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OF DRUG HELPLINES

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EDITORIAL

I would like wish all our readers and contributors a very happy, healthy and prosperous 2003 !

FESAT has a exciting and interesting year ahead ! With your active participation in our Seminar in Amsterdam on 14 and 15 Feb 2003, we will discuss the future developments of our European network. I would like to thank those of you who have sent back their areas of interest and concrete proposals. The main topics will be discussed in more detail in Amsterdam - this will help us to develop the future activities of FESAT.

As we move further on in the year, we will hold the first Conference of Associated Services. This conference will take place in Milan Italy on 3 -5 April 2003 and will be dedicated to the Associated Services. The conference will be a new opportunity to share new ideas, information, problems, solutions and results.

Finally, as an extension of the FESAT Monitoring Project, a newsflash system is being developed. This system will allow FESAT Members across Europe to exchange useful information on emerging drug trends. You can find more information about this in this edition of Lines.

Roseleen Hanton,
President of FESAT
Coordinator of "South East Regional Drug Helpline", Waterford, Ireland

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Mark McLean - *National Drugs Helpline, Healthwise, UK*

A 'DRUG NEWS INFORMATION EXCHANGE' FOR FESAT

We now have an established, twice-yearly system for collecting data on helpline calls. We ask about overall trends in the numbers of calls on specific drugs or from specific populations, but also look for comments on these and for feedback about new drugs and drug-using behaviours.

This is a regular mechanism which, with your support, we would like to continue. But we recognise that it would sometimes be useful to circulate 'news' received by a helpline in a quicker and more dynamic way, and not to wait until the next data collection.

There are already some national and European mechanisms in place to assist the flow of information about 'drug news'. Each EU country has an organisation which plays the role of a 'focal point' in the REITOX network for providing information to EMCDDA about drug trends. However, we know that different helplines have different types of relationships with the focal point in their country - the Flemish speaking drugs helpline in Belgium has a strong link in a 'news chain' but we do not believe every other helpline is in the same situation. We also know that some time is required to collect information from the focal points and to produce the annual report and that the drug situation can change during this period. Finally, the type of information that the system covers is limited to reported phenomena in synthetic drug use.

We would like to investigate the possibility of a 'drug news information exchange' (DNIE) within the membership of FESAT. Such a system would allow each member to give information to the rest of the network about a trend that they had identified. Each member would also be able to look for trends that had been identified by the others. and get some sort of confirmation out of it ?

The sort of information that could be exchanged would of course include details of new drugs, drug combinations and drug preparations. Drug helplines can be the earliest recipients of this information and can perform an 'early warning' function of potential health dangers. But there are other types of information that would be just as useful. For example, information about alternative names of drugs, use of drugs by specific communities, planned or actual changes to drug laws, and changes in public attitudes towards drugs.

Because this information arrives with the listeners, who are not always the same people as the managers, there is a risk that it may be ignored. In fact, without the engagement of the listeners, the DNIE will not be very effective. Of course, some information that is 'new' for an individual helpline worker may not be 'new' for the service, but it is important to motivate staff to say when they have encountered something which is new and interesting to them. The motivational cycle is completed if you make sure all information from abroad also reaches them - making it a system of collecting information but also receiving useful information.

It is also important to ensure hat the 'new' information reaches the person in the organisation who will be able to send it to FESAT.

This person, or a colleague, may want to apply 'controls' to the information before they send it to FESAT.

Internally, perhaps the information is not so new - or, perhaps it is significant that, for example, a type of call has become common. There are considerations about confidentiality so that information which identifies an individual may need to be suppressed.

In some cases, an 'external' control will be useful. For example, if the helpline has received reports about a combination of drugs being taken in a particular region amongst a particular age group, then it is sensible that a helpline worker contacts a face-to-face drug agency in that area and asks for some confirmation.

We would need to consider the best procedure for giving information to the DNIE and receiving it from the DNIE, using resources such as the FESAT web site, e-mail and so on.

In addition to the improved flow of information across Europe, we think a DNIE will strengthen the relationship between FESAT and EMCDDA. It would stimulate more contact between the members of FESAT. Finally, it may enhance the profile and perceived usefulness of drug helplines as a whole.

We hope to discuss this in more detail at a workshop in Milan on Saturday 5 April 2003. In particular, we would be interested to know:

- What sort of 'news' would you like to receive about other helplines ?
- How would information be added or distributed ?
- What 'controls' would take place for the information ?

Victor Silva - *Linha Vida SOS-DROGAS, Porto, Portugal*

Bursary report

STUDY TRIP TO NETHERLANDS

INTRODUCTION

Being a worker in the drug field for a few years, and having a special personal interest in the issues of drug use, as soon as I had knowledge of the possibility of receiving a bursary from FESAT, I immediately applied to travel to the Netherlands.There were a few special reasons for my choice: First of all, in The Berlin Conference I had the opportunity to meet some of the Dutch colleagues, and our conversations about the Dutch experience were very interesting. Furthermore, I had been following the Dutch policies about drugs since my university times. The opportunity to see “in situ” the practical applications of such policies, was one I could not refuse.

Another reason for choosing the Netherlands for my visit was the fact that most of the synthetic drugs like ecstasy that are being increasingly used in Portugal come from the Netherlands.This is a tendency that has been increasing steadily in last few years. It would be interesting to see how the Dutch were dealing with this problem, since we are beginning to have it too.

In the beginning of this year, I began my Master’s Thesis investigation on Drugs and Dug addiction, and chose as the object of my research the club cultures and ecstasy and ecstasy-like drug use, using qualitative research methods.

Therefore, once again, I was hoping to meet with Dutch researchers in the field, so as to know about investigations carried out in the Netherlands and exchange ideas.

Last, but not least, it would be interesting to visit the Drug Infolijn, to meet with their workers, to see and discuss the ways they work.

DESCRIPTION

1. The Drug Infolijn

The Drugs Infolijn opened in 1996 and is part of Trimbos Instituut, the Dutch institute for drug and mental health issues.

This helpline is open 24 hours a day, 7 days a week, although an automated Voice Response System covers part of these hours.

The callers that want to speak to an expert personally on the phone, must call between 13.00 and 21.00.

The main aim of the line is to provide the general public with neutral and objective information about drugs, so that callers can make better decisions about their own health and that of others.

The Infolijn has one coordinator, a secretary, a central team and a flexible team, which is composed by workers from a temporary work enterprise. The background of the workers is diversified, although most are psychologists: Psychology, Social Work, Medicine and Health Education.

The workers undergo specific training for about two to three months and attend regular seminars on drug issues, whenever is necessary. The Infolijn is well advertised, especially in schools, universities and students residences. Also, all the Trimbos Instituut materials refer to the Infolijn, and whenever a mass media campaign on drugs is made, the line is advertised.

The Dutch Telephone Office (KPN) registers the total number of calls and the telephone consultants register every personal conversation. The number of calls has been steady since 1996 around 30 000, varying between 25 000 and 35 000 a year.

The callers are mainly drug users (around 27 to 28 per cent); students (15 per cent), partners, friends or family of drug users (around 12 per cent); parents (10 per cent) and people interested in using a drug (5 per cent).

The most common questions are about hashish and weed (around 21 per cent of calls); ecstasy (16 per cent) and cocaine (13 per cent).

People that call want information about the risks of drugs; effects; presence in blood and urine; communication with user; physical and mental dependence; law and interaction with other drugs or medication.

In what relates to the way the call is answered, open questions are used to gather the biggest amount of information possible, so as to give a proper answer. Developmental issues are taken into account, according to the age of the caller.

For what I was able to observe, there aren't many differences in the way the Infolijn and Linha Vida Porto works, except for the type of calls received (the majority of calls are heroin or cannabis related). The training of workers is done pretty much the same way and the guidelines for answering the calls are very similar, although we tend to have staff meetings more often, with an outside supervisor, where calls are discussed. Summing it all, there are much more similarities than differences.

2. L'Unity Peer project - Jellinek Preventie

As part of my objectives was to see how intervention in club scenes were done in the Netherlands, I had the opportunity to visit The Unity Peer project, in Amsterdam, where a meeting was held with Floor van Bakkum and his colleague Sanne.

The Unity project has the main objective of harm prevention in club and rave contexts. This is done by a team of volunteers, who belong to the rave scene. This is, then, a peer prevention project. The idea is that the information is passed better to the users, if the people who give that information are their peers. There are a few slogans that describe accurately the philosophy of this intervention, that are used in leaflets and other information materials: "Think for yourself, care about others" which is meant to increase self awareness about the use of drugs and also the need to help other people; "Less is more", to pass the message that the abuse of a drug may lead to undesirable effects; "Just say Know" a word game which remembers the frightening message "just say No" that has little or no effect, but with a completely different aim, which is to increase the knowledge about drugs, thus allowing people to do a well informed decision about using drugs and "Prepare and repair", which relates to the need of preparing physically and mentally the use of drugs in a party, and repairing afterwards its effects, in a no-nonsense, objective harm reduction strategy by the use of useful information like tips to recover in the days following a

party and diets that help the body recover from the excesses of the parties.

The Unity project acts in raves or parties with more than 1000 people. Stands are set up where the volunteers work. They don't go after users, or partygoers. They stay in the stand and anyone who has questions or needs help, can go there. This seems to me like a good strategy. They don't "hunt down" users – which can have a harmful effect, annoying people with information who don't want it. The people in the party know they can go to the stand if they want information, allowing for the information to be given in a proper way, answering the questions that are made.

The Dutch government finances the Unity project, although Jellinek and the Unity project itself are completely independent. At the time of the visit, the Unity project had 30 volunteers, all of them part of the club/rave scene or culture.

To become a volunteer, the main characteristic asked for is that the volunteer has an open mind. This is logical, as the objective is not to forbid the use of drugs, but generating the empowerment of the partygoers, so as they can make their own choices, having the correct information. Volunteers undergo a 3-day training course about drugs and are supervised so as make sure the information given is accurate and is not inconsistent with information given by other volunteers. The volunteers also undergo an evaluation, to make sure they know what they'll talk about in the parties.

The most common questions made by partygoers are about ecstasy, alcohol, GHB, cocaine, long-term risks of use, and combinations with other drugs. The Unity project also advises party organizers and health care services in the parties.

3. DIMS - Drug Information Monitoring System

The DIMS, a project by Trimbos Instituut, which has the cooperation of several local government institutions and ONG's across The Netherlands, has the aim of monitoring the substances in the pills that are sold in the country, like ecstasy or others, in a logic of public health. I had the pleasure of meeting with Peter van Dijk, on the day that Trimbos received the samples gathered in over 20 pill-testing facilities across the country.

On the day of my visit to Jellinek in Amsterdam, they were doing pill tests, (Jellinek has also a pill testing facility, in cooperation with the DIMS project) so I asked to observe. It was a rainy day, so during the time I was there no one came in, although I knew later that some users came to test their pills.

Because of legal restrictions, each person can only take 3 pills to be tested each time. The pills are subjected to several variable analysis, like the symbol they have, the height, the presence or not of a break (to divide the pill in 2 or 4 parts), the colour, etc. The pills are also subjected to a reagent test, which determines if the pill has MDMA, MDA or other substances, although this is only a presumption test. It does not detect other substances potentially harmful. In the light of these various variables, the pill is looked in the pill database from DIMS (DIMS has a database of several hundred types of pills, with its quimical composition). If the pill corresponds to the database, the user is given the information about the composition of the pill and also about some harm reduction techniques. If the pill is not on the database (which is increasingly common) and if the user agrees to give the pill, the pill is sent to Trimbos Instituut, were it will be subjected to a more sensible test. After the test is done, the user who gave up his pill to be tested is informed, in a confidential way

DIMS receives these pills from all around the country – at least where that is permitted by local authorities – analysis the pills according to the variables already described and continuously updates the database and informs the pill testing facilities. When a potentially dangerous pill is detected in the market, a warning is immediately done, by several means, like leaflets in parties and cooperation with mass media. A few years ago, a type of pill containing PDA (a potentially harmful substance), which caused a few deaths in Belgium, Germany and the Netherlands was detected. The warning was launched and in a matter of days the pill and all the pills similar to it completely disappeared from the market. The potential for public health improvement and harm reduction is therefore very important.

As the Dutch law forbids the possession of these drugs, DIMS, Trimbos Instituut and the pill testing facilities have a special authorization from the government to manipulate these substances and police cannot act in the premises or near the pill testing facilities, so as to prevent arrests of users. This is a pragmatic way to follow the law, but also allowing these harm reductions projects to do their work.

It was interesting to see that some of the pills received in DIMS were Viagra. Peter Van Dijk explained me this phenomenon. As ecstasy – although it can increase the libido of the user – makes erection difficult, users are increasingly combining the two, and Viagra is also sold in the black market. This can be also the reason for an increasingly common use of GHB in

the dance scene in the Netherlands, which has ecstasy-like effects, but also has a physical and psychological sexual arousal effect unlike ecstasy.

In my opinion, and given the current situation about the pills circulating in the market and sold as ecstasy, this kind of intervention is very important, as it can prevent deaths and also allows Trimbos Instituut to have an idea about the substances circulating in the market.

4. Research

As explained earlier in this report, in my visit to the Netherlands, I intended to meet with researchers on drugs, especially qualitative researchers or researchers working around dance cultures and drugs associated.

Tom Ter Bogt is currently working in research concerning the Dance Scene, using qualitative and quantitative methodologies. The main conclusion from his research (not yet published) is that according to the different kinds of dance music (Hardcore, Trance, House, Commercial House), the populations that attend these parties are different, as are the main drugs used. In hardcore, the main drugs are amphetamines and ecstasy, while in the trance scene are psychedelic drugs and in House more of cocaine and alcohol.

These results were very interesting to me, because my prospective results from my master's thesis research follow these results. This is important, because has implications to prevention and harm reduction policies and also allows a better knowledge of the different scenes. These results may imply also that we are facing trans-national youth subcultures, with more or less the same characteristics.

Hans Verbraek is one of the responsibles for CVO. An anthropologist, Verbraek is very interested in qualitative methodologies, and we had several conversations about the drug issue, research and current investigations being done in Portugal and in The Netherlands, where Imar Faasen from Trimbos and Associated Researcher at CVO also participated.

Verbraek and Faasen told me about several investigations done in the Netherlands in the past years and gave me also some of the researches. Also, we had discussions about the political and social determinants of drug use and drug policies in The Netherlands, about scientific theories, that are very vast and specific and don't belong in this report.

The opportunity of knowing these two researchers – I already knew Imar Faasen - was very important. First, because it allowed me and them to know a little bit better the "state of the art" in research being done in the Netherlands and in Portugal; Second because they were very helpful in my own research and third, because there was a common interest in maintaining the contact following the end of my visit, which will inevitably allow for further discussion and exchange of experiences and information.

5. Politics and Prevention

In a meeting with Harald Wychgel, the Dutch drug policy and the prevention strategies were discussed.

The main objective of Dutch drug policy is to avoid or limit the risks of drug use to the individual, his or her immediate environment and society. Since 1976, the Dutch law distinguishes between drugs that pose unacceptable risks to public health (hard drugs such as heroin, cocaine, ecstasy and amphetamines) and hemp products (soft drugs, marijuana, hashish). Possession, dealing, sales, production have been made punishable for all drugs. However, penalties for soft drugs are less severe than those for hard drug offences. Priority is given to investigation of imports or exports of hard drugs. In what relates to soft drugs, the maximum sentence for possession or sale of up to 30 grams of hemp is one month in prison, but a prison sentence of 4 years is possible for cases implying import or exports. The maximum sentence for hard drugs is 1 year in prison and 12 years for imports or exports.

The Dutch criminal law recognizes the expediency principle. This means that the public prosecution department has the power to refrain from prosecuting criminal offences if this serves the general interest of society. Use is not punishable. Investigation and prosecution of hard drug possession for personal use (0.5 grams) or up to 5 grams of hashish or marijuana generally is not prosecuted. Also, and as long as the Coffee Shops adhere to the AHOJ-G criteria (see below), sales of up to 5 grams of soft drugs per transaction are not specifically investigated. However, if the police discover drugs in a coffee shop, they do seize them and priority in investigation is given to coffee shops that specialize in sales for export purposes.

The Dutch coffee shops are famous all over the world. In these stores, sales of soft drugs are not prosecuted under certain conditions, like the AHOJ-G criteria: no advertising (A), no sales of hard drugs (H), no nuisance (O) no admission of minors of 18 years (j) and no sales of large quantities – more than 5 grams per transaction.

The sale of alcohol is also forbidden. The reason for the existence of these shops is The Netherlands desire to distinguish between the hard and soft drugs markets, to avoid criminalizing users and to maintain administrative convenience. The majority of coffee shops are small-scale, café-style businesses. Most offer a wide range of hashish and marijuana products. The number of coffee shops has diminished in the last few years, mainly due to strict enforcement of the law by authorities.

There were 1200 coffee shops in 1995 and only 846 in 1999, and, of the 538 municipalities, 433 had coffee shops. Many municipalities have introduced administrative measures to prevent or combat nuisance associated with coffee shops. These actions can also be taken in face of various reasons, such as suspicion of hard drugs sales, the presence of coffee shops near residential districts or schools or where drug tourism is attracted, especially in border towns. Broadly speaking, there are three types of coffee shop policies in The Netherlands: prohibition (coffee shops are forbidden); policy with supplementary conditions and policy without supplementary conditions.

A connection is sometimes claimed between the rise in cannabis use among young people and the coffee shops. However, this is considered unlikely by Dutch responsibles. The increase in the number of cannabis users preceded the increase in the number of coffee shops and it is forbidden to sale cannabis to people under the age of 18. The most significant argument is the fact that soft drug use has increased in most Western Europe countries and the USA, although these countries do not have coffee shops and have a more repressive policy than The Netherlands.

Nowadays, and unlike other European countries, heroin is not considered a big problem in The Netherlands. The number of heroin users has stabilized around 28000 for years, and Dutch government, alongside with drug free programs, has introduced free methadone programs, with an estimated 11000 to 12000 clients. Methadone is sometimes supplied on a reduction basis, although and because reduction is a difficult process, methadone is increasingly given on the basis of maintenance, with the dosage being stable.

Also, several syringe exchange programs have been developed in the 1980's. Syringe exchange facilities are located at addiction care services, private locations, cash machines and pharmacies. In 1998, 130 syringe exchange programs were running in the Netherlands in 60 different cities. The accessibility of injecting equipment did not result in an increase of drug use. The number of syringes exchanged in Amsterdam dropped from 1 million in 1993 to 600 000 in 1996 and the annual number of new cases of HIV among intravenous users has dropped between 1991 and 1996. These results cannot be attributed only to the syringe exchange programs, but also to other preventive measures like face to face counselling, prevention information, safe sex and safe use encouragement, social assistance and methadone supply.

In the last few years, the drugs on the rise in the Netherlands have been cocaine and ecstasy, with GHB making a big entrance lately, as already described. This led the Dutch government to apply specific measures, namely in relation to ecstasy. Nowadays, XTC is the most widely consumed synthetic drug. First detected in 1985, the XTC breakthrough in The Netherlands occurred in the late 1980's and early 1990's, partly in connection with the growing popularity of Acid House music culture. Dutch policy on XTC focuses on educational and prevention campaigns, but also in harm reduction. The Dutch government memorandum "City Hall and House", in 1995 contains recommendations to assist local authorities in facing the dangers of XTC use at large scale-events. Some measures include setting a maximum number of people per event, ensuring that first-aid personnel are present, drug testing facilities, the existence of a chill-out room, control of ambient temperature and ensuring that there is sufficient drinking water.

The preventive measures are also a big investment in The Netherlands. Harald Wychgel explained the "Healthy School" project, aimed at children and youngsters. Nowadays, around 75 per cent of Dutch schools have this project. It consists of classes, dealing with alcohol, tobacco, cannabis and other drugs, with the aim of preventing or at least increasing the age of the first experiences with drugs. Teachers that have specific training teach the classes.

The programs are implemented accordingly to the results of the National Drug Monitor. The results have shown that people in Holland begin experimenting tobacco, alcohol and gambling around 10 to 13 years old; cannabis around 14; ecstasy and cocaine later, so the programs dealing with each drug are implemented in those different years. The program, that has independent evaluation, has been important in rising the age of the experiments with drugs, meaning that people begin experimenting with drugs later, allowing for a bigger awareness and responsibility in the use of drugs. Once again, the pragmatism of Dutch policies are evident. People will still experiment on drugs, but at least they'll experiment in an age that allows better understanding of their actions.

In technical terms, the program seemed to me to be very well designed, aimed at issues like attitudes towards drugs, using debating techniques and passing along proper, realistic and objective information, and also being aware of the developmental issues of the target groups, fitting the program to the ages of the subjects. Parents are also involved, which makes, as far as I'm concerned, the "Healthy School" project a "state of the art" prevention program.

DISCUSSION and CONCLUSIONS

This visit was very important to me, as it allowed me to see how a different country deals with the drug issue. Two words came to me when speaking about the Dutch experience, policies and intervention programs with my Portuguese colleagues: Pragmatism and integration. Pragmatism because of the harm reduction programs and policy about soft drugs. Integration, because prevention, harm reduction, treatment and research fit together very well in the Dutch way of dealing with drugs. The philosophy in all these areas is similar, and tends to acknowledge the importance of self-determination in the use of drugs. It is time, I think, for us to think of a drug user as a person that made the choice of using drugs and only later becomes an addicted person.

If we work towards self-determination, allowing people to make well-informed options, the risk of addiction is certain to decline, and also the risks associated with use of drugs. We have to come to terms with the fact that we will never stop drugs from being used. We can, however, decrease the number of users, and prevent some of the risks. So many years of prohibition laws have only achieved the goal of increasing drug use. It is necessary to rethink the way we work, even if bound to prohibition international treaties. The Dutch have come up with a very pragmatic way of doing this, where they respect the international law but still have a liberal policy about drugs. It is not a perfect policy, at times it seems pretty much senseless – yes, we forbid drug use, and yes, we allow drug use – but given the international law constraints it seems very pragmatic. The concept of not enforcing a law when it can do more harm appeals to me even if the existence of laws that aren't enforced sounds strange.

The Dutch policy is very critised, but it's an undisputed fact, as far as I'm concerned, that the results are very good. Also, Dutch officials show a genuine interest in the right way to do things, and that is evident in the fact that politicians, prior to making drug related decisions have, until now, asked researchers and drug workers how to deal with specific problems. That was the case when ecstasy made its appearance.

With the recent political changes in the Netherlands, I became aware that there was the risk of cutting-edge projects (e.g. the heroin prescription programme) being cancelled or reviewed. I was also aware that the drug policy is becoming increasingly restrictive and controlled (more control over coffee shops, for instance) because of other countries' complaints (mainly because of drug tourism). But my question is: aren't drug tourists drug users in their own countries ? At least in the Netherlands they can safely buy their drugs - only if 18 or older - and don't have to deal with street dealers and all the problems associated.

However, we could see in the last years small steps being taken by other European countries towards a more Dutch-like policy: Spain and Portugal, for instance have decriminalized the use of drugs. This seems that, slowly, Dutch policy is becoming increasingly recognized. The results speak for themselves. However, when speaking of Dutch drug policies, we tend to focus on the coffee shops, forgetting all that is done at the research, prevention and treatment areas. Those are the areas we should study, adapt and implement in our countries. If it works there, it should work here, with the necessary cultural adaptations. Portuguese drug law has evolved tremendously in the last few years.

However, we are still working our way to having a decent, working, drug strategy. We have the law, but we still don't invest as we should in prevention. Harm reduction policies have begun to be implemented, but there is still a lot of moralistic talk. It's OK to exchange a syringe in a pharmacy, but within a prison population where most people are drug users, the syringe exchange programs are

Bibliography

Trimbos Instituut, (2001). Jaarverslag 2001 Drugs Infolijn

Trimbos Instituut, (1998). Fact Sheet Hard Drugs policy: Update Opiates.

Trimbos Instituut, (1998). Fact Sheet Drugs Policy:

The Criminal justice and administrative authorities.

Trimbos Instituut (1996). Fact Sheet Education and Prevention policy alcohol and drugs.

National Drug Monitor, (2000). Fact Sheet Cannabis Policy update 2000.

National Drug Monitor, (1999). Fact Sheet Hard Drug Policy: XTC update 1999.

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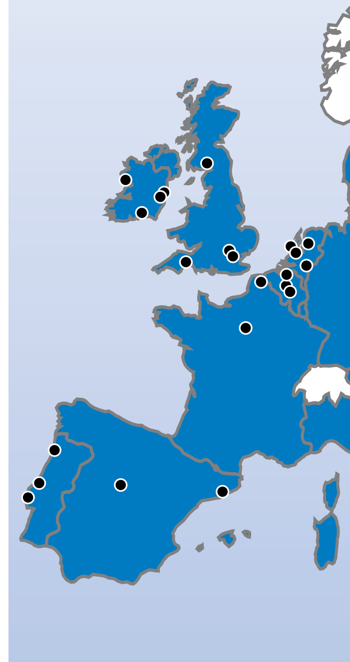

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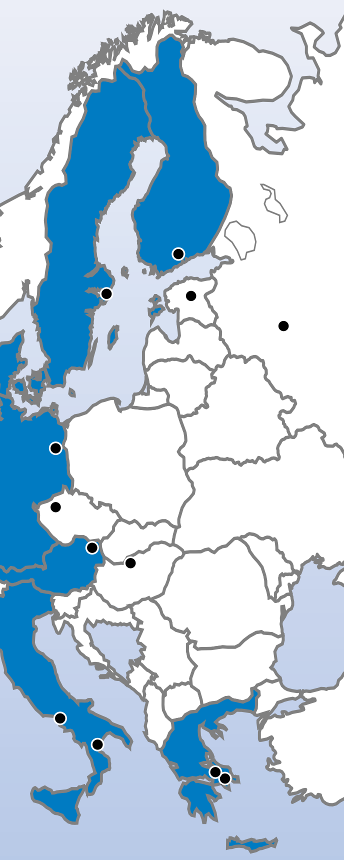
NDATION OF DRUG HELPLINES

Network



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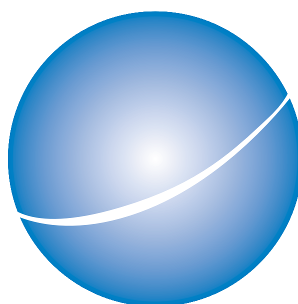
forbidden. We began pill testing, but there is only one drug testing facility in the whole country, and it only does presumption tests. The mass media campaigns against drugs are common, but have fear- inducing and moralistic messages that are more likely to induce use than to prevent it. Sometimes, they even inform young people that there is a new drug that they didn't know existed and that they shouldn't use – we all know the results of this: increased demand for that drug – as was the case with ecstasy a few years ago. However, the Portuguese panorama is better than a few years ago. Politicians are increasingly asking for expert opinions, research on drugs is increasing, although much of the time without practical application, because the results show a need for a change to policies and interventions that are unpopular with the general public. When we discussed the possibility of implementing shooting galleries, all hell broke loose, and the government had to withdraw that project. We still have a long way to go, but it seems were on the right direction, in spite of all these problems.

The benefit of visiting other countries, with a more – in my opinion - evolved drug policy and strategy is that we don't have to make the same mistakes, and we can learn from the experience of the other countries.

It could seem strange that in my conclusion I decided to write about political issues. But it's the political issues that will determine how the work is done and which interventions are implemented, if prevention is a priority, if harm reduction is not, etc. It will determine what and how we can do things.

As drug field workers we must be aware of these constraints. The drug problem is not only an individual problem; it is also a social and cultural one. If we forget these variables, we become blind. If we don't follow the cultural tendencies (like music) of young people, we won't be able to do our work. The main character on the movie "Trainspotting", a heroin addict, says: "the music is becoming different, the drugs are different". We must know the culture, the music and the drugs, to do our work. We must know reality so as to do a proper job and influence political decision-makers. And, working in a drug helpline, being most of the time the first expert the caller talks to, we must be aware of all this, so we can help them in an objective and correct way.

At a time when borders aren't what they used to be, with increasing contact between youth of different European countries, to know about the realities of other countries is a first step to knowing the upcoming tendencies in drug use in our own country. This is what is happening nowadays with ecstasy, it's what is already beginning to happen with GHB. Following my visit to the Netherlands, I feel more prepared for the upcoming challenges in work. And that is, as far as I'm concerned, the biggest benefit I had with the visit.



Carlos Roig - Montserrat, *Clinical psychologist, ALTA Group, Barcelona, Spain.*

INTERNATIONAL AIDS CONFERENCE, BARCELONA

July 2002

In recent days, Barcelona was transformed; the city converted itself into a mosaic of cultures, people, and ideologies. Representatives of practically all countries of the globe (some 18,000 people) attended the conferences of AIDS experts, representing of several NGOs, governments, other organisations. There were politicians, volunteers, medical personnel etc. If a sentence could summarize the general feeling of the day, it would be: 'Doctors Without Borders Fight Against AIDS'.

It was encouraging to listen to the various reports, conferences and debates that proceeded during the Congress. The most relevant topics were:

1. The number of deaths that will occur within years (25-30 million people) in the Third World.

2. Lack of participation of the Western governments.

3. Capacity of certain pharmaceutical companies (present at the Congress with very luxurious stands)

A unanimous request was the petition for drugs at low prices, so that all AIDS patients from the poor countries of Africa, South America and Asia can have access to them. It was encouraging to see the presentation of a new drug that prevents the virus from penetrating the human cells.

All that was very well, but now the key-question is asked, or perhaps this is more of a reflection. It is true that a plenty of AIDS patients from the Third World will die, but what is going to happen to poor people without resources and education from our developed countries. What kind of future awaits them ?

They will be able to live with the antiretroviral drugs, but we already start to hear the voices of the most conservative parties, attracting the attention on the high cost that it will represent for the states of each nation. In a moment of deep economic crisis, as well in the USA as in Europe, for us working with NGOs and trying to help AIDS patients, they present a time of prosperity to us, but we believe that is rather the opposite.

The organizers of 14th international conference published a review. The review can be consulted at www.aids2002.com. 60 people took part in this bulletin, reporting on a daily basis on what occurred with a whole series of information, photographs and session summaries. The topics that we find in the bulletin include the current HIV/AIDS situation in various places of the world, with articles referring to zones like Maghreb, the south of Europe and the south of Africa. The participants came from the following geographical areas:

- North America
- Latin America
- Caribbean
- Pacific Asia
- Africa

To obtain the best results in the various working groups, the topic "let us build bridges" was created. It had to lead to the maximum of the two components (science and action) to arrive at "Skills buildings", with a very large program of 74 workshops and the Bridging Sessions, one of the newest innovations of this conference. The sessions lasted 90 minutes with 30 minutes of discussion and participation of the public. The relevant topics were: vaccines, microbicides, and treatment access. Each session saw a great number of experts on the various themes.

Finally, we will highlight the "declaration of Yun que of Montjuic", realized by a group of people of the Caribbean zone, more precisely of San Juan of Puerto Rico, all of whom were HIV patients. "Knowledge and compromise for action" would be the central message of this declaration. All the medical professionals can work hand in hand with HIV patients, the basic community organizations, NGO's and governments, and thus, all linked, we could send a message of hope in the battle of survival of HIV patients.

Vito MALCANGI - Presidente e Responsabile del Servizio di consulenza legale del C.A.D. Milan, Italy

THE NORMATIVE SYSTEM TO SUP ADDICTION TREATMENTS

It is common that many people who abuse toxic substances find themselves trapped in the net of justice.

Introduction

The legislator recognises that these acts are not inevitably due to a specific delinquent tendency, but rather to a direct consequence of drug-addiction. He considers it convenient to adopt standards that encourage the subject to emancipate himself of such conditions. Thus, once the primary cause of the deviant behaviour is eliminated, the person could be reintegrated completely in the socio-familial and professional context. The opportunities offered by the law cannot always be used in a meaningful way by the drug user because of his own precarious economic situation and of his family, a situation that reduces the possibility of effective legal assistance.

Accepting that the therapeutic path cannot ignore the legal situation, the person in charge of the drug addict, in order to provide necessary help, must have legal background knowledge. In the area of legal advice regarding drug addiction, we have noted frequently since 1971 the need to acquire legal information on the subject, to ensure a valid selection and formulation of the therapeutic program. Such a requirement, as we have considered, is related to the fact that many subjects carry a more or less heavy burden of problems with penal justice. Frequently we have to take care of people who have been subject to lawsuits and convictions and who have been 'cut apart' in various penal procedures. The therapeutic help available needs to be integrated into the legal history of the person concerned and into the legal advice that they receive. This is to avoid the therapeutic program from being interrupted in its progress by a prison order or summons on behalf of the magistrate, which oblige the person to leave the community even temporarily, thus stopping the course of rehabilitation.

The support of the legal advice or assistance, is almost always made more difficult because of the lack of economic resources which generally affects the subject and his family. This is a situation caused by the behaviours which belong to more or less recent personal history of the person. In such a situation, it is difficult to propose the assistance of a lawyer. Amongst other things, notwithstanding this difficulty, it is worth saying that, in this field, the official presence of a person having a specific competence would be useful, because the choices to be made do not often coincide with those a professional would make in an ordinary way. In fact, it is necessary in this case to accomplish a complex validation of the situation of the subject. It is not enough to look at short-term successes that can be null and void in the context of a fuller validation of the process. It is necessary on the contrary to keep in mind the main goal that is, finally, to put in place measures which are relevant alternatives to prison.

It is worth saying that it would be useful to equip advisors with some minimum knowledge of the institutions so they can help the subject in simpler initiatives toward institutions which do not require the help of a professional. Moreover, it appears essential to stabilize the limits within which the advisor can help the person with their own knowledge. I would say that in the broad outline, we could give three hypothetical situations:

1) the advisor is able to give exhaustive advice to the person

2) the advisor calls upon the specific consultation of a lawyer: When a situation arises in an ambiguous way and more depth is required, it is necessary to arrive at a balanced choice.

3) the complexity of the legal situation requires total involvement of a professional and the actor cannot alone take the responsibility for advice.

It would be a good initiative to create a multi-field team with the specific duty to provide training and legal consultation to the advisors of the social sector public and private who are in charge of people with legal problems. The frequency of requests for advice by the advisors put forward this need. The idea of "specialized" legal team would have the advantage of avoiding incomprehension on the part of the advisor and would solve the potential conflict between legal and therapeutic interests. With the goal of real advantage for the patient, collaboration between various professional competences would lead to the appropriate solution for each case.

The achievement in a more advanced state of common understanding can be obtained by the promotion of the meetings with the advisors, structured opportunities to equip these advisors with basic concepts about the legal institutions which feature regularly in the cases in treatment. After having acquired a minimum of knowledge on the procedures to be followed, which can be individualized in each case by the qualified magistrate, this allows the advisor to help the patient on contacting a legal authority.

PORT DRUG

ALTERNATIVE MEASURES

TO PRISON DETENTION AND OTHER REMARKS ON THE TOPIC OF PERSONAL FREEDOM, WITH PARTICULAR REFERENCE TO DRUG ADDICTS AND ALCOHOLICS.

The legal problems generally encountered during the treatment of drug-addicted persons almost always go back to their past or even present circumstances in the judicial net. It would thus appears useful to give a description of alternative measures to prison detention and to make other remarks about personal freedom which may be taken into account by the magistrate in this field. It is particularly significant to observe that the normative solutions are different for the person who is awaiting sentence in contrast to the person convicted, thus we differentiate the situation between the 'free' person and the detained person. Often these situations are not clear cut, so someone convicted can be free and conversely a person can be detained awaiting sentence. I also make a point that, as well as the standards specific to the drug addict and or the alcoholic person, there are institutions and "benefits" which are accessible in a general way and for all.

For greater clarity, it is convenient to examine separately the situations and the possibilities envisaged by the law for the people awaiting judgement, of those that refer to convicted people with irrevocable sentences.

I) People awaiting judgement or convicted but awaiting sentence

a) If held:

- **Held in residence** : substitution of prison detention with that of detention in residence of his own or another private place except a public treatment place.
- **Freedom by revocation of the arrest measure**: free while waiting for the final judgment

- **Revocation of prison measure (in certain particular cases)**: judgement which can be put forth in favour of the drug addict or the alcoholic who follows a therapeutic program within an organized structure and the interruption of this same program can be prejudicial to the detoxification of the person. In such a situation, necessary controls are established to make sure that the person continues the program of reintegration. Sometimes, difficulties arise in the relationship between the prisoner and the outside world (service, assistance structure, communities and other private groups). There is not always communication between the prison, the specialized teams and the public and private agencies. Communication is therefore required between all the parties that deal with the drug addict. Moreover, we can see sometimes a certain concern of some communities with regard to the assistance of people who are in situation of arrest in residence, and who are not under any supervision of social services.

b) If free :

Possibility of withdrawal of the coercive measure of prison detention (in particular cases) :
In favour of the drug addict or the alcoholic who in controlled freedom follows a therapeutic program. In the cases in question, it is asked for the same antecedents and envisages the same conditions indicated in the order of revocation of the measure of prison detention.

In this case, there emerges a difficulty relating to the possibility of knowledge on behalf of the judge about the real situation of the person in relation to the program of reintegration and their relationship with the host agency. With a project led by ASL, the court of Milan and other social private structures, it was possible to overcome the difficulties for the application of this standard. The judge in the decision of the application or at least in the measure of assumption of responsibility by the PM must evaluate the objective and subjective conditions. If a person on trial is a drug addict, the law provides that the preventive measure of detention cannot be applied or can be revoked when such a measure and consequent interruption of the therapeutic program in action can create obstacles in the course of rehabilitation of the person. But the judge almost never has the necessary information to apply such a standard correctly. To fill this gap and to provide to the magistrate with the elements necessary to his evaluation, a project is in hand, involving the Court of Milan, the ASL and some associations of the social private sector including CAD (Centre of assistance and treatment of addictions). The project relates to the processes of the Directissime Rite*. In this type of procedure, the person stopped for an obvious offence is not imprisoned. Instead, they are directly brought in front of the judge, who, after having co-validated the arrest, if legitimately operated, before deciding if the preventive measure applies, allows the drug addict (if he requires it) to request collocation in presence of a social advisor to the court.

During collocation, the advisor obtains all the relevant information on the person and the eventual therapeutic program in progress, including from the people who are responsible for this. Then the advisor informs the magistrate about the real situation of the person and their obligation to follow or start a socio-rehabilitating path. The judge does not then apply prison measure giving the opportunity to the drug addict of starting or continuing a therapeutic program. In the event of need for immediate medical treatment, or if the person resides in another city, the young person is returned to the officially agreed structure where he will receive all the medical and psychological treatments needed. The validation of this project, integrated with a necessary network, provides the magistrate with useful personal information on the person which assists his decision-making, and also

gives an opportunity for the person to meet an advisor.

2) *Subjects condemned with irrevocable sentence*

a) If held (entrusted to the public ministry for particular cases)

This is an alternative to prison detention for complex residual sentence with reduction of up to 4 years (following a single conviction rather a sentence made up of cumulative convictions) for a drug addicted or alcoholic person who is already on a rehabilitation program or who intends to start one. To be accepted by the authorities, it is necessary to produce a certificate established by a public health agency to attest status of drug addiction and the nature of the program created to recuperate the convicted person. By producing the above-mentioned certificate, it is possible to obtain the immediate release directly from the competent public ministry (in anticipation of the decision of the monitoring court on the concession of benefit).

Detention in residence

This measure is not aimed at drug addicts specifically. It can be applied to a sentence of up to 4 years (the limit was raised from 3 to 4 years by normative measure 165/1998) even if it constitutes a residual share of a major sentence, if the sentence involved imprisonment. It may be applied without limit for arrests (following convictions for minor offences defined as contraventions).

Such a measure authorizes the expiation of the sentence at home or in another private place, even a place in which the public are treated or helped. This is for people with conditions of age or of health, for a pregnant woman or a mother with children of less than 10 years old or for the father in the same circumstances when the mother died or is in incapable of taking care of the children.

Finally, if the sentence is obligatorily or optionally suspended due to the existence of health conditions that are incompatible with criminal imprisonment (even if the judgment is higher than 4 years), then the monitoring court can apply a detention in residence, establishing a term of duration of its application. This term which can be extended. This measure can be requested by the arrested person as soon as the sentence becomes final, thus avoiding prison (article 47 of Penitentiary Law).

Alternative measures to prison detention for people with AIDS

With regard to people suffering from AIDS or a serious immune deficiency as defined by article 286(a) of the penal code procedure, measures involving the assumption of responsibility by the social services and detention in residence even beyond the limits of existing judgements may be applied. Such a possibility is given to people who follow or wish to undertake a treatment program in the infectious diseases department of a hospital or a university or other departments involved in the regional plans for helping people with AIDS (article 47 quater of the Penitentiary Law)

Suspension of the prison sentence

If a person is sentenced for up to 4 years for offences committed in relation to drug addiction, the monitoring court can suspend the execution of the sentence for 5 years if it is established that the person is starting or is already on a therapeutic and socio-rehabilitative program. The monitoring court must be presented with a certificate from a public organisation which attests the type of therapeutic and socio-rehabilitative program chosen, the indication of the program's structure and the methods and eventual outcomes of the program. If the convicted person follows the therapeutic program and does not commit any major offences in the 5 years following the suspension of the sentence, the sentence is revoked. The suspension of the sentence is revoked if the person stops the program without a justified reason or he commits a major offence. With the required documents, the prisoner can contact the authority of the public ministry that manages the carrying out of the sentence and obtain the immediate release while waiting for the final decision of the Court of Monitoring.

b) If free

- **Provisional detention**
- **Detention in residence**
- **Suspension of the execution of the detention**

The people who may apply these alternative measures have recourse to imprisonment. But if the person is free before the sentence is ordered or within the 30 days of the notification, the authority concerned with alternative measures can propose (with the necessary certificate) this suspension by lodging it with the secretariat of the executive committee of the public prosecutor. Once the authority is received, the public ministry suspends the execution and transmits the acts to the monitoring court for the final decision (articles 47, 47ter and 50 of the Penitentiary Law; art.90-93 and 94DPR 309/90)

BRIEF FINAL CONSIDERATIONS

The standards that we have examined, and the problems relating to their practical application in connection with the complexity of the phenomenon of which we are talking about, guide the content and structure of the training and briefing of advisors in the public and private sectors on the themes considered. Moreover, they give rise to the need for active collaboration between all the public and private agencies that are brought in from different angles to deal with the problems of drug addicts or alcoholics. Only a large investment and an effective collaboration can facilitate the resolution of such complex problems that involve all the advisors in their various professional roles.

FESAT

FIRST CONFERENCE OF ASSOCIATED SERVICES

4 - 5 April 2003 • Milan - Italy

Thursday 3 April

15.00 – 18.00
- Registration

Friday 4 April

08.00 – 09.00
- Registration and installation of stands by the services

09.00 – 10.30
Opening session (English – French – Italian)
- R. Hanton - FESAT President
- Italian Officials
  - Municipality of Milan
  - Health Department of the Lombard Region (A.S.L.) – City of Milan
- European Commission
- EMCDDA

10.30 – 11.00
- Coffee Break

11.00 – 12.30
- Rafaella Rossin, Linea Verde Alcohol (L.V.A.) - A.S.L. – City of Milan: "The Milan helpline network for Drugs and Alcohol".
  Presentation 20 mins – Question time 10 mins
- Clemente Suardi, C.E.A.S., Commune di Milano: "The collaboration between the Linea Verde and the Territory services – A monitoring experience".
  Presentation 20 mins – Question time 10 mins
- Prof. Patrick Kenis – "An external evaluation of FESAT ".
  Presentation 20 mins – Question time 10 mins

12.30 – 14.00
- Lunch

14.00 – 16.00
- Workshops 1 – 2 – 3

16.00 – 16.30
- Coffee Break

16.30 – 18.30
- Workshops 1 – 2 – 4

Saturday 5 April

09.00 – 10.30
Plenary session (English - French – Italian)
- B. Hibell/M. McLean : "The Monitoring Project of FESAT – Emerging trends 2000 – 2002"
  Presentation 20 mins – Question time 10 mins
- M. Cantin : "Drogue: aide et référence - A Quebec service ten years later"
  Presentation 20 mins – Question time 10 mins
- H.-V. Happel : "The Grey/Ad hoc Helplines Survey of FESAT"
  Presentation 10 mins – Question time 5 mins
- T. Jaakkola : "Guidelines for setting up a helpline"
  Presentation of this new FESAT tool
  Presentation 10 mins – Question time 5 mins

10.30 – 11.00
- Coffee Break

11.00 – 12.30
- Associated Services Official Meeting
  (plenary room - F)

12.30 – 14.00
- Lunch

14.00 – 15.30
- Workshops 5 – 6 – 7

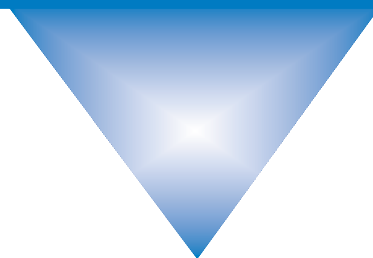
15.30 – 16.00
- Coffee Break

16.00 – 17.30
- Workshops 8 – 9 – 10

17.30 – 18.00
Closing session (English - French – Italian)

Conference venue :

Palazzo delle Stelline
Corso Magenta, 61
20123 Milan, Italie



FRIDAY 4 April — **WORSKHOPS ARE ONLY IN FRENCH AND ENGLISH**

	PLENARY ROOM - F	ROOM - M
14.00 – 16.00	***WORKSHOP 1 : E-mail counselling*** **Chair/facilitator : P. Pissara (P)** - G. Gottwald-Nathaniel, Treffpunkt Drogenberatung API (AUS) : "*Standards in e-mail counseling*" - A. Lodzina, Confidence Line (Latvia) : "*Delivery of Services by e-mail/Internet*"	***WORKSHOP 2 : Media*** **Chair/facilitator : C. Roig (E)** - H. D. Wychgel, Drugs Infolijn, (NL) : "*Promotion and its impact on the number of callers*" - M. J. Roque, Linha Vida Porto (P) : "*The training of journalists in drugs*"
16.30 – 18.30	***WORKSHOP 1 (continuation) : E-mail counselling*** **Chair/facilitator : P. Pissara (P)** - T. Peltoniemi, A-Clinic (FI) : "*AVEC Internet portal – 15 Finnish organizations helping people on drugs, alcohol, mental health, family and violence problems*"	***WORKSHOP 2 (continuation) : Media*** **Chair/facilitator : C. Roig (E)** - A. Boucher, Infor-Drogues (B) : "*Unexpected results from a press release*"

SATURDAY 5 April — **WORSKHOPS ARE ONLY IN FRENCH AND ENGLISH**

	PLENARY ROOM - F	ROOM - M
14.00 – 15.30	***WORKSHOP 5 : Monitoring*** **Chair/facilitator : Ph. Bastin (B)** - B. Hibell, CAN (SE) : "*FESAT Monitoring Project – Two years experience*" - T. Evenepoel, Druglijn (B) : "*What role can a helpline play in drug news information exchange?*"	***WORKSHOP 6 : Grey/Ad hoc helplines*** **Chair/facilitator : A. M. C. Kok (NL)** - H.-V. Happel (D) : "*Grey and Ad hoc Lines – Specialities, recent status, experiences*" - M. Ferrara, Infor-Drogues (B) : "*Impact of the media's response to the Belgium government's new policy on cannabis on the public's demands*"
16.00 – 17.30	***WORKSHOP 8 : Function & limits of helpline services*** **Chair/facilitator : G. Gottwald – Nathaniel (A)** - V. Baptista, Linha Vida Lisboa (P) : "*Function and limits of Helpline Services*"	***WORKSHOP 9: Helplines in Eastern Europe*** **Chair/facilitator : H.V. Happel (G)** - D. Rechnow (R), T. Jaakkola (FI) : "*Russian speaking ethnic minorities in Baltic region – Helpline services and equal opportunity policy*" - S. Sekutkovska & Y. Tulevski (M) : "*First steps in setting up drug helplines in Macedonia*"

ROOM - L

WORKSHOP 3 : Evaluation
Chair/facilitator : B. Hibell (SE)

- V. Kalabalikis, Ithaki Drug Helpline (GR) : "*Data collection in collaboration with EMCDDA*"
- V. Silva, Linha Vida Porto (P) : "*The evaluation of drug helplines*"

WORKSHOP 4 : Different topics for the same helpline
Chair/facilitator : C. Manduzio (I)

- M. Cantin, Jeu : aide et référence (CA) : "*Jeu : aide et référence - an essential Québec service*"
- B. Cohen, Drogues, Alcool, Tabac Info Service (F) : "*From illicit to licit drugs: evolution of a specialized service on drug use towards a public service open for all. The experience of D.a.t.i.s.*"

ROOM - L

WORKSHOP 7 : Team training
Chair/facilitator : T. Jaakkola (FI)

- V. Silva, Linha Vida Porto (P) : "*The training of new drug helplines workers*"

F.E.S.A.T.

Publications

ORDER FORM

All publications are available in English and French.

I would like to receive :

☐ in French ☐ in English

☐ I would like to receive "Lines" on a regular basis

☐ "Guidelines of good practice" (a publication of the Telephone Helplines Working Group, UK, 1993). *Also available in German*

Thematic reports :

☐ Conferencereader Berlin - March 2001

☐ FESAT Training Activities 1997 - 1999

☐ Drug Helplines and Legal Aspects

☐ Equal Access for All - Ethnic Minorities and European Drug Helplines Services

☐ Towards a Common Telephon Number for European Drug Helplines Services

☐ Families and Drug Helplines

Name : ______________________

Service : ______________________

Address : ______________________

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Please return to :
Permanent Office FESAT
19 rue du Marteau
B-1000 Brussels

Drug Helplines are telephone services, providing any caller who telephones them with a high quality of service, which is reliant upon the competence of the staff who run them and ethical guidelines regarding human rights.

They represent an essential link in the national and/or local strategy for reducing the demand of drugs.

They can be defined by their function, the place they have within the different sectors involved (social, health and education) and the conditions which allow their existence.

THE CHARTER

Official address :
Trimbos-instituut
Postbus 725
3500 AS Utrecht
The Netherlands

For all contacts :
Permanent Office
FESAT
19, rue du Marteau
1000 Brussels
Belgium

Tel.: (32) 2 219 28 87
Fax: (32) 2 219 14 98

E-mail:
fesat@skynet.be
http://www.fesat.org

Their function

By actively listening and not judging, drug helplines inform, guide, befriend, support, advise and help in order to:

- break the taboos surrounding drugs;
- take away the isolation and feelings of exclusion;
- help the caller start upon or maintain a process of change.

In order to fullfil these functions the services are reliant upon the many skills of the people who run them - people who are specially trained in listening and helping over the phone and in the problems of drugs use and drug abuse.

Their place in society

With regard to drug issues, drug helplines have their place at the interface of the public and the services which provide help, treatment and prevention. They provide specialist answers to callers' questions and offer a general service to organisations which specialise in drug addiction.

With regard to the people who use them (young people, adults, professionals, drug users and those around them) they aim to facilitate links and contact with them and promote equal access to the resources available (of information and care).

With regard to their particular place in society, drug helplines can provide a permanent guide to:

- changes and trends in the availability of drugs;
- changes in the way drugs are taken;
- whether or not there is an adequate or inadequate number of general or specialised drug services;
- public feeling, their needs and difficulties;
- the effect of political, social and legal affairs.

The condition of their existence

In order to fullfil their function, drug helplines must be able to rely on a contract which guarantees their financial stability; defines the nature of their links with funders; sets the statutory proceedings they may have to follow and how to resolve any lobbying they may be subject to.

In order to provide the public with a fully effective service they should offer a permanent service with a process of ongoing training.

Drug helplines should guarantee the anonymity of the caller and make sure any information taken remains confidential.

They must guarantee to provide the telephone advisors with ethical guidelines, which set limits and rights through a contract, the contents of which must be open to public knowledge.

Equally in the contact with callers and in their links with society, drug helplines must seek to develop an environment which is conducive to talking and for questions to be answered on the subject of drug use without dramatisation, without trivializing, and without exclusion or rejection.