

THE STATE OF HARM REDUCTION IN WESTERN EUROPE

2020



THE GLOBAL STATE
OF HARM REDUCTION



The State of Harm Reduction in Western Europe 2020

Written by Robert Csák

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Designed by Mark Joyce

Published by Harm Reduction International

61 Mansell Street, Aldgate, London E1 8AN

Telephone: +44 (0)20 7324 3535

E-mail: office@hri.global

Website: www.hri.global

Acknowledgements

This report was made possible by the collaborative input of harm reduction organisations networks, drug user organisations, researchers, academics and advocates. Harm Reduction International would like to acknowledge the invaluable contribution of these individuals and organisations:

Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction; Machteld Busz, Mainline; Mat Southwell, EuroNPUD; Adriana Curado, GAT Portugal; Tony Duffin, Ana Liffey; Niamh Eastwood, Release; Alexandrina Iovita, GFATM (prev UNAIDS); Pernilla Isendahl, Projektledare Naloxon i Region Skåne; Kirsten Horsburgh, Scottish Drugs Forum; Marc Marthaler, Stefanie Knocks and Jean-Félix Savary, Infodrog; Sigurður Ólafsson, Landspítali UH; José Queiroz, APDES; Susanna Ronconi, Italian Harm Reduction Network; Josep Rovira, ABD; Eberhard Schatz and Rafaela Rigoni, Correlation European Harm Reduction Network; Dominique Schori, Saferparty Streetwork Zurich; Olivier Simon, Lausanne University Hospital (CHUV); Milena Simonitsch, Caritas Kontaktladen & Streetwork; Dirk Schäffer, Deutsche AIDS Hilfe; Heino Stöver, Akzept; Bernd Wersé, Centre for Drug Research, Goethe University; Tessa Windelinckx, Free Clinic Belgium; Sarah Woods, Mainline.

Thanks also to the following people for input and guidance:

Naomi Burke-Shyne, Colleen Daniels, Suchitra Rajagopalan, Sam Shirley-Beavan, Catherine Cook, Olga Szubert, Emily Rowe, Gen Sander, Cinzia Brentari, Giada Girelli, Anne Taiwo, Tamara Chavez, Dagmar Hedrich, Machteld Busz, Marc Marthaler, Dominique Schori, the International Network of People who Use Drugs (INPUD), and the Women and Harm Reduction International Network (WHRIN).

The State of Harm Reduction in Western Europe 2020 benefits from the generous support of the Government of Switzerland Federal Office of Public Health, together with the MAC AIDS Fund, the Robert Carr Fund for Civil Society Networks and the Open Society Foundations.

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TABLE 1:
Epidemiology of HIV and viral hepatitis, and harm reduction responses in Western Europe

Country/ territory with reported injecting drug use	People who inject drugs [1] 1	HIV prevalence among people who inject drugs (%) [1] 2	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%) [1] 3	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) [1] 4	Harm reduction response			
					NSP ⁵ [1]	OAT ⁶ [1,2]	Peer distribu- tion of naloxone	DCR ⁷
Andorra	nk	nk	nk	nk	nk	nk	x	x
Austria	12,000-17,000 [3]	8.7	28.6	4.9 ⁸	✓41	✓(B,M,O)	x	x
Belgium ⁹	23,828	10.5	22	5.6	✓98 (P=28)	✓(B,H,M)	x ^[4]	✓1 ¹⁰ [8]
Cyprus	331 ¹¹	3.3	48.8	5.9	✓7	✓(B,O) [9]	x	x
Denmark	nk	nk	nk	nk	✓5	✓(B,H,M)	✓ ^[10]	✓5 ^[11]
Finland	15,611 ¹²	1.2 ¹³	74 ¹⁴	nk	✓61	✓(B,M,O)	x	x
France	117,000 ¹⁵	4.7 ¹⁶	63.8 ¹⁷	0.81 ¹⁸	✓553	✓(B,M)	x ¹⁹ [12]	✓2 ^[13]
Germany	nk	1.6-9.1 ²⁰	62.6-73 ²¹	0.4-1.4 ²²	✓23	✓(B,H,M,O)	x ^[15]	✓24 ^[14,15]
Greece	3,339 ²⁴	4.1	60.5	2.2	✓12	✓(B,M)	x	x
Iceland	700 ²⁵ [16]	5 ^{[3]26}	10 ^{[16]27}	nk	✓ ^[17,18]	✓ ^[17]	x	x
Ireland ²⁸	1,151 ²⁹ [19]	6	76 ³⁰ [3]	0.5	✓120 (P=96)	✓(B,M)	x ^{[20]31}	x
Italy	nk	30.5	60.1	2.4 ^[19]	✓73 (P=28)	✓(B,M,O)	✓21	x
Liechtenstein	nk	nk	nk	nk	nk	nk	x	x
Luxembourg	1,467 ³²	13.2 ³³	62.9	nk	✓10	✓(B,M,O)	x	✓2 ^[22]
Malta	703 ^[19]	1.2	60.1	nk	✓8	✓(B,M,O) ^[23]	x	x
Monaco	nk	nk	nk	nk	nk	nk	x	x
Netherlands	840 ³⁴	3.8 ³⁵	59.3 ^{[24]36}	6.3 ³⁷	✓175	✓(B,H,M,O)	x	✓24 ^[25]
Norway	8682	1.3	38.8	0.9 ³⁸	✓81	✓(B,H,M)	✓ ^[26]	✓2 ^[26]
Portugal	13,162 ³⁹	13	83	1	✓2,137 (P=1691)	✓(B,M)	x	✓1 ^[27]
San Marino	nk	nk	nk	nk	nk	nk	x	x
Spain ⁴⁰	13,136	0.8 ⁴¹	61.4 ⁴²	7.7 ⁴³	✓760 (P=575)	✓(B,M)	x	✓13 ^[28]
Sweden	8,021 ⁴⁴	7.4 ⁴⁵	54.6 ^{[3]46}	0.4 ^{[3]47}	✓26 ^[29]	✓(B,M) ^[30]	x	x
Switzerland	42,000 ^{[19]48}	10-12 ^[31]	74.6 ^{[3]49}	nk	✓	✓(B,H,M,O) ^[32]	x	✓14 ^[33]
Turkey	12,733 ^{[34]50}	0.5	49.2	3.5	x	✓(B,M,O) ^[35]	x	x
United Kingdom	122,894 ⁵¹	1.2 ⁵²	51-58 ^{[36,37]53}	0.2 ⁵⁴	✓627 (P=461) ⁵⁵	✓(B,H,M,O)	✓ ^{[38,39]56}	x

nk = not known

1 Unless otherwise stated, data is from 2016.

2 Unless otherwise stated, data is from 2018.

3 Unless otherwise stated, data is from 2018.

4 Unless otherwise stated, data is from 2018.

5 All operational needle and syringe exchange programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = pharmacy availability.

6 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B), (H) medical heroin (diamorphine) and any other form (O) such as morphine and codeine. Figures for the number of sites are often not available in Western Europe due to a variety of service providers, which includes general practitioners.

7 Drug consumption rooms, also known as supervised injecting sites.

8 Based on subnational data.

9 People who inject drugs population estimate refers to lifetime injecting drug use and is based on national data from 2015. Infectious disease prevalence estimates based on subnational data from the Flemish community from 2016.

10 One drug consumption room operates in Liège with the approval of local government, though no national legislation permits such facilities.^[5-7]

11 Year of estimate: 2018

12 Year of estimate: 2012.

13 Based on subnational data from 2014.

13 Year of estimate: 2014

14 Year of estimate: 2017.

16 Year of estimate: 2015.

17 Based on subnational data from 2011.

18 Based on subnational data from 2011.

19 While take-home naloxone is available in France, it can only be acquired with a personal prescription.

20 Based on subnational data from 2013-2014.

21 Based on subnational data from 2013-2014.

22 Based on subnational data from 2013-2014.

23 A total of 176^[1] syringe dispensing machines operate in Germany, but the total number of NSPs is unavailable.^[14,15]

24 Year of estimate: 2018.

25 Year of estimate: 2012

26 Data from 2017.

27 Data from 2020.

28 Year of estimates: 2010.

29 Year of estimate: 2015.

30 Year of estimate: 2014, definition of PWID: lifetime injecting

31 While take-home naloxone is available in Ireland, it can only be acquired with a personal prescription.

32 Year of estimate: 2015.

33 Data from 2016.

34 Year of estimate: 2015.

35 Based on subnational data from 2016.

36 Year of estimate: 2019

37 Based on subnational data from 2017.

38 Based on subnational data from 2015

39 Year of estimate: 2015.

40 Year of estimate: 2017.

41 Data from 2017.

42 Data from 2017.

43 Data from 2017

44 Years of estimate: 2008-2011.

45 Based on subnational data from 2013.

46 Data from 2015

47 Based on subnational data from 2015.

48 Year of estimate: 2015.

49 Year of estimate: 2016, definition of PWID: lifetime injecting (and to be or have been on opioid substitution)

50 Based on a subnational estimate and number of high-risk opioid users, including but not exclusively people who inject drugs.

51 Years of estimate: 2004-2011.

52 Based on data from England and Wales only.

53 Hepatitis C prevalence among people who inject drugs is 51% in England, Wales and Northern Ireland, and 58% in Scotland.

54 Based on data from England, Northern Ireland and Wales only. Data from 2017.

55 This figure does not include NSPs in England due to a lack of national data.

56 In the United Kingdom, peer distribution of naloxone is limited to a small number of projects.

1. Introduction

The *Global State of Harm Reduction 2020* shows that the implementation of vital harm reduction services has worsened since 2018, after having stalled since 2014. The number of countries where needle and syringe programmes (NSPs) are available remained level at 86, and the number of countries where opioid agonist therapy (OAT) is available decreased by two to 84.^[40] Western Europe is one of the only regions where these core harm reduction services are available in most countries. Every country, with the exception of the microstates⁵⁷ and Turkey, has explicit supportive references to harm reduction in national policy documents, and has implemented NSPs. OAT is even more widespread, as it is also available in Turkey. Harm reduction has a long history in the region. Western European countries were among the first to adopt harm reduction services. It is among the regions with the highest available resources for harm reduction and it leads the way in many harm reduction initiatives. Ten out of twelve countries in the world that have officially sanctioned drug consumption rooms (DCRs) are in Western Europe, 20 out of the 24 countries in the region have OAT in prison settings, and Switzerland is the only country in the world where heroin-assisted treatment (HAT) is available in prison.^[41,42]

However, the coverage of harm reduction services in most countries of the region is still below the coverage targets set by the World Health Organization (WHO),^[43,44] and people who use drugs still face significant barriers to access these services in some parts of the region. One of the most prevalent barriers to accessing NSPs or OAT in Western Europe is the uneven distribution of services within countries as geographic gaps exist even in countries where harm reduction services have been available for decades. Rural communities are particularly underserved in many countries in Europe. In addition to the geographic gaps in coverage, there are sub-groups of people who use drugs that experience barriers to access in Europe, including women who use drugs, people experiencing homelessness, men who have sex with men, and people who use non-injecting methods of drug use. Furthermore, NSP provision may be especially inadequate for people who inject stimulants. Stimulant injecting has recently been associated with localised HIV outbreaks in the region – highlighting the need for harm reduction interventions for people who inject stimulants.^[45-47]

TABLE 2:
Global availability of harm reduction services by region

Global State of Harm Reduction region (number of countries in the region)	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room	Peer distribution of naloxone	OAT in at least one prison	NSP in at least one prison
Asia (25)	11	14	15	0	4	5	0
Eurasia (29)	26	27	26	0	2	21	5
Latin America and the Caribbean (24)	9	4	4	0	2	0	0
Middle East and North Africa (19)	7	7	5	0	0	6	0
North America (2)	2	2	2	1	2	2	1
Oceania (12)	2	2	2	1	1	2	0
Sub-Saharan Africa (38)	11	10	9	0	0	3	0
Western Europe (24)	20	20	21	10	4	20	4
TOTALS	88	86	84	12	15	59	10

57 Andorra, Liechtenstein, Monaco, San Marino

This report presents harm reduction interventions addressing opioid use, interventions addressing the use of non-opioid substances and interventions with relevance to a range of substances. It draws on the findings of the *Global State of Harm Reduction 2020* report, and supplements those findings with original research on harm reduction in Western Europe, with a special focus on Switzerland. It also addresses service provision and coverage, trends in drug use and emerging areas of harm reduction.

Increasing access and availability of HIV and hepatitis C testing, counselling and treatment in community settings and low threshold services⁵⁸ is an area where progress is needed. Implementing and scaling up community-based interventions and peer-led services can help overcome geographical coverage issues. Community-based service delivery has the potential to increase HIV testing uptake among otherwise hard to reach communities, populations at higher risk and those with potentially poorer access to health care services.^[49]

In recent years, advocacy for DCRs has been effective in the region. Portugal began implementing a mobile DCR in 2019.^[50,51] There are ongoing efforts to open a DCR in Ireland and strong efforts to establish an officially sanctioned DCR in Scotland.^[52] Civil society and advocacy groups have been pivotal in achieving these goals.^[53,54]

The regional response to the COVID-19 pandemic shows that harm reduction services can adapt quickly and effectively to changes in the environment. Harm reduction services in the region were able to adjust service delivery and integrate innovative methods to meet the needs of the communities they serve. Governments took action to decrease barriers in OAT provision in many countries during the pandemic. The crisis highlighted the important role of harm reduction services in reaching key populations and providing a range of essential services beyond those aimed at reducing harms associated with substance use. Harm reduction and outreach workers were often the first to inform and educate their clients on COVID-19 preventive measures and lockdown rules.^[55-59]

58 Low threshold services are services aiming to minimize barriers in access, with no requirements on clients' drug use (eg abstinence). They do not impose any requirements on clients (eg mandatory counselling), nor do they have any bureaucratic requirements (eg identification documents, health insurance etc). Low threshold services usually have a harm reduction focus, though harm reduction services are not necessarily low threshold services.^[48]

2. Harm reduction for opioid use



2.1 OPIOID AGONIST THERAPY (OAT)

There are an estimated 1.3 million high-risk opioid users⁵⁹ in the European Union (EU)⁶⁰ – 0.4% of the adult population. About half of them, or 660,000 people, received OAT in the EU and Norway in 2018,^[60] with overall coverage slightly increasing between 2016 and 2018 after a decline between 2010 and 2015.^[1,61] Rates of injecting opioid use have fallen in the past decade, and the number of people entering treatment for the first time using heroin has fallen by more than half since 2007.^[60] The number of first-time treatment entrants for primary heroin use decreased in the majority of countries,^[60] with and an ageing, vulnerable cohort of people who use opioids increasingly defining treatment demand.^[61] The majority of clients are now over 40 years old, are predominantly male, are most commonly being prescribed methadone and are typically receiving treatment for more than 2 years.^[62]

Between 2017 and 2019, OAT coverage remained stable in Belgium, France, Italy, Luxemburg, Malta, the Netherlands, Norway, Portugal and Switzerland,^[23,63-68,69] and increased in Austria, Iceland, Ireland, Sweden and Germany (the last is attributed to a slight increase in prison availability).^[18,70-73] There is a declining trend in the number of clients on OAT in Spain due to a decline in the number of heroin users.^[28] The coverage slightly decreased in Cyprus, though few clients receive OAT (209 people in 2017).^[9] The most prevalent OAT medication in the region is methadone (nearly two-thirds of OAT clients in Europe are receiving it) and the use of buprenorphine in the pharmacological treatment of opioid dependence is steadily increasing.^[22,61]

There are still barriers to accessing OAT, with the most prevalent obstacles being long initiation time and insufficient availability of take-home OAT, though the COVID-19 pandemic has brought at least temporary positive changes in many countries in the region (see COVID-19 section for more details). Other barriers include access for specific subpopulations, for example, in Switzerland, heroin-assisted treatment is not available to people under 18 years of age.^[64] In Belgium and Germany, people who inject drugs living in rural areas have difficulties accessing OAT.^[66,70,74] In Switzerland, OAT is available without health insurance, however, it cannot be accessed anonymously,^[75] and despite personal data protections, some clients are reluctant to disclose their identity.

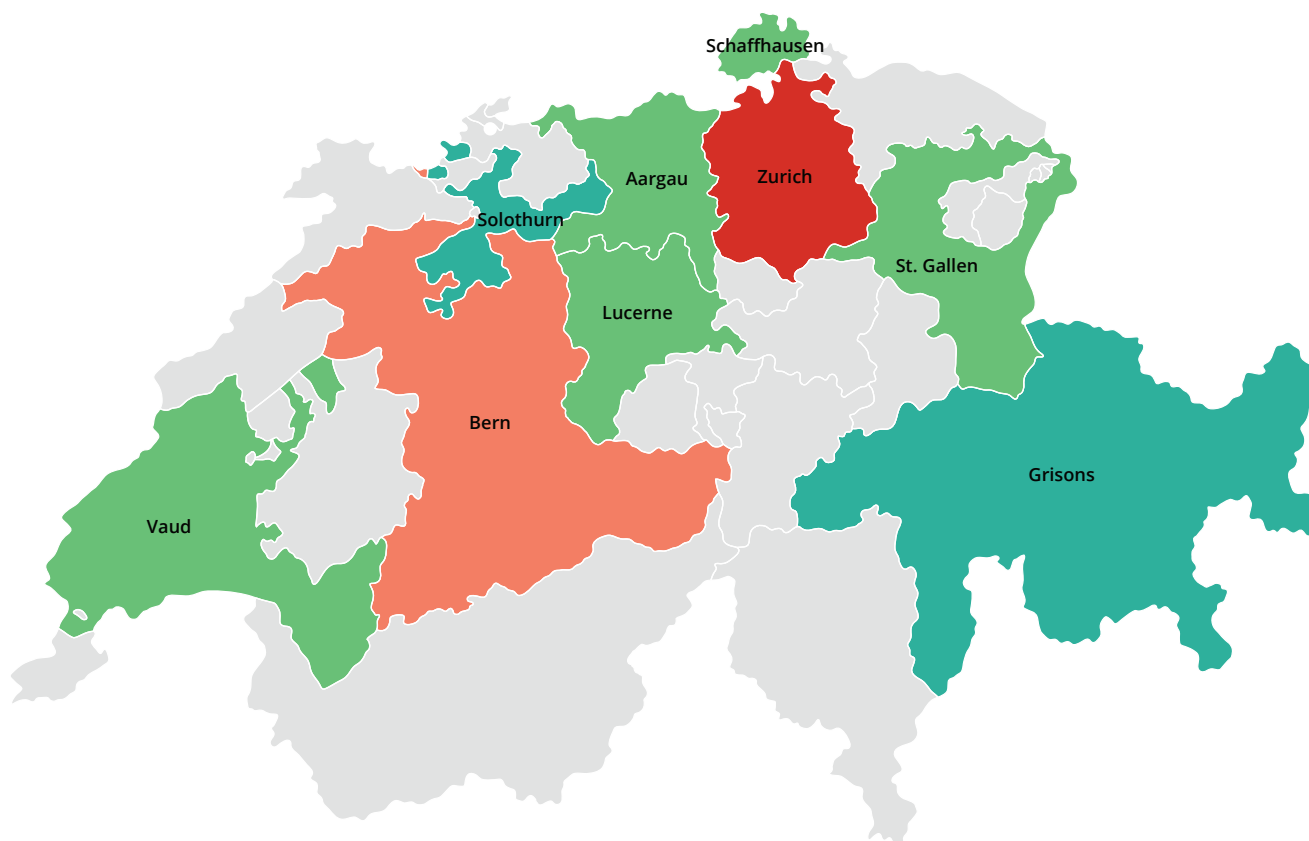
Heroin-assisted treatment (HAT) is available in seven countries: Denmark, Germany, Luxembourg, the Netherlands, Norway, Switzerland and the United Kingdom. HAT has been available in Switzerland since 1994,^[76] and a recent survey among HAT patients reflects the regional trend of an ageing population. The proportion of HAT clients under 35 decreased from 78% to 15% between 1994-2017, on the other hand, there were hardly any HAT clients over 55 in 1994, while in 2017, 15% of the clients accessing HAT were in this age group.^[32] Geographical gaps are a barrier to access HAT, as there are some cantons where it is not available.^[32,75] In 2019, 22 institutions in 13 Swiss cantons were authorised to administer pharmaceutical heroin, which means that half of the 26 Swiss cantons do not have an institution where HAT is available.^[77]

HAT was recently introduced in Glasgow, Scotland - a significant development in harm reduction in the United Kingdom,^[78] though it was suspended due to the COVID-19 pandemic.^[79] Norway was the seventh country in the region to implement HAT^[80] with plans to start treatment for 400 people at the end of 2020.^[81,82] In 2013, a 12 month HAT clinical trial in Belgium and follow-up study found that treatment benefits included a reduction in illicit heroin use, and improved physical and mental health.^[83,84] However, the Belgian government has not moved to make HAT available outside of the clinical trial.^[83,84]

59 Defined as injecting drug use or regular use of opioids, mainly heroin

60 The United Kingdom is included in EU data as it was in the EU at the time of data collection.

FIGURE 2.1:
Distribution of institutions administering HAT in Switzerland by canton^[77]



Number of institutions:

- One
- Two
- Four
- Five

Changing population of people who use drugs



There are several signs of change among the populations of people who use drugs in the region. While traditional harm reduction responses like NSP and OAT were tailored to the needs of an urban, heroin-injecting population, but this community is decreasing. The prevalence of injecting drug use is in decline in much of Western Europe. The cohort of people receiving OAT is ageing, and the decreasing demand makes it challenging to maintain the same level of harm reduction services: as this population decreases, so does the perceived urgency of ensuring an adequate response.^[28,65] At the same time there are populations where harm reduction responses are less established. People who use drugs and live in rural areas require more targeted service delivery, as geographical gaps in the coverage of harm reduction services is a common problem in the region (see sections 2.1, 2.2, 2.7).

Despite the complex harms, stigmatisation and structural violence they face, women who use drugs are still frequently overlooked as a group with unique needs who need targeted interventions. Though interventions for women who use drugs exist in the region, a substantial increase in female-only services is needed to appropriately address their needs.^[85]

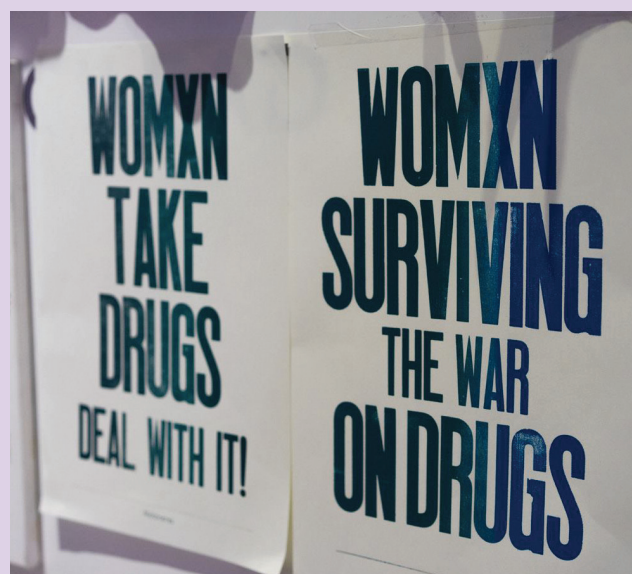
Injecting stimulants is associated with increased injecting frequency and substantial potential health risks,^[46,86-88] yet appropriate harm reduction responses for stimulant use remain under-implemented.^[89] Different NSP provision is needed for people who inject stimulants, and medical substitution therapy should also be considered.^[90]

Non-injecting use is another area where harm reduction responses are not sufficient, though DCRs are increasing

the spaces for smoking use. Using unsafe crack pipes has significant health risks,^[91] but the provision of safer smoking equipment is scarce.^[27,92] More widespread availability of drug checking services would be important in this area, both in terms of the number of countries and settings.

More specialised interventions can help to increase the coverage of harm reduction initiatives in communities where multiple needs have to be addressed. 'Housing First' programmes are well suited to serve people who use drugs who are experiencing homelessness,^[93] by providing stable housing as a foundation for those who have complex needs. People who use drugs with migrant and refugee backgrounds also experience difficulties accessing harm reduction interventions. Language is often a barrier but more significantly, the lack of health insurance negatively impacts access to harm reduction in the region.^[64,74] Providing OAT, HIV and hepatitis C testing and treatment in low threshold community settings could offer easier access to this group.

The community of men having sex with men is also inadequately served by existing or traditional harm reduction services. Though injecting use is prevalent in chemsex settings,^[65,92,94] few NSPs are tailored to the needs of this population. Chemsex-specific harm reduction interventions have been developed and implemented in the Netherlands and Portugal.^[27,65]



Photos: Nigel Brunson



2.2 OPIOID OVERDOSE

Fatal and non-fatal opioid overdose is a significant public health concern across the globe (in particular in North America, see the *Global State of Harm Reduction 2020* North America chapter for more details). In 2018, 34% of all those entering drug treatment in Europe reported opioid use as the main reason for entering treatment.^[60] Although the majority of opioid treatment entrants use heroin, other opioids also pose substantial public health concerns. Significant levels of mortality risk have been associated with the non-medical use of prescription opioids in some European countries, including opioid analgesics and OAT medications, particularly methadone.^[95] Potent synthetic opioids such as fentanyl and its derivatives, are also playing an increasing role in both non-fatal and fatal drug overdoses in the region.^[95] Awareness of public health risks associated with fentanyl derivatives has resulted in actions that include increased restrictions in producer countries. The market might be adapting to these measures as out of the eight new synthetic opioids detected for the first time in 2019 by the EU’s Early Warning System, six were not fentanyl derivatives, though they potentially have similar health risks, and seizure data.^[60]

The number of drug-related deaths has decreased over the years, with an estimated 9200 overdose deaths involving illicit drugs, primarily opioids, in the European Union, Norway and Turkey in 2018.^[60] Three quarters of those dying from overdose are male (76%), with a mean age of 41.7 years.^[60] The mean age has increased continuously over recent years, which echoes the ageing opioid user population in the region.^[60] While fatal overdose among younger age groups has generally been stable, overdose deaths among the 50-plus age group increased by 75% between 2012 and 2018. The trend in age is different in Turkey compared to the EU and Norway, where overdose deaths were among a younger population, with a mean age of 32.5 years.^[60] The trends in Switzerland are similar to the region and show an ageing population, with 44% of drug-related deaths among people over 50 in 2018, a substantial increase since 1995 when the same group accounted for 4.5% of overdose deaths in the country.^[96] In 2018, over 34 years olds made up the overwhelming majority of drug-related deaths (82%), while in 1995, those who were younger than 34 years were the largest group (81%).^[96] Experts in the region highlight the urgent need for a comprehensive approach that adapts to the needs of people, including increased access to and easier initiation of OAT, and implementing harm reduction programmes such as NSP, DCR and take-home naloxone programmes (see next section).^[95]

FIGURE 2.2: Drug-related deaths in Switzerland, 1995-2018^[96]

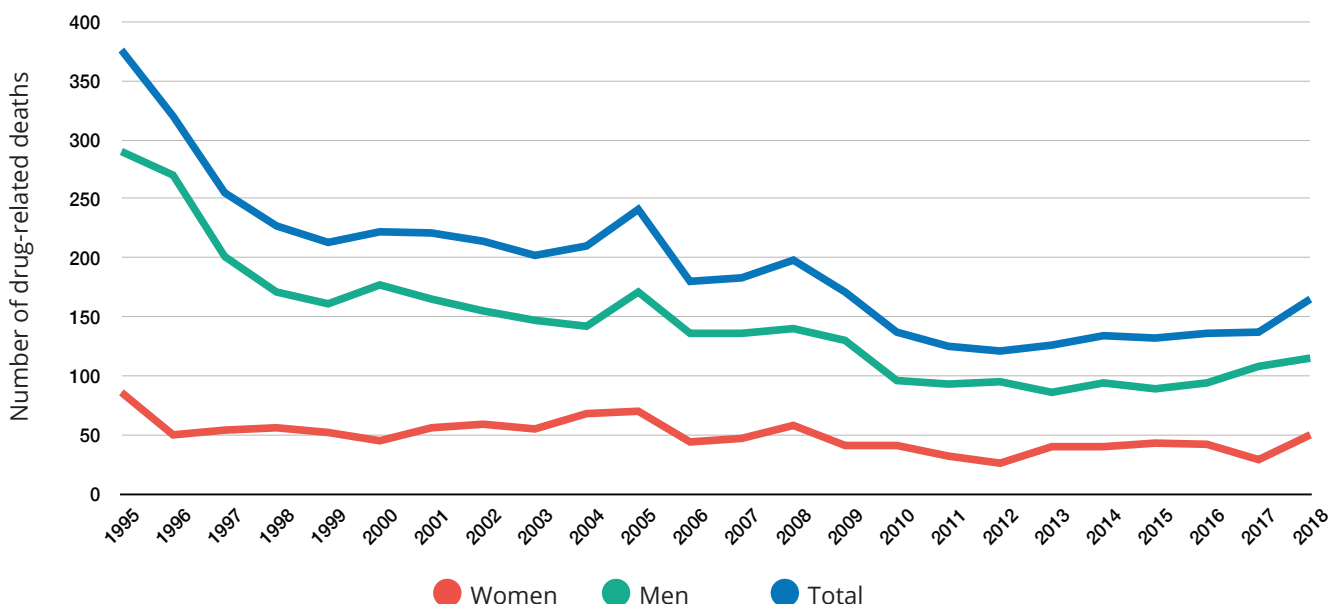


FIGURE 2.3:

Proportion of drug-related deaths in Switzerland by age group, 1995-2018^[96]

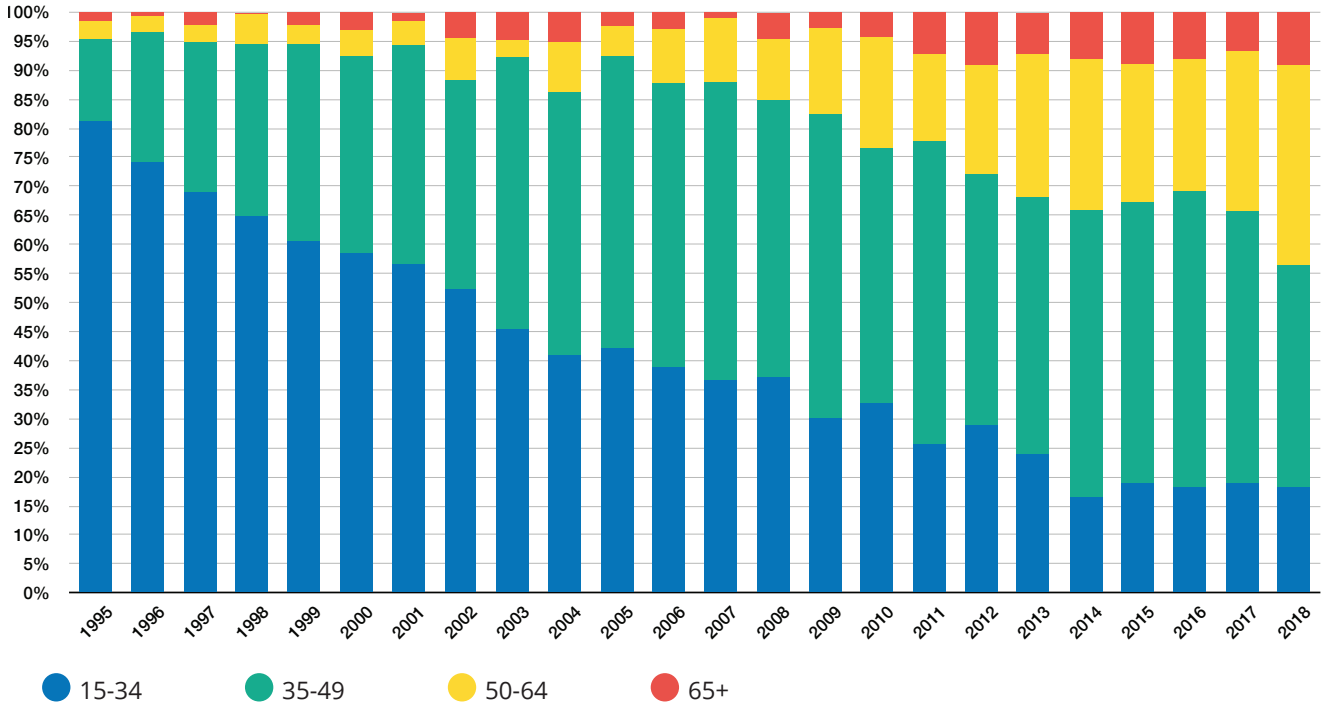
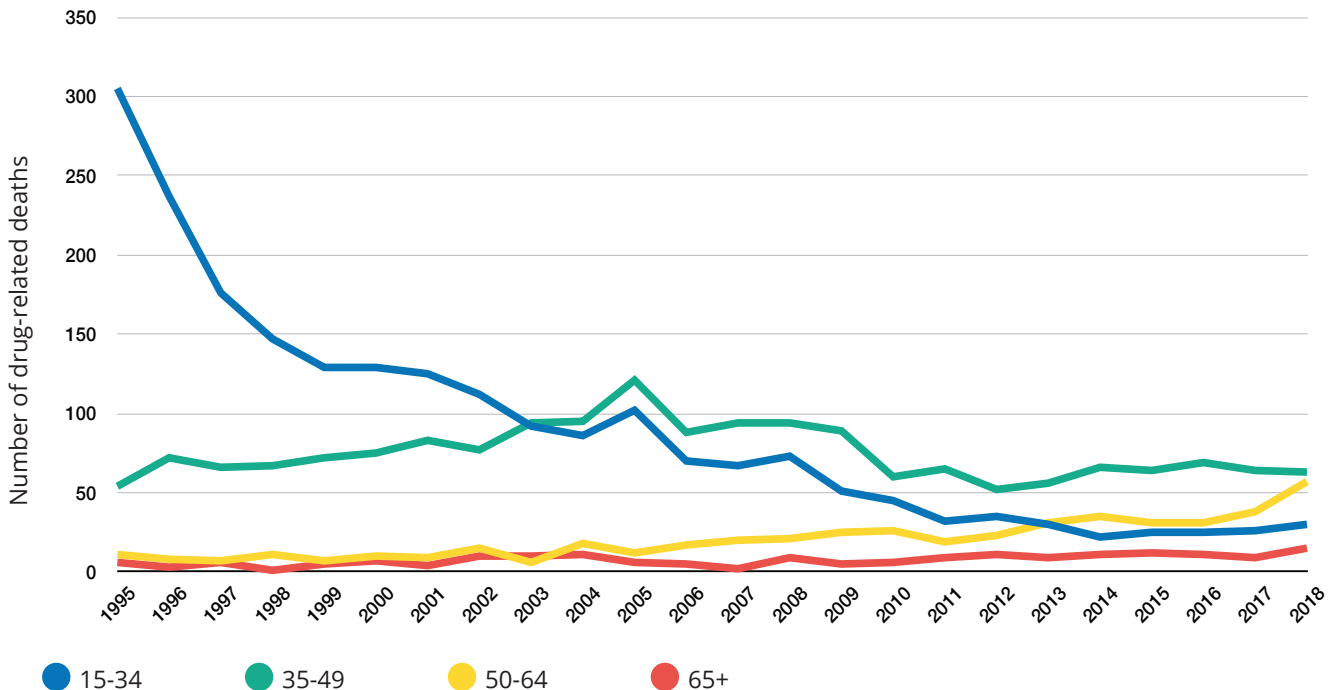


FIGURE 2.4:

Drug-related deaths in Switzerland by age group, 1995-2018^[96]



2.3 NALOXONE

Naloxone is an opioid antagonist that reverses opioid-induced respiratory depression, and can prevent opioid overdose deaths if administered in a timely manner. Community-based naloxone provision to opioid users and take-home naloxone programmes were first proposed in the 1990s.^[10] These programmes decrease overdose-related mortality by combining training on overdose risk and management with the distribution of naloxone to potential bystanders, aimed at making it more readily available in places where overdoses might occur.^[97,98] There are also naloxone peer-distribution programmes, where training programmes are delivered by a peer trainer and approved peer workers are authorised to distribute naloxone on an outreach basis without the direct participation of an approved prescriber.^[99,100] A systematic review found that take-home naloxone programmes are feasible, cost effective and can reduce overdose deaths: out of 2336 naloxone administrations at least 2249 (96.3%) successfully reversed a potentially fatal overdose.^[10]

Take-home naloxone programmes are now available in 10 countries in Western Europe: Austria, Denmark, France, Germany, Ireland, Italy, Norway,⁶¹ Spain, Sweden and the United Kingdom.^[29,61,101,102] The number of countries with take-home naloxone programmes increased since 2018, with two countries (Austria and Sweden) introducing the programme.^[29,101,102] Take-home naloxone is available in one city in Austria (Graz), and 50 people have received training and naloxone kits since it began in 2020.^[101] Sweden implemented a take-home naloxone programme in two regions in 2018, and take-home naloxone became available in most regions in 2019.^[29] There is also a plan to develop take-home naloxone in Belgium, though it has not been implemented at the time of the publication.^[66] There are no take-home naloxone programmes in Switzerland, since it is not available outside medical and emergency settings in the country.^[42]

Naloxone peer distribution programmes currently operate in Denmark, Italy, Norway and the United Kingdom, with no new countries introducing the programmes since 2018. Peer-led naloxone distribution programmes expanded in the United Kingdom, where 14 local authorities reported implementing, or having concrete plans to implement the initiative in 2019.^[104] EuroNPUD, the European Network of

People Who Use Drugs, implemented a Naloxone Access and Advocacy Project in the United Kingdom, which peer audited take-home naloxone in three locations, ran local advocacy events, and developed guidelines for implementing and advocating for naloxone peer-distribution programmes.^[99,100] In Portugal, injectable naloxone became available in DCRs and in 2020, nasal naloxone became available to harm reduction service providers.^[27] Misconceptions about naloxone (e.g. it encourages risky behaviours), a lack of widespread access even in countries where take-home naloxone is available,^[63,74,105,106] and legal barriers (e.g. medical background required to administer naloxone in an emergency) are hindering the introduction and scale up of programmes.^[66,70,106]

61 In Norway, this refers to a multi-site pilot programme.^[103]

3. Harm reduction for non-opioid substance use

3.1 DRUG CHECKING

Drug checking services enable people to get the contents of their drugs analysed - an important harm reduction initiative for people who use stimulants. It also has relevance for people who use other substances as it can detect highly potent synthetic opioids like fentanyl. Recent developments in Switzerland made drug-checking relevant for cannabis users too (see box on synthetic cannabinoid receptor agonists in herbal cannabis p16). Drug checking services have been implemented in at least nine countries: Austria, France, Italy, Luxembourg, the Netherlands, Portugal, Spain, Switzerland and the United Kingdom. However, implementation faces legal barriers in many countries, such as Germany, where drug checking is explicitly included in policy documents, but the majority of states consider it illegal.^[70,107] Based on a concept developed by three civil society organizations, drug checking for new psychoactive substances (NPS) is now being offered by an organisation in Berlin with state funding for implementation and evaluation in the 2020/2021 budget.^[70,107,108] While drug checking in Portugal is well established in nightlife settings, it is not available in other settings, because samples have to be received on site; and sending in samples by mail or through other harm reduction services is not available.^[27]

Switzerland was among the first countries to implement low threshold drug checking programmes, with organisations offering drug checking since the early 1990s.^[109,110] Drug checking services in Switzerland are free and anonymous, with a compulsory counselling session to screen for high risk drug use patterns and discuss safer drug use and harm reduction strategies.^[111] There are seven drug checking services operating in the cantons of Bern, Basel-Stadt, Geneva and Zürich,^[109] with an additional three new drug-checking services opened in 2020 in Luzern, Olten and Biel.^[42] The service in Luzern is a three-year pilot of a local organisation (Verein Kirchliche Gassenarbeit),^[112] and the Biel and Olten programmes are supervised by an organisation from Bern (rave it safe, the drug checking programme of Contact Foundation). The programme in Olten is close to the end of the pilot phase and once it ends, it will operate as an independent, regular, drug-checking programme. There are geographical gaps in drug-checking availability in Switzerland, for example, there is only one programme in the French speaking part of Switzerland (Geneva). However, the University of Lausanne recently started to offer ad-hoc drug checking at the DCR in Lausanne. The drug checking method being used is less precise than other services but has the advantage of immediate results; as this is ad-hoc the counselling session included in the national guideline is not implemented.^[42]

Drug checking services in Switzerland

Drug checking services in Switzerland target recreational drug use in nightlife settings. Swiss drug-checking services analyse around 4000 samples per year, mostly cocaine, MDMA and amphetamine. According to a study commissioned by the Federal Office of Public Health (FOPH),^[110,113] two thirds of the clients of drug checking services are men between 18-40 years, and the majority (59%) shows some high risk consumption patterns. The study found that after using the drug checking service, two thirds of the clients said that they would use less risky substances after counselling, and almost half of them said they would use smaller quantities. Furthermore, results showed that people with high-risk, drug using patterns were less likely to change their behaviour after using the service compared to other service users, which highlights the importance of awareness raising through counselling.

After chemical analysis, half of the substances submitted to the service were found to be problematic (high dose or dangerous content), and a warning was issued to the user and on the programme's website. Among clients who received a warning 90% decided to not use the substance or use less, highlighting the effectiveness of drug checking services.



3.2

AMPHETAMINE-TYPE STIMULANTS (ATS) AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

The most frequently used stimulants in Europe are cocaine, amphetamine, methamphetamine and MDMA.^[61] The cocaine market is the second largest drug market in the European Union (after cannabis).^[61,102] In 2019, more than 2.5% of people aged 15 to 34 years old reported using cocaine in the past year in six countries: Denmark, Ireland, Spain, France, the Netherlands and the United Kingdom.^[61] Cocaine use increased in France (3%), Netherlands (4.5%) and the United Kingdom (4.7%) and decreased in Spain (2.8%).^[61,114,115] The lowest prevalence of drug use was reported in Germany, Italy and Switzerland, all under 2% in 2020.^[116] The prevalence of MDMA use among young people in the EU was 1.7% in 2019, ranging from 0.2% in Portugal to 7.4% in the Netherlands.^[61] Prevalence of amphetamine use among young adults in the EU is 1%, and downward trends were observed in Denmark, Spain and the United Kingdom, with surveys suggesting an increase in the Netherlands.^[61] Amphetamines and MDMA tend to be associated with recreational use and nightlife settings in Germany, the Netherlands, Switzerland and the United Kingdom.^[64,74,92] Methamphetamine use is very low in Western Europe,^[61] Norway being the only country where wastewater analysis suggests relatively high prevalence.^[68] Methamphetamine use was reported amongst men who have sex with men in the Netherlands and the United Kingdom,^[65,92] while in Austria and Germany methamphetamine use is limited to specific regions.^[70,73]

Besides increasing prevalence of cocaine use, the availability of cocaine also increased, with both the number of cocaine seizures and the total quantity seized in the European Union reaching the highest levels ever recorded, with more than 110 000 seizures totalling 181 tonnes.^[60] With the increased availability and proportion of people who use cocaine, reported health consequences of cocaine use increased as did the number of people who entered treatment for the first time, increasing by 37% between 2014 and 2017.^[116] An analysis of cocaine treatment demand trends in ten Western European countries⁶² between 2011 and 2018 found that France, Ireland, Spain, Switzerland and the United Kingdom showed a stable or slightly decreasing proportion of treatment entrants with cocaine use until 2013–15, followed by a strong increase for the most recent period (until 2018).^[116] The other countries

showed continuous increase during the study period, with the strongest increase in cocaine-related treatment demand in France, Ireland and Luxembourg (15–17% per year).^[116]

The prevalence of the use of NPS is much lower than ATS and cocaine. NPS are disproportionately used by marginalised populations in the region.^[117–119] Synthetic cannabinoid (e.g. “spice”) use has been reported among prison populations and people experiencing homelessness, while synthetic cathinones (e.g. “bath salts”) are frequently used by people who inject drugs, and have been associated with an increased risk of hepatitis C infection.^[61,70,92,115,117,120–122]

Though NSPs and DCRs can be accessed by people who inject stimulants, reports show that existing harm reduction services are not always adequate for ATS user needs. For example, difficulties in reaching ATS users in low threshold settings were reported from Belgium.^[66] Very few ATS-specific harm reduction responses are implemented in the United Kingdom,^[92] while crack smoking kit distribution is the only stimulant-specific response in Portugal.^[27]

⁶² Belgium, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Spain, Switzerland and the United Kingdom. These 10 countries together accounted for more than 95% of the total European treatment demands for cocaine as primary substance in 2017.^[116]

New psychoactive substances (NPS)

The phenomenon of NPS emerged around a decade ago in Western Europe, and is now an established market. The EMCDDA is monitoring more than 730 new psychoactive substances.^[61] The peak of the new substances identified was in 2014-15, with around 200 NPS identified during that period. Post 2015, this number decreased and stabilised at levels similar to the beginning of the decade.^[61] After the initial difficulties in designing health-based responses to NPS, there is now EMCDDA guidance,^[123] and general principles of harm reduction remain relevant.^[123] The term NPS is an umbrella term covering vastly different substance groups. Different types of NPS have become associated with different user groups and settings. NPS can be associated with serious health and social harms,^[61,124] thus appropriate harm reduction responses are crucial.



New psychoactive substances are disproportionately used by marginalised populations in the region. Synthetic cannabinoid (e.g. “spice”) use has been reported among prison populations and people experiencing homelessness, while synthetic cathinones (e.g. “bath salts”) are frequently used by people who inject drugs, and have been associated with an increased risk of hepatitis C infection.

SYNTHETIC CANNABINOID RECEPTOR AGONISTS

The substances in this category are functionally similar to THC⁶³, the active compound of cannabis, and are usually smoked in herbal mixtures. They are frequently associated with prison settings and people experiencing homelessness. Relevant harm reduction interventions are outreach programmes, drop-in centres, and counselling and education in prison settings.^[93,121,125]

SYNTHETIC CATHINONES

These substances are stimulants related to cathinone, one of the psychoactive components of the khat plant, and are usually found in powder form. Synthetic cathinones are mostly used in nightlife and recreational settings in Western Europe, though recently they have been mostly associated with men who have sex with men who are engaging in chemsex. NPSs, injection and snorting kit distribution could be beneficial harm reduction interventions for people who use synthetic cathinones.

PSYCHEDELIC SUBSTANCES

There are NPS with hallucinogenic effects which are mostly associated with nightlife settings, and recreational use, with less treatment demand. Harm reduction services in nightlife or party settings (e.g. drug information, education, help with psychedelic emergencies or “bad trips”, chill out spaces, water, snacks) remain relevant, particularly drug checking services.

SYNTHETIC OPIOIDS

Synthetic opioids, most notably fentanyl, are associated with the current overdose crisis in North America. Though these substances are uncommon in Western Europe, reports suggest growing availability in the European Union, and growing presence of these substances in overdose cases.^[61,102] Overdose prevention measures are appropriate harm reduction responses to the risks of overdose from potent synthetic opioids, including DCRs, naloxone and drug checking.

63 Tetrahydrocannabinol (THC) is the main psychoactive component of cannabis.

Synthetic cannabinoid receptor agonists (SCRAs) in herbal cannabis

A recent development of the European NPS market in 2020, is the emergence of herbal cannabis laced with synthetic cannabinoid receptor agonists (SCRAs). According to reports, there is low THC content cannabis in the drug market with SCRAs sprayed to them and sold as “regular” cannabis. In 2019, SCRAs were tested for the first time as an additive to herbal cannabis or hashish in various Swiss drug checking services.^[126] Since the beginning of 2020, inquiries and analyses of SCRAs have increased in Zurich.^[126] Switzerland was the first to detect this phenomenon, and it is predominantly observed there in the region,^[126] though other Western European countries (for example, Austria, France, Germany, Italy, Luxembourg) have also reported it since.^[42,64]

Regulations regarding hemp products may influence the high prevalence of these SCRA laced cannabis in Switzerland compared to other Western European countries.^[64] A revised narcotics law came into force in Switzerland in 2011, which set the maximum THC content of industrial hemp at 1%.^[64] Different hemp products have been introduced to the market since, such as textiles, cosmetics, scented oils, edible and smokable products known as “CBD⁶⁴ weed.” These smokable CBD products with less than 1% THC content are often the base onto which SCRAs are sprayed.^[64]

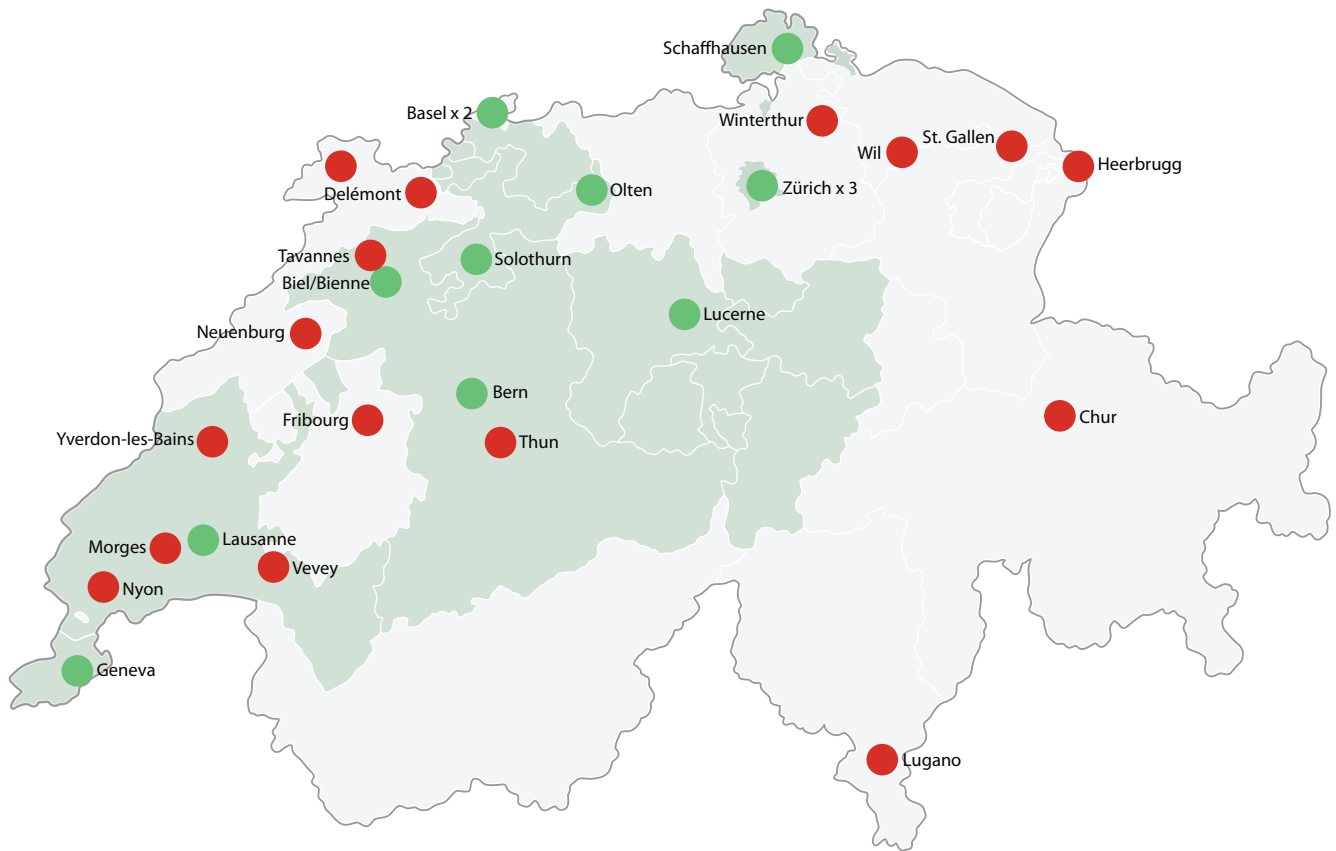
As a harm reduction and prevention measure, the drug-checking service DIZ in Zurich, introduced cannabis into their drug checking programme. It has been available since October 2020, offering free and anonymous cannabis checking every Thursday evening at their centre.^[129] According to a report on the results of this service, 48 out of the 50 cannabis samples tested positive for SCRAs were herbal cannabis with less than 1% THC content.^[126] The analysed samples contained less than 1% THC and have been consistently sold as “regular” cannabis at purchase,^[64,126] which underpins the assumption that “CBD weed” is being used to produce SCRAs laced herbal cannabis.

64 Cannabidiol, or CBD is one of the most extensively studied cannabinoids that can be found in cannabis. While the main psychoactive component of cannabis is tetrahydrocannabinol (THC), CBD is not considered as psychoactive, the recent review by the World Health Organization's Expert Committee on Drug Dependence found that CBD 'has no potential for abuse and no potential to produce dependence'.^[127] In November 2020, the European Court of Justice published a judgement stating that cannabidiol extracted from the cannabis plant should not be considered a drug under the 1961 United Nations Single Convention on Narcotic Drugs.^[128]

4. Non-substance-specific harm reduction interventions

FIGURE 4.1:

Location of low-threshold harm reduction services and drug consumption rooms in Switzerland, 2020



Key:

- With drug consumption room
- Without drug consumption room
- ◊ Consumption Room Catchment Area



4.1

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

Needle and syringe programmes are amongst the most widely available harm reduction services in Western Europe, available in all countries except Turkey (with no available data on Andorra, Liechtenstein, Monaco and San Marino). The number of countries in Western Europe in which NSPs operate is unchanged since the Global State of Harm Reduction 2018, and provision of syringes has been stable since 2018 in most countries.^[9,27,28,63-65,67,68,74,101,130] Belgium, Finland, Iceland, Ireland, Luxembourg and Sweden have all seen increases in the number of syringes distributed over recent years.^[66,69,71,72,131-133] The number of syringes distributed through NSPs decreased in Greece and coverage has remained below recommended per person benchmarks, despite a decrease over the last few years in the estimated number of people who inject drugs.^[134,135] Luxembourg, Spain and the Netherlands also reported declines in injecting drug use.^[28,65,136,137] Due to a decrease in funding over the past five years, there has been a reduction of specialist NSPs in the United Kingdom, with a shift to provision in pharmacies.^[92] Pharmacies also play an important role in syringe distribution in Iceland, Spain and Portugal.^[1,27,28,92,131,138,139] Pharmacies can increase the coverage and availability of syringes but they cannot provide the comprehensive harm reduction services available at a specialist harm reduction service with NSP, and more limited opening hours can hinder access to sterile injecting equipment for people who inject drugs.^[92,131]

There are barriers in access even in countries which pioneered harm reduction. While the coverage of NSPs in Western Europe is sufficient for people who use opioids in urban areas, access to NSPs in rural or remote areas is a major issue in the region. For example, there is no stable NSP provision in the southern region of Italy,^[63] and there are cities in the northern regions of Italy (e.g. Novara, Vicenza) where NSPs are not available.^[63,140] Reports indicate there is lower coverage in rural areas in Austria, Belgium, Germany, the Netherlands and Portugal.^[27,65,70,74,101] Analysis by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) found that Greece has the worst geographical coverage in the region, with NSPs available in only 4%⁶⁵ of the country.^[22,141] In addition to geographical gaps, there are groups of people who inject drugs that experience

barriers to access. There are reports of migrants who inject drugs facing barriers to accessing harm reduction services in Austria, Germany, Italy, the Netherlands.^[74,101,142]

People who inject stimulants are another group where NSP provision is suboptimal, which is a serious issue as stimulant injecting was associated with local HIV outbreaks in five countries⁶⁶ in the past few years.^[45,46,143] Furthermore, stimulant injecting is very common, a recent analysis of discarded syringes in eight European countries⁶⁷ found stimulants in the majority of syringes from amphetamines (Amsterdam), synthetic cathinones (Budapest), cocaine (Cologne), synthetic cathinones (Paris) and cocaine (Lausanne). Opioids such as heroin (Cologne), buprenorphine (Helsinki), heroin (Oslo) and methadone and carfentanil (Vilnius) were also found in syringes.^[144] Moreover, one third of the syringes tested contained residues of two or more substances from different drug categories, highlighting that people who inject drugs often inject more than one substance.^[144] The most frequent combination was a mix of a stimulant and an opioid, and benzodiazepines were often found in syringes that also contained traces of opioids.^[144] These results show the importance of continuous adjustment of service provision to match the actual trends in the community they serve.

⁶⁵ Measured in NUTS3 level, a statistical territorial unit of the EU. See: <https://ec.europa.eu/eurostat/web/nuts/background>

⁶⁶ Ireland, Germany, Luxemburg, and the United Kingdom. See HIV and antiretroviral therapy (ART) section.

⁶⁷ Syringes were collected from the bins of street automatic injection-kit dispensers and at harm reduction services in eight European cities: Amsterdam (2019), Budapest (2018-19), Cologne (2018-19), Helsinki (2018-19), Lausanne (2018-19), Oslo (2019), Paris (2018-19) and Vilnius (2019). The contents of 988 (2018) and 1 330 (2019) used syringes were analysed in seven laboratories using chromatographic and spectroscopic methods.



4.2

DRUG CONSUMPTION ROOMS (DCRS)

The number of countries with DCRs has increased since 2018, with Portugal opening a mobile DCR in 2019.^[27,145] In the summer of 2020, there were 88 DCRs in 10 countries: Belgium, Denmark, France, Germany, Luxemburg, Netherlands, Norway, Portugal, Spain, Switzerland,^[27,64,66,132,146] and further increases are expected. In Iceland and Ireland, efforts to open DCRs have the support of their national governments,^[131,147,148] while in Finland and the UK subnational governments are supportive but legal challenges at the national level have prevented implementation.^[78,92,149,150]

In Portugal, the latest country to introduce a DCR in the region, two civil society organizations, Grupo de Ativistas em Tratamentos (GAT) and Médicos do Mundo, run a mobile DCR. The Lisbon City Council provides funding for the two-year pilot project, after which financing is expected to come from the National Drugs Agency.^[27] Furthermore, Porto also commenced a mobile programme in 2019, and as of August 2020 the local government allocated the budget to open a pilot fixed-site DCR in Porto,^[50,51] and there are plans to open two fixed-site DCRs in Lisbon in 2021.^[22,27] Countries with established DCRs have also opened new sites since 2018. In Germany, for example, two states opened their first DCR, Berlin opened a third, and the number of mobile DCRs increased.^[74] In Luxembourg, a second facility was established in Esch-sur-Alzette,^[22] and in Switzerland, a pilot mobile DCR program began in Zurich.^[64] There are a total of 13 DCRs in Switzerland, with about 1000 visits per day.

DCRs increasingly include supervised inhalation alongside injecting. With a decrease in injecting and an increase in access to OAT, service providers are adapting to the needs of people who smoke drugs.^[146] This is a strong trend in Germany, where DCRs continuously add new slots for inhalation due to increasing demand,^[74] and most facilities in the Netherlands have only areas for smoking.^[151] In the Netherlands, the number of DCRs decreased from 37 in 2010 to 24 in 2018, however these numbers do not include in-house DCRs in sheltered housing facilities.^[65,152] A decline in the number of people who inject drugs has resulted in the closure of some DCRs in Switzerland and Spain.^[65,146] The changing trends in drug use are reflected in the characteristics of DCR visits in Swiss facilities, according to the most recent data from 2020. The most commonly used substances in DCRs were cocaine (40%) followed by heroin (28%) and mixture of heroin and cocaine (25%).^[153]

Substances were smoked in the majority of cases (59%), while injecting and snorting accounts for 21% and 20% of cases respectively.^[153]

5. Health care for people who use drugs

5.1 HEPATITIS C

Harm reduction for people who inject drugs is among the priority interventions in the global effort to eliminate hepatitis C by 2030,^[154] as it is estimated that more than half of all people who inject drugs have been infected with hepatitis C at some point in their lifetimes.^[155] NSPs, DCRs, OAT and the distribution of safer smoking equipment are all means of reducing the sharing of equipment and high-risk injection practices associated with viral hepatitis transmission.^[156–158] Furthermore, harm reduction interventions are crucial to engage people who use drugs in hepatitis C testing and treatment.^[156,158] Western Europe is among the regions where many countries are on track to meet WHO hepatitis C elimination targets. At the end of 2020 there were seven countries in the region: France, Iceland, Italy, Netherlands, Spain, Switzerland and the United Kingdom.^[159]

The prevalence of hepatitis C antibodies among people who inject drugs varies widely across Western Europe, ranging from 10% in Iceland to 76% in Ireland (as shown in Table 1, p4). The United Kingdom and Iceland have recently reported an encouraging decline in the prevalence of hepatitis C among people who inject drugs following the scaling up of direct-acting antiviral (DAA) treatment.^[46] Hepatitis strategies are now in place in 17 EU countries and Norway.^[61] Although there is no hepatitis C strategy for the whole United Kingdom, there are strategies in Northern Ireland, Scotland and Wales.^[78,92] There is no national hepatitis C strategy or testing programme targeting people who inject drugs in Italy.^[63] The most recent analysis of policy documents in the region found that only two countries (Cyprus and Malta) continue to restrict access to hepatitis C treatment for people who inject drugs.^[160]

Switzerland has national guidelines on viral hepatitis for people who inject drugs, developed by Infodrog on behalf of the Federal Office of Public Health.^[64,161] The aim of the guidelines is to establish minimum standards for the prevention and treatment of hepatitis C among people who use drugs in contexts from low threshold services to treatment. It contains setting specific guidelines for low threshold harm reduction programmes (Kontakt und Anlaufstellen⁶⁸), outpatient and inpatient services, OAT and HAT services, and also for healthcare and prison settings.^[161] A training programme, adapted for Switzerland

by Infodrog and the Swiss Association for the Medical Management in Substance Users (SAMMSU) for medical professionals on managing patients with hepatitis C is also available. The training covers hepatitis C epidemiology and prevention, testing and diagnosis and treatment.^[162] Training programmes are available in at least eight further Western European countries: Belgium, France, Germany, Italy, Portugal, Spain and the United Kingdom.^[163]

Although hepatitis C treatment is free in many countries in the region,^[27,65,66,92,101,131] cost of treatment remains a barrier to those without health insurance in insurance-based health systems such as Austria, Germany, Luxembourg and Switzerland. This negatively impacts access for people who inject drugs who are refugees or migrants.^[64,74,101] The availability of hepatitis C testing in the region is high, with Cyprus being the only country where testing is not offered in harm reduction services.^[164] In the United Kingdom, hepatitis C testing has been scaled up significantly and has been made available in harm reduction services, drug treatment services, pharmacies, health clinics and at general practitioners.^[92] Despite the availability of rapid hepatitis C tests in harm reduction services in Italy, uptake of testing is very low, with less than one fifth of drug service clients tested. Low testing is attributed to insufficient information on availability among clients.^[63] Insufficient test uptake was also mentioned in Switzerland, but the main barrier to access is the insufficient coverage of harm reduction services. It is estimated that coverage of OAT is about 70%, and 75% of people who inject drugs are in NSPs, which means that providing testing at OAT and NSPs would not improve access to testing for 25–30% of the population.^[64] A study modelling hepatitis C prevalence in three regions in Switzerland to assess elimination goals concluded that beside intensified screening for hepatitis C and scale up of DAA treatment, increased access to harm reduction programmes is necessary to reach elimination targets in Switzerland.^[165]

While hepatitis C testing and counselling are offered by harm reduction services, treatment provision is an area where the region lags behind. A study found that treatment prescription is available in services for people who use drugs only in Cyprus, Denmark, Germany, Luxembourg and England,^[164] and several NSPs offering hepatitis treatment in Sweden.^[29] However, a wide range of best practices and

68 "Kontakt- und Anlaufstellen" are low threshold harm reduction centres/services, offering sterile injection equipment and advice for people who use drugs. There are "Kontakt- und Anlaufstellen" with and without supervised drug consumption rooms.

innovative models of care in harm reduction services are present in the region. There are at least eight countries (Austria, Belgium, Denmark, France, Luxembourg, Portugal, Spain, and the United Kingdom) where hepatitis C treatment in low threshold settings, peer support and community-based programmes and multidisciplinary treatment provision integrated to OAT and NSP is present.^[166]

The placement of hepatitis testing in inappropriate settings is consistently reported as a barrier to testing and treatment. In Germany, for example, hepatitis C testing is mainly available in medical settings (doctor's offices, hospitals), which does not sufficiently meet the needs of people who inject drugs. In order to effectively increase hepatitis C testing,^[74] targeted harm reduction measures are needed to reach vulnerable subpopulations of people who inject drugs.^[142] In the Netherlands, a specialised outreach project was launched to provide hepatitis C testing at drop in centres and homeless shelters to reach those who would not normally attend the municipal health services for testing.^[65] Although there are some informal arrangements to provide community-based testing in Portugal, most testing and treatment is hospital-based; health services are not adapted to the needs of people who inject drugs, and stigma and discrimination are still an issue.^[27] Civil society identified the fear of stigmatisation and discrimination by medical professionals as the main barrier to accessing hepatitis C care in Austria.^[101]

5.2. TUBERCULOSIS (TB)

The incidence of TB in Western Europe is generally low, ranging from 4.5 cases per 100,000 in Iceland and Greece to 17 per 100,000 in Turkey and 20 per 100,000 in Portugal.^[167] Western Europe is a region where the decline of TB prevalence was the fastest in the recent years according to the WHO, however, this is still not enough to achieve the WHO End TB Strategy targets.^[167] Despite the low TB prevalence rates in the region, people who use drugs are a community with higher risks in the general population. People who use drugs have higher rates of TB and latent TB infection regardless of their HIV status.^[168] People living with HIV who inject drugs are two to six times more likely to develop TB disease,^[169-171] and TB is the leading cause of mortality among people who inject drugs and who are living with HIV.^[172]

In Western Europe, TB diagnosis and treatment is generally available for people who inject drugs, but there are barriers to accessing services, including the fear of stigmatisation and discrimination, and the lack of health insurance, which disproportionately affects refugees and migrants.^[74,101] The level of integration of TB into harm reduction and HIV programmes varies by country, with good integration reported in Belgium, Iceland, the Netherlands and the United Kingdom but little integration in Germany.^[65,66,70,74,74,131] Though TB diagnosis is accessible for people who inject drugs in Portugal, and there are partnerships between harm reduction services and TB diagnostic centres, further integration is needed.^[27] This is a general problem, as TB services rarely include harm reduction interventions such as OAT. Stronger integration of harm reduction and TB services could be beneficial in terms of access and availability of these services in the community.



5.3. HIV AND ANTIRETROVIRAL THERAPY (ART)

The number of new cases of HIV in Western Europe attributed to injecting drug use each year has decreased by around 45% since 2010.^[143] In 2018, there were 996 new HIV diagnoses attributable to injecting drug use in the EU, representing 4.6% of all HIV diagnoses.⁶⁹ This proportion exceeded 10% only in Greece.^[46] In Switzerland, the trends are similar, injecting drug use is identified as the possible route of acquiring HIV in the minority of new cases. 4.5% of all new HIV infections among women, and 3.3% of all new HIV infections among men in 2019 were related to injecting drug use.^[173] More than half of new HIV diagnoses among people who inject drugs in the European Union in 2018 were diagnosed late,^[61,143] meaning increased access to testing and scaling-up of opportunities for earlier intervention are needed. Among those countries in Western Europe where data is available on the UNAIDS HIV targets⁷⁰ for people who inject drugs, only four reached the first target of 90% of people who inject drugs living with HIV who know their status: Finland, France, Germany, Portugal.^[174] Six countries reached the target of 90% being on anti-retroviral therapy (ART): Austria, France, Malta, Switzerland, Sweden and the United Kingdom (Luxembourg at 88% is close to reaching the target,^[174] while the proportion is just 55% in Germany).^[74] Seven countries reached the target on viral suppression (90% of those receiving treatment achieve viral suppression) for people who inject drugs: Belgium, France, Luxembourg, Germany, Sweden, Switzerland and the United Kingdom.^[174]

Despite the decline in diagnosed HIV infections among people who inject drugs, localised HIV outbreaks have been documented in the past five years in Ireland, Germany, Luxemburg, and the United Kingdom.^[46,61] All four outbreaks have been associated with marginalised populations of people who inject drugs and people who inject stimulants (cocaine injecting in Luxemburg and the United Kingdom, and NPS injecting in Ireland and Germany). As stimulants are commonly injected more frequently than opioids, an increase in stimulant injecting can lead to a shortage in sterile injecting equipment.^[46,61,86-88] These outbreaks occurred in countries with good availability of NSP, OAT and ART, which highlights the importance of adapting traditional models of care to the needs of local communities. In Germany, for example, community-based

testing has been expanded and testing is also now being offered in low threshold drug services.^[174] In Portugal, HIV testing is also available in community-based organisations across the country, targeting key populations including people who inject drugs. This network plays an important role in overcoming barriers like fear of stigmatisation and discrimination, lack of knowledge about the healthcare system, and poor health literacy.^[27]

Though HIV testing and treatment is generally available in the region, there are significant barriers to access and only one country, France, has met all three UNAIDS targets. Organisations in the region saw similar problems in HIV testing and treatment as for hepatitis C testing and treatment. Though ART is available and free, a lack of health insurance hinders access to HIV treatment in insurance-based health systems.^[64,70,74] The unequal geographic distribution of service providers within countries is also a barrier for people who inject drugs living in underserved regions. Stigma and discrimination towards people who inject drugs is still a serious barrier in many countries. The latter was reported in connection with health services in Portugal and Germany.^[27,70]

69 Proportion of all HIV diagnoses for which the route of transmission is known.

70 UNAIDS 90-90-90 targets are: By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression. <https://www.unaids.org/en/resources/documents/2017/90-90-90>

6. Harm reduction in prisons



People in prison report higher lifetime rates of drug use and injection than the general population in EU countries,^[61] and in the absence of adequate services for people who inject drugs, the risk of unsafe drug use and the transmission of blood-borne diseases in prisons is high.^[174] Recent studies strengthened the evidence base. One study among people who use drugs in Germany found that previous imprisonment is associated with increased likelihood of hepatitis C infection, regardless of gender.^[142] Another in Irish prisons showed high prevalence of hepatitis C with risk factors including a history of injecting drug use, prison tattooing, community tattooing, and sharing injecting equipment among male prisoners.^[175]

OAT in prison is available in all countries in the region except Turkey, but only four countries provide NSPs in prisons. These are: Spain (all prisons), Switzerland (15 out of 106 facilities, accounting for 21% of the prison population), Luxembourg (one of two prisons) and Germany (one syringe-dispensing machine in one out of 181 prisons - a women's prison with 200 inmates).^[28,64,69,70,74,176] Though harm reduction equipment, such as needles, foil and condoms are, in principle, available in all Spanish prisons, the number of facilities with active NSPs has decreased to 47 in recent years following a decrease in the number of people who inject drugs.^[28]

Access to OAT in prisons varies significantly between and within countries in the region. In Germany for example, one person reported receiving OAT in Saxony, while 1068 people reported receiving OAT in Berlin.^[177] Major regional differences were also reported in Switzerland, coverage of OAT and HAT is low in the French and Italian speaking parts of Switzerland compared to the German speaking regions.^[64] Although OAT can be initiated in prisons in every country in the region except Cyprus,^[178] reports suggest direct and indirect barriers hinder access. OAT initiation is available in only four prisons in Portugal, while in Belgium initiation depends on local policies in each prison.^[27,66] Other countries have more indirect barriers. In the Netherlands, for example, prison doctors can be hard to reach and sometimes offer minimal medical care.^[65] Being in treatment prior to imprisonment was identified as an advantage to access in Austria, and negative attitudes towards people who use drugs in prisons is an issue in Germany and Italy.^[63,70,74,101] People who are released from prison are particularly vulnerable to opioid overdose.^[104]

However, newly released prisoners are only seen as a target population for take-home naloxone programmes in France, Italy and the United Kingdom.^[106] A study found that take-home naloxone and training was delivered in 51% of prisons to only 12% of the released prisoners with opioid use history in the United Kingdom.^[92,104] Overdose training (without naloxone) is available in some prisons in Belgium,^[66] and in one prison in Germany.^[70,74]

HIV and hepatitis C testing and treatment in prisons are available in every country but data on coverage in prison settings is not available.^[178] Different barriers affect accessibility of treatment in prisons: long bureaucratic processes make it difficult to continue treatment in prisons in Italy;^[63] the lack of health insurance and unclear financing of treatment is a barrier in Switzerland;^[64] there are financial barriers to hepatitis C treatment uptake in Belgium (difficult to initiate treatment, because it is reimbursed by the prison);^[66] and it is not clear how regular screenings are in Portugal and the Netherlands.^[27,65]

Heroin-assisted treatment in prison settings: fifteen years of experience shows favourable results



Programmes targeting people who use opioids were among the first harm reduction services. Their relevance has been highlighted by recent overdose crises in North America and the elevated risk of synthetic opioids emerging in the drug markets. The implementation of a criminal justice system based continuum of care for people who use opioids still lags behind, despite the fact that many people who use opioids are present in prison settings. A study in the United States showed that a quarter to a third of all people who use heroin pass through the country's prisons and jails each year.^[179]

Traditional OAT like methadone and buprenorphine is available in prisons in 59 countries worldwide, though Switzerland is the only country where HAT is also available in a prison setting. Since 2000, HAT is available at the Realta penitentiary, it was also available in another facility, Schöngrün penitentiary which closed in 2015.^[41] Realta is an open prison, where prisoners can leave the prison during the day and work outside. There are 120 places in the facility, with 10 treatment slots for HAT (increased from the initial six places in 2000).

At Realta, HAT, as other forms of OAT, can be continued and/or initiated during the prison term. The eligibility criteria for HAT during detention includes:

- » At least 2 years of demonstrable problematic heroin use;
- » At least two recognized treatment attempts (such as a OAT) with unsuccessful treatment retention (defined as using additional, illegally obtained opioids despite receiving prescription medication);
- » Medical, psychological, or social harms due to opioid drug use;
- » Consent of the referring legal authority (probation and correctional services).

HAT is delivered twice daily, between 7:00 and 7:15 a.m. and 6:30 and 6:45 p.m. by two nurses. After receiving it from the nurse, people inject or take it orally themselves in a dispensing room where they are monitored from an adjoining room.^[41]

A recent study analysed fifteen years of HAT data from the Realta facility, and found one of the main obstacles of implementing OAT or HAT in Swiss prisons are concerns about accidental overdose and participants' ability to work,^[41] comparing health outcomes and work performance of HAT participants to the general prison population.^[41] The analysis found that HAT in a prison setting was beneficial with positive health outcomes such as no mortality due to overdose, non-fatal overdose or serious medical complications among HAT participants over the study period, and no safety issues during or after heroin distribution was ever reported. HAT clients worked slightly less than the general prison population on average (17 and 18.7 days per month, respectively), and no accidents associated with participation in HAT were recorded during the fifteen-year period.

HAT in prison settings can be delivered safely over extended periods of time, and it is a valuable treatment option during incarceration for people who use opioids. Studies show that people who use opioids but don't have access to OAT while in prison have increased risk of fatal overdose after release, whereas initiation and continuation of OAT can decrease this risk upon release.^[41,180,181] Studies showed that people who use opioids but don't have access to OAT while in prison have increased risk of fatal overdose after release, whereas initiation and continuation of OAT can decrease this risk upon release.^[41,182] The Swiss example shows that HAT in prison is safe and feasible, and is a good option to decrease the risks of people who use opioids who are unresponsive to other OAT medications.

7. COVID-19 and harm reduction



People who use drugs, especially people who smoke or inject drugs, face additional risks and vulnerabilities to COVID-19⁷¹ infection compared to the general population.^[60,184] Smoking or inhaling particularly increases COVID-related risks, as it is associated with pulmonary and respiratory problems.^[91] People with a long history of opioid or stimulant use are more likely to have a compromised immune system,^[60] and people who inject drugs can have underlying medical conditions that make them more vulnerable. For example, HIV, TB and hepatitis C prevalence is higher in this population than in the general population.^{[3] [184]} Therefore, maintaining services for this population is even more vital during a public health crisis such as the COVID-19 pandemic. Although the pandemic seriously affected service delivery and the coverage of harm reduction services in the region, Western Europe experienced less severe impact on harm reduction service delivery.^[58]

The availability and coverage of harm reduction services decreased after the COVID-19 measures were introduced in the region, but the majority of EU countries (14 out of 25) reported only a slight decrease and six countries reported no change in availability.^[58] Reports to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) showed that services were affected differently – NSPs and OAT programmes experienced serious decreases or closure in about half of the countries, while drop-in-centres were seriously disrupted in almost 80% of countries.^[58] It is important to add that COVID-19 measures and the decrease of harm reduction service availability affected communities differently, and people with multiple vulnerabilities were affected the most. For example in Barcelona, Spain, most harm reduction services reduced or restricted their programmes, which impacted women and gender non-conforming people, as these measures significantly decreased their access to services where they also accessed food, shelter and psychosocial support.^[185]

Most drug consumption rooms (DCRs) in the region remained open during the pandemic with the exception of Norway where they were closed following the recommendations of the country's health authority.^[58,64,186] DCRs adapted service delivery modes to comply with the physical distancing rules. The number of clients using facilities were limited, and many introduced additional

preventive measures such as fever checks upon entry, mandatory hand washing and wearing face masks. To compensate for the decrease in capacity, temporary DCRs were opened in Barcelona, another mobile DCR was implemented in Lisbon, and DCR opening hours were increased in Germany. The DCRs in Zurich set up outdoor tents to ensure physical distancing was observed.^[58,64,187] Furthermore DCR teams from three facilities in Zurich merged (60 employees), and this combined team provided support for one large emergency site.^[185] Initially, the lack of personal protective equipment and disinfectants was an issue, but it was resolved over time, and the supply was restored. Later in the year, two DCRs received special permits, and the physical size of the services was expanded to make them safe under the COVID-19 regulations, so they could serve the same number of clients as prior to the pandemic. One of the DCRs installed a 200 square meters tent next to the facility, and another other service converted meeting rooms to consumption rooms.^[185] These measures seem to be effective, and at the end of 2020 there were only two clients and two DCR staff who tested positive for COVID-19.

The COVID-19 crisis catalysed the establishment of regular consulting or monitoring networks of professionals working in the fields of drug policy and harm reduction, and strengthened cooperation between organisations in many countries (e.g. Italy, Ireland, Netherlands, Norway, Portugal, United Kingdom).^[56,63,65,92,188,189] In the United Kingdom, for example, a national network monitoring group with biweekly online meetings has been established to monitor the drugs market and harm reduction during the crisis, involving a wide range of stakeholders from service providers, networks of people who use drugs, law enforcement, advocacy groups and researchers.^[92]

To compensate for decreased access and coverage, harm reduction services adjusted service delivery to the lockdown environment. Across Western Europe, NSPs have encouraged users to take away larger quantities of injecting equipment,^[58] allowing secondary needle exchange and safe injection practices during lockdown. Outreach was used to maintain the coverage of NSPs and take-home naloxone programmes in Italy;^[63] and innovative ways of service delivery were introduced, for example click and collect schemes for harm reduction

71 Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease and cancer, are more likely to develop serious illness.^[183]

equipment in the United Kingdom, and mail delivery of syringes and other commodities in France.^[58,92] Peer involvement became more pronounced in many countries; peer networks provided secondary needle exchange and outreach services, and disseminated information on lockdown measures and COVID-19.^[189,190] As a result of the pandemic and subsequent lockdown restrictions, the income of certain subpopulations of people who use drugs decreased substantially, for example sex workers and people experiencing homelessness.^[64,78,92,187] In response, a temporary OAT service was installed in Hamburg, Germany, where anyone could initiate OAT and access medication without costs, regardless of health insurance status.^[187]

OAT practices were reformed in many countries, for example, distribution of OAT medications and naloxone in low-threshold outreach settings in Luxembourg, Spain and Portugal.^[58,189] and less restrictive prescribing practices across the region (longer take-home periods and significantly shorter initiation time).^[56,58,63,65,78,92] For example, in Switzerland the FOPH relaxed the rules for OAT and HAT. For OAT video calls to observe dosing were introduced, and take-home periods were extended to two weeks or in some cases a month.^[191] In case of HAT, FOPH decreased their HAT authorisation time from one week to one day, and a two-day take-home period was introduced (previously clients had to visit HAT clinics, generally twice a day), which could be extended to one week take-home period for HAT clients with no risk of diversion; furthermore, HAT delivery was allowed for nursing and home care services to ensure better accessibility.^[191] These changes came into effect very quickly, with FOPH making decisions in March 2020, responding to the pandemic swiftly to protect people who use drugs and minimise the risk of COVID-19 infection.^[42] The Federal Council confirmed these modifications and changed respective policies for HAT in September 2020. According to expert opinion, these changes show positive outcomes, as HAT clients use their medication responsibly, there are no signs of diversion, and trust increased between the actors involved in delivery.^[42] These new rules will remain in effect until December 31 2021.^[42]

Initiation time for OAT in Switzerland was also reduced, for example, a hospital in Geneva (the Hôpitaux Universitaires de Genève), has accepted new OAT clients without previous appointment since the beginning of the pandemic, and procedures were streamlined to ensure OAT initiation within 24 hours. The hospital also increased OAT promotion in cooperation with a harm reduction service in the city (Première Ligne).^[191] In 2020, the Federal Office of Public Health began a study to assess OAT programme delivery during the COVID-19 pandemic, and will possibly update and improve OAT policy based on the results.^[75]



Photo: City of Zurich

Opinions on COVID-19 changes in OAT delivery – a survey in Geneva

During the summer of 2020, the addictions department of Hôpitaux Universitaires de Genève carried out a survey to assess opinions in the measures introduced in connection with the pandemic.^[191] The overwhelming majority of the respondents would like to see an extension of longer take-home periods for OAT and HAT, and found the longer opening hours beneficial, as it decreased the number of clients at the OAT clinic at the same time. Consultations via phone or video calls was also favourable, almost 40% of clients would continue to do so in the future.

More than 80% of the respondents would keep the home delivery of OAT medication.⁷² Half of the HAT clients would like to keep the possibility of home administration of medical heroin for injection use, and third would keep the decreased number of clients at the HAT self-administration room.



Photos: City of Zurich

Lessons learned from the COVID-19 pandemic

Harm reduction services are essential public health interventions, pivotal in reaching key populations.

The pandemic showed that many harm reduction services are innovative and quick to adapt, and can maintain the best possible coverage, linking otherwise hidden key populations to other social and health care services. Harm reduction should be included in public health policies accordingly, and appropriate funding should be provided to ensure service delivery.

COVID-19 adaptations in OAT, NSP and treatment delivery can increase access to services and should remain in place.

Long-awaited changes in harm reduction service delivery took place during the pandemic. Longer take-home periods for OAT and less restrictive initiation procedures were set

up in many countries, providing evidence that these are feasible and beneficial. Greater emphasis should be given to low-threshold community settings in the distribution of harm reduction commodities, as well as testing and treatment for HIV, viral hepatitis and TB.

Greater community involvement is crucial to increase coverage and accessibility of services.

Networks of people who use drugs played an important role during the pandemic, contributing to service delivery with secondary needle exchange, while providing input for professionals working in harm reduction, and disseminating crucial information among the drug user community. Peer involvement should be extended to provide more accessible services tailored for the needs of the community.

⁷² It is possible to administer HAT medication (diacetylmorphine) in different routes: in 2019 the majority (52%) of new treatment entrants chose oral administration, 30% chose intravenous administration, while 5% chose intramuscular administration and 13% chose multiple ways of administration.^[77]

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Harm Reduction International
61 Mansell Street
Aldgate, London E1 8AN
United Kingdom
E-mail: office@hri.global
Website: www.hri.global

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