On 11th May, 2008, I attended the 4th International Conference on Alcohol and Harm Reduction in Barcelona.

At the same venue, from 11th to 15th May, I attended the 19th International Harm Reduction Association (IHRA) Conference, along with 1200 people from 80 different countries.

IHRA describes itself as “the leading organisation in promoting evidence-based harm reduction policies and practices on a global basis for all psychoactive substances”. Pleasingly, legal drugs – especially alcohol and nicotine – are included in their brief. It was pointed out by South Australia’s Professor Anne Roche of Flinders University that the term ‘harm reduction’ was first applied to alcohol abuse and was appropriated by the wider drugs field. Ironically, it is now being suggested that this approach now be tried in dealing with the problems associated with alcohol!

Dr Miguel Andres told the conference we must deal with drugs in the context of health – that is what harm reduction is all about. I observe that we don’t have tobacco and alcohol under the control of the Attorney-General in South Australia, and nor should we, because they are rightfully covered as health issues in this state.

The biggest revelation for me in this conference came from attending sessions on tobacco harm reduction, and to recognise that much of the movement in Australia is on the verge of being prohibitionist – see my notes on the sessions “Global Efforts on Tobacco Harm Reduction” and “The arguments against (and responses for) tobacco harm reduction”. Parts of both of these sessions dealt with the issue of smokeless tobacco, and the attempts to roll it out in Canada, and the responses of the anti-tobacco lobby. I had not recognised till then how uncompromising the anti-tobacco lobby has been in Australia. As I now view it smokeless tobacco is like a methadone maintenance program without a doctor to tell you how much to take, which must be provocative to the medical community.

Additional to the spoken word was a Film Festival and I was lucky enough to view the Australian documentary “Just Punishment” (about the institutional killing of Australian man, Van Nguyen, for drug possession) and “Waiting to Inhale” (a US documentary about the production of medical marijuana in California).

The twin issues of harm reduction and its intimate integral relationship with human rights dominated the conference.

This report is mostly my notes from attending and listening to addresses, speeches and presentations.
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“Drug using mothers; factors associated with retaining care of their children”
Gail Gilchrist: University of the West of Scotland, UK

“Addressing the forgotten co-morbidity: developing a combined pain and dependency service”
Dr Michael Orgel

“Youth, drug markets and violence in Canada: What can harm reduction do?”
Patricia Erickson: senior scientist with Centre for Addiction and Mental Health

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Bernadette Pauly - Asst Professor in School of Nursing, University of Victoria, Canada

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Meaghan Thumath - founding member of the Nursing Harm Reduction Network; Cedar Project Partnership, Sheway

“A little bit of toast: enhancing client engagement with low threshold interventions”
Suzanne Long - Team Leader, Blackfriars CDAT, South London & Maudsely NHS Foundation Trust

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Sebastian Salvadores Cobas: Enfermo
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<td>Association for the Reduction of Tobacco Related Harm</td>
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<td>CNA</td>
<td>Canadian Nursing Association</td>
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<td>International Network of People who Use Drugs</td>
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<td>MAT</td>
<td>medication-assisted therapy</td>
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<td>PCB</td>
<td>Programme Co-ordinating Board</td>
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<td>SIR</td>
<td>Safe injecting room</td>
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<td>STI</td>
<td>sexually transmitted infection</td>
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<td>UNAIDS</td>
<td>Joint United Nations Program on HIV/AIDS</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session (in this context usually meaning the 1998 session on drugs)</td>
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<td>UNODC</td>
<td>United Nations Office on Drugs and Crime (of which the current Executive Director is Antonio Maria Costa)</td>
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**SATELLITE SESSION: INTERNATIONAL CONFERENCE ON HARM REDUCTION AND ALCOHOL**

**INTRODUCTION**

Alcohol is an increasing problem across Western Europe (source ESPADA). Designated driver campaign (BOB) is well-accepted across Western Europe.

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"Policy options, drinking and youth culture"

ANN ROCHE (Prof.) – Flinders University, National Centre for Education and Training on Addiction (NCETA)

NCETA has been looking at cultural influences on young people’s drinking. (The first phase report is already on their website).

We need to understand why young people drink. There are symbolic meanings constructed around alcohol. The media sometimes uses alcohol as a way of demonising young people. Alcohol is often used as a way of group identification; what they drink identifies that group, similar to the clothes worn. It’s tribal, and the advertising industry understands this very well. It is ‘bounded pleasure’: young people have clearly delineated time zones in which the behaviour occurs.

Young people are not passive in all this – we underplay their role as active agents. Nor are they heterogeneous. They transform meanings of consumerism to meet their own needs.

A high proportion of binge drinkers are completing secondary education and going on to tertiary education: this longer time in education maintains the child role longer. We are dealing with a new concept of ‘kidadults’ or ‘adultesence”: eternal pursuit of youthfulness. ‘Youth’ is now more than a transition period. We live in a culture which fetes youth.

**Social factors at work:**

- In Australia one in six young people grow up in a family where parents have separated
- There has been a decrease in religiosity and religion is protective of people from drugs/alcohol
- Social relationship networks are now accomplished at enormous speed – family less dominant, but what their peers do is very important
- Australian nationalism is now connected with alcohol (at the cricket and football)
- Young people stay at home to much older ages; parents are not disciplinarian but friends
- In staying at home, money is saved on rent so young people have more money available for leisure which in turn creates more drinking options
- Earlier adolescence leads to pressure to look and act like teenagers/young adults
- Young people have more freedom about where they go
Marriage is later than previous generations, and more are never marrying; couples have fewer children and have them later so there is more time for recreation.

Modelling from parents is important in setting a pattern of drinking.

High youth employment leads to more alcohol consumption.

Risky drinking is a consequence of leisure boredom, leisure accessibility and the leisure setting – family events saturated with alcohol.

Products with increased alcohol content, especially pre-mixed spirits, are being promoted. Alcohol products are being marketed:

- to mimic psychoactive drugs,
- with the development of designer drinks,
- by the introduction of theme pubs and bars,
- by differentiation of products,
- with youth-oriented packaging,
- with lifestyle and image advertising (advertising is self regulation with weak industry codes).

FEEDBACK
A basic principle of policy development is that it must be evidence-based & data-driven. The media can educate but can also stigmatise. There is a need for young people to create their own space.

“Alcohol from a youth perspective”
Caitlin Padgett – Youth RISE

Caitlin spoke about her own experience with alcohol abuse. Neither information or the personal impact made any difference until she realised that alcohol was the common denominator in any other drug-taking and risky behaviour.

She says it is important to speak honestly with other young people about alcohol, but this is not happening. There are a lot of mixed messages for young people – they can’t wait to get their hands on ‘the good stuff’.

Alcohol is a powerful drug, masquerading as a powerful tool – it fulfils many needs, and if the needs are met then alcohol will continue to be used. Adolescence is already defined as a time of self-exploration and experimentation and alcohol bridges the gaps, gives confidence, eases pain etc, which are real gifts for young people.

“Over the influence”, a book about drugs, concludes: “not all use is abuse; change is slow; young people use drugs for a reason; and you can make positive changes while still using drugs”. These apply equally to alcohol.

FEEDBACK
Young people find it difficult to get adults to present them with meaningful information.
There is a need for holistic education which recognises the diversity of youth and accepts that young people will take risks.
Sensible drinking approaches are often moralistic
Should we be framing the alcohol debate in the same way as illicit drugs?

“Botellon: about youth and binge drinking in Spain”
Gonzala Musitu Ochoa –Scientific Committee, Spanish Federation of Alcoholic Drinks

Botellon: a temporal space created weekends between 11 at night and 3 in the morning. 64% of Spanish youth participate in the botellon. It is an appropriation of public space and is related to sociability, and, in turn consumption of substances (cannabis, tobacco, cocaine).

In a survey conducted of 2500 young people who meet at Merced Square, they said it was a good way to meet friends and enjoy life. Food, glasses and ice are available nearby. 83% drank cocktails, 6.7% drank beer. Alcohol costs too much in bars and pubs

Part of the behaviour is a rebellion against an “oppressive” world – they are the architects of it. The botellon transmits to adults the message “we are here and you are there”, but says it in a peaceful way. They need it to be different to adult leisure and norms

FEEDBACK
“Youth” is related to marital status: Parenthood involves less risk-taking and more responsibility.
Intention is an integral part of binge-drinking - the aim is to get drunk (as compared, for instance to the more adult practice of wine-tasting). The decision-making is very conscious risktaking (esp. for underage). For the public it is different – their concern is about the behaviour associated with the drinking.
The key is the group and not the individual intention.

“Night Life in Copenhagen”
Ronni Abergel, Consultant to Alcohol and the City Project, Copenhagen

Ronni has previously worked in youth violence prevention, then in crime prevention.

In January this year a 19 y.o. was stabbed to death because he would not hand over the hat he was wearing. Some people are too drunk to defend themselves. Some young people, because of their difference, get excluded and cannot get into venues.

This project has funding from the City of Copenhagen, government, unions and industry (Diageo). It will
- utilise nightlife staff in harm reduction techniques;
- improve co-operation between police and the industry;
- better co-ordinate crime prevention initiatives;
- reduce alcohol and drug related harms.
Issues addressed will be random acts of violence between young people, low tolerance between different cultural groups and discrimination against minorities

FEEDBACK
Drugs, sex and alcohol revive around night life – it is nature’s way of separating the young so they can indulge in courtship behaviour. Social services exist during the day, but do not operate at night.

Businesses are taking on the role of managing harm within their own establishments and should be recognised for engaging in responsible behaviour.

Different style of policing and different allocation of resources required.
The nighttime economy is part of the evolution of the city – more regulation might not be the solution.

“Learning the ABC: Adults, Booze and Children”
Jack Law – Executive Director, “Alcohol Focus Scotland”

Worldwide, binge-drinking is spreading from developed to developing countries. There is also a developing trend towards home drinking.

The alcohol industry aggressively targets and markets to young people. We are all influenced by marketing, availability and price, not just young people.

Youth cultures are reinforced by the alcohol industry – they emphasise connection and availability. Drinking is promoted as a leisure project, which reduces the idea of risk.

The experience of young people is the same, but the interpretation is different. Children take their cues from adults (parents) and the way they drink – it gives permission.

Advertising and warning labels divert attention from questions about how the parents drink

What could be done? Restrict the volume and content of commercial communications and improve market regulation. Education programs are only useful within a context – they influence knowledge but not necessarily behaviour.

Reference was made to a children’s book “Rory” about a dog that gets ignored and how the dog thinks it’s his fault.

info@alcohol-focus-scotland.org.uk
www.alcohol-focus-scotland.org.uk

FEEDBACK
This is a new model: a lot of people do not see it as particularly pressing
Is it a harm-reduction approach? Yes – it asks parents to moderate their drug use so as to bring about change in the children. Teachers could also play a role
“The Global Alcohol Harm Reduction Network”
Jamie Bridge – IHRA Communications and Project Development Officer

In 2004 IHRA determined to broaden focus to include alcohol and tobacco. IHRA has set up a Global Alcohol Harm Reduction Network but it has been in existence for only six months.
GAHR-Net is free to join, with 700+ members and an aim to share and discuss ideas and experiences, news and developments, to provide support and advice.
www.ihra.net/alcohol and the 50 best articles at www.ihra.net/AlcoholHarmReduction
There will be an online discussion group; there will be a bi-monthly newsletter with an aim to improve alcohol focus in IHRA 2009.
Jamie.Bridge@IHRA.net

“The Role of the Hospitality Industry”
Jim Peters – Responsible Hospitality Institute, USA

RHI was set up about 25 years ago with the aim to make places safe to socialise. Sociability is the lubricant of society, and is an innate need.

Different venues provide different social environments. The hospitality industry is very interested in security, safety and quality of life issues (such as noise in carparks, and waste).

Demographic changes: people who are younger go out more frequently than those who are older, teenage girls of today will create new demands
KEYNOTE ADDRESS: 2008 ROLLESTON ORATION
Prof Paul Hunt – UN Special Rapporteur

People who use drugs are routinely subjected to human rights violations. Police beat people suspected of using drugs. Drug users are forced into detox without their consent. Drug users are denied information about HIV prevention. Government officials harass those who speak in support of harm minimisation. Police fail to investigate the domestic violence reported by a woman who uses injecting drugs. Young people who use drugs are denied factual information.

The human rights indictment list is long. Widespread, systemic abuse of human rights occurs because drug users are some of the most vulnerable in society. Yet there is no public outrage and no public inquiries.

This long litany of abuse sometimes even gets public support. History teaches us that when a group of people is rendered invisible, widespread human rights abuses often follow.

The UN was established in response to appalling human rights abuses, but many human rights abuses did not attract significant attention within the UN because of the Cold War. Every human right, every principle, was hard fought.

The Code includes numerous treaties. It is the 60th anniversary of UN Declaration of Human Rights this year. It is easy to dismiss this international code of human rights – it is breached with impunity every day in Guantanamo Bay, Palestine, Sudan etc. Human rights are blunt instruments and sometimes have no impact at all, but sometimes they have helped in the struggle against injustice.

But processes have been established to hold states to account for their abusive conduct. NGOs have taken up thousands of human rights law cases, and some of these have generated positive change. Not all human rights accountability procedures involve the courts.

150 countries have agreed to be bound by the cultural covenant’s rights. There is no escape hatch for countries. They have to report annually to show how they are implementing these rights – independent experts ask the delegations about the committee reports.

Informed by the ‘shadow’ reports they can ask why the government is not supporting harm reduction, they can be asked by the human rights committee at Geneva. The Committee can prepare criticisms that are published on the web. This in turn provides a tool for the NGOs to go back to their countries and advise them of that criticism.

We should have no illusions about human rights protections, but they do provide a way of holding states to account, of asking tough questions and demanding answers. UN special rapporteurs are independent, reporting directly to the General Assembly. In 2006 they visited Sweden and found an inadequate approach in regard to harm reduction and this was reported.
Governments suffer from acute amnesia. It is imperative that the international Narcotics Control Board must cease to behave as if in a parallel universe. We are left with a deeply unsatisfactory status quo.

Implementation of human rights conventions must proceed across the community. They are being incorporated in the approach to trade and health: it is time for them to be applied to drug policy.

Health and human rights have matured rapidly in recent years. Traditional human rights tools must have health policies – ‘naming and shaming’ and slogans are no longer sufficient. They must be able to engage in policy-making processes, prepare impact assessments, benchmark and analyse budgets.

The General Assembly has affirmed that it is time for human rights to take their place so policies must become more robust and more meaningful for those who are most marginalised.

Human rights is sometimes characterised as unrealistic or impractical – not so. There is overwhelming evidence that harm reduction initiatives work and they are cost-effective. When workers call for harm reduction initiatives it is their opponents who are tied to ideology, not them.

The health system must be responsive to the needs of those who use drugs. When working for harm reduction initiatives, the goals must be sensitive to the needs of all.

Human rights do have a constructive role to play and I urge you to incorporate human rights into your work.
What might constitute universal access? UNAIDS has been collecting the evidence – though this does not necessarily translate into implementation.

There are 9 elements to a comprehensive prevention, treatment and care of HIV in injecting drug users:
1. Needle and syringe programs
2. Opioid substitution therapy
3. Voluntary HIV counselling and testing
4. Anti-retroviral therapy
5. STI prevention
6. Condom programming for IDUs and partners
7. Targeted information, education and communication for IDUs and their sexual partners
8. Hepatitis diagnosis treatments (Hepatitis A, B and C) and vaccination (Hepatitis A and B)
9. TB diagnosis, prevention and treatment

These elements should be implemented across the board and combined. Should ask questions like: If we have a condom program, what are we doing about IDUs?

What does the UN Secretary-General’s latest report reveal? More countries are reporting that they have programs. 34% of countries report that they are implementing programs for IDUs (some countries are not reporting).
MAJOR SESSION: HARM REDUCTION IN SPAIN

Abstract: Spain, like any other southern European countries, has suffered from the serious impacts of HIV/AIDS and hepatitis C infections and overdose deaths – especially in the 80s and the early 90s as a consequence of a huge heroin epidemic. HIV/AIDS and overdoses became some of the leading causes of death amongst young people. In Spain, this led to significant efforts to introduce and improve harm reduction strategies encompassing syringe exchange, methadone maintenance programs (both in the community and in prisons), outreach to hidden groups of drug users, drug consumption rooms and peer involvement.

“Ten years of methadone maintenance programs in Spanish prisons”
Dr Santiago Rincón Moreno

16.6% of prisoners on methadone pre-imprisonment continue on methadone programs in prison. Methadone programs have been implemented across all Spanish prisons. Spain has a legal duty to do so.

The aim is to reduce risks associated with consumption. The methadone is produced in a laboratory, pre-packaged with the dose for the particular prisoner. The prisoner has to present identification at the point of exchange, and is watched to ensure that the complete dose is taken.

A full medical is given to incoming prisoners and if they are drug users they are offered a treatment program. Prison is an ideal setting because the same patient is given medication every day. Harm reduction involves syringe exchanges, methadone, and naltrexone.

“The Heroin Program in Andalusia”
Dr Francisco José Caracuel

Program PSP-PEPSA worked in association with a hospital, with people who have failed on methadone programs: the aim was to see if physical and mental health is improving on this program.

Patients had to wait 10 minutes in the waiting room before getting their heroin injection, during which time they were exposed to educational programs, such as how to relax and to get better sleep without resorting to pills.

They had 2 teams, one research and one clinical and are still following up patients 3.5 years after the trial finished. Results show a reduction in cocaine consumption; 45% are back in the workforce. Only one in 5000 patients had to be administered naloxone during the course of the program.

“The Latin Alliance – Reconceptualising Harm Reduction in Southern Europe”
Miguel De Andres (psychiatrist)

Everyone sees harm reduction the way they want to. A doctor who sees someone die from AIDS has an ethical obligation to convert to a harm reduction approach. But it is
more difficult to get someone to convert to harm reduction if the come purely from a political perspective.

In Mexico harm reduction has a political dimension. Portugal has harm reduction law.

There are lots of programs possible in harm reduction but if it is just needle exchange and methadone it is too narrow. Vending machines would be possible – the aim is for consumers to safely access the drugs.

We talk about the three prongs of prevention, treatment and harm reduction, yet prevention is part of harm reduction. We must deal with drugs in the context of health – that is what harm reduction is all about.

Harm reduction is evolving as with any science. It should involve policy making and laws. Harm reduction is much more than drug substitution. We are not succeeding in reaching governments – universities must become involved. The media does not know what harm reduction is.

The harm reduction approach is friendly. What patients think of the service is really important. WHO speaks of “expert” patients.
UNGASS discussion
International Drug Policy Consortium

The UN has a role in overseeing HIV prevention, but it is controversial within the UN with different agencies having different views about implementation and focus. It is a controversial issue for diplomats. The ten year review of the UN Drug Control policy is beginning.

Stijn Goossens
International Society of People Who Use Drugs

In regard to the 2008 UN High Level meeting on HIV/AIDS, the key issues are universal access, concentrated epidemics, women and girls, long term responses, resources, sex workers, sexual minorities, travel restrictions, workplace responses, civil society involvement, and AIDS accountability.

“A drug free world by 2008” was a slogan rather than the objective in 1998.

The Commission on Narcotic Drugs meets in March each year. The 2008 meeting was not a full debate. Governments admitted that they have not achieved significant reductions in drug use, and they admitted to unintended consequences to the policies. Lots of governments simply did not engage in the debate because they want to continue with the zero tolerance approach.

The next meeting will be held on 11 Mar 2009. It will be a two day Ministerial meeting. 192 countries will aim for a consensus position, which will set the tone for the next ten years. The drafting is beginning now through a working group process.

There are five working groups:
- Drug demand reduction
- Drug supply reduction
- Money laundering
- Crop eradication and alternative development
- Precursors and amphetamine type stimulants

Intergovernmental working groups meet just once, and any government can attend the groups. None of the working groups is designated to look at HIV. The demand reduction group is the one through which the HIV topic could be investigated.

NGO involvement in the process is not simple. Generally, the views of civil society have not been welcomed by UNODC, and NGOs are limited to working with/through their national governments.

Pascal Tanguay: Communications Manager – Asian Harm Reduction Network

There are organic links between UNGASS on Drugs and UNGASS on HIV. People working on drugs issues need to learn from the HIV people who have been working alongside the UN for 20 years.
Issues

Better allocation of harm reduction funding
Improving the language
Communicating with governments (need to use language that does not threaten governments)
Ensuring your civil society groups are part of your government’s team

UNODC papers still refer to drug users as “addicts” or “abusers”.

There are relationships to be explored in relation to the:
UNGASS on children
UNGASS on women and gender
UNGASS on population and development
UNGASS on environment
UNGASS economic co-operation

There are possible inroads through representation on the Human Rights Council.

We should each look for inconsistencies within our own country’s position. Governments will have someone from their Justice Department (for instance) turn up and say that his country opposes harm minimisation, which is at odds with the country’s health programs.
CONCURRENT SESSION: CANNABIS
Chair: Marcus Day (Co-ordinator: Caribbean Harm Reduction Coalition, St Lucia)

“The Social Supply of Cannabis Among Young People: the case for an alternative conceptualisation of the drug market and for an alternative policing approach”
Ross Coomber, University of Plymouth

The use of cannabis is normalised in Britain. The 2000 Police Foundation Report acknowledged the difference between ‘social suppliers’ and dealers. Despite this recognition, some police are unnecessarily criminalising or disproportionately punishing these young people. At the time of the conference, cannabis in Britain was about to be rescheduled upwards as a class B drug, with the potential for higher penalties.

Ross Coomber and Paul Turnbull surveyed 182 people aged between 11 and 19 who had recently used cannabis. They found that kids chip in to buy because they don’t have the money to spend on their own – the average spend is 20 pounds. 55% bought directly from a seller who was a friend or a family member, 21% from acquaintance. Social networks are an essential aspect of buying and selling in the youth cannabis area. Brokering was seen as an altruistic measure, they did not see themselves as drug dealers, and were not seen as drug dealers by those who bought from them. Their acquisition of cannabis had nothing to do with drug markets.

We are slowly acknowledging that social supply exists, and we need to reduce the harms of the criminal justice system we need an appropriate criminal justice system approach.

As this cohort grows up this concept of social supply will move into the adult world.

“Cannabis Monitoring in Switzerland: the Sentinel System”
Jeanne-Pierre Gervassoni – Université de Lausanne

Most young men have tried cannabis, and most people have tried it at least once in their lives. There are 26 cantons in Switzerland with different laws in each state. In preparation for new narcotics laws, a five year monitoring program was set up.

Cannabis shops are closing down - all cannabis shops in Zurich have been closed down – growers now plant 1 cannabis to 10 maize plants to avoid police helicopter detection. In Zurich the police are adopting a zero tolerance approach, although in other cantons the police have a minimal presence.

There is little or no importation of cannabis – most is coming from small growers (the large scale ones are closing down)

The age of first consumption is stable. Alcohol and binge drinking have also become fashionable and there is more mixed cannabis/alcohol use. Alcohol is perceived as a worse problem than cannabis.

Stopping people from using cannabis is turning them towards cocaine, as the people who were supplying cannabis are the same people who are now supplying cocaine.
The medical position in Switzerland is that cannabis is as harmful as tobacco. They also put out a message not to smoke cannabis with tobacco because it is more addictive.

“Implementing medical cannabis distribution in the US – the New Mexico test case”
Daniel Abrahamson: Director, Legal Affairs, Drug Policy Alliance, California

There are 50 states in the US with each having its own set of laws, but if there is a conflict Federal law prevails. Twelve states have chosen to not criminalise cannabis use for medical conditions: this creates tension, but not necessarily a conflict. Nevertheless the Feds can still come in and use their own resources to apply Federal law. The drug war is mostly engaged in at state level.

States that decide to not criminalise do not have to use that part of their budget on police, courts, prisons etc. Doctors are protected, not prosecuted; carers are protected, not prosecuted. Some states give out ID cards to the users. Most state laws are silent about the procurement of the marijuana, whether the users can grow it themselves or buy it and from who.

New Mexico will go further. It has a strong tradition of herbal use brought with the migrants from Mexico. The population of 1.2m is independent and self-sufficient with a tradition of figuring things out for themselves. Access to medical care is hard to get in some parts of the state.

Bill Richardson, the Governor of New Mexico introduced the bill, and the Drug Policy Alliance assisted in the drafting. DPA conducted polls about medical marijuana use particularly in the jurisdiction in which Richardson wanted to win, showing that medical marijuana had popular support, and that, if he campaigned on it he would stand out from the other candidates. President George Bush tried to get rid of the laws, which gave Richardson a platform to attack Bush.

In the campaign DPA used the human face of a young (and attractive) woman, Erin Armstrong, who publicly declared her use of marijuana as part of dealing with her cancer.

The Act assumes a state-licensed/protected production system of cannabis. Both patients and carers can be producers of cannabis. There are three other options in the regulations, so if the Federal Government takes them on and wins there will be a fallback position on the other options. The Federal Government could use the list of registered users in New Mexico, but it is expected that would be the system that would be attacked rather than individuals.

New York decriminalised marijuana laws 30 years ago out of concern for young people, but the authorities are now arresting more young people than ever before for cannabis offences. Doctors in New York now have to work below the radar with medical marijuana.
“What do we know about needs and opportunities for training in harm reduction strategies and approaches?”

Ambrose A Uchtenhagen – Research Institute for Public Health and Addiction, Zurich University

No country has national guidelines for course content for a harm reduction curriculum. Education and training is mostly driven by providers, rarely based on a needs assessment. There are few incentives to provide or undertake education. AHRN in Monar, Poland, provides a course curriculum in harm reduction. Georgia wants training in overdose management, safer use education and BB1 prevention and management. Incentives for professionals to undertake training are rare.

I-theta (International Think Tank – Educational Training on Addiction) is an informal expert network whose secretariat is sponsored by the Swiss Government and which encourages education and training in harm reduction.

“Harm reduction education and training: Central Asia experiences”

Gulmira Torokulova: Regional Capacity Building Co-ordinator, Central Asia Regional HIV/AIDS Programme (CARHAP)

The main focus is building skills and knowledge working with CARHAP targets. They use a pool of consultants to build up networks amongst NGOs, increasing their knowledge of harm reduction.

The approximately 60 consultants have expertise in harm reduction, organisational development, advocacy, finance, BCC, and M&E. Between them they use ‘train the trainer’ techniques, consultancy and mentorship, sharing of experiences and organisational research. The government provides technical assistance with a program pre- and post-release.

The curriculum for medical staff now includes harm reduction principles. Training modules have to be approved by the Minister for Health.

Providing knowledge and skills, matching expertise with local needs will have long term benefits for the region.

“Which came first – ‘bad’ rules or ‘bad’ clients?”

Jean-Francois Martinbault – Sandy Hill Community Health Centre, Ottawa

In an organisation, traditionally the view is one-dimensional: we serve clients, and clients receive a service. Organisations are represented by policies and procedures, employee interactions with clients, the services offered, and the built environment. Clients adapt to your rules, policies and procedures (or flaunt them). Homeless people come in to use showers and toilets, but what if they inject while there?
An organisation views its clients through a particular lens, which in itself may not be based on evidence. But the lens moulds the processes of the organisation. We view the clients through an institutional framework. Clients who ‘break’ the rules may be trying to reduce a power imbalance. We should be aware that clients are never passive – they try to fit the service to meet their needs, and try to comply with the mixed messages from the employees of the organisation. They are more than just a response to our rules.

Too many organisations fail to explain the rules to the clients. Polices and procedures should be reviewed annually – every rule must be able to be justified on paper. In doing this things should be discussed as they are, not as they should be. Don’t use opinions.

Clients are not passive - they interact with your organisation.

“How to build an international network for education and training in harm reduction strategies and approaches; plans for preparing an evidence-based curriculum”

Joy Barlow – University of Glasgow
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STRADA is a partnership between Drugscope and the University of Glasgow. It is not about being drugfree. It is about workforce development in drug and alcohol services, and not just providing welfare workers and psychologists. The workforce could include someone with a postgraduate certificate in Addiction Services, for instance. Workforce requirements need to be planned. The workforce needs skills to know when to confront and when to support – have a workforce which is passionate.

Key issues: respect, communication, awareness, recognition, assessment and referral. Each time we do a job we have to test our assumptions. The attitude of staff is important; knowledge can help.

What should an evidence-based curriculum contain? A survey of service-users showed they want respect and recognition of them as whole people.

Online training and education is a good way to obtain factual information and acquire practical knowledge. It gives an opportunity for bringing in experts from all around the world.

Many harm reduction programs are delivered by NGOs which cannot afford academic salaries.

The Royal Society of the Academy of Arts report says that we should concentrate on harms, not illegality.
GLOBAL ISSUES: “Reflections from the 51st Session of the Commission on Narcotic Drugs”
Marcus Day and Pascal Tanguay

The UNCND told the meeting it was inappropriate for them to consider human rights in their deliberations. Every country filed to send someone from their health/drugs council, except the Caribbean.

Make sure the person who goes from your country is properly briefed. The experience of some is that, when invited to participate, they were not given information on how to engage with the complexities of the UN.

In his opening speech to the 51st session, Mr Costa, the Executive Director of UNODC, denigrated a preparatory conference held the previous year in the US by saying that there were only 200 good people in attendance plus 1000 lunatics who were all obviously on drugs!

On this occasion he claimed that everything the UNODC does is about reducing harm. However, in supporting incarceration he appears to believe that incarceration is harm reduction!

Red Cross does HIV work and 110 national federations of the Red Cross are now asking the UN for humanitarian drug policies. UNAIDS also made a powerful statement during the CND criticising countries that impede access to health and social interventions. There will be a UNGASS on HIV in June in New York – civil society reps will have to encourage the UN to link this into the UNGASS on drugs

Civil society is moving away from prohibitionist policies – the US has lost the respect of the world. At the conference they played a negative or blocking role. Many at the ODC have long supported harm minimisation, but could never come out publicly – funding by the US determines the public position of many countries.

PCB has five standing NGO delegates with no voting rights, but the capacity to engage. Thematic discussions were held with governmental input all day. Civil society representatives were invited to give input, but at that point all the government reps had left, so their views were not heard by the people who needed to hear them.

Bolivia gave notice that it will formally write to ask for coca leaves to be descheduled from the Class A list.

Criminalising the natural substances leads to harder drugs

The IDPC report of the proceedings is available on the web at www.idpc.info
PLENARY SESSION: WHAT CAN BE DONE TO ENSURE GENDER EQUITY IN THE FIELD OF HARM REDUCTION?

Abstract: Women in both industrialised and non-industrialised countries continue to be heavily affected by sex and drug related harms linked to substance abuse (including alcohol). The marginalisation of women in their communities is extremely complex. Factors that have been associated with sex and drug-related harms have included cultural, religious and indigenous issues, as well as poverty, interpersonal violence, homelessness, sex work, child apprehension and other family-related issues. Despite these issues, there has been limited global attention on harm reduction programs and services for women. In order to develop a truly global approach for harm reduction, it is critical to review and evaluate gender-based inequalities, best practices, programming and needs from around the world.

“Using our culture as harm reduction: addressing the impact of the Residential School System with Aboriginal women who use drugs and alcohol in Saskatchewan, Canada”
Margaret Akan - Aboriginal AIDS organisation, Saskatchewan

Aboriginal children in Canada were taken away from their families and placed in residential schools for the whole school year, some managing to get back to see their families once a year. The last of these schools closed in the 1980s and compensation has been paid out to many of the survivors. HIV, STIs, gender based violence, sexual exploitation, homelessness, poverty, alcohol – are all ripples from the residential schools.

Harm reduction is the way to reach people, through needle exchange programs and clinics – the Aboriginal elders have had to understand people struggling with addictions. Women of childbearing age are struggling with addictions. The system usually takes children away from drug-addicted parents. This program aims to embrace the women and their families. We must listen to the voice of the women and work at their pace. If we take away their children we take away their hope for living.

The “Sisters in Spirit” manual goes back to some of the traditional wisdom of the ancestors. Some of the traditional teachings are now being incorporated into the school system.

These women do not have bargaining power, which puts their health status at risk. They have to overcome the rage and cruelty of society. They live in fear.

Women are increasingly the leaders and the healers in Aboriginal communities in Canada. Women now need to adopt ownership and control of the research to bring their people back to life.

There is a need family-oriented services with AIDS now being experienced across generations.

Too many people are dying from their lifestyle.
“Harm reduction programs for the regular sexual partners of substance users”
M. Suresh Kumar

Most of the injecting drug users in India are male; they very often are involved in high risk sexual behaviour.

In a study of 250 couples, two-thirds of the IDUs admitted to having sex with sex workers – in most it was unprotected sex, thereby increasing risk of sexual transmission of disease to their intimate partners. Yet only in 5% were both partners positive: the majority were male positive and female negative. However, 40% of women partners of drug users have an STI of some sort. The women do not know about their risk, so there is a need to target them.

Knowledge abounds about condom effectiveness, but most women do not know the drug use and HIV status of their husbands, especially because of arranged marriages. Having sex with a condom is a symbol of infidelity, so even if they know of their partner’s HIV status the women cannot negotiate condom use - have no bargaining power. Women have low economic status, being dependent on their husbands. Indians only do sex, they do not talk about it, and all sex is male-centred.

Alcohol use is playing a significant role in unsafe sexual behaviour and in domestic violence – most domestic violence is preceded by alcohol use – it is accepted that men will beat their wives, and wives accept that they will be beaten.

One in five women who are partners of IDUs is using a condom. Outreach results in a doubling of condom use by women.

Women are powerless in India, yet they are supposed to symbolise energy and power. Women need to be mobilised.

“The cultural and religious context of women and drug use”
Marina Mahatir

There are Koranic injunctions against alcohol, although it is silent on drugs – some interpret the alcohol injunction as meaning against intoxicants as a whole. Yet places like Afghanistan, Malaysia and Indonesia have drug problems. Even with capital punishment there is an increase in drug use in Islamic countries.

With HIV there is a greater urgency – and using religion is one approach to containing drug use.

There is an increasing number of female drug users, but a denial of this reality because of a view that women will not do these things; women are supposed to be subservient and obedient (social, not necessarily religious).

If a man wants his wife to use drugs she is obliged to, and there is no negotiating power for a woman in regard to condom use. Female spouses of drug users go to their mothers, and are told to go back to their husbands.
The Koran has a cultural allowance for ‘temporary’ marriages, so, in Iran, women with husbands in prison have male neighbours who will offer support in return for sex.

Muslim women have rights to education, to not enter into marriage, to leave a marriage, to speak out – but in many countries knowledge about these rights is muted. Much more is known about the rights of men.

Some Malaysian wives knew of their husband’s drug status at the time of their wedding but did not know of the HIV risk associated with that.

More women counsellors and more women religious teachers needed – men do not appreciate the vulnerability of women. Women are resistant to the message because they are afraid.

Men are the protectors, yet they are failing to protect. Men must be reminded of their responsibilities, including their need to empower the women. Education gives women more power – through it the Koran can be used to show where injustices to women are occurring.

“The prevention of Foetal Alcohol Syndrome”
Kirstie Rendall-Mkosi

In the Western Cape Province of South Africa, some babies are born drunk.

Historically, farms paid alcohol as wages. Alcohol provided an escape from reality – it is legacy that has permeated life on the farms. The “Dorp” system saw workers, who were effectively slaves, given alcohol for morning tea, afternoon tea, and a bottle to take home on the weekend. The system is officially outlawed, but the pattern is set culturally, and workers spend their weekends drinking at shabeens.

FAS is the highest in the world in parts of South Africa, with those born with the condition having lower intellect and being more likely to be involved in crime.

Women on the farms are disadvantaged – you owe your housing and employment to the (male) manager. Men promote their partner drinking with them – women do not have much chance to get out of this cycle.

Any alcohol reduction would be good because there is broadly a dose-response relationship for FAS. Provision of alternative weekend activities is needed.

Ante-natal clinics are well utilised – many of the women are underweight and undernourished; up to 40% of women in this area drink throughout their pregnancy.

The standard public health approach of working first with those at high risk, then the families, is being used.

There is a lot of gender-based violence in relationships, so men should be encouraged to understand that they should support their partner so that, together, they will have healthy children.
MAJOR SESSION: ALCOHOL HARM REDUCTIONS FOR AT-RISK POPULATIONS
(session sponsored by ICAP, an industry group www.icap.org)

Abstract: Drawing upon experience and best practice this session aims to identify ways in which harmful social and health outcomes related to alcohol misuse can be minimised for particular “at-risk” populations. It offers an opportunity to showcase the need for tailored approaches and the advantage of targeted interventions that are responsive to the reality of drinking and specific problems and risks of individual groups. This session will explore the application of the alcohol harm reduction approach in four areas where particular drinking patterns may increase the risk for harm: heavy drinking among young people; public drinking by young people; socially excluded groups; and heavy drinking by women.

“All harm reduction for alcohol use in colleges and universities: Making programs accessible to all students”
Art Blume – Associate Professor, University of North Carolina Charlotte; author of book “Treating Drug Problems”; member of sub-committee American Psychological Association

All is the operative word in this title.

ASTP (Alcohol Skills Training Program) and BASIC (Brief Alcohol Screening and Intervention for College Students) have been found to be successful in the US. Web-based programs are also available.

The university’s harm reduction programs are often targeted broadly - programs for the majority do not always work for the minorities. They are not necessarily appropriate for non-traditional students, ethnic minorities (eg Spanish-speaking students) or sexual minorities. Such people may experience prejudice, homophobia, racism or language differences. The uni has revised ASTP to be more culturally relevant.

Prejudice, including homophobia and racism, is encountered by minorities on campus on a daily basis. Additionally there can be language difficulties and cultural misunderstandings. There are tensions between professionals and non-majority, disempowered stakeholders. Prejudice is experienced through a lack of role models, for instance, having, no lecturers or professors of a similar culture, to innuendos through to overt prejudice, such as explicit comments related to ethnicity, gender sexual and orientation.

Student peer harm reduction models build group alliances to motivate movement towards less risky drinking. A manual was translated into Mexican/Spanish then back translated into English to check accuracy then was pilot tested with positive results.

A community-participatory model develops programs through collaboration with community stakeholders – the community will decide what programs are best for the wellbeing of the community, which results in a self-sustaining program when the professionals have left. With two way feedback between community stakeholders and the professionals the program is co-developed. Stakeholders ensure that it is culturally relevant then the professionals make sure it fits with harm reduction principles.
The community decides what outcomes they want evaluated, while the professionals work out the methods which will be needed to do this. Stakeholders work out the culturally appropriate methods, and the professionals prepare the manuals, brochures and websites.

Backup plans are needed from time to time if the community’s plans do not work – it does little good to argue with the community.

“Point of purchase (PoP) interventions and their usefulness in reducing the consequences of risky drinking by young adults”
Dr Alasdair Forsyth - Scottish Centre for Crime and Justice Research

Research was conducted in city centre bars in Glasgow. Thirty-two qualitative interviews were conducted which revealed that, of 20 young people who had attended a club in the previous week, 19 had ‘front-loaded’ before attending, the reason being that it cost 3.50 for a drink in an upmarket place. When young people ‘front-load’ with products from supermarkets, the bars and pubs are judged by the behaviour that results from supermarket products.

In-pub observations showed only 14 aggressive incidents in 100 hours of observations cf. to 34 aggressive incidents in nightclubs in 100 hours observation. Outlets should be judged on their point of purchase interventions and not the numbers of disorderly incidents.

In a residential area a search of rubbish found it contained bottles and glass, but there was almost no evidence of drug use.

When ID restrictions are enforced, underage drinkers find adults to buy them. This tends to cause money pooling and buying of much harder drinks, such as vodka – so risk is increased.

Outlets with larger economies of scale are able to be more picky in enforcing security, which can in turn force young people into more down-market pubs. If you close the skid-row type of hotel some people have nowhere to go, thereby increasing risk of learning more harmful street drinking patterns.

Many alcohol servers are the victims and not the perpetrators of such behaviour, and they are potential allies in harm reduction policies.

“Alcohol, Social Inclusion and Health”
Dusan Nolimal – Institute of Public Health, Slovenia

Post-modern society values the individual. Homelessness is a new problem in Slovenia, post-Socialism. “Erased” people from the former Yugoslavia are without citizenship.

9-22% of EU citizens are at risk of poverty and social exclusion because of heavy alcohol use.
Harmful drinking co-exists with mental problems (dual diagnosis). Heavy alcohol use can be both a cause and a consequence of social exclusion. Many excluded people do not have access to basic health and social services, including information on alcohol harm reduction.

The Government is not doing enough for homelessness. A project in response to this has produced a street paper titled “Kings of the Street” with connections established between the newspaper vendor and the buyers. They have also set up a theatre group, a football team, and provide excursions for homeless people.

Social inclusion intervention is an important harm reduction approach. A “Social Inclusion and Health Project” has been set up by the Institute of Public Health of Slovenia. So far project is just in Ljubljana. It focuses on people who are at risk of becoming dependent on alcohol or other drugs. It is combining harm reduction and health promotion.

Homeless people with alcohol problems are in different stages of maturity – some are experimenting with drugs, some have mental problems; others get to a point of not wanting the abuse anymore; people do not want to freeze during Winter.

There are significant links between child abuse, mental health problems, alcohol/drug misuse and social exclusion.

Alcohol taxes, school-based education, media campaigns may not impact on socially excluded individuals. Harm reduction programs at the community level is what is needed. Reducing alcohol related harms reduces social inequalities and social exclusion.

“From Lady to Ladette? Women as an at-risk group”
Betsy Thom – School of Health and Social Sciences, Middlesex University

We have seen tremendous changes in women’s lifestyles and drinking behaviour. More women drink alcohol, and their drinking has become more visible, and more at a harmful level. Nevertheless, women drink less than men, and less harmfully than men, and they report fewer alcohol-related problems.

WHO figures confirm that men’s rates of harmful drinking are well in excess of women. So why are women categorised as an at-risk group? Are they threats to themselves or are they a threat to society?

“Ladettes” make up only a small proportion of women, but language is constructing an image of all young women as bad girls. This is linked to the idea of women being the guardians of society, including being responsible for the welfare of their men. This small group of women could have some long term health problems, but it builds a stereotypical picture by the media of all women. It reinforces traditional roles, creates stigma, reduces the capacity to seek/be given help, and prevents analysis of the rationale for the behaviour. Their drinking could be for reasons just like the men - I’ve had a hard week and I deserve relaxation - but this is not considered an OK attitude for a woman.
Women are supposed to be morally worthy, so this marginalisation is likely to see them delay seeking help (if help is what is wanted). At a crisis point (e.g. admission to hospital emergency dept) there is more openness to change/support. Many women do not want alcohol per se to be addressed. They would prefer counselling for depression, marriage breakdown, workplace stress.

Self-help is available via the internet, and many women prefer this because it's anonymous, accessible, and requires minimal professional interaction.

There is a need to tackle negative stereotypes of women and this tendency to apply the stereotype to all. The stereotyping extends to attitudes of health professionals responding to recidivists in A&E.
“Smokeless tobacco availability and promotion in Edmonton: Exploring the barriers to, and the opportunities for, tobacco harm reduction”

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Harm reduction for tobacco means substituting less harmful forms of nicotine for cigarettes. The elimination of tobacco or nicotine use is not expected. In a health context, smoking tobacco is misleadingly called “tobacco use” – the vast majority of the harm comes from the smoking of the tobacco. Get rid of the smoke and you get rid of 98-99% of the risks.

To take advantage of a tobacco harm reduction approach, consumers need accurate information about the health risks of various tobacco products, to be aware of the alternatives and to have access to them. Snus is one such alternative.

Sweden has switched largely to snus, and this has resulted in Sweden having one of the highest rates of tobacco use in Europe, but one of the lowest health consequences of tobacco use. Smokeless tobacco is banned from sale in the rest of the EU.

But there is a powerful anti-tobacco lobby in Canada which is vilifying these new products. They have a puritanical emphasis on “good” behaviour and abstinence rather than public health. Their approach is anti-harm minimisation as they are treating snus as being the same as cigarettes, and smokers will not likely make a change to a product that would reduce health impacts.

Anti-tobacco activists have harshly criticised Du Maurier’s advertising campaign for snus pouches as a move to increase the share of Du Maurier’s cigarettes.

The Canadian Tobacco Act prevents tobacco products from being promoted unless otherwise authorised. From the beginning of this year, smoking in public places and workplaces has been banned, with a prohibition on smoking within a prescribed distance of a doorway, window, or air intake. From 1st July this year it will be illegal to have retail displays of tobacco products and this will include snus, even though it does not have the same health impacts. It will become difficult for the consumer to obtain accurate information and it is more likely they will continue to buy the cigarettes they are used to smoking.

Alberta Uni research followed the rollout of the Du Maurier snus last year. In a majority of stores it was impossible to miss traditional tobacco products, compared to snus which could be ‘found easily if looking for it’.
“Tobacco related harm reduction; a public private partnership in the making in South Africa”

Chan Makan: The Association for the Reduction of Tobacco Related Harm

The Central Drug Authority identifies alcohol and tobacco as the most commonly abused drugs in South Africa. ARTH supports government moves to minimise tobacco-related harm, but government policy is not consistent when compared to alcohol.

There are 30,000 legal alcohol outlets compared to 240,000 illegal outlets (probably an underestimate) – the shabeens – and the government does nothing about them. Shabeens arose during the apartheid years so they are a powerful symbol of the past.

If government policies are to be interpreted it appears that the government thinks alcohol is less harmful than tobacco. Attacking tobacco on its own will not work.

The central government legislates for the wholesale side of the tobacco industry, while provincial governments legislate for the retail side. Politically, closing the shabeens down would cut off the revenue stream and put people out of work.

ARTH has decided to focus primary prevention efforts on those who are vulnerable or most at risk with targeted campaigns. The programs are youth focussed, attempting to target those who have not yet used tobacco.

There is a proliferation of illegal outlets in the areas where young people are most at risk.

After 14 years of independence, strategy development in South Africa is good, while the challenge is implementation. The communities targeted are poor and under-resourced, sometimes children-headed families (due to AIDS), excessive substance abuse, and domestic violence. It is a young population with extremes of wealth and poverty.

Teachers are trusted so ARTH has aligned itself with the teachers. Sports, school athletics programs, arts and culture are being reintroduced into schools. The reintroduction of physical activities has reduced school violence.

“FootyWild”: in association with the AFL(!), Aussie Rules is being promoted and has been taken up in a big way.

“Ke Moja”: a ‘no to drugs’ campaign promoted by the President provides specialised coaching for students showing obvious talent in dance and the arts.

ARTH seeks and obtains funding from tobacco companies on the basis that they have a social responsibility to do so.

It is difficult to persuade young people to make healthy lifestyle choices in the face of inconsistent government policies.
Chop-chop is black market tobacco and 8.6% of the Australian population has smoked chop-chop (sold at about 1/3 of the price of legal tobacco by weight). It is grown illegally through market gardens and some personal production and is estimated to costs Australia $450m each year in lost taxes.

Evidence suggests that chop-chop carries more health risks than licit tobacco (although users believe it to be more natural given that it has had no additives in the production etc.) Problems arise because it is not well-dried, so fungus develops which is taken in when smoked. But there is not a great deal of rigorous research, so RMIT organised some user perspective surveys.

Results from RMIT focus group
· Belief that it had less health impact than licit tobacco
· Quality of chop-chop not high, containing stones, cabbage leaves, wood fragments
· All of them reported moisture problems and the need for further drying at home
· Reported health effects from chop-chop: headaches, nausea, heartburn, serious fungal infections.

Phone survey group (over 1600 respondents)
· 7.1% said they were current users
· 24.5% said they had ever used it
· Those who began smoking at under 16 years were more likely to use chop-chop
· Those with disabilities had a greater chance of using chop-chop

Conclusions – no causality, but chop-chop smokers had decreased mental and physical health. No significant relationship in regard to income and education levels (but using hard phone lines excludes young people and the homeless)
MAJOR SESSION: “HUMAN RIGHTS AND HARM REDUCTION”
Chair: William E Butler

Abstract: All over the world, people who use drugs (and communities affected by problematic drug use, drug production and drug trafficking) face abuses of their human rights in the name of drug control. Despite their central position in the ‘Charter of the United Nations’, the guarantees in the ‘Universal Declaration of Human Rights’ (and the binding nature of the core international human rights treaties), drug control measures have, in many cases, taken human rights discourse off the agenda at both national and international levels. There is a conspicuous lack of top-down policy guidance on human rights and drug control from the United Nations. The UN drug control bodies rarely discuss human rights. The UN human rights bodies rarely discuss drugs. The result is a policy environment in which human rights abuses take place with little international oversight.

“One Complicity or abolition? UNODC and the Death Penalty for Drug Offences”
Rick Lines - Senior Policy Adviser, IHRA
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One hundred and thirty-seven countries have abolished the death penalty in law or practice. Of the 60 retentionist states, half have laws that allow it to be applied to drug-related offences; not all use it for this purpose - the US can but does not. Countries that do use it include China, Egypt, Kuwait, Malaysia, Singapore, Laos, Cambodia, Indonesia, Iran, Saudi Arabia, Thailand and Vietnam. Vietnam which advises that it is mostly used for drug-trafficking while in Singapore 76% of executions were for drug-related offences. China holds mass public executions for drug traffickers.

The International Covenant on Civil and Political Rights, Article 6(2) allows the death penalty for the “most serious crimes”. But drug-related crimes are not the most serious according to the UN Human Rights Committee (see IHRA’s Dec 07 report). The UN is bound to observe international human rights law.

The UNODC is providing technical assistance and financial aid to these countries and in so doing is assisting in more arrests, successful prosecutions and therefore more people receiving the death penalty, and hence could be violating human rights laws.

IHRA has applied UN standards for corporates to this issue and is calling for Human Rights Impact Assessments (HRIA). IHRA put a report together called “Complicity or Abolition: UNODC and the Death Penalty for Drug Offences” and Human Rights Watch (HRW) has endorsed this. It has five recommendations
1. Publicly denounce the death penalty for drug offences and make clear that this practice is a violation of human rights law;
2. Make the abolition of the death penalty for drug-related offences a pre-condition for country-level financial and technical assistance, and other support for drug-enforcement;
3. Advocate, through the treaty and legal affairs division, for the abolition of the death penalty for drug offence;
4. Develop guidelines in conjunction with the Office of the High Commission on Human Rights on law enforcement and human rights for UNODC programs;
5. Establish a formal and transparent process for conducting human rights impact assessments as part of all UNODC activities and projects.

In February 2008 the report was given to Antonio Maria Costa (UNODC Exec), and it appeared to have had some impact because in March 08 he spoke out against the death penalty, although not strongly: “Although drugs kill, we do not need to kill ...”.

In April 2008 the UNODC responded to the IHRA/HRW paper and a number of actions were agreed to. The report will be redrafted in the light of feedback and released formally in September at the UN Human Rights Council meeting in Geneva.

IHRA/HRW are also drafting a briefing paper on human rights impact assessments and their application to drug control measures.

IHRA/HRW will raise the issue with EU member states (the EU lobbies against the death penalty) to look at human rights practices in the countries to which they give aid.

Some countries define trafficking in terms of the amount – trafficking or possession. Some Islamic countries state that their human rights will be interpreted within Sharia law.

In December 2007 the UN called for a worldwide moratorium on the death penalty. CND watered down a resolution passed this year: Cuba successfully amended the draft resolution by deleting the clause about removing the death penalty for drug offences.

“Ethical and human rights imperatives to ensure medication-assisted treatment for opioid dependence in prisons and pre-trial detention”
R Douglas Bruce, MD, MA - Clinical Instructor, Yale University School of Medicine
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Medication-assisted treatment encompasses buprenorphine and methadone. There is overwhelming evidence that MAT reduces HIV and HCV risks, overdose deaths, unsafe injection practices, and evidence that abrupt withdrawal from opioids causes harmful medical consequences, including renal failure.

“If a drug user is locked up for some time without drugs, it’s not difficult to break his mentality. He’ll sign anything.” Yevgeny K, Kyiv, Ukraine.

Police are not averse to using withdrawal as a way of getting testimony.

The human rights justification is enshrined in the Protection Against Torture and Cruel, Inhuman and Degrading Treatment. There is an obligation not to inflict harm on a person in detention and a positive duty of care to protect the lives and well-being of persons in detention. This includes prevention of life-threatening diseases and acts that cause physical and mental pain.
Rights to Health include obligations to prevent disease. Laws that result in unnecessary morbidity and mortality are specific breaches of the obligation to respect the right to health.

Way forward:
- Need to involve the people who use drugs;
- Health care professionals must recognise the role they are playing in doing harm (patients are viewed as being the cause of their own illness but they don’t do this with someone who has developed Type 2 diabetes)
- Advocate for MAT as part of comprehensive prison healthcare services
- Advocate for alternatives to incarceration
- Ensure that the implementation of MAT programs conform to human rights standards
- Reform laws and policies to ensure universal access to MAT
- Reform drug laws to reduce the criminalisation of drug offences
- Reform criminal law to provide alternatives to imprisonment

In medicine we argue for the scientific evidence to carry the day, yet many in the medical profession have labelled an opioid problem as a moral problem. Addiction is a medical issue. If methadone works, then denial of methadone is medically and ethically wrong. Would we decide that insulin is morally wrong and then deny treatment to diabetes patients?

Many of these individuals should not have been arrested in the first place, e.g. a patient arrested and incarcerated for stealing alcohol (in the form of Listerine) to prevent his alcohol withdrawal because alcohol was not available for purchase on a Sunday.

Heroin is 96% pure on US streets, leading to very high tolerance, so a lot of methadone is needed for replacement therapy – but this allows people who go to work and to be effective. Withdrawal from heroin at this strength is more severe. In Pennsylvania, as a consequence of prisoners hanging themselves while going through withdrawal, methadone programs were introduced into the prison system.

“Positioning human rights at the centre of harm reduction for injecting drug users in the context of HIV prevention, treatment and care”
Ann Fordham: International HIV Alliance (Ann has a Master of Human Rights at the University of Sussex)

IDUs have limited access to HIV services, which violates their rights to the highest attainable standard of care.

Paragraph 11 of the 2006 UNGASS HIV Declaration: “The full realisation of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic … addressing stigma and discrimination is also a crucial element”.

Yet, there are 13 million injecting drug users in the world, 80% of them in developing countries. Ninety-two percent of IDUs have no access to HIV prevention services of any
kind. Barriers to access include international laws and policies through to family discrimination. Inability to protect oneself from HIV is a human rights abuse.

Drug users experience stigma, causing them to stay quiet; lack of knowledge, lack of income; structure of health systems can be obstacles in terms of bureaucracy, location, lack of confidentiality, police harassment at the site; access to ARVs limited in many countries; UN covenants shape national laws that mitigate against harm reduction; more than ½ countries reporting to the UN acknowledge that other polices prevent access.

WHO/UNODC/UNAIDS Comprehensive Package of Interventions:
1 Opioid substitution therapy
2 Voluntary HIV counselling and testing
3 Anti-Retroviral Therapy
4 STI prevention
5 Condom programming for IDUs and partners
6 Targetted education, information and communication for the sexual partners of IDUs
7 Hepatitis treatment and vaccination
8 TB prevention diagnoses and treatment
9 Needle and syringe programs

Community mobilisation is a capacity building process, empowering and involving other stakeholders such as family and law enforcement officials.

In Manipur, India, in a project called SASO families were brought together with family members who were injecting drug users, with the aim of attacking stigma and discrimination in the community. The result has been a reduction in stigma, better family support for ARV adherence, an increase in demand for services, and it has built networks amongst HIV affected women.

In the Ukraine the Alliance advocated for methadone, using public health and human rights imperatives. In 2005 the Alliance countered efforts by the Ukraine government to ban methadone, and by 2008 had successfully advocated so that legislative barriers that might have prevented the legal provision of methadone were removed.

The consequence is that
a) drug related harm reduction has become part of the platform of the Ukraine government; and
b) civil society groups now have access to methadone, and not just government agencies.

Harm reduction has two pillars – public health and human rights.
LUNCHTIME SESSION: “Beyond prohibition: controversy and tensions within harm reduction”  
Steve Rolls, Transform

How can the drug law debate move forward within the harm reduction context? Within the movement there is understanding that prohibition does not work. Blood-borne diseases might not have emerged as a problem without prohibition – Prohibition is at the heart, but there is a lack of engagement from practitioners in long term law reform.

IHRA conference presenters’ addresses are symptomatic, and does there is not the time to go into the causes.

Very few harm reduction organisations take a substantive position on bringing substances within a regulatory framework – and IHRA has never had a plenary session on this. Why?

Drug law reform is controversial, people taking it on are presented as supporting drugs. It does not lead itself to simple answers. The harm reduction movement lacks the language and analysis to engage in the debate. The media want to polarise the debate: prohibitionists versus crazy liberationists, rather than in the middle where we want to be operating – this creates more heat than light. Debate has not progressed since the 60s.

There are ways to deal with this debate that are not confrontational and that is by moving from politics back into the realm of science.

Mark Haden – Addiction Services Clinical Supervisor, Vancouver Coastal Health, British Columbia

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Drug prohibition creates a robust black market which makes illegal drugs. Cigarettes are a product that can kill, but is marketed as entry to sophistication. Alcohol uses cross marketing with references to drugs and sex.

The human rights model has two weaknesses – the responsibility is always with governments, whereas human rights is about individuals. Nor does it fundamentally address health issues. The public health model has political traction, but weaknesses. We need both the human rights and public health models together and the strengths of one will balance the weaknesses of the other. Canadians need more public health when it comes to alcohol and tobacco control and more human rights when it comes to medical marijuana and methadone.

To control drugs we need product restrictions and customer access regulations. (If you want to get a handgun you have to get training first). As far as product restriction, branding should be prohibited, formulation and quality need regulation with proper labelling regarding content. Customers would need proof of age and residency, licensing of users and registration of purchasers, and proof of dependency prior to purchase.
Sale of drugs would also have to be regulated through government-run entities with a percentage of any taxes/profits going to prevention and treatment programs.

For growing/supply suggest using use Fair Trade. (Seagrams was an illegal producer of alcohol during prohibition – need to get the illegal networks involved.)

Some controls can be administrative, others social. Societies throughout time have used social norms (for instance having wine only with food), rituals, and sacred rituals to control drug use. Social controls increase social cohesion – prohibition prevents this from happening. It is better therefore if we can move from administrative to social controls.

Reduce the cashflow of violent & criminal organisations by moving to small-scale production. Prohibition favours large criminal groups. Reducing the cashflow reduces violence and corruption.

One model for all drugs would not work. We do this in order to protect our children. To protect our children we need an evidence-based model which has foundations in both public health and human rights.

Let’s incrementally change the model to achieve the outcomes we desire.

“City of Vancouver: Four Pillars Drug Policy Program”
Donald McPherson: Drug Policy Co-ordinator, City of Vancouver

Most of the harms of prohibition reside in city areas. Vancouver’s preventive program was about the negative consequences. The program brought the community together and asked them what they thought prevention was, and about their relationship with psychoactive drugs.

They discovered there is a tremendous preventive power in regulation and control of substances with the aim of preventing harm. Understanding emerged that there were no simple solutions.

Harm reduction has worked with tobacco – Vancouver has one of the lowest rates of tobacco use in North America, and dropping (14%).

Laws are federal, but the municipality has to clean up every day. Drug policy is the only endeavour where one is not allowed to think outside the box, even though the box is battered and falling apart.

Petrol is not the problem in petrol-sniffing, but the breakdown of families is. No-one is talking about banning petrol as a consequence.

No politician in Vancouver would dare to oppose injecting sites, although the law enforcers opposed a regulated market (which means better engagement is needed with them). The health providers need to work with politicians to give them the language and the courage. Political leadership and community support from the three Mayors in getting Vancouver’s heroin program running.
The pre-conditions for moving forward are:
• Support by the general public
• Survivability by politicians
• Support by law enforcement
• Support by evidence of reducing harm
• Sustainable under international treaties
• Subject to evaluation and review
• Separating use from dependence

Cities have a key leadership role to play in determining responses to substance abuse. Informed public discussion is critical.

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“The “Open Up” project: improving the oral health of drug users in Victoria”
Peter Dawson: Peninsula Drug and Alcohol Program (PenDAP), Peninsula Health
(Peter worked in drug and alcohol for 6 years, before that in mental health and disability.)

Location: Frankston, parts of it semi-rural, but the urban section has a significant street drug trade. 1000+ syringes are distributed each day in the needle-syringe exchange.

Clients often report with extremely poor dental health with consequent lowered self-esteem resulting in difficulties in getting jobs, rental properties. The medical condition is dry mouth (Xerostomia) – with less saliva to protect the teeth, leading to tooth decay and drug disease.

They developed a cartoon character, Polly Drug User, and her posters, designed to be non-offensive, could go to community health centres, public and private dental clinics, and GP surgeries.

At methadone dispensation sites, the provision of water was encouraged. Also encouraged were clinicians to go beyond initial assessments and raise oral health with their clients.

1000 Packs containing water bottle, sugar-free chewing gum, toothpaste and toothbrush and some educational material were put together with help from sponsors.

“Meth mouth” – smoking heavily reduces drug supply to the gums, dry mouth etc. Banning of ice-pipes in Victoria led to more injecting of ice

The Polly film about dry mouth is played in the waiting room.

Illicit drug users are concerned about their teeth. Some users have so much tooth pain that they self-medicate for their pain; some will not smile in order to hide their teeth.

In Australia we do not do health promotion in drug and alcohol services very well. Outreach is what is needed, rather than getting people to report to dentists (where they have significant form-filling esp. about IDU and HIV status).

“Drug using mothers; factors associated with retaining care of their children”
Gail Gilchrist: - University of the West of Scotland, UK
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Drug use does not predicate poor parenting, but other factors do. Drug using mothers are often separated from their children more than once. We know very little about these children, such as who is caring for them or what their living arrangements are.

Gilchrist undertook a study in Glasgow in 2007 of 185 women from a sex-worker drop-in centre or a drugs crisis centre. The results were that less than half the women had their children living with them. Involvement with prostitution, homelessness, imprisonment, depression, and living with another drug user, were strong indicators that the woman
would not have her children living with her. Current use of heroin, and the women themselves having been in residential care as children, were also strong indicators of the likelihood of not have their children living with them.

Limitations of the study: not a random sample, but it focuses on those for whom the need for intervention is greatest. It has shown that intervention needs to be earlier. Parenting classes are something that must be considered.

“Addressing the forgotten co-morbidity: developing a combined pain and dependency service”
Dr Michael Orgel - Consultant in Substance Misuse, Edinburgh
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Perception of pain is individual, so patient must be listened to – only the patient can tell.

Pain is pain – get professionals to acknowledge this. Patients with drug dependence should not be denied pain relief just because they are drug dependent. 20-25% of patients in community addiction services have pain issues.

Other nursing and medical staff are fearful of the stigma.

In some areas only oncologists can deliver opioids – other sufferers are denied.

Based on the inherent right to human dignity, access to pain relief is an essential human right. The inability of millions of people to gain access to legitimate opioid treatment is collateral damage from the ‘war on drugs’.

“Youth, drug markets and violence in Canada: What can harm reduction do?”
Patricia Erickson: senior scientist with Centre for Addiction and Mental Health; doctoral study in criminology

Erickson undertook a study with the aim of increasing the understanding of the drug-violence relationship in 3 groups of youth: detainees, dropouts and students aged 14-17 years. [In the US the crack epidemic focused on violence and young Afro-Americans who had no other job opportunities.]

All 3 groups used cannabis significantly more than other drugs. They got them from people they know and older youth, and they do not regard them as traffickers.

They were asked their perceptions about arrest, injury, assault, prison, death. Non-dealers (users?) saw a lower risk to themselves than the dealers.

Over 60% of the incarcerated group had carried guns – we should be concerned about violence as a hidden harm.

Only legal distribution of drugs would be likely to address this hidden harm. Most young people do not realise that possession is an offence – they don’t recognise that they are part of an illegal market.
CONCURRENT SESSION: “SEX WORK – THE IMPACTS AND HARMS OF CRIMINALISATION AND HOW TO REDUCE THEM”
Chair: Laura Murray

“The Swedish model: an excuse to ignore harm minimisation”
Pye Jakobsson: International spokesperson for the Rose Alliance

Drug users and sex workers are regarded as imperfect in Sweden. The political decision was made that sex work is violence against all women. Despite sex-workers choosing to be involved they are classified as victims - society wants to save them. The principle is that all such activity is forced.

The penalty for the man who pays (money, drugs, alcohol) for a sexual service is up to 6 months imprisonment. Touching of genitals is classed as a sexual service. A pimping law prevents the women working together.

The government is now looking at rape law reform, but as there is no consent in prostitution law, this could see the clients charged with rape.

Sex workers have tried to get into the debate, but they are prevented – the government/bureaucrats will argue that the particular woman asking to be heard does not represent the group.

Sex workers prepared a report “Between Lie and Reality” which shows that the stigma attached to sex work is the same as for people working with drug users.

Sex workers have to lie about their status in order to get good health care. In every social situation they have to lie. One insurance company told a sexworker it would be unethical to insure her. Anonymity is denied through health services so they have to lie about their work. They even have to lie in order to pay taxes!

Outreach for sex workers is severely limited to parking for three hours in a car, with a sign saying ‘Social Service’ and waiting for a sex-worker to look for them. Giving out free condoms is an ‘unwanted activity’.

Drug users are told that they have a drug problem because they are sexworkers, so you have to stop doing sexwork in order to get assistance. Sexworkers are regarded as inadequate mothers.

“Only rights can stop the wrongs”.

“‘Just do it’: Decriminalisation as a best practice model for sex industry regulation – the Australian experience”
Rachel Wotton: International Spokesperson, Scarlet Alliance

Legalisation is restrictive, puts tests in place. Decriminalisation puts the industry in charge.
In all states and territories except NSW the police are the regulators of the industry. However, WA has just passed legislation for decriminalisation and implementation is next.

NSW went for decriminalisation with the aim to eliminate corruption in the police force and to increase the health and safety of sex workers and their clients. The result is that the sex worker has the same rights as the client. There has been a decrease in the amount of money required for police services. They have been able to bring in Workcover and get non-smoking rooms for the girls. There are some flaws in the system because of the way it was rolled out.

“How do commercial sex policies affect the people that they target? Policing sex workers in Washington DC.”

Jennifer Kirby: volunteer with “Different Avenues”

In 2006 Washington DC passed several new laws that were anti-sexwork – gave police power to declare any section of the city as being sexwork free and new powers to impound vehicles. Sex-workers formed an alliance in 2005 to fight the laws; they had the experiential knowledge, but the lawmakers told them to provide more evidence that the laws would be harmful rather than the lawmakers having to prove otherwise.
Most people in Sweden understand that smokeless tobacco is safer, although it is not actively promoted.

Smokers should be informed – there is no justification for lying to or misleading the public.

People who oppose harm reduction use deontological arguments.

It’s easy to support prohibition – easier for a doctor to tell a patient to give up smoking, rather than saying to use smokeless tobacco.

The key problem with tobacco harm reduction is with the industry – if a non-tobacco company had introduced it, it would not have created cynicism – industry recognises that they have a responsibility (compare car manufacturers putting seatbelts in cars).

Nicotine is a poison and not a medicine, so it was difficult for Nicorette to get onto the market for many years. Only the tobacco companies would take the initiative to introduce smokeless tobacco.

There is a continuum of dependence for those who need that nicotine to get functional – Snus is not aimed at social smokers, it’s aimed at people who don’t want to quit smoking – it’s for high dependency, not low dependency smokers. Some smokers do not want help.

Industry and consumers are not heard above the very strong anti-tobacco lobby in Canada. The movement against smoking in the US is very trenchant. Canada is inheriting this attitude across the border.

Abrupt cessation is not the norm with any drug. Patches are not tobacco replacement therapy, they are nicotine replacement therapy. Terminology is important.

We can have tobacco industry reps in the room and they are treated with some respect, but that would not be the same for a ‘drug’ dealer.

Smokeless tobacco is the illegitimate child of harm reduction.

There is the mindset that a pharmaceutical product must be used.

Harm reduction and anti-prohibition are not the same.

Paul L Bergen, Research Associate, School of Public Health, University of Alberta (for more information about snus)
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**Costa question time**

**Q: drug use V drug addiction – alcohol approach applied to illicit drugs**

We cannot apply the alcohol harm reduction approach to illicit drugs. The conventions of the UN produce enormously positive results; tobacco addiction is decreasing in developed countries, increasing in developing countries. Tobacco and alcohol use are widespread because they are controlled. This is shown by the fact that each year 5m people die from tobacco deaths compared to 250,000 from illicit drugs. The use of illicit drugs has been limited to 1/10 of the population, therefore the UN conventions have worked.

Q: reconcile donor countries that impose their policies (criminalisation) on other countries

There are 192 countries, but the weighting is different. UNODC policy aspects work with all governments, then technical assistance and capacity building in the developing countries only. Resources are made available from a limited number of donor countries for good humanitarian reasons, often tied or ear-marked and that is not always appreciated by the receiving countries.

**Q: relationship between availability of cannabis in Netherlands and relatively low use**

He has visited Amsterdam and met with the Mayor and senior bureaucrats of the Municipality of Amsterdam. The UNODC will now produce a discussion paper which will be on the website – but the position remains the same that availability causes use!

**Q: the practitioners are chronically underfunded. The UNODC website has a global youth network but resources to support young people who use drugs are almost non-existent.**

The UNODC does not have resources of its own, only 9% comes from the UN and the rest comes from donor countries – assisting NGOs in rich countries is not a priority.

**Q: why are you so optimistic about what treatment can do?**

By analogy, we have been able to defeat other illnesses. Maybe as a consequence of the wrong genes, pregnancy (hormones), lack of post-natal care (psychological), youth, being an immigrant, or work pressures, some people are more vulnerable to the harms of tobacco. TB was defeated although it killed massively in the 19th C. By new medicines, better housing, lifestyle, drug addiction can be treated and prevented.

**Q: how will the 3 HRs interplay?**

The UNODC is not a health institution, this is up to WHO. The UNODC is not a human rights institution, although it can pursue through some of its program. Neither is it a harm reduction institution, but it can ensure this occurs through its programs.
MAJOR SESSION: THE GLOBAL CONTRIBUTION OF NURSING TO HARM REDUCTION

Chair: Stephane Ibanez-e-Benito – nurse in UK, founder of International Nursing Harm Reduction Network

Abstract: There are over 12 million nurses, midwives and health visitors in the world and they are key players in the promotion of harm reduction in health care practice – often coming into contact with people with substance abuse issues when they are at their most vulnerable. The general philosophy of nursing itself is perfectly aligned to the concept of harm reduction

“The development of a national nursing policy on harm reduction”

Bernadette Pauly RN, PH.D.: Asst Professor in School of Nursing, University of Victoria, Canada
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There are inequities in health care for drug users. RNs are often the first point of contact with these people in hospitals, prisons and streets – they can help create a space to help prevent harm.

In 1990 work began to get HIV/AIDS on the Canadian Nursing Association (CNA) agenda. They passed a resolution in 2007 to commission a paper on harm reduction in nursing practice, specifically in relation to the harms of illicit drugs.

For the CNA, harm reduction does not require the user to give up use although it may focus on reducing intake. It focuses on reducing the harms associated with alcohol, tobacco and illegal drugs.

Development of trust is critical in dealing with health issues at the street level. Many of these people have stopped trusting and relationships have to be carefully developed in a climate of distrust. Nursing care has always been delivered in the context of a relationship.

There are physical and social harms: overdoses, blood-borne diseases, soft tissue infection, violence, homelessness and poverty, stigma and discrimination. To develop policy a literature review was necessary – many of the papers focus on the physical harms, and not the social harms.

The harms are shaped by social housing policies, drug policies, income policies, gender and ethnic inequalities: public housing stock is reducing, social system support has not increased, and there has been in increase in punitive measures, such as minimum sentences. Low socio-economic status is a factor in uptake of drugs.

A national anti-drugs strategy without harm reduction was implemented in Canada in 2007. Stigma is reinforced by these laws and social policy is eroded. Nurses are then caught between evidence and policy and as a consequence are unable to meet professional and ethical standards of practice. CNA says it is responsible action for an employer to ensure that nurses have the tools to teach users to inject more safely.

The underlying values of neo-liberalism and social justice are in conflict. Those working in Human Rights are in a parallel conversation.
“Indigenous communities and overrepresentation in the child welfare system, a potential risk factor for HIV/AIDS?”

Meaghan Thumath – Sheway, founding member of the Nursing Harm Reduction Network; Cedar Project Partnership

70 – 80% of clients of “Sheway” are aboriginal – many have had multiple traumas including having children taken from them. A study looked at young Canadian aboriginal women (14-30) who use drugs.

- 262 respondents
- 76% had been pregnant at least once
- more than half the women had birthed two or more children
- 36% had terminated a pregnancy
- the median age for the first pregnancy was 17, although the ages ranged from 10-25

The aboriginal people in Canada have a history of dispossession and trauma, with the creation of a stolen generation. Colonisation disrupted traditional culture and rules.

Aboriginal children make up 9% of the child population, but make up 49% of children-in-care in British Columbia. Aboriginal women are 6 times more likely to contract HIV.

Almost half had been sexually abused as children, with the average being at 6 years of age, but many of them had had welfare interactions by age 4. An issue requiring further investigation may be that the welfare intervention was a traumatic event for the mother.

Every HIV+ baby costs a million dollars, so there is value in harm reduction intervention. The issue is about social deprivation rather than substance abuse in itself. Drug users spend a lot of time looking for drugs.

There are parenting successes, and “Sheway” builds safety plans with the mothers about what will happen if they have a relapse, who they want to look after their children. If they decide to hand over their children they speak directly to the welfare services beforehand

“A little bit of toast: enhancing client engagement with low threshold interventions”

Suzanne Long - Team Leader, Blackfriars CDAT, South London & Maudsley NHS Foundation Trust

Community Drug and Alcohol Team is part of the London and Maudsley Addictions Division. They have 400 + clients, 25% from the criminal justice system, 80% with a primary opiate addiction.

They discovered that client coffee mornings work! Their clients do not know from day to day whether they will have food, drink and shelter – using Maslow’s “hierarchy of needs” only 2% of the client population ever achieve self-actualisation.
The service provided a casual setting with food – tea, coffee and toast – for clients turning up for their daily methadone. Newspapers and chess-boards available, clients could help themselves to the food and drink, and staff hung around to just chat with them.

As the program developed themes were introduced for instance, discussion about diet, bringing in a dentist to talk to them. They might be informed of bad heroin in a particular suburb at the time and told of the symptoms that could follow if used.

Now it is more than coffee, tea and toast – they have a range of spreads, fruit and porridge available. Clients hugely value the service with a minimum of 20 attending each week. When the short of staff and the sessions had to be cancelled, 26 clients signed a petition asking for the sessions to be reinstated.

Clients are having more say on the food and are even assisting in the shopping. It is run one morning a week, and the clients have asked for a second morning, and this is in the process of being set up.

There have been only 3 incidents of inappropriate client behaviour in 4 years (one of using drugs on the premises). Clients have been able to be referred to family therapy as a result of these mornings.

“Doctor, where’s the nurse?”
Sebastian Salvadores Cobas: Enfermo

The service is a safe injecting room (SIR). Our work has gone beyond our expectations – 62,661 injections in 2007; 140 visits a day. The unit works 24/7 which is critical – different attendances at different times of the day – waking up late is a way of life for the clients.

A physician works at specific times of the day, but the nurses are always available – the doctor imposes the regulations, and the nurses work within them. The physician sets the guidelines, but the nurses can customise to suit the clients – the nurses do the daily followup. Nurses are responsible for keeping the records.

Nurses refer the patients to HIV/HCV and the TB units. Doctors make the first diagnosis but nurses engage the clients to make them more responsible.

Doctors prescribe the methadone but the nurses dispense and followup any side effects and adjust the doses.

Nurses handle the overdose cases, not the doctors. There were 95 cases of heroin overdoses in 2007. Nurses have a great sense of achievement about helping/saving the patient; sometimes people who have overdosed feel ashamed, but the nurses encourage them to stay. Bonds develop between nurses and clients.

As much as they can, nurses supervise the injecting so that it is hygienic and goes into the right place – nurses can help to the extent of finding the vein. (Vancouver SIR staff are prevented from assisting the clients with injections.)
Sometimes IDUs are ashamed of being watched injecting themselves, so they prefer the SIR.

Clients come to the nurses for information and for stitch removal - nurses insist on hygiene and body care. Nurses educate about vaccination and administer the vaccines. Nurses work with other practitioners to help the clients regarding social needs and legal issues. Sometimes we just listen to them, keep them company over grief and death-related issues, palliative care, being there.

Sometimes they get help from other consumers – the nurse responsibility is to keep the procedure as clean as possible – washing hands insisted upon before going into the cubicle (encourages better street use)

Politicians should understand that small changes are important.

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