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# OVERDOSE PREVENTION SERVICES UPON RELEASE FROM PRISON

BEST PRACTICES FROM SCOTLAND,  
DENMARK, ITALY AND SPAIN

 **Fact Sheet**



# Eurasian Harm Reduction Network

The Eurasian Harm Reduction Network (EHRN) is a regional network of harm reduction programmes, groups of people who use drugs and their allies from across 29 countries of Central and Eastern Europe and Central Asia (CEECA) who work to advocate for the universal human rights of people who use drugs in order to protect their lives and health. EHRN's mission it is to promote humane, evidence-based harm reduction approaches to drug use, with the aim of improving health and well-being, while protecting human rights at the individual, community and societal level.

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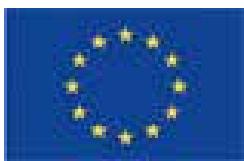
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# ABBREVIATIONS

<b>EMCDDA</b>	<b>European Monitoring Centre for Drugs and Drug Addiction</b>
<b>EHRN</b>	<b>Eurasian Harm Reduction Network</b>
<b>EU</b>	<b>European Union</b>
<b>IEC</b>	<b>Information, Education &amp; Communication</b>
<b>NSP</b>	<b>Needle &amp; Syringe Programme</b>
<b>OST</b>	<b>Opioid Substitution Treatment</b>
<b>THN</b>	<b>Take-Home Naloxone</b>
<b>UNODC</b>	<b>United Nations Office on Drugs and Crime</b>
<b>UK</b>	<b>United Kingdom</b>
<b>WHO</b>	<b>World Health Organization</b>

## EXECUTIVE SUMMARY

It is widely acknowledged among European Union policymakers that there is a demand to improve the range and quality of health and social care services for prisoner populations and, most notably, for marginalized and at-risk groups vulnerable to drug-related harms. This includes reducing the high rates of overdose among those who use opioids.

People who inject opioid drugs are at particular risk of overdose following release from prison. However, overdose-related deaths are preventable, and continued efforts are needed to improve continuity of care for prisoners, while systematically implementing recommended approaches that are shown to reduce drug-related deaths. This should comprise opiate substitution treatment and overdose prevention programmes which incorporate naloxone distribution as a routine intervention at the point of release from prison for people who inject drugs.

Progress has been made in some European countries, although significant gaps between prison and community-based services still exist, in terms of both coverage and quality of health services available to prisoners. Over the last decade, prison healthcare has increasingly been recognized as part of public healthcare, and changes have been made as to who takes responsibility for this, alongside specific drug and health strategies or regulations for the prison setting. While European Prison Rules specify that prisoners should be offered a medical examination as close as possible to the time of release, this type of routine 'exit' health examination does not seem to be common in Europe.

There is a strong argument to suggest that any successful approach to improving prison health in the future must recognize the importance of including harm reduction and drug treatment services which are integrated with mental healthcare and other relevant services. This requires a significant scale-up of services within prisons, a functioning throughcare mechanism and substantial efforts to improve this liaison and continuity of treatment.

A number of interventions targeting opioid users have been recommended to reduce the risk of a fatal overdose in the period shortly after release from prison. They include pre-release counselling on overdose risks and prevention, along with training in first aid and overdose management – again optimizing referral to maintain solid links between prisons and community-based services.

Naloxone is provided on release from prison across the Scottish prison system but is not widely reported in other European countries, including those studied in this report (Estonia, Hungary, Lithuania, Poland and Romania). There are some examples of good practice, and these successful schemes should be reflected in the development of new overdose prevention and management programmes across Europe. Thus, the distribution of naloxone among opioid users leaving prison should continue to be promoted and lobbied for until there is more widespread access to life-saving measures such as take-home naloxone.

To summarize, it is essential to close the gap between the prisons and community to ensure an equivalence of evidence-based treatment and care which includes comprehensive cover of overdose prevention and management programmes, as well as opiate substitution treatment.

# INTRODUCTION AND TERMS OF REFERENCE

In 2013 a two-year project: 'Quality and Continuity of Care for Drug Users in Prisons' (CARE) funded by the European Commission was launched by the Fachhochschule Frankfurt am Main – University of Applied Sciences. As one of the implementing partners, Eurasian Harm Reduction Network (EHRN) was responsible for the implementation of 'Workstream 3', which focuses on continuity of care and overdose prevention for prisoners upon release.

This 'Fact Sheet' reports on good practice models in four European Union (EU) countries – Scotland, Denmark, Italy and Spain (more specifically, the Catalonia region) – on overdose prevention and management programmes upon release from prison. The main findings are concluded with recommendations made regarding their relevance to the five target countries of the project: Estonia, Hungary, Lithuania, Poland and Romania.

Information gathered includes programme descriptions; evidence of effectiveness; functioning; and involvement of people who use drugs. The methodology for collection and documentation of good practices is based on reports and guidance from leading organizations in the field such as the World Health Organization, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) etc. This fact sheet is of particular relevance to prison staff, health care professionals and people who use drugs.

A separate, complementary mapping report describing the situation in the target countries (Estonia, Hungary, Lithuania, Poland and Romania) regarding overdose prevention services upon release from prisons was also produced within Workstream 3: 'Overdose prevention services upon release from prison: Estonia, Lithuania, Hungary, Poland and Romania'.

## Methodology

The following set of data collection methods was agreed by the consultant(s) and EHRN:

- a) **Consultant(s) reviewed** (in consultation with EHRN) **EHRN methodologies of previous mapping** exercises and determined whether they could be adapted to this work.
- b) **Desk review** of literature and documents: the consultant(s) conducted a desk review of existing publications, documents and other materials that relate to the project topics and deliverables, as outlined above.
- c) **The consultant(s)**, with support from EHRN, **consulted with partners of the CARE project** as an information resource, and sought advice from them on relevant documents and organizations at the national level.
- d) **Interviews** (by telephone and skype) were carried out with key individuals and organizations in the target countries, to gather information about existing programmes and best practices.
- e) **Templates and structures** for mapping deliverables were suggested by the consultant(s), then discussed and approved with EHRN.

## **DATA LIMITATIONS – A NEED FOR COMMON STANDARDS**

Various EMCDDA reports, including the Country Data Sheet and Situation Summary, inform much of the content of the country profiles in this report. Up until 2012, the EMCDDA defined 'problem drug use' as injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines.

Data regarding prison populations were obtained from the SPACE I 2011 Report, which is part of the SPACE project. The first part of the project (SPACE I) provides a global overview on the populations detained in penal institutions across Europe (Aebi and Delgrande, 2013).

The Drugs and Prisons in Europe Report (EMCDDA, 2012a) states that available data on drug use and prison responses have a number of methodological limitations, relating to both the nature of the subject (i.e. drug use and prison) and the lack of standardization in data collection tools within and between countries. The report demonstrates that prison healthcare delivery varies significantly between countries and that a number of serious shortcomings remain. In many cases, the monitoring and evaluation of drug-related health services are rare and do not follow the same standards, while at the European level there is a lack of harmonization of data collection. This makes it difficult to draw comparisons and limits the possibility of presenting a complete picture and objective assessment of the need for drug-related health responses in prisons, including overdose prevention and management interventions.

Furthermore, figures on drug-related deaths can be difficult to interpret due to the limitations of some monitoring systems. Unfortunately, some countries show a low detection rate of overdose in the general mortality registries, with a significant proportion of deaths recorded as 'unknown' or with a non-specific cause (e.g. respiratory failure) and which may be a result of overdose (EMCDDA, 2012b). There have been fluctuating trends in drug-related deaths in some countries, so it is difficult to establish whether preventative measures have had any impact.

Under the last EU Drugs Action Plan, which ended in 2012, Member States were called on to endorse indicators to monitor drug use, drug-related health problems and drug services in prison on the basis of a methodological framework (European Commission, 2008). As a complement to the healthcare-related recommendations of the European Prison Rules, an EU monitoring framework of drug-related prison healthcare would address national drug-related prison health policies, data collection and monitoring infrastructures as well as quality standards and guidelines for drug-related services and interventions in prisons. A corresponding set of indicators on service needs (i.e. drug use, risk behaviours, health consequences) and service provision will facilitate compilation of objective, reliable and comparable data on drug-related prison healthcare in Europe. This acknowledges the need for common standards.

## **ADDITIONAL CONSTRAINTS OF THE CARE PROJECT METHODOLOGY**

One of the biggest difficulties encountered is related to translations. Many of the documents to be reviewed are in the national languages of the focus countries, and in some cases translation of literature was required (Denmark, Estonia, Italy, Poland and Spain). No budget was allocated for this, so a combination of Google Translate alongside support and guidance from national contacts was used.

In addition to this, just one or two people were identified from each of the countries to survey and interview. In Denmark, identifying a contact person took longer than planned, and



arranging interviews in some countries took up to five weeks after initial contact was made.

Moreover, the interview in Italy was compromised because the interviewee had a limited understanding of English, and identifying alternative English-speaking contacts had been unsuccessful. This lack of capacity to translate interviews and resources affected data collection.

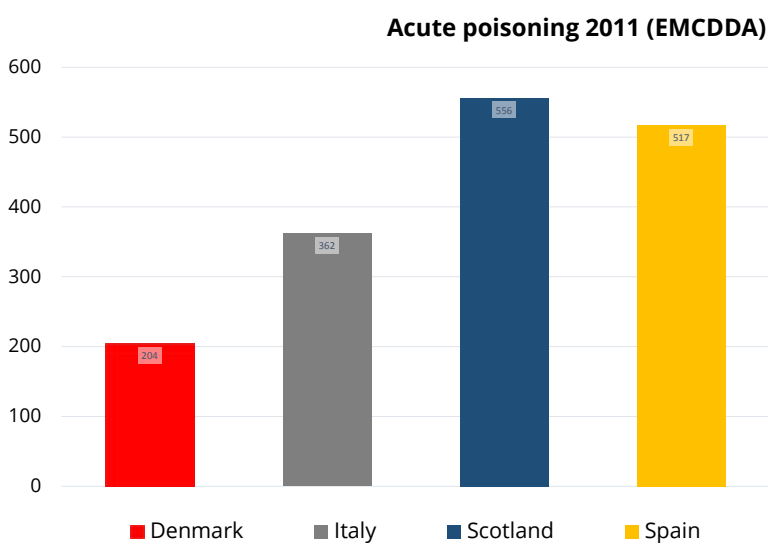
Access to Spanish contacts and data was difficult too, and we have been unable to obtain a response from Spanish national programme representatives, although additional support was gained from the Public Health Agency for Catalonia; therefore, much of the section regarding Spain refers to the situation in Catalonia.

Furthermore, the time span planned for the activities was not sufficient: a vast amount of information relevant to the assessment was identified; however, due to the lack of time, not all of it could be reviewed and included. This was addressed by clearly defining tasks and limiting the assessment to respond to what has been described in the project.

Finally, some of the information provided by interviewees differed from data gained elsewhere and when cross-referencing reports, so there are discrepancies between some of the data.

# DRUG-RELATED DEATHS

Drug-related deaths are a major cause of mortality in Europe, particularly among people aged between 15 and 49. One study found that between 10% and 23% of drug-related deaths in this age group could be attributed to opioid use (Bargagli, Hickman et al., 2006). In 2006 the UK and Germany accounted for half of all reported deaths (EMCDDA, 2009). As the two charts below show, indicators of overdose highlight the large number of people whose death is due to overdose and the proportion of all deaths these comprise.

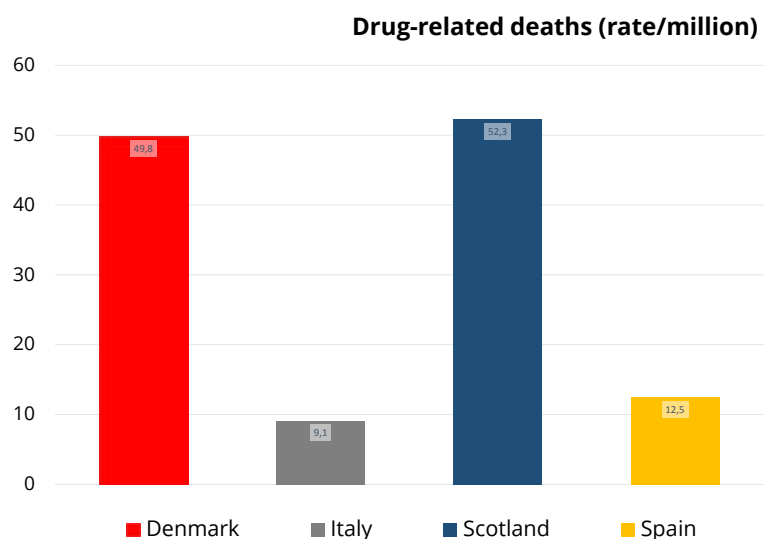


Release from prison is associated with an increased risk of dying from drug overdose due to high rates of relapse and lower opioid tolerance. This risk does not appear to have decreased in the last 20 years (WHO, 2010).

Over the last decade, Europe has seen an increase in its prison population. People who use drugs comprise a large proportion of the overall prison population, with studies showing that a majority of prisoners have used illicit drugs at some point in their life and many have chronic drug use patterns. Prisoners differ greatly from the

general population in their reported experience of heroin use. Less than 1% of the general population have ever used heroin, whereas lifetime prevalence among European prisoners is much higher.

A review of drug-related deaths occurring within 12 weeks after release (in Europe, Australia and the USA) indicated that 60% of deaths were drug-related (Merrall, Kariminia et al., 2010). A study in England and Wales also produced the same results and also reported that, during the first week after release, female prisoners were 69 times more likely to die of drug-related causes, and male prisoners 28 times more likely (Farrell and Marsden, 2008), than the general population of the same age and gender.



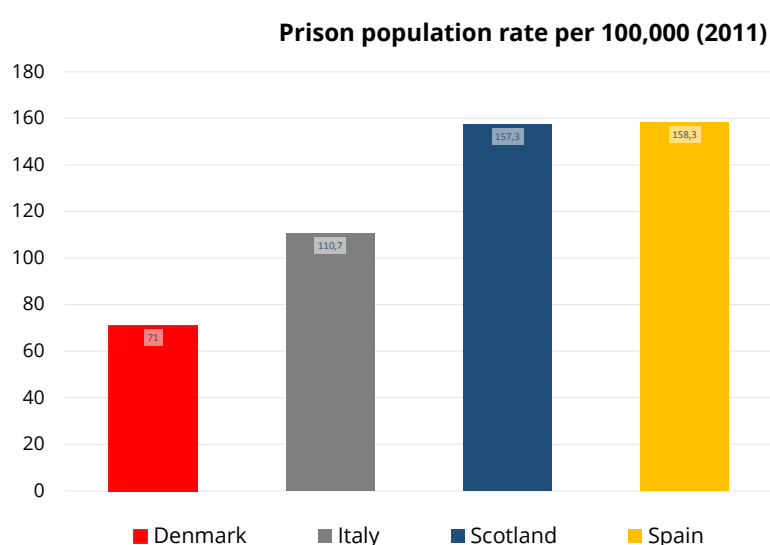
Clearly, this is a critical time for action – ensuring continuity of care and targeted overdose interventions which support swift access

to community-based treatment services while ostensibly saving lives. It is, therefore, vital that there is cooperation between services inside prisons and health and social care services outside, to ensure support and a seamless transition into community treatment.

The term 'throughcare' refers to arrangements for managing the continuity of care before, during and immediately after custody. Within some prisons, pre-release units have been established to facilitate such referrals and to allow opportunities for improved engagement.

A systematic review of the effectiveness of opioid maintenance treatment in prison (Hedrich, Alves et al., 2012) analysed data from 21 studies, including six experimental studies. The review highlights the importance of establishing an effective liaison system between prison and community-based programmes, to achieve continuity of treatment (throughcare) and longer-term benefits. This applies to making naloxone available both within prisons and outside in the community.

Prison populations have additional vulnerabilities, often having complex (frequently unmet) needs. All evidence points to the fact that, compared with the general population, prisoners (and particularly people who use drugs) are extremely disadvantaged and marginalized. Many prisoners have limited education and low socio-economic status; poverty, violence and crime are common features in many of these people's lives. Similarly, women prisoners (while only accounting for a minority of prisoners) have challenging health and social care needs. The tables below highlight variations in the extent to which imprisonment is used within each country's criminal justice system and the extent to which sentencing directly relates to drug offences.



Surveys on prison health cite elevated levels of physical and mental health problems among prisoners per se. Indeed, they often suffer from multiple mental health problems and co-morbidities coupled with chronic (often problematic) drug use (dual diagnosis). Thus, these prisoners require specialized services to treat both their drug use and health problems; cooperative links with external services to enable effective throughcare are fundamental.

In a majority of countries, newly sentenced prisoners are routinely assessed for drug use and drug-related problems. Procedures other than urine testing (to detect use of illicit substances) are reported in 16 countries. The common approach is a clinical assessment carried out by a medical doctor, psychiatrist or psychologist to ascertain a diagnosis of drug dependence and mental health problems. In some countries, standardized tests, questionnaires and interviews are used for this purpose.

Prisoners have been recognized as a vulnerable population, and responding to the drug-related healthcare needs of prisoners has been identified as a public health priority by the EU and its Member States. This is evident in the EU Drugs Action Plan 2009–2012, which sets the objective of providing drug users in prison with improved access to healthcare, to prevent and reduce health-related harms associated with drug dependence (European Commission, 2008).

As a general principle, prisoners are entitled to the same level of medical care as people

living in the community, and prison health services should be able to provide drug-related treatment and care in conditions comparable to those experienced by people who use drugs outside. Equally, pre-release measures are essential for those who use or have used drugs.

In the majority of European countries, drug treatment in prisons is provided by staff employed by the prison administration. However, in some countries, it is also common for prison administrations to collaborate with a range of community-based providers, public health services or non-governmental organizations (NGOs) to deliver drug treatment services to those in detention. Collaboration can entail bringing in personnel from public services to work alongside prison staff or having external providers 'reach in' and work independently inside prison.

In 2004, in response to concerns about increasing prison populations, the European Parliament adopted a recommendation on the rights of prisoners in the EU which includes the treatment of drug users in prison and reduction of health-related harm (European Union, 2004). Growing importance is now being attached to ensuring common minimum prison standards across the EU Member States and the exchange of best practices.

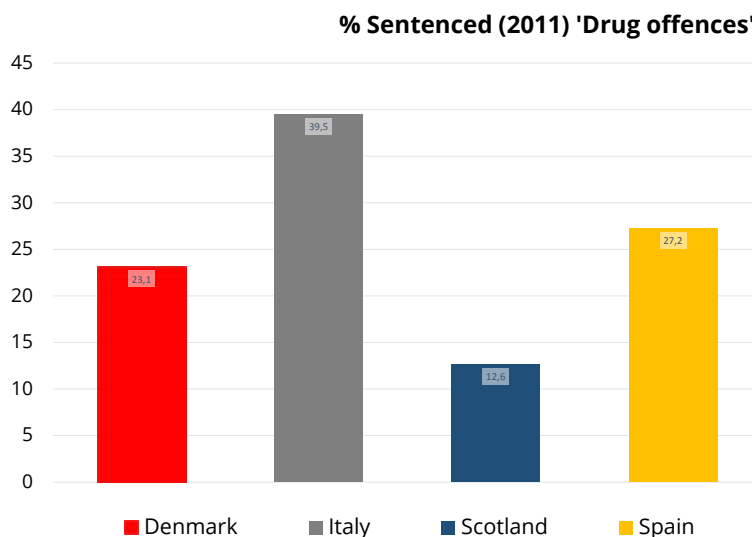
Most social care and rehabilitation strategies and procedures for those leaving prison are directed at the general prisoner population. However, a number of interventions targeting opioid users have been recommended to reduce the risk of fatal overdose in the period shortly following release from prison. They include pre-release counselling on overdose risks and training in first aid and overdose management; optimizing referral to achieve continuity of drug treatment between prison and the community (throughcare); and the distribution of naloxone among opioid users leaving prison.

Reliable data about the availability of pre-release measures are scarce. However, provision of naloxone on release from prison is available across Scotland (and Wales) but is not currently reported from other countries.

Scotland, undoubtedly, has the most developed (national) overdose prevention and management programme in Europe, including take-home naloxone (THN), and its models of delivery should be referred to for best practice examples.

Needle and syringe programmes (NSPs) existed in prisons in five EU Member States (Germany, Luxembourg, Portugal, Romania and Spain), although varying levels of provision are reported. Indeed, uptake of the programme in Romania was very low (only 83 prisoners participated in the programmes established in 10 prisons), and it is important to note that these prison NSPs were discontinued in 2013 due to a lack of demand, with expiry of the needles and syringes. Nonetheless, HIV infection continues to rise among this prison population and remains a serious concern.

Although the introduction of NSPs in prisons is recommended by international organizations (UNODC, 2012), and expert groups in several European countries have considered the measure (e.g. Austria, France, Hungary, Norway and the UK), they face strong opposition, since NSPs are



perceived as being contradictory to the goal of a drug-free prison. However, several countries do provide disinfectants as an alternative.

It is relatively straightforward to propose recommendations that potentially prevent overdoses. Yet, it is clear that there are barriers at several levels: first, for people who use drugs; second, for witnesses; third, for service providers; and fourth, for policymakers/national stakeholders.

Without understanding the dynamics of these groups, the impact of recommendations is likely to be limited. This also entails addressing issues around stigma and discrimination, since the attitudes of professionals and how organizations respond to people who use drugs and overdose situations is of critical importance in terms of access and engagement.

Equally, those who may not be familiar with drug use and injecting techniques (witnesses such as family members or carers) need the confidence to act appropriately in an emergency situation, and the tools to be able to do so. Intranasal administration of naloxone may be a preferred means of reversing overdose in some situations.

Proactive commitment is required from service providers, policymakers and national stakeholders, alongside a willingness to develop such a programme by front-line staff.

Service providers should consult with people who use drugs and endeavour to understand the circumstances and locations in which overdoses arise, so that they can make informed proposals and advocate more successfully by involving those who are affected.

“ Notley et al. (2012) identify a number of barriers (to treatment generally) which were grouped under three main headings: system barriers; social barriers; and personal and interpersonal barriers.

- System barriers included, among other things, poor communication between services.
- The main social barrier was stigma, particularly among certain communities.
- Personal and interpersonal barriers (identified within this research) include a perceived lack of choice and personal control.

All these factors can, perhaps, be applied to the key considerations required for assessing the need, planning, implementation and the continued development of successful overdose prevention and management (naloxone) programmes. ”

## COUNTRY OVERVIEW: SCOTLAND

The overall picture of drugs distribution in the UK appears increasingly complex and diverse. Many traffickers import and distribute more than one type of drug. The main source of heroin in Scotland is from the north-west of England via the Glasgow area. Almost all the heroin in the UK originates from Afghan opium. In 2011 a significant amount of the heroin seized at the borders had been trafficked directly from Pakistan via parcels, air freight, air courier or maritime containers.

In 2011 there were 152,406 convictions or cautions for drug offences in the UK, which is an increase from 2009 (147,013) and a similar level to 2010 (152,451). Of these offences (where a drug was known), 9.8% were related to heroin. As of 1 September 2011 there were 842 people serving sentences for primary drug offences in Scotland.

In general, the quantity of drug seizures has been decreasing, and in recent years the number of heroin seizures has declined, with the lowest number (9150) reported in 2011. In 2010 the quantity of heroin seized was the lowest amount since 1995 (832 kg), but in 2011 the quantity seized increased to 1849 kg. Data for Scotland were available in 2010 for the first time since 2006. The Misuse of Drugs Act 1971, with amendments, is the main law regulating drug control in the UK. It divides controlled substances into three classes (A, B, C) based on harm, with Class A being the most harmful. These classes provide a basis for attributing penalties for offences.

Drug use per se is not an offence under the Misuse of Drugs Act; it is the possession of the drug that constitutes an offence. Convictions for the unlawful possession of Class A drugs such as heroin (or cocaine) involve penalties of up to six months' imprisonment or a fine; on indictment, penalties may reach seven years' imprisonment.

Under the Misuse of Drugs Act, a distinction is made between the possession of controlled drugs, and possession with intent to supply to another; the latter is for drug trafficking offences which are defined as transporting or storing, importing or exporting, manufacturing or supplying drugs covered by the Act. The penalties applied depend on the classification of the drug and on the penal procedure. For trafficking Class A drugs, the maximum penalty on indictment is life imprisonment. In 2000 a minimum sentence of seven years was introduced for a third conviction for trafficking in Class A drugs.

Access to effective treatment is a priority of the UK drug strategies, and treatment capacity has increased substantially, although it could still be improved. The Treatment Demand Indicator (TDI) data on numbers presenting to treatment are from four separate systems in the UK. In Scotland such data are monitored via the Scottish Drug Misuse Database.

In accordance with the Scottish Drugs Strategy (Scottish Government, 2008), people who use drugs are offered a range of treatments including opiate substitution treatment (OST), residential and community rehabilitation, community detoxification and psychosocial/motivational interventions. Between April and June 2012, 90% of people gained access to specialist treatment within three weeks.

Despite this priority, there has been a drop in the number of prescriptions for OST (including

methadone) in Scotland over the last couple of years. Prior to this there had been year-on-year increases from 2003/04 until 2010/11. The number of prescriptions for Suboxone (Buprenorphine and Naloxone) has been rising each year since 2007/08.

Information on acute deaths in the UK is provided by three General Mortality Registers (England/Wales, Scotland and Northern Ireland) and one Special Mortality Register. The latest data are for 2011, and reporting is based on three different definitions: the EMCDDA definition refers to death caused directly by the consumption of at least one illegal drug; while the Drug Misuse Definition developed for the UK Drug Strategy measures cases of death where the underlying cause is drug use, drug dependence or poisoning where any of the substances scheduled under the Misuse of Drugs Act are involved; and the third definition, used by the Office for National Statistics (ONS), is much wider than previous definitions and also includes death as a result of legal prescription drugs.

The EMCDDA Country Summary predominantly cites data which refer to the whole of the UK; therefore, it is not particularly helpful in providing a detailed overview of the situation in Scotland. However, based on the EMCDDA definition, the number of drug-related deaths in the UK rose steadily from 1996 to 2001, fell from 2001 to 2003, increased in 2008, and fell to 1930 in 2010. In 2011 the number of deaths continued a downward trend to 1785. Based on the Drug Misuse Definition, the number of drug-related deaths in the UK had the same pattern, but the total number of cases was higher. In 2008 a total of 2569 cases were recorded, while in 2009 the number dropped to 2481 and continued to fall to 2250 in 2011. Opiates were mentioned on the death certificate in around 86% of these cases.

In the UK (2011) males accounted for 1323 deaths (74.1%) and females for 462 deaths (25.9%), using the EMCDDA definition and data. In Scotland males accounted for 72.7% of deaths. The number of deaths among males in the UK decreased by 13.6% between 2010 and 2011, while the number of deaths among females increased by 16.1%. Drug-related deaths among women increased in each of the UK jurisdictions between 2010 and 2011 – by 23.6% in Scotland (to 152).

Across the UK the biggest increase was among women aged over 50 years old. This was an increase of 54% among those aged between 50 and 54 years old (n = 43); by 150% among those aged 54–59 years old (n = 40); and by 40% among those aged 60–64 years old (n = 21). The average age of death was 39.4 years for men – around five years younger than women at 44.8 years. The average age of death increased from 31.5 years in 1996. Overall, most deaths in the UK (2011) occurred in those aged 35–39, although deaths among this age group decreased by 13.9% from the previous year. Since 2008, when drug-related deaths were at their peak, deaths decreased for all age groups apart from the older age groups aged 50–59 years old and over 60 years old.

As has been the case for the last 10 years, most deaths in the UK continue to be linked with the use of opiates, primarily heroin/morphine (n = 820) and methadone (n = 765). However, between 2010 and 2011 there was a 23% decrease in the number of mentions of heroin/morphine on death certificates and a 52% increase in mentions of methadone in the UK.

In Scotland the number of deaths mentioning methadone was higher than the number mentioning heroin for the first time since 1997. This may be a result of the reduced supply of heroin reported in late 2010 and early 2011. In addition to this, data from the Scottish National Drug-Related Deaths Database (SNDRDD) for 2010 (Graham, Stoner et al., 2012) showed that, of the 162 deaths with methadone detected, 53% (n = 86) were not receiving OST at the time of their death.

Deaths involving tramadol increased by 11% between 2010 and 2011 and are mentioned in

four times the number of deaths as in 2003. Alcohol was implicated with one or more drugs in 29% of deaths (Davies, English et al., 2012).

DRUG-RELATED DEATHS IN THE UK					
<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>		<b>Gender:</b> 73.9% male
<b>2250</b>	1930	2481	2569	<b>UK</b>	<b>Mean age:</b> 40.8 years
<b>584</b>	485	545	574	<b>SCOTLAND</b>	<b>Source:</b> National Records of Scotland

The rate of drug-related deaths in Scotland remains higher than the UK average, with 10.58 drug-related deaths per 100,000 population in Scotland in 2011, compared with 2.83 in the UK.

An earlier investigation into drug-related deaths in Scotland and more recent information from the SNDRDD have shown that the majority of these deaths are opioid-related, the majority are 'accidental overdoses', the majority are 'witnessed', and around half of those people have spent time in prison (Zador, Kidd et al., 2005; Graham, Stoner et al., 2012; Hoolachan, Hecht et al., 2013).

## OVERDOSE PREVENTION AND MANAGEMENT PROGRAMMES

In Scotland 'The Road to Recovery' (National Drug Strategy) has been in place since 2008. It recommended offering a range of services, including alerting drug users to the dangers of lower tolerance, as a way to help prevent drug-related deaths. The strategy also highlighted the role that general practitioners (primary healthcare providers) could play in recognizing risk and where there may be a potential fatality. Crucially, the document identified the need to give people the confidence to know when to intervene – what to look for and do – as key to helping bring about a reversal in the overdose trend. Central to this, the strategy recommended adequate training and provision of relevant information to staff and service users, family and friends, which may also bring about improvements over time.

One of the major ways the strategy's vision was implemented was through a National Naloxone Programme ('the National Programme'). This was the first programme of its kind internationally, being centrally coordinated and funded by the Scottish government, aiming to reach all those at risk of opioid overdose, including those in prison.

The aim of the National Programme is to contribute to a reduction in fatal opioid overdoses in Scotland, which has a higher prevalence than the UK average. It has also been recognized that there is an increased risk of overdose during the first few weeks after release from prison and following discharge from hospital or detoxification and rehabilitation centres.

Pilot naloxone programmes were conducted in 2006–2007 and 2009. The National Programme launched late in 2010 and commenced in 2011. To date, 13 out of 14 Local Health Boards have opted in to the National Programme, although there are some regional variations with regard to delivery models.

Having this national infrastructure, collaborative commitment and integration is considered critical to the evolving success of such a programme. The National Programme in Scotland has been developing over the last three and a half years, and its successful delivery depends on both multi-disciplinary professionals and trained peers from communities of people who use drugs.

This peer education approach has extended to the prison programme and now involves peers in providing overdose prevention and management training (via a 'brief interventions' model)



to other prisoners who have a history of opioid use.

The supply of THN kits by prisons was introduced, incrementally, from February 2011. By June 2011 all Scottish prisons were taking part in the programme, and approximately 100 prison staff participated in training during the introduction and implementation phase. The model for delivery was based on supplying naloxone on release to those who are identified as being 'at risk' (i.e. an opiate user/person in receipt of OST) on admission or while in prison. A nurse ensures that the naloxone is placed with the prisoners' personal belongings, which are stored at reception, then given to them on release from custody.

In one open prison, naloxone kits may be issued for home leave as well as on release. Prison distribution varies across the 16 prisons that currently facilitate it, and there may be slight differences in the delivery of the programme in each establishment. Eight prisons increased the number of THN kits they issued between 2011/12 and 2012/13, while for seven prisons the numbers of kits distributed decreased.

The development of peer involvement in prisons progressed recently with six prison peers having been trained as part of the National Programme peer training initiative in Edinburgh Prison (late 2013). Since then, a further five prisoners have been trained as a result of this initiative, so a total of 11 prison peers have now been trained. This builds on an existing peer involvement scheme which has been operating in Inverness Prison for the past year or so. There has also been success with other harm reduction policies (to reduce Hepatitis C transmission) in Scottish prisons, which should support confidence in current developments to scale up the naloxone programme within prisons.

On 1 November 2011, responsibility and accountability for the provision of healthcare services to prisoners transferred from the Scottish Prison Service to the National Health Service. These services, including the provision of naloxone, are now provided by the respective Local Health Boards.

The National Programme is also aiming to develop naloxone distribution within general practices (primary healthcare centres) over the next 12 months. The second report from the SNDRDD indicated that, of 365 drug-related deaths, over half of those individuals had been in contact with either a general practitioner or drugs service at least 12 weeks before their death. This is, therefore, a missed opportunity and has the advantage of attracting some of those being released from prison.

All of these interventions have the potential to make a significant impact on Scottish drug-related deaths after release from prison, if the roll-out of these programmes and uptake are successful. An independent process evaluation of the National Programme is currently underway, and this will include evaluation of prison interventions.

The National Programme in Scotland is recognized as a model of good practice and is also supported by a national practitioner network and advisory groups.

## EFFECTIVENESS AND BENEFITS

<b>Number of naloxone peer networks</b>	8	<i>This number includes prison peer networks</i>
<b>Number of community peer trainers</b>	67	<i>Some drop out, but many are still active</i>
<b>Number of community take-home naloxone (THN) kits issued (2012/13)</b>	3833	10.8% increase on previous year 80% First supply 18.1% Repeat supplies 1.8% Unknown
<b>Number of community THN kits issued (2011/12)</b>	3458	83.8% First supply 12.8% Repeat supplies 3.5% Unknown
<b>Gender distribution for 2012/13</b>	65.2%	Male
	34%	Female
	0.8%	Unknown
<b>Age distribution for 2012/13</b>	8.5%	Under 25
	42.8%	Aged 25–34 years
	47.8%	Aged 35 and over
<b>Percentage of people who inject drugs supplied with naloxone (2012/13)</b>	20%	86.8% = 2680 kits to people at risk of overdoses 10.7% = 329 kits supplied to service workers 2.5% = 78 to family/friends – consent gained
<b>Number of overdose reversals (2 years)</b>	365	<i>Under-reported incidences of overdose reversals</i>
<b>Number of prison overdose programmes</b>	16	<i>All prisons providing programme slightly differently</i>
<b>Number of prison THN kits issued</b>	746	(2012/13)
	715	(2011/12)
<b>Prison gender distribution for 2012/13</b>	76.6%	Male
	23.1%	Female
	0.3%	Unknown
The 23.1% of kits supplied to women in prison points to a higher uptake of kits than among male prisoners. Women represent less than 6% of the total prison population.		
<b>Age distribution for 2012/13</b> Age profile of prison recipients is younger than community recipients. However, Scottish prison data shows that age profile of prisoners is also relatively younger.	20.1%	Under 25
	44.5%	Aged 25–34 years
	34.5%	Aged 35 and over
<b>Number of prison peer trainers</b>	11	First groups of peers trained – Edinburgh Prison
<b>Consent to recording of personal data</b>	98.7%	Worth noting that most people do not object to such data being collected!
<b>Comparative uptake of THN</b>	375	More kits distributed in 2012/13. These figures include kits issued in both the community and prisons.

*Please note: Most data relate to kits issued rather than individuals and, therefore, include repeat kits. However, 293 people trained by peer trainers and 204 kits issued to people trained by peer trainers (where known).*

## Other Reflections and Benefits

- In both December 2012/13 and 2011/12 the largest number of kits supplied in the community was recorded, coinciding with festive overdose prevention campaigns – the festive period being a recognized high-risk period for people who use drugs.
- Engaging professionals and peers, together, in training and service delivery has many benefits and contributes to reducing stigma and discrimination, while informing a deeper level of understanding in the community.
- The programme has the benefit of evolving over time, which has enabled interventions to become more streamlined and efficient – typically now 15-minute ‘brief interventions’. The National Programme has been able to demonstrate good governance.
- The government has commissioned an independent ‘process evaluation’ to identify best practice, barriers and enablers to further roll-out and, if possible, any other behaviours that have been influenced as a result of training and the use or impact of naloxone.
- The model mainly used in prisons at the moment identifies prisoners at risk (opiate users) on admission or during their sentence, and naloxone is supplied on release. This has the potential to be successful if commitment and consistency of distribution can be maintained.
- The Lord Advocate’s guidelines relaxed regulations governing naloxone to permit non-health professionals to hold it in settings where people may be at risk of overdose (e.g. homeless hostels, shelters etc.). This guidance on naloxone is totally unique in allowing a prescription-only medicine to be supplied to a service which would not normally store ‘stock’ medication.

## NALOXONE SUPPLY

In the community, medicines are normally supplied to a named patient only. Naloxone is a parenteral (i.e. injectable) Prescription Only Medicine (POM) under the UK Medicines Act (1968). This means that it can only be supplied to a named patient using either a prescription or a Patient Group Direction (PGD). A PGD is a legal device that allows appropriately qualified nurses or pharmacists to supply POMs in specific, defined circumstances.

There is a limited list of exceptions to this, and in 2005 naloxone was added to that list. The 2005 amendment allowed the development of THN schemes. While supply of naloxone must be to a named person, it can now (legally) be administered **by anyone present** at the scene (who is in a position to intervene before emergency services arrive) **to anyone** who is suspected to have overdosed, to save a life. Access to supplies is not restricted to people receiving treatment; it is available to anyone that the nurse/pharmacist identifies as being at risk of overdose irrespective of current or previous contact with treatment services.

As mentioned above, in March 2011 legal guidance from the Lord Advocate allowed the supply of naloxone “to extend to staff working for services in contact with people at risk of opiate overdoses” (if the staff member has completed naloxone training). When a supply is issued to a named care worker, it is not intended to be their personal supply. The individual is receiving

the supply on behalf of the service for storage and use within the service. If the staff member leaves the service, then the supply of naloxone should stay within the service.

## PEER INVOLVEMENT

Peer work is innovative, and five Local Health Board areas have adopted a peer model which shows promise for the wider development of peer programmes in prisons. Peers are selected following a skills-based assessment, and (peer-led) training is facilitated. The ability to engage with the training programme is the main factor.

The training of peer trainers usually involves a half-day of drugs awareness (including issues in relation to stigma and discrimination), followed by two days of overdose prevention and management training for trainers. The same content is also delivered for the staff training.

The peer trains their peers using a one-to-one 'brief intervention' model which encourages more people to engage. This can take as little as 15 minutes depending on the knowledge and capabilities of the individual.

There will be exceptions when peers need more time, and interventions are tailored to meet specific needs. More thorough 'Basic Life Support' training is still undertaken if requested, although this component is generally delivered via written and pictorial materials. Peer trainers are skilled enough to adapt to the person in front of them and determine the level of training required by the individual's experience.

The first two groups of prison peers have been trained in Edinburgh Prison. These 11 peers have received two days of training and are now ready to deliver overdose prevention and management training, as a brief intervention, across the prison to their peers. The specific needs of female prisoners are also to be addressed; there are plans to train a group of female prisoners in Edinburgh later this year. It is debated whether women might be more receptive to receiving naloxone, as the 23.1% of kits supplied to women in prison points to a higher uptake of kits than among male prisoners, since women represent less than 6% of the total prison population.

The prison services should be willing to actively support the peers in all their activities. Prison peers will be visited once a month by the National Coordinator to ensure that they are up to date with any National Programme news, and to refresh skills as necessary, while also gaining support. The delivery model will need to be further revised and scaled up to take account of peers being released and new prison peers

### “ TRAINING OUTLINE

Training for delivery of the naloxone distribution programme covers:

- why there is a need for naloxone;
- the drugs involved in opioid overdose;
- risk factors for opioid overdose;
- how to recognize an overdose; and
- what to do and what not to do.

This is followed by a practical skills session which teaches people how to inject naloxone, how to administer basic life support and how to place someone into the recovery position.

The naloxone is administered by intramuscular injection into the outside of the thigh through clothing. ”

Scottish National Programme

being trained.

This kind of peer engagement has the benefit of reducing stigma and discrimination; it allows staff to appreciate the skills of the peer trainers, while the activity itself contributes to awareness-raising among prison employees and healthcare professionals, and promoting the need for widespread naloxone distribution for those at risk in prison. Positive links with nurses will improve the uptake of naloxone, as they are responsible for supplying naloxone to prisoners upon release.

The National Programme is committed to, and generally demonstrates, good levels of peer involvement in the implementation of overdose prevention and management programmes, including those in prisons.

## CHALLENGES

- There have been various challenges around training the prison population and prisoners refusing training. Training uptake is now more successful as an individual 'brief intervention' rather than in a group setting, which replicates the approach in the community.
- Prisons are a part of the National Programme. However, supply has not been as high as expected, particularly given the awareness of prisoners as an at-risk population and the evidence to support this. There have been some operational issues which have recently been overcome, and strategic work in relation to uptake of the programme in prison is being continued.
- New prisoners will have to be trained to replace those peer trainers who are released or transferred to another prison.
- The prison regime itself can cause problems given the length of time available to deliver the 'Training for Trainers' Peer Programme, and as a result of any other operational or security issues that often arise in a prison setting.
- It is also necessary to address the needs and training of female prisoners (since male prisoners are not allowed to train them). It is important to note that women are 69 times more likely than the general population to die of drug-related causes during the first week after release (whereas men are 28 times more likely to die during that period).
- Prison distribution varies among establishments – the prison programmes may all be slightly different in their delivery models.
- There are also issues around sustainability, and it is important to develop effective throughcare systems to link newly released prisoners with community programmes.
- It has long been recognized that families are a crucial component in an effective response to overdose prevention and management. Many families have been keen to get involved in the programme, but there are lots of ethical and human rights issues about issuing medication without the explicit consent of the individual at risk. As such, family and carers cannot be supplied with naloxone, which presents a fundamental barrier, although some people are willing to provide consent. Families can, of course, and are encouraged to, receive the training, as this remains a crucial element for recognizing and promptly dealing with an overdose appropriately.
- THN would be valuable to those who have a significant other returning to the home after a period in prison (in a detoxification or rehabilitation centre).

# COUNTRY OVERVIEW: DENMARK

The vast majority of heroin is reported as originating in Afghanistan and Pakistan. The National Commissioner of Police Statistics indicates that the number of seizures and the quantity seized have declined for most drugs in recent years, after an increase at the start of the 21st century. In 2011, 37 kg of heroin were seized, and a total of 21,211 drug offence reports were filed, the highest annual number ever reported. On 1 September 2011 there were 593 people serving sentences for drug-related offences in Denmark.

In October 2010 a new action plan, 'The Fight against Drugs II', was launched. The 2010 plan comprises 19 specific initiatives within the four pillars of drug policy: prevention, treatment, harm reduction and law enforcement. The main goals are to reduce the demand for and supply of drugs.

Following local government reform in 2007, the 98 municipalities became responsible for organizing both the social care and medical treatment of people who use drugs, while the five regions are responsible for psychiatric, primary and public healthcare.

The Social Services Administration is responsible for referring a person for medical and social treatment of drug problems/dependency, and the preparation of his/her treatment plan is a mandatory action according to the Social Services Act. There are guarantees of access to drug treatment within 14 days of referral. People who are entitled to treatment can choose between public and private treatment programmes within a framework of a prescribed treatment plan.

The most recent estimate of the number of 'problem drug users' (defined as those reporting persistent use of illicit drugs, including cannabis, which leads to physical, psychological and social consequences) was undertaken in 2009, applying the capture-recapture method and including two data sources, the National Registry of Patients and the National Register of Drug Users Undergoing Treatment. The total number of drug users was estimated at 33,074, with the number of heroin users seeking treatment decreasing.

Between 2004 and 2008 the National Board of Health supported the EADHEP project, which began estimating the number of people who inject drugs. In 2006 there were estimated to be about 13,000.

The Registry of the National Board of Social Services now collects data on drug treatment in outpatient and inpatient settings. In 2011, 130 out of 145 treatment services provided data on treatment demand. Some 5686 clients entered treatment, of which 1847 were new treatment clients. About one in six (17%) of all treatment clients reported using opioids as the primary drug.

Until 2011, drug-related deaths were registered in the National Board of Health's Cause of Deaths register, and subsequently by the State Serum Institute. The register applies the European definition of drug-related deaths. It includes deaths caused by injurious use of drugs, addiction and drug psychoses, as well as deaths caused by poisoning, namely intentional and unintentional poisoning.

Clients are usually treated as outpatients; this may be supplemented by day or inpatient treatment if more structured interventions are required. Treatment for opioid users comprises OST and psychosocial counselling. The latest available estimates, from 2011, show that 7600 clients were receiving OST, of whom 6200 were on methadone and 1400 on buprenorphine. In January 2010 the government initiated a scheme of treatment using medically prescribed heroin, offered to the most seriously affected heroin users. There were 198 people in heroin treatment in April 2013.

Denmark has a strong tradition of harm reduction work, and NSPs have been established in Denmark since 1986. In recent years, several initiatives to address socially marginalized people who use drugs, those with a dual diagnosis (i.e. drug use and psychiatric co-morbidity) and underage (youth) drug users have been supported.

According to the Cause of Deaths register, in 2010 there were 204 drug-related deaths in Denmark, the lowest recorded number since 1995. Some 77.5% of drug-related deaths were males, and the mean age at time of death was 44.7 years.

Law enforcement is based on either Section 191 of the Criminal Code or on the Consolidated Euphoriant Substances Act of 2008, depending on the type and quantity of drugs involved. According to the Euphoriant Substances Act, import, export, sale, purchase, delivery, receipt, production, processing and possession of drugs are defined as criminal offences. The penalty under this Act is a fine or imprisonment for a maximum of two years. Possession for personal use usually involves a fine, which increases depending on the type and quantity of drugs involved. In some cases, the possession of dangerous drugs for personal use may also result in short-term imprisonment. The Act had already been amended in 1996 to increase the penalty for professional drug dealers, who had previously avoided serious sanctions by only carrying very small quantities of drugs at a time. An offence which involves the transfer of (or the intention to transfer) at least 25 g of heroin carries a prison sentence of between 10 and 16 years, with up to 25 years in particularly serious cases.

A new law to allow the medical prescription of heroin to dependent persons became effective on 1 July 2008, while in 2012 a law allowing the Minister of Health to grant permission for drug consumption rooms to be opened and operated came into effect.

## **OVERDOSE PREVENTION AND MANAGEMENT PROGRAMMES**

In 2010 Denmark initiated a one-year pilot project distributing naloxone in one Danish municipality to assess its relevance for wider scale-up. The City of Copenhagen collaborated with the Danish Drug Users Union (DDUU) as equal partners in the programme.

The DDUU was instrumental in establishing the naloxone pilot and directly involved in its planning and development. The City of Copenhagen funded the health centre to educate 28 people (peers) to respond to overdose. These peers were allocated several doses of naloxone to use in the community. Based on recommendations from the pilot model, the programme is now being trialled in four or five of the larger cities across Denmark.

Since then, a community – i.e. local citizens with previous experience of setting up mobile injection rooms, initially with volunteers and then, subsequently, funded – has established its own naloxone project, Antidote.

There are no naloxone programmes within prisons currently, but given the established peer networks involved in providing a range of harm reduction interventions, this may be an area which can be addressed in terms of future development.

## EFFECTIVENESS

- 28 peers trained as overdose therapists
- 14 cases of overdose reversed over a period of 10 months.

## PEER INVOLVEMENT

The City of Copenhagen collaborated with the DDUU to establish the naloxone pilot and directly involved them in its planning and development. Some 28 peers were trained to respond to overdose – they were allocated several doses of naloxone, and 14 cases of overdose were reversed in 10 months.

The Copenhagen project has demonstrated a simple and sustainable way to prevent overdose deaths in Denmark. Those engaged with the planning of the project believe that, by involving people who have daily/frequent contact with people who use drugs, environments which are otherwise closed to professionals can be accessed.

The Copenhagen project's primary objective was to determine the content and structure of an overdose prevention course and how to deliver such training to peers (called 'overdose therapists'). Ongoing training, support and debriefing was also provided by the DDUU.

This project has successfully shown that overdose prevention is effective and efficient when it is delivered in close cooperation with the local drug environment – and as supported by numerous international studies.

The Copenhagen project has a high degree of user involvement at all levels:

- a) The DDUU is involved in the planning and development of materials to be contained in the overdose prevention kit;
- b) the Overdose Prevention Kits are produced by people who use drugs; and
- c) continuous assessment of equipment and project design has been undertaken in collaboration with associated health professionals and other project stakeholders.

The DDUU recommends that the prescription requirement for naloxone be removed and that the drug be made available over the counter. If not, the future development of overdose programmes may be restricted by medical resources that are already scarce.

It was also agreed that the equipment should be simplified. This project used the pharmaceutical form, already available in Denmark and which has to be drawn up manually. However, other types of naloxone are available, including pre-loaded syringes and an intranasal spray, which are generally much easier to use.

The DDUU recognizes the value of other groups being trained, including family, friends and employees in shelters etc., as well as those people receiving opioid analgesics for pain management.



# COUNTRY OVERVIEW: ITALY

Heroin comes largely from Afghanistan, and a large proportion of illicit drugs are trafficked through Italy destined for other EU countries. The quantity of heroin seized by the police has continued to decline, although in 2011 the amounts remained quite high at 811 kg. The purity of heroin is estimated to be 21.9%.

The national policy on drugs in Italy focuses more on prevention and reduction of dependent drug use, rather than harm reduction. The Italian National Action Plan on Drugs has 89 objectives. Demand reduction activities include prevention, treatment, rehabilitation and reintegration.

The coordination of drug-related treatment is carried out at regional level by heads of the local drug departments or drug services. The regional government establishes treatment delivery services, manages accreditation of private community treatment centres and records the number of treatment centres. To ensure quality of treatment, the regions are given responsibility for adoption of treatment guidelines. However, within significant parts of the regions, such tools have yet to be adopted. Both the public and private sectors provide treatment, and both are funded through the Regional Health Fund. These funds are allocated to the regions by the government each year.

A total of 57,577 clients entered treatment in 2011; 33,679 were new treatment clients. Data indicate that 55.3% of all clients entering treatment reported primary opioid use. The most widely used form of OST is methadone (introduced in 1975), although the use of buprenorphine has been increasing since it was introduced in 1999. In 2011 there were 109,987 clients receiving OST (of whom 93,119 were on methadone and 16,868 on buprenorphine).

The Presidential Decree 309/90, Article 43, stipulates that OST can only be initiated by general practitioners, specialized medical practitioners and treatment centres, and should be implemented alongside psychosocial interventions and other rehabilitative measures. OST provision outside specialized centres is rare. Detoxification is available in residential settings and, to some degree, in general hospitals, although these facilities are used less.

Some outreach programmes exist at a local level, operated by both public and private, health and social care organizations, together with specific projects funded through the National Drugs Fund. Both the outreach programmes and projects financed through this fund include NSPs and information dissemination.

Programmes targeted at harm reduction are more extensive in the northern and central Italian regions, and tend to be focused on the larger cities. Harm reduction interventions are delivered through fixed sites, mobile units, outreach programmes and needle and syringe dispensing machines.

The Consolidated Law, adopted by Presidential Decree No. 309 (09/10/1990) and subsequently amended, provides the legal framework for licit trade, treatment and prevention, and prohibition and punishment of illicit activities in relation to psychoactive substances.

Since February 2006, possession of drugs for personal use has been punishable by administrative sanctions. A maximum quantity determines the threshold between possession

and trafficking. If a person is found in possession of illegal drugs for the first time, administrative sanctions are not usually applied; instead, the person receives a warning from the Prefect and a formal request to refrain from use. The individual may also voluntarily request treatment or rehabilitation, and proceedings will be suspended while s/he is referred for treatment.

The penalty for production, sale, transport, distribution or acquisition is 6 to 20 years' imprisonment. When the quality or quantity of the substance is considered less serious, the penalty may be one to six years' imprisonment.

On 1 September 2011 there were 14,868 people in Italian prisons who had been sentenced for drug-related offences.

National data on direct drug-related deaths are collected by the Special Registry maintained by the Central Directorate for Antidrug Services (DCSA) of the Ministry of the Interior. Trends in drug-related deaths peaked in 1996 followed by a progressive decrease and stabilization between 2002 and 2007. Since then, a declining trend has been observed.

DRUG-RELATED DEATHS – <i>Special Registry maintained by DCSA</i>					
<b>2011</b>	<b>2010</b>	<b>2009</b>	<b>2008</b>	<b>2007</b>	<b>Gender:</b> 86.7% of deaths were male
<b>362</b>	374	484	517	606	<b>Mean age at time of death:</b> 36.9 years

More than half of the drug-related deaths had toxicology testing results available, which indicated opiate overdose as the most prevalent cause of death. Total deaths represent 9.1 per million population.

## OVERDOSE PREVENTION AND MANAGEMENT PROGRAMMES

Naloxone is reported to be distributed in community settings via NSPs, outreach, drug services and over the counter in pharmacies. However, we have been unable to find specific evidence to support this, nor any details regarding models for service delivery.

Equally, we are unaware of any prison overdose programmes currently being implemented. It is important to note that there were issues with the availability and translation of documents; therefore, this may not be an accurate reflection of the situation in Italy.

## COUNTRY OVERVIEW: SPAIN

Spain is one of the countries in the EU most targeted by international drug traffickers owing to its geographical position. According to information from law enforcement agencies, heroin comes from Afghanistan via Turkey and the Balkan route. The number of heroin seizures has generally declined. In 2011, 412 kg were seized, although this is more than in 2009 and 2010. In 2011 a total of 415,354 drug-law offences were reported, of which just 2% related to heroin offences.

On 1 September 2011 there were 13,511 people in Spanish (State Administration) prisons who had been sentenced for drug-related offences, while in Catalonia there were 2041.

The Government Delegation for the National Plan on Drugs, based within the Ministry of Health, Social Policy and Equality, is responsible for monitoring and collecting data at the national level.

A new Spanish National Drug Strategy (2009–2016) was adopted in early 2009. This comprehensive strategy focuses on illicit drugs, alcohol and other substances, incorporating: demand reduction (prevention, risk reduction and harm reduction, treatment and social reintegration); supply reduction; improvement of basic and applied scientific knowledge; training; and international cooperation. The strategy has 14 objectives including “guaranteeing quality assistance adapted to the needs of all people affected by drug use; reducing or limiting the harm caused to drug users’ health; and facilitating their social integration”.

In Spain drug treatment is mostly funded by the public budget of the central government, autonomous communities (regions) and autonomous cities, and by some municipalities, usually the big cities. Each region is entitled to organize and deliver health interventions according to its own plans, budgets and personnel. At the regional level, all of Spain’s 17 autonomous communities have developed strategies which address drug dependency issues. Catalonia, Galicia and the Basque Country launched revised strategies in 2011, while Navarre developed a new document in 2012. Quality standards and monitoring systems for clients receiving OST exist at the level of the autonomous communities, and data are reported to the Government Delegation for the National Plan on Drugs.

The public sector is the primary provider of treatment, followed by NGOs and private organizations. Some regions have integrated treatment for drug dependency within primary care units, some within mental health services, and some have a separate treatment network that retains a connection with the general healthcare system.

As a general rule, care is organized on three levels: primary health care acts as the gatekeeper, the secondary level provides integrated treatment services, and tertiary-level care units supply highly specialized and long-term care, such as detoxification or residential (rehabilitation) treatment.

This very specific drug dependence care network is widely spread throughout the country. The majority of services are provided through specialist (public) outpatient facilities. In 2010 this care network included: 526 outpatient units (treating approximately 93,300 patients); 53 inpatient detoxification units (treating 3984); 128 therapeutic communities (which admitted 7596); and 2526 locations where OST (i.e. methadone) was available.

Methadone was introduced and licensed as a treatment in 1990. According to the amended Spanish Royal Decree 5/1996, methadone and buprenorphine treatment can be initiated by specialized medical doctors and treatment centres.

The latest available estimate of the total number of people in methadone maintenance treatment programmes in 2010 was 81,022. Buprenorphine and buprenorphine/naloxone combinations are also available, although their use is not yet widespread. In 2010 around 1350 clients were receiving this treatment. Pharmacies are involved in dispensing medication to patients.

Between 1999 and 2002, several estimates of 'problem drug use' were made, applying the demographic and multiplier methods. In 2010 the number of dependent opiate users (heroin in particular) was estimated at 1.2 per 1000 inhabitants aged 15–64. This means that about 38,500 dependent opiate users were estimated to be living in Spain in 2010.

Based on treatment data, there were an estimated 7393 people who inject drugs in 2010, the majority using heroin or other opiates. Incidence estimation studies showed a sharp decline in the number of new heroin users, and injecting drug use has fallen dramatically in the past 30 years, regardless of the primary substance. Thus in 2010, of all opioid users admitted to treatment, only 15.8% reported injecting the drug, while 10% of new treatment clients who were opioid users reported injecting.

In 2010, data on treatment demand were gathered from 507 outpatient centres and treatment units in prisons. A total of 53,508 clients entered treatment in 2010, of which 26,805 were new treatment clients. Data indicate that 34.3% of those entering treatment were primary opioid users. Among those entering treatment for the first time, 18.2% were opioid users. Some 20% of all clients were under the age of 25, while 45% were 35 years and over. In terms of gender, 85.1% of clients were male, and 14.9% were female.

Poly-drug use is common among Spanish treatment clients, with around two thirds of treatment clients reporting the use of two or more substances within 30 days prior to admission for treatment. The single most important factor for fatal overdose appears to be the use of (other) depressant drugs at the same time as illicit opiates, and such risks and trends should always be taken into consideration.

Most specialist harm reduction programmes include a 'socio-sanitary' service that offers preventive educational interventions, overdose prevention activities, sterile injecting equipment, emergency care and assistance to injecting drug users. Public outpatient clinics, and several NGOs, also carry out harm reduction activities. In 2011 a total of 1029 NSPs distributed about 2.7 million syringes, and eight facilities for supervised drug consumption were available in the following regions: Madrid (one facility), Catalonia (six facilities) and the Basque Country (one facility).

Since 1993 Spain has maintained a Special Registry based on forensic and toxicological sources, which collects data on deaths caused by 'acute reactions to drugs' in specific geographical areas (covering approximately 50% of the Spanish population). Data are collected on deaths among those aged between 15 and 49, where the direct and main cause is 'an acute adverse reaction after a non-medical and deliberate use of psychoactive substances' (excluding alcohol and tobacco). Since 2003 the age group has been expanded to cover those aged between 10 and 64.

In 2010 the Special Registry registered 517 drug-related deaths. In addition to the Special Registry, the Spanish General Mortality Register also provides information on drug-related deaths, and in 2010 it reported 393 deaths. This latter registry is believed to underestimate around 40% of the number of drug-related deaths when compared with figures recorded in the Special Registry. According to the General Mortality Register, the number of drug-related

deaths fell between 1999 and 2001, then remained stable until 2005 (at approximately 670) and subsequently resumed a downward trend.

2010	DRUG-RELATED DEATHS	
517	Special Registry	<i>Gender and age unknown</i>
393	Spanish General Mortality Register	Gender: 84% males Mean age at time of death: 39 years

It has been reported that the numbers of drug-related deaths are only systematically collected in the city of Barcelona. Over the last few years, there has been an annual death rate of between 60 and 70 people out of a population of 1.5 million.

The Law on the Protection of Citizens' Security (1992) classifies drug consumption in public and illicit possession as serious order offences punishable by administrative sanctions. In 2010 the 'organic law' enacted amendments to the penal code in reference to drug-related provisions. Fines are the usual punishment, but the law allows the execution of the fine to be suspended if the person (freely) attends an official drug treatment programme.

For trafficking, Spanish law lays down penalties in line with the seriousness of drug-related harm to health and any aggravating/mitigating circumstances that may exist, such as the sale to minors under 18 or the sale of large quantities. Penalties can be up to 20 years and three months in prison, with such long terms reserved for cases with aggravating circumstances. When no such circumstances exist, sentences can be between one and three years if the drugs do not damage health, and, in line with the amendments enacted in 2010, up to six years when they do. In 2011 Royal Decree 840 set out a procedure for the suspension of drug-related prison sentences of five years and less, if the individual agrees to participate in a treatment programme.

## OVERDOSE PREVENTION AND MANAGEMENT PROGRAMMES

This description relates to a programme in Catalonia. We are unaware of any structured, nationwide overdose programmes in Spain. All drug centres in Catalonia have protocols on overdose prevention and management; this includes hospital detoxification units, harm reduction services, outpatient drug treatment centres and therapeutic communities.

In Catalonia there are approximately 7000 people receiving methadone treatment out of a general population of 7.5 million.

Naloxone is a medically prescribed drug, and its wider distribution and use is only permitted to save a life. Those receiving kits must be assessed by a doctor; if deemed appropriate, they are then dispensed as many ampoules as they need. Naloxone is provided for treatment within emergency medical services, and in all harm reduction services, drug consumption rooms and some outpatient drug treatment centres.

Drug consumption rooms are able to reach many with naloxone programmes, and the centres have public health targets to train people who use opioids. People who use drugs are paid to attend the programme. Initially, naloxone training programmes were extremely comprehensive but also rigid and protracted; the training is now more flexible as confidence has grown. It is reported that some peer educators (who are former users) work from apartments to distribute naloxone, but this is not a formal arrangement.

Over 150 drug workers have been trained to educate people who use drugs on overdose prevention and management. Between 2009 and 2012, approximately 3000 people who use drugs were trained and 4500 naloxone kits distributed.

Work is being undertaken to progress a prison-based naloxone programme in Catalonia. Although three years have been spent developing operational protocols, there is strong opposition from trade unions regarding naloxone kits with needles (and despite the plan for kits being given out on release). There was a recent meeting at which the use of a nasal naloxone administration was suggested as a solution. No decision had been made at the time of interview. However, it has been agreed that educational programmes about overdose will be delivered in all Catalan prisons.

Naloxone is not available within therapeutic communities, although staff do offer overdose prevention advice and information about the risks of lowered tolerance on discharge from residential treatment.

# GOOD PRACTICE SUMMARY EXAMPLES

## APPLICABLE TO:

### ESTONIA, HUNGARY, LITHUANIA, POLAND AND ROMANIA

**Estonia** is already using the Scottish model of delivery for development of its community-based overdose prevention and management programme and should be commended for this.

It is, therefore, important that Estonia continues to observe the development of the Scottish National Programme, in particular THN within the prison setting, while also heeding any lessons learned from it. Scotland has an independent process evaluation of the National Programme underway, the results of which may be invaluable to Estonia.

Since Estonia will also embark on a pilot prison naloxone programme (towards the end of the year), it has the chance to demonstrate best practice by learning from both prison delivery models of the Scottish National Programme.

If the Estonian prison naloxone programme (using prison and healthcare staff to identify risk and supply naloxone on release) is more widely rolled out, then hopefully, once established, there will be the opportunity to expand the programme by training prison peers, as per the latest phase of the Scottish National Programme which focuses on a peer education approach and will have progressed further. Again, retaining a good awareness of improvements, continued links with the Scottish National Programme and effective liaison between all parties are fundamental.

The success of a prison programme will depend on the commitment of national stakeholders and policymakers, alongside the motivation of prison staff. The training of prison staff and (internal) healthcare professionals should provide appropriate knowledge and skills, while aiming to enable ownership of the programme. Ongoing support and training should also be available to maintain the momentum and viability of the programme.

Estonia is in a unique position compared with the other countries of focus and the rest of the EECA region, in that it has a more advanced community-based naloxone programme (and a pilot prison programme on the way), although it is still early days. As such, it is necessary for Estonia to seek sustainable and effective ways to deliver the programme which are not too resource intensive. It is also pertinent to scale up low-intensity drug treatment within prisons and to ensure that pre-release overdose counselling is more widely available and taken up.

**Lithuania** has no plans to instigate a naloxone programme, either in the community or in prisons, and reports that its overdose rate is very low (i.e. 45 in 2011, although such deaths may be under-reported). However, one death is one too many, and other measures must be taken to try and counter the risk of overdose in the absence of naloxone distribution. Protocols on overdose prevention and management should be available in all treatment and harm reduction services, as well as in prisons, as per the Catalonian model.

The predominant overdose response strategy in Lithuania is via the dissemination of information, education and communication (IEC) materials. It is important that this 'advice' is more widely available and maintained in all settings (i.e. low-threshold agencies, NSPs, outreach, homeless hostels/shelters, specialized drug treatment centres, detoxification and rehabilitation services, and in all prisons or detention centres).

Such IEC materials should also be available to those who may come in contact with people who use drugs (i.e. police and prison staff; night club employees; family and friends). All of this should be complemented with training and 'brief interventions' regarding overdose prevention and management where possible.

The production of peer-led IEC materials, which are circulated within the prison (and community-based services), offers further opportunities for providing overdose prevention interventions and is one way to involve peers. Furthermore, peers may be trained as 'peer educators' to provide accurate advice within their communities. This can, potentially, benefit prisoners too.

Since there are comprehensive OST programmes in Lithuania, this offers a good opportunity to provide 'brief interventions' (on overdose prevention) to service users on presentation. Equally, a formal approach to providing this type of brief intervention within harm reduction or low-threshold services should be implemented on initial contact with people who use opioids.

The Scottish model shows that this level of intervention can be effective and easily attained, while the Danish model shows the value of peer-led provision in disseminating information among people with whom professionals/services may not have contact.

It is also important for community-based services to establish proactive links with prisons to enable effective throughcare arrangements. Prisons should ensure that pre-release overdose counselling is available for those at risk – people who identify as being opioid users or those on OST – and that they proactively promote its uptake.

Community services may also wish to consider 'in-reach' work within the prison setting (if this can be negotiated) to provide education on: the risks of overdose; signs and symptoms; myths in response to overdose; and the correct actions to take in the event of overdose. Again, if agreed, this can be extended to training peer educators in the prison setting.

**Poland** is considering piloting a community-based naloxone distribution programme, although naloxone is registered and its use currently limited to medical personnel and emergency services. Legislative obstacles need to be overcome, but if the programme is rolled out more widely and deemed a success, then it could be extended to prisons, with people who use opioids being supplied with naloxone upon release. Poland can learn from Estonia, Scotland and Denmark.

There are seven prison OST programmes, although they are only available to those who had been receiving OST in the community. Nonetheless, these programmes are in a prime position to provide education and brief interventions on overdose prevention in the first instance, and this should be encouraged, but skills training and support will be required for prison staff. This need not be resource intensive and, as per other countries, could eventually encompass a peer education component with the agreement of national stakeholders. It is also necessary to ensure that pre-release units are established and used within prisons.

The general aim of the Polish National Programmes is to reduce drug use and drug-related social and health problems. As such, a more comprehensive approach to overdose prevention and management programmes has the opportunity to fit well within this objective.

In Poland, telephone helplines, websites and a variety of educational leaflets are nationally available. The provision of IEC via a peer involvement approach is a common response strategy, and the dissemination of information materials is currently the predominant overdose prevention strategy, with materials (including a quarterly magazine) being circulated in a range of settings including prisons. The production of peer-led IEC materials offers further opportunities for providing overdose prevention interventions and is one way to involve peers.



Furthermore, peers may be trained as 'peer educators' to provide accurate information and advice within their communities. This can, potentially, benefit prisoners too.

**Hungary** does not have a naloxone programme, nor are there any plans to introduce one. Naloxone is a prescription drug, the use of which is limited to medics, and its wider distribution is illegal.

Heroin use is decreasing in Hungary, and there are fewer overdoses – most of these occurring from methadone intoxication. Nevertheless, the scale of the problem should not discourage policymakers and national stakeholders from taking a proactive approach in reducing drug-related deaths. Arguably, naloxone distribution would reduce overdose rates further, but this is not a particular priority and will have to continue to be advocated for.

While OST is technically available in prison, there are logistical, geographical and systemic barriers to receiving it. The provision of OST offers some opportunities to reduce drug-related deaths, as it is generally a protective factor, and uptake in prisons should be improved.

It is also necessary to ensure that pre-release units are established and used within prisons, along with collaborative systems for throughcare and, at the very least, signposting to community-based services to ensure early engagement.

The production of peer-led IEC materials (targeting prisoners) offers further opportunities for providing overdose prevention interventions and is one way to involve peers. Furthermore, peers may be trained as 'peer educators' to provide accurate advice within their communities which can, potentially, benefit prisoners too.

**Romania** has a prevailing lack of capacity for low-intensity drug treatment in prison, and there are very limited development opportunities in services, both in prisons and in the community. Prison NSPs were recently discontinued due to a stated lack of demand, with only 83 prisoners participating in NSPs established in 10 prisons. The sterile needles and syringes have now passed their expiry date.

These factors seriously limit opportunities for the development of effective overdose prevention and management programmes. Naloxone is only available to medical personnel and emergency services. It was reported that there are no policy or practice responses to overdose prevention and management in Romania. This conflicts with other data, but nonetheless we have been unable to find any evidence of formal overdose prevention programmes (or naloxone distribution), which suggests an 'ad hoc' approach. Protocols on overdose prevention and management should be made available in all treatment and harm reduction services, as well as in prisons, as per the Catalonian model.

Prison in-reach, training of prison staff and more effective systems for throughcare could increase the opportunities for developing some interventions in relation to overdose prevention and management. This includes pre-release counselling on overdose risks and prevention, along with training in first aid and overdose management and a routine medical examination on exit. While European Prison Rules specify that prisoners should be offered a medical examination as close as possible to the time of release, this type of routine 'exit' health examination does not seem to be common in Europe (including Romania) but should be enforced as a requirement.

People who use drugs are poorly represented nationally, and there are limited opportunities for peer involvement. The distribution of naloxone upon release from prison is unlikely at the moment. However, a strategic approach to overdose prevention and management should continue to be promoted and lobbied for as a fundamental measure to reducing drug-related

deaths.

In the meantime, the production of (peer-led) IEC materials which targets prisoners offers further opportunities for providing overdose prevention interventions and is one way to involve peers.

# INDIVIDUAL ROLES AND RESPONSIBILITIES

- **National stakeholders:** The willingness to work with people at all levels and involve peers – i.e. people who use drugs – in the planning, implementation and evaluation of services is crucial. Advocacy work to ensure that this can occur is also vital.

*Both Scotland and Denmark exhibit such an approach.*

- **Prison staff:** To fulfil a positive role in the distribution of naloxone, prison employees require education and training. They have to be able to appreciate the needs of people who use drugs, the serious risk of overdose on release and the necessity for widespread distribution of naloxone. It would be better to train those staff who have an active interest in this area and who are able to establish a good rapport with people who use drugs.

*The National Programme in Scotland has effectively facilitated this, with 16 prisons distributing naloxone. In Catalonia it has been agreed that educational programmes about overdose will be delivered in all Catalan prisons.*

- **Healthcare professionals:** Those in prisons who may, in the first instance, be responsible for naloxone distribution (*as per the Scottish model*) also require education and training. Again, they should value this role and be highly motivated to make a difference. This will ensure consistency of delivery and equally development of services.
- **Drugs services/workers:** They can improve liaison between themselves and prisons, and take a proactive approach to improving throughcare by ensuring that newly released prisoners are swiftly linked with community services to provide naloxone, if available and in the absence of a prison naloxone distribution programme.

*Protocols on overdose prevention and management should be available in all treatment and harm reduction services, as well as in prisons as per the Catalonian model.*

- **People who use drugs:** The communities who are affected themselves, potentially, have most knowledge and can increase access to vulnerable populations who may be otherwise hard to reach. As such, their involvement in planning, implementation and evaluation must actively be sought *as per the Danish (and Scottish) models*.

# USEFUL RESOURCES

## SDF website for information on peer activities

<http://www.sdf.org.uk/drug-related-deaths/naloxone-peer-educator-initiative/>

<http://www.youtube.com/watch?v=JFPmcHsfleA>

<http://www.youtube.com/watch?v=pwCLhbqeIH0>

[http://www.youtube.com/watch?v=4A6\\_3rp7Hlk](http://www.youtube.com/watch?v=4A6_3rp7Hlk)

<http://www.sdf.org.uk/news-and-media/sdf-news/sdf-naloxone-peer-educators-invited-to-help-train-in-glasgow-pharmacies/>

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