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CIVIL SOCIETY MONITORING OF HARM REDUCTION IN EUROPE, 2019

DATA REPORT

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CIVIL SOCIETY MONITORING OF HARM REDUCTION IN EUROPE, 2019

DATA REPORT

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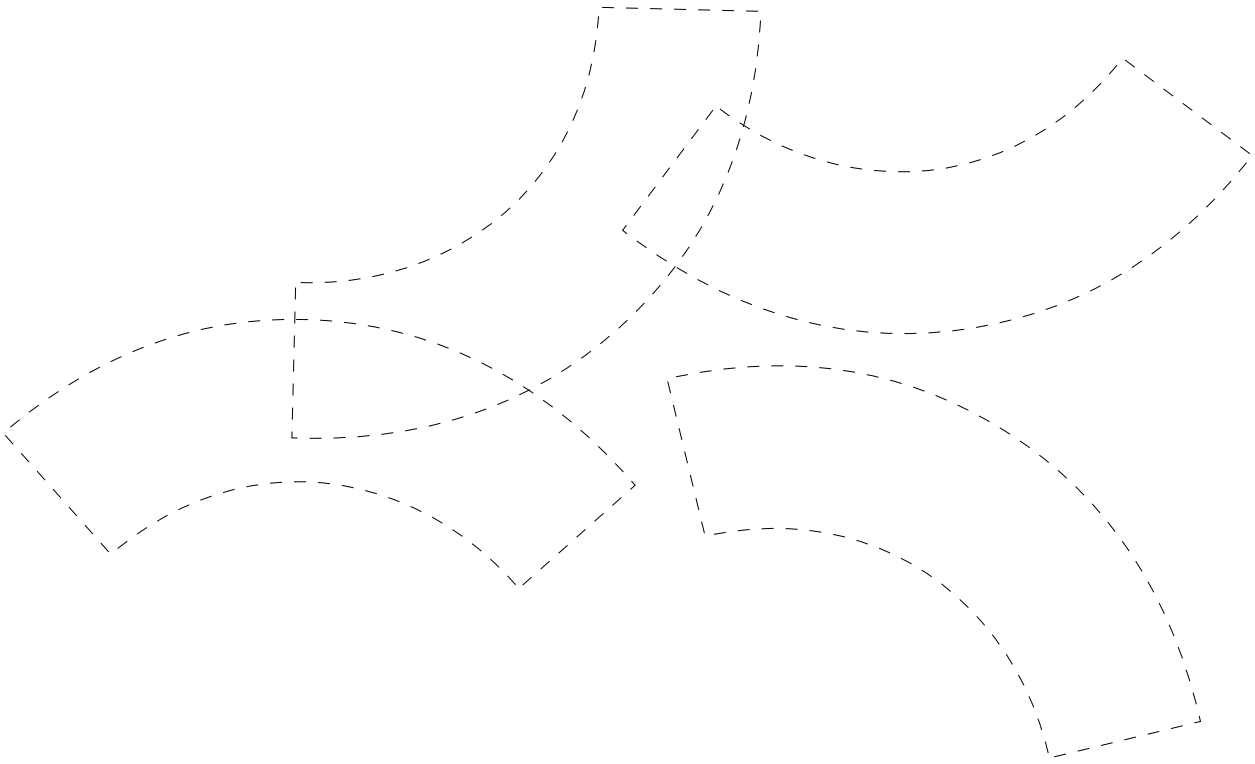


PREFACE

This is the first monitoring report covering certain areas of drug policy and practice produced by Correlation – European Harm Reduction Network (C-EHRN) within the context of our operational grant from the European Commission. The purpose of this report is to enrich the information and knowledge base of harm reduction interventions in Europe from the viewpoint of civil society organisations, meaning organisations that directly work for, and with, people who use drugs. We believe that this approach is a necessary, and useful, contribution to the development of drug policy in the region.

We plan to repeat this reporting on an annual basis to identify developments and changes over time. A lot is being learned in this first pilot phase and adaptations to the focus and questions will be made, accordingly, as well as a recognition of certain limitations with regards to coverage and validation which we cannot easily overcome. Consequently, the information provided in this report is sometimes anecdotal and represents the situation in a particular city or region and informs us as to the experiences of a specific organisation in the field. Such 'real life' information can contribute significantly to an understanding of the advantages, barriers and challenges of drug policy.

We will use the insights and information collected in this report within our advocate efforts to strengthen harm reduction policies in Europe and, we hope, our partners and contributors will do the same in their environment at a regional and national level.

More than one hundred organisations and individuals from 35 European countries have contributed to the collection of data with an amazingly high response rate; we thank all contributors for their great work and commitment. Without their engagement, this work would never have been undertaken at all.

In particular, we would like to thank the authors of this report, Tuukka Tammi and Rafaela Rigoni, who were supported by the coordinators of the expert groups, Mojca Maticic, Daan van der Gouwe and Dirk Schäfer, respectively. A special thanks to Dagmar Hedrich of EMCDDA for her ongoing and patient support.

We thank the European Commission, DG Sante, for their financial support and to the Regenboog Groep, Amsterdam, for their ongoing support of Correlation – European Harm Reduction Network.

Eberhard Schatz

On behalf of the C-EHRN team

ABBREVIATIONS

1B-LSD	1-butanoyl-lysergic acid diethylamide
1P-LSD	1-propionyl-lysergic acid diethylamide
2C-B	4-Bromo-2,5-dimethoxyphenethylamine
4-CMC	4-Chloromethcathinone
3-MMC	3-Methylmethcathinone
4-MEC	4-Methylethcathinone
4-MMC	4-methyl methcathinone or 4-methyl ephedrone; also known as Mephedrone
ACMD	Advisory Council on the Misuse of Drugs (UK)
ADHD	Attention Deficit Hyperactivity Disorder
AFEW	AIDS Foundation East-West
ALDP	Association de Lutte contre la Délinquance et la Pauvreté (Association to fight crime and poverty)
Alpha-PHP	alpha-Pyrrolidinohexiophenone
Apdes	Agência Piaget para o Desenvolvimento (Paget Agency for Development)
BBV	Blood-Borne Virus
C-EHRN	Correlation - European Harm Reduction Network
CASO	Portuguese Drug Users Union
CoE	Council of Europe
CSI	Civil Society Involvement
CSIDP	Civil Society Involvement in Drug Policy
CSO	Civil Society Organisation
DAA	Direct Acting Antiviral
DAH	Deutsche Aids Hilfe
DCR	Drug Consumption Room
DDM	Drug-induced Deaths and Mortality
DGAIA	General Directorate of Care for Children and Adolescents (Spain)
DMT	N,N-Dimethyltryptamine
DRD	Drug-Related Death
EASL	European Association for the Study of the Liver
ECDC	European Centre for Disease Control
EDR	European Drug Report
EHBO	Orange Cross First Aid (the Netherlands)
EiPLA	N-ethyl-N-isopropyl
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
EWS	Early Warning System
FP	Focal Point
GBL	Gamma Butyrolactone
GHB	Gamma-Hydroxybutyrate
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)
GP	General Practitioner
HCV	Hepatitis C Virus

Hex-en	N-Ethylhexedrone; also known as NEH
HMIP	Her Majesty's Inspectorate of Prisons (UK)
HOPS	Healthy Options Project Skopje (North Macedonia)
HR	Harm Reduction
HRI	Harm Reduction International
HSE	Health Service Executive (Ireland)
INSERM	Institut National de la Santé Et de la Recherche Médicale(National Institute of Health and Medical Research, France)
IOTOD	Improving Outcomes in the Treatment of Opioid Dependence
MD	Medical Doctor
MDMA	3,4-Methylenedioxymethamphetamine, commonly known as ecstasy
MDPV	Methylenedioxypyrovalerone
MSM	Men who have Sex with Men
NA	Not Applicable
NAA	National Anti-Drug Agency (Romania)
NDT	New Drug Trends
NGO	Non-Governmental Organisation
NHIF	National Health Insurance Fund
MiPLA	N-Methyl-N-isopropyllysergamide (also known as Methylisopropyllysergamide and Lamide)
NPS	New Psychotropic Substance
NSP	Needle-Syringe Programme
NTD	New Trends in Drugs
OD	Overdose
ODP	Overdose Prevention
OFDT	Observatoire Français des Drogues et des Toxicomanies (French Monitoring Centre for Drugs and Drug Depen dence)
OST	Opioid Substitution Therapy (also known as OAT, Opioid Agonist Treat ment)
PCP	Phencyclidine
PCR	Polymerase Chain Reaction
PROI	Progressive Reinforcement of Organizations and Individuals (Bosnia and Herzegovina)
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
QUAG	Quality Assurance Group (Norway)
RNA	Ribonucleic Acid
SCRA	Synthetic Cannabinoid Receptor Agonist
SEG	Scientific Expert Group
SICAD	Service for Interventions in Addictive Behaviours and Addiction (Portugal)
SO	Synthetic Opioid
THN	Take-Home Naloxone
WHO	World Health Organizatio

Countries taking part in the C-EHRN monitoring survey 2019

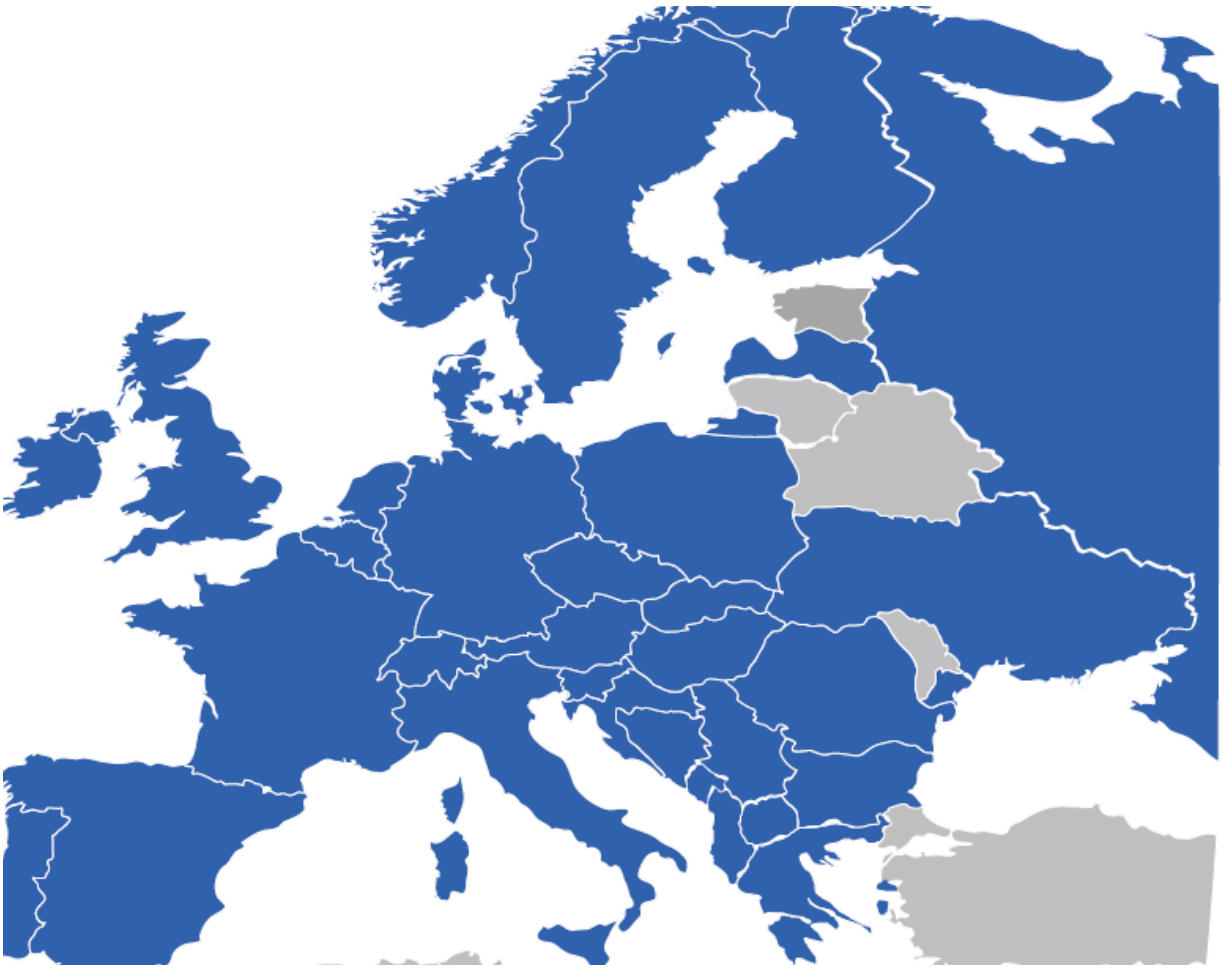


Figure 1 Countries taking part in the C-EHRN monitoring survey 2019

EXECUTIVE SUMMARY

This report enriches the information and knowledge base of harm reduction interventions in Europe from the viewpoint of civil society organisations (CSOs) that directly work for, and with, people who use drugs. This approach is a necessary, and useful, contribution to the development of drug policy in the region and C-EHRN plans to repeat this reporting on an annual basis to identify developments, changes and trends over time.

The report consists of four parts. The *introduction* provides background information concerning the development of the questionnaire, the data collection process, methodology used, and the nature of the data. *Chapters 2-5* report on civil society involvement in drug policy and related decision-making processes as well as on hepatitis C and drug overdose prevention and management services together with the use of new drugs and new patterns of consumption. Each chapter begins with a short summary of the main results and ends by discussing conclusions and policy implications.

Most CSOs responding to the C-EHRN survey are experienced in contributing to data collection and, crucially, have close contact with many important actors in the field and have access to timely and quality information that complements the data collection mechanisms already in place. Consequently, this report reinforces the added value of the role played by CSOs in the collection of data that can inform harm reduction practice. In most countries, **civil society involvement** is, to some extent, enabled through dialogue and/or information exchange but, often, the impact is regarded as unbalanced and ineffective. Permanent and formalised structures that ensure dialogue between civil society and government representatives are beneficial for such civil society involvement as structures allow for cooperation on a regular basis and oversee both the formulation of policy and its implementation. Formalised structures, however, do not safeguard meaningful involvement of civil society if they do not lead to accountable outcomes.

C-EHRN Monitoring shows that people who inject drugs (PWID) are still not allowed access to treatment of the **hepatitis C virus (HCV)** in 10 European countries. Although 23 countries have guidelines that include specific HCV management for PWID, many C-EHRN respondents are somewhat pessimistic about the impact of such guidelines on improving access to the HCV cascade-of-care in their country, especially to good practice, integrated, test-and-treat services at the same site. HCV testing and treatment at pharmacies remains very rare. On a more positive note, 23 European countries reported PWID organisations working actively to increase political awareness concerning HCV interventions. Compared to 2018, more attention has been paid over the past year to HCV awareness campaigns (in 15 countries), to testing at the service providers' own premises (in 18 countries), and to treatment at the service providers own site (in 15 countries). The main barriers to address HCV among PWID include a lack of funding, knowledge, recognition, political support and skilful staff as well as weakness of civil society organisations and legal barriers.

In 15 countries of the region, the government monitors the number/proportion of people who progress through each stage of the HCV cascade-of-care at the national level, with monitoring at the regional or local level also performed in 12 countries whereas monitoring is not performed at any level in a further 9 countries. There are still big differences within Europe as to where and how PWID can undertake a HCV test. This means PWID are in an unequal position in different European countries, regions and cities. Rapid HCV testing is available to prisoners in 21 countries.

Treatment of HCV using direct acting antivirals (DAAs) is available in all countries of the region except North Macedonia. However, 10 of 34 countries still place restrictions on access to DAA's for those people who are active drug users. However, if access to DAA treatment is achieved, the costs are reimbursable by health insurance or through

the public health service in all countries except the United Kingdom.

Consequently, to reduce the HCV-related disease burden among PWID and achieve the 2030 elimination goals as set out in the WHO Global Health Sector Strategy on Hepatitis, a radical change in the HCV response is needed in many European countries. National treatment guidelines that specifically address recommendations for treating PWID, guaranteed access by PWID to DAA treatment, improvements in the continuum-of-care and introduction of one-stop HCV testing and treatment services - including such services delivered by harm reduction organisations - needs to be further developed and adopted by all government and civil society stakeholders.

A further key contribution by civil society is collecting data on the context of **drug-related overdose** events and interventions at a local level, feeding into already existing data and reports. Only 5 countries reported separate overdose prevention strategies or action plans. Much improvement is needed to be able to adequately respond to overdoses in Europe. Evidence demonstrates that a range of measures – including drug consumption rooms (DCR), take-home naloxone (THN) programmes in the community, and naloxone distribution before release from prison - can reduce opioid and other drug-related overdose deaths. However, C-EHRN Monitoring shows a mixed picture of policies and measures across Europe. There is a significant disparity in how, and by whom, such overdose data is collected which can ultimately influence what is recorded as a drug-related death. To address this, the EMCDDA should encourage the respective national health authorities, their own Reitox Network, as well as others who collect such data, to collaborate more with national harm reduction networks and experts in their field of work. Furthermore, due to the uneven status of **naloxone** – the safe and simple response to an opioid overdose as recommended by WHO – political authorities are called upon to take appropriate legal initiatives to ensure, without delay, that naloxone is available free of charge and without prescription in pharmacies for people who use drugs; experience from Italy can be the basis for this action. In addition, to obtain a real overview of the number of doses of naloxone administered and data on the successful use of naloxone, a national reference point should be established to collect and analyse this and other data.

In general terms, the results of C-EHRN Monitoring correspond with what we know from other sources concerning **new drug trends**. In addition, the process of data collection as undertaken by C-EHRN Focal Points in each country has the potential of generating additional information and at a quicker pace than other methods, bringing added, qualitative value to this sector.

A review of the approach used by C-EHRN Monitoring to collect such information suggests that focus groups held several times each year would be more effective than a questionnaire as it would lead to consensus-based data. Also, a focus on drug trends, including new drugs, is preferable rather than the emergence of specific drugs. In addition, the focus should be at the city/urban level, rather than national, as this will likely provide higher quality data, and a reduction in the number of questions is recommended.

INTRODUCTION

In the field of harm reduction, civil society organisations (CSO's) play a vital role in developing and implementing effective measures to address the negative consequences of drug use. They work directly for, and with, people who use drugs (PWUD) and have a good understanding of their daily problems. Due to their low-threshold approach, civil society-based harm reduction agencies are often the first contact point for PWUD.

In 2018, the Correlation European Harm Reduction Network (C-EHRN) began to develop a monitoring tool in support of European harm reduction agencies. This novel monitoring tool complements existing monitoring systems using grass-root level data and, as a long-term goal, to improve the effectiveness of harm reduction responses and policies in Europe. In addition to addressing the involvement of CSO's and drug-user organisations in national drug-policy making, this new monitoring tool focuses on harm reduction activities related to the hepatitis C virus (HCV), drug overdose prevention, and trends in the appearance, and use, of new drugs.

What is harm reduction?

Harm reduction has many definitions. The Correlation European Harm Reduction Network focuses on harm reduction in the broadest sense – as a health and social issue which refers to "policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. […] The harm reduction approach to drugs is based on a strong commitment to public health and human rights." (Harm Reduction International)

There are already well-established monitoring activities in the field of drug use and harm reduction in Europe. In the area of the European Union (EU) (plus Norway and Turkey), monitoring of harm reduction interventions and policies has been conducted for some time by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) which gathers harm reduction data through its 30 national focal points (Reitox Network, including Norway and Turkey from outside of the EU). In addition to their flagship publication, *Annual report on the state of the drugs problem*, the EMCDDA presents national data on its website where every member state has its own *country profile*. The EMCDDA also conducts separate studies on, for example, new user populations, health consequences, emerging substances, patterns of use, and strives to identify new trends, early warning and rapid reporting of drugs.

Globally, Harm Reduction International (HRI) has conducted biannual surveys and, since 2008, has published *The Global State of Harm Reduction*. The latest comprehensive report is for 2018 (Stone & Shirley-Beavan 2018) with an update issued in late 2019. With regards the EU, HRI's Global State report relies largely on the data compiled and processed by the EMCDDA; HRI combines survey results and other data sets with a literature review and some of HRI's data sources are also focal points of C-EHRN.

Current harm reduction monitoring tools are well developed and bring much valuable information to policy-making and practice. However, these tools are still not able to fully and systematically reflect the perspective of civil-society based harm reduction organisations and of drug user groups working in the field of harm reduction. Needless to say, the inside knowledge and information of communities and their organisations are crucially important in informing drug policies and practice.

This report documents the data collected in 2019 using the first version of the C-EHRN monitoring tool. The final C-EHRN monitoring tool, a questionnaire (annexed to this report), consists of over 100 questions. Many of the questions are multiple-choice, but respondents are also asked to freely comment on their answers, to explain and interpret, and to provide additional information, links and other sources.

To support the development of the monitoring tool, and to review the final report, C-EHRN established four expert groups: a scientific expert group (SEG), including representatives from the EMCDDA and HRI, and three thematic expert groups for HCV, overdose prevention, and new drug trends. The chapter of this report on civil society involvement was organised by the C-EHRN office. The final monitoring questionnaire was developed through continuous dialogue with the above-mentioned expert groups who proposed both individual questions and whole question patterns. The different phases of the overall development process in 2018-2019 are described in the below timeline.

Learning-by-doing: development of the monitoring tool 1.0

The first draft of the monitoring questionnaire was put together at the beginning of 2019 and then piloted in five countries (Finland, Germany Italy, Poland, Romania). The final launch of the tool, and the gathering of data, was undertaken during the summer of 2019.

From the very beginning, development of the monitoring tool was considered to be a *learning-by-doing* process. The first questionnaire was known to contain too many questions as well as questions that would be abandoned in the following rounds of development. The learning process also generated new questions.

At first, the questionnaire was sent to the C-EHRN focal points in 34 countries (larger countries, such as Germany and France, have 2 focal points, all other countries have one) as a separate text file to give them the possibility to share it as a whole, or in part, with their colleagues who have relevant expertise. Instructions attached to the questionnaire proposed different data gathering methods. The C-EHRN focal points answered those questions for which they have expertise or compiled the needed information from others. It was the responsibility of the focal point to form a network of experts, divide the work among them, and then to make the final decision upon who is most capable to answer different questions. After completion of the entire questionnaire, the C-EHRN focal points gathered all answers and transferred them online (using the Survey Monkey web app) to the C-EHRN Office.

Monitoring tool development timeline

March 2018: The first C-EHRN workshop on monitoring, Amsterdam;

June 2018: Lead consultant and the expert groups start planning with help of C-EHRN coordination;

October 2018: Expert group coordinators meeting, Lisbon (INSHU conference);

November 2018: Special session on monitoring with the C-EHRN focal points, Bucharest (European harm reduction conference);

January 2019: Meeting of the scientific committee and leaders of the three thematic expert groups to discuss the first draft questionnaire, Berlin;

April 2019: Piloting in five countries and fine tuning of the questionnaire, including input from expert groups;

June-August 2019: Questionnaire sent to C-EHRN Focal Points, completed and returned back to the C-EHRN office;

September-November 2019: Data analysis, cleaning of data, gathering of missing information, re-checking of answers with respondents;

October 2019: Results, process and the way forward discussed with C-EHRN focal points (representatives of the data network), Helsinki & Lisbon;

October 2019: Gathering of missing information;

November 2019: Re-checking of data with the focal points;

December 2019: Finalising of the first data report.

In the instructions to respondents, it was stressed that the purpose of the process was *not* to collect data from official sources but from the viewpoint of civil society. It was also emphasised that the primary purpose is not to prepare a representative data collection but rather to provide a well-grounded critical assessment of the current situation and recent developments in their national, regional or local harm reduction scene by focusing on the three thematic areas. Furthermore, the instructions stated that, "…you might also collect contradictory information or certain information may not apply for the entire country. Please briefly describe that situation in one of the open boxes. *These comments can be subjective and anecdotal by nature* – we are interested in your own interpretations concerning why the state of affairs is like it is." It is useful to keep in mind these instructions to the respondents when reading the results.

Assessment of the process and data

Overall, the quality of data can be considered diverse. It ranges from very detailed and precise data to rather general and sometimes difficult-to-interpret responses. In some cases, the answers were from just one person, whereas in other cases the answers were the result of consulting various local, regional or national experts. Also, some pieces of information remained missing or contradictory with other information sources despite a complementary data validation round in the autumn of 2019.

Two months after the data gathering was completed, the C-EHRN focal points were asked about their experiences in answering the questionnaire. The average time the focal points used to work on the questionnaire was 6-8 hours. The total time, however, ranged from a couple of hours to several days. Maximum time used was 10 days. The focal points were also asked how many individuals they approached in order to gather information. Typically, 3-6 people from one country contributed. The number of contributors ranged from 2 to 15. In most countries, the experts approached were willing to help with answers, although in an extreme case only 2 out of 24 contacted people eventually contributed. The C-EHRN focal points were also asked to assess if some questions or sections were too laborious or difficult to answer. Most common difficulties were related to the section on new drug trends – which is reflected by the uneven quality of data in this section. Such challenges can be used to adjust this part of the monitoring tool and are reported in more detail in Chapter 4 of this report.

It can be concluded that the C-EHRN monitoring tool has already produced a rich and unique corpus of data which tells us quite a different story of the daily realities in harm reduction services and in the lives of drug users than what has been reported elsewhere. The data show a wide range of barriers as well as a disproportionate difference between the official situation (policies, strategies, guidelines) and the reality of harm reduction service providers. On the other, it also documents many kinds of progress and new opportunities for the harm reduction sector.

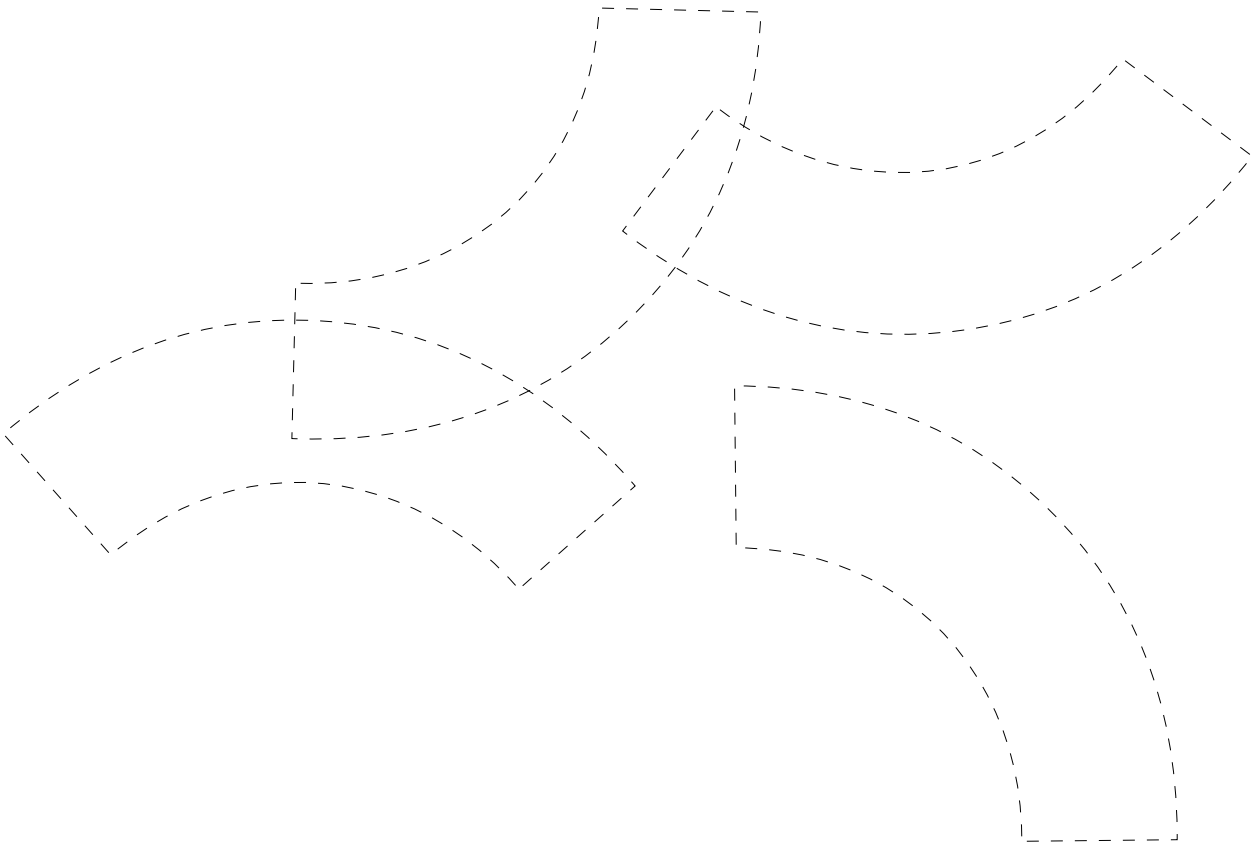
REPORT STRUCTURE

The report consists of four parts.

This first *introductory part* provides background information about developing the questionnaire, the data collection process, methodology used, and the nature of the data. It also acknowledges the wide range of experts and organisations that have provided the information for this inaugural data report.

Chapters 2-5 report data about civil society involvement in drug policy and related decision-making processes in European countries, as well as hepatitis C, and overdose (OD) prevention and management services together with new drugs and new patterns of consumption. Each part starts with a short summary of the main results and ends by discussing conclusions and policy implications.

Chapters on CSO's and HCV are partly based on earlier surveys previously completed by C-EHRN, whereas the chapters on OD and new trends in drugs (NTD) are based on questions presented for the first time.



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PARTICIPATION OF CIVIL SOCIETY ORGANISATIONS IN POLICYMAKING

Introduction

At the European Union level, the issue of how to strengthen civil society involvement (CSI) in drug policy has increasingly attracted attention over the last few years. This began with presentation of the "Green Paper on the role of Civil Society in Drugs Policy in the European Union" by the European Commission in 2006. Subsequently, there was the establishment of the "Civil Society Forum on Drugs", a platform for regular dialogue on policy development and implementation between the Commission and representatives of European civil society.

The current EU Action Plan on Drugs 2017-2020 (European Council 2017) (not only refers to civil society involvement at the EU level, but also calls for action at national level to "promote and strengthen dialogue with, and involvement of, civil society and the scientific community in the formulation, implementation, monitoring and evaluation of drug policies". The successful implementation of good practice in drug demand reduction in member states is further hinged (among other indicators) on the "involvement of civil society in the implementation of the standards, including in planning and introduction" (European Council 2017).

Although the significance of Civil Society Organisations (CSOs) is undisputed and acknowledged, the question is the extent to which CSOs are involved in the formulation, implementation and evaluation of drug policy. What mechanisms are in place to facilitate the sharing of CSO knowledge, expertise and data with policymakers, and are they used by policymakers and CSOs?

Moreover, CSOs have first-hand experience on how official policies translate (or not) into practice to address the needs of people who use drugs. In this regard, CSOs have great potential to collect in-depth data about drug policy implementation. They can also compare the extent that official data informing policy correctly describes the context they find on the ground. However, are CSOs involved in the collection of official data and how do official data collectors evaluate the data currently available?

This chapter will address these questions and, accordingly, provide information on the actual involvement of CSOs. It draws on data collected by C-EHRN's survey in the 35 European countries described in the introduction of this report and following the same methodology.

Cooperation between CSO's and Policymakers

Cooperation Mechanisms

There are different types of cooperation between policymakers and CSOs in which debates and inputs on drug policies occur (Lahusen, Verthein and Martens 2018). On one end of the spectrum, information exchange does not happen. On the other end, strong cooperation is in place and a solid partnership has been established.

Following the definition of cooperative mechanisms of the Council of Europe (CoE) (CoE 2009), four different levels of cooperation can be considered:

- *Information*: This is a relatively low level of cooperation. It consists of a two-way process of information sharing and the provision of access to it between public authorities and CSOs;
- *Consultation*: This is an ad hoc mechanism through which public authorities ask CSOs for their expertise and opinion regarding a specific policy issue or development;

- *Dialogue*: This is a two-way communication mechanism built on mutual interests and potentially shared objectives to ensure a regular exchange of views; and,
- *Partnership*: This is the most comprehensive type of cooperation. This mechanism stipulates and articulates shared responsibilities for each step of the policymaking process: agenda-setting, policy drafting, and implementation of activities.

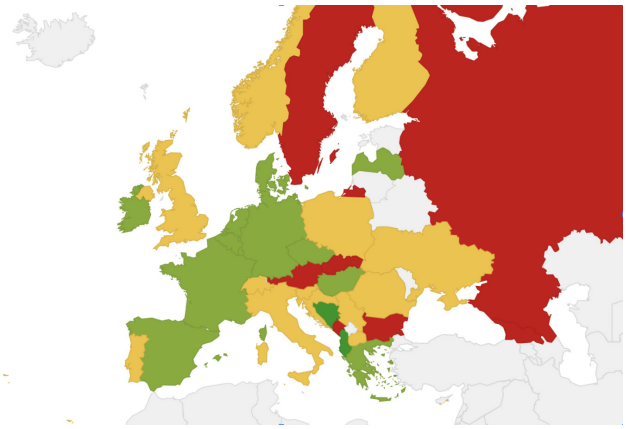
Evaluating Cooperation

Survey participants were asked to evaluate the existing cooperation of CSOs with policymakers at two different levels: at a macro level - cooperation between CSOs and policy makers in their own country; and at a micro level - cooperation of their own organisation with policymakers. The evaluation has a subjective nature and respondents were asked to further explain how cooperation is organised at the organisational level.

How respondents evaluate cooperation with policy makers in their country

Most participants (over 80%) reported having structural cooperation between policymakers and CSOs on drug policy in their country. Austria, Bulgaria, Georgia, Montenegro, the Russian Federation, Slovakia, and Sweden reported having no cooperative mechanisms.

Those reporting structural cooperation were asked to evaluate which level of cooperation exists among CSOs and policymakers in their country. Respondents were given four options according to CoE definitions: information, consultation, dialogue and partnership. Map 1 shows the reported form of cooperation for the respective countries. Figure 2 shows the percentages for the different types of cooperation. No respondent referred to have the cooperation level of information.



Map 1. Level of cooperation between CSOs and policymakers (country level)

No cooperation
Consultation
Dialogue
Partnership

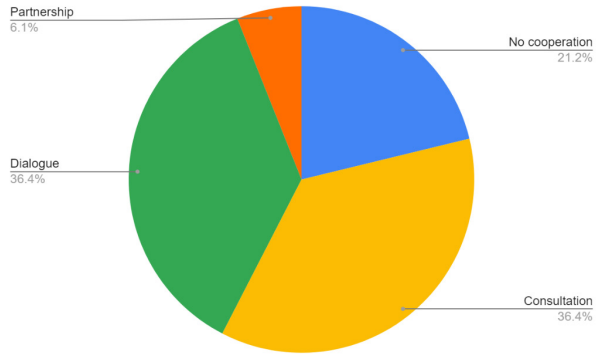


Figure 2. Level of cooperation between CSOs and policymakers (country level)

How respondents evaluate the cooperation between their organisation and policymakers

Respondents that indicated having cooperation between CSOs and policymakers in their country were asked if their specific organisation was involved in this exchange and were requested to describe how the cooperation took place. This was an open question and answers were analysed for main themes. Although most reported a certain level of involvement of their organisation, the kind of engagement varied.

The following pages describe the kind of involvement of respondent organisations with policymakers, comparing them to the different types of cooperation reported in their respective country. Map 2 illustrates how respondents evaluated such cooperation (and thereby is not representative of national level cooperation).

Civil society involvement in a system *without formal cooperation*

Participation (attempts)

Respondents from Montenegro, Russia and Sweden reported that their countries have not established any formal mechanism of exchange between CSOs and policymakers. Nevertheless, their organisations participate in discussions and drug policy meetings with important stakeholders, including policymakers and politicians.

This kind of exchange is described as informal and is organised in different ways: as seminars (Sweden); exchange with different service providers; community-led services and PWUD (Sweden and Montenegro); and informal meetings with participants of a Civil Society Forum, initially established by the Global Fund (Russia). In the case of Bulgaria, participants reported that CSOs engaged with the National Council on Drugs and suggested the establishment of a permanent and formal exchange mechanism, but this initiative has not yet succeeded.

Organisations from: Bulgaria, Montenegro, Russia, and Sweden.

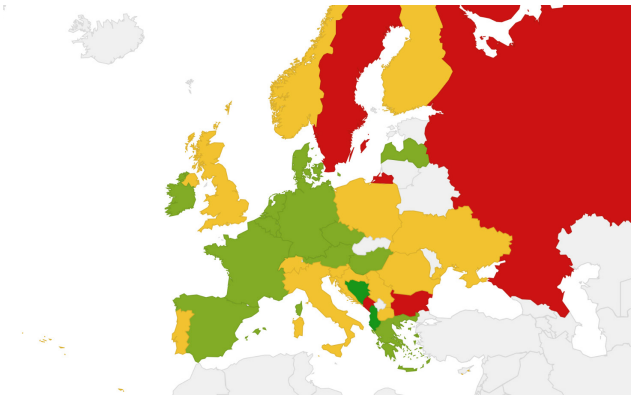
Civil Society Involvement in cooperation based on *Consultation*

Organisations which operate within a country where cooperation between CSOs and policymakers is based on a level of consultation, report different mechanisms: invitations to ad hoc working groups and public hearings (e.g. Finland, Italy, Poland, Serbia, Switzerland and Ukraine); the opportunity to contribute with information and technical assistance to the drafting of drug policy documents (e.g. Romania, North Macedonia and the United Kingdom); and being part of a local policy advisory board (Norway).

With regard to the consultation in working groups or public hearings: in Finland, the *Ministry of Health* provides the *A Clinic Foundation* with the opportunity to give a speech during a public hearing and to provide written statements every four years; in Serbia, *Prevent* was consulted during a public hearing on amendments to the Law on Psychoactive Controlled Substances. At the same time, it is reported that the consultation process in Serbia is not transparent and that CSOs were not consulted before the Parliament adopted the Amendments to the Criminal Code that introduced stricter penalties for drug trafficking in the country.

Regarding civil society contributions in drafting policy documents: respondents from Romania report that there is a formal consultation mechanism. However, this is generally used by the government because the law explicitly requires transparency in all public policy areas. In reality, cooperation with CSOs remains limited and their knowledge, information and advice is not taken into account. The *National Antidrug Agency* is more open and responsive than the *Ministry of Health*, but they no longer play an important role in the development and implementation of drug policies. In North Macedonia, *HOPS* provided technical support in writing the national drug strategy. In the United Kingdom, *Release* provides information to, and consultations with, policymakers via written and oral submissions of evidence to select committees, All-Party Parliamentary Groups, government consultation responses and policy briefings, which prepare individual parliamentarians for debates or meetings related to drug policy.

Organisations from: Romania, Croatia, Finland, Italy, North Macedonia, Norway, Poland, Portugal, Serbia, Slovenia, Switzerland, Ukraine and the United Kingdom.



Map 2. Level of cooperation that C-EHRN Focal Points have with policymakers

- *Cooperation attempts (no formal coopertion)*
- *Cooperation under Consultation*
- *Cooperation under Dialogue*
- *Cooperation under Partnership*

Civil Society Involvement in cooperation-based *Dialogue*

Organisations operating within a country with cooperation based on dialogue report being invited to working groups and supervisory bodies (Austria, Czech Republic, Denmark, and Spain); informal consultations; task forces; dialogue meetings with regards to drug policy (the Czech Republic, France, Luxembourg, the Netherlands and Spain); and collaboration within professional harm reduction networks (Hungary, Spain, and the Netherlands).

In Luxemburg, for instance, *Jugend- an Drogenhellef* has substantial dialogue with the *Ministry of Health* and the *Suchtverband* (Federation of Dependence), to provide information and advice regardingthe legalisation of cannabis, the global drug policy and National Action Plan against Drugs. In the Netherlands, *Mainline* has regular dialogue, at both a municipal level in Amsterdam and at national level with the *Ministry of Health*, to share practical experiences, knowledge and the most relevant signals and drug trends based on their outreach and research activities. This cooperation, however, is linked to a funding relationship which does not necessarily provide opportunities for critical input.

Austria is a federal country with nine states and the level of civil society involvement is different in each state ranging from information exchange to dialogue. Although some organisations are non-governmental, they are largely (over 90%) funded by the state or regional funds. *Suchthilfe Wien* is a local governmental organisation responsible for the implementation of some parts of the Viennese drug strategy. This means that they are involved in regular exchange with policymakers and part of the drug advisory boards. The federal states play an important role in the conception and implementation of drug policy measures and, thus, in the exchange between CSOs and policymakers. Representatives from organisations and experts participate in advisory boards/committees that inform, consult, or are in dialogue with, policymakers.

Organisations from: Austria, Belgium, Czech Republic, Denmark, France, Germany, Greece, Hungary, Ireland, Latvia, Luxemburg, Netherlands, and Spain.

Civil Society Involvement in exchange based on *Partnership*

The only two organisations operating in countries which have established cooperation with policymakers based on *Partnership*, reported being involved in expert groups.

The participant from Bosnia and Herzegovina, for instance, is part of the expert group for drafting drug-related policies, including the National Drug Strategy. The Albanian organisation is a member of various working groups, meetings, trainings and consultations within the framework of the Global Fund programme and other coordinating events.

Organisations from: Albania, Bosnia and Herzegovina.

Level of satisfaction with exchange mechanisms

The organisations participating in any type of cooperation with policymakers in their country were asked to rate their level of satisfaction with regards to this cooperation by grading it with a number from zero to ten. For the analysis, the grades were clustered into five different levels of satisfaction: high-satisfaction (grades above 8.5 out of 10); good satisfaction (grades 7.0 - 8.5); average satisfaction (5.5-6.9); low satisfaction (3.6 – 5.4); and very low satisfaction (3.5 and below).

The levels of satisfaction did not automatically correspond to the levels of national cooperation. However, organisations operating in countries with higher levels of cooperation, such as dialogue and partnership, tended to report higher levels of satisfaction. Table 1 compares the reported levels of cooperation at the country level with the satisfaction of the organisations (C-EHRN Focal Points) regarding this cooperation. For an easier visual comparison, the different levels of country cooperation and the levels of satisfaction of an organisation were depicted by similar symbols (see table legend).

Table 1: Comparison between levels of national cooperation and satisfaction at the organisational level

Country	National level of cooperation	Organisation	Level of satisfaction in the organisation (C-EHRN Focal Point)
Albania	🤝🤝🤝🤝🤝	Aksion Plus	🤝🤝🤝🤝
Austria	🤝	Suchthilfe Wien GmbH	Not applicable
Belgium	🤝🤝🤝🤝	Free Clinic	🤝
Bosnia and Herzegovina	🤝🤝🤝🤝🤝	Association PROI	🤝🤝🤝🤝🤝
Bulgaria	🤝	Initiative for Health Foundation	🤝
Croatia	🤝🤝🤝	Udruga "Vida"	🤝
Czech Republic	🤝🤝🤝🤝	SANANIM	🤝🤝🤝🤝🤝
Denmark	🤝🤝🤝	Centre for vulnerable adults and families	🤝🤝
Finland	🤝🤝🤝	Ehyt Ry Finnish	🤝🤝
France	🤝🤝🤝🤝	Fédération Addiction	🤝🤝🤝🤝
Georgia	🤝	Georgian Harm Reduction Network	Not applicable
Germany	🤝🤝🤝🤝	Deutsche Aids Hilfe	🤝🤝🤝
Greece	🤝🤝🤝🤝	POSITIVE VOICE	🤝🤝🤝
Hungary	🤝🤝🤝🤝	Rights Reporter Foundation	🤝
Ireland	🤝🤝🤝🤝	Ana Liffey Drug Project	🤝🤝🤝🤝
Italy	🤝🤝🤝	Forum Droghe	🤝🤝
Latvia	🤝🤝🤝🤝	Association HIV.LV	🤝🤝
Luxembourg	🤝🤝🤝🤝	Jugend- an Drogenhellef	🤝🤝🤝🤝🤝
Montenegro	🤝	Juventas	🤝
Macedonia, North	🤝🤝🤝	Healthy Option Project Skopje	🤝🤝🤝

Netherlands	🤝🤝🤝🤝	Mainline	🤝🤝🤝🤝
Norway	🤝🤝🤝	proLAR Nett	🤝🤝🤝🤝
Poland	🤝🤝🤝	MONAR Association	🤝🤝🤝
Portugal	🤝🤝🤝	Agência Piaget para o Desenvolvimento	🤝🤝🤝
Romania	🤝🤝🤝🤝🤝	Asociația Carusel	🤝🤝🤝🤝
Russia	🤝	AFEW International	Not applicable
Scotland	🤝🤝🤝	Scottish Drugs Forum	🤝🤝
Serbia	🤝🤝🤝	Prevent	🤝🤝🤝
Slovakia	🤝	Odyseus	Not applicable
Slovenia	🤝🤝🤝	Stigma	🤝🤝
Spain	🤝🤝🤝🤝	Red Cross Barcelona	🤝🤝🤝🤝
Sweden	🤝	Stockholm drug user's union	🤝🤝🤝
Switzerland	🤝🤝🤝	Infodrog	Missing answer
Ukraine	🤝🤝🤝	AFEW-Ukraine	🤝🤝
United Kingdom	🤝🤝🤝	Release	🤝

🤝 No formal cooperation/Very low satisfaction;

🤝🤝 Information/Low satisfaction;

🤝🤝🤝 Consultation/Average satisfaction;

🤝🤝🤝🤝 Dialogue/Good satisfaction;

🤝🤝🤝🤝🤝 Partnership/High satisfaction

High-satisfaction level (above 8.5 out of 10)

Organisations in only three countries – Bosnia and Herzegovina, the Czech Republic, and Luxembourg – reported a high level of satisfaction. In Bosnia and Herzegovina (Partnership Level), reasons for being satisfied were related to good cooperation and exchange of opinions and information with policymakers. ANO - an umbrella association of drug-related NGOs in the Czech Republic (Dialogue Level) is highly satisfied as they are actively involved in drafting the national drug policy agenda.

In Luxembourg (Dialogue Level), the high level of satisfaction is linked to the fact that the organisation is involved in the dialogue and the evaluation of the drug action plan for 2015-2019 and the elaboration of the new action plan for 2020-2024.

Organisations from: Bosnia and Herzegovina, Czech Republic and Luxembourg.

Good satisfaction level (between 7.0 and 8.5)

Six organisations – from Albania, France, Ireland, the Netherlands, Norway, and Romania – reported a good level of satisfaction related to the cooperation that they have with policymakers. Cooperation was considered to be well established, frequent, and functioning well. However, organisations saw room for improvement. The respondents from Ireland wished for better representation of CSOs and has called for the establishment of a working group to discuss and consider alternative approaches for the possession of small amounts of drugs for personal use. The Netherlands sees an imbalance in cooperation between CSOs and policymakers at the national level as this kind of cooperation is limited to non-governmental organisations (NGOs) with a funding relationship with the *Ministry of Health*. A more open, transparent and balanced approach would support an effective exchange and could inform the development of future drug policies. The respondent from Albania reports a greater commitment from policymakers is required, including the provision of financial resources for local partnerships.

Organisations from: Albania, France, Ireland, the Netherlands, Norway, and Romania.

Average satisfaction (between 5.5 and 6.9)

Organisations with an average level of satisfaction responded with more criticisms. This applies to respondents from Germany, Greece, North Macedonia, Poland, Portugal, Spain, and Sweden, respectively. One reason for criticism was that cooperation was not organised on a regular base, and only when the government needed input and/or in cases of negative media attention (e.g. in Germany and Portugal). Other respondents perceived the cooperation as window dressing: it was used to maintain the status quo rather than shaping new drug policy (e.g. Poland and Spain) based on the real needs of the community. Some cooperation is considered as uneven and unbalanced: good and effective at the local level but weak at the national level (Sweden); good in general but not with regards to HIV/AIDS issues (Ukraine); or good with some individual policy officers but bad in general (Serbia).

Organisations from: Germany, Greece, North Macedonia, Poland, Portugal, Spain, Sweden, and Ukraine.

Low satisfaction (between 3.6 and 5.4)

A low level of satisfaction was reported by organisations from four countries – Denmark, Finland, Italy, and Latvia. Episodic cooperation only (Latvia and Scotland) and inconsistency across regions (Italy) were mentioned as critical points. Other points related to only a few politicians hearing CSO inputs (Finland) and a feeling that participation in cooperation mechanisms, rather than taking up new demands of the population, only serves to prevent new harmful interventions from happening and to preserve, at some level, rights already acquired (Denmark).

Organisations from: Denmark, Finland, Italy, Latvia, and Scotland.

Very low satisfaction (3.5 and below)

Finally, six organisations reported a very low level of satisfaction with cooperation. In the case of Bulgaria, this is due to a total lack of exchange: the organisation has tried to reach out to the national authorities for dialogue and exchange but

has never received any official answer. CSO's in Croatia, Hungary and the United Kingdom have mentioned that they can share knowledge, information and advice in the existing exchange mechanisms but the respective government has systematically ignored their input and expertise.

Organisations from: Belgium, Bulgaria, Croatia, Hungary, Montenegro, and the United Kingdom.

How CSO's contribute to the production of relevant data

One of the pillars of the C-EHRN Monitoring Tool is reliance on the potential of CSOs to collect relevant and timely data for the formulation and evaluation of drug policies. More information, therefore, is needed on the extent to which CSOs already partake in the collection of such data. The survey asked participants whether they already contribute to the collection of data made available by other agencies (the EMCDDA specifically) and how they relate (if at all) with EMCDDA Focal Points. Respondents were also requested to describe how they access relevant information and how they evaluate the information reported in their country profiles on the EMCDDA website, specifically on the theme of overdose. Currently, most information on overdose comes from official sources such as forensic investigations or police reports. Can these sources adequately inform practice and describe what happens on the ground? Are there gaps in the information that CSOs can help to fill? The answers to these questions are described below.

Relationship among C-EHRN Focal Points and EMCDDA Focal Points

Most of the organisations (26 of 35) that collected data and information for this Monitoring Tool reported having some contact with EMCDDA national focal points. As for the nine organisations with no current exchange, all expressed their willingness to cooperate and contribute to the national reporting of the EMCDDA (see Table 2).

Most of the CSOs that cooperate with EMCDDA national Focal Points directly share data and information on their programme activities and results, as requested by the Focal Point. This is the case for organisations in Austria, Belgium, Bulgaria, the Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Ireland, Luxembourg, Poland, Portugal, Romania, Slovakia, Slovenia, and Spain. Also, Albania, Bosnia and Herzegovina and Georgia have said that they have cooperation with the EMCDDA even if they are not part of its reporting system.

Table 2: Current state of relations between C-EHRN Focal Points and EMCDDA Focal Points.

Currently in contact with EMCDDA national focal point		Not in contact
Albania	Ireland	Croatia
Austria	Luxembourg	Italy
Belgium	Montenegro	Latvia
Bosnia and Herzegovina	Macedonia, North	Norway
Bulgaria	Netherlands	Russia (no EMCDDA FP)
Czech Republic	Poland	Scotland
Denmark	Portugal	Switzerland (no EMCDDA FP)
Finland	Romania	Ukraine (no EMCDDA FP)
France	Serbia	United Kingdom
Georgia	Slovakia	
Germany	Slovenia	
Greece	Spain	
Hungary	Sweden	

In the Netherlands, although not providing direct input to the EMCDDA Focal Point, *Mainline* frequently collaborates with the focal point organisation and related staff. In Sweden, the drug user union provides direct input, advice and comments to the focal point. The respondents from Montenegro, North Macedonia, and Serbia report that there is some type of exchange.

For those not having any relationship with EMCDDA Focal Points, the reason is mostly because the EMCDDA Focal Points do not ask them for any kind of input and information or because no EMCDDA Focal Point exists in the country (Russia, Switzerland, Ukraine). In Croatia and Scotland, respondents provide data about their programmes to other institutions which, supposedly, feed information to the national Focal Point. In Latvia and the United Kingdom, the C-EHRN Focal Points have not, so far, been asked to contribute to EMCDDA reporting. In Italy and the Ukraine, the EMCDDA Focal Points are perceived by our respondents as not having any interest in cooperating and exchanging information with CSOs. Russia and Switzerland are not part of the EU and thereby EMCDDA monitoring and, consequently, do not have a Focal Point.

How C-EHRN Focal Points collect and evaluate data (on overdose)

C-EHRN Focal Points were asked to report on how they get information on drug-related overdoses in their country, considering both official and unofficial channels.

DATA FROM OFFICIAL CHANNELS (AND ITS LIMITATIONS)

Virtually all participant organisations gather data through official sources, usually from national governing bodies or, otherwise, EMCDDA. Participants get official data through:

- National (Public) Health Institutes (e.g. Albania, Croatia, Finland, Spain);
- Forensic Institutes (e.g. Albania);
- National Statistics Institutes (e.g. Serbia, Switzerland, United Kingdom);
- Narcotics Agencies (e.g. Romania and Russia);

- Other specific drug-related reports (e.g. Croatia, Ireland, Italy, Norway and Scotland); and,
- EMCDDA National Focal Point Reports (e.g. Bulgaria, Denmark, Finland, Greece, Hungary, Luxembourg, the Netherlands, Slovakia, Slovenia).

Bosnia and Herzegovina, Georgia, and Montenegro were the only reports to completely lack official data on overdose.

Despite the existence of official data on drug-related overdoses, there is a significant disparity in how, and by whom, such data is collected which ultimately influences what is recorded as an overdose or drug-related death. Such disparity causes several problems, not only to draw data comparisons but also to plan for adequate policy responses.

A brief description of the **main problems** reported by participants regarding data from official channels is given below:

- **Further forensic investigations are not always carried out** if a different cause of death is determined. Toxicological analysis of death is often not performed due to financial/cost reasons (mentioned by Switzerland, Montenegro, and Ukraine).

> "Further forensic investigations are not always carried out. For example, cardiac arrest may be identified as a cause of death, but drugs may not be sought in the blood, although, for example, cocaine overdose was not excluded as a causal cause of cardiac arrest". (Switzerland FP)

- It is not always clear whether a substance detected in the blood *caused* the death of a person. **Poly-drug use is a clear complicator** (mentioned by Portugal, Switzerland, and Spain).

> "Catalonia reported 138 deaths related to substances in 2017. The majority of them (124 cases) for consumption of hypnosedants, followed by cocaine and heroin. 30 of the deaths were caused by the combination of opiates and hypnosedants." (Spain FP)

- The cantons only provide data for death statistics to the National Statistics Institute. The **individual substances are not systematically recorded** centrally at a national level (Switzerland).
- Besides prescription drugs sold on the illicit market, **personally prescribed pharmaceuticals can also be linked to drug-related deaths** (Finland).
- Official data lacks validity as **many states/ locations do not perform autopsies**. Local harm reduction providers get, from their practice, higher numbers of drug-related deaths than those given by government (Germany).
- Data might also be unreliable in detecting the actual pattern since, **due to stigma, overdose deaths may be reported as having a different cause** (Greece).

> "Because of stigma, many parents actually bribe the doctors to report the cause of death as something different than an overdose". (Greece FP)

- **Data is not collected regularly and/or there is a lag for data from official national databases of at least two years**, meaning the information is too outdated to provide adequate policy responses. (Austria, France, Italy, and Serbia).

- **Changes in the way of collecting data can cause misleading conclusions** about a country's situation and response to OD (Netherlands).

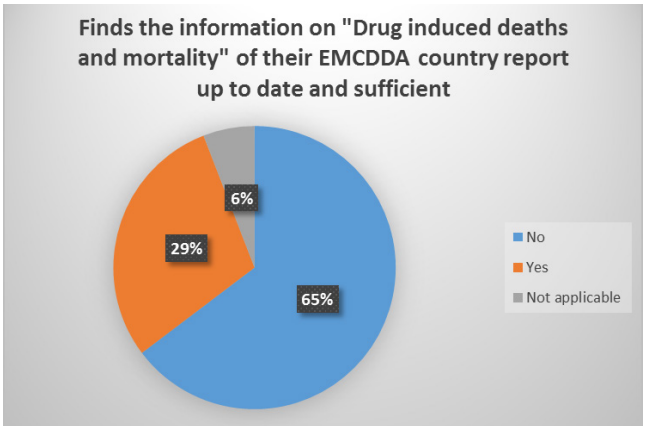
> "Until 2016, suicide involving drugs was only registered as suicide in the Dutch national statistics. In 2016, the EU asked us to register suicide involving drugs as drug-related deaths. Since then, data shows an increase in OD rates in the Netherlands, and so this rise might have a simple statistical explanation". (Netherlands FP)

EMCDDA National Reports

Most of the respondents did not contribute data to the EMCDDA National Focal Point regarding "Drug-induced deaths and mortality" (DDM). The six organisations directly contributing to data were from the Czech Republic, Denmark, Montenegro, Scotland, Slovakia, and Spain, respectively. Contributions included data from clients and, in the case of Denmark, take-home naloxone.

Irrespective of their contribution, respondents were asked to **assess if their Country Profile information page on the EMCDDA website, on "Drug-induced deaths and mortality", is up-to-date and sufficient**. More than half of respondents had a negative assessment of the data (see Figure 3, below). Switzerland and Ukraine did not evaluate the report since both are not part of the EMCDDA monitoring system.

Figure 3: Assessment of EMCDDA country report information



Reasons for not considering the data up-to-date and sufficient included the following:

The **lag between the dates of data collection and the publication**, a problem already mentioned above (Austria, Bosnia and Herzegovina, France, Ireland, Italy, Georgia, Montenegro, and Romania);

A perceived **lack of space for the voices of people who use drugs and of harm reduction providers** in data gathering (Czech Republic, Montenegro, and Poland); and,

Not being an EU member means the country is not monitored by EMCDDA (Switzerland).

Specific suggestions for EMCDDA monitoring regarding DDM include specifying the type of drugs involved in overdoses to understand the geographic drug trade market in the EU; craft prevention messages if/when necessary; and inform users about local potent drug trends. This ideally includes, if useful, monitoring of fentanyl overdose rates in proportion to overall overdoses (and similarly oxycodone, GHB, GBL, MDMA, or NPS) (mentioned by the Netherlands). It is worth noting that the EMCDDA protocol includes collection of information on the drugs involved where autopsies were performed and data is available. The Stats Bulletin provides totals "involving opiates", "not involving opiates", and involving "unknown/mixed/unspecified" substances.

Data from unofficial channels (and its limitations)

Thirteen (out of 34 countries) reported gathering (complementary) data on drug-related deaths through informal channels. Such data collection, however, is ad-hoc and non-systematic. In most cases, the information comes from the clients of harm reduction programmes and staff from other harm reduction and drug treatment programmes (e.g. Bulgaria, Czech Republic, France, Greece, Montenegro, North Macedonia, and the Netherlands). In others, information comes from medical staff, such as ambulance system doctors (in the capital area of Finland). In Italy, a website of a professional organisation collects specific institutional data and information from the media and local informal focal points. In a few cases, participants are collecting their data to have a better overview of their context. In the Czech Republic, for instance, *SANANIM* has partnered with another NGO to collect and analyse data about the death of their clients. In the Netherlands, *Mainline* has produced a critical report about the official data on drug-related deaths and has partnered with *Trimbos* and *De Regenboog* to record the number of drug overdoses in drug consumption rooms (DCR's) in 2018, including non-fatal overdoses.

Conclusions

Monitoring

Most CSOs responding to this survey were already contributing to data collection, at least indirectly. They do, however, hold critical views on certain

aspects of how official data is collected and reported. On the other hand, the vast majority of respondents cannot currently continue with data collection themselves, except for some ad-hoc initiatives and with low support. CSOs have closer contact with many important actors in the field and have access to timely and quality information that can complement the data collection mechanisms already in place. The present Monitoring Tool, in this context, hopes to contribute to the reinforcement of the role of CSOs in the collection of data that can inform harm reduction practice.

Policy implications

Countries with a higher degree of formal structures, such as partnerships and dialogue, score higher on the level of satisfaction of civil society involvement. In most countries, civil society involvement is, to some extent, enabled through dialogue and/or information exchange but, often, the impact is regarded as unbalanced and ineffective. Countries with no, or almost no, level of exchange simply ignore requests or inputs from CSOs whilst organisations from such countries engage in advocacy and networking with other stakeholders to improve the situation.

Factors such as depending on government funding, the size and power of certain CSOs, as well as competing goals and concepts may influence the level and impact of civil society involvement, together with the competence and structural capacities of CSOs to develop strategies at the policy level. These features, however, were not captured by the Monitoring Tool in its present form.

Permanent and formalised structures that ensure dialogue between civil society and government representatives on development are beneficial for civil society involvement. These structures allow for cooperation on a regular basis between civil society and government actors and oversee both the formulation of policy and its implementation. Formalised structures as such, however, do not safeguard meaningful civil society involvement if they do not lead to accountable outcomes.

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HEPATITIS C

Introduction

PWID are the driving force of HCV infection throughout Europe. With the advent of highly effective treatment with direct acting antivirals (DAAs) the World Health Organization (WHO) has adopted a strategy to eliminate hepatitis C as a public health threat by 2030. To achieve this goal, key policies must be implemented, particularly for PWID, and a cascade of care should be introduced and monitored. HCV prevention is a fast-moving field in which grassroot developments need to be closely followed as well as undertaking advocacy for good practices.

While WHO and the European Centre for Disease Control (ECDC) have been working on the monitoring system to help countries assess progress towards eliminating hepatitis C, the EMCDDA has been working on an *elimination barometer* for PWID. In addition, C-EHRN has collected the experiences of CSOs providing harm reduction services on interventions in the HCV continuum-of-care and presented best practice examples in 2018. Furthermore, C-EHRN recently conducted a telephone survey on the Legal Barriers for Providing HCV Community Testing in Europe.

However, to better understand the barriers to, and opportunities for, HCV testing and treatment, a much greater involvement by harm reduction agencies, as well as the drug user community, in the development of HCV policy and practice is needed.

The following data from *C-EHRN Monitoring* contributes to this shortfall by providing timely, cross-sectional information on the situation, and progress made, in the HCV field as seen by harm reduction experts from the 35 C-EHRN Focal Points in 34 European countries (Scotland is treated separately from the rest of the United Kingdom). *C-EHRN Monitoring* also provides anecdotal information on the miss-match between official guidelines/strategies and the real-life situation at the local, regional and national levels throughout Europe.

The section of the C-EHRN Monitoring Tool on HCV consists of four parts: (1) the use and impact of national strategies/guidelines on accessibility to HCV testing and treatment for PWID; (2) the functioning of the continuum-of-care in different countries and regions; (3) potential changes in the continuum of services compared to the previous year; and, (4) the role of harm reduction services and PWID NGO's in this context.

Results

HCV prevention at current national policy level

The first part of the C-EHRN monitoring survey assesses the use and impact of national strategies or guidelines on the accessibility to testing and treatment for people who use injectable drugs from the viewpoint of services, working with people who use drugs.

There were still six countries that do not have national HCV treatment guidelines. One of these countries, Denmark, has, however, a number of strong policy documents regarding Hepatitis C care for PWID. Therefore, EMCDDA counts Denmark as 'having a policy'.

Table 3. What is the most relevant medical HCV treatment guideline in your country?

	National guidelines	EASL guidelines	No national guidelines
Albania	x		
Austria			x
Belgium		x	
Bosnia and Herzegovina			x
Bulgaria	x		
Croatia		x	
Czech Republic	x		
Denmark			x
Finland	x		
France	x		
Georgia	x		
Germany	x		
Greece	x		
Hungary	x		
Ireland	x		
Italy		x	
Latvia		x	
Luxembourg			x
Montenegro	x		
Macedonia, North			x
Netherlands	x		
Norway	x		
Poland			x
Portugal		x	
Romania	x		
Russia	x		
Scotland	x		
Serbia		x	
Slovakia	x		
Slovenia	x		
Spain		x	
Sweden	x		
Switzerland	x		
Ukraine	x		
United Kingdom	x		
TOTAL	**22**	**7**	**6**

In 6 countries, the HCV treatment guidelines still do not include specific measures for PWUD. Many respondents were also somewhat pessimistic about the impact of the guidelines on better access to testing and treatment of PWID in their country and even by their own organisation (see the table below).

Table 4. PWUD in the guidelines and impact of the guidelines

	Do your HCV treatment guidelines include specific measures for PWUD?	Do you think these guidelines impact accessibility to testing and treatment of PWID **in your country**?	Do these guidelines have an impact on better access to the service provided **by your organisation**?
Albania	Yes	Yes	Yes
Austria	N/A	N/A	N/A
Belgium	Yes	Yes	Yes
Bosnia & Herze-govina	N/A	N/A	N/A
Bulgaria	No	Yes	No
Croatia	Yes	Yes	No
Czech Republic	Yes	Yes	Yes
Denmark	N/A	N/A	N/A
Finland	Yes	Yes	Yes
France	Yes	Yes	Yes
Georgia	Yes	Yes	Yes
Germany	Yes	Yes	Yes
Greece	Yes	Yes	Yes
Hungary	Yes	Yes	No
Ireland	Yes	No	Yes
Italy	Yes	No	No
Latvia	Yes	MI	MI
Luxembourg	N/A	N/A	N/A
Montenegro	Yes	Yes	No
Macedonia, North	N/A	N/A	N/A
Netherlands	No	Yes	No
Norway	Yes	Yes	Yes
Poland	N/A	N/A	N/A
Portugal	Yes	Yes	Yes
Romania	No	Yes	Yes
Russia	No	No	No
Scotland	Yes	Yes	No
Serbia	Yes	No	No
Slovakia	No	No	No
Slovenia	Yes	Yes	Yes
Spain	Yes	Yes	Yes
Sweden	Yes	Yes	Yes
Switzerland	Yes	Yes	Yes
Ukraine	Yes	Yes	Yes
United Kingdom	No	No	Yes
	Yes=23 No=6 MI=1 N/A=6	Yes=22 No=6 MI=1 N/A=6	Yes=18 No=10 MI=1 N/A=6

Mismatch between national guidelines and real-life practice

The respondents were asked to freely comment on the national guidelines and their implementation. As noted above, many respondents were somewhat pessimistic about the impact of the guidelines on better access to testing and treatment of PWID in their country and even by their own agencies. Even if the guidelines exist, they might have limited relevance in practice. A range of challenges - such as outdated guidelines and complicated testing and treatment systems - as well as a lack of services and other disparities between formal guidelines and reality were reported.

For example, in Bulgaria a very complicated procedure needs to be followed to get treatment:

> "The patient needs to be hospitalised a few times for 3-4 days each time in a specialised gastroenterology clinic (there are 13 in the country) to perform blood and PCR tests, liver biopsy. Most of this could be done in an ambulatory way, not by hospitalisation, but the hospital receives its funding through clinical pathways and hospitalisation is a very important part of the treatment. This obstructs patient's everyday life and work, is extremely expensive to the National Health Insurance Fund (NHIF) and causes delay in access to DAAs (it takes 5-6 months to start treatment, in some cases it can be a year)." (Bulgaria FP)

Albanian harm reduction services report similar difficulties:

> "The practical implementation of the guidelines is far from being real. Formally, it is difficult to follow protocols but we are trying to help in private ways." (Albania FP)

In Finland, despite a new policy document in which needle exchange points are encouraged to start DAA treatment with PWID, in practice this has not taken place. A clear statement is missing that the municipalities and drop-in centres are obligated to actively treat PWID. At present, only one drop-in centre offers PCR testing in Finland.

In Slovakia, the guidelines are from 2012 and they still refer to interferon treatment.

Lack of harm reduction services set barriers in many countries. For example, in Hungary the main problem is that drug users in need of treatment are "completely invisible for the system because of the closing of harm reduction services".

In some countries, guidelines are regarded too narrow and/or medically oriented. For instance, in Poland there is an official document related to HCV treatment, but it cannot be called a national guideline as the document is mostly about medical issues:

> "One sentence is touching the drug user issue. It is one of the criteria which makes it impossible to qualify for the programme in that 'active addiction to alcohol or other psychoactive substance'. In practice, however, as long the person is in regular contact and comes for the regular visits and blood tests, doctors do not exclude drug users from entering treatment. At least in Krakow, but we heard about similar practices in other cities and clinics." (Poland FP)

Another problem is that people who live with HCV might be uninsured and, consequently, do not receive medical care even if they are long term carriers of the virus. This is the case in Romania.

In Ukraine, too, a demanding testing system and its high price, combined with the discrimination of PWUD, is reportedly preventing HCV testing and treatment. To get treatment for viral hepatitis, full diagnostics are needed which are often too expensive for PWUD; this prevents PWUD from seeking such services. Also, there is a high level of stigma and discrimination from healthcare professionals towards PWUD.

> "These guidelines should include a section on key populations and vulnerable groups: MSM, people who use drugs, sex workers, migrants, homeless, etc. Specific measures for people who use drugs to have access to testing and treatment. The main issue is that there is very little willingness by doctors to test for Hep C." (Russia FP)

On the other hand, harm reduction agencies do not necessarily need official guidelines to start working on HCV. And even if guidelines exist, they might have limited relevance in practice, such as in Serbia.

> "Our organisation has provided screening for hepatitis C for more than 10 years, so the guidelines were not necessary for our work. For clinicians, EASL and national guidelines have no impact when we talk about treatment of PWID. ECDC and EMCDDA recommendations are available in the Serbian language but I am not sure if our clinicians know it." (Serbia FP)

It should be noted that there were also statements that PWUD, and people in prison, do not need to be separately mentioned in guidelines.

> "There is nothing specific for PWUD because they have access to screening and treatment like any other group. According to the guidelines and policy, there is no reason for differential treatment for these groups when screening and considering DAA treatment." (Netherlands FP)
>
> "Some experts think it would be good to have guidelines to treat people in prison. The national guidelines do not say anything about this. In my opinion, this is right because we don't need additional guidelines for prison. They should treat people as they do outside prison."
> (Germany FP)

Availability of and access to new drugs (DAA's)

According to the C-EHRN survey, the new drugs for HCV treatment (DAA's) are available in all countries but North Macedonia. However, there are still perceived restrictions in access to DAA's. All but 10 countries do not limit access by HCV-ab positive people to DAA treatment. 12 of these only allow patients diagnosed with fibrosis (any stage), and in Albania and Serbia is a grade of severe fibrosis required to access DAA treatment.

Table 5. Are there new drugs for treatment of hepatitis C (direct acting antivirals, DAAs)available in your country? If yes, are they accessible?

	Are there new drugs for treatment of hepatitis C (DAA's) available in your country?	Are there new drugs for treatment of hepatitis C (DAA's) accessible in your country?
Albania	Yes	Yes, with restrictions
Austria	Yes	Yes, with no restrictions
Belgium	Yes	Yes, with no restrictions
Bosnia & Herzegovina	Yes	Yes, with restrictions
Bulgaria	Yes	Yes, with no restrictions
Croatia	Yes	Yes, with restrictions
Czech Republic	Yes	Yes, with no restrictions
Denmark	Yes	Yes, with no restrictions
Finland	Yes	Yes, with restrictions
France	Yes	Yes, with no restrictions
Georgia	Yes	Yes, with no restrictions
Germany	Yes	Yes, with no restrictions
Greece	Yes	Yes, with no restrictions
Hungary	Yes	Yes, with no restrictions
Ireland	Yes	Yes, with no restrictions
Italy	Yes	Yes, with no restrictions
Latvia	Yes	Yes, with no restrictions
Luxembourg	Yes	Yes, with no restrictions
Montenegro	Yes	Yes, with restrictions
Macedonia, North	*No*	*Not available*
Netherlands	Yes	Yes, with no restrictions
Norway	Yes	Yes, with no restrictions
Poland	Yes	Yes, with restrictions
Portugal	Yes	Yes, with no restrictions
Romania	Yes	Yes, with no restrictions
Russia	Yes	Yes, with restrictions
Scotland	Yes	Yes, with no restrictions
Serbia	Yes	Yes, with restrictions
Slovakia	Yes	Yes, with restrictions
Slovenia	Yes	Yes, with no restrictions
Spain	Yes	Yes, with no restrictions
Sweden	Yes	Yes, with no restrictions
Switzerland	Yes	Yes, with no restrictions
Ukraine	Yes	Yes, with no restrictions
United Kingdom	Yes	Yes, with restrictions

Table 6. In case they are accessible, is there an official policy on Restrictions for the use of new HCV drugs?

	In case they are accessible, is there an official policy on restrictions for the use of new HCV drugs?	In case there is an official policy restricting the use of new drugs related to the stage of liver disease, they are to be used only for patients with:
Albania	Yes	Fibrosis stages 3 and 4
Austria	No	
Belgium	No	
Bosnia & Herzegovina	No	
Bulgaria	No	
Croatia	Yes	Fibrosis stages 1, 2, 3 and 4
Czech Republic	No	
Denmark	No	
Finland	Yes	
France	No	
Georgia	No	
Germany	No	
Greece	No	
Hungary	No	
Ireland	No	
Italy	No	
Latvia	Yes	Fibrosis stages 1, 2, 3 and 4
Luxembourg	Yes	Fibrosis stages 1, 2, 3 and 4
Montenegro	Yes	Fibrosis stages 1, 2, 3 and 4
Macedonia, North	NA	
Netherlands	No	
Norway	No	
Poland	No	
Portugal	No	
Romania	Yes	Fibrosis stages 1, 2, 3 and 4
Russia	Yes	Fibrosis stages 1, 2, 3 and 4
Scotland	No	
Serbia	Yes	Cirrhosis (fibrosis stage 4)
Slovakia	No	
Slovenia	No	Fibrosis stages 1, 2, 3 and 4
Spain	No	
Sweden	Yes	Fibrosis stages 1, 2, 3 and 4
Switzerland	No	
Ukraine	Yes	Fibrosis stages 1, 2, 3 and 4
United Kingdom	No	Fibrosis stages 1, 2, 3 and 4

Table 7, below, shows the countries in which drug users - either active users, former users or users in OST – are allowed formal access to HCV treatment. **Active drug users are still not allowed access to HCV treatment in 10 countries.**

In some cases, there is conflicting information reported as to whether PWUD really have access to treatment even if that is the official national policy. For instance, according to the official policy in Montenegro, OST is not an obstacle to HCV treatment with new drugs, but there are also sources who report that people in OST do not get access to liver staging or to antiviral treatment.

One of the countries where active drug users are not allowed access to treatment is Slovakia. There, it is very difficult to get treated even when enrolled in OST, as described below.

"People who use drugs are not allowed access to any HCV treatment covered by health insurance. In order to get treatment covered by health insurance, they need to prove abstinence for 1 year. If the person has used drugs in the past (10 years ago), or is currently in opioid substitution treatment (OST), s/he still needs to prove abstinence of 1 year (there are drug tests every 3 months, or so). In substitution treatment, in theory a person needs to prove abstinence from other illegal substances in order to get treatment. It means for PWUD that from the diagnosis until treatment there is a minimum 1 year waiting period during which s/he needs to prove abstinence by passing several drug tests.

The hepatologist usually does not care about drug use and is not conducting drug tests. The problem starts when the hepatologist requests HCV treatment from an insurance company for a diagnosed person - the insurance company then checks ALL medical records of the person concerned in order to approve the treatment - if there is some record about drug use/or dependence treatment, it automatically refuses the request and asks for 1 year of abstinence." (Slovakia FP)

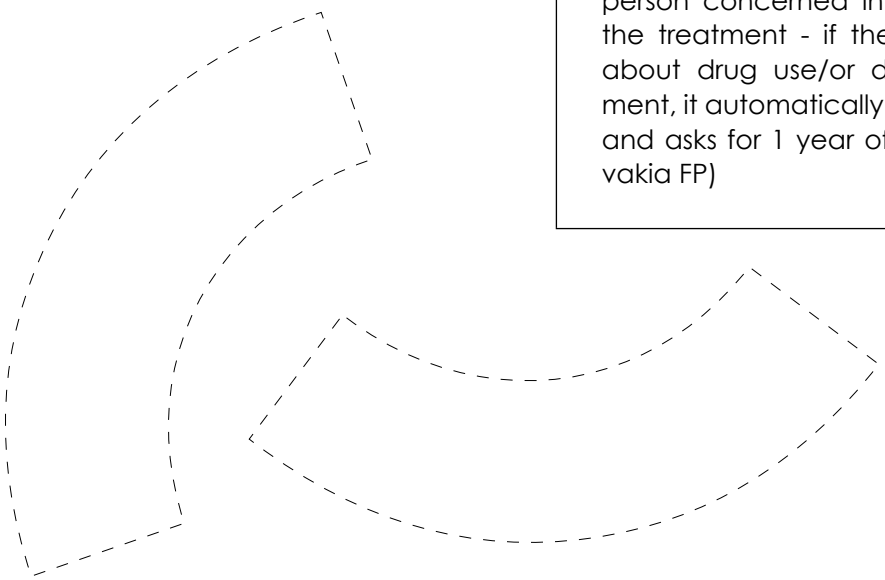


Table 7. Drug-user groups who are allowed HCV treatment with new drugs

	PWID on OST	PWID (active)	PWID (former)
Albania	X	X	X
Austria	X	X	X
Belgium	X	X	X
Bosnia & Herzegovina	X		X
Bulgaria	X		X
Croatia	X		X
Czech Republic	X	X	X
Denmark	X	X	X
Finland	X		X
France	X	X	X
Georgia	X	X	X
Germany	X	X	X
Greece	X	X	X
Hungary	X	X	X
Ireland	X	X	X
Italy	X	X	X
Latvia	X	X	X
Luxembourg	X	X	X
Montenegro	X		X
Macedonia, North			
Netherlands	X	X	X
Norway	X	X	X
Poland	X	X	X
Portugal	X	X	X
Romania	X		X
Russia			X
Scotland	X	X	X
Serbia	X		X
Slovakia	(X)		X
Slovenia	X	X	X
Spain	X	X	X
Sweden	X	X	X
Switzerland	X	X	X
Ukraine	X	X	X
United Kingdom	X	X	X
	Yes=33 **No=2**	**Yes=25** **No=10**	**Yes=34** **No=1**

Respondents were also asked to assess whether DAA's were used in practice as stated in the official policy documents. All countries answered that they are used properly except in Finland, Hungary, the Netherlands, Poland, Serbia and Switzerland (n=6).

One point of divergence has to do with regional differences and inequalities, as in Finland:

> "There are regional differences in the way drug users are offered treatment; in most municipalities, the public healthcare system measures "motivation" and the possibility for compliance to treatment. The treatments are still used to try to influence people to stop using drugs before they get the new DAA treatment. There is still a debate about who is paying for the treatment and it seems the healthcare system is on hold, waiting for the financial stuff to get cleared out." (Finland FP)

Poland represents a positive point of divergence because, even if the official criteria eliminates active drug users from DAA treatment, in practice active drug users do get the treatment.

In Serbia, it is the opposite: even if the national HCV guidelines do not discriminate against PWID, in practice PWID are not treated as DAA's are given to very few people and drug users are not a priority.

The Dutch respondent was of the opinion that the problem does not necessarily lay with the treatment system, or with the professionals, but also with those living with HCV:

> "The threshold for DAA treatment is still rather high among many HCV patients due to hardwired misinformation. Frequently, we hear from patients that they still fear the side effects; the treatment itself (based on the older forms of treatment); they believe they have to wait until they have complaints (this might be fed by professionals); or they fear starting a new treatment because of failure in the past or because they fear finding out other health problems if they go into treatment. Also, many know how costly the treatment is and some feel they do not deserve this treatment." (Netherlands FP)

Who is paying for HCV treatment?

HCV treatment with DAA's is reimbursed by health insurance or the public health service in all countries except the United Kingdom. In Germany, all persons with social or private health insurance are reimbursed for HCV treatment with DAA's. However, in total, only 85% of the German population are covered by social health insurance. Some migrant groups, who do not have regular residency status and therefore no access to regular health insurance, can only be treated for emergency health conditions and usually not for a chronic disease, and, therefore, do not have access to DAA's. In Switzerland, health insurance is mandatory for Swiss citizens; nevertheless, some individuals - especially in prison and asylum seekers - may not have such health insurance. In such instances, financing of HCV treatment is difficult.

In some countries, PWID are not automatically reimbursed. This is reported to be the case in Romania, Serbia, and Hungary.

"The hepatologists usually don't care whether the person is a drug user or not. The problem is the health Insurance company. If the hepatologist indicates treatment for a person with HCV – s/he sends the request for treatment to the health insurance company - and the request is pending. Meanwhile, the health insurance company looks into all of the health records of the patient. If they find something connected to drug use – for example, drug dependence treatment 20 years ago – they deny the request for treatment and ask for 1 year abstinence first. The person has to go to a drug test every 3 months. If the health insurance company sees that the person has debts, the request is denied immediately." (Serbia FP)

"There is a problem with those PWID who have no health insurance - a lot of paperwork is needed to enable them to access treatment; very few service providers help them with that." (Hungary FP)

"We still have co-payment for diagnostics and monitoring costs for HCV treatment (nearly $100) per course. This reveals barriers for PWID to be involved in the treatment programme. Also, there are other barriers." (Serbia FP)

Other restrictions on HCV care in practice, as mentioned by C-EHRN Focal Points, include the cost of testing (mentioned by Finland and the Czech Republic); a hospital-centric model instead of supporting low-threshold and peer-based programmes (mentioned by Ireland); long waiting times for assessment and treatment (mentioned by Poland and Portugal); and PWUD not being a priority for the HCV care system (Italy).

"The medical procedure predicts a few medical examinations before the patient will get on to treatment. A liver assessment by elastography to diagnose cirrhosis is one of them. Without it, you cannot go a step further. Unfortunately, some of the clinics have no direct access to Fibroscan and patients have to wait months for elastography. it seems like access to DAA's is not the problem in Poland. The real limitation is efficient and fast processing of the liver assessment before a patient will enter into treatment. That is especially problematic for PWUD because thepossibility of long-term planning is very limited. According to doctors, there is a lack (in the procedure) of proper liver assessment after treatment and some bio-chemical blood tests during treatment." (Poland FP)

"Even though no formal restrictions are applied, the number of patients for each clinic is so huge that waiting lists are usual. This means that a priority is assigned to each patient and in case no medical conditions can determine a priority (currently the more severe HCV infections have been already treated), clinicians can use social criteria to prioritise. It could happen that more marginalised people with HCV (e.g. the homeless) are at the end of the list because they are considered less compliant." (Italy FP)

"The cost of the PCR-test is the biggest reason why it´s not common to test many people, there are still debates going on if active PWID should be treated or not." (Finland FP)

Changes in the continuum of care

A good functioning continuum of care, including low threshold and harm reduction services, is increasingly important for accessibility and impact of HCV testing and treatment. C-EHRN monitoring contains a pattern of questions asking how the continuum of care is functioning in different countries and regions.

Evidence exists that DAA treatment in PWID is as successful as in non-injectors. Therefore, it is crucial to improve the low uptake of HCV testing and treatment among PWID by including the harm reduction and drug user organisations in the continuum of services that provide HCV management within every European country.

The following findings provide some important information to the WHO Global Health Sector Strategy which calls for health systems to deliver HCV testing and treatment for PWID in different settings, to reinforce strategic linkages between various health services, and to ensure the quality of services and actively engage the PWID community as well as harm reduction services. Therefore, the roles and responsibilities at every level of the health system, as well as beyond it, need to be defined with respect to their delivery of hepatitis treatment.

Testing

There are still big differences within Europe as to where and how PWID can undertake a HCV test. This means PWID are in an unequal position in different European countries, regions and cities.

C-EHRN monitoring data shows both good and bad practice examples. As a good practice example, Scotland is where HCV testing takes place at practically every service mentioned as an option (see the Table 8, below).

However, national-level data on testing and treatment is still missing from some countries. For example, the C-EHRN FP response from Romania is based only on the harm reduction agency practice in Bucharest, whereas there is a lack of information at the national level about HCV testing and treatment for PWID.

Table 8. Where PWID can be tested for HCV antibodies? X = quick test ('oral swab or antibodies finger prick'), Y = confirmatory test ('C RNA blood test')

	Gastro-enterology clinics	Infectious disease clinics	Drug dependence clinics	Harm reduction services or community centres	General practitioner	Pharmacy	Prison
Albania	x y	x y	x	x			x
Austria	x y		x y	x	x y		x y
Belgium	x y	x y	x	x	x		x
Bosnia & Herzegovina		x y	x	x			x
Bulgaria	y			x y			
Croatia	x y	x y	x	x	x y		(x)
Czech Republic	x y	x y	x	x	y		x y
Denmark		x y	x y	x	x y		
Finland	y	x y	x y	x y	x y		x y
France	x y	x y	x	x	x y		x y
Georgia	x	x y	x	x y	x		x
Germany	y	x y		x y	x y		x y
Greece		y		x			
Hungary		y		x			x y
Ireland	y	y	y		y		y
Italy		y	x	x		x	x y
Latvia		y		x	y		y
Luxembourg		x y	x		x		x
Montenegro		y					
Macedonia, North		y					
Netherlands	x y	x y	x		x y		x y
Norway	x				x y		
Poland		y	x	x	x		x
Portugal	x y	x y	x y	x y	y		x y
Romania	y	y	x	x	x		x
Russia		x y	x	x			
Scotland	x y	x y	x y	x y	x y	x y	x y
Serbia				x			
Slovakia	y		y	x			y
Slovenia		y	y	y	y		y
Spain	y	y	x y	x y	y		y
Sweden	x	x y	x y	x y	x		x y
Switzerland	x y	x y	x y	x	x y		
Ukraine		x y		x	x		x
United Kingdom	x y	x y	x y	x y	x	x	x y
	x=14 y=18	**x=19 y=30**	**x=22 y=12**	**x=28 y=9**	**x=18 y=16**	**x=3 y=1**	**x=21 y=17**

Treatment

Point-of-care testing increases HCV testing and linkage to care. It is important that the same facilities are able to offer both HCV testing and treatment. When comparing the situation (see Tables on HCV treatment, below), we can conclude that the integration of testing and treatment at the same location is still too rarely the case.

Drug dependence clinics offer HCV treatment in 12 countries, and in prison in 15 countries. Prisons are an important setting for HCV testing and treatment as PWID have high rates of imprisonment, and among those inmates who are PWID, the prevalence of chronic HCV infection is high. Even if a number of countries have mentioned prisons as a treatment setting, some respondents also commented that, in practice, it is not in all prisons in their country.

Testing (Italy, Scotland) and treatment (Greece, Scotland) at pharmacies remains very rare. Testing by General Practitioners takes place in about half of countries (18) but HCV treatment through GP appointments is quite rare (in only 5 countries). However, in France, treatment for hepatitis C can be prescribed by any physician since May 2019.

Table 9. In case HCV treatment is accessible by PWUD in your country, where are they treated for HCV?[33]

	Gastroenterology clinics	Infectious disease clinics	Drug dependence clinics	General practitioner	Pharmacy	Prison
Albania	X	X				
Austria	X					
Belgium	X					X
Bosnia & Herzegovina	X					
Bulgaria	X					
Croatia	X	X				
Czech Republic	X	X	X	X		X
Denmark		X				
Finland	X	X	X	X		X
France	X	X	X	X		X
Georgia	X	X	X	X		X
Germany	X	X	X	X		X
Greece					X	
Hungary	X	X				
Ireland	X	X	X			X
Italy		X				X
Latvia		X				X
Luxembourg		X				
Montenegro		X				
Macedonia North	X	X				
Netherlands	X	X				
Norway	X					
Poland		X				X
Portugal	X	X	X			X
Romania	X	X				
Russia		X				
Scotland	X	X	X	X	X	X
Serbia		X				
Slovakia	X	X				
Slovenia	X	X				
Spain	X	X	X			X
Sweden		X	X			X
Switzerland	X	X	X			
Ukraine		X				
United Kingdom	X	X	X			X
	24	**29**	**12**	**6**	**2**	**15**

When asked to assess if there is a clear linkage-to-care protocol/guidelines so that people diagnosed with HCV are referred directly to care management, respondents from 19 countries answered that the protocol/guidelines were clear, but in 12 countries they were regarded as unclear. Respondents of three countries could not make an assessment.

Table 10. Is there a clear linkage-to-care protocol/ guidelines so that people diagnosed with HCV are referred directly to care management?

Albania	Yes	**Montenegro**	Yes
Austria	No	**Macedonia**	No
Belgium	No	**Netherlands**	Yes
Bosnia & Herzegovina	I don't know	**Norway**	Yes
Bulgaria	No	**Poland**	No
Croatia	Yes	**Portugal**	Yes
Czech Republic	No	**Romania**	I don't know
Denmark	I don't know	**Russia**	Yes
Finland	No	**Scotland**	Yes
France	Yes	**Serbia**	Yes
Georgia	Yes	**Slovakia**	No
Germany	Yes	**Slovenia**	Yes
Greece	Yes	**Spain**	Yes
Hungary	No	**Sweden**	Yes
Ireland	No	**Switzerland**	No
Italy	No	**Ukraine**	Yes
Latvia	Yes	**United Kingdom**	Yes
Luxembourg	Yes		

For the development of a HCV cascade of care, up-to-date information is essential. The respondents were asked if their government monitors the number and proportion of people who progress through each stage of the HCV cascade of care. Altogether, 20 countries do monitor the number of HCV patients at some level, but in 9 countries such a monitoring system does not exist.

Table 11. Does your government monitor the number/proportion of people who progress through each stage of the HCV cascade of care?

	Yes, at national level	Yes, at regional level	Yes, at local level	Not on any level	I don't know
Albania	X				
Austria				X	
Belgium			X		
Bosnia & Herzegovina					X
Bulgaria				X	
Croatia	X	X	X		
Czech Republic	X				
Denmark				X	
Finland				X	
France	X	X			
Georgia	X				
Germany				X	
Greece	X				
Hungary					X
Ireland					X
Italy		X	X		
Latvia	X				
Luxembourg	X				
Montenegro	X				
Macedonia, North				X	
Netherlands					X
Norway			x		
Poland					X
Portugal	X				
Romania					X
Russia			X		
Scotland	X	X	X		
Serbia				X	
Slovakia				X	
Slovenia	X				
Spain	X	X			
Sweden			X		
Switzerland				X	
Ukraine	X				
United Kingdom	X				
N	**15**	**5**	**7**	**9**	**6**

More or less action on HCV?

The respondents were asked to estimate whether the service providers had invested more or less attention to i) HCV awareness campaigns; ii) HCV testing at their own locations; and, iii) HCV treatment at their own locations. The overall result can be considered positive as there was more action taking place in several countries.

Compared to the previous year, *more* attention to **HCV awareness campaigns** had been invested in Belgium, Bulgaria, Croatia, Denmark, Italy, Luxembourg, the Netherlands, Norway, Poland, Portugal, Romania, Scotland, Serbia, Switzerland and Ukraine (N=15). In other countries, the situation had remained the same or there had been less awareness campaigning.

Compared to the previous year, *more* attention had been paid to **HCV testing** at the service providers own locations in Albania, Belgium, Bulgaria, Croatia, Denmark, Finland, France, Georgia, Germany, Italy, Luxembourg, the Netherlands, Poland, Romania, Scotland, Switzerland, Ukraine, and the United Kingdom (N=18). In other countries, the situation had remained the same or there had been less testing at their own location.

Compared to the previous year, *more* attention had been paid to **HCV treatment** at the service providers own locations in Belgium, Denmark, France, Georgia, Italy, the Netherlands, Poland, Romania, Scotland, Slovenia, Spain, Sweden, Switzerland, Ukraine, and the United Kingdom (N=15). In other countries, the situation had remained the same or there had been less treatment at their own location.

The role of harm reduction and drug user organisations

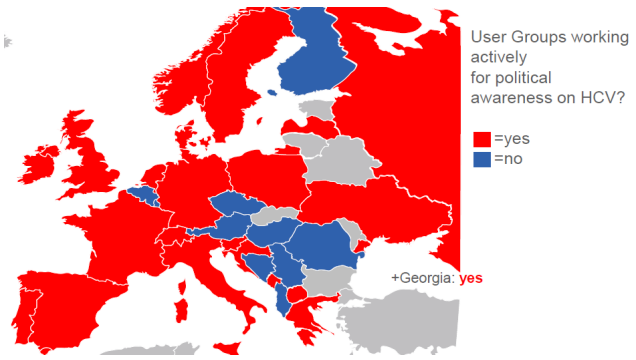
In countries with progressive HCV treatment policies, drug user interest groups have had a pivotal role in raising the issue with the public through awareness and in advocating for the right of PWID to low threshold HCV testing and treatment. C-EHRN monitoring asked in which European countries there are drug user groups (NGO's) who are actively working for political awareness with regards to HCV.

Active user groups were recognised in:

- Croatia (Hepatos - Croatian Association for Liver Disease);
- Denmark (Brugernes Akademi/The Users Academy);
- France (ACT UP, ASUD, PSYCHOACTIF, AIDES);
- Germany (JES Bundesverband e.V);
- Georgia (New Vector, Hepa+, New Way and others);
- Greece (PeerNups);
- Ireland (The Hepatitis C Partnership, UISCE);
- Italy (ISOLA DI ARRAN/Torino);
- ITANPUD/PWUD (national network);
- Latvia (Association HIV.LV/ a formal NGO; Association of patients with C hepatitis/informal group);
- Montenegro (Montenegrin Harm Reduction Network LINK);
- Macedonia (HOPS, ELPA);
- Netherlands (3 organisations in Amsterdam, SoaAIDS);
- Norway (ProLARNett);
- Poland (JUMP'93 in Warsaw);

- Portugal (APDES, GAT, CASO);
- Russia (Forum of PWUD);
- Slovenia (Association Slovenia Hep and Stigma);
- Spain (ASSCAT - Catalan Association of liver patients);
- Sweden (Stockhom Drug User Union);
- Switzerland (Swiss Hepatitis C Association);
- Ukraine (All Ukrainian Association of PWUD, Volna); and,
- United Kingdom (Hep C coalition, Harm Reduction Group).

In Austria, Bosnia and Herzegovina, the Czech Republic, Finland, Hungary, Luxembourg, Romania, Scotland and Serbia there were no (named) drug user groups which would currently be politically active in HCV awareness raising.



Map 3

At the end of the HCV section of the C-EHRN monitoring survey, respondents were asked to name any barriers and limitations that harm reduction organisations might face while trying to address HCV among PWID.

The most mentioned barriers and limitations include the lack of funding for harm reduction in general and especially for HCV. The lack of funding went hand-in-hand with the lack of political support and general recognition of harm reduction measures. Lack of funding, support and recognition were mentioned by Focal Points in Albania, Germany, France, Hungary, North Macedonia, Ireland, Romania, Serbia and the United Kingdom.

> "The main limitation is funding. Over the last 5 years, all harm reduction services have seen significant cuts in funding and increases in workload. With harm minimisation and stabilisation being priorities, BBVs - including HCV - are not priorities." (United Kingdom FP)

> "The requirement to have health insurance, a complicated procedure to apply for, and perform, treatment; besides, there is a lack of interest from doctors to deal with PWID." (Bulgaria FP)

Lack of knowledge and training about HCV, and lack of skillful staff, were also mentioned (by the Czech Republic, France, Russia, Ireland and Germany).

> "We need better networking, or even better would be having a hepatologist directly working in HR services." (Czech Republic FP)

Legal barriers regarding the possibility of doing community-testing set another challenge. Legal barriers were mentioned by Greece and Montenegro.

> "NGOs are not able to provide services such as testing and self-testing, since our law does not allow non-medical organisations to use medical procedures such as drawing blood for testing." (Montenegro FP)

Conclusions

The results show that PWID are still in an unequal position in different European countries, regions and cities, and often deprived of proper HCV interventions. When comparing the continuum-of-care situation, it becomes obvious that the integration of testing and treatment at one site is still too rarely the case. However, the overall result on progress can be considered positive as there has been more action taking place in several countries. In countries with progressive HCV treatment policies, PWID NGO's have played a pivotal role in raising the issue with the public and advocating for the right of PWID to low threshold HCV testing and treatment.

Most countries reported having national guidelines for HCV treatment, and include specific management of PWID. Nevertheless, many respondents were somewhat pessimistic about the impact of guidelines on better access to testing and treatment services by PWID in their country and even by their own agencies. DAA's are available in all countries except North Macedonia. However, there are still restrictions in accessing DAA's in 10 of 34 countries for those who are active drug users. Most respondents assessed DAA's as being used in practice in accordance with official policy documents. DAA treatment is reimbursed by health insurance or the public health service in all countries except the United Kingdom.

A variety of options exist for PWID to get HCV testing and treatment, with some good and some bad practice examples. While in two major medical settings - gastroenterology and infectious disease clinics - a confirmatory HCV RNA blood test and DAA treatment are offered, GPs perform a confirmatory test in a majority of countries, whereas DAA treatment is prescribed by GPs in only five countries. A confirmatory RNA test is a standard of care at harm reduction services in 9 countries and in the prisons of all 17 countries where testing is offered. While DAA treatment is provided at drug dependence clinics in 12 countries, in 15 countries it is also provided in prisons. HCV testing and treatment at pharmacies remains rare. The government monitors the number/proportion of people who progress through each stage of the HCV cascade-of-care at a national level in 15 countries; monitoring at the regional or local level is also, or only, performed in nine countries, whereas in nine countries monitoring is not performed at any level.

Compared to the previous year, more attention has been paid to HCV awareness campaigns (in 15 countries), to testing at the site of service providers (in 18 countries), and to treatment at the site of service providers (in 15 countries).

Twenty-four European countries reported having PWID NGO's that are actively working on political awareness in regard to HCV interventions, whereas no such NGO support is reported in nine countries. The main barriers to address HCV among PWID include a lack of funding, knowledge, recognition, political support or skilful staff, as well as weakness of CSOs and legal barriers.

In order to reduce the HCV-related disease burden among PWID and achieve the 2030 elimination goals, a radical change in the HCV response is needed in many of the European countries investigated in this C-EHRN survey. National treatment guidelines that specifically address recommendations for treating PWID, unrestricted access to DAA treatment, improvements in the continuum-of-care and introduction of single site testing and treatment services - including harm reduction organisations - need to be further developed and adopted. Involving all stakeholders, including relevant NGOs, in the monitoring and reporting of national responses would be a significant step forward towards the elimination of HCV as a public health threat as set out in the WHO Global Health Sector Strategy on Hepatitis.

OVERDOSE PREVENTION AND MANAGEMENT

Introduction

Drug-related overdoses (OD) are on the rise in many European countries. Along with policy planning and systematically implemented actions, sufficient good-quality information is needed to prevent ODs. Civil society involvement has important roles to play in policymaking and implementing activities at the community level where drug-related ODs occur. In this C-EHRN monitoring tool, another important civil-society role is brought to light: collecting data on the OD-related context and interventions at a local level, feeding into already existing data and reports.

In this context, C-EHRN conducted a monitoring survey to collect information on the situation, and progress made, regarding OD prevention as seen by 35 C-EHRN focal points from 34 European countries (Scotland was treated separately). These comprise all countries defined at the introduction of this report, except from Latvia, which did not answer the survey questions on OD.

Interventions to prevent drug (opioid)-related OD deaths can be undertaken at three levels (EMCDDA, 2017): (1) **Reducing fatal ODs**: for instance, by providing Drug Consumption Room (DCR) and Take Home Naloxone (THN) programmes; (2) **Reducing ODs risk**: for example, by improving retention in Opiod Substitution Therapy (OST) programmes, and providing OD risk assessments in treatment facilities and prisons, and promoting OD awareness; and, (3) **Reducing vulnerability**: providing a broad set of interventions, such as through outreach and low-threshold services, an enabling environment (removing barriers to access care), empowering PWUD, and promoting public health.

C-EHRN monitoring focuses on the first two levels. Regarding the prevention of fatal ODs, C-EHRN collects extensive data on the existence and implementation of THN programmes, with a brief section on DCRs. Regarding reducing OD risk, the Monitoring Tool collects data on OD prevention in prison settings (naloxone and release programmes), and other prevention measures such as the action of first responders, and in promoting OD awareness through education and training for PWUD and other professionals. Although the report focuses on opioids, a brief section is included on OD prevention for other drugs. The monitoring report does not distinguish between fatal and non-fatal overdoses.

An added value of civil society experts was to provide anecdotal information on the miss-match between official guidelines/strategies and the real-life situation as experienced at the local, regional and national levels.

Results

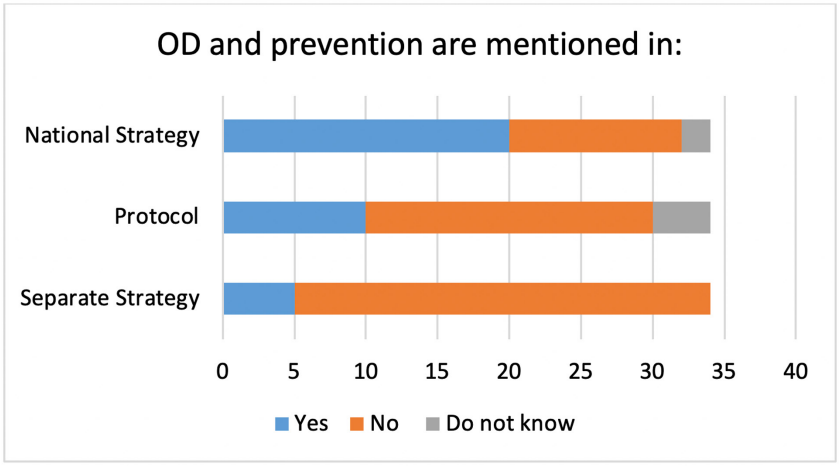
OD prevention at current policy level

Strategic planning and programming are essential for effective action. Therefore, C-EHRN monitoring asked participants whether **drug-related overdose deaths, and ways to prevent them, are mentioned in the respective national drugs strategy or action plan.** This information has never previously been collected when considering existing monitoring tools. Twenty out of 34 countries reported having OD prevention mentioned in their national drug strategy or action plan (Figure 4, below).

Respondents were also asked if there were **nationally defined protocols for overdose management.** For instance: how to identify an OD; when, and to whom, to administer naloxone; and instructions on what needs to be considered. These protocols might involve instruction for ambulance staff and other first responders; the right of police (not) to accompany an ambulance, and so on. Respondents from 10 countries recognised such protocols.

Five countries (Italy, Luxembourg, Norway, Spain, Sweden) reported having **separate drug overdose prevention strategies or action plans** and an expert group is currently working to build one in France. In Italy, these separate strategies correspond to guidelines and protocols around naloxone distribution in some regions[34]; and in Norway, to a national overdose strategy[35]. In Luxembourg, the presence of DCRs is considered a separate prevention strategy. Other C-EHRN Focal Points whose countries have DCRs did not mention DCRs as a separate OD prevention strategy. Therefore, to maintain consistency in the reported data, DCRs have not been included as a separate OD prevention strategy.

Figure 4: OD prevention at current policy level



In at least eight countries (Bosnia and Herzegovina, Finland, Germany, Montenegro, Portugal, Poland, Russia, and Slovenia) drug-related deaths are not mentioned: neither in the national drug policy and national guidelines nor in separate strategies or national protocols on OD. Table 12, below, shows the state of OD prevention (ODP) at the policy level by country.

Table 12: State of OD prevention at the policy level by country

	ODP in national drug strategy or action plan	Separate strategy or action plan for ODP	National protocols for OD management
Albania	✓	✗	✗
Austria	✓	✗	✗
Belgium	✗	✗	✗
Bosnia and Herzegovina	✗	✗	✗
Bulgaria	✓	✗	Do not know
Croatia	✗	✗	Do not know
Czech Republic	✓	✗	✓
Denmark	✓	✗	✗
Finland	✗	✗	✗
France	✓	✓	✓
Georgia	Do not know	✗	✓
Germany	✗	✗	✗
Greece	✓	✗	✗
Hungary	✓	✗	✗
Ireland	✓	✗	Do not know
Italy	✗	✓	✗
Luxembourg	✓	✗	✓
Montenegro	✗	✗	✗
Macedonia, North	✓	✗	✓
Netherlands	✗	✓	✗
Norway	✓	✓	✓
Poland	✗	✗	✗
Portugal	✗	✗	✗
Romania	✓	✗	✗
Russia	✗	✗	✗
Scotland	✓	✗	✓
Serbia	✓	✗	✗
Slovakia	✓	✗	✗

	ODP in national drug strategy or action plan	Separate strategy or action plan for ODP	National protocols for OD management
Slovenia	✗	✗	✗
Spain	✓	✓	✓
Sweden	✓	✓	✗
Switzerland	✓	✗	✗
Ukraine	✓	✗	✓
United Kingdom	✗	✗	✓

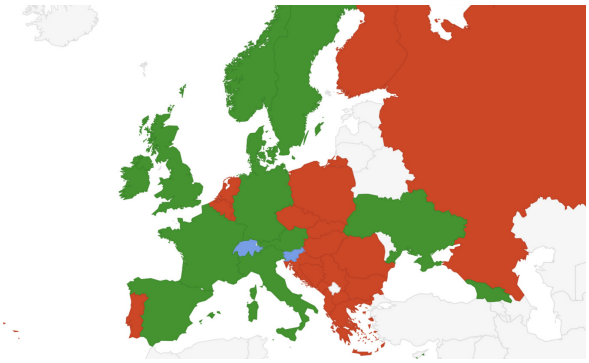
Access to Take-Home naloxone

Take-home naloxone (THN) programmes are an evidence-based opioid overdose prevention initiative that is increasingly implemented in Europe. The idea behind THN programmes is to expand the availability of naloxone from medical emergency staff to people who use opioids, their peers, family members, and other trained lay-people[36].

"Official" availability of THN programmes

In the C- EHRN monitoring survey, 13 countries reported having THN available. Nevertheless, as explained below, availability in some countries might be restricted to a few regions or cities. In addition, Slovenia and Switzerland have plans to make THN available soon (see Map 4, below).

Map 4. Availability of take-home-naloxone



THN not available
THN under discussion
THN available

In 2019, the EMCDDA reported naloxone distribution initiatives in 12 countries and discussions towards naloxone availability in two others. Table 13, below, compares the countries covered by C-ERHN and EMCDDA surveys according to their reported availability of THN programmes in 2019.

Table 13: Countries reporting THN in 2019: C-EHRN and EMCDDA surveys

	C-ERHN	EMCDDA
Albania	✗	Country not covered
Austria	✓ (one region/project)	✓ (one region/project)
Belgium	✗	✗
Bosnia and Herzegovina	✗	Country not covered
Bulgaria	✗	✗
Cyprus	Country not covered	Under discussion
Croatia	✗	✗
Czech Republic	✗	✗
Denmark	✓	✓ (local/regional)
Estonia	Country not covered	✓ (local/regional)
Finland	✗	✗
France	✓	✓
Georgia	✓	Country not covered
Germany	✓	✓ (local/regional)
Greece	✗	✗
Hungary	✗	✗
Ireland	✓	✓ (local/regional)
Italy	✓	✓
Lithuania	Country not covered	✓ (local)
Luxembourg	✗	✗
Montenegro	✗	Country not covered
Macedonia, North	✗	Country not covered
Netherlands	✗	✗
Norway	✓	✓
Poland	✗	✗
Portugal	✗	✗
Romania	✗	✗
Russia	✗	Country not covered
Scotland	✓	✓ (under UK)

	C-ERHN	EMCDDA
Serbia	✗	Country not covered
Slovakia	✗	✗
Slovenia	Under discussion	✗
Spain	✓	✓ (regional - Catalonia)
Sweden	✓ (regional)	✓ (regional)
Switzerland	Under discussion	Country not covered
Ukraine	✓	Country not covered
United Kingdom	✓	✓

No discrepancies were found in the information gathered for the common participant countries. The C-EHRN survey covered 9 additional countries that are not included in ECMDDA monitoring: Albania, Bosnia and Herzegovina, Georgia, Montenegro, North Macedonia, Russia, Serbia, Switzerland and Ukraine.

Why are THN programmes not available?

For respondents in countries without THN programmes, the main reason given (or guessed) is that legislation in these countries allows **naloxone to be handled only by medical staff**. Naloxone can only be prescribed by medical professionals and, at least in its injectable form, can only be administered by medical staff. This is the case in Belgium, Bosnia and Herzegovina, Croatia, Greece, Hungary, Luxembourg, Poland, and Russia. Similarly, in many countries **only medical facilities can distribute injectable naloxone;** thus, the drug is available only at hospitals and through mobile emergency facilities. This was mentioned by North Macedonia, the Czech Republic, Montenegro, Portugal, and Serbia. In Croatia, for instance, *Udruga Vida* heard from emergency medical technicians they encountered in the field - such as at medical emergency tents at music festivals - that they cannot administer naloxone to a person without the presence of a physician. If there is no physician around, they must give the naloxone to the person or a friend to administer it.

Other reasons given included a ban on the use of naloxone (Slovenia); the prevalent use of street buprenorphine (Finland); and the unwillingness of medical doctors to prescribe naloxone (Slovakia). In the Netherlands, there is a perceived lack of need for THN programmes at present, given a low overdose rate related to opiate use, the quick response from first aiders (who successfully administer naloxone), strong prevention messages, and the wide availability of drug checking.

> "In Greece, naloxone as an antidote to OD is forbidden to be either sold in pharmacies or distributed by outreach workers. By law, only medical doctors can provide naloxone to a person having an OD. Sometimes ambulance staff, and stretcher bearers - because people literally die on their hands - violate this law and inject naloxone into patients. You cannot buy, or find by any other way, naloxone. Making a long story short, usually you die helpless on the streets". (Greece FP)

"Official" THN availability versus availability in practice

From the 14 countries reporting to have THN programmes, only four (Georgia, Italy, Norway, and Spain) affirmed that THN is available and used as it should be. Despite the legal availability, many countries with THN reported barriers to its use in practice; the provision of THN is restricted in one way or another. One challenge is that some **THN programmes have remained project-based** and have not been established as a common practice in health services. This is the case in Denmark and Austria, for example.

> "At this time, take-home naloxone is, unfortunately, only available in Graz (in the stadium as a pilot scheme for two years) for drug users. After this pilot scheme, it would be desirable that naloxone is available for prisoners, relatives of drug users, social workers, police-officers... (in all parts of Austria) paid by public health insurance". (Austria FP)
>
> "We have provided naloxone in Denmark based in a project setting for 9 years. There is reluctance at state level to provide THN for all communities. This might change from 2020." (Denmark FP)

Another problem regarding the actual availability of THN is the **need for a medical prescription** to acquire it. That is the case, for example, in Germany and Ireland. In both countries, people who are dependent on opioids, or who are enrolled in an OST programme, are the only ones who can get a prescription for THN. However, many active users do not have contact with a doctor, and furthermore, naloxone cannot be carried by another person to administer to people who use opioids.

In countries were a prescription is not needed, a problem encountered is the **lack of widespread availability** of (different types of) naloxone. This was mentioned, for example, by France and Ukraine.

> "It is possible for pharmacies to sell naloxone without prescription due to advocacy by CSOs, especially the PWUD community. However, most pharmacies do not order naloxone, so for PWUD it is problematic to get it easily. Harm reduction programmes that were supported by the Global Fund could provide naloxone; now, however, when harm reduction is transferring to government funding, this will most likely not continue". (Ukraine FP)
>
> "Since 2017, naloxone (Nalscue) can be delivered by harm reduction services, health centres in addictology, hospitals and by health professionals working in prisons. So far, it is not available in drug stores, nor in needle exchange services, peer associations and prevention services and into recreational settings (festivals, nightclubs...). Nalscue is quite expensive and cannot be reimbursed by the social security services. (France FP)

Finally, **some THN programmes have unnecessary barriers** in place which are not compatible with a low threshold service, as mentioned by the Focal Point in the United Kingdom:

> "Among the 138 local authorities that provided take-home naloxone in England in 2016/17, 18% (25) require a person to be referred to a take-home naloxone provider; 17% (24) require a person to book and attend an appointment with a take-home naloxone provider, meaning that this is not available to someone that drops in to the service provider without an appointment; and 20% (28) require a person to be assessed by a take-home naloxone provider".[37] (United Kingdom FP)

In a few cases, even with the legal restrictions, naloxone **distribution occurs informally** (in an ad-hoc and at a local level). This is the case in Sweden, for example, run by the Stockholm drug user's union who have distributed around 1,800 doses of naloxone, and a few needle-syringe programmes (NSPs) in Skåne, Uppsala and Stockholm.

> "In Sweden, it is against the law to give a medication against a person's will if you do not have medical training. Interpretation of the law is that if you are unconscious, you cannot give consent. This theoretically makes it impossible to give naloxone to someone in need. However, we are finding ways to get around this barrier. You can delegate a person to administer naloxone to you, for example a partner or wife/husband, but you both have to go to a doctor and pass the naloxone training course. Our system really is crazy because you can't hurt someone with naloxone but it's still hard to try and change the law". (Sweden FP)

Who oversees THN programmes?

In terms of who oversees THN programmes, the responsibility can be with either CSOs or public bodies, and sometimes shared by both (see Table 14).

Table 14. Who is in charge of THN programmes?

	In charge of THN programmes
Austria	Private doctors and a NGO in Graz (Steiemark).
Denmark	Nationally, six community projects with six communities and the NGO, Antidote Denmar.
France	Ministry of Health.
Georgia	Georgian Harm Reduction Network.
Germany	Doctors involved in OST and GPs.
Ireland	Health Service Executive, National Office of Social Inclusion.
Italy	Outreach units, drop-in centres, public drug units.
Norway	SERAF (national drug research centre)*.
Scotland	Local health boards and Alcohol and Drug Partnerships: funding of kits; Scottish Drugs Forum: coordination and training.
Spain	Government of Catalonia (Generalitat de Catalunya, Subdirecció de Drogodependències de Catalunya); (THN does not exist in the rest of Spain).
Sweden	Drug users union in Stockholm and NSPs/OSTs in Skåne, Uppsala and Stockholm.
Ukraine	Civil society and international organisations (WHO, Ukrainian institute of public health policy, Alliance for Public Health, local HR NGOs).
United Kingdom	National naloxone programmes in Scotland, Wales, and Northern Ireland. In England, local authorities are responsible.

* *In Norway, there is also a Naloxone Quality Assurance Group (QUAG) organised by the Health Service Executive, National Office of Social Inclusion.*

Types and cost of available naloxone

In the countries where THN programmes are available, naloxone is predominantly available in its injectable form, although nine countries have nasal spray available. The price variation is quite significant across countries, especially when comparing Western and Eastern European countries. As a rule, nasal spray is costlier. In most countries reporting THN programmes, the price of naloxone is fixed. See Table 15 for more information.

Table 15. Costs and types of naloxone available in THN programmes

	Type available	Price of one dose	Price variation
Austria		≈ €37 (sold in boxes of 2 ≈€75)*	✓ (€50 to €80 for 2 doses)
Denmark		≈ €24 (nasal-Nyxoid)	✗
France		≈ €23 (injectable - Prenoxad) €35 (nasal-Nalscue)	✗
Georgia		≈ €1	✗
Germany		≈€20 (opioid users pay only 5€ for receipt)	✗
Ireland		€30 (nasal spray) €23 (injectable)	✗
Italy		≈ €1.50 (injectable for health services) ≈ €3-6 (injectable at pharmacies) ≈ €15-25 (nasal)	✗ (injectable form)
Norway		Do not know	Do not know
Scotland		≈ €20 (injectable -Prenoxad)	✗
Spain		≈ €2 (sold in boxes of 10 ≈ € 20)	✓ (Braun ≈ €20 and Kern ≈ €25 box of 10)
Sweden	SDUU (injection) Nyoxoid (NXP/OST)	≈ €22 (nasal- Nyoxid in boxes of 2 ≈ €48) ≈ €15 (injectable)	Free (nxp/ost) €60 (including doctor fees and the naloxone)
Ukraine		≈ €0.50 (sold in boxes of 10 ≈ €5)	✗
United Kingdom		≈ €16 (nasal-Nyxoid in boxes of two, ≈ €33) ≈ €4.20 (injectable- Prenoxad sold in boxes of 5 ≈ €21)	✓ Slight variation depending on the pharmacy. Prenoxad can be down to ≈ €18

= nasal spray *= for intravenous/intramuscular use*

Some countries reported not having THN programmes but affirmed that people have **ad-hoc access to naloxone**. This was mentioned in Russia, Slovakia and Belgium. In the case of Russia, naloxone is a prescribed medicine which cannot officially be bought without a prescription from a medical doctor; in many instances, however, one can get it without prescription. Besides, there are few harm reduction projects in the country that sometimes distribute naloxone but at a very limited scale. In Slovakia, however, everyone can theoretically get a prescription for naloxone from a psychiatrist but, in reality, psychiatrists tend not to prescribe it. The organization *Odyseus*, for instance, tried to get a prescription of naloxone for their social workers from a drop-in centre but the psychiatrist refused to prescribe it because the social workers were not opioid users. In Belgium, a TNH programme pilot had to stop due to legal pressure.

"We started a pilot but had to stop due to legal pressure. Everybody can get naloxone at the pharmacy with a medical doctor's prescription, but no one can inject it into somebody else if they are not medically trained. In Belgian law, only medical doctors and nurses can inject someone (even intramuscularly). There are some exceptions, like for parents who need to inject their children with an epi-pen or insulin. It's a grey zone for life saving medication, but the justice department works only through the 'letter of the law'. We are now trying to change this and start a pilot again with permission of a medical commission. But this decision takes a while. We heard that they wanted to support this pilot, but we need this on paper for the justice department and are still waiting for this report (one year now)". (Belgium FP)

Legal status of naloxone

In most countries **where THN programmes** are available, naloxone can be provided by harm reduction services **without a medical prescription**. This does not necessarily mean that, in general, naloxone no longer requires a prescription. For example, in the United Kingdom, an exception applies: naloxone remains a prescription-only medicine but the Human Medicines Amendment (No. 3, Regulations 2015, Regulation 10) enables naloxone to be supplied by drug treatment services[38] for the purpose of saving life in an emergency. Initially, this only applied to injectable formulations of naloxone but was recently amended to add intranasal formulations as well. The following examples are from Scotland and Denmark:

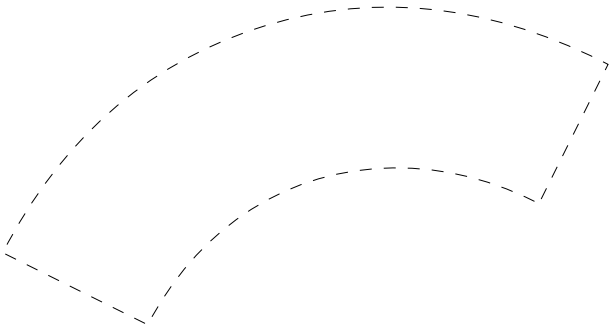
"Naloxone is still a prescription-only medicine but, due to a change in regulations in October 2015, it can be supplied without prescription by anyone working at a drug service to anyone likely to witness an overdose. This will either be via a Patient Group Direction (mostly nurses/pharmacists) or a locally agreed 'framework' which can also be used by nurses, etc., but has mainly been introduced to allow third sector workers to supply." (Scotland FP)

"Naloxone can be delegated to helpers via a structured THN programme so the medical doctor does not need to be present if the trainer is trained and follows the protocol. By following the rules for use by lay-persons to treat acute medical conditions in third persons, we have managed to provide naloxone through a two-level model. Naloxone trainers are trained by a MD and pass on the delegation of naloxone to naloxone-helpers who can treat persons with an overdose". (Denmark FP)

Table 16: Legal status of naloxone in countries where THN is available

	Only with private prescription (doctor)	With prescription (paid by health insurance)	Over the counter status (without prescription in pharmacies)	By harm reduction providers
Austria	✓			
Denmark	✓			✓
France			✓	✓
Georgia	✓			✓
Germany		✓		
Ireland	✓			
Italy			✓	
Norway				✓
Scotland				✓
Spain	✓			✓
Sweden				✓
Ukraine			✓	✓
United Kingdom		✓		✓

In virtually all countries where naloxone can only be acquired through a private prescription, the drug must be purchased and is not reimbursed by health insurance. The exception to this is Slovakia, where part of the cost is paid by health insurance and part by the client although, officially[39], the person who is buying naloxone in a pharmacy is supposed to pay the full price. Also, in France since June 2019, *Prenoxade* (injectable naloxone) can be purchased in drug stores and reimbursed. In Germany and the United Kingdom, costs are covered by health insurance. At the time of the survey, only in Italy and Ukraine could people buy naloxone in pharmacies without a prescription.



For whom THN is available

Table 17: Groups for which THN is accessible

	PWUD and partners
Austria	Clients of "*Kontaktladen & Streetwork im Drogenbereich*" in Graz (PWUD and OST clients) and can be purchased by anyone with a prescription in pharmacies.
Denmark	PWUD and people in contact with drug users (staff, relatives, residents of drug-use areas).
France	PWUD accessing harm reduction services, drug treatment centres, hospitals, and mobile teams; prison staff (health services). Can be purchased by anyone in pharmacies (intramuscular form).
Georgia	PWID and (sex) partners or friends.
Germany	OST clients and PWUD. Unclear for relatives.
Ireland	People who are dependent on opioids.
Italy	Clients from HR facilities and can be purchased by anyone in pharmacies.
Norway	PWUD and harm reduction staff.
Scotland	Anyone likely to witness an overdose, mainly PWUD, drug service staff, relatives and friends, and prison staff.
Spain	OST clients, people actively using opiates and their relatives and friends; people frequenting drug use scenes.
Sweden	PWUD accessing the few NSPs which have THN (ad hoc). Can be purchased in pharmacies for those able to get (and pay for) a medical prescription.
Ukraine	PWUD accessing harm reduction services, theoretically can be purchased by anyone at pharmacies (however, there is a lack of availability). New project *SOS* plans to distribute to anyone likely to witness an overdose.
United Kingdom	Staff working at hostels or housing services; people released from prison; street outreach or satellite workers; healthcare services, hospital liaison workers or GPs; religious groups or street pastors; police officers and people leaving police custody; peer mentors; staff at soup kitchens, food banks or recovery cafes; probation services; domestic violence services or women's refuges; women-only support groups; mental health services or mental health admission wards; street wardens or local park guards; sex worker services; social services or social workers; employment and family support services[40].

Naloxone training

Table 18. Naloxone training

	Mandatory training for carrying naloxone	Who can be a trainer	Who can be a trainee	N. trained in respondent's organization	N. trained in the city	N. trained in the country
Albania	✓	Missing answer	Toxicologists and outreach workers	5 (in the organisation)	30 +	All toxicologists are entitled
Austria	✓	The medical staff of *Caritas Marienambulanz* and social worker of *Kontaktladen & Streetwork*	PWUD and OST clients (clients of *Caritas Kontaktladen & Streetwork*)	35 (by the organisation - between Nov. 2018 and May 2019)	35	35
Denmark	✓	Medical doctors and NGO staff trained people in the communities 2010 – 2018; trained community people can be trainers	Everybody who enrolls in a naloxone traning programme and has a relation to drug use	3206 (by the organisation - between 2017- 2018)	689 (2017-2018)	3,206 (2017-2018)
France	✓	Professionals, peer-workers, volunteers	Nasal spray: compulsory for harm reduction staff (including volunteers) and optional for PWUD; Injectable: PWUD	422 (by the organisation - professionals and service users)	40 in Bordeaux	at least 500 (2017-2018)
Georgia	✓	Harm reduction staff	PWID and peers	over 15,000 (by the organisation)	7,000	Do not know
Germany	✓	Medical doctors, expert harm reduction staff	PWUD, harm reduction staff, and drug service staff	100 (in 2019)	Do not know	Do not know
Ireland	✓	HSE provides training the trainers to frontline staff of HSE and NGOs	People who are prescribed naloxone, their relatives and friends	≈100 (by the organisation, 2015-2019)	≈2,000 (2015-2019)	≈3,000 (2015-2019)
Italy	✗	N/A	N/A	N/A	N/A	N/A
Norway	✓	Staff from low threshold services, community, and user unions	Usually users unions and peers	11 (in the organisation)	Do not know	Do not know

	Mandatory training for carrying naloxone	Who can be a trainer	Who can be a trainee	N. trained in respondent's organization	N. trained in the city	N. trained in the country
Scotland	✓	Drug service staff and other staff in contact with PWUD, pharmacists, and peers.	Anyone likely to witness an overdose, mainly PWUD, drug service staff, relatives and friends, and prison staff.	Do not know	Do not know	Do not know
Slovakia	✗	N/A	N/A	N/A	N/A	N/A
Spain	✓	Harm reduction staff trained in overdose care (doctors, nurses, social workers, social educators, psychologists) and health agents	People who actively use opiates or are in treatment, their relatives and friends; harm reduction staff	96 PWUD (by the organisation in 2018)	924 people (in 2018)	Do not know
Sweden	✓	Medical doctor	All NSP clients who get naloxone.	1,800 (by the organisation)	Circa 2,500	Circa 4,500
Ukraine	✓	The staff of organisations that support harm reduction projects	Harm reduction staff selected on a competitive basis	10 in Eney club	Do not know	Do not know
United Kingdom	✗	Training not mandatory but recommended in clinical guidance*	Anyone	10 (in the organisation)	N/A	N/A

* *In the United Kingdom, while the respondents agree that training should be offered where possible, they were concerned that this may potentially act as a barrier in some cases (where there is a mentality of risk aversion which makes THN unnecessarily high threshold to access). Clinical guidelines available at, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf*

Future policy plans for increasing access to naloxone

Respondents were asked if their country has a strategic plan for increasing access to naloxone and, if so, by whom such plans are being made. At least ten countries - Albania, Belgium, France, Germany, Italy, Luxembourg, Norway, Scotland, Spain, and the United Kingdom - reported having such plans. In Italy[41] and Belgium, these plans are made by civil society actors (NGOs). In Albania, Germany, Luxembourg, and the United Kingdom[42], plans are made by both the government and NGOs. In France, Norway[43], Scotland, and Spain, these plans are government driven.

Many countries that do not yet have THN programmes reported having current professional or political initiatives or discussions to start these programmes or to widen the use of naloxone. These initiatives are summarised in the table below. The only countries with no THN available, and which reported to not have plans for increasing access to naloxone, were Bulgaria, Croatia, North Macedonia, and Greece. In several countries – Poland, Portugal, Russia, and Serbia - the initiatives taken have not achieved any success to-date.

Table 19 presents a list of C-EHRN Focal Points and whether they have THN programmes and, if not, whether they have plans to start such programmes and, in that case, a brief description of the respective plan.

Table 19: Plans to increase naloxone access

	Has THN programme	Plans to start THN	Brief description of plan
Albania	✗	✓	Naloxone was included in the latest National Plan of Drug Control, 2019-2023. Both doctors and outreach workers are being trained to deliver naloxone based on a national training schedule and methodology.
Austria	✓ (1 region/ project)	✓	Vienna is planning to start a naloxone programme A Steiermark NGO started a programme in 2018. There are THN programmes also in the pipeline in the regions of Burgenland and Vorarlberg.
Belgium	✗	✓	*Free Clinic* (NGO) is trying to set up a pilot at a local level. They are having discussions with the medical board. If the board agrees, they can continue the process at the justice level and start a pilot in Antwerp.
Bosnia and Herzegovina	✗	✗	No drug office is responsible of such a programme.
Bulgaria	✗	✗	n/a
Croatia	✗	✗	n/a
Czech Republic	✗	✓	A work group with experts from the Government Council for Drug Policy Coordination, the NGO sector and the EMCDDA National Focal Point is liaising with officers from the Ministry of Health to legalise the carrying of naloxone by the general public.
Denmark	✓	✓	There is state funding for naloxone distribution by a NGO between 2019-2022. There will probably be community funding, including a coordinating body and a national coordinator for 2 years from 2020.
Finland	✗	✗	n/a
France	✓	n/a	n/a
Georgia	✓	✗	n/a
Germany	✓	✓	*Akzept*, *JES Deutsche Aids Hilfe*, and local HR services try to support THN initiatives. Meanwhile, there are more than ten THN initiatives operating in Germany, including self-help groups (e.g. *JES* in Cologne). DAH suggested training for police at the national level, so THN is not only carried by local HR services, *Akzept* and *DAH*[44].
Greece	✗	✗	n/a
Hungary	✗	✗	There are no plans to start THN because the current government is not pro-harm reduction and do not intend to change the regulation of naloxone. Naloxone can only be administered by a specialist doctor, it cannot even be prescribed and no plans are known from the government that aims to change this. Besides, heroin use is very low in Hungary at present.
Ireland	✓	n/a	n/a
Italy	✓	n/a	n/a
Luxembourg	✗	✓	NGOs and the Ministry of Health are debating the issue.
Montenegro	✗	✓	NGO *Juventas* tries to draw attention by campaigning on overdose awareness day. Actions are focused on raising awareness about OD prevention and lobbying for naloxone to be available in NGO's working with PWUD.

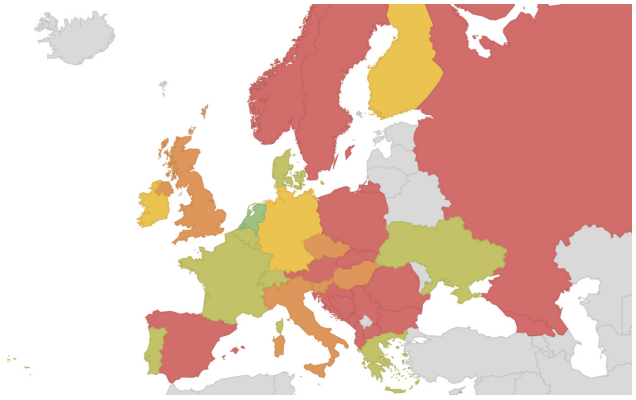
	Has THN programme	Plans to start THN	Brief description of plan
Macedonia, North	✗	✗	n/a
Netherlands	✗	✓	There are local initiatives to advocate for training of peers, other professionals, and people working with "at-risk" users, although there are no concrete plans so far. There are also advocacy initiatives to train peers in DCRs, especially those close to the border with Germany.
Norway	✓	n/a	n/a
Poland	✗	✓	The National Bureau for Drug Prevention established a group of experts to prepare a proposal for a new regulation on naloxone one year ago. This was a mixed group with government officials and NGO representatives. However, there have been no positive outcomes.
Portugal	✗	✓	SICAD has proposed a pilot project to deliver the nasal spray among outreach teams[45] but this has not advanced. APDES, NGOs, and CASO keep advocating for free naloxone for everyone and available to PWUD.
Romania	✗	✓	The National Drugs Agency organised training on overdose prevention and response and affirmed that THN would be implemented shortly as part of a more extensive programme.
Russia	✗	✓	The forum of people who use drugs regularly sends letters to different government agencies to advocate for naloxone.
Scotland	✓	n/a	n/a
Serbia	✗	✗	During the process of amending the Law on Psychoactive and Psychotropic Substances, a group of CSOs (including "*Prevent*") proposed an amendment to allow the use of naloxone for anyone in need; the amendment was rejected.
Slovakia	✗	✗	n/a
Slovenia	Under discussion		The National Institute for Public Health proposed to the Ministry of Health to introduce naloxone as a harm reduction service and the proposal was accepted.
Spain	✓	n/a	n/a
Sweden	✓ (non-legal and limited)	✓	The government and expert groups for NSP plan to have naloxone distribution through all NSP/OST programmes but many have not yet started. There have been minor changes to the law to make it more accessible: for example, now a doctor can delegate to nurses to prescribe naloxone. Currently, the only NGOs handing out naloxone are in Stockholm and *The Linköping Drug Users Union*, both getting their supply on a donation basis.
Switzerland	Under discussion	✓	Still under negotiation but will probably result in a collaboration between *Infodrog* (mandated by the Federal Office of Public Health), local institutions and, if necessary, cantons and cities.
Ukraine	✓	n/a	n/a
United Kingdom	✓		Among the three local authorities in England that did not have a THN programme in place (at the time of *Release's* survey), only 1 outlined concrete plans to implement such a programme[46].

Drug Consumption Rooms

As C-EHRN is conducting separate data collection on existing DCRs, only two questions this issue were included in the present monitoring survey. The first question asked if respondents knew of any - professional or political - new initiatives to start DCRs in their country; the second question was about the national legal framework allowing for, or hindering, DCR pilot.

New initiatives on DCRs

Altogether, 17 countries reported ongoing discussions, or new initiatives, on starting new DCRs. Map 5, below, shows the different stages in which these discussions are per country followed by explanations.



Map 5: DCR status in Europe

- *No (new) initiatives*
- *Advocacy with no results*
- *New regulations*
- *Plans for (new) DCRs*
- *Changes in DCRs*

Advocacy but no result yet

In 5 countries, advocacy initiatives are being taken, although they have not yet yielded concrete results. **Hungary** promoted a DCR campaign a few years ago[47]. In **Slovenia**, the campaign *Izzivi odprte scene* (Open scene challenges) began in May 2017 to deal with open drug scene problems. Despite an agreement that a safe room is an appropriate solution for open scene problems, the respective parties cannot find a consensus so far. In **Italy**, an expert working group asked for a DCR experimental protocol in Torino in 2018 but with no results so far. In **Scotland**, the devolved Government is committed to delivering a DCR, although, at present, Scotland's law officer, the Lord Advocate, has taken the view that this is a matter for the Government of the United Kingdom. So far, the UK Government has refused to approve the DCR in Scotland[48]. In the **Czech Republic**, there is a continuous initiative, mainly from NGOs, to open DCRs, at least as a pilot.

New regulations

In 3 other countries, new regulations are being proposed, or set into place, in order to allow for (new) DCRs. In **Germany**, *Akzept* (an umbrella organisation for harm reduction) and *DAH* have demanded that DCRs be implemented in all German states. However, at present (December 2019), DCRs are only operating in 7 of the 16 states. The state of Baden Württemberg enacted a new law in 2018 to implement its first DCR in the city of Karlsruhe in 2019. Another initiative to implement a DCR came from the state of Bremen. In **Finland**, the City of Helsinki decided in March 2019 to propose that the government prepare a reform to the law needed to pilot a DCR. **Ireland** legislated to allow DCRs in 2017. A preferred provider, *Merchants Quay Ireland*, was identified through a procurement process. Planning permission is being sought to adapt a building to allow for the pilot service to open; the opening is anticipated in mid-2020 at the earliest.

Concrete plans for (new) DCRs

In 7 countries, concrete initiatives in the form of new DCRs were reported. In **Belgium**, a new DCR was set to start in Liege in the autumn of 2019). **Denmark** might open new facilities in Copenhagen; presently there are two consumption rooms in Copenhagen, one in Odense, one in Vejle and one in Aarhus (projects in Aalborg and Esbjerg have finished). In **Luxembourg**, a second DCR[49] opened in Esch by *Jugend- an Drogenhellef* in July 2019. A third is planned in the north of Luxembourg in the coming years. In **Portugal**, the city of Lisbon has run a mobile DCR unit since April 2019, and it has approved the opening of two new DCRs. In Porto, a consortium of organisations[50] proposed to the municipalities (Porto and Gaia), and to a group of local partners, to open one mobile unit and one fixed unit. In April 2019, at the HRI conference in Porto, the Mayor of Porto presented a public promise to start the mobile unit. **Switzerland** opened two new DCRs in 2018 (in Lausanne and Olten) and in two other cities (Chur and Yverdon) political discussions are taking place. In **Ukraine**, a DCR project opened in 2019 in Sumy City by the local NGO '*CLUB Chance*" at a local narcology clinic. In **France**, the current experimentation project will be longer in order to allow new cities to join. In **Greece**, the *Organism Against Narcotics (OKANA)* announced that a pilot DCR would (re) start soon. A DCR existed in Greece from October 2013 for 9 months but was closed as it never obtained a legal basis. Now, despite the announcement from *OKANA* about a new pilot before governmental elections, nothing has yet happened.

Changes to current DCRs

In the **Netherlands**, DRCs have been changing to adapt to new drug consumption patterns. The number of traditional/separate DCRs is declining, and some DCRs that have been running for years are developing/changing their focus, their services, their primary goal, and even the substances they allow to be used. New developments include the introduction of supervised alcohol consumption rooms and sheltered housing facilities where people can use substances either in their rooms or in a shared user room. Recently, Utrecht province thoroughly inventoried the functions of their DCRs and, in one city, they are exploring the possibility of allowing GHB use on-site. Den Haag has re-opened its DCR facility after an evaluation of the needs related to the open drug scene.

Legal framework to allow for DCRs

About half of the countries (14) reported having a legal framework allowing for DCRs, usually in the form of laws (public health or national drug strategy). For those not having a legal framework, the main problem related to current drug laws is that providing a space for people to use drugs is punishable. Table 20, below, and the following *info box* further explain the situation by country.

Table 20: Legal framework to allow for DCR experimentation

	Has a legal framework allowing DCR experimentation	Observations
Albania	No response	
Austria	✗	
Belgium	✓	Only as a medical experiment. The current DCR is running as a medical pilot.
Bosnia and Herzegovina	✗	
Bulgaria	✗	The Penal Code states punishments for those who continuously provide space for drug-taking, which may impede experimentation initiatives.
Croatia	✗	Carrying any amount of drugs (even small amounts for personal use) is punishable by law and all professionals have an obligation to notify the authorities if anyone has drugs in their possession.
Czech Republic	✗	There is also no legal framework against DCRs; it depends on the interpretation of declarations and laws. The police interpretation focuses on prohibition, talking about the opening of a DCR as criminal offense. There is not enough political support.
Denmark	✓	
Finland	✗	However, the city of Helsinki has recently proposed that the government establish a DCR.
France	✓	Only as a medical experiment. According to the 2016 Public Health Law, DCRs can be opened as an experiment for six years. So far, two have opened (Paris, Strasbourg).
Georgia	✗	
Germany	✓	German law ("Betäubungsmittelgesetz", §10a) allows the implementation of DCRs since 2000; see, https://www.gesetze-im-internet.de/btmg_1981/__10a.html
Greece	✓	
Hungary	✗	Drug use is a criminal offence, as well as the facilitation of such use. Even the legal grounds for NSPs has not yet been clarified.
Ireland	✓	The Misuse of Drugs (Supervised Injecting Facilities) Act from 2017.
Italy	?	Controversial. From the perspective of CSOs and HR networks, the current drug law would permit DCRs as health, professionally supervised, services; in the perspective of (some) policymakers, the law is restrictive.
Luxembourg	✓	
Montenegro	✗	

	Has a legal framework allowing DCR experimentation	Observations
Macedonia, North	✗	
Netherlands	✓	Municipalities are free to decide if they want to allow for a DCR in their city.
Norway	✓	Only for injections, not yet for smoking. A pilot project is expected in 2019.
Poland	✗	Currently, there is no political background for such initiatives.
Portugal	✓	Law-Decree 183/2001 from June 21st, 2001[51].
Romania	✗	Providing a space for PWUD to safely use drugs is illegal and punishable by law. However, DCRs are mentioned in The National Anti-Drug Strategy for 2013-2020 as one of the services that should be provided for PWUD.
Russia	✗	
Scotland	✓	See United Kingdom, below.
Serbia	✗	
Slovakia	✗	The national drug policy does not allow for DCRs.
Slovenia	✓	The National Drug Strategy and the Criminal Code.
Spain	✓	There are 7 DCRs in Catalonia and 1 in the Basque region.
Sweden	✗	Not available to date but there are plans for it.
Switzerland	✓	
Ukraine	✓	The only DCR project is part of the harm reduction office and is a structural part of narcology. Its work is fully institutionalised, comprising a nurse and two social workers that provide services funded by the local budget, using a social contracting scheme. Unfortunately, this is the only project of this type in the country.
United Kingdom	✗	The Misuse of Drugs Act 1971 hinders the Scottish Government's ability to establish a DCR (see infobox).

Infobox: UK legal framework hindering DCR experimentation in Scotland

The Misuse of Drugs Act 1971 hinders the Scottish Government's ability to establish a DCR as this would engage several possible offenses under the Act. For example, those accessing the DCR will be in possession of a controlled substance, and so will be at risk of arrest and prosecution under Section 5 of the Act. Equally, staff of a DCR may be at risk of prosecution under Section 8 of the Act – this offense creates a risk of criminal liability for managers of premises concerning specific drug-related activities such as supply of drugs, but not use of drugs other than cannabis (and opium). The risks are not new – they are already managed by drug services through the provision of needle exchange programmes. It is hard to imagine that those accessing these programmes to obtain sterile equipment would not have the substance they intend to inject. Equally, policies will be in place to protect staff from prosecution under Section 8 of the Act, such as taking action if there is dealing on the premises, both in needle and syringe programme and drug treatment settings.

Amending the Act, or devolving the matter to Scotland, would enable a DCR to be established. However, a DCR could be established in Scotland in the absence of central government action on this issue. While devolving legislation on the control of drugs to the Scottish Government would facilitate the implementation of a DCR, in the absence of devolution, a DCR could operate if there was an agreement between Police Scotland, prosecutors, and local NHS boards to allow for the provision of such a facility. This would involve police agreeing not to arrest and bring prosecutions for possession offenses. This is the same process that exists in England concerning drug checking at festivals and in town centres. (United Kingdom FP)

Overdose prevention in prison

Naloxone and pre-release naloxone programmes

Overdose risk is high in the immediate period after release from prison due to high rates of relapse and lower opioid tolerance. Elevated opioid overdose risk following prison release is an opportunity for OD prevention, for instance, by having naloxone available. Only France, Italy, Norway, Scotland, Spain, and the United Kingdom reported having naloxone available in prisons. In France, Norway, and the United Kingdom, the respondents were unsure if it is available in all prisons.

> "I cannot say with certainty that naloxone is available in every prison in England as there is no publicly available data on this." (United Kingdom FP)

In the countries where naloxone is available in prisons, mostly staff and/or medical staff are the ones allowed to administer it. Only in France can inmates also handle naloxone.

According to C-EHRN monitoring data, only France, Italy, and the United Kingdom (including Scotland) reported having pre-release naloxone programmes. In Italy, an experimental project took place in 2018 involving three prisons for 3-6 months. In Genova prison (Marassi) and Brescia prisons there are stable pre-release services. In England, pre-release naloxone programmes are available in approximately half of the prisons. Nevertheless, as explained by the C-EHRN Focal Point, actual availability might be lower:

"The ACMD recently reported that "only 12% of prisoners who were previously heroin-dependent left an English prison with naloxone in 2017/18", although this is only looking at people that are known to person drug services, thereby excluding a significant number of people likely to witness or experience an opioid-related OD. Additionally, HMIP recently reported that, "Nearly all prisons now provided naloxone to suitable patients on release to manage the risk of substance use overdose, but Bedford, Channings Wood, Hull, Humber, Onley, Peterborough, and Wandsworth did not, which was a missed opportunity." However, this statement is rather vague and conflicts with our findings in this area." (United Kingdom FP)

Table 21: Availability of naloxone in prisons

	Naloxone available in prisons	Who can access it	Pre-release naloxone available
France	✓	Inmates, staff and medical staff	✓
Italy	✓	Medical staff	✓ (in some prisons)
Norway	✓	Staff	✗
Scotland	✓	Staff and medical staff	✓
Spain	✓	Medical staff	Do not know
United Kingdom	✓	Don't know	✓ (At least in 58 of 109 prisons surveyed in England)

Other OD prevention measures upon release from prison

Prison release is a risky period (48 hours) from the viewpoint of a drug overdose. That is why information and education are needed for both inmates and prison staff, especially health care personnel. The same concerns in-patient treatment for people with opioid dependence. WHO has estimated that 20% of drug-related deaths (DRDs) appear in connection to prison release or treatment relapse. According to the C-EHRN monitoring survey, OST is available in prisons in all participant countries other than Georgia, Hungary, Russia, Slovakia, and Ukraine.

Participants were asked whether their country has OD prevention responses linked to prison release. Slightly less than half of the countries (15 out of 33) reported having such measures. In most cases, however, these actions are not systematic and are carried out by CSOs with lower support from the prison authorities or the government. Exceptions to this are France, the Netherlands, Norway, and the United Kingdom (including Scotland), where a more systematic approach to OD prevention on release is undertaken by prison staff. Even in these countries, however, practice is not always reliable. Table 22, below, further describes the reported OD prevention responses in prison release in the different participant countries.

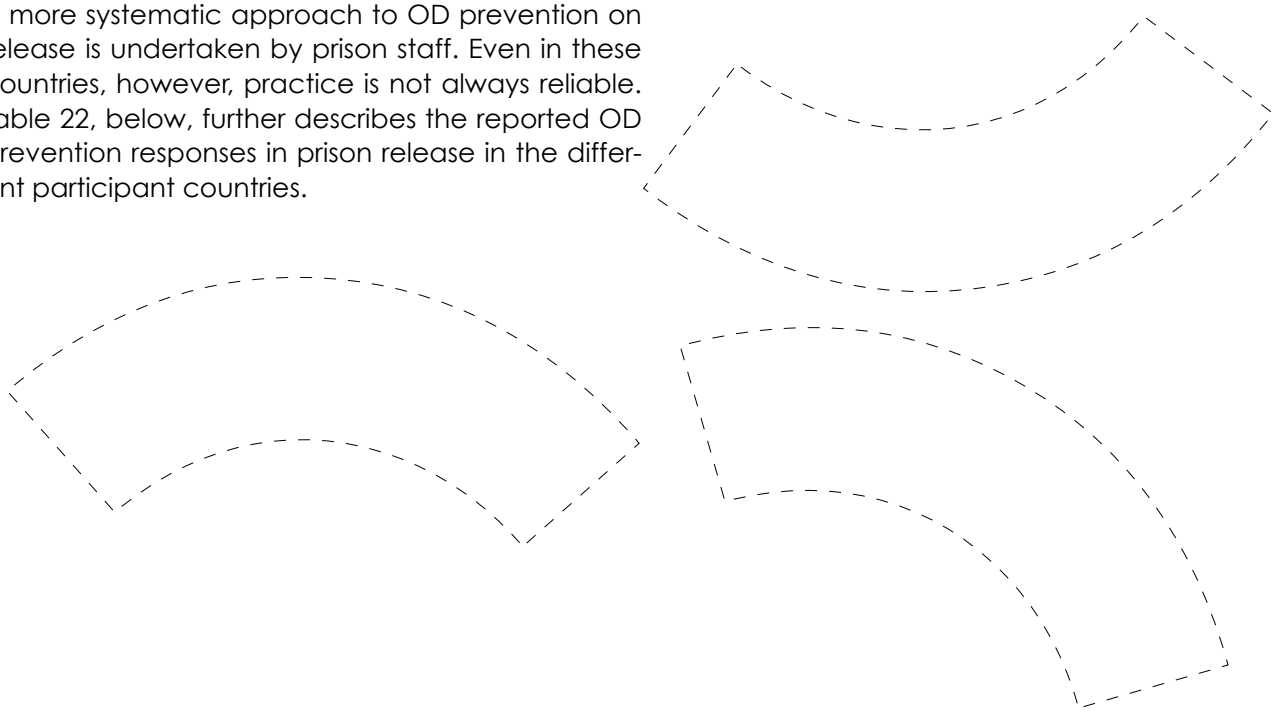
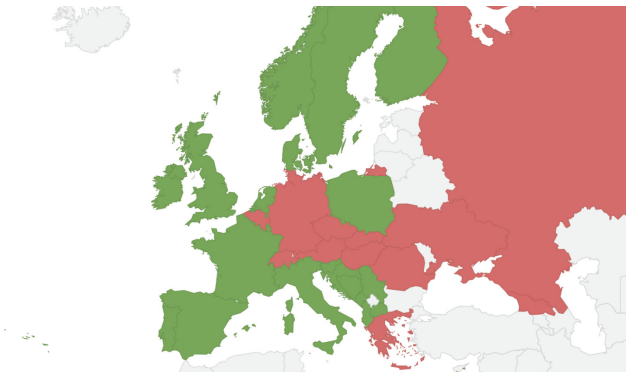


Table 22: OD prevention responses upon prison release

	OD prevention for prison release	Respondent description
Albania	✗	n/a
Austria	✓	**Carried out by one CSO only, not systematically.** The organisation *Neustart* has a monopoly on helping released prisoners and can decide to convey the client to institutions with a main emphasis on drug prevention. Apart from that, there is no directly linked procedure for ex-convicts and OD prevention.
Belgium	✗	n/a
Bosnia & Herzegovina	✗	n/a
Bulgaria	✗	n/a
Croatia	✓	**Carried out by some CSOs, but not systematically.** *Udruga "Vida"* provides services aimed at the social integration of ex-inmates who are on OST, including health counseling and encouraging regular contact with care services.
Czech Republic	✓	**Carried out by some CSOs, but with difficulties**. A few NGOs prepare inmates for release and post penitentiary care, which includes information on the state of the black market and support to go to inpatient or outpatient care (therapeutic communities, OST, etc.). The communication with the prison system is difficult as they resist admitting that their facilities are not drug-free. Only after many years of negotiation, a machine for condoms was set up.
Denmark	✓	**Carried out by one CSO, but with difficulties.** The *Center for Vulnerable Adults and Families* has tried to implement smaller THN projects in Danish prisons but they are not supported by senior prison management.
Finland	✓	**Carried out by health professionals working in prisons.** They deliver prevention information, such as a *first 48 hours* OD booklet and OST referral to community.
France	✓	**Carried out by health professionals working in prisons.** They deliver prevention information to inmates about the OD risk and sometimes also naloxone, although this not common practice.
Georgia	✗	n/a
Germany	✗	Only the state of Bavaria is now allowing, and funding, trainings at the point of release from prison within a statewide pilot project.
Greece	✗	n/a
Hungary	✗	There are no overdose prevention responses for prison release.
Ireland	✗	n/a
Italy	✓	**Carried out by a few prisons,** but still very limited. At an experimental stage, few prisons deliver naloxone for prisoners who are drug users upon their release.

	OD prevention for prison release	Respondent description
Luxembourg	✓	In connection with the *Jugend- an Dorgenhellef*.
Montenegro	✗	n/a
Macedonia, North	✗	n/a
Netherlands	✓	**Carried out by health professionals working in prisons.** A **national guideline** describes the treatment of prisoners who are dependent on drugs as well as their aftercare when released[52]. However, this does not automatically mean that it goes well in practice. It is safe to assume that the extent to which the knowledge of staff is up-to-date and capable of holding open, non-judgmental, discussions with PWUD will differ between prisons and even between individual staff members.
Norway	✓	**Carried out by health professionals working in prisons**, who invite all inmates to talk about the risk for OD before release.
Poland	✓	**Carried out by some CSOs, but not systematically.** There are no mandatory activities; in some places (like detoxification departments or OST centres) inmates get information about higher OD risk after a period of abstinence.
Portugal	✗	n/a
Romania	✗	n/a
Russia	✗	n/a
Scotland	✓	**Carried out by health professionals working in prisons** who deliver naloxone to prisoners upon release. Much work has been undertaken to improve discharge arrangements for people leaving prison. In recent years, there has been a reduction in the rate of fatal overdose following release from prison.
Serbia	✗	It is foreseen in the Action Plan of the National Drug Strategy but is not being implemented.
Slovakia	✗	n/a
Slovenia	✗	n/a
Spain	✓	**Carried out by health professionals working in prisons**, **but not systematically.** Some of the workshops that take place in prison include this agenda but are not mandatory for all OST clients.
Sweden	✗	Not currently available but there are plans for it.
Switzerland	✓	**Carried out by a few prisons but not systematically.** A few prisons cooperate with drug treatment services to plan for release. In general, harm reduction in prisons is poorly developed[53].
Ukraine	✗	n/a
United Kingdom	✓	

Respondents were also asked whether OST is systematically continued with a referral from prison health care to a new treatment provider in the community. More than half of participants (20) have continuous referral but, still, many (13) countries do not. A division between Western and Eastern Europe is visible in this regard. Map 6, below, illustrates the countries with, and without, systematic OST referral after release from prison.



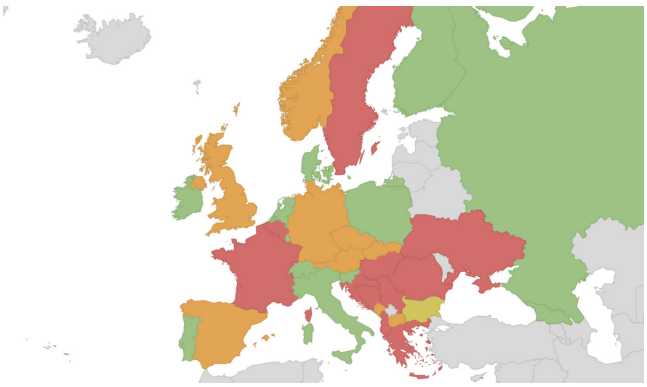
Map 6: Availability of prison post-release OST referral

Post release OST referral not available
Post release OST referral available

Other OD prevention measures

Evaluation of first responders

C-EHRN Focal Points were asked to evaluate the training and capabilities of first responders (ambulance, fire brigade, police) for handling overdose situations in their country, region or city. Map 7, below, illustrates the evaluation for the different countries followed by explanations.



Map 7: Evaluation of first responders to OD situations

Not good
Their preparedness varies
Good
Does not know

Good training and capabilities

About a third of respondents (11 out of 34) considered first responder training and capabilities for handling overdose situations as **good**. These included respondents from Denmark, Georgia, Ireland, Italy, Luxembourg, the Netherlands, Poland, Portugal, Russia, Slovenia, and Switzerland. Some reasons given for such evaluations were the good performance and speed of first responders (e.g. Finland, Ireland, Poland, the Netherlands, and Slovenia); good knowledge about OD (e.g. Georgia, Portugal, and Switzerland); being equipped with naloxone (e.g. Georgia, Poland, and Portugal); and having good collaboration with harm reduction services (e.g. Switzerland). Another important issue is for first responders to not report to the police (e.g. Denmark).

"They perform quite well. The ambulance is the first responder and there is no reporting to police; users do not feel threatened by responders."[54] (Denmark FP)

"Nurses and doctors from emergency services are well prepared to act in overdose situations and they have naloxone available with them." (Portugal FP)

Preparedness varies

Another third (10) of respondents – Austria, the Czech Republic, Germany, North Macedonia, Montenegro, Norway, Scotland, Slovakia, Spain, and the United Kingdom – mentioned that **the preparedness of first responders varies considerably**. Several reported that ambulance crews do a good job, but other first responders (such as police and the fire brigade) are not prepared (e.g. Austria, the Czech Republic, Germany, North Macedonia, Scotland, Slovakia and Sweden). Another problem lies in the prejudicial attitudes towards PWUD (e.g. Spain and the United Kingdom). Finally, in some cities, people may be giving too-high doses of naloxone according to PWUD being rescued (e.g. Norway).

"There is some very basic training, and training varies a lot. There are very experienced workers and inexperienced ones too. It is a little bit of a lottery as to who will come." (Czech Republic FP)

"Police officers do not have many capabilities; if there is an OD, they usually call the ambulance, or the ambulance is handling it on its own." (Slovakia FP)

"Most of the services providers are trained to treat an overdose, but we found that there are many prejudices against the group of people in active drug consumption." (Spain FP)

Absence of good training and capabilities

The other third of respondents (11) considered the preparedness of first responders as **not good**. This was the case in Albania, Belgium, Bosnia and Herzegovina[55], Croatia, France, Greece, Hungary, Romania, Serbia, Sweden, and Ukraine). Reasons for a negative assessment included not having naloxone (e.g. France, Romania, Bosnia and Herzegovina); having limited knowledge and training about OD (e.g. Ukraine, Albania, Croatia); not cooperating to help PWUD (e.g. Serbia); and calling the police when there is an OD case (e.g. Hungary).

"Most of those services do not know the existence of naloxone and do not deliver it." (France FP)

"We have been fighting for the emergency services not to call the police to OD cases - unfortunately with not so much success. We have several cases when police are called automatically."[56] (Hungary FP)

"Only the ambulance has the right to use naloxone. In one case, when our clients needed their help, they did not want to come. It took 5 minutes of negotiation over the phone to do this. In the end, his life was saved." (Serbia FP)

Groups receiving OD prevention and education

PWUD

C-EHRN Focal Points were asked if there is information and/or education/training available for PWUD (and their friends and family members) on overdose prevention measures. From the 34 respondents, seven reported not having any education and training for PWUD, their friends or family members. These were from Croatia, Greece, Hungary, Slovakia, Slovenia, Sweden, and Switzerland.

In 26 countries, there is education and training for PWUD – Albania, Austria, Belgium, Bulgaria, the Czech Republic, Croatia, Finland, France, Georgia, Germany, Italy, Ireland, North Macedonia, the Netherlands, Norway, Poland, Portugal, Romania, Russia, Scotland, Serbia, Spain[57], Ukraine[58], and the United Kingdom[59]. In all these cases, however, CSOs were primarily responsible for delivering OD prevention education to this population. This may imply a non-continuous and non-systematic service offer. Most of them provide PWUD with information material on OD prevention. These mostly comprise of brochures (e.g. Austria, Bulgaria, North Macedonia[60]), but sometimes also online information (e.g. Bulgaria[61], France[62], and the Netherlands). Some provide training or information sessions for PWUD (e.g. Austria, Finland, the Neth-

erlands, Romania, and Russia); others offer handbooks and manuals (e.g. Poland and Serbia).

> "We offer training and materials to professionals and PWUD from various user groups on both OD prevention and response. We offer information related to opiates, but also on stimulants and GHB[63]. Among recreational users, peer-to-peer educators from *Unity* offer information on OD prevention and response at parties and online." (Netherlands FP)
>
> "PWUD only receive information on, or participate in education/training about, overdose prevention measures when NGOs or outreach teams provide this kind of training. There is nothing formal." (Portugal FP)

According to C-EHRN respondents, only in France, Ireland[64], and Norway[65] is the government taking responsibility to educate and train PWUD in the form of funding.

Professionals

C-EHRN Focal Points were asked if there is information and/or education/training on OD available for different professionals, to which more than half of respondents gave a positive answer.

General public (campaign) and people visiting drug checking services

Focal points also answered if there is information and/or campaigns for the general public on overdose prevention measures, and if there are drug-checking services in their country especially targeting overdose prevention. Only five respondents reported specific campaigns and six reported OD prevention (ODP) through drug checking services. Table 23, below, illustrates the groups targeted for ODP and education in different countries:

Table 23: Groups targeted for OD prevention and education

Country has ODP education…	For PWUD	For professionals	For the general public through campaigns	At drug checking services
Albania	✓	✓[66]	✗	✗
Austria	✗	✗	✗	✓
Belgium	✓	✗	✗	✗
Bosnia and Herzegovina	✓	✗	✗	✗
Bulgaria	✓	✗	✗	✗
Croatia	✗	✗	✗	✗
Czech Republic	✓	✓	✗	✗
Denmark	✓	✓[67]	✗	✓
Finland	✓	Don't know	✗	✗
France	✓	Don't know	✗	✓
Georgia	✓	✗	Will be done	✗
Germany	✓	✓[68]	✗	✗
Greece	✗	✗	✗	✗

Country has ODP education…	For PWUD	For professionals	For the general public through campaigns	At drug checking services
Hungary	✗	✗	✗	✗
Ireland	✓	✗	✗	✗
Italy	✓	✓[69]	✓[70]	✓
Luxembourg	✓	✓[71]	✗	✓
Montenegro	✓	✗	✓[72]	✗
Macedonia, North	✓	✗	✗	✗
Netherlands	✓	✓[73]	✗	✓
Norway	✓	✓	✗	✗
Poland	✓	✓	✗	✗
Portugal	✓	✓	✓[74]	✗
Romania	✓	✓[75]	✗	✗
Russia	✓	✓	✗	✗
Scotland	✓	✓	✓	✗
Serbia	✓	✗	✓[76]	✗
Slovakia	✗	✗	✗	✗
Slovenia	✗	✗	✗	✗
Spain	✓	✓[77]	✗	✓
Sweden	✗	✓	✗	✗
Switzerland	✗	✓[78]	✗	✓
Ukraine	✓	✓[79]	✓[80]	✓
United Kingdom	✓	✓	✓[81]	✓

OD and fentanyl

Respondents were asked whether fentanyl and other Synthetic Opioids (SO) are available in their country/region/cities and if they have perceived of any changes in the situation regarding these drugs. They have also answered whether there are prevention campaigns around fentanyl and other SOs and if fentanyl test strips are being used. Table 13, below, outlines their responses.

Where fentanyl and SOs are present

Almost two-thirds of participants (21 out of 34) mentioned having noticed the presence of fentanyl and other SOs in their country, region or city. From these, at least 6 noticed recent changes in the situation concerning the appearance of such substances. One perceived change is the increased availability of these substances, which sometimes comes with a few cases of OD and

doubts from professionals on how to deal with the public using such drugs. This was mentioned with regards to the Czech Republic, Denmark, France, Italy, Greece, Norway, and the Netherlands. In Switzerland, there have been occasional seizures of SOs by customs agents, and the substance is said to have appeared in some DCRs, although this has not been confirmed. At present, therefore, it seems to be a marginal phenomenon. In Sweden and Ireland, recent changes related to an increase in poly-drug use has brought significant risks.

"It is not official, but DCR users say their regular dealers would be able to get their hands on Oxycodon quite easily and/or any other drug widely available via the darknet. Still, in reality, we did not see any increase of drugs. There is mainly an increased awareness among professionals in the use of Oxycodon, fentanyl and, to a lesser degree, other prescribed opiates such as codeine. In most cities, we do hear of a black market for these substances. It is available through dealers but, possibly more significant (among marginalised PWUD), users sell their prescribed drugs among each other. This is done with opiates but more so with benzodiazepines." (Netherlands FP)

"Fentanyl is sold on the black market as "injectable heroin"". (Greece FP)

"Fentanyl and new SOs are widely spread in France. There's been an increase in the use of SOs. Centres face difficulties to deal with this "new public". (France FP)

"Fentanyl OD's have been reported but mainly among young experimenting users." (Denmark FP)

Absence of fentanyl and SOs

In at least ten of the countries where respondents did not notice the presence of fentanyl or other SOs, there are also no recent changes observed, nor are there fentanyl test strips or campaigns related to these drugs. In these countries, fentanyl and other SOs do not appear to be of importance. In Hungary, for instance, the use of opioids has declined in the last ten years.

One country, Austria, noticed recent changes but in reference to the apparent disappearance of new SOs. There, *Checkit!* (offering drug checking in Vienna) detected new SOs at the end of 2017 and during the first months of 2018, but not after that. Since 2017, all submitted samples are screened for (new synthetic) opioids with an additional analytic technique, but no such substances were detected in samples after the beginning of 2018.

Table 24: OD prevention and fentanyl

	Fentanyl / new SO available	Changes in country/region/ city situation	Fentanyl or other new SO campaigns	Fentanyl test strips being used
Albania	✗	✗	✗	✗
Austria	✗	✓	✓	✗
Belgium	✓	✗	✗	✗
Bosnia & Herzegovina	✗	✗	✗	✗
Bulgaria	✓	✗	✗	✗
Croatia	✓	✗	✗	✗
Czech Republic	✓	✗	✓	✗[82]
Denmark	✓	✓	✗	✓
Finland	✓	✗	✗	✗
France	✓	✓	✓	✓
Georgia	✓	✓	✓	✓
Germany	✓	✗	✗	✗
Greece	✓	✗	✗	✗
Hungary	✗	✗	✗	✗
Ireland	✗	✓	✗	✗
Italy	✓	✓	✗	✓
Luxembourg	✗	✗	✗	✗
Montenegro	✓	✓	✗	✗
Macedonia, North	✗	✗	✗	✗
Netherlands	✓	✓	✓	✓
Norway	✓	✓	✗	✗
Poland	✓	✗	✓	✓
Portugal	✗	✓	✗	✗
Romania	✗	✗	✗	✗
Russia	✓	✓	✗	✗
Scotland	✗	✗	✗	✗

	Fentanyl / new SO available	Changes in country/region/ city situation	Fentanyl or other new SO campaigns	Fentanyl test strips being used
Serbia	✗	✗	✗	✗
Slovakia	✓	✗	✗	✓
Slovenia	✓	✗	✗	✓
Spain	✓	✗	✗	✓
Sweden	✓	✓	✗	✗
Switzerland	✓	✗	✗	✗
Ukraine	✗	✗	✗	✗
United Kingdom	✓	✗	✗	✗

OD prevention for other drugs

Respondents were asked if there are overdoses and related responses to other drugs than opioids, such as NPS, GHB, MDMA, cocaine, or others. More than half of participants (19 out of 34) answered positively. At least 11 of these mentioned **stimulant drugs** as a cause of ODs. They referred mostly to cocaine but also MDMA and, to a lesser extent, GHB and synthetic cathinone.

Cocaine has been mentioned in France, the Netherlands, Montenegro, Romania, Serbia, Slovenia, and the United Kingdom. In the Netherlands, for instance, overdoses related to the use of stimulant drugs are reported and are much more common than opiate overdoses, especially in combination with alcohol. This not only includes lethal overdoses but any overdose that leads to serious adverse side effects for the substance user. In Montenegro, clients of the NGO *Juventas* have been reporting increased use of cocaine, and especially injected cocaine, besides NPS. In Slovenia, three clients from the NGO *Stigma* died due to cocaine poisoning in 2018, and one dropped into a coma due to cocaine consumption. In the United Kingdom, there have been known ODs related to cocaine and MDMA (particularly at festival settings), GHB, and NPS (particularly in prisons and among the homeless population).

MDMA was mentioned by respondents from Denmark, Belgium, France, the Netherlands, Serbia and the United Kingdom. In Denmark, incidents of severe MDMA-overdosing have been reported among young experimenting users. In Serbia, cocaine, GHB, GBL, and Tryptamines are more prevalent on the market than before, as is high purity ecstasy. In 2018, the death of five young people occurred in a short time period, most probably as a result of use of high purity ecstasy. In Belgium, there is discussion as to whether deaths of people who used MDMA are indeed ODs or there are other causes. In the Netherlands, MDMA and other stimulant ODs are not uncommon and there is a lot of information distributed among users on how to prevent OD and the risks of overdosing. People who use these drugs can also get information on the content of their pills and contamination although, in practice, many marginalised PWUD do not make use of this service. In addition, professionals have guidelines, training, and information on how to respond to stimulant ODs, such as Excited Delirium Syndrome, psychotic episodes and, in the case of MDMA, serotonin syndrome.

GHB was mentioned by Focal Points in Serbia, France, the Netherlands and the United Kingdom. In the Netherlands, there is information for professionals and for PWUD on how to respond to a GHB

overdose. *Mainline* often gets questions from professionals about this as it can shock and/or worry healthcare and social service personnel, but also nightlife staff when they encounter such ODs. Among some user groups, GHB ODs occur quite regularly and some municipalities really struggle with the popularity of this substance as an OD cannot only lead to coma, or even death, but can also cause very uncontrolled behaviour and physical convulsions. In the United Kingdom, the *Gay Men's Health Collective* produces tailored harm reduction materials for MSM which includes information on GHB OD prevention[83].

Synthetic cathinones were mentioned by Focal Points in France, Poland, Georgia, and Spain. In Georgia, many non-injectable new stimulants are purchased online and, since most users do not know about the dosages and contents of these materials, OD happens quite often. The responses to these other drugs, besides the ones mentioned above, include information campaigns[84], drug checking, OD training, and DCRs. In Spain, for example, the *Red Cross* has noticed a remarkable decrease in acute reactions to consumption that causes death. That is the case especially in Catalonia where there are supervised consumption rooms and naloxone programmes to attend to users in situations of respiratory depression and a long tradition of consumer health education. In order to continue advancing to zero deaths due to acute reaction to consumption, the organisation considers it necessary to extend the hours of the DCRs, to continue with the consumer education tasks, and to act on those drug sales that do not comply with minimum safety conditions.

Conclusions

Only five countries reported separate overdose prevention strategies or action plans. Much improvement is needed to be able to adequately respond to overdoses in Europe.

There is solid scientific evidence on the measures that can reduce opioid and other drug-related overdose deaths. They include drug consumption rooms (DCR), naloxone distribution before release from prison and take-home naloxone (THN) programmes outside prison. Despite this evidence, the C-EHRN report shows a completely mixed picture of policies and measures across Europe. Due to the fact that drug-related deaths in Europe have been at a high level for many years, expert groups - involving civil society organisations (CSO) - need to be established in European countries to advise policymakers and authorities on the development and implementation of strategic plans to prevent and reduce drug-related deaths.

The report also shows that there is an inconsistent collection of data on overdose and that CSOs are not involved in this data collection and analysis. This significant disparity in how, and by whom, such data is collected can ultimately influence what is recorded as a drug-related death. To address this, the EMCDDA should encourage the national health authorities, their own Reitox Network, as well as others who collect this data to collaborate more with the national harm reduction networks and experts from their field of work.

Due to the uneven status of naloxone, the political authorities are called upon to take appropriate legal initiatives to ensure that naloxone is available free of charge and without prescription in pharmacies for people who use drugs. The experiences from Italy can be the basis for this action. In order to obtain a real overview of the number of doses of naloxone administered, and data on the successful use of naloxone, a national reference point should be established to collect and analyse this and other data.

Despite the uneven situation regarding policies and measures to prevent drug-related overdose, positive developments are evident in individual countries. Altogether, 17 countries reported ongoing discussions or new initiatives on starting new DCRs. In many places, national harm reduction networks are the driving force behind ongoing discussions about establishing DCRs. These health and drug policy activities play a key role in increasing the number of countries in Europe with DCRs.

In addition, the C-EHRN monitoring survey needs to be developed when it comes to overdose responses. The most important limitation of the survey is the involvement of stakeholders selected by C-EHRN Focal Points. They were not always very familiar with their respective government's policy even if they are familiar with the harm reduction activities in their own organisation. The validity of the answers provided was not cross-referenced with current, official policy, so there may potentially be some inaccuracies in the answers.

References

EMCDDA (2017). Health and social responses to drug problems: a European guide. Publications Office of the European Union, Luxembourg.

Further Reading

EuroHRN (2014): "Preventing Avoidable Deaths: Essentials and Recommendations on Opioid Overdose."

Since 2018, a full report on the DRD expert network meeting has been published: http://www.emcdda.europa.eu/news/2019/latest-update-on-drug-related-deaths-and-mortality-in-europe_en

The evidence-base of interventions is presented in the EMCDDA's Beat Practice Portal: http://www.emcdda.europa.eu/best-practice/evidence-summaries and filter by desired outcome "reduce mortality".

Recently, a topic page with FAQs on DRD was published: http://www.emcdda.europa.eu/publications/topic-overviews/content/faq-drug-overdose-deaths-in-europe_en

Rapid Communication on DRD. http://www.emcdda.europa.eu/system/files/attachments/9885/DRD%20and%20mortality%20in%20Europe.pdf

Tobin K, et al. Awareness and access to naloxone necessary but not sufficient: Examining gaps in the naloxone cascade. Int J Drug Policy. 2018 Sep; 59: 94–97. doi: 10.1016/j.drugpo.2018.07.003

MONITORING NEW DRUG TRENDS (NDT)

Introduction

The continuous emergence of new substances and changing patterns of drug use requires new health and harm reduction responses. While heroin remains the most commonly used illicit opioid worldwide, a number of sources suggest that licit synthetic opioids (such as methadone, buprenorphine and fentanyl) are increasingly misused. Opioids other than heroin reported by treatment entrants include misused methadone, buprenorphine, fentanyl, codeine, morphine, tramadol and oxycodone[85]. Such opioids now account for 22% of all primary opioid clients and, in some countries, non-heroin opioids represent the most common form of opioid use among specialised treatment entrants. While consumption levels of new psychoactive substances (NPS) are low overall in Europe, in a 2016 EMCDDA study, over two-thirds of countries reported that their use by high-risk drug users resulted in health concerns. In particular, the use of synthetic cathinones by opioid and stimulant injectors has been linked to health and social problems. In addition, the smoking of synthetic cannabinoids by marginalised populations, including among homeless people and prisoners, has been identified as a problem in a number of European countries.

From the perspective of C-EHRN, there is a lack of knowledge of, and cooperation between, the various players in the field, including the EMCDDA's REITOX National Focal Points, its Early Warning System (EWS) and CSOs. New approaches in this field are needed to regularly update existing data on new drug trends and drug using patterns. Harm reduction and community organisations working closely with PWUD may see changes in drug use much quicker than other organisations working in this field.

Therefore, it is considered important, and of great value, to establish a mechanism to pick up, monitor and report on emerging drug trends at a much more rapid pace. The fact that the data collected by C-EHRN in this way may be anecdotal, small-scale, or is appearing for a short period of time, is considered not as an obstacle, but as complementary.

Timeline of NDT activities

November 2018: establishment and first meeting of the NDT expert group, Bucharest.

January 2019: meeting of scientific committee and leaders of the 3 expert groups to discuss plans for 2019, Berlin.

Spring 2019: development and fine-tuning of the NDT questionnaire, including input from NDT expert group.

Summer 2019: questionnaire sent to C-EHRN Focal Points, completed and returned to C-EHRN.

Autumn 2019: results analysed.

October 2019: results and way forward discussed in Helsinki and Lisbon.

Methodology

In early 2019, questionnaires were developed and adjusted and shared with the expert group. Amongst other things, there was a discussion about the definition of *new drugs* and NPS, and also the geographic scope of the questions and the level of detailed information being sought, such as local, regional and/or nationwide trends and developments.

As a result, the questionnaire on new drug trends was fine-tuned, consisting of a large number of questions, such as the top 5 traditional drugs at the city, regional and national level; the top 5 NPS

at those levels; and trends and developments in, for example, groups of users, and route of administration, etc.

As described in the introduction to this report, the complete questionnaire was sent to all C-EHRN Focal Points in May 2019. Over the summer, questionnaires were returned, with almost all questionnaires returned in September-October, following which the data was analysed.

Finally, the results were discussed by the expert group during a Correlation monitoring meeting held in Helsinki at the beginning of October 2019. Later that month, the monitoring activities of Correlation were presented and further discussed with a larger audience during a structured session at the *LXAddiction2019 Conference* in Lisbon.

Results

While drafting the questions on new drug trends, C-EHRN was aware of some difficulties that could and would be encountered. However, the added value of ground-level information, even anecdotal, about emerging (changes in) substances used, or routes of administration, or of different groups using substances, etc., was also evident. Trends at the local level may expand to other cities, regions or even countries and it is always useful to be prepared for such developments.

"*Shabou* is known for its high content of methamphetamine, it is made based on this, as well as adrenaline, epinephrine, ephedrines and amphetamine. In the last four years, there has been an increase in the demand for detoxification and treatment in the Care and Monitoring Centres in Barcelona, although the level of consumption in Spain is very low. People usually come from other services, such as Primary Care (social work, health) and childcare teams. Although it is a heterogeneous group, a large part of the population consuming *Shabou* comes from the Philippines, and according to data from DGAIA (General Directorate of Care for Children and Adolescents) currently 97% of cases of withdrawal in Catalonia are carried out in this group, which could be related to consumption. It would seem that the beginning of consumption is through labour, quickly moving to be used in the playful and sexual spheres. For drug professionals, this is a difficult approach, the person has low adherence to treatments or work plans, and a high impact on psychophysical health."

"There is a significant increase in arrivals of unaccompanied minors to Spain, mainly from North Africa. In Barcelona, approximately 200 young people arrived each month in 2018. Among them there are an unknown percentage of consumers of substances, especially inhalants and hypnosedatives with, or without, a prescription. This implies that a group with similar characteristics in age, culture and origin are in a situation of high vulnerability and social exclusion. The institutions are overwhelmed by the volume of people in this situation in recent months. A coordinated and urgent approach is necessary at the institutional, social, health and educational levels." (Spain FP)

> "Chemsex now appears to be associated with methamphetamines, mephedrone, GHB, GBL and ketamine, all of which - except GHB/GBL and ketamine – are stimulants that trigger increased heart rate, blood pressure and euphoric feelings, providing greatly reduced levels of inhibition and sexual appetite, and enhancing the duration of the sexual episode, as well as the participation of a large number of partners on a single occasion." (Portugal FP)

Despite these issues, some very interesting information has been discovered. For example, answers are given in Table 25, below (in groups following EMCDDA classification), to the question: "At the moment, what are the 3 predominant new substances used in your country/region/city"[86].

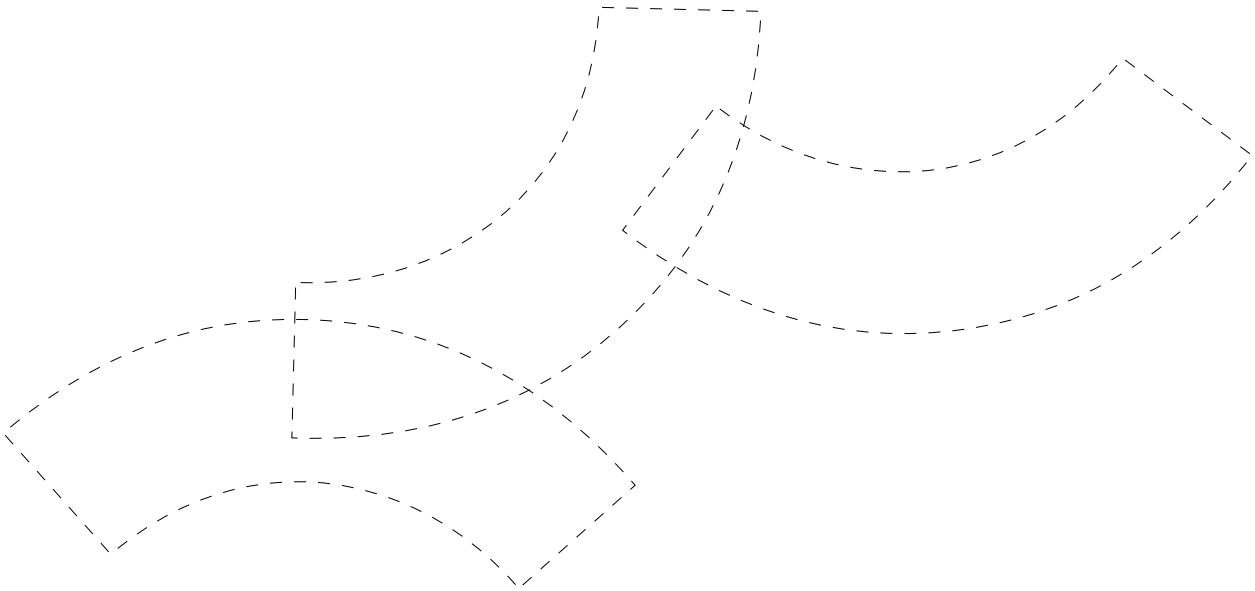


Table 25. At the moment, what are the 3 predominant new substances used in your country/region/city+*

	1	2	3
Albania+			Others (GHB)
Austria+	Cathinones (Mephedrone)	Cathinones (N-Ethylhexedrone)	Others (1p-LSD)
Belgium			
Bosnia & Herzegovina			
Bulgaria			
Croatia+	Cannabinoids (synth. cannabinoids)	Others (poppers)	Arylcyclohexylamines (ketamine)
Czech Republic+	Cathinones ("funky")	Cannabinoids (synthetic cannabinoids)	
Denmark+	Others (Nitrous gas)		
Finland	Opioids (Furanylfentanyl)	Cathinones (N-ethylhexedrone, Alpha-PHP)	
France	Cathinones (3-MMC)	Indolalkylamines (f.e. tryptamines) (DMT)	Cannabinoids (F-MDMB-PINACA, 5F AKB48)
Georgia			
Germany+	Cannabinoids (synthetic cannabinoids)		Cathinones (MDPV)
Greece	Cathinones (Mephedrone)	Arylcyclohexylamines (Special K)	
Hungary	Cannabinoids (synthetic cannabinoids)	Cathinones (cathinones)	
Ireland	Others ("Street Tablets")		
Italy+	Phenethylamines (fenitelamine)	Cannabinoids (synth. cannabinoids)	Opioids (synthetic opioids)
Luxembourg+		Phenethylamines (2CB)	Arylcyclohexylamines (ketamine)
Montenegro+			
Macedonia, North			
Netherlands+	Cathinones (3-MMC, 4-MMC)	Phenethylamines (2CB)	Arylcyclohexylamines (ketamine)
Norway+	Cannabinoids (Syntetic cannabiz)	Benzodiazepines (Syntetic diazepam)	
Poland*	Cathinones (Hex-en)	Cathinones (Clephedrone)	Cannabinoids (synthetic cannabinoids)
Portugal+	Others (GHB, GBL)		Arylcyclohexylamines (ketamine)
Romania			
Russia+	Cathinones (Mephedrone, alpha-pvp, MDDV)		
Scotland+	Benzodiazepines (Etizolam)	Others (Gabapentanoids)	Cannabinoids (SCRAs)
Serbia			
Slovakia+	Cannabinoids (herba - syntetic canabinoid)		
Slovenia+	Arylcyclohexylamines (ketamine)	Others (1p-LSD)	Others (GBL/GHB)
Spain			
Sweden			
Switzerland	Phenethylamines (2CB)	Cathinones (3-MeMC, 2-MeMC, 4-CMC, 4-CEC)	Others (1P-LSD, 1B-LSD)
Ukraine	Cannabinoids (Spices)	Cathinones (Mephedrone)	
UK+	Arylcyclohexylamines (ketamine)	Cannabinoids (SCRAs)	

New user groups/new ways of using as reported by 6 countries:

SPAIN: 1) "Shabou" (high content of methamphetamine+ adrenaline, epinephrine, ephedrine, amphetamine; smoked, snorted, injected); 2) Unaccompanied minors (mainly from Northern Africa; glue, benzos.).

ITALY: 1) Chinese (ketamine, PCP, heroin); 2) Sub-Saharan Africans (alcohol, cannabis, tramadol).

PORTUGAL: Chemsex (methamphetamines, mephedrone, GHB, GBL, ketamine).

NETHERLANDS: 1) Marginalised users of opiates and freebase cocaine (ketamine, GHB, medicines, alcohol); 2) Chemsex (methamphetamine and NPS, primarily 4mmc, 3mmc, 4mec); 3) Recreational users (Synthetic cathinones (3-MMC, 3-CMC, 3-MEC, 4-CL-PVP; snorting bumps or oral bombing).

SWEDEN: Immigrants (heroin).

SERBIA: MSM population (GHB).

At the time of the analysis, 33 countries had returned the questionnaire. However, 10 countries did not provide any response to these questions, and four others did not fill in the first and/or second option (9 countries used all 3 options, thereby sending back a top 3 of predominant new substances).

For reasons of clarity, the answers were restructured and clustered into the groups that they belong to according to their molecular structure.

NPS belonging to the group of cathinones are mentioned most often (14 times), followed by cannabinoids (11 times) (see Table 1). Generally, this is in correspondence to the (scarce) data about the prevalence of NPS use as reported by the EMCDDA in their annual European Drug Report. Equally, the use of NPS belonging to the group of new synthetic opioids in all but two reporting countries is not considered to be high, i.e. not among the top 3 most predominant NPS. Overall, a huge variety in popularity of specific NPS is visible between EU countries.

"Cocaine prevalence appears to be generally increasing and we are seeing increases in injecting cocaine and smoking crack in some areas. In some areas, we have increased reports of Xanax (alprazolam). The majority of 'street' valium in Scotland now contains Etizolam." (Scotland FP)

"These users have, over the years, rarely shown interest in other drugs. In recent years, we hear of more and more incidents where multiple residents of sheltered housing or healthcare service clients suddenly (and often only for a brief period) start using *ketamine* or *GHB*. Mostly, such phases pass and are related to the accessibility of the substance. *Speed* and *alcohol* are not new in these scenes, although the popularity of cheap strong *beer* and the illusion that someone is doing well because they stopped using heroin and now drinks 8 half-litres of beer a day needs harm reduction attention. On the black market, there is a continued market for *benzodiazepines* as they are widely prescribed and have market value among these users. Additionally, we hear of slightly more selling of *oxycodon* (and, to a much lesser degree, *fentanyl*) among users, but this could also be due to our increased awareness of the matter and is nothing compared to the *benzo's* sold on the market. Other medicinal products sold and used are *ADHD* medications, including *ritalin* and *dexamphetamine*, and sporadically *modafinil* and occasionally *lyrica*, *pregabaline* and *phenibut*. It is noted that for all of these substances, we are talking about more than a handful of users nationwide, not of major trends. They are still incidents."

"The price of *meth* [*methamphetamine*] has dropped significantly in recent years; also, in Amsterdam, more dealers seem to be selling *meth* and two dealers who we have contact with report having more clients. Online, there also seems to be a slight increase in those mentioning *meth* and injecting when looking for sex partners, and professionals throughout the country report seeing more people who have become addicted to chemsex-related drug use and/or experience serious health and social problems related to this use. This can be partially explained through increased awareness and accessibility of professionals for people doing chemsex but is likely also due to an increase [in its use]." (Netherlands FP)

Since data about actual use of NPS is generally limited or mostly lacking throughout the EU and further afield, the data presented here may give some insight into the popularity of NPS as divided by groups: the most commonly used groups of NPS seems to be synthetic cathinones and synthetic cannabinoids.

Limitations

Opinions on what to consider as a *new drug* differs as there is no clear definition for this. C-EHRN Focal Points have a clear view on local drug trends, but not necessarily on regional or national trends.

The quality of the data was very diverse, ranging from very detailed and precise to rather superficial and sometimes difficult to understand. In some cases, the data returned was - as expected - filled in by just one person, whereas in other cases the answers were the result of consulting various local, regional or national stakeholders, possibly affecting the quality of the data.

Furthermore, some data received was also difficult to interpret. For example, when marijuana was classified under new substances, does this mean that a mistake was made since cannabis cannot be a new substance anywhere in Europe, or that it was, indeed, a new substance that was recently being used in the local market? It was unclear whether a reported substance was actually new or was merely a misspelling of an already existing substance, such as MDDV as a misspelling of MDPV, or really a new substance that has not yet been reported to the EMCDDA? And what about other substances such as 'blue amphetamine'?

Many countries have difficulties in knowing the actual composition of the new substances reported in light of the unavailability of low-threshold drug checking services.

Conclusions

In general terms, some of the results correspond with what is known from other sources, such as use of synthetic cannabinoids in custodial setting in, for example, Scotland, whereas others provide possibly new insights, such as the appearance of psychedelics MiPLA and EiPLA in the Dutch drugs market. Furthermore, the process of data collection as undertaken by C-EHRN Focal Points certainly has the potential to generate additional information and at a quicker pace than other monitoring methods; it certainly can lead to added qualitative value.

Following this internal analysis, outcomes were discussed by the expert group that met in Helsinki in October 2019. The experts confirmed both the concerns raised above as well as the added value of some of the data and of grassroots-level monitoring of new drug trends.

It was decided that the focus of the monitoring, and thus the questionnaire, needs to be adjusted as follows:

1. No longer should the focus be on specific drugs, e.g. NPS or new substances, but rather to focus on drug trends which could include new drugs, but not necessarily. And the focus should be on trends in any use or groups of people using, or trends in, the route of administration, etc.;
2. No longer should the focus be on different geographic levels: city, region, country. Instead, the focus should be at the city level, i.e. on the trends and developments in the city where the C-EHRN Focal Point is located. This approach will most likely give the best quality data; and,
3. Drafting a detailed report on outcomes per question is not considered suitable; rather, a report would be more appropriate on the process and the lessons learned as well as the way forward.

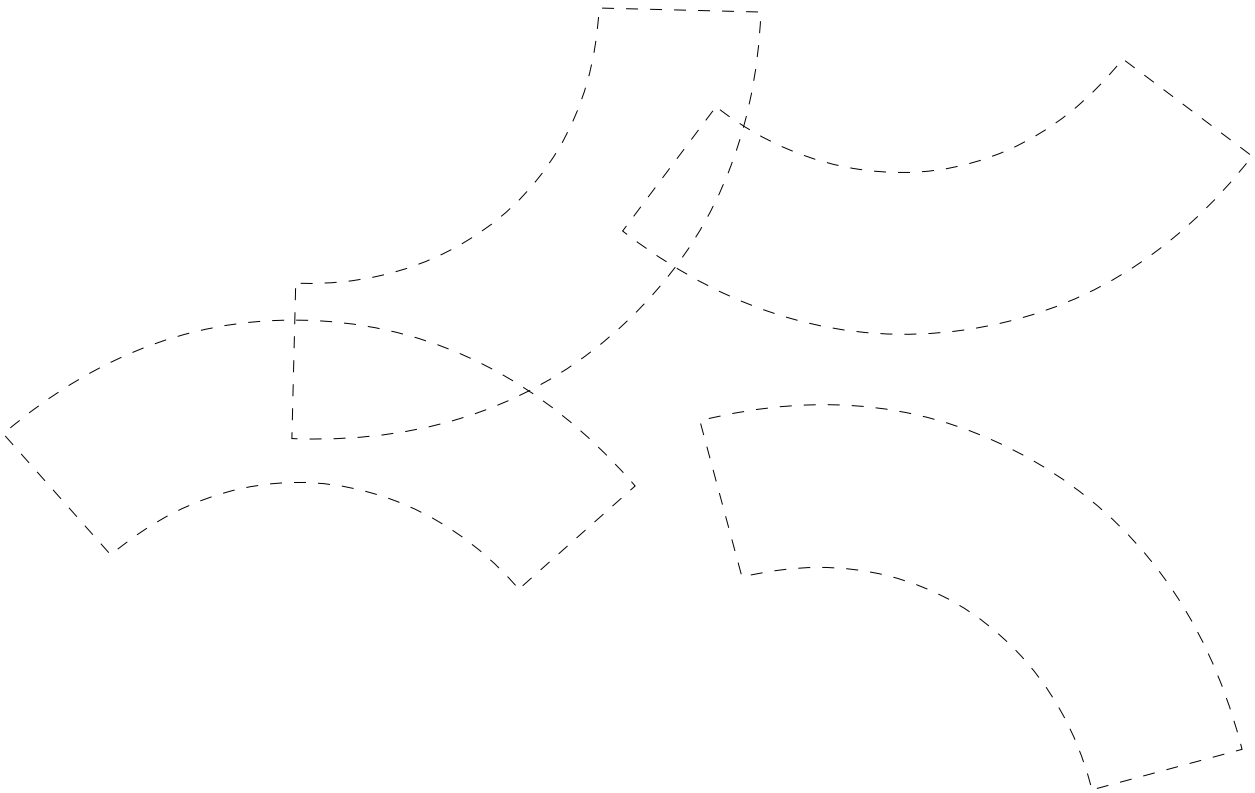
Lessons learned

A questionnaire may not be the best tool to report on new drug trends. Instead, each Focal Point should be tasked with organising focus groups several times a year and the collection of information from experts in the field as a potentially better way to achieve consensus-based data.

Even if a questionnaire continues to be used as the tool to monitor new drug trends, it is clear that the questions should be simplified, thereby taking into account the opinions of the expert group. In addition, it would be preferable to have a fewer number of questions.

You can assess the initial questionnaire at:

https://www.correlation-net.org/resource-center-publications/



Endnotes

1. These three thematic areas are priority areas for the C-EHRN work programme and also, more generally, within its current work programme.
2. Recent monitoring reports on HCV, overdose prevention and new drug trends by the EMCDDA, as well as other agencies, are listed in the corresponding sections of this report.
3. Harm Reduction International. Global State of Harm Reduction: 2019 updates. London, UK; Harm Reduction International, December 2019. https://www.hri.global/global-state-of-harm-reduction-2019
4. See the annexed questionnaire.
5. Altogether, 20 of the 34 focal points answered the evaluation survey.
6. Yearly review of persons who use drugs, https://www.hzjz.hr/wp-content/uploads/2018/11/Ovisni_2017.pdf
7. https://thl.fi/fi/tutkimus-ja-kehittaminen/tutkimukset-ja-hankkeet/kansallinen-huumausaineiden-seurantakeskus-reitox
8. Annual data releases on deaths related to drug poisoning and drug misuse deaths in England and Wales, https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsrelatedtodrugpoisoninginenglandandwales/2018registrations/pdf
9. Regional statistical overview of people who use drugs, http://www.zzjzpgz.hr/statistika/statistika2017/pdf/16.pdf
10. National Drug-Related Deaths Index - https://www.hrb.ie/data-collections-evidence/alcohol-and-drug-deaths/
11. The Special Register of mortality by the Central Directive for the Anti-drug Service for the Ministry of Home Affairs gathers OD data. They collect data of episodes where the Police Force were involved, based on circumstantial evidence (unequivocal signs of intoxication from psychotropic drugs). In addition, Mortality Registers at regional level are available.
12. Official drug-death report.
13. Bi-annual 'Drug Death Database Report' from Information Services Division Scotland provides a detailed overview of the personal circumstances surrounding the deaths from unidentifiable information collected at local level. https://www.nrscotland.gov.uk/files//statistics/drug-related-deaths/2018/drug-related-deaths-18-pub.pdf
14. According to EMCDDA, for technical reasons a reporting time lag for data from official national databases of at least 2 years is unavoidable at present. The timeline for data on drug-related deaths means that, at the national level, databases that contain the data are only consolidated - at the earliest - after the end of the year in which the deaths occurred. Thus, EMCDDA National Focal Points can only report them at the earliest in the Standard Tables and Workbooks of the year following the death. This leaves a short period for data checking, cleaning and analysis for the European Drug Report or other publications, resulting in a minimum of 2 years delay. More timely sources and methods are needed.
15. This is part of the definition for extracting data from Special Registries used by EMCDDA. More information is available at http://www.emcdda.europa.eu/topics/drug-related-deaths_en
16. Profiles at http://www.emcdda.europa.eu/countries_en, under 'Drug Harms'. Other resources on drug-related deaths are available at EMCDDA, such as EDR, ERG, and Stats Bulletin. The fact that respondents were not requested to consider those might have influenced their evaluation of the information.
17. Available at http://www.emcdda.europa.eu/data/stats2019/drd
18. Latvia did not answer this part of the survey.
19. GeOverdose, https://www.geoverdose.it/
20. https://docs.google.com/spreadsheets/d/10seRr2egRUP74xOBT6uVgQQRxxJRUcNia7ylUxk_vrY/edit#gid=0
21. https://mainline.nl/posts/show/12163/rapport-druggerelateerde-sterfte-in-nederland
22. https://www.trimbos.nl/docs/eebe7cf1-179d-407b-94d0-8a202d8ec296.pdf
23. Schatz E, Perez Gayo R, Raulet I (2019). Good practice examples of hepatitis C prevention, testing and treatment by harm reduction services in Europe. Correlation European Harm Reduction Network, Amsterdam. https://www.correlation-net.org/wp-content/uploads/2019/09/good-practice_-example_web.pdf; Schatz E, Perez Gayo R, Raulet I (2019). Hepatitis C interventions by organisations providing harm reduction services in Europe – analysis and examples. Correlation European Harm Reduction Network, Amsterdam. https://www.correlation-net.org/wp-content/uploads/2019/07/HepInterventions_FullReport_high.pdf; Farrell J, Schatz E (2019). Legal Barriers for

Providing HCV Community Testing in Europe. Briefing Paper. Correlation European Harm Reduction Network, Amsterdam. https://www.correlation-net.org/wp-content/uploads/2019/07/HCV-Testing-Barriers-Report_FINAL.pdf

24. http://www.emcdda.europa.eu/publications/topic-overviews/hepatitis-policy_en#panel7
25. There are National Health Fund guidelines for new drug treatment.
26. EASL guidelines include specific measures for PWID.
27. N/A = not applicable because there are no national guidelines.
28. Policy paper (in Finnish), https://www.julkari.fi/bitstream/handle/10024/138094/THL%20Ohjaus%204_2019_C-hepatiitin%20hoitopolku.pdf?sequence=1&isAllowed=y
29. https://www.intermedis.pl/pliki/2015_Program_lekowy_B_71_leczenie_pWZW_C_kuracja_bez_interferonu.pdf; a specialist working with Hep. C treatment in Krakow pointed to this document as the main medical guidelines, "Program lekowy B.71".
30. HCV treatment with DAA's is not available in North Macedonia.
31. GP's are not allowed to do HCV RNA (blood tests) in France; they are allowed to prescribe tests but not to do them by themselves.
32. Moradi, G., Goodarzi, E., & Khazaei, Z. (2018). Prevalence of Hepatitis B and C in prisons worldwide: A meta-analysis during the years 2005-2015. Biomedical Research and Therapy, 5(4), 2235-2251.
33. Harm reduction services were not listed as a response option in the questionnaire – this is a major oversight which needs to be corrected in the next round.
34. Regione Piemonte Harm Reduction LEA Working Group, https://www.fuoriluogo.it/oltrelacarta/lea-della-rdd-in-piemonte/#.Xacn0W5uJPZ; Regione Umbria, http://www.regione.umbria.it/documents/18/0/DGR+1439-2006+Linee+di+indirizzo+prevenzione+decessi+per+overdose/a89eb7d3-3e4a-4a65-9ebc-959fe5c96bdb
35. https://www.regjeringen.no/no/dokumenter/nasjonal-overdosestrategi-2019-2022/id2636987/
36. http://www.emcdda.europa.eu/publications/topic-overviews/take-home-naloxone_en
37. More information about findings from 2016/17 is available at https://www.release.org.uk/blog/take-home-naloxone-england . Release recently updated its naloxone research and identified additional barriers, such as the lack of clarity around who is responsible for commissioning THN in prisons (More information at https://www.release.org.uk/sites/default/files/pdf/publications/Release%20prison%20governance%20inquiry%20submission%2030.05.19.pdf); and the confusion around whether police officers can carry naloxone (more information at https://www.nat.org.uk/sites/default/files/publications/drug_related_deaths_in_england.pdf).
38. "Drug treatment services" includes a wide range of people that can supply naloxone without a prescription – further guidance on this is available at https://www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-theavailability-of-naloxone
39. According to the database at https://www.adc.sk/databazy/produkty/detail/naloxone-wzf-polfa-252872.html
40. Of the 152 local authorities (including the 3 local authorities that did not provide THN at the time of the survey): 3 did not provide THN kits to OST patients (or to anyone else in their area); 15 did not provide THN kits to clients of NSPs; 16 did not provide THN kits to family, friends, and/or carers of 'at risk' individuals; 13 did not provide THN kits to clients leaving community/residential/inpatient opioid detoxification; 38 did not provide THN kits to people in contact with outreach services for homeless populations; 88 did not provide THN to clients of community pharmacies. For more information, please refer to Release's naloxone report at https://www.release.org.uk/sites/default/files/pdf/publications/Finding%20a%20Needle%20in%20a%20Haystack_0.pdf
41. ITARDD (Italian HR Network and Forum Droghe with the collaboration of local CSOs and Public Sector Professional Organisations). Campaign Mai senza naloxone (Never without naloxone) https://maisenzanaloxone.fuoriluogo.it/
42. Government guidance has been issued since regulatory reforms were enacted permitting naloxone to be supplied without a prescription in certain circumstances; available at https://www.gov.uk/government/publications/widening-the-availability-of-naloxone/widening-the-availability-of-naloxone. Release's research on naloxone found insufficient coverage and limited accessibility and, as a follow-up, hosted a steering group in early April 2019 in partnership with the National Addiction Centre at King's College London. The aim of the steering group was to get key stakeholders togeth-

er for a day to discuss some of the main aspects of naloxone provision and to produce guidelines on the provision, and administration, of naloxone for people at risk of an opioid overdose and those likely to witness one. Guidelines coming from this meeting are expected in 2019. Government departments and other experts are informally considering whether to make naloxone an over-the-counter medication rather than its current status which is prescription only and which is exempt from prescription under certain circumstances.

43. SERAF center for drugs and addiction.
44. see: https://naloxoninfo.de
45. https://www.publico.pt/2018/06/07/sociedade/noticia/portugal-vai-distribuir-kits-antioverdose-as-equipas-de-rua-1833337
46. "We do not currently provide Naloxone in Bracknell Forest. Staff training is booked for w/c 12th October and once this has been completed, we will initially provide Naloxone to all of our prescribing clients." No such plans were outlined in the 2 other local authorities without THN; instead, their responses were as follows: North East Lincolnshire: "No – however, in 2017/18, we began running a pilot Naloxone scheme in partnership with local homeless accommodation providers that allows these providers to maintain a supply of Naloxone on the premises in case of emergency."; Darlington: "Take-home Naloxone (THN) isn't currently provided. It was not included in the contract with the current treatment provider."
47. https://drogriporter.hu/en/room-in-the-8th-district-campaign-report/
48. Calls to introduce a DCR in Glasgow have been supported by the Scottish Government, the Advisory Council on the Misuse of Drugs, and the Police and Crime Commissioners. More information is available at, https://www.nhsggc.org.uk/media/238302/nhsggc_health_needs_drug_injectors_full.pdf http://www.parliament.scot/parliamentarybusiness/report.aspx?r=11468&mode=pdf https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/576560/ACMD-Drug-Related-Deaths-Report-161212.pdfhttp://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-and-social-care-committee/drugs-policy/written/98260.pdf (Appendices). Central government (in London) continues to prevent efforts to implement a DCR in the UK by ignoring the evidence on the grounds of the law. See, https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2018-11-01/187139/
49. In addition to the existing DCR in Luxembourg City (CNDS Abrigado).
50. Médicos do Mundo, Norte Vida, Arrimo, SAOM), APDES (from Gaia) and CASO Association.
51. Decreto-lei 183/2001, de 21 de Junho. Available at: https://dre.tretas.org/dre/142253/decreto-lei-183-2001-de-21-de-junho
52. More information is available at, http://www.emcdda.europa.eu/attachements.cfm/att_231338_EN_NL03_DJI%20Richtlijn%20Med%20zorg%20gedetineerde%20verslaafden.pdf
53. See also, Shirley-Beavan S. The State of Harm Reduction in Western Europe. London, UK; Harm Reduction International, 2019. https://www.hri.global/files/2019/05/20/harm-reduction-western-europe-2018.pdf with a focus on Switzerland.
54. See, Rudolph S.S., et al. Prehospital treatment of opioid overdose in Copenhagen - Is it safe to discharge on-scene. Resuscitation 82 (2011) 1414–18. DOI: https://doi.org/10.1016/j.resuscitation.2011.06.027
55. Also stated that research would be needed to evaluate emergencies and hospitals who provide naloxone.
56. More information at, https://drogriporter.hu/en/the-ambulance-should-not-inform-the-police-in-overdose-cases/
57. Example available at, http://drogues.gencat.cat/ca/professionals/reduccio_de_danys/programes/sobredosi/materials/
58. Example available at, https://www.youtube.com/watch?v=Raq-bvW2x7g&feature=youtu.be Informational brochure http://aph.org.ua/wp-content/uploads/2016/08/peredozirovka_preview.pdf
59. Example available at, https://iotodeducation.com/resources-and-tools/case-studies/
60. Example available at, https://hops.org.mk/naloksonot-spasuva-zhivoti-analiza-na-pravnata-ramka-za-zgolemuvane-na-dostapnosta-na-naloksonot-pri-opijatno-predozirane-vo-republika-makedonija/
61. Example available at, http://www.initiativeforhealth.org/wp-content/uploads/2015/05/BOOK_overdose_24p.pdf
62. The website www.naloxone.fr aims to train users, their friends/family and professionals.

63. Example available at, https://english.mainline.nl/page/training-expertise and https://english.mainline.nl/page/webshop
64. Example available at, http://www.drugs.ie/features/feature/cocaine_campaign; http://www.drugs.ie/resources/naloxone/ ; http://www.aldp.ie/wp-content/uploads/2018/06/UseYourHeadv21.pdf; and, http://www.aldp.ie/resources/streettablets/
65. Example available at, https://issuu.com/magazynmnb/docs/mnb_r__b_to_bezpieczniiej_www, pages 58-65.
66. Provided routinely every three months during their specialisation period at the main Hospital, Toxicology Department.
67. All local participants in the save life project have local instructions; MD's have general instruction on how to prescribe.
68. Deutsche AIDs Hilfe provided 4 workshops for PWUD and staff in 2019; Akzept produced a brochure.
69. Included in any training and professional updating in the drug field.
70. National campaign Mai senza naloxone, https://maisenzanaloxone.fuoriluogo.it/
71. Continuous education of the ambulance and fire brigade staff with the DCR (CNDS-Abrigado).
72. Juventas has an OD awareness campaign; for 2019, they will release a documentary on OD in Montenegro.
73. Undertaken by Mainline or EHBO (first aid training). In the Netherlands, first aid training is widely available and it naturally includes response to OD (heart massage and artificial resuscitation). Every company which employs more than 15 people has to have personnel trained in first aid. Also, every fireman, swimming instructor, teacher, police officer, train driver, bus driver, etc., is provided with first aid training and many sportsmen and private citizens are strongly advised to follow such a course. Addiction treatment services offer EHBDU (first aid for alcohol and drug incidents) training to bar and nightlife personnel. Medical staff in hospitals, security guards and police officers are trained on how to deal with people under the influence or overdosing.
74. APDES disseminates information and advocates for OD prevention measures on International OD Awareness Day. In the "Support Don't Punish" Campaign, they advocate for FREE and available naloxone for PWUD. This is an important moment for information dissemination in the general community.
75. The NAA recently organised a training session on OD.
76. Most often in the framework of overdose awareness day, but also through different activities during the year.
77. More information at, http://drogues.gencat.cat/ca/professionals/reduccio_de_danys/programes/sobredosi/materials/
78. Training programmes (first aid) for employees in harm reduction organisations are an integral part of services. Examples at, https://www.infodrog.ch/files/content/materialien_de/broschuere_umsicht.vorsicht.pdf; https://www.praxis-suchtmedizin.ch/praxis-suchtmedizin/index.php/de/heroin/opioi-dueberdosierung-opioidintoxikation
79. Brochure,https://www.opensocietfoundations.org/uploads/4c28eeca-38e1-48a6-867c-270599597266/overdoserus_20090604_0.pdf
80. Educational video, https://www.youtube.com/watch?v=Raq-bvW2x7g&feature=youtu.be
81. Release is mostly aware of advocacy around naloxone, such as IOTOD's THN toolkit, EuroNPUD's Naloxone Access and Advocacy Project, and ongoing campaign work by the Naloxone Action Group, the English Harm Reduction Group and the Scottish Drugs Forum.
82. Plans to begin testing.
83. http://gaymenshealthcollective.co.uk/chem-sex-booklet/
84. In Ireland, for instance, http://www.drugs.ie/. Examples include a GHB Campaign, http://www.drugs.ie/ghb_campaign1/
85. http://www.emcdda.europa.eu/edr2019_en
86. Note: in the questionnaire, the same question was repeated separately for city, region and nation, but for this table it has been combined.

Correlation
European
Harm Reduction
Network