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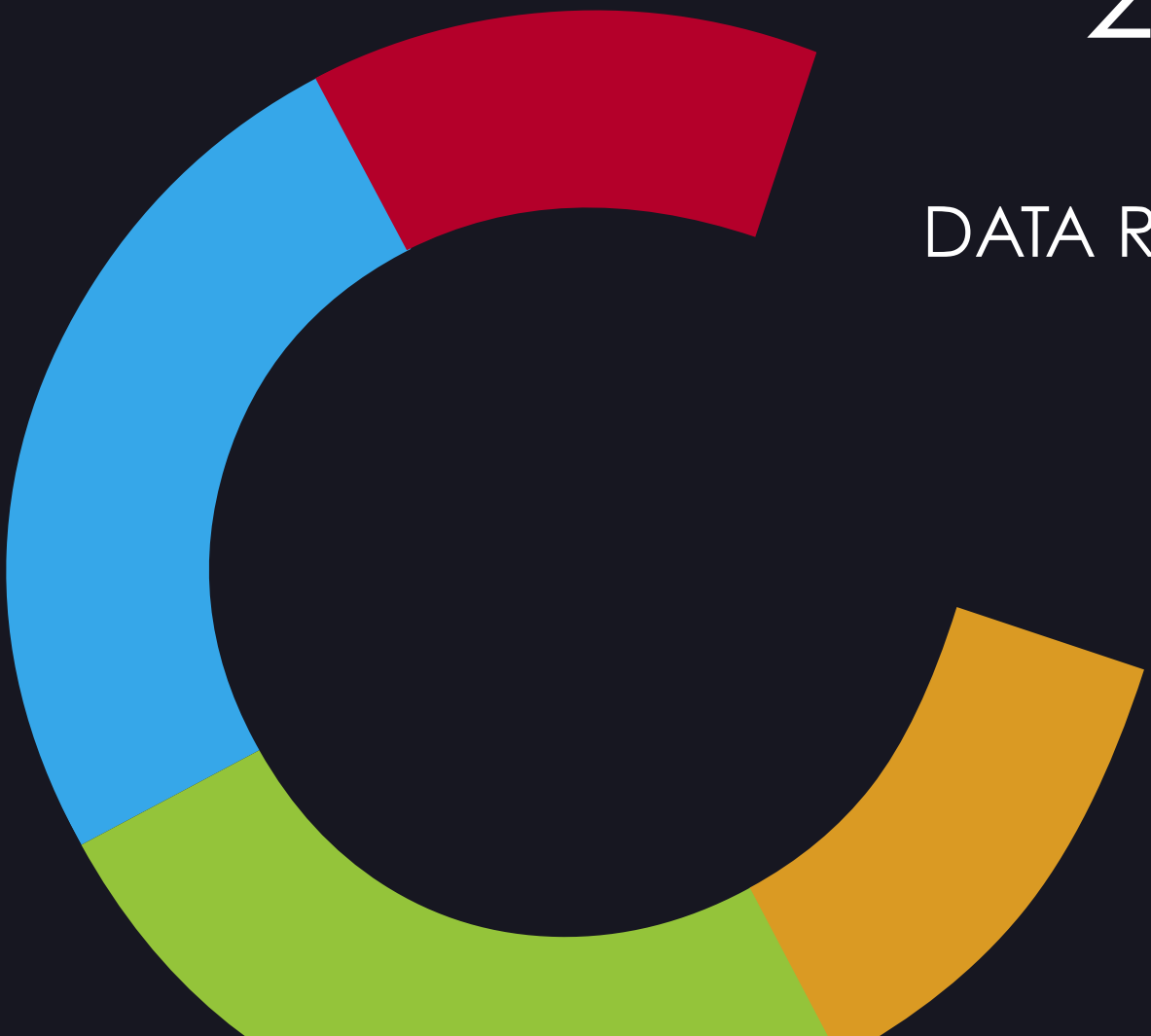
Network

CIVIL SOCIETY MONITORING OF HARM REDUCTION IN EUROPE 2020

DATA REPORT



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CIVIL SOCIETY MONITORING OF HARM REDUCTION IN EUROPE 2020

DATA REPORT

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Preface

This is the second civil society-led monitoring report 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. We believe that this approach is a necessary, and useful, contribution to the development of drug policy in the region.

We learned a lot from the former process and the 2019 edition and modified the approach, the focus and certain questions to enable respondents to report closer to their own experiences. Consequently, the information provided in this report sometimes 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. Even stronger, we directly approached representatives of networks and organizations of people who use drugs to share their view on the developments with us.

2020, however, was not a regular year and the world wide pandemic had its influence on people, organisations and the care system in general. Accordingly, we added a section on the impact of COVID-19 on harm reduction services and we will continue to measure this impact.

We will use the insights and information collected in this report within our advocacy 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 34 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, Rafaela Rigoni, Tuukka Tammi, Daan van der Gouwe, and Victoria Oberzil, who were supported by the coordinators of the expert groups and the reviewers of this report. We are also grateful to HRI and Robert Czack for contributing with a chapter to this report. A special thanks to Dagmar Hedrich and her EMCDDA colleagues for their 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 and Karin Schiffer

On behalf of the C-EHRN team

Acronyms and abbreviations

3-MMC	3-Methylmethcathinone, also known as Metaphedrone
AFVD	Association Francophone Pour Vaincre Les Douleurs; Francophone association to overcome pain (France)
Aides	A French community-based non-profit organisation
APDES	Agência Piaget para o Desenvolvimento
APSEP	Association des Professionnels de Santé exercant en Prison; Association of Health Professionals working in Prison (France)
ART	Antiretroviral Therapy
ASUD	Autosupport des usagers de drogues; Self-support for drug users (France)
C-EHRN	Correlation – European Harm Reduction Network
COPD	Chronic Obstructive Pulmonary Disease
COVID	Coronavirus Disease
CSFD	Civil Society Forum on Drugs
CSIDP	Civil Society Involvement in Drug Policy Project
CS	Civil Society
CSO	Civil Society Organisation
DAA	Direct-Acting Antiviral
DCR	Drug Consumption Room
EASL	European Association for the Study of the Liver
ECDC	European Centre for Disease Prevention and Control
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ENPUD	European Drug User Union
ER	Emergency Room
EU	European Union
EuroNPUD	European Network of People Who Use Drugs
FP	Focal Point
FSW	Female Sex Worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHB	Gammahydroxybutrate, a depressant
GP	General Practitioner
HAT	Heroin Assisted Treatment
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
HRI	Harm Reduction International
HSE	Health Service Executive (Ireland)
ID	Identification
IEC	Information, Education, Communication
IHRD	International Harm Reduction Development Programme (Soros Foundation)
INPUD	International Network of People who Use Drugs
Lab	Laboratory
LGBT	Lesbian, Gay, Bisexual, Trans
LGBTI	Lesbian, Gay, Bisexual, Trans, and Intersex
LGBTQIA+	Lesbian, Gay, Bisexual, Trans, Queer/ Questioning, Intersex, Asexual, all of the other sexualities, sexes, and genders
LSD	Lysergic acid diethylamide, also known colloquially as acid; an hallucinogenic drug
Lube	Lubricant
MDMA	3,4-Methylenedioxymethamphetamine, commonly known as ecstasy
MENA	Middle East and North Africa
MMT	Methadone Maintenance Treatment
MSM	Men having Sex with Men

NAAC	Cyprus National Addictions Authority
NDT	New Drug Trend
NEP	Needle Exchange Programme
NFP	National Focal Point
Nk	Not Known
NPS	*New Psychoactive Substance*
NSP	Needle and Syringe Programme
OAT	Opioid Agonist Therapy
OD	Overdose
OFMA	Observatoire Francais des Medicaments Antalgiques; French Observatory for Analgesic Drugs
OST	Opioid Substitution Therapy
PDF	*Portable Document Format*
PsychoActif	A community dedicated to information, mutual aid, the exchange of experiences and the construction of knowledge on drugs, in a risk reduction approach
PWI	*People Who Inject*
PWID	*People Who Inject Drugs*
PWS	*People Who Smoke*
PWU	*People Who Use*
PWUD	People Who Use Drugs
Reitox	Réseau Européen d'Information sur les Drogues et les Toxicomanies; the European information network on drugs and drug addiction, which includes designated national institutions or agencies responsible for data collection and reporting to the EMCDDA on drugs and drug addiction.
RESPADD	Réseau de prévention des addictions; a non-profit association which brings together more than 600 health establishments (hospitals, clinics, EHPAD, medico-social establishments, etc.) engaged in the prevention and management of addictive practices. (France).
SEG	Scientific Expert Group
SFETD	La Société Française d'Etude et Traitement de la Douleur; French Society for the Study and Treatment of Pain
SFSPO	Société Francophone des Sciences Pharmaceutiques Officinales; Francophone Society of Official Pharmaceutical Sciences
SICAD	Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências (Intervention Service in Addictive Behaviours and Dependencies) (Portugal)
STI	Sexually Transmitted Infection
TB	Tuberculosis
THN	Take-Home Naloxone
UNFPA	United Nations Population Fund, formerly the United Nations Fund for Population Activities
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

1

Introduction

The importance of CSO's in monitoring harm reduction

In the field of harm reduction, civil society organisations (CSO's) play an essential 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 needs. Their inside knowledge and information are critical in developing adequate drug policies and practices.

CSOs can act as transmission belts that filter societal preferences and channel them to policymakers. In practice, however, their capacity to effectively interact with policymakers varies considerably. Where a constructive and respectful relationship between policymakers and CSOs is missing, decision-makers may have minimal knowledge about what PWUD need, resulting in a lack of adequate, inclusive policies, based on mutual understanding and real necessities.

It has long been shown that community monitoring can play an essential role in improving service delivery (1). Civil society is increasingly assuming the role of holding governments and donors accountable, among others, by engaging in independent monitoring and evaluation of services and programmes (2). In combination with advocacy, monitoring tools are crucial strategies to hold governments accountable and to improve the implementation of policies and programmes in line with the needs of PWUD and their environments (3).

A complementary role

Other agencies already have well-established monitoring activities in the field of drug use and harm reduction, both globally and in Europe. At a global level, *Harm Reduction International* (HRI) has conducted a biannual survey since 2008, publishing its data in the report *The Global State of Harm Reduction* (4). Data collection involves a coordinated effort across practitioners, academics, advocates and activists, and provides an independent analysis of the state of harm reduction in the world. In Europe, the *European Monitoring Centre for Drugs and Drug Addiction* (EMCDDA) has conducted systematic monitoring since 2007. Harm reduction data is collected by its 30 National Focal Points (*Reitox NFP Network*), that are often lead by research or administrative institutions. These include all European Union (EU) countries plus Norway and Turkey. Core publications include the annual *European Drug Report* (5) and the Health and social responses to drug problems: a European guide (6).

Despite these excellent efforts, there are still gaps in information about harm reduction and the needs of PWUD. In some cases, data might not systematically reflect the perspective of harm reduction CSOs and their service users on availability, accessibility and quality of harm reduction interventions and ways of improvements. In others, it reflects civil society perspectives but only offers a generic overview of the European region, without much detail on policy implementation and experiences at the service delivery level in each country. These are the gaps that the C-EHRN intends to fill, complementing the work undertaken by others. This monitoring tries to reflect the 'street experiences' of harm reduction service providers and their service users, focusing on how drug policies and specific harm reduction guidelines are (or are not) being implemented at the street level. Such in-depth and rich information is crucial for the development of policies and services for PWUD, and can be of great value for CSO advocacy and for policymakers.

Methodology

C-EHRN has established four expert groups to support the development of the monitoring framework, draft the questionnaires, assess the data, and review the final report: A scientific expert group (SEG) and three thematic expert groups for Hepatitis C (HCV), overdose prevention (OD), and new drug trends (NDT)[2]. These groups, together with C-EHRN staff, have contributed to the development of the framework of C-EHRN monitoring and have added to the formulation of the questionnaires. To gather data on the experiences of harm reduction service providers and service users at ground level, C-EHRN builds on a network of national Focal Points (FPs).

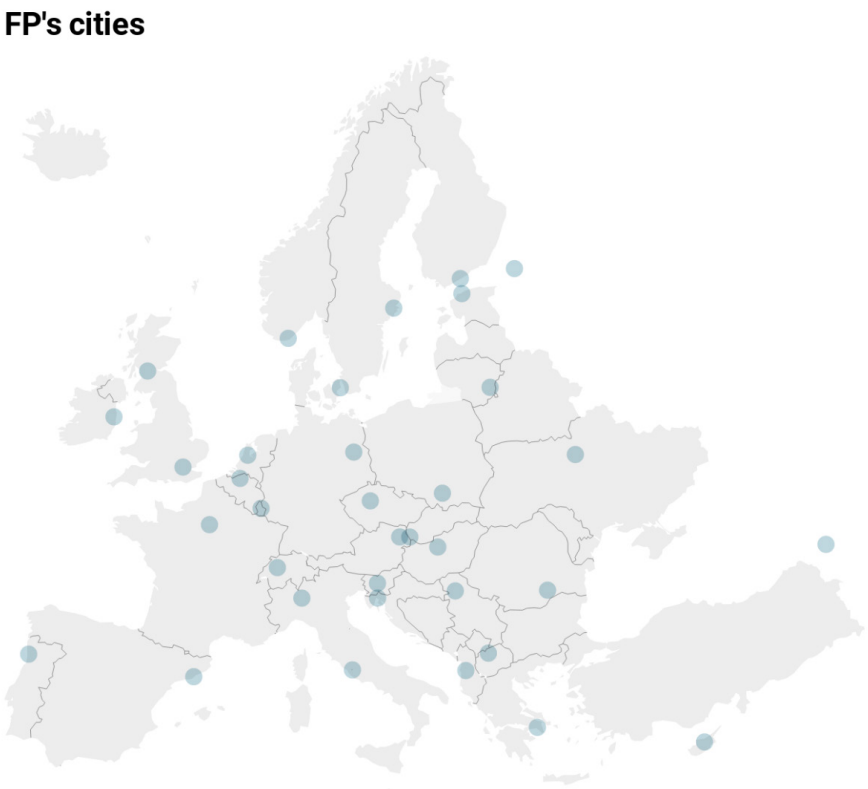
C-EHRN Focal Points

The Focal Points are organisational members of C-EHRN selected by:

- Their willingness to commit to the network's principles, mission and vision at the national and European level;
- Proven thematic expertise in the field of drug use and harm reduction;
- Connectedness at the national and European level; and,
- Ability to fulfil the role of an intermediary at a national level.

C-EHRN strives to select at least one FP per country, but some countries can have more than one representative if additional thematic expertise is needed, or no FP when no member is available for such a role. C-EHRN currently has 35 FPs in 34 countries[3]. Map 1 shows the location of the FPs partaking in the 2020 monitoring.

Map 1: Location of C-EHRN Focal Points

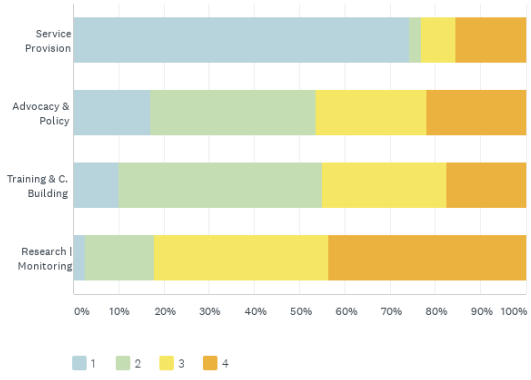


The tasks of FPs include being consulted for specific thematic or regional expertise; providing inputs and information, particularly for monitoring purposes, including answering the monitoring questionnaire annually. FPs do not receive financial support to perform their functions. Nevertheless, they receive a few benefits, such as being invited to the annual C-EHRN conference (one scholarship available per country); free C-EHRN seminars and training; being able to promote their activities on the network's website and through the network's other communication channels, and in speaking on behalf of the network at the national level.

Profile of FPs

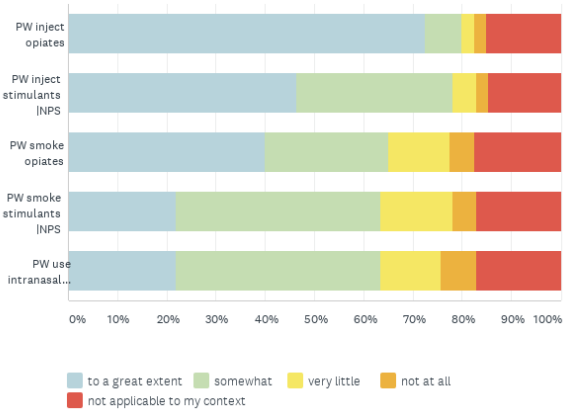
More than 70% of C-EHRN FPs[4] have as their main priority of their organisation the provision of services, making them highly appropriate in describing how harm reduction activities play out in practice. That is followed by advocacy and policy activities (17%), training and capacity building (10%), and, to a much lesser extent, research (2,5%) (see Figure 1).

Figure 1: Priorities (1 to 4) of FPs organisations.



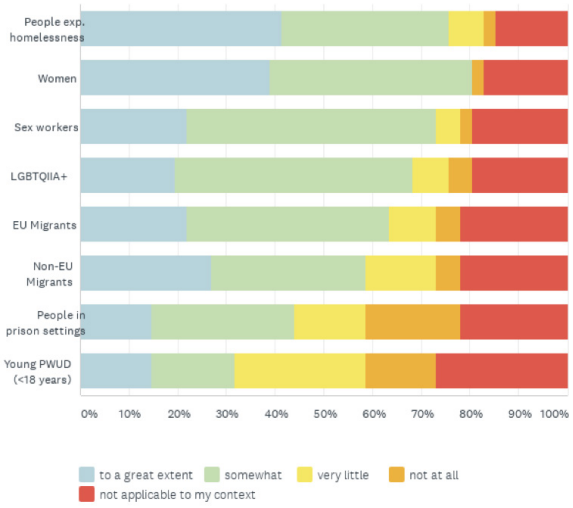
The populations to which FP organisations are able to provide services can be seen in Figures 2 and 3. The main services provided (offered by more than 50% of FPs) are outreach work, HCV and HIV prevention, testing and treatment, drop-in centres, needle and syringe exchange, STI prevention, and legal support. Less than 15% of FPs provide housing or shelter, Heroin Assisted Treatment (HAT) or Drug Consumption Rooms (DCRs).

Figure 2: Populations to which FP organisations provide services (related to drug of choice)



PW: people who
NPS: new psychoactive substance(s)

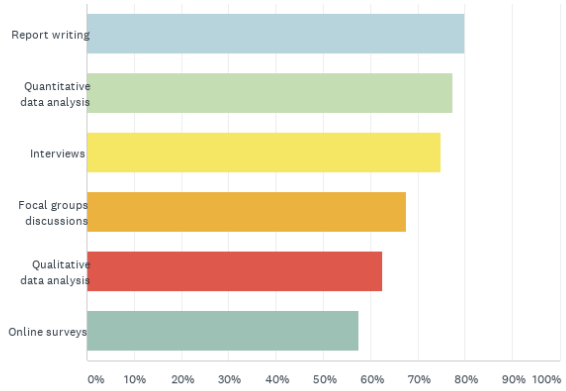
Figure 3: Populations to which FP organisations provide services (key populations)



Even though research is not a priority for the vast majority of C-EHRN FPs, all of them are involved in some type of research activity. Besides C-EHRN monitoring, 83% of FPs are involved in data collection for monitoring and evaluating within their own organisations, 53% perform needs assessments, and 52% the monitoring of drug trends; more than 80% use the data collected for advocacy purposes. Virtually all FPs are involved in some kind of

policy and advocacy activity, mostly at the local/ regional or national level. Figure 4 shows the main research activities of FPs.

Figure 4: Main activities for those undertaking research



A new questionnaire in 2020

Based on feedback from both FPs and SEG members, the 2020 questionnaire was reformulated and shortened. In comparison to 2019, more questions now focus on the implementation (local) level, and on the experiences of FPs and their clients rather than on the national level. This was done to: 1) improve the reliability of data, since the experiences and knowledge of most FPs focuses on the local/regional level; and, 2) better address the main objective of this monitoring tool, which is to reflect fundamental qualitative data at the service delivery level.

Also in 2020, new sections were included on basic harm reduction services and on the harm reduction response to the COVID-19 pandemic.

A short questionnaire for PWUD

In 2020, on an experimental basis, a parallel short questionnaire was sent to PWUD in partnership with the European Network of People Who Use Drugs (EuroNPUD). The questions addressed access to harm reduction services, involvement in planning, monitoring and delivery of harm reduction services, and influence of the COVID-19 pandemic in life and access to harm reduction services.

Data gathering and analysis

FPs gathered data for this report based on a questionnaire distributed to them both as an online survey and as a PDF attached to an e-mail. The PDF was intended as a working document to be shared with contributors to the data gathering. The questionnaire is available at the C-EHRN website[5]. The short questionnaire for PWUD was sent via e-mail to contacts selected by EuroNPUD. From those answering, only feedback from respondents living in the same cities as FPs were retained; those were, in general, 1-2 respondents per city.

Closed questions were analysed for general percentages or represented in tables with descriptions of features per city/country. Open ended responses were analysed with thematic analysis (7) and key findings illustrated with quotes. Data were verified and analysed by the report authors. The different chapters were revised by the respective thematic expert groups.

Limitations

C-EHRN Monitoring is still in an early developmental phase; 2020 is only the second year of reporting. Following the feedback of the expert groups and the FPs, several adjustments were made to the 2020 questionnaire as compared to 2019. In addition, the influence of the COVID-19 pandemic might have influenced results. For this reason, in many cases it is still not possible to trace a comparable line as expected in a monitoring process. Both expert groups and FPs are still adjusting, and trying to find the best and more feasible indicators, as well as better ways to collect reliable and consistent data.

Given the nature of this monitoring structure and the focus of the work of C-EHRN FP organisations, data in this report cannot claim to be representative of Europe or the nations in which FPs are based. Most FPs work locally, or regionally, and have an in-depth knowledge of how harm reduction plays out in the streets. Respecting this experience was chosen over national representative-

ness, to provide a more nuanced analysis of the implementation of harm reduction at the local level. If, on the one hand, the monitoring loses in its ability to reflect a broader European situation focusing on developments at the national level, it gains in reflecting fundamental qualitative data at the service delivery level that can only be collected by CSOs, and which is lacking in several national/global reports. Other specific limitations can be found in the respective chapters.

A more complete account of the methodology, challenges and lessons learned with the C-EHRN monitoring can be found elsewhere (8).

Report structure

The report consists of 8 chapters.

This first introductory chapter provides information on the importance of CSOs in monitoring harm reduction; the methodology used for the present monitoring and the differences regarding the first monitoring report in 2019; the profile of the C-EHRN Focal Points (FPs) collecting data for this report; and the limitations of this monitoring.

Chapter 2 is a special chapter written by HRI. It contextualises the state of harm reduction in Europe in comparison to other world regions, based on the data reported in the *Global State of Harm Reduction 2020* (4). The other chapters are based on data collected by C-EHRN FPs in 2020.

Chapter 3 reports data about civil society involvement in drug policy and related decision-making processes in European countries.

Chapter 4 is a newly introduced chapter, describing the state of essential harm reduction services in FP cities.

Chapter 5 describes experiences with the availability and accessibility of interventions that constitute the continuum of care for hepatitis C.

Chapter 6 describes the status of, the need for, and changes to, overdose prevention in the previous year at the local level in Europe.

Chapter 7 focuses on the perceived New Drug Trends in FP cities. Finally,

Chapter 8 discusses how the COVID-19 pandemic has affected harm reduction services and the lives of people who use drugs in different European cities.

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2

CONTEXTUALISING HARM REDUCTION IN EUROPE

Harm Reduction International's report, the *Global State of Harm Reduction 2020*[6], shows that implementation of vital harm reduction services has worsened globally since 2018, after having stalled since 2014. The number of countries where needle and syringe programmes (NSPs) are available remained level at 86, and the number of countries where opioid agonist therapy (OAT) is available decreased by two to 84.[1] Europe[7] represents one of the regions with the greatest number of harm reduction service available: almost half of the countries worldwide where NSP and OAT are available are in Europe, and ten out of twelve countries with officially sanctioned drug consumption rooms (DCRs) are European.

However, geographic gaps, and an uneven distribution of services, exist even in countries where harm reduction has been available for decades; for example, rural communities are particularly underserved in many countries in Europe. In addition to the geographic gaps in coverage, there are sub-groups of people who use drugs that experience barriers in Europe, including women who use drugs, men who have sex with men, people who use stimulants, or non-injecting methods of drug use, and people experiencing homelessness. Though these barriers in access to harm reduction services exist in Europe, and harm reduction coverage and funding is far from sufficient, there is no other region in the world where more than ninety percent of the countries have at least one NSP or OAT site, and more than ninety percent of the countries reference harm reduction in their national drug policies.

While there are still serious issues in harm reduction implementation in European countries, even in countries pioneering harm reduction, this region is in a privileged position compared to Asia, Latin America and the Caribbean, the Middle East and North Africa (MENA), and sub-Saharan Africa, where unfavourable drug policy environments limit harm reduction service implementation and some governments adopt punitive drug strategies that pose serious threats to the rights of people who use drugs.

Table 1: Global availability of harm reduction services by region

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

Table 2: European availability[8] of harm reduction services in practice and policy

Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room	Peer distribution of naloxone	OAT in at least one prison	NSP in at least one prison
Albania	✓	✓	✓	✘	✘	✓	✘
Bosnia and Herzegovina	✓	✓	✓	✘	✘	✓	✘
Bulgaria	✓	✘	✓	✘	✘	✓	✘
Croatia	✓	✓	✓	✘	✘	✓	✘
Czechia	✓	✓	✓	✘	✘	✓	✘
Estonia	✓	✓	✓	✘	✓	✓	✘
Georgia	✓	✓	✓	✘	✘	✓	✘
Hungary	✓	✓	✓	✘	✘	✓	✘
Kosovo	✓	✓	✓	✘	✘	✘	✘
Latvia	✓	✓	✓	✘	✘	✓	✘
Lithuania	✓	✓	✓	✘	✘	✓	✘
North Macedonia	✓	✓	✓	✘	✘	✓	✓
Moldova	✓	✓	✓	✘	✘	✓	✓
Montenegro	✓	✓	✓	✘	✘	✓	✘
Poland	✓	✓	✓	✘	✘	✓	✘
Romania	✓	✓	✓	✘	✘	✓	✘
Russia	✘	✓	✘	✘	✘	✘	✘
Serbia	✓	✓	✓	✘	✘	✓	✘
Slovakia	✓	✓	✓	✘	✘	✘	✘
Slovenia	✓	✓	✓	✘	✘	✓	✘
Ukraine	✓	✓	✓	✘	✓	✓	✘
Andorra	nk	nk	nk	✘	nk	nk	nk
Austria	✓	✓	✓	✘	✘	✓	✘
Belgium	✓	✓	✓	✓	✘	✓	✘
Cyprus	✓	✓	✓	✘	✘	✓	✘
Denmark	✓	✓	✓	✓	✓	✓	✘
Finland	✓	✓	✓	✘	✘	✓	✘
France	✓	✓	✓	✓	✘	✓	✘
Germany	✓	✓	✓	✓	✘	✓	✓
Greece	✓	✓	✓	✘	✘	✓	✘
Iceland	✓	✓	✓	✘	✘	✓	✘
Ireland	✓	✓	✓	✘	✘	✓	✘
Italy	✓	✓	✓	✘	✓	✓	✘
Luxembourg	✓	✓	✓	✓	✘	✓	✓
Malta	✓	✓	✓	✘	✘	✓	✘
Monaco	nk	nk	nk	✘	nk	nk	nk

Country or territory	Explicit supportive reference to harm reduction in national policy documents	At least one needle and syringe programme operational	At least one opioid agonist therapy programme operational	At least one drug consumption room	Peer distribution of naloxone	OAT in at least one prison	NSP in at least one prison
Netherlands	✓	✓	✓	✓	✘	✓	✘
Norway	✓	✓	✓	✓	✓	✓	✘
Portugal	✓	✓	✓	✓	✘	✓	✘
San Marino	nk	nk	nk	✘	nk	nk	nk
Spain	✓	✓	✓	✓	✘	✓	✓
Sweden	✓	✓	✓	✘	✘	✓	✘
Switzerland	✓	✓	✓	✓	✘	✓	✓
United Kingdom	✓	✓	✓	✘	✓	✓	✘
TOTAL	40	40	40	10	6	38	6
Percentage of implementing countries worldwide	45%	47%	48%	83%	40%	64%	60%
Percentage of European countries	91%	91%	91%	23%	14%	86%	14%

Needle and syringe programme implementation

Needle and syringe programmes are the most widely implemented harm reduction service globally, and, as of 2020, eighty-six countries implemented such services overall. However, there is a large disparity between world regions in NSP implementation, both in terms of availability and coverage. Of 206 countries worldwide, 179 report some injecting drug use.[2] In Eurasia, North America, Oceania, and Western Europe almost all countries with reported injecting drug use implement NSPs, but it is severely lacking in many countries in other regions including Asia, MENA and sub-Saharan Africa.

There are large differences among countries with NSPs in terms of coverage and accessibility. NSPs in Australia distributed 698 syringes per person who injects drugs (per year) in 2019,[3] whereas in Benin, in sub-Saharan Africa, NSPs only provide ten syringes per person visiting the programme per month[9]. In India, despite the increase in the number of NSPs in the country, the number of syringes distributed per person is just 35, even though new estimates suggest that injecting drug use is more prevalent in the country than previously documented.[5] Gaps in geographic distribution of services is a problem across all regions. Remote areas and rural populations are underserved even in high-income countries such as the United States, Canada, Australia, New Zealand and many countries throughout Western Europe. Another cross-regional issue is NSP provision for people who use stimulants. The needs of this population are generally not met despite the fact that stimulant injecting has been associated with local HIV outbreaks in four countries (Ireland, Germany, Luxembourg, and the United Kingdom) in Western Europe in the past five years.[6–8]

Stigma and discrimination against people who inject drugs continues to exist and hinder service access in all contexts and all regions,[9–11] and the lack of appropriate, gender-specific programmes for women who use drugs is a serious issue. Moreover, black, brown, and indigenous people experience serious additional barriers and discrimination, for example in North America and Oceania. Migrants who inject drugs face similar problems in access to harm reduction services in Western Europe.

Provision of opioid agonist therapy

Methadone is the most frequently prescribed OAT medication worldwide, followed by buprenorphine or buprenorphine-naloxone. Heroin assisted treatment is the least available option, being available only[10] in Canada, Denmark, Germany, Luxembourg, the Netherlands, Switzerland and the United Kingdom. While OAT is available in nearly all countries in Europe, OAT provision is insufficient in many other regions. For example, in sub-Saharan Africa, OAT is available in eight out of 49 countries with reported presence of injecting drug use in the region. OAT remains unavailable in Zimbabwe and Nigeria, despite significant populations of people who inject opioids and high HIV prevalence in both countries. In Latin America and the Caribbean, OAT is only available in Argentina, Colombia, Mexico and Puerto Rico; however, this is partly because in Latin America and the Caribbean, opioid use is relatively uncommon, and the region has the lowest proportion of opioid users among treatment admissions worldwide.[12]

Despite availability, significant barriers exist in the accessibility of OAT for certain communities. Women, transgender people, indigenous people, and people experiencing homelessness all face significant issues related to access in all regions. Cost is also a serious barrier in access to OAT in many countries; practices in implementation generate a serious financial burden for clients, such as significant out-of-pocket expenses in some cases in Australia, Lebanon and Mexico. Furthermore, geographic distribution of services is uneven, with particularly insufficient coverage in rural areas, a serious issue in every country.

Overdose prevention and drug consumption rooms

Globally, officially sanctioned drug consumption rooms (DCRs) are available only in Australia, Belgium, Canada, Denmark, France, Germany, Luxembourg, Netherlands, Norway, Portugal, Spain and Switzerland. The number of countries where DCRs are implemented has increased since 2018, with Portugal opening a mobile service in 2019.[13] Canada has the highest number of DCRs in the world with 39; in addition, a further 20 overdose prevention sites, which are primarily volunteer-run and funded, have also been opened in the country. There are two DCRs in Australia, the second facility opening in 2018 in Melbourne, and an independent review of the first 18 months of its operation found that it was beneficial not just in reducing harms, but in providing access to health and support services.[14] In Western Europe, DCRs increasingly include supervised inhalation spaces to adapt to the needs of people who smoke drugs and the decline in injecting;[15] for example, in the Netherlands, all 24 DCRs in the country allow smoking, while injecting is allowed in only 19.[16]

Naloxone provision to those who are at risk of an opioid overdose, or who might witness an overdose, is an effective means of preventing overdose deaths.[17,18] However, restrictive legal environments (for example where naloxone is available only in medical, emergency or treatment settings) hinders the implementation of naloxone distribution programmes across the world. Asia has only four countries where some form of naloxone distribution is available (Afghanistan, India, Myanmar and Vietnam). In the MENA region, Iran is the only country where naloxone is available outside of medical settings, and take-home naloxone is implemented; and in sub-Saharan Africa, naloxone remains largely unavailable or difficult to access. Naloxone remains highly limited in Latin America and the Caribbean, even in areas where opioid use is prevalent. However, there is a peer distribution network of naloxone in northern Mexico, and naloxone became available in Puerto Rico after a long advocacy campaign by civil society. Though naloxone is available in several countries of Eurasia, Ukraine is the only country in the region where naloxone is available without prescription.

The number of countries found to facilitate peer distribution of naloxone, whereby individuals can pass on naloxone without each recipient requiring a personal prescription, increased from 12 in 2018 to 15 countries[11] globally. Six of those are in Europe: Denmark, Estonia[12], Italy, Norway, Ukraine and the United Kingdom.

Viral hepatitis, tuberculosis and HIV

According to the latest report from the United Nations Office on Drugs and Crime (UNODC), an estimated 11.3 million people inject drugs globally, while HIV prevalence is estimated to be 12.6% and hepatitis C prevalence 48.5% among this population.[19] People who inject drugs are particularly vulnerable to HIV and viral hepatitis, but other groups, such as people who smoke opioids or stimulants, are also at greater risk than the general population.[20,21]using STI diagnosis history as an indicator. A cross-sectional study was conducted in 323 NIDUs of two facilities for alcohol and/or drug dependence treatment in the Goiás State, Central Brazil. All participants were interviewed about risk behaviors and STI history. Multivariable analysis was performed in order to identify predictors of STIs. Adjusted prevalence ratio (APR People who use drugs are disproportionately represented among tuberculosis (TB) cases and are at greater risk of developing more serious TB,[22] while people living with HIV who inject drugs are two to six times more likely to develop TB than the general population.[23–25]

The early implementation of harm reduction approaches (such as NSPs and OAT), and the sustained harm reduction response is credited with maintaining low prevalence of HIV among people who inject drugs in Australia, New Zealand and Switzerland, among others.[26–28] On the other hand, one of the most reported barriers to HIV and hepatitis C testing and treatment is services implemented in settings that are not appropriate to the needs of key populations. Treatment and care among people who use drugs has focused mainly on the needs of people who inject opioids. In Latin America, data shows that use of stimulant drugs has also been associated with higher risk of HIV transmission through unsafe sexual behaviours.[29,30] Furthermore, the sharing of pipes and higher-risk sexual practices among people who use stimulants are associated with increased hepatitis C infection.[12,31,32]

Stigma and discrimination towards people who use drugs, as well as unstable housing, poverty, criminalisation and incarceration, continue to act as major barriers to people accessing testing and treatment in every region. Additionally, there are still barriers to hepatitis C treatment for those actively using drugs, despite evidence showing strong treatment benefit with current treatment regimens for such patients.[33,34] Scaling up of, and access to, harm reduction interventions (not just the aforementioned NSP, OAT, naloxone distribution, but also community-based testing and treatment) are included among key measures in decreasing the prevalence of HIV and hepatitis in international and regional guidelines.[35–38] Community-led programmes are an effective way to reduce the barriers to diagnosis and treatment for key populations beside people who use drugs, such as transgender people and people experiencing homelessness.

Harm reduction during the COVID-19 pandemic

The pandemic showed that harm reduction services are essential public health interventions, crucial in reaching key populations. Networks of people who use drugs also played an important role during the pandemic, developing guidelines for avoiding COVID-19 and harm reduction tips for people who use drugs.[39,40] Peers played a crucial role beyond advocacy during the pandemic, showing that greater community involvement is fundamental to increase accessibility of services. They contributed to service delivery and in filling the gap in service provision with peer-to-peer needle and syringe distribution, providing input for other services working on-the-ground, and disseminating crucial information among the drug user community.

People who use drugs, especially people who smoke or inject drugs, face additional risks and vulnerabilities to COVID-19[13] infection compared to the general population.[42–44] Furthermore, people who use drugs may be less able or willing to adhere to quarantine and physical distancing measures in general, since they may need to seek out harm reduction services like NSPs and OAT programmes, or need to procure drugs to

avoid withdrawal symptoms.[42] Therefore, maintaining services for people who use drugs is even more vital during a public health crisis such as the COVID-19 pandemic. All the more so, since interruption of harm reduction services – closures, staffing restrictions, decreasing coverage, or reducing funds – can lead to a spike in HIV and hepatitis C infections.[45]

Although the pandemic seriously affected service delivery and the coverage of harm reduction services throughout the globe, in North America, Oceania and Western Europe, the impact was less severe compared to other regions. For example, the majority of European Union countries reported only a slight decrease or no change in availability of harm reduction services.[46] In Asia however, key populations experienced delays in accessing HIV and harm reduction services.[47] In Latin America, contact with harm reduction programmes has been limited due to physical distancing, and in MENA, harm reduction services had to reduce the number of working days, or close entirely, in all countries in the region. In sub-Saharan Africa, OAT services were entirely suspended in some countries during COVID-19 and take-home OAT is rarely available in the region.

There were also positive changes in service delivery during the pandemic. Most importantly, longer take-home periods for OAT, and less restrictive initiation procedures, were set up in many countries, providing evidence that these are feasible and beneficial. Out of the 84 countries where OAT is available, 47 countries (with at least one country in every region) expanded take-home periods for OAT medications and 23 made distribution more accessible with home delivery or OAT distribution in outreach services.[48] Nine countries expanded induction practices, including facilitated or rapid initiation.[48] Innovative measures were introduced to compensate for decreased availability; for example, online consultations replaced some face-to-face meetings in the MENA region, and service providers set up online shops for injecting equipment in the United Kingdom and New Zealand. These COVID-19 adaptations in OAT, NSP and treatment delivery can increase access to services and should remain in place.

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3

Participation of Civil Society Organisations in policymaking

Introduction

The importance of civil society involvement in policy making, including the development and implementation of drug policies, is widely recognized (1). In Europe, both the European Union and the Council of Europe (2) have recognised the essential need for the contribution made by CSOs to the development and realisation of democracy, securing the transparency and accountability of public authorities. Reports such as those produced by the Civil Society Involvement in Drug Policy Project[14] (CSIDP) provide relevant information on what kind of resources, capacities and mechanisms are needed to ensure meaningful civil society involvement (3). A continuous challenge is to identify and monitor if, and how, such meaningful involvement is assured.

This chapter intends to contribute to that by addressing the civil society involvement in policymaking in the cities and countries of C-EHRN FPs. Cooperation between CSOs and policymakers is evaluated by FPs at national and local levels. As explained in the introduction, in 2020 a stronger focus was added at the local level to be able to be closer to the experience of CSOs and to bring more insights into how official mechanisms get (or not) implemented on the ground. For that, the indicators used are those proposed by the code of good practice for civil participation in the decision-making process of the Council of Europe (4) and the assessment for the meaningful involvement of civil society in the area of drug policy in Europe by the Civil Society Forum on Drugs (CSFD) (1). The first set of indicators, defining levels of cooperation, was also used in 2019; the second, defining indicators to evaluate the aim and nature of cooperation, are used for the first time in 2020. As compared to 2019, new indicators were also included in the 2020 report to map CSO contributions to data collection and reporting, and participation in organised networks and national platforms. Due to the several changes regarding indicators, it is still not possible in this report to draw comparisons between 2019 and 2020.

Cooperation between CSO's and policymakers

Cooperation mechanisms

The cooperation between policymakers and CSOs to debate and give input on drug policies can assume different forms. At one end of the spectrum, cooperation is restricted to information exchange. At the other end, a solid partnership is established (5).

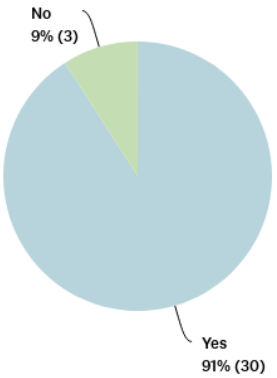
Following the definition of cooperative mechanisms of the Council of Europe (4), four different levels of cooperation can be considered:

- *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.

Cooperation at the national level

The great majority of the FPs reported the existence of structural cooperation between CSOs and policymakers on drug policy in their countries. Only FPs from Finland, Sweden and the Russian Federation reported having no national cooperative mechanisms (see Figure 5).

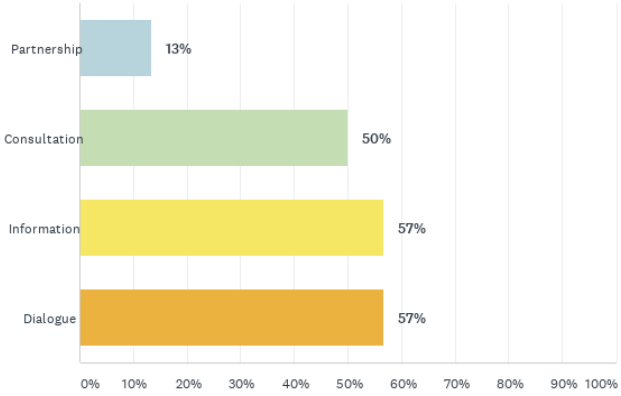
Figure 5: Is there any structural exchange mechanism between policymakers and CSOs in the field of drug policy in your country, at the national level?



Types of national-level collaboration

Information and dialogue were the most cited types of collaboration (57% each). Half of the respondents referred to having a consultation level of cooperation between CSOs and government at the national level, and only 13% referred to partnership.

Figure 6: Types of national collaboration between CSOs and governments



Reasons for a lack of national-level cooperation

The main reason given for a lack of cooperation were intolerant drug policies pursued by the respective countries or, otherwise, the lack of importance given to harm reduction.

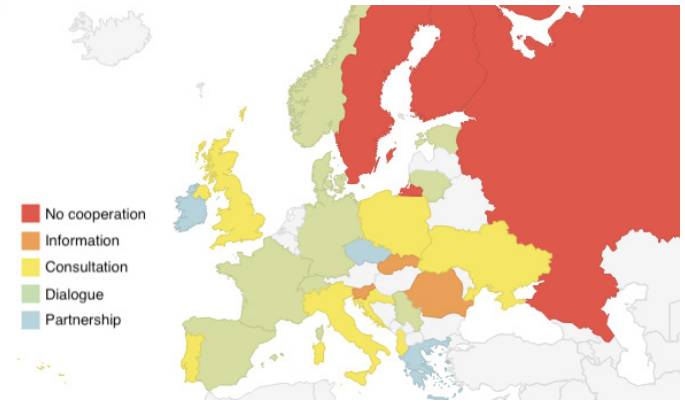
> *Harm reduction is seen as a niche-scene and is often disregarded by policymakers. There is no "systemic way" to influence policymakers*
> (FP Helsinki, Finland).

> *Because of the restrictive drug policy in Russia.*
> (FP Saint Petersburg, Russian Federation)

> *Government has a strict zero tolerance policy against all kinds of drugs.*
> (FP Stockholm, Sweden)

Map 2 portrays the highest type of collaboration mentioned at the country level by respondents in 2020.

Map 2: Highest type of collaboration - country level, 2020



FPs were asked to evaluate the exchange between government and CSOs from the perspective of its aims and nature. The indicators were developed by the thematic working group of CSFD, based on a literature review on the quality of civil society involvement that the group conducted in the summer of 2020 (1).

The aim of the exchange between government and CSOs

FPs were asked to indicate to what extent the following statements applied to their country context. The exchange between government and CSOs aims to:

- **Inform** Civil Society (CS) of new policy developments
- **Collect input** and knowledge from CS at the grassroots level to learn more about new developments, trends and problems
- **Share** developments, trends and problems from the field and the grass root level
- **Discuss** which kind of drug policies are effective, beneficial or harmful
- **Develop** new strategies and approaches
- **Improve** access to, and the quality of, **services** (health, social and drug-related services)

The 5-point scale for answering included the following options: strongly agree (1); agree (2); undecided (3); disagree (4); and, strongly disagree (5).

Figure 7 shows the overall results. Over 60% of FPs agree (or strongly agree) that the exchange between government and CSOs aims at informing CSOs on new policy developments and collecting their input on new developments, trends and problems. About half agree that the aim is to share information on such developments and needs. About 35-40% think that these exchanges aim at discussing policies, developing new strategies and approaches, and improving services. According to these findings, the majority of respondents view civil society involvement as a one-way information flow from the government to civil society, rather than an interactive, constructive exchange of ideas and views between decision makers and civil society.

***Figure 7: How much do you agree with the following statements about the aim of* exchanges between government and CSOs?**

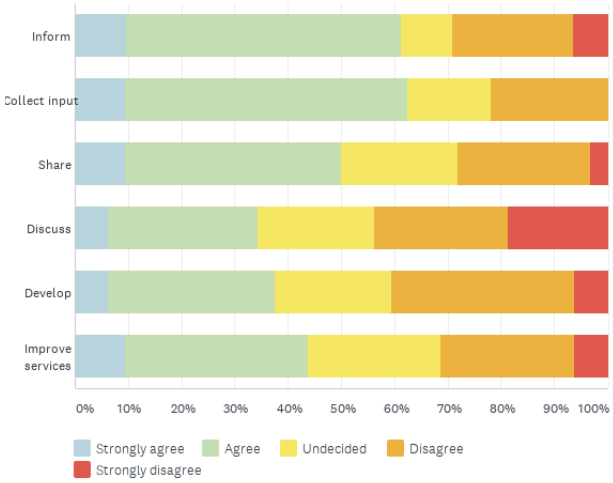


Table 3 shows the answers per FP. It must be born in mind that the evaluations as to the aim of the exchange between government and CSOs are subjective and, thus, not easily comparable between countries and cities. However, if comparisons are attempted, the best overall average (means of agreement for all 6 statements) includes Bern (Switzerland), Barcelona (Spain), Nicosia (Cyprus), and Amsterdam (Netherlands). Again, in comparison, the overall situation was estimated to be worst in Helsinki, London and Bratislava.

Table 3: How much do you agree with the following statements about the aim? (per city)

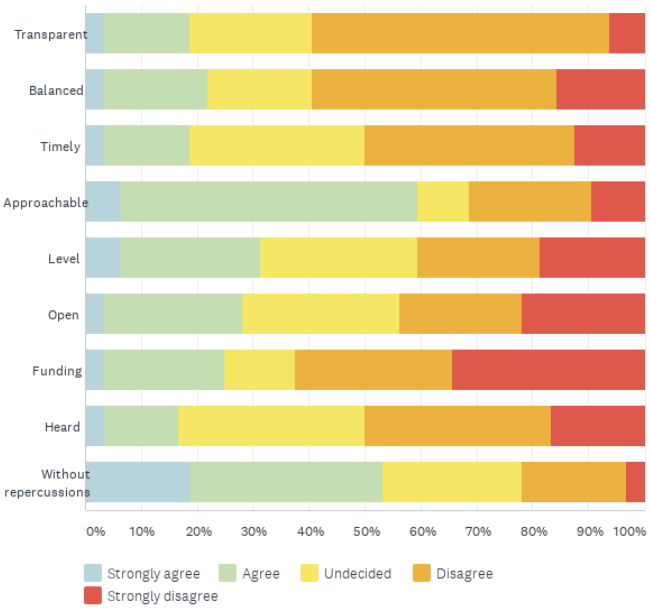
Please indicate how the following statements apply to the situation in your country.The exchange between government and CS aims to:							
Country	City	Inform	Collect input	Share	Discuss	Develop	Improve services
Albania	Tirana	3	3	2	2	2	2
Austria	Vienna						
Belgium	Antwerp	4	2	2	5	5	2
Croatia	Rijeka	1	2	2	3	2	2
Cyprus	Nicosia	2	2	2	2	2	1
Czech Republic	Prague	2	2	2	4	4	5
Denmark	Copenhagen	2	2	3	2	4	4
Estonia	Tallinn	2	2	2	3	2	2
Finland	Helsinki	5	4	5	5	4	4
France	Paris	2	2	2	2	2	2
Georgia	Tbilisi	2	3	3	5	3	4
Germany	Berlin	2	2	3	3	2	3
Greece	Athens	3	2	2	1	2	2
Hungary	Budapest	4	4	4	4	4	3
Ireland	Dublin	3	3	3	3	3	3
Italy	Milano /Roma	4	3	4	4	4	4
Lithuania	Vilnius	2	2	2	4	3	3
Luxemburg	Luxemburg	2	2	2	2	2	2
Norway	Kristiansand		2	2	2	2	2
Poland	Krakow	4	2	2	4	4	3
Portugal	Vila Nova de Gaia	4	4	4	5	4	3
Republic of N. Macedonia	Skopje	2	2	2	2	3	3
Romania	Bucharest	4	2	3	3	4	4
Russia	Saint Petersburg						
Scotland, UK	Glasgow	2	3	3	3	3	2
Serbia	Novi Sad	2	2	4	4	2	2
Slovakia	Bratislava	2	4	4	5	5	5
Slovenia	Ljubljana	2	4	4	4	4	4
Spain	Barcelona	1	1	1	2	1	1
Sweden	Stockholm	4	4	4	4	4	4
Switzerland	Bern	1	1	1	1	1	1
The Netherlands	Amsterdam	2	1	1	2	3	2
Ukraine	Kyiv	2	2	3	3	3	3
United Kingdom	London	5	4	4	5	4	4

The nature of the exchange between government and CSOs

Another set of indictors produced by the working group of the Civil Society Forum on Drugs (1) aimsto investigate the nature of the exchange between governments and CSOs. FPs were asked to indicate to what extent they agree with the following statements about the exchange between government and CS in their country:

- It is organised in a **transparent** way (e.g. it is easy to follow the decision making process)
- It is organised in a **balanced** way (represents different services well, communities, worldviews).
- It is organised in a **timely** manner (e.g. CS is informed in a timely way about any kind of new policy/development and the agenda of the meeting).
- Government officials are easily **approachable** by CSOs (e.g. they respond to emails/ phone calls).
- Decision makers are represented at the appropriate **level** (e.g. those who make deicisions are involved).
- The government is **open** to civil society initiatives (e.g. civil society initiatives are easily taken up by government).
- Adequate **funding** is provided (e.g. there is public funding for advocacy work).
- Civil society input is **heard** and taken into account when it comes to decision making.
- Civil society can speak openly and frankly and criticise **without facing repercussions** or budget cuts.

Figure 8: How much do you agree with the following statements about the nature of the exchange between government and CS?



Over half (between 52-59%) of FPs agree that civil society can criticise the government without facing repercussions or budget cuts, and that government officials are easily approachable by CSOs. Only about a third agree that decision makers are represented at the appropriate level and that the government is open to civil society initiatives. Even less (about 20%) think that exchanges between CSOs and the government are transparent, or that there is a balance between different perspectives. Over 60% disagree that adequate funding is provided.

Table 4 shows the responses from each FP. The 5-point scale for responses include the following options: strongly agree (1); agree (2); undecided (3); disagree (4); and, strongly disagree (5). Again, FP evaluations on the nature of the exchange between government and CSOs are subjective and, thus, cannot be easily compared between countries and cities. However, when a compar-

ison is attempted, the best overall average (the mean of agreement for all 9 criteria) was in Bern (Switzerland), Luxembourg, Barcelona (Spain), and Berlin (Germany). Again, in comparison, the overall situation was perceived to be worst in Helsinki, London and Bratislava.

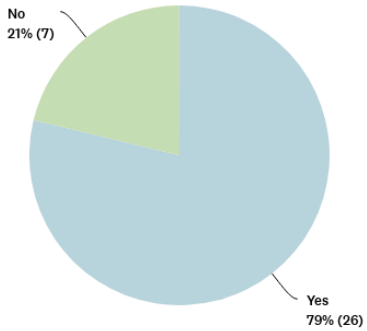
Table 4: How much do you agree with the following statements about the nature of the exchange between government and CS? (per city)

How much do you agree with the following statements about the exchange between government and CSOs in your country?										
Country	City	Transparent	Balanced	Timely	Approachable	Level	Open	Funding	Heard	No repercussions
Albania	Tirana	4	4	4	4	4	5	5	3	5
Austria	Vienna									
Belgium	Antwerp	4	4	4	4	4	4	4	4	4
Croatia	Rijeka	4	4	5	4	3	4	5	4	4
Cyprus	Nicosia	3	3	3	4	3	3	4	3	3
Czech Republic	Prague	4	4	2	2	4	2	5	5	2
Denmark	Copenhagen	4	4	4	2	3	2	2	3	2
Estonia	Tallinn	2	3	3	2	3	3	3		3
Finland	Helsinki	5	5	5	5	5	5	4	5	4
France	Paris	2	4	4	2	2	2	2	3	1
Georgia	Tbilisi	4	3	2	2	3	3	5		1
Germany	Berlin	2	2	2	2	3	2	3	2	2
Greece	Athens	3	4	3	4	4	3	5	4	3
Hungary	Budapest	4	2	4	2	5	5	5	5	4
Ireland	Dublin	3	3	3	2	2	3	3	3	3
Italy	Milano /Roma	4	4	4	5	5	5	5	4	2
Lithuania	Vilnius	4	4	3	2	2	4	5	4	2
Luxemburg	Luxemburg	2	2	3	2	2	2	2	2	2
Norway	Kristiansand	3	2	2	3	2	3	2	3	1
Poland	Krakow	4	4	3	2	3	4	3	3	2
Portugal	Vila Nova de Gaia	4	5	4	2	2	3	4	4	3
Republic of N. Macedonia	Skopje	3	4	3	3	3	3	4	2	2
Romania	Bucharest	4	4	4	4	4	4	4	4	2
Russia	Saint Petersburg									
Scotland, UK	Glasgow	3	3	3	2	2	2	2	3	3
Serbia	Novi Sad	4	2	4	4	4	4	4	4	4
Slovakia	Bratislava	3	5	5	3	5	5	5	5	3
Slovenia	Ljubljana	4	4	4	2	5	4	2	4	4
Spain	Barcelona	2	2	4	1	1	2	4	3	1
Sweden	Stockholm	5	5	3	2	4	5	5	4	1
Switzerland	Bern	1	1	1	1	1	1	1	1	1
The Netherlands	Amsterdam	4	4	2	2	2	2	2	2	2
Ukraine	Kyiv	4	3	4	2	3	3	4	3	2
United Kingdom	London	4	5	5	5	5	5	5	5	3

FP participation

About 80% of FP harm reduction organisations are directly involved in structural cooperation around drug policy with national policy makers.

Figure 9: Is your organisation involved in cooperation exchange at the national level?



Main forms of involvement

The main forms of involvement of FPs are either to provide information, or to participate in discussion forums. To a lesser extent, FPs take part in the direct drafting of policies and guidelines. Many feel, however, that their suggestions are not always included. The main forms in which FPs are involved in cooperation exchange with policymakers are highlighted below, with examples given by FPs.

- Providing information to the government on drug use trends; the needs of PWUD; the needs of harm reduction services; emergency situations; and to give suggestions on possible solutions to problems (e.g. FPs in Antwerp, Belgium; Rijeka, Croatia; Tallinn, Estonia; Berlin, Germany; Porto, Portugal; Krakow, Poland; Bratislava, Slovakia; Ljubljana, Slovenia; Amsterdam, the Netherlands; and in London, UK).

> *"We have a signalling function for the Ministry of Health. We provide bi-annual updates on the national state of affairs and challenges in the field. Also, if necessary, we have more regular contact. For instance, in between March and June 2020 we held regular contact with the Ministry to inform them on the impact of COVID-19 on harm reduction services.*
> (FP Amsterdam, Netherlands)

> *"APDES is occasionally called to give some inputs on some particular subjects or topics like the evolution of field dynamics. Still, this tends to happen in an urgent situation or, for example, when the State authorities failed to provide detailed information to the media.*
> (FP Porto, Portugal)

> *"By writing annual reports and projects in which we describe the problems we are facing and suggest solutions to these problems. Then the Government finances our efforts in carrying out these solutions and asks for information on our work. Also, we used to have a national office for combating drug use (it was suspended in 2019) which regularly initiated dialogue with NGOs, but now they mostly collect data on our work and our clients. From time to time, they will ask us to fill out a survey in order to get our perspective on a policy or situation.*
> (FP Croatia)

- Participating in drug policy and related forums or committees (e.g. FPs in Prague, Czech Republic; Paris, France; Dublin, Ireland; Luxembourg; Kristiansand, Norway; Barcelona, Spain; Bern, Switzerland; and in Kiev, Ukraine).

> *Nationally, we are part of an umbrella organisation (ANO) which chairs the drug policy forum of the government.*
> (FP Prague, Czech Republic)

> *Fédération Addiction ensures political representation of the health professional network at the national level when dealing with policy makers. We contribute to the decision-making process by communicating about the reality of the current situation in the field, and representing the interests of health practitioners and drug users. During the COVID-19 epidemic, weekly discussions have been organised between the public authorities and us. We've provided them with data about the way the professionals and services tackled the epidemic.*
> (FP Paris, France)

- Direct involvement in drafting policies and/ or guidelines related to drugs or related issues (HIV, HCV, homelessness, etc.)(e.g. FPs in Stockholm, Sweden; Athens, Greece; Vilnius, Lithuania; Skopje, Republic of North Macedonia; and in Novi Sad, Serbia).

> *We are involved in formulating guidelines for needle exchange, OST. Usually, we are asked to give our input and opinion. Sometimes these inputs are included.*
> (FP Stockholm, Sweden)

> *Regarding drug policy, we are taking part along with other CSO's in a group that frequently meets up with the national coordinator for narcotics for bottom-up design and implementation of the national drug strategy. Also, there are several contacts with state officials in the sector of health and social policy regarding the design and the implementation of more humane policies towards vulnerable groups. Also, there is the establishment of a proper collaboration with OST provider entities and other state supported harm reduction services. (FP Athens, Greece).*

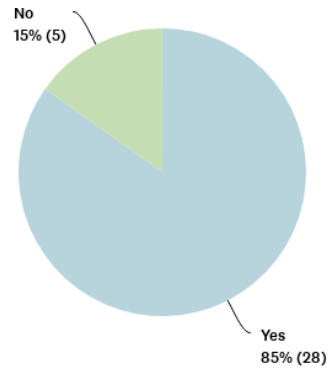
> *The Office for Combating Drugs has included ourselves and several other organisations in the process of drafting the new Action Plan of the Strategy for the Fight against Drugs. Together with institutions, we have prepared a new action plan but it has never been adopted by the Ministries. There is an initiative by the European Commission to standardise treatment, rehabilitation and resocialisation programmes. At the initiative of a consultant from the European Commission, the Ministry of Health included CSOs in the standardisation process.*
> (FP Novi Sad, Serbia)

As it is clear from the previous quotes, despite their participation, some FPs feel that their contributions are not taken seriously, or are not turning into practice.

Cooperation at the municipal level

Evaluation

Figure 10: Is there any structural exchange mechanism between policymakers and CSOs in the field of drug policy in your country, at the municipal level?



Reasons for the lack of municipal-level cooperation

The reasons given for a lack of structural collaboration at the municipal level, when it occurs, is that structural exchange mechanisms tend to be organised at the national level. Another reason is the restrictive posture of the government against drugs.

> *In London, there is no mechanism to engage on drug policy as this is seen as a national issue and treatment is devolved to the local boroughs. That being said, there is an opportunity to engage with police in some areas outside of London, especially in relation to diversion schemes which divert people caught in possession of drugs at the pre-arrest stage – five areas of England and Wales have specific schemes.*
> (FP London, UK)

> *The government has a strict zero tolerance policy against all kinds of drugs.*
> (FP Stockholm, Sweden)

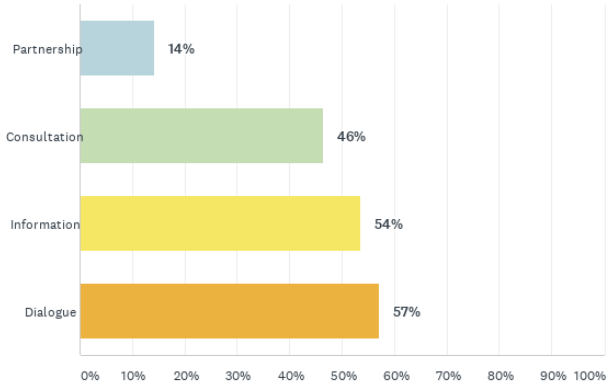
> *There are no coordination or policy-making councils at municipal levels. In general, decision-making on drug policy is very centralised and concentrated mainly within the Ministry of Interior and the Ministry of Justice;thus, not much is in place at municipal levels to take local decisions or to facilitate coordination.*
> (FP Tbilisi, Georgia)

> *There are no actual official platforms to give out information about the current situation of drug users to policymakers. There are some "meetings" where the social and health care ministry calls the third sector to hear what they say and then often disagree, saying that it can't be done. There is no official structure for the voice of PWUD and/or the third sector that I know of. The meetings, when rarely organised, are exclusive to only some organisations and have zero influence on anything*
> (FP Helsinki, Finland).

Types of municipal-level cooperation

When cooperation is present, the main types of collaboration follow the national pattern: the most mentioned ones are dialogue (57%) and information (54%), followed by consultation (46%) and, to a lesser extent, partnership(14%).

Figure 11: Types of collaboration between CSOs and government municipalities

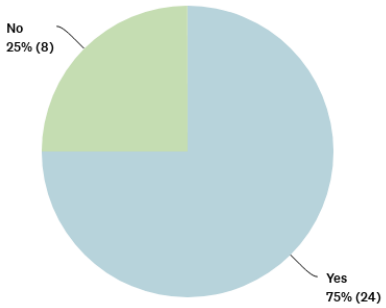


> *In very few cases (Turin, Italy, is an example) there have been partnerships for the definition of HR basic assistance levels. It must be noted that in many cities no exchange mechanism is in place, and where it is in place it mostly relates to information and consultation levels.*
> (FP Italy)

FP participation

About 75% of FP organisations are directly involved in structural cooperation around drug policy with municipal policy makers; this is slightly less than their reported cooperation at the national level.

Figure 12: Is your organisation involved in cooperation exchange at the municipal level?



Main forms of involvement

To a certain extent, the main forms of involvement of FPs at the municipal level are similar to their participation at the national level: providing information, participating in local discussion forums, and helping to draft local guidelines. A difference is that, besides being more targeted and specific to the local context, local participation is more personalised and can be more intense.

> *Fixpunkt and other providers are deeply involved in drug policy in Berlin.*
> (FP Berlin, Germany)

> *We have as an organisation and I personally developed a good relationship with municipal authorities, even when they changed after elections. We have taken part in numerous committees regarding various subjects for drug policy and in the response that the city of Athens (mayor, city council, etc.) must have towards PWUD/PWID. Also, as an organisation, we took part in important meetings between the Mayor, his specialised counsellor for addictions and problematic drug use. Moreover, we are working closely together*

at various levels with the people who run the Municipal shelter for homeless drug users and we constantly exchange information with the people who run it and the entities behind it. We have also, as an organisation, the luxury - let's say - to communicate directly with the Mayor for various things regarding our issues
(FP Athens, Greece)

> *Local governments exchange information with us, and we have reached agreements regarding common clients and their needs.*
> (FP Tallinn, Estonia)

> *Vilnius city municipality has a council on drug prevention issues that meets regularly. Some NGOs are on it. But the council is rather nominal. Cooperation on specific issues with specific municipal officials does happen quite often.*
> (FPVilnius, Lithuania)

> *The achievement has been the immediate improvement in hygiene and safer consumption for users, as well as more widespread health and public order benefits following monthly meetings with working groups of the third sector. Also, active elaboration in the updating of the REDAN Protocols.*
> (FP Barcelona, Spain)

> *The exchange of opinions to find solutions for the housing of drug dependent people who are homeless. There has been an effort from NAAC's position to involve them in the process, although there is still a lot to do.*
> (FP Nicosia, Cyprus)

Also, similar to the national level, participation at the local level is not always regarded as having a positive impact. Nevertheless, involvement at the local level seems to be slightly higher.

> *The Porto municipality, in spite of having a small group addressing drug related problems, does not use this expertise in a regular and systematic way. Depending of the political circumstances, the local authorities can be open to a briefing and occasional meeting (normally coming from a community solicitation – situation occurred during the consumption room episode). Still, the traditional approach from the local level is to take decisions based on a very strict and rigid top-down model. Nevertheless, we must say that in the Lisbon municipality, there is a serious effort to establish a more horizontal model in the decision making process. The municipality has created a regular group for consultation (with regular and systematic meetings) named "Porto LX" where civil society NGOs have a seat and are called to express an opinion over different subjects regarding communities living in a vulnerable situation.*
> (FP Porto, Portugal)

CSO contributions are not always taken seriously

Despite participation at different levels, some FPs feel that their contributions are not always taken seriously, and/or are not applied into practice. This was mentioned by FPs in Novi Sad (Serbia), Krakow (Poland), Rijeka (Croatia), and FPs from Athens (Greece) and Helsinki (Finland).

> *Last year, we (MONAR – Krakow) were twice involved by the National Bureau for Drug Prevention in work on issues related to harm reduction. One of them was a national meeting of people working in harm reduction programmes (something like a conference), which we shaped and programmed. The second event was a discussion on the national plan for HCV treatment. Unfortunately, neither our statements to abandon the criterion of excluding active drug users from treatment, nor any other findings, appeared in later materials.*
> (FP Krakow, Poland)

> *The attitudes and lack of knowledge of policymakers in Finland is the biggest problem; evidence-based policymaking is getting more scarce and intimidation tactics of politicians is growing. Drug users and drugs are a good enemy. We know what things could help people (i.e. help with prevention overdose deaths), but we are not allowed to put them into practice.*
> (FP Helsinki, Finland)

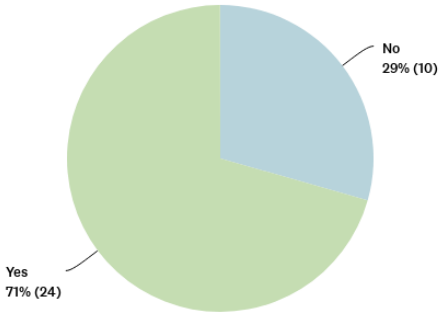
> *There is a major underrepresentation of the community. The general environment of CSO's in Greece is not exactly friendly with community leaders and they tend to try to influence and control every collective formed from the directly affected community. There is a huge degree of hypocrisy, both by state representatives and CSO's, towards PWUD/PWID. Very frequently, we have been used as material for tokenism and our initiatives have been severely attacked by ''relics'' of civil society that pretend to be friendly with us and [say] that they fight for our own rights. We are excluded from places that by definition are inclusive and it is a common belief that we are not able enough to join decision making processes and groups for drug policy formation. Even in initiatives in which we are included, we are treated as being totally incapable of designing effective policy guidelines; and there is the constant urge to totally control us. Also, there is the ''Divide and Conquer'' dogma. Hypocrits that pretend to be our allies try to divide us in order to pass their own agendas.*
> (FP Athens, Greece)

> *We feel like we can get in touch with policy makers, inform them of trends and problems in the field, but our inputs are rarely considered by policy makers.*
> (FP Croatia, Rijeka)

Civil Society networks and platforms

The majority of FP organisations are part of a civil society network or national platform in the area of harm reduction, human rights, or development aid (see Figure 13). These networks are intended for exchange with other CSOs, either at the national or local level.

Figure 13: Is your organisation part of a civil society network?



The main types and purpose of networks in which C-EHRN FPs are involved:

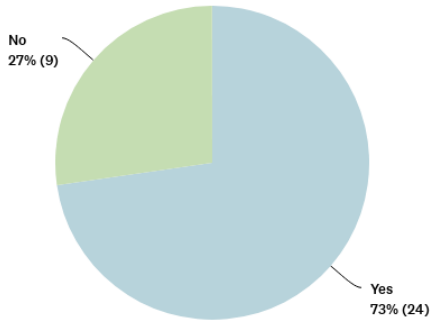
Types of networks	Purpose of networks
National or local harm reduction networks and platforms.	Advocate for the sustainability of harm reduction services and for changes in drug policies and practices; produce and collect knowledge.
Networks or associations of people who use drugs (including EuroNPUD and INPUD).	Defend and protect the rights of PWUD, make their needs visible, and fight against stigma and criminalisation.
Networks of services working with key populations, such as the homeless, sex workers, youth, or inmates.	Coordinate collaboration in cross-cutting fields; support each other's development and capacity building; implement joint advocacy campaigns; act with competent institutions in cases of human rights violations.
Networks of drug service providers (including, but not exclusively focused on, harm reduction)	Exchange knowledge and good practices, foster cooperation and development among services, as well as service quality.
Task force networks focused on specific diseases, such as STIs, HIV, TB, or HCV.	Exchange and develop knowledge and competencies in the care of specific diseases, and draft specific guidelines and policies.

In the case of the FP in Paris (Federación Addiction), the organisations is, per se, a national network.

Civil Society contribution to data reporting

Most C-EHRN FPs are currently contributing to data reporting in their country (other than the present monitoring).

Figure 14: Is your organisation contributing to data reporting in your country?



> *For those not contributing, the reported reasons are lack of capacity and time, or the fact that other organisations are responsible for national data collection on harm reduction (for instance, the EMCDDA Reitox Focal Points)* (FPs from Stockholm, Sweden; Helsinki, Finland; Milan and Rome, Italy; Vilnius, Lithuania; Kristiansand, Norway; Krakow, Poland; Glasgow, Scotland; Novi Sad, Serbia; and in London, UK).

For those working on data reporting, the main types of contribution include:

- Provision of data related to their own service provision (number of people assisted, services distributed, treatment completion, etc.). The data is mostly shared with the EMCDDA national Reitox Focal Point, but sometimes is directly shared with local or national government;
- Being part of an Early Warning System for new psychoactive drugs.

Conclusions

Most FPs are directly involved in cooperation exchange with the government, either at the national or the local level. Most of them are also part of networks and contribute to data reporting in their country. Nevertheless, while structural cooperation between CSOs and governments exist in the majority of countries, FPs consider that most of it relates to lower levels of cooperation, such as information exchange and consultation. Both at the national and the local level, governments are much more likely to engage with CSOs to gather necessary data and information to solve specific problems rather than to jointly draft policies and guidelines. Even when higher levels of cooperation occur, several CSOs feel that their inputs are not taken into practice.

More than half of the FPs view government representatives as being easily approachable by CSOs and that civil society can speak openly and frankly and criticise the government without facing repercussions or budget cuts. Nevertheless, important challenges to civil society involvement are still present. The challenges most mentioned relate to a perceived lack of transparency from the government and a lack of balance between different perspectives (from services, communities, and worldviews), besides a lack of adequate funding to CSOs.

All-in-all, it seems that there is still a long path to travel for civil society be meaningfully involved in drug policies. Even in cases where FPs said that they were satisfied with civil society involvement, sometimes this was felt as window dressing. Such a lack of meaningful involvement might also mean that governments are not used to work in partnership with CSOs. More efforts are needed to highlight the importance of civil society participation and to guarantee its practical implementation.

Finally, it is worth stressing the need for quality standards/principles for civil society involvement. Great steps have already been developed by the CSFD in creating some indicators, used as part of C-EHRN monitoring for the first time this year. Further development of these indicators, and evaluating their ability to reflect civil society involvement, is needed. Measuring meaningful civil society involvement is a difficult task. As already mentioned in this report, FPs evaluations might be very subjective, and it is difficult to achieve comparable data in relation to other countries and sometimes even in relation to the previous year. Besides, monitoring CSO involvement might require a broader approach, such as by investigating the needs and views of government representatives, for instance.

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4

Essential Harm Reduction services

This is a new section in the C-EHRN Monitoring Report. The aim is to start monitoring developments on a range of essential harm reduction services in European cities within the previous 12 months. The state of harm reduction services in the responding cities is assessed from two directions: from the viewpoint of people using the service (service-users) on the one hand, and from different harm reduction services on the other. Respondents were also asked to estimate how their situation compares with the national situation and to name major needs of PWUD in their city.

Differences between services and user groups

The first question concerned the state of harm reduction services for different user groups. Altogether, 13 populations in need of services were named in the questionnaire. The 5-point scale for answering includes the following options (if the services are able to provide services for different groups): *to a great extent (5); somewhat (4); very little (3); not at all (2); not relevant to my city (1).*

As shown in Table 5, in most of the cities there are services provided to drug users who inject drugs (opioids, stimulants or NPS) and who experience homelessness. The scarcest situation with regard to city-level harm reduction services are for people who use drugs intranasally or by smoking, as well as for migrants and prisoners. However, for the latter two groups (prisoners and migrants) the city level might not be the most relevant when it comes to offering services.

In some of the cities, there are harm reduction services mainly for PWID and sex workers: this is the case in Vilnius (Lithuania), Tbilisi (Georgia) and Stockholm (Sweden). In addition to the named 13 populations, one more service user group was named: in Krakow (Poland), there are specific services for aging drug users.

The second question assessed the situation in cities with regards to 19 different harm reduction services. In general, the most prevalent harm reduction services in 35 European cities were needle and syringe exchange programmes (NSP), opioid substitution treatment (OST), and outreach work. The least prevalent services were drug consumption rooms (DCR), drug checking through the use of fentanyl test strips, and naloxone provision in prisons.

In addition to the named 19 services, other activities were also recognised. In Tallinn (Estonia), officials have launched a programme which gives the police the possibility to refer detained drug users to a support programme instead of punishment. In Krakow, there is a special day shelter for homeless stimulant users in a drop-in centre to prevent psychoses.

It must be born in mind that the estimations as to the extent to which services are available are subjective and, thus, not easily comparable between countries and cities. However, if a comparison is made, the best overall average (mean of service provision for all 13 subsets; see Table 5) when it comes to serving all 13 groups of PWUD was in Bern (Switzerland), Paris (France) and Tirana (Albania). Again, in comparison, the overall situation was estimated to be worst in Vilnius, Stockholm and Budapest (Hungary).

Table 5: Are harm reduction services in your city able to provide services for the following populations

	People who inject opiates (including synthetic opioids)	People who inject stimulants or new psychoactive substances	People who smoke opiates	People who smoke stimulants or new psychoactive substances	People who use intranasal amphetamines/cocaine/ cathinone, etc.	Sex workers	People experiencing homelessness	Women	LGBQTI	Young people who use drugs (under 18 years of age)	EU Migrants	Non-EU migrants	People in prison settings
Tirana	5	4	5	4	3	5	5	5	5	5	5	5	5
Vienna	5	4	3	3	4	3	5	4	3	4	4	3	2
Antwerpen	5	5	5	4	4	4	4	4	3	3	4	4	4
Rijeka	5	4	2	2	2	4	5	5	5	5	3	3	4
Nicosia	4	4	4	4	3	2	3	4	3	2		3	3
Prague	4	4	4	4	4	4	5	3	4	4	4	4	3
Copenhagen	5	5	5	5	2	4	4	4	4	3	4	4	1
Tallinn	5	5	5	4	4	4	3	4	3	2	1	1	3
Helsinki	5	5	4	4	4	4	4	4	3	4	4	3	3
Paris	5	5	5	5	5	5	5	5	5	4	4	4	4
Tbilisi	5	5	3	3	2	5	2	5	2	2	2	2	3
Berlin	3	3	5	4	3	5	4	4	4	3	4	4	4
Athens-	4	3	4	3	3	3	4	3	3	3	3	3	3
Budapest	3	3	1	3	3	3	3	3	3	3	2	2	2
Dublin	5	5	4	4	4	4	5	4	4	2	4	3	4
Milano	4	3	4	3	3	4	4	4	4	2	4	3	4
Bishkek	5	4	2	2	2	5	5	5	5	3	1	5	5
Vilnius	4	2	2	2	2	3	2	3	2	2	2	2	2
Luxemburg	4	4	4	4	3	5	5	3	4	3	4	4	5
Kristiansand	5	4	4	3	3	4	4	4	4	4	3	3	4
Krakow	5	5	2	4	3	3	5	3	3	5	4	5	4
Vila Nova de Gaia	5	3	5	3	3	4	4	3	3	3	4	4	2
Skopje	5	4	4	4	4	5	4	4	4	5	4	4	1
Bucharest	4	4	3	3	1	4	4	4	4	4	1	1	2
Saint	5	4	3	3	4	4	4	5	4	2	2	3	2
Glasgow	5	4	5	4	4	4	5	5	4	3	3	4	5
Novi Sad	5	4	3	3	3	5	5	5	5	5	5	5	3
Bratislava	4	4	3	3	3	4	4	4	4	2	1	1	2
Ljubljana	5	5	5	5	5	3	5	5	3	4	3	3	4
Barcelona	4	5	4	4	5	4	5	4	4	3	3	3	4
Stockholm	4	4	2	2	2	2	2	2	3	2	2	2	2
Bern	5	5	5	5	5	5	5	5	5	5	5	5	4
Amsterdam	5	4	5	4	5	5	5	4	5	4	5	4	3
Kyiv	5	4	2	2	2	5	4	4	4	4	3	4	4
London	5	5	3	3	3	4	5	4	4	4	5	5	4

Table 6: Are the following services available in your city for people who use drugs?

	Outreach work	Peer support	NSP	Safer smoking kits	Safer intranasal kits	DCR	Drop-in center	Drug checking	Fentanyl Test strips	OST	OST in prison	Naloxone	Take-home naloxone	Naloxone in prison	Sexual risk prevention	HIV services (prevention, testing or treatment)	Specific employment opportunities/income generation for PWUD	Online harm reduction	Shelters	Legal support
Tirana	5	5	5	5	4	1	4	1	1	5	5	3	3	3	5	5	3	3	3	3
Vienna	5	3	5	4	4	2	4	4	1	5	4	3	3	2	4	5	3	3	5	3
Antwerpen	2	4	4	3	4	2	5	2	2	5	5	2	2	2	4	5	3	3	4	3
Rijeka	2	4	5	2	2	2	5	2	2	5	5	3	2	4	4	4	4	4	5	4
Nicosia	2	2	4	2	2	2	4	2	2	4	4	4	4	2	2	4	2	2	2	2
Prague	5	4	5	3	3	2	5	2	4	4	3	3	3	2	4	5	3	4	4	4
Copenhagen	5	5	5	3	2	5	2	5	5	4	4	2	4	4	4	4	4	4	4	4
Tallinn	5	5	5	2	2	2	5	3	2	4	4	5	5	4	5	5	3	3	3	3
Helsinki	5	4	5	1	3	2	5	2	2	5	5	3	2	3	5	5	3	5	4	4
Paris	5	5	5	5	5	4	5	5	4	5	5	4	5	4	4	5	3	4	3	4
Tbilisi	5	5	5	2	3	2	4	3	2	5	2	5	5	2	5	5	3	2	2	4
Berlin	5	3	5	5	4	5	5	2	2	5	5	3	3	2	4	5	4	3	4	4
Athens-	3	3	3	2	2	2	3	2	2	5	4	2	2	2	4	4	2	2	3	3
Budapest	3	2	3	2	2	2	4	2	2	4	2	2	2	2	3	3	3	3	4	4
Dublin	5	3	5	4	4	2	4	2	2	5	5	4	4	2	4	4	3	4	5	3
Milano	2	3	4	3	3	2	4	3	2	5	5	4	4	3	3	3	3	3	2	3
Bishkek	5	5	5	2	2	2	2	2	2	5	5	5	5	5	4	5	3	2	3	4
Vilnius	3	2	4	2	2	2	2	2	2	4	3	4	4	2	4	4	2	2	2	2
Luxemburg	3	2	5	3	3	5	5	4	2	5	5	4	3	2	5	5	3	4	5	4
Kristiansand	2	5	4	3	2	2	4	2	2	5	5	5	5	4	4	4	4	3	4	4
Krakow	3	3	5	2	2	2	5	4	3	5	5	2	2	2	4	5	3	3	5	5
Vila Nova de Gaia	5	4	5	4	3	2	4	2	2	5	3	3	2	2	4	4	3	3	4	3
Skopje	5	5	5	2	2	1	5	1	1	5	5	3	1		5	5	2	4	2	5
Bucharest	2	3	4	1	1	2	2	2	2	4	3	4	2	2	4	4	2	3	4	2
Saint	5	5	5	2	2	2	3	2	2	1	1	4	4	1	4	5	3	5	3	4
Glasgow	2	5	5	2	2	2	5	2	2	5	5	5	5	5	5	5	4	4	5	3
Novi Sad	5	5	5	2	2	2	5	2	2	5	5	4	2	2	5	5	2	5	2	4
Bratislava	5	3	4	2	2	2	4	2	2	4	2	2	2	2	3	3	3	3	3	3
Ljubljana	5	3	5	1	4	1	5	5	1	5	5	4	2	2	4	5	1	3	4	4
Barcelona	5	4	5	4	4	5	5	4	2	5	5	5	5	4	5	5	3	1	3	5
Stockholm	2	5	5	2	2	2	4	2	2	5	4	4	4	2	2	4	2	2	4	3
Bern	5	5	5	5	5	5	5	5	5	5	3	5	5	3	5	5	5	5	5	5
Amsterdam	5	4	5	4	4	5	5	5	3	5	4	4	3	3	5	5	5	5	5	5
Kyiv	5	5	4	2	2	2	3	3	2	5	4	4	3	4	5	5	3	4	4	4
London	2	4	5	2	2	2	4	2	2	5	5	5	5	3	4	4	2	5	5	4

Highlight: Harm reduction in Tirana, Albania

People who inject drugs (PWID) are one of the largest key populations in Albania. A total number of 6,182 PWID (range of 3,626 to 8,737 with a 95% confidence interval) have been estimated to live in Albania. A crude estimate is that in Tirana there are 4,324 PWID. The HIV prevalence is low in Albania; it is estimated that 1% of PWID live with HIV.

Interview with Besnik Hoxha from Aksion Plus

Q: According to the data you reported for the monitoring, Tirana is able to reach various types of sub-groups of people who use drugs and also offer several types of harm reduction services.

Are these services based on the national drug strategy?

A: *Yes, in some regions for specific issues. Yet there is a budgeting gap for some activities.*

Q: Could you let us know how have these services developed? And for how long have you had them?

A: *HR programmes started around 2000 and are delivered via: drop-in centres, mobile units, outreach workers, and secondary distribution.*

Q: How are the services organised? (are the different population groups assisted in the same service or are there specific services for different key-pops?)

A: *We mostly serve PWID and their injecting/sexual partners, in addition to their family members. Other sub groups are also included: female sex workers and LGBTI.*

Q: How many harm reduction services are there in Tirana? Is the coverage sufficient?

A: *In Albania, HR services are provided to PWID by two NGOs, one that implements the OST programme in Tirana and eight other municipalities, and the other one that provides the needle and syringe programme in Tirana and three other municipalities. HIV prevention services to PWID are provided by two NGOs, Aksion Plus and Stop AIDS.*

Aksion Plus implements the Methadone Maintenance Treatment (MMT) programme in Tirana, Durrës, Vlorë, Shkodër, Elbasan, Berat, Korçë, Sarandë and Fier. Nearly 950 clients attend OST centres, and in prisons as well. We provide MMT, as well as condoms, lubricants, and IEC materials at their drop-in centres. Services are provided by 15 office staff which includes a manager, medi-

cal doctors, nurses, a lab technician, psychologists, and social workers.

Stop AIDS implements needle and syringe programming in Tiranë, Durrës, and Elbasan. Stop AIDS provides needles and syringes, condoms, and HIV and other STI testing through both outreach and drop-in centres. Services are provided by office staff that includes a manager, medical doctor, nurses, a lab technician, psychologists, social workers and 25 outreach workers and peer educators.

Regarding testing of HIV and other STIs, they are conducted by almost all GFATM sub-recipientS focusing on PWID, MSM and FSW. Currently, under the GFATM support, HR services are being offered in nine cities of the country, in addition to eight prisons (pre-detention and prison settings).

Q: *What types of services are those?*

A: *OST with nine centres across the country and a combination of HR services is being applied: drop-in Ccentres, mobile units, and outreach activities.*

Q: Are peers involved in service delivery?

A: *Yes. Former or current drug users are involved as outreach workers.*

Q: Who pays for them? City, national sources, donors? And how sustainable they are?

A: *They are paid by the Global Fund project. We are planning to involve local and central government to continue these services after the GFATM project. Some laws and bylaws are drafted for this purpose. WHO Albania is facilitating this process.*

Q: Can you let us know your current challenges/future plans, what is missing?

A: *Lack of funds, low salaries of the staff, staff burnout, lack of interest and will from the government to invest in harm reduction programmes, as well as a lack of interest from international donor agencies to support harm reduction programmes. Only UNFPA Albania has funded some complementary activities for PWID and other sub groups. In the presence of COVID-19, everything is getting more complicated and uncertain.*

How do cities compare with the national situation?

Respondents were asked to estimate how their city compares with the national situation in terms of harm reduction coverage. A great majority (94%) answered that their city has better (79%) or similar (15%) service coverage than the rest of the country. This clear result can probably be explained by the fact that most of the partaking cities are capitals and/or bigger cities which typically have more PWUD and harm reduction services than smaller cities or rural areas.

Despite this – the relative situation being better in their city than nationally – a majority (59%) of respondents said that current harm reduction services are insufficient to meet the needs of PWUD.

Figure 15: Are harm reduction services in your city able to provide services for the following populations? (N=34)

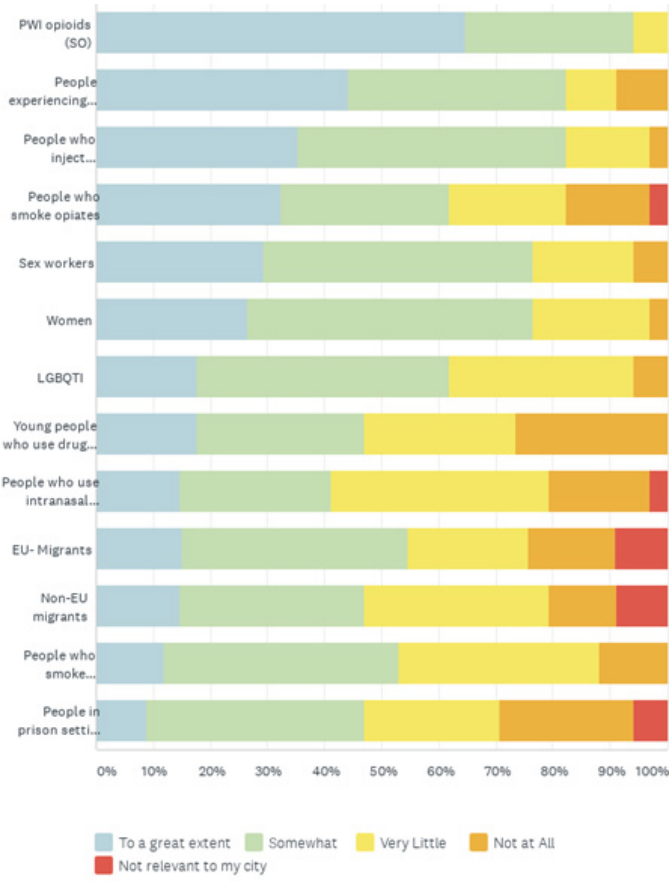


Figure 16: Are the following services available in your city for people who use drugs? (N=34)

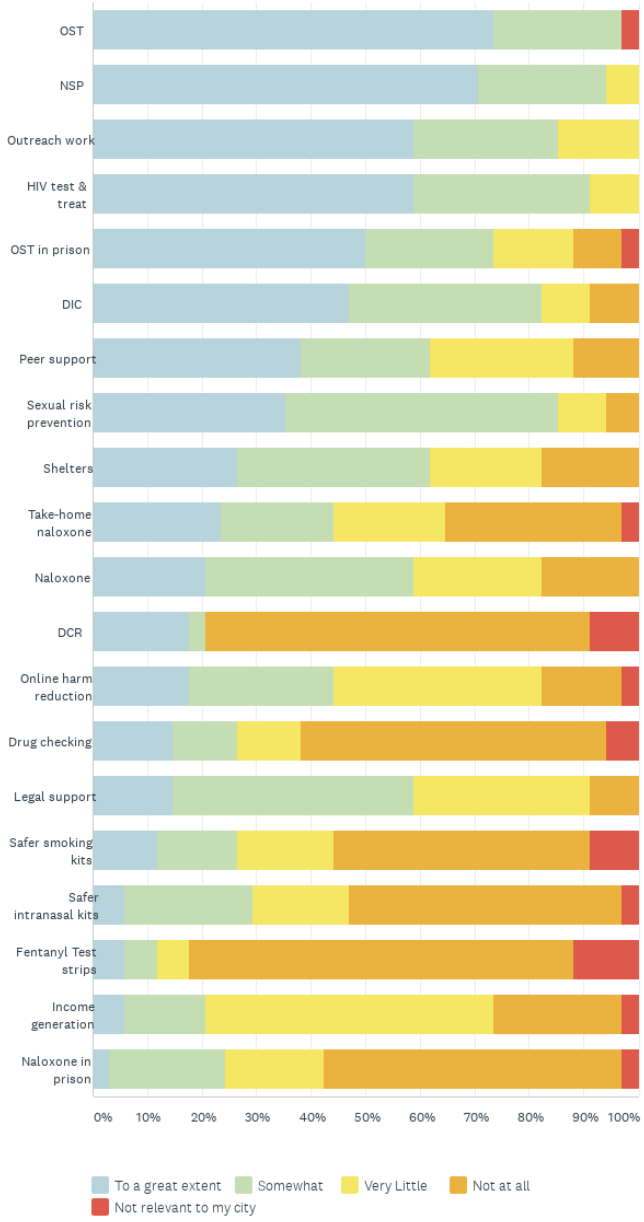


Figure 17: Do you feel the current harm reduction services at your city can meet with needs of PWUD?

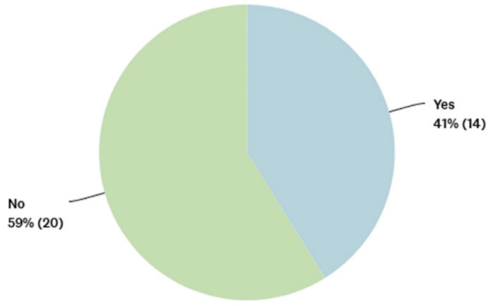
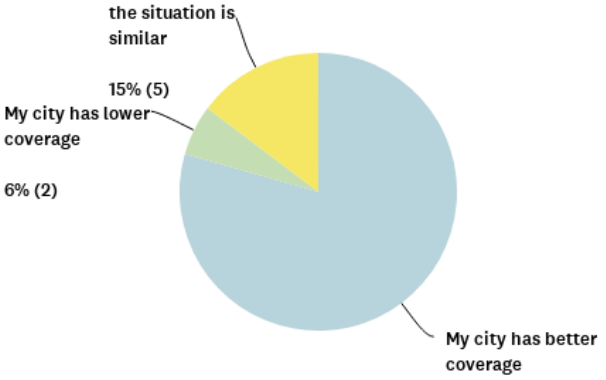


Figure 18:. How does your city compare with the national situation in terms of harm reduction coverage?



Improvements needed to harm reduction services

Respondents were asked to freely describe the major needs that PWUD might have in their cities, and what is needed to improve the harm reduction services. The main needs and anticipated improvements that were mentioned are as follows:

- Tirana: shelters, employment opportunities for PWUD.
- Vienna: safer use measures in prison, employment opportunities for PWID, drug consumption rooms (DCRs).
- Antwerp: more services and funding.
- Nicosia: methadone maintenance, shelters, harm reduction in prison.
- Prague: more services, more OST, opening of a DCR.
- Copenhagen: More health services, substitution treatment for those without a Danish social security number.
- Tallinn: safer-use information also for non-injecting drug use, DCRs, shelters for PWUD (when not sober).
- Helsinki: drug checking service, DCR, better access to HCV treatment.
- Tbilisi: services for non-injectors, new types of OST (heroin and other), drop-in services at existing harm reduction sites.
- Athens/Thessaloniki: housing, psychosocial support with integrated services.
- Budapest: political support for harm reduction/no attacks against service providers, adequate funding for services, trained and motivated professionals/peer leaders.
- Dublin: Access to income generation for PWUD, DCRs, greater access to naloxone.
- Rijeka: drug checking, better availability of naloxone.
- Milan/Rome: 24/7 HR services, better service coverage, DCRs.
- Bishkek: OST with buprenorphine, gender-based services, a comprehensive client-oriented approach.
- Vilnius: Scaling-up of existing services, outreach work, drug checking.
- Kristiansand: DCR, low threshold outreach work, more OST, employment for PWUD.
- Krakow: DCR, naloxone distribution.
- Porto: DCR, take-home naloxone, HR services for women, improving shelters and services for the homeless, alcohol interventions, interventions for stimulant users, extension of drug checking.
- Skopje: Improving HCV prevention, safer smoking kits, drug checking, take-home naloxone.
- Bucharest: improving service coverage and quality, coordination with other services.

- St. Petersburg: more mobile units and drop-in centres for PWUD.
- Glasgow: greater availability of injecting equipment, lower threshold to - and wider choice of - OST, DCR, drug checking.
- Novi Sad: take-home naloxone, shelters for PWUD, safer smoking kits and intranasal kits, water for injections, masks, shelters for PWUD, extending DCR opening hours, more DCRs for smoking.
- Stockholm: anonymous needle exchange services, quicker access to OST, naloxone without prescription (peer-to-peer distribution).
- Amsterdam: more services and outreach work among MSM who inject drugs.
- Kiev: community centres and drop-in centres, increased availability of services and right to choose between services, shelters, dispensing food, free rehabilitation.
- London: DCRs, drug checking, paraphernalia for smoking and intranasal use.

> *"To allow several organisations that have experience and access to clients to deliver harm reduction services in the city. The choice of a service provider should not have one criterion (for selecting a winner) - a low price. This directly affects the quality of the services provided. The volume and burden on social workers (which now exist within the framework of state procurement) should be reduced, since they do not allow the provision of quality services and access 'hard-to-reach groups'. Accordingly, the price for services should be revised and provide for the possibility of high-quality service provision. Organisations that receive government money must register as VAT payers. This changes the accounting of the organisation, complicates it, and leads to the risks of auditing. The mechanism that is used in the transition of services to state funding should not change the structure of the work of non-governmental organisations, and vice versa, to contribute to the development of civil society organisations in Ukraine; the development of the harm reduction package and algorithms of work with the involvement of community members."*
> (FP Kiev, Ukranie)

> *"If we consider the marginalised PWUD that primarily use base-cocaine and heroin: the services generally meet their needs. Similarly, PWUD in the party scene have access to drug testing in two different locations and access to ample drug education. As far as we know, the only PWUD group that is not served sufficiently are MSM who inject their drugs in chemsex settings. They have limited access to services as they do not use the needle exchange services for homeless injectors, and they are also hard to reach for education on safer injection practices. Unsafe injection practices are common."*
> (FP Amsterdam, Netherlands)

> *"There is a need for "legal reform in respect of the interventions described as the main needs (see London in the list above) or an increase in local agreements with police and public health to permit these activities. Greater funding – local authorities became responsible for funding and commissioning of drug and alcohol services under the Health and Social Care Act 2012, while facing an estimated 37.3% reduction in central government funding between 2010-11 and 2015-16. As a result, "drug misuse treatment" has faced more reductions in funding than any other public health area in 2016-17 with a 14% reduction in funding between 2015-16 and 2016-17. Net expenditure on adult drug and alcohol services has decreased by 19% in real terms between 2014-15 and 2018-19."*
> (FP London, UK)

In general, many respondents generally called for more funding and political support for harm reduction as well as wider understanding of harm reduction approach their cities and countries.

Conclusions

Often, country-based monitoring reports are only provided if a given country has, or has not, a certain harm reduction service. To be more analytical, it is important, 1) to go to the city/local/regional level; 2) assess differences in service provision between cities and within one country; and, 3) assess which services are lacking in the city and if the existing services can meet demand.

The overall picture from this novel part of the C-EHRN monitoring tool is that there is an insufficient amount of harm reduction services available in European cities, and that in many cities the existing services are largely focused on, and limited to, PWID and their services (especially NSP and OST). In most European cities, the harm reduction services lack funding and political support. In many cities, the integration of harm reduction services with other parts of the health and social care system is weak.

Info box: PWUD experiences

As part of C-EHRN monitoring in 2020, a separate questionnaire was sent to PWUD. Altogether, 38 PWUD from 36 different European cities responded.

Respondents were reached through the European Drug User Union (ENPUD) and its national member organisations. In what follows, assessments by PWUD are presented as to the state of harm reduction services in their city of residence.

In many respects, the answers from PWUD are in line with answers from C-EHRN focal points. As shown in Figure 19 below, PWUD also assess that needle exchange services and OST are relatively easy to access in their cities. Alternatively, drug consumption rooms, take-home naloxone, and drug checking services are rare.

Figure 19: Please check the following harm reductio services and tell us how accessible they are for PWUD in your city (n=38)

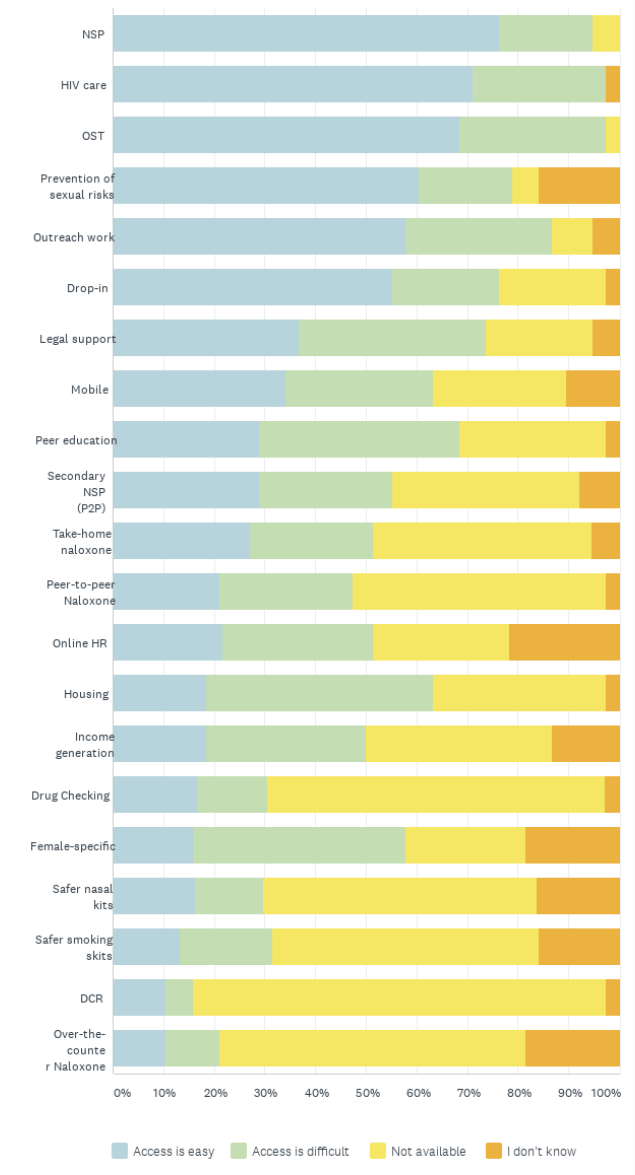
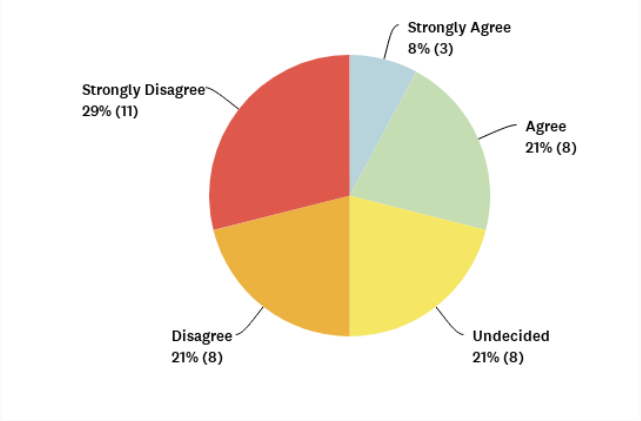


Figure 20 below shows that only 11 users out of 38 felt that PWUD are involved in the planning, delivery and evaluation of harm reduction services in their cities. A participatory approach in harm reduction service design is clearly something to be developed.

Figure 20: People who use drugs are meaningfully involved in the planning, delivery and evaluation of harm reduction services in my city (n=38)



PWUD were also asked to freely describe what difficulties they encounter in their daily lives. The following are some answers from different cities:

Prague (Czech Republic): *"No place to inject, not enough OST possibilities, no substitution for meth, housing problems, no naloxone".*

Helsinki (Finland): *"Services are open at 'office hours', there is no harm reduction services at night time. HCV-testing is easy to get, but the path to treatment isn´t available easily. Low threshold services need more service-hours."*

Athens (Greece): *"No money at all for community networks, we can't work voluntarily any more, we have produced debts in our family and our house."*

Budapest (Hungary): *"Basically 2-3 places remain in the city who work with active addicts, and they usually have narrow opening hours, limited staff and equipment because of their short budget. Even if there are other services, they are on the other side of the city, or you don't even know about them. The governments methadone programme has a limit that has been maxed out for years, so you can't get methadone (only on the black market), only Suboxone."*

Dublin (Ireland): *"Homelessness is a big issue. Alcohol use among PWUD and an unreliable black market for benzos, Z-drugs and Pregabalin."*

Vilnius (Lithuania): *"Harm reduction services are very weak. Most of them are concentrated on injecting drug users, while more and more people are using drugs intranasally or orally, or smoking. As well, there is no peer-to-peer involvement at all in the existing services (excect "Young Wave", who are providing harm reduction in nightlife settings and who are not getting any funds/support from the government)."*

Krakow (Poland): *"The most significant problems are the issues related to OST and difficulties with them. In the OST (methadone) programme in Rydygier Hospital there has been conflict with the personnel, especially with the doctor who is head of the treatment programme. For the doctor consultation, patients have to wait for months. Rules for methadone patients are too strict and it is too easy to be relegated from treatment."*

Bucharest (Romania): *"Hard to get into rehab or get new needles other than in the pharmacy. NSPs are few and far away."*

London (UK): *"We have lost a lot of very knowledgeable workers when it comes to harm reduction. It's all about the recovery agenda and people successfully completing drug treatment. We need to go back 10-15 years when we were treated with respect as adults."*

5

Hepatitis C

Introduction

People who inject drugs (PWID) account for the majority of new cases of hepatitis C virus (HCV) infections in Europe. In the WHO European region, an estimated two million PWID are living with active HCV infection, about 75% of whom are thought to live in Eastern European countries.

On the basis of the first C-EHRN monitoring of 35 European countries in 2019, as well as other information sources, it is evident that HCV testing and treatment for PWID remains insufficient: despite progress reported from several countries, further improvements of the existing continuum-of-care interventions for PWID are needed (1,2).

This section reports on the experiences of CSOs that provide harm reduction services as to the availability of, and access to, interventions that constitute the HCV continuum of care. It 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.

Unlike in 2019, the questions focus mostly on city level situations instead of national level. On many reported issues for the HCV chapter, however, we can assume that the city and national situation are the same, which enables us to make also comparisons in progress between 2019 and 2020.

When making comparisons, however, it should also be born in mind that there are some differences in participating countries and cities between 2019 and 2020.

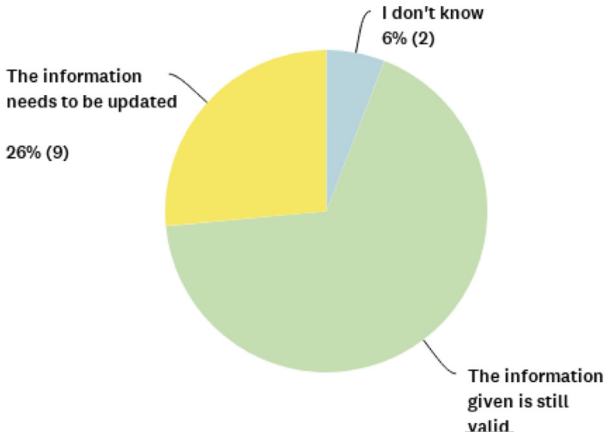
Results

HCV prevention at current national policy level

Firstly, respondents were asked to assess the summarised public information on HCV at the EMCDDA website about their country and whether it was up to date, or if anything had changed recently regarding new or updated hepatitis C strategies, guidelines, etc.

For the majority of countries the information on the EMCDDA website was up to date (see Figure 21). It must be noted, however, that Georgia, North Macedonia, Serbia and Ukraine, who also chose this answer, are not part of the EMCDDA's data gathering network. Countries that belong to the network and said their information needs to be updated included Austria, Croatia, France, Ireland and Lithuania.

Figure 21: Is the EMCDDA information in the summary of your country up to date, or did anything change recently regarding new or updated hepatitis C strategies, guidelines, etc.? [15]



National guidelines and real-life practices

One part of the C-EHRN monitoring survey assesses the use and impact of national strategies or guidelines on accessibility to testing and treatment for PWID. Respondents were asked to assess the use, and impact, of national strategies or guidelines on access to testing and treatment for people who use injectable drugs from the viewpoint of services working with PWUD.

Almost all countries use either their own national guidelines or EASL guidelines that include PWID (see Figure 22). Only three countries - Cyprus, Lithuania, and Russia - did not have any HCV guidelines which would include information related to related to PWID[16].

Respondents were asked about the implementation of national HCV guidelines. Even if 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.

Respondents (whose country has guidelines) were then asked to assess how these guidelines impact access to HCV testing, treatment and other services for PWID. Overall, many respondents saw a positive impact of the guidelines, but many also did not answer this question, which may indicate that the relevance of the guidelines is unclear. The least positive impact (48%) of the guidelines was seen by services provided by CSOs (see Table 7).

Figure 22: Do you think these guidelines impact accessibility to testing and HCV treatment of people who inject drugs (PWID) in your city?

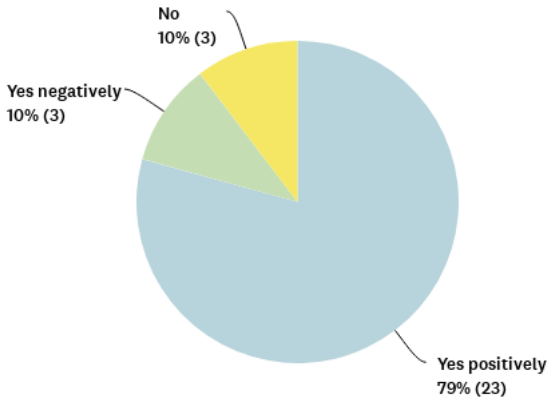


Table 7: In Which areas did you notice that Guidelines had positive impact on access to testing, treatment and other services for people who inject drugs (PWID)(answered: n=23; not answered: n=11)

	%	n
HCV information & counseling	74	17
HCV treatment	70	16
HCV testing	61	14
Specialised HCV services	52	12
CSO services	48	11
Other	22	5

In some countries, respondents also saw a negative impact of the guidelines. Reasons for a negative impact included, "HCV treatment is prescribed only by specialists" (n=9), "HCV treatment is not possible outside the specialised healthcare system" (n=7), and "HCV testing is not possible outside the healthcare system" (n=3).

Ukraine reported that the current national guidelines mention PWID only with regards to testing, new guidelines being developed but they had not been approved for use yet at the time of data collection. The new guidelines will give priority to PWID to be treated:

> *"Diagnostic analyses are necessary for treatment and are not cheap, so often PWID don't have access to treatment services. Also, there is a high level of stigma and discrimination from health professionals towards PWID. The current National Guidelines mention PWID only in regard to testing. The new modern guidelines have been developed by the Centre of Public Health but are not approved for use yet. The guidelines will give priority to PWID to be treated."*
> (FP Kyiv, Ukraine)

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

According to the 2020 data, the new drugs for HCV treatment (DAA's) a[17]re available in all countries[18]. However, there are still a range of perceived restrictions to DAA access. Altogether 13 countries (19%) reported different restrictions in the use of DDA's.. A list of applied restrictions is presented below (see Table 8). Various restrictions are still common, even if there is a slight improvement in the overall situation.

Table 8: Restrictions applied in HCV treatment (n=13 countries)

	%	n
Other restrictions	40	6
Restrictions to injecting drug use	31	4
Accessible for former injecting drug users	23	3
Accessible for drugs users on opioid substitution treatment	23	3
Accessible only for F3 and F4	13	2
Accessible only for F2, F3 and F4	13	2
Accessible only for F1, F2, F3 and F4	13	2

The biggest group, six countries, was in the category "other restrictions" which include:

- Austria: "DAAs reimbursed only when prescription comes from a specialized hepatological centre".
- Georgia: "Only Gilead products are accessible".
- Lithuania: "The main restriction is mandatory state health insurance which not all PWIDs have."
- Slovakia: "PWID patients, twelve months of abstinence confirmed every three months by toxicological examination".
- Sweden: "Abbvie's medicine for all genotypes is very limited access because of the high price."
- Cyprus: "Very restrictive criteria for the provision of DAAs in general, along with its very high price."

Respondents were asked in which countries people who use, or have used, drugs - either active users, former users or users on OST – are allowed formal access to HCV treatment. With regard to PWID access to DAA treatment, the worst situation is reported from Albania, Romania and Russia where DAAs are not allowed for any subgroup of PWID.

Active drug users are not allowed access to HCV treatment in 9 countries. In this regard, the situation has remained the same as in 2019; in addition to Albania, Romania and Russia, these countries include Estonia, Lithuania, Poland (official policy excludes active drug users from treatment but in practice they are able to access treatment), Serbia, Slovakia, and Ukraine.

Are DAAs used according to official policy?

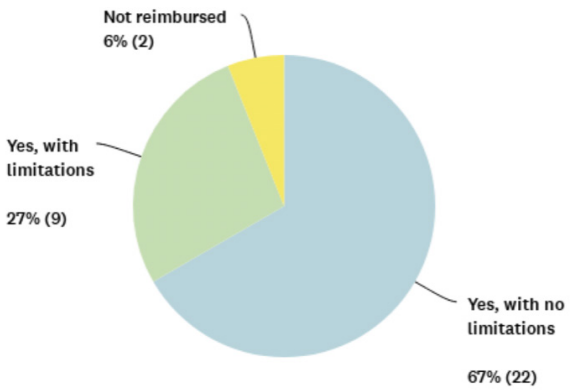
The majority of C-EHRN focal points reported that in their cities (and presumably also on a country level) DAA's are used according to the official policy, but there were also four countries where there is a discrepancy between policy and practice:

1. (Budapest/Hungary), most PWID cannot access treatment even if the official policy allows and requires it[19].
2. (Milano & Rome/Italy), even if there are no official restrictions in the access criteria, "in practice vulnerable groups, including PWID, are not supported in accessing testing and treatment for HCV."
3. (Krakow/Poland), the situation is the opposite: although the guidelines exclude active drug users from treatment, in practice they are generally accepted for treatment.
4. (Novi Sad/Serbia), "the national guidelines do not discriminate PWID, but in practice, the DAA is given to very few people, so those priorities do not include PWID".

Who is paying for HCV treatment?

HCV treatment with DAA's is reimbursed by health insurance or the public health service in most of the countries. Treatment with the new drugs is reimbursed with no limitations in 22 countries (67%) and with limitations in nine countries (27%). In two countries (Albania and the UK)[20], hepatitis C treatment with DAA t is not reimbursed.

Figure 23: Is treatment with the new drugs for hepatitis C (DAAs) reimbursed in your city (country)?



Those mentioning limitations in reimbursement include: Czech Republic, 'only one treatment possibility is covered as an unofficial rule (difficult to get reinfection treated again); Estonia and Finland, many PWID are denied treatment if they are actively using drugs, even if this is not in accordance with official guidelines; Georgia, patients need to pay the costs of diagnostics on reinfection; Poland, the waiting times for an appointment with a specialist are long, as are the waiting time for an assessment of the stage of liver fibroscopic examination; Slovakia, there are several difficulties (continuous proof of abstinence; the need to register with an unemployment office every two weeks; and difficulties in getting confirmatory tests) in getting reimbursement in practice.

Changes in the continuum of care

A well-functioning continuum of care, including low threshold and harm reduction services, is important for accessibility and impact of HCV testing and treatment. It is crucial to improve the low uptake of HCV testing and treatment among PWID by including the addiction treatment services, harm reduction facilities and drug user organisations in the continuum of services that provide HCV management within every European country.

C-EHRN monitoring contains a pattern of questions asking how the continuum of care is functioning in different countries and regions.

In most countries (85%), PWID can have a rapid test for HCV (see Figure 24) in low threshold settings at harm reduction services. Rapid tests are also quite commonly available in drug treatment (65%) and at infectious disease clinics (62%). PWID can get tested by a general practitioner in about half of the countries (44%; 51% in 2019). However, rapid testing for PWID at pharmacies has remained very rare.

Similar to last year, confirmatory blood testing for HCV RNA is most commonly available for PWID at infectious disease clinics (97%) and gastroenterology clinics (65%) but, compared to last year, their availability seems to have improved at drug treatment clinics (50%; 35% in 2019) and at harm reduction centres (41%; 26% in 2019). The increase is encouraging but we must bear in mind that there are some differences in participating countries in 2019 and 2020.

As in 2019, PWID are most commonly treated for hepatitis C at infectious disease clinics (in 90% of reporting countries) and gastroenterology clinics (in 65% of reporting countries). In 32% of countries, treatment was provided at harm reduction services or community centres.

Point-of-care testing increases HCV testing and linkage to care. It is important that facilities offering testing are able to offer both HCV testing and treatment. There are still big differences within Europe as to where, and how, PWID can undertake a HCV test and Inequities in access exist across European countries, regions and cities. It can also be concluded that the integration of testing and treatment at the same location is still too rarely the case.

Figure 24: Where can people who inject drugs (PWID) be tested for HCV using a point-of-care rapid test (detection of antibodies toHCV in oral swab or finger prick)?

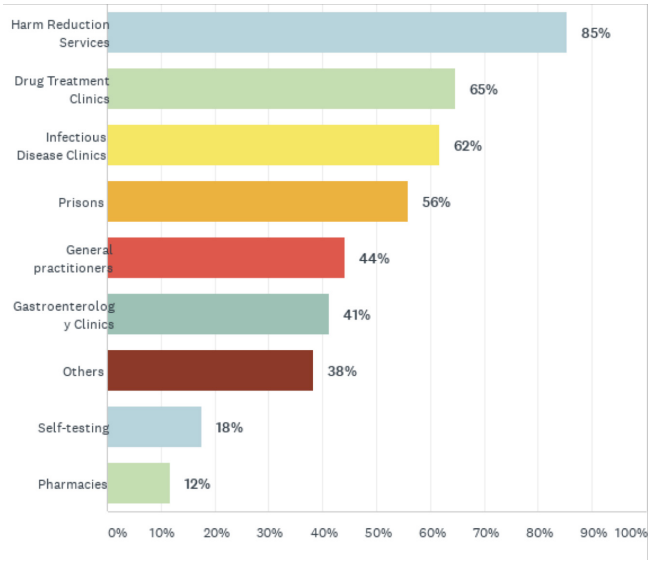


Figure 25: Where can people who inject drugs (PWID) perform a confirmatory blood test for HCV RNA?

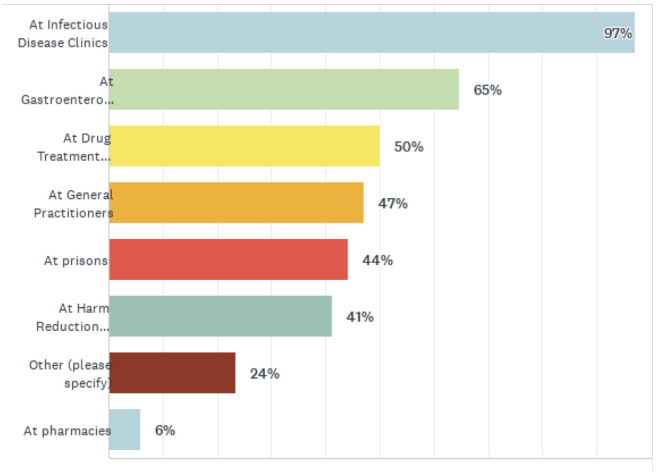


Figure 26: Where can HCV infected people who inject drugs (PWID) perform a non-invasive diagnostic procedure for the evaluation of the stage of liver disease (i.e. Fibroscan®)?

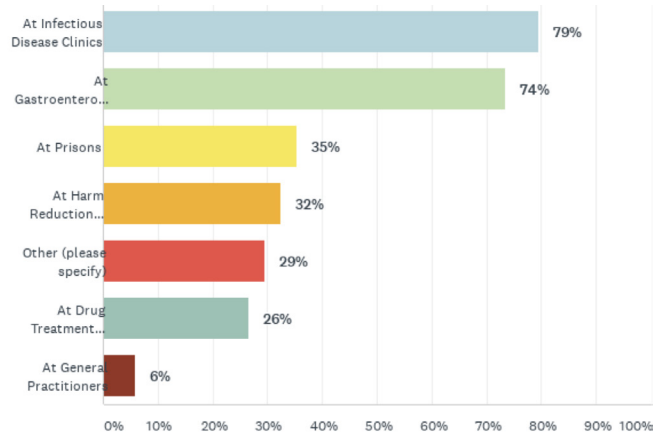
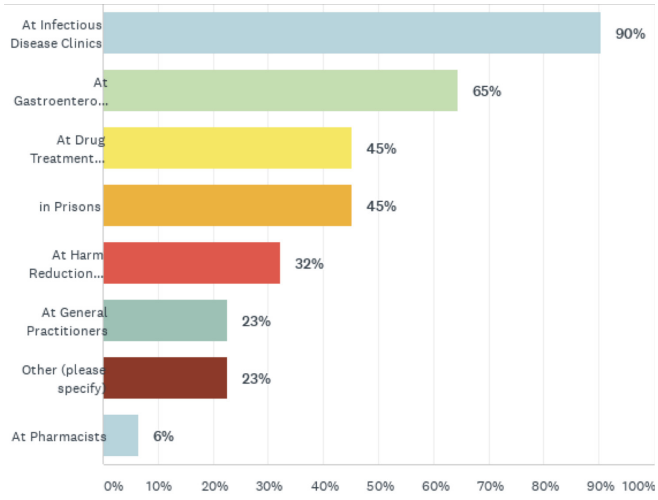


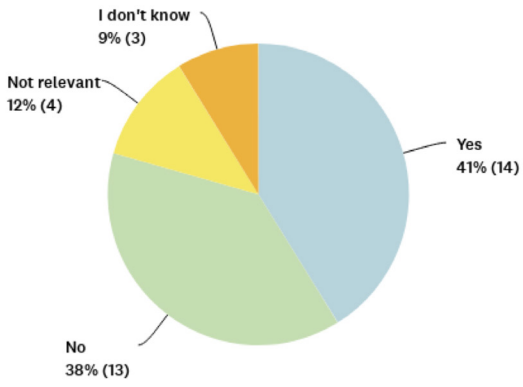
Figure 27: In case where DAAs are accessible to people who inject drugs (PWID), where are they treated for HCV?



Are there written guidelines for the linkage-of-care?

Respondents were asked if the linkage-to-care for PWID is achieved by a written protocol or guidelines. More concretely, they were asked to assess if there is, for instance, an agreed protocol to refer clients from harm reduction services to other treatment and care systems. Respondents from 14 countries answered that the protocol/guidelines were clear, but in 13 countries they were regarded as unclear. Respondents of three countries could not make an assessment.

Figure28: Is linkage-to-care for people who inject drugs (PWID) achieved by a written protocol/guidelines?

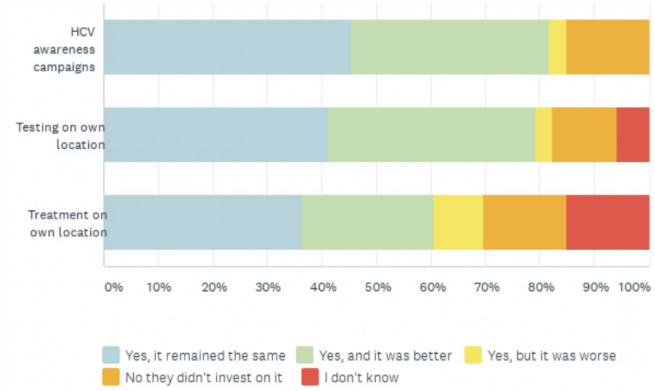


More or less action and coordination on HCV?

Focal points were also asked to compare the changes in HCV activities between 2018 and 2019 have PWID service providers in their country invested more or less attention in HCV awareness campaigns, testing at their own location, and treatment at their own location? Most commonly, these activities were reported had either remained at the same level or improved.

HCV awareness raising and testing at their own location was reported to have become worse in Croatia, and HCV treatment at their own location has become worse in Albania, Croatia and Germany.

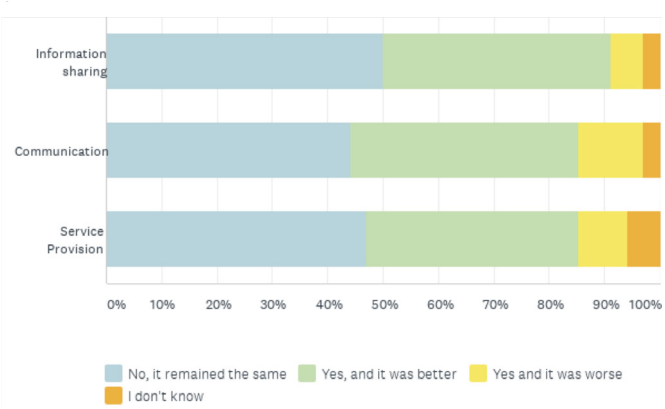
Figure 29: Compared to 2018, have service providers for people who inject drugs (PWID) in your city invested attention in 2019 to the following activities?



When asked about the progress in coordination between health care and social care providers (especially NGOs and harm reduction services), in most of the cities and in all dimensions (information sharing, communication, service provision) the situation has remained the same or improved.

Negative progress was reported by four countries: information sharing has become worse in Croatia and Greece; communication has become worse in Croatia, Greece, Ireland and Sweden; and, servicer provision has become worse in Croatia, Greece and Sweden.

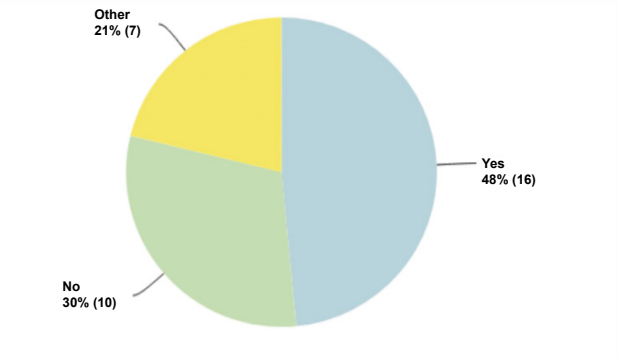
Figure 30: Compared to 2018, did the coordination between health care providers (general practitioners, clinics) and social service providers (like non-governmental organizations, harm reduction, services) change in 2019 regarding HCV?



The role of harm reduction and drug user organisations

In countries with progressive HCV treatment policies, drug user interest groups[21] 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. In 2020, the question was addressed at the city level whereas in 2019 it was at the country level. In 2020, 16 of the partaking cities had drug user groups actively working for political awareness with regards to HCV. In 10 cities the user groups were not active with regard to HCV, and in 7 cities (response option "other") no drug user group existed. In 2019, there were active user organisations in 15 countries.

Figure31: Are drug user groups active for (political) awareness with regards to HCV in your city? (n=33[22])



Conclusions

The results from 2020 show that PWID are still in an unequal position, and often deprived of proper HCV interventions,in different European cities and countries The overall picture has not changed much from that of 2019. There is still a lot to be developed in the continuum-of-care, and the integration of testing and treatment at one site is still too rarely the case.

Almost all countries have either their own national guidelines or EASL guidelines that include the HCV management for PWID. Only Cyprus, Lithuania, and Russia do not have such HCV guidelines.

The new drugs for HCV treatment (DAA's) are available in all countries, even if in practice there remains restrictions for PWID to access DAA's in some countries.

What is postive is the fact that 85% or respondents reported accesss to rapid test in harm reduction sites: Whilst still more needs to be done this is an encouraging result.

Active drug users are not allowed access to HCV treatment in 10 countries. In this regard, the situation has remained the same as was in 2019. In addition to Albania, Romania and Russia, these countries include Estonia, Lithuania, Poland ((although officially they do not have access but in practice yes), Serbia, Slovakia, Slovenia and Ukraine.

On the positive side, however, is that several countries report progress, more action and attention as well as better communication and information sharing is taking place on HCV. In 2020, countries that reported negative developments included Croatia, Greece, Ireland and Sweden.

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6

Overdose prevention

Introduction

Preventing overdose and overdose deaths[23] is an ongoing public health challenge. Drug overdose (OD) is a major cause of death, especially among young people in Europe. In the region, people who use opioids are 5 to 10 times more likely to die than their peers of the same age and gender (1). In 2019, countries reporting to the EMCDDA (28 EU Member States, plus Turkey and Norway) registered more than 9,400 overdose deaths; that represents a slight decline from 2017, although underreporting is likely to occur (2). Half of these deaths were reported by the UK and Germany alone; such high numbers might be related to underreporting in other countries and a higher at-risk population in these two nations.

A number of evidence-based harm reduction interventions help in the avoidance of overdose and overdose deaths. Among them are access to naloxone (3–5)programmes that enable bystanders to provide first aid and administer naloxone before an ambulance arrives can save lives. We conducted a systematic review of the available studies on take-home naloxone to reverse opioid overdose and included 21 studies for analysis (with various study designs, Opiate Substitution Therapy (OST) (6,7), Drug Checking services, and Drug Consumption Rooms (DCRs) (8–10)which provides a drug consumption room in Barcelona among other services. The objectives of our study were to compare the client profile, the facility use, the drugs used, and the number of non-fatal overdose episodes between (1. OD prevention campaigns and training, as well as guidelines on how to prevent overdoses, are key in addressing and reducing the risk of an overdose (11,12). Despite the evidence, overdose prevention measures are not always implemented on the ground; at least, not to the extent that they are needed.

This chapter focuses on mapping the state, needs, and changes to overdose prevention in the last year at the local level in Europe. 35 C-EHRN focal points collected information on:

- The presence of OD prevention guidelines in official policies
- The context in which ODs are occurring (drugs involved and characteristics of OD cases)
- Challenges and desired improvements regarding OD prevention on the ground
- The state of trainings and campaigns for OD prevention
- The state and needs regarding naloxone access
- The state and needs regarding OST access.

As compared with the monitoring report of 2019, data on DCRs or OD prevention in prisons have not been included in this 2020 report; this data is already collected and reported elsewhere (13,14). Another difference to the 2019 report is that the focus of the 2020 report is mostly on the city - instead of the national level. This has allowed for more detailed qualitative information to be collected about how policies are implemented (or not) at the ground level. Such in-depth information is crucial to inform policy makers for better planning, and NGOs for advocacy purposes.

OD prevention in official policies

In 25 of the 35 countries where FPs responded the survey, OD prevention is mentioned in at least one official policy document. Most of the time, guidelines are set at the national level, but specific interest groups and associations also have guidelines for OD prevention. In fewer cases, guidelines exist at the regional and local levels only. Yet, in at least seven countries (Belgium, Croatia, Hungary, Poland, Romania, Slovenia, and Sweden), OD prevention is not yet featured in any official policy documents. Figure 1 shows a percentage comparison, and Table 1 the reporting that FPs gave

for their respective country, with total numbers per category. FPs from Austria[24], Georgia[25], Italy[26], North Macedonia[27], and the UK[28] mentioned a few specificities. In 2019, "national strategy", "protocol", or "separate strategy" were given as options to respondents on existing guidelines for OD prevention. Since more detailed categories were included in 2020, strict comparisons have not been made. Nevertheless, it is possible to say that with regards to the overall existence of guidelines for OD prevention, no significant changes seem to have occurred in 2020 when compared to 2019.

Figure 32: Existing guidelines for overdose prevention

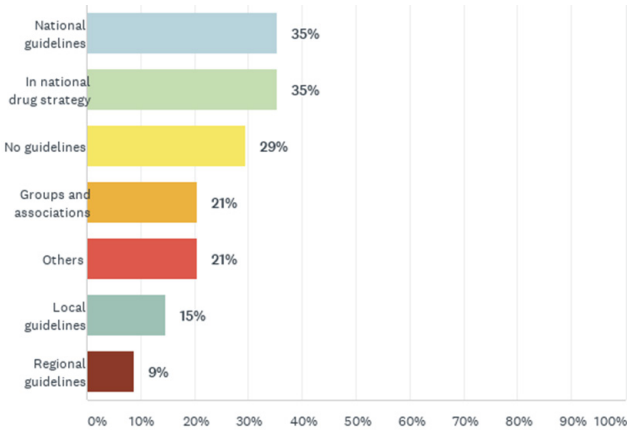


Table 9: Existing guidelines for overdose prevention per country

Country	FP City	National guidelines	Regional guidelines	Local guidelines	Specific groups have guidelines	In national drug strategy	No guidelines
Albania	Tirana					x	
Austria	Vienna						x
Belgium	Antwerp						x
Croatia	Rijeka						x
Cyprus	Nicosia					x	
Czech Republic	Prague	x	x	x		x	
Denmark	Copenhagen						
Estonia	Tallinn	x					
Finland	Helsinki			x	x		
France	Paris	x				x	
Georgia	Tbilisi	x			x		
Germany	Berlin			x			
Greece	Athens	x					
Hungary	Budapest						x
Ireland	Dublin	x					
Italy	Milan/Romea		x	x			
Lithuania	Vilnius	x					
Luxembourg	Luxembourg	x			x	x	
Norway	Kristiansand	x					
Poland	Krakow						x

Country	FP City	National guidelines	Regional guidelines	Local guidelines	Specific groups have guidelines	In national drug strategy	No guidelines
Portugal	Porto				x		
North Macedonia	Skopje				x		
Romania	Bucharest						x
Russia	Saint Petersburg				x		
Scotland	Glasgow	x	x	x	x	x	
Serbia	Novi Sad					x	
Slovakia	Bratislava					x	
Slovenia	Ljubljana						x
Spain	Barcelona	x	x	x		x	
Sweden	Stockholm						x
Switzerland	Bern					x	
Netherlands	Amsterdam					x	
Ukraine	Kiev	x			x	x	
United Kingdom	London						
TOTAL		**12**	**3**	**5**	**7**	**12**	**10**

What ideal guidelines should contain

In an open question, C-EHRN FPs were asked to mention important issues missing in existent guidelines, and features that ideal guidelines should address. The results are as follows:

- Provision of Naloxone and Take Home Naloxone
- Low-threshold provision of OST
- Continuum of care and follow-up
- Coordination of continuous training for OD prevention
- OD prevention guidelines for non-opioids (stimulants, NSP, GHB, synthetic cannabinoids and polydrug use)
- Provision of services, such as DCRs and drug checking
- Assure emergency rescue access
- Being updated, to include evidence-base and recent knowledge

> *The guidelines are not always up-to-date. There is no current information about knowledge over recent years.*
> (FP Austria)

> *We still don't have Naloxone!!! Not in services, and not for take away.*
> (FP Prague, Czech Republic)

> *There is very little funding, and there is no structure set for maintaining the naloxone training. Guidelines should include continuous training coordination.*
> (FP Copenhagen, Denmark)

> *There are precise guidelines for the prevention of opioid overdoses, [but] there are no specific guidelines for the prevention of overdose from other psychoactive substances.*
> (FP Tallin, Estonia)

> *Guidelines are focused on very traditional (opiate use) forms of harm reduction. Inclusion of OD prevention among polydrug users, stimulant users, GHB users, and inclusion of services such as drug checking, would be an improvement.*
> (FP Amsterdam, Netherlands)

> *The guidelines are for take home naloxone only. The main problem with the guidelines is that they require a medical institution and a medical provider to participate in the prescription and distribution of take home naloxone via low threshold centres which are not licensed medical care institutions. Low threshold centres need to enter into a cooperation agreement with a licensed clinic and the clinic's doctor must come to the low threshold centre to prescribe and hand out naloxone. The prescription is done anonymously (no personal data disclosed), but the doctor must see the PWUD. Also, medical clinics are not paid to do this.*
> (FP Vilnius, Lithuania)

> *Over 50% of fatal ODs occur amongst those who have not been in contact with treatment services in the last five years and the various guidelines do not specifically address this issue, services often have high thresholds in relation to accessing OST with many requiring people to remain on daily/supervised consumption for prolonged periods. This has changed under COVID-19, but in our view this is a significant barrier to accessing OST which could act as a protective factor.*
> (FP London, UK)

> *Guidelines should include that an ambulance MUST come when someone calls because of an overdose, and should allow take-home naloxone.*
> (FP Novi Sad, Serbia)

Overdose context

Drugs involved in ODs

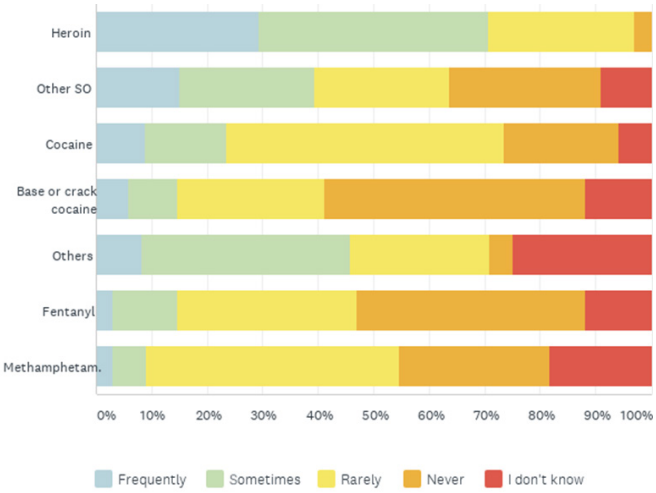
FPs were asked how frequently they have heard of overdoses involving a list of specific drugs in their city in the last year. Results can be seen in Figure 33.

Altogether, heroin, fentanyl and other synthetic opioids make up almost half of the overdoses FPs have frequently heard about in their cities during 2020. Most of these opiate-related overdoses were linked to heroin, with a very small proportion related to fentanyl. Stimulants such as cocaine, crack cocaine and methamphetamine were mentioned as being involved in frequent overdoses by 20% of FPs.

In several cases, overdoses that FPs had heard of involved the use of multiple substances (category "others" in the graph). Other frequently mentioned substances included benzodiazepines, methadone, alcohol and other amphetamines, often in combination with other drugs. Less mentioned substances included synthetic cannabinoids and GHB.

Such findings follow a similar trend of the latest data collected by the EMCDDA on overdose deaths (1). Most overdose deaths were linked to the use of opioids, especially injected heroin, with a substantial number of deaths involving polydrug use, particularly heroin in combination with other central nervous system depressants, such as alcohol or benzodiazepines. Stimulants are implicated in a smaller number of overdose deaths in Europe, and often in combination with other substances.

Figure 33: Overdoses the 35 FPs heard of involving the following drugs in their city in the past year



Characteristics and circumstances of OD victims

In an open question, FPs were asked to describe the typical characteristics of OD victims that they know of, and the circumstances of their deaths. The most frequent characteristics related to ODs known to C-EHRN FPs were:

- Being in a situation of homelessness
- Using drugs alone (in a private setting or on the streets)
- Engaging in polydrug use
- Being recently released from prison, drug treatment, or other health treatment involving drug abstinence (such as in detoxification units in hospitals)
- Lacking proper nutrition and sleep
- Not calling for help/emergency for fear of the police
- Not having access to naloxone

> *Due to several circumstances, such as the release from prison or therapy, people who inject drugs or use multiple drugs run a much higher risk of having an overdose. So do our clients. Most ODs happen in private households. They are typically not in OST and died in their own flat. OD is frequently caused by combined ingestion of Morphine/Heroin, Benzodiazepines and Alcohol.*
> (FP Vienna, Austria)

> *Most common circumstances of OD is when people get out of therapeutic community/hospital/prison, where they were treated for addiction, and they use drugs again.*
> (FP Rijeka, Croatia)

> *Occasional meth overdoses are always among MSM and characterised primarily through episodes of multiple days of meth use and no sleep. GHB overdoses happen in the party scene, among MSM and among marginalised polydrug users.*
> (FP Amsterdam, Netherlands)

> *Currently in Kiev, street methadone prevails and is mostly injected. We know of deaths when a person drank alcohol on top of it, fell asleep, and just died during sleep. Often people mix different psychoactive substances. People use alone and have no other people to help. They are also afraid to call an ambulance and do not have access to naloxone.*
> (FP Kiev, Ukraine)

Having access to (Take Home) Naloxone is crucial for preventing opioid OD deaths. Having access to harm reduction information about polydrug use is essential and should be further developed. Finally, access to DCRs and residential DCRs (shelters or social housing where drug use is allowed) are strong protective factors against OD, especially for those using alone or in a situation of homelessness. DCRs are protective not only for people who use opioids, but also those using stimulants and other types of substances. Besides offering a safe and hygienic space for drug consumption, DCRs also help in combating isolation and improving community care (15). Such protective factors are also noted by C-EHRN FPs.

> *Since the implementation of DCRs in the central city, most ODs are non-lethal and treated by the nurse staff according to the local guidelines. We had some ODs in our local homeless shelters but all staff are trained in naloxone treatment.*
> (FP Copenhagen, Denmark)

Challenges in OD prevention

C-EHRN FPs were asked (open question) about the main challenges regarding OD response in their cities in the last year. To them, the main difficulties relate to the lack of (low-threshold) access to life-saving OD prevention programmes such as:

- Opioids (and stimulant) Substitution Treatment
- Naloxone
- Take Home Naloxone
- Drug checking
- DCRs
- OD prevention in prison and upon release from prison

Interestingly, as Chapter 2 shows, the European region is in a privileged position worldwide in terms of the availability of these harm reduction services: 91% of the countries in Europe has at least one operational OST programme and 86% has at least one OST operational in a prison. Numbers for DCRs, though, are much lower (23%), but still, Europe has most of the DCRs available in the world (14). Yet, on the ground, having at least one service is far from sufficient to handle the needs of PWUD throughout an entire nation. Furthermore, there are disparities within Europe in terms of service availability and the legal possibility of having, for instance, DCRs and drug checking.

Another crucial challenge relates to the stigmatisation and criminalisation of PWUD, including the fear of police intervention when calling an ambulance, and the refusal of ambulances to assist PWUD. This shows that, despite the general support for harm reduction in the European region, much needs to be improved in terms of supporting and securing the human rights of PWUD.

> *The biggest challenge is the lack of services aimed at OD prevention. We don't have Take-Home Naloxone programmes (Naloxone is only administered in the ER), no drug checking, no drug consumption rooms.*

> *These aren't recognised as relevant by the Government, only needle exchange is.*
> (FP Rijeka,Croatia)

> *We need to increase the OST capacity. And we also need to open more possibilities of substitution treatment for methamphetamine.*
> (FP Prague, Czech Republic)

> *Not everybody believes that police would not come after calling first aid. Also, Naloxone is not available to PWID if they are not clients of an NSP programme. Finally, there is the problem of mixed drugs: people who had an overdose did not know exactly what kind of drug they were consuming.* (FP Tbilisi, Georgia)

> *The ambulance just does not want to come [for PWUD].*
> (FP Bratislava, Slovakia)

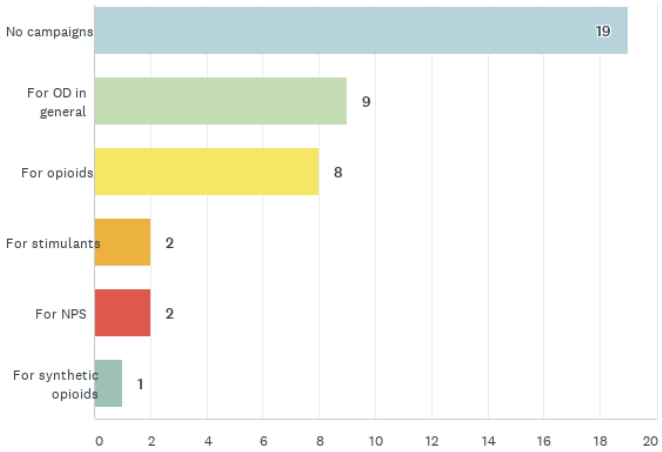
> *The main challenge for this year in the prevention of overdoses would be the opening of the 24-hour supervised consumption rooms. As various studies have described, there is a clear link between DCRs and a decrease in mortality from overdoses. Another challenge would be to facilitate the acquisition of naloxone vials, for example, delivered free of charge in pharmacies or primary care centres.*
> (FP Barcelona, Spain)

> *Some problems are the political objection to DCRs, limited access to naloxone, and restrictive prescribing practices of OST. In addition, services can be quite paternalistic, not meeting people where they are at, coupled with a history of trying to encourage/make people reduce the OST dosage they are on. In some instances, police being called thereby reduces the likelihood of OD being reported.*
> (FP London, UK)

Overdose prevention campaigns

Despite all the challenges and the rising number of overdoses, OD prevention campaigns are still not sufficiently put forward. In almost 60% of C-EHRN FP cities, there were no OD prevention campaigns in 2019. Only a quarter (26%) offered campaigns for OD prevention in general and/or for prevention of opioid OD. In very few cases, OD prevention campaigns approached the use of stimulants or NPS (6% each) and, in even fewer cases, the use of synthetic opioids (3%) (Figure 34).

Figure 34: Overdose awareness campaigns in the city in the past year (of 34 FPs)



Overdose prevention training

In more 29 of 34 FP cities, OD response training is available, targeting medical staff, harm reduction staff and people who use opioids. In less than a third of cities, OD prevention training also reaches friends and family of PWUD and, in only about 20%, people who use drugs other than opioids. Other possibilities include first aid training (to teachers, fire department, and company personnel) with techniques can potentially be used in an OD, and police training to deliver naloxone. Yet, in 7 of the cities, there is currently no OD prevention training, although information on OD prevention is somehow available. This was the case in Tirana, Rijeka, Athens, Budapest (where also no information is available), Porto (Portugal), Novi Sad, and Ljubljana.

Figure 35: Overdose response training in the city is available to:

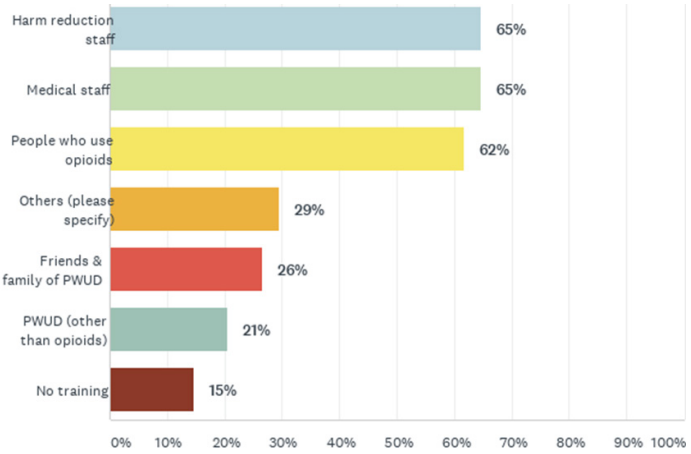


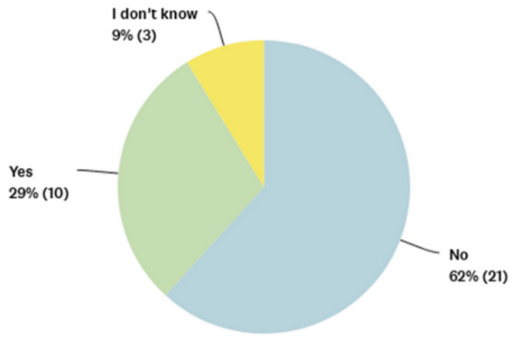
Table 10: Overdose response training availability per city

Country	City	Harm Reduction Staff	Medical Staff	PWU opioids	Friends and family	Other PWUD	No training, but info
Albania	Tirana						x
Austria	Vienna	x	x	x		x	
Belgium	Antwerp	x		x			
Croatia	Rijeka						x
Cyprus	Nicosia	x	x				
Czech Republic	Prague	x	x	x			
Denmark	Copenhagen	x	x	x			
Estonia	Tallinn	x	x	x	x	x	
Finland	Helsinki	x	x				
France	Paris	x	x	x	x		
Georgia	Tbilisi	x		x	x	x	
Germany	Berlin	x	x	x		x	
Greece	Athens						x
Hungary	Budapest						x
Ireland	Dublin	x	x	x	x		
Italy	Milan/Rome		x	x			
Lithuania	Vilnius	x	x				
Luxembourg	Luxembourg	x	x	x			
Norway	Kristiansand	x	x	x	x		
Poland	Krakow	x		x		x	
Portugal	Porto						x
North Macedonia	Skopje	x	x	x			
Romania	Bucharest		x				
Russia	Saint Petersburg			x		x	
Scotland	Glasgow	x	x	x	x	x	
Serbia	Novi Sad						x
Slovakia	Bratislava		x				
Slovenia	Ljubljana						x
Spain	Barcelona	x	x	x	x	x	
Sweden	Stockholm			x [29]			
Switzerland	Bern	x	x	x			
Netherlands	Amsterdam	x	x				
Ukraine	Kiev	x		x	x		
UK	London	x	x	x	x		

Desired improvements in overdose prevention

For most C-EHRN FPs, overdose prevention activities have not improved in their cities in the past year.

Figure 36: Have activities on OD prevention in your city improved in the past year?



In an open question, FPs described the main changes in OD prevention activities that they would like to see happening in their cities. These are as follows:

- Increased and low threshold access to Naloxone and Take Home Naloxone (without the need for prescription and free of charge for PWUD)
- Increased and continuous training on OD prevention, also for non-opioids, for harm reduction staff, PWUD and their contacts
- Campaigns and information on OD prevention for the general population
- Funding for Naloxone and OD prevention training
- Opening and scaling-up of DCRs and drug checking services
- Less restrictive prescribing practices for OST or HAT (Heroin Assisted Treatment)
- Attention to OD prevention for non-opioids
- Sensitise health professionals and first responders to fight stigma against PWUD.

> *It would be desirable that naloxone is available for convicts, relatives of drug users, social workers, police-officers... (in all parts of Austria) paid by health insurance.* (FP Vienna, Austria)

> *More services (specifically better availability of Naloxone), more training on overdose prevention in the general population and especially medical staff and people working with PWUD.* (FP Rijeka, Croatia)

> *More training for harm reduction staff as well as provision of take home Naloxone without prescription or other requirements.* (FP Nicosia, Cyprus)

> *We need training on overdoses of substances other than opioids and synthetic opioids (how to prevent, how to help until an ambulance reaches the victim, what to do).* (FP Tallinn, Estonia)

> *We wish for the introduction of Naloxone in Helsinki, the ability to use and give out Fentanyl-strips to PWUD, and establishing safe injection sites.* (FP Helsinki, Finland)

> *We need a broad campaign about overdose, including the general population, not only targeted groups. Trainings on Naloxone and OD management is needed for medical staff (besides first aid and hospitals). Also, police should know how to respond to overdose and should be equipped with Naloxone.* (FP Tbilisi, Georgia)

> *We need the removal of barriers for take home naloxone and steady funding for take home naloxone distribution.* (FP Vilnius, Lithuania)

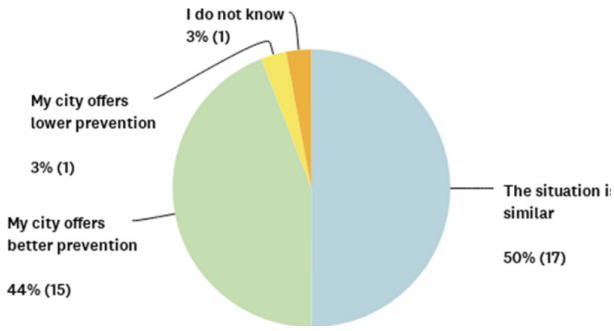
> *Provide more information about OD prevention for PWUD and have naloxone available for everyone. Also, change the attitudes of medical and emergency ambulance staff toward PWUD. Sometimes PWUD prefer not to call an ambulance because of the attitude and stigma they face.*
> (FP Bratislava, Slovakia)

> *The possibility to get Nalaxone for free in city pharmacies and clinics. Conducting a campaign for relatives of people dependent on drugs about measures that can be taken in case of an overdose. Medical training, as an ambulance often refuses to come in the case of an overdose. Availability of nasal naloxone, and overdose programmes for people who use stimulants.*
> (FP Kiev, Ukraine)

FP context compared to national context

Almost half of the participants assessed that OD prevention in their cities is comparable to the national situation in their respective country. Also, almost half think that their city offers better OD prevention when compared to the national context. This shows that the OD prevention context described by C-HERN Monitoring is in good part based on the best examples available in a country. Since most FPs are based in a metropolis or a large city, it can be assumed that the current data might not reflect the context of smaller cities and rural areas.

Figure 37: How does your city compare with the national situation in terms of OD prevention?

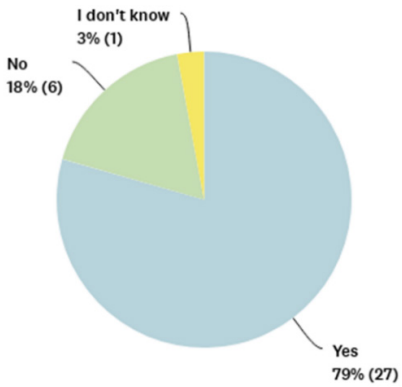


OD prevention for opioids

Naloxone availability

Naloxone is available in the majority (80%) of FP cities. Yet, in at least 6 cases, the life-saving drug was reported as not available. This was the case in Antwerp, Prague, Helsinki, Athens, Budapest, and Bucharest. The FP in Luxembourg was not aware of the current situation. According to the EMCDDA, the medication naloxone is included in the pharmacopoeia of all European countries, although in many cases only in injectable form and requiring a medical prescription (16). This lack of practical availability might be the reason why FPs mention naloxone as not being available in their cities.

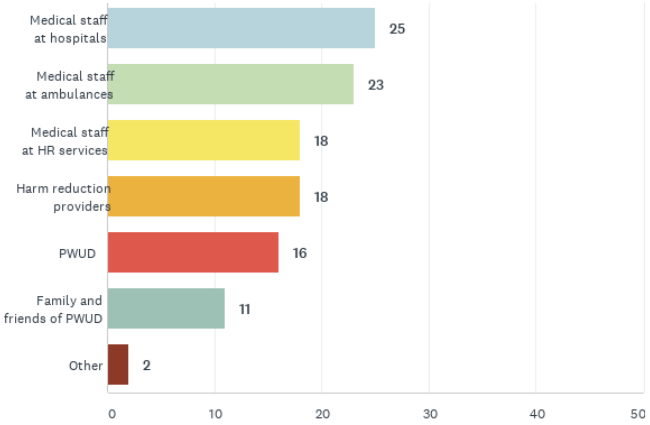
Figure 38: Is naloxone available in your city?



To whom is naloxone available

For those 27 FPs reporting the availability of Naloxone, the drug is mostly available to medical staff at hospitals (93% of the cases), ambulances (85% of the cases), or medical staff in harm reduction services (67%). In about 60-70% of cases, it is also available to harm reduction staff and directly to PWUD. Only in 40% of cases is it available to family and friends of PWUD.

Figure 39: If available, who has access to naloxone?



How naloxone is available

When available in FP cities, Naloxone is mostly found in its injectable form (61%), although intranasal is also available in 50% of the cases. Training is available, both for peer administration (61% of cases) and staff administration (57%). Slightly more than half of respondents mentioned that Naloxone is available for take home (54%) and/or distributed by drug service providers (54%). Nevertheless, only in a few of the FP cities is naloxone reimbursed by health insurance (21%), or available in pharmacies without prescription (18%).

Table 11 shows the availability of naloxone reported per city (for the cases where availability was reported). It is interesting to note that according to the EMCDDA, only 12 countries have Take-Home Naloxone (THN) available: Austria, Denmark, Estonia, France, Germany, Ireland, Italy, Lithuania, Norway, Spain, Sweden, and the United Kingdom (including Scotland) (2,16). Despite this, FPs in the cities of Vilnius and Kristiansand did not report availability of TNH. On the other hand, FPs in Nicosia, Tbilisi and Kiev reported the drug to be available for take home.

Table 11: How naloxone is available in FP cities

Country	City	In-	Injection	Training staff admin	Training peer admin	Take-home	In drug services	Paid by health insurance	Pharmacies without prescription
Albania	Tirana				x				
Austria	Vienna	x		x	x	x	x		
Croatia	Rijeka		x	x				x	
Cyprus	Nicosia	x		x		x	x		
Denmark	Copenhagen	x		x	x	x			
Estonia	Tallinn	x		x	x	x			
France	Paris	x	x	x	x	x	x	x	x
Georgia	Tbilisi		x	x	x	x	x		
Germany	Berlin	x		x	x	x		x	
Ireland	Dublin	x	x	x	x	x	x		
Italy	Milan /Rome	x	x			x	x		x
Lithuania	Vilnius			x			x		
Norway	Kristiansand	x			x		x		
Poland	Krakow		x						

Portugal	Porto	x	x						x
North Macedonia	Skopje		x						
Russia	St. Petersburg		x		x		x		
Scotland	Glasgow		x	x	x	x	x		
Serbia	Novi Sad		x					x	
Slovakia	Bratislava		x						
Slovenia	Ljubljana	x							
Spain	Barcelona		x	x	x	x	x		
Sweden	Stockholm	x		x	x	x		x	
Switzerland	Bern	x	x	x			x	x	x
Netherlands	Amsterdam		x						
Ukraine	Kiev		x		x	x	x		
UK	London	x	x	x	x	x	x		

Challenges in naloxone availability

Despite reported availability, several challenges remain in gaining access to Naloxone. According to FPs (open question), the main challenges in their respective cities during the past year include:

- No access to Take Home Naloxone
- Naloxone available only at drug services, thus, not for all PWUD
- Need for medical prescription
- Administration by medical staff only
- Lack of insurance coverage for Naloxone
- Lack of funding for Naloxone
- Lack of funding and support for Naloxone training

Examples of such challenges given by C-EHRN FPs include the following:

> *Naloxone is only available in an ambulance and in some hospitals.*
> (FP Skopje, North Macedonia)

> *Naloxone is available just for medical staff and at the hospital.*
> (FP Bratislava, Slovakia)

> *Naloxone is a prescription medicine in Estonia, it can only be dispensed by a medical professional, but they are lacking in harm reduction. Drug users must have and display ID in order to be issued with naloxone.*
> (FP Talinn, Estonia)

> *Naloxone is only available in hospitals and ambulances. According to current regulation - people who use drugs and harm reduction organisations / services may not possess this drug. The challenge is to change these rules. These are country-wide regulations and must be changed at the national level.*
> (FP Krakow, Poland)

> *Naloxone is not available to PWUD directly, only through pharmacies, and it is too expensive.* (FP Porto, Portugal)

> *Only medical staff in ERs have access to Naloxone and it can be administered only when a person is brought into the ER because of an OD.*
> (FP Rijeka, Croatia)

> *In Austria, injectable naloxone is only available for medical staff, and handing out Naloxone requires a private prescription by a physician. This prescription refers to opioid addicts. The Naloxone will be handed out in a pharmacy. Clients who participate in the THN training get the prescription from a low-threshold medical institution for people with no insurance (Caritas Marienambulanz) with which we cooperate. After attending the training (which lasts around one hour), the participants get handed out the naloxone kit.*
> (FP Vienna, Austria)

> *Intranasal naloxone is limited due to cost implications. Peer-to-peer supply is limited due to a lack of peer initiatives across London and England.*
> (FP London, UK)

> *In Denmark, funding from the state is given for the provision of naloxone to drug users in treatment. There is no systematic funding for provision and follow-up to people outside the treatment system.*
> (FP Copenhagen, Denmark)

> *Naloxone without prescription is only accessible at harm reduction sites.*
> (FP Tbilisi, Georgia)

> *Our main challenges are availability in pharmacies and in prison settings; training and advocacy among professionals; and the costs of the treatment.*
> (FP Paris, France)

> *In Ireland, there are relatively more restrictive pathways for accessing Naloxone. This requires a trained keyworker to initially conduct a risk assessment and to educate the client about Naloxone and train them, or their relatives, on how to administer either or both the nasal and injectable forms of Naloxone. Once this is completed, the client requires a doctor (usually their own GP, a GP working in specialised homeless services, or an OST addiction prescriber) to issue a prescription for Naloxone. Due to the scheduling of Naloxone in Ireland, the person to whom it is prescribed must not give the Naloxone to anyone else to hold for them. However, the HSE do allow for GPs to issue prescriptions retrospectively, within a 24 hour period, to allow, in particular, for the administration of Naloxone in an overdose scenario.*
> (FP Dublin, Ireland)

> *By order of the Ministry of Health, two ampoules of Nalaxone can be bought in a pharmacy without a prescription, but, in practice, they often refuse to sell without a prescription. When we heard about overdoses and tried to provide Nalaxone, we were informed that it was impossible to get it anywhere else but with us.*
> (FP Kiev, Ukraine)

What needs to improve

C-EHRN FPs, were also asked to openly comment on the main changes needed regarding naloxone availability in their cities. These include the following:

- It must be available for friends and relatives of PWUD
- It must be available for take home
- It must be available in prisons and other custodial settings
- It must be available at in- and out-patient therapeutic institutions
- It must be available in pharmacies
- It must be increasingly available through peer distribution
- It must be paid by health insurance
- Access must not require a medical prescription
- Legal barriers for administration by non-medical staff and PWUD peers must be removed
- Training for peer administration must be provided

Changes between 2019 and 2020

Policy change in process

Over 60% of C-EHRN FPs reported not being aware of any policy change in process to increase access to naloxone in their city.

Those reporting policy changes in process were in Vienna (Austria), Nicosia (Cyprus), Paris (France), Norway, Porto (Portugal), Poland (at national level), London (UK), and in Kiev (Ukraine).

In Nicosia (Cyprus) take-home Naloxone programmes were under discussion in 2019 and finally became available in 2020.

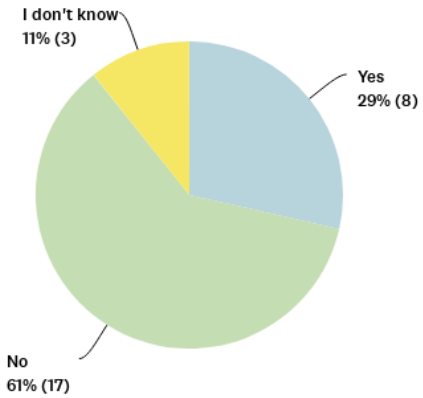
> *"More effort is done to provide naloxone to opioid users through drug treatment centres. In addition, efforts are being made so that take home Naloxone is available as an over-the-counter medicine.*
> (FP Nicosia, Cyprus)

In Vienna (Austria) and Tbilisi (Georgia), naloxone has started being distributed by drug service providers. In Berlin (Germany), it has started to be prescribed to opioid users.

In Kiev (Ukraine), a limited amount of Naloxone is now available at pharmacies without prescription, and the lifesaving drug is also part of the first aid kit of police officers. In Vilnius (Lithuania), there are no changes yet, but there is a plan for police officers to carry intranasal naloxone.

> *"Changes have been made to the order of the Ministry of Health, according to which Nalaxone can be bought in pharmacies of the city without a prescription in the amount of two ampoules. Changes have been made to the list of components of the policeman's first-aid kit and Nalaxone has been introduced there (even nasal, but it is not available in our city and the country).*
> (FP Kiev, Ukraine)

Figure 40: Is there a policy change in process to increase access to naloxone in your city?



The UK started discussions to expand Naloxone provision beyond drug treatment services, possibly including facilities dedicated to people experiencing homeless.

> *"Policy for the distribution of Naloxone is a national one – UK-wide – as naloxone is prescription only but can be legally supplied outside a prescription by 'drug treatment services'. There are discussions at a national level to expand this definition to other relevant settings, such as homeless services, but this is at a very early stage.*
> (FP London, UK)

In Portugal, Naloxone was available to harm reduction providers in 2019 but only at the mobile DCR in Lisbon. In 2020, nasal naloxone was made available for a couple of months to harm reduction teams across the country, but the medicine expired in April 2020 and, therefore, teams are waiting for their new allocation. Injectable naloxone was available for a couple of months in 2020 for the use of HR teams.

> *"The National Drugs Agency (SICAD) will provide another allotment of nasal naloxone to HR teams across the country. They don't oppose naloxone being distributed to clients, family and friends, but there is no guidance or training available.*
> (Porto, Portugal FP)

In Paris (France), Naloxone started being reimbursed by health care insurance. Moreover, a national training platform for overdose prevention was created by a civil society-led initiative with support from the French government. Read more information on this case in Box 1.

Case 1: OD prevention national training in France

Since 2018, Fédération Addiction and its partners,- AFVD, Aides, APSEP, ASUD, association of general medicine, the college of therapeutic communities, ELSA France, , OFMA, Psychoactif, RESPADD, SAFE, SFETD, and SFSPO - have been involved in a working group on OD prevention supported by the French government. The group aims at encouraging people who use opioids, their contacts, and professionals to use appropriate strategies to reduce the risks of lethal opioid overdose. The group is coordinated by Dr Nicolas Authier, and composed of multidisciplinary professionals (pharmacists, doctors, first aid instructors, and harm reductionists).

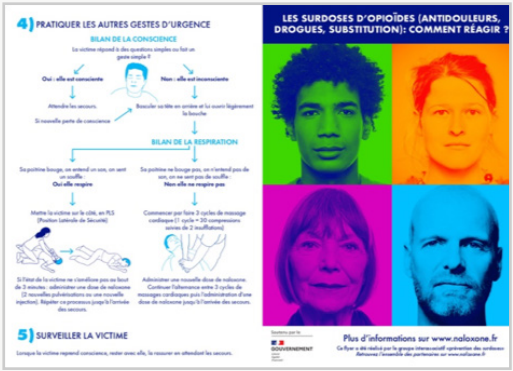
In 2020, this civil society-led group set up a national training plan for OD prevention through the online platform www.naloxone.fr. The training is intended for people who use opioids, those who are in OST, as well as family and friends of users and professionals. The 7-step training includes:

1. Knowing essential information on opioid overdose
2. Protecting victim and witnesses
3. Calling emergency services
4. Administering naloxone-based medicine
5. Freeing respiratory tract and taking stock of the victim's condition
6. Putting victim in recovery position
7. If necessary, doing cardiac massage

Each stage of the training is composed of a video clip, accompanied by a recap and a quiz to evaluate knowledge gained. The platform also contains information such as epidemiological data, legal texts, and presentation of Naloxone-based medicines, among others.

It is also possible to perform a general test to obtain a training certificate. For individuals, the certificate enables them to verify new knowledge acquired with the training. For harm reduction workers, the certificate is considered sufficient and may be required to distribute Naloxone.

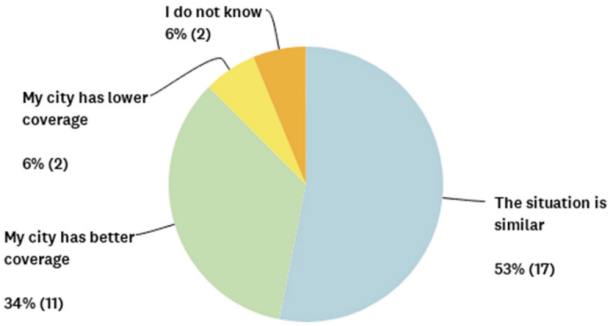
In addition to the website, the group has produced a poster and a flyer for OD prevention. The poster describes four contexts in which Naloxone can be used in the event of an opioid OD, and it can be displayed in pharmacies and drug-related services, for instance. The flyer describes how to react if someone is having an opioid OD.



FP context compared to national context

More than half of respondents assessed that Naloxone availability in their cities is comparable to the national situation. 34% think that their city offers better coverage when compared to the national context, and 6% that it offers lower coverage. Similar to general OD prevention, the context described by the C-HERN Monitoring for Naloxone availability is in good part based on the best examples of availability in a country and, thus, current data might not reflect the context of smaller cities and rural areas.

Figure 41: How does your city compare with the national situation in terms of Naloxone availability?

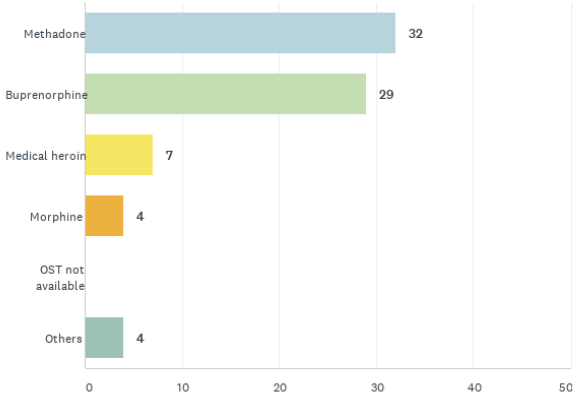


Opioid Substitution Therapy (OST)

Medications available for OST

In most C-EHRN FP cities, both methadone (97% of the cases) and buprenorphine (88%) are available for OST, with methadone only (Bucharest, Romania) or buprenorphine only (Nicosia, Cyprus) being available in a few cases. When available, medical heroin (21%) and morphine (12%) complements the availability of methadone and/or buprenorphine. Medical heroin is available in Amsterdam (Netherlands), Bern (Switzerland), Glasgow (Scotland, since last year), Kristiansand (Norway), Luxembourg (Luxembourg), Berlin (Germany), and Copenhagen (Denmark). Morphine is available only in Berlin, Copenhagen, Vienna, and Bern, and in a few cases also in Kristiansand (Norway).

Figure 42: Which of the following OST medications are available in your city?



Other available medications for OST include:

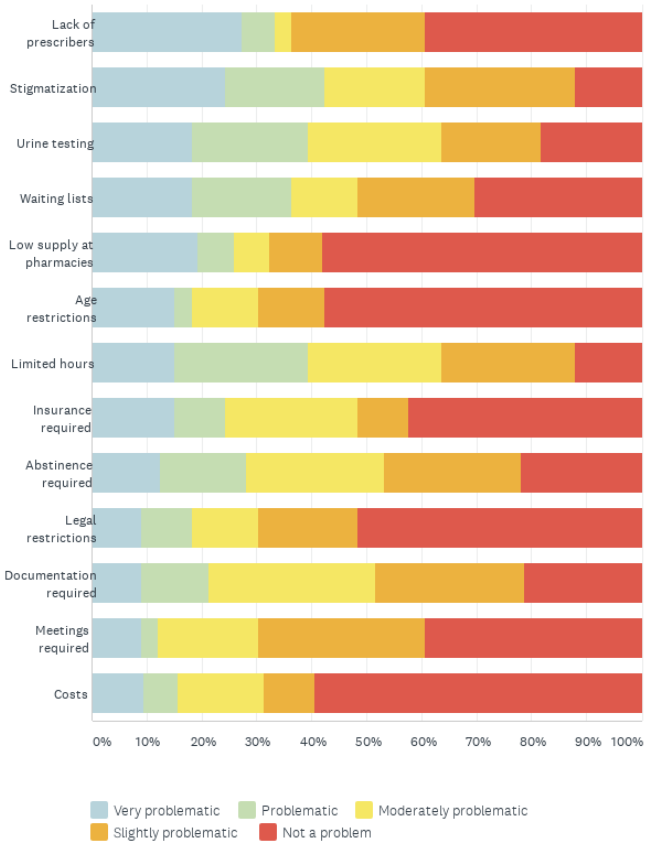
- Suboxone (Budapest, Hungary and Ljubljana, Slovenia)
- Substitol (Ljubljana, Slovenia, Berlin and other cities/Germany)
- Diacetylmorphine (Berlin, and approx.. 9 other cities in Germany)
- Levomethadone and codeine (Berlin, Germany)
- Methylphenidate for peple who use methamphetamine (Prague, Czech Republic).

In St. Petersburg (Russia), OST is prohibited, and in Bratislava (Slovakia), the real availability of buprenorphine is limited:

> *In theory, buprenorphine treatment should have been available since 1999 and in combination with Naloxone since 2008. But the reality is that since 2019, people on buprenorphine treatment don't have access to it because there is a lack of these pills in the Slovak market due to withdrawal of one distributor from the Slovak market last year. This medication is not registered as necessary, so Slovakia/ Ministry of Health doesn't need to secure the availability of this treatment.*
> (FP Bratislava, Slovakia)

OST accessibility

Figure 43: What factors limit OST access in your city? Please rate them according to the level of the barrier they represent to achieving sufficient OST coverage.



Several factors limit OST accessibility in FP cities.

The main limiting factors are stigmatisation of PWUD and the high threshold to enter, or remain in, treatment. The thresholds considered most problematic are urine testing, the requirement that people abstain from using illegal drugs, the need for documentation, and the limited hours of service delivery. Other problematic thresholds mentioned by more than half of respondents include the lack of OST prescribers, long waiting lists, requirements for social coverage or medical insurance, and a requirement that people participate in meetings. Legal and age restrictions, an inadequate supply at pharmacies, and the costs of treatment, are other limiting factors. Figure 43 shows how FPs rated several pre-selected barriers to OST access.

What needs to improve?

C-EHRN FPs were aked to openly comment on the most needed improvements regarding OST access in their citities. Their main responses include:

- Increased OST coverage, especially in smaller cities
- Increased number (and options) of prescribers
- More options for medicines to be used as a substitute
- Lower threshold to start and continue treatment
- OST availability in prisons and other closed settings
- More attention to counselling and social support during treatment

> *In North Macedonia, about 1,600 people are treated with methadone, and 250 with buprenorphine, while the size of the population of people who inject drugs is estimated at about 6,800; the scope of programmes for treatment of addictions is about 27%.*
> (FP Skopje, North Macedonia)

> *A huge problem of substitution treatment in Poland is the lack of access to prescription substitution drugs. This means that anyone who wants to be treated this way must agree to participate in large programmes. It also means that people from small towns have no chance of accessing substitution treatment because no one opens substitution programmes for only a few people.*
> (FP Krakow, Poland)

> *Doctors should prescribe larger OST doses and not push clients to reduce doses.*
> (FP Budapest, Hungary)

> *Maintenance programmes should be implemented with methadone for injection. Another option would be heroin-dispensing programmes. The hours of access to the methadone dispensing should also be extended, even creating a 24-hour dispensing centre.*
> (FP Barcelona, Spain)

> *Patients should have more opportunities in choosing a physician who prescribes OST.*
> (FP Vienna, Austria)

> *One should have more options in regard to the substance given as a substitute.*
> (FP Nicosia, Cyprus)

> *We need to ameliorate the opening hours to better meet client needS. Take home methadone/buprenorphine should increase, as it happened during the COVID lockdown.*
> (FP Milan/Rome, Italy)

> *The service needs more counsellors who have experience and are able to advise clients (for example, why they feel bad, how can they improve their well-being, what is happening to them) and guide them. This part of the service is currently incomplete.*
> (FP Tallinn, Estonia)

> *The main issue is that the treatment mainly consists of the medicine and there is very little social-counselling and psychological assistance available.*
> (FP Helsinki, Finland)

> *The waiting list that comes and goes is an issue. But we cannot forget the criminal indifference of some service providers regarding the beneficiaries, and the huge level of stigma towards PWUD from the psychiatrists that usually run the substance-free treatment units.*
> (FP Athens, Greece)

> *It is necessary to expand the list of drugs for OST, and reduce the level of stigma, as well as introduce a more loyal attitude towards co-consumption. Support programmes need to be strengthened and we must start researching programmes of substitution therapy for stimulants.*
> (FP Kiev, Ukraine)

Changes between 2019 and 2020

For the vast majority of participants (70%), OST has not improved in their city in the past year. The FPs reporting improvement were from Tirana (Albania), Vienna (Austria), Copenhagen (Denmark), Dublin (Ireland), Bern (Switzerland), Amsterdam (Netherlands), and Kiev (Ukraine). When present, most improvements occurred due to adjustments made to respond to the COVID-19 pandemic. It is, therefore, not clear if those will continue.

> *During the COVID-19 pandemic, the waiting time for starting OST (Methadone) fell from 12-to-14 weeks to 2-to-3 days.*
> (FP Dublin, Ireland)

> *Up till recently, European migrants, particularly those from Eastern Europe, had no access to methadone treatment. Due to COVID-19, a pilot started, allowing 17 European migrants access to methadone treatment. This pilot started because they had a harder time accessing heroin and methadone from the black market. It is not certain how this pilot will develop post-corona. Also, due to corona, people were given more weekly prescriptions (rather than having to pick up their methadone daily). This gives people more trust and freedom. On the other hand, we have heard of some people who miss the regular contact with their care.*
> (FP Amsterdam, the Netherlands)

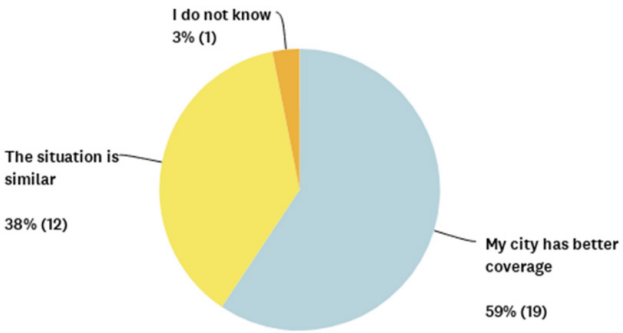
FP context compared to national context

About 60% of FPs consider that their city has better OST coverage when compared to the national situation. The main reason mentioned for the best coverage is that FP cities are bigger and, thus, count more services. In smaller and rural areas, OST coverage is compromised. The city situation was regarded as similar in 12 cases: Croatia, France, Georgia, Greece, Hungary, Italy, Norway, Poland, Spain, Switzerland, the Netherlands, and the UK. Nevertheless, even in these cases, a few differences occurred in terms of more, or more specialised, services in bigger cities.

> *In other cities the situation regarding access to OST is a lot worse; there are long waiting lists for the treatment because of the lack of prescribers. Vienna has the best supplementation with OST. 85% of prescriptions are done by GPs (very easy to get access). Medication is delivered by pharmacies and there are useful take home regulations in terms of reintegration.*
> (FP Vienna, Austria)

> *Better access to substitution treatment is available only in Warsaw, where there are many programmes offering this kind of treatment. Mostly bigger cities in Poland have similar access to OST, like in Krakow.*
> (FP Krakow, Poland)

Figure 44: How does access to OST in your city compare with the national situation?



> *In big cities, like Rijeka, inadequate supplies at pharmacies isn't a problem, but in smaller cities it is a big problem. The pharmacies in smaller cities often don't have OST, so it has to be specifically ordered which puts the people who use OST in a bad position where they sometimes have to wait for days for their therapy to arrive.*
> (FP Rijeka, Croatia)

> *In Prague, there are several OST programmes. The capacity is around half of what is needed. In some parts of the Czech Republic, there are no OST programmes at all, or they are far from the homes of PWID.*
> (FP Prague, Czech Republic)

> *The largest cities are similar but access to medical doctors to prescribe is problematic, especially in rural communities.*
> (FP Copenhagen, Denmark)

Conclusions

There is an urgent need for the development of specific OD prevention measures that can address the current challenges seen in the field.

OD prevention measures should be included in national drug policy strategies, action plans and guidelines. *Policies and guidelines* should be updated with recent evidence and include:

- Guidelines for low-threshold access to Naloxone (e.g. over-the-counter, without the need for a medical prescription, community-based, and paid by health insurance).
- The obligation to provide people suffering from an OD stigma and punishment-free emergency services.
- OD prevention for non-opioids (such as stimulants, NSP) and address polydrug use.

Regarding *services,* there is a need for:

- Setting, and scaling, up DCRs and residential DCRs (in shelters or social housing), especially given FP observations that many ODs happen to people using alone or who are homeless.
- Setting, and scaling, up drug checking services.
- Scaling-up Take-Home Naloxone programmes and an increase in low threshold access to Naloxone for PWUD and people likely to witness an overdose.
- Lowering the threshold of OST programme initiation and continuation.
- Investing in substitution treatment for stimulant drugs.
- Further developing, and providing, OD prevention for stimulants and polydrug use.

In terms of campaigns and training,

- Funding and developing targeted OD prevention campaigns, including prevention for OD with opioids, stimulants, and NPS.
- Funding and developing OD prevention campaigns for the general public.
- Sensitising health care professionals, and other first responders, to properly assist PWUD, without stigma, refusal, or punishment.

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7

Highlights in New Drug Trends

Introduction

The continued appearance and use of NPS on the global and European markets remains a major concern for policymakers, law enforcement officers, but also for CSOs working in the field. International sources have warned of potential health risks for quite some time (1–3). But since the number of new drugs entering the market is still high (in 2019, 55 NPS were identified for the first time within the EU; in other words, 1 new substance per week). Although the body of knowledge regarding NPS is growing, we still lack essential information about many of these substances, e.g. regarding effects, risks, etc. Given that CSOs work closely with PWUD, they are able to gather essential information about these new substances, information which is difficult to gather by, for example, scientists, or law enforcement officials. Besides NPS, civil society monitoring also included other developments regarding the use of drugs, for instance new patterns of drug use, new routes of administration, the use of known substances by a different group of PWUD or the combined use of different substances (new and/or known). So the focus of this activity includes a broader field than just the use of new drugs. New approaches in this field are needed to regularly update existing data on new drug trends and drug use patterns. Harm reduction and community organisations working closely with PWUD may see changes in drug use much more quickly 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 may be anecdotal, small-scale, or is appearing for a short period of time, is considered not an obstacle, but as complementary to other data sources.

Adjustments to the questionnaire and introduction of focus groups

In January 2020, C-EHRN in Amsterdam discussed in a core group the monitoring activities of the previous year with a focus on what needed improvement, such as the quality and reliability of the data gathered. As for the New Drug Trends section, several occasions during 2019 had already allowed discussions to take place on issues related to monitoring new drug trends by civil society organisations (4).

These discussions and brainstorming sessions resulted in several adjustments to the questionnaire compared to that used in 2019: a shortened questionnaire; and a focus on the local level (the city where the FP is located) rather than at a regional or national level. In so doing, the quality and reliability of the data collected will increase, and thus its interpretation. Furthermore, it was decided to not only use online questionnaires, but to also promote the idea of Focal Points organising focus groups or group discussions with local experts in the field, including PWUD. However, because of the coronavirus outbreak in March of 2020 in most EU countries, it was considered not feasible to conduct face-to-face interviews and, therefore, FPs continued to use the 'safe' online questionnaires.

After a number of reviews, the 2020 questionnaire was sent out to FPs in May, and in September analysis of the filled-in questionnaires began. The request to fill in the CSO monitoring questionnaire was sent to the 37 C-EHRN FPs, of which 33 filled in the questionnaire using Survey Monkey. Below are some of the highlights gained from the monitoring of New Drug Trends in 2020.

New drug trends in C-EHRN FP cities

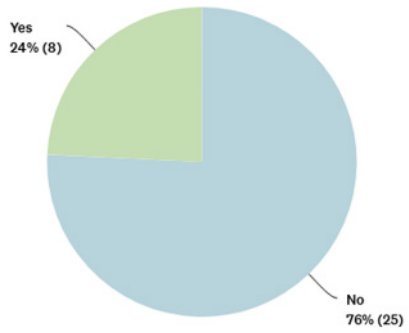
New drug trends can arise in many ways: a new or unknown substance that arrives on the market; an already known drug but used by a new group of people; a new route of administration of a substance; the combined use of different substances, sustained changes in behaviour and language relating to new drug use, etc.

Emergence of new substances

The first question asked was related to the emergence of a new or unknown substance in the local market. Since it is new or unknown to the target groups or CSOs, its use holds extra risks for the user. Therefore, timely monitoring of the use of such substances, as well as gathering information on risks and effects, is essential to provide harm reduction services for users of such substances as early as possible. CSOs are the agencies closest to PWUD and are, therefore, the first who can, and should, report on such issues.

Figure 45: In the previous year, have you witnessed any new developments regarding the use of drugs in your city amongst your target group(s): (a) The emergence of a new or unknown substance?

This question had 33 responses: Yes: 8 FPs (24%)



A small group of FPs have, therefore, seen the emergence of a new substance entering the local market. This may be an indication that although many new substances are newly offered on the local market every year, most of them are not used, at least not soon after they appear on the sellers markets. It can also be the case that substances already disappear from the market even before they are detected. It is worth noting that this period, in which almost a quarter of the FPs reported new developments regarding the use of drugs in thier city, includes the period from when the COVID19 pandemic began. It is not fully understood yet the full impact of the pandemic on drug routes and drug markets in Europe.

The FP in Antwerp, Rijeka, Tallinn, Budapest, Skopje, Bucharest, Glasgow, and Stockholm reported the emergence of new substances on the local markets: these include synthetic cannabinoids (mentioned by Rijeka, Bishkek and Budapest FPs); ketamine (Antwerp); Isotonitazene (Tallinn); 2C-B (Skopje); crack cocaine (Glasgow); and oxycodone (Antwerp). It seems that most of these new drugs on the market are used by marginalised and homeless people, and/or people with mental disorders. Reasons for using these new substances include the unavailability of desired drugs, and curiosity.

Case 1

Name of new substance: "Riječki šit" ('shit from Rijeka'), also called Paški, Đefri, Škipa, Gashijev šit or Ciganski šit.

What is it? It is supposed to be a mix of everything available (synthetic cannabinoids, kerosine, rat poison, antidepressants, and ketamine.

First heard of: Around March 2020.

Reason for using: Curiosity and desire to experience pleasure.

Effects: 'it makes you feel like a child again, and everything is okay and funny; hallucinations (optical and sound)'.

Unwanted effects: Strong fear and paranoia.

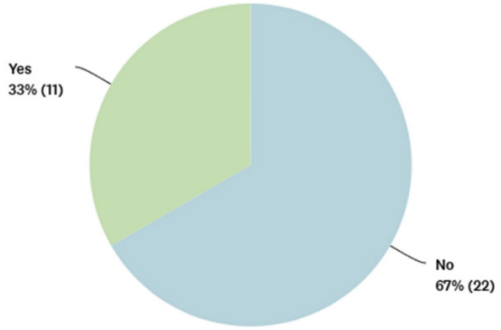
Number of people using: Unknown (maybe 50-100).

Known substances newly used by your target groups

Learning about known substances being used for the first time by the target group of CSOs may indicate, for example, changes in the availability or quality or price of the drugs they usually take. This may be of particular interest to CSOs working in this field, since shifting from one substance to another may lead to changes in drug patterns, risk behaviours and possible unknown health risks. Timely and up-to-date information on this phenomenon may inspire CSOs to rapidly address any negative consequences of use of these drugs by the target group.

Figure 46: In the previous year, have you witnessed any new developments regarding the use of drugs in your city amongst your target group(s): (b) The emergence of a known substance but used for the first time among (one or more of) your target group(s) in your city (e.g. GHB use among people who traditionally only used heroin)? (Please mention only the most remarkable or worrying changes).

This question had 33 responses: Yes: 11 FPs



Two-thirds of respondents mentioned no new developments regarding the use of known substances for the first time by any of their target groups.

FPs in Vienna, Antwerp, Nicosia, Tallinn, Krakow, Porto (Vila Nova de Gaia), Glasgow, Barcelona, Stockholm, Amsterdam, and London mentioned the emergence of a known substance by a new target group. Examples include: young people starting to use benzodiazepines in Vienna; ketamine in Glasgow; and in Stockholm, young people have started to use NPS; synthetic cathinones in Tallinn, or synthetic cannabinoids in Krakow by street opioid users; methamphetamine use by heroin/crack cocaine users in London; 3-MMC in chemsex scenes in Amsterdam and GHB in LGBT scenes in Porto; 'Shabu' (methamphetamine) by Asian immigrants.

Case 2:

Known substance used for the first time by target group

What substance: synthetic cathinones ('bath salts').

Used now by: Street opioid users.

Since when: First quarter of 2019.

In what form: powder.

Route of administration: mostly injecting.

Reason for using: Unavailability of street fentanyls.

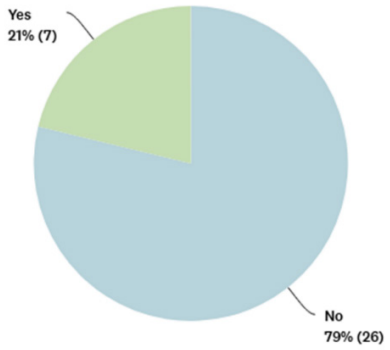
Source: NGO Convictus, Tallinn (Estonia).

New routes of administration

Known PWUD using new or different routes of administration may also be a sign of changes in the quality of drugs they use, or may reflect a shift from recreational use to more problematic use. As such, it may also involve extra health related risks, e.g. when PWUD shift from smoking cocaine to injecting. Quick interventions, based on this monitoring, may minimise harm done to these PWUD.

Figure 47: In the previous year, did you witness in your target group(s) the emergence of a new or different route of administration of specific substances?

This question had 33 responses: Yes: 7 FPs.



Examples reported are young people sniffing MDMA instead of oral intake (Vienna); OST injecting (methadone (heptanon), buprenorphine) (Rijeka); Oxycodone bought online and injected or snorted (Helsinki); 'bio-drugs' taken orally; crack cocaine by means of smoking (Tbilisi); opioid by injection (Stockholm); and chemsex drugs among MSM (Amsterdam).

Case 3:

PWUD using different routes of administration

By whom: People who inject drugs, people who are homeless.

What substance: Cocaine.

Route of administration: Injected, or smoked if crack.

S**ince when:** Over the last year or two this has increased.

Reasons: Increased availability, enhances effects of other drugs that are used.

Source: Scottish Drugs Forum, Glasgow (UK).

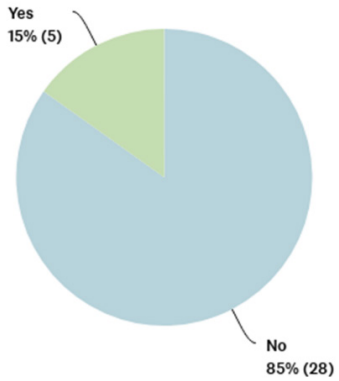
New combinations of substances

Combined use, or the use of more than one psychoactive substance during one session, always includes additional health risks as the effects may be much different from what is expected. Being aware at an early stage of a trend like this may help CSOs to develop early interventions to support PWUD.

Two FPs mentioned the combined use of ketamine and cocaine (Glasgow and Vienna). Other combinations mentioned include: cannabis and amphetamines (Tbilisi); methadone and amphetamines (Barcelona); and combinations of various fake and real benzodiazepines, as well as the combined use of Lyrica (gabapentin) and opiates (Stockholm).

Figure 48: In the previous year, did you witness in your target group(s) new combinations of substances?

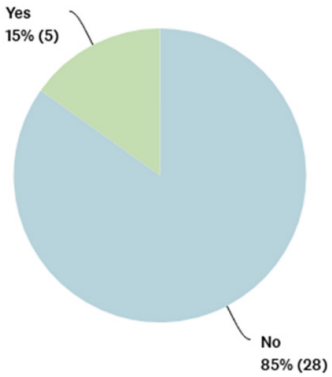
This question had 33 responses: Yes: 5 FPs, Vienna, Tbilisi, Stockholm, Glasgow, Barcelona.



Changes in the target groups

Figure 49: In the previous year, did you witness any changes in the existing target groups you provide services for (e.g. younger, new immigrant groups)?

This question had 33 responses: Yes: 5 FPs.



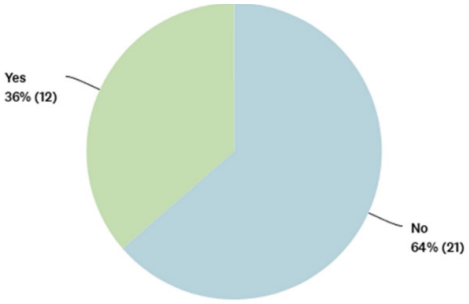
Examples include: OST users experience more problems in everyday life (Nicosia); the MSM chemsex scene is increasing (Budapest); a decrease in NPS use in favour of increased use in pharmaceutical opioids (Krakow); immigrants returning home from other EU countries (Bucharest); and immigrants inhaling opioids (Stockholm).

New target groups

FPs in Antwerp, Rijeka, Nicosia, Tbilisi, Athens/Thessaloniki, Krakow, Porto, Bucharest, Glasgow, Belgrade, Barcelona, and Stockholm started services last year for new groups of PWUD. These include: MSM; non-EU immigrants; migrants; students from Asia; young people using non-injectable drugs; PWUD in the chemsex scene; immigrants from countries of the former USSR; homeless populations; gender specific services; people returning from other countries; and people who buy drugs online.

Figure 50: In the previous year, did you start providing services for any new group(s) of PWUD?

This question had 33 responses: Yes: 12 FPs



Case 4:

New groups of PWUD for which services were provided

New group of PWUD: Chemsex community.

Activities conducted by our NGO: Peer-to-peer support, linkage with mental health professionals.

Chemsex is a quickly rising trend in the gay community and involves very risky behaviour related to blood borne infections. As an association of HIV+ people, we took that very seriously in terms of prevention and peer support. Also, there are no specialised services for that and people do not have somewhere to get support.

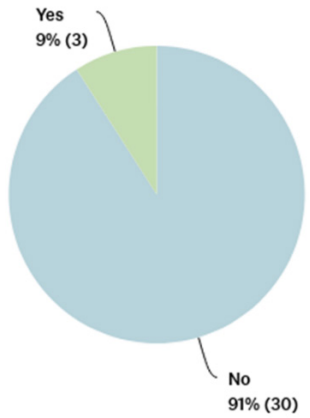
The NGO reached more than 80 people from this community over the past year.

Source: NGO Positive Voice, Athens/ Thessaloniki (Greece).

PWUD whose needs are not met

Figure 51: In the previous year, did you come across any new group(s) of PWUD for whom your organisation, or any other organisation, are currently not providing any services?

This question had 33 responses: Yes: 3 FPs.



FPs in Skopje, Bucharest, and Stockholm mention groups for whom no services are yet provided: people who use non-opiate drugs (MDMA, amphetamine, LSD, magic mushrooms, cocaine) and young people and PWUD at parties.

Case 5:

PWUD whose needs are not being met

PWUD: People who use non-opiate drugs (MDMA, amphetamine, LSD, magic mushrooms, cocaine).

It is not a new group, but we haven't developed services for them yet.

How long has this group been around? More than 3 years.

What is needed for this group of PWUD includes the following:

1. Social services, legal services, services from a psychologist and psychiatrist.
2. Additional harm reduction outreach activities at music events such as:
   - Setting up an info-stand with educational materials on latest trends in drugs and the risk of drug use; sexual health issues; and information on prevention of HIV, HCV and other blood borne infections.
   - Highly experienced and educated outreach team that will provide: advice on drug use and risks associated with it; medical advice, including first aid; legal advice when approached by the police, etc.
   - Display posters with a chart of drug combination risks which will be visible and easily accessible.
   - Have an internet connected laptop for team members to look up pictures and information on specific substances; also to check if a substance is already registered in an online database of lab tested substances.
   - Have harm reduction supplies such as: condoms and lube; straws for snorting; syringes for measuring a liquid dose; vitamins and minerals (Vitamin C, Magnesium).
   - Have a list of local services to give to people seeking help with substance use or sexual health issues.

Challenges

The new shortened questionnaire provided improved data collection. For example, the scope was now more clearly defined (fewer questions) and narrowed down (to the local level). A number of issues previously faced were, therefore, solved. However, the new questionnaire continued to have some flaws that came to light especially while analysing the data received and include the following:

Corona crisis

The corona crisis may have led CSOs staff to have to spend their valuable time in addressing the additional needs of PWUD in their services, rather than answering questions and doing research. This may have led to the fact that a number of FPs mentioned that nothing happened, or filled in very little while answering the questions.

No focus groups (as planned)

Based on feedback from the previous monitoring round, the questionnaire was too long. Consequently, focus groups/group discussions were introduced with relevant local stakeholders to discuss new drug trends and to jointly answer the questions. A number of FPs had already agreed to do the data collection in this way. However, during the period of data collection, most, if not all, participating cities suffered from corona-related measures. This included severe restrictions in organising gatherings in many cities, and the number of people allowed to participate in those face-to-face meetings.

Issues in interpreting the data

Issues were faced in interpreting the data received. For example, if a FP provides very short answers to the questions, does that mean that little information was available, or that the way of questioning is not suitable for gathering data on new drug trends? On the other hand, some FPs replied to all questions with a lot of information. Does that mean that in these cities a lot is going on, or merely a very dedicated and enthusiastic person filled in the answers?

What people think is in the substance versus lab-tested information

Another limitation of the way data is collected is the differences between self-reports of the content of, for example, a new substance (see Case Study 1) versus information that comes from a lab analysis of the sample. Self-reports of substance content can give crucial information on new substances, such as its general effects and appearances, however as consumers' experience is strongly influenced by the set and setting (context and psychological state), they also have to be carefully assessed. Comparisons between the strength perceived by users and the effective rate of psychoactive substance as determined through a full-blown analysis have demonstrated that they can be different.

PWUDs share information with Harm Reduction service providers, this is very early drug trend information that can aid the development of as close to real time policy responses at a local level. The gathering of intelligence from Harm Reduction services is important; however, we know it is not research, it is not lab-tested information and it is not empirical data. Harm Reduction Intelligence gathering is important information and requires a continually developing system of local corroboration and verification."

Definition of 'a trend'

Caution is also required when talking about a trend. Without a clear definition, questions regarding trends may leave space for different interpretations between different FPs. It would be useful to develop indicators, such as the number of persons involved, the length of the period in which the phenomenon is observed, and others. Although the term has been excluded from the questionnaire, reference to trends is likely to really mean 'observations'.

Reliability of some answers

As has been the case in 2019, sometimes information given by FPs is very different from what other (official) sources report. We see this as helpful information that can inform the debate on drug policy at local/national level.

Staff at the Correlation HQ have limited capacity to follow-up on the questionnaire. Follow-up has been undertaken concerning all non-returned questionnaires and, in a few cases, when replies have been

unclear. However, there is no capacity to do this in all cases. It is wise to allocate more time for this, as it may reduce some of the limitations mentioned elsewhere.

Conclusions

Data collection regarding new drug trends by CSOs has improved compared to previous years, although the level of responses in terms of input or quality still differs greatly. C-EHRN has contributed to a better understanding of emerging drug trends, at least at the local level. The importance and added value of CSOs providing ground-level information on developments regarding drug use at local level can be clearly seen, but work still needs to be done to make full use of these resources. Also, continuous attention should be paid to the quality of the data, and to streamlining the information, such as in the level of detail of information provided. Finally, adequate and qualitative data collection is more time consuming that initially expected. Disseminating updates on new drug trends for all FPs several times a year is, at present, not possible. There is lack of capacity within C-EHRN to do this, but also the monitoring of new drug trends is not the core business of CSOs in the field and, therefore, to do so is usually an extra task on top of the already heavy workload on most professionals working with PWUD. Furthermore, COVID-19 has made the workload even greater.

While reports of emerging new substances in some cities (such as synthetic cannabinoids or synthetic cathinones, as well as the increased use of methamphetamine and GHB in chemsex scenes in a number of cities) are in line with other sources, such as the European Drug Report (1) or the World Drug Report (3) other FPs mentioned lesser known NPS for the first time last year, such as Isotonitazene by the Estonian FP in Tallinn. Data, however, is still rather limited since most of FPs do not have much input. This is something that C-EHRN plans to improve next year by changing the data collection methods, possibly including online group discussions and interviews.

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8

COVID-19 and Harm Reduction

Introduction

Since the beginning of 2020, European countries have experienced an unprecedented public health threat with the emergence of COVID-19. People who use drugs (PWUD) and harm reduction services in Europe are uniquely vulnerable during the pandemic. European countries implemented a variety of virus containment strategies, such as border closures, service reductions, increased police presence, as well as diversion of sterile supplies and staff to hospitals [1]. In addition to these disruptions, PWUD may face an increased risk of exposure to COVID-19 due to crowded living conditions and may be at higher risk of severe complications should they contract the virus [1,4]. Preliminary research on the pandemic's effect on PWUD and drug services in Europe has been conducted by the European Centre for Monitoring of Drugs and Drug Abuse (EMCDDA). To complement this, C-EHRN has collected the ground-level experiences of Civil Society Organisations (CSO's) providing vital harm reduction services from May to July 2020 in cities across the European region, as well as data from PWUD themselves. This data from C-EHRN Focal Points (FP's) and PWUD examines both the challenges and successes during the first wave of the pandemic and provides timely information on the real-life situation, with valuable lessons learned and areas of focus for future advocacy.

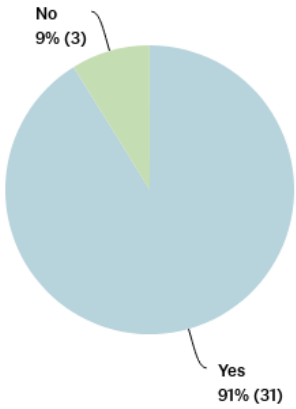
The COVID section of the C-EHRN Monitoring Tool consists of ten questions on COVID-related impact on harm reduction services and on PWUD in FP organisations or cities. A separate questionnaire was sent to PWUD with four questions covering the COVID pandemic. Data was collected from May to July 2020, reflecting the first wave of the pandemic.

Results

Challenges faced by harm reduction services

The first part of C-EHRN monitoring assessed the various challenges faced by harm reduction services during the pandemic. CSOs were asked whether their harm reduction services were affected, and which modifications to services they undertook during the first wave of the pandemic.

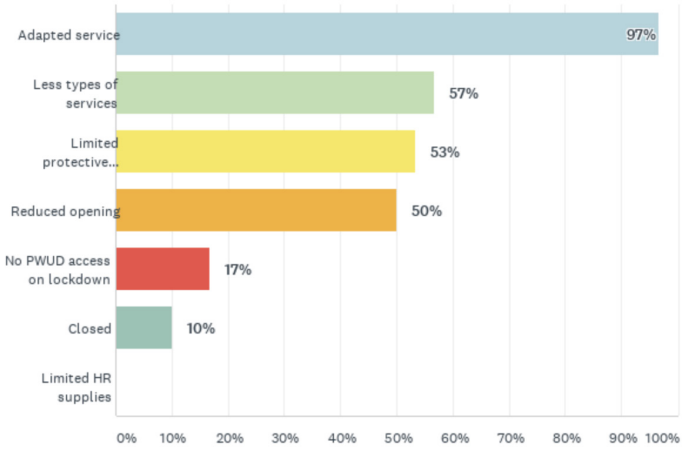
Figure 52: Has the COVID-19 pandemic affected daily harm reduction practices?



The majority of FPs reported that the pandemic had indeed affected their daily harm reduction practices. However, FPs from three cities - Antwerp, Helsinki and London - reported that the COVID-19 pandemic did not affect daily practices in their organisations.

Harm reduction facilities were then asked which challenges their services had faced during the first wave of the pandemic.

Figure 53: Challenges faced by harm reduction services during the first wave of the pandemic



The majority of FPs reported rapid adaptation of services. FPs in Vienna, Athens and St. Petersburg reported closure during the pandemic, and FPs in Tirana, Rijeka, Berlin, Porto and St. Petersburg reported that PWUD could not access services in their city due to lockdowns.

No FPs reported limitations in harm reduction supplies from the services that remained open. The responses shown in Figure 2 correlate with preliminary findings from EMCDDA's research which suggests there has been a decline in the availability of European drug services during the early months of the pandemic. Services still providing care to PWUD needed to rapidly implement new hygiene and social distancing measures. Additional challenges found by the EMCDDA include a lack of adequate protective equipment for staff, challenges linked to remote technology, staffing shortages, and managing the demand for substitution treatment [3].

Major adaptations noted in the comments by FPs included service windows, new online services, home delivery services, a new need for food and water distribution, cessation of drop-in services, and disruption in HIV/HCV services. FPs in Bucharest, Porto and Copenhagen reported an increase in programmes and opening hours.

> *"Our facilities were open throughout the COVID-19 period and care was maintained at different stages. The entire service was adapted to the new situation. From an initial stage, access to consumption spaces was maintained, limiting the number of people; the delivery and receipt of material that is sterile or already used for injectors as well as for smokers; delivery of containers; nursing care; Hep C and supervised antiretroviral treatments; replacement of naloxone kits; and the delivery of food packs. Subsequently, other spaces and services were adapted, week-by-week, in order to expand attention to all areas: showers; laundry service; permanence and food in the drop-in space with safe distances; use of masks; and all measures including disinfection and cleaning with specific products."*
> (FP Barcelona, Spain)

> *"We had to adapt our services. No drop-in or groups. Focus was on providing services on a one-to-one basis on outreach, in-reach/fixed site.* (FP Dublin, Ireland)

> *"Increase in programme and opening hours, development of new components (mask, disinfectants, and massive food distribution, "home" delivery.*
> (FP Bucharest, Romania)

> *"We expanded daily opening. Limited access to the clinic service, but expanded access to outreach. Isolation facilities for the homeless, including undocumented migrants (after a while). Night shelter for street homeless regardless of nationality.*
> (FP Copenhagen, Denmark)

> *We adapted our services – not only with protective material – but, for example, in GIRUGaia we began intensive telephone contact with our clients 2 times a week [ ]To respond to users' needs, and to help them during the social isolation period, Kosmicare has made available online its psychological support and harm reduction counselling sessions. This service was created to support people that are experiencing difficult and/or challenging situations related to the use of drugs, that are facing some negative drug-related psychological consequences or difficulties managing their drug use.* (FP Porto, Portugal)

Positive changes in harm reduction during the pandemic

While the COVID-19 pandemic has wrought with many hardships for PWUD and harm reduction CSOs, it has also provided a unique opportunity for innovative practices, as well as a few potential "silver linings". Preliminary findings have shown a large demand for opiate substitution treatment (OST) and the transition to online harm reduction services.

FPs were asked about the potential positive changes in harm reduction services at their organisation during the first wave of the COVID-19 pandemic, with their responses shown in Figure 54.

Education on COVID-19 was endorsed by the majority of FPs. Many of the other changes centred around OST, such as increased length of prescriptions and take-home doses; new phone or telemedicine services; or increased interest in, and enrolment onto, OST. In Prague and Novi Sad, FPs reported that new forms of OST were available. Outreach services and access to housing and shelters, and naloxone distribution also ranked highly. The responses per city/organisation can be seen in Table 12.

Other positive changes mentioned by FPs include more shelters for people experiencing homelessness; new methylphenidate prescriptions for stimulant use (Prague); more attention and funding to outreach work and the supply of sterile syringes (Athens); nasal Naloxone training for staff and PWUD (Lisbon); distribution of food and hygiene products (Bucharest); increased volunteering for outreach (Novi Sad); and better hygiene and tranquillity in DCRs and drop-in sites due to a lower number of service users (Amsterdam).

Figure 54: Positive changes or innovations in harm reduction services

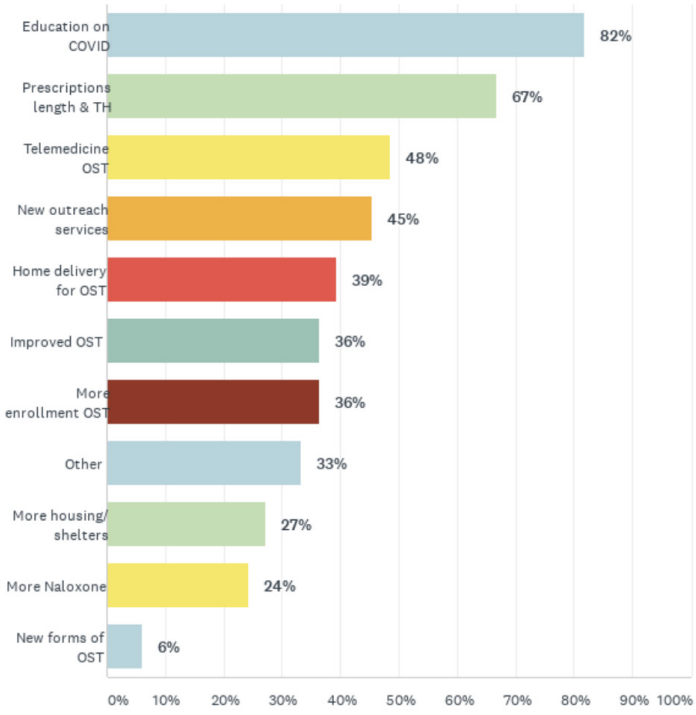


Table 12: Positive changes reported by FPs in response to the first wave of the COVID-19 pandemic

	Improvement in OST services	Increased length of prescriptions and take-home doses	New phone or telemedicine services for OST	Increased interest and enrolment in OST	Home delivery of OST	New forms of OST available	Improvement regarding access to housing and shelters	Increased or started Naloxone distribution	New outreach services added
Albania, Tirana		x	x						
Austria, Vienna		x	x		x		x		x
Belgium, Antwerp	x	x	x	x	x				
Croatia, Rijeka			x						
Cyprus, Nicosia								x	x
Czech Republic, Prague		x	x			x	x		
Denmark, Copenhagen	x	x		x	x				x
Estonia, Tallin			x		x				
Finland, Helsinki		x							
France, Paris		x	x				x	x	x
Georgia, Tibilisi		x							x
Germany, Berlin	x	x	x	x	x		x		
Greece, Athens									x
Hungary, Budapest									x
Ireland, Dublin	x	x	x	x	x		x	x	x
Italy, Milan/ Rome	x	x	x	x				x	
Lithuania, Vilnius								x	
Luxembourg, Luxembourg	x	x							
Norway, Kristiansand									x
Poland, Krakow	x	x	x	x					x
Portugal, Porto		x	x	x	x		x	x	
North Macedonia, Skopje									x
Romania, Bucharest									x
Russia, St Petersburg									x
Scotland, Glasgow		x	x	x	x	x	x	x	x
Serbia, Novi Sad		x							
Slovakia, Bratislava	x								
Slovenia, LJubliana						x			x

	Improvement in OST services	Increased length of prescriptions and take-home doses	New phone or telemedicine services for OST	Increased interest and enrolment in OST	Home delivery of OST	New forms of OST available	Improvement regarding access to housing and shelters	Increased or started Naloxone distribution	New outreach services added
Spain, Barcelona	x	x	x	x	x		x		
Sweden, Stockholm		x							
Switzerland, Bern	x	x			x				
Netherlands, Amsterdam	x	x	x	x	x		x		x
Ukraine, Kiev		x	x	x	x				
UK, London	x	x	x	x	x		x	x	

FPs were asked to comment on other positive changes in harm reduction services during the first wave of the COVID-19 pandemic.

> *New sheltering possibilites for the homeless, new substance methylphenidate available in the pharmacology assisted treatment to methamphetamine.*
> (FP Prague, Czech Republic)

> *All OST was delivered to users' own homes. Outreach OST to the homeless.*
> (FP Copenhagen, Denmark)

> *More attention and more money directed to the street work and to the supply of sterile injections.*
> (FP Athens, Greece)

> *Mobile DCR supported the emergency shelters set up in Lisbon. Nasal naloxone training of staff and some clients of the emergency shelters in Lisbon. Increased length of prescriptions and take-homes - only in drug treatment centres, not low threshold.*
> (FP Porto, Portugal)

> *Massive food and hygiene product distribution.*
> (FP Bucharest, Romania)

In the first wave of the epidemic, a 24-hour homeless shelter for about 20 people opened in Ljubljana. The shelter was open for about two months. Besdies, due to the suspension of public transport, some users did not have access to substitution medicines, so our association took over the distribution of medicines for these users. (FP Lubljiana, Slovenia)

> *Clients volunteer to help deliver materials in the field.*
> (FP Novi Sad, Serbia)

> *Specific and personalised health follow-ups for our clients, especially those who had symptoms.*
> (FP Barcelona, Spain)

> *Larger enrolment in OST by >50% but no new patients in.*
> (FP Stockholm, Sweden)

> *Better hygiene in DCRs, more tranquillity/less aggression and frustration in drop-in centres, and not only improved access but also improved quality (more independent bedrooms) at shelters.*
> (FP Amsterdam, Netherlands)

Difficulties faced by PWUD during the pandemic from the perspective of harm reduction service providers

FPs were asked to identify potential difficulties faced by PWUD in their countries during the pandemic and to rank them according to difficulty.

Figure 55: Main difficulties faced by PWUD from the perspective of harm reduction CSOs

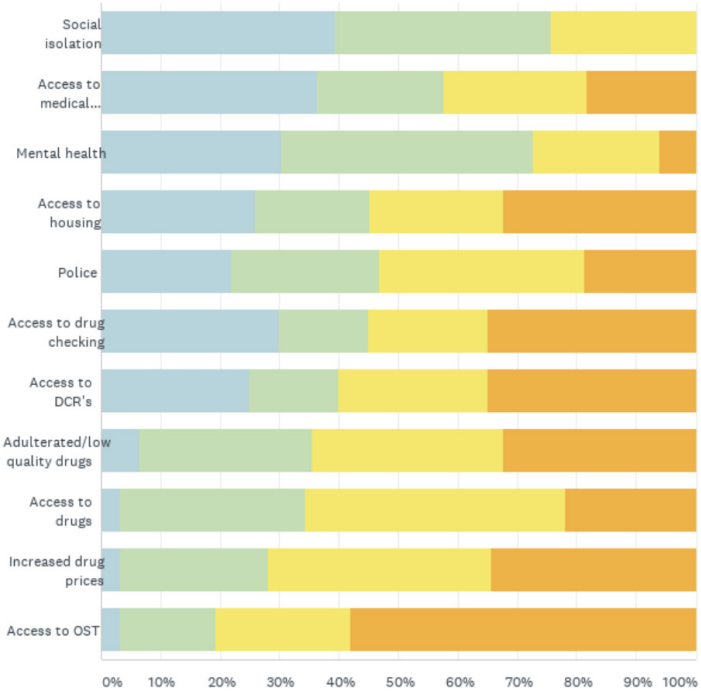
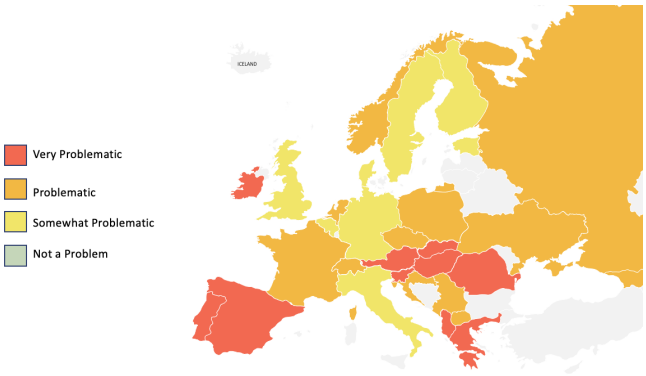
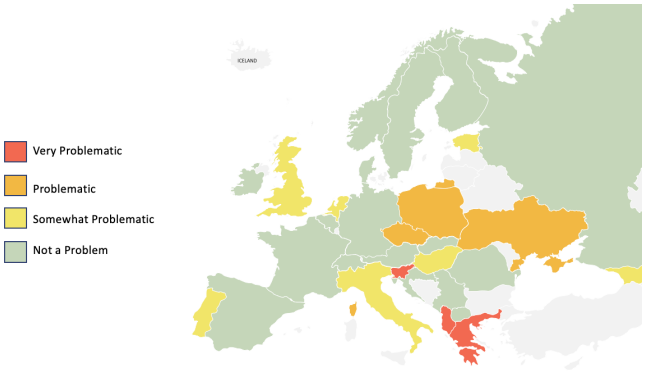


Figure 56: Social isolation for PWUD during the pandemic



In contrast, limited access to OST in their country was ranked by FPs as the least problematic. It was only noted as very problematic by respondents in Slovenia, as shown in Figure 57. This might be related to the fact that several positive developments regarding access to OST occurred during the first wave of the COVID-19 pandemic, as previously mentioned.

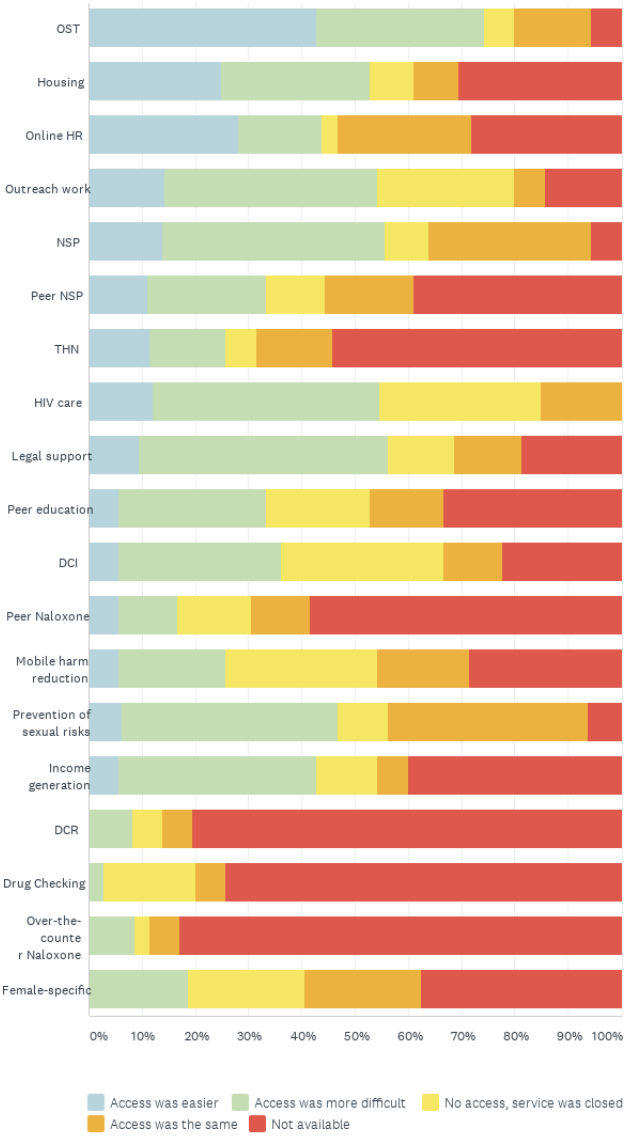
Figure 57: Limited access to OST during the pandemic



Limited access to drugs, adulterated or low-quality drugs, and an increase in prices were perhaps not as widespread and/or problematic as anticipated by preliminary research [1]. Social isolation, as well as an increase in mental health disorders, may be related to the severity of the COVID-19 outbreak, as well as the degree of lockdown and limitations to services in the region.

Voices of PWUD during the pandemic

Figure 58: Harm reduction access during the pandemic by PWUD



To complement this data from the harm reduction FPs, a new survey this year for PWUD included four questions on harm reduction during the pandemic. PWUD were asked to rank their access to various harm reduction services in their city during the pandemic.

OST, housing, online harm reduction, and outreach work were ranked by PWUD as easiest to access. The majority of PWUD respondents noted a reduction in the types of services available, though some new services (such as delivery) were noted.

> *Services were cut in half during COVID.*
> (Helsinki, Finland, PWUD)

> *Everybody closed the services and left alone the drug users in the streets to police appetite, drug users were searching for WATER and a TOILET not drugs. Very big disappointment from everybody.*
> (Athens, Greece, PWUD)

> *Heroin was delivered to patients' homes by bicycle courier. Fewer drug consumption rooms were open.*
> (Zurich, Switzerland, PWUD)

> *Online harm reduction services were more available; the OST programme gave us Methadone for all week; we had bigger amounts of sterile equipment, but when we spent it was not easy to get a new one because of the state of emergency and police hours.*
> (Novi Sad, Serbia, PWUD)

Changes in drug use by PWUD during the pandemic

PWUD were asked if their drug use, or that of their peers, was affected by the COVID-19 pandemic in terms of which drugs were used, and how they prepared or took them. Early research by the EMCDDA suggested an overall decline in drug use among PWUD, but with heterogenous results and significant variability by country and drug type [1]. Many respondents noted an increase in alcohol use. No change in drug use was reported by ten participants. Respondents noted an increase in al-

cohol use in Vienna, Budapest, and Glasgow (n=3). Participants from Copenhagen, Athens, Helsinki, Budapest, Kristiansand, Stockholm and Porto (n=7) noted that drugs were more expensive. In particular, the respondent from Finland noted the price of buprenorphine had "doubled." Participants from Copenhagen, Athens, Luxembourg, Porto and Stockholm (n=5) all noted a decrease in the quality of substances available. More buprenorphine on the streets was noted by participants from Prague, whereas more methadone in the street supply was noted in Novi Sad. Cannabis was noted as harder to come by from respondents in Dublin and Porto.

> *For a period, the drugs were bad and expensive.*
> (Copenhagen, Denmark, PWUD)

> *Amphetamines got more common, Buprenorphine and Benzos were not available. If you got buprenorphine, the price was double.*
> (Helsinki, Finland, PWUD)

> *I have been drinking a lot more alcohol and buying more prescribed tablets on the street (Tramadol).*
> (Glasgow, Scotland, PWUD)

> *Higher prices, and worse quality and emergence of new NPS.*
> (Stockholm, Sweden, PWUD)

> *Less cocaine was consumed and increasingly at home. There were more purchases in Darknet.*
> (Zurich, Switzerland, PWUD)

Health of PWUD during the COVID-19 pandemic

Participants were asked to comment on the mental and physical health of themselves or their peers during the COVID-19 pandemic. An increase in mental health disorders was noted by thirteen PWUD out of the 24 respondents.

> *Social distancing has affected my psyche, I have been too scared to meet anyone or even go outside. I also have used more alcohol. One of the most traumatised things in my life.*
> (Helsinki, Finland, PWUD)

> *More need of psychologist and psychiatric services.*
> (Tallinn, Estonia, PWUD)

> *Mental health issues are prevailing in the community due to many factors and the lack of psychosocial support. The lockdown had a tremendous affect on mental health, and people are more disorganised and chaotic.*
> (Athens, Greece, PWUD)

> *It was hard for me, because I couldn't go to a psychiatrist. One my friends died during the pandemic and it was a very difficult moment for me.*
> (Novia Sad, Serbia, PWUD)

> *Peoples' mental health has been affected negatively and suicide rates have gone up.*
> (Stockholm, Sweden, PWUD)

Physical health was also noted to be affected by a number of respondents, some of whom attributed it to the use of tobacco and alcohol.

> *I have COPD and it has got worse as I am smoking a lot more tobacco.*
> (Glascow, Scotland, PWUD)

> *I was sick before the pandemic, having a bad septic infection and then septic arthritis. It was hard to get treatment and get myself a hip replacement during the pandemic.*
> (Bucharest, Romania, PWUD)

Other findings noted by respondents include a closure of health services, stress from lack of work, and a rise in violence and peer-on-peer robbery and violence.

PWUD life under the COVID-19 pandemic

Respondents were asked to comment on other ways the COVID-19 pandemic has affected PWUD in their city. Frequent themes mentioned by PWUD include:

- Problems with the police (e.g. in Antwerp, Athens, Budapest, and Novi Sad).
- Difficulty gathering and meeting to obtain drugs (e.g. in Tirana and Vienna).
- Lack of tourists/lack of money in general (e.g. in Moscow, Glasgow, Amsterdam, Luxembourg and Dublin).
- Plight of the homeless (e.g. in Ljubljana, Krakow and Cologne).
- Lack of drop-in centres for social contact (e.g. in Greece).

> *It was almost impossible to meet up; therefore, buying drugs was more difficult.*
> (Vienna, Austria, PWUD)

> *Mostly people who used buprenorphine tried to switch to benzos before they, too, stopped being sold.*
> (Helsinki, Finland, PWUD)

> *Most of the respondents experienced difficulties related to homelessness, not substance use per se.*
> (Krakow, Poland, PWUD)

> *New people couldn't enter an OST programme because of Covid.*
> (Vilnius, Lithuania, PWUD)

> *It has been a lot more difficult to get around with money. No source of income. No easy access to drop-in centres, so no social control.*
> (Amsterdam, Netherlands, PWUD)

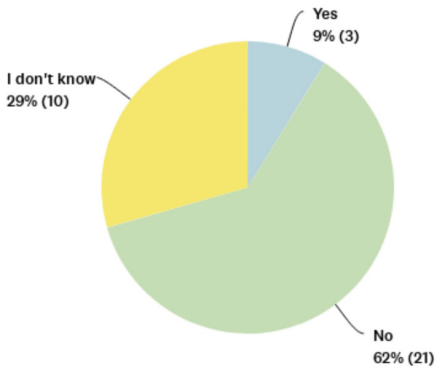
> *Some of my friends were penalised for walking during the police hour.*
> (Novi Sad, Serbia, PWUD)

> *There is loads more begging, some sex workers have been forced to start begging as they have no customers. This is causing a lot of conflict with the established beggars fighting over the best spots.*
> (London, UK, PWUD)

Overdose and the COVID-19 pandemic

Harm reduction focal points were asked about whether they noted an increase in overdose (OD) during the pandemic. This was hypothesised by many experts early in the pandemic to be a potential risk due to more PWUD using alone, less access to naloxone, an increase in adulterated substances, etc. [1].

Figure 59: Increase in OD observed during the pandemic

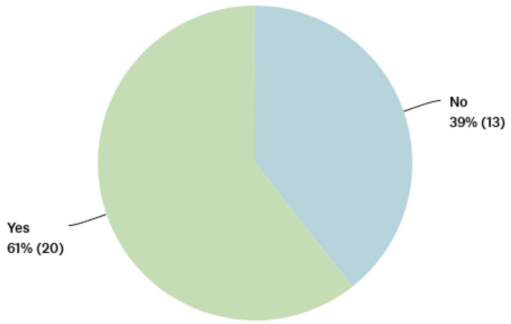


While the majority of the C-EHRN FPs did not note an increase in overdose, one-third did not know. FPs in Kiev, Novi Sad, and Stockholm reported increased rates of overdose during the pandemic.

Government response for PWUD during the COVID-19 pandemic

FPs were asked to evaluate whether their government responded to protect PWUD and harm reduction professionals during the pandemic in their country.

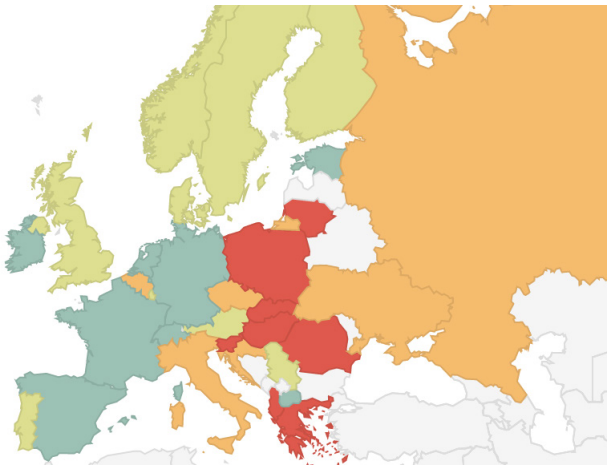
Figure 60: Government response to protect PWUD and harm reduction services during the pandemic



When asked to comment and give examples of the most frequent government responses to protect harm reduction and PWUD, FPs mentioned a number of items. Five FPs mentioned guidelines provided by their government (Vilnius, London, Paris, Helsinki, and Nicosia). FPs from ten countries reported their government assisted with the expansion of OST or the loosening of regulations regarding take-home doses (Tallin, Paris, Berlin, Tbilisi, Dublin, Rome, Kristiansand, Barcelona, Amsterdam, and Kiev). Distribution of protective and hygiene equipment was reported by seven FPs (Nicosia, Prague, Tallin, Porto, Barcelona, Amsterdam, and Bern). New shelters for the homeless were mentioned by five FPs (Vienna, Germany, Dublin, Barcelona, and Amsterdam).

FPs were asked to rate the government response to the pandemic on a scale from very poor to above average.

Figure 61: Focal Point rating of Government responses for PWUD



|||=Above Average |||=Average |||=Below Average |||=Very Poor

> *"All medical staff had access to necessary protective materials. Medical services must continue, this includes OST and heroin maintenance treatment. The National Government offers financial security to ensure that municipalities do not cut funding of low threshold services, thus ensuring continued services. Additional funding was made available for services to facilitate COVID transitions and the opening of additional shelters for the homeless.*
> (FP Amsterdam, Netherlands)

> *"During the pandemic, care and open consumption spaces have been maintained, as well as care in all areas, adapting it to the new situation and preventive measures. Lockdown spaces and shelters have been opened for people who live on the street and specifically with consumption spaces for people who live on the street and use drugs. Specific supervised programmes have been started for people with problematic alcohol consumption, avoiding withdrawal syndromes and allowing their lockdown. Rapid induction into OST programmes has been managed and these programmes have been adapted*

to enable longer take-home care to guarantee the possibility of lockdown while maintaining treatment. The availability of all available sterile consumable material in the quantities required has been maintained, as well as sexual prevention material, for smoked consumption and naloxone kits in order to prevent possible adverse reactions. There has been permanent contact by the government and monitoring of the adaptation of the different facilities, giving updated information on the different measures that had to be adopted at all times to prevent infections.
(FP Barcelona, Spain)

> *There was implemented 5 days dose delivery for OST clients for the first time in Georgia. We advocated for it for years, but COVID gave us this possibility.*
> (FP Tbilisi, Georgia)

> *The Ministry of Health released recommendations to low threshold centres on protective measures. They were not easy to implement and practically no funding was allocated to buy masks or disinfectants. Vilnius municipality gave access to COVID-19 testing for low threshold workers.*
> (FP Vilnius, Lithuania)

> *Rapid response, OST in low threshold, more shelters, information.*
> (FP Berlin, Germany)

> *A message came from the National Institute for Health Development that during the pandemic, drug users must receive services, and we did not close any services, we adapted them; for example, counselling services (went online, but also met with clients physically if necessary), to reduce direct contacts and risks. Clients received an unlimited amount of injecting accessories and methadone for a longer period of time at home. We were provided with disposable masks and gloves by the Government.*
> (FP Tallinn, Estonia)

> *There was no specific approaches to treatment which meant that different cities had different approaches. There was no national strategy for COVID testing of drug users.*
> (FP Copenhagen, Denmark)

> *The help came after long time, almost after the main crisis. Distribution of protective equipment. The help from the government is still chaotic even in these days.*
> (FP Prague, Czech Republic)

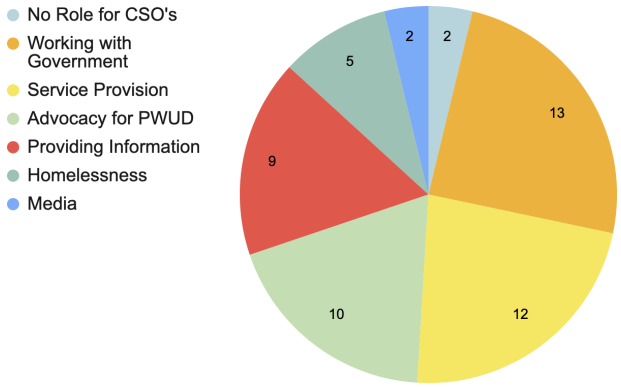
Role of CSO's during the pandemic

The next section asked the FPs to comment on the role of CSOs in advocating for, or increasing, services for PWUD during the pandemic. Most frequently mentioned was working with the government, followed by service provision and advocacy for PWUD.

Interfacing with the government and/or municipality during the pandemic was most frequently reported by thirteen FPs as the role for CSOs. The next most frequently mentioned was providing direct services to PWUD. Providing advocacy for PWUD was noted by ten FPs. Distributing information about COVID-19, and hygiene, was reported by nine FPs. Five FPs specifically mentioned addressing homelessness as part of their role during the pandemic. Two FPs, in Vienna and Vilnius, reported that CSOs did not play a role during the pandemic. The FPs in Helsinki and Stockholm reported that their role involved interacting with the media.

> *The CSO including my organisation have been highly committed to increasing services for PWUD. Our work helped the public authorities to take measures.*
> (FP Paris, France)

Figure 62: Role of CSOs reported during the pandemic



> *We adapted our services so that all drug users could get what they needed. We promoted the reduction of risk behaviours related to drug use during a pandemic, as well as guidance on behaviours and activities that are important for controlling viruses and reducing the risks associated with Covid-19. We are a source of information, communicating with other institutions such as the Unemployment Insurance Fund, shelters, health care institutions, medical institutions, doctors, etc.*
> (FP Tallin, Estonia)

> *Our organisation took part in regular calls with the city of Bratislava, when we spoke about implementing quarantine measures for homeless people. Our goal was to not base any new service related to COVID-19 for homeless people on abstinence as one of the requirements. Also, we became members of a working group at the ministerial level regarding homeless people and COVID-19, so people who use drugs will not be missed out of the services.*
> (FP Bratislava, Slovakia)

> *The CSOs played a big role in participating in meetings in order to establish the needs and gaps in services during the pandemic, the lockdown, and to approach problems affecting PWUD living on the street.“*
> (FP Barcelona, Spain)

> *We drew the attention of the authorities and the public to the fact that there are social groups for which the COVID-19 epidemic caused specific problems (e.g. homeless people who could not stay there without a home, or the difficulties of people living with HIV access to consultations and medical examinations).*
> (FP Krakow, Poland)

> *It was also pointed out that these programmes will contribute to the prevention of COVID among people who use drugs and other marginalised communities by informing, distributing the necessary materials. The government has announced a call for funding civil society organisations to prevent COVID and support marginalised communities. We distributed food packages, hygiene products, brochures, vitamins to people who use drugs and sex workers.*
> (FP Skopje, North Macedonia)

> *We created an online database to find services that are open during the lockdown; we organised video conferences for service providers; we translated guidelines; we created posters; HepaGo is doing street outreach, etc.*
> (FP Budapest, Hungary)

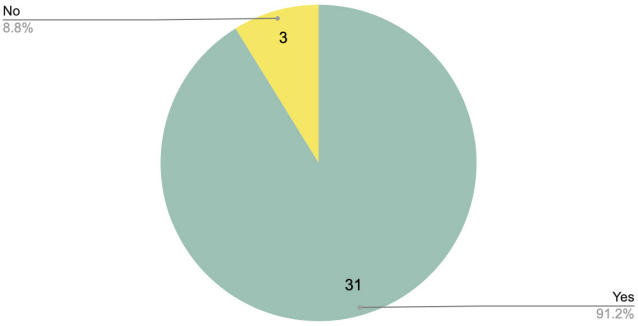
> *More counselling about health matters and education about hygiene, distribution of protective materials (surgical masks, latex gloves, disinfectants). But mostly, every CSO worked based on their intuition since there were no specific guidelines for CSOs, and especially none for harm reduction services.*
> (FP Rijeka, Croatia)

> *Many organisations in Ukraine have not stopped their work and have adjusted the services to the conditions that have developed. For example, our organisation fully provided PWUD with their previous access to services, and also carried out transportation for clinic registration for HIV and receiving ART. We also began to advise people on rights and help them get vital services.*
> (FP Kiev, Ukraine)

Potential for innovation and lessons learned during the pandemic

Nearly all FPs endorsed the pandemic as an opportunity to practice innovative harm reduction. Of those that responded "no", the FP in Vilnius noted it was, "too difficult just to focus on the basics", and the respondent in Ljubljana who responded "no" commented, "it was improvisation."

Figure 63: Opportunity to practice innovative harm reduction services



FPs were asked to freely comment on innovation during the pandemic. Most frequently mentioned was a transition to online services by eight FPs. New home delivery services, and positive changes to OST, were the next most frequently mentioned by five FPs. New outreach services were mentioned by three focal points, and two CSOs mentioned new food services. The FP from Tallin noted that their clientele seemed pleased by the switch to online services and would like this to continue. In Amsterdam, the FP noted they were able to expand OST to non-Dutch European migrants, whereas the respondent in Copenhagen commented that there was still no OST available for migrants. Extending drug-checking services to more vulnerable people was under discussion according to the focal point in Porto. Respondents from Barcelona noted a more sympathetic attitude of the state towards PWUD living on the street, and also reported some more personalised follow-up cases and interventions to improve their situation.

> *It has widely allowed for more digitalisation and more attention to hygiene. Some DCRs, for instance, have improved their ventilation and access to soap and water, or they intend to do so. Also, some services have really picked up outreach care very well; for instance, offering meals, work, medication or even paraphernalia at home. Several wish to continue these services. In Amsterdam, they have started a pilot offering European migrants methadone treatment. Thus, access to methadone has increased for a small group of people.*
> FP Amsterdam, Netherlands)

> *New phone for outreach work can be a major tool to approach clients and to go deep into the relationship with them. Possibility of extending the drug checking service to more vulnerable people.*
> (FP Porto, Portugal)

> *It usually takes a lot longer for our clients to embrace innovation, but in a pandemic and curfew due to Covid, maximum reduction of public transport has made it easier for our clients to get services through the innovations we have introduced.*
> (FP Skopje, North Macedonia)

> *There was no opportunity to implement innovative harm reduction service practise because we were focused on crisis intervention and survival.*
> (FP Bratislava, Slovakia)

PWUD and lessons learned from the pandemic

PWUD were asked to comment on their perspective for lessons learned from the pandemic. The importance of harm reduction was mentioned most frequently (6 PWUD), followed by expansion of OST and increase in OST flexibility (5 PWUD). The importance of peers was noted by two respondents, and the damage of stigma to the most vulnerable in the community during a pandemic was noted by two participants.

> *Peers are a great help in the Corona crisis. They maintain contact with the PWUD and provide them with up-to-date information. They can initiate COVID-19 virus and antibody tests if necessary, and also perform first preliminary examinations, such as fever measurements.*
> (Zurich, Switzerland, PWUD)

> *We could have learned a lot if PWUD were involved in health and social policies, in service monitoring and evaluation...this way we only learned global normalising lessons that may serve most but are very insufficient for marginalised groups.*
> (Porto, Portugal, PWUD)

> *We should have some savings of money, drugs and sterile equipment in case something like this happens again.*
> (Novi Sad, Serbia, PWUD)

Conclusions

Overall, FPs from countries with more strict lockdown procedures reported more reliance on home delivery and mobile outreach services. Positive FP rating of government responses correlates well with other positive outcomes reported during the pandemic. FP and PWUD from Barcelona, Zurich, Tallinn, Dublin, Berlin, and Amsterdam all rated their government responses as "above average" and noted other positive outcomes such as expanded OST, better sheltering for the homeless, etc. Conversely, in regions where the FP rated government responses as "below average", the FP and PWUD also reported more difficulties, such as problems with the police, and with sterile supplies for harm reduction.

In Western Europe, FP responses varied depending on the city, with many positive reports coming from Barcelona, Dublin, Amsterdam, Zurich, Paris, Berlin, and Lisbon detailing many positive harm reduction changes, whereas others referenced a more heterogeneous picture during the pandemic. Many FPs noted rapid law changes to expand OST, and improvement in housing for the homeless. Scandinavia was more mixed, with more positive responses regarding the pandemic coming out of Copenhagen and more negative comments from Stockholm and Helsinki. Central Europe (in the EU) reported very few government responses for PWUD aside from Prague, and more negative responses regarding the pandemic's effects on harm reduction and PWUD were stated, though some positive innovations were noted. In Southern and Eastern Europe, responses were very mixed. FPs in Skopje and Tbilisi reporting more positive responses, whilst those in Athens and St. Petersburg painted a more grim picture during COVID-19 times. The Balkan states were also mixed, with the FP in Tallin reporting a dramatically more positive picture than the FP in Vilnius regarding harm reduction services during the pandemic.

Important lessons to be learned from the initial response during COVID-19 is that services can be adapted rapidly and that expansion of OST, outreach services, and home delivery are vital components of harm reduction during a pandemic. Social isolation and mental health are important concerns for PWUD, with increased outreach and digital connection/phone services being important considerations to overcome these problems. Certain pandemic responses detailed by FPs demonstrate a window of opportunity to overcome political will in implementing rapid-scale changes to harm reduction services by rolling out new services or service changes. Important future considerations for future second and third waves of the pandemic are to prioritise expansion of outreach services, OST, and housing for vulnerable populations in connection with vital harm reduction services. Other infectious disease needs (such as HIV/HCV testing and treatment) must not be forgotten, and advocacy must continue to maintain the needed sterile supplies for harm reduction provision during a pandemic. Harm reduction services are a vital component in a pandemic response in caring for the vulnerable population of PWUD in Europe, and continued research as to the longer-term influence of the pandemic on these vital services will be important for future C-EHRN monitoring.

References

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2. *EMCDDA. EMCDDA update on the implications of COVID-19 for people who use drugs (PWUD) and drug service providers. 2020. https://www.emcdda.europa.eu/system/files/publications/12879/emcdda-covid-update-1-25.03.2020v2.pdf*

3. *EMCDDA. Impact of COVID-19 on drug services and help-seeking in Europe. 2020. https://www.emcdda.europa.eu/system/files/publications/13073/EMCDDA-Trendspotter-Covid-19_Wave-1-2.pdf*

4. *Holloway, Ian W., Anne C Spaulding, Ayako Miyashita Ochoa, Laura A Randall, Adrian R King, HBOU Study Team, and Paula M. Frew. 2020. COVID-19 Vulnerability among People Who Use Drugs: Recommendations for Global Public Health Programmes and Policies. Journal of the International AIDS Society 23 (7): e25551. doi: 10.1002/jia2.25551*

Endnotes

1. *Although Scotland is part of the UK, it is treated separately in this report.*
2. *The names of participant can be found under "contributors".*
3. *FP names, organisations, cities and countries can be found under "contributors". Both Italian FPs submitted one combined questionnaire. We have also received contributions from: (1) Chinara Imankulova, of AFEW Kyrgystan, Bishkek, Kyrgyz Republic; and, (2) Karen Mamo from Malta. These last two, however, where not included in the current report due to geographic coverage (1) and time restrictions (2).*
4. *Data extracted from the network member survey conducted in 2020.*
5. *https://www.correlation-net.org/wp-content/uploads/2020/05/C-EHRN_Monitoring_2020-Questionnaire.pdf*
6. *Unless otherwise stated, data and trends on harm reduction service provision presented in this chapter are based on Harm Reduction International. The Global State of Harm Reduction 2020. London; 2020. https://www.hri.global/files/2020/10/26/Global_State_HRI_2020_BOOK_FA.pdf*
7. *Europe refers to all countries included in this report. Where other regions (Asia, Eurasia, Latin America and the Caribbean, Middle East and North Africa, North America, Oceania, Sub-Saharan Africa, and Western Europe) are mentioned, reference is being made to regional categories used in the Global State of Harm Reduction report. For a detailed list of countries in each region, please check Harm Reduction International's Global State of Harm Reduction web page: https://www.hri.global/global-state-of-harm-reduction-2020*
8. *The table reports on availability, which does not necessarily mean accessibility. There might be serious barriers in access to these services on the ground*
9. *WHO has set a NSP coverage target of 300 syringes per person who injects drugs per year to reach hepatitis elimination goals by 2030; World Health Organization. Combating Hepatitis B and C to reach elimination by 2030. Advocacy Brief. Geneva; World Health Organization, May 2016, Table 1, p3. https://apps.who.int/iris/bitstream/handle/10665/206453/WHO_HIV_2016.04_eng.pdf[4].*
10. *After the Global State of Harm Reduction 2020 was published, C-EHRN FP from Norway reported that the country has also started providing Heroin Assisted Treatment.*
11. *Afghanistan, Australia, Canada, Denmark, Estonia, Italy, India, Mexico, Myanmar, Norway, Puerto Rico, Ukraine, the United Kingdom, the United States and Vietnam.*
12. *Naloxone is availiable in HR units but officially peers cannot distribute it, only nurses.*
13. *Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people, and those with underlying medical problems such as cardiovascular disease, diabetes, chronic respiratory disease and cancer, are more likely to develop serious illness.[41]*
14. *https://csidp.eu/*
15. *Includes also countries that are not part of the EMCDDA's data gathering network.*
16. *In 2019, Poland reported not having any guidelines, but in 2020 they reported having 'other guidelines': Program lekowy B.71 (Ministry of Health). https://www.intermedis.pl/pliki/2015_Program_lekowy_B_71_leczenie_pWZW_C_kuracja_bez_interferonu.pdf*
17. *Several different types of restrictions could be reported by one country.*
18. *Still in 2019, DAA's were not available in North Macedonia but are now available.*
19. *"This is because they will not walk to the hospital on their own initiative, you need to do outreach and motivate them - and there is no investment into this, only a few professionals do this work." (from the answer by the Hungarian FP).*
20. *In UK, treatment is provided free at the point of delivery so no reimbursement is needed.*
21. *In some countries, HCV activist groups - different from drug user groups - have also played a major part but questioons about the these groups was not included in the C-EHRN monitoring survey..*
22. *Missing information from Skopje/Northern Macedonia.*

23. *Overdose deaths' refers to deaths that are caused directly by the consumption of one or more illicit drug. The term 'overdose prevention' refers to preventing both overdose without fatal consequences and overdose deaths.*
24. *In Austria, there is no specific strategy for OD prevention. There are, however, guidelines for dealing with illegal drugs and PWUD, and harm reduction is mentioned in documents such as: "Österreichische Suchtpräventionsstrategie, Strategie für eine kohärente Präventions- und Suchtpolitik - Leitlinie - Qualitätsstandards für die Opioid-Substitutionstherapie (OST)".*
25. *National harm reduction guidelines include OD management.*
26. *There is no national drug plan in Italy. The last one (2010) has never been approved by the regions due to a conflict between regions and the government. Some regions/cities have recommendations about OD prevention.*
27. *HOPS published guidelines in 2015 intended for physicians working in emergency services, hospital emergency departments, and CSOs working in the field of harm reduction.*
28. *There are OD prevention guidelines in Scotland and Wales, whilst there is take home naloxone guidelines in England, but not OD prevention. The London FP is not aware of any guidelines in Northern Ireland.*
29. *Only those PWU opioids who are enrolled in OST or a registered NSP.*

Correlation
European
Harm Reduction
Network

C-EHRN envisions a fair and more inclusive Europe, in which people who use drugs, including other related vulnerable and marginalized people, have equal and universal access to health and social services without being discriminated against and stigmatized.

We advocate for a harm reduction approach that is based on solid evidence and on human rights principles, and addresses both health and social aspects of drug use.