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Operational recommendations on demand reduction and related measures, including Prevention and Treatment, as well as other Health-related issues

First of all I'm grateful to speak in behalf of civil society on this forum.

When I was preparing this statement I was reading the outcome document and I was thinking: "What's in a name?". Specialy on the subtitle. It goes like this:

"Our joint commitment to effectively addressing and countering the world drug **problem**"

In a sociological approach we have to question who's problem it is? Is it "the" problem of the people who use drugs? Is it the problem of the drug dealer? Or is it the problem of the grower of the poppies or the coca crop? Is it the problem of the unequal society? Is it the problem of the service providers? Is it the problem of politicians or law enforcers? I don't have the time to elaborate on this but let it be clear. We all, as mankind, have a part in the problem. Consequently we all have to deliver a part of the solution to. Specially policy makers can make a huge difference. They can and should make it happen. And since we are talking about mankind and humanity we certainly have to speak about it in the light of the Human Rights, fundamental freedoms, the inherent dignity of all individuals and the principles of equal rights and mutual respect among States.

Seen from this same sociological perspective I'm glad to see that UNODC/UNGASS2016 recognizes the importance of mainstreaming gender and age perspectives in drug-related policies and programmes and also the important role for civil society. The reaffirmation of the need to address the key causes, including those in health, social, human rights, economic, justice, public security and law enforcement fields and the recognition of the value of comprehensive and balanced policy also point in the same direction.

The two promoted axes of actions in the first chapter are prevention and treatment. On these two items I would like to share some thoughts with all of you

First of all I'd like to emphasize the reciprocity of prevention and treatment. They need each other. Because a lot of treatment methods not only treat or cure but also prevent worse. Particularly Harm Reduction or Risk Reduction interventions. By knowing the effective treatment we also can adjust and do some finetuning to improve our prevention strategies. To make them more effective. Let it be clear: they need both our best efforts. We cannot raise the funds from one strategy by taking funds away from the other.

The Early Warning System, as we know it coordinated by EMCDDA and further distributed by the regional partner organizations, as an informing and preventive measure has already proven its usefulness. To improve its effectiveness we should widen the scope. For that there is need for new or amended legislation that facilitates freely accessible substance testing. It will provide us valuable, straight of the street information. It could serve prevention, treatment, health, law enforcement, local, national and even international policy making. Strange but a fact: International policymaking is in many cases the fastest way to get things moving on national or regional level. By saying this I would like to emphasize the importance of this meeting.

Early intervention is not only about age of the target population. It is the phase where a person is going through and when he or she gets our intervention. The most important consideration should be the timeframe of the intervention and not the kind of intervention. I like the idea of "it's easier to bend a twig than a tree" But the twig can also grow on the tree and is still be bendable. Delay of the age of onset needs everyone's attention because it is a predictor. To address this problem we need tailor sized programmes that are age and youth appropriate. The biggest mistake is to treat youngsters as little adults or as little children. They have their own specific needs. They need a specific approach and specific solutions. If you only make them target of your interventions they can and will easily dodge your well-intentioned attempts. In most cases they are and have a bigger part of the solution in proportion of the problem. We should treat youngster as co-creators of their solutions. That means total involvement in the design, the plan, the implementation and the evaluation. And yes, we need evidence based measures and tools but it is not the only one holy grail. If we reduce our acts by only Evidence based actions it will be an impoverishment. Evidence based theories and practices can't be always tailor sized for everyone or for everywhere. Sometimes the regional differences are incompatible. I would like you to allow and even promote new initiatives. And yes, initiatives often exists of trial and error. Many bridges collapsed and many boats sunk before the first men reached the other riverbank. It will provide us with new evidence and good practices. The time will be good spend because the problem is approached from different perspectives and from different angles . It's like differential diagnostics: we need to know what's not working. If we don't try we know nothing.

All prevention and treatment measures should be freely accessible by all age groups and whoever might be in need of it. Also for minors. Certainly if we want to prevent worse. To secure their future, and in the end our own future because they have to take care of us later, we have to exert all available methods and measures to succeed. We can't leave anyone behind. We can't just forbid and use only "just say no" strategies and refrain them from effective Risk and Harm reduction interventions when necessary. All interventions can have their place, regardless of the ideology or philosophy. Whatever the nature of the intervention is, the starting point should always be: "Do no harm!" and "Don't make the cure harder than the disease". It's in the nature of mankind that we only will change for profit for ourselves. Legal thresholds should not be an obstacle. Policymakers can fix this.

Since Opioid Substitution Therapy is more widely accepted it is time to evolve in this matter to. Methadone programmes are yet in many countries available. The same for Buprenorphine. But what with Heroin Assisted Therapy? There is quite some evidence for this therapy. For a certain group of PWUD it would be the best solution to connect them back with society and to keep them as healthy as possible. Maybe it's time to be less moral and more pragmatic. I'm glad with UNODC inviting countries to consider medication assisted programmes even though it could be more promoted or even gently pushed. Medication assisted programmes contribute directly to the health of people who use drugs by preventing possible infections and preventing the adverse effects of substance use. The social profit is significant in case of a better general well-being of people who use drugs. Of all people by the way.

I just talked about what people can use so now it is time to say something about how people use. Needle Exchange Programmes are a cornerstone of good drug policy. To make the most of it, they also need to offer paraphernalia for all methods of use. It facilitates less harmful ways of use. They

are the perfect places for Nalaxone antagonist programmes and perfectly situated for referring for screening on blood born infections. Or referring to treatment programmes when appropriate. Seen from the economical perspective it is of course better, and even a lot cheaper, to prevent Blood born Infections instead of treating them. People can contribute more to society when they are healthy and not sick. Budget austerity in these preventive measures catch you later with a much bigger bill. A bad example is the closing of two Needle exchange programmes in the eighth district in Budapest for political recuperation reasons. Needle exchanges programmes are also important as early interventions. The first period and more exactly the first three months of IV use are predictive for the later way of use and the future risk management of IV users. IV starters are often initiated or introduced by peers. For this reason you can see the importance of education of peers and giving to the point health promotion in general.

In the end the question is where to use drugs? Let it be well known and evidence based proven. Drug Consumption Rooms solve a lot of problems while it mostly causes only few. One goes about "Not In My BackYard". The second is often based on the apparent immorality of "allowing, permitting or facilitating" substance use. These problems are basically solvable with political courage. Again it is important to be pragmatic and solution oriented instead of being moral indignant. The return is much bigger and more diverse. Health care, law enforcement, society and the people who use drugs share the many benefits. Policy shaping and making is essential here. Therefore I appeal to you to make this happen.

If we fail the just discussed interventions we will have to treat more HCV and HIV infections. For this statement I highlight a good practice for a comprehensive treatment for HCV when you cannot use the "under one roof methodology". With our peer driven C-buddies project we found the cement between different partners. The partners were the Needle Exchange Programme, Free Clinic as low threshold service provider for counselling and drug care and the specialist Hepatologist in a city hospital. The C-buddies are well educated, reimbursed or in employment, underwent and completed previously a HCV treatment and have street credibility. They support People Who Inject Drugs from the first screening, through the whole treatment, up to and including the aftercare. They offer help on all domains of life and build bridges between all the possible needed partners to successfully complete the treatment. The outcome is spectacular extraordinary. The compliance is more than 90 (ninety) %. Working with peers, not only voluntary peer supporters but especially also, normal paid, peer educators and recent street credible (ex-) PWUD's pays the effort.

Beside all interventions, tools, prevention and treatment we definitely need to reach the PWUD's. And again cooperation is the key. A balanced and trusted cooperation between civil society and policy makers. NGO's need policy makers to shape the conditions so they can do their work and policy makers need NGO's to contribute to resolve the drug problem. A first and primordial step in this direction is decriminalization of personal use of drugs. It will lower the threshold significant for PWUD to enrol in all kinds of programmes that serves them best. A lot of PWUD can't find job because they have a substance line on their criminal record. As a matter of fact: I have no knowledge of other crimes that harms other citizens less as personal use of drugs or possession of substances for personal use. Beside of all the advantages for society, health care and the PWUD's themselves it would also be a tremendous profit for law enforcement and the justice department. They can use all their resources and efforts for supply reduction and public safety. By decriminalisation of personal use you bring the solution of the individual drug problems back in to society instead of in prisons. In

prison is often no treatment available It's also again a bad line on your criminal record in order to find a job or a future. I'm sure Mr Randy Thompson will elaborate on this issue coming Thursday. Decriminalisation leads to better and earlier enrolment in treatment and less exclusion. Some medical benefits are: less need for dental care, they will have less pulmonary damage and less arterial or venous damage. This leads to direct benefit for the health of PWUD's with more expected healthy years. Briefly summarized: less costs and more social benefit also contributed by PWUD's And at least ex-users stand a chance for a normal life. Neither we have to fear to devalue prevention measures by decriminalization. Prevention based on scare tactics aren't effective and are in many cases counterproductive towards solutions

I guess my given time is almost spend so I would like to focus on international cooperation to conclude. There is a lot of good experience all over the world and how to share it? There is a huge difference between push and pull information strategies. Pull information is often lost in the massive overloads of information and scattered. In my opinion the best dissemination of information and good practices is IRL from persons to persons. For this we need networks. In my daily practice we are partner organization of Youth Organisations for Drug Action and the Correlation Network. On the internet site of Correlation network you can find many tools and support for your ongoing and future actions. Until now, these networks are always depending on temporarily and project based funds. As example I can tell you that the Correlation network had to minimize its activities the past years due to a lack of funding. In the Yoda network we had to postpone a policy week training due to administrative troubles on the funder's site. On this moment, as we speak, we are applying for a call from the EU for the coming years as a partner organisation with the Correlation network. A lot of time and efforts are spend in applying for calls and grants. Time is money and time is also like money. You can only spend it once. This thinking en writing of calls and projects is also paid by our clients because at that time we are not there for them. We are forced to do because we're depending on those funds. I like to use this opportunity to make a warm call to fund this kind of networks on a more structural base. I'm convinced that also in times of budget cuts and austerity the outcomes will exceed the spended money many times. Larger regional, continental and worldwide orientated bodies, like the EU and the UN are indispensable for these matters. They could also at least suggest or even impose States to provide funds for networks of civil society and NGO's on national level.

Thank you for your attention and I wish everyone a constructive day.