

Statement Kristof Bryssinck

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?". Specially 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? 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.

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 Risk and Harm Reduction interventions. By knowing the effective treatment we also can adapt 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 has already proven its usefulness. To improve its effectiveness we should widen the scope. For that there is need for 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 and policy making.

Early intervention is not only about age of the target population. 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 bent 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 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. We should treat youngsters as co-creators of their solutions. This means total involvement in the design, the implementation and the evaluation.

And yes, we need evidence based 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. I would like you to allow and even promote new initiatives. And yes, new 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 well 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. We can't just forbid and use only "just say no" strategies and refrain them from effective Risk and Harm reduction interventions when necessary. We can't leave anyone behind. 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!"

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. And include Heroin Assisted 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. It's time to be less moral and more pragmatic. Medication assisted programmes contribute directly to the health of people who use drugs by preventing infections and the adverse effects of substance use. The social profit is sky-high.

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 Naloxone antagonist programmes and perfectly situated for referring ~~for screening or to treatment programmes when appropriate~~ Seen from the economical perspective it is of course better, and even a lot cheaper, to prevent 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.

Needle exchanges programmes are also important as early intervention. 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

In the end the question is where to use drugs? Drug Consumption Rooms solve a lot of problems while they mostly cause 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 ~~making~~ making is essential here.

If we fail the discussed interventions we will have to treat more infections. For this statement I highlight a good practice for a comprehensive treatment for HCV. ^{hepatitis C} With our peer driven C-buddies project we found the missing cement between different partners. The partners ^{are} ~~were~~ the Needle Exchange Programme, Free Clinic and the specialist Hepatologist. The C-buddies are well educated, 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 . Working
 not treating them is no option

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with paid peers an recent street credible Persons WUD's pays the effort.

Beside al planned interventions, 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. 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 a legal job because they have a substance line on their criminal record. 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, 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

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I guess my given ~~my~~ time is spend so I would like to focus on international cooperation to conclude. There is a lot of good experience all over the world but 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 the YODA network and the Correlation Network. On the internet site of Correlation network you can find many tools and support for your ongoing and future actions. These networks are always depending on temporarily and project based funds. On this moment, as we speak, we are applying for a call from the EU for the coming years. 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 projects is also paid by our clients because at that time we are not there for them. 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 spenden money many times. Larger regional, continental and worldwide orientated bodies, like the EU and the UN are indispensable for these matters.

Please remember one thing of my statement: support, don't punish
Thank you for your attention and I wish everyone a interesting and constructive day.

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