Essential Harm Reduction Services.

Report on policy implementation for people who use drugs

Civil Society Monitoring of Harm Reduction in Europe **2024**

Correlation
European Harm Reduction Network

Title

Essential Harm Reduction Services: Report on policy implementation for people who use drugs. Civil Society Monitoring of Harm Reduction in Europe 2024.

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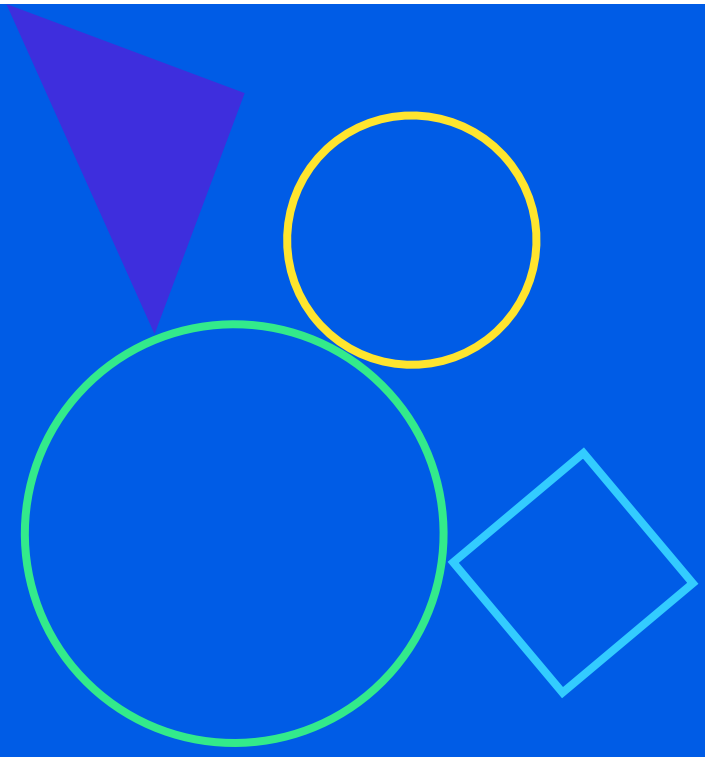
European Harm Reduction Network

DE REGENBOOG GROEP

Contents

Acronyms

ARV	Antiretroviral
C-EHRN	Correlation - European Harm Reduction Network
ECDC	European Centre for Disease Prevention and Control
CSO	Civil Society Organisation
DAA	Direct Acting Antiviral
DAT	Diamorphine Assisted Treatment
DCR	Drug Consumption Room
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
EUDA	European Union Drugs Agency
FP	Focal Point
HaDEA	European Health and Digital Executive Agency
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
LGBQTI+	Lesbian, Gay, Bisexual, Queer, Transgender and Intersex
MDMA	The synthetic psychoactive drug 3, 4-methylenedioxy-methamphetamine, also known as Ecstasy
N	Number
NGO	Non-Governmental Organisation
NHS	National Health Service
NPS	New Psychoactive Substance
NSP	Needle/Syringe Programme
OAT	Opioid Agonist Therapy
PrEP	Pre-Exposure Prophylaxis
THN	Take-Home Naloxone
UNODC	United Nations Office on Drugs and Crime
w/o	without



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Introduction & Methodology

Introduction

According to the United Nations Office on Drugs and Crime (UNODC), there were globally 292 million people who used drugs in 2024 – a 20% increase compared to a decade earlier. Within this group, there were 64 million people 'with drug use disorders'[1] and only 1-in-11 were in treatment. The estimated number of people injecting drugs was 13.9 million (700,000 more than in 2021), and nearly half of them lived with Hepatitis C (UNODC, 2024).

Meanwhile, in Europe, an estimated four million adults used cocaine in the previous year (an increase from 3.7 million in 2021); 2.9 million using MDMA (up from 2.3 million in 2021); and 2.3 million using amphetamines (compared to 2 million in 2021). The number of 'high-risk opioid users'[2] was estimated at 860,000 (a decrease from one million in 2021), and approximately 60% of them received opioid agonist treatment (513,000) (EUDA, 2024c). Cocaine was the second most frequently reported drug among people entering treatment for the first time, with 21% mentioning it (EUDA, 2024a). The European Union Drugs Agency (EUDA) also reports stable and high availability of most controlled substances in Europe, increasing availability of ketamine, and the appearance of a new synthetic mixture on the European market, 'pink cocaine' (EUDA, 2024b).

The changing trends in drug markets, stable and high availability of a wide range of substances, new emerging challenges, and very low treatment enrolment show clearly that the role of harm reduction is essential in addressing drug-related harms. Harm reduction services play a crucial role in reducing risks associated with drug use. They also help lessen the negative effects of strict drug laws, fight social stigma, and improve the overall well-being of people who use drugs. Given the significance of harm reduction, it is essential to monitor these efforts across Europe. This monitoring helps us to understand what is working, identify areas for improvement, and adapt to changing needs. By staying informed, we can better support people who use drugs and enhance safety in our communities.

Methodology

Changes in the survey

In 2024, drawing from experiences gathered in 2023 Monitoring, C-EHRN introduced several changes in the questionnaire, which this year included 16 questions in total, including questions on availability (examined also in earlier assessments); accessibility; acceptability; and quality of services. The question on accessibility was reformulated in 2024 to make it easier to answer by respondents; namely, instead of asking

1. UNODC terminology.
2. EUDA terminology.

them to assess the extent of service acceptability as a high-level concept encompassing multiple dimensions, we asked about each dimension separately. Moreover, the scale was simplified from 5-point Likert to a traffic lights scale as shown below:

Question 3. To what extent are the following services acceptable in your city for people who use drugs?

- Services are respectful of the culture of individuals, minorities, peoples and communities
- Services are designed to respect relevant ethical and professional standards
- Service providers respect confidentiality and informed consent
- Services are gender-sensitive
- Services are age-sensitive
- Services operate in a way that makes the community comfortable in accessing them

For each of these aspects of acceptability, the respondents were asked to choose one of four possible answers:

- Yes
- Partially
- No
- I don't know

Another change was introduced in the question about barriers harm reduction services experience when reaching out to specific sub-populations of people who use drugs, namely, 'Stigma' was included as a new barrier.

Finally, regarding areas and ways in which people who use drugs are involved in harm reduction services, we separated questions about people with lived experience from questions about people with living experience. This distinction helps us better understand the opportunities that people who currently use drugs have to engage in various functions in harm reduction services in comparison to people who do not use illicit substances anymore.

Respondents and data collection

This year, harm reduction service providers from across Europe assessed the state of essential harm reduction services in European cities for the fifth time, with as many as 40 cities responding to our survey in 35 countries (see Map 1). This has been the highest number of respondents filling in the questionnaire in the history of C-EHRN Monitoring, and included two new organisations from previously uncovered cities:

- Ares do Pinhal from Lisbon, Portugal; and,
- Drug Information Centre (DIZ) of the City of Zurich, Switzerland.

In addition, service providers from Skopje, St. Petersburg, and Tbilisi returned to Monitoring in 2024 after one or two year-long absences[3].

Data in this report was collected during the spring of 2024. The respondents represent the Correlation – European Harm Reduction Network (C-EHRN) Focal Points (FPs).

In some countries, there are more cities represented: Berlin and Bielefeld in Germany; Milan and Rome in Italy; Krakow and Warsaw in Poland; Lisbon and Porto in Portugal; Bern and Zurich in Switzerland; and London, Glasgow, and Newport in the UK. Approximately every other participant answered the survey on their own (18 respondents), while Focal Point Copenhagen answered on their own but indicated having 'regular connection with peer-driven networks and projects' (FP Copenhagen). Exactly half of the respondents answered jointly with colleague(s) and, among them, there were two FPs additionally consulting external experts (FP Milan and FP Porto), one consulting peers alongside colleagues (FP Prague) and two FPs answering the questionnaire by consulting all of these three groups (FP Glasgow and FP Skopje). FP Dublin responded to the survey 'through working across Dublin city with other experts throughout 2023' (FP Dublin).

To have a better overview of the information flows between C-EHRN FPs and other harm reduction services as well as decision makers, we also asked the respondents about existing mechanisms or practices (such as working groups, informal personal meetings, networks, etc.) for the exchange of information. The information about the flows among services can serve as a proxy indication of the awareness of respondents regarding the situation in other harm reduction services.

For both exchange among harm reduction services and between services and local authorities, 22 FPs reported the existence of mechanisms and/or practices for the regular exchange of information. Irregular exchange was reported between harm reduction services in 11 cities, and between harm reduction services and local authorities in 11 cities. A complete lack of mechanisms and practices for information exchange between harm reduction services was reported by FP Athens, and between harm reduction services and local authorities by FP Bălți and FP Malta. In addition, several FPs explained the local situation in more detail; in Krakow, Malta, and Sofia, there are no other harm reduction services with whom to exchange information.

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3. The full list of Focal Points participating in the 2024 Monitoring survey on essential harm reduction services includes: Amsterdam (Netherlands); Antwerp (Belgium); Athens-Thessaloniki (Greece); Bălţi (Moldova); Barcelona (Spain); Berlin (Germany); Bern (Switzerland); Bielefeld (Germany); Bratislava (Slovakia); Budapest (Hungary); Copenhagen (Denmark); Dublin (Ireland); Glasgow (Scotland, UK); Helsinki (Finland); Iceland (exceptionally whole country); Krakow (Poland); Kyiv (Ukraine); Lisbon (Portugal); Ljubljana (Slovenia); London (England, UK); Luxembourg (Luxembourg); Malta (exceptionally whole country); Milan (Italy); Newport (Wales, UK); Nicosia (Cyprus); Paris (France); Podgorica (Montenegro); Porto (Portugal); Prague (Czechia); Rome (Italy); Skopje (North Macedonia); Sofia (Bulgaria); St. Petersburg (Russia); Stockholm (Sweden); Tallin (Estonia); Tbilisi (Georgia); Tirana (Albania); Vienna (Austria); Warsaw (Poland); and Zurich (Switzerland).

	Answered alone	Answered jointly with (a) colleague(s)	Answered by consulting external experts	Answered by consulting peers
Amsterdam		■		
Antwerp	■			
Athens	■			
Balti		■		
Barcelona	■			
Berlin		■		
Bern	■			
Bielefeld	■			
Bratislava		■		
Budapest	■			
Copenhagen	■			■
Dublin, Ireland				
Glasgow		■	■	■
Helsinki		■		
Krakow	■			
Kyiv		■		
Lisbon		■		
Ljubljana	■			
London		■		
Luxembourg	■			
Malta	■			
Milano		■	■	
Newport		■		
Nicosia		■		
Paris		■		
Podgorica		■		
Porto		■	■	
Prague		■		■
Reykjavík	■			
Rome		■		
Saint Petersburg	■			
Skopje		■	■	■
Sofia	■			
Stockholm	■			
Tallinn	■			
Tbilisi	■			
Tirana		■		
Vienna	■			
Warsaw		■		
Zurich	■			
TOTAL	**18**	**20**	**4**	**4**

Table 1. The way C-EHRN Focal Points answered the Harm Reduction Essentials monitoring questionnaire in 2024.

Map 1: C-EHRN Focal Points location & contribution years.

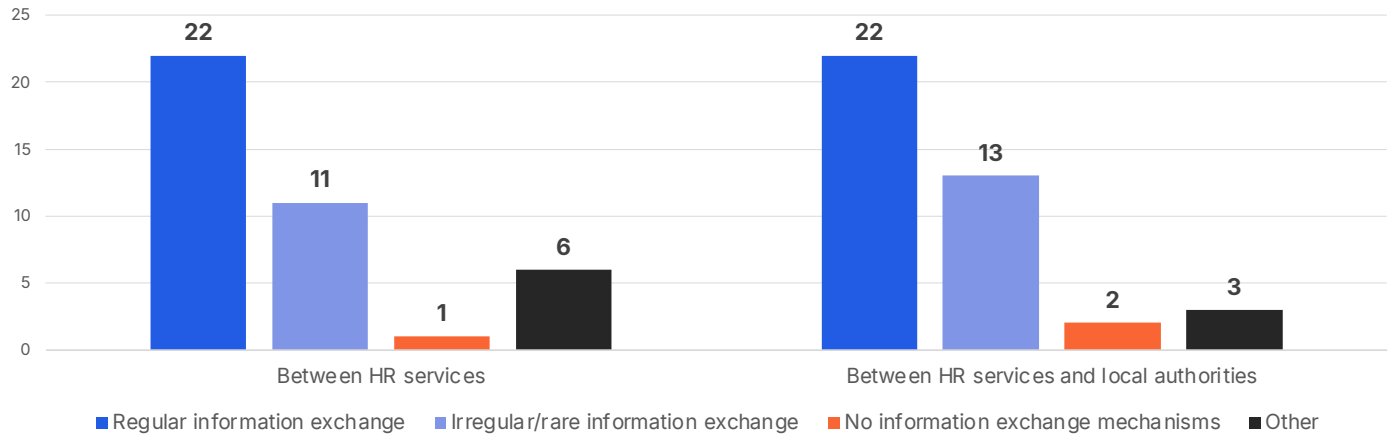

*Figure 1. The existence of mechanisms or practices (such as working groups, informal personal meetings, networks, etc.) for the exchange of information in examined cities as assessed by C-EHRN Focal Points (**N:40; skipped: 0**).*

FP Copenhagen

'There is no continuous structure for services to inform policy levels'.

FP London

'Formally, no mechanisms are in place which properly serve this function. (...) There isn't service to service information exchange, and even locally, forensic toxicology lab reporting is incredibly delayed, meaning that local services do not know what is in their drug supply until months and months after overdoses have occurred, long after that information could have been put to use. Informally, 'Release' convenes a group known as the 'Drugs Monitoring Network.' The Drugs Monitoring Network is a national project to share local level information (including anecdotal reports) about drug supplies in the hopes to catch concerning trends early and share harm reduction strategies accordingly. Many of our members are front line harm reduction workers/NSP staff and peer workers as well as academics or people working in public health bodies with intel to feed in.'

FP Podgorica

'Regular meetings are rarely organised among CSOs that work in this area. Informal meetings are organised occasionally and there is exchange of information or discussion on a topic in focus, but this is not frequent.'

C-EHRN Focal Points are usually located in the capital city of countries, and sometimes in other large cities (such as FP Milan, FP Krakow). As a result, the situation in their localities is usually quite different than in the rest of the country. In 2024, 32 FPs (80%) reported that the situation in their cities was better than national harm reduction coverage. Conversely, 3 FPs reported that coverage in their cities is lower than nationally (Krakow, Luxembourg, Prague), and 4 FPs said that the situation is similar (Bălți, Bern, Copenhagen, London).

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Results

As in 2023, this year C-EHRN also asked Focal Points to assess the availability, accessibility, acceptability and quality of various harm reduction services in their cities. Availability, accessibility and quality were rated on a 5-point Likert scale, while questions on acceptability used a 3-point scale described in the Methodology section.

Availability of harm reduction services

Figure 1 showcases the availability of a range of harm reduction services in FP cities, understood as 'functioning harm reduction facilities, services and programmes in sufficient quantity' . The services with the highest reported availability include HIV testing (25/40 FPs, 62.5% reporting 'great' extent of availability); HIV treatment (23/40 FPs, 57.5%); and opioid agonist therapy (OAT) (23/40 FPs, 57.5%). Conversely, the lowest availability was observed (in ascending order) in the case of NSP in prison (31/40 FPs, 77.5%, indicating 'not at all'); naloxone in prison (27/40 FPs, 67.5%); and drug consumption rooms (27/40 FPs, 67.5%). It is also worth mentioning that drug checking and income generation opportunities for people who use drugs both had a relatively high share of 'not at all' responses (19 and 11, respectively) and 'to a small extent' (11 and 15, respectively), which makes their availability low.

Among the most available services, a complete lack of a service was reported only once: for OAT in St. Petersburg. On the other hand, table 2 shows the overall least available services and the cities that reported having them:

NSP in prison	Naloxone in prison	DCR
Bălți	Bălți	Amsterdam
Barcelona	Barcelona	Athens
Bern	Glasgow	Barcelona
Kyiv	Luxembourg	Berlin
Luxembourg	Milan	Bern
	Newport	Bielefeld
	Paris	Copenhagen
	Stockholm	Lisbon
		Luxembourg
		Paris
		Porto
		Zurich

Table 2. The least available harm reduction services and the cities reporting their existence.

4. Definitions of availability, accessibility, acceptability and quality are adopted from WHO Fact Sheet: The Right to Health
5. Three services with the highest proportion of 'to a great extent' answers.
6. Three services with the highest proportion of 'not at all' answers.

The city-level results are in line with national-level data reported by EMCDDA (now known as EUDA), where availability of methadone maintenance treatment was reported in 27-out-of-29 European countries in 2024 (EUDA, 2024b).

The data shows clearly that public health-related services – serving the general public and people who use drugs alike – are the most prevalent ones in European cities. In contrast, services more focused on people who use drugs, such as those addressing overdose, are among the least available, along with social reintegration services serving both the general public and people who use drugs. These data align with the phenomenon of the medicalisation of harm reduction that is prevalent in Europe. The medicalisation of harm reduction refers to the trend of perceiving harm reduction more narrowly as an intervention from the realm of public health and integrating harm reduction approaches into mainstream healthcare services for people who use drugs. This phenomenon has led to an increased focus on health-related aspects, sometimes at the expense of more holistic, person-centred, care or attention being given to social determinants of health, and social justice considerations.

FP Bratislava

'In Bratislava, there are currently 4 fixed points where people who use drugs or the general public can safely dispose of infectious waste or used syringes. All the fixed points are operated by two NGOs. At the beginning of 2024, five more fixed points were installed in cooperation with the municipality of Bratislava.'

FP Copenhagen

'HIV has a very low prevalence. HCV testing and treatment have been developed over the last years but despite its availability in the regional health system, it is still not available to all frontline health workers, unchanged since 2023.'

FP Helsinki

'Outreach work carried out by NGOs plays a significant role in harm reduction efforts on a broad scale. However, HIV testing remains at a low level, and STI testing does not occur at an appropriate level. Additionally, PrEP medication is not available for people who use injectable drugs. Substitution treatment already started in the community is continued in prisons, but treatment is hardly ever initiated in prison.'

FP Lisbon

'In terms of drug checking, the partners working in the area divide people who use drugs into two contexts, recreational and vulnerable (in collaboration with the DCR in Lisbon). In this case of recreational users, the availability has been increasing a lot and the coverage of the service is reaching its limit given the high demand. As for the most vulnerable people who use drugs, the reality is that the service is very insufficient.'

FP Ljubljana

'There is a community testing service for sexually transmitted infections - project Expand.'

FP London

'DCRs, paraphernalia for smoking/intranasal use, and drug checking are all restricted due to current regulations and legislation, such as the UK's Misuse of Drugs Act 1971. Regarding drug checking, there is now a special Home Office license which allows for the provision of these services, but it is incredibly limited with high barriers to entry and limited to checking only 'drug of dependence' or substances posing significant harm.'

FP Milan

'Testing services for HIV and HCV are widely available in harm reduction services but their access is limited in public drug treatment services.'

FP Podgorica

'NGO Juventas and NGO LINK started providing harm reduction services in the nightlife setting last year, providing people who use stimulants with water and vitamins along with counselling.'

FP Porto

'There is a need of amplifying the DCR services in Porto; also, to promote a decentralisation of the Hospital Infection services regarding the diagnosis and treatment.'

FP Reykjavik

'The mobile drug consumption room in Reykjavík closed in March 2023 after a one-year pilot project. It will be opened again in June 2024 in a house in central Reykjavík. The reason for being closed for over one year is because of problems with finding a house or land for it.'

FP Tallinn

'Prisons do not dispense naloxone to inmates. Naloxone is issued to a person when he/she/they leave prison. We do not have specific accommodation, legal support or income generation for people who use drugs, but some service providers offer a certain amount of support to this target group as well. One of the conditions for accommodation is that the person is sober when going there, which reduces the chance of getting a place to stay. HCV testing is carried out in special institutions because there have been no rapid tests in harm reduction for some time (the national procurement has failed).'

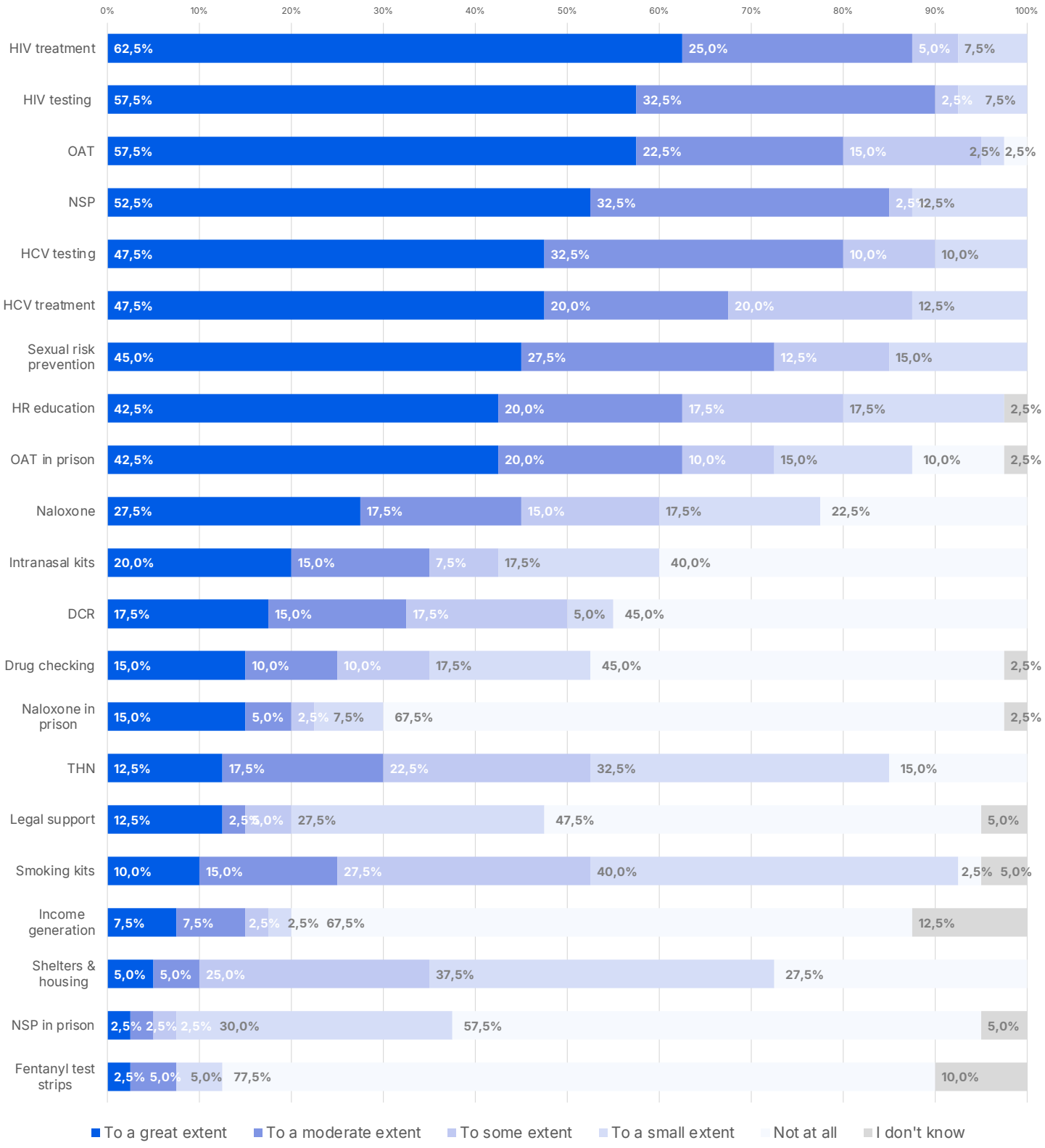

*Figure 2. The extent of availability of harm reduction services for people who use drugs as assessed by C-EHRN Focal Points (**N=40; skipped: 0**).*[7]

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7. Categories in the graphs of this report are sorted from the highest to the lowest proportion of 'to a great extent' responses.

Accessibility of harm reduction services

Focal Points also assessed accessibility of various harm reduction services, understood as the situation where 'harm reduction facilities, services and programmes are accessible to everyone, within the appropriate jurisdiction. Accessibility has four overlapping dimensions:

- non-discrimination
- physical accessibility
- economic accessibility (affordability)
- information accessibility'.

The data on accessibility of harm reduction services includes only those cities where Focal Points reported some level of availability of a given service in the previous question[8]. Hence, the number of responses per service assessed varies between services as shown in Figure 3 which includes services listed in order based on the highest proportion of 'to a great extent' responses.

The highest level of accessibility was reported for needle and syringe programmes (24/40 FPs, 60.0%, reporting 'great accessibility'[9]), and HIV treatment and HIV testing (23/40 FPs, 57.5% each). On the other hand, the lowest accessibility was identified for fentanyl test strips (5/14 FPs answering 'no accessibility', 35.7%); drug checking (6/19 FPs, 31.6%); and income generation possibilities for people who use drugs (9/29 FPs, 31.0%). The low perceived accessibility of drug checking might be a consequence of the modes of their operation (specialised services in fixed locations or music festivals and clubs) and target groups (people who use drugs in party settings). C-EHRN Focal Points work mostly with people in vulnerable situations whose access to drug checking venues can indeed be limited.

In an open text box, some FPs further described the situation regarding accessibility of harm reduction services in their cities, highlighting problems such as discrimination; legal, language, economic and geographic barriers; and restrictive operating hours as barriers affecting service accessibility.

8. In other words, they chose answers other than 'not at all' or 'I don't know' when asked about availability.
9. The proportions of specific answers regarding the level of accessibility were calculated excluding 'I don't know' answers from the denominator.

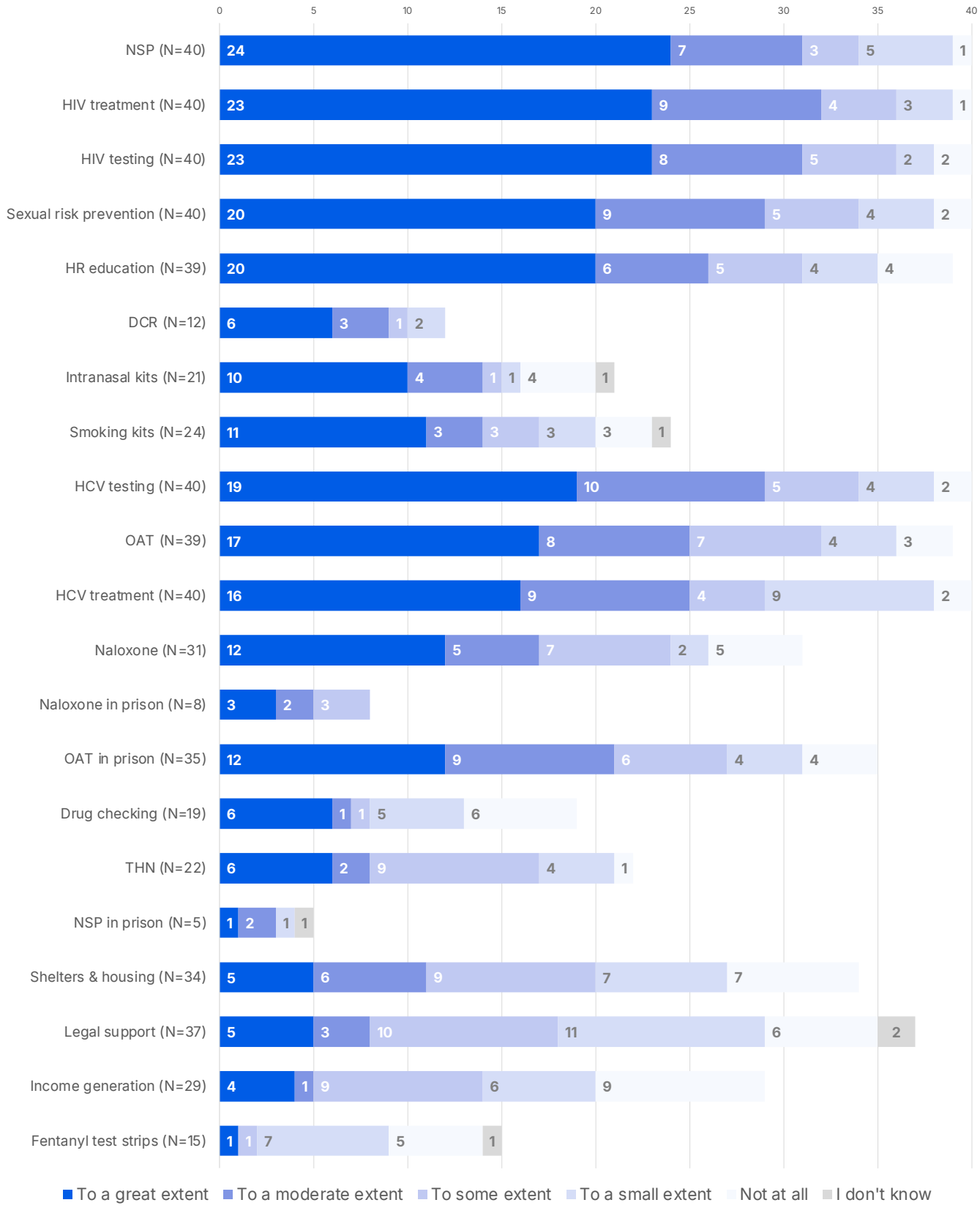


*Figure 3. The extent of accessibility of harm reduction services for people who use drugs as assessed by C-EHRN Focal Points (**skipped: 0**).*

FP Athens

'Harm reduction education is only available from CSOs. Intranasal kits also. Drug checking the same. OAT in prison is very limited and with questionable ethical standards. There are no NSP in prison. There is no naloxone in prison. There is no take home naloxone. There are extremely limited employment opportunities for people who use drugs. HIV/HCV Testing is mostly community-based and, thus, more flexible towards communal needs. Still, the confirming test must be performed in a public hospital, or a private clinic, and the positive result must be declared to the Greek CDC. HIV and HCV clinics are overpopulated and understaffed at the same time. Some CSOs provide legal support for PWUD, but still the services are very limited as well.'

FP Glasgow

'Heroin Assisted Treatment (Enhanced Drug Treatment Service) has been available for a few years but with limited availability. Numbers are slowly increasing. Complex needs service. Locality-based services which can be difficult for people in the city centre to access. Some outreach services operate in the city, but it can be confusing for clients to know which services are doing what. Out of hours access is not available, but also no limit on NSP. Good foil provision but no other inhalation devices, despite a large increase in crack cocaine use. Language barrier, hours restrictive, time with people limited.'

FP Lisbon

'OAT is not easily accessed by migrant populations in a non-regular situation or without identification in public facilities. There's still a gap between the screening for HCV and the delivery of medication. This gap has been reduced because of some investment offered by doctors as an individual choice.'

FP Malta

'There are no other services in Malta apart from services related to opioid use, and these are also somewhat limited. Only people seeking treatment are provided with these services. No test is available for all drugs, and drug consumption rooms do not exist.'

FP Milan

'In Milan, drug checking services are sometimes accessible during big events (such as music festivals, parades) during which other harm reduction organisations offer them. Some key populations experience discrimination in accessing healthcare services for treatment. In some cases, exams and diagnostics for HCV care are not free of charge.'

FP Podgorica

'Fentanyl test strips are available only when NGOs obtain them through some project activities.

FP Tallinn

'HCV testing is carried out in special institutions because there have been no rapid tests in harm reduction for some time (national procurement has failed). One of the conditions for HCV treatment is valid health insurance.'

Acceptability of harm reduction services

Acceptability was the third aspect of harm reduction services that Focal Points were asked to assess, including the following criteria:

- Respect for culture and sensitivity
- Observing ethical and professional standards
- Respect for confidentiality and informed consent
- Gender-sensitivity
- Age-sensitivity
- Operate in a way that makes the community comfortable in accessing services.

Regarding the aggregate acceptability of the services across all above criteria, HIV testing (80.9% of the FPs), DCRs (79.5%) and HCV testing (79.2%) were the services considered the most accepting of different sub-groups of people who use drugs and their varied needs. Conversely, OAT in prison (28.6% of the FPs), naloxone (22.2%) and legal support services (18.7%) were identified as the least accepting services.

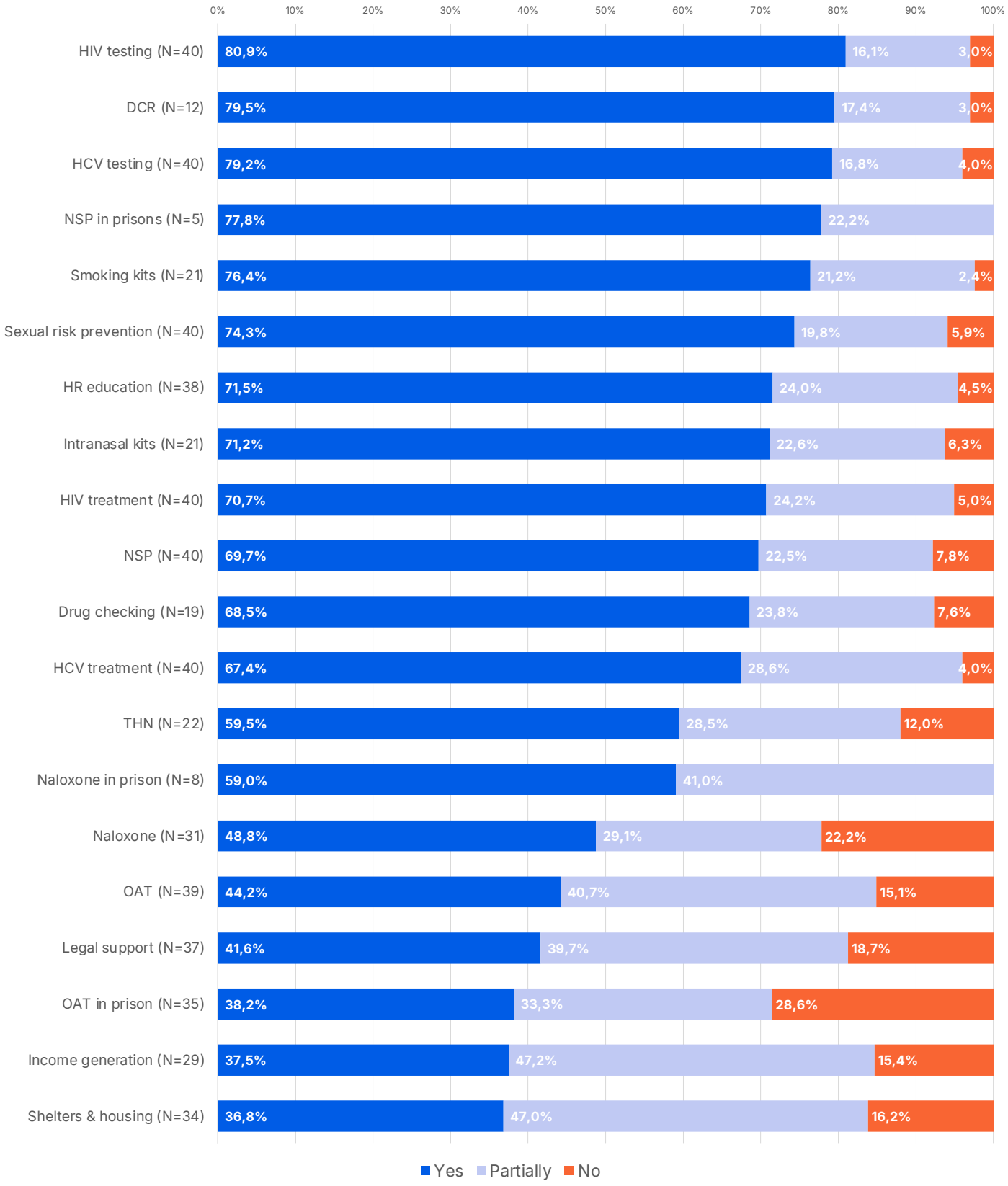


*Figure 4. The extent to which specific harm reduction services meet all the acceptability criteria as assessed by C-EHRN Focal Points (**skipped: 0**).*

A look from another angle shows that respect for confidentiality and informed consent scored the highest among acceptability criteria. Here, 79.2% of the FPs considered the services to be respectful, 16.3% partially respectful and 4.5% did not consider them respectful.

Highest score[10]		Lowest Score[11]
NSP in prison (3/3 FPs, 100%)	**Services are respectful of the culture of individuals, minorities, peoples and communities**	Naloxone (5/27 FPs, 18.5%)
HIV testing (37/40 FPs, 92.5%)		OAT in prison (5/29 FPs, 17.2%)
HCV testing (36/39 FPs, 92.3%)		Legal support (14.3% 5/35 FPs)

*Table 3. Services with highest and lowest extent of meeting the acceptability criterion of being respectful of the culture of individuals, minorities, peoples and communities (**skipped: 0**).*

This was followed by respecting ethical and professional standards, where 77.2% of the FPs believe the services respect these standards, 17.0% consider that the services respect them partially and 5.8% do not consider them respectful.

Highest score		Lowest Score
Smoking kits distribution (20/20 FPs, 100%)	**Services are designed to respect relevant ethical and professional standards**	OAT in prison (7/30 FPs, 23.3%)
DCRs (12/12 FPs, 100%)		Naloxone (5/28 FPs, 17.9%)
NSP in prison (3/3 FPs, 100%)		Legal support services (5/35 FPs, 14.3%)

*Table 4. Services with highest and lowest extent of meeting the acceptability criterion of being designed to respect relevant ethical and professional standards (**skipped: 0**).*

10. The highest proportion of 'Yes' answers.
11. The highest proportion of 'No' answers.

The third best aspect was making the community comfortable in accessing services, with 59.0% of the FPs believing the services make the community comfortable, 31.6% partially and 9.4% don't believe the services do so.

Highest score		Lowest Score
NSP in prison (3/3 FPs, 100%)	**Services operate in a way that makes the community comfortable in accessing them**	OAT in prison (9/29 FPs, 31.0%),
HIV testing (31/39 FPs, 79.5%)		Shelters and housing (9/33 FPs, 27.3%)
Smoking kits distribution (17/22 FPs, 77.3%)		OAT (9/38 FPs, 23.7%)

*Table 5. Services with highest and lowest extent of meeting the acceptability criterion of operating in a way that makes the community comfortable in accessing them (**skipped: 0**).*

In terms of respecting the culture of individuals, minorities, peoples and communities, 57.8% of the FPs believe the services are respectful, 34.0% partially and 8.1% believe they are not respectful.

Highest score		Lowest Score
Smoking kits distribution (19/21 FPs, 90.5%)	**Services are respectful of the culture of individuals, minorities, peoples and communities**	OAT in prison (8/31 FPs, 25.8%)
DCRs (10/12 FPs, 83.3%)		Naloxone (6/29 FPs, 20.7%)
Intranasal kits distribution (13/18 PFs, 77.8%)		Shelters and housing (7/34 FPs, 20.6%)

*Table 6. Services with highest and lowest extent of meeting the acceptability criterion of being respectful of the culture of individuals, minorities, peoples and communities (**skipped: 0**).*

When considering age sensitivity, 54.3% of the FPs believe the services are sensitive, 32.1% partially and 13.6% do not believe they are sensitive to the age of clients.

Highest score		Lowest Score
HIV testing (28/38 FPs, 73.7%)	**Services are age-sensitive**	OAT in prison (9/26 FPs, 34.6%)
DCRs (8/11 FPs, 72.7%)		Naloxone (7/36 FPs, 26.9%)
HCV testing (26/37 FPs, 70.3%)		Legal support (8/34 FPs, 23.5%)

*Table 7. Services with highest and lowest extent of meeting the acceptability criterion of being age-sensitive (**skipped: 0**).*

Gender sensitivity seems to be the aspect of acceptability performing the poorest, with 48.3% of the FPs considering that the services are sensitive, 38.6% partially sensitive and 13.1% do not believe they are sensitive to the gender of clients.

Highest score		Lowest Score
HCV testing (29/39 FPs, 74.4%)	**Services are gender-sensitive**	OAT in prison (11/28 FPs, 39.3%)
Sexual risk prevention (29/40 FPs, 72.5%)		Naloxone (7/26 FPs, 26.9%)
HIV testing (29/40 FPs, 72.5%)		Legal support (9/34 FPs, 26.5%)

*Table 8. Services with highest and lowest extent of meeting the acceptability criterion of being gender-sensitive (**skipped: 0**).*

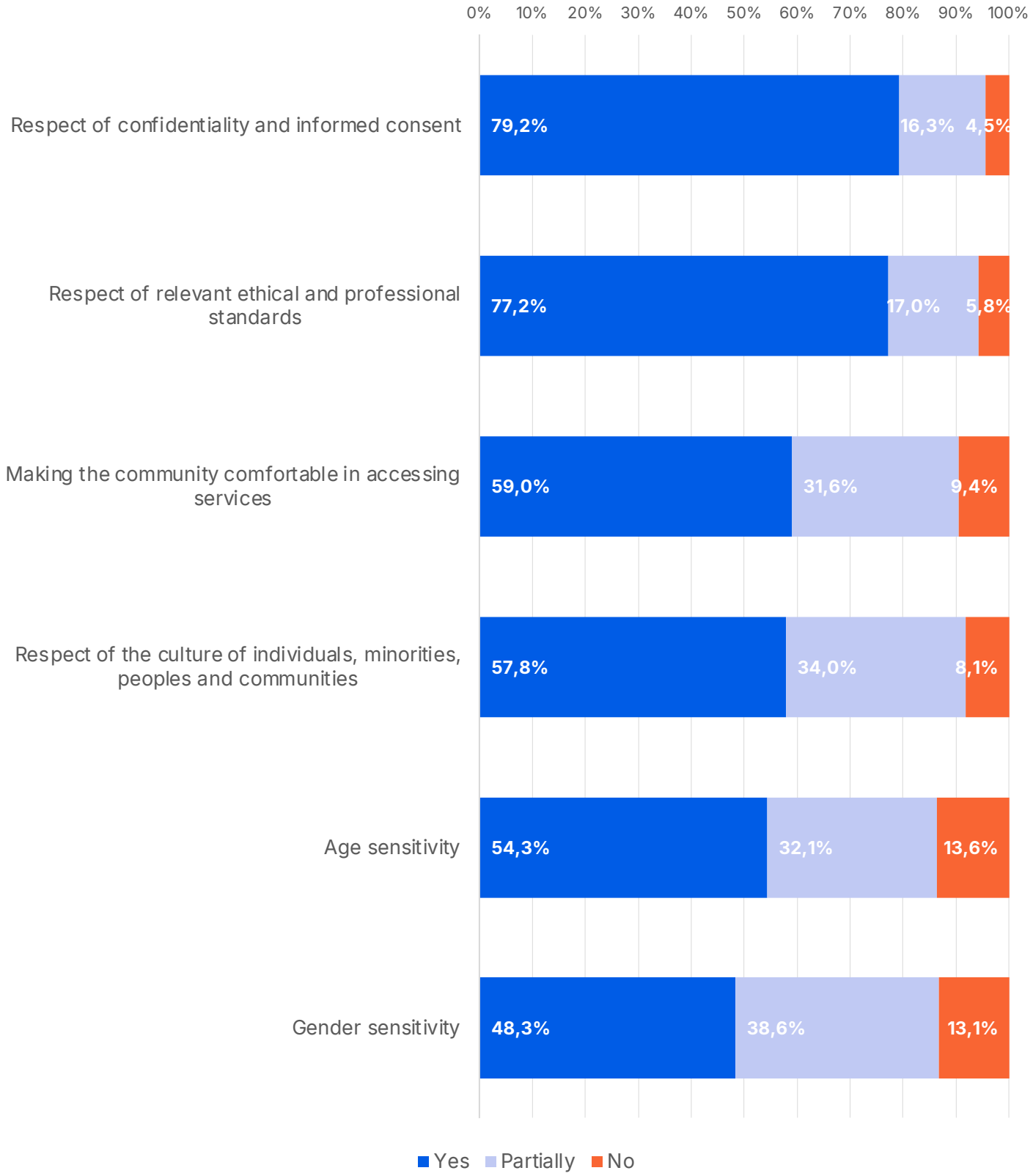


*Figure 5. The extent to which specific acceptability criteria are met by all harm reduction services as assessed by C-EHRN Focal Points (**skipped: 0**).*

Quality of harm reduction services

The last aspect of harm reduction services that FPs assessed was quality, defined in the following way: 'harm reduction facilities, services and programmes must be scientifically appropriate and of good quality'. As previously, this dimension included specific criteria.

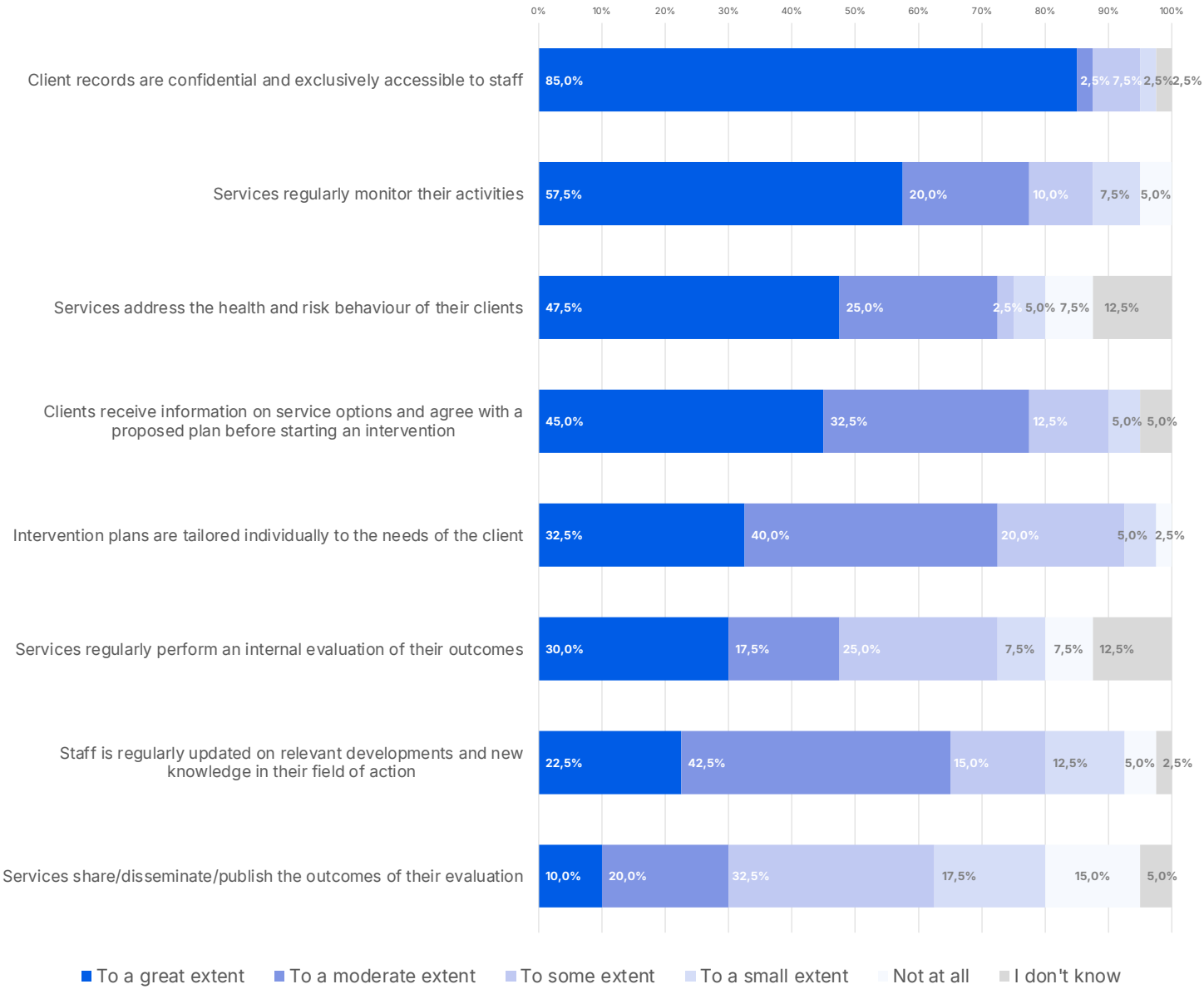


*Figure 6. The extent of quality of harm reduction services for people who use drugs as assessed by C-EHRN Focal Points (**N=40; skipped: 0**).*

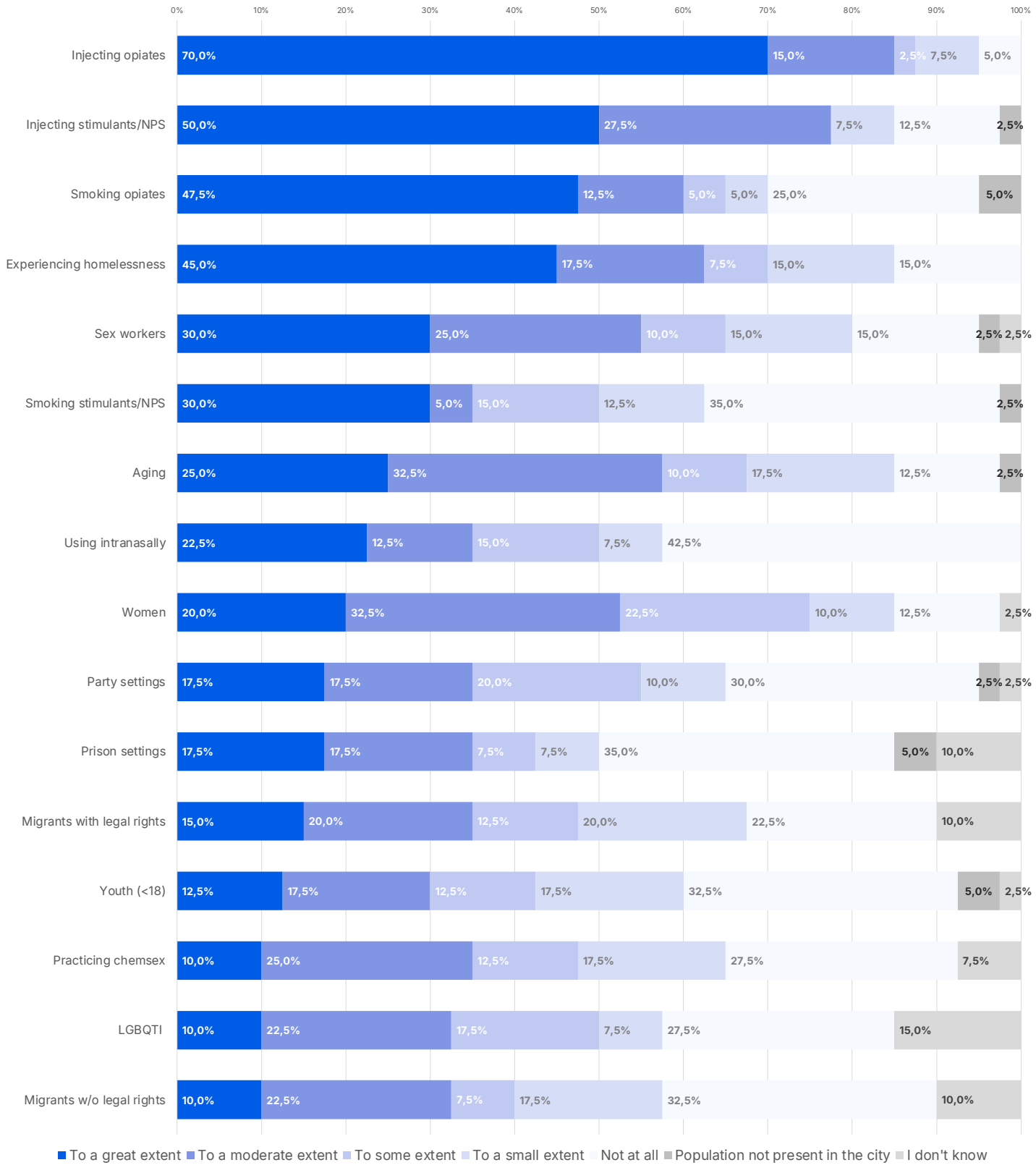


*Figure 7. The extent to which harm reduction services can be delivered to specific sub-populations as assessed by C-EHRN Focal Points (**N=40; skipped: 0**).*

The overall quality of harm reduction services across all dimensions was reported as relatively high. Data shows that harm reduction services in Europe take good care of the confidentiality of client records, monitoring their activities, and addressing health and risk behaviours of their clients. Conversely, there seems to be a sizable room for improvement in terms of practices of service evaluation and dissemination of evaluation results, as well as keeping staff informed about new developments in the field.

Service delivery to different user groups

Besides assessing the crucial aspects of harm reduction services themselves, FPs were also asked to report on the extent to which specific sub-populations of people who use drugs are reached.

In 2024, harm reduction services were delivered to the greatest extent to people who inject opiates (34/40 FPs, 85% reporting 'great' or 'moderate' extent), followed by people who inject stimulants or NPS (31/40 FPs, 77.5%), and people experiencing homelessness (25/40 FPs, 62.5%). Conversely, the most underserved sub-populations[12] included migrants who use drugs with no legal rights to assistance (20/40 FPs, 50.0%, reporting no outreach or 'small extent' of service delivery, and 4/40 FPs, 10%, reporting 'great extent'); young people who use drugs (20/40 FPs, 50% for 'no' or 'small' extent and 5/40 FPs, 12.5%, FPs for 'great extent'); and people who practice chemsex (18/40 FPs, 45.0% reporting 'no' or 'small' extent of service delivery and 4 FPs, 10%, reporting 'great extent').

The population with the highest proportion of 'I don't know' answers were LGBQTI+ (6/40 FPs, 15.0%); followed by migrants with legal rights to assistance (4/40 FPs, 10.0%); people in prison settings (4/40 FPs, 10.0%); and migrants with no legal rights to assistance (4/40 FPs, 10.0%).

FP Copenhagen

'There is no access to information about the prison system and the policy level seems to prioritise a hard approach to criminality.'

FP Helsinki

'The situation concerning minors is highly critical, as they are not provided with any harm reduction elements such as guidance, supplies, and testing.'

FP Antwerp

'We reach a large population of people who inject stimulants, but limited people who inject NPS (for me these are two different groups).'

12. These sub-population have the highest proportion of 'not at all' and 'to a small extent' answers combined, and the lowest proportion of 'to a great extent' answers.

FP Bratislava

'Harm reduction services in prison do not exist due to legal limitations. Since 2020, Odyseus is providing special services for cis- and trans women, where twice a month the drop-in is open and provides services only for those populations.'

FP Lisbon

'People in prison are provided with OAT and health care but none of the HR services mentioned are provided.'

FP London

'LGBTQI people who use drugs often are offered harm reduction support within sexual health centres, outside drug services. Less support is available now to migrants who use drugs without rights to assistance - a status known as NRPF in the UK - as 'NRPF' accommodation, which was opened up for rough sleepers with NRPF during the pandemic, has been shut, meaning that less overall support is available and there is more focus on deportations.'

Barriers hindering service delivery

To gain more insight into the reasons behind the reported levels of outreach, we asked the Focal Points to identify barriers preventing harm reduction services in their city from reaching out to specific sub-populations. They could choose multiple barriers that apply in their context.
In total, Focal Points identified 1,106 barriers across 16 sub-populations and 8 barrier categories:

- Legal issues (punitive/restrictive laws & policies)
- Limited capacity of services/staff
- Service accessibility (location, opening hours, language...)
- Lack of specific knowledge/guidelines in the programmes
- Lack of meaningful involvement of the community
- Lack of funding
- Lack of political will
- Stigma.

The three most commonly identified barriers to effective outreach across all sub-populations

Population	Dominant barriers
Migrants w/o legal rights (N=20)	Stigma (14 FPs, 70.0%)
	Legal issues (12 FPs, 60.0%)
Youth (<18) (N=20)	Legal issues (14/20 FPs, 70.0%)
	Lack of specific knowledge/ guidelines in the programmes (12/20 FPs, 60.0%)
Practicing chemsex (N=18)	Lack of funding (15/18 FPs, 83.3%)
	Lack of specific knowledge/ guidelines in the programmes (14/18 FPs, 77.8%)

*Table 9. Number of Focal Points reporting specific barriers affecting the ability to deliver harm reduction services to the most underserved sub-populations (**skipped: 0**).*

were 'Lack of funding' (mentioned 168 times, representing 15.2% of the barriers), followed by 'Lack of meaningful involvement of the community' (148 times, 13.4%) and 'Lack of political will' (148 times, 13.4%). The three least frequently mentioned barriers were 'Service accessibility' (113 times, 10.2%), followed by 'Legal issues' (117 times, 10.6%) and 'Stigma' (131 times, 11.8%).

When analysing barriers for sub-populations that were identified as the most underserved, stigma and legal issues were particularly prominent. Table 9 shows the most frequently mentioned barriers for the three most underserved sub-populations.

Cooperation with other services and institutions

As in previous years, Focal Points were also asked about the extent of cooperation of harm reduction services in European cities with other services and institutions. Figure 8 shows the level of cooperation of harm reduction services with other services.

In 2024, the highest number of FPs reported good cooperation with services providing food and/ or clothing - addressing basic needs (30/40 FPs,

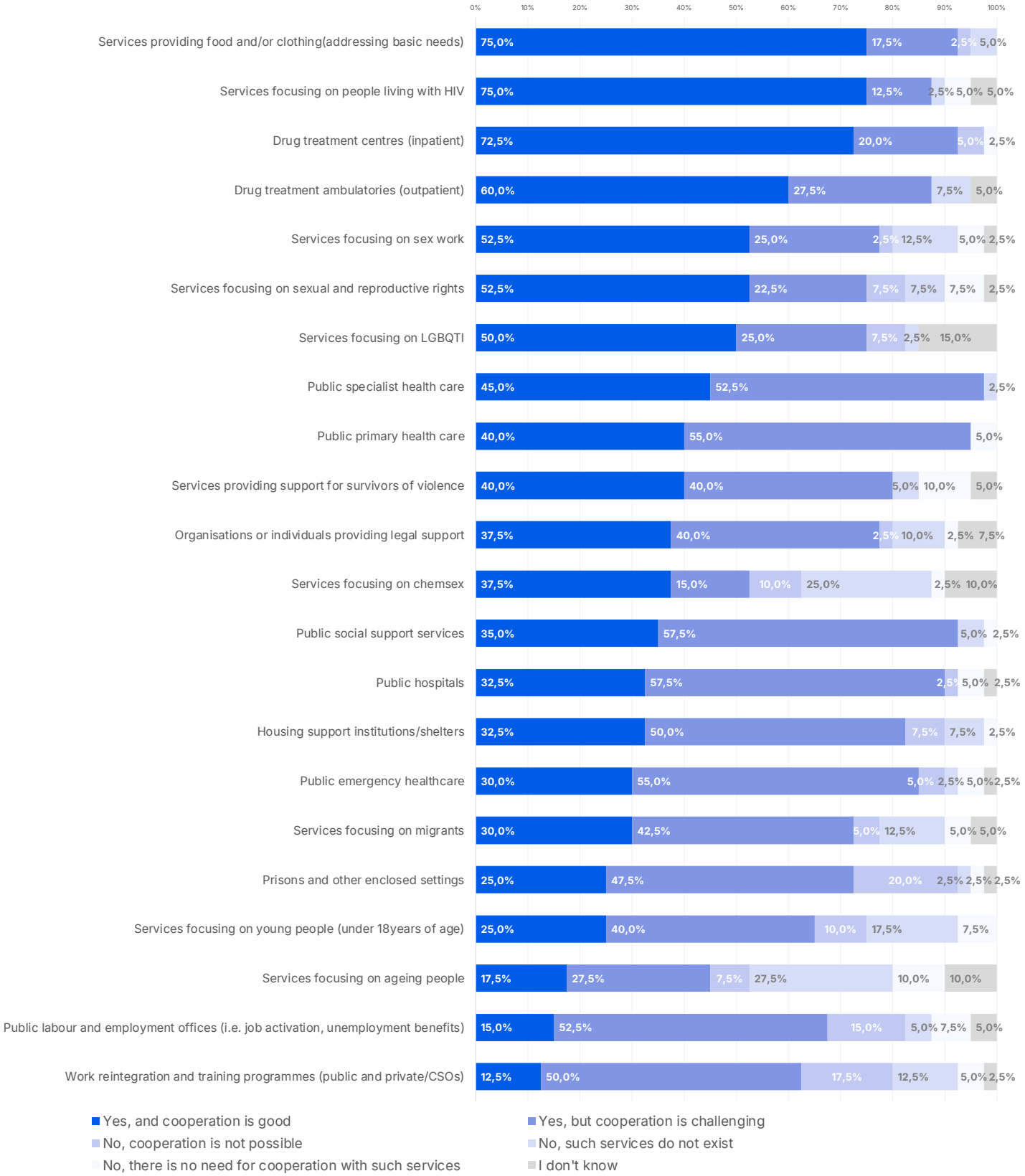


*Figure 8. The extent to which harm reduction services cooperate with other services reaching specific sub-populations as assessed by C-EHRN Focal Points (**N=40; skipped: 0**).*

75.0%), services focusing on people living with HIV (30 FPs, 75.0%) and inpatient drug treatment centres (29 FPs, 72.5%). In contrast, cooperation was reported as challenging to the largest extent for public social support services (23 FPs, 57.5%), public hospitals (23 FPs, 57.5%), public emergency healthcare (22 FPs, 55%) and public primary health care (22 FPs, 55%). Further, cooperation was considered impossible mostly in the case of prisons and other enclosed settings (8 FPs each, 20.0%), work reintegration and training programmes (7 FPs, 17.5%), and public labour and employment offices (6 FPs, 15%).

Focusing on the cases where cooperation seems to be the weakest, in the case of prisons and other enclosed settings, the eight FPs reporting 'cooperation is not possible' included Bern, Bratislava, Budapest, Copenhagen, Krakow, Milan, Rome, and Saint Petersburg. Meanwhile, 19 FPs (47.5%) reported 'challenging' cooperation with prisons. Regarding the work reintegration and training programmes, the seven FPs reporting no possibility of cooperation included Antwerp, Athens, Helsinki, London, Milan, Reykjavík, and Tbilisi, while 20 FPs indicated 'challenging' cooperation. In terms of public labour and employment offices, there are six FPs reporting no possibility of cooperation, including Athens, Krakow, Milan, Podgorica, Reykjavík, and Tbilisi, while 21 cities (52.5%) pointed to 'challenging' cooperation.

The lack of possibility of cooperation because of a lack of specific types of services was the highest in the case of services focusing on ageing people (11 FPs, 27.5%), services for people engaging in chemsex (10 FPs, 25.0%), and services targeting young people (7 FPs, 17.5%).

Regarding specific locations, the best cooperation between harm reduction services and other entities was reported in Barcelona (22/22 types of services with 'good cooperation', an increase from 17/22 in 2023), Dublin (22/22), and Zurich (18/22). The cities where cooperation is mostly challenging includes Lisbon (20 services), London (18 services), and Saint Petersburg (17 services). The three cities with the highest number of 'cooperation is not possible' answers include Athens (10 services), Milan (5 services), and Saint Petersburg (4 services), while Stockholm (9 services), Ljubljana (8 services), and Berlin (6 services), reported the highest extent of lack of cooperation due to the lack of services.

C-EHRN Focal Points highlighted several issues related to collaboration with other institutions. Some argued that initiating and maintaining such cooperation should be the responsibility of higher-threshold services, while others highlighted the siloed character of the healthcare system and decreasing cooperation. Some Focal Points perceived cooperation as good only with services operated by CSOs, and some highlighted that collaborations happen at the level of personal relationships and individuals and are not institutionalised.

FP Copenhagen

'Only Danish citizens can apply for housing services focusing on ageing people: Special nursing homes for older drug users are available. A new Housing First framework was set in motion by the national government, but it is almost impossible to implement immediately in Copenhagen due to the lack of appropriate social housing.'

FP Helsinki

'The cooperation between public health care and harm reduction is largely employee-driven and depends entirely on the motivation of individual workers to facilitate collaboration and advocate for harm reduction efforts.'

FP Lisbon

'Some items are in the challenging category, but it can be very challenging and almost impossible (for example, organisations or individuals providing legal support) or a little bit challenging (public primary health care) and in those cases also depends on the subject and people.'

FP London

'It is also worth noting that cooperation here has a positive connotation that is not reflective of our service users' experiences, which is that collaboration between organisations translates into increased surveillance of these people by the state. Public specialist health care, hospitals, and emergency departments are all able to work with harm reductionists if the will and resources were present; however, this very rarely happens today. Healthcare in particular works in extreme siloes due to transformations within the NHS and the overall level of pressure on the health system.'

FP Podgorica

'Since Montenegro is a small country with a changing political structure, in the last few years, we constantly have to lobby for human rights of people at risk of social exclusion. We have cooperation with government bodies, such as Ministries, health centres and other CSOs, but systemic solutions are things that potentially cause issues. For example, if we have as a client a woman who uses drugs but is also a victim of domestic/partner violence in need of shelter, we do not have anyone to refer this person to. Also, every service that answered with "cooperation is good" is provided within the NGO and that is the reason why cooperation is good, not challenging or non-existent.'

FP Reykjavik

'There is no cooperation between HR services in the Reykjavík area, with services for migrants or LGBTQI. I think the only reason for that is the lack of interest by service providers to put a focus on these groups. Since 2022, there have been social workers working in the emergency department of the national hospital. That has made the collaboration between public emergency healthcare and HR service very good.'

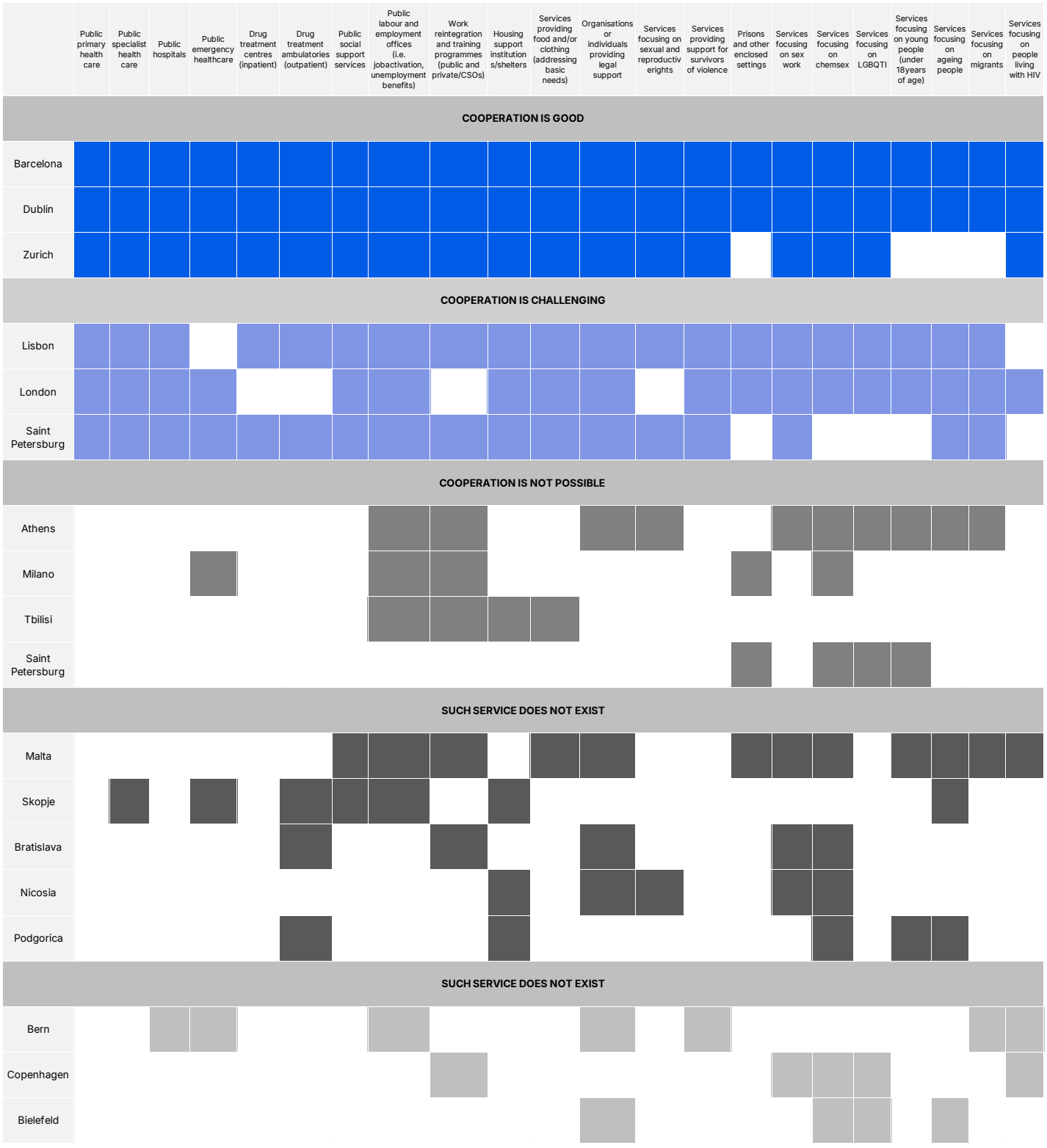


Table 10. Cities with the highest proportion of specific answers regarding cooperation of harm reduction services with other organisations and institutions.

Involvement of people with lived and living experience

Focal Points were asked about the extent of involvement of people with living and lived experience in harm reduction services in their cities in four areas of service operation. The data shows an overall low level of involvement of people who use drugs in harm reduction services.

Regarding people with living experience, the two areas where the levels of involvement were reported as the highest are implementation of services, where 4 FPs (10.0%) indicated a 'great' extent; 4 FPs (10.0%) 'moderate' extent; and 11 FPs (27.5%) 'some' extent. This is followed by design/planning, where 3 FPs (7.5%) reported a 'great' extent; 6 FPs (15%) 'moderate' extent; and 9 FPs (22.5%) 'some' extent'. People with living experience seem to be minimally involved in service evaluation (12 FPs, 30.0% answering 'no' and 12 FPs, 30.0% 'small' involvement). The lowest level of involvement was reported for service governance, where 19 FPs (47.5%) indicated 'no' involvement and a further 8 FPs (20.0%) a small extent of involvement.

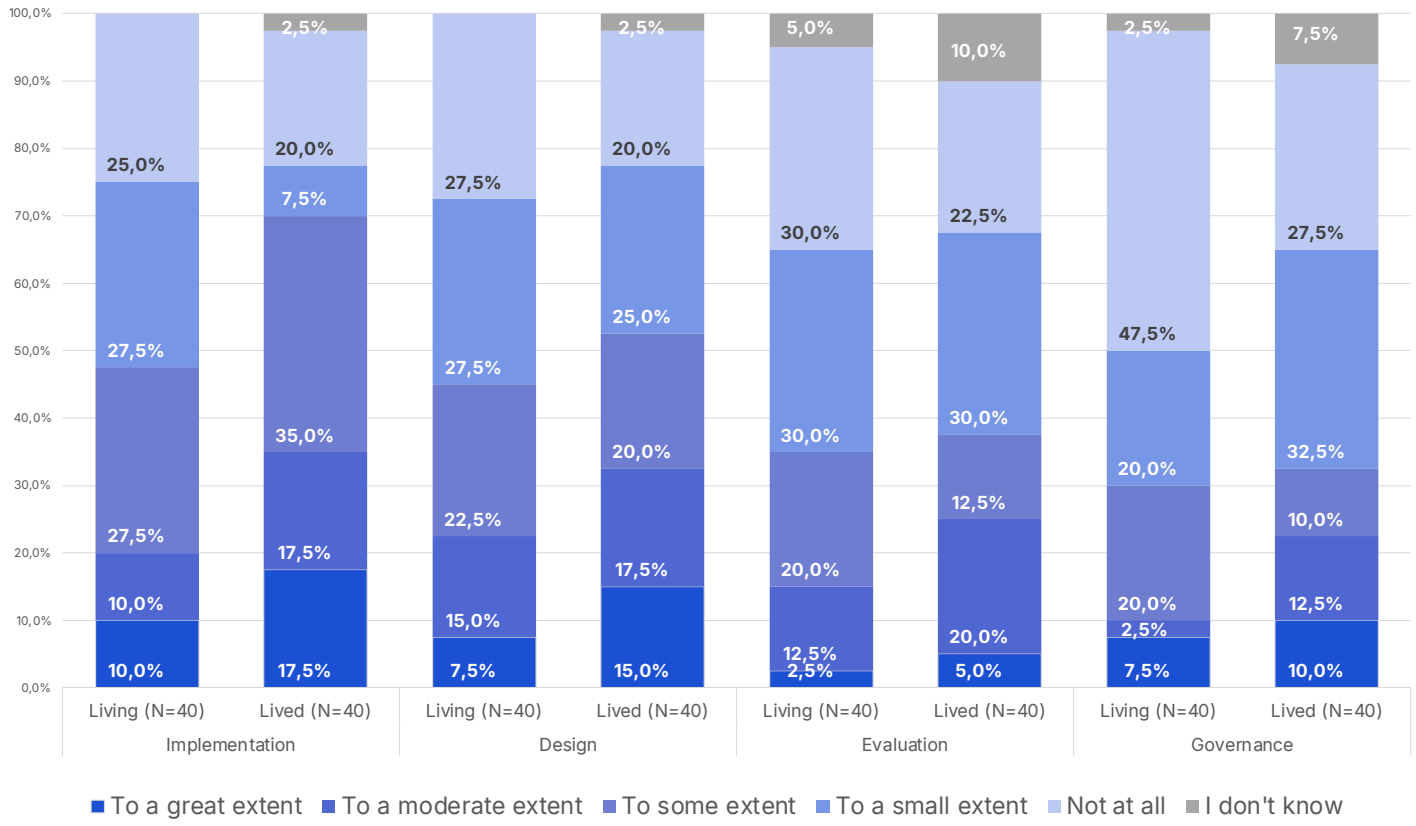


*Figure 9. The extent of involvement of people with living and lived experience in harm reduction services as assessed by C-EHRN Focal Points (**N=40**).*

The situation was similar in case of people with lived experience, with the highest involvement in service implementation (7 FPs, 17.5% reporting 'great' and 'moderate' involvement each; and further 14 FPs, 35.0% reporting some involvement) and design (respectively, 6 FPs, 15.0%; 7 FPs, 17.5%; and 8 FPs; 20.0%). In case of service evaluations, 9 FPs, 22.5% reported no involvement and 12 FPs, 30.0% small involvement; and in the case of governance, these numbers were 11 FPs, 27.5% and 13 FPs, 32.5%, respectively.

The above data shows that while the distribution of the levels of involvement of people who use drugs are similar for both groups across different aspects of service provision, the overall involvement of people with lived experience is higher than the involvement of people with living experience. Table 11 shows the average proportion of responses for each answer category across all examined aspects of service provision.

Answer option	Average proportion of responses for people with living experinece	Average proportion of responses for people with lived experinece
To a great extent	6,9%	11,9%
To a moderate extent	10,0%	16,9%
To some extent	22,5%	19,4%
To a small extent	26,3%	23,8%
Not at all	32,5%	22,5%
I don't know	1,9%	5,6%

Table 11. The average proportion of responses to the questions: To what extent are people with living/lived experience of drug use involved in harm reduction services in your city?

Subsequently, Focal Points were asked how people with living and lived experience are involved in harm reduction in their cities.

Regarding the former group, 10 FPs did not know this information. Among those who did provide it, in the largest proportion of the cities, people with living experience are involved in services usually as volunteers (in the vast majority as volunteers - 13/30 FPs, 43.3%; in the majority as volunteers – 6/30 FPs, 20.0%). Only 4/30 FPs (13.3%) reported involvement in the vast majority as paid staff, and a further 4 FPs in the majority as paid staff (13.3%). Three FPs indicated balanced distribution – to the same level as volunteers as paid staff (10.0%).

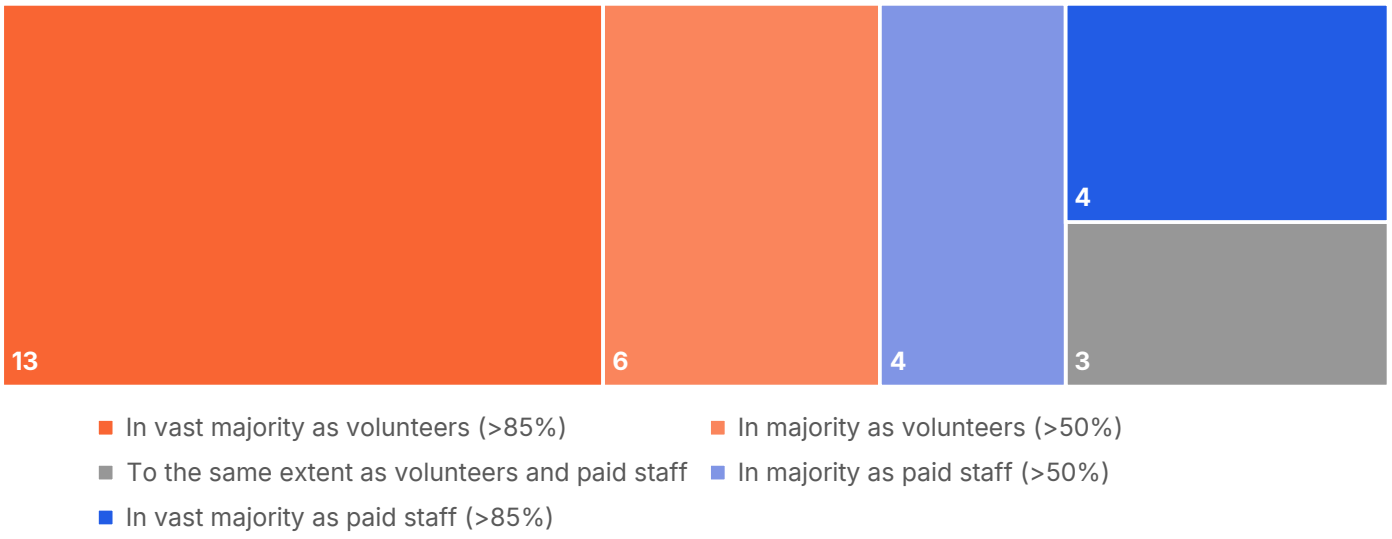


*Figure 10. The way people with living experience are involved in harm reduction services as assessed by C-EHRN Focal Points (**N=30; skipped: 0**).*

Regarding people with lived experience, 6 FPs did not know how they are involved in harm reduction services. From those who provided specific answers to this question, most respondents indicated involvement in the vast majority as volunteers (9/34 FPs, 26.5%), and a further 5/34 FPs (14.7%) as volunteers; 7/34 FPs (20.6%) indicated balanced involvement, while 6/34 FPs (17.6%) reported involvement of people with lived experience in a majority as paid staff, and a further 7/34 FPs (20.6%) in the vast majority as paid staff.

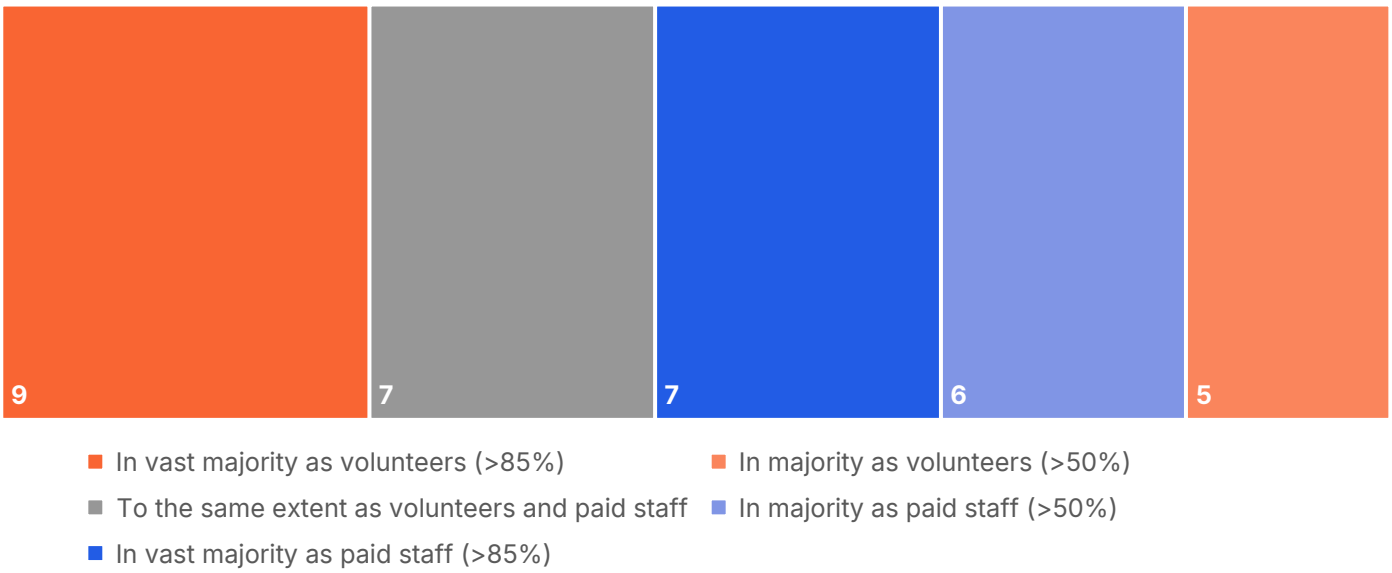


*Figure 11. The way people with lived experience are involved in harm reduction services as assessed by C-EHRN Focal Points (**N=34; skipped: 0**).*

FP Copenhagen

'There are no specific rules for when to involve people with lived experience. It's always a policy issue but often not implemented.'

FP Malta

'People with living experience continue to be too afraid to speak up due to legal, economic and social repercussions.'

FP Milan

'In Milan, harm reduction services included the participation of people of lived and living experience of drug use (mostly experience of injecting opiates) until around 2010, and in some organisations they were involved at all levels – including governance. In recent years, the new programmes are planned, implemented and monitored by street workers and professional educators who do not have any personal history of drug use.'

FP Podgorica

'Regarding CSOs, people from communities have the opportunity to be the part of design/ implementation and planning but are sometimes not motivated to do so.'

FP Copenhagen

'The national capital has a long tradition for HR-thinking. There is generally a rather high political wish to include drug users and homeless groups in political strategies but there is, for instance, no user involvement in the implementation of new DCR's until now.'

Similar to the areas of involvement of people with living and lived experience in harm reduction services, one can also notice differences between the two groups in the way of their involvement. More specifically, people with living experience are to a much higher extent involved in services as volunteers, and to a lesser extent as paid staff. Table 12 shows the proportions of specific answers among these two groups.

Answer option	Proportion of answers for people with lived experience (N=30)	Proportion of answers for people with living experience
In vast majority as volunteers (>85%)	26,5%	43,3%
In majority as volunteers (>50%)	14,7%	20,0%
To the same extent as volunteers and paid staff	20,6%	10,0%
In majority as paid staff (>50%)	17,6%	13,3%
In vast majority as paid staff (>85%)	20,6%	13,3%

Table 12. The proportion of responses to the questions: How are people with living/lived experience of drug use involved in harm reduction services in your city?

Developments of essential harm reduction services over the period 2020-2023

There are 25 Focal Points that answered the survey every year since 2020; hence, they are eligible for comparison. The composition of this group of Focal Points is skewed towards Western Europe, with ten Western cities present in the group. The group also includes seven cities from Central-Eastern Europe and the Balkans, five cities from Southern Europe and three Scandinavian cities.

Service availability

The availability of specific harm reduction services has been assessed since the first Harm Reduction Essentials Survey in 2020.

The comparisons between 2020 and 2024 focused on two key aspects: (1) difference in the number of FPs reporting services available to a 'great extent' and 'not at all' in each year; and, (2) general service availability, incorporating all response categories ('not at all', 'small extent', 'some extent', 'moderate extent' and 'great extent') from the FPs.

Changes in the number of FPs reporting 'great extent' of availability

Between 2020 and 2024, the services that experienced the greatest perceived increase in availability, based on the number of FPs reporting that the service exists to a 'great extent', are prevention of sexual risk (+4 FPs choosing this answer in 2024 compared to 2020); followed by safer intranasal kits (+3 FPs); safer smoking kits (+2 FPs); naloxone in prisons (+2 FPs); and naloxone (+2 FPs). On the other hand, some services experienced a decrease in the number of FPs reporting their availability to a 'great extent'. The most significant decline was observed in needle syringe programmes (-7 FPs); shelters and housing (-5 FPs); OAT (- 2 FPs); DCRs (-2 FPs); and legal support (-2 FPs).

Changes in the number of FPs reporting 'not at all' available services

In contrast, some services saw an increase in the number of Focal Points reporting no availability between 2020 and 2024. Take-home naloxone (THN) saw the largest increase in this category (+4 FPs indicating 'no' availability in 2024 compared to 2020), followed by employment and income generation services for people who use drugs (+2 FPs), and naloxone in prisons (+1 FP).

Conversely, some services showed improvements in availability, as indicated by a decrease in the number of FPs reporting the service as 'not at all' available. These services include drug checking (-2 FPs reporting no availability in 2024 compared to 2020), fentanyl test strips (-2 FPs) and prevention of sexual risks (-2 FPs). Table 13 shows the number of FPs reporting 'great extent' and 'no' availability of examined services in 2020 and 2024.

	Not at All		Great Extent	
	2020	2024	2020	2024
OAT	0	0	19	17
NSP	0	0	19	12
Smoking kits	0	9	4	6
Intranasal kits	10	9	2	5
DCR	16	15	6	4
Drug checking	13	11	5	4
OAT in prison	2	3	13	14
Naloxone in prison	14	16	1	3
Naloxone	6	6	5	7
THN	8	12	6	5
Fentanyl test strips	16	14	2	1
Shelters & housing	2	2	8	3
Income generation	4	6	2	1
Legal support	1	1	4	2
Sexual risks prevention	2	0	8	12

Table 13. Number of Focal Points reporting 'no' and 'great' availability of harm reduction services in 2020 and in 2024.

General decrease in availability

In 2024 compared to 2020, the most notable reduction, measured in points across all Focal Points, was observed in shelter and housing (-7 points), NSP (-6), drug checking (-2) and fentanyl test strips (-2).

Shelter and Housing

A total of 10-out-of-25 FPs (40%) reported a reduction in the availability of shelters and housing between 2020 and 2024. The FPs indicating the decrease were Krakow (-3, from great to small extent); London (-3, from great to small extent); Stockholm (-2, from some extent to no availability); Berlin (-1, from some to small extent); Bern (-1, from great to moderate extent); Budapest (-1, from some

to small extent); Dublin (-1, from great to moderate extent); Glasgow (-1, from great to moderate extent); Luxemburg (-1, from great to moderate extent); and Vienna (-1, from great to moderate extent).

Needle and Syringe Programmes

Although no FPs reported that NSP services were entirely unavailable, this service experienced the second most sizeable reduction in availability between 2020 and 2024. More specifically, a total of 9-out-of-25 FPs (36%) reported a decrease in service availability: Stockholm (-3, from great to small extent); London (-2, from great to some extent); Berlin (-1, from great to moderate extent); Dublin (-1, from great to moderate extent); Helsinki (-1, from great to moderate extent); Krakow (-1, from great to moderate extent); Nicosia (-1, from some to small extent); Porto (-1, from great to moderate extent); and Prague (-1, from great to moderate extent).

Drug checking

Drug checking services have also seen a reduction in availability from 2020 to 2024, with 6-out-of-23 FPs (26%) reporting it, including Copenhagen (-3, from great to small extent); Krakow (-2, from some to no availability); Luxemburg (-1, from some to small extent); Milan (-1, from small to no availability); Paris (-1, from great to moderate extent); and Tallinn (-1, from small to no availability).

Antwerp, Bratislava, Budapest, Dublin, Glasgow, Helsinki, and Nicosia have continued to report that drug checking services do not exist since 2020. However, Athens and Thessaloniki, Berlin, and Prague have reported, for the first time since 2020, that the service is available, albeit to a small extent.

General increase in availability

Between 2020 and 2024, the three services that showed the largest increases in availability were prevention of sexual risks (+18 points), naloxone (+11 points), and safer smoking kits (+12 points).

Prevention of sexual risks

A total of 14-out-of-25 FPs (56%) reported an increase in the availability of prevention on sexual risks services between 2020 and 2024. The cities reporting it were: Milan (+3, from small to great extent); Antwerp (+2, from some to great extent); Bratislava (+2, from small to moderate extent); Dublin (+2, from some to great extent); Krakow (+2, from some to great extent); Ljubljana (+2, from some to great extent); Paris (+2, from some to great extent); Porto and Vila Nova de Gaia (+2, from some to great extent); Prague (+2, from some to great extent); Athens and Thessaloniki (+1, from some to moderate extent); Berlin (+1, from some to moderate extent); Nicosia (+1, from no availability to small extent); Stockholm (+1, from no availability to small extent); and Vienna (+1, from some to moderate extent).

In 2024, 12 FPs reported that this service exists to a great extent: Antwerp, Barcelona, Dublin, Krakow, Ljubljana, Luxemburg, Milan, Paris, Porto, Prague, Tallinn and Tirana. No FP in 2024 reported the lack of sexual risk prevention services in contrast with 2020, when it was reported by FP Nicosia and FP Stockholm.

Naloxone

The increase in the availability of naloxone included 11/25 FPs (44%) reporting an improvement between 2020 to 2024: Copenhagen (+4, from no availability to great extent); Vienna (+3, from small to great extent); Athens and Thessaloniki (+2, from no availability to some extent); Milan (+2, from some to great extent); Stockholm (+2, from some to great extent); Berlin (+1, from small to some extent); Budapest (+1, from no availability to small extent); Dublin (+1, from some to great extent); Luxembourg (+1, from some to moderate extent); Paris (+1, from some to moderate extent); and Prague (+1, from small to some extent).
In 2024, 7/25 FPs reported that naloxone was available to' a great extent': Barcelona, Copenhagen, Glasgow, Milan, Stockholm, Tallinn and Vienna. In contrast, in 2020, there were 5 FPs reporting 'great extent': Barcelona, Bern, Glasgow, London and Tallinn.

Some cities maintained their availability of Naloxone throughout the years. Barcelona, Glasgow, and Tallinn reported great extent of availability in both 2020 and 2024. Copenhagen moved from no availability in 2020 to a 'great extent' in 2024. Vienna increased from a small extent in 2020 to a 'great extent' by 2024, while Stockholm and Milan improved from 'some extent' in 2020 to 'great extent' in 2024.

However, 6 FPs reported no availability of naloxone in 2024. These cities include Amsterdam (which decreased from some extent in 2020 and moderate extent in 2023); Antwerp (which has consistently reported no availability since 2020); and Bern (which saw a decline from great extent of availability in 2020, 2021, and 2023). Other cities reporting no availability in 2024 include Bratislava (which remained unchanged since 2020); Helsinki (which fluctuated between small extent in 2020 and 2022, and no availability in 2021 and 2023); and Krakow (which fluctuated between no availability in 2020 and 2024, but had great extent in 2021 and 2022, and some extent in 2023). Athens and Thessaloniki, as well as Budapest, initially reported no availability in 2020 but improved to some extent and small extent, respectively, by 2024.

Safer smoking kits

The availability of safer smoking kits saw a notable increase between 2020 and 2024 with 10 FPs reporting improvements: Tallinn (+4, from not at all to great); Krakow (+3, from no availability to moderate extent); Luxemburg (+3, from small to great extent); Athens (+2, from no availability to some extent); Barcelona (+2, from some to a great extent); Prague (+2, from small to moderate extent); Amsterdam (+1 point, from some to moderate extent); Bratislava (+1, from no availability to small extent); Copenhagen (+1, from small to some extent); and Dublin (+1, from some to moderate extent).

Service quality

Regarding quality, the comparisons between 2022 and 2024 focused on two key aspects: (1) difference on the number of FPs reporting service quality to a 'great extent' and 'not at all' in each year; and, (2) general service quality, incorporating all response categories ('not at all', 'small extent', 'some extent', 'moderate extent' and 'great extent') from the FPs.

Changes in the number of FPs reporting 'great extent' of meeting quality criteria

When analysing the number of FPs reporting service quality to a 'great extent', the quality criteria seeing the most significant increases were 'addressing the health and risk behaviour of clients' (+6 FPs, from 10 in 2022 to 16 in 2024), 'confidentiality of client records' (+2 FPs, from 20 to 22), and 'conducting regular internal evaluation of service outcomes' (+2 FPs, from 6 to 8).
On the other hand, some quality criteria experienced a decrease in the number of FPs reporting them to be met to 'a great extent'. Specifically, regularly updating staff on relevant developments and new knowledge in their field of action (-4 FPs reporting great extent between 2022 and 2024, from 9 to 5); informing clients on service options and agreeing with a proposed plan before starting an intervention (-3 FPs, from 14 to 11); and tailoring intervention plans individually to the needs of the client (-3 FPs, from 11 to 8).

Changes in the number of FPs reporting 'no extent' of meeting quality criteria

	Not at All		Great Extent	
	2022	2024	2022	2024
Services address the health and risk behaviour of their clients	0	1	10	16
Clients receive information on service options and agree with a proposed plan before starting na intervention	0	0	14	11
Clients records are confidential and exclusevely accessible to staff	0	0	20	22
Intervention plans are tailored individually to the needs of the client	0	1	11	8
Staff is regularly updated on relevant developments and new knowledge in their field of action	1	1	9	5
Services regularly monitor their activities	1	3	10	10
Services regularly perform an internal evalation of their outcomes	0	2	6	8

Table 14. Number of Focal Points reporting 'no' and 'great' quality of harm reduction services in 2020 and in 2024.

Between 2022 and 2024, two quality criteria saw an increase in the number of FPs reporting not meeting these criteria at all. Specifically, regular monitoring of service activities (+2 FPs, from 1 in 2022 to 3 in 2024) and conducting regular internal evaluation of service outcomes (+2 FPs, from 0 in 2022 to 2 in 2024).

It is noteworthy that no criteria saw a decrease in the number of FPs reporting 'not at all'.

General increase in quality

In 2024, compared to 2022, the two service quality criteria showing the most significant improvements were: addressing the health and risk behaviour of clients by services (+8 points) and keeping client records confidential and exclusively accessible to staff (+5 points).

Services address the health and risk behaviour of their clients

From 2020 to 2024, there has been a notable increase in the level of meeting the criterion of addressing the health and risk behaviours of service clients.

Specifically, this increase was reported by 10/25FPs (40%): Ljubljana (+3, from small extent to great); Nicosia (+2, from some to great extent); Antwerp (+1 point, from moderate extent to great extent); Barcelona (+1, from moderate extent to great extent); Budapest (+1, increased from small to some extent from 2022 to 2024); Paris (+1, from moderate to great extent); Porto (+1, from moderate to great extent); Prague (+1, from moderate to great extent); Tallinn (+1, from moderate to great extent); and Tirana (+1, from moderate to great extent).

Client records are confidential and exclusively accessible to staff

In 2024, more FPs than in 2022 also indicated improvements regarding confidentiality of client records. Such a situation was reported by 4-out-of-25 FPs (16%): Antwerp (+1, from moderate to great extent); Barcelona (+1, from moderate to great extent); Helsinki (+1, from moderate to great extent); and Stockholm (+1, from moderate to great extent).

General decrease in quality

In 2024 compared to 2022, the two most significant areas of service quality that saw a decrease were: conducting regular internal evaluation of service outcomes (-5 points) and regularly updating staff on relevant developments and new knowledge in their field of action (-6 points).

Services regularly perform an internal evaluation of their outcomes

A total of 8-out-of-25 FPs (32%) reported a decrease in the extent to which regular evaluation of service outcomes were conducted by harm reduction services in their cities. These FPs were specifically: Bratislava (-2, from moderate to small extent); Copenhagen (-2, from great to some extent); Dublin (-2, from moderate to some extent); Helsinki (-2, from moderate to small extent); London (-2, from some extent to not at all); Budapest (-1, from small extent to not at all); Glasgow (-1, from moderate to some extent); and Luxembourg (-1, from moderate to some extent).

Staff are regularly updated on relevant developments and new knowledge in their field of action

Regarding the criteria of staff being regularly updated on relevant developments and new knowledge in their field of work, 9/25 FPs (36%) reported a decrease: Glasgow (-2, from great to some extent); Helsinki (-2, from moderate to small extent); Vienna (-2, from great to some extent); Athens (-1 point, from small extent to not at all); Bern (-1, from great to moderate extent); Luxembourg (-1, from moderate to some extent); Nicosia (-1, from great to moderate extent); Prague (-1, from great to moderate extent); and Tirana (-1 from great to moderate extent).

Service delivery to different sub-populations

Changes in the number of FPs reporting 'great extent' of service delivery

In terms of three sub-populations that experienced notable improvements in the extent of service delivery to them from 2020 and 2024, they include: people who inject opiates (+6 FPs reporting great extent, from 15 in 2020 to 21 in 2024); people who smoke stimulants or NPS (+5 FPs, from 4 to 9); and people who smoke opiates (+4 FPs, from 11 to 15). On the other hand, service delivery 'to a great extent' decreased for migrants who use drugs with no legal rights to assistance (-2 FPs, from 4 to 2).

Changes in the number of FPs reporting 'no extent' of service delivery

From 2020 to 2024, the three sub-populations that experienced the largest increase in the number of FPs reporting no service delivery to them were: people who use intranasal amphetamines/cocaine/cathinone, etc. (+7 FPs reporting 'no' service delivery, from 2 in 2020 to 9 in 2024); people who smoke stimulants or NPS (+6 FPs, from 1 to 7); and migrants who use drugs with no legal rights to assistance (+5 FPs, from 2 to 7). On the other hand, there was no sub-population for which the number of 'not at all' answers in this question decreased between 2020 and 2024.

General increase in service delivery

Between 2020 and 2024, the three sub-populations for which the extent of service delivery increased the most were: women who use drugs (+14 points), people who smoke opiates (+13), and sex workers (+12).

Women who Use Drugs

Regarding Women who Use Drugs, there was an increase in the extent of service delivery reported by 13/25 FPs (52%): Stockholm (+3, from moderate to great extent); Amsterdam (+2, from moderate to great extent); Barcelona (+2, from moderate to great extent); Berlin (+2, from moderate to great extent); Krakow (+2, from moderate to great extent); Tallinn (+2, from some to great extent); Antwerp (+1, from moderate to great extent);

	Not at All		Great Extent	
	2020	2024	2020	2024
People who inject opiates (including synthetic opiods)	0	2	15	21
People who inject stimulants or NPS	0	2	11	14
People who smoke opiates	2	3	11	15
People who smoke stimulants or NPS	1	7	4	9
People who use intranasal amphetamines/cocaine/cathinone, etc	2	9	5	8
People expericing homelessness	1	3	13	14
Sex workers	2	2	6	9
Women who use drugs	1	2	5	6
LGBQTI who use drugs	0	4	4	4
Young people who use drugs (under 18 years old)	6	6	3	3
Migrants who use drugs with legal rights to assistance	2	5	4	4
Migrants who use drugs with no legal rights to assistance	2	7	4	2
People in prison settings	5	8	3	5

Table 15. Number of Focal Points reporting 'no' and 'great' extent of service delivery to specific sub-populations in 2020 and in 2024.

Athens and Thessaloniki (+1, from moderate to great extent); London (+1, from moderate to great extent); Luxembourg (+1, from moderate to great extent); Nicosia (+1, from moderate to great extent); Prague (+1, from moderate to great extent); and Vienna (+1, from moderate to great extent).

People who Smoke Opiates

For people who smoke opiates, an increase in service delivery included 10/25 FPs (40%): Stockholm (+3, from moderate to great extent); Athens (+2, from moderate to great extent); Barcelona (+2, from moderate to great extent); Dublin (+2, from moderate to great extent); Luxembourg (+2, from moderate to great extent); Prague (+2, from moderate to great extent); Vienna (+2, from moderate to great extent); Bratislava (+1, moderate to great extent); London (+1, from moderate to great extent); and Milan (+1, from moderate to great extent).

Sex Workers

Considering sex workers, 11/25 FPs (44%) reported an increase in service delivery levels: Ljubljana (+3, from moderate to great extent); Milan (+2, from moderate to great extent); Prague (+2, from moderate to great extent); Glasgow (+2, from moderate to great extent); Antwerp (+1, from moderate to great extent); Barcelona (+1, from moderate to great extent); Copenhagen (+1, from moderate to great extent); Dublin (+1, from moderate to great extent); Krakow (+1, from moderate to great extent); Tallinn (+1, from moderate to great extent); and Vienna (+1, from moderate to great extent).

General decrease in service delivery

There was only one sub-population for whom the overall extent of service delivery decreased between 2020 and 2024: migrants who use drugs with no legal rights to assistance (-4 points).

Migrants who Use Drugs with No Legal Rights to Assistance

The decreased service delivery was reported by 10/25 FPs (40%): London (-4, from great extent to not provided); Glasgow (-2, from some extent to not provided); Paris (-2, from some extent to not provided); Amsterdam (-1, from some to small extent); Helsinki (-1, from small extent to not provided); Krakow (-1, from great to moderate extent); Luxembourg (-1, from some to small extent); Nicosia (-1, from small extent to not provided); Prague (-1, from some to small extent); and Tirana (-1, from great to moderate extent).

3

Limitations and the way forward

Harm reduction services are essential in addressing possible harms related to substance use and the negative consequences of stringent drug policies. By reducing health-related risks and combating social stigma, they strive to maximise the well-being of people who use drugs and are affected by discrimination, criminalisation and otherwise marginalised. Effective monitoring of harm reduction services is crucial for a better understanding of gaps and challenges in service delivery and in policy. Establishing such effective mechanisms that also ensure high data quality is, however, an extremely challenging task.

The C-EHRN Civil Society Monitoring framework has been adjusted, improved and polished since its launch in 2018. Still, the method of data collection is not without limitations. The framework of C-EHRN Monitoring involves a survey conducted with harm reduction service providers in 40 cities across Europe. Hence, the whole Monitoring exercise relies heavily on expert judgement. C-EHRN Focal Points have extensive knowledge of the situation regarding harm reduction in their cities. In almost all FP cities, there are – albeit established to a varying extent – mechanisms of information exchange between services. Still, the experience of the last two years of Monitoring has shown some shortcomings the C-EHRN Monitoring data collection.

Since 2023 (the previous round of data collection and reporting), the part of C-EHRN Monitoring addressing essential harm reduction services has included a chapter describing trends over time, based on the annual responses of 25 Focal Points who participated in the Monitoring throughout the years 2020-2024. In both 2020 and 2024, a few Focal Points provided interesting comments about their data trends during the feedback stage. Seeing the information from a different perspective, including a comparison of the perceived situation between 2020 and 2024, they re-evaluated their judgement regarding these trends. While some such challenges in assessment are external to, and independent of, the research process (for example, personal changes in Focal Points), others may be inherent to collecting data in the form of expert judgement.

To address the latter type of challenges, throughout 2024, the C-EHRN Monitoring Team has been working with an external consultant specialising in monitoring, evaluation and survey design to develop a data collection instrument that will minimise the room for different interpretations of questions and subjectivity of responses, thereby enhancing the data quality. The new Harm Reduction Essentials Questionnaire has already been piloted with several Focal Points and will be launched in 2025.

Key messages

Availability

HIV testing and treatment and OAT are the most commonly available harm reduction services. There is a particular gap concerning NSP and naloxone in prison, and DCRs. Overdose prevention and social reintegration services are less common than public health services directed towards the general public that can be used by people who use drugs.

Medicalisation

There seems to be a continuous trend towards medicalisation, where harm reduction is seen primarily as a public health intervention rather than a person-centred approach that addresses social determinants of health and social justice.

Accessibility

While NSP, HIV treatment, and HIV testing are reported as the most accessible, accessibility was the lowest for fentanyl test strips, drug checking services, income generation and housing for people who use drugs.

Acceptability

The most and least acceptable services for specific sub-groups of people who use drugs were HIV testing, DCRs, and HCV testing, and OAT in prisons and legal support services, respectively. Confidentiality and informed consent were the highest-rated acceptability criteria.

Quality

Harm reduction services in Europe are generally reported as of relatively high quality — especially with regard to upholding the confidentiality of clients and health risk monitoring — but with significant potential for improvement with regard to service evaluation and staff training on new developments.

Service delivery to specific sub-populations

HR services were provided to the highest extent to people who inject opiates. Conversely, migrants without legal rights to assistance, youth and people who practice chemsex were reported as the most underserved groups.

Barriers

FPs indicated a total of 1,106 barriers affecting the delivery of harm reduction services to particular sub-populations, with funding, meaningful community involvement and political will being the most frequently cited barriers overall, whereas a lack of specific knowledge and legal issues were particularly prevalent among the most underserved groups.

Collaboration

The best cooperation was reported with the services addressing the basic needs, HIV, and inpatient drug treatment, while it was mostly challenging with public social services and health care system organisations. Cooperation was reported as impossible to a largest extent in the case of prisons and employment-related services.

Peer involvement

Overall, people with lived experience are more involved in harm reduction services than people with living experience. In both groups, most people are involved as volunteers rather than paid staff. The involvement is higher in service co-design and delivery, with considerably less engagement in service evaluation and governance.

4

Conclusions

The C-EHRN Essential Harm Reduction Services Monitoring report 2024 highlights needs, gaps, and policy imperatives within an increasingly challenging reality. Europe's drug market is rapidly evolving, with the threat of synthetic opioids, increasing drug purity and availability, and a broader crisis in mental health and mental health care. Each of these trends converges to create an environment where the vulnerabilities of people who use drugs are amplified, underscoring the necessity for harm reduction services that are well-funded, accessible, and adaptive.

One of the most significant gaps in the harm reduction field is the shortage of overdose prevention and response. The drug market in Europe has been changing rapidly in recent decades, with new harmful substances emerging on a regular basis. Probably for the first time in history, European countries have the chance to prevent a crisis instead of reacting to one. Still, essential overdose prevention and response services, such as take-home naloxone, drug checking and drug consumption rooms, are overwhelmingly limited. This likely translates to the rise of preventable deaths, especially since the changes in the drug market can happen virtually overnight, leaving the policymakers and service providers unable to respond in a timely manner. Overdose prevention and response services must be urgently scaled up within an integrated, harm reduction-based response.

The reported data also highlights the continuous trend towards the medicalisation of harm reduction services, focusing on public health and infectious diseases. While public health aspects of drug use and the service response are important, excessive focus on them often results in overlooking the social and broader health needs of people who use drugs. Services that address social determinants of health, such as housing, employment, and mental health, need to be developed and more integrated into harm reduction responses. This is also a valid consideration in the context of specific sub-populations of people who use drugs who are the most underserved, such as migrants without legal rights to assistance, youth and non-gender conforming individuals.

Concerns regarding youth include the growing mental health crisis across Europe. Among young people, suicide has been the second leading cause of death in recent years. Still, almost half of them have unmet needs regarding mental health care **(OECD & European Union, 2022)**. Individuals with dual diagnosis of mental health problems and substance use are exposed to elevated levels of risk and, therefore, require high-quality, person-centred care. In contrast, our data also shows that young people are one of the most underserved sub-groups among people who use drugs. Bridging the gap between mental health and harm reduction services is imperative.

Results from the C-EHRN Monitoring 2024 report clearly indicate gaps in service availability and accessibility, often exacerbated by legal restrictions, funding shortages, and prevalent societal stigma about drug use. Despite the overwhelming supportive evidence, most harm reduction services remain under-resourced and highly precarious. The range of barriers preventing harm reduction services from effective service delivery to different groups can only be addressed through a transformation of drug policy – one that prioritises maximisation of well-being, human

rights and social justice approaches to drug use, and acknowledges harm reduction as an essential component of community health.

Beyond tackling these broader systemic problems, there is also a pressing need for better integration of harm reduction with other care services, especially in terms of housing and employment.

Finally, harm reduction service design and delivery must include the voices of those with living and lived experience if they are to be effective. The report highlights the gaps in this area which should be addressed. Greater inclusion of people with living and lived experience in the operation of harm reduction services encourages a more inclusive and effective approach.

In conclusion, the current situation in the field of harm reduction in Europe seems to be relatively challenging, with reactive policies adopting obsolete solutions. Meanwhile, with the ongoing public health challenges, Europe needs more proactive, future-oriented, agile, yet robust services. Through enabling more integrated service systems, decriminalisation of people who use drugs, and destigmatisation of drug use, we can achieve a situation where harm reduction services provide an optimal level of support for both people who use drugs and those who do not.

Recommendations

Increase funding and political support for harm reduction services

to address these major barriers to effective service delivery. Governments should allocate dedicated budgets at national level, and in regions especially affected by harm reduction funding crises, and EU-level funding mechanisms should be established to support local organisations.

Expand harm reduction services in prisons

to mitigate the higher risk for drug-related harms among people in this setting, including overdose and infectious diseases. Providing these services can significantly reduce health risks, improve overall public health outcomes, and support successful reintegration into society upon release.

Enhance cooperation between harm reduction services and public healthcare systems

to improve accessibility and integration of care. Establishing formal referral pathways between harm reduction services and hospitals and integrating harm reduction training into medical curricula can help achieve this goal.

Implement policies to reduce stigma associated with drug use and harm reduction services

Stigma is a significant barrier to service access. Launching public education campaigns to challenge misconceptions about drug use and dependence and providing anti-stigma training for healthcare providers and law enforcement, is essential.

Increase availability and accessibility of drug checking services

to address changing drug market trends and reduce the risk of overdose. Establish legal frameworks to support drug checking services and in implementing mobile drug checking units accessible by people in vulnerable situations.

Expand naloxone distribution programmes

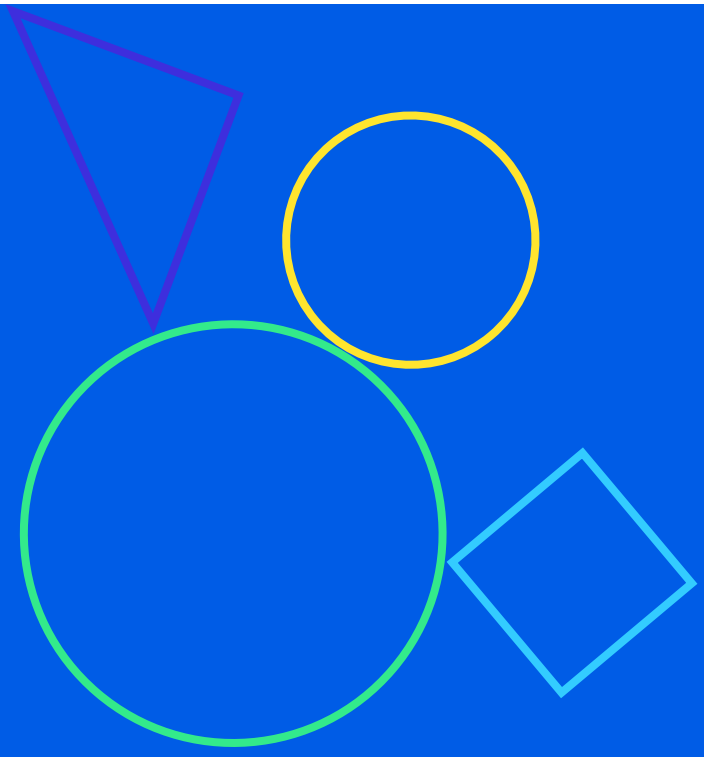
as an element in a comprehensive response to prevent opioid overdose deaths. Implement take-home naloxone programmes in all EU member states and allow over-the-counter naloxone sales in pharmacies to improve access.

Support meaningful involvement and participation of people with lived and living experience

in service design, implementation, and evaluation. Establish facilitating legal frameworks and ensure sufficient funding to enable harm reduction services to create paid positions for people with lived/living experience and ensuring their representation in policy-making processes.

Promote a holistic approach to harm reduction

that goes beyond medical interventions to include social support and community integration. Ensure integration of mental health support into harm reduction services and develop housing-first programmes for people who use drugs experiencing homelessness.



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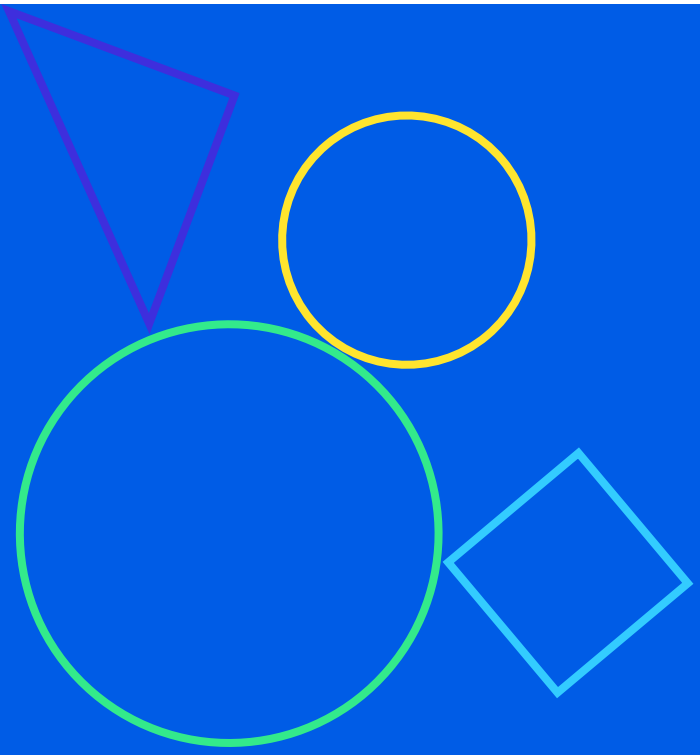

Appendix

Contributing C-EHRN Focal Points

Country	City	Organization	Main contact
Netherlands	Amsterdam	Mainline	Ingrid Bakker
Belgium	Antwerp	Free Clinic	Tessa Windelinckx
Greece	Athens	Positive Voice	Marios Atzemis
Moldova	Balti	Union for Equity and Health	Ala Iatco
Spain	Barcelona	Red Cross Catalonia	Maria Himalaya Vallejo Cañete
Germany	Berlin	Fixpunkt e. V.	Astrid Leicht
Switzerland	Bern	Infodrog	Marc Marthaler
Germany	Bielefeld	Drogenberatung e.V. Bielefeld	Jan-Gert Hein
Slovakia	Bratislava	Odyseus	Dominika Jasekova
Hungary	Budapest	Rights Reporter Foundation	Peter Sarosi
Denmark	Copenhagen	HealthTeam for the Homeless	Henrik Thiesen
Ireland	Dublin	Ana Liffey Drug Project	Tony Duffin
Scotland	Glasgow	Scottish Drugs Forum	Kirsten Horsburgh
Finland	Helsinki	EHYT Finnish Association for Substance Abuse Prevention	Kim Kannussaari
Poland	Krakow	MONAR-Krakow	Judyta Put
Ukraine	Kyiv	Club Eney	Vielta Parkhomenko
Portugal	Lisbon	Ares do Pinhal	Hugo Faria
Slovenia	Ljubljana	Association Stigma	Katja Krajnc
England	London	Release	Shayla Schlossenberg
Luxembourg	Luxembourg	Jugend- an Drogenhëllef	Martina Kap
Italy	Milano	Fondazione LILA Milano	Maria Luisa (Lella) Cosmaro
Wales	Newport	Kaleidoscope - Gwent Drug & Alcohol Service	Kate Jones
Cyprus	Nicosia	Cyprus National Addictions Authority	Evi Kyprianou
France	Paris	Fédération Addiction	Marine Gaubert
Montenegro	Podgorica	NGO Juventas	Marija Mijović
Portugal	Porto	APDES	José Queiroz Barbosa
Czech Republic	Prague	SANANIM	David Pešek
Iceland	Reykjavík	Matthildur	Svala Jóhannesdóttir
Italy	Rome	Forum Droghe	Antonella Camposeragna
Russia	Saint Petersburg	Humanitarian Action	Alexei Lakhov
Malta	Malta	Harm Reduction Malta	Karen Mamo
Bulgaria	Sofia	Center for Humane Policy	Yuliya Georgieva
North Macedonia	Skopje	Healthy Options Project Skopje - HOPS	Blagorodna Koceva Simjanov
Sweden	Stockholm	Stockholms Drug Users Union	Niklas Eklund
Estonia	Tallinn	OÜ ReCuro Estonia	Greete Org
Georgia	Tbilisi	Georgian Harm Reduction Network	Maka Gogia
Albania	Tirana	Aksion Plus	Besnik Hoxha
Austria	Vienna	Suchthilfe Wien gGmbH	Marcus Ramusch
Poland	Warsaw	PREKURSOR Foundation for Social Policy	Magdalena Bartnik
Switzerland	Zurich	Drug Information Center (DIZ) /Division Harm reduction for illicit substances, City of Zurich	Dominique Schori

Correlation

European Harm Reduction Network

correlation-net.org

Correlation

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