# Drug Policy and City Government

## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>4</td>
</tr>
<tr>
<td>Cities and Drugs: The State of Affairs</td>
<td>6</td>
</tr>
<tr>
<td>Innovative Urban Drug Policy: From the Margins to the Mainstream</td>
<td>10</td>
</tr>
<tr>
<td>History of Cities Innovations</td>
<td>10</td>
</tr>
<tr>
<td>Mediation of Conflicting Citizen Concerns at the Local Level</td>
<td>12</td>
</tr>
<tr>
<td>Cities Coalitions and Knowledge Sharing</td>
<td>13</td>
</tr>
<tr>
<td>From Europe to North America and Beyond</td>
<td>14</td>
</tr>
<tr>
<td>Urban Drug-Related Issues: Safety, Violence and Law Enforcement</td>
<td>15</td>
</tr>
<tr>
<td>Violence and Illegal Drugs in Cities</td>
<td>15</td>
</tr>
<tr>
<td>Law Enforcement and Safety</td>
<td>16</td>
</tr>
<tr>
<td>Citizen Well-Being, Public Health and Urban Social Resilience</td>
<td>17</td>
</tr>
<tr>
<td>Urban Drug Markets: Paths to the Local Regulation of Cannabis</td>
<td>19</td>
</tr>
<tr>
<td>Recommendations</td>
<td>21</td>
</tr>
<tr>
<td>City Profiles and Policy Responses</td>
<td>22</td>
</tr>
<tr>
<td>References</td>
<td>31</td>
</tr>
</tbody>
</table>
During the past decade, drug policy reform has made unprecedented advances at the international, regional and national levels. As members of the Global Commission on Drug Policy, we have seen and accompanied several of these changes. In 2016, the UN General Assembly Special Session on drugs adopted an outcome document that reorients drug control to more balanced policies. In 2019, the UN System adopted a common position on drug-related matters. Countries have started legally regulating some drugs. And decriminalization of small quantities of drugs for personal use is quietly gaining traction worldwide. High-level discussions on drug policy reform have started among member states of intergovernmental regional forums in Africa, the Americas and Europe.

One particular level is formally absent from this debate, however. It is also the level where policymaking is most confronted with the damage caused by punitive drug policies and where the largest numbers of socially vulnerable people live: cities and municipalities.

Cities, which bear the brunt of repressive national and international drug control policies, are growing quickly. The total urban population will represent 68 percent of the world population by 2050. Drug trafficking, the most profitable illicit economy for organized crime, generates visible violence in cities that is used to intimidate citizens and coerce loyalty, as well as to confront law enforcement and secure trafficking. The links between violence, aggressive drug trafficking and blindly punitive legal responses are clear in Latin America and the Caribbean, where 42 of the world's 50 most violent cities are concentrated along cocaine trafficking routes.

To help cities tackle the problems that repressive policies pose for people in urban areas, and to analyze the capacity of cities to respond, we decided to publish this position paper and offer it to mayors, heads of municipalities and local governments to inform their drug policies. This paper provides an overview of what cities have done, what they are doing now and where they are headed.

Local policy makers have helped to drive drug control policy - and its reform - since the 1930s, when they opposed the prohibition of less potent drugs and drew attention to the impact of criminalization on the rule of law in North America. In the 1980s, they faced the HIV crisis driven by drug injection. Since then, some European cities have introduced harm reduction policies, aimed at minimizing the negative impact of behavior, whether it is legal or illegal.

Today, policy innovation is happening in cities all over the world – not only in high-income countries, but increasingly in programs and initiatives led by municipal bodies in Latin America and the Caribbean, in North Africa and in Sub-Saharan Africa.

We, the members of the Global Commission on Drug Policy, know that cities have a pivotal role to play even if punitive drug laws are adopted at the national level. We understand that cities have the scope to confront the problems created by repressive drug control, including gaining community trust, protecting public health, responding to violent turf wars and preventing the marginalization of entire communities.

Cities have the legal flexibility to design and implement pilot projects that alleviate the harm caused by punitive national policies. But not all of them have the same powers, competencies or resources. While some have health departments, police departments, local jails and housing services, others do not. Yet mayors play a pivotal role in drug control policies for our societies. Mayors are the closest elected officials to all of their constituents.

We encourage mayors to offer their citizens a large spectrum of harm reduction services and not to shy away from implementing these effective but – unfairly – sometimes controversial services. We further call on mayors to instruct their municipal police forces to end harassment of people who do no harm but use drugs. Fear of arrest and fear of abuse must no longer prevent people dependent on drugs from accessing services they are entitled to, including rights-based health, housing and social services.

The world is changing rapidly, even more so since early 2020. Drug policy reform is crucial to build fairer and more inclusive societies. International mechanisms for appropriate drug policy now exist. The combination of the spirit of the sustainable development agenda and the outcome of the UN General Assembly Special Session on drugs allows for the reforms that are necessary to leave no one behind. The time to implement effective drug policies is now. Cities and municipalities – which are at the core of the fight for equal access to health and social services – are the most efficient agents of change.

Helen Clark
Chair
Former Prime Minister of New Zealand

Pavel Bém
Former Mayor of Prague
RECOMMENDATIONS

Cities are the authorities most exposed to the damage caused by prohibitive drug policies. We, the members of the Global Commission on Drug Policy (a number of us having been mayors and members of municipal parliaments) believe that city authorities are also the most efficient agents of change as they fight for equal access to health and social services. As cities will host 68 percent of the world population by 2050, while concentrating larger numbers of socially vulnerable people, we recommend immediate action to improve urban drug policy.

Cities and municipalities must:

1. Design and implement local drug policies that put city dwellers’ health and safety first

Cities and municipal governments and parliaments have the legal leeway to launch pilot projects to remedy the health issues caused by problematic drug use. Policies should prioritize safe neighborhoods and healthy communities. Health and social interventions, including evidence-based treatment, harm reduction and prevention programs lessen transmission of HIV, hepatitis and tuberculosis. Such programs also reduce petty crime, violence, degradation and displacement of communities. They are cost-effective, and do not require massive reorientation of municipal resources. Data collection and monitoring must be an integral part of pilot projects.

2. Ensure local/municipal drug policies are coherent and provide a platform to include everyone involved

No single field or discipline has the power to address all the dimensions of drug policy. From the inception of drug control debates at the city level, mayors should gather everyone concerned around the same table: families affected, law enforcement, prosecutors, educators, people who use drugs, municipal health and social workers, experts and civil society representatives. Building consensus among the different parties and taking into account the concerns of each as legitimate and relevant are key to developing well-informed, effective and long-lasting drug policy strategies that cohere with other public policies at the local level.

3. Ensure that local drug policies benefit from modern deterrence strategies and focus on reducing violence generated by illegal drug markets to achieve peaceful cities for all

Municipal/city authorities must accept that it is unrealistic to expect to eliminate the illegal drug market, and that managing and controlling it are far better long-term strategies to ensure safe, resilient and inclusive cities. Blanket repression must be replaced by focused deterrence strategies that aim to change behavior, including moving illegal drug sales away from sensitive areas such as schools or treatment centers. Targeted law enforcement interventions can reduce the violence caused by the drug market. They require a proactive, analytical approach to operations, based on intelligence and an understanding of the socioeconomics of the local context, and shaped by local needs and available resources.

4. Take control of local drug markets by legally regulating access to currently illegal drugs

City governments and parliaments should consider experimenting with legal regulation of currently illegal drugs within their urban territories. Such experiments should be strictly evaluated, incremental and inclusive. They could be pilots starting with substances that are easier to control, for which evidence exists on the best kinds of regulation, such as cannabis; or with substances used for medical treatments, such as substitution and agonist therapies to counter opioids. Such pilots, if well implemented, could demonstrate that there are alternatives to using repression to control drugs within a city.
CITIES AND DRUGS: THE STATE OF AFFAIRS

"All drug politics is local". City governments rather than national governments are the key actors and decision-makers on how to approach and implement drug policies. Historically, some have also been the first to support harm reduction and more ambitious drug law reforms. Nevertheless, as the comment noted: “in the global prohibition system, national governments matter and city governments are irrelevant because the ‘parties’ to the drug treaties and the members of the UN [drug control] system are the member states themselves.”

This divide creates a tension that remains unresolved today: cities around the world are committed to changing drug policy but their powers are limited and the scope of their actions depends to a significant degree on the national and international context. However, there is growing recognition that more local drug policy-making, especially at the municipal level, may be more effective than national policy-making because it can better respond to cultural differences, social circumstances and local politics.

Large cities, in particular, often bear the brunt of national drug problems and the consequences of national drug policies. Cities have to confront public disorder caused by street dealing, social and public health issues resulting from problematic drug use, and the high costs of enforcing prohibitionist drug legislation. This trend will only increase, as cities will host 68 percent of the world population by 2050 and concentrate a larger number of socially vulnerable people.

New York City, for example, experiences high levels of problematic use of opioids, with the “rate of drug poisoning deaths involving opioid analgesics [having] increased by 267 percent from 2000 to 2011.” Cape Town and its province carry the highest burden of drug-related crimes in South Africa, accounting for more than a third of drug-related crimes. In Shanghai, methamphetamine users have become the new most-used drug, a trend observed all over East Asia.

Drug policy involves many policy areas, including public health, social assistance, law enforcement, urban planning and social cohesion, to name just a few. The associated policy measures interact and, if not carefully coordinated, can counteract one another. However, the powers and competencies of city governments vary widely, as do their financial and institutional resources. Most cities have substantial autonomy when social and public health policies are concerned. They have little say over criminal justice matters, however. These fall within the remit of national, state or federal authorities, and in the case of drug policies, are also governed by requirements stemming from international drug control conventions. Some city governments have their own police departments, many do not. Some have substantial health and social services, while many cities, particularly in low- and middle-income countries, do not have sufficient budgets for those. Some have elaborate systems of consultation with their residents; others operate in a top-down manner.

It is not possible to take all these interacting governance variables and policy options into account. This position paper therefore narrows its focus to some positive and innovative examples. It aims to inform local policymakers, city administrators and officials – as well as concerned residents, social advocates and people who use drugs – about the limits and possibilities of public drug policy-making in cities. Inevitably, the examples often come from high-income countries in Europe and North America, where cities have more financial resources, more robust institutions and a longer history of urban planning, public health and social control policies. In low- and middle-income countries, drug policy-making takes place in a context where rapidly expanding cities face even more challenging problems related to poverty and development. Around 1 billion people live in slum conditions today, lacking basic services like clean water and sanitation.

CITIES CONTINUE HARM REDUCTION SERVICES DESPITE COVID-19 PANDEMIC

Around the world, harm reduction services are concentrated in urban areas, where large numbers of people live in proximity. While the COVID-19 pandemic has highlighted the capacity of cities to respond to challenges, it has also uncovered deep-rooted inequity, inequality and uneven access to services among neighborhoods and populations.

People who inject drugs are considered vulnerable in many jurisdictions. In Lausanne, Switzerland, this has prompted the delivery of substitution therapies to their homes by health workers since the restrictions implemented in early 2020.

In Abidjan, Côte d’Ivoire, community workers have continued delivering harm reduction services to people who use drugs, with the support of the local authorities, despite political instability.

Toronto, Canada, has introduced specific COVID-19 prevention campaigns calling on people who inject drugs to do so in injection facilities supervised by health and social professionals.

Such innovative approaches have alleviated the consequences of COVID-19 for people who use drugs. Their success is also an indication of renewed commitment by city authorities and social workers.

Consider the development of sustainable urban development initiatives for those affected by illicit drug-related activities to foster public participation in crime prevention, community cohesion, protection and safety and to stimulate innovation, entrepreneurship and employment.

Operational recommendation on strengthening international cooperation based on the principle of common and shared responsibility, UNGASS 2016 outcome document “Our joint commitment to effectively addressing and countering the world drug problem.”
At the international level, recognition is increasing of the importance of cities in global governance structures, of the grave harm that illegal drug-related activities can inflict and of the potential of development-oriented drug policies to minimize harm in developing countries. At the 2016 UN General Assembly Special Session on the World Drug Problem, states called for consideration of “the development of sustainable urban development initiatives” in the 2016 Outcome Document in order “to foster public participation in crime prevention, community cohesion, protection and safety and to stimulate innovation, entrepreneurship and employment” to counter the consequences of illicit drug-related activities. Such initiatives would fit well with Goal 11 of the UN Sustainable Development Goals: to make cities inclusive, safe, resilient and sustainable.

Each city has to establish how to implement effective and innovative drug policies in a way that matches its own realities, powers, competencies and resources. Cities have limited formal powers in shaping some core aspects of drug policies, like criminal law, and tackling organized crime and international drug trafficking. Even so, many cities have played a critical role in the transition from conventional criminal justice approaches to more effective harm reduction and wider drug law reform, often running far ahead of national governments. One primary explanation for this vital role of city governments is that elected officials in cities have far greater exposure to their constituents than regional, national or international officials.

City governments favor pragmatic solutions for their local problems, often avoiding policies primarily based on dogma and partisanship. This can lead to a high degree of experimentation and flexibility, which is less common at the national level. Innovative local responses to problematic drug use, based on harm reduction paradigms, have often emerged in the face of national and international policy inertia, and were considered controversial in the 1990s. They attracted political opposition that sometimes led to policy retrenchment or even reversals. Nevertheless, cities sought the instruments, alliances and powers necessary to adapt repressive national policies to the immediate threats facing their communities. This process, described as “local customization,” has contributed to policies better suited to the unique needs of cities and local communities.
Subsequently, pioneering cities elsewhere took up these policy innovations when confronted with emergencies, and implemented and/or adjusted them to fit local circumstances. This type of policy diffusion continues to this day. Policies pioneered at the city level have also been adopted and embraced by national governments. The “four-pillar” model pioneered by Swiss city governments in the 1980s and 1990s – prevention, treatment, harm reduction and law enforcement – is now national policy and internationally recognized as a template for redefining drug policy. Deemed politically controversial at its inception in 1994, the model now serves as an inspiration for cities and countries looking for effective policy approaches. Its embedded principle of harm reduction gradually gained the support of the Swiss population, and, although it took almost a decade, was recognized by the World Health Organization (WHO) in 2003 and the European Union (EU) in 2008.

The partial embrace of harm reduction in Iran and China in the last 20 years shows how this process of bottom-up reform transforms into top-down reform. Whether policy innovations spread horizontally between cities or through an “up then down” movement encompassing international drug policy bodies, national states or other levels of government, the visible advocacy of cities plays a key role in transforming policy environments and shifting public opinion. As such, cities may act as “policy laboratories” and catalysts for reform beyond their city limits.

**Copenhagen often sets the agenda with issues that the national political system has not yet understood or considered.** For example, the debate about allowing civil unions between gay couples started at the City Hall in 1987, even though national politicians were opposed to it. But we kept up our pressure and in 1989 it was allowed. Another example is drug addicts who were forced to take their drugs out on the streets or in stairwells. We also pushed to allow councils to establish safe injection rooms, and this year Copenhagen opened the first council-run legal injection room.

Frank Jensen, Mayor of Copenhagen, Denmark, 2012

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**THE PRAGUE DECLARATION: SEVEN MUNICIPAL PRINCIPLES FOR URBAN DRUG POLICY**

In 2010 a group of European mayors, led by Pavel Bém, then mayor of Prague and now a member of the Global Commission, articulated city drug policies in a statement known as The Prague Declaration. The declaration argued that “local/municipal/urban drug policies have the most direct impact on the drug situation” and laid out seven core principles for effective local drug policies:

1. **No one size fits all** – drug policies must be adapted to their local contexts.
2. **Realism is the key** – a drug-free world is an unrealistic and harmful goal.
3. **Human rights apply to ill people in particular** – drug dependence is a chronic disease, and people suffering it should not be criminalized or have their human rights removed.
4. **Public health and public safety concerns must not be seen as contradictory** – harm reduction is not a compromise, both health and security approaches aim to reduce harm.
5. **Evidence-based decisions only** – decisions must be rooted in science, not solely in ideology.
6. **Evaluation and monitoring** – monitoring for continual improvement should be a core element of programs, and data should be broken down locally.
7. **Constant and improving mutual information flows between local, national and international levels of drug policy through a common voice** – national and international policies must be informed by local experiences.

These principles echo, in the domain of drug policy, a growing body of international literature and policy that highlights the critical role of cities as governance spaces. The Multilevel Governance Charter adopted by the Committee of the Regions of the European Union in 2014 states that “no single level [of governance] can deal with the challenges we face alone,” and aims “to connect regions and cities across Europe.”
The principle of subsidiarity in governance calls for issues facing cities and human settlements to be addressed at the level of authority closest to constituencies, such as mayors and municipal governments and parliaments. But drug policy-making is very complex because of jurisdictional overlaps. Different levels of government as well as different agencies, bodies, regulators, and departments may be involved in domains that relate to drug use and regulation in cities. "Local customization" can provide frameworks that allow supportive states to conceptualize and legitimize the contributions of cities to policy development, and cities to establish multi-stakeholder platforms of coordination on the ground.

Frameworks need to strike the correct balance between policy coherence and flexibility. Too strong a focus on the role of criminal legislation and other national-level competencies can make local policy makers feeling constrained by restrictive policies and unable to meet the complex needs of their citizens. A lack of a coherent “master framework” can lead to local policies that are confusing for citizens and create gaps, ambiguities, and “grey markets”.

Cities are carrying forward lessons from their largely successful struggles to transform repressive drug control systems and introduce harm reduction. European Cities on Drug Policy and other organizations and coalitions have given local governments a sense of their own capacities and their legitimate interest in transforming drug policies.

However, the history of harm reduction and other policy innovations shows that relationships with other levels of government have not always been supportive. In several countries, organizing groups of cities “horizontally” has provided a stronger path for cities to negotiate their flexibilities and possibilities, as tolerated and recognized by national governments. By forming networks, national or international, cities can share best practices, develop evidence collection, pursue shared political advocacy programs, amplify one another’s voices and push for policy reform in the face of reluctance at other levels of government.

Exploring the forces that made radical reforms possible in Vancouver, Canada, an official involved in developing the city’s pioneering drug strategy argues that it called on the city to take on several different traditional and legitimate roles of municipalities:

- as a provider of support to vulnerable populations;
- as a facilitator of services;
- as a facilitator for building capacity;
- as a facilitator of communication and dialog;
- as an advocate;
- as a regulator; and
- as a model.

Actions by cities to tackle the injection drug crisis in their jurisdictions may appear radical and put cities in the position of confronting or contradicting policy directives from other governance levels. In an important way, however, these actions draw on what are already core capacities and responsibilities of municipalities, from caring for vulnerable citizens, to negotiating “win-win” solutions among conflicting residents, to piloting new approaches and collaborating with other levels of government.

POLICY COHERENCE AND FLEXIBILITY: ‘LOCAL CUSTOMIZATION’

Ruth Dreifuss, member of the Global Commission, and Svante Myrick, Mayor of Ithaca (NY, USA) discuss the Ithaca Plan to reform drug policy, November 2016.
INNOVATIVE URBAN DRUG POLICY: FROM THE MARGINS TO THE MAINSTREAM

HISTORY OF CITIES INNOVATIONS

Worldwide, national drug policies have been formulated in the context of a global prohibitionist regime established by the Single Convention on Narcotic Drugs of 1961 and the Convention on Psychotropic Substances of 1971. These United Nations treaties restricted the availability of narcotic drugs and psychotropic substances, limiting their use only to medical and scientific purposes and aiming to prevent their diversion into illegal channels. The 1988 UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances significantly strengthened the obligations of countries to apply criminal sanctions to combat all aspects of illegal production, possession and trafficking of drugs.

WHEN NEW YORK LED THE WORLD ON CANNABIS – BY DECADES

One of the earliest examples of a city attempting to initiate a different approach to national drug policies was that of New York under the unconventional and popular three-term Mayor Fiorello LaGuardia (1934-45). LaGuardia had been an outspoken opponent of alcohol prohibition in the United States (1920-33). He was unconvinced by the increasing media hysteria over cannabis, epitomized by the 1936 film Reefer Madness, and skeptical about the wisdom of the 1937 Marijuana Tax Act, which banned the substance in the United States. In 1938, LaGuardia formed the Mayor’s Committee on Marihuana, which embarked on a clinical investigation of the effects of cannabis and a sociological survey of its use in the city to determine “the pertinent facts regarding this form of drug addiction and the necessity for its control.” In 1944, the Committee published its findings. The Marihuana Problem in the City of New York was one of the first studies to question the prohibition of cannabis, which had been initiated by Harry Anslinger, head of the Federal Bureau of Narcotics (FBN). Anslinger would go on to become one of the main architects of the global prohibition of drugs after World War II. The report’s findings upheld La Guardia’s initial suspicions that New York did not suffer from serious problems related to cannabis and found that the substance was neither addictive nor causally connected to crime.

The FBN, whose mission depended on dealing with drug policy within a criminal justice framework, was able to deter LaGuardia and other opponents from acting on the outcomes of the study and potential reforms. Subsequent studies into the effects of cannabis, in particular in the 1970s by several national commissions, would uphold many of the findings of the LaGuardia Committee’s report.

In the early 1990s, the European Cities on Drug Policy, a network initially of Dutch, German and Swiss cities, advocated new and at the time controversial initiatives. In 2001 the network offered a valuable explanation of the dynamics of drug policy making in cities:

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Public health responses to people who inject drugs and the spread of HIV in the early 1980s were pioneered by city governments – in conjunction with advocates and NGOs – starting with Liverpool and Amsterdam, rather than the national governments of the United Kingdom and the Netherlands. Many cities in Western Europe were confronted with a substantial increase in numbers of people who inject drugs, mainly heroin, often concentrated in open drug scenes. Overdose deaths increased, other infectious diseases spread, such as hepatitis and tuberculosis, and levels of street crime rose (street dealing, robberies, car and house burglaries). Collectively, these posed a serious threat to public health, public safety and security.

The initial response of using traditional repressive measures to harass and disperse these open drug scenes proved ineffective. Gradually a new approach was developed: many cities responded with a combination of prevention, enforcement, harm reduction and treatment measures. Health care services, social services and the police developed cooperation mechanisms. Readily accessible "low-threshold" services – offered with minimal demands, such as without attempting to control consumers’ intake of drugs – were implemented to end the open drug scenes, mainly needle and syringe programs and opioid substitution therapies. These responses were expanded to embrace other harm reduction measures such as social inclusion through housing-and-work programs, safe consumption facilities and heroin-assisted treatment. A study of the responses in five European cities - Amsterdam, Frankfurt, Lisbon, Vienna and Zurich – concluded that:

"Cities experience social phenomena and the expression of tensions connected with them immediately. But it is also there that a true social dialogue can materialize and take influence on the situation that affects all citizens of the community more or less directly on a day-to-day basis. Therefore, local approaches are important particularly on account of their proximity to the problem and the fact that responses may be implemented, experienced and understood immediately. Also, financial and personal resources can be applied more speedily and effectively at local levels, an argument that becomes more and more important as drug policy also has to be increasingly "cost-effective" and the enormous local budgets for drug policy we have seen in the early nineties are being cut down or redistributed." 30

THE FRANKFURT WAY

Throughout the 1980s, Frankfurt hosted a major open drug scene centered around Taunusanlage park, near the central train station. This open scene concentrated considerable health harm including high rates of HIV and hepatitis infection and overdose deaths. As in other European cities, the police initially responded with periodic crackdowns that resulted in, at best, temporary relocations of the scene. Starting in the late 1980s, the city pioneered a new approach known as "The Frankfurt Way". 37

A central element of the new response was the establishment of a coordinating committee in 1987 and then a coordinating office in 1989. Known as the Frankfurt Monday’s Round, this was a bimonthly multi-agency group formed by the mayor to bring together experts working on drug-related issues and to adjust the policy and practices of magistrates, police, prosecutors, the municipal drug policy coordination office and representatives of the local drug services. 38

This structure helped to coordinate and facilitate the roll-out of a wide range of harm reduction interventions. Low-threshold methadone clinics and drop-ins were decentralized and expanded, and supervised injection sites were established, the first in 1994 and three more in 1996. The city continued to adapt its drug policy over the years to address new challenges – such as crack cocaine – and to remove weaknesses of the initial approach, for example by providing more housing and other support services. 39

The Frankfurt model aims to balance the needs and interests of people who use drugs with those of wider society, relying on close cooperation with city police and “zero tolerance for public nuisance.” 40 The approach has shaped policy in many cities in Europe and globally and is believed to have played a key role in getting the open drug scene in Frankfurt under control. This led to important gains for public health, saved lives and increased public safety. 41

"Underlying these measures has been a basic acceptance of drug users including those who have been unable or unwilling to stop the use of illegal drugs, but this was combined with a policy not to permit the continuation of destructive behavior in terms of public nuisance. The cities established policies of 'no tolerance' for public nuisance but nevertheless developed appeasement, and found approaches to 'coexistence' between society and users of illegal substances. This helped to end unfruitful controversies between liberal and conservative ideologies and policies. The solutions are found in appropriate combinations of harm reduction and restrictive measures." 42

In many cities, the process of policy innovation followed an approach characterized in Spain as “better to ask forgiveness than permission.” Emboldened public officials and advocates, supported by some segment of their constituency, pursue legally risky policies rather than asking permission from other levels of government and risking rejection up front. Many cities in Europe have employed this strategy creating a fait accompli, which echoes the strategy of civil society groups that have provided controversial services – such as supervised consumption facilities – as emergency measures rather than waiting for city-level support.
Local authorities have not always taken swift action of their own volition, however, and civil disobedience has often been employed to advocate for unorthodox measures to confront crises. In the 1980s in the Netherlands, for instance, the Junkiebond (Junkie Union, a group that advocates on behalf of people who use drugs) in Amsterdam and Rotterdam pioneered needle exchange and a guerrilla “low-threshold” methadone maintenance program that shifted the focus from abstinence to stabilization and harm reduction. These innovations were subsequently adopted by the Municipal Health Service and the local health department in both cities. In Liverpool and the larger Merseyside area, similar guerrilla tactics were employed. In Australia, the first needle and syringe program, in Sydney in 1986, and the first medically supervised injecting center, in 1999, established when both were still illegal, also required “tolerated” civil disobedience.

City governments must also deal with “not in my backyard” reactions of disgruntled residents, which can both prompt and impede harm reduction interventions. Drug consumption facilities were introduced in the Swiss cities of Zurich and Bern partly because of citizens’ widespread discontent with open drug scenes. Residents reacted to spillover effects of drug use that included crime, shoplifting, robberies and burglaries, desperately ill people in the streets, and the deaths that persisted despite health outreach – notably in the infamous Platzspitz in central Zurich, which became known as Needle Park. At the same time, residents sometimes oppose interventions like safe consumption sites because they fear that public disorder will result. Such harm reduction measures are vital, however, so their successes need to be publicized and their failures remedied to garner support for them and decrease opposition.

This kind of mediation of citizens’ conflicting concerns, allowing for coexistence in an urban space, is one of the hallmarks of municipal politics. In the heroin crisis, cities were confronted on one side with organizations of people who use drugs, their families, drug policy reformers and harm reduction supporters. On the other side, angry residents, irritated by the nuisance of “condoned” open drug scenes, sometimes threatened to take matters in their own hands, supported by drug policy conservatives offering abstinence-only programs.

Drug policies need to be focused on reducing harm among people who use drugs, instead of furthering the stigma associated with the criminalization of drug use. The expansion of harm reduction services in Lisbon and in Portugal has made a significant impact in reducing the numbers of new HIV cases in people who inject drugs.

Anne Hidalgo, Mayor of Paris, France, 2020

Fernando Medina, Mayor of Lisbon, Portugal, 2020
DRUG CHECKING SERVICES IN FESTIVALS IN CANBERRA

Pill testing, or drug checking, is a way to reduce harm by allowing people who use drugs to find out the content and purity of substances that they intend to consume. The first experiments in public pill testing in Australia took place in 2000. The first pill-testing pilot sanctioned by a state or territory took place at the Groovin’ The Moo music festival in Canberra in 2018. It was determined that such testing could be carried out without legislative changes in the Australian Capital Territory, with the cooperation and support of law enforcement critical for the success of the trial. A second trial took place at the same festival in 2019. An evaluation by the Australian National University concluded: “we find support for the development of further services that provide pill testing and harm reduction information for people who use illicit drugs at festivals.”

In October 2019, the Drugs, Poisons and Controlled Substances Amendment (Pill Testing Pilot for Drug Harm Reduction) was introduced in the Parliament of the state of Victoria, as a private member's bill. It seeks to establish Victoria’s first pill testing pilot program for the purposes of drug harm reduction, creating licenses for two years with the possibility of extension.

CITIES COALITIONS AND KNOWLEDGE SHARING

Innovative policies initiated in several European cities in the 1980s and 1990s were controversial and often met with disapproval at the national and international level. In response, the pioneering cities Amsterdam, Frankfurt, Hamburg and Zurich signed the Frankfurt Resolution. The resolution made a blunt assessment of the problem the cities had to face: “the attempt to eliminate both the supply and the consumption of drugs in our society has failed.” It then made a clean break with the dominant drug policy commandments, which required combating problematic drug use solely through criminal law and compelled abstinence.

In 1991, the resolution became the charter of the European Cities on Drug Policy. This network advocated for piloting new initiatives, sharing best practices and developing a shared research, evidence and advocacy base, which allowed the cities to defend and promote controversial solutions. Over time, more cities joined forces to advocate for a more pragmatic, less prohibitionist drug policy, including the decriminalization of cannabis, and initiated innovative harm reduction measures. A process of policy transfer evolved, in which policy models developed in one setting were deployed and adjusted in another setting and policy knowledge and policy models moved from city to city through urban actors thinking and acting regionally, nationally and, increasingly, globally.

While cities were sharing information on effective drug policies, a similar process of knowledge transfer evolved among organizations for people who use drugs, social and public health workers, and academics. Once drug policy innovations had been developed and facilitated by pioneering cities, civil society organizations and policy advocates, they spread globally in a variety of ways.

In Vancouver, Canada, drug policy was developed in the context of the city's opioid crisis in the 1990s, which included an open injection drug scene, and an associated outbreak of HIV and other blood-borne infections. Policy development drew on the knowledge and expertise of cities within the ECDP network to launch similar interventions – the first of their kind in North America. Vancouver’s “four pillar” approach was modelled on the Swiss national drugs strategy, which was itself largely based on the pioneering experiments of Swiss cities. Vancouver's approach combined prevention, treatment, repression and harm reduction, and emphasized inter-agency cooperation at the city level. The strategy was developed after consultations and fact-finding missions to European cities by city-level policy-makers.

The transformation of Vancouver’s approach to drugs was facilitated by a political alliance that included not only local policy makers but also an advocacy group of people who use drugs as well as other civil society groups, including families and friends of consumers. In 2000, after nearly a decade of mobilization by advocates, the mayor released “A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver.” In 2003, the city opened North America’s first legally sanctioned supervised injection site in the city's Downtown Lower East Side neighborhood. In 2011, the Supreme Court of Canada ruled, in a 9-0 decision, that the risks of closing Vancouver’s safe consumption facility by the federal government contravened Canada’s charter of rights by threatening the lives of people who inject drugs.
As in Europe, the emergence of North America’s opioid-related overdose crisis is provoking city-led initiatives. In response to the rising death toll, Boston, Ithaca, New York City, Philadelphia, San Francisco and Seattle are considering safe consumption facilities, following the example of Vancouver. A single unsanctioned supervised injection program has begun operating in the East Coast. The American federal government opposes such policies, the operation of such sites being illegal under federal law. However, a federal judge ruled recently that opening a safe injection site in Philadelphia was not violating federal law. Meanwhile San Francisco has also announced its intention to introduce legislation authorizing safe consumption facilities, despite opposition from State authorities in California and the US Department of Justice.

In South America, São Paulo and Recife in Brazil and Bogotá in Colombia have found innovative ways to deal with the open drug scene of inhalable-cocaine consumers and the related health and safety emergency. The programs in Brazil were based on Housing First approach developed in New York City, in which safe, affordable and low-threshold social housing has proven to be crucial in reducing problematic drug use. However, with the exception of the program in Recife (which is run by the state of Pernambuco), the promising innovative programs in São Paulo and Bogotá were dismantled after four years when the mayoral majority changed, underlining the importance of building consensus so that public policies endure beyond the term of a specific city government. The city council of Barcelona, for instance, first created a roundtable on drug policies in 1988, in which representatives of all the municipality’s political groups came to a consensus on a municipal drug plan. The roundtable met with the clear intention that drug issues were not to become a political battlefield. This forum facilitated the drug plan that was subsequently approved by consensus in the plenary session of the city council, thus ensuring continuity for the health strategies addressing drugs.

**FROM EUROPE TO NORTH AMERICA AND BEYOND**

De Braços Abertos (“With Open Arms”) was a broad-based program that began in 2013, coordinated by the Municipal Health Department of São Paulo, Brazil, and involving 15 municipal secretariats. It targeted crack consumers in an area of the city known as “Cracolândia” (Crackland). Employment opportunities, housing, medical support (including for problematic drug use), and a drop-in center were provided, and abstinence from drug use was not a condition for participation. This was one of the first initiatives in the Americas to address the specific needs of stimulant and non-injection consumers.

De Braços Abertos introduced a “rights package” (housing, food, employment and health), and was developed in response to 15 years of failed repressive approaches, ranging from police raids and evictions to repression and compulsory treatment. The program targeted the open drug scene with a population of 500 to 2,000, mainly homeless people and people who use drugs. The program integrated harm reduction with a heavy police presence designed to bring the neighborhood “under control” and received positive support from the city’s police. According to a poll by Brazil’s biggest newspaper, Folha de São Paulo, 69 percent of São Paulo residents approved of the program. An evaluation showed that 95 percent of the people in the program felt positive changes in their lives, 67 percent reduced their crack use, and 53 percent regained contact with their family.

The program competed with Recomeço (Fresh Start), a program launched by the São Paulo state government in 2013, with the traditional punitive perspective aiming for a “world free from drugs” and relying heavily on hospitalization in religious therapeutic communities. However, in the 2016 municipal elections, the new mayoral majority promised to stop Braços Abertos and adopted a municipal program aligned with Recomeço, renamed Redenção (Redemption). In May 2017, a significant police crackdown using rubber bullets and stun grenades dispersed the drug scene in Cracolândia. The raids split the open drug scene into two dozen mini-scenes across the city, with dozens rather than hundreds of consumers in each, and profoundly undermined Braços Abertos.

> Sometimes traditional politicians are afraid to take measures that provoke a strong reaction from some people. You can even lose an election. But losing an election for a good cause is good. You can become a prisoner of power if you do not take correct steps. But if you are not attached to power, you can take measures that are going to be understood in the medium turn, so we are going to focus on policies and not elections. If we can separate the two things, it’s good for the city.

Fernando Haddad, Mayor of São Paulo, Brazil, 2016
The New York City Approach by NYC Health Commissioner Dr. Dave A. Chokshi

New York City, like the rest of the United States, is in the midst of an overdose epidemic—a critical public health challenge that is made all the more pressing by the COVID-19 pandemic. Through our HealingNYC initiative, we invested more than $60 million to launch a multifaceted response to reduce overdose deaths by expanding access to naloxone, overdose prevention and response education, and medication-assisted treatment.

Since the launch of HealingNYC, we established and implemented the country’s largest overdose education and naloxone distribution program, which has included the distribution of over 400,000 naloxone kits to community-based and other organizations registered as Opioid Overdose Prevention Programs. We’ve taken other steps to make naloxone widely available citywide by allowing dispensing of naloxone in pharmacies under a citywide standing order, equipping emergency medical services workers to “leave behind” naloxone with families or friends of someone who overdosed, dispensing naloxone kits to visitors of Rikers Island jails, and dispensing naloxone to probation officers. We have developed partnerships to keep New Yorkers informed, including an effort with bars and nightclubs in Brooklyn that helped us warn people through judgement-free coasters and posters that fentanyl was detected in the cocaine supply.

We also changed the standard of care for patients experiencing an overdose in many emergency departments across the city. We established a nonfatal overdose response system that operates 24/7 and deploys wellness advocates to many emergency departments throughout the city. In this innovative model, peer Wellness advocates offer overdose prevention strategies, including tips for safer drug use, and linkages to care and other services, serving as a low-threshold point of connection for people at risk for overdose death.

Medications, including methadone and buprenorphine, are the first-line treatment. We have implemented a multi-pronged approach to increase access to these highly effective medications which includes: supporting low-threshold buprenorphine provision at emergency departments and syringe service programs, launching the Buprenorphine Nurse Care Manager initiative at primary care safety-net clinics, and training over 2,000 providers to prescribe buprenorphine.

During the COVID-19 pandemic, we also launched a virtual buprenorphine clinic and the country’s first methadone delivery system to prevent treatment disruption and protect the health of patients. Since its implementation in April 2020, our methadone delivery system has made over 4,000 deliveries to people who need to isolate or quarantine because they have COVID-19, are experiencing COVID-like symptoms, or are at high risk of serious illness.

A public health approach is necessarily data-driven, and the data show that the burden of overdose is not felt equally across the city. Neighborhoods in the South Bronx and East Harlem consistently have among the highest rates of overdose citywide. We therefore have taken a place-based approach to the overdose epidemic by implementing the Rapid Assessment and Response initiative, where public health educators engage and provide overdose prevention resources to community venues, substance use treatment centers, pharmacies, and shelters in areas of the city seeing the highest overdose rates. We also quadrupled the funding for syringe service programs, which provide critical services to people who use drugs including sterile drug use supplies, overdose prevention education and harm reduction counseling.

Now, more than ever, we need to continue to invest in our public health systems. Recent overdose data released by the Centers for Disease Control and Prevention show that overdose deaths increased nationwide – including in New York City during the COVID-19 pandemic, driven by the increased presence of fentanyl in the illicit drug supply. As fentanyl exacerbates the challenges of the overdose epidemic, we must re-invest in evidence-based public health approaches to promote and protect the health of people who use drugs.

Harm Reduction for New Psychoactive Substances

With the emergence of new psychoactive substances, cities pioneered new harm reduction measures. Ecstasy (MDMA) emerged and became popular within the house music subculture and at dance events. Its prohibition and subsequent incidents with adulterated pills led to pill testing services and a wider set measures employing an “integral” approach to consumer safety—such as chill-out rooms, outlets for fresh drinking water, a first aid service and sufficient ventilation. These were pioneered in Amsterdam in 1986.

When it became clear that house music and rave parties would become an established youth culture, this harm reduction approach was formalized followed the pattern established with traditional drugs. Treatment organizations, prevention and training institutions, and municipal health services became involved and began institutionalizing harm reduction practices. When more and more municipalities were confronted with the phenomenon, the Dutch government felt obliged to formalize the arrangements that had evolved at the local level.
City governments need to mediate conflicting concerns not only among citizens but also among institutions. Conflicts arise in particular between local priorities of social cohesion and public health and national or federal priorities of criminal justice and drug supply control. Many cities do not have their own police departments or criminal prosecution offices. Even if they do, institutional interests and policy priorities may still diverge.

The spotlight fell on this kind of conflict after the police killing of George Floyd on May 25, 2020, in Minneapolis. The subsequent widespread Black Lives Matter protests were accompanied by calls to defund or even abolish the police and reallocate funds to social development like housing and employment services to create healthier and safer communities.83

URBAN DRUG-RELATED ISSUES: SAFETY, VIOLENCE AND LAW ENFORCEMENT

CITIES INVOLVEMENT IN THE RESPONSE TO CRIME AND VIOLENCE

Recent research from Latin America concluded that there is a need to enhance local government resources to reduce crime in high-risk crime areas, which is often related to drug markets. Crime, the researchers write, “is very context-specific and requires nuanced and flexible policies able to more adequately address the roots of the issue, whether this is a lack of social and economic development or a reduction in murders because one cartel has asserted hegemony in its area of operations.” They recommended that “local governments, including cities, should be empowered to act in ways which are specific to their context and follow strategies that work based on the specific threat being faced.”84 Each city – and each neighborhood – has its own specific risk factors that need to be addressed through careful policymaking.85

Major cities have been more successful in reducing lethal violence than their national authorities. In a sample of 68 cities globally, homicide rates decreased by 34 percent compared with a decrease of only 16 percent in the respective countries.86 However, when looking at measures to reduce urban violence, it remains crucially important to maintain standards of human rights and civil liberties. The increasing use of cutting-edge technology, such as military drones, combined with facial recognition and crime prediction methodologies using artificial intelligence, are a potential risk. Several studies emphasize that higher levels of violence are linked to poverty and social inequality.87

The US debate on defunding the police reflected what happened in the 1990s in European cities. In pushing for a transition from predominantly law enforcement approaches to public health ones, gaining the cooperation of local police departments was often a vital first step towards a city-wide common approach,88,89 and is considered crucial for its success.90 This is especially true where new approaches promise better outcomes for public safety, as well as public health.

Enforcing drug laws requires a significant investment of police time, so police forces have a direct interest in more effective policies that allow them to allocate their scarce resources more effectively. A study in Copenhagen showed that issuing a simple “street warning” for cannabis possession consumed an average of 80 minutes of police time, while an arrest required 10 hours.91 Periodic interventions consume even greater amounts of police resources. Police may also have doubts about the effectiveness of criminal sanctions. During the emergence of harm reduction programs in the county of Merseyside, United Kingdom, the police “were becoming disillusioned with arresting the same people time after time […] They recognized the potential to reduce this of the new approach […] They began to adopt a public health role as well as a public order role.”95

VIOLENCE AND ILLEGAL DRUGS IN CITIES

Drug trafficking not only represents a major source of revenue for organized crime but also generates the highest levels of violence of all organized crime activity.92 Violence is used to control territories, secure trafficking routes, intimidate authorities and competing criminal organizations, ensure internal loyalty and coerce communities.

Drug violence is most visible in Latin America, which in 2018 concentrated 42 of the 50 cities in the world with the highest homicide rates, mostly related to drug trafficking and control.93 In the United States, Baltimore’s high homicide rates are driven by drug-related violence,94 with Cape Town, South Africa, experiencing similar increasing homicide rates.95 The governance gap in poor neighborhoods with limited social, educational and health services, combined with drug enforcement interventions, allow criminal groups to control entire territories within cities. In São Paulo’s favelas, criminal groups have replaced the welfare state, providing assistance and protection to impoverished communities.100
Harm reduction and other interventions at the city level are vulnerable to changes in policy and political orientation, at either the national or the local level. In 2015, Bogotá was home to significant harm reduction programs launched in 2012. Then-Mayor Gustavo Petro had aimed to tackle crime and problematic drug use in the notorious neighborhood known as El Bronx with harm reduction principles. The creation of mobile medical care centers for people dependent on drugs, providing outreach, medical assistance and harm reduction services, were especially important and widely celebrated.

In 2016, however, the new mayor, Enrique Peñalosa, initiated police raids on neighborhoods with a high concentration of people who use drugs and/or open drug scenes and dismantled harm reduction programs. In a particularly notorious raid in June 2016, more than 2,500 riot police officers stormed the Bronx neighborhood. The raid attracted accusations of widespread police violence, especially against homeless people, and human rights violations.

Militarization and disregard for the human rights of residents, especially the homeless, continue today even as the neighborhood is rebranded as a “creative district” and open for real estate development. In the short term, the 2016 raid resulted in only a handful of arrests and the relocation of people who use drugs and other marginalized residents to new areas of the city.

In Latin American cities, harm reduction approaches aimed at tackling the negative health impacts of problematic drug use are still novel and small-scale. However, several cities have taken a pioneering stance in extending harm reduction paradigms to the reduction of violence related to the drug trade. In many cities, violence linked to struggles between organized criminal groups for control to drug markets has often been met with, and exacerbated by, violent responses from police and paramilitary groups. These violent conflicts create a climate of fear for people living in cities, particularly those in slums, favelas, or other low-income and underserved communities, which may be partially or totally controlled by non-governmental forces.

While militaristic and authoritarian responses by police to drugs and drug use remain common, often pursued in conjunction with “zero tolerance” or prohibitionist rhetoric and policy, several cities have begun to articulate and pilot alternatives. In 2011, the Rio de Janeiro Declaration brought a new understanding to law enforcement approaches to drug control. Through the declaration, the State Military Police of Rio de Janeiro and the Command of Pacification Police Units highlighted their objections to predominantly repressive approaches to drug control, which place the burden of enforcing drug laws on police without providing the social, educational and health support necessary to address the root causes of problematic drug use.

In the last five years, an economic downturn and a shift towards a militarized approach by the then state governor Wilson Witzel affected Rio’s pacification units development, contributing to a dramatic increase in violence and police killings.
Engagement and cooperation with law enforcement has been an important element in the harm reduction approach to open drug scenes. Certain harm reduction activities are already core to the activities of police forces, which try to safeguard the safety of consumers, minimize violence and disorder, and refer people who use drugs and other vulnerable people to support services. Several cities and municipal police forces around the world have undertaken what may be characterized as harm reduction approaches to policing: models that focus on reducing violence, disorder, and other social and health harms linked to drug markets, rather than stamping out drug use altogether.

Enforcement-led approaches, such as short-term crackdowns and large-scale stop and search, are not likely to eliminate retail drug markets, and may increase levels of violence and harm to health. Policing tactics that are perceived by the community as unfair, unlawful and ineffective will harm community relations and undermine the legitimacy of enforcement. However, skillfully designed and implemented policing tactics may make drug markets less disorderly and less violent, make communities safer and boost police legitimacy as well. Focused deterrence strategies may reduce both harm and crime. As various studies have shown, however, the success of such strategies – in particular the Drug Market Intervention program (see box) – depend on the context and on careful implementation and evaluation.

**CITIZEN WELL-BEING, PUBLIC HEALTH AND URBAN SOCIAL RESILIENCE**

Violence reduction strategies need to be complemented by urban planning and upgrading that builds strong social and urban resilience. Such approaches need to focus on youth, deploy the largest possible set of social, health-related and violence-related harm reduction services, engage in mediation and connect everyone involved in drug control. This includes affected families, law enforcement, prosecutors, correctional workers, educators, people who use drugs, municipal and national health and social workers, addiction specialists and epidemiologists, interdisciplinary researchers, experts and civil society representatives.

Mayors have the capacity and legitimacy to engage all these groups. Geneva, for example, established in 1981 a Consultative Commission on Addictions to support the design of drug policies for the city and the canton. The commission is composed of representatives of the police, welfare services, social services, hospital dependence services, youth and education services, the prosecutor’s office and probation services.

This process of creating a safe space for debate, exchange and consensus building among city dwellers enables a better assessment of the drug-related challenges in each city. Drug policies based on prohibition measure their implementation through limited indicators, mainly seizures of trafficked illegal drugs, arrests of consumers and traffickers, and numbers of problematic consumers seeking treatment. These indicators fail to show the real scale of drug production, use or trafficking.

Other strategies to optimize living conditions in urban settlements and alleviate drug-related issues involve urban upgrading, although their assessment includes many subjective dimensions. Tackling poor housing and conditions in slums or social housing, especially in poor areas, neighborhoods and communities, has worked in different settings around the world. In France, following the riots in the banlieues (suburbs) in 2005, the National Urban Renovation Plan concentrated on 550 “sensitive neighborhoods.” These benefited from increased state funding to ensure urban upgrading that improved the security, safety and well-being of the community. In Woippy, for instance, a town adjoining the city of Metz, the plan led to less problematic drug dealing, a safer environment for inhabitants and better prevention programming through youth-targeted services and activities.

**THE HIGH POINT DRUG MARKET INTERVENTION PROGRAM**

The Drug Market Intervention program piloted in 2004 in High Point, North Carolina, United States, set out to tackle persistent violent crime linked to crack cocaine markets. The intervention sought to deal with violence and public disorder, rather than to eliminate drug use. Importantly, the project sought to rebuild the community’s trust in the police, and strengthen social norms against drug dealing by “creating swift and certain consequences by ‘banking’ existing drug cases; addressing racial conflict between communities and law enforcement; setting strong community and family standards against dealing; involving dealers’ family members, and offering education, job training, job placement, and other social services”. The methodology has since been replicated with support of the Federal Department of Justice’s Bureau of Justice Assistance and implemented in over 25 other sites in the United States.

The police pursued a differentiated strategy, targeting the most violent and high-level drug dealers with strong legal sanctions. For non-violent dealers, a different process was used: the police gathered evidence of criminal activity and presented it to dealers at a community meeting (or “call-in”), together with influential community members; conveying a strong moral message that such behavior would no longer be tolerated, while offering community support as an alternative to criminal proceedings if dealers refrained from criminal drug sales.
Collaboration between everyone involved, especially police, health and social workers, is pivotal to local drug policy effectiveness. Health and harm reduction services can be jeopardized if police intervention drives people adhering to a treatment regimen (for dependence or infectious diseases) away from services because of fear of arrest and prosecution. Collaboration between support and repression services is also fundamental to building community intelligence and cooperation, undoing clusters of drug-related illness and violence in the heart of cities and implementing better violence reduction strategies.

Harm reduction helps to engage people who use different psychoactive drugs, by providing them with more pragmatic choices, while motivating them to make contact with treatment providers when they are ready. Bangkok Metropolitan Administration is among the first in Thailand and Southeast Asia to launch a series of campaigns of harm reduction.

Mom Rajawongse Sukhumbhand Panibatra, Governor of Bangkok, Thailand, 2009

URBAN DRUG MARKETS: PATHS TO THE LOCAL REGULATION OF CANNABIS

The time has come to provide an opportunity for Jamaicans to benefit from the marijuana industry.
Angela Brown Burke, Mayor of Kingston, Jamaica, 2014

While the legal regulation of recreational cannabis markets is being implemented at the national level in many countries, city governments and their role are overlooked in this important debate. From its inception in the early 1990s, however, the European Cities on Drug Policy network has called for the reform of cannabis policies, taking its cue from the only example available at the time: the semi-regulated market model of tolerated recreational cannabis sales in the Netherlands.

COPENHAGEN’S ATTEMPTS TO LEGALLY REGULATE CANNABIS – THE KØBENHAVNERMODEL

Between 2011 and 2016, the municipal majority of Copenhagen made four formal requests to the Danish government to implement a cannabis legal regulation trial, but these were denied. The city of Copenhagen presented a plan that included regulated production of cannabis and cannabis resin locally, sales through city-run dispensaries limited to a maximum of 5 grams to adults over the age of 18, and sales only to holders of the Danish insurance card, ensuring only nationals and residents have access to the substance.

The trial, intended to last three years, became known as the Københavnermodel, the Copenhagen Model. Lord Mayor Frank Jensen stated: “the way we have tried to limit cannabis over the years has not worked. For the past 20 years, we have made it the job of the police to stop the cannabis trade, but cannabis has never been bigger than it is now. That is why we now want to take the trade away from the gangs and create a controlled market where people can buy cannabis and know its strength. The uncontrolled cannabis market results in products being sold on the street that are so strong it can make people psychotic on their first try.”

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Before 2008, cannabis money kept the province running. But since then, the revenues have gone elsewhere, even though cannabis growers continue to sell their harvest. A recent US report estimated that cannabis revenues in Morocco amount to $23 billion each year. If only one of these billions were reserved for Al Hoceima, it would become like Monaco!
Ilyas El Omari, President of the Tangiers-Tetouan-Al Hoceima Region, Morocco, 2017
The coffeeshop model was the consequence of Dutch cities’ attempts to cope with the substantial increases in arrests for possession of small amounts of cannabis for personal use, in combination with measures to separate the cannabis market from drugs with a high health risk, such as amphetamines, cocaine and heroin. The model was pioneered in Dutch cities and eventually accepted at the national level. Due to the limits of latitude in the UN drug conventions, however, the coffeeshop model became a compromise: cannabis sales were allowed at the “front door” of the shop, but the supply at the back door was illegal and everyone involved pretended not to know where it came from. This “back door problem” eventually led to bigger issues, since the illegal supply relied on the involvement of organized crime groups.119

Mayors of the larger Dutch cities, confronted with expanding indoor illegal cultivation in their municipalities and growing concern about the role of organized crime, have been advocating since 1999 for legal control of the “back door” and comprehensive regulation to provide a safe, controlled supply chain for cannabis. In 2017, the Association of Dutch Municipalities asked the national government to create the necessary structure and legislation to facilitate local experiments in regulated cannabis cultivation, and the government agreed to an experiment with a “closed coffeeshop circuit” in ten cities.

In North America, before the formal legal regulation of cannabis in various US states and Canada, the recreational cannabis market operated through a well-established illegal market and, to some extent, through medical use. In the late 1990s and early 2000s, soft medical access regimes and nebulous rules and regulations were introduced by states on the West Coast of the United States and Canada, amounting almost to a de facto and mainly city-regulated recreational regime.120

Before legal regulation in Canada in October 2018, a cannabis retail market already existed. Nationwide, 997 retailers were identified the year before legalization, including 215 illegal – but largely tolerated – brick-and-mortar dispensaries. Vancouver had the most dispensaries (69) followed by Toronto (62),121 and some neighborhoods were allegedly home to more dispensaries than there were coffeeshops in Dutch cities. Vancouver officially licensed cannabis retailers in 2015, even though they were not allowed under federal legislation.122 When national regulation was implemented, many existing dispensaries were not initially awarded retail licenses, due to a bidding process that did not give priority to already operating premises. This has created significant tensions as established dispensaries continued to operate without licenses.123

I have been convinced that we can establish a regulatory framework that keeps our streets safe, rights the wrongs of the past, and gives economic opportunity to communities hit hardest by the war on drugs. Bill de Blasio, Mayor of New York City, United States, 2018

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BEYOND THE NETHERLANDS, EUROPEAN CITIES EYE CANNABIS LEGAL REGULATION

Local and regional authorities in several European countries are looking at the legal regulation of cannabis, because they have been pressured by grassroots movements (in particular cannabis social clubs)124 or because they want to reduce the involvement of criminal groups, improve public order and eradicate street dealing. The regulation of cannabis markets is beyond the mandate of municipal governments, which necessitates cooperation with national governments.125

Apart from the Netherlands, several cities have submitted pilot projects for cannabis dispensaries with regulated supply, including Copenhagen (Denmark); Berlin, Bremen, Cologne, Düsseldorf, Frankfurt-am-Main, Hamburg, Hannover and Münster (Germany); Basel, Bern, Geneva and Zurich (Switzerland). In Belgium and Spain, some regional and local authorities want to allow cannabis social clubs, while in Belgium, France, Portugal and the United Kingdom, campaigns for formally regulated cannabis social clubs are gaining momentum.126
Actions taken by European and North American cities to address the injection drug crisis in their jurisdictions may appear radical. Sometimes they may also put cities in the position of confronting or contradicting policy directives from other governance levels. In an important way, however, these actions draw on what are already core capacities and responsibilities of municipalities: caring for vulnerable citizens, negotiating “win-win” solutions among conflicting residents, piloting new approaches and collaborating with other levels of government. Cities have obligations to protect civic space and the health and well-being of their residents, and they have a strong interest in attractive, well-functioning urban spaces with minimal disorder and public nuisance.

At the national level, drug policies cause divisions similar to those in multilateral settings, leading to the preservation of the status quo and outdated policies. We, the members of the Global Commission on Drug Policy (many of us having been mayors and members of municipal parliaments) believe that city authorities, which bear the greatest exposure to the harm caused by prohibitive policies, are also the most efficient agents of change as they fight for equal access to health and social services. As cities will host 68 percent of the world population by 2050,^{127} while concentrating larger numbers of socially vulnerable people, we recommend immediate action to improve urban drug policy.

Cities and municipalities must:

1. **Design and implement local drug policies that put city dwellers’ health and safety first**
   
   Cities and municipal governments and parliaments have the legal leeway to launch pilot projects to remedy the health issues caused by problematic drug use. Policies should prioritize safe neighborhoods and healthy communities. Health and social interventions, including evidence-based treatment, harm reduction and prevention programs lessen transmission of HIV, hepatitis and tuberculosis. Such programs also reduce petty crime, violence, degradation and displacement of communities. They are cost-effective, and do not require massive reorientation of municipal resources. Data collection and monitoring must be an integral part of pilot projects.

2. **Ensure local/municipal drug policies are coherent and provide a platform to include everyone involved**
   
   No single field or discipline has the power to address all the dimensions of drug policy. From the inception of drug control debates at the city level, mayors should gather everyone concerned around the same table: families affected, law enforcement, prosecutors, educators, people who use drugs, municipal health and social workers, experts and civil society representatives. Building consensus among the different parties and taking into account the concerns of each as legitimate and relevant are key to developing well-informed, effective and long-lasting drug policy strategies that cohere with other public policies at the local level.

3. **Ensure that local drug policies benefit from modern deterrence strategies and focus on reducing violence generated by illegal drug markets to achieve peaceful cities for all**
   
   Municipal/city authorities must accept that it is unrealistic to expect to eliminate the illegal drug market, and that managing and controlling it are far better long-term strategies to ensure safe, resilient and inclusive cities. Blanket repression must be replaced by focused deterrence strategies that aim to change behavior, including moving illegal drug sales away from sensitive areas such as schools or treatment centers. Targeted law enforcement interventions can reduce the violence caused by the drug market. They require a proactive, analytical approach to operations, based on intelligence and an understanding of the socioeconomics of the local context, and shaped by local needs and available resources.

4. **Take control of local drug markets by legally regulating access to currently illegal drugs**
   
   City governments and parliaments should consider experimenting with legal regulation of currently illegal drugs within their urban territories. Such experiments should be strictly evaluated, incremental and inclusive. They could be pilots starting with substances that are easier to control, for which evidence exists on the best kinds of regulation, such as cannabis; or with substances used for medical treatments, such as substitution and agonist therapies to counter opioids. Such pilots, if well implemented, could demonstrate that there are alternatives to using repression to control drugs within a city.
CITY PROFILES AND POLICY RESPONSES

- Bogota
- Quezon City
- Zurich
- Sydney
- Baltimore
- Abidjan
- UN-Habitat
In 2019, I testified before Congress on marijuana and racial justice, and told the committee, “...there is no better illumination of this country’s failed war on drugs than the city of Baltimore.” I meant every word of it. As a majority black city, our population has seen first hand the devastating impact of the drug war. As one of the few black female prosecutors in the country, I have set out to change that.

Since the era of Nixon, through Reagan, we have fought a war on drugs in this country where the belief was that we could incarcerate our way out of our ever increasing drug problems. In Baltimore, we saw, like many cities, communities of color decimated by this approach. Tough sentences sent people away for decades, for problems better addressed by the public health system. Children lost their parents to the system, people with criminal records lost access to jobs and housing, and we exacerbated poverty. Most strikingly, we did nothing to reduce drug use. One of my predecessors and mentors, Kurt Schmoke, was mayor of Baltimore in the 1980s, and he was one of the few leaders to realize the damage we were doing. I see my role, in part, as righting the wrongs of the past, which is why my office has a different approach to drug use and sentencing in general.

A year ago, when the global pandemic forced statewide closures, we were forced to address the failures of the war on drugs again; this time in order to address the public health threat that COVID-19 created in our prisons and jails. In consultation with public health experts and subject matter experts we stopped prosecuting the following offenses in order to decrease the numbers of individuals entering the criminal justice system to increase community health while continuing to address public safety:

- CDS (drug) possession
- Attempted distribution CDS
- Paraphernalia possession
- Prostitution
- Trespassing
- Minor traffic offenses
- Open container
- Rogue and vagabond
- Urinating/defecating in public
- Minor traffic offenses

Additionally, we have:
- Dismissed 1423 pending cases because of our COVID policies
- Quashed 1415 warrants for the aforementioned offenses
- Pushed our governor to reduce the prison population, resulting in two executive orders on the early release of 2000 people
- Opened a Sentencing Review Unit to review and reduce harsh sentences for juvenile lifers and elderly individuals, including drug sentences that are inhumane and outdated.

Not surprisingly, the results of these policies have been:
- The overall incarcerated population in Baltimore City is down 20% during COVID (around 3000 people)
- There has been a 39% reduction (around 8292 people) in people entering the criminal justice system compared to this time last year. (March 19 2020-March 3 2021)

On crime and public safety, the data during this time has been very encouraging. Unlike many American cities, we saw a reduction in crime in many areas, including:
- Violent crime is down 20% (comparing March 13, 2020 and March 13, 2021)
- Property crime is down 36% (same period)

The killings of George Floyd and Breonna Taylor represented an inflection point for our country. There was a widespread call to rethink the criminal justice system. As I wrote in the New York Times around the time George Floyd was killed, “Prosecutors must recognize their power to shape the criminal justice system and must realize that when we criminalize minor offenses we expose people to needless interaction with law enforcement. For people of color in America, an arrest can lead to life-altering trauma. Prosecutors must examine their policies and use discretion to diminish the possibility of such deadly interactions.”

The onset of COVID-19 showed what was possible in terms of policy changes, and the killing of George Floyd showed what was essential. My hope is that our country embraces these changes we have made in Baltimore, and we go in the direction of Portugal and decriminalize drugs nationally. We have taken a huge step toward ending the war on drugs, but we must push on and right the wrongs of the past in a manner that balances the needs of both public safety and public health, as our policies have shown this year.
CITY HIGHLIGHT: AN EMERGING URBAN RESPONSE TO DRUGS IN ABIDJAN

ROBERT BEUGRÉ MAMBÉ
GOVERNOR (2011·INCUMBENT)

PREVENTION
• Outreach and psychosocial centres
• Training of health and social workers
• Grants to civil society and community services
• Harm reduction campaigns for HIV prevention

TREATMENT
Grants to hospitals, dependence treatment centres and civil society delivering outpatient and inpatient care and therapies

COORDINATION
• Provides vehicles to law-enforcement
• Takes part in the design of national HIV plans
• Coordination platform for different institutions: homelessness, child rights, drug policy, etc.

REINTEGRATION
Support for training, education, employment and first aid housing

OBJECTIVES
Better outreach to youth and vulnerable people
Build a city-run rehabilitation centre
Build community committees to prevent drug use culture
Build a city-centred observatory to collect data
Create Outreach Centres in every municipality of Abidjan
Build capacity and reinforce existing services
The Office of the Mayor of Bogota D.C., through its Development Plan entitled “A new social and environmental contract for the Bogota of the 21st century”, Article 141, specifies that “The plans of the constituent entities of the District Council on Narcotics must contemplate specific actions in response to the Policy for Drug Abuse Prevention… the constituent district entities of the District Council on Narcotics should address specific actions for the prevention and harm reduction caused by the consumption of psychoactive substances intended for recreational, habitual and problematic users.”

Article 142 seeks to promote, politically, technically and budgetarily, the actions of the Public Policy for Prevention and Care Services of the Consumption and the Prevention of the Linkage to the Supply of Psychoactive Substances in Bogotá D.C., along the Land-Use Plans of the following sectors: health, education, social, security, culture, sports and recreation, for the next four years.

Mayor Claudia Lopez’s proposal, in terms of drug policy, includes four fundamental pillars for a comprehensive approach to the drug phenomenon. The first is education, understood as the basis for prevention that aims to delay the age of onset of experimentation among children and adolescents. Also, to understand and attend to social determinants related to drug abuse such as psychosocial problems, poverty, abuse, violence and record of addictions in the family structure or in the nearby social network.

The second is care, understood as harm reduction. Its main objective is to reduce the harmful consequences and risks for individuals and communities from drug trade and abuse. Harm reduction foresees not to cause other damage to people already immersed in problematic use of psychoactive substances and to guide the actions for damage compensation related to problematic consumption.

The third is attention, understood as the treatment directed to overcome problematic drug use. Law 1566 of 2012 obliges the National Government to guarantee specialized care for those who suffer from mental health problems or any other pathology resulting from consumption, abuse and addiction to psychoactive substances, through the Social Security System and specialized institutions. This attention must include a range of interventions and support programs for people with consumption problems and should focus on a comprehensive health care rather than a treatment for abstinence.

Finally, public order, oriented to the prosecution of high- and medium-level producers and dealers and the identification of “ollas”, a term given to streets where drug dealing is rampant, instead of the criminalization of drug consumers. The Police Department drug policy should aim to reduce crime and reduce the perception of insecurity and ensure public order, while protecting the lives of the most vulnerable. Thus, the strategy is based on those four pillars in order to tackle the drug phenomenon in an articulated and integral way, moving away from prohibitionism while prioritizing care and self-care of the city’s inhabitants.

The city has been making progress in risk and harm reduction for some years now, especially through strategies such as “Farra en la Buena” [Chilled Party] for responsible alcohol consumption, which reduced violence in priority areas of the city, and through the program Integral Intervention Points for People Who Inject Drugs at fixed points or in mobile unit teams that have continued to develop their actions even during the COVID-19 pandemic. Nevertheless, it is necessary to advance on the political and technical discussions for the implementation of harm reduction services for smokable cocaine users, one of the illegal substances with the highest local and national prevalence of use and thereby, one of the biggest impacts on public health.

In the Integral Intervention Points, other harm reduction actions are being developed to handle the abuse of injected drugs such as: heroin, ketamine, cocaine and alcohol; there, services are provided to users from an interdisciplinary team (psychiatrists, psychologists, nurses and social workers).

In the COVID-19 context (1 April to 7 June 2020) the Integral Intervention Points have taken care of 196 people. Finally, District Agreement 761 of 2020 approved by the Council of Bogotá (District Development Plan 2020-2024 and its article 142) is a new opportunity and challenge for the city that politically, technically and economically will allow the development of other services and actions for an integral approach to the citizenry in terms of risk and harm reduction caused by drug abuse.

Bogotá has retaken leadership in Colombia on a comprehensive approach to drug problem.
During the first half of the 1990s, Zurich had a large open drug scene in its center near the train station. The so-called “Platzspitz” was famous around the world as the “Needle-Park”. There was a great level of neglect, a high crime rate and, due to the unhygienic conditions outdoors, the number of infections with communicable diseases (e.g. HIV) rose sharply. During this era it became clear that Zurich’s situation could not be tackled with repressive measures alone. To address this situation, a four pillar strategy was adopted.

**PREVENTION**
- Strengthen the sense of responsibility
- No total abstinence required
- Prevention of problematic use and dependence
- Specific support to parents, families, adolescents and young adults

**REPRESSION**
Punishment of criminal proceedings as the production, the transport and the selling of illegal drugs.

**TREATMENT**
- Flexible forms of inpatient and outpatient withdrawal
- Psychosocial and medical outpatient care and medium and long-term inpatient therapies
- Abstinence-based approach also highly regarded for those who are willing to
- Diaphin (heroin) substitution treatment

**HARM REDUCTION**
- Needle and syringe programs
- Low-threshold centres
- Drug checking
- Drug consumption rooms provide around 900 persons with drug dependence an hygienic environment for supervised consumption and social workers’ support in close collaboration with the police

**PRINCIPLES**
- **URBAN COMPATIBILITY**
  focus on the issues related to legal and illegal drugs consumption, not the consumption itself.
- **GUARANTEE OF PUBLIC SAFETY**
  fight against drug dealing and criminal activity
- **INTEGRATION NOT EXCLUSION**
  Zürich’s drug policy aims the social integration of people consuming drugs

**CURRENT INNOVATIONS**
- **CANNABIS PROJECT**
The City of Zurich supports all efforts towards legal regulation of cannabis in the interest of urban compatibility in collaboration with other Swiss cities.

**IMPROVEMENT OF URBAN SERVICES**
A range of services is available to support people with dependence disorders, contributing significantly to the quality of life of the entire population.
Quezon City has been active in addressing the problem of illegal drugs since the mid 1990’s via the creation of the Quezon City Anti-Drug Abuse Advisory Council (QCADAAC). This agency was institutionalized via ordinance in 2003 and placed under the Office of the Vice Mayor. It is a 24 member policy-making body consisting of members of the local city council, law enforcement agencies, the judiciary, and various agencies of the local government, the NGO sector and the religious sector. Its programs are run by a staff of 177 trained personnel.

**MISSION**
- Prevent Drug Abuse through education and advocacy
- Treatment and rehabilitation of drug dependents
- Establish linkages with stakeholders

**LEGISLATION**
The Quezon City Dangerous Drugs Code is a model piece of legislation at the Local Government Unit and was adopted on October 15, 2018.

**PREVENTION PROGRAMS**
2017: Special Drug Education Centers (SDECs)
Preventive and developmental services against potentially risky behaviors

15 October 2018
Quezon City Anti-Drug Abuse Council
Operating at grassroots in 142 villages

**TREATMENT AND REHABILITATION**
2016: Community-Based Rehabilitation Program (CBRP)
Twelve modules for PWUDs and three modules for their families

1990: Drug Treatment and Rehabilitation Center
Universal access - 150 beds
The City of Sydney (the City) takes a harm minimisation approach to reducing the social, economic and health problems that can be associated with the use of drugs. In Australia, state governments are primarily responsible for health and harm minimisation policy. However, local government plays a key role as the level of government closest to community.

The City collaborates with a range of partners – including community members, government agencies, non-government organisations, academic institutions and business – to identify and codesign solutions to respond to priority issues in our local area.

This is underpinned by the City’s Community Safety Action Plan 2019-2023, which outlines a commitment to reducing harm from drugs and alcohol by providing targeted harm minimisation initiatives in Sydney, and increasing awareness of where to get help and support. The City participates in local forums, Community Drug Action Teams, and drug health programs to improve safety in our community.

The City has a strong history of advocacy in harm minimisation approaches to drug health, including supporting the establishment of the Medically Supervised Injecting Centre in 2001. When she was the Member for Bligh in the State Parliament, the Lord Mayor of Sydney, Clover Moore, was instrumental in setting up a New South Wales drug summit that recommended the trial of professionally monitored injecting rooms that guaranteed users sterile facilities and immediate medical attention.

The centre, which is located in Kings Cross in Sydney, aims to reduce the number of deaths from drug overdoses, provide a gateway to treatment and counselling, reduce public injecting and discarded needles and syringes, and help reduce the spread of blood-borne viruses.

Since it opened, the centre has supported around 16,500 clients and managed over 8,500 overdoses without a single fatality. Discarded sharps and public injecting have significantly reduced, improving overall community safety.

More recently, the City has advocated for drug testing at events and festivals to create a safer environment for attendees who use drugs. In 2019, the Lord Mayor hosted a drug testing demonstration at Sydney Town Hall. The demonstration sought to advocate for the testing process and provide information on this evidence-based approach to drug testing.

The City works closely with government and not for profit services to manage the impacts of injecting drug use in the public domain. This includes managing a network of more than 140 community sharps bins to provide options to safely dispose of needles and syringes, and prevent needlestick injury in public places, facilities and venues. Where a bin is located, 99 per cent of all sharps are disposed of appropriately.

Through our grants program, the City regularly provides funding to frontline services to support harm minimisation approaches to drug use. Since December 2014, we have provided funding and support for the Take Kare program, which prior to the Covid-19 pandemic, operated in the city every weekend. Roving teams of trained volunteer ‘ambassadors’ provide on-the-spot assistance to people who are intoxicated. A dedicated Safe Space provides vulnerable young people with a place to rest, rehydrate, charge their phones, get first aid, find transport home, or wait for friends or family.

The City works to support vulnerable people within the community. This includes a dedicated team of Public Space Liaison Officers who are on the street every day supporting people sleeping rough in Sydney. These officers work with specialist health and drug services to help people access the support they need.
After more than twenty years of prevention practice at the local level, we know that drug abuse is no longer viewed as a public health problem alone, but as a deep developmental problem in our cities. Drugs impact society and are a key factor which hinders economic and social development of the city and the country, whether in the developed world, developing countries, or economies in transition. This impact has been magnified by the complex context of far-reaching financial austerity and globalization, now compounded further with the COVID-19 pandemic and its socio-economic consequences. Policy-makers face a growing range of challenges and targeted pressures for results and change at the local, national, and global levels. This context underscores the need for governments to use available evidence and the tested tools that are known to reduce drug abuse. Of nearly 12 million people worldwide who are believed to be actively injecting drugs, nearly 1.6 million are living with HIV and about 6.1 million are living with hepatitis C. By 2016, the adverse effects of drug abuse accounted for nearly 17 million years of healthy life lost worldwide, due to premature death and disability. To tackle this loss, there is a clear need to accelerate targeted efforts under Sustainable Development Goals 3, 11 and 16.

There is growing interest in scaling up inclusive urban policy governance standards and applying existing guidelines, including the use of evidence to inform and develop good principles of drug policy governance based on municipal interventions to prevent or reduce drug abuse linked to violent crime. However, drug policy application in urban areas is a particularly contentious and diverged policy area. Governance-related challenges thrive in this domain, particularly in relation to public administration. Cities do not act or respond in a consistent way and it is not possible to impose a “one-size-fit-all” policy.

Globally, there is need to assess the extent to which drug policy-making in cities may be aligned with the perceived characteristics of good governance and suggest possible improvements where applicable. Evidence from municipal safety interventions shows that addressing drugs related to violent crime requires good governance such as the development of solidarity practices, city consultation processes and institutional reform which enhance ethics, citizenship and inclusion. Good ethical governance is grounded in the need for cities to recognize that inhabitants have a role to play in their safety. In inclusive cities, people and public institutions can interact in designing and developing policies, creating an enabling environment for more ownership, compliance, transparent governance and enforcement.

In some countries and regions, drug policy has a narrow legal basis in the existing treaties and is mostly non-binding, hence warranting urgent revisions where possible. The range of interests, the overarching aims of drug policy, and the inclusion of an evidence base for potential impacts of such policies must be considered. For example, in the EU region, the key policy instruments include eight-year EU Drug Strategies, underpinned by four-year Action Plans which set out specific objectives at national, EU or international level. EU governance in the field of drugs is characterized by the proactive support provided to non-governmental organizations within the EU as well as in accession, associated or third countries.

Global and local urban leaders understand the gravity of the drug problems in their cities today much more than they did decades ago. Historically, the aims of drug policies were rooted in the cessation of distribution and use of drugs and policies relied upon punishment to achieve the targets. Today we know these policies have not been successful. The root of this failure can be seen as the lack of focus on saving the lives of urban drug users rather than punishing users as the primary target. If local leaders are to save the lives of people facing substance use disorders, then they need new policies that address the underlying cause of abuse, founded on the belief that urban drug users’ lives matter.

In over 80 countries, the existing drug policies are directly or indirectly designed to keep the drug manufacturing and distribution in the hands of dangerous criminals, and not in well managed pharmaceutical companies. However – from South America to Europe – health-centered drug policies are being implemented that are proving to be remarkably more effective at improving public safety and health than outright criminalization. At the heart of this policy change is the recognition that the criminalization of drug use is not justifiable and that it is a barrier to more effective responses to drug use. Portugal presents the most significant post-criminalization, health-centered drug policy where decriminalization of low-level drug possession led to a drastic decrease in rates of violent crime, addiction, and disease transmission.
Many global leaders are beginning to recognize that the prevailing drug policies attempt to control the drug market through force, prohibition and incarceration rather than putting the lives of drug users in the center of the policy responses. These policies – indirectly – create a hugely profitable and efficient drug trade. Debates about the problems of violence, poverty, race, health, education achievement and opportunity, community development, the environment, civil liberties and terrorism all recognize that illegal drug markets contribute to the seriousness of the problem. Consequently, under many existing drug policies, drug users are victims in the first instance but also more likely to be victims for losing housing, school, fired from their jobs, and removed from treatment programs.iii

Progress towards the 2030 goals can be made by first making a shift to understanding the damage to human life and urban economies caused by drug abuse and lack of safety, and through relatively simple transformation of tools that already exist. Latin America, for instance, has developed a wealth of knowledge, strategies, proven successes and has demonstrated the benefits of institutionalised municipal safer cities/citizenship security policies and programmes. Governments and cities need to transform their decisions from traditional or intuitive approaches, to strengthening their policy decisions based on evidence and established successful practice, learning through communities of practice, measuring progress, and adapting in real time. Measurement is essential to monitor outcomes in rates of reduction in drug abuse, to raise awareness at the policy level, and to foster more national and city innovation. The potential benefits to quality of human life are significant, as are the benefits to strengthened GDP in high violence regions. Therefore, city leaders must invest in creating safe and compassionate societies, where drug policies seek to minimize the suffering of drug users, among many other policy priorities.

UN Habitat has been at the forefront working with cities and local governments in refining their urban drug policy linked to violent crime and lack of safety through a careful consideration of four key factors in cities:

a. the degree of social cohesion
b. the extent of urban inequalities
c. the risks of the built environment
d. and the scope of inclusiveness in urban governance

Experience has shown that city authorities are better equipped to build urban safety, free from drugs when they formulate inclusive urban policies and systemic interventions such as analysis and redesign of the morphology of the urban environment to favor self-protection. Such initiatives can also foster social links, reinforce social cohesion, reduce social inequalities, mitigate exclusion, and bridge the gap of the ‘urban divide’. Transformation at this scale is easier said than done. Tools which address any or all of the four key criteria noted above is a strong framework to start.

Recommendations for national and local governments

1. Increase awareness of the strategies proven to reduce drug abuse linked to violence;
2. Develop and train the human capacity to use the UN system wide Guidelines on Safer Cities and Human Settlements for success;
3. Encourage cities to join communities of practice to learn from each other’s success;
4. Ensure ways to measure progress as what gets measured gets done;
5. Multiply more prevention strategies integrated into national urban policies that implement national plans, invest adequate and sustained funding, and demonstrate increases to economic growth.

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i UNODC, World Drug Report, Booklet 2, 2017
REFERENCES
advantage of this grey area, private clubs that produce cannabis for non-profit distribution solely to a closed group distribute enough cannabis to meet their personal needs without having to turn to the black market. They are based

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ADDITIONAL RESOURCES

www.anyoneschild.org
www.au.int/en/sa/dswdc
www.drugpolicy.org
www.fast-trackcities.org
www.emcdda.europa.eu
www.hri.global
www.hrw.org
www.idhdp.com
www.idpc.net
www.inpud.net
www.incb.org
www.menahra.org
www.ohchr.org/EN/HRBodies/HRC/Pages/WorldDrugProblem.aspx
www.institutoria.org
www.sdglab.ch
www.talkingdrugs.org
www.tdpf.org.uk
www.unaids.org/en/topic/key-populations
www.unodc.org
www.cicad.oas.org
www.wola.org/program/drug_policy
www.wacommissionondrugs.org
www.who.int/topics/substance_abuse/en/

REPORTS

www.globalcommissionondrugs.org/reports/

• War on Drugs (2011)
• The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic (2012)
• The Negative Impact of the War on Drugs on Public Health: The Hidden Hepatitis C Epidemic (2013)
• Taking Control: Pathways to Drug Policies That Work (2014)
• The Negative Impact of Drug Control on Public Health: The Global Crisis of Avoidable Pain (2015)
• The World Drug Perception Problem: Countering Prejudices against People Who Use Drugs (2017)
• Regulation: the Responsible Control of Drugs (2018)
• Classification of Psychoactive Substances: When Science Was Left Behind (2019)
• Enforcement of Drug Laws: Refocusing on Organized Crime Elites (2020)

POSTION PAPERS

www.globalcommissionondrugs.org/position-papers/

• The Opioid Crisis in North America (October 2017)
• Drug Policy and the Sustainable Development Agenda (September 2018)
• Drug Policy and Deprivation of Liberty (May 2019)
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f GlobalCommissiononDrugs
t GlobalCDP
t Global Commission on Drug Policy
The purpose of the Global Commission on Drug Policy is to bring to the international level an informed, science-based discussion about humane and effective ways to reduce the harms caused by drugs and drug control policies to people and societies.

**GOALS**

- Review the base assumptions, effectiveness and consequences of the “war on drug” approach
- Evaluate the risks and benefits of different national responses to the drug problem
- Develop actionable, evidence-based recommendations for constructive legal and policy reform