Highlights

Full spectrum harm reduction C-EHRN monitoring report 2025

Barriers and risks faced by people who use drugs vary across different groups. Tailored services must be implemented to reduce health and social inequities experienced by **specific populations**.

Integration efforts are largely focused on connections with drug treatment centres, while services addressing broader economic, legal and social drug-related harms often remain uncoordinated.

	Most integrated	Least integrated
Healthcare	Inpatient drug treatment centre access	Public emergency healthcare
Work and employment	Public labour and employment offices	Work reintegration and training programmes

Peer involvement remains limited and often relies on volunteer work. Expanding compensated, supported peer involvement enhances service engagement and sustainability.

Correlation
European Harm Reduction Network

Full Spectrum Harm Reduction in Europe

Specific populations, service integration, and peer involvement

Civil Society Monitoring of Harm Reduction in Europe **2025**

Correlation
European Harm Reduction Network

Title

Full Spectrum Harm Reduction in Europe. Specific populations, service integration, and peer involvement. Civil Society Monitoring of Harm Reduction in Europe 2025.

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Acknowledgements

We acknowledge the valuable contributions of [Name] and [Name], whose expertise and careful review strengthened this report.

Recommended citation

Bellows, C. et al.(2026). Full Spectrum Harm Reduction in Europe. Specific populations, service integration, and peer involvement. Civil Society Monitoring Harm Reduction in Europe 2025. Amsterdam, Correlation – European Harm Reduction Network.
DOI: 10.5281/zenodo.21280489

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Figure 1: Location of C-EHRN Focal Points, 2025

This report is based on data collected in 2025 from C-EHRN Focal Points: civil society organizations delivering harm reduction services in 42 cities.

Harm reduction is not one-size-fits-all

Many subgroups of people who use drugs have unique needs and risks influenced by complex social, psychological, and systemic factors. Due to the diversity of experiences across subgroups, tailored harm reduction (HR) approaches are essential in minimizing negative consequences associated with high-risk behaviours while promoting empowerment and dignity.

Unhoused people who use drugs face storage and shelter instability

Storage for unhoused people who use drugs was available through at least one harm reduction service in only half of cities

Unhoused people are subject to a disproportionately high prevalence of drug use and associated harms [1]. While the majority of cities had at least one HR service offering safe spaces for this subgroup to rest and recover – with only Tirana, Gdańsk, Skopje, Valletta, and Reykjavik reporting an absence of the service – only about half of the cities had at least one HR service providing storage for belongings and medication. Without access to secure storage locations, unhoused individuals endure high rates of property and medication theft, the latter of which has been identified as a significant barrier to medication adherence – including medications for Hepatitis C treatment [2].

Recommendation

→ Beyond protecting the personal belongings of unhoused people who use drugs, access to storage services should be increased to ensure harm-minimizing supplies are not stolen or confiscated.

Finding shelter and housing remains a problem for many unhoused people who use drugs

Only half of the focal points reported the availability of mainstream services providing long-term housing without an abstinence requirement. This is particularly concerning, considering that Housing First initiatives have been shown to increase time in independent accommodation, reduce psychiatric symptoms, improve community integration, and promote empowerment and recovery among those who are unhoused [3].

Even more concerning is that **only 61.90% of focal points reported the availability of short-term shelters for the general population that accepted people under the influence of substances**, putting those in the remaining cities at risk of experiencing violence and health-related problems from prolonged exposure to extreme weather [4,5,6].

Recommendations

→ Increasing the availability of shelters that accept those under the influence is an urgent next step for the immediate safety of unhoused people who use drugs.

→ Working towards the longer-term goal of expanding the availability of housing first programs is an important undertaking in removing this subgroup from cycles of instability, ultimately promoting sustained safety and well-being.

Scarce violence prevention services for sex workers who use drugs

HR services providing sex workers with self-defense training and safety planning, and "bad date" lists to warn about dangerous clients, were available in less than one quarter of cities. Expanding these services are critical, as sex workers who use drugs are at an elevated risk of violence compared to those who do not [7].

Figure 2: Availability of violence prevention services for sex workers

Frontline Voice – FP Valletta

"Sex workers continue to be viewed as criminals."

Social stigma and perceptions of criminality associated with sex work may be at the root of the lack of tailored services for this subgroup. Sex workers who use drugs have reported trying to hide their drug use due to stigma and internalized shame [8], reducing engagement with HR services and endangering their lives.

Recommendation

→ Not only improving access to violence-prevention HR services for sex workers who use drugs, but ensuring that these services are delivered in safe and non-judgemental environments, are important next steps for European countries.

Sexual health services are common, but chemsex outreach remains limited

Less than half of focal points reported HR outreach or support for people who practice chemsex in the venues or online spaces where chemsex takes place. This creates a gap in accessibility, as people who practice chemsex don't identify with other groups of people who use drugs [34], and may not seek out traditional HR services.

This gap contrasts the broader availability of HR sexual health services, which are present in the majority of cities. Chemsex has been a growing concern in Europe, particularly among men who have sex with men [10], where an estimated 11-21% report engaging in chemsex [9]. This group faces a heightened risk of HIV and other sexually transmitted infections [10]. However, targeted chemsex support remains far less common, leaving many people without services that are tailored to their needs.

Recommendation

→ Outreach services should be available at relevant chemsex venues, providing people who practice chemsex with harm reduction services and reducing associated harms.

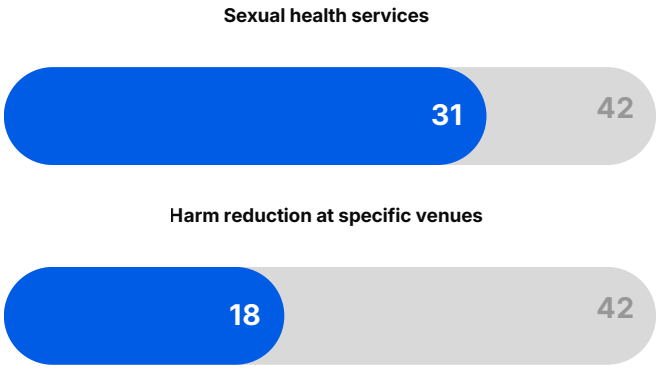

Figure 3: Comparison between sexual health service availability and outreach service availability for people who practice chemsex

Heat- and dehydration-related drug harms are often overlooked in party settings

Compared to the general population, drug use is significantly higher among people attending nightclubs, music festivals, and other recreational party settings [11]. However, "chill-out" spaces to rest and cool down and free, easily accessible water to prevent dehydration – two services uniquely relevant to people who use drugs in party settings – remain absent in many cities. A lack of accessible water and spaces to rest and cool down puts this group at risk of potentially fatal hyperthermia and severe dehydration associated with the use of certain drugs popular in party settings, such as MDMA [12].

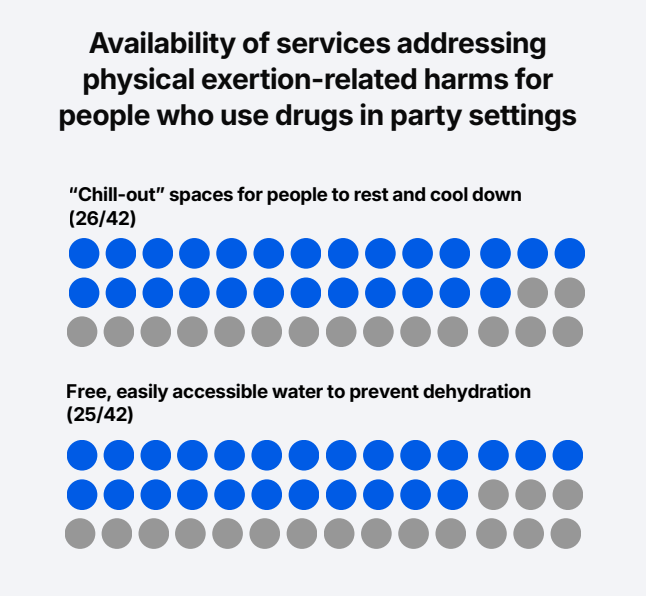

Figure 4: Availability of "chill-out" spaces and free, easily accessible water

Frontline Voice – FP Porto

"Currently, there are no interventions in this [party] context aimed at harm reduction, despite urgent needs on the ground. Financial arguments continue to be used to justify not implementing this type of service."

Recommendation

→ Services addressing physical exertion-related harms should be incorporated for people who use drugs in party settings.

Cumulative harms faced by women who use drugs remain widely unaddressed

Despite women constituting roughly one third of people who use drugs [13], current HR services are frequently ill-equipped to meet their unique needs. While 61.90% of cities reported HR interventions addressing intimate partner violence and abuse, women-specific HR services remain far from universal.

Just over half of focal points report woman-focused programmes and sexual health services, leaving many women who use drugs without tailored support.

HR services in a small number of cities (Bern, Antwerp, Glasgow, Zurich, Paris, Vienna, Barcelona, Dublin and London) offer a comprehensive package for women, including: women-only or women-focused programmes, women-only days or specific hours of operation, sexual health services, services for pregnant and parenting women, and interventions addressing intimate partner violence and abuse. On the other end of the spectrum, Bucharest, Rome, Nicosia, Gdańsk and Valletta reported a complete absence of any women-specific HR services.

This gap is particularly concerning, given the high lifetime prevalence of gender-based violence among women who use drugs [14], including intimate partner violence, and associated social isolation and increased risk of HIV [15].

Recommendation

→ Moving forwards, there is a need for HR services to incorporate women-focused programmes, sexual health services, and interventions addressing intimate partner violence and abuse for a more holistic and integrated approach to promoting well-being.

LGBTQI+-affirming harm reduction services are limited

Compared to heterosexual and cisgender counterparts, the LGBTQI+ population experiences a significantly higher prevalence of substance use [16,17]. **HR services that contribute towards a safe and inclusive environment for LGBTQI+ people who use drugs** – such as gender- and sexual-affirming care, interventions addressing lack of social networks and isolation, and LGBTQI+-exclusive opening times – **are each available in only a minority of cities.**

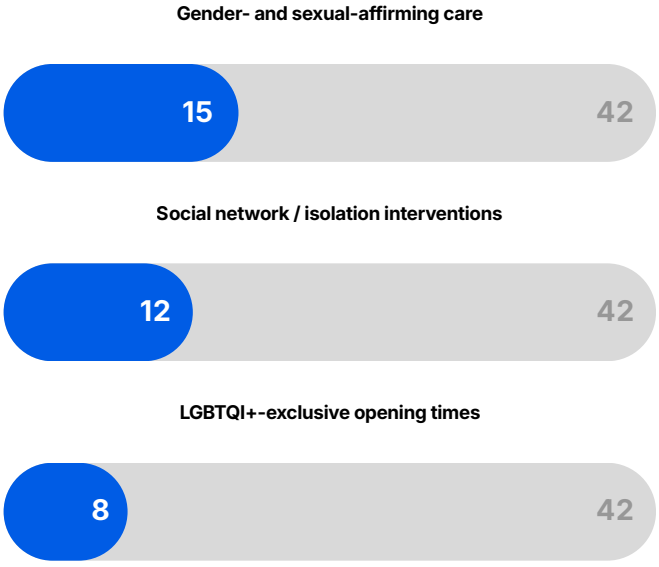

Figure 5: Availability of services aiming to reduce identity-based stigma and discrimination-related barriers to care for LGBTQI+ people who use drugs

Recommendation

→ Since fear of stigma and discrimination due to sexual and/or gender identity often prevents this population from accessing health and social services [18,19], explicitly affirming and community-supporting services must be incorporated to diminish barriers to care.

Age and drug use

Many HR services overlook the needs of young people who use drugs

Age-appropriate messaging for young people who use drugs and HR services addressing issues relevant to this age group are only available in roughly half of cities. Online and app-based counselling, endorsed by some young people who use drugs due to its efficiency, anonymity, and reduced perceptions of stigmatization [22], is available in less than half of cities. Young people trying to access HR services oriented towards adults encounter social and age-related challenges and barriers [21], demonstrating the need for tailored services. This need is urgent, with some European countries experiencing rising numbers of deaths involving stimulants among young people who use drugs [20].

Recommendation

→ Increasing the availability of HR services through age-appropriate, digital means is an important step in reaching this subgroup. Engaging young people who use drugs in designing tailored HR services can help increase the relevance and accessibility of services [23].

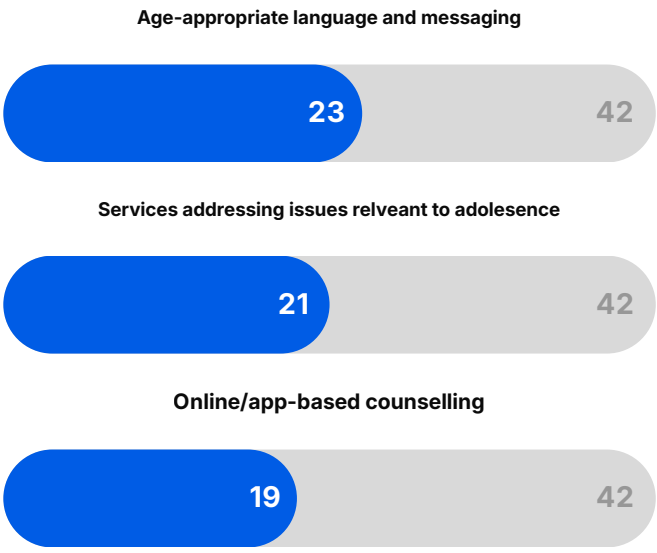

Figure 6: Availability of services tailored to the experiences of young people who use drugs

Few cities address the social challenges of ageing people who use drugs

Few HR services provide services to foster social connection and community among ageing people who use drugs, despite an association between perceived social isolation and loneliness and nonmedical drug use among ageing individuals [25].

With people over the age of 40 comprising a growing proportion of those with opioid use problems in Europe [24], there is a pressing need for tailored services to support this subgroup. Currently, Glasgow, Newport, Munich, Warsaw, Copenhagen, and Dublin are the only cities to provide numerous tailored services, revealing a gap where age-specific harms go unaddressed in many cities.

Figure 7: Availability of services tailored to the experiences of ageing people who use drugs

Recommendation

→ Services such as addressing social isolation and self-esteem, activation programs (including volunteering, courses, cultural and sports activities), and peer/buddy initiatives should be widely implemented.

→ Initiatives addressing medication and drug interaction management, as well as service adaptation for accelerated ageing, frailty and cognitive decline, are additional important aspects of tailored care [26]

Language barriers limit service accessibility for foreign national who use drugs

Multilingual HR materials were available in approximately 60.47% of cities, while HR services available in multiple languages or services that hire translators were available in approximately 55.81% of cities. Cultural mediation, in which a professional facilitates communication between individuals with various linguistic and cultural backgrounds [29], was available in just over one quarter of cities. Travellers, and migrants who have experienced adverse events, are at increased risk of problematic drug use [28,29]. However, language barriers limit access to healthcare for many foreign nationals [27], leaving many vulnerable individuals without essential support.

Recommendation

→ HR services must improve availability of not just multilingual harm reduction materials, but also inclusive and accessible services that foreign nationals can actively engage in through their spoken language.

Harm reduction service integration

When social services, healthcare, and community organizations are uncoordinated and operate separately, the health inequities experienced by people who use drugs persist [30]. Integrated and person-centered care, allowing people to access multiple types of support through connected systems and referrals, is essential for improving well-being.

Cities with most diverse integreation	Cities with most limited integration
• Helsinki • Antwerp • Glasgow • Barcelona • Prague	• Gdańsk • Bucharest • Tallinn

Healthcare integration focuses most on access to drug treatment centres

- Access to inpatient and outpatient drug treatment centers were the most integrated with HR services through case management. Still, this was only reliably offered in roughly half of cities

- Public emergency health care was the least integrated health care service

People who use drugs are at an increased risk of numerous negative medical complications, such as organ damage and contracting infectious diseases [35,36]. Though integrated health care services improve health outcomes [37], many cities still have significant gaps in the integration of HR and health care services. **Except for drug treatment services, cooperation is mostly either nonexistent or existing only exceptionally for nearly all services.** This includes access to public general hospitals and public emergency health care.

Legal and social assistance integration is moderately available

Beyond specialized harm reduction services, focal points were also asked about the availability of mainstream services that people who use drugs could access.

- 33 out of 42 of cities offered legal administrative support, or similar social assistance, to help people who use drugs in handling problems and requests related to public authorities and service providers
- 27 out of 42 cities offered legal advice or representation available at reduced or no cost, specifically for people who use drugs under criminal or court procedures triggered by drug-related crimes

Public social support services cooperation with harm reduction services was reported to exist mostly via linkage to care (64.29% of cities), in which clients are actively connected to other services. It existed to a lower level via case management (42.86% of cities), referring to ongoing, coordinated support involving multiple services and a tailored client plan

Legal and social assistance go hand in hand by addressing the adversities at the root of problematic drug use, rather than solely addressing its symptoms. Integrating legal assistance directly into healthcare settings addresses underlying socioeconomic factors that may be contributing to problematic drug use, resolving social welfare issues and addressing barriers to accessing support [38, 39].

Work and employment services show lower levels of integration

- Only half of cities provided mainstream, short-term – that is, less than one day – work opportunities that could be accessed by people who use drugs

Work and employment services are generally less integrated in HR compared to healthcare services and legal and social assistance. Since a bidirectional relationship exists in which drug use is a risk factor for unemployment and unemployment is a risk factor for drug use [40], these services are particularly relevant for populations who utilize harm reduction.

What is needed for more comprehensive service integration?

Integrating healthcare, work and employment services, and legal and social assistance into HR services is an essential step towards improving the well-being of people who use drugs.

Steps toward successful service integration include continued monitoring of service use among people who use drugs, clear-communication and information-sharing across service providers, and a person-centred approach to support the individual's unique needs [41].

Peer involvement

Peer involvement in HR services promotes health benefits and plays a fundamental role in creating and promoting a person-centered care, facilitating service engagement, integration, and enhancing feelings of comfort and dignity among people who use drugs [31,32]. **However, a minority of cities involve people who use drugs in the governance, design and planning, implementation, and evaluation and monitoring of harm reduction services.**

- The highest rate of frequent peer involvement was in service implementation, at 30.95%, with the lowest being both governance of services and the design and planning of services, both at 26.19%
- Bălţi, Newport, Tbilisi, Podgorica, Warsaw, Barcelona, Skopje frequently involved peers in all aspects of service provision.

In cities with peer involvement, it is divided somewhat evenly between volunteer positions and employed positions, with a slight trend towards volunteering.

In some cities, peer involvement centres those who are absinent

Only favouring the voices of those who are abstinent disregards the valuable insights and experiences of many people who use drugs. Criminalization, discrimination, and stigmatization of drug use prevents those who are actively using drugs from being incorporated in planning policies and programs [42].

Frontline Voice - FP Valletta

"Usually it is people who are now considered 'clean' who are sometimes included as 'peer' workers and involved in other roles."

Frontline Voice – FP London

"Very few harm reduction services [involving peers] exist and many require a level of abstinence in order to be involved in governance/design /implementaiton/monitoring."

What does sustainable peer involvement look like?

Under-supported peer roles in HR services risk significant emotional labour and burnout among peers [32]. While funding for harm reduction services is often limited, providing peer workers with adequate compensation avoids perceptions that their work is devalued compared to non-peer staff, and provides economic support to peers who may be at risk of experiencing poverty and homelessness [33].

Recommendation

→ To ensure that peer involvement is sustainable, HR organizations should work towards providing peers sufficient with emotional support and compensation.

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