South East European Drug Policy Network Meeting Report

Approaches to treatment of drug dependence – quality of services and effectiveness of interventions

4th – 5th March 2011, Thessaloniki, Greece

The International Drug Policy Consortium (IDPC) and the Diogenis Association (Drug Policy Dialogue in South East Europe) organised a seminar on approaches to treatment of drug dependence in Thessaloniki, Greece on 4th – 5th March 2011.

The aim of the seminar was to learn about the background, the methodology of work, the effectiveness and the challenges of the programmes implemented by the Therapy Centre for Dependent Individuals (KETHEA) and the Organisation Against Drugs (OKANA). Participants visited KETHEA and OKANA programmes in Thessaloniki and discussed the feedback of the visits in a plenary session, exchanging information about practices in other countries in the South European Region. The seminar aimed also to discuss ideas and proposals for the strategy and action plan of the Network for 2011-2012 and to share drug law developments in the SEE countries and NGO involvement.

A group of 24 NGO participants and policy makers from Albania, Bosnia and Herzegovina, Bulgaria, the Former Yugoslav Republic of Macedonia (FYR Macedonia), Greece, Croatia, Montenegro, Romania, Serbia and Slovenia participated in the meeting. This was the third meeting of the SEE network since it was formed in March 2010.[1]

[1] Two previous meetings were held, one in Athens, Greece, in March 2010 (for more information, see: http://idpc.net/publications/report-see-meeting-athens-march-2010), and the other in Ohrid, Former Yugoslav Republic of Macedonia, in September 2010 (for more information, see: http://idpc.net/publications/south-east-europe-network-meeting-ohrid).

Friday 5 March, 2011

Small Group Visits to KETHEA and OKANA

On day one, participants in small groups visited different programmes of KETHEA and OKANA, two of the biggest providers of treatment, harm reduction and reintegration programmes in Greece. This was followed by a visit of all participants to ITHAKI, the first Residential Therapeutic Centre of KETHEA in Greece. The sessions of the first and the second day were held at the premises of the ITHAKI centre. Participants provided reports of their small group visits and commented on some aspects of the visited programmes in comparison with the situation in other countries of the region. After the reports, presentations were given by OKANA and KETHEA, followed by discussion.

OKANA – Prevention Centre "Dictyo A'"(Network A) of Western Thessaloniki

There are 71 Prevention Centres in Greece. The Centre visited was in West Thessaloniki. The work includes drug prevention in schools. This is organised through the teachers, with supervision from OKANA. OKANA provides training for teachers and workshops for pupils in schools on the theme of drug prevention for approximately 2 hours per week. But the programme does not only include drug prevention – OKANA acts as a supervision body for the whole of Greece and everybody who works in this field works with OKANA. This is very different to the situation in other countries in the region. In Serbia, for example, there are many organisations working with pupils and coordination exists on a municipality level, but there is no institution like OKANA which provides and supervises prevention programmes and workers for the whole country. The Republic Commission for the Fight against Drugs, a Serbian governmental body, is just partially supervising the work in the prevention field. Participants who visited the OKANA programme found that it was useful to see how one national programme can have a positive impact in a country.

OKANA – The Third Substitution Treatment Unit (Methadone) at the "Papanikolaou" Hospital

This programme is located outside of the city centre. It is a small facility but well organised by the staff. There are 240 clients in total -among them many adults- on methadone and buprenorphine. The average dose is 60ml and the highest dose 140-160ml. The Unit has a take home policy where clients are able to take methadone home after a long period of treatment. The facility also provides counselling, but there is a long waiting list to access the service, with people waiting for 3-4 years. As soon as there is a free place available, they are replaced. Urine tests are conducted once a week or once every 2 weeks. It is a well equipped and surveyed system. Participants felt that it was a nice place for drug users.

Referring to experiences in other countries in the region, in Serbia, the medical team and the building are usually smaller, although there are state institutions with bigger teams and facilities. Methadone has been in use for 20 years, and buprenorphine detoxification and substitution programmes started last year. Up until now, there has been no practice of transferring patients from methadone to buprenorphine or vice versa. In Albania, the methadone treatment is very community orientated and people with a low threshold can come and have a coffee, even with their parents, to encourage good relationships between the client and their parents. In Albanian centres, clients have to have someone to sign for them as a guarantor to confirm that they come from that city. The guarantor must be somebody that knows the client and can guarantee that they will not leave the programme. Otherwise, they might be escaping from prison or have made an agreement to sell the substitution drugs to their dealer (the programme found that clients would come in, put the substitute in their mouth and then go out and sell it). The outreach worker is considered to be the bridge between the client and the service. Most Albanian clients enter treatment

accompanied by their parents. Although parental consent is not an exclusion criteria, the programme has found it useful to work closely with the parents. This is not the case in OKANA, as a person can be admitted without parental consent. Only basic documents need to be provided.

A programme involving adolescents, in FYR Macedonia, has encountered a very different experience and, in some cases, does not require someone to sign for the clients. The centre realised that, sometimes, parents could cause greater harm to the client, including throwing away the methadone that their child is receiving from treatment. In other occasions, parents have unrealistic ideas, which can also cause harm to their child. The centre found that there could sometimes be better cooperation between the client and their parents if the parents were not required to give their consent. Another example given of the programme being abused where there is no guarantor required was of a sexual worker in treatment which staff at the programme were unaware of. Her pimp was claiming to be her partner but was blackmailing her and forcing her to give the methadone to him.

OKANA – The Fifth Substitution Treatment Unit (Buprenorphine) at the Ahepa Hospital

Participants visited a buprenorphine centre located in a university clinic. The service is free of charge and there are approximately 200 patients in treatment. There is a waiting list for about 4 years or longer due to lack of funding. The programme includes group therapy, family therapy, and involves staff nurses, psychologists and psychiatrists. Some facilities provide somatic treatment[2]. Health care professionals, such as pathologists, deal with hepatitis B and C and HIV/AIDS. Participants felt that the rules were very strict. For example, if a client has an appointment at 10 am but they are late or do not call to say they are going to be late, they then have to wait until 2.30 pm or the end of day to be seen. If a client is found to be manipulating the tablets several times, such as putting them in their mouth and then selling them later, they have to leave the programme. Others tend to drop out and then reintegrate the programme. Clients are regularly tested for drugs. 32ml of buprenorphine is provided to the client on Monday and Wednesday. This amount has to last only 2 days when given on Monday but 3 days when given on Wednesday. Although the programme does not claim to be a harm reduction programme, it seems to abide by harm reduction principles. If clients are not drug free after one year, then they are excluded for 2 months. The programme's security is much more important than what is found in programmes in FYR Macedonia.

There is no buprenorphine in Greek prisons. Methadone can be given in prisons for up to 20 days and then they have to be detoxified. Compared with Slovenia, participants had a very good impression of the programme with the exception of the waiting list and the absence of substitution treatment in prisons. The programme puts much emphasis on family therapy. The facility is very simple made out of office containers, but can be easily built and is functional. In Serbia, buprenorphine detoxification and maintenance therapy are not financed by the state, but there is an initiative to cover the costs for 600 patients on buprenorphine by health insurance.

KETHEA – Anadysi Non Residential Therapeutic Programme for Adolescents

This is a non-residential facility for adolescents. 18 people per year undergo long-term family systemic therapy, which analyses the relationship between members of the family. The facility provides many activities, including group sessions, individual counselling and family therapy with parents. Other activities include basketball and music. Parental consent is needed. Most of the clients are cannabis smokers. In the past year, approximately 60% came due to pressure from their parents and approximately 20-25% from the criminal justice system (CJS). A form is used, where a person can point out the state that they are feeling in

[2] This is not provided in certain countries of the region, including Macedonia

the first instance as an easy way in which to explain their emotions and are then asked to elaborate on those feelings. Individual plans are then drawn up by staff, used and followed. The aim is to change behaviour and facilitate communication between the drug user and their family. Indeed, parents who do not understand each other could be a factor leading to their child engaging in addictive behaviour. The main challenge is for the counsellor to negotiate with the parents to change their personal lifestyle. This is because the parents do not seem to understand that their lifestyle may be related to their child's drug use. They often see it as an external problem and therefore not their responsibility. The goal is to change the adolescents' behaviour and to get them to have another attitude to personal use, by helping them to identify the trigger for their drug using behaviour.

Participants found that the insistence on self-awareness was impressive. Clients are required to consider their feelings, emotions and thoughts in relationship with others and themselves. The two-phase programme takes approximately 1 year to complete. The first phase lasts for approximately 1-2 months, during which the client comes twice a week. After this, they start another 9 months, where they begin group sessions. The approach is systemic and does not focus on drug use but the relationships between the people who are involved, such as the client and their parents. It is a drug free programme with no medication used. The building is owned by KETHEA and participants felt that it was a very well equipped place for adolescents. The main difference between Greece and other countries in the region is that public funding is not provided in other countries which affect the stability of their programmes. Parents sometimes force their children to join the treatment.

KETHEA – Family Support Unit

This programme started less than 10 years ago. Before that, it acted as a self-help group for families. It currently consists of 3 phases. One activity involves parents and family members who are not involved in the work of the organisation in general. The second activity is meant for family members who are undergoing the therapy, which is the main work of the programme. The last activity is more open and provides seminars for every citizen living in Thessaloniki. The main activity involves meetings every second week. Clients meet regularly for at least one year, but the treatment can continue if necessary. People can also drop out and start again later on. Clients sign a contract which defines the most important issues for them, the organisation and the parents. Currently, there are 170 members engaged in this work. The programme meets with approximately 500-600 families per year. Each group consists of approximately 17-20 people at each stage and professional assistance is offered.

KETHEA – National Telephone Helpline 1145

The national telephone helpline started in 2000 and provides a service to drug users, their relatives and friends. It is open from 9 am to 9 pm from Monday to Friday. There is currently 3 staff and last year, they received approximately 3,000 calls. The majority of calls are from mothers, fathers, partners or wives. There are fewer calls from the drug users themselves. The calls are confidential and anonymous. However, the caller is given a unique identification number in case they want to call again without having to provide all their basic information again. Basic details, such as gender and age, are recorded for monitoring and evaluation purposes only. Information is only recorded if the caller provides it and is not asked for by staff. It is not possible for callers to meet with the staff face to face although this is often requested. If callers would like further assistance, then they are referred to suitable programmes including those in KETHEA. The participants felt that the work was difficult for the staff that worked for long periods alone, and were concerned about the lack of supervision provided to staff members often dealing with very difficult emotional issues.

KETHEA – Special Programme for Addicted Parents and their Children (Non-Residential)

This programme was established 10 years ago, in 2001. Its main objective is to strengthen the relationship between a mother and her child, and the woman's role as a parent. Women who do not have children can be included in the programme but the criterion is that they work during the morning time. If they do not have work, they are sent to the therapeutic community. There are 3 phases to the programme: counselling, therapy and follow up support. The 1st phase consists of counselling for 3 months. There are approximately 3 sessions a week for 4 hours. This is the phase during which people drop out the most. The 2nd phase consists of a supporting group for 6 months and then there is a re-entry group for another 6 months. There is a special group which includes ex-prisoners, relapse, prevention and parents. They sign an agreement in which they are not allowed to use alcohol or drugs, and to be outside home after midnight. Once every two weeks, they undergo a urine test. The whole therapy phase lasts one year and after this, there is follow up which lasts 6 months. They have to visit the programme twice a week and, after 2 months, once a week. During the follow up phase, they have to visit the centre once a month. There is also a hidden garden (from other service users) exclusively for the use of children who can stay there with the staff. Members of the group have to stay in touch every day. Currently, there are 11 people in the counselling and 15 in therapy. 1 in 3 are considered to be successful cases. Different techniques are used, such as theatre and drama. Most service users are single or divorced women.

KETHEA – Counselling Centres for Imprisoned Drug Addicts in Northern Greece

Participants spoke with two staff members. Psychosocial support is provided in a preface stage, which is followed by two further stages. The preface stage lasts for 1 month and includes 4 meetings with the client during which they are provided with information about the programme and are encouraged to enrol. The 2nd and 3rd phases last 6 and 3 months. There are approximately 12-15 people at a time. The aim of the 1st phase is to learn about the programmes, how to help each other and how to listen to each other. During the 2nd phase, each client has to write essays about the 1st phase such as about how they are feeling and how they would describe the programme. Every group nominates one president responsible for ensuring that everyone else follows the rules. There are 3 important rules:

1. The use of drugs is forbidden
2. Violence is forbidden
3. What you hear in the group cannot be spoken about outside the group.

Breaking the rules results in exclusion from the group. The aim of the 2nd phase is to build self-capacity and encourage patients to speak freely about their feelings. It is a step-by-step approach to prepare them for their future release from prison. The aim of the last phase is to change their behaviour and lifestyle. During that phase, there is the possibility to leave the prison for a couple of days. However, it is obligatory for them to call or visit KETHEA in Thessaloniki at least once. Every group is facilitated by one of the therapists, for example, a psychologist or social worker. At the end of the 2nd phase, they have to complete a project which involves planning what is going to happen after release from prison. In KETHEA programmes, there are approximately 1,500 prisoners throughout Northern Greece, 70% of whom were imprisoned for crimes correlating with drugs. Residents in prisons are aged between 22 and 50 years old. In Greek criminal law, there is a possibility for prisoners to work – one day of work in prison counts as 2 days of their prison sentence. The whole programme is anonymous and open for all. However, it is predominantly provided in Greek, although there is an Albanian Group who is provided the service in Albanian language.

Participants noted that in FYR Macedonia, Bosnia and Herzegovina and Montenegro, harm reduction services are free of charge, but are also anonymous and confidential. The crucial

issue in Greece is the health of prisoners because they are not offered any health services. Recently, the Ministry of Justice has offered to provide these services. KETHEA is only involved in running the counselling part of the service, while the medical part falls within the remit of the government.

This was compared with Montenegro, where prisoners benefit from hospitals and healthcare services. However, the treatment available is far below international standards. There may officially be a prison doctor but this is often more of a token gesture to enable the door of the prison hospital to remain open and the prison doctor would not provide the necessary treatment. Other specialists will only come when a prisoner has been given an appointment, and are they are therefore not available to treat every prisoner. Medical services in prisons which do not meet needs and expectations are an open issue.

After the reports of the visits from the participants, OKANA and KETHEA commented on these presentations and provided the background, philosophy and methodology of their work.

OKANA

The first units of OKANA were established in 1996, one in Thessaloniki and one in Athens. There are now 25 units throughout Greece. Half of them are located in Athens and Thessaloniki and the other half are dispersed throughout Greece. There are currently 5,200 patients undergoing substitution treatment and equally as many on the waiting list. 2,100 patients are using methadone and 3,100 are on buprenorphine. The waiting list fluctuates from several months for some units in the province to up to 6 years in Athens. This situation will hopefully improve after the Parliament takes new measures this year. The political view in Greece was that substitution treatment would be delivered only by specialised centres such as the ones the participants visited. The substitution treatment offered is of higher quality than in other countries. The political decision of rendering substitution treatment only to specialised centres has been an important factor contributing to the slow increase of substitution treatment services in Greece. There are 3 types of therapy:

1. **Medication** – OKANA has been the only organisation providing methadone treatment since 2002. Buprenorphine treatment and a mixture of naloxone and buprenorphine are also available.
2. **Psychosocial treatment** – Phychosocial treatment is used in every OKANA programme but because they are all open programmes (where people come to collect their substitution treatment and then leave), it cannot be controlled and therefore cannot reach the level of residential or drug free programmes.
3. **Healthcare services** – each unit has one pathologist. Every user that enters the programme has a full medical screening (especially for HIV, hepatitis and tuberculosis). Training is provided in every centre.

Substitution treatment in Greece started as an abstinence-driven programme with a specific limited time target of 2 years, the goal being that, by the end of this two year period, full abstinence including from the substitution drug would have been achieved by clients. After the first couple of years of implementation of the programme, the first evaluation was conducted by an external committee. The results showed that only a small percentage of patients, approximately 10%, were able to achieve full abstinence from all drugs. 30-40% of the patients were excluded from the survey because they had dropped out from the programme. The remaining 50-60% had significantly reduced their drug use, their health and social behaviour had improved and they were not engaging in criminal activities. This led to a change of philosophy for the programmes, where the goal of abstinence was aggregated with that of harm reduction. It was then acknowledged that whereas some people would be able to achieve abstinence quickly, others might take longer to achieve it, and other may

never be able to. It was also acknowledged that the patients should have a freedom of choice in their treatment. Every evidence-based treatment should be made available, and users should be able to choose the one most suitable for them. However, this does not mean that the users will always make the correct choice for them. OKANA wishes patients to have the choice but will help and guide them to make the right choice without taking away their freedom of choice. They have the choice of entering two different types of programmes, both through substitution treatment – one has the higher expectancy goal of abstinence whilst the other has the possibility of following a drug free programme after the substitution treatment is over. Although OKANA offers drug free treatment, the main institute that provides drug free programme is KETHEA. There are two other psychiatric units in hospitals, one in Thessaloniki and one in Athens. KETHEA is keen to establish a strong collaboration with them. The two main issues are the long waiting lists to attend treatment programmes, and there being no methadone treatment in prison. On that second point, the Ministry of Justice has recently decided to start two methadone treatment pilot programmes in prison, one in Athens and one in Patras in addition to the drug free programmes that KETHEA already provides.

KETHEA

KETHEA then commented on the participants' reports of their visits and presented KETHEA. For almost a decade, between 1983 and 1994, KETHEA operated as the only organisation providing drug dependence treatment. The first methadone substitution programme provided within the framework of the new government policy (OKANA) only began in 1996. Today, there are 25 methadone substitution treatments of which OKANA have 22 in addition to 5 drug free units. There are also 3 drug free programmes run by the national mental health system (NMHS). There is one residential centre in Thessaloniki and 107 KETHEA units are organised in 18 multi–phase programmes. Currently, there is no private treatment or prescriptions available through general practitioners (GPs). Approximately 5,000 clients per year enter treatment in KETHEA units, and an additional 6,000 integrate family programmes, while 2,000 receive counselling in prisons. Evaluation studies have only been done for drug free programmes.

In the KETHEA services network, there are 22 counselling induction centres, 5 residential therapeutic communities, 10 open care therapeutic communities, 18 rehabilitation centres, 20 family programmes, 9 prisons programmes in terms of counselling, a harm reduction centre in Athens, 3 vocational training centres, 3 dental clinics, and 2 therapeutic communities in prison. The prevention department in Athens operates mainly through programmes in schools whilst the training institute provides basic training for professionals. The main characteristics of the typical client are the following:

- Dropped out of school at around 14 years of age First use of illicit drugs approximately one year later(often cannabis)
- Main substance use starting at around 19 years old
- Became drug free after seeking treatment approximately 8 to 9 years later.

KETHEA's multi-phase programme is based on the trans-theoretical model of change. This includes pre-contemplation (reducing abuse's negative effects), contemplation (increasing motivation and readiness), decision (preparation for change), action (change behaviour) and maintenance (relapse prevention). The main idea is to fit the services provided to the needs of the client. There is also a continuum of care where another form of intervention is provided to the client. A needs-assessment is done to decide what kind of care should be given to the client, starting from less intensive to more comprehensive treatment.

KETHEA together with the School of Law of the Aristotle University of Thessaloniki and the department of the University of California, San Diego, run a one year graduate programme under the title "Forensic Addictions Corrections Treatment" (FACT). As part of this, a summer course in English with translation in Greek will take place in Thessaloniki from 27th June to 1st

July 2011. The course is especially designed for people who work with dependent drug users in prisons. At the end of the programme a certificate will be provided to the participants by KETHEA. Applications for scholarships should be directed to the department of Education of KETHEA, e-mail: education@kethea.gr.

Discussion

It was suggested that the public health approach should consist in getting more people into treatment as Greece seemed to have a high quality service but for a limited number of people. The question of evaluation was raised and how Greece was able to prove that their services were of a high quality. For example, whether it was possible for them to determine how many drug users had suffered, or died from an overdose? However, Greece has not yet carried out any evaluations. It was pointed out though that the KETHEA and OKANA drug free programmes do not have a waiting list. Therefore, if somebody wishes to receive treatment, they can enter a drug free programme. It was recognised that there is a significant problem with waiting lists for substitution programmes and that more units are required to reach all the people who need treatment. The political decision stating that only specialised centres would deliver substitution treatment has limited the creation of new units. Currently in Greece, 15 to 20% of problematic drug users are in substitution therapy with another 15% on the waiting list. According to the European average, 50 to 60% of drug users should be able to access therapeutic programmes – Greece has therefore a long way to go to be able to provide treatment to sufficient numbers of users. For those people who cannot access drug dependence treatment, harm reduction services, including needle and syringe programmes (NSPs) have been developed, but need to be scaled up to meet the needs of drug users.

There are approximately 10,000 drug users with no access to any kind of treatment. The main problem is how to provide them with basic services. It was suggested that Greece could develop a nationwide networking approach where every treatment programmes available would work more collaboratively together. Another suggestion was to gain a better understanding of public health approaches to drug use. The economic crisis in Greece has proved to be a challenge. It was suggested that Greece could carry out a cost-benefit analysis for treatment to provide evidence that it is cost-effective. This is because the cost of treatment is lower than the cost of dealing with problems such as drug-related deaths, HIV treatment and drug-related crime. No such cost effectiveness studies have yet been conducted in Greece, but it was recognised that a significant amount of money has been spent on police activities.

However, there is overwhelming evidence that proves the effectiveness of harm reduction measures. However, although governments may be aware of the evidence, the main issue is that of translating this evidence into a political decision, and that this can be a time consuming process, often taking many years to realise. This South East Europe Drug Policy Network is an opportunity to influence the political process.

The issue of politicians not being interested in dealing with the issues related to drug users and prisoners was raised. This is the case, for example, in Montenegro. It was suggested that organisations working in the drugs field should not be defined by the political decisions made in their countries and that is important for them to also recognise their responsibility for dealing with issues related to drug users. This is because organisations working on the ground, through better collaboration, could possibly have a greater impact on influencing policy than politicians.

Saturday 5 March 2011

The organisational structure of the Network

The conclusions of the Working Group meeting (3 March 2011) were presented to the Network members. The Working Group was established in Athens last year and includes representatives of all the countries represented in the Network. The civil servants are not part of the Network, as far as the organisational structure is concerned. Only NGOs can be part of the initiative, but civil servants and policy makers will continue to be invited to attend Network meetings, as their advice is appreciated and the Network is keen to maintain a good collaboration with them. The work plan for the Network was discussed in Athens in 2010 and the majority of what was planned has already been accomplished.

The network had planned to produce two briefing papers of which one on harm reduction has already been published on the IDPC website (http://idpc.net/publications/idpc-paper-harm-reduction-south-east-europe). The issue of how useful publications were and how they could be used more effectively to influence drug policy was discussed. It was suggested that the Network needed to use the publications to engage in dialogue with their contacts in government. The publications can be used to influence governments in the region as they provide evidence that it is not just one country but that there are several countries who are thinking in the same way. The Network needs to consider how the use of publications to influence policy can be implemented in practice.

The plan to visit Bosnia-Herzegovina, Montenegro and Slovenia was implemented. These visits were considered to be successful by those involved and provided the Network with the opportunity to share experiences between organisations. However, it could possibly be organised differently in the future to ensure the possibility for participation from each country represented in the Network.

The issue of Network membership was also discussed. The idea is to think about each country without being limited to organisations based in the capitals. Members need to provide suggestions as to how to expand the Network in their own countries. Three policy seminars have been held, the first was in Athens[3], the second in Ohrid[4] and this constitutes the third. Further seminars will need to be planned in the future.

The problem of funding was also raised. The Network's current funding is through a grant awarded by the European Commission to IDPC. It is important that the Network finds a way to function autonomously. Discussions with the IDPC Secretariat and Diogenis will need to be held.

It was decided by the Working Group not to make the Network a formal organisation at this time. The model of the South Eastern European-Adriatic Addiction Treatment Network (SEEAnet) was explained by their President. According to European legislation, it is not possible to register a network internationally and can only be officially registered as a legal entity in one country. SEEAnet was registered in Slovenia and has an elected president and a board of directors. It was decided that the SEE Network would follow this model with Diogenis being the lead agency with an advisory board made up from members of the Working Group to act as the managing body. The following five people agreed to be on the board:

1. Andrej Kastelic, SEEAnet, Slovenia
2. Elena Yankova, Initiative for Health Foundation, Bulgaria

[3] For more information, see: http://idpc.net/publications/report-see-meeting-athens-march-2010
[4] For more information, see: http://idpc.net/publications/south-east-europe-network-meeting-ohrid

3. Genci Mucollari, Aksion Plus, Albania
4. Tijana Pavicevic, Juventas,Montenegro
5. Thanasis Apostolou, Diogenis, Greece

The members of the Network present were asked if they had any objections to this decision and none were raised.

The issue of how to secure the financial means to organise Network activities was discussed and the Network's vision, mission and policy principles were agreed upon. The vision, mission and policy principles will be distributed among the members of the Network for their comments before they are finalised.

It was suggested that the Network needed a website but it was recognised that this would require someone regularly working on it and that the Network does not have the financial means to employ anyone at this stage. The Network was informed that the advisory board would share the work load for the time being.

IDPC Update

A short introduction was given by the IDPC Secretariat and the changes that will be taking place.

Governance update: IDPC is going through a transition period. IDPC was set up in 2007 and for the past 4 years, the Consortium has remained 'informal' – this means that IDPC has not been a legal entity in its own right. The secretariat of IDPC has been hosted for the past three years at Release in the UK. The Consortium has now reached a level of maturity that has allowed it to become an independent and separate legal entity.

The secretariat is currently managing the transitional process and it is expected that by the 1st April 2011, IDPC will be operating as an independent UK-based charity, with three staff at the secretariat, and a number of consultants around the world. This change will not affect IDPC's relationship to its members or to the regional networks.

Work plan process: The secretariat is currently collating the regional work plans to present to the IDPC Steering Group at their annual face-to-face meeting in Vienna at the end of March. On the basis of these work plans, the Steering Group will decide how to allocate the IDPC resources available across the various regions and thematic areas for the coming financial year. Given the limited availability of the resources, it is unlikely that IDPC will be able to fund all the activities envisioned and there may also need to be fundraising efforts within the regions to cover certain activities.

In terms of work plan, the regional network needs to think about its priorities under three headings:

- Networking and communications: how to expand the network and identify new IDPC members; how to stay in contact with each other; how to use the IDPC website and alerts.
- Publications: what briefing papers or advocacy notes do you want to produce from the region?
- Advocacy: in which countries does the network want to try to influence national policy; and on what subjects – for example, drug strategy development, drug law reform, treatment, law enforcement strategy, prisons.

Introduction by Diogenis

The Diogenis Association has chosen the name of an ancient Greek philosopher as its distinctive title. The full name of the Association is: “Association Diogenis: Initiative for Drug Policy Dialogue in South East Europe”. Diogenis was a Greek philosopher who emigrated from the city of Sinopi (at the Black Sea) to Athens. He was not afraid to challenge the establishment when he saw the situation there such as the plight of the slaves. He is well-known for walking around in the streets of Athens with a lamp, looking for a true man!

Diogenis has been registered as an organisation under Greek civil law. Diogenis is one of the members of the SEE Network but as the current lead organisation is keen to move the Network forward and maintain good collaboration between the organisations in the region.

There are currently two IDPC partner members from the South East European Region. SEEAnet is one and was one of 10 founding members of IDPC. The Andreas Papandreou Foundation (APF) was the other one but with their consent, Diogenis has taken their place as a partner member. This has been announced in the IDPC January 2011 Alert.

IDPC is overseen by a Steering Group made up of eleven representatives from partner members who play an active role in the work of IDPC. Thanasis Apostolou has been appointed twice as a steering group member but has decided not to continue. Andrej Kastelic has agreed to become an IDPC steering group member to represent South East Europe which will take effect after the last steering group meeting of the financial year which will take place in Vienna at the end of March. The Network members were asked if there were any objections to this and none were raised.

Ideas and proposals for the strategy and action plan of the Network for 2011-2012

The participants divided into two working groups to discuss the following topics:

- Relevant issues in the area of treatment and harm reduction (seminars, workshops, study visits, research)
- Advocacy work: Which issues in which countries are in discussion at the moment and how to support proposals for drug policy reform?
- Drug law developments in the SEE countries and NGO involvement.
- Harm reduction and National legislation (actions, research, dialogue with the authorities), other relevant areas.
- Representatives from each group presented back to the network what had been discussed and the conclusions that had been reached.

Relevant issues in the area of treatment and harm reduction

It was suggested that policy could be influenced through advocacy more effectively as a network. The Working Group included country representatives from FYR Macedonia, Serbia, Montenegro, Bosnia and Herzegovina Albania and Greece.

In Albania, there is a new strategy on drugs being developed and UNODC and WHO are in the process of facilitating communication. The UNODC has facilitated two working group meetings to discuss the development of a new National Drug Strategy, promoting harm reduction as one of its pillars. Professor Thomas Babor from the USA, Massachusetts led one of these sessions at the last meeting of the working group. Opiate substitution treatment (OST) is expanding in the country with support from the Ministry of Health. However, there are no guidelines for methadone at an official level yet. The regulations for cannabis are stringent and if someone is found with one joint, it can lead to imprisonment for 2 years. Reducing penalties for non-violent cannabis users could be an advocacy topic.

In FYR Macedonia, the Ministry of Health funds NSPs which have been included in the

national budget. Approximately 30,000 syringes and 50,000 condoms have been provided. There is an emerging problem with Amphetamine-type Stimulants (ATS).

In Montenegro, the first law on drugs will be adopted in the near future. There is a need for a national substitution treatment programme and preventing mother-to-child transmission (PMTCT) treatment protocols to avoid future cases with pregnant mothers using drugs being denied treatment. There is also the problem of harm reduction services not being available in prisons. The introduction of buprenorphine treatment could provide the Network with the opportunity to influence political processes including international advocacy. For example, Montenegro has started negotiations for EU accession.

In Bosnia-Herzegovina, all harm reduction programmes are financed by the Global Fund. Buprenorphine and methadone are both available for treatment. The Republica Srpska is developing a new drug strategy. Treatment in prisons is an issue.

In Greece, a new law on drugs will introduce smaller penalties for drug users and ensure that drug services are provided in prisons. The process is ongoing (see also the paragraph below on changes in the Greek penal law in this report).

In Romania, the main issue is the appearance of new drugs. Further information can be found in: http://www.harm-reduction.org/news/2046-romania-new-drugs-an-old-problem.html

In Slovenia, the advocacy goal is to open safe injection rooms. More substitution treatment needs to be promoted. Alternatives to imprisonment could be another advocacy topic for the whole region.

In Serbia, the HIV/AIDS Strategy was adopted in 2005, and the National Strategy to fight drugs (2009-2013) was adopted in 2009. The law on drugs was adopted in December 2010 and a second law is being developed on drug dependence prevention, treatment and rehabilitation. State health insurance covers HIV/AIDS treatment and substitution treatment. The Global Fund is the main supporter of harm reduction services like NSPs, condom distribution etc. A network of NSPs in the capital and all bigger cities has been developed since 2004.

In conclusion, regional problems are:

- The lack of availability of drug services in prisons (Bosnia-Herzegovina, Montenegro, Greece and probably other countries as well).
- In the countries supported financially by the Global Fund, there is no public funding for harm reduction services with the exception of FYR Macedonia (but the amount is not considerable).
- Underage clients do not have access to needle exchange and OST services due to parental consent requirements. It was suggested that adolescents should be put on the agenda of the next meeting.
- Alternatives to imprisonment are not implemented in most of the SEE countries.
- New drugs are an upcoming issue. The new drugs phenomenon is already affecting EU countries in the region such as Hungary, Romania and Bulgaria and is expected to enter other Balkan countries.
- OST treatment is still hard to access and the coverage is low throughout the region.

Further to the above mentioned advocacy issues, the following suggestions for the Network strategy and action plan were made:

- Explore the possibilities of the action plan between the EU and the Western Balkans adopted in 2003 to undertake activities as NGOs in collaboration with the countries in the region. The active implementation of this action plan could provide an opportunity to strengthen cooperation between countries in the region.

- Explore the opportunity to be supported by the European Commission. The EU member states of the region (Bulgaria, Greece, Romania and Slovenia) may facilitate this. Slovenia, present at the meeting expressed its willingness to support this idea
- Submit a proposal to the European Commission for funding.
- Develop a relationship with the Head of the Unit – Coordination of Anti-Drugs Policy for the European Commission
- Source other avenues of funding with the aim of becoming financially more independent.
- Gather all the current legislation in the countries in the SEE region. For example, the law in Slovenia has already been translated into English and other countries have also made translations of their laws.
- Strengthen collaborations with other countries in order to gain more support to have a greater impact on influencing policy and legislation.
- Build on partnerships with other Networks.

It was decided that the advisory board will make a concrete proposal for a work plan for 2011-2012 taking into account the proposals made by the participants. The proposals will be sent to the members of the Network to comment on. If members are not in agreement, then further discussions would take place.

Information about developments in the Greek Penal Law

Greek penalties for drug use are very heavy. Aggravated penalties carry a minimum of 10 years although there are mitigating circumstances. In the Greek Criminal Justice System, drug dependency is considered as a mitigating circumstance and can result in the person being given special care inside the prison or the choice of alternative measures.

A person now has the right to receive care inside the prison, whether or not they have been deemed to be drug dependent before the court. If a person declares that they are dependent on drugs after sentencing, they also have the right to receive care for somatic dependence which can be supported by substitution treatment. The goal is for them to receive alternative treatment outside of prison during their probation period, after having been supported in prison. The philosophy being this policy is that this form of treatment is more effective than the care given whilst inside prison.

These guidelines therefore address the issue of care for dependent drug users within the criminal justice system, and include recommendations for lower penalties and more support for alternative systems.

After release, alternative measures available are therapeutic communities (TCs) and substitution treatment. It is possible to be released before completing the whole sentence on the condition of probation – a sentence can be declared extinct as soon as either two-thirds or four-fifths of a sentence has been completed. If a dependent user goes to prison, they will receive care in prison but if they are given a supervision order, they can also receive care outside the prison facility. Therapeutic communities are paid by the government. Substitution treatment is not yet available inside prison. However, according to the new draft proposal, substitution treatment will be given as somatic care in addition to psychological support to enable the drug dependent to be prepared when released from prison. If the crime is for personal use (such as cultivation of pots of cannabis), then the person will not go to prison. The current legislation provides a very high penalty for supply with a minimum of 10 years. In the whole of Greece, approximately 50% of prisoners are incarcerated for supply. The price of drugs is very high and prisons are overcrowded by suppliers. The Ministry of Justice is responsible for the cost of prisons whilst the Ministry of Health is responsible for medical care inside prisons. This could prove to be beneficial when care programmes in prisons are to be developed as it may be easier to obtain funding from the Ministry of Health than the Ministry

of Justice as they are more likely to support them.

The law does not state the precise amount for possession of heroin or other drugs and it is at the discretion of the judge as to whether the amount found is considered to be for someone's own personal use or for supply. They will base their decision on witness accounts and any evidence that has been collected as it can sometimes be difficult to have a clear diagnosis for drug dependence. When a person privately meets a doctor, they are more likely to tell the truth about their condition. However, if a person is asked whether they are a drug dependent before sentencing knowing that they will receive a lower penalty if they say they are, they are more likely to admit to being one. It is therefore not always effective to ascertain whether a person is a dependent user before entering the criminal justice system. The opportunity for a person to declare that they are a drug dependent after sentencing is more effective as it allows more time for medical professionals, such as prison doctors, to determine whether or not someone is dependent. There are 3 kinds of penalties: up to one year for personal use; between 10 and 20 years for supply in regular cases; and life sentence for supplying large amounts. Furthermore, judges did not use the option of care or alternative measures because of the difficulties with diagnosis. The issue of overcrowded prisons was one of the reasons that have led to drug policy reform.

This aim of the reform is to introduce new criteria for the diagnosis of drug dependency through procedural measures and encourage alternative measures to be used. New penalties are higher but more flexible. For example, the penalty for supply is no longer 10 years, but 5 years and in some cases even less. Substitution treatment is effective but the dependent drug user is not psychologically supported. There is currently no formal evaluation as to what the effects are from an adopted law. In Greece, there are limited statistics and information is often only available after 2-3 years.

The 54th Session of the Commission on Narcotic Drugs on 21-25 March 2011

Information was provided regarding the 54th session of the CND. The CND is the governing body which takes decisions on drugs legislation at the UN level. The United Nations (UN) office dealing with the drugs issue is the United Nations Office on Drugs and Crime (UNODC). The CND gathers every year for a week, during which country delegates meet to discuss their drug policy and evaluate their plan of action for the coming year. This year, the CND is taking place from 21st to 25th March 2011. Three members of the Network will participate to the meeting.

This year, the thematic debates at the CND will be organised around three round table discussions rather than the usual Plenary session. Several NGOs are also planning to organise informal side events on topics related to drug policy. IDPC is organising several side events in cooperation with other IDPC members. NGOs are also allowed to formally participate to discussions, but this right is very limited. The Vienna NGO Committee on Drugs (VNGOC) is recognised as a partner in this arena and provides a platform for NGOs to contribute to the international drug policy discussions by giving NGOs the opportunity to speak.

The main purpose of the CND is to assess whether progress has been made with the objectives that had been set the previous year. The UNODC Executive Director usually begins the meeting with a speech summarising the trends in drug policy for the past year. The UN position tends to be one of conciliation between the different Member States. The International Narcotics Control Board (INCB) is the body that oversees the implementation of the international drug control conventions. It is its responsibility to ensure that countries implement the conventions correctly. In the past, the INCB has been shown to be overly conservative with regards to the implementation of the conventions.

One issue that may cause some discussion during this year's session is the issue of coca chewing for traditional purposes. 17 countries have opposed a proposal from Bolivia to change the 1961 Single Convention on Narcotic Drugs on this point. The objecting countries are afraid that, if the change occurred, the integrity of the conventions, and the international drug control convention as a whole, would be in danger of breaking apart.

New European Union (EU) Strategy on drugs and NGO consultation

The EU Drug Strategy approved by the European Council in 2004 will come to an end in 2012. This year, a new strategy is being prepared. The Horizontal Working Party on Drugs (HDG), which is represented by countries from the EU, meets on a monthly basis to prepare the new EU Drugs Strategy and Action Plan. The issue of trafficking cocaine, via Africa to Europe is one of the biggest problems at the moment. Heroin routes are being replaced by cocaine routes and cocaine is being shipped from Latin America to Europe. Other issues include drugs and the criminal justice (current penal laws and the emergence of new drugs). The strategy will address ways in which these issues can be dealt with. Health is going to be a prominent element in the new strategy. The Civil Society Forum is a platform promoting civil society engagement at the EU level. The Network could use this forum as an opportunity to influence the EU drug policy. There is also the possibility for individual organisations to write a reaction on the EU draft proposal for the new drug strategy.

Other networks and initiatives of interest

The Correlation Network, a Europe-wide network working on drug policy, is organising a conference on 9-11 November 2011 in Slovenia. Network members have been invited by the Correlation Coordinator. The conference will address specific issues on outreach, internet, electronic, peer support and policy recommendation on Hepatitis C. Further information can be found on the Correlation website (www.correlation-net.org). It was also suggested that the Correlation Coordinator should be invited to present the activities of the Correlation Network at a SEE Network meeting in order to further build a good relationship with them.

The Eurasian Harm Reduction Network (EHRN, www.harm-reduction.org) has produced a report on the cost of current drug control systems in four countries. The objective of the report is to compare these costs with those that may be saved through alternative strategies (e.g. HIV treatment versus opiates, NSPs, probation). EHRN has embarked on a global campaign, 'Count the Costs' (www.countthecosts.org) in collaboration with Transform (www.tdpf.org.uk) and a number of other organisations, using media tools to present ideas to politicians and engage the public in the drug policy debate, and are in the process of building a database of evidence-based interventions to present to the UN.

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