumption in the Eastern and South Eastern cities with high heroin use. Belgrade was the exception, a city with high actual heroin use and notable amphetamine consumption and at the same time the only site with remarkable cocaine and ecstasy use. Figure 2 also illuminates differences in the use of cannabis, which is very frequent in Nordic cities, medium in the cities at the Balkan route and low in Eastern cities – proofing its meaning as the symbol of the "Western counter-culture".

Figure 1: Last month prevalence of use of (brown and white) heroin, "other" opiates and substitution substances, marginalised drug users; in percentages

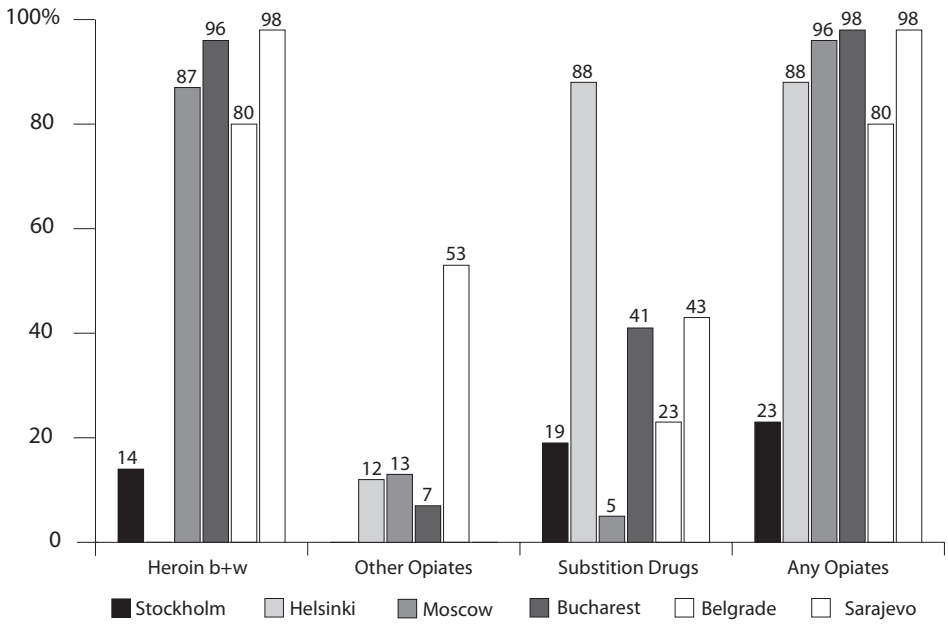


Figure 2: Last month prevalence of cocaine, amphetamines, ecstasy and cannabis herb and resin, in percentages

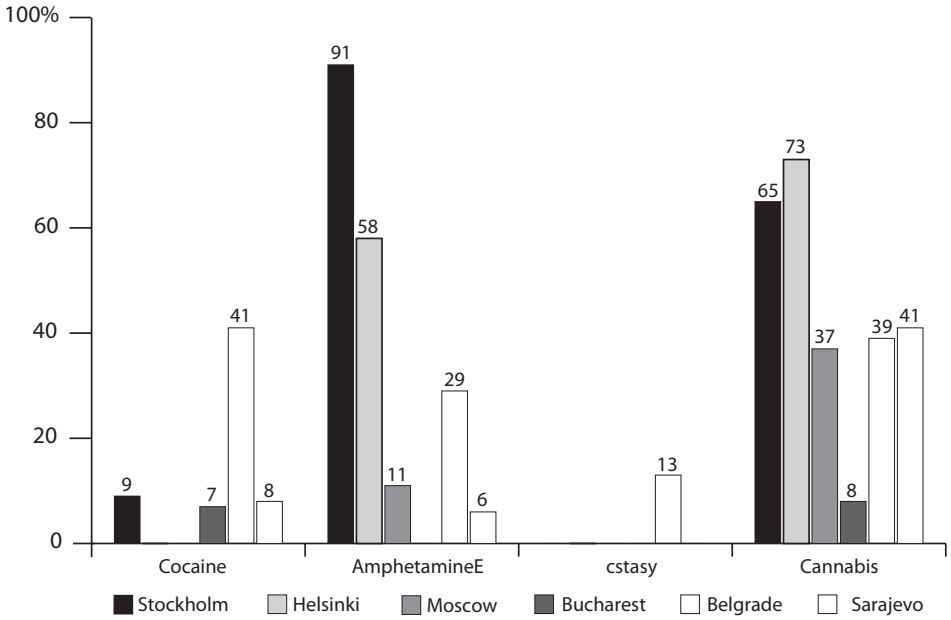


Table 5 confirms the top position of heroin in the drug menu of marginalised drug users in the former communist cities, which in Stockholm was replaced by amphetamine and methamphetamine and in Helsinki by the substitution drug bubrenorphine.

Table 5: "The drug, the most difficult to go without…" , marginalized users, in percentages

	SH (N=100)	HS (N=100)	MC (N=100)	BR (N=101)	BG (N=100)	SJ (N=100)
Heroin, brown + white	9	-	63	73	79	86
Substitution drug	-	54	-	-	-	-
Amphetamine	48	18			8	

5 Modes of consumption and frequency

Consumption modes vary by the drugs and to a lesser extent also among the sites

Consumption modes vary by the drugs and to a lesser extent also among the sites. Heroin was mostly injected with the exception of Sarajevo and Belgrade where it was also or mainly sniffed and/or taken orally. In the Nordic cities and in Moscow also amphetamine and methamphetamine were mainly injected, whereas in Belgrade amphetamine and also cocaine were sniffed. Administration of all drugs varied with availability: injection of substances increased with low availability, sniffing, which requires larger amounts, or oral use increase

with high availability. Cannabis herb and resin were everywhere mostly smoked or inhaled and used in the same way by marginalised and socially integrated drug users.

The data presented in Table 6 show the frequency of consumption by the average number of consumption days during the last month and by the average number of consumption days per average month of the last year. As discussed above last month measures proved to be more plausible than last year estimates, but assessment was a challenge for research in itself: the research team of Moscow explained the poor results for annual consumption with the high percentage of intoxicated interviewees.

Table 6 shows frequency of use of all main substances: brown heroin, amphetamine including methamphetamine and substitution drugs. Cocaine was considered to allow a comparison with the first sample. As with socially integrated users, marginalised users consumed preferred drugs more often – heroin in the Eastern and South-Eastern cities, amphetamine and methamphetamine in Stockholm and Helsinki. But heroin consumption did not only vary with the setting, it was more frequently taken than e.g. amphetamine everywhere.

Table 6: Number of days of drug use per last month (and average month of last year) by type of substance and by city, marginalised drug users, means

	SH (N=100)	HS (N=100)	MC (N=100)	BR (N=101)	BG (N=100)	SJ (N=100)
Heroin, brown	3,9 (7,2)	- (2,3)	28,2 (25,3)	19,8 (19,0)	23,5 (12,9)	19,8 (15,7)
Amphetamine (amphetam. + methamphet.)	13, 1 (13,3 + 11,3)	9,9 (8,7 + 5,7)	9,6 (7,8 + 11,2)	- (4,1)	6,3 (0,7 + 0.1)	6,3 (1,9)
Cocaine	2,2 (7,2)	- (2,4)	- (12,5)	10,5 (5,9)	5,9 (0,8)	5,3 (3,1)

6 Poly drug use and drug combinations

Table 7 shows the number of drugs used during the last year and Table 8 the main substance combinations. For reasons of lucidity both tables concentrate on heroin (brown and white), cocaine and amphetamine (including methamphetamine). Because of their prominent position among substances consumed by marginalised interviewees, also ”other opiates and opioids” were considered.

Poly-drug use was more pronounced among marginalised than among socially integrated drug users

Table 7 shows that poly-drug use was more pronounced among marginalised than among socially integrated drug users: Marginalised users in most sites regularly consumed more than one drug, in Helsinki and Belgrade it were more than two.

Table 7: Number of drugs used last month, marginalised drug users, in percentages

	SH (N=100)	HS (N=100)	MC (N=100)	BR (N=101)	BG (N=100)	SJ (N=100)
1	24	19	54	48	13	34
2	59	39	36	44	34	40
3	9	28	7	7	28	18
3+	8	14	-	-	25	8

Table 8 underlines the position of substitution substances in the menu of drug users in all sites: They obviously were the second choice besides the favoured heroin in former communist cities and besides amphetamine in the cities with a market tradition. In Moscow where substitution is prohibited, marginalised users contrary to their counterparts in other sites concentrate on heroin. Belgrade is the exception: the Serbian marginalised users developed a more extensive multi-drug use and presumably fell prey to the temptations of the diversified drug market.

Table 8: Main drug combinations last month, marginalised drug users, in percentages

	SH (N=100)	HS (N=100)	MC (N=100)	BR (N=100)	BG (N=101)	SJ (N=100)
Heroin b+w	-	-	85	52	36	52
Amphetamine	77	11	-	-	16	-
Substitution drugs	6	40	-	38	12	35
Heroin b+w + cocaine	-	-	-	-	13	-
Heroin b+w + amphetamine	-	-	6	-	5	-
Substitution drugs + amph.	-	35	-	.	-	.
Heroin + subst. + coc.	-	-	-	-	6	-
Heroin + subst. + amph.	-	9	-	-	-	-

7 Summary

Consumption patterns of marginalised drug users were associated to lifestyles developed in disadvantaged local milieus and subcultures

Consumption patterns of marginalised users by definition were different from those of socially integrated users and they also varied among the cities: consumption patterns of marginalised drug users were associated to lifestyles developed in disadvantaged local milieus and subcultures.

The marginalised users in Stockholm were guarded and protected by health and drug services and they had grown old: the oldest respondent counted 65 years. Cocaine, heroin and ecstasy had been the drugs of choice in earlier stages of their drug career, but they were replaced by amphetamine, metamphetamine and cannabis resin. Amphetamine and methamphetamine were injected and actually taken every third day, cannabis resin was used more frequently. Only few marginalised drug users were substituted and if they were in a programme, they additionally used illicitly acquired opiates and opioids mostly as substitution drug.

The marginalised users living in Helsinki were younger, they had shorter drug careers and developed different patterns of consumption. Heroin, cocaine and ecstasy – also their drugs of choice in earlier stages – had only partly been replaced by amphetamine and cannabis – resin as well as herb. The majority turned to substitution substances – methadone as well as subuxone. Though the substitution programme was extended and flexible it was not the only source of methadone and subuxone: both substances were more frequently acquired illegally. The marginalised drug users in Helsinki could be addressed as poly-drug users who consume rather infrequently.

In Moscow substitution is not considered to be a proper medical treatment and prohibited substitution drugs did not become a noteworthy part of the drug menu of marginalised drug users. Consumption concentrated on white heroin followed by brown heroin and sometimes was complemented by cannabis, mostly herb. The Russian marginalised drug users that could not be classified as poly-drug users, were frequent as well as risky users: they injected heroin almost daily, that was more often than in any other city.

The marginalised drug users interviewed in Bucharest were the youngest, had the shortest drug careers and also were the socially most excluded: among them were many Roma and many prisoners. Though almost one half of the respondents was substituted, mainly with methadone, almost all reported (brown) heroin use in the last month. Heroin consumption, however, was not as frequent as for instance in Moscow.

Belgrade and Sarajevo have a common geo-political past and as regards selected issues such as drug consumption and drug-related controls, also a common presence. Presumably in response to the rich and diversified supply with illicit substances Serbian marginalised users developed a distinct poly-drug use pattern with a preference for (brown) heroin. They frequently also used stim-

ulants and cannabis herb and additionally prescription drugs containing opioids and substitution substances. Due to recruitment and the special interview setting the Serbian drug users might have described their consumption habits more accurately than all others.

Sarajevo contrary to Belgrade has an extended substitution programme – about half of the respondents were maintained with methadone. Concomitant drug use was restricted to heroin use, which was as widespread as in Belgrade but less frequent. The extended substitution programme, which possibly contributed to the reduction of heroin consumption, also might be associated with the lower intensity of actual poly-drug use. The marginalised drug users reported more frequent use of cocaine and ecstasy in former years.

Markets, Purity, Amounts, Prices and Expenditure

1 Introduction

This chapter is dedicated to the calculation of amounts consumed by individual drug users per each of the five drugs of interest per occasion and per month and of respective expenditures. The calculations do not miss plausibility, though their footing is precarious. Several weak points have been discussed in previous chapters such as the memory of consumers interviewed being partly under the influence of drugs and the disregard of annual consumption cycles due to failure of assessment. Further weak points are taken up in following chapters such as the unknown and varying quality (purity) of the illicit commodities of interest and the varying units of drugs sold on local markets.

A last shortcoming of the calculation of amounts and expenditures mentioned in the introduction was that not every drug consumption had a price and was convertible to monetary value: especially cannabis is shared and consumed with friends as an expression and reconfirmation of friendship. Cannabis in this respect resembles alcoholic beverages, the main "socialising" drug in industrialized countries. Drug consumption among friends and respective expenditures are regulated by informal rules and controls that partly more effectively shape their targets than controls by the state and the market. Fieldwork and interviews indicated more sources for drugs than markets and friends such as e.g. cooperation for the purchase of a special substance but the framework of the study did not allow to investigate them in more detail.

2 Markets are just one source of drugs

In all cities drug markets were just one source of supply and in some not even the main source

In all cities drug markets were just one source of supply and in some not even the main source: The variations of the drug markets' position in drug retail across the sites are depicted in Table 1 which also shows the differences of drug sources among socially integrated and marginalised users.

Socially integrated drug users mainly were supplied by friends, though friends in Nordic cities including Moscow were far more important than in the South-Eastern cities of Bucharest, Belgrade and Sarajevo. The data indicate that

private retail networks develop easier in extended civil societies and in remote sites in regard to drug markets, whereas close to the centres of "big drug business" private networks hardly can compete with professional retail.

The private networks in Scandinavian cities provided with home-grown cannabis herb as well as with stimulants such as amphetamine and also cocaine. Occasionally they supplied socially integrated users with all substances they demanded. In former communist countries cannabis was mostly retailed by professional dealers who presumably collaborated with the professional growers of herb in this area.

Figure 1a: Friends as source of drugs among socially integrated users, in percentages

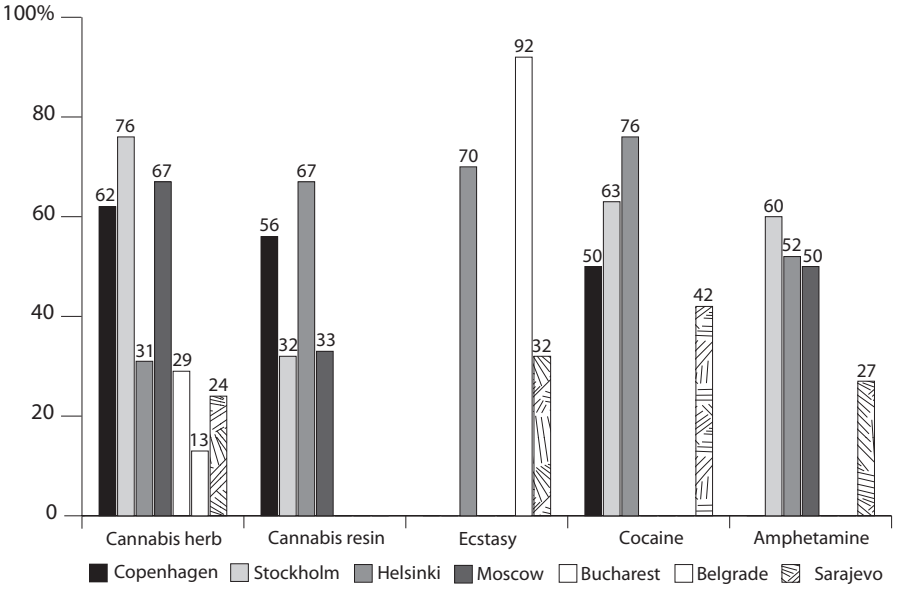
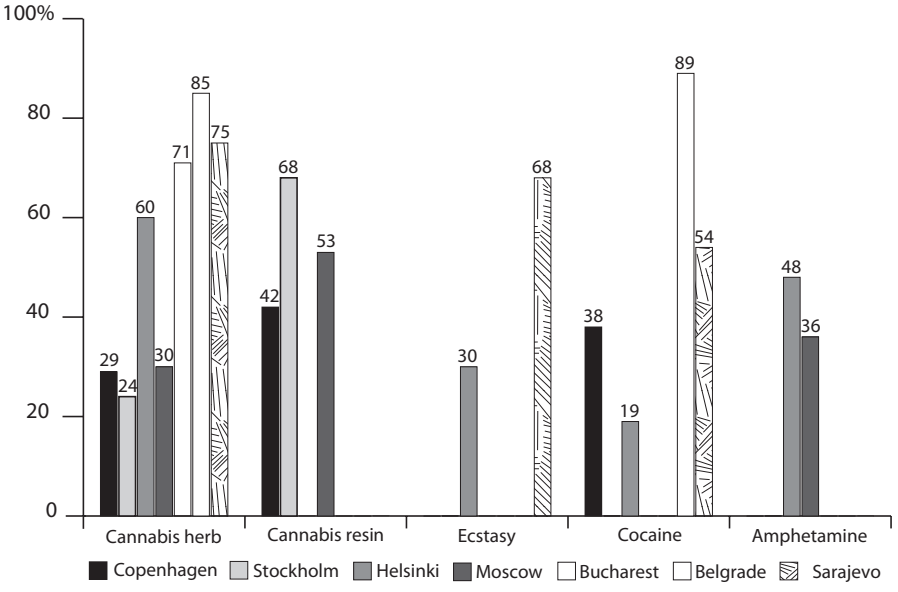


Figure 1b: Market/dealer as source of drugs among socially integrated users, in percentages



Marginalised drug users are mainly supplied by professional dealers

Marginalised drug users are mainly supplied by professional dealers, especially with heroin, cocaine and amphetamine, but also with cannabis herb and resin. Though private networks still are of importance for the supply in Nordic cities all marginalised drug users seemed to depend on professional dealers selling without any liability and at high prices commodities of dubious and sometimes health-damaging quality.

Figure 2a: Friends as source of drugs among marginalized drug users, in percentages

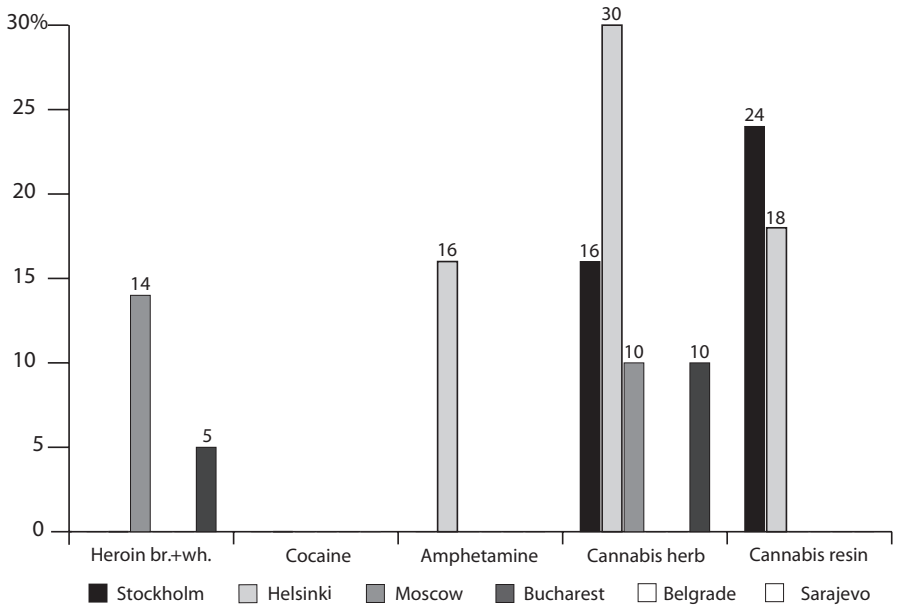
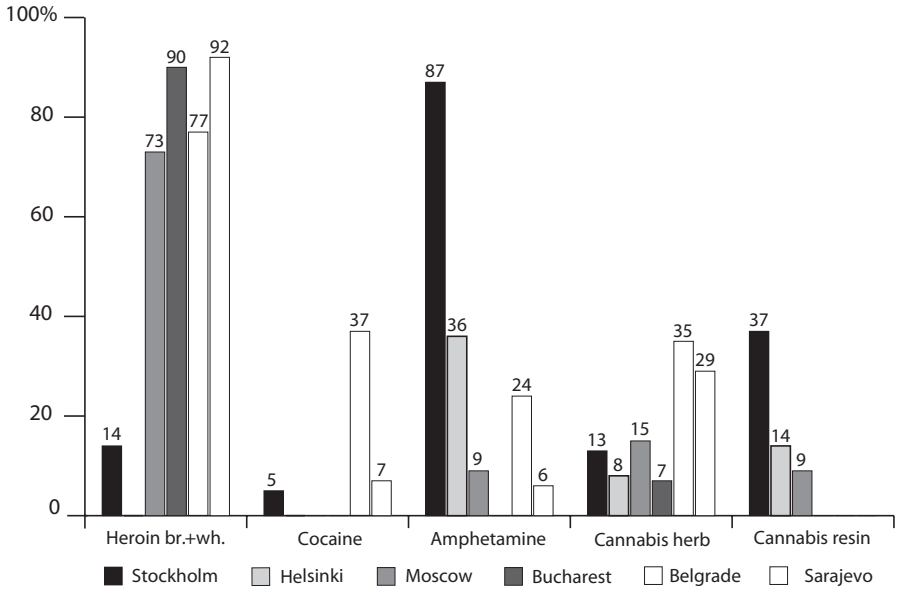


Figure 2b: Market/dealer as source of drugs among marginalised drug users, in percentages



In regard to substances heroin was the drug almost exclusively retailed by professional dealers

In regard to substances heroin was the drug almost exclusively retailed by professional dealers, who seldom use the drug themselves. The retail of amphetamine and methamphetamine did not substantially differ from that of heroin, only cannabis was mainly dispersed by private networks. In other words: illicit drug markets realise their interests mainly with the most controlled and most expensive substances, whose high dependency potential would be much better guarded by private retail networks liable to consumers at risk.

3 Purity and quality remained unknown

To come to the point: Assessment of purity did not only fail with the interviews with key persons in the framework of the city reports – among them experts from forensic laboratories for drug analysis –, also drug users did not provide for the respective information. Marginalised drug users who – because of their higher consumption risks – had been expected to be more knowledgeable than socially integrated users, were hardly better informed. The lacking information on purity restricted the calculation of monthly consumed amounts and monthly expenditures on street drugs of varying quality. This restriction is to be considered as a serious deficit in the assessment of quantitative parameters of drug consumption.

Drug users and interviewers were overstrained alike with the question on purity. Interviewers in Stockholm and Bucharest in their efforts to reduce the failure replaced the question on percentages by its predecessor – the rating on low/medium/high purity. But since they did not communicate their strategy in time it could not be adopted by the teams of the other cities.

Table 1 shows the responses to the “purity questions” by marginalised drug users. The response rate was very low in four cities but astonishingly high in Belgrade and Moscow. Also astonishingly high were the estimates in Moscow, even more so if the estimates of the expert are considered that were among the lowest for all drugs except ecstasy – e.g. 5 to 7% for brown street heroin and 0 to 12% for brown heroin bought at wholesale parties (see City Report).

Compared to the figures on mean purity at retail for 2011 published by EMCDDA and Europol in their second report on drug markets (2016) the estimates of the Russian marginalised users more or less precisely coincided with the upper limits of variation whereas the estimates of the Serbian respondents closely followed the lower limits which were as follows: brown heroin 6 to 44%, cocaine 22 to 60%, amphetamine 5 to 30%, cannabis herb “potency 1” 16%, cannabis resin “potency 4” 16%. One forensic expert provided lower estimates: He thought that the purity of all street drugs had dropped to close to zero. The few estimates presented in Table 1 were finally considered to be artefacts of the

special interview setting in the two sites. All in all it is to be concluded that users are not a sound source of information on purity and quality of substances and that they are more to be considered as target if not prey of adulteration and defraud endangering their life.

Table 1: Estimated purity of drugs consumed last time, marginalized drug users, mean, number of respondents in parentheses

	SH	HS	MC	BR	BG	SJ
Heroin, brown	-	.	43,3 (N=27)	-	11,8 (N=80)	8,0 (N=68)
Heroin, white	-	-	64,1 (N=41)	-	-	-
Cocaine	-	-	-	-	27,5 (N=38)	-
Amphetamine	-	39,5 (N=44)	80,0 (N=10)	-	11,8 (N=20)	-
Cannabis herb	-	-	79,9 (N=25)	-	35,7 (N=34)	-
Cannabis resin	-	36,9 (N=14)	-	-	-	-

4 Amounts consumed per occasion and per month

Table 2 shows the average amounts of selected drugs taken at a typical occasion by socially integrated drug users, Table 3 follows with the calculation of the average amounts taken during the last month by the same group. Also with these calculations caution is advisable: As other consumers, drug users have problems to recall their drug use – that of one month ago more than the "last" one. And as (more than?) consumers of other commodities drug users are inclined to over- and underestimate (exaggerate and hide?) amounts.

The data collected nevertheless did not lack plausibility and correspond to the data discussed in former chapters: Ranked for large amounts of substances taken per occasion and during the last months cities as different as Sarajevo and Copenhagen were "cannabis places" (Copenhagen presumably qualified with support of its especially recruited sample), Sarajevo and Moscow "centres of stimulant use" and Bucharest the "ecstasy capital". Belgrade where all drugs were taken in remarkable amounts, had to be labelled as "city of multi-drug use" and Stockholm and Helsinki as "low amount sites".

Table 2: Average amounts taken "at a drug-using day", socially integrated drug users, in gram, means, number of respondents in parentheses

	CH	SH	HS	MC	BR	BG	SJ
Cannabis herb	1,5 (N=80)	1,0 (N=5)	0,6 (N=96)	O,8 (N=48)	0,8 N=89)	0,4 (N=68)	1,8 (N=24)
Cannabis resin	1,9 (N=59)	-	0,5 (N=11)	0,5 (N=83)	-	-	-
Ecstasy pills		1,4 (N=7)	1,4 (N=16)		2,1 (N=16)	1,6 (N=13)	1,7 (N=23)
Cocaine	0,9 (N=21)		0,3 (N=20)	4,6 (N=8)	-	1,6 (N=27)	2 (N≠45)
Amphet-amine	-		0,5 (N=21)	0,6 (N=15)	-	0,9 (N=43)	1,9 (N=33)

Table 3: Average amounts taken in last month, socially integrated drug users, in gram, means

	CH	SH	HS	MC	BR	BG	SJ
Cannabis herb	12,6 (N=75)	7,4 (N=5)	13,0 (N=96)	12,7 (N=48)	5,7 (N=89)	6,1 (N=68)	28,6 (N=22)
Cannabis resin	18,3 (N= 58)	-	3,3 (N=11)	10,3 (N=82)	-	-	-
Ecstasy pills	-	1,9 (N=7)	3,8 (N=16)	-	6.8 (N=16)	4,1 (N=13)	4,8 (N=9)
Cocaine	1,4 (N=21)	-	0,9 (N=96)	8,8 (N=8)	-	6,4 (N=27)	19,3 (N=41)
Amphet-amine	-	-	3,0 (N=21)	3,9 (N=15)	-	4,3 (N=43)	16,2 (N=21)

Marginalised consumers used larger amounts than socially integrated users

A first comparison of the two samples of users confirms what was to be expected: marginalised consumers used larger amounts than socially integrated users, especially of widely-spread substances such as cannabis herb and amphetamines.

Besides that, in correspondence to drug preferences, Moscow and Belgrade were the cities where marginalized drug users consumed the largest amounts of brown and/or white heroin per occasion and per month. The largest amounts of cocaine were taken in Bucharest and though amphetamine use was most spread in Stockholm, the largest amounts were taken in Sarajevo. Sarajevo was also the city where the marginalised drug users consumed the highest amounts of cannabis herb, whereas the largest amounts of cannabis resin were used in Stockholm.

Two findings were of special interest: in Sarajevo both drug user groups stood out for amounts of cannabis and amphetamine consumed per occasion and per month, but heroin as taken by almost all marginalised users was consumed in smaller doses per occasion and per month than for instance in neighbouring

Belgrade. The outstanding amounts of heroin consumed in Belgrade contradict assumptions on extraordinary high quality of opiates in the drug trade area on the Balkan but support associations with the extended substitution programme in Bosnia-Herzegovina.

Outstanding amounts of heroin are not only consumed by marginalised drug users in Belgrade but also in Moscow

Outstanding amounts of heroin are not only consumed by marginalised drug users in Belgrade but also in Moscow – a finding that in combination with the responses on purity presented in Table 1 supports images of an either exaggerating "heroic" or an "escapist" subculture of marginalised drug users.

Table 4: Average amounts taken "at a drug-using day", marginalised drug users, in gram, means, number of respondents in parentheses

	SH	HS	MC	BR	BG	SJ
Heroin, brown	0,6 (N=8)	-	1,5 (N=31)	1,0 (N=97)	2,0 (N=80)	0,8 (N=80)
Heroin, white	0,6 (N=9)	-	0,8 (N=56)	-	1,0 (N=5)	-
Cocaine	1,3 (N=6)	-	-	2,0 (N=7)	2,0 (N=41)	1,8 (N=7)
Amphetamine	1,6 (N=91)	1,2 (N=56)	1,1 (N=9)	1,3 (N=8)	1,2 (N=27)	2,0 (N=5)
Cannabis herb	1,7 (N=9)	1,4 (N=50)	2,5 (N=25)	-	0,5 (N=21)	3,1 (N=6)
Cannabis resin	1,6 (N=48)	1,3 (N=42)	1,0 (N=9)	-	-	-

Table 5: Average amounts taken in last month, marginalised drug users, in gram, means, number of respondents in parentheses

	SH	HS	MC	BR	BG	SJ
Heroin brown	1,3 (N=8)	-	44,2 (N=31)	22,2 (N=96)	49,7 (N=80)	17,6 (N=80)
Heroin white	8,3 (N=9)	-	13,6 (N=56)	-	4,0 (N=5)	-
Cocaine	2,5 (N=6)	-	-	20,4 (N=6)	11,5 (N=41)	12,4 (N=7)
Amphetamine/ Methamphe-tamine	22,1 (N=91)	14,3 (N=56)	7,9 (N=9)	-	8,6 (1,4)	31,8 (N=5)
Cannabis herb	12,2 (N=8)	12,2 (N=50)	26,5 (N=25)	10,2 (N=8)	4,4 (N=21)	36,8 (N=5)
Cannabis resin	20,9 (N=48)	13,6 (N=42)	6,2 (N=9)	-	-	-

5 Drug prices vary

Tables 6 and 7 show the average price in Euro paid for selected drugs per gram by socially integrated and by marginalized drug users at their last purchase. To commemorate: Calculation of average prices was preceded by conversion of local units and weights and local currencies into grams and Euros. And since purity remained unknown, the calculation only considers street drugs.

Drug prices varied among categories of substances and among cities but not among groups of consumers

Drug prices varied among categories of substances and among cities but not among groups of consumers, a finding that supports the reliability of the responses. In regard to substance groups, the prices paid for the stimulants cocaine and amphetamine did neither differ remarkably among consumer groups nor among the cities: Cocaine, which in all sites was far more expensive than amphetamine, could be purchased at about 57 Euro per gram in Sarajevo and about 70 Euro in Stockholm. The amount of Euro for 1 gram cocaine was about the same in all cities, but the value of the Euro differed. Considering the living costs, cocaine thus was cheaper in the Nordic cities than in the cities on the Balkan route. The price of amphetamine, which everywhere was cheaper than cocaine but especially in the cities at the Balkan, was somewhat more sensitive to living costs.

The price of widely-taken cannabis and hardly-consumed and obviously out-fashioned ecstasy – both substances that had been favoured by the youth movement of the 1960s – was even more in accordance with local living costs. Both drugs were cheapest in Sarajevo and Belgrade: In Sarajevo socially integrated drug users bought one gram of cannabis herb for 5 Euro, in Moscow they spent about four times as much; marginalised users reported prices between 3,2 Euro per gram cannabis herb in Belgrade and 14,3 Euro in Bucharest. The differences were visible but modest, presumably due to the well-established and diversified Marihuana market, mostly supplied by European production (EMCDDA, 2013; 2016).

With white and brown heroin prices varied most

With white and brown heroin – the substances with the highest addition potential and mostly consumed by outsiders – prices varied most: In Belgrade and Sarajevo marginalised users paid about 20 Euro for 1 gram of brown heroin but they paid two times as much in Bucharest and Moscow and at least ten times as much in Stockholm. Heroin thus was the drug with the price most closely matching living costs, but “purchase equality” was not reached also in this case: Marginalised drug users in the Nordic cities preferred amphetamine, which in Helsinki and Stockholm had about the same price as heroin in Belgrade and Sarajevo. In other words: Drug prices favour drug users living in welfare states and their substance preferences. Or should it be: the price structure of drugs favours drug consumption in the capitals of welfare states?

Table 6: Average prices per gram/pill paid for last consumption, socially integrated drug users, means, number of respondents in parentheses

	CH	SH	HS	MC	BR	BG	SJ
Cannabis herb	8,3 (N=28)	14,5 (N=22)	12,8 (N=32)	18,8 (N=18)	12,6 (N=64)	5,5 (N=83)	5,1 N=15)
Cannabis resin	7,7 (N=30)	-	-	15,2 (N=52)	-	-	-
Ecstasy, pills	-	-	11,9 (N=11)	-	12,2 (N=12)	2,3 (N=12)	6,6 (N=19)
Cocaine	49,4 (N=11)	-	-	-	-	62,8 (N=27)	56,7 (N=21)
Amphet-amine	-	-	31 (N=10)	-	-	9,7 (N=43)	8,6 (N=14)

Table 7: Average prices per gram/pill paid for last consumption, marginalised drug users, means, number of respondents in parentheses

	SH	HS	MC	BR	BG	SJ
Heroin, brown	146,2 (N=8)	-	41,9 (N=31)	37,3 (N=94)	21,5 (N=79)	20,8 (N=76)
Heroin, white	190,5 (N=6)	-	30,4 (N=42)	-	44,7 (N=5)	-
Cocaine	70, 0 (N=5)	-	-	-	61,3 (N=40)	60,3 (N=7)
Amphetamine	20,4 (N=89)	27,8 (N=36)	28.5 (N=6)	-	10,4 (N=27)	11,3 (N=5)
Cannabis herb	-	11,0 (N=8)	7,2 (N=14)	14,3 (N=7)	3,2 (N=36)	-
Cannabis resin	-	8,7 (N=14)	13,8 (N=10)	-	-	-

The prices presented in Tables 6 and 7 confirm the prices published by the EMCDDA and Europol for 2011 and vice versa: They mostly neither surmounted upper limits of the estimates of the Monitoring Centre and the European police organisation nor did they fall below (brown heroin: 24-134€/g, cocaine 50-98€/g, amphetamine 8-28€/g, cannabis herb 5-24€/g, cannabis resin 3-18€/g; EMCDDA, 2013).

6 Two measures of monthly expenditures

Monthly expenditures were estimated by drug price, amount of the drug taken at a "typical consumption day" and by monthly frequency of consumption on individual level. "Objective" calculation of expenditures was confronted with a "subjective" summary estimate of the user on last month's expenditures for drugs. Tables 8 and 9 present objective and subjective estimates for socially integrated and for marginalised consumers.

Table 8 presents the objectively estimated monthly expenditures for the substances of interest of socially integrated drug users. The estimates mostly rely on the small number of interviewees who responded to all relevant questions and they were respectively fragile. The objective calculation of monthly expenditures varied stronger than subjective estimates and exceeded them remarkably: Calculations on monthly expenditures probably overestimated "extra" acquisitions.

Outstanding amounts of heroin are not only consumed by marginalised drug users in Belgrade but also in Moscow

The picture becomes more consistent with marginalised users and higher response rates and the data more closely correspond to the data on prices and amounts. Expenditures of marginalised drug users in Belgrade – where the largest amounts of cheapest heroin were consumed – are only half of those of the marginalised users in Moscow, where similar amounts of remarkably more expensive heroin were taken. The monthly expenditures on heroin in Stockholm approached the Russian peak though the Swedes only consumed less than one fifth of the average amounts used in Moscow.

Table 9 also shows the limited impact of prices on heroin consumption in sites with extended substitution programmes. In Sarajevo and Bucharest heroin use including concomitant use of heroin was widely spread but comparatively low average amounts of heroin were used. Thus, consumption was similar but prices were not the same: the expenditures of heroin users in Bucharest were more than two times higher.

Objective calculations and subjective estimates of expenditures were roughly consistent and supported each other

Objective calculations and subjective estimates of expenditures were roughly consistent and supported each other. With the exception of Moscow, accordance was even higher when only preferred drugs were considered – such as cannabis herb among socially integrated users, heroin and amphetamine among marginalised users – and in poorer settings – e.g. in Sarajevo. The less realistic estimates of socially integrated users had to do with the prevalence of sharing.

Table 8: Average expenditures for last month consumption, objective calculation and *subjective estimate*, socially integrated drug users, in Euro, means, number of respondents in parentheses

	CH	SH	HS	MC	BR	BG	SJ
Cannabis herb	39,4 (N=24)	119,0 (N=5)	160,0 (N=96)	198,9 (N=17)	81,2 (N=64)	33,6 (N=67)	162,7 (N=13)
Cannabis resin	177,7 (N=28)	-	-	148,9 (N=50)	-	-	-
Ecstasy pills	-	-	69,8 (N=16)	-	85,4 (N=16)	50,1 (N=13)	29,8 (N=9)
Cocaine	88,6 (N=10)	-	-	-	-	415,6 (N=26)	777,0 (N=19)
Ampheta-mine	-	-	135,4 (N=10)	-	-	40,9 (N=13)	77,1 (N=12)
Subjective estimate	32,4 (N=102)	64,9 (N=48)	85,4 (N=100)	143,9 (N=106)	99,8 (N=88)	106,1 (N=112)	229,5 (N=61)

Table 9: Average expenditures for last month consumption, objective calculation and *subjective estimate*, marginalised drug users, in Euro, means, number of respondents in parentheses

	SH	HS	MC	BR	BG	SJ
Heroin, brown	229,4 (N=7)	-	1853,8 (N=31)	847,1 (N=94)	951,5 (N=79)	330,8 (N=75)
Heroin, white	1486,8 (N=6)	-	515,9 (N=42)	-	-	-
Cocaine	216,8 (N=5)	-	-	-	684,8 (N=40)	655,8 (N=7)
Amphetamine	448,2 (N=89)	459,3 (N=36)	254,7 (N=5)	-	82,7 (N=27)	-
Cannabis herb	-	98,4 (N=18)	175,8 (N=14)	168,1 (N=7)	11,8 (N=22)	-
Cannabis resin	-	102,0 (N=23)	85,5 (N=9)	-	-	-
Subjective estimate	451,6 (N=96)	510,7 (N=100)	771,6 (N=92)	875,9 (N=75)	838,9 (N=100)	359,8 (N=95)

7 Summary

The cities investigated in the course of the Second Multi-City Study can be combined into three groups

The cities investigated in the course of the Second Multi-City Study can be combined into three groups according to their socio-political background and drug policy considered in Part 1 and their consumption patterns presented in Part 2.

Capitals of extended welfare states

(1) The "Nordic cities" of Stockholm, Helsinki and Copenhagen are capitals of extended welfare states and Member States of the EU since many years. Stockholm and Helsinki were cities with strict drug regimes but also with extended drug services including substitution treatment. Copenhagen only at the turn of the millennium adopted strict drug controls, though it retained the harm-reduction measures established by the tolerant drug regulations before 2004 including an extended substitution programme. The Nordic cities are well supplied with cannabis herb and amphetamines produced in Europe and with cannabis resin from North Africa – the main drugs of the socially integrated as well as of the marginalised drug users and mostly retailed by private networks. The Nordic cities are on the verge of a professional heroin market and of professional heroin trade (EMCDDA, 2016), which among other things kept drug consumption patterns at low risk and expenditures on a moderate level. Drug use of socially integrated as well as marginalised drug users was characterised by a restricted drug menu and by low doses of intake.

Capitals of countries in transition from planned to market economy

Bucharest and Sarajevo are the capitals of countries in transition from planned to market economy. Transition is supported by the European Union and support among other things requests the adoption of EU drug policy aims, targets and strategies by national drug regimes. Accordingly, a substitution programme was built up in both cities, which was quickly extended and at the time of the study covered a higher percentage of drug users than in the Nordic cities. Cost-effective low-threshold substitution treatment became the drug strategy of choice, because of especially deprived problem drug users on the one hand and because of the poor resources of the states of Romania and Bosnia-Herzegovina on the other hand. Both cities differ in one main drug-related aspect: Sarajevo is close to the main European heroin traffic route and the main European cannabis production, Bucharest is not.

Retail of drugs nevertheless had a similar structure: Peer networks were of subordinated relevance, criminal networks, however, strong and in a position to prevent non-profit ventures. Consumption patterns were similar: both user groups were moderate poly-drug users, integrated users concentrated on cannabis herb but occasionally took stimulants, marginalised users favoured brown heroin only or in combination with the main substitution substance methadone; frequency of consumption was moderate to high, amounts were large. Harm reduction measures of the EU obviously contributed to the development of similar consumption patterns in both cities. But also the impact of the illegal

market was not to be overlooked, which affected Sarajevo more than Bucharest: Intensity of consumption (amounts consumed, frequency and diversity of substances) was higher in Sarajevo than in Bucharest and in some aspects made the city comparable to Belgrade and Moscow, the cities with the most risky consumption patterns of the study.

Capitals of countries with a strong regulative state

Belgrade and Moscow are capitals of countries with an imperial communist past and, at present, a strong regulative state that intervenes in economy and society and guards traditions. Drug treatment is a fine example of such a state policy: Drug controls in both cities are strict and drug treatment remained a special high-threshold branch of the medical-psychiatric sector. It was hardly extended and diversified and it stuck to abstinence orientation and only exceptionally adopted harm reduction as goal of a cure. At the time of the fieldwork for the study substitution was still prohibited in Moscow, in Belgrade it had been established as minor high-threshold service. Drug treatment originally was tailored for socially integrated drug addicts that are still represented among its patients. But problem use also developed in less privileged social settings and the resistance against treatment reform thus became resistance to acknowledge user groups that additionally suffer of severe infections.

Retail, consumption and expenditures in Moscow and Belgrade shared their main features and differed in others. Consumption patterns in both cities stood out for highest amounts consumed per occasion and highest expenditures, indicating high-risk consumption patterns, possibly developed on the basis of national traditions which had been better preserved than in the other cities investigated. Consumption patterns differed in regard to retail and to the drug menu. Retail for integrated drug users for substances other than heroin was mainly organised within the private sphere in Moscow, in Belgrade supply was controlled by professional dealers. Consumption in Moscow was mainly “restricted multi-drug use”: consumption of a main substance – of cannabis resin by integrated drug users and of white heroin by marginalised users – and occasional use of one additional drug – of amphetamine by both samples. In Belgrade multi-drug use of both groups of drug users had more enfolded than elsewhere. In regard to highest amounts and highest expenditures, Sarajevo joined the competition of Belgrade and Moscow proving that nearby drug production and nearby drug trade routes are important ingredients for the development of highest-risk consumption patterns but that there are also additional drivers.

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PART 3

Estimates

Ricardo Rodrigues

Estimates

Ricardo Rodrigues

1 Introduction

The present study covers drug consumption and expenditure in seven European cities mainly clustered around Northern and Central and Eastern European countries: Belgrade, Bucharest, Copenhagen, Helsinki, Moscow, Sarajevo and Stockholm. As it became apparent in the previous chapters, these cities reflect not only a wide variety of geographical locations, but also of drug policies and drug consumption patterns. This chapter aims to draw some further insights into the estimated dimension of drug markets.

The estimation of illegal consumption such as of drugs presents a number of challenges. Its estimation through the use of representative samples is difficult for the illegal nature of the consumption makes it challenging to know beforehand what a representative sample of drug consumers might be and to then gather that representative sample, as drug users represent "hidden populations" (Eisenbach-Stangl, 2007). Other important parameters such as purity of drugs used are also likely to not only vary considerably, for example, in accordance with different distribution channels, but also to be subject to high measurement errors.

The present chapter provides an estimation of drug use and expenditure between the cities covered in this study that is based on a methodology that aims to improve the precision of the estimates and that was used previously in a similar study (Stanciole, 2009). The use of post-stratification weights has the potential to reduce bias and increase precision in these cases. The present chapter is organised as follows: the following section describes the data sources while the third section provides a brief explanation of the methodology used, i.e. of the post-stratification weighting. Section 4 presents the resulting estimates for both monthly drug consumption and expenditures. Section 5 presents some policy-oriented conclusions.

The use of post-stratification weights has the potential to reduce bias and increase precision

2 Data

A survey questionnaire was conducted among two different populations of drug users in each city, to draw patterns of consumption and expenditure on illegal drugs. Chiefly among these were: brown heroin, cocaine, amphetamines, cannabis herb and resin and ecstasy. The two different kinds of drug users surveyed were denominated "marginalised" and "socially integrated" drug users. Table 1 provides descriptive statistics for the two samples in each city.

Table 1: Descriptive statistics for integrated and marginalised drug users, in percentages

	Marginalised drug users						
	Belgrade[a]	**Bucharest[b]**	**Copenhagen**	**Helsinki**	**Moscow**	**Sarajevo**	**Stockholm[c]**
Gender	N=100	N=101	NA		N=100	N=100	N=100
Male	72.0	79.2	NA	71.0	81.0	94.0	86.0
Female	28.0	20.8	NA	29.0	19.0	6.0	14.0
Age groups							
<20 years	5.0	4.0	NA	2.0	6.1	2.0	
20-35 years	24.0	90.1	NA	84.0	83.7	80.0	9.0
36-50 years	38.0	5.0	NA	14.0	9.2	18.0	53.0
>50 years	26.0	1.0	NA		1.0		38.0
	7.0		NA				
	Socially integrated drug users						
	Belgrade[a]	**Bucharest[b]**	**Copenhagen**	**Helsinki**	**Moscow**	**Sarajevo**	**Stockholm[c]**
Gender	N=113	N=100	N=198	N=102	N=114	N=112	N=48
Male	64.6	67.0	68.2	71.6	71.1	67.9	70.8
Female	35.4	33.0	31.8	28.4	28.9	32.1	29.2
Age groups							
<20 years	23.9	9.0	11.9	1.0	6.1	14.3	
20-35 years	56.6	91.0	82.5	89.2	77.2	79.5	85.4
36-50 years	19.5		4.1	9.8	16.7	6.3	10.4
>50 years			1.5				4.2

Notes: (a) age groups are <20, 20-24, 25-29, 30-39, >39; (b) 95% Confidence interval; (c) Data for Sweden. Age groups 35-49; >49. Overall sample is small.

The post-stratification weights were devised on the basis of estimates of the prevalence of drug use for the two profiles of consumption per age group and gender in each city, as shown in Table 2. This information was based on estimates from the national partners and experts and additional sources of information. Although the composition of city samples had partially been deter-

mined by available information on the profile of drug users by gender and age, it was not always possible to fully adhere to that profile during the interview process.

Table 2: Strata sizes used for the post-stratification weights, in percentages

Marginalised drug users						
	Belgrade[a]	**Bucharest[b]**	**Copenhagen**	**Moscow**	**Sarajevo**	**Stockholm[c]**
Gender distribution						
Male	80	66,3	68	80	90	77
Female	20	33,7	32	20	10	23
Age distribution						
<20 years	6,9	8,6	10	5	5	3,1
20-35 years	14,1	78,7	45	57	70	46
36-50 years	33,4	11,9	35	35	25	46,3
>50 years	37,4	0,8	10	3	0	4,6
	8,2					
Socially integrated drug users						
	Belgrade[a]	**Bucharest[b]**	**Copenhagen**	**Moscow**	**Sarajevo**	**Stockholm[c]**
Gender distribution						
Male	NA					
Female	NA					
Age distribution						
<20 years	NA					
20-35 years	NA					
36-50 years	NA					
>50 years	NA					

Notes: (a) age groups are <20, 20-24, 25-29, 30-39, >39; (b) 95% Confidence interval; (c) Data for Sweden. Age groups 35-49; >49. Overall sample is small. No data available for Helsinki for either sample.

3 Methods

Due to the selection process of the interviewees, the distribution of important characteristics such as age or gender of a sample may deviate from the estimated distribution of the population, in this case drug users. Information on age and gender of individuals was only available after the interviews were conducted. Given the "hidden nature" of the population under study, methods such as snowballing had to be used to reach potential interviewees, which could have

limited the ability to fully adhere to the representative profile of users. Under these circumstances, applying post-stratification weights allows for the correction of bias and increases accuracy for it is then possible to calculate a weighted average which "essentially reproduces the population mean aside from effects of grouping" (Little, 1993: 1001).

Following Little (1993), for the purpose of the post-stratification estimation carried out in the context of this study, the sample mean is calculated using the following formula:

$$\bar{x}_{ps} = \sum_{h=1}^{H} P_h \bar{x}_h = \frac{1}{r} \sum_{i=1}^{r} w_i x_i$$

where x_i is the value of the variable X for a given i respondent and w_i is the specific weight to be applied. The weight w_i is given by $w_i = rP_h/r_h$, where r stands for the sample size of interviewees, r_h is the number of interviewees in strata h and P_h is the population proportion taken from the estimates shown in Table 2.

4 Results

4.1 Estimated monthly consumption of drugs

The estimated monthly consumption for specific drugs is taken based on information provided by interviewed drug users on their consumption on a typical day and information on how many days they have consumed a particular drug in the previous month.

The different consumption patterns across cities are evident from Table 2, not only in terms of quantities but also from the absent drugs in some of the cities.*

There are some significant changes resulting from the use of post-stratification weights among the marginalised drug users

There are some significant changes resulting from the use of post-stratification weights among the marginalised drug users. Post-stratification estimates for Moscow are lower, as a result of correcting for the different drug consumption patterns of the relatively younger drug users sample. In Stockholm estimates for the consumption of amphetamines are significantly lower and cannabis resin mean consumption is 50% higher after applying post-stratification weights and this becomes the illegal drug with the highest average monthly consumption – a result only evident after the post-stratification. Weighted results also clearly confirm that consumption of brown heroin is clearly the highest in Belgrade.

Among socially integrated drug users the greatest changes brought by the use of post-stratification weights are observed in the consumption of the different types of cannabis. Monthly consumption of cannabis herb is by far highest

* Results based on less than 10 observations were excluded.

in Sarajevo and after applying post-stratification weights, the consumption is higher in Moscow than in Copenhagen. As for cannabis resin, consumption is the highest in Copenhagen and almost doubles after applying post-stratification weights.

Table 3: Shows the results estimated per capita drug consumption (in grams)

	Belgrade[a]		Bucharest[b]		Copenhagen		Moscow		Sarajevo		Stockholm[c]	
	Sam-ple	PS*** mean	Sam-ple	PS*** mean	Sam-ple	PS*** mean	Sam-ple	PS*** mean	Sam-ple	PS*** mean	Sam-ple	PS*** mean
Marginalised drug users												
Brown heroin	49,7	52,9	22,3	23,0	NA	NA	44,2	38,1	17,6	17,9	NA	NA
Cocaine	11,5	12,1	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Amphe-tamines	8.6*	8.1*	NA	NA	NA	NA	NA	NA	NA	NA	22,1	17,2
Cannabis herb	4.4*	4.0*	NA	NA	NA	NA	26.3*	22.2*	NA	NA	NA	NA
Cannabis resin	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	20,9	30,9
Ecstasy	3.5**	3.2**	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Socially integrated drug users												
Brown heroin	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cocaine	NA	NA	NA	NA	1.4*	1.6*	NA	NA	19,3	17,6	NA	NA
Amphe-tamines	NA	NA	NA	NA	NA	NA	3.9*	3.6*	16.2*	15.1*	NA	NA
Cannabis herb	NA	NA	5,7	5,6	12,6	8,4	12,7	9,8	28.6*	32.6*	NA	NA
Cannabis resin	NA	NA	NA	NA	18,3	33,4	10,3	8,6	NA	NA	NA	NA
Ecstasy	NA	NA	6.8*	7.2*	NA	NA	NA	NA	NA	NA	NA	NA

Notes: (a) age groups are <20, 20-24, 25-29, 30-39, >39; (b) 95% Confidence interval; (c) Data for Sweden. Age groups 35-49; >49.
* Less than 30 observations; ** Less than 15 but more than 9 observations; *** Post-stratified mean.

4.2 Estimated monthly expenditure on drugs

Table 4 provides the estimates for per capita monthly expenditure on different drugs, in Euro. After weighting, the monthly expenditure on brown heroin among marginalised drug users increases in Belgrade, Bucharest and Sarajevo and although the weighted mean expenditure decreases in Moscow, amounts spent on average there on brown heroin are still significantly higher than in the other cities. On the contrary, monthly expenditure in cannabis herb by marginalised drug users increases substantially in Moscow, albeit based on a relatively

low number of observations. In Stockholm, per capita expenditure on amphetamines and cannabis resin are substantially closer after the post-stratification weights.

As for socially integrated users, the post-stratification average monthly expenditures present some differences in comparison with the sample averages. Most notably, monthly expenditure with cannabis herb would be the highest in Sarajevo, rather than Moscow – albeit figures for Sarajevo should be taken with caution due to an extremely reduced number of observations. Similarly, monthly expenditures in Copenhagen for cannabis resin are much higher after applying post-stratification weights. The only possible comparison that one might draw between samples within the same city is for Moscow for cannabis resin. Although the sample means indicate that expenditure on this substance is higher among socially integrated users, the post-stratification results actually show the opposite.

Table 4: Estimated per capita monthly expenditure (in Euro)

	Belgrade[a]		**Bucharest[b]**		**Copenhagen**		**Moscow**		**Sarajevo**		**Stockholm[c]**	
	Sample	PS*** mean	Sample	PS*** mean	Sample	PS*** mean	Sample	PS*** mean	Sample	PS*** mean	Sample	PS*** mean
Marginalised drug users												
Brown heroin	951,51	990,15	847,14	874,30	NA	NA	1853,79	1599,20	330,82	345,96	NA	NA
Cocaine	684,79	675,71	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Amphetamines	82.78*	74.78*	NA	NA	NA	NA	NA	NA	NA	NA	443,2	371,24
Cannabis herb	11.79*	10.47*	NA	NA	NA	NA	175.82*	231.77*	NA	NA	NA	NA
Cannabis resin			NA	NA	NA	NA	NA	NA	NA	NA	213,2	319,43
Ecstasy	11.04**	9.95**	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Socially integrated drug users												
Brown heroin	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Cocaine	NA	NA	NA	NA	88.58**	82.64**	NA	NA	776.99*	877.14*	NA	NA
Amphetamines	NA	NA	NA	NA	NA	NA	NA	NA	77.08**	80.90**	NA	NA
Cannabis herb	NA	NA	81,21	79,27	39.43*	33.43*	198.89*	115.68*	162.73**	184.34**	NA	NA
Cannabis resin	NA	NA	NA	NA	177.71*	232.43*	148,87	132,96	NA	NA	NA	NA
Ecstasy	NA	NA	85.4**	87.75**	NA	NA	NA	NA	NA	NA	NA	NA

Notes: (a) age groups are <20, 20-24, 25-29, 30-39, >39; (b) 95% Confidence interval;(c) Data for Sweden. Age groups 35-49; >49.
* Less than 30 observations; ** Less than 15 but more than 9 observations; *** Post-stratified mean.

5 Discussion

The results presented here do not contradict the existence of marked differences in the patterns of consumption and expenditure between the cities included in this study

The results presented here do not contradict the existence of marked differences in the patterns of consumption and expenditure between the cities included in this study. The application of the post-stratification weights shows that for Moscow the sample of users, both integrated and marginalised, is likely to be composed of relatively above average users of drugs – which could account for the apparent upward bias of the sample means for both consumption and expenditure. For other cities the pattern is however less clear.

More than anything, applying the post-stratification weights presented here does not claim to present the real picture of drug consumption and expenditure as recognised in previous studies (Stanciole, 2009); the accuracy of this methodology hinges critically on the size of the strata weights and assumptions about the distribution of the population, in this case across age groups and gender. This is therefore rather a further contribution to the discussion of drug consumption and expenditure patterns in the surveyed cities.

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PART 4

Drug Cultures

Irmgard Eisenbach-Stangl / Stephan Quensel /
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Drug Use and Drug Cultures

Irmgard Eisenbach-Stangl

Difficulties of research in this field have been repeatedly highlighted throughout the report

The Second Multi-City Study aimed at the assessment of quantitative (economic) parameters of drug consumption: at amounts of drugs consumed on individual level and at respective expenditures. Difficulties of research in this field have been repeatedly highlighted throughout the report. And indeed, the Second Multi-City Study suffers of several shortcomings, most prominent among them the effectless efforts to assess purity systematically. But despite all shortcomings the study succeeded in broadening knowledge on consumption and purchase patterns, and brought about relevant insights in interrelations between aspects of consumption patterns and components of settings. Last but not least: By the extended efforts to refine and extent data collection the study touched the limits of predefined methods and design and opened the view to approaches better suited to investigate the field in question.

Reflection on shortcomings of research increases knowledge on the subject

Reflection on shortcomings of research increases knowledge on the subject and inspires the search for innovative alternatives. This opportunity should not be missed. The first issue taken up for discussion is the assessment of purity. Assessment at first sight failed because of a misinformed choice of informants: Experts as well as drug users refused the interview or the response or were not knowledgeable. The second sight reveals the unrealistic expectations carrying the research design. How and where should systematic knowledge on the quality of goods develop, which are prohibited and prosecuted and by definition got excluded from consumer rights and quality controls? Also the methods chosen are to be submitted to reflection: Thus the questions might have been inadequate or inadequately formulated. And indeed, the meaning of the information requested never was seriously considered. In the case of experts purity might be a professionally delicate issue, in the case of drug users an issue of subcultural status or money. But since purity in both cases is a prominent issue of everyday life and an indicator for skills, the inability to respond adequately could have touched honour and pride. And if (professional) identity is at stake, refusals might not be the optimal protection but at least effective.

The second shortcoming chosen for reflection concerns the assessment of the amounts of drugs consumed. It at first sight also deals with “the set”, that is the drug users. But at second sight, again, the method is to blame. The refinement and extension of the questionnaire in regard to the assessment of amounts intensified its repetitive character, overburdened the respondent with

details and thus provoked bad and missing responses. Interviews are better suited to deal with generic human ignorance and forgetfulness and the special fragile memory of any user of intoxicants. As narrative or as semi-structured return interviews they can adapt to consumers' capacities to recall consumption. An even better suited method has historical tradition and proves its usefulness since decades: Data collected by diaries on expenditures on "ordinary and luxury goods" complemented the statistics on household expenditures of the Viennese Chamber of Labour between 1924 and 1936. Also the famous Austrian study on the "Unemployed of Marienthal" by Marie Jahoda, Paul F. Lazarsfeld and Hans Zeisel (1933/1978) carried out in the same period, made use of diaries to assess use of time. And diaries also complemented the first Austrian survey on alcohol consumption in 1979 (Mader et al., 1981). Monitoring of drug consumption (Best et al., 2000) proposed to control health-damaging frequent and frequently changing concomitant drug use of substituted drug users, is another option though better suited to support treatment than research. In regard to frequent changes, diaries are superior; for the investigation of personal and social contexts of change also interviews have merit.

To the merits of the Multi-City Studies

To the merits of the Multi-City Studies: Design and method of the studies are well chosen if the aim is the assessment of basic aspects of consumption and of trends. The course of "drug careers", of "drug fashions" – in another perspective, of "drug epidemics" – identified by the rich database of EMCDDA at about the same time and sometimes even earlier, also became visible in the questionnaire studies in 13 cities (EMCDDA, 2012; 2013): The decline of heroin consumption associated with increasing licit and illicit use of opioids prescribed in substitution and addiction treatment; the take-over of cannabis resin by cannabis herb; the sudden decline of the drug of the electronic dance music scene, ecstasy; the interchanging ability of cocaine and amphetamine and their appeal to socially integrated as well as marginalised drug users. In other words, design and method chosen qualify the Multi-City Studies as a sensitive, rather simple and cost-effective instrument for the assessment of consumption trends.

To come to a further merit: Because of the mentioned advantages of their design both Multi-City Studies but especially the second one contributed to research on drug consumption in poorly investigated European countries, many of them with markets in transition and with widely unknown living conditions and impact on drug use and life circumstances of drug users. The investigation of the interrelationship of drug consumption and (risky) societal contexts was also promoted by the inclusion of cities nearby main drug traffic routes and drug production areas. And risky in a wider sense is also the ambiguity of Nordic drug policy, shaped by extended welfare measures on the one hand and by extended repressive controls and pronounced negative attitudes toward drug use and drug users on the other hand.

The Second Multi-City Study finally contributed to the extension and consolidation of the European drug research field and network

The Second Multi-City Study finally contributed to the extension and consolidation of the European drug research field and network: The inclusion of several cities with poor (drug) research structures and with hardly developed drug research practice (Bühringer et al., 2009) in a study with comparative design for more than three years promoted the development of local research competences, the inclusion of so far neglected research areas and the establishment of contacts and cooperation among researchers in the centre and at the periphery of European research.

By the research questions of the Multi-City Studies drug use and consumption changes were reduced to quantitative (economic) aspects, they with few exceptions neither targeted the drug user (the set) – his or her experiences, motives, affects, hopes, relations, needs, perceptions – nor did they link drug use to societal structures besides the drug market (the setting). The findings prove that it was not possible to reduce drug use to amounts of goods and prices. Though not systematically considered by the design, the main social factors made themselves visible. Their impact on consumption and users was repeatedly addressed in the interpretation of the consumption data and will be further analysed in the last chapters. Stephan Quensel investigates the penetration of drug use by the penal law embedded in various national "criminal cultures". Pieter Vanhuysse analyses the impact of welfare regimes of the countries in question on drug use and drug users. And Börje Olsson discusses the findings on drug consumption in the framework of consumption cultures of intoxicants.

A final distinction taken from a study on alcohol consumption (Allamani et al., 2011; 2015) is fruitful: The study aimed at the identification and measurement of social factors determining alcohol consumption and it distinguished forces according to their goal. "Forces directly targeting consumption changes" as "all preventive substance consumption policies" were classified as "planned factors". "Unplanned, contextual factors" were all forces quasi as side-effect bringing about changes of consumption, of consumers and of consequences – sometimes quickly, often slowly, sometimes visible, often hidden, seldom expected, mostly surprising, and mostly remarkable and sustainable. Drug markets according to this classification are planned – they aim at profit and therefore target consumption changes – cultural factors are unplanned, and criminal cultures as welfare regimes are mixed – a category not foreseen by the quoted study. The concept of "criminal culture" as that of the "welfare regime" emphasizes that also "planned forces" such as criminalisation of drugs and its enforcement and the establishment of shelters for homeless drug users are never isolated at work, that they always become effective in the context of a cultural system or structure. But if all forces are embedded in cultural (interpretative) structures, also drug markets have to be seen and studied in a cultural context. A conclusion with the potential to keep the economic chain disclosed.

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Drug Culture and Criminal Culture

Stephan Quensel

Activities in regard to drugs – illegal, semi-legal medical and illegalized substances – in all of their facets are *culturally* determined: Who consumes how which drug, at what occasion, with what meaning and in what social context – gender, age, social class, urban-metropolitan or rural setting – depends on cultural structures which also cover illicit activities. As the first Multi-City Study showed: In the six cities investigated crack, cocaine and amphetamine substituted each other, which drug was taken was determined by the city traditions (Eisenbach-Stangl et al., 2009: 235ff).

A crucial part of any "drug culture" is the nature and extent of criminalization

A crucial part of any "drug culture" is the nature and extent of *criminalization*: Culturally determined is, which drugs are considered illegal and which may be prescribed medically, what repertoire of sanctions is chosen and how regulations are enforced, which vary between tolerance – the "Koffieshop" in the Netherlands – and death penalty in some non-European countries. The nature and weight of this "criminal culture" – as that of the drug culture as a whole – are shaped by the respective national frame.

1 The influence of criminal policy on drug culture

"Criminal culture" shapes drug culture in three ways

"Criminal culture" shapes drug culture in three ways: (1) directly, (2) as a frame for alternatives and (3) as impact on attitudes of the population.

1. The criminal culture *directly* influences the way of life of those who live with drugs:

- Consumers react to criminalisation by the development of *defence strategies*. Some adolescent cannabis consumers, for instance, develop low-risk consumption patterns, others – such as the integrated drug users in Helsinki and Moscow presented in this volume –, in order to avoid prosecution and punishment, go "underground". One consequence of the second defence strategy is that "hidden drug users" – who also do not make use of drug services – outnumber registered drug users as in Moscow, where

the relationship is estimated to be seven to one. Another consequence is the lacking knowledge on purity and prices of illicit drugs which became visible in both Multi-City Studies and does not only impair research but also endanger the life of drug users.

- Also, the *misery* of many "junkies" is a direct consequence of punishment and prosecution which further advance their marginalization.
- Since the risk of prosecution is a main driver of prices, criminalisation is finally responsible for an overpriced drug market of dealers, which – as the Italian report in the first Multi-City Study showed – promotes adulterations of drugs by e.g. the use of diluents. The overpriced dealer market also has an impact on consumption practices: it promotes risky "legal hights" with "unregulated psychoactive substances" (EMCDDA, 2010a: 108); intravenous opiate use (in the first study called the "most risky mode of consumption") instead of sniffing, a consumption mode only prevailing in Amsterdam, due to a special tradition, and in Belgrade and Sarajevo, due to the high availability of opiates and risky poly-drug use. Last but not least the overpriced dealer market raises the risk of "secondary" criminalization in the context of "procurement crime".

2. The particular national "criminal culture" determines and limits the scope of alternative drug controls and service offers such as:

- "*Therapy* instead of punishment", which allows to escape repression.
- The provision with drugs defined as *substitutes* by state health insurance (in Finland and the Czech Republic methadone but not expensive buprenorphine is free – EMCDDA 2010, 93) or admission to a heroin or opiate programme.
- "*Harm reduction*" by pill-testing programmes (as in Vienna), by syringe exchange (an "acknowledged measure of European drug policy", which nevertheless is hardly available in Sweden – EMCDDA, 2010a: 100), by health rooms for safe drug consumption (as in Amsterdam and in Copenhagen, though drug users in the Danish capital are not allowed to inject themselves), shelters and public meeting points free of police controls (EMCDDA, 2010a).
- Last but not least, the nature of national criminal policy determines prevention – a strategy increasingly attracting attention – and either strengthens deterring anti-addiction programmes or reflections on personal drug use and its consequences.

3. Finally, the impact of criminal policy on drug policy may be observed by the way the "*drug problem*" is defined on national level, how it is discussed in the public, what threat is attributed to drug use and what attitudes towards

drug users prevail. The debate is cyclically escalated by the media, as well as by politicians, preferably in times of elections, but also by the "drug subculture" that can become remarkably annoying. Consequently "drug scenes" are dissolved as in Amsterdam and Vienna. But recent history proves that escalation also can be turned in the opposite direction and lead to acceptance of increasing cannabis use whereby the drug threat is shifted to licit substances – to nicotine or to juvenile alcohol consumption.

The cyclically escalating public drug debate shapes the public image of drugs, which according to the Multi-City Studies in Moscow and Stockholm is rigid, medically oriented, recently got softened in Helsinki, became neoliberal in London and Prague, was aggravated in Warsaw and Belgrade, is cautious in Eastern Europe (Prague, Bucharest, Sarajevo), understanding in Copenhagen, Vienna and Turin and still exemplary in Amsterdam.

The cyclically escalating drug discourse generates numerous *unwanted* products as corruption of the judiciary institutions via procurement crime, the black market, money laundering, drug smuggling and smuggling organizations up to the Mexican Drug War, in which 12,359 people were killed in 2011 (Die Zeit, 2012: 26). But escalation is not a compulsory phenomenon. The type of national "legal" culture as well as confidence in the national welfare state (Lappi-Seppälä, 2007) play a role, as does the way in which international drug policy intervenes in national drug issues as in Poland where – under pressure of the USA – liberal drug policy was abandoned (Eisenbach-Stangl et al., 2009: 138f). In regard to the drug discourse Mexico and, in a different way, the USA are to be seen as one extreme, Eastern European cultures mark the centre, the old EU countries – exemplary the Scandinavian countries and the Netherlands – provide two opposite examples of the other extreme.

2 How to measure criminal culture?

The strictness of criminal cultures can be measured by the extent and frequency of police interventions

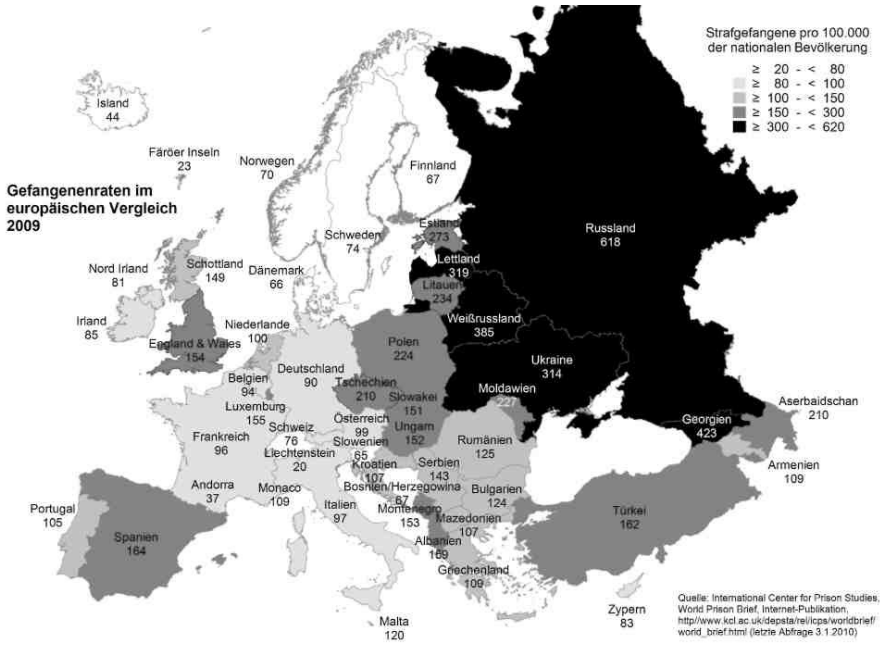
The strictness of criminal cultures among other things can be measured by the extent and frequency of police interventions, which already by definition more often target "marginalized" persons, or – perhaps more objectively – by percentages of imprisoned offenders and by length and strictness of imprisonment.

As regards percentages of prisoners Russia was the leading country in 2009 (618 prisoners per 100,000 inhabitants), only surpassed by the USA (760 prisoners per 100,000 inhabitants). The Scandinavian countries Denmark, Finland and Sweden (with, respectively, 66, 67, 74 prisoners per 100,000 inhabitants) and, among other countries, also Bosnia-Herzegovina (67 per 100,000) mark

the opposite position. Poland and the Czech Republic are "leaders" in Central Europe (224 and 210 per 100,000) whereas Italy, Austria and since recently also the Netherlands (respectively 97, 99, 102 per 100,000) approach Scandinavian standards, which for various reasons are missed by Romania, Serbia and the UK (125, 143 and 154 per 100,000 – Dünkel, 2010).

In the USA and the old EU countries a strict drug policy and accordingly long prison sentences for drug offences are the main reasons for the high percentages of prisoners (and – as the second Multi-City Study shows – for a dense surveillance of drug users by the police): 10 to 30% of all prisoners (EMCDDA, 2010: 45) are either direct drug offenders or had committed a procurement offence or were "ordinary" criminals who had consumed illicit substances (according to the Multi-City Studies, in Italy about one quarter of all prisoners, in Sweden more than one half). In women's departments respective percentages in some countries approach 50% – unfortunately, or significantly, reliable figures are missing.

Prisoner rates for 100,000 of the national population in European comparison, 2009



Source: International Centre for Prison Studies, 2010.

The shortcoming of reliable figures also impairs an informative comparison of drug deaths

The shortcoming of reliable figures also impairs an informative comparison of drug deaths, which according to rough estimates amount to 1-2% of each cohort of drug users annually (EMCDDA, 2011). Drug users die because of an overdose – fought against by health rooms and in the UK and Italy also by the provision of syringes filled with naloxone (EMCDDA, 2010a: 106). They die indirectly because of an infectious disease such as HIV and hepatitis – successfully

fought against by education complemented by the distribution of syringes and condoms as the "Report on Drug Policy" of the Global Commission (2011) and the Multi-City Studies show. Finally, they die by suicide (up to one fifths of all drug deaths) – that could be reduced by adequate survival offers. A last reason for drug-related deaths to be mentioned, is violence in the drug milieu, which in old EU countries was aggravated by the ageing of drug users and in the Netherlands stimulated a discussion on special homes.

Present drug policy is characterised by contradictious features

Present drug policy is characterised by contradictious features, which are especially visible in Sweden where long drug careers are no exception but where drug deaths are two times as frequent as in Europe as a whole. Swedish drug policy is based on drug strategies which on the one hand aim at a "drug free society" and impair the introduction and extension of harm reduction measures, but which on the other hand are part of a welfare state providing outsiders irrespective of their special stigma with a great variety of compensatory services. Thus, survival chances are high, but such is also social isolation.

3 The impact of the criminal culture on treatment and substitution services

Criminal policy also has an impact on national drug treatment policy

Criminal policy also has an impact on national drug treatment policy and on the extent and nature of national treatment- and substitution services, which can reduce procurement crime and drug-related deaths. EMCCDA summarizes that in most Eastern and in some Southern European countries treatment services are "relatively limited ... which is reflected in long waiting lists" (EMCDDA, 2010a: 17). This is also true for the availability of substitution programmes that also vary in regard to the substances used (in Vienna morphine and codeine, in Denmark increasingly buprenorphine, naloxone in Finland and heroin in London, Amsterdam and Copenhagen – EMCDDA, 2010a: 106).

substitution programmes attract varying segments of drug users and cover varying percentages

According to their availability, to the substances used and to further characteristics, substitution programmes attract varying segments of drug users and cover varying percentages: Whereas substitution of any substance is prohibited in Moscow and supply is largely limited in Poland, Belgrade (9% of problem opioid users) and Copenhagen (10%), it reaches about 30% of problem opioid users in Finland and Prague, 40-50% in Vienna and the UK, 50% and more in Italy and two thirds in Amsterdam (EMCCDA, 2010a: 92). In the new EU country Romania and the candidate country Bosnia-Herzegovina substitution of about 40 and 50% of "marginalized" drug users serves as inexpensive alternative to penal measures, whereas in Amsterdam and Vienna it is integrated into a wide range of services.

Substitution drugs got the potential to replace illicit opiates as substance of desire among drug users as well as became a desired commodity on the black market as it happened in Vienna, Prague and Helsinki. Drug services thus might compete and cooperate with illicit business and become a major player in criminal drug policy – though not by intension of course.

The prevalent ambivalence towards substitution also imprints the establishment of maintenance programmes in prisons: in Poland, Sweden, Finland and the Netherlands only up to 5% of inmates received opioid-supported substitution treatment, in Italy and Austria 7 to 8% and in Denmark and England 13-15% (EMCDDA, 2010a: 47).

4 Impact of criminal culture on consumption patterns

Both Multi-City Studies investigated the impact of national criminal cultures on consumption patterns and their changes. Two generic findings attract attention and evoke astonishment, though they had to be expected: (1) The relative ineffectiveness of national criminal culture in regard to changes of consumption patterns and (2) the existence of a comparable culture of integrated drug users in all cities investigated.

As the "global war on drugs has failed" also efforts to combat drug use and drug trade on national level did not reduce drug consumption

1. As the "global war on drugs has failed" (Global Commission, 2011) also efforts to combat drug use and drug trade on national level did not reduce drug consumption: The still relatively liberal criminal policy of the Netherlands with its coffee shops and its generous substitution programme was the most successful: The wide availability neither motivated multi-drug use nor did it raise the intensity of drug consumption. But it at least kept markets for "hard" and "soft" drugs separated, reduced risky consumption patterns (injecting) and raised life expectancy of marginalised users (city report of Amsterdam). Drug use in Eastern European countries, that before 1989 had been low and "no public issue" (city reports of Warsaw, Bucharest and Moscow) during the 1990s caught up and reached European level. The increased police activities accompanying the growing prevalence rates did not prevent the shrinking of drug prices but raised the misery of drug users. Swedish drug policy, which kept aiming at a "drug-free society", not least because of the drug-political shift towards harm reduction in Europe turned into the "most restrictive drug policy in the world" (city report of Stockholm) and the dissolving of public drug scenes in Vienna and Copenhagen strengthened local drug markets (city reports, Eisenbach-Stangl et al., 2011). In regard to cannabis in most countries "use ... increased during the 1990s and after the turn of the millennium" (EMCDDA, 2010: 49): In 2007 8.4%

of 15-24-year-old Europeans had used cannabis in the past 30 days; lifetime prevalence among 15- and 16-year-old youth reached 45% in Prague, between 26% and 32% in the Netherlands, Moscow and England and only in Finland and Sweden was below 10% (EMCDDA, 2010: 52). Also, cocaine use was increasing and among young people amounted to 6.2% and 3.4% in the UK and Denmark, whereas it was – still? – low in Romania and Poland with 0.1% and 0.3% (EMCDDA, 2010: 76). On the whole: the driver of all addressed changes of drug preferences during the last three decades and further shifts such as the waning of heroin in Western and its rise in Eastern European countries, the rise of substitution drugs, locally restricted attraction of crack (Amsterdam and London), the international ecstasy wave at the turn of the millennium and the increasing popularity of marihuana at the expense of hashish due to increasing "private" production, obviously is neither criminal drug policy nor drug treatment policy or any other planned state policy. The change of consumption patterns seems to be driven by numerous factors and their interplay and in the present context is best referred to as "drug fashions".

2. Even more astonishing is the so far hardly investigated drug culture of "*integrated drug users*". It developed mostly in metropolitan contexts and widely independently of the respective criminal policy – albeit more or less cautious as the difficult search for suited interview partners in both Multi-City Studies teaches. Integrated drug use did not only develop as the frequently discussed "juvenile rave-cannabis culture" (Parker et al., 1998; Werse, 2007) but since a longer time could be observed in bourgeois milieus mostly with the background of higher education (Kemmesis, 2004). Integrated drug users remain strictly separated from the criminalized drug scene also in regard to supply: their drugs are of higher quality. Drug prohibition does not deter socially integrated drug use, but in the longer run consumption becomes modelled according to that of licit substances. The illicit drug culture developed by socially integrated users is based on legal money and rules and controls, which allow to keep the balance between "work and pleasure" – heroin consumption, among other things, is labelled as disreputable. As the authors of the first Multi-City Study conclude: "In general, findings ... indicate that it is possible to use drugs like marijuana or ecstasy for years and maintain life conditions rated high on both objective and subjective measures." (Eisenbach-Stangl et al., 2009: 195). The "*marginalized*", in addition to numerous shortcomings – low education, unemployment, homelessness –, are further marginalized by criminalization: by stigmatising penalties, by loss of relationships and by integration in deviant milieus, by poor resources and by the necessity to use illegal means for drug supply on the black market. Visibility of additional "marginalization" is

Integrated drug users remain strictly separated from the criminalized drug scene

The "marginalized", in addition to numerous shortcomings are further marginalized by criminalization

higher in countries with a high living standard: Marginalized and integrated drug users in Eastern European countries are therefore more alike in regard to their subjective estimates of quality of life: “Marginalized users in Nordic countries probably suffer of stronger exclusion and stronger stigmatization that cannot be made up by extended welfare measures.”

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Welfare Regimes and Drug Users

Pieter Vanhuysse

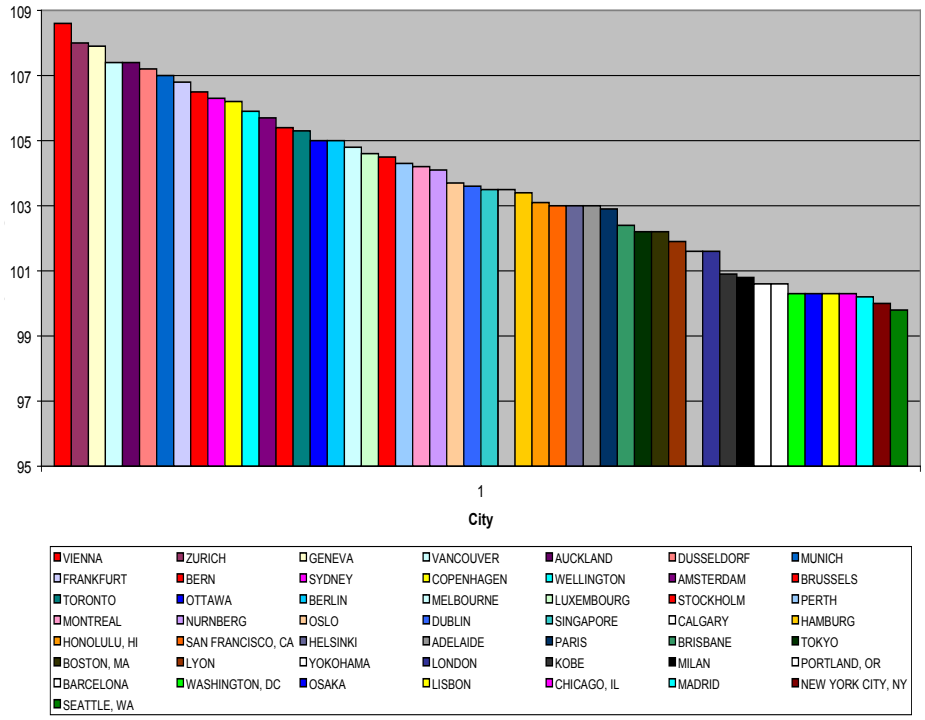
An institutional welfare state perspective

Above and beyond the cross-city differences in drug policies described in Part 1 of this report, the cross-city variation in many of the outcome trends among drug users described in Part 2 can to some degree be deduced from larger differences in the governance environments and general policy inputs at the city level. One way of viewing large cities such as the ones studied in this book is by analyzing them as vectors of policy performances that can be measured by the quality of services they provide to their citizens (Kaufman et al., 2005; see also Taylor, 2005; Fuchs et al., 2010; Hudson, 2012). An influential measure of city performance in this respect is the yearly Mercer Index of Quality of Living in large cities, which is a relatively objective measure of the general quality of living in a given city, conducted on a yearly basis for more than 380 cities worldwide, based on detailed assessments and evaluations of 39 criteria or factors across 10 key categories.

One way of viewing large cities such as the ones studied in this book is by analyzing them as vectors of policy performances that can be measured by the quality of services they provide to their citizens

As Figure 1 indicates, of the cities studied in this book, neither Moscow nor Bucharest, Belgrade or Sarajevo are included in the top-50 cities regarding quality of living in 2009. On the other hand, three of the cities studied, Copenhagen, Stockholm and Helsinki occupy respectively the 11th, 20th and 31st rank, with Quality of Living index values above that of the base city for comparison, New York. The social services and the public goods that cities provide are crucial in determining this quality of living ranking. In fact, most of the ten categories that make up the index in Figure 1 are in great part a function of the quality of governance and the resources available in a given city, including dimensions that are important to drug users such as the medical environment, public services and transport, and housing. The much higher satisfaction with their housing situation of the integrated drug users in Copenhagen, Stockholm, and Helsinki, for instance (Chapter on Social Position, Figure 13), is clearly consistent with these three cities' high overall infrastructure provision as captured by the quality of living index.

Figure 1: City Quality of Living index 2009, top 50 cities



Note: Baseline is New York City (index value = 100).
Source: Mercer website (http://www.mercer.com/qualityofliving).

The cross-city variation in outcome trends among drug users derives at the *national* level from differences in institutional and public policy constellations

However, there is little doubt that, to a large degree, the cross-city variation in outcome trends among drug users derives at the *national* level from differences in institutional and public policy constellations, particularly in terms of the set-up, scope, and generosity of the larger *welfare states* in which these cities are placed. The analytical focus by Gøsta Esping-Andersen and others on the ways in which advanced welfare states provide different "social rights package deals" to their citizens has indicated that the advanced Western democracies cluster into at least four distinct welfare regime types, or "worlds of welfare" (e.g. Esping-Andersen, 1990, 1999; see also Arts and Gelissen, 2002; Castles, 1993; Sabbagh et al., 2007; Sabbagh and Vanhuysse, 2010; Vanhuysse and Goerres, 2012). Two of these worlds put much emphasis on welfare provision through flexible and deregulated markets. Liberal regimes (including Canada and the USA) provide smaller and largely flat-rate benefits. They are characterized by lower taxes and higher income inequalities, but they effectively promote new jobs and cheap household services. Radical regimes (including New Zealand and Australia) combine high benefit equality with low social security contributions, low levels of redistribution, and high levels of wage and job regulation. Two other welfare regime types rely to a high degree on state involvement in welfare provision. Conservative regimes (including Germany and France) allocate relatively generous welfare benefits mainly on the basis of previous earnings.

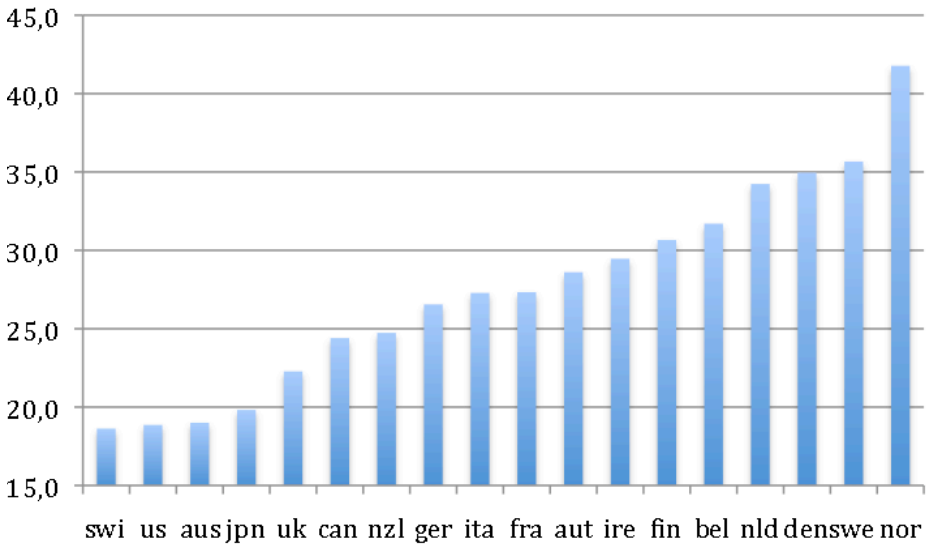
They tend to promote the interests of highly skilled and well-paid jobholders at the expense of young, unskilled, female and elderly workers and they put high family care burdens on women. The high cost of childcare makes it expensive for women to combine work with children, which adds to existing problems of labour market exclusion, high labour costs, and adverse retiree-to-worker rates. Lastly, social-democratic regimes (including Norway and Sweden) provide generous benefits on a universal basis. They promote women's independence by providing extensive and relatively low-cost day-care facilities and by stimulating female employment through public sector absorption and active labour market programmes.

One key factor is differences in overall welfare state generosity

As applied to the countries hosting the cities studied, one key factor is differences in overall welfare state generosity. The main dividing line here is undoubtedly between the three Nordic cities in this report's sample on the one hand, and the four other cities on the other. One core difference here relates to the ways in which welfare states provide safety nets for those in material or emotional distress and those who, for any number of other reasons, find themselves on the margins of the active labour market and of mainstream society (Esping-Andersen, 1990). In this respect, Nordic welfare states are well-known to be especially generous by international comparison, not just compared with poorer societies and newer democracies such as Serbia, Romania, Bosnia-Herzegovina and Russia, but even as compared to all other rich welfare states in the OECD world. In Esping-Andersen's (1990) terminology, Nordic welfare states are the world champions in *decommodifying* citizens – i.e. making sure that all citizens can fall back on some degree of material safety, independently of their individual success in the market economy.

For instance, the influential Scruggs Welfare State Entitlement Database calculates an *overall* welfare state benefit generosity index for the 18 richest OECD democracies in order to measure the generosity of benefits provided by a given country's welfare state as a whole (see also Scruggs, 2006). Not surprisingly, none of the former communist countries in the Second Multi-City Study's sample make the list. In fact, new EU Member States such as Romania and Bulgaria tend to perform badly even when compared to other former communist countries (and somewhat older EU Member States) such as the Visegrad-four (Hungary, Poland, and the Czech and Slovak Republics), whether in terms of public expenditure on social programmes or in terms of poverty rates (Vanhuysse, 2009; Rat, 2009). But Sweden, Denmark and Finland occupy respectively the second-, third- and sixth-highest position within the Welfare State Entitlement Database sample, with another Nordic country, Norway, occupying the first position (see Figure 2).

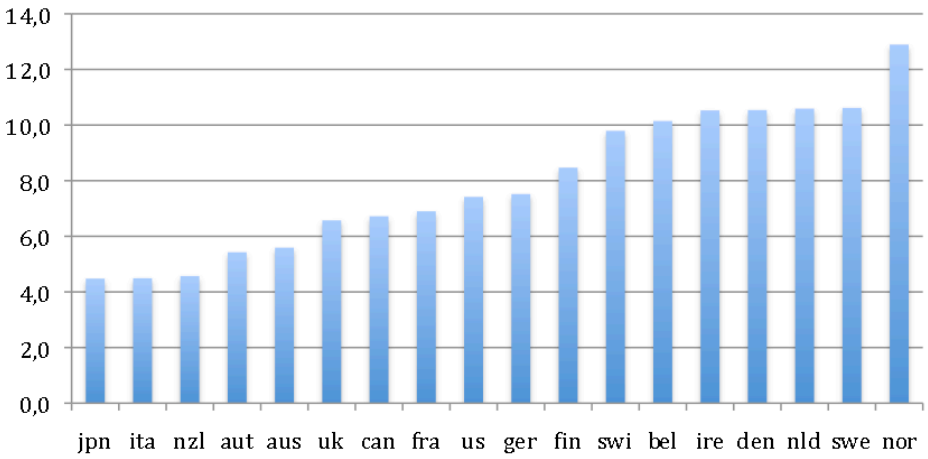
Figure 2: Overall generosity score for advanced welfare states



Source: Scruggs Comparative Welfare Entitlements Dataset

These higher levels of overall welfare state generosity go some way towards explaining why respectively 23 and 26% of the socially integrated drug users in Stockholm and Helsinki (albeit only 7% in Copenhagen) can claim social security as their main source of income, as compared to virtually zero percent in all four of the former communist cities in this study's sample (Chapter on Social Positon, Figure 7). Similarly, the high Nordic welfare generosity is consistent with the higher levels of subjective security ("feeling secure") and of life agency ("influence on own life") among Nordic as compared to non-Nordic integrated drug users (Chapter on Social Position, Figures 11 and 12). And as regards the socially marginalized drug users, the overall welfare state generosity may help to explain why as much as 89 and 73% of these marginalized users in Stockholm and Helsinki (albeit only 7% in Copenhagen) can claim social security as their main source of income, as compared to respectively only 7, 6, 5 and 1% in Belgrade, Sarajevo, Moscow and Bucharest (Chapter on Social Position, Figure 7). In simple terms, the state provides a strong and meaningful social safety net in these Nordic societies for marginalized citizens generally and thereby also for drug users, whereas it does not do so in these former communist countries. As a result, marginalized users in these Nordic countries have to resort to a much lesser degree to deviant sources of income such as prostitution, begging and dealing or to criminal offenses leading to police contacts in general (Chapter on Social Position, Figure 8).

Figure 3: Unemployment benefit generosity score for advanced welfare states



Source: Scruggs Comparative Welfare Entitlements Dataset

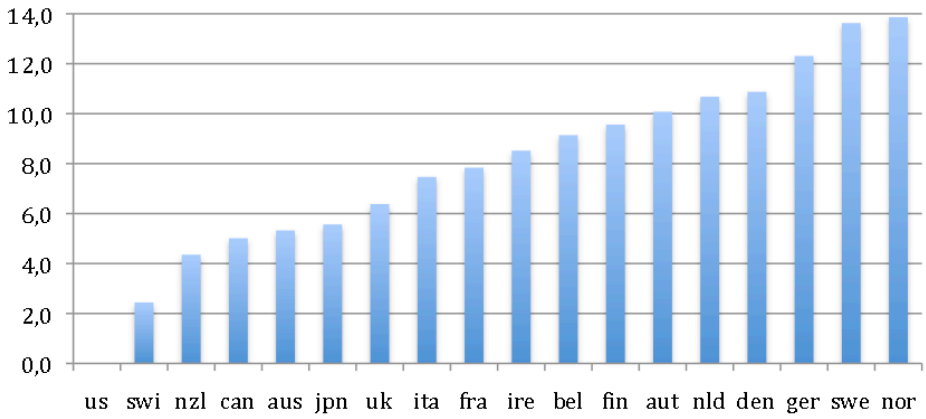
The generosity of prevailing welfare state models touches the lives of drug addicts also in a number of more specific ways via individual welfare state programmes

The generosity of prevailing welfare state models touches the lives of drug addicts also in a number of more specific ways via individual welfare state programmes. For instance, the larger resources spent on public housing in Nordic cities such as Stockholm, Helsinki and Copenhagen can explain why so much fewer socially integrated users (have to) depend on family, partners or friends for accommodation than in the other cities (Chapter on Social Position, Table 2). Moreover, Nordic welfare states, Sweden first and foremost, notoriously tend to spend very significant public resources on human capital investment and (re-) training, both through the provision of cheap early childhood-to-university education (Esping-Andersen, 2009; Vanhuysse, 2008) and through retraining and reskilling for marginalized or unemployed workers (Iversen and Stephens, 2008; Tepe and Vanhuysse, 2013). This goes some way towards explaining why both types of drug users – even marginalized ones – in Stockholm have higher levels of university education than in almost every other city studied (Chapter on Social Position, Figure 5b).

Similarly, as argued throughout this report, in addition to primary integration via work and tertiary integration via substitution, secondary integration of drug users can be promoted through compensation schemes such as unemployment benefits. As we have seen in the chapter on the Social Position (Figure 9), this tertiary integration mechanism via substitution is, seemingly paradoxically, comparatively small in cities such as Copenhagen and Helsinki. But this might in fact merely reflect the fact that the secondary mechanism, i.e. unemployment compensation, is so much larger in these Nordic cities. In fact, there is a major Nordic/non-Nordic divide along this dimension as well. On the Scruggs Unemployment Benefit Generosity Index specifically, Sweden, Denmark and Finland

occupy respectively the second-, fourth-, and eighth-highest position within a sample of 18 rich OECD democracies, with Norway again occupying the first position (see Figure 3). In other words, these Nordic countries are generous regarding the social safety net they provide to unemployed citizens even when compared with other rich democracies, and they are many times more generous when compared with the four former communist societies studied here. Not surprisingly therefore, if and when socially integrated drug users have no regular income, they can live from state welfare support in Stockholm and Helsinki, but need to live from family support in the former communist cities.

Figure 4: Sickness benefit generosity score for advanced welfare states



Source: Scruggs Comparative Welfare Entitlements Dataset

Similarly, health care and sickness benefit provision are a core concern for drug users

Similarly, health care and sickness benefit provision are a core concern for drug users, as they are clearly a high-risk category for health problems. In this regard the much better access to health services reported by integrated drug users in Copenhagen, Stockholm and Helsinki, as compared to all four other cities studied, closely reflects the greater generosity of these welfare states in this domain. For instance, in terms of the Scruggs Sickness Benefit Generosity Index, Sweden, Denmark and Finland occupy respectively the second-, fourth-, and seventh-highest position within a sample of 18 rich democracies, with Norway again occupying the first position (see Figure 4). Better health access for drug users is in turn likely to have both private and social benefits. That is, in addition to leading to better health for the individual users, health access is also likely to benefit society as lower levels of hepatitis and HIV among drug users will lead to lower contamination across society. In Moscow, for instance, the high levels of HIV/AIDS incidence may be at least in part explained by the total absence of drug substitution policies combined with poor general access to health care services for drug users.

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National Drug Cultures

Börje Olsson

Use and misuse of drugs as well as associated problems take different forms in different societies

Use and misuse of drugs as well as associated problems take different forms in different societies. The ways to control and manage the perceived problems are also diverse and produce varying consequences. This is indicated by the preceding chapters presenting results from interviews with drug users in a number of European cities. In this chapter, the aim is to describe the major characteristics of drug use patterns and drug control in some Nordic capitals and to put this in relation to the specific historical, cultural and social context in which they developed.

The interview study results reported in this report cover the capitals of three Nordic countries: Copenhagen (Denmark), Helsinki (Finland) and Stockholm (Sweden). The Nordic countries also include Norway, Iceland and the autonomous provinces Åland Islands (Finland), Faroe Islands (Denmark) and Greenland (Denmark). As the latter countries did not participate in the study, we will in the following only discuss the three capitals Copenhagen, Helsinki and Stockholm and the countries they belong to. These three countries represent quite different contextual factors behind drug use patterns and designs of drug control in Nordic countries or phrased differently, in Western developed welfare societies. Despite the fact that the Nordic region is often seen as very homogeneous in terms of policy, economy, social circumstances, etc., there are clear internal variations which can be discerned when drug use and drug controls are compared. It is an important observation that different contexts produce different forms of use and misuse, as well as various forms of drug control and it is also important to emphasize this in order to avoid stereotypes.

A first important distinction between the Nordic countries are the different social histories of drug use and drug control

A first important distinction between the Nordic countries are the different social histories of drug use and drug control. Different conditions and contexts are no doubt at hand, which contributes to the emergence of different drug use patterns as well as ways of dealing with the perceived drug problems. One important clue to understand the different patterns of drug use might be to look into the various histories of alcohol and alcohol control (Lenke, 1991). Finland and Sweden belong to the so-called liquor belt, where alcohol traditionally has not been integrated into the everyday life, but was a product which was generally consumed at special occasions, such as during weekends and holidays, and where drunkenness was common. Drinking was highly ritualistic – which in itself included various control strategies – and deviations from the norms, such as drinking during working hours or intoxication on weekdays, were stigmatized.

An absolutist temperance movement, even a total ban in Finland, and a highly individualized alcohol control in the form of a rationing book system in Sweden, were characteristic of how these countries tried to handle alcohol problems. Denmark deviated from these patterns and its drinking patterns and alcohol control is more similar to continental European countries. Beer is the typical beverage, which also is relatively integrated in everyday contexts, and the temperance movement was not in favour of a total ban on alcohol but advocated moderate drinking practices.

It is likely, even if it has not been scientifically studied, that these characteristics also affected drug use and drug control in the three countries. At least it is a background against which the development must be interpreted. These traditions contributed to the development of separate control traditions in, on the one hand, Finland and Sweden, and on the other, Denmark. Zero tolerance and strict control policies developed in the former countries while Denmark had a more liberal attitude, which became visible, among other things, in its distinction between hard and soft drugs. The different temperance traditions took a more condemning approach to drug addiction in Finland and Sweden, which contributed to a very strong stigmatization of all drug users and all forms of drug use. Stigmatization and marginalization of users and a strict legal and police control as the main strategy to resolve the problems, became characteristic of Finland and Sweden. The same can be said also for so-called hard drugs in Denmark while soft drugs like cannabis were treated less strictly.

Some significant differences in drug policy can be mentioned which are primarily relevant for and affect actual living conditions of drug users, in particular as regards marginalization and health. Denmark and Sweden initially developed in parallel and in a similar way. In both countries more extensive non-medical use of drugs developed at roughly the same time, that is, from about the mid-1960s onwards. The basis for the drug policies that emerged was a strict legal regulation where control institutions such as the police and customs rapidly got increasing resources. Penalties for drug offences were tightened gradually, but initially both countries gave priority to work towards drug trafficking and serious drug offences while the users themselves were primarily seen as a matter for the treatment system and the social institutions. At the beginning of the 1980s, the two countries started to diverge in this regard. Denmark in principle continued on this road by broadening and strengthening the control policy measures, but still with a clear focus on the more serious forms of drug crimes and on so-called hard drugs. Soft drugs, mainly cannabis, were treated in a more lenient way. Sweden did, however, a re-evaluation of how the police resources were to be used, and now the focus was turned towards the individual user and the street level. It was a fairly clear reversal from trying to strangle the availability of drugs by attacking the production and trade to reducing the demand by actively disrupting users. Both countries spent significant resources to develop the treatment system, but with at least one important difference. When the HIV

epidemic spread among drug users, Denmark choose a clear harm reduction line, while Sweden went against such actions in favour of a massive outreach programme designed to identify and motivate drug users to enter drug-free treatment programmes (EMCDDA, 2011).

The further development, from the early 1980s, shows that Denmark carried through some significant changes. On the one hand, Danish drug policy has become more restrictive, for instance through the re-criminalization of possession of drugs in 2004. Since the liberal-conservative government came into power in 2001, its self-styled "zero-tolerance" policy has been to implement legal tightening of drug crimes and to raise the penalties for drug offences, while also increasing access to treatment, particularly in prisons. Different laws have been implemented or tightened in order to carry out the "zero-tolerance" line (Amussen and Jepsen, 2007). Here, one can trace ideas of both zero-tolerance and public nuisance, *inter alia*, to send a clear signal that drug use is unacceptable. As an effect, the traditional division between hard and soft drugs and between drug dealers and drug users has been dissolved. Now the use of any drug including the use of cannabis is criminalized. It should be underlined, however, that the swing towards repression is not an entirely new phenomenon. Storgaard (2005) argues that drug policy – about different control policies for users versus dealers, "soft" drugs versus "hard" drugs, etc. – has been a permanent parliamentary battlefield in Denmark over the last 30 years, with the liberal-conservative and the centre-left wing, headed by the Social Democratic Party, in opposing camps. The centre-left wing's policy has dominated Danish drug policy until 2001 and therefore a more liberal drug policy had been applied in Denmark. The liberal views were reflected by a reform of the treatment system and by making treatment a social right as well as by the introduction of low-threshold institutions such as a heroin substitution treatment and social services for socially excluded drug users (EMCDDA, 2011).

Sweden, however, focused on the drug-free society as the ultimate goal with control policy measures entirely central and focused on the individual users. Initially, this strategy appeared to be successful, but clear setbacks occurred during the 1990s, setbacks not least related to the economic and financial crisis in Sweden during this decade. The public economy was severely hit which, in turn, resulted in significant reductions of treatment and social services. Furthermore, increased unemployment and marginalization in society led to both a breeding ground for addiction and increased difficulties in rehabilitation and possibilities to return to a normal life. If Sweden ever had a balanced drug policy with a good mix of control, prevention, treatment and social measures, it disappeared during this period and has yet not been restored. Moreover, all available data show that Sweden is further away from the goal of a drug free society than ever before in modern history. Lately, increased problematic drug use, high drug-related morbidity and mortality rates and increasing marginalization of drug users, seem to, on purely pragmatic grounds, have forced a number of harm reduction measures to be realized, not least by a sharp increase of substitution treatment.

Finland's drug use and drug policy are characterized by the relatively late introduction of drug use in society. Even though Finland was partially hit by the "drug wave" of the late 1960s and early 1970s, this never led to such great concerns and comprehensive drug policy developments as in many other Western European countries (Hakkarainen et al., 2007). As a country belonging to the "Vodka belt", Finland kept its focus on alcohol as the major addiction problem. Increases in drug use and related harms in the mid-1990s, however, brought drug problems on the political agenda (Tammi, 2005). Increases in recreational use of cannabis and other party drugs was one side of the coin, another was a more significant increase in the use of heroin and other opiates. The latter manifested itself in growing harms from drug use and rising numbers of socially excluded users with multiple problems. The breakdown of the former Soviet Union contributed to this development through new levels of supply and lower prices (Hakkarainen et al., 2007). The drug policy response stressed the complexity of the problem and broadened the perspective from a more narrow control-oriented criminal policy towards social and public health perspectives in which harm reduction played an important role. Finnish scholars conclude that the drug policy in the country can now be labeled as a dual-track model where traditional criminal-control approaches live side by side with more pragmatic harm-reduction measures (Tammi, 2005).

An interesting question that was mentioned initially is whether historical, social and cultural differences between the three countries in any way affect the extent of drug use, drug use patterns and their consequences. What image provide the interview data collected in this study and how can it be understood in the light of such contextual factors? This is the purpose of this concluding discussion. The two groups of drug users described have been divided into socially integrated and marginalized users.

The image of the socially integrated user does not by itself provide a completely clear picture. For this, the sampling procedures are not entirely reliable and the sample sizes are too small. If the results are seen in combination with other available data about socially integrated drug use in the three Nordic countries, it is still possible to draw some conclusions. First, it should be stressed that such drug use is relatively rare. Denmark, with the historically most liberal approach to drugs, has consistently the highest prevalence levels, followed by Finland, while Sweden has the lowest levels (EMCDDA, 2011). Cannabis is by far the most commonly used drug. About 7% of Danes aged up to 24 years have used cannabis in the past month compared to 3.3% in Finland and 2.1% in Sweden. The corresponding proportions for cocaine, amphetamines and ecstasy are usually well below 1%. These data refer to the national level, comparable data for the three capitals are missing, but they are consistently at higher levels. This distribution of substances is also valid for the interviewed users; cannabis use dominates, followed by the others at much lower levels.

Despite half a century of drug use for recreational purposes, the prevalence levels remained relatively low and stable during most of this period. Alcohol has maintained its dominant position as preferred substance among the majority of the population. Its cultural and social integration has, if anything, been reinforced in modern times. The limited prevalence of drugs is of course associated with the enormous popularity of alcohol, with the gradual liberalization of alcohol policy and with the very strict control policy that still surrounds drug use. The latter also means that the socially integrated drug users realize a range of control strategies for their use in order to remain undetected and to cause as little negative consequences as possible. At least in Sweden, this group can be described as a "hidden population". Only in exceptional cases is their use open in the sense that it is visible to others than the closest circle of friends. A clear indication of this were the great difficulties in Stockholm when it came to finding interviewees that were willing to participate in the present study. This has been a problem also in previous studies. Drug users have been very reluctant to take part in investigations, and when they did, they were very cautious to provide sensitive information (Rödner Sznitman, 2007, Statens Folkhälsoinstitutet, 2010).

It is difficult to argue that socially integrated drug use has gone through a process of normalization

For these reasons, it is difficult – if not impossible – to argue that socially integrated drug use has gone through a process of normalization. Some would possibly argue that cannabis use in Copenhagen has been more or less normalized. The recent tightening in the stance to drug use conducted in Denmark, however, pushes cannabis use more towards a subcultural and illegal activity. Politically, it has, like Finland and Sweden, thereby highlighted the ideological will to clearly mark a rejection of drug use and to impede and marginalize the phenomenon.

Problem drug use in the three cities shows both similarities and differences. Copenhagen and Stockholm have a long history of drug abuse, where the roots of the "modern" drug problem go back to the 1950s and 1960s. In Helsinki, it took another 30 years before problem drug use began to spread at any significant extent. One explanation for this may be that Finland was situated in the European periphery when industrialization and modernization took off after World War II. The historical links with Russia / the Soviet Union may also have contributed to this time lag.

There are also some differences in preferred substances although these have become smaller over the years. Stockholm has been unique in the world with its great dominance of amphetamines among problem- and marginalized drug users. It is only in recent decades that heroin use has come to play a major role in the drug use pattern. Copenhagen has more resembled the continental European pattern with a larger proportion of heroin and other opiates. Helsinki has had clear elements of both amphetamine and heroin, and in recent years a widespread use of buprenorphine (subutex) has emerged. In all three cities

the marginalized users have a very extensive multiple drug use. They are not only using narcotic substances, but also legal medical drugs and, not to forget, alcohol.

Attitudes to drugs are indeed strictly negative in all three countries with a less restrictive setting in Denmark and the most repressive one in Sweden. This is probably reflected in the design of various harm reduction measures that do not require immediate abstinence. Denmark has gone furthest in this direction with a series of such measures, which now has been supplemented by a heroin prescription project for the heaviest addicts. One clinic is situated in Copenhagen. Stockholm has long been critical of such policies, although there are some caring elements to reduce harms. It is typical that it took until spring 2013 before the first syringe exchange programme opened in the city. Many politicians and some key NGOs fought the longest against the introduction of this programme as they regarded it to be incompatible with the dominant zero-tolerance policy. The fact that Finland officially adopted a pragmatic harm-reduction policy facilitated the development of several such measures in Helsinki.

Some less flattering similarities between the cities also deserve to be mentioned. From a European perspective, all present relatively large numbers of drug-related morbidity and mortality cases. There are currently no signs that this troublesome situation is changing. Social exclusion and marginalization of problem drug users are also very significant and the group's situation has deteriorated in recent years, when the financial crisis has hit the public economy and the ideological success of neo-liberal ideas dismantled social welfare at an increasing pace.

The drug situation in the three Nordic capitals included in this study has in many ways changed since the "modern" drug problem developed

The drug situation in the three Nordic capitals included in this study has in many ways changed since the "modern" drug problem developed. Initially, the use of drugs was something very peculiar in these countries so strongly characterized by an alcohol culture focused on celebration and inebriation. Furthermore, these cities belonged to societies where social welfare ideas were not only strong on an ideological level, but were a central part of how the societies were built. Among other things, this meant very high ambitions when it came to people with different types of deviant behaviour of which drug use was one. Therefore, strict control policies were combined with prevention measures and expansion of the treatment systems. Stockholm and Sweden were characterized by a "massive" drug policy that was ultimately aimed at a drug-free society (Olsson, 1994).

What characterizes the situation today? The socially integrated drug use has remained strangely unchanged. Prevalence rates have not gone through any drastic changes and with the exception of cannabis in Copenhagen, this use has remained a marginal phenomenon. It is interesting to note that despite this stable and basically positive situation almost all drug prevention is – if we exclude control policies – targeting young people and cannabis. One may suspect that the so-called steppingstone and gateway theories play a significant role in

this focus of prevention. Empirical data do not support that socially integrated young people's cannabis use would have much to do with problem drug use in these cities. The latter form of drug use is strongly associated with traditional social exclusion processes making the chosen prevention strategy more or less ineffective. A change for the group of problem drug users is that their numbers have gradually increased over time and, as mentioned earlier, that their social, psychological and physical situation has deteriorated. Society, by contrast, has "learnt" to live with its most problematic drug users. They are perhaps the most marginalized group in our societies today and socially "handled" in a different way to at best reduce morbidity and mortality and to not create too big troubles for the large prosperous middle class. In addition to a continued strict control policy, today's drug policy strategy seems to put most emphasis on more or less permanent substitution treatment programmes and social and geographical separation of drug users in order to reduce so-called public nuisance.

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