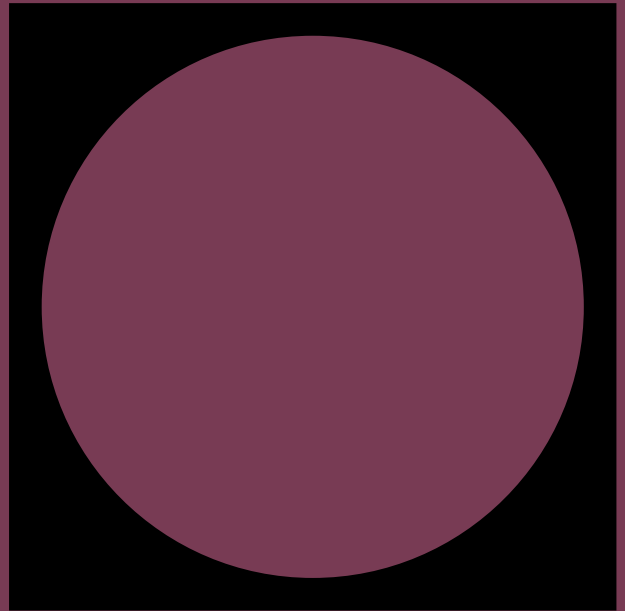


HARM REDUCTION SERVICES IN SWITZERLAND



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OVERVIEW

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This update to the Western Europe chapter of the Global State of Harm Reduction 2022 focuses on harm reduction services for young people in Switzerland.

INTRODUCTION

Countries in Western Europe were among the first to adopt harm reduction services. This long tradition puts harm reduction in a favourable position, both in terms of policy inclusion and funding, compared to other regions around the globe. Core harm reduction services, including needle and syringe programmes (NSP) and opioid agonist therapy (OAT), are available in most Western European countries. However, according to the latest available data, only Luxembourg, Norway, and Spain meet the World Health Organization (WHO) 2020 targets for Hepatitis C elimination of providing at least 200 syringes per person who injects drugs per year and having 40% of the population of opioid users on OAT.¹⁻³ In Western Europe, one of the most prevalent barriers to accessing harm reduction services in general, is uneven distribution of services within countries. People who use drugs living in rural areas are particularly underserved in many countries across the region. This is a problem, for example, in Belgium, Germany, Ireland, Italy, Portugal, Scotland, Spain, Sweden, Switzerland, and the United Kingdom.⁴⁻¹⁵ Unfortunately, there were no changes in this regard since our 2020 report.

The number of countries in Western Europe in which NSPs operate remains unchanged since the Global State of Harm Reduction 2020, with services available in 20 countries: all countries in the region except Turkey (and no data on Andorra, Liechtenstein, Monaco, and San Marino). Although

the first months of the COVID-19 pandemic brought serious disruption to harm reduction services in the region, most countries in Western Europe were able to maintain NSP services during COVID-19.¹⁶ Between 2019 and 2020, in relation to the COVID-19 measures introduced, the number of syringes distributed fell by more than 10% in five countries (Greece, Ireland, Malta, Portugal, and the United Kingdom), while there was a slight increase in Austria, Norway, and Sweden, and no change in other countries in the region.^{5,14,17}

However, COVID-19-related disruptions in harm reduction services had adverse effects on the health of people who use drugs. Pandemic-related restrictions reduced outreach activities and low threshold harm reduction service capacities in general, leading to reduced HIV and hepatitis C testing availability in the region.^{1,8,13,18,19} User groups providing peer-to-peer NSP and outreach services were essential in bridging the gap in harm reduction service coverage during COVID-19.⁵

Though COVID-19 still affects harm reduction services, in 2021, some cities (Copenhagen, London, Paris, and Rome) reported that daily practices of harm reduction services were no longer affected by the pandemic and, overall, there were fewer reductions in service provision after 2020.¹³ Nevertheless, reduced opening hours and other limitations in NSPs' capacity reduced access to harm reduction commodities like syringes, and harm reduction services had to be adapted through

various means to counter COVID-19-related disruptions. For example, the expansion of peer-to-peer syringe distribution (with more peer-to-peer NSP services) or the implementation of mail delivery of injecting equipment in at least four countries (Austria, Belgium, Italy, and the United Kingdom).

4–6,8,15,20

HARM REDUCTION FOR OPIOID USE

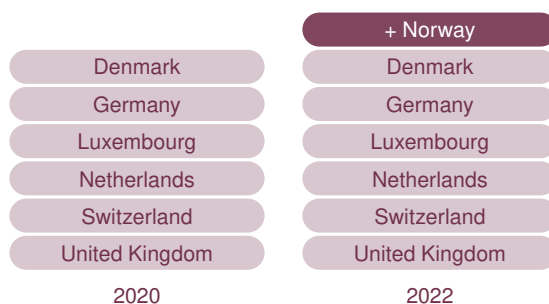


OAT is available in all countries in Western Europe, including Turkey.²¹ However, availability does not mean accessibility. There are various barriers to accessing OAT in the region. Inadequate access is evidenced in the United Kingdom by the fact that half of people who have died from opioid overdoses have not been in contact with treatment services. This lack of contact with the most vulnerable people who use opioids can be attributed to high barriers to accessing treatment, such as drug tests, daily or supervised pick up of OAT medicines, and mandatory group therapy.⁴ Similar barriers are reported in Italy, where overly rigid protocols and a lack of client involvement in discussing dosage and therapeutic goals hinder access.⁶ An important initiative would be increasing OAT access through low threshold, community-based programmes, and mobile outreach settings. For example, in Lisbon, a low threshold OAT programme run by Ares do Pinhal experienced a significant increase in the number of clients during the first months of COVID-19-related restrictions in 2020, providing access to OAT when other OAT services were not available.^{14,22}

Harm reduction services in prison settings are a good example of differences between availability and accessibility. Though OAT is available in prisons in most countries in Western Europe, there are serious barriers to access: there are more countries where it is not available in all prisons, and in some cases, it is not possible to initiate OAT while incarcerated. For example, in Portugal, OAT is available in 49 prisons, but initiation of OAT is only possible in four, thus OAT is predominantly only available to those who started OAT before incarceration.¹⁴ Similarly, in Italy, OAT is made available in all prisons but access is hindered for those who were not enrolled on OAT prior to incarceration.⁶ In Belgium, there are bureaucratic barriers to receiving OAT in prisons, as it requires a complex process that varies from prison to prison.¹⁵ NSP in prison settings is available in four countries in the region (Germany, Luxembourg, Spain, and Switzerland). However, accessibility is problematic: it is implemented in one of two prisons in Luxembourg, in one women's prison in Germany (a syringe-dispensing machine), in 15 prisons (accounting for one fifth of the prison population) in Switzerland, and in a decreasing number of facilities in Spain (47 in 2019).^{9–11,23–25} Switzerland is the only country where heroin assisted treatment (HAT) is available in prisons, though it is only available in one prison in the country.^{11,26}

The pandemic has shown that it is possible to operate OAT programs with less restrictions, greater autonomy, and increased user choice. OAT regulations were eased in many countries, and there was a substantial move towards take-home OAT in the region. For example, in the United Kingdom, most people were moved onto seven to 14 day

Heroin-assisted therapy (HAT) in Western Europe



prescriptions instead of daily or supervised pick-up of OAT medication, with the vast majority reporting improved treatment experience, feeling more trusted and more in control of their own treatment.^{4,5} There were similar experiences in Italy, Spain, and Switzerland.^{6,7,11,27}

HAT is available in seven countries – an increase since 2020 – with Norway joining the six countries where HAT has been previously available (Denmark, Germany, Luxembourg, the Netherlands, Switzerland, and the United Kingdom). The five-year pilot programme started in Bergen and Oslo in the first half of 2022, and is available for people who use opioids for whom other OAT medications were not appropriate.^{28–30} The programmes are open seven days a week, and clients can take heroin in injectable or tablet form with supervised dosing (a take-home policy will not be available). There were 40 patients enrolled in August 2022 (of whom at least 6 were women³¹) and this figure is expected to rise as the HAT programme's capacity increases.^{28–30,32} An evaluation of the HAT programme in the United Kingdom found a positive impact among programme participants, including increased engagement with psychosocial interventions, reductions in consumption of street heroin, reduction of risky injecting practices, improvements in secure housing, and reductions in the volume and cost of criminal behaviour.³³ Unfortunately, at the end of 2022, one of the two HAT programmes in the United Kingdom had to close because funding had run out.³⁴

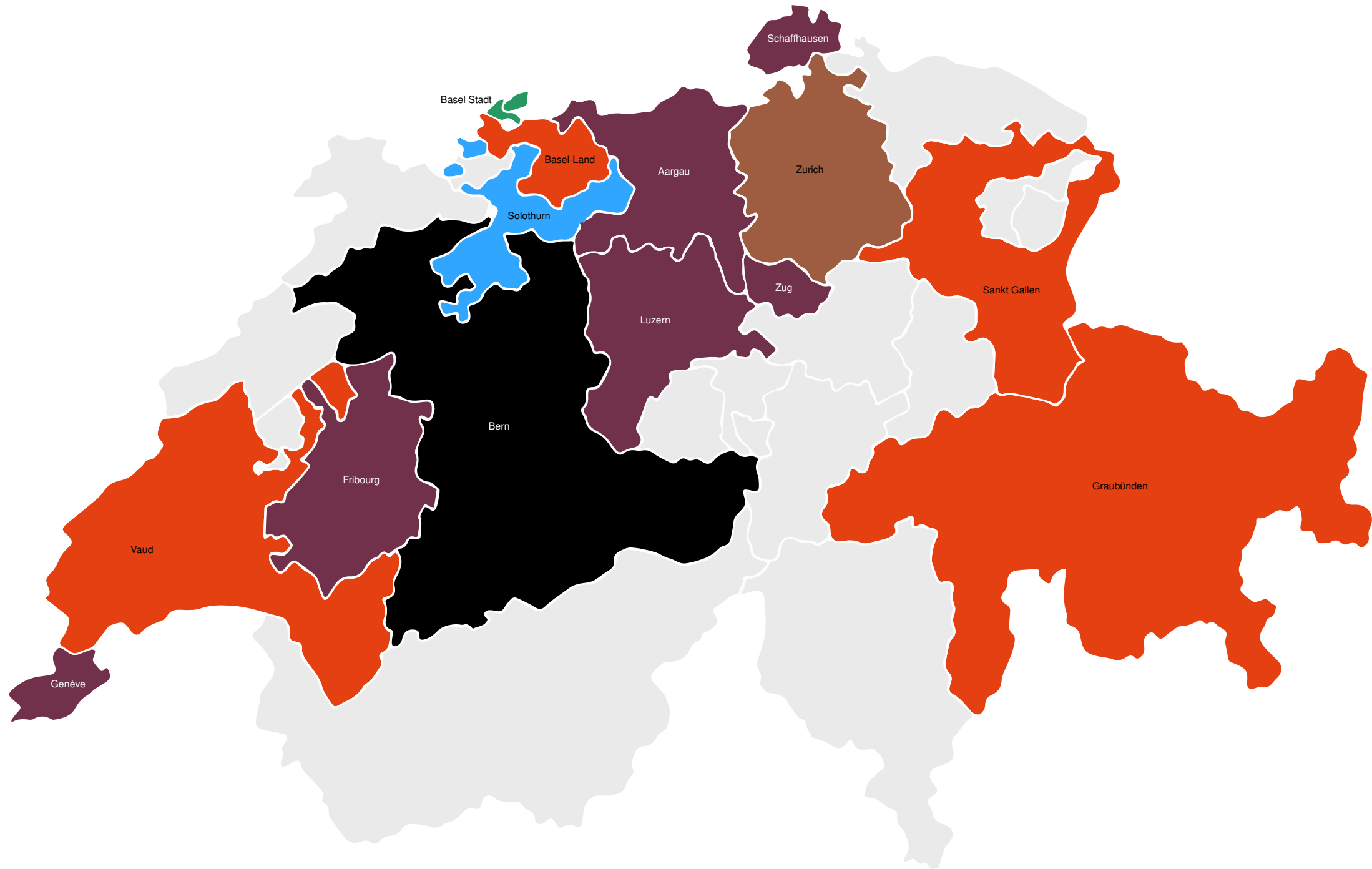
In Switzerland, where HAT was introduced in 1994, patients need to be older than 18, have at least two years' opioid dependence history, have failed at least two other treatment attempts, and exhibit negative mental, physical, or social consequences of drug use.³⁵ In 2021, HAT was available in 23 HAT centres in 15 Swiss cantons and 1,427 people had a valid HAT permit at the last data collection.²⁶ In general, HAT is offered in specialised outpatient centres, and clients attend daily for supervised dispensing and administration.³⁶ Geographical gaps are a barrier to access HAT, as the HAT centres are mainly located in big cities and urban areas and there are some cantons where it is not available.²⁶ As only 15 cantons were authorised to administer pharmaceutical heroin, nearly half of the 26 Swiss

cantons do not have an institution where HAT is available.

In response to the COVID-19 pandemic, the Swiss Federal Council expanded take-home HAT from a maximum of two days to dispensing four daily doses, or up to seven daily doses in certain cases.³⁶ A report on the expanded take-home HAT at an outpatient centre found the expansion beneficial: with the new rules, take-home HAT was expanded significantly with 45 new clients on top of the 19 who had been qualified previously, with many clients reporting improvement in their quality of life, gaining more freedom in organising their everyday life, and no overdose events having occurred.³⁶ Unfortunately, the expansion of take-home HAT was a temporary policy adjustment as a reaction to the pandemic, and professionals were concerned that the changes could be reversed.³⁶ However, as of October 2020, the Swiss Federal Council has been working on a revision of the HAT regulation in order to permanently implement most COVID-19-related temporary changes.³⁷ Furthermore, the revision would introduce dispensing outside of HAT centres (for example, in pharmacies, health and social care facilities, or prisons), so HAT clients would be able to access their HAT medication in a closer, more convenient location.³⁷

In Switzerland, nasal HAT has been considered as an alternative to injectable or oral pharmaceutical heroin, a suitable treatment option for patients who are unable to inject or primarily use nasal route of administration.³⁸ To explore the feasibility and acceptability of intranasal diacetylmorphine treatment, an observational comparative study started in 2020 in multiple centres in Switzerland.^{39,40} The first results are promising: the nasal HAT was well received by the clients, though for higher doses it might need to be supplemented with oral HAT because of the limited absorption capacity of the nasal mucosa.⁴⁰ Nasal HAT is an important initiative as injecting use is in decline: among first-time clients entering treatment in 2020 in the EU, Norway, and Turkey with heroin as their primary drug, only 22% reported injecting as their main route of administration, down from 35% in 2013.¹

DISTRIBUTION OF INSTITUTIONS ADMINISTERING HAT IN SWITZERLAND BY CANTON



- Number of institutions:
- One
 - Two
 - Three
 - Four
 - Five
 - Seven

HARM REDUCTION FOR STIMULANT AND NEW PSYCHOACTIVE SUBSTANCE USE

Stimulants are the second most commonly used substances after cannabis. It is estimated that in Europe in the last year, 3.5 million adults consumed cocaine, 2.6 million MDMA, and 2 million amphetamines, while heroin or other opioids were used by 1 million^a People who use stimulants should have adequate access to harm reduction services for stimulant use, such as safer smoking kits, drug consumption rooms or drug checking, and harm reduction programmes such as NSPs should provide services tailored for the specific needs of people who use stimulants.

Additionally, drug preferences among people who inject drugs are changing, and injection use of stimulants is on the rise. For example, injection of crack cocaine has increased in England and Wales, and injection of powder cocaine has increased in Scotland.⁴² Furthermore, poly and/or multi drug use among people who inject drugs is widespread, with stimulants playing a central role. An analysis of the residual content of used syringes published in 2022 found that 85% of syringes collected in Ireland contained both heroin and cocaine, and a quarter of the samples contained heroin, cocaine, and methamphetamine.⁴³ The syringes collected by the ESCAPE network of eight European cities (Amsterdam, Budapest, Cologne, Helsinki, Lausanne, Oslo, Paris, and Vilnius) in 2020-2021 showed a similar situation, with a third of all syringes containing two or more drugs, a mix of stimulant and opioid drugs being the most frequent combination.^{1,44} As stimulant injecting is associated with more frequent injecting, NSPs should consider adjusting their syringe distribution policies, allowing for a higher number of syringes while avoiding one-for-one needle exchange schemes.

Smoked cocaine use is on the rise across the region: treatment demand for smoked cocaine problems tripled from 2016 to 2020,¹ with increases reported

in Belgium, France, Ireland, Italy, Portugal, Spain, and the United Kingdom. Harm reduction services in Brussels, Copenhagen, Lisbon, Paris, parts of Ireland, and Italy have also reported significant increases in smoked cocaine use among clients.^{1,13,45} Distributing safer smoking kits is an intervention that can prevent the harms and risks associated with smoking from improvised or homemade pipes or pipe sharing, such as toxin inhalation from repurposed plastic bottles or tin cans, and lip cuts and burns leading to transmission risk of HIV, hepatitis C, and tuberculosis.⁴⁶ Safer smoking kit distribution is available in at least ten countries in the region: Austria, Belgium, France, Germany, Italy, the Netherlands, Portugal, Spain, Switzerland, and the United Kingdom.^{6,7,9-11,14,15,20,47} However, there might be a data gap in this area: compared to the number of NSPs or distributed syringes in a country, safe smoking kit distribution is not part of the routine drug monitoring activities in the region. Inadequate funding is the main barrier to implementation in Germany, Italy, Portugal, and Spain,^{6,7,9,14} and it is often a bottom-up initiative by harm reduction services. For example, in Portugal, some harm reduction teams distribute crack smoking equipment, but the national agency responsible for funding harm reduction programmes does not cover it and the organisations have to use other resources to buy them.¹⁴ In Italy, some harm reduction programmes started safer smoking kit distribution to respond to the increased need in the community, but they are not included among the harm reduction commodities paid for by the central public health budget.^[6] In the United Kingdom, it is illegal to distribute safer smoking kits under the current paraphernalia laws, the only exemption is aluminium foil, so it is the only harm reduction equipment that is distributed for smoking^{4,5,48}. This is a problem, because stimulant pipes are essential pieces of harm reduction equipment, both in engaging people who use stimulants with harm reduction services, and in reducing transmission risks for HIV, Hepatitis C, and tuberculosis. Despite current paraphernalia laws in the United Kingdom, a pilot safe inhalation pipe provision programme has started in the country

a Safer smoking kits may include metal filters, rubber mouthpieces, push sticks for cleaning pipes and collecting crack residue and heat-resistant glass pipes, and they can also include items like alcohol wipes and hand wipes.

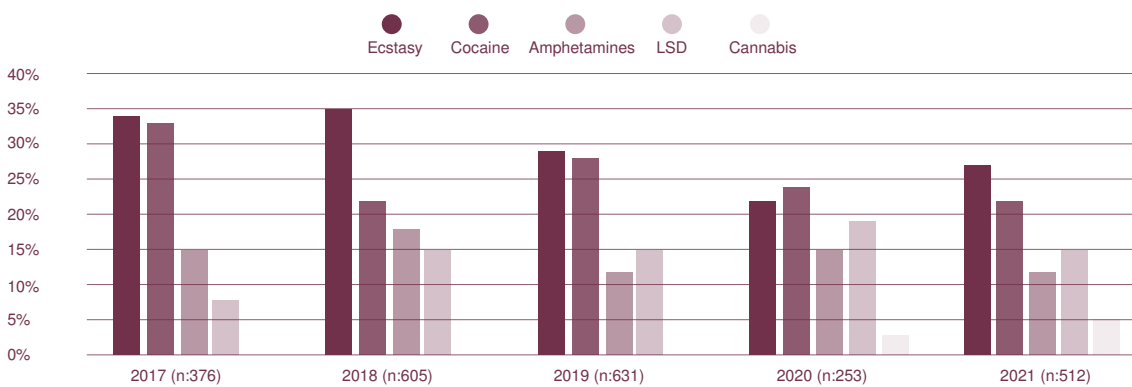
in four areas, with the local police force supporting the intervention, and safer smoking kit distribution (including pipes) will be available at the study sites for 6 months.^{4,5,49}

Drug checking is another harm reduction service usually targeting people who use stimulants, which enables people to get the contents of their drugs analysed. Drug checking services deliver the results combined with a psychosocial consultation to reduce the harms associated with drug use. The majority of service users report disposing of a drug if it contains unexpected substances, with reduced polydrug use and taking smaller doses also reported after using the service.^{50,51} Another benefit of such services is that they can issue publicly available warnings when high-risk ingredients are found. Drug checking services have been implemented in at least eleven countries in Western Europe: Austria, Belgium, France, Germany, Italy, Luxembourg, the Netherlands, Portugal, Spain, Switzerland, and the United Kingdom. Coverage is a serious barrier to access: there is only one drug checking service in Belgium, Germany, Portugal, and Spain, and there are two services in Austria and the United Kingdom, with the first officially licensed regular drug checking service in the United Kingdom having started in May 2022 in Bristol.^{4,7,10,14,15,52,53} Though drug checking is usually considered a service for people who use

stimulants in nightlife and festival settings, this is a service other communities can also benefit from. For example, in Portugal, a pilot drug checking service started in 2022 in Lisbon, targeting marginalised people who use drugs on the streets.¹⁴ Another example is that between 2020 and 2021, drug checking services identified synthetic cannabinoids in herbal cannabis products in eight countries^b in samples submitted by people who experienced serious negative effects after use.⁵⁴

In Switzerland, testing of cannabis has been conducted since 2020 due to serious negative experiences among people who use cannabis (related to synthetic cannabinoids). Synthetic cannabinoids accounted for a substantial proportion of alerts from drug checking services in Switzerland: out of the 169 alerts published in 2021, 71 (42%) were about synthetic cannabinoids, while 85 (50%) were tablets, mostly ecstasy pills containing extremely high doses (more than 200mg) of MDMA.⁵⁵ Testing results validate the expansion of services to people who use cannabis, as synthetic cannabinoids were overrepresented in alerts in the past years.^{54,55} Still, over the past five years, MDMA and cocaine were the most frequently submitted substances to the services in Switzerland, while LSD became the third (overtaking amphetamines in 2019).⁵⁵

Substances submitted to drug checking services by drug use assessment questionnaire respondents in Switzerland between 2017–2021



^b It was first identified by a drug checking service in Zurich, Switzerland in February 2020, and later in the United Kingdom, France, the Netherlands, and Austria in 2020, and Luxembourg, Germany, and Italy in 2021.

^c In total, approximately 4000 samples are tested in drug checking services in Switzerland.¹¹⁴

DRUG CONSUMPTION ROOMS

The number of countries with drug consumption rooms (DCRs), including mobile drug consumption facilities, has increased since 2020, with Greece and Iceland opening DCRs in 2022, and the first DCR for people who smoke drugs in Portugal having been opened in 2021 in Lisbon.^{14,56,57} Additionally, an unsanctioned mobile DCR was operating in the United Kingdom in Glasgow between September 2020 and May 2021.⁵⁸ As of July 2022, there are 93 official DCRs in 66 cities and 12 countries^d across Western Europe.^{57,59} DCRs usually offer a range of services in addition to supervised consumption spaces, for example, overdose training, take-home naloxone programmes, NSPs, psychosocial support, and referrals to other health and social services.^{60–62} DCRs provide a safe environment to use drugs under the supervision of trained professionals who can intervene in the event of an overdose, and studies have shown that people who inject drugs are highly willing to use these safe places.^{58,63,64} A good illustration of the importance of this initiative can be found in Copenhagen, where some people would use their drugs close to the DCR, even when they could not enter the facility due to COVID-19 restrictions, because DCR staff could quickly assist with naloxone in case of an overdose.¹³ Available evidence on DCRs shows that they are effective in preventing overdose deaths: there has never been a fatal overdose reported in any of the DCRs around the globe.^{65,66}

DCRs are usually associated with opioid use, however, people who use stimulants comprise a significant proportion of DCR clients in the region. For example, non-injecting use of cocaine is prevalent in DCRs in Zurich, the clients of the unsanctioned DCR in Glasgow were predominantly injecting cocaine, and DCRs in Paris and Lisbon report crack-using clients are dissolving it for injection.^{1,13,58,67} The overall trend of decreasing prevalence of injecting use affects the DCRs in the region. In general, more and more people who use the DCRs are smoking their drugs. For example, there is an increasing

trend of smoking methamphetamine in the DCR in Athens, and in Barcelona, civil society actors report an increasing need for a DCR for smoked use.^{13,62} Existing DCRs can be an appropriate base for implementing supervised inhalation spaces. A systematic review found that integrating such services does not require increased resources to implement or operate, beyond physical infrastructure requirements for accommodating inhalation (for example, ventilation or outside spaces).⁶⁸

DCRs typically integrate services tailored to the local needs. For example, in Lisbon, the DCR operated by Ares do Pinhal offers two consumption rooms (one for injecting and one for smoking), psychosocial support, a coffee desk, medical consultations, and infectious disease screening. To serve the significant proportion of their clients experiencing homelessness, they offer a laundry service, bathroom, free clothes, and even a pet-sitting service, as a lot of their clients have pets they cannot leave anywhere and this would prevent them from accessing the DCR.⁶² Furthermore, the DCR has a community team ensuring that any discarded injecting paraphernalia in the neighbourhood is collected.⁶²

Considering the needs of the neighbourhood is an important aspect, as the concerns of local residents can be a significant barrier to the implementation of DCRs.^{69,70} For example, in Zurich, DCRs are open at different times during the day, ensuring that at least one DCR is available in the city throughout the day (the three DCRs in Zurich cover opening hours from 07:30 to 21:30), while avoiding a concentration of use in one area.⁶⁷ Furthermore, to decrease visible dealing in the neighbourhood, micro-dealing is tolerated at the premises (in agreement with the local police), provided that it is happening only in the designated space at the facility, no scales are used, it is done discreetly (e.g. money not visibly transferred), and the micro-dealers are people who use drugs themselves and clients of the DCR.⁶⁷ DCRs in Switzerland play an important role in the distribution of harm reduction commodities. In 2021,

d Belgium, Denmark, France, Germany, Greece, Iceland, Luxembourg, Netherlands, Norway, Portugal, Spain, Switzerland.

DCRs in Switzerland distributed around 1.3 million needles and syringes, and almost 10,000 crack pipes.⁷¹

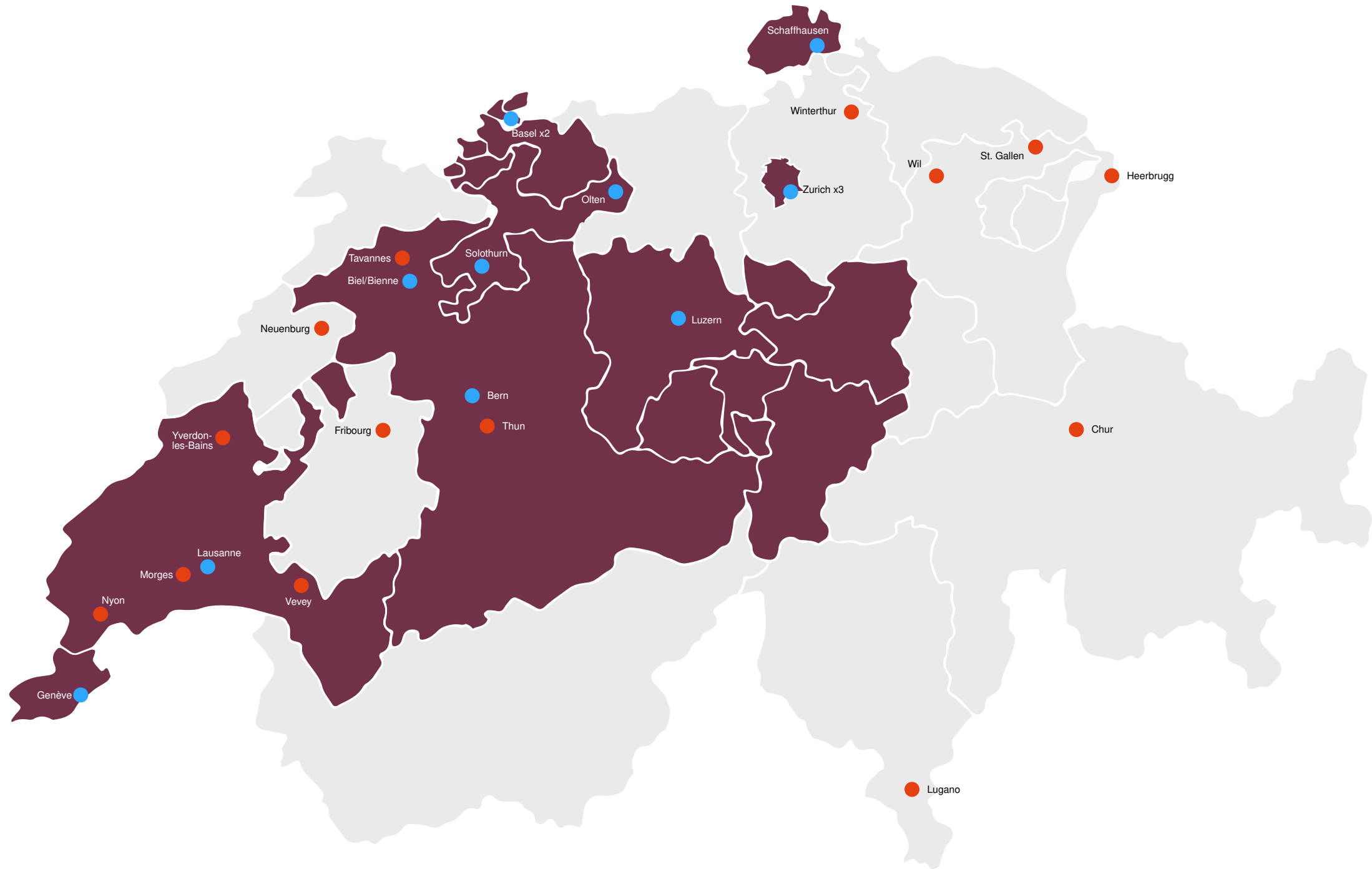
The lack of appropriate legal frameworks and political will seems to be the most prevalent barrier to implementing new DCRs in the region.^{4,6–9,15,62,69,70} Though in Brussels, Belgium, the second DCR in the country opened in May 2022, legal issues are hindering further expansion.¹⁵ The new DCR in Athens opened after many years of advocacy. OKANA opened the first DCR in Athens in 2013 as a response to the HIV epidemic in the country, but the facility was suspended by the Greek government and it took nearly a decade to open a new DCR in the city.^{62,72} Similarly, there has been a decade long advocacy campaign for a DCR in Ireland, and even though the appropriate legislation was enacted, a High Court challenge has been hindering implementation since 2020.^{73,74} However, in a different legal environment, the unsanctioned DCR in Glasgow was run without an appropriate legal framework, and the DCR closed because of the lack of funding and unsustainable staffing model^e, not because of legal or police action.⁵⁸ Furthermore, there is an ongoing initiative to reform the legal framework and introduce DCRs in Finland, where the parliament is required to put the issue on its agenda following a successful citizens' initiative.^{75–77} In the Swiss context, uneven geographical distribution of DCRs are a significant barrier to access. Moreover, DCRs only serve people registered in the local area, further hindering access to the service.^{78–80}

Peer involvement is crucial in DCR design and implementation, and engaging potential service users is essential to understand the needs of local communities. Continued participation of people who use drugs in the operation and development of the service can help provide a safe space for all clients, ensuring accessibility, use, and consumer satisfaction.^{81,82} Furthermore, DCR providers should welcome active drug users as staff members.⁸¹ For example, in Portugal, a peer programme was implemented with a flexible payment model (where

participation is paid by hour or task), allowing peers to participate in various programme activities of the mobile DCR such as street outreach, trainings, advocacy events, and meetings with residents.¹⁴ In Barcelona, Spain, Metzineres offers low threshold peer-led harm reduction services for women and nonbinary people who use drugs, including a DCR. Metzineres highlights that community-led organisations can provide adequate services for the most stigmatised and marginalised communities, with many programme participants reporting that this is the first place that they feel safe.^{81,83} A significant step forward in the region has been reported in Germany, where the first DCR operated by a peer organisation is expected to open in 2023.⁹

e Volunteers faced risks to their liberty and their earnings from other sources, for example, medical students volunteering were warned that they can be barred from practice if convicted of a criminal offence.⁵⁸

NUMBER OF LOW THRESHOLD DROP-IN CENTRES (KONTAKT- UND ANLAUFSTELLEN) IN SWITZERLAND



Number of institutions:
■ Consumption Room Catchment Area
● Without drug consumption room
● With drug consumption room

HARM REDUCTION FOR YOUNG PEOPLE

Young people who use drugs^f are a population with higher vulnerability compared to adults who use drugs. More young people are using drugs compared with previous generations, and young people are more likely to use any drug in most regions and most drug types across the globe.⁸⁴ Moreover, evidence suggests that early (12–14 years old) to late (15–17 years old) adolescence is a critical risk period for the initiation of substance use, and that substance use may peak among young people aged 18–25 years.^{85,86} Although cigarette and alcohol use is more prevalent among students (15- to 16-years-old) in Europe, they use illicit substances too.⁸⁷ According to the European School Survey Project on Alcohol and Other Drugs (ESPAD) report, in Western Europe, early initiation (first use at age 13 or younger) of cannabis use varies between 1.2% (Greece) and 4.5% (France) in the school-aged population (under 0.9% for ecstasy and amphetamines in the region).⁸⁷ Lifetime use of illicit drugs varied considerably across the ESPAD countries^g. On average, 17% of ESPAD students reported having used any illicit drug at least once.⁸⁷ Italy has the highest percentage of students reporting lifetime use of any illicit drug in the Western Europe region with 28%, and Iceland has the lowest rate with 7.3%. As in the adult population, the most frequently used drug is cannabis among school-aged children. Among Western European countries, Italy reported the highest lifetime prevalence among school-aged children (27%), and the lowest was reported in Iceland (6.4%).⁸⁷ Switzerland is among the Western European countries with higher prevalence rates in this age group, with 22.3% of 15-year old children having reported cannabis use at least once in their lifetime.⁸⁸

Harm reduction interventions for young people who use drugs is an especially complex area where the issues of consent, identity, agency and maturity, as well as the child's 'best interests' or child

protection laws that may require duties of reporting, are intersecting with public health goals and the principles of harm reduction service delivery: offering services without judgment, ensuring anonymity, respect, and dignity.⁸⁹ Furthermore, implementing appropriate harm reduction interventions for young people is hindered by similar issues to those faced by other vulnerable sub-populations of people who use drugs. There are significant data gaps: age-disaggregated data on injecting use or prevalence of HIV or hepatitis C is scarcely available, while it is estimated that young people aged 15–24 years accounted for 35% of all new HIV and hepatitis C infections worldwide in people over 15 years of age.⁹⁰ A global or regional population size estimate for people who inject drugs under the age of 18 is unavailable, and has been unavailable for a decade.⁹¹ However, there are more recent estimates on the proportion of under 25-year olds among people who inject drugs: 27.9% of people who inject drugs globally and 29.8% in Western Europe belong to this age group.⁹² Bridging the existing data gap is especially challenging, as the majority of research excludes participants under 18 years of age due to legal constraints and ethical concerns.⁹⁰

“There are significant data gaps: age-disaggregated data on injecting use or prevalence of HIV or hepatitis C is scarcely available, while it is estimated that young people aged 15–24 years accounted for 35% of all new HIV and hepatitis C infections worldwide in people over 15 years of age. A global or regional population size estimate for people who inject drugs under the age of 18 is unavailable, and has been unavailable for a decade.”

f If not stated otherwise, young people who use drugs refers to people who use drugs younger than 18 years old, as generally in Western Europe, 18 years is the legal age of adulthood.

g In 2019, ESPAD was carried out in 35 countries: Austria, Bulgaria, Croatia, Cyprus, Czechia, Denmark, Estonia, Faroes, Finland, France, Georgia, Germany (Bavaria), Greece, Hungary, Iceland, Ireland, Italy, Kosovo, Latvia, Lithuania, Malta, Monaco, Montenegro, Netherlands, North Macedonia, Norway, Poland, Portugal, Romania, Serbia, Slovakia, Slovenia, Spain, Sweden, and Ukraine.

People who use drugs face stigma and discrimination – a significant structural barrier to accessing social or health care services. Young people who use drugs are more vulnerable to these negative consequences because they may depend on adults or institutions for support, care, food, housing, protection, or other resources. Stigma and discrimination, or fear of law enforcement because of their drug use can, therefore, impose serious barriers to access.^{86,90,93} Furthermore, policies often restrict access on the basis of age, resulting in many young people who use drugs experiencing barriers to accessing harm reduction services due to their age.^{86,93} These barriers hinder young people's access to a range of services, including HIV or hepatitis C testing and counselling, OAT, DCRs, and drug checking.^{86,94}

Existing harm reduction programmes are mostly designed, evaluated, and funded to focus on adult people who use drugs with little regard to the specific needs of young people who use drugs, which can hinder accessibility and increase young people's reluctance to use these services.^{86,93} A recent article by young people who use drugs and their allies highlights that young people are still an excluded and marginalised group in the harm reduction context, despite peer involvement increasingly being the norm in harm reduction initiatives.⁸⁶ It is pivotal to include young people who use drugs in tailoring services for this population; interventions should not be designed based on what adults deem appropriate for young people. Young people who use drugs are not a homogenous group; community involvement and input from young people can ensure that the services are appropriate to the need of the target population.⁸⁶

“Young people who use drugs are more vulnerable to these negative consequences because they may depend on adults or institutions for support, care, food, housing, protection, or other resources. Stigma and discrimination, or fear of law enforcement because of their drug use can, therefore, impose serious barriers to access.”

Despite these barriers, young people who use drugs will use harm reduction programmes when appropriate services are available.^{93,95} A study in Canada found that DCRs provide an important point of contact for high-risk adolescents experiencing homelessness who had lived or spent time in the neighbourhood of the DCR.⁹⁶ Other studies found that young adults participated in take-home naloxone programmes and fentanyl test strips if such programmes were available at sites they used.^{97–99} These programmes are demonstrating that harm reduction services can engage at-risk young people who use drugs, populations that would be hard to reach with traditional health and social services.⁹³

SPOTLIGHT

HARM REDUCTION FOR YOUNG PEOPLE IN SWITZERLAND

Switzerland is among the few countries across the globe where most harm reduction services are available, from NSP, OAT, and drug checking, to heroin assisted treatment in and out of prison.^{26,100} Professionals working in the field of harm reduction and substance use were unanimous in their opinion that all harm reduction services available in the country should also be accessible for young people who use drugs.⁹⁴ However, access to harm reduction services in the country for young people who use drugs under the age of 18 is limited, with lower coverage across harm reduction services compared to adults in general.⁹⁴ For example, DCRs are strictly for people who use drugs over the age of 18. Anonymity and self-declared age put NSPs in a grey zone with regional differences.^{94,101} Experts working in the field of harm reduction highlighted that this limited availability is rooted in local policies and the lack of political will, as the Swiss law regulating drug use and addiction-related services at the federal level impose age-related restrictions only on HAT, where the admission criteria is being at least 18 years old.^{102,103} Though federal laws set the framework, cantons have great autonomy due to the fact that they have their own constitutions and laws, and run their own educational systems, social services, and police. Therefore, implementation, policies, and funding of services can differ greatly from canton to canton. For example, drug checking services are available in six cities (Basel, Bern, Geneva, Lucerne, Olten, Zurich), while only one drug checking service in Zurich is available officially for people under 18.^{94,101,104}

Another aspect of Swiss drug policy important to the issue of harm reduction for young people who use drugs, is the concept of early detection

(Früherkennung).^{94,103} This policy regulates the role and responsibility of people working in education, social care, the health system, and law enforcement when drug use-related problems are suspected in children and young people.^{103,105} Though harm reduction is included in the policy as one of the interventions that can be offered depending on the situational assessment,¹⁰⁶ harm reduction services should be explicit about their role in early detection to avoid undermining the trust of their clients. For example, drug checking services developed guidance to integrate early detection into their work and defined the possible actions for clients under the age of 18: providing information about the risks of drug use under 18 and about the related youth protection regulations.¹⁰⁷ However, the guidance also clarifies that early detection can be integrated to drug checking services insofar as it does not endanger the relationships with their clients.¹⁰⁷

Nevertheless, in practice, young people who use drugs might access harm reduction services in Switzerland because most services are anonymous. For example, DILU, a drug checking service in Lucerne, is an anonymous service where age is self-declared, so anyone using the service can access sterile syringes at the premises.¹⁰⁸ A similar situation was reported in Bern, as the NSP is anonymous and, in theory, accessible for all.¹⁰⁹ The contradiction between anonymity and age restriction can lead to inconsistencies. For example, in Vaud, young people who inject drugs can access sterile injection equipment, but they are not allowed to use the local DCR. They therefore cannot inject under professional supervision, unlike people who inject drugs over 18 years of age.¹¹⁰

ACCESS TO NSPS

Young people who use drugs accessing NSPs is a grey zone, with substantial differences between cantons. For example, young people who inject drugs in Lucerne can access syringe dispensing machines, but not the NSP.¹⁰⁸ Reports indicate that young people cannot access NSPs in Basel, and they have to ask older people who inject drugs for equipment.⁷⁹ The situation is similar in Solothurn, where under 18s are not admitted to NSPs.⁸⁰ In Bern, NSPs are open for young people who inject drugs, though it is not clear to what extent this age group uses the service. [109] In addition to general barriers, such as uneven geographical distribution of services with difficult access for people living in rural areas, lack of political will and appropriate funding for NSPs for young people is hindering access.⁹⁴

ACCESS TO OAT

Access to OAT seems to be an area where the difference between adults and young people who use drugs is smaller compared to other harm reduction services. This relatively good coverage can be attributed to the perceived low demand for this programme among young people. According to expert opinions, cases where OAT is needed in this age group are very rare, though the issue of data availability was also raised.^{110,111} In general, access to OAT for young people is not automatic. For example, in Grisons, cantonal guidelines allow OAT only for adults (over 18), but exceptions can be made if OAT is needed, with training for general practitioners also available.¹¹² In Vaud, only those over 18 can access OAT, but the cantonal doctor can authorise OAT from the age of 16.¹¹⁰ Scepticism and reluctance among professionals in prescribing OAT medications to young people was mentioned as a specific barrier in access to OAT.^{111,112}

ACCESS TO DCRS

Young people cannot access DCRs in Switzerland. There are no regional differences, as age limits prevent access in all ten cities where DCRs are available in the country without exception.^{94,113}

ACCESS TO SAFER SMOKING EQUIPMENT

Generally, safer smoking equipment (SSE) is available at DCRs, meaning that age restriction is a serious barrier for young people who use drugs in accessing such harm reduction commodities.⁹⁴ Outside of DCRs, access is possible: young people can buy SSE at specialised shops⁷⁹ and may have access at festivals if SSE is distributed there.¹¹⁰

ACCESS TO DRUG CHECKING

Young people who use drugs can access the drug checking service in Zurich but, elsewhere, people under 18 are not formally permitted to use the service.^{78,109} However, experts highlighted that drug checking services are anonymous, and age is self-declared.^{108,110} The first step in using drug checking services is an interview where proof of identity is not necessary: the interview is based on mutual trust, and the staff won't check the information provided.¹¹⁰ This is a pragmatic practice, prioritising the need for the service and building trust in the community over age restrictions.

Besides age restrictions, young people who use drug checking services face the same barriers as others: uneven geographical coverage of drug checking services (they are available only in big cities), and funding issues regarding available testing capacities.⁹⁴ A lack of funding creates a significant barrier to access and, in particular, service availability. For example, in Basel, the drug checking service can take ten samples every 2 weeks, which is not adequate for the need for drug checking in the city.⁷⁸

A recent analysis of client questionnaires highlighted the underrepresentation of young people among people who use drug checking services in Switzerland: of the 564 respondents, only 29 were under 18.⁵⁵ Age-disaggregated data shows higher rates of recreational use of benzodiazepines and prescription opioids, and higher rates of combined use of alcohol and benzodiazepines among under 18s compared to over 18s.⁵⁵ Finally, the report emphasised the need for access to cannabis drug checking for young people who use drugs, as cannabis is the most frequently used substance in this population.⁵⁵

8 Information on harm reduction services and young people in Switzerland is based on an expert survey with respondents from Basel-City, Bern, Geneva, Grisons, Lucerne, Solothurn, Vaud and Zurich cantons, and respondents covering Central Switzerland and German-speaking Switzerland (latter representing a professional association of addiction specialists).

CONCLUSION

Young people who use drugs are a vulnerable sub-population of people who use drugs, and unrestricted access to appropriate harm reduction services is therefore crucial. Swiss experts consulted for this report unanimously agreed on the importance of providing young people access to available harm reduction services without age restrictions.⁹⁴ The most important issues hindering the implementation of harm reduction for young people were the lack of political will and funding for young person-oriented harm reduction services, and the bias towards offering prevention and treatment to under 18s when drug use is suspected.⁹⁴ Disparate policies for young people under 18 is also a significant issue. Bureaucratic burdens like requiring case-by-case authorisation to gain access to services, or restricting young people's access to harm reduction commodities, lead to higher barriers compared to adults, thereby creating a more unsafe environment for young people who use drugs. Additionally, different local policies can further complicate the implementation of services and can lead to geographical inequalities in availability of services. The most important issue regarding access to harm reduction for young people who use drugs is the availability of specialised services tailored specifically to this age group. Both professional opinion and literature are unequivocal: all available harm reduction services should be available to all people who need it, young people included.^{86,93,94} However, there is an important caveat: existing harm reduction services designed and implemented focusing on adults who use drugs are not appropriate for young people who use drugs. We should develop new harm reduction services that ensure that young people are meaningfully involved throughout all aspects of programme design, implementation, and evaluation, giving young people agency and autonomy over decision-making processes.⁸⁶

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