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CIVIL SOCIETY MONITORING OF HARM REDUCTION IN EUROPE 2020

EXECUTIVE SUMMARY

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Content

C-EHRN Focal Points

Country	City	Organization
Albania	Tirana	Aksion Plus
Austria	Vienna	Suchthilfe Wien gGmbH
Belgium	Antwerp	vzw Free Clinic
Croatia	Rijeka	NGO for helping people with drug use disorders "Vida"
Cyprus	Nicosia	Cyprus National Addictions Authority
Czech Republic	Prague	SANANIM
Denmark	Copenhagen	Health Team for the Homeless
Estonia	Tallinn	NGO Convictus Estonia
Finland	Helsinki	EHYT Ry/ A-Clinic Foundation
France	Paris	Fédération Addiction
Georgia	Tbilisi	Georgian Harm Reduction Network
Germany	Berlin	Deutsche Aidshilfe
Greece	Athens-Salonika	Positive Voice
Hungary	Budapest	Rights Reporter Foundation
Ireland	Dublin	Ana Liffey Drug Project
Italy	Milan/ Rome	Fondazione LILA Milano Italian League for Fighting AIDS/ Forum Droghe
Lithuania	Vilnius	Coalition "I Can Live"

Country	City	Organization
Luxembourg	Luxembourg	Jugend - an Drogenhëllef
Netherlands	Amsterdam	Mainline Foundation
Norway	Kristiansand	proLAR Nett
Poland	Krakow	MONAR – Krakow
Portugal	Vila Nova de Gaia	Agência Piaget Para o Desenvolvimento
North Macedonia	Skopje	HOPS - Healthy Option Project Skopje
Romania	Bucharest	CARUSEL
Russia	St. Petersburg/ Amsterdam	Charitable Fund "Humanitarian Action"/ AFEW
Scotland	Glasgow	Scottish Drugs Forum
Serbia	Novi Sad	Prevent
Slovakia	Bratislava	Odyseus
Slovenia	Ljubljana	Association Stigma
Spain	Barcelona	Red Cross Catalonia
Sweden	Stockholm	Stockholm Drug Users Union
Switzerland	Bern	Infodrog
Ukraine	Kiev	ICF "AIDS Foundation East-West" (AFEW-Ukraine)
United Kingdom	London	Release

Acronyms and abbreviations

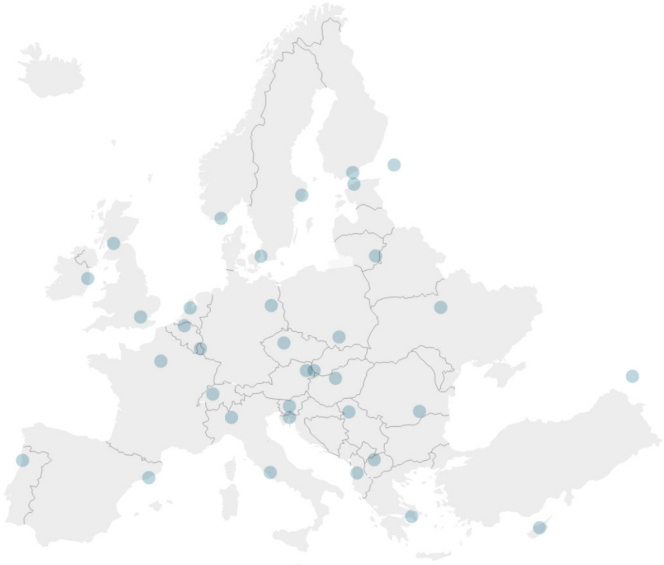
C-EHRN	Correlation – European Harm Reduction Network
COVID-19	Coronavirus Disease
CSO	Civil Society Organisation
DAA	Direct-Acting Antiviral
DCR	Drug Consumption Room
FPs	Focal Points
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
MSM	Men having Sex with Men
NPS	New Psychoactive Substances
NSP	Needle and Syringe Exchange Programme
OD	Drug overdose
OST	Opioid Substitution Therapy
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs

Introduction

A civil society-led monitoring of harm reduction can play an essential role in improving service delivery and contribute to the generation of crucial data for advocacy purposes. Civil society organisations (CSO's) work directly for, and with, people who use drugs (PWUD) and have a good understanding of their daily needs. Their inside knowledge is critical in developing adequate drug policies and practices.

To complement the work of other monitoring agencies, and to bring insight into how the implementation of harm reduction occurs, Correlation -European Harm Reduction Network (C-EHRN) has published a report on *Civil Society Monitoring of Harm Reduction in Europe* since 2019. It gathers data on the experiences of harm reduction service providers and service users at ground level, building on a network of national Focal Points (FPs) in Europe. For the 2020 monitoring, C-EHRN includes 35 FPs in 34 countries, as shown in the map below. To get insight at the implementation level, and to profit from the experiences and expertise of FPs, the 2020 monitoring focuses mostly on cities rather than countries.

Map: Location of C-EHRN Focal Points



Contextualising Harm Reduction in Europe

Europe represents one of the regions of the world with the greatest number of harm reduction services. Almost half of the countries worldwide where Needle and Syringe Exchange Programmes (NSP) and Opioid Substitution Treatment (OST) are available, are in Europe. Besides, ten out of twelve countries with officially sanctioned drug consumption rooms (DCRs) are European. There is no other region in the world where more than ninety percent of the countries have at least one NSP or OST site, and more than ninety percent of the countries reference harm reduction in their national drug policies. Nevertheless, geographic gaps, and an uneven distribution of services, continue to exist in Europe. Rural communities are particularly underserved in many countries, and some sub-groups of people who use drugs experience barriers to service access, including women who use drugs, men who have sex with men (MSM), people who use stimulants or non-injecting methods of drug use, and people experiencing homelessness. Migrants face similar problems in access to harm reduction services in Western Europe. Furthermore, stigma and discrimination against people who use drugs continues to exist and hinders service access in all contexts and in all regions in the world, including Europe.

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Stigma and discrimination against people who use drugs continues to exist.

Participation of Civil Society Organisations in policymaking

A continuous challenge is to identify and monitor if, and how, a meaningful involvement of harm reduction CSOs in policymaking is assured. To contribute to that, C-EHRN monitoring addresses the involvement of CSOs in drug policymaking in the cities and countries of the respective FPs.

Most C-EHRN FPs are directly involved in **cooperation exchange with their governments**, either at the national (80% of FPs) or the local (75% of FPs) Level. The main forms of involvement are either to provide information, or to participate in discussion forums. To a lesser extent, FPs take part in the direct drafting of policies and guidelines. Most are also part of networks and contribute to data reporting in their country.

Nevertheless, while structural cooperation between CSOs and governments exist in the majority of countries, FPs consider that most of it relates to lower levels of cooperation. Over 60% of FPs view civil society involvement as a one-way information flow from the government to CSOs, rather than an interactive, constructive exchange of ideas and views between the two parties. Exchange between government and CSOs aims mostly at informing CSOs of new policy developments and in collecting their input on new developments, trends and problems. In only about 35-40% of the cases, FPs indicated that exchanges aim at discussing policies, developing new strategies and approaches, or improving services. Even when higher levels of cooperation occur, several CSOs feel that their inputs are not taken into practice.

More than half of the **FPs view government** representatives as being easily approachable by CSOs and that civil society can speak openly and frankly, and criticise the government without facing repercussions or budget cuts. Nevertheless, important challenges to civil society involvement are still present. The majority (80%) mentioned challenges related to a perceived lack of transparency from the government and a lack of adequate funding to CSOs, besides a lack of balance regarding the inclusion of perspectives from different stakeholders (such as service providers and communities).

There remains a long path to travel for civil society to be meaningfully involved in drug policies. More efforts are needed to highlight the importance of civil society participation and to guarantee its practical implementation.

Essential harm reduction services

There is an insufficient coverage of harm reduction services available in Europe, especially to some sub-groups of PWUD. In many cities, the existing services are largely focused on, and limited to, people who inject opioids and services targeting them (especially NSP and OST), leaving behind those who do not inject and who use other drugs. Also, women who use drugs, migrants, and incarcerated PWUD lack access to harm reduction in a number of cities/countries of Europe. In addition, in most European cities, harm reduction services lack funding and political support, and need to be better integrated with other parts of the health and social care system.

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Hepatitis C

People who inject drugs (PWID) account for the majority of new cases of hepatitis C virus (HCV) infections in Europe. Nevertheless, HCV testing and treatment for PWID remains insufficient in practice.

HCV guidelines related to PWID seem to be well developed. Almost all FPs reported that their countries have either their own national guidelines that include PWID. In some countries, however, a negative impact of the guidelines is noted. This includes HCV treatment being prescribed only by specialists (9 FPs), or not being possible outside of the specialised healthcare system (7 FPs), and HCV testing not being possible outside of the healthcare system (3 FPs).

New drugs for HCV treatment (**DAA's**) are available in all countries, but there are still a range of perceived restrictions to their access. In 19% (13) of the cities, different restrictions in access to DDA's were reported. Restrictions may be applied to people who are currently using drugs, or DAA's might be available only for those engaged in an OST programme. The majority of C-EHRN focal points reported that DAA's are used in their cities according to the official policy, but there were also four cities where there is a discrepancy between policy and practice. Discrepancies included lack of reimbursement, and lack of access by PWID despite official policy.

A well-functioning **continuum of care**, including low threshold and harm reduction services, is important for accessibility and impact of HCV testing and treatment. It is crucial that the same facilities are able to offer both HCV testing and treatment. Nevertheless, in Europe, this integration of testing and treatment at the same location is rare. There are still big differences within Europe as to where, and how, PWID can undertake a HCV test. Most FPs (85%) reported that in their countries, PWID can have a rapid test for HCV in low threshold settings at harm reduction services. Rapid tests are also quite commonly available in drug treatment (65%) and at infectious disease clinics (62%). PWID can get tested by a general practitioner in about half of the countries (44%). However, rapid testing for PWID at pharmacies has remained very rare. Confirmatory blood testing for HCV RNA is most commonly available for PWID at infectious disease clinics (97%) and gastroenterology clinics (65%) but, compared to last year, their availability seems to have improved at drug treatment clinics (50%; 35% in 2019) and at harm reduction centres (41%; 26% in 2019). PWID are most commonly treated for hepatitis C at infectious disease clinics (90%) and gastroenterology clinics (65%). In 32% of countries, treatment was provided at harm reduction services or community centres.

Positive developments were reported in terms of some programmes investing more attention in HCV **awareness** campaigns, and in testing and treatment at their own location, in relation to 2019.

Overdose prevention

Drug overdose (OD) is a major cause of death in Europe, especially among young people. Despite the need, overdose prevention measures are not always implemented on-the-ground; at least, not to the extent that they are needed.

Twenty-five of the 35 FPs who responded to the survey reported that **OD prevention** is mentioned in at least one **official policy** document in their countries. Most of the time, guidelines are set at the national level, but specific interest groups and associations also have guidelines for OD prevention. Yet, in at least seven countries, OD prevention is not yet featured in any official policy documents. Even when available, FPs pointed out that policies and guidelines should be updated with recent evidence and include: guidelines for low-threshold access to Naloxone; the obligation to provide people suffering from an OD stigma- and punishment-free emergency services; and OD prevention for non-opioids and also address poly-drug use.

Altogether, heroin, fentanyl and other synthetic opioids make up almost half of the **overdoses** FPs have frequently heard about in their cities during 2020. Most of these opiate-related overdoses were linked to heroin, with a very small proportion related to fentanyl. Stimulants such as cocaine, crack cocaine and methamphetamine were mentioned as being involved in frequent overdoses by 20% of FPs. Several overdoses involved the use of multiple substances. The typical characteristics of OD victims were: being in a situation of homelessness; using drugs alone (in a private setting or on the street); engaging in poly-drug use; being recently released from prison, drug treatment, or other health treatment involving drug abstinence; lacking proper nutrition and sleep; not calling for help/emergency services for fear of the police; and not having access to Naloxone.

Naloxone is available in 80% of FP's cities. Yet, in at least 6 cases, the life-saving drug was reported as not available. For those FPs reporting the availability of Naloxone, the drug is mostly available to medical staff at hospitals, ambulances, or medical staff in harm reduction services. In about 60-70% of cases, it is also available to harm reduction staff and directly to PWUD. Only in 40% of cases is it available to family and friends of PWUD. When available in FP cities, Naloxone is mostly found in its injectable form (61%), although intranasal is also available in 50% of the cases. Training is available, both for peer administration (61% of cases) and staff administration (57%). Slightly more than half of respondents mentioned that Naloxone is available for take home (54%) and/or distributed by drug service providers (54%). Nevertheless, only in a few of the FP cities is naloxone reimbursed by health insurance (21%), or available in pharmacies without prescription (18%).

In more than 60% of FP cities, **OD response training** is available, targeting medical staff, harm reduction staff and people who use opioids. In less than a third of cities, OD prevention training also reaches friends and family of PWUD and, in only about 20%, people who use drugs other than opioids. Almost half of the FPs assessed that OD prevention in their cities is comparable to the national situation in their respective country. Also, almost half of the FPs think that their city offers better OD prevention when compared to the national context. This shows that the OD prevention context described by C-EHRN Monitoring is in good part based on the best examples available in a country.

Yet crucial **challenges** exist regarding OD prevention in Europe. **There is a need for** setting, or scaling-up, DCRs and residential DCRs, as well as Take-Home Naloxone programmes. Access to low threshold access to Naloxone for PWUD and people likely to witness an overdose is crucial, besides lowering the threshold of OST programme initiation and continuation. OD prevention for stimulants and poly-drug use needs to be further developed. Finally, stigmatisation and criminalisation of PWUD remains a challenge hindering OD prevention. This shows that, despite the general support for harm reduction in the European region, much needs to be improved in terms of supporting and securing the human rights of PWUD.

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New Drug Trends

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

A small group of FPs (8) have seen the **emergence of a new substance entering the local market** in their cities. These drugs include synthetic cannabinoids, ketamine, Isotonitazene, 2C-B, crack cocaine, and oxycodone. Most of these new drugs are reportedly being used by people in situation to homelessness, or who are suffering from mental health problems.

Two-thirds of respondents mentioned no new developments regarding the **use of known substances for the first time by any of their target groups**. For the one-third reporting new trends, examples included young people sniffing MDMA instead of oral intake; OST injecting (methadone (heptanon), buprenorphine); Oxycodone bought online and injected or snorted; 'bio-drugs' taken orally; crack cocaine by means of smoking; opioids by injection; and chemsex drugs among MSM. Known PWUD using new or different routes of administration may also be a sign of changes in the quality of drugs they use, or may reflect a shift from recreational use to more problematic use.

Only 5 FPs mentioned having witnessed their target group(s) engaged with **new combinations of substances** in the last year. Two FPs mentioned the combined use of ketamine and cocaine. Other combinations mentioned include: cannabis and amphetamines; methadone and amphetamines; and combinations of various fake and real benzodiazepines, as well as the combined use of Lyrica (gabapentin) and opiates.

Also only 5 FPs mentioned having witnessed **changes in the existing target groups for which they provide services**. Examples include: OST users experiencing more problems in everyday life; the MSM chemsex scene is increasing; a decrease in NPS use in favour of increased use of pharmaceutical opioids; immigrants returning home from other EU countries; and immigrants inhaling opioids.

12 FPs **started services last year for new groups of PWUD**. These include: MSM; non-EU immigrants; migrants; students from Asia; young people using non-injectable drugs; PWUD in the chemsex scene; immigrants from countries of the former USSR; homeless populations; gender specific services; people returning from other countries; and people who buy drugs online.

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

While C-EHRN monitoring has contributed to a better understanding of emerging drug trends, at least at the local level, work still needs to be done to make full use of these resources. Continuous attention should be paid to the quality of the data.

COVID-19 and Harm Reduction

Since the beginning of 2020, European countries have experienced an unprecedented public health threat with the emergence of the coronavirus. People who use drugs (PWUD) and harm reduction services were affected by the variety of virus containment strategies, such as border closures, service reductions, and increased police presence. The C-EHRN Monitoring investigated the effects of the COVID-19 pandemic on harm reduction services and on PWUD in FP organisations or cities. Data was collected from May to July 2020, reflecting **the first wave of the pandemic** in most FP cities**.**

For the majority of FPs, **the pandemic has affected** daily harm reduction practices. Most reported a rapid adaptation of services, including an increase in programmes and opening hours, new online services, home delivery services, and a new need for food and water distribution. Some also reported the cessation of drop-in services, and disruption in HIV/HCV services. Three FPs reported closures during the (first wave of the) pandemic, and 5 FPs reported that PWUD could not access services in their city due to lockdowns. No FPs reported limitations in harm reduction supplies from the services that remained open.

While the COVID-19 pandemic has wrought many hardships for PWUD and harm reduction CSOs, it has also provided a unique opportunity for **innovative practices**, as well as a few potential "silver linings". Nearly all FPs endorsed the pandemic as an opportunity to practice innovative harm reduction. Many changes centred around OST, such as increased length of prescriptions and take-home doses; new phone or telemedicine services; or increased interest in, and enrolment onto, OST. Outreach services and access to housing and shelters, and naloxone distribution also ranked highly. Other positive changes include more shelters for people experiencing homelessness; new methylphenidate prescriptions for stimulant use; more attention and funding to outreach work and the supply of sterile syringes; nasal Naloxone training for staff and PWUD; distribution of food and hygiene products; increased volunteering for outreach; and better hygiene and tranquillity in DCRs and drop-in sites due to a lower number of service users.

FPs reported several **difficulties faced by PWUD** in their countries during the pandemic. Social isolation, as well as an increase in mental health problems, was ranked highest by the majority of FPs as problematic in their country. Both may be related to the severity of the COVID-19 outbreak, as well as the degree of lockdown and limitations to services in the region.

From the **PWUD perspective**, accessibility to harm reduction services in their city was partially compromised during the pandemic. OST, housing, online harm reduction, and outreach

work were ranked by PWUD as easiest to access. The majority of PWUD respondents, however, noted a reduction in the types of services available. About half of PWUD also noted an increase in mental health problems. Other ways the COVID-19 pandemic has affected PWUD in their city include: problems with the police; difficulty gathering and meeting to obtain drugs; lack of tourists/lack of money in general; plight of the homeless; and lack of drop-in centres for social contact.

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

> “Harm reduction services are a vital component in a pandemic response in caring for the vulnerable population of PWUD in Europe.

Limitations

C-EHRN Monitoring is still in an early developmental phase; 2020 is only the second year of reporting. Given the nature of this monitoring structure, and the focus of the work of C-EHRN FP organisations, most data in this report cannot claim to be representative of Europe or the countries in which FPs are based. Most FPs work locally, or regionally, and have an in-depth knowledge of how harm reduction plays out on the streets. Respecting this experience was chosen over national representativeness to provide a more nuanced analysis of the implementation of harm reduction at the local level. If, on the one hand, the monitoring loses in its ability to reflect a broader and comparative perspective of the different European nations, it gains in reflecting fundamental qualitative data at the service delivery level that can only be collected by CSOs, and which is lacking in several national/ global reports.

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

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