Crime prevention and drug use in an urban environment

Introduction

Cities encompass many different kinds of neighbourhoods where a variety of types of drug use take place, ranging from recreational use, to problematic and abusive behaviours (Rhodes, 2002). As Kübler and Wälti (2001) point out, problems linked to drug use tend to be concentrated in urban environments, and especially city centres. Cities provide the conditions and infrastructure necessary to ensure that the drug market functions well: they provide anonymity – an advantage sought by both consumers and dealers; transport systems make it easy for key players in the drug market to meet; and cities are an important point of convergence for national and international drug trafficking (Kübler & Wälti, 2001). Equally there are places associated with drugs that are specific to cities, such as ‘open drug scenes’ where passers-by can witness drug use and trafficking in public spaces (Bless, Korf, & Freeman, 1995), as well as drug use in recreational settings such as nightclubs and festivals (EMCDDA, 2015). Given this concentration of drug-related issues, cities also find themselves confronted with the associated criminality. Among other factors, the concentration of poverty, and poor mobility in some areas of the city have a significant impact on the criminality associated with drug use (EMCDDA, 2015).

It is especially pertinent to consider the role of cities in relation to drug use, given that the international community is at a crucial turning point in terms of drug policy. The year 2016 was notable because the UN General Assembly Special Session on Drugs (UNGASS) took place, with a specific focus on evaluating the effectiveness of long-standing prohibitionist and punitive drug policies (Lai, 2016). For many, this was an opportunity to review the negative consequences of repressive policies and the failure of the “war on drugs”, particularly the high levels of violence, criminalization and incarceration which have ensued (Global Commission on Drug Policy, 2011). It also highlighted alternative strategies which focus on prevention, human rights and public health approaches.

The Session helped to illuminate the conflicts that still persist in relation to the most appropriate drug policies. Such debates at the international level tend to obscure developments at a more local level, however. It is cities which are largely responsible for implementing drug policies, and which find themselves facing the problems on the frontline (EMCDDA, 2015). The experience of cities provides important information about the success or failure of different approaches, once they are put into practice on the ground.

This chapter, therefore, focuses on the prevention of crime associated with drug use from the perspective of those who implement it – that is to say – cities. It reviews the different conceptualizations of the relationship between crime and drug use identified in the literature. Secondly, it examines global trends in drug use, and the evolution of the legal drug control framework at the international level. Finally, the chapter examines the characteristics of an effective strategy for preventing crime associated with drugs, drawing on a comparative study of municipal drug strategies adopted by ten cities around the world.

Different conceptualizations of the link between drugs and crime

The link between drugs and crime has essentially been conceptualized in two ways by researchers: for some there is a causal link between drugs and crime; for others, the relationship is seen as correlational (Brochu, 2006). Among the proponents of a causal approach, some researchers argue that substance use leads to crime (Goldstein, 1985; Parker & Bottomley, 1996; Powell, 2011), while others conclude that the relationship is the opposite – that it is crime that leads to drug use (Powell, 2011; White & Gorman, 2000). Supporters of the correlational approach on the other hand, argue that the relationship between drugs and crime is coincidental, or that it can be explained by a set of common causes (Dembo, Williams, Wothke, & Schmeidler, 1994; Powell, 2011; Stevens, Trace, & Bewley-Taylor, 2005). These different conceptual frameworks are examined in more detail below.
While it is important to note that the majority of drug users never commit crimes (MacCoun, Kilmer, & Reuter, 2003), there is a significant correlation between crime and the use of drugs in a number of countries. This is the case, for example, in Canada (ICPC, 2012) and the United States (National Association of Drug Court Professionals cited in National Council on Alcoholism and Drug Dependence, 2015). Almost two-thirds of their respective prison populations have disorders linked to drug addiction, compared with only 10% of the general population of the two countries (National Institute on Drug Abuse, 2014; Health Canada, 2014).

Drug use leads to crime

The classic conceptual explanation of the causal relationship between drugs and crime is Goldstein’s tripartite model (1985). It includes three explanatory models:

1) psycho-pharmacological,
2) economic-compulsive and
3) systemic. The third component of Goldstein’s model – the systemic – refers to crime associated with illegal drug trafficking, rather than directly linked to the use of drugs, so only the first two components are discussed here.

a) The psycho-pharmacological model

Goldstein’s psycho-pharmacological explanatory model “focuses [...] on the role of intoxication in the manifestation of aggressive behaviour” (Brochu, 2006, p. 127). Intoxication is seen here as the cause of criminal acts. More specifically, stimulants (Insulza, 2013), benzodiazepines (Sutherland et al., 2015) and phencyclidine (Bey & Patel, 2007) provoke uninhibited, aggressive and violent behaviour in consumers. Methamphetamines induce increasing difficulty in controlling anger and violent behaviour in those addicted to them (Sutherland et al., 2015). In addition, substantial and long-term use of this drug has the effect of modifying an individual’s social behaviour (Baskin-Sommers & Sommers, 2006). Nevertheless, it should be noted that while drugs can trigger violent behaviour, there is a stronger correlation with alcohol use (EMCDDA, 2007).

b) The economic-compulsive model

The second explanatory model argues that crime takes place in order to support a drug habit, so theft and burglary, for example, are instrumental in providing money to buy drugs. “Unlike the previous model, this one does not attribute crime to impulsiveness..."
resulting from intoxication, but instead suggests that addiction to a drug and the high price of the product constitute an incentive for criminal action” (Brochu, 2006, p. 130). This type of criminal behaviour is generally associated with substances that are highly addictive. A UK study, for example, showed that heroin, cocaine and crack are most often associated with this type of acquisitive criminal activity (Great Britain Home Office, 2010; Insulza, 2013). A study in Colorado in the United States identified methamphetamine as being a particular risk (Gizzi & Gerkin, 2010). Other studies similarly show that addiction to an expensive drug can lead users to commit crimes such as shoplifting, selling drugs, prostitution and burglary (EMCDDA, 2007). Some researchers have shown that the amount of property crime committed by heroin addicts is significantly higher than crimes against the person (Bryan, Del Bono & Pudney, 2013).

Crime leads to drug use

Unlike Goldstein’s three-way model, this theoretical model argues that involvement in crime and delinquency leads to subsequent drug use. The criminal sub-culture provides a range of resources that make it possible to start drug use and to maintain a habit. The criminal setting provides the contacts necessary to obtain illegal substances, and the sub-culture, with its own rules and protocols, gives legitimacy to drug users, while the money generated by criminal activity supports individuals in their drug habits (White & Gorman, 2000; Brochu & Parent, 2005; Grapendaal, Leuw et Nelen, 1995 dans Brochu, 2006).

The common cause model

When the link between drug use and crime is conceptualized as correlational, that link is not a direct one. This theoretical model argues that a series of common causal factors explain both drug use and criminal behaviour. These risk factors include low levels of social support, problems at school, and being involved in delinquent groups or gangs (Powell, 2011). The use of illegal drugs, therefore, is not seen as leading directly to criminal acts.

Thus the explanation for the strong link between crime and the use of drugs, lies in the combination of risk factors at the individual, relationships and community levels, which are shared by both types of behaviour. Atkinson, Anderson, Hughes, Bellis, Sumnall & Syed (2009) established a list of these common factors. They include at the individual level, depression, impulsiveness and a search for sensation. In addition, mental health disorders seem to be closely linked to both drug use and crime. In the US, 30% of people with a mental health disorder subsequently develop problems of addiction to drugs or alcohol, or almost two times the rate for those without mental health problems (Reiger et al., 1990 in Skinner and CAMH, 2011).

In terms of relationship factors, the influence of the family is one of the main risk factors for adolescents in terms of drug abuse (Vakalahi, 2001 in Lee, 2012). Abusive use of substances by parents, family conflict, lack of supervision or rejection by the family are all factors that place children or adolescents at risk, making them more inclined to turn to crime or drug use (Atkinson et al., 2009). Relationships with peers are also very important, and association with people who are themselves involved in drug use and abuse is a major risk factor (Atkinson et al., 2009).

Finally, the community also has an influence on an individual’s opportunities to commit crime or use drugs: living in a neighbourhood which is disordered, in which drugs are easily available, with low socio-economic status, for example, will increase their vulnerability (Atkinson et al., 2009).

Nevertheless, it is important to stress that no single risk factor is determinant, and it is rather the accumulation of risks and the absence of protective factors that lead to “problem” behaviours (Jessor and Jessor, 1977; Hawkins et al., 1992; Farrington, 1995 in Sansfaçon, Barchechat, Lopez, & Valade, 2005).

Trends, global statistics and the evolution of the legal context

Trends and global statistics on drug consumption

Today, the use of illicit drugs is a phenomenon that affects all societies. As the UN Office on Drugs and Crime (UNODC) indicated in its World Drug Report 2015, no less than “246 million people, or 1 out of 20 people between the ages of 15 and 64 years, used an illicit drug in 2013” (UNODC, 2015, p.3). However, the distribution of use and types of drugs is unequal. This fact is of particular interest given, as shown previously, that the type of drug has an influence on the type of crime associated with its use, and thus on the prevention measures which may be required.

Globally, cannabis remains the most commonly used drug by far. The World Health Organization (WHO) estimates annual prevalence at 2.5% of the world population (WHO, 2016). However, the low prevalence of drug use in Asia, including cannabis, tends to considerably reduce the world average. In Oceania, the Americas and Africa levels of cannabis use are three or four times higher than the global average (see Figure 5.4). Cannabis use in Europe is also higher than
The use of ecstasy varies between continents, and even within a given continent rates can vary considerably. For example, in the Americas, the prevalence rate is 0.5%, ranging from 6.8% in the US to 0.1% in Paraguay and 0.01% in Ecuador (see Figure 5.5). Elsewhere, the annual prevalence rate in Oceania was almost 2.5% in 2013, or more than six times the world annual prevalence rate for ecstasy use of between 0.2% and 0.6% (UNODC, 2015). Amphetamines and, more specifically methamphetamines, are a major problem for Eastern and South-East Asia (INCB, 2016). In several countries there has been an increase in the use and abuse of amphetamines including ecstasy. Despite this, the annual prevalence rate (0.7%) remains lower than that in the Americas (1%) and significantly lower than that in North America (1.4%), which has the highest annual prevalence in the world.

Opiate abuse is a major problem in the Americas in general, and more specifically in North America where the annual prevalence rate reached 3.8% in 2013, compared with the global average of 0.7%. In South America, annual prevalence was 1.2%, still higher than the global average (INCB, 2016). Even if opiate use has remained stable, this type of drug use remains the most problematic since it is associated with most new cases of HIV transmission, and with deaths due to overdoses (UNODC, 2015). Heroin continues to have devastating effects in the US, with overdose mortality almost tripling between 2010 and 2013 (INCB, 2016). In 2013 almost 35% of deaths associated with overdoses in the world were reported in North America. By contrast, Asia, which has more than 50% of the world’s population, accounted for only 7% of global mortalities due to overdosing (UNODC, 2015). In addition, of the 246 million drug users in the world in 2013, 27.4 million – almost one out of 10 – had...
problematic use and 12.19 million injected drugs. It should also be noted that almost a quarter of the 12.19 million people injecting drugs were living in Eastern and South-Eastern Europe (UNODC, 2015).

The evolution of drug controls at the international level

The drug strategies adopted by cities – this chapter’s main topic – have not evolved independently. They reflect legislation adopted at the national level, which is in turn shaped by international norms and standards. Three international agreements with almost universal adherence govern drug use: 1) the Single Convention on Narcotic Drugs, 1961; 2) the Convention on Psychotropic Substances, 1971; 3) the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

Until recently, the international community has tended to favour prohibition because, in theory, the signatory countries to these conventions cannot authorize recreational use of the drugs listed.

A number of trends, which have changed over the decades, characterize the involvement of the UN in the field of drug control. In the 1990s, a global consensus began to take shape around drug control. This resulted in the creation of the UN’s institutional framework on drugs (Jelsma, 2015), including the first UNGASS on drug abuse in 1990; the implementation of the United Nations International Drug Control Programme (UNDCP) in 1991; and the first World Drug Report in 1997. The same decade was characterized by the militarization of the fight against narcotics (Jelsma, 2015), notably with the use of armed forces in the fight against drugs, for example, to eradicate crops, or dismantle organized criminal groups associated with the illicit market (Csete et al., 2016).

In 1998, however, at the second UNGASS on the world drug problem, the different parties were unable to reach an agreement. This resulted in two divergent approaches: one led by the US that was concerned with punitive prohibition and led to the development of the “war on drugs” in the 2000s (Bewley-Taylor, 2012), while the other encouraged a more pragmatic approach to drugs, aiming to reduce the harmful effects and/or introduce decriminalization.

The war on drugs resulted in serious social and economic consequences, especially in the producer countries in the South. For example, the forced eradication of crops such as coca in Latin America projected rural populations into the heart of the conflict (IDPC, 2012). Another notable example of the harmful effects of the war on drugs was the decision by the Mexican government to directly involve its military forces in the fight against drug trafficking. The result of this intervention has been to increase the homicide rate to unprecedented levels, so much so that life expectancy in the country has dropped (Csete et al., 2016).

Furthermore, international pressure led some countries, such as Ecuador, to implement very strict drug laws, resulting in excessive use of incarceration and extreme overcrowding in prisons (IDPC, 2012). In Mexico in 2009, 75% of prisoners were incarcerated for possession of a small quantity of drugs, even though they had relatively little involvement in drug trafficking (Metaal and Youngers, 2011). In general, this type of mass incarceration does not decrease drug use, and actually plays a part in exacerbating health and social problems (IDPC, 2012). In addition, there has been use of torture and other forms of abuse during incarceration (Csete et al., 2016).

Since the results obtained did not live up to the expectations of 1998, many countries have questioned repressive drug policies. Tensions increased between the parties, particularly on the subject of the alternative use of risk reduction measures (Bewley-Taylor, 2012). This implied that countries had to recognize the failure of the main objective of international narcotic conventions, of a “world without drugs”, and opt instead for alternatives shown to be more effective means of responding to the health and social problems linked to drug use. In 2009, therefore, 26 countries made a joint declaration announcing their interpretation of the term “related support services”, cited in the Policy Declaration and Plan of Action as including “risk reduction measures” (ECOSOC, 2009).

More recently, countries have tended to adopt a broader interpretation of the clauses in the conventions. Some of these interpretations have in fact tested the principles of the international regime and reignited tensions among the interested parties. These disagreements focus essentially on legal flexibility with regard to personal use, reducing harmful effects, and the importance of respecting human rights. They are exemplified by Bolivia’s withdrawal from the 1961 Convention in 2011, followed by its reintroduction with reservations; by the legalizing of the production and use of cannabis in certain states in the US (Boister, 2016); and the regulation of the cannabis market in Uruguay (2013). Given the ineffectiveness of deterrent policies, alternative approaches have been explored, particularly through the Declaration of Antigua Guatemala (2013), which gave the Organization of American States (OAS) the power to explore new evidenced-based approaches to deal with drug problems which respect human rights, and are in agreement with international treaties (OAS, 2013).
CHAPTER 5 CRIME PREVENTION AND DRUG USE IN AN URBAN ENVIRONMENT

In 2012 the presidents of Colombia, Guatemala and Mexico sent a joint request to Ban Ki-Moon to rigorously review international drug policy (Murkin, 2012) and explore other, alternative, approaches (Rolles et al., 2016). The next UNGASS meeting, initially scheduled for 2019, was moved forward to 2016. The resolution adopted by the General Assembly on 19 April 2016, entitled “Our joint commitment to effectively addressing and countering the world drug problem” (A/RES/S-30/1, 2016), essentially returned to the aims of the three drug control conventions. More specifically, the resolution reaffirmed the determination “to actively promote a society free of drug abuse”. The new resolution thus calls for “effective measures aimed at minimizing the adverse public health and social consequences of drug abuse, including appropriate medication-assisted therapy programmes, injecting equipment programmes”.

Although the Session established recommendations for drug use prevention measures, crime prevention and treatment, many were disappointed by its results. The direction taken in the final document to a large extent recommends maintaining the status quo, with its focus on criminal justice approaches, and only some shift of emphasis towards alternatives (Lohman, 2016), as can be seen in the lack of specific indications with regard to reducing harmful effects and decriminalization (Ochoa, 2016). Certain themes are highlighted, such as human rights and proportionality in punitive sentences. However, it has been argued that it is not strong enough, and does not respond to the request of countries that hoped to see the abolition of the death penalty for crimes associated with drug use, a sentence those countries argue is contrary to international law (Ochoa, 2016).

Guidelines for an urban drug strategy

As this chapter has already discussed, the problems associated with drug use are primarily found in urban settings (EMCDDA, 2015). Cities are often the first to be confronted with (new) drug issues, and are often pioneers in terms of developing solutions. As suggested by Room (2006, p. 136), “the city is the level of government which has the immediate responsibility to deal with many of the problems from psychoactive substance use and intoxication.” Several initiatives have for example been developed by cities in response to the problem of drug injection in public places, such as needle and syringe exchange programmes, and supervised injection sites which help to reduce the harmful effects of drug abuse. Innovative measures are also often developed and tested by the community sector, which intervenes on the frontline to respond to the needs of drug users. Initiatives that are effective may then be adopted by the municipal authorities (EMCDDA, 2015).

Recognition of the importance of cities in the treatment of drug problems has emerged gradually. There have been several initiatives and declarations demonstrating the growing involvement of cities in resolving urban drug use problems. In 1990, Amsterdam, Zurich, Frankfurt and Merseyside organized a conference questioning the deterrent approach. These cities suggested that public health approaches and the reduction of harmful effects should be explored (EMCDDA, 2015). Subsequently, the European Cities on Drug Policy network emerged, along with the Frankfurt Resolution (1990). In 1994, however, the European Cities Against Drugs network was created following the signing of the Stockholm Resolution, and favoured a prohibition approach with the aim of drug abstinence (EMCDDA, 2015).

More recently, the Declarations of Prague (2010), Vienna (2010), Athens (2013), Canberra (2016) and Warsaw (2016) have demonstrated the growing mobilization of cities favouring a public health approach to urban drug problems (EMCDDA, 2015). These declarations all include recommendations for implementing effective drug policies in urban settings. In particular, they recommend the following (ICSDP, 2010; Urban Drug Policies in the Globalised World, 2010; UDPC, 2016):

- Local policies must be adapted to local issues, and municipalities must continue to be the leading players when it comes to developing innovative policies and programmes.
- Municipalities must have clearly defined roles and responsibilities.
- Cities must have a certain amount of autonomy in relation to their regional and national governments when it comes to implementing urban drug policies.
- Drug addiction is a health problem; it is thus neither ethical nor scientifically justifiable to criminalize it.
- Public health and public safety are not contradictory objectives, and mechanisms must ensure there is coordination between the key players from both sectors.
- The decision-making process regarding policy must be evidenced-based.
- Good evaluation and follow-up mechanisms for policies, programmes and initiatives must be set up.
- Information must be coordinated and shared – particularly via exchange platforms and partnerships – between local key players, as well as between the local, regional and national governments.
The characteristics of an effective prevention strategy

The aim of this section is to present the key characteristics of an effective drug-related crime prevention strategy:
1) the strategy must be holistic;
2) it must encourage coordination between the various sectors and interventions;
3) it must promote a favourable social environment and reduce marginalization; and
4) it must include effective evidenced-based intervention programmes.2

Adopting a holistic approach

The consumption of illegal drugs, and the associated prevention strategy, should not be considered in isolation, since it is intricately linked to other social problems. For example, as suggested at the beginning of this chapter, a significant proportion of the prison population in Canada and the US is affected by drug addiction, similarly being a gang member is known to greatly increase the probability of drug use (Atkinson et al., 2009).

Thus it is essential that a global approach be adopted, creating mechanisms that help to integrate strategies which focus on a range of different concerns. This is the approach taken by the governments of the US and Canada, who recognize that crime, gang membership, violence and drug use are closely interlinked, and require a coordinated response with the creation of inter-agency and multi-sector programmes (ICPC, 2015).

The same is true with regard to the significant links between mental health disorders and drug addiction – referred to as concurrent disorders or comorbidities. It is important that strategies include close collaboration between both sectors. Individuals who develop an addiction as a result of a mental health condition must be able to access health programmes which can treat their drug problem.

Prevention strategies may vary in the extent to which they apply an integrated approach. At one extreme, the prevention policy in the Netherlands considers drug addiction as a mental health condition, and treats it as such (Trimbos Instituut and WODC, 2015). Other government strategies favour establishing close collaboration between institutions that treat drug addiction and mental health, as is the case in Switzerland, where integrated management standards have been established for people who are drug dependant (quality standard QuaThéDA: Qualité, Thérapie, Drogue, Alcool) (ICPC, 2015).

Encouraging coordination between different interventions and sectors

Another essential element for establishing an effective prevention strategy is the establishment and implementation of coordination mechanisms. This applies to different programmes which may focus on the various risk factors, to coordination between the different aspects of the overall strategy such as prevention, treatment, harm reduction and law enforcement, as well as coordination between the national strategy and local government implementation.

Given the many common risk factors associated with drug use and crime, it is important that interventions do not focus on a single factor, but rather integrate several. In other words, the initiatives must be multi-sectoral. Coordination mechanisms need to be well thought-out so that interventions which work at the level of the individual, in terms of family and relationships, and at the community level, are well integrated.

Secondly, there must be collaborative mechanisms to bring together the different partners involved in the strategy, to avoid counter-productive results. A common example is the misunderstanding and antagonism which can be provoked by both repressive or harm reduction interventions. If health services provide clean syringes for health reasons (harm reduction) and the police confiscates them (law enforcement), the lack of synergy between these two sectors makes it particularly difficult, not to say impossible, to achieve the objectives of the strategy (ICPC, 2015). This problem is especially important in relation to prevention programmes around drug use, since initiatives such as safe injection sites may reduce harm, crime and insecurity, but may not be seen as acceptable policy by the public or some governments.

Finally, coordination between the national strategy and local government must be well thought-out, in terms of the choice of programmes adopted, funding and the sharing of information. This can differ considerably from one country to another. Certain countries adopt a centralized approach, as is the case in Portugal, for example (SICAD, 2013), where central government decides on the interventions to be implemented at the local level. On the other hand, in the UK, municipalities have considerable flexibility in terms of the types of programmes they decide to implement (HM Government, 2010).
Promoting a favourable social environment and reducing marginalization

In light of the range of risk factors associated with drug abuse and crime, it is clear that the most effective prevention entails promoting social inclusion and improving social and economic conditions, to reduce vulnerability to depression or stress, support families and reinforce family ties, and create healthy communities.

Reducing marginalization, which is associated with poverty and inequality, is especially important. In terms of the risk factors for drug use, marginalization plays a central role. It manifests itself, for example, in difficulty gaining access to the job market, homelessness, and in the health system. It is so important in fact that the International Drug Policy Consortium (IDPC) argues that poverty and inequality have more influence on a society’s drug use than drug policies (IDPC, 2012).

Reducing marginalization as part of the prevention strategy requires a focus on three distinct stages: prior to drug use and addiction, by developing programmes to promote inclusive societies; at the stage of addiction; and reintegration after treatment. The aim should not be to isolate people with drug problems, but to support their links with and integration into their communities. This is particularly important in terms of measures to support employment, for example, by encouraging regular or daily work, and through appropriate access to the health care system and housing benefits. Finally, it is important at the end of the treatment period to help marginalized individuals re integrate into society, so that they are not once again faced with the same risk factors which led to their addiction in the first place.

Implementing evidenced-based prevention programmes

In order to ensure an effective drug-related crime prevention strategy, the programmes implemented in the context of this strategy must be evidenced-based. Measures that have been evaluated and have proven their effectiveness present a higher success rate. In the context of evidenced-based programmes, crime prevention associated with illegal drug use can have one of three objectives. First, to prevent drug use so that the criminal behaviour associated either with the psychopharmacological effects of drugs, or to support a drug habit ceases. It may also be the objective to prevent harm, rather than focus on the associated crime or on stopping drug use, which is the approach used in harm reduction. Finally, the aim may be to prevent recidivism among individuals who have committed crimes linked to their drug use. Classification of these programmes can be made on the basis of the results obtained. The contribution by Lucie Léonard and Julie Savignac at the end of this chapter provides an overview of programmes implemented in Canada, some of which adopt a harm reduction approach while others aim to prevent drug use among youth.

a) Preventing drug use

Traditionally, the prevention of drug use involves four types of approaches: awareness-raising campaigns, interventions in schools, programmes with families, and community-based interventions.

Awareness-raising campaigns generally aim to educate people about the harmful consequences of drug use and to discourage it. Reviewing a number of national strategies suggests that currently this approach does not receive much support (ICPC, 2015). This may be because of the difficulties of evaluating the impact of such campaigns, which are generally not very conclusive in terms of their ability to reduce drug use (see for example UNODC, 2013 and EMCDDA, 2013). In certain cases it has also been found that they are counter-productive, making people resistant to anti-drug messages (UNODC, 2013), or even openly adopt the proscribed behaviour on the grounds that their freedom of choice is under threat (Hornik, Jacobson, Orwin, Piesse, & Kalton, 2008). In addition, awareness campaigns may encourage the idea that using illegal drugs is a common practice, and thus encourage people to try them (Hornik et al., 2008).

The campaigns which have attracted more attention appear to be those that do not focus on drugs, but rather on reinforcing social resistance. This approach is discussed further below.

There are two main types of intervention in school settings: providing information to potential users about the risks associated with drug use, and reinforcing the ability to resist social pressure. Many countries are beginning to abandon the drug-awareness approach, recognizing that its impact is limited or counter-productive (ICPC, 2015). A number of studies have shown that neither drug-awareness (for example Botvin & Botvin, 1992 in Botvin & Griffin, 2007; Hawthorne, 2001) nor programmes which promote fear of the consequences (UNODC, 2013), discourage potential users.

The second approach focuses on reinforcing the ability to resist social pressure. Such programmes aim to strengthen young people’s ability to refuse to use drugs despite pressure from their peers, or to avoid situations in which this might occur. This approach has been recognized as being more effective than awareness-raising. Based on a meta-analysis of such
programmes Botvin and Griffin (2007) identified the following elements which made them effective:
- interactive learning;
- reinforcing the skills that make it possible to resist the social pressure associated with drug use;
- correcting the false impression that using drugs is the norm for young people.

Although these types of programmes have yielded positive results, it is important to underline that interventions in schools are generally not very effective if they are not associated with other prevention programmes (e.g. Botvin, 1999; Flay, 2000; Lloyd et al., 2000, in Ariza et al., 2013). As indicated earlier in this chapter, family and community factors also play an important role in drug use, and school interventions cannot be expected to impact these in any depth (Hawthorne, 2001).

Interventions which work with the family, are among the most effective. A number of studies have identified that to prevent young people from developing problems with drug use and addiction, the three most important factors are (Ary et al., 1999; CSAP, 2000; Dembo et al., 2000, in Kumpfer et al., 2003):
- a positive relationship with the parents;
- coherent supervision and discipline;
- parents with values that are contrary to those of substance abuse.

Thus to prevent drug use in young people it is essential to work with families as a whole (see for example Kumpfer et al., 2002, in Kumpfer et al., 2003). The most effective prevention programmes appear to be those which focus on the entire family (Gates et al., 2006, in EMCDDA, 2013); early interventions¹ (Olds, 1997; Olds, Henderson, Cole, Eckendore, Kitzman, Luckey, Pettit, Sifora, Morris, & Power, 1998, in Dusenbury, 2000) extend across the life span, address multiple risk and protective factors, and generalize across settings; (3; and cognitive-behavioural programmes (Kazdin, 1995; Sanders, 1996; Serketich and Dumas, 1996; Taylor and Biglan, 1998; Webster-Stratton and Taylor, 1998, 2002, in Kumpfer et al., 2003).

Finally, interventions in the community aim to involve young people at risk of drug use in alternative activities (Jones et al., 2006), and to reinforce their relations with community organizations (UNODCCP, 2002 in Diamond et al., 2009). A number of studies have shown that the most effective preventive interventions at the community level combine the following characteristics (see Toubbourou, Duff, & Bamberg, 2003; Perry et al. 1996, Wood et al., 2006, in Diamond et al., 2009):
- they focus on more than one risk factor;
- they involve the entire community;
- they are implemented during childhood and adolescence.

Box 5.2 Example of good practice – Holyoake DRUMBEAT programme (Melbourne, Australia)

The Holyoake DRUMBEAT programme aims to develop relational abilities through the use of music and the expression of beliefs, emotions, behaviour and ideas. Initially developed for young Aboriginal men in a school setting to prevent future drug use, it now reaches out to several at-risk groups who can be reluctant to take part in traditional dialogue approaches. They include marginalized young people, prison populations and even refugees (Holyoake, 2003).

It is argued that people develop their identity, their team spirit and their empowerment through music and self-expression. For example, if someone is unable to talk about a humiliating experience, the facilitator may invite them to play drums to express their feelings, and subsequently invite them to name the emotion they have just expressed. Positive changes have been observed in the groups targeted, among other things a decrease of almost 30% in risky behaviours, an increase of 10% in self-esteem, and a reduction in absenteeism (Wood et al., 2013).

As has already been shown, drug prevention programmes are often more effective in a family or community than a school setting. The Holyoake DRUMBEAT approach can be adapted to family, community or school contexts. It uses an experiential approach that focuses on corporal and musical expression, allowing young people who are reticent about communicating verbally to express themselves in another medium, in this case drumming.

b) Harm reduction and its role in crime prevention

A second approach to drug-related crime prevention is to decrease the harm linked to drug use rather than focusing on ending drug use (IDPC, 2016). This approach argues that achieving a drug-free society is illusory, and that it is better to acknowledge this and to protect drug users from harm. It focuses more realistically on the harmful effects of drug use in terms of both health and safety. This makes it possible to maintain good relations with those who are addicted, to avoid even greater exclusion, and to provide support to prevent their personal or social situations from becoming more critical (EMCDDA, n.d.).

For these programmes to be effective, IDPC (2016) stresses the following key elements: drug users must participate in the design and implementation of programmes; the programmes must be easily accessible;
the service must be adapted to local conditions; local law enforcement organizations must facilitate access to the services; and, finally, the entire local community must be both consulted and involved.

Thus, in addition to their health benefits for users, harm reduction programmes can help decrease criminal behaviour committed under the influence of drugs, feelings of insecurity resulting from drug use (the psychopharmacological effects), and acquisitive crime to finance drug use.

A number of countries have implemented programmes to reduce the psychopharmacological effects of drug abuse, ranging from safe injection sites to interventions in nightlife settings, legislation prohibiting specific drug use, and community reintegration programmes.

**Safe injection sites** allow people to use illegally acquired drugs – especially cocaine and heroin – in a supervised space (Great Britain Home Office, 2014). These sites also help to increase the sense of public safety and order, providing safe places away from the streets and public view (Hedrich, Kerr, & Dubois-Arber, 2010).

Some countries have decided to focus on decreasing crime and insecurity generated by night-time drug use, such as that associated with bars, venues, discotheques and other places of entertainment and their surrounding areas. Drug use in recreational nightlife settings is often associated with high-risk behaviours, particularly violence, risky sexual practices and trafficking of illegal substances (Rhodes and Hedrich, 2010). Specific measures include ensuring that the clients of recreational night-time establishments have access to free drinking water and first aid services. Other measures implemented in some countries include raising awareness among nightclub clients (Rhodes & Hedrich, 2010).

In some countries such as Belgium, **legislation and municipal regulations** are used to prohibit specific behaviours including public nuisance, problem drug use, drug use in proximity to schools, or in some cases open drug use in public spaces (ICPC, 2010).

Finally, **community reintegration** also makes it possible to decrease the insecurity associated with the use of drugs in public spaces, as well as public nuisance problems. This may include, for example, the use of housing benefits and supports for the homeless (ICPC, 2015).

Harm reduction may also help to reduce the **criminal behaviour associated with the acquisition of drugs** by, for example, dispensing heroin under government medical supervision. Heroin is a very expensive drug, and highly addictive. Programmes which prescribe heroin to addicts who are very dependent under supervision, are usually utilized following the failure of other forms of treatment (Nadelmann, 2015). A number of evaluations of these types of programme show that they significantly reduce the crime associated with drug use among heroin users (Aebi, Ribeaud, & Killias, 1999; van den Brink et al., 2003).

### Box 5.3 Example of good practice – Insite (Vancouver, Canada)

The Insite clinic opened in 2003. It was the first supervised injection site to be created in North America. Its operation and personnel costs are all funded by Vancouver Coastal Health, one of the regional health services in British Columbia (Vancouver Coastal Health, n.d.). The clinic provides some 12 cubicles where drug users can inject their drugs, acquired in advance, under the supervision of the nursing and medical staff. These health care professionals are able to react quickly in the case of an overdose. The staff of Insite also include social workers and therapists who can provide users with counselling and advice about the community services and resources available, particularly treatment services and housing (British Columbia Centre for Excellence in HIV/AIDS, 2009).

Wood et al. (2006) reviewed evaluations of Insite conducted between 2003 and 2006. On the basis of the results, they concluded that Insite provided the Vancouver community with a number of benefits, not only in terms of harm reduction, but also recidivism prevention. The evaluations demonstrated that Insite had been able to attract drug users who are typically difficult to reach through conventional public health programmes, and that these users were more likely to turn to treatment programmes for their addiction, having used the clinic. Gaining access to treatment helped to decrease their drug use (or at least reduce the associated harmful effects); and it reduced the probability that they would commit offences under the influence of drugs. In addition, a significant reduction in the number of injections performed in public was noted following the opening of the clinic, reducing in turn the insecurity generated by public drug use. Finally, it was shown that opening the clinic was not associated with any increase in drug trafficking or crime associated with drugs in the surrounding area.
Preventing recidivism among drug-related offenders

Preventing recidivism among drug users may be achieved through the use of law enforcement including imprisonment, or through public health approaches. The latter approach assumes that a drug addiction is related to pre-existing risk factors requiring treatment rather than punishment (Chandler et al., 2009, Dackis et O’Brien, 2005, McLellan et al., 2000, in UNODC, 2010). Some research has shown that treatment programmes (and thus a public health approach) reduce drug-related crime more than imprisonment (Gerstein and Harwood, 1990, Guzdish et al., 2001 in UNODC, 2010). As the contribution by Javier Sagredo underlines, prisons can, unlike prevention programmes, result in integration into a criminal milieu, or introduce non-users to drugs.

Drug treatment programmes are voluntary, and an individuals should never be forced to take part, which would be a violation of their human rights and accepted medical standards (UNODC & WHO, 2008, in UNODC, 2010). Treatment programmes may be offered as an alternative to imprisonment by a court. Some national governments enable an arresting officer to direct a person to a treatment centre if they judge that this approach is suitable (ICPC, 2015).

At the sentencing stage, a court of law or a specialized drug court may offer a treatment programme (IDPC, 2012). In Canada, one evaluation showed that the courts which generally opted for the treatment of drug addiction rather than punishment, helped reduce criminal recidivism more than those using imprisonment (Bureau de la Gestion de la Planification Stratégique et du Rendement, 2012).

Treatment programmes may also be offered in prison, and have also shown a decrease in recidivism (see in particular Insulza, 2013 and National Institute of Justice, 2011).

In the case of indigenous populations, some national strategies include the establishment of restorative justice and community justice alternatives. Insulza (2013) stresses that these play a significant role in social integration and recidivism prevention.

### Comparing cities

#### The selection of cities

For the purposes of this chapter, ten cities were identified which had one or more drug prevention policies – either already implemented, or in the process of being adopted. The selection was based on three criteria: cities located in a country whose national drug strategy had previously been analysed by ICPC for its report on drug-related crime (ICPC 2015), this enabled in-depth comparisons to be made between municipal and national strategies; cities with readily accessible information on their drug policies; and ensuring a diverse geographical distribution. The final selection included five European cities (Amsterdam, Biel, Glasgow, Lisbon and Stockholm), two North American cities (Ithaca and Vancouver), one in Africa (Cape Town), one in South America (Bogotá), and one in Asia-Pacific region (Melbourne).

The aim of the analysis was not to provide a systematic identification of urban drug policies, but to identify strategies which have innovative aspects, those which help to prevent drug-related crime, and to identify similarities and differences between these municipal strategies.

Given the specific context of each city and country, it was also important to assess the degree of autonomy which respective local governments have in relation...
to their national government strategies. The analysis examines the approaches and objectives targeted by each municipality, to assess whether they adopt a holistic approach, encourage coordination and multi-sector collaboration, promote a favourable social environment and reduce marginalization, as well as implement effective programmes. As discussed above, these are all necessary elements for an effective prevention policy.

Autonomy of the cities in relation to drug policy

To assess the degree of autonomy of each city, they were classified into two groups on the basis of their national government's jurisdictional policy:
1) a centralized approach (Canada, Portugal, the US) and
2) a decentralized approach (Australia, Colombia, the Netherlands, South Africa, Sweden, Switzerland, the UK).

a) Centralized approach

The national drug strategies of Canada, Portugal and the US are centralized. In all three cases, the prevention processes are selected and implemented by one or more agencies or organizations under the control of the national government (ICPC, 2015; Reitox Network, 2012). For instance, as part of Canada's National Anti-Drug Strategy, the Anti-Drug Strategy Initiatives program provides funding to organizations – such as NGOs, universities, and other levels of government including provinces, territories and municipalities – to help them implement health promotion, prevention and treatment projects (Government of Canada, 2015). In Portugal, the Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (SICAD) comes under the Ministry of Health and is responsible for coordinating the implementation of the national plan with municipalities and non-governmental organizations.

b) Decentralized approach

Two types of decentralization can be identified: countries which delegate policy powers to regional or state authorities, as in the case of Australia, Switzerland and the UK, and those which delegate policy-making powers to municipalities themselves, as is the case in Colombia, the Netherlands, Sweden and South Africa.

Regions

The UK delegates part of the responsibilities associated with the national drug strategy to the governments of its constituent countries – for instance the Scottish and Welsh Governments – whereas in Switzerland and Australia the design and implementation of drug prevention strategies must take account of national and regional policies. Thus the cities of Biel, Glasgow and Melbourne are required to design their drug-related strategies in relation to both their regional and national governments. Nevertheless, all three cities had some autonomy over the kinds of prevention programmes they established and partnerships with local actors. Biel and Glasgow are responsible respectively for social and professional integration (Direction de la Formation, de la Prévoyance et de la Culture, 2011) and community reintegration of addicts (City of Glasgow, 2014). Biel and Melbourne have a certain amount of autonomy with regard to harm reduction (City of Melbourne, 2014; Direction de la Formation, de la Prévoyance et de la Culture, 2011). Finally, Glasgow has considerable autonomy regarding regional and national government in terms of the protection of vulnerable populations, particularly children, and initiatives for families which aim to reduce drug-related crime (City of Glasgow, 2014).

Cities

In the case of Colombia, the Netherlands, Sweden and South Africa, decentralization is to the advantage of cities. In all four cases, national strategies stipulate that municipalities must develop local policies to prevent drug use (Department of Social Development, 2013; Ministry of Health and Social Protection, 2014; Reitox Network, 2012). The four cities are responsible for coordinating action and play a major role in preventing drug use and its harmful effects, and

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Source: Authors
reducing supply (City of Cape Town, 2014; Reitox Network, 2012; Secretaria de Salud, 2011). In addition, Amsterdam and Stockholm are also responsible for the regulations governing coffee shops6 in the Netherlands and head/smartshops7 in Sweden, as well as supervising night-life and preventing public nuisance (Reitox Network, 2012). Amsterdam also has responsibility for preventing recidivism, the reintegration of prisoners on their release, and homeless people who use drugs (Reitox Network, 2012a).

The views of the city governments examined are generally in harmony with those of their national governments in terms of their approach to drug issue, with the exception of Ithaca and Vancouver. For instance, both Stockholm’s programme and the national Swedish strategy incorporate a range of policy objectives – prevention, supply and demand reduction, as well as treatment – geared towards achieving a drug-free society. Ithaca and Vancouver, for their part, recommend a public health approach, even though neither the US nor the Canadian governments have so far endorsed harm reduction in their strategy8 (ICPC, 2015). This is in spite of the fact that in both cases, their national government strategy favours centralized implementation and coordination. Portugal, which also applies a centralized approach, sees harm reduction as the foundation of the national strategy. The role of cities is recognized and their actions integrated into the framework of partnerships with the central administration (Reitox Network, 2012). It is possible that national strategies which take a strong prohibitive approach to drug use, and give little autonomy to cities, may encourage them to develop alternative approaches.

The characteristics of the municipal strategies in the study

How far do the city strategies meet the criteria for effective prevention? As we have seen, this requires an approach that it is holistic; that encourages coordination between services and interventions; that promotes a favourable social environment and reduces marginalization; and uses evidenced-based practices and programmes.9

a) Adopting a holistic approach

Of the cities studied, several have adopted a broad vision on how to deal with drug issues which takes account of the range of associated factors. In the US, for example, Ithaca clearly stipulates in its strategy that: “Too often, our past approaches have failed to recognize that fundamentally, the community prevalence of health problems, such as problem drug use, and social problems, such as participation in the illegal drug economy, reflect deeper issues related to social and economic opportunity and racial inequality” (City of Ithaca, 2016, p. 2).

A series of consultations carried out by the city concluded that the drug problem was intimately linked to unemployment, geographical isolation, racism and poverty, all factors that can encourage a sense of hopelessness and increase the probability of problematic drug use (City of Ithaca, 2016). This encouraged the city to set out objectives – such as reducing racial inequality, and economic and community development – that do not directly target drug use, but instead tackle the issues that have an impact on it. Factors such as poverty, social inequality and lack of job opportunities have been widely identified as risk factors common to crime and drug use (Atkinson et al., 2009). The interventions planned by Ithaca hope to reduce both drug use and crime.

While Amsterdam does not have an integrated drug strategy at the municipal level, the city targets a number of issues associated with drugs through a range of policies. This includes policies concerning coffee shops, the organization of social assistance, treatment for problem drug use, licencing of major events, educational and other prevention activities (Laar et al., 2013). These policies cover a range of prevention approaches: for example, social assistance and treatment programmes for drug addicts help to reduce harmful effects and prevent recidivism, while educational and other prevention programmes help prevent initiation into drug use. Thus while Amsterdam does not have a specific integrated drug strategy, the range of programmes help to respond to risk factors associated with drug use.

The city of Melbourne provides a good example of a holistic approach to drug-related crime prevention. Drug issues are integrated into its overall crime prevention strategy Beyond the Safe City. The strategy focuses on creating a safe and healthy environment in the city, and takes a global approach to the causes of crime, violence, drug and alcohol problems and other antisocial behaviours (City of Melbourne, 2014). Programmes target risk factors, for example, by developing resilience in children and young people, helping them develop their social skills, deal with stress through conflict management, and encouraging them to participate in the life of their city. This aim is not only to prevent crime and violence but also drug use.

Finally, given the close link between drug addiction and mental health disorders, prevention strategies need to include specific mechanisms to allow for collaboration. The city of Vancouver has a strategy that specifically targets the links between drugs and mental health. This helps to improve collaboration
between the different services involved in the treatment and prevention of drug addiction and mental health disorders, particularly health and housing departments, the police, and community organizations offering peer support services (Mayor’s Task Force on Mental Health and Addictions, 2014). The strategy provides a framework for a harm reduction and recidivism prevention approach, ensuring that drug users with mental health problems can access addiction treatment programmes.

b) Encouraging coordination between sectors and interventions

The drug problem is a complex, multi-dimensional issue that requires a multi-disciplinary and multi-level approach. As Kübler and Wälti argue (2001, p. 43) “Contemporary drug policy in the urban context is mainly a question of creating coordinated action among a multitude of actors and agencies that are involved, in various ways, in addressing the drug problem.” The effectiveness of the response depends to a large extent on how well a strategy is articulated between national, regional and local governments, and especially on coordination between policy makers and stakeholders at the local level.

Given that cities must liaise closely with their citizens, community organizations, the private sector and other levels of government, coordination is essential (ICPC, 2010). What kinds of framework mechanisms have cities developed to ensure that they can coordinate public health and public order concerns around drugs and drug-related crime (Hughes et al., 2013)? What is their _modus operandi_? Drawing on a descriptive review of drug coordination (2002), as well as a report on coordination agreements within the Member States of the EU (2001) carried out by EMCDDA, two types of mechanisms can be identified: a coordination unit and a specialized agency.

The coordination unit

The coordination unit is composed of public employees attached to a specific municipal department or agency, usually concerned with health or social services. According to the EMCDDA, this type of mechanism is fairly informal and does not have the strong coordination powers of a specialized agency or one specific to drugs (2002). For example, in Biel, a committee of specialists was created to coordinate the provision of services to people with addiction problems, and provide a network of experts on the subject. In this case, the coordination unit was overseen by both the Direction de la Formation, de la Prévoyance Sociale et de la Culture, and la Direction de la Sécurité.

The specialized agency

The primary aim of a specialized agency or an agency specific to drugs, according to the EMCDDA, is to improve coordination between actors. A specialized agency is not under the authority of another department, and given its specific mandate in the field of drugs, it has wider and more holistic powers which than those of a coordination unit (EMCDDA, 2002). Of the cities studied, Cape Town, under the leadership of the central government, created a local drug action committee responsible for ensuring the coordination of specific drug actions within the city. Another example can be found in Lisbon, where all decisions in terms of coordination are made by SICAD, a specialized agency created by the central government.

c) Promoting a favourable social environment and reducing marginalization

Several cities include initiatives to reduce vulnerabilities by improving living conditions in their municipal strategies. Bogotá stands out in this respect: of the seven objectives in its municipal strategy which are specific to drugs, four aim to promote a favourable social environment. This includes reinforcing and developing the capacities of families and communities to prevent drug use, reinforcing social and emotional skills, encouraging full participation in the life of the city, and improving the quality of life. The right to protection and health for citizens is also underlined and promoting a culture of prevention (Alcaldía Mayor de Bogotá D.C., 2011).

In Ithaca one of the objectives of their strategy is directly concerned with reducing marginalization. The city aims to promote economic and community development to improve the living conditions of young people and families, including increasing the economic opportunities and public health services in communities, and ensuring that the most vulnerable individuals receive benefits (City of Ithaca, 2016).
Among other objectives, Vancouver’s mental health and drug addiction strategy aims to reduce the stigma attached to those suffering from mental health disorders or addiction problems. The strategy sees stigmatization as a barrier to accessing services and treatment, and contributes to their sense of exclusion, especially those living in poverty (Mayor’s Task Force on Mental Health and Addictions, 2014).

d) Implementing evidenced-based prevention programmes

As previously mentioned, evidenced-based prevention programmes in the field of drug-related crime can either aim to prevent drug use, reduce the harm associated to drug use, or prevent recidivism among drug-related offenders. We presented different types of evidenced-based programmes that could be implemented to achieve such objectives. Across the selected cities, many have incorporated similar programmes in their strategy.

Many municipal strategies aim to prevent drug use with awareness-raising campaigns and interventions in schools, with families and in community settings, including those in Biel, Bogotá, Cape Town, Glasgow, Ithaca, Lisbon and Vancouver. For example, Cape Town which has a holistic and integrated strategy targeting individual, family and social risks factors, includes programmes in schools, with families and in communities. As discussed above, programmes which work only in schools have been found not to be effective in preventing future drug use (ICPC, 2015), so the Cape Town model demonstrates good practice. School-based programmes help young people improve their communication skills, resist peer pressure and control feelings of anger. Family programmes reinforce the ability to cope with problematic behaviours. Other interventions aim to improve socioeconomic conditions. Thus the strategy targets the range of risk factors associated with future drug use.

As indicated above, several cities have adopted a harm reduction approach, including proving heroin under medical supervision, developing supervised injection sites and treatment programmes, all found to be effective in reducing harm and associated crime.

Biel and Vancouver both have supervised injection sites reducing the risks of illegal drug use and offering supports. Ithaca plans to open a 24 hours crisis centre, which will include a “decompression” zone for people under the influence of drugs. The aim is to connect people with treatment services, and minimize public intoxication and drug-taking, thus reducing the insecurity that public drug use can provoke (City of Ithaca, 2016). The city is also considering setting up a methadone clinic and a supervised injection site. Several other cities also have a “treatment” component to their strategy. This can take the form of substitution measures, such as dispensing methadone. In Glasgow, the “path to recovery” is seen as unique for each individual (Alcohol and Drug Partnership, 2014). Treatment is seen as a process related to the objectives set by the person themselves. This could include developing techniques for avoiding relapse into drug use, rebuilding relationships damaged by drug use, or engaging with society in a significant manner. Thus intervention is not focused specifically on drug use, but on repairing the harm it has generated in the user’s life. In Lisbon, the Alcântara refuge is a temporary residence for drug users. It provides a place where they can plan entry into a treatment programme, and takes them out of the environment which led to or enabled their drug taking. The refuge helps direct them to appropriate resources and treatment (Reitox Network, 2012).

A number of cities include the prevention of recidivism in their strategies, targeting those with a criminal history associated with drug use. Biel, for example, provides rehabilitation services, including job placements, training and housing (Direction de la Formation, de la Prévoyance et de la Culture, 2011). Drug treatment courts are also found in some cities, proving alternatives to imprisonment and reintegration programmes. Vancouver implemented a drug treatment court in 2001, the second city in Canada to do so after Toronto in 1998 (Somers et al., 2012). In a longitudinal evaluation Somers et al. (2012) concluded there was a significant reduction in crimes committed by those who went through the drug court, compared with a control group who did not.

Conclusions

This chapter has examined some of the main issues concerning the prevention of drug-related crime in an urban context. It is clear that such prevention must take into account a number of factors which can support and foster drug use and are specific to the city context. Global trends in drug use and drug control at the international level marked a turning point in 2016, with the UN Special Session on drugs, and the acknowledgment that punitive policies have been counterproductive and costly. Alternative approaches including prevention and harm reduction are now more widely endorsed.

The chapter also reviewed the two main theoretical models developed in the literature to explain the links between drug use and crime – one which sees a causal relationship between crime and drug use, and one which regards it as correlational. A number of risk factors for drug use and crime have also been clearly identified in the literature, relating to the characteristics of individuals, family and relationships and
communities. They underline the fact that the links between crime and drug use are complex and multi-faceted, and that drug use is often linked to a range of other problematic social issues.

On the basis of the literature, and drawing on a comparative analysis of ten cities, we can outline the key components of an effective strategy targeting drug-related crime issues. They include the importance of developing a holistic strategy, ensuring multi-level and multi-sector coordination, and promoting a favourable social environment and reducing marginalization. In addition, given that cities are where most drug use and drug-related crime take place, it may be important for them to have a certain degree of autonomy from national or regional governments in terms of deciding the appropriateness of specific strategies in terms of the context of their city. This includes in relation to the implementation of harm reduction programmes. Finally, it is also essential to build in monitoring and evaluation mechanisms into city strategies, to ensure that programmes and policies are built on good evidence and modified where necessary, as well as to ensure the sharing of information at the local level and with non-governmental organizations, at regional, and at the national level.
The prevention of drug-related crime, especially amongst young people, is a major issue for the Canadian Federal Government. In the 2015 Throne Speech, the Government of Canada committed to legalizing and regulating marijuana; however, restricting access to marijuana and protecting children and adolescents by preventing them from obtaining marijuana remain two central objectives that the government seeks to achieve with the new policies and the new system of legalization (Government of Canada, n.d.).

Drug consumption, and more recently the legalization of marijuana, is a constant concern, particularly given the more prevalent involvement of youth and other vulnerable populations, economic costs, concerns about emerging issues, and the desire to foster healthier and safer communities for all citizens. Besides being a priority for public safety, substance abuse is a central priority for public health in particular because of the impact it has in adulthood, for example, in terms of chronic diseases, addictions and mental health problems (EMCDDA, 2009).

According to estimates by the United Nations Office on Drugs and Crime (UNODC), approximately 200 million people worldwide have reported using marijuana on at least one occasion in 2012. A report by UNICEF released in 2013 ranks Canada amongst the countries in which young people consume the most marijuana in the world (EMCDDA, 2009).

In Canada, despite bans on consumption, marijuana remains the most consumed illegal substance. In fact, it is the second most consumed drug for recreational use in Canada, after alcohol, especially among young people. About 22 million Canadians aged 15 or older, around 75% of the population, drank alcohol in 2013. In comparison, 11% of Canadians aged 15 or older reported having used marijuana on at least one occasion in 2013. A deeper examination of the data shows us that in 2013, 8% of adults over 25 and 25% of young people aged 15 to 24 reported having consumed marijuana in the past year. This data is also corroborated by the 2013 Canadian Tobacco, Alcohol and Drugs Survey (Statistics Canada, 2015), where young people aged 15 to 24 were the group with the highest rate of self-reported illicit drug use in the last year among all Canadians. These young people were also four times more likely to report wrongdoing due to drug use than adults aged 25 and over. Young people are also more likely than adults to indulge in risky consumption and suffer more harm in their life trajectories (Young, M.M. et al., 2011). It has also been shown that investment in drug prevention is successful. For every dollar invested, between 15$ and 18$ could be saved (McInnis, O.A. & Young, M.M., 2015).

Through its multiple implications and repercussions, effective prevention of substance abuse among young people and a greater understanding of the issues arising from legalization requires an approach that is coordinated, holistic, and multi-sectoral between key players at various levels of government as much as at the local level.

Several federal prevention initiatives have emerged and one of the best known is probably the National Anti-Drug Strategy, an interdepartmental collaboration between twelve ministries led by Justice Canada, in operation since 2007. Through this strategy, the Government of Canada “contributes to safer and healthier communities by helping prevent use, treat dependency and reduce production and distribution of illicit drugs as well as by addressing prescription drug abuse.” (Government of Canada, 2014).

Public Safety Canada (PS) has been active within the context of the National Anti-Drug Strategy. Indeed, PS through its National Crime Prevention Strategy (NCPS) has financed ten evidence-based programmes for the prevention and reduction of substance abuse among youth. Funding for such programmes comes under the NCPS mandate since the correlation between addiction to alcohol or other drugs and crime has been well established in scientific research, particularly the role of early alcohol and other drug abuse on crime, demonstrating the need for prevention and early intervention with young people (National Crime Prevention Centre, 2009).
Evidence-based programmes for the prevention of substance use among youth

When talking about evidence-based programmes, registries or programme classification systems do exist, their main objective being to categorize programmes based on their level of effectiveness of results, taking into account the rigidity, reliability and validity of the evaluation, factors related to implementation and, in some cases, the sustainability of results and the number of programme replications (Gabor, T., 2011). These registries act as search engines to identify the best programmes and are in a way a simple and interactive way to operationalize the evidence-based approach. These registries also act as knowledge dissemination hubs for programmes and practices and are empowering local communities to choose the most appropriate programme to suit their situation and clientele.

In Canada, such a programme classification system does not exist yet. Currently, there are several in the United States, in different fields of activity. In the specific field of substance abuse and mental health, there is the Substance Abuse and Mental Health Services Administration (SAMHSA)’s National Registry of Evidence-based Programs and Practices (NREPP), which includes more than a hundred evidence-based programmes.

Backed up by the evidence/data provided by these classification systems, the NCPS has supported the reproduction of evidence-based programmes in the Canadian context for the prevention and reduction of consumption among young people. For example, from 2009 to 2013, six organizations received funding to implement the Botvin LifeSkills Training Program (LST), a school-based prevention programme that targets early drug and alcohol abuse by teenagers, especially those who are in middle school (sixth and seventh grades). Most of these projects included an Aboriginal clientele and the results of one of the projects have been the subject of an evaluation.

Another prime example is Towards No Drug Abuse (TND), a programme designed to help young people, aged approximately 14 to 19 years, to reduce tobacco, alcohol or drug use as well as related violent behaviour. From 2009 to 2014, the John Howard Society of Hamilton (Ontario) has implemented the TND programme in schools under the Hamilton-Wentworth District School Board. Other programmes, also considered model and promising programmes that have a positive impact on reducing substance abuse among young people, are currently supported by NCPS and their results are under evaluation. For example, Functional Family Therapy (FFT) has been implemented in Alberta, and the Strengthening Families Program (SFP), has been replicated in nine sites across Canada since 2010, including three under evaluation.

Substance abuse prevention and reduction programmes for youth, whether they are programmes in urban or rural areas, should be evidence-based, and be evaluated systematically. Programme evaluation, in addition to renewing and developing new knowledge, also strengthens, through lessons learned, the key principles already supported by research to constantly guide future projects towards a strategic and effective approach.
Crime and drug use: Dominant paradigms

The institutional and social stereotypes that have facilitated the problematization of the illegal drugs phenomenon in today’s societies have traditionally been characterized by fear and anxiety related to the substances themselves and the people involved. This fear of deviant behaviour, illness, violence, crime, and social exclusion, has been primarily translated into, by both the health and justice sectors, measures of repression and control, of imprisonment and exclusion, based on a conceptualization of drug use as a personal choice and not as a phenomenon with deep biological, psychological, health, cultural, economic, and social roots.

Bias in the literature and the data; spurious causal relationships

As we have seen, there is evidence that there are some correlations between drug use and crime. However, some studies have revealed a statistically significant negative relationship between drug use and violent crime (Valdez, Kaplan, & Curtis, 2007). Even when drug users commit an offence in order to obtain drugs, these offences are for the most part non-violent (theft, prostitution, selling of drugs), violence being avoided when alternatives exist (Johnson et al., 1985).

Other studies (French, McCollister, Alexandre, Chitwood, & McCoy, 2004; Pernanen, Cousineau, Brochu, & Sun, 2002) including both predatory and property crimes. No study, however, has examined the cost of crimes associated with drug users both as victims and as perpetrators. In the present study, recent data were analyzed from a targeted sample of chronic drug users (CDUs continue to focus on re-emphasizing the existence of almost direct causal connections between drug use and crime, using as evidence the confluence of both practices within the offending population. The relationship with crime is then automatic when we study in isolation the population in conflict with the law. Thus it seems sufficient to demonstrate that the prevalence of drug use or problematic drug use is higher than that among the general population. However, in such cases, the principal reference group should not be the general population; rather, the reference should be established across control groups of individuals who present similar personal, relational, structural, or other relevant risk factors.

In chronological terms, drug use can also emerge post hoc, as a result of criminal behaviour or the consequences it involves for individuals (such as imprisonment). In this sense, it has been shown that there is a close relationship between incarceration and drug use (Montanari et al., 2014): up to 26% of drug users in European prisons started using drugs in prison, and up to 21% of imprisoned intravenous drug users began injecting in prison (Allwright et al., 2000; EMCDDA, 2002); similarly, prisoners also often take additional substances (Todts et al., 2008) or change to other substances or methods of use that are more problematic (Niveau & Ritter, 2008).

Beyond the three aspects proposed in the Goldstein model, which we have already seen (the psychopharmacological aspect, the economic-compulsive aspect and the systemic aspect), the connection between drug use and crime is often reinforced artificially with the addition of a fourth aspect – that inherent to those crimes that result directly from drug use, categorized in many cases as being “against public safety” or among crimes without victims (and, naturally, committed without violence), such as use (in private or in public) or possession of illegal drugs. Here, the link is direct and occurs in all cases, given the immediate penal classification.

These correlations and nexuses have historically been used as evidence to build profiles that automatically and causally link drug use and crime, and to justify repressive and educational measures as a means of reducing both phenomena.

And yet neither drug use nor crime occurs in a laboratory; rather, they are subject to a series of interactions with other pre-existing determinants that characterize their development (Otero López, 1997). The vulnerabilities, context-specific characteristics, social practices and dominant relational modes and ways of life, and
the existence of cultural determinants that are associated with the informal, the violent and the illegal (or the pursuit of pleasure or new experiences, or the relief of pain), and the permanent interaction between these factors, are elements to take into account in efforts to understand the drug use–crime equation, even if the causal relationship can be shown to be spurious.

Responses in public policy

The impact of the criminalization of drug users has been dramatic. The connection of a large number of users with the penal justice system has had enormous personal, family, economic and social costs, making it hugely difficult to reintegrate such individuals both socially and into the job market, given the persistent presence of prior convictions. Moreover, many drug users have been exposed as a result to repressive police practices, abusive situations and restrictions to many of their basic civil, political and social rights. Meanwhile, criminalization has pushed drug use further underground, making it more difficult to implement inter-sectoral responses and to connect problematic users with health and social services and with treatment and harm reduction programmes. This has contributed to the transmission of serious illnesses, such as AIDS, and has put people’s lives in danger.

These state responses have, in many cases, led to increased poverty and vulnerability, difficulties with reintegration in the social and work spheres and greater dependency on illegal economic practices and, eventually, on criminal activities that lead to violence. This has increased the potential for criminal recidivism of those who enter into this cycle, in which many are mired just because they are criminalized as simple users, without offering opportunities for recovery – social, economic or health-related.

We only need to look at the fact that prior convictions represent a formidable obstacle in the search for formal employment in many ways, leaving people with only informal or illegal income-generating opportunities. The rehabilitation function of the penal system has not been prioritized; on the contrary, prisons have emerged as an overpopulated space with the potential to generate violence, human rights abuses, criminal networks and criminal recidivism (UNDP, 2013).

Human development as the ultimate aim of interventions: Perspectives and promising initiatives

Anchoring drug policies in a human development paradigm supposes that these policies should no longer have a negative impact on the development of individuals, but should play out in favour of sustainable and inclusive development for all. Such policies, including those that relate to drug use problems, must not continue to insist on using objectives based on numbers of people detained, processed or imprisoned, but rather must look to count numbers of people who are positively and fully reintegrated in community life. When respect for human rights, public health, quality education for all, gender equity, citizen safety and reduced violence, environmental sustainability and economic and social inclusion become our objectives, they also change our perspectives, as well as the incentives for and consequences of policies.

Using this lens brings us to a series of logical consequences that will facilitate a more effective approach to issues associated with problematic drug use and its possible links to crime, with priority given to the idea of “care” and individual well-being rather than zero tolerance and abstinence. This underlines the need for sustained efforts with regard to the determinants and risk factors that spread across people’s involvement in criminal behaviour, based on what we have learned from the violence and crime prevention field. Social policies, as well as policies related to work and economic reintegration and social protection, should be at the centre of the response, along with appropriate prevention proposals targeting those who have already come into contact with drugs, whether or not this contact is problematic.

Another logical consequence will be the decriminalization of drug users, who should not be subjected to repressive methods or have to enter into the criminal or penal justice system. This would then substantially reduce the problems associated with this phenomenon. Approaching the problem from a community perspective, by contrast and, within this, offering access to treatment and harm reduction that is of sufficient diversity and quality, will promote social integration, reduce stigma and marginalization and facilitate the development of life plans within the community for those targeted. And it is more cost-effective to do this rather sooner than later.

This approach should incorporate specific measures, at the different intervention levels, to work with people who come up against the law and who also have problems with drug use (CICAD & OEA, 2014):

- Interventions before the criminal procedure aimed at avoiding contact with the criminal justice system and reducing prosecution, by means of programmes of “diversion” towards treatment and other social support services. Programmes like Law Enforcement Assisted Diversion in Seattle, United States, have produced interesting results.
- Criminal procedure methods that avoid imprisonment, in cases where prosecution occurs: alternative penalties such as fines or community service; judicial
monitoring of treatment; or suspended sentence programmes (or the use of "conditional freedom", as in the HOPE programme in Hawaii, United States) can eliminate some of the negative consequences of imprisonment. Similarly, these can play a role in mitigating the sentencing guidelines concerning drug-related offenses, as in Wales, England and the United States (Smart on Crime), in order to reduce convictions for this type of crime.

-Within the period of detention, facilitating universal access to treatment and harm reduction methods for the prison population, whose drug use problems are greater than those of the general population.23
- Finally, post-procedural approaches that facilitate early release and improved social reintegration.

All these proposals entail adaptation of the programme design to specific contexts and populations. Involvement and active participation of the different public, private and civil society actors at the local level, and the provision of resources to facilitate effectiveness, are key elements in local communities developing successful solutions with an emphasis on economic and social inclusion.
Endnotes

1 The boundaries shown on this map do not imply official endorsement or acceptance by the UN. Dashed lines represent undetermined boundaries. The dotted line represents approximately the Line of Control in Jammu and Kashmir agreed upon by India and Pakistan. The final status of Jammu and Kashmir has not yet been agreed upon by the parties. The final boundary between Sudan and South Sudan has not yet been determined.

2 These characteristics were identified in a comparative study of seven national drug policies conducted by ICPC (2015). The study included a review of the literature and interviews with government representatives.

3 Early interventions generally support families with high risk factors from pregnancy onwards.

4 This refers to Belgium’s Directive commune de la Ministre de la Justice et du Collège des procureurs généraux relative à la constatation, l’enregistrement et la poursuite des infractions en matière de détention de cannabis.

5 These specialized courts include representatives of social services and medical treatment, and work with users who have committed non-violent crimes (ICPC, 2015).

6 Establishments where the sale of cannabis is legal.

7 Shops specializing in the sale of legal plant based psychotropic drugs.

8 It must be noted that the Canadian government’s approach to drug policy is moving towards a greater emphasis on harm reduction, as the Minister of Health, Jane Philpott, stressed during her plenary statement at UNGASS (Government of Canada & Health Canada, 2016). She noted the important work being done at supervised consumption sites such as Insite and mentioned the Canadian government is currently considering the legalization or decriminalization of cannabis.

9 See Section 4 of this chapter on The characteristics of an effective prevention strategy.

10 Research Consultant, Public Safety Canada.

11 Acting Director Research Division, Public Safety Canada.

12 See (Savignac, J. & Dunbar, L., 2015) for more details on the evidence-based approach and the selection of an effective programme.

13 See Blueprints for Healthy Youth Development for programmes for prevention and positive social development of young people; Crime Solutions for programmes related to prevention and the justice system; Coalition for Evidence-Based Policy and the Top Tier initiative for social programmes; What Works Clearinghouse for the field of education; and What Works in Reentry Clearinghouse for the reintegration of offenders.

14 See www.nrepp.samhsa.gov/ for more information on NREPP.

15 See http://lifeskillstraining.com for more information on the LST programme.

16 For more information on the evaluation results of the LST programme in the Canadian context, see (Rosario, G., 2016) Research report: Evaluation Summary of the Life Skills Training Program.

17 See http://tnd.usc.edu/ for more information on the TND project.
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CHAPTER 5
Crime prevention and drug use in an urban environment


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CHAPTER 5 CRIME PREVENTION AND DRUG USE IN AN URBAN ENVIRONMENT

RETAINED MATERIAL

**Contributions**

Drug-related crime prevention in the urban context – some examples of programmes funded by the National Crime Prevention Strategy, Public Safety Canada


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**Prevention of crime related to drug use**


