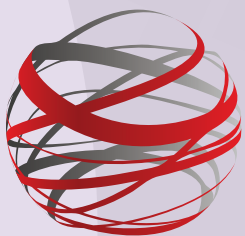
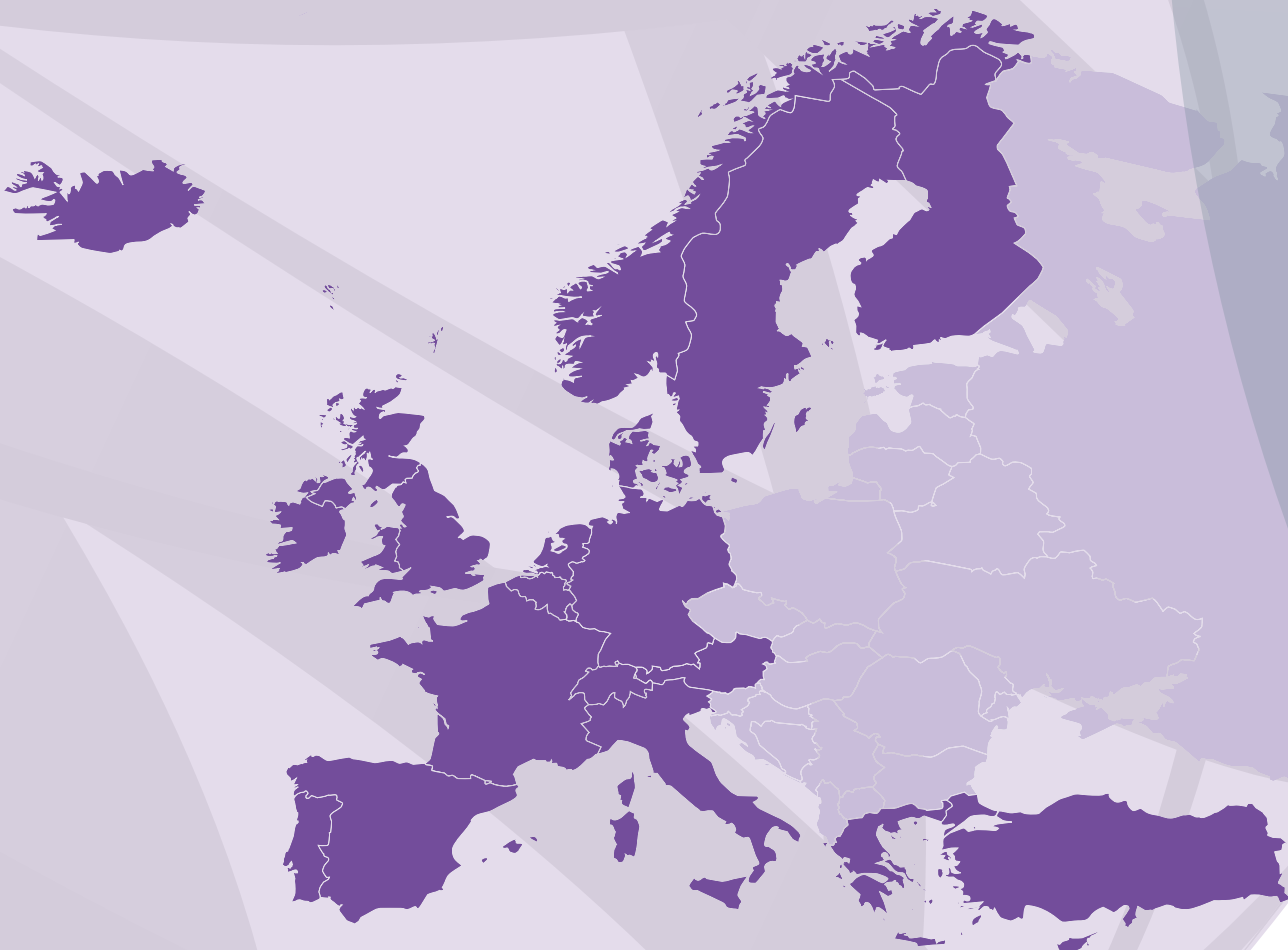


# THE STATE OF HARM REDUCTION IN WESTERN EUROPE 2018



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# The State of Harm Reduction in Western Europe 2018

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Table 1.1: Epidemiology of HIV and viral hepatitis, and harm reduction responses in Western Europe

Country/ territory with reported injecting drug use	People who inject drugs <sup>[1]a</sup>	HIV prevalence among people who inject drugs(%) <sup>[1]a</sup>	Hepatitis C (anti- HCV) prevalence among people who inject drugs(%) <sup>[1]a</sup>	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs(%) <sup>[1]a</sup>	Harm reduction response			
					NSP <sup>b[1]</sup>	OST <sup>c[1,2]</sup>	Peer- distribution of naloxone	DCRs <sup>d</sup>
Andorra	nk	nk	nk	nk	nk	nk	x	x
Austria	12,000- 17,000 <sup>[3]</sup>	4	38	4.4 <sup>e</sup>	✓39	✓(B, M,O)	x	x
Belgium <sup>f</sup>	23,828	10.5	22	5.6	✓116	✓(B, H,M)	x <sup>[4]</sup>	✓1 <sup>g[8]</sup>
Cyprus	126	1.5	43.3	1.5	✓2	✓(B, O) <sup>[9]</sup>	x	x
Denmark	nk	nk	52.5 <sup>h</sup>	nk	✓	✓(B, H,M)	✓ <sup>[10]</sup>	✓5 <sup>[11]</sup>
Finland	15,611 <sup>i</sup>	1.2 <sup>j</sup>	74 <sup>k</sup>	nk	✓53	✓(B, M,O)	x	x
France	108,607 <sup>lm</sup>	4.7 <sup>n</sup>	63.8 <sup>o</sup>	0.81 <sup>p</sup>	✓509	✓(B, M)	x <sup>q[12]</sup>	✓2 <sup>[13]</sup>
Germany	nk	1.6-9.1 <sup>r</sup>	62.6-73 <sup>s</sup>	0.4-1.2 <sup>t</sup>	✓ <sup>u</sup>	✓(B, H,M,O)	x <sup>[15]</sup>	✓24 <sup>[14,15]</sup>
Greece	4,173	5.1	63.5	1.6	✓13	✓(B, M)	x	x
Iceland	nk	nk	45 <sup>[16]</sup>	nk	✓ <sup>[16]</sup>	✓ <sup>[16]</sup>	x	x
Ireland <sup>v</sup>	1,151 <sup>[3]w</sup>	6	41.5	0.5	✓	✓(B, M)	x <sup>[17]</sup>	x
Italy	nk	28.8	56.6	nk	✓66 <sup>[18]</sup>	✓(B, M,O)	✓ <sup>[18]</sup>	x
Liechtenstein	nk	nk	nk	nk	nk	nk	x	x
Luxembourg	1,467 <sup>y</sup>	13.2	nk	nk	✓11	✓(B, M,O)	x	✓1 <sup>[19]</sup>
Malta	688 <sup>[3]z</sup>	1.2	46.3	nk	✓8	✓(B, M) <sup>[20]</sup>	x	x
Monaco	nk	nk	nk	nk	nk	nk	x	x
Netherlands	840 <sup>aa</sup>	3.8 <sup>ab</sup>	57	0 <sup>ac</sup>	✓175	✓(B, H,M,O)	x	✓24 <sup>[21]</sup>
Norway	8,888 <sup>ad</sup>	1.5	nk	0.9 <sup>ae</sup>	✓51	✓(B, M)	✓ <sup>[22]</sup>	✓2 <sup>[22]</sup>
Portugal	13,162	14.3	82.2	2	✓2,099	✓(B, M)	x	x
San Marino	nk	nk	nk	nk	nk	nk	x	x
Spain <sup>af</sup>	11,048 <sup>ag</sup>	31.5	66.5	10.5	✓838	✓(B, M)	✓ <sup>ah[23]</sup>	✓16 <sup>[23]</sup>
Sweden	8,021 <sup>ai</sup>	7.4 <sup>aj</sup>	96.8 <sup>ak</sup>	nk	✓10	✓(B, M) <sup>[24]</sup>	x	x
Switzerland	42,000 <sup>[3]al</sup>	10-12 <sup>[25]</sup>	42.1 <sup>[25]am</sup>	nk	✓	✓(B, H,M,O)	x	✓14 <sup>[26]</sup>
Turkey	12,733 <sup>an[27]</sup>	nk	39.8 <sup>ao</sup>	3.9 <sup>ap</sup>	x	✓(B, M,O)	x	x
United Kingdom	122,894 <sup>aq</sup>	0.9 <sup>ar</sup>	51-58 <sup>[28,29]as</sup>	0.4 <sup>at</sup>	✓606 <sup>au</sup>	✓(B, H,M,O)	✓ <sup>av[31,32]</sup>	x

nk – not known

a Unless otherwise stated, data is from 2016.

b All operational needle and syringe exchange programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = pharmacy availability.

c Opioid substitution therapy (OST), including methadone (M), buprenorphine (B), (H) medical heroin (diamorphine) and any other form (O) such as morphine and codeine. Figures for the number of sites are often not available in Western Europe due to a variety of service providers, which includes general practitioners.

d Drug consumption rooms, also known as supervised injecting sites.

e Based on subnational data from 2016.

f People who inject drugs population estimate refers to lifetime injecting drug use and is based on national data from 2015. Infectious disease prevalence estimates based on subnational data from the Flemish community from 2015.

g One drug consumption room operates in Liège with the approval of local government, though no national legislation permits such facilities.<sup>[5-7]</sup>

h Year of estimate: 2008.

i Year of estimate: 2012.

j Based on subnational data from 2014.

k Year of estimate: 2014.

l Derived from treatment data based on self-reported injecting in the last three months.

m Year of estimate: 2015.

n Year of estimate: 2015.

o Based on subnational data from 2011.

p Based on subnational data from 2011.

q While take-home naloxone is available in France, it can only be acquired with a personal prescription.

r Based on subnational data from 2013-2014.

s Based on subnational data from 2013-2014.

t Based on subnational data from 2013-2014.

u A total of 172 syringe dispensing machines operate in Germany, but the total number of NSPs is unavailable.<sup>[14,15]</sup>

v Year of estimates: 2010.

w Year of estimate: 2015.

x While take-home naloxone is available in Ireland, it can only be acquired with a personal prescription.

y Year of estimate: 2015.

z Year of estimate: 2015.

aa Year of estimate: 2015.

ab Based on subnational data.

ac Based on subnational data.

ad Year of estimate: 2015.

ae Based on subnational data from 2015.

af Year of estimates: 2015.

ag Estimate derived from treatment data and relates to people reporting injecting in past year.

ah In Spain, naloxone peer-distribution programmes only operate in Catalonia, with naloxone available through medical services in six further autonomous communities.

ai Years of estimate: 2008-2011.

aj Based on subnational data from 2013.

ak Based on subnational data from 2013.

al Year of estimate: 2015.

am Year of estimate: 2011.

an Based on a subnational estimate and number of high-risk opioid users, including but not exclusively people who inject drugs.

ao Year of estimate: 2015.

ap Year of estimate: 2015.

aq Years of estimate: 2004-2011.

ar Based on data from England and Wales only.

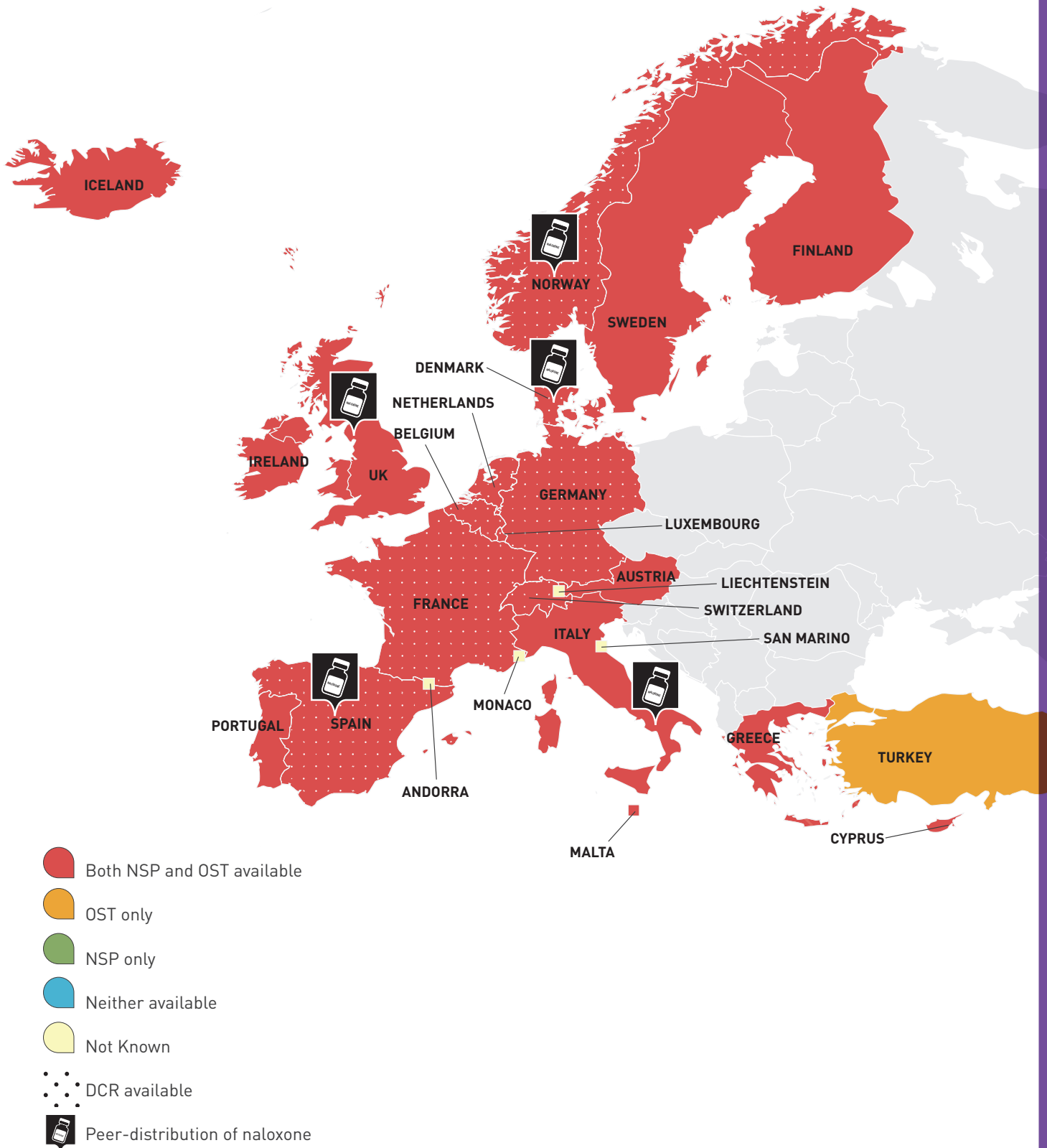
as Hepatitis C prevalence among people who inject drugs is 51% in England, Wales and Northern Ireland, and 58% in Scotland.

at Based on data from England, Northern Ireland and Wales only.

au This figure does not include NSPs in England due to a lack of national data.

av In the United Kingdom, peer-distribution of naloxone is limited to a small number of projects.

Map 1.1: Availability of harm reduction services



# 1. Introduction

Seen with a global perspective, Western Europe has an extensive harm reduction response to illicit drug use, with a wide range of services adapted to the needs of people who inject drugs operating in almost all countries. It is one of few regions in which the availability of basic harm reduction services – such as needle and syringe programmes, and opioid substitution therapy – is the rule and not the exception. It is also home to interventions at the cutting edge of harm reduction, including drug consumption rooms, drug-checking services and housing programmes. However, implementation of these varied harm reduction interventions is uneven, both between and within countries.

This report presents harm reduction interventions in three categories: those addressing opioid use, those addressing use of non-opioid substances and those with relevance to a range of substances. It draws on the findings of the *Global State of Harm Reduction 2018* report, and supplements those findings with original insight on harm reduction in Western Europe, with a special focus on Switzerland. It addresses service provision and coverage, trends in drug use and emerging areas of harm reduction.

Opioid substitution therapy (OST) is available in every country in Western Europe, primarily using methadone, buprenorphine and buprenorphine-naloxone combinations. This makes it one of the most advanced regions in the world in the provision of substitution therapy. However, challenges in the implementation of OST persist. Barriers to enrolment around the region include cost, stigma, discrimination, limitations based on clinical guidelines, geographic concentration of services and, in some cases, the requirement to abstain from illicit drug use. This region leads in the provision of heroin-assisted therapy, with six of the seven countries worldwide being found in Western Europe (Belgium, Denmark, Germany, the Netherlands, Switzerland and the United Kingdom, the exception being Canada).

A significant concern in Europe is overdose deaths, an estimated 84% of which involved opioids in 2016.<sup>[1,32]</sup> Naloxone, an opioid antagonist that can reverse the effects of overdose, is available to medical personnel in most countries in the region. The World Health Organization recommends that naloxone is made available to any person likely to witness an overdose. However, take-home naloxone is only available in eight countries (Denmark, France, Germany, Ireland, Italy, Norway, Spain and the United Kingdom), and peer-distribution networks are only permitted to operate in five (Denmark, Italy, Norway, Spain and the United Kingdom). The recent phenomenon of fentanyl

presence in drug-related deaths in England and Wales makes overdose responses even more vital.<sup>[33]</sup>

The harm reduction response to use of amphetamine-type stimulants, cocaine and its derivatives, and new psychoactive substances is less established than the response to opioid use in the region. However, a range of interventions specifically addressing these substances is emerging. Drug-checking services, both on-site at parties and festivals and at fixed locations, have expanded over recent years, and are now available in at least nine countries (Austria, France, Italy, Luxembourg, the Netherlands, Portugal, Spain, Switzerland and the United Kingdom) to address harms caused by high-purity, adulterated and unknown substances. However, in many countries drug-checking services continue to suffer from a lack of legal and financial support from the state. Beyond drug-checking and low-threshold informational services, the harm reduction response to new psychoactive substances, such as synthetic cannabinoids and synthetic cathinones, remains stunted.

Certain harm reduction interventions are relevant to people using a range of substances, for example those addressing injecting drug use. Needle and syringe programmes (NSPs) are available in every country in Western Europe except Turkey. In this respect, it is one of the regions in the world with the widest availability of this key harm reduction service; however, availability varies between countries. In Spain and the Netherlands, the number of syringes distributed has reduced since 2016, in line with decreases in the population of people who inject drugs in those countries;<sup>[34,35]</sup> while elsewhere in the region (for example in Ireland and Sweden), programmes have been expanded and more syringes have been distributed over the period.<sup>[24,36]</sup> Expansions of existing NSP programmes have also incorporated the increasing use of syringe dispensing machines, now available in at least six countries in the region.

Drug consumption rooms (DCRs) in Western Europe address the harm reduction needs of people who use both stimulants and opioids. They are a key intervention in preventing overdose, higher-risk drug use practices and drug use in public spaces, as well as providing a point of contact between people who use drugs and health and social services. At the time of publication, 88 DCRs exist across eight countries (Belgium, Denmark, France, Germany, the Netherlands, Norway, Spain and Switzerland) in Western Europe, with Belgium opening its first facility in 2018. These constitute 75% of the total number of DCRs around the world, with Australia and Canada

the only countries outside the region hosting officially designated DCRs.<sup>[37]</sup>

Though prevalence and incidence of blood-borne diseases is relatively low in Western Europe, controlling infectious diseases among people who inject drugs remains a primary driver of harm reduction in the region. Despite this, two countries continue to limit access to hepatitis C treatment for people who use drugs (Cyprus and Malta), and three countries restrict access based on stage of liver disease (Belgium, Cyprus and Greece).<sup>[38,39]</sup> The incidence of HIV among people who inject drugs halved between 2007 and 2016, though injecting drug use was still responsible for 5% of new HIV infections in the European Union (EU) in 2016, and 6% of new infections in Switzerland in 2017.<sup>[32,40]</sup> People who inject drugs continue to face formal and informal barriers to testing and treatment for blood-borne diseases. Stigma, self-stigma and criminalisation all contribute to lower testing and access to treatment among people who inject drugs than the general population<sup>[18,41]</sup>, and migrants, women and people in rural areas are reported to face compounded barriers.<sup>[15,42]</sup>













































The policy environment has continued to progress gradually in favour of harm reduction. At least 17 of the 25 countries in the region have policy documents supportive of harm reduction. At the regional level, an independent evaluation of the EU Action Plan on Drugs 2013-2016 found that harm reduction was lagging behind other pillars of the EU Drug Strategy 2013-2020, noting that there was more significant opposition to this element of the strategy from certain member states.<sup>[43]</sup> Following this evaluation, the EU adopted the Action Plan on Drugs 2017-2020.

The new plan includes emphasis on scaling up harm reduction, with reference to OST, NSPs, naloxone peer-distribution, DCRs and drug-checking.<sup>[44]</sup> The Swiss Federal Law on Narcotics and Psychotropic Substances and the National Addiction Strategy 2017-2024 both establish harm reduction as one of four pillars of drug policy.<sup>[45]</sup>

In 2018, the European regional network of civil society organisations working in the field of drugs and harm reduction became the beneficiary of a grant from the European Commission and began to operate under the name Correlation – European Harm Reduction Network.<sup>[8,21]</sup> Correlation works to improve regional collaboration on harm reduction through a network of focal points in each country.<sup>[21]</sup> In November 2018, the European Harm Reduction Conference convened harm reduction practitioners and advocates from across the region in Bucharest, Romania to present the latest research, innovative practices and the latest developments in drug policy.<sup>[21]</sup>

A 2017 report by Harm Reduction International found that certain parts of the European Union are experiencing a funding crisis for harm reduction.<sup>[46]</sup> This crisis is observed to be more serious outside Western Europe; however, concerns were raised in several countries of the region, particularly Greece. Six Western European countries (Belgium, France, Germany, Ireland, the Netherlands and the United Kingdom) were assessed to have high levels of government investment in harm reduction, with governments providing over 90% of funding (see Table 1.1).<sup>[46]</sup>

**Table 1.2:** Harm reduction funding in selected Western European countries at a glance<sup>[46]az</sup>

Country	Harm reduction coverage	Transparency of spending data	Government investment in harm reduction	Civil society view on the sustainability of funding
Greece				
Italy				
Sweden				
Portugal				
Finland				
United Kingdom				
Ireland				
Belgium				
France				
Germany				
The Netherlands				

aw This table uses a traffic light system designed to provide an at-a-glance indication of the health of harm reduction funding, and first appeared in a 2017 report from Harm Reduction International entitled *Harm Reduction Investment in the European Union*.<sup>[46]</sup>



## 2. Harm reduction for opioid use

### 2.1 Opioid substitution therapy (OST)

In the European Union and Norway, there were 636,000 people receiving OST in 2016, corresponding to approximately half of people who are dependent on opioids in these countries.<sup>[32]</sup> This is a small decrease of 1.2% since 2016 and a decrease of 10% since 2010.<sup>[47]</sup> Coverage in most countries has been largely stable over the last two years, with no serious contractions or expansions in access. In Switzerland, approximately 70-80% of people who use opioids are enrolled in OST, representing one of the world's highest levels of coverage.<sup>[26,48]</sup>

Methadone remains the most commonly prescribed medication for OST across Western Europe, and is especially dominant in outreach services, such as those in Portugal.<sup>[41]</sup> A buprenorphine-naloxone combination (sold under the brand name Suboxone) forms a growing proportion of OST prescribed in Germany, Italy and Spain, and is the main substitution medicine in Finland. Buprenorphine-naloxone combinations are sometimes favoured by practitioners because the presence of naloxone dissuades injection,<sup>ax</sup> and therefore reduces the risk of diversion to the illicit market.<sup>[49]</sup> However, the cost to the patient is higher for buprenorphine-naloxone combinations in Spain and it is only available in high-threshold facilities in Portugal.<sup>[23,41]</sup> In Germany and Switzerland, slow-release morphine is also available for OST.<sup>[14,15,26,48,50,51]</sup>

OST programmes are a key element of a harm reduction-oriented policy on drug use. However, in some cases OST is used exclusively as a tool for abstinence-focused interventions. For example, even low-threshold OST programmes in Luxembourg require abstinence from all illicit drugs while undergoing therapy, as do higher-threshold services in Portugal.<sup>[19,41]</sup> Conversely, in a step towards a harm reduction-centred framework, new regulations in Germany (driven by harm reduction organisations and people who use drugs) have changed the official objective of OST from striving for abstinence from all illegal substances to striving for abstinence from heroin only.<sup>[14]</sup> While this is still problematic for people who use drugs, it represents a significant step in the right direction.

In the United Kingdom, civil society organisations report that some OST clients are being forced to reduce their dosage to a sub-optimal level, and can be subject to drug testing.<sup>[30,31]</sup> This appears to be a

result of a lack of funding combined with clinical guidelines and key performance indicators that lack commitment to a harm reduction framework.<sup>[30,31]</sup> A 2018 United Kingdom government report into drug-related deaths indicated that the role of sub-optimal doses of methadone in opioid overdose deaths requires greater attention and research.<sup>[52]</sup>

Certain populations face difficulties when accessing OST, notable among which are migrants, who are reported to experience difficulties in Belgium, and people without health insurance (including undocumented migrants) in Switzerland.<sup>[4,48]</sup> In Italy, new national guidelines on basic medical care introduced in 2017 ensure that OST is officially available to all in the country, including non-citizens and undocumented migrants (though civil society organisations report some access issues for these populations in practice).<sup>[18]</sup>

As is the case with other harm reduction services, access is lower for people living in rural areas. In Germany, people are often forced to travel up to 50km in order to access OST, due to the low number of physicians who apply to be authorised to prescribe substitution medication. A 2017 revision of the legal framework for OST seeks to address this issue by increasing the number of authorised physicians and extending responsibility for OST provision beyond general practitioners.<sup>[14]</sup> In Portugal, low-threshold services offering OST with no requirement for abstinence are available predominantly in major urban centres, meaning people outside those areas have no access to these best practice services.<sup>[41]</sup>

Further barriers to accessing OST in the region include age restrictions, limited opening hours and long waiting lists.<sup>[4,14,31,41]</sup> For example, age thresholds exist in Belgium, Portugal and Switzerland.<sup>[4,26,41]</sup> A 2018 Freedom of Information Act request to the government in Northern Ireland found that the average waiting time for OST in Belfast was 29 weeks.<sup>[53]</sup> In particular, women are reported to face more restrictions than men, including a lack of childcare at OST services, clinical restrictions on OST for pregnant women, hostile and judgemental attitudes from health professionals, and an absence of women-specific services.<sup>[31,41,54]</sup>

ax Naloxone is an opioid antagonist that can reverse the effects of opioid drugs. A buprenorphine-naloxone combination can cause opioid withdrawal when injected or snorted, but not when taken orally (naloxone is poorly absorbed when taken this way).



## Heroin-assisted therapy

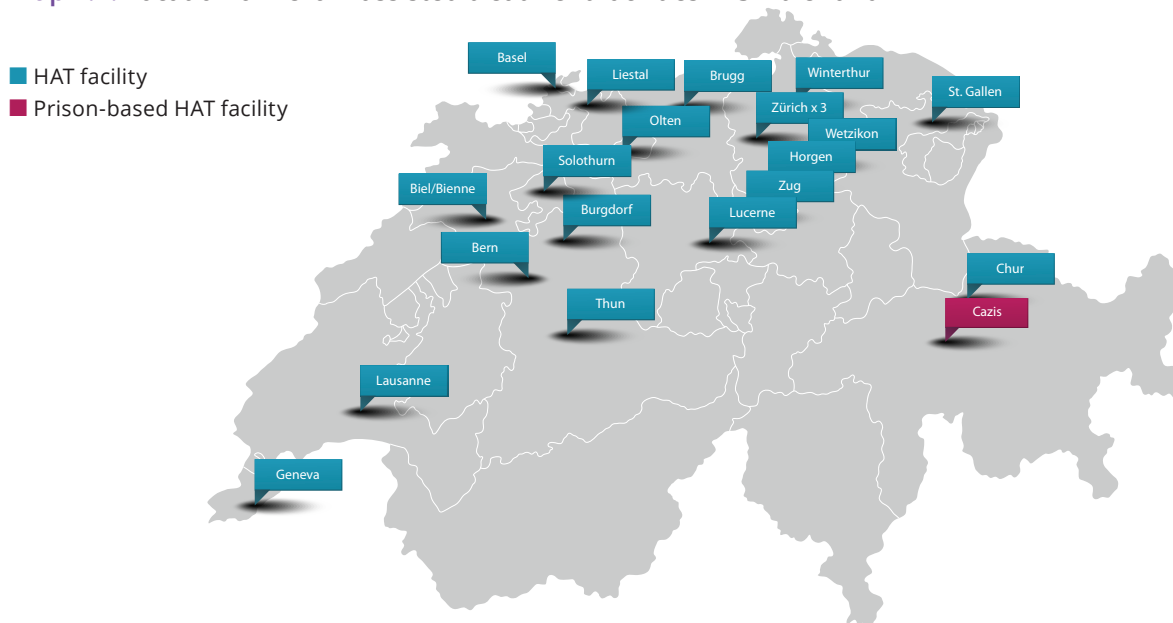
Heroin-assisted therapy (HAT), the prescription of diamorphine (medical heroin) for OST, is available in six countries in the region: Belgium, Denmark, Germany, the Netherlands, Switzerland and the United Kingdom.<sup>[2,14]</sup> A pilot programme using diamorphine also began recently in Luxembourg,<sup>[19]</sup> and in 2018 the Norwegian government announced a diamorphine trial that will begin in 2020.<sup>[55]</sup> The only country outside Europe offering HAT is Canada.<sup>[37]</sup>

Implementation varies by country, but HAT is generally prescribed in limited circumstances. For example in Denmark, prescription of HAT is reserved for people who use opioids for whom other substitution therapies have not been successful.<sup>[2,11]</sup> Studies and trials over the past two decades in Belgium, Canada, Germany, the Netherlands, Spain, Switzerland and the United Kingdom have found that HAT can be highly successful for people who have not found other substitution therapies to be effective.<sup>[2,56]</sup> It produces greater adherence than other forms of OST, reduces street heroin use and criminal involvement, and leads to better health outcomes.<sup>[2,56]</sup> In the United Kingdom, HAT is available, but civil society organisations report that there are fewer prescribing doctors than in 2012, and that services are reluctant to prescribe diamorphine because of the high cost.<sup>[31]</sup>

Notwithstanding the fact that HAT has been available in Switzerland since the mid-1990s, limitations of access mean that HAT only accounts for 9% of people on OST in the country.<sup>[57]</sup> In total, 23 facilities exist that are authorised to distribute diamorphine for substitution purposes.<sup>[58]</sup> Until 2018, only one of these facilities (in Geneva) was in the French-speaking part of Switzerland, with a further facility in the bilingual city of Biel/Bienne. In June 2018, a facility began operating in French-speaking Lausanne; however, HAT remains considerably less accessible in the French-speaking cantons.<sup>[26]</sup> As is the case with drug consumption rooms, no HAT facilities operate in the Italian-speaking region.<sup>[59]</sup> Across Switzerland, HAT facilities operate in only half (13) of the 26 cantons.<sup>ay</sup> As evidenced by Map 2.1, facilities are generally centred around the major cities of Basel, Bern and Zurich

OST is available in 70% of Swiss prisons; however, HAT is available in only one prison, the Realta/Cazis prison in Grisons.<sup>[26]az</sup>

**Map 2.1:** Location of heroin-assisted treatment facilities in Switzerland<sup>ba</sup>



ay These are: Aargau, Basel-Land, Basel-Stadt, Bern, Geneva, Grisons, Lucerne, St Gallen, Schaffhausen, Solothurn, Vaud, Zug and Zurich.

az For more information on harm reduction in prisons, see p.27.

ba Locations are: Brugg, AG; Burgdorf, BE; Horgen, ZH; Liestal, BL; Zug, ZG; Lucerne, LU; Thun, BE; Schaffhausen, SH; Winterthur, ZH; Basel, BS; Bern, BE; Zurich, ZH (x3); St Gallen, SG; Chur, GR; Geneva, GE; Olten, SO; Solothurn, SO; Wetzikon, ZH; Biel/Bienne, BE; Lausanne, VD. The prison is in Cazis, GR.

## 2.2 Opioid overdose<sup>bb</sup>

According to data covering the European Union, Norway and Turkey, approximately 84% of the 9,138 drug-related deaths in the region in 2016 involved opioids.<sup>[1]</sup> Drug-related deaths have steadily declined in some countries (such as Spain, Denmark and Portugal)<sup>[1,23]</sup> and increased in others, with almost two-thirds of drug-related deaths in the region taking place in Germany, Turkey and the United Kingdom.<sup>[32]</sup> High numbers of drug-related deaths have also been observed in Finland, Norway and Sweden.<sup>[1]</sup>

In Germany, there were 1,333 drug-related deaths in 2016, up 40% compared with 2012.<sup>[1]</sup> In the

United Kingdom, the number of drug-related deaths continued to be among the highest on record with 3,756 in 2017, and a 101% rise in deaths related to heroin and morphine between 2012 to 2017.<sup>[30,33]</sup> The situation is particularly grave in Scotland, where 2017 was the fourth consecutive year that drug-related deaths have been the highest on record (934 deaths).<sup>[60]</sup> In 2017, there were five times as many deaths from drug use as from traffic accidents in the country.<sup>[60,61]</sup> According to official statistics, 87% of these deaths involved opioids and 59% involved benzodiazepines; in all but 52 cases, more than one drug was found in the body.<sup>[60]</sup>

### Drug-related deaths in Switzerland

Switzerland has been successful in substantially reducing the number of drug-related deaths (largely attributed to opioids) since 1995. According to data from the Federal Office of Public Health, the overall number of drug-related deaths in the country fell by 64% from 1995 to 2016, from 376 to 136.<sup>[62]</sup> For comparison, the number of drug-related deaths in England and Wales increased by 250% over the same period.<sup>[63]</sup> However, while the fall in the number of deaths since 1995 has been considerable, the trend has stalled and the number of drug-related deaths in Switzerland has been stable since 2010 (see Figure 2.1). Additionally, the decline in drug-related deaths from 1995 to 2016 among women (51%) was less pronounced than the decline among men (68%).<sup>[64,65]</sup> These observations present a public policy challenge to provide overdose prevention services such as OST and naloxone to the most vulnerable populations of people who use drugs.

A further trend seen across Europe, including in Switzerland, is the aging of the opioid-using population, also reflected in drug-related death data.<sup>[32]</sup> While the number of drug-related deaths among people aged 20 to 29 fell between 2012 and 2016 in the European Union, the number of drug-related deaths rose among those in every age group over 30.<sup>[32]</sup> This trend is reflected in Swiss drug-related death data. In 1995, people aged over 40 accounted for 10% of drug-related deaths; in 2016, 73% of drug-related deaths were among people over 40 (see Figure 2.2).<sup>[62]</sup> In 1995, 25 to 29-year-olds made up the largest proportion of drug-related deaths; in 2016, 45 to 49-year-olds are the biggest group (see Figure 2.3).<sup>[62]</sup> Indeed, drug-related deaths among people in their 40s and 50s have increased in number since 1995.<sup>[62]</sup>

<sup>bb</sup> Information on deaths related to non-opioid substances can be found in the sections on amphetamine-type stimulants (p.15) and new psychoactive substances (p.17).

Figure 2.1: Drug-related deaths in Switzerland, 1995-2016



Figure 2.2: Proportion of drug-related deaths in Switzerland by age group, 1995-2016

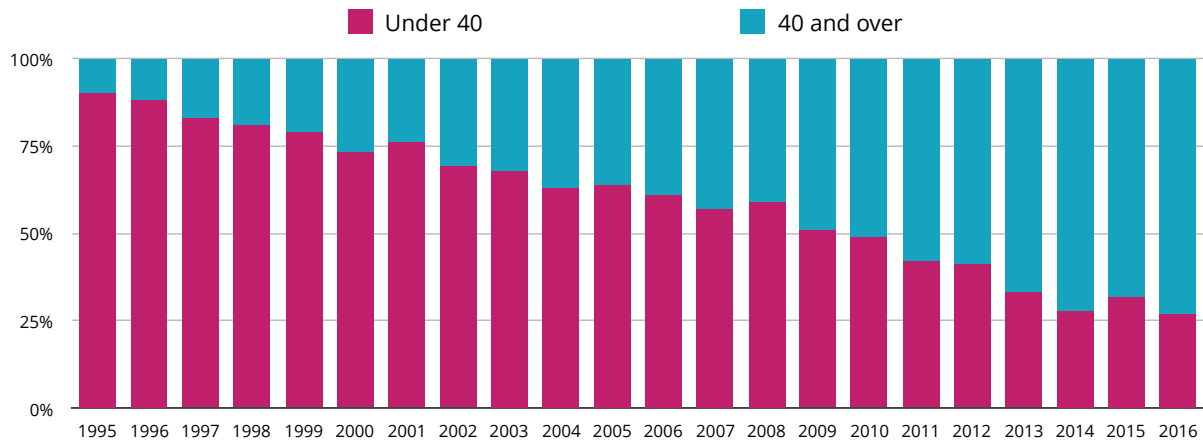
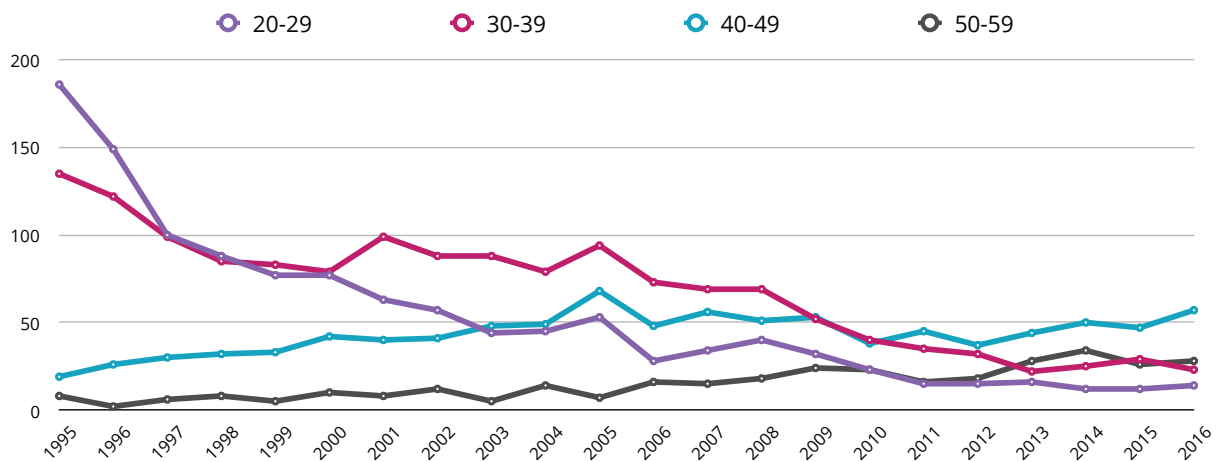


Figure 2.3: Drug-related deaths in Switzerland by age group, 1995-2016



## 2.3 Naloxone

In order to address the current rise in overdose deaths across Western Europe, and to reach those people most vulnerable to overdose, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) recommends a combination prevention approach including naloxone, DCRs, OST and drug-checking services across Western Europe.<sup>[66]</sup> World Health Organization (WHO) guidelines recommend that all people likely to witness an overdose, not only medical professionals but also people who inject drugs, their family and their peers, should have access to naloxone.<sup>[67]</sup> As such, WHO recommends the availability of naloxone outside medical facilities. Evidence from Norway suggests that take-home naloxone distribution programmes are effective in ensuring naloxone reaches these populations and that naloxone is present at a target proportion of witnessed overdoses.<sup>[68]</sup> A 2015 systematic review by EMCDDA found that naloxone training interventions improved knowledge about the signs of overdose, management of overdose patients and naloxone use.<sup>[69]</sup>

A new, more concentrated nasal spray form of naloxone was approved by the European Commission in November 2017.<sup>[32]</sup> These nasal forms have the advantage of reducing injuries and may be perceived as being easier to use.<sup>[71]</sup>

Take-home naloxone is available in eight countries in Western Europe (Denmark, Germany, France, Ireland, Italy, Norway, Spain and the United Kingdom) and plans in are development for take-home naloxone in three more (Austria, Cyprus and Luxembourg).<sup>[9,19,32,70]</sup> Take-home naloxone is not available in Switzerland.<sup>[26,48]</sup>

While take-home naloxone is available in the United Kingdom, research from Release has found that 9% of local authorities in England were not supplying it in 2017, and only 12 naloxone kits were distributed for every 100 people who use opioids in 2016/2017.<sup>[31,72]</sup> Barriers to access in parts of the country include requirements that people who use opioids have a prearranged appointment, are assessed by a naloxone provider or are referred into a service providing naloxone.<sup>[31,72]</sup> Additionally, people under the age of 18 are given access to naloxone on a more limited basis than adults.<sup>[31,73]</sup> Despite these barriers, more than 40,000 naloxone kits have been distributed in Scotland, Northern Ireland and Wales.<sup>[74]</sup> In Wales alone, naloxone is reported to have been used in 1,654 overdoses from 2009 to 2017, saving lives in all but 23 (98.6%) incidents.<sup>[75]</sup>

Facilitating the distribution of naloxone among people who use drugs and their peers is one method of maximising the availability of naloxone at an overdose occurrence. Naloxone peer-distribution programmes currently operate in at least five countries in Western Europe (Denmark, Italy, Norway, Spain and the United Kingdom).<sup>bc</sup>

**Table 2.1:** Selected modes of naloxone distribution in Western Europe

Italy	In Italy, naloxone is an over-the-counter medicine, meaning it can be obtained without prescription from pharmacies. <sup>[66]</sup>
Denmark	In Denmark, over the course of a naloxone peer-distribution pilot project, physicians are permitted by the national health board to delegate their authority to prescribe naloxone to trainers. <sup>[10]</sup>
Germany	In Germany, each dose of naloxone must be prescribed by a physician, who must be present at the training sessions. It remains officially illegal to carry naloxone without prescription. This is not considered to be a peer-distribution scheme. <sup>[77]</sup>
United Kingdom (Scotland)	In the peer-distribution programme in Scotland, naloxone is distributed to training participants without the need for a prescription. National regulations permit anyone working in a drug service to provide take-home naloxone (not only nurses, pharmacists and doctors) and permit family members to access take-home naloxone with the consent of a person deemed at risk of overdose. <sup>[78]</sup>

Peer-distribution programmes for naloxone have existed in Italy since 1991, and people who inject drugs are heavily involved through both training and policy-making.<sup>[18,66]</sup> The national health system in Italy is able to access large amounts of relatively low-cost naloxone by buying in bulk for distribution to healthcare facilities, pharmacies and harm reduction services.<sup>[66]</sup> In Norway and Ireland, take-home naloxone pilots have recently been extended,<sup>[22,36,71,79]</sup> while in

bc In the United Kingdom, this refers to a programme in Glasgow;<sup>[76]</sup> in Norway, this refers to a multi-site pilot programme.<sup>[68]</sup>

Catalonia, Spain over 7,000 people (including people who use or have used drugs, prisoners, families and professionals) have been trained in naloxone delivery and more than 9,500 doses have been distributed.<sup>[23]</sup>

An increase in drug-related deaths has led to the implementation of small-scale naloxone peer-distribution in some German states, where nasal spray naloxone has been approved and is reimbursable by health insurance since September 2018.<sup>[14,15]</sup> In France, nasal spray naloxone, approved in 2017 and initially only given out by emergency services and hospitals during a trial phase, is now also being distributed in all harm reduction services, with those who have undergone OST prioritised due to the higher risk of overdose.<sup>[13]</sup> In Belgium, a recent pilot of naloxone peer-distribution was closed down due to legal issues, with naloxone only permitted for use by medically trained personnel.<sup>[4]</sup>

New, non-injectable formulations (such as nasal spray) may facilitate naloxone use in a wider range of settings, for example by bystanders not used to injecting.<sup>[32]</sup>

## 2.4 A note on fentanyl

While Europe is not yet experiencing the level of fentanyl use seen in North America, its rise as a public health concern and its high risk of overdose adds weight to already strong arguments for increasing the availability of naloxone and DCRs.<sup>[32]</sup> From 2016 to 2017, fentanyl- and fentanyl analogue-related deaths increased by 80% in England and Wales, though the total number of deaths remained relatively small (106).<sup>[33]</sup> An analysis among people in treatment for opioid use across England in 2018 found that approximately 3% of them tested positive for fentanyl.<sup>[80]</sup> Of those who tested positive, 80% were unaware that they had purchased fentanyl.<sup>[80]</sup>

Fentanyl has not been recorded in Swiss drug markets, for example by a study examining needle residue in Vaud.<sup>[81]</sup> However, fentanyl has been seized on entry into Switzerland by post,<sup>[82]</sup> emphasising the need for drug and harm reduction services to remain aware of its potential entry into the Swiss supply.

## 3. Harm reduction for non-opioid substance use

### 3.1 Drug-checking

Drug-checking, also known as pill-testing, is a key harm reduction intervention for use of amphetamine-type stimulants (ATS) and new psychoactive substances (NPS). These services aim to reduce drug related harm by better informing individuals about the drugs they intend to consume, thereby allowing them to make considered choices about their drug use.

Drug-checking services operate in at least nine countries in Western Europe: Austria, France, Italy, Luxembourg, the Netherlands, Portugal, Spain, Switzerland and the United Kingdom. Services operated by civil society organisations have served people who use drugs in Italy for many years, and since 2016 now do so with support from public institutions in some regions.<sup>[18]</sup> In the region of Piedmont, drug-checking has been included as an essential public health service in regional guidelines.<sup>[18]</sup>

Drug-checking in Western Europe is carried out in a number of ways. The most widespread form is on-site and mobile drug-checking services at nightclubs and festivals, such as those operated by The Loop in the United Kingdom, Pipapo in Luxembourg and CheckIn in Portugal.<sup>[31,41,85]</sup> Fixed-site drug-checking services are accessible either by physically attending the facility (such as the Drug Information and Monitoring System, DIMS, in the Netherlands) or by post (as in the case of the Welsh Emerging Drugs and Identification of Novel Substances Project, WEDINOS, in the United Kingdom).<sup>[83,86]</sup>

#### Drug-checking services in Switzerland

In Switzerland, onsite drug-checking services are now operated with local government approval at nightclubs and festivals in Basel, Bern, Zurich and (from 2019) Geneva.<sup>[26]</sup> The service in Zurich, operated by saferparty, is currently the most active, with services offered approximately ten times per year, such as at the Harterei venue and Club X-Tra in late 2018.<sup>[87]</sup> In Bern, Rave It Safe provides on-site checking twice per year.<sup>[88]</sup> Basel-based SaferDance operates drug-checking services up to three times per year in partnership with the Pharmacists Office in Bern.<sup>[89]</sup> The Nuit Blanche? programme operated by the Première Ligne Association in Geneva will begin to offer drug-checking services in 2019.<sup>[90]</sup> This will be the first and only drug-checking service operating in the French-speaking part of Switzerland.

In Bern (Rave It Safe) and Zurich (saferparty), walk-in services are offered on a weekly and twice-weekly basis respectively.<sup>[91]</sup> Each testing occasion is accompanied by a compulsory counselling session and data collection through an optional questionnaire.<sup>[91]</sup> At both centres, test results are communicated in person, by phone or by email several days later.<sup>[91,92]</sup> Both facilities also suffer from a lack of capacity which limits their ability to respond to need: the saferparty service in Zurich is limited to testing a maximum of 25 samples on Tuesdays or 15 samples on Fridays.<sup>[92]</sup> Both centres report that after several years, people who access the services are now better informed about the risks of drug consumption and harm reduction strategies than they were when the services began operating.<sup>[91]</sup>

Drug-checking services offer harm reduction for both high-purity and highly adulterated substances, though the former category appears to be more prevalent in Western Europe. For example, DIMS has found that the average dose per MDMA pill has increased 27% from 123mg in 2012 to 156mg in 2016.<sup>[93]</sup> The strongest pill checked by DIMS in 2016 contained 266mg of MDMA, more than twice the maximum dose recommended by harm reduction organisations.<sup>[93]</sup> In one year from 2015-2016, the average MDMA content of samples checked in Zurich rose by 27% from 120mg to 152mg.<sup>[94]</sup> DIMS has found that common adulterants include substances such as PMMA, which can cause an overdose at lower doses than MDMA.<sup>[93]</sup>

A key function of drug-checking projects, in addition to the direct harm reduction service provided to people who use drugs, is to contribute to national monitoring and early warning systems. For example, the primary objective of DIMS in the Netherlands is to monitor new and existing drug markets and to issue warnings when a particularly dangerous substance is identified in the drug market.<sup>[95]</sup> The various drug-checking and harm reduction organisations in Switzerland also share data to disseminate warnings when high dosages are detected, including in areas where no drug-checking services are available (for example by Danno.ch in Ticino).<sup>[59,91,96,97]</sup> However, it should be noted that no centralised database for monitoring purposes or formalised early warning system exists in Switzerland.<sup>[26]</sup>

Legal and regulatory issues related to the handling of illegal substances continue to be a barrier to drug-checking services. For example, the Danish national health board has declined to permit drug-testing services, pending evidence from the United Kingdom



and the Netherlands.<sup>[98]</sup> Though legislation allowing for drug-checking exists in Portugal, services are restricted to on-site testing and samples cannot be removed to a laboratory for further checks.<sup>[41]</sup> The geographically isolated nature of some festivals with heavy ATS and NPS use in Portugal has also been identified as a barrier to harm reduction responses.<sup>[41]</sup> A lack of state funding for drug-checking has also been highlighted as a major barrier to carrying out these projects, for example in Italy and Portugal.<sup>[18,41]</sup>

### 3.2 Amphetamine-type stimulants (ATS)

Use of amphetamine-type stimulants (ATS) in Western Europe has stabilised over the last two years following a decline since the early 2000s.<sup>[32]</sup> However, consumption varies considerably between countries in the region. For example, last-year prevalence of MDMA use among 15 to 34-year-olds ranged from 0.2% in Portugal to 7.4% in the Netherlands.<sup>[32]</sup> Evidence from across Europe suggests ATS are primarily used by young people (with a mean age of 23) in party contexts.<sup>[18,99]</sup> In Switzerland, 36,000 people are estimated to have used MDMA in the past year, and 27,000 are estimated to have used amphetamines.<sup>[26,100]</sup> Civil society organisations indicate this is likely to be an underestimate due to a reluctance to admit to socially sanctioned behaviour.<sup>[26]</sup>

In addition to drug-checking services, other harm reduction interventions exist in Western Europe to address ATS use, particularly in those party contexts where ATS use is most prevalent in the region. Informational projects run by civil society organisations or groups of people who use drugs operate in several countries to ensure people who use drugs are aware of the potential risks and best practices.<sup>[4,14,31]</sup> Ensuring that water and calm spaces are accessible at parties and festivals forms part of the harm reduction response in the Netherlands, Switzerland and elsewhere.<sup>[21]</sup> To reduce the harm caused by nasal consumption of MDMA and cocaine, organisations in Italy provide 'safer sniffing kits'. These include paper straws to prevent nasal damage, chewing gum and sweets to prevent excessive teeth-grinding, and water and fruit juice to prevent dehydration.<sup>[18]</sup>

Though routine data collection in Western Europe often does not differentiate between amphetamine and methamphetamine use, there is some evidence that methamphetamine use has increased over recent years in some populations in the region.<sup>[32]</sup>

Other harm reduction interventions for people who

use stimulants outside party contexts have been documented by a recent report by Mainline, an Amsterdam-based harm reduction organisation. These include safer smoking kits, primarily focused on crack cocaine use but also relevant to people who smoke methamphetamine; online informational and advisory services; therapeutic interventions; housing programmes (see p.21); and substitution therapies using both natural (for example cannabis, khat and coca leaves) and synthetic (such as modafinil and methylphenidate) agents.<sup>[101]</sup>

While definitive evidence suggesting safer smoking kit distribution programmes reduce disease transmission is not yet available,<sup>[102,103]</sup> a body of evidence from Canada and Mexico has found such programmes to be effective in reducing injection (associated with a higher risk of blood-borne disease transmission),<sup>[104-106]</sup> reducing the use of unsafe or shared equipment,<sup>[107,108]</sup> and preventing the incidence of burns and other pipe-related injuries to the mouth and gums.<sup>[102,109,110]</sup> These programmes are relevant to populations using both methamphetamines and cocaine derivatives.

DCRs (see p.19) and NSPs (see p.18) are also highly relevant harm reduction interventions for people who use ATS. DCRs in Germany and Switzerland, and in Catalonia, Spain specifically serve people who inhale drugs such as methamphetamines.<sup>[15,23,51]</sup> However, civil society organisations in Portugal and the United Kingdom report that an emphasis in harm reduction facilities on people who use opioids can discourage people who inject ATS from accessing them, indicating the need for tailored harm reduction services for people who use ATS.<sup>[31,41]</sup>



## Chemsex and harm reduction

Civil society organisations in both the United Kingdom and the Netherlands report that there has been a rise in the prevalence of methamphetamine and new psychoactive substance use among men who have sex with men, sometimes associated with use in sexual contexts.<sup>[30,111,112]</sup> While there is a relative dearth of data on this phenomenon (known as 'chemsex') and the extent of these practices may be overstated,<sup>[31,113,114]</sup> a sharp rise was observed in men who have sex with men accessing health services for issues related to methamphetamine, GHB and mephedrone from 2005-2012.<sup>[30,111]</sup> From the available data, it is impossible to determine if this is related to drug use in sexual contexts or other factors.<sup>[115]</sup>

Nevertheless, this population is found to have a distinct drug use profile from other people who inject drugs, has been more likely to inject mephedrone or ketamine (used to sustain, enhance, disinhibit or facilitate sex) and has also been observed to be more likely to share syringes.<sup>[28]</sup> In the United Kingdom, there is a clear demand from patients in sexual health clinics for harm reduction measures associated with the use of these substances, which may include NSPs and other services adapted to the needs of this population.<sup>[116]</sup> For example, the Dean Street Clinic in London offers a NSP together with informal counselling and advice specifically tailored to men who have sex with men who use drugs in sexual contexts.<sup>[31,117]</sup>

In Switzerland, the Swiss HIV Cohort Study has since 2007 asked participants about recreational drug use. Among men who have sex with men living with HIV, use of both methamphetamines and GHB/GBL (both associated with use in sexual contexts) is noted to have increased considerably from 2007 to 2017: GHB/GBL use has increased by almost 200% (from 1% to 2.9%) and methamphetamine use has increased by 900% (from 0.2% to 2%). Use of both drugs was also observed to be associated with increased hepatitis C coinfection and incidence of depression. This evidence demonstrates a need for harm reduction programmes tailored to men who have sex with men, as well as training for health care professionals in addressing drug use in sexual contexts.<sup>[118]</sup>

Chem-Safe, a website operated from Spain by Energy Control since 2017, aims to provide online harm reduction information to men who have sex with men who use drugs in sexual contexts.<sup>[101,119]</sup> The anonymity and confidentiality provided by an online platform is considered particularly important, given the sensitive nature of the information and service users who may be stigmatised because of their sexual orientation, HIV status or drug use.<sup>[101]</sup> Despite early successes in accessing this population, Chem-Safe currently has no ongoing financial support and relies on the uncompensated work of the project's coordinator.<sup>[101]</sup>

### 3.3 Cocaine and its derivatives

Cocaine remains the most commonly used illicit stimulant in Western Europe.<sup>[32]</sup> There appear to be marked differences in consumption patterns and behaviours between different populations of people who use cocaine in the region, particularly between those who use powder cocaine and those who use crack cocaine.<sup>[18,32]</sup> Most datasets in the region do not distinguish between crack and powder cocaine use, making the observation of trends in use of each form challenging.<sup>[32]</sup>

In a representative survey conducted in Switzerland in 2016, 4.2% of respondents said they had used cocaine at least once in their lives, compared with 3% in 2011.<sup>[100]</sup> However, the proportion who had used cocaine in the preceding 12 months was lower (0.7%)

and in the last 30 days lower still (0.1%).<sup>[100]</sup> Notably, last-year prevalence of cocaine use among people aged 20 to 24 is considerably higher at 2.2%.<sup>[100]</sup> Accordingly, Switzerland is home to approximately 50,200 people who have used cocaine in the last year. In addition, waste water analysis in 2017 indicated a sharp increase in cocaine residues in almost all Swiss cities, a conclusion consistent with data collected at nightclubs and seizures by police.<sup>[26]</sup> This may indicate increased use, or may be a reflection of the increased purity of cocaine in Switzerland.

A study of syringe residue in Lausanne, Switzerland found that between 64% and 70% of syringes tested had been used for cocaine injection.<sup>[120]bd</sup> The presence of a significant population of people injecting cocaine indicates a need for needle and syringe services (and drug consumption rooms) to be sensitive to the needs

bd The study collected one syringe per person injecting drugs; as such, the high prevalence of cocaine in syringe residue cannot be attributed to higher frequency of injection observed among cocaine users.

of people who use stimulants as well as to those who inject opioids. Another notable finding from the study was the 23-32% of syringes that contained evidence of both cocaine and heroin, indicating prevalent poly-drug use.<sup>[120]</sup>

Beyond injection, harm reduction for cocaine use varies considerably according to differing patterns of use. For people who use powder cocaine recreationally, drug-checking services (see p.14) can have a significant impact in identifying high-purity and dangerously adulterated samples. Purity of cocaine has increased significantly in samples checked in Zurich, Switzerland, with the average cocaine content rising from 41.7% in 2009 to 76.7% in 2016.<sup>[121]</sup> An increase in purity has also been observed in the Netherlands.<sup>[112]</sup> Drug-checking is also relevant to harm reduction for injected cocaine use: a study of used syringes in Lausanne found that 70-73% of syringes used for cocaine also contained traces of caffeine, 48-70% phenacetine, 53-64% levamisole and 14-32% lidocaine.<sup>[120]</sup>

Harm reduction for inhaled crack use appears to be mostly absent from Western Europe, though innovations providing sterile inhalation equipment to prevent the spread of infectious diseases are being implemented in Ireland, in development in Spain and in demand in Portugal.<sup>[23,41,122,123]</sup> These programmes, relevant to both crack and methamphetamine use, have been found to be effective in reducing high-risk practices (see p.15). Portuguese civil society organisation GIRUGaia operates a harm reduction outreach programme in Porto providing clients, 90% of whom use crack, with legal support and assistance in attending court appointments.<sup>[41]</sup> The harm reduction response to crack use in Western Europe is significantly smaller than the response to opioid use, in part because of lower prevalence. The European Monitoring Centre for Drugs and Drug Addiction has highlighted the need for more research to establish best practices in harm reduction in this area.<sup>[124]</sup>

### 3.4 New psychoactive substances (NPS)

As with ATS, prevalence of new psychoactive substance (NPS) use varies by country and substance. However, data on NPS use is considerably more limited. Synthetic cannabinoids, such as the substance often known as spice, are the most prevalent category of NPS in Western Europe, with high prevalence reported

in France, Germany, Spain, Sweden and the United Kingdom.<sup>[125]</sup> The potential harms from synthetic cannabinoids vary considerably with the strength of particular strains. These can include severe seizures, psychosis and heart attacks, and there have been several outbreaks of fatal poisoning, including in Manchester, United Kingdom in 2018.<sup>[125]</sup> The harm reduction response to synthetic cannabinoids in Western Europe appears to be limited to providing information of the potential risks of use, such as that provided by Release in the United Kingdom.<sup>[126]</sup>

NPS are also present in party contexts. In the Netherlands, almost one quarter of young adults in the nightlife scene have used 4-FA, a stimulant associated with around 8% of drug-related health incidents in the country.<sup>be[112]</sup> In Italy, 3.5% of 15 to 19-year-olds have ever used an NPS, mostly hallucinogens such as DMT at psychedelic trance parties.<sup>[18]</sup> This figure increases to 11.9% when including synthetic cannabinoids.<sup>[18]</sup> Across the region, a significant barrier to data collection and harm reduction for NPS is that use is often unintentional or people do not know what they are taking.<sup>[18,23,26,41]</sup> For example, the Be Aware On Night Pleasure Safety (BAONPS) drug-checking project has found that one third of NPS samples collected in Italy do not contain what was expected.<sup>[18]</sup> This has been found to be a particular issue with online purchases.<sup>[18]</sup> For this reason, drug-checking services offer an opportunity to people who use these substances to ensure they are aware of their contents and the potential harms they may cause.

Very little data is available on NPS use in Switzerland. According to a representative survey undertaken by Addiction Suisse, NPS are primarily used by young people.<sup>[100]</sup> The survey found that among people aged 20 to 24, 3% report having used a drug other than cannabis, heroin and cocaine in the preceding 12 months.<sup>[100]</sup> Other notable findings include the near complete absence of spice (with the highest last-year prevalence found among people aged 35-44 of 0.1%).<sup>[100]</sup> GHB/GBL was found to be a more commonly used NPS, with 0.8% last-year prevalence among people aged 20 to 24. From the available data, it is not possible to determine the contexts in which people are using the substance; however, data from elsewhere indicates higher prevalence among men who have sex with men (2% in 2017; see p.16).<sup>[100,118]</sup> Drug-checking is the primary harm reduction response to NPS in Switzerland.

be There were 456 health incidents related to 4-FA in 2016, two of which were fatal.<sup>[112]</sup>

## 4. Cross-cutting harm reduction interventions

### 4.1 Needle and syringe programmes (NSPs)

Since 2014, NSPs have operated in every country in Western Europe except Turkey (with no data on Andorra, Liechtenstein, Monaco and San Marino). Across the region, these services take the form of pharmacy- and drug service-based needle programmes and exchanges, outreach programmes and syringe dispensing machines.

Austria, Belgium, Finland, Ireland, Luxembourg, Portugal and Sweden have all seen increases in the number of syringes distributed over recent years.<sup>[24,36,70,127-130]</sup> In Sweden, low-threshold NSPs now operate in eight council areas, compared with three in 2015, and changes in legislation effective from March 2017 have facilitated the establishment of new NSPs.<sup>[24]</sup> In Luxembourg, a new mobile outreach service was launched in November 2017.<sup>[129]</sup> In Ireland, NSPs operate through fixed-site facilities, outreach services and pharmacies, where packs are distributed containing injecting equipment for between three and ten injections, with an average of 1,614 people using the services per month.<sup>[36]</sup>

While increased coverage should be celebrated, it must also be acknowledged that there remain populations not reached by NSPs. For instance, though there has been an increase in the number of NSPs operating in the Flemish areas of Belgium (and from 2014 to 2016 the total number of syringes distributed annually increased to 1.1 million), 80% of people who inject drugs in the country claim to know other people who use drugs who do not use NSPs.<sup>[127]</sup> This is a clear indication that, despite successes in increasing coverage, more outreach work is necessary to ensure that all people who inject drugs have access to sterile injecting equipment.

Similarly in Switzerland, where coverage of NSPs has remained stable over recent years and the availability of sterile injecting equipment is reportedly high, a 2015 study estimated that 24% of active people who inject drugs did not engage with needle and syringe programmes.<sup>[26,131]</sup>

In other countries in the region, distribution of needles and syringes has decreased over recent years. In some cases, such as in Spain and the Netherlands, this is the continuation of a long-term trend attributed to a reduction in heroin use and injection in general, as well as the success of harm reduction programmes.<sup>[34,35]</sup>

In other cases, such as Italy and the United Kingdom,

a lack of funding has limited the expansion or continuation of NSP services. Due to budget cuts in Italy, the number of harm reduction services offering NSPs fell from 106 in 2012 to 66 in 2015, a negative trend that civil society organisations expect will continue unless the new national minimum guidelines for health services, Livelli Essenziali di Assistenza, are implemented properly.<sup>[18,132]</sup> A survey of people who inject drugs in the United Kingdom found that only 46% indicated that service provision was adequate in 2016.<sup>[28,30]</sup> Civil society organisations in the United Kingdom report that there has been no government effort to expand coverage to address this deficiency.<sup>[30,133]</sup>

### Syringe dispensing machines

A growing and innovative means of distributing sterile syringes is syringe dispensing machines. These facilities, which function like vending machines to dispense syringes for free or at a nominal cost, are demonstrated to be effective in enabling harder-to-reach populations to access sterile injecting equipment.<sup>[134]</sup> This is related to the greater anonymity and confidentiality offered by an automated system, which can make them more accessible and acceptable to stigmatised or otherwise marginalised groups.<sup>[134]</sup> As such, syringe dispensing machines may increase coverage even where coverage of needle and syringe programmes is already high.

Syringe dispensing machines are now available in at least seven countries in Western Europe: Cyprus, Denmark, France, Germany, Luxembourg, Switzerland and the United Kingdom.<sup>[9,11,15,26,129,135,136]</sup>

The German state of North Rhine-Westphalia is a leader in this area, with over 100 syringe dispensing machines operating in the region, with a particularly beneficial impact on facilitating access to sterile injecting equipment for people who use drugs in rural areas.<sup>[15]</sup> In Paris, France, a 12-year study found that syringe dispensing machines are effective in distributing sterile equipment and collecting used needles and syringes.<sup>[136]</sup> In the United Kingdom, the first syringe dispensing machine was installed in 2018, following 2014 national guidelines that highlight the unique ability of these facilities to reach younger and more at-risk people who inject drugs.<sup>[135,137]</sup>

In several Western European countries, particularly those with highly decentralised political and health systems, access to NSPs is geographically uneven. For example, 30% of Italian regions (six out of 20) have no NSPs, with southern regions less likely to host NSPs.<sup>[132]</sup> However, civil society organisations expect this to improve over the coming years with the implementation of the new Livelli Essenziali di Assistenza.<sup>[18]</sup> Coverage is reportedly decreasing in southern Portugal even while it increases elsewhere in the country.<sup>[18,41,132]</sup> There are no NSPs in the German-speaking part of Belgium.<sup>[127]</sup> In Austria, Greece and Spain, people who use drugs living in rural areas have difficulty accessing harm reduction services that are primarily located in provincial capitals and other large cities.<sup>[23,70,138]</sup> In Switzerland, NSPs in the Italian-speaking canton of Ticino are largely limited to hospitals and emergency rooms.<sup>[59]</sup>

A further concern is whether current NSPs are meeting the needs of all groups of people who inject drugs. Among people who inject opioids in the United Kingdom, the perception that OST is recovery-focused reportedly leads to people being reluctant to access NSPs where they are integrated with OST clinics.<sup>[31]</sup> This is exacerbated where the same personnel are responsible for recovery-oriented OST and needle and syringe provision.<sup>[31]</sup> In a positive step towards meeting the needs of people who inject opioids, a 2015 Health Service Executive Ireland review recommended that the contents of injection packs be improved by including a wider range of paraphernalia, such as sterile spoons, filters and foil.<sup>[36,123]</sup>

Additionally, it is unclear to what extent NSPs are able to meet the needs of people who inject drugs other than opioids. Civil society organisations in Portugal report a perception that NSPs are focused on people who inject opioids, and are not an appropriate point of contact for people using other drugs.<sup>[41]</sup> In Portugal and the United Kingdom, a growing proportion of people who inject drugs inject performance- and image-enhancing drugs, but civil society organisations report that services are not sufficiently sensitive to their specific requirements.<sup>[31,41]</sup> Similarly, men who have sex with men are forming an increasing proportion of people who inject drugs (from 4.4% in the United Kingdom in 2006 to 7.9% in 2016), and have a distinct profile from other people who inject drugs; for example, being more likely to inject methamphetamines and ketamine, and more likely to share syringes (for more information on drug use among men who have sex with men, see p.16).<sup>[28]</sup>

Some efforts have been made to create services

for specific groups of people who inject drugs; for example, a harm reduction facility operated by Caritas in Malta provides a NSP exclusively serving women who inject drugs.<sup>[20]</sup> Similarly, facilities in London, United Kingdom exist serving men who have sex with men (see p.16).

## 4.2 Drug consumption rooms (DCRs)

Eight countries in Western Europe (Belgium, Denmark, France, Germany, the Netherlands, Norway, Spain and Switzerland) now host a total of 89 DCRs. Belgium is the latest addition to this group, with the country's first DCR opening in September 2018. Since 2016, new facilities have also opened in France, Spain, Switzerland and Norway.<sup>[37]</sup> The City of Lisbon is preparing to open Portugal's first three DCRs in 2019: one mobile facility and two fixed-site DCRs.<sup>[8,41]</sup> Plans and legislation also exist for facilities in Dublin, Ireland<sup>[139]</sup> and Reykjavik, Iceland,<sup>[210]</sup> and for a second drug consumption room in Luxembourg.<sup>[19]</sup>

Despite a considerable volume of evidence demonstrating the health and social benefits of DCRs, they remain a politically controversial policy in many Western European countries. The Irish drug consumption room was originally due to open in late 2017, but was delayed due to objections from local business owners.<sup>[139,140]</sup> In Scotland, civil society organisations, harm reduction service providers and people who use drugs succeeded in winning the support of the Scottish Parliament for the establishment of a DCR in Glasgow in 2018, in response to the high number of drug-related deaths, high HIV prevalence among people who inject drugs, and concern over public injecting and publicly discarded injecting equipment in the city. However, the Scottish government's proposal for a DCR was blocked by the United Kingdom government.<sup>[30,31,141]</sup> In Belgium, the newly established drug consumption room in Liège has operated since September 2018 with the support of local officials, but is not officially sanctioned at national level.<sup>[5-8]</sup>

In 2016, 1,717 people used DCRs in Luxembourg,<sup>[129]</sup> 3,110 people used Spanish DCRs<sup>[35]</sup> and 7,155 people used Danish DCRs.<sup>[11]</sup> Frankfurt's four DCRs oversee 200,000 injections annually<sup>[15]</sup> and the Oslo DCR in Norway has supervised more than 300,000 injections since opening.<sup>[22]</sup> Even with this large volume of use, there have been no reported deaths in any of the DCRs in Western Europe.

Western European DCRs are increasingly adapting to the needs of people who use drugs. For example,



two mobile DCRs operate in Berlin, Germany in order to access harder-to-reach populations.<sup>[14,142]</sup> In Luxembourg and Switzerland, all DCRs permit the consumption of drugs through inhalation as well as injection,<sup>[51,129]</sup> and three rooms specifically for inhalation exist in Spain.<sup>bf[23]</sup> This enables not only people who inject drugs, but also people who smoke cocaine, heroin and methamphetamines to benefit from the enhanced safety and supervision in DCRs. In the Netherlands, DCRs mainly target people who smoke their substances (in line with the breakdown of drug use in the country and harm reduction information promoting smoking over injecting).<sup>[101]</sup> All 24 DCRs in the country permit smoking, 19 permit injection and 13 permit sniffing, though most separate different means of administration into different rooms.<sup>[143]</sup>

DCRs in the Netherlands are also notable for offering integrated personal and social services to clients, as well as providing safer equipment and a safer environment for drug use. Dutch DCRs, such as the Princehof facility in Amsterdam, provide clients with access to social workers, support with administrative issues, referrals to mental and physical healthcare, and housing and employment advice.<sup>[101]</sup> This is supplemented with warm meals, tea and coffee, showers and recreational activities, and low-threshold work opportunities such as cooking, cleaning and bicycle repair.<sup>[101]</sup> The result is a welcoming environment for people who use drugs, who report the positive social contact available through attending the DCR as a main reason for their involvement.<sup>[101]</sup> Furthermore, Dutch DCRs have expanded into intensive housing support facilities, such as the one at Schurmannstraat in Rotterdam. This facility, accessible only to those with a professional referral, can house up to 20 people at a time, and contains a living room that also serves as a DCR.<sup>[101]</sup>

Integrated services such as those in the Netherlands not only reduce the direct health harms of drug use, but can also strengthen DCRs' function as a starting point for engagement between people who use drugs and other health and social services. Similarly, a 2016 qualitative study of the experience of people who use drugs in Danish DCRs found that the non-judgmental interaction between staff and peers helped forge a sense of social acceptance and trust that made them more likely to be comfortable when referred to other health services. This was identified as the most important feature of DCRs for people who inject drugs, and paves the way for overdose prevention and greater access to general healthcare.<sup>[144]</sup> This

is particularly relevant as the average age of people who use drugs increases, and issues of social isolation and age-related health problems become increasingly relevant.<sup>[145,146]</sup>

In Basel and Zurich in Switzerland, feasibility studies are currently being carried out into providing drug-checking services in DCRs.<sup>[26]</sup> As with other drug-checking services (see p.14), this would ensure that people using DCRs are able to make informed decisions about drug use, and would avoid complications arising from unexpected adulterants or higher-than-expected purity. This service is already available at one DCR in Vancouver, Canada, where staff offer clients the chance to test heroin samples for fentanyl. Research finds that it has been successful in highlighting the presence of fentanyl in the local drug supply.<sup>[147]</sup> However, the same study also found that the drug-checking service was only used during 1% of DCR visits,<sup>[147]</sup> although previous research suggests that up to 90% of people who use drugs would be willing to use drug-checking services in similar environments.<sup>[148,149]</sup> Despite the low uptake of the service, even testing a small sample of substances allowed the service to gain an insight into the substances being used and alert other clients.<sup>[147]</sup>

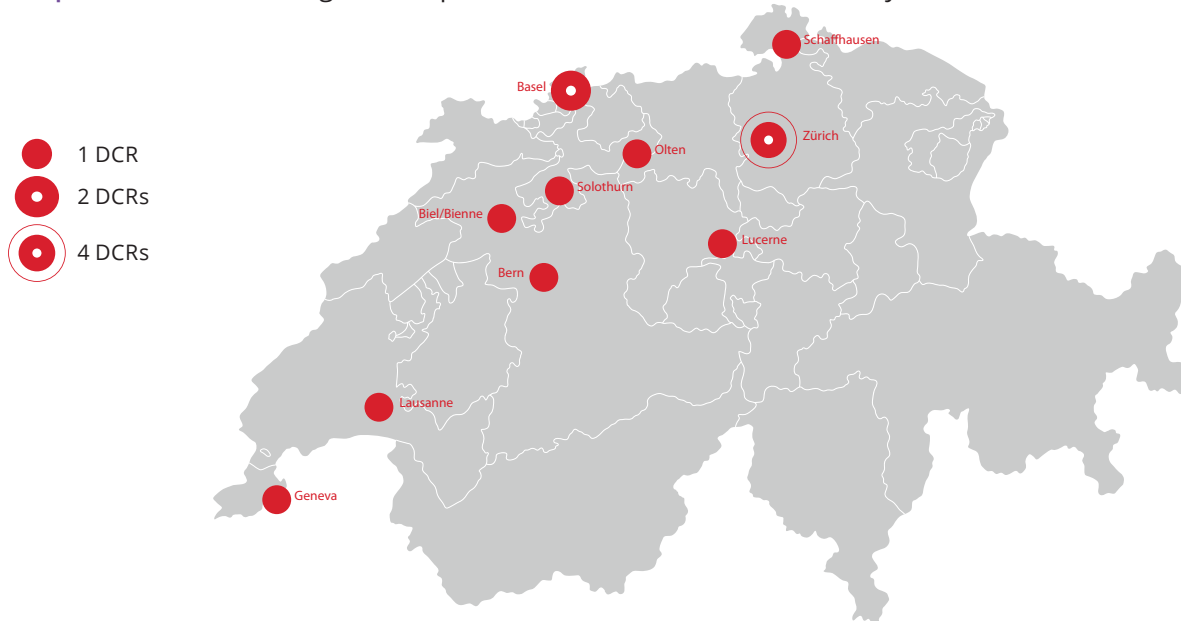
While DCRs are distributed throughout the Netherlands and in all major cities,<sup>[34,143]</sup> in other countries regional variation in service provision presents a barrier to access for people who inject drugs. For example, only two of Spain's 19 autonomous communities (Catalonia and the Basque Country) have DCRs,<sup>[23]</sup> leaving people who inject drugs elsewhere in the country (including Madrid) without such services. Similarly, only six of Germany's 16 states offer DCRs.<sup>[14,142]</sup> In Bavaria, the state government has consistently rejected calls from civil society to introduce DCRs, despite a high number of drug-related deaths in its major cities, such as Munich, Augsburg and Nuremberg.<sup>[15]</sup>

Switzerland is a further example of a country in which DCRs are geographically concentrated. Only eight of the 26 Swiss cantons have a DCR: Basel-Stadt (two), Bern (two), Geneva, Lucerne, Schaffhausen, Solothurn (two), Vaud and Zurich (four).<sup>bg[26]</sup> Only two are found in French-speaking cantons (in Geneva and Lausanne), and there are none in the Italian-speaking region. Four are located in the city of Zurich alone, though one of these is expected to close in the near future.

bf Inhalation rooms in Spain always share a site with injection rooms.

bg In the canton of Bern, the DCRs are in the cities of Bern, Biel/Bienne and Olten. In the canton of Zurich, all three are in the city of Zurich.

Map 4.1: Location of drug consumption rooms in Switzerland, February 2019<sup>bh</sup>



Legal exclusions also limit access to DCRs in Western Europe. For example, in Luxembourg and some regions of Germany, DCRs exclude people on OST by law.<sup>[14,19]</sup> However, since 2016 two German states (Hesse and North Rhine-Westphalia) have amended state laws to allow access to people on OST.<sup>[14]</sup> Migrants are also often unable to access services, particularly undocumented migrants, for example in Dutch and Swiss DCRs.<sup>[101]</sup> In several countries, access is also denied to people under the age of 18.<sup>[19]</sup>

### 4.3 Housing as harm reduction

There is a well-documented positive association between drug use and insecure housing circumstances, particularly homelessness.<sup>[150]</sup> Furthermore, evidence from North America and Western Europe suggests that people experiencing homelessness are not only more likely to use drugs, but are also more likely to exhibit risky injecting behaviour, more likely to inject in public places and are more vulnerable to HIV infection.<sup>[150-153]</sup> As such, the evidence indicates people experiencing precarious housing situations may benefit from harm reduction interventions.

Housing First is an emerging intervention in Western Europe addressing the needs of people experiencing homelessness. It includes harm reduction as one its

eight guiding principles, on the understanding that housing is a human right and therefore should not be dependent on abstinence from substance use.<sup>[154]</sup> In Western Europe, Housing First initiatives operate in at least 13 countries: Austria, Belgium, Denmark, Finland, France, Ireland, Italy, the Netherlands, Norway, Portugal, Spain, Sweden and the United Kingdom.<sup>[154]</sup> In Finland, these programmes have been established for more than a decade, helping Finland to become the only country in Western Europe to have seen levels of homelessness decrease in that time.<sup>[155]</sup>

While in some cases the harm reduction principle has been neglected in Housing First projects,<sup>[156]</sup> examples of a strong harm reduction influence exist in Western Europe. For example, in Belgium the Housing First programme explicitly endorses harm reduction and involves specialist social workers with expertise in harm reduction providing case management.<sup>[157,158]</sup> The project was run as a pilot from 2013 to 2016, and since 2016 has been expanded at both federal and regional levels.<sup>[157]</sup> The Turning Point Housing First programme in Glasgow, Scotland was initiated in 2010 as part of a wider response to drug-related deaths among people experiencing homelessness.<sup>[154,159]</sup> The programme employs peer workers as front-line staff, rather than as a supplementary support project, and explicitly does not require any degree of abstinence

bh Locations are: 1 DCR: Geneva, Lausanne, Biel/Bienne, Bern, Olten, Solothurn, Schaffhausen, Lucerne; 2 DCRs: Basel; 4 DCRs: Zurich.

from illicit substances.<sup>[159]</sup> The programme noted marked improvements in social inclusion and physical health among those enrolled in the programme after five years.<sup>[159]</sup>

Though data on homelessness in Switzerland is generally unavailable, evidence from civil society organisations in Basel, Geneva and Lausanne suggests that homelessness is increasing.<sup>[160]</sup> There, traditional shelter programmes offer people experiencing homelessness the opportunity to progress to sheltered or supported housing.<sup>[160,161]</sup> However, these programmes do not operate in accordance with a harm reduction approach, and do not assist people into independent personal housing.<sup>[160,161]</sup> As yet, no Housing First programmes operate in Switzerland, though Schwarzer Peter, a homelessness organisation in Basel, has explored implementing a Housing First project.<sup>[154,162]</sup> The organisation will convene a conference on the topic in April 2019, with the explicit aim that the Housing First concept will gain a foothold in both Basel and Switzerland more widely.<sup>[162]</sup>



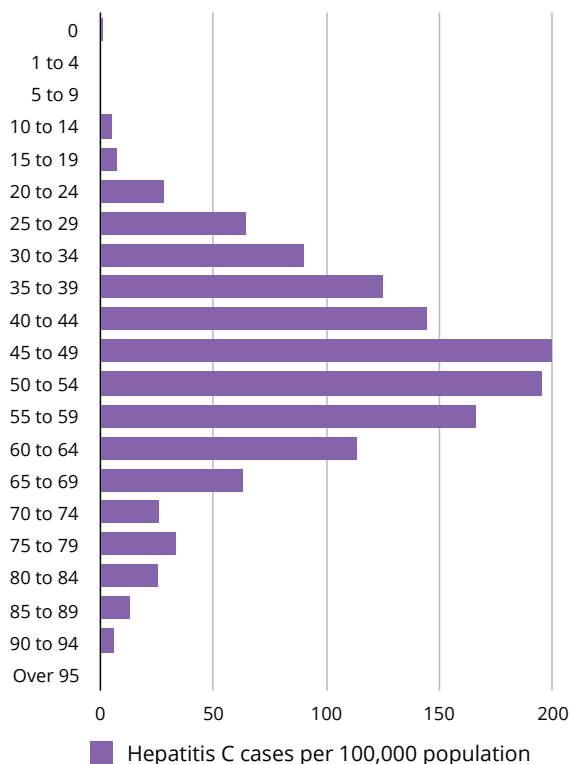
# 5. Health care for people who use drugs

## 5.1 Hepatitis C

Overall, the availability and quality of national level data on viral hepatitis among people who inject drugs is poor. Reported prevalence of hepatitis C antibodies varies widely across Western Europe, with prevalence among people who inject drugs ranging from 22% in Belgium to 96.8% in Sweden (as shown in Table 1). Data from the European Union and Norway indicates that prevalence is higher among older people who inject drugs, demonstrating the accumulation of risk over years of potential exposure.<sup>[32]</sup>

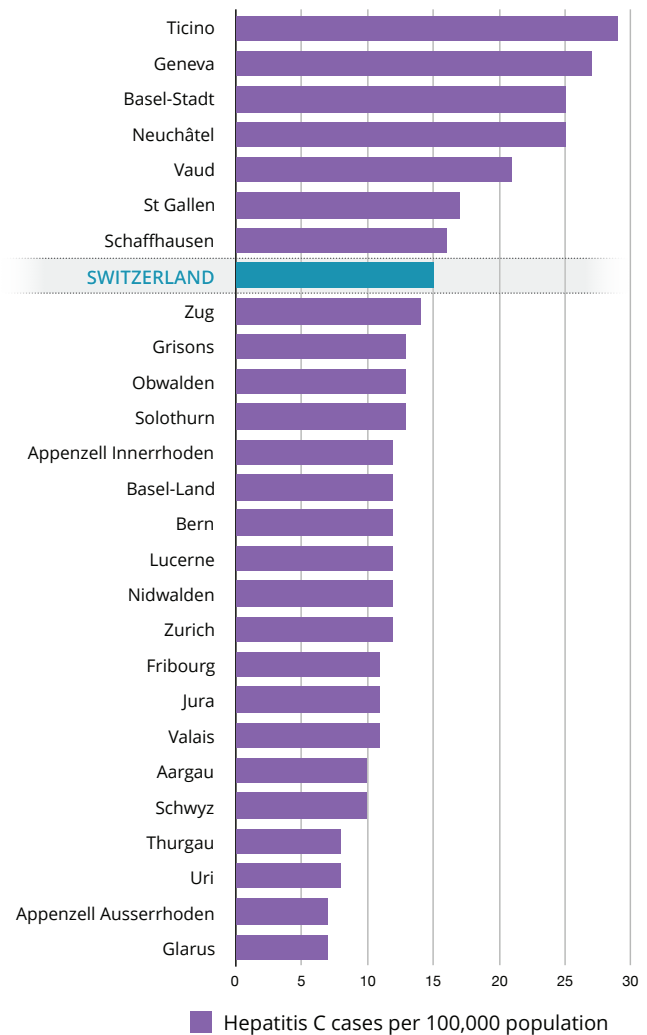
With the advent of new direct-acting antivirals, capable of curing 95% of cases, prevalence of hepatitis C is projected to fall over the coming years.<sup>[163]</sup> However, there is some evidence that prevalence of hepatitis C has grown since 2012 in the United Kingdom, where 92% of new infections occur among people who inject drugs;<sup>[28,30]</sup> and there was an outbreak of hepatitis C among people who inject drugs in Northern Ireland in 2016.<sup>[28]</sup> While prevalence of viral hepatitis is expected to decrease in the region in future, morbidity and mortality is projected to rise,<sup>[39]</sup> highlighting the need for ongoing interventions to address the viral hepatitis epidemic.

**Figure 5.1:** New hepatitis C cases per 100,000 population in 2018, by age group



A key factor in the increased morbidity and mortality associated with hepatitis C is the increasing average age of people who inject drugs. For example in Switzerland, new cases of hepatitis C in 2018 were concentrated among people aged between 40 and 60 (see Figure 5.1).<sup>[164]</sup> Also notable in Switzerland is the high incidence of hepatitis C in certain cantons. For example, the number of cases per 100,000 of the population is more than twice as high in Geneva (27) as in Zurich (12) (see Figure 5.2).<sup>[164]</sup> Ticino, Basel-Stadt, Neuchâtel and Vaud also have incidence rates considerably higher than the national rate.<sup>[164]</sup>

**Figure 5.2:** New hepatitis C cases per 100,000 population in 2018, by canton



Though viral hepatitis screening is available to people who inject drugs for free or at a nominal cost in most of the region, several countries report low uptake of testing. For example, in Italy only 27% of people who inject drugs have ever been tested for hepatitis C,<sup>[18]</sup> and approximately half of people living with hepatitis C in the United Kingdom are unaware of their condition.<sup>[28]</sup> From 2012-2016, the number of tests undertaken rose by 23.7% in the United Kingdom, in part thanks to policy changes such as the adoption of routine opt-out testing of people who inject drugs in Wales.<sup>[28,30]</sup> In Switzerland, accessing other harm reduction services, such as NSP and OST, is linked to a greater likelihood of being testing for hepatitis C: levels of testing are lowest among people who inject drugs that do not access any other services.<sup>[26]</sup>

Previously, the high cost of direct-acting antivirals has led to limitations being placed on eligibility for treatment under national and private health insurance schemes; for example, caps on the number of patients or prioritisation of those with advanced liver damage. These restrictions have gradually been withdrawn over the past two years, and as of 2018 only three countries in the region enact these restrictions on access to treatment (Belgium, Cyprus and Greece).<sup>[39]</sup> A recent study by the European Monitoring Centre for Drugs and Drug Addiction found only two Western European countries officially continue to restrict access to hepatitis C treatment for people currently using drugs (Cyprus and Malta).<sup>[38]</sup> In Denmark (from November 2018),<sup>[165]</sup> France, Germany, Iceland, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain and Switzerland, the treatment is officially available to all people who inject drugs living with hepatitis C, regardless of the state of the disease.<sup>[13,18,23,39,130,166]</sup> In Austria, the Netherlands and Switzerland, guidelines state that people who inject drugs and people on OST should be actively sought out to receive treatment.<sup>[34,70,167]</sup> In Iceland, the Treatment as Prevention programme focused efforts on treating people who inject drugs with free direct-acting antivirals in order ultimately to achieve hepatitis C elimination, and saw a 65% reduction in hepatitis C prevalence among people who inject drugs accessing addiction treatment from 2015-2017.<sup>[168]</sup>

Despite advances in accessibility, cost remains a significant barrier to hepatitis C treatment for people who inject drugs, particularly for those without health insurance in insurance-based health systems (such as in Germany, Luxembourg and Switzerland).<sup>[15,19,51]</sup> In September 2018, the European Patent Office dismissed a challenge to Gilead Science's patent on sofosbuvir, a key component of hepatitis C treatment.

The ruling allows Gilead Science to continue charging extremely high costs for patented direct-acting antiviral treatment (i.e. the production of generic alternatives in Europe remains a violation of the patent).<sup>[169]</sup> Stigma and discrimination, related to a lack of knowledge and awareness among both health professionals and people who inject drugs, has also been cited as a barrier to treatment across the region.<sup>[18,41,50,170]</sup> People currently using drugs also face exclusion from hepatitis C treatment by health professionals, even where this is explicitly against national guidelines (in Germany and Portugal, for example).<sup>[14,41]</sup> The result is that many people living with hepatitis C go without treatment even though it is available to them. For example, in the United Kingdom, no health authority outside London regularly meets its quota of people treated with direct-acting antivirals.<sup>[30]</sup>

Modelling studies for three settings in the United Kingdom underline the importance of direct-acting antiviral treatment in combination with harm reduction interventions in preventing hepatitis C among people who inject drugs. One suggests that without OST, new infections would rise by 483% by 2030.<sup>[171]</sup> Scaling up current NSP and OST services could achieve a 90% reduction in incidence.<sup>[171]</sup> This must be combined with awareness-raising campaigns and proactive testing to reduce stigma and ensure everyone who requires treatment receives it, as recommended by people living with hepatitis C in a 2017 survey.<sup>[170]</sup> Direct-acting antivirals present an opportunity to eliminate hepatitis C in Western Europe, in accordance with the World Health Organization goal of eliminating hepatitis C by 2030.<sup>[172]</sup> However, this can only be achieved by ensuring that all people at risk of hepatitis C have access to preventative services, testing and treatment.

## 5.2 Tuberculosis (TB)

Incidence of TB in Western Europe is generally low, ranging from 2.4 cases per 100,000 in Iceland and 4.5 per 100,000 in Greece, to 18 per 100,000 in Turkey and 23 per 100,000 in Portugal.<sup>[173]</sup> These cases are predominantly concentrated among certain groups, such as recent migrants, prisoners and people who inject drugs.<sup>[173]</sup> The level of integration of TB into harm reduction programmes also varies across the region, with good integration in Belgium, the Netherlands, Spain and Switzerland, and little integration in Italy and Portugal.<sup>[4,18,21,23,39,50]</sup> Good practice notes that outreach to marginalised populations may help to mediate between these groups and formal health services.<sup>[41]</sup> Similar to other infectious diseases associated with

injecting drug use, stigma and a lack of awareness also play a significant role in compounding the TB epidemic among people who inject drugs.<sup>[18,41,50]</sup>

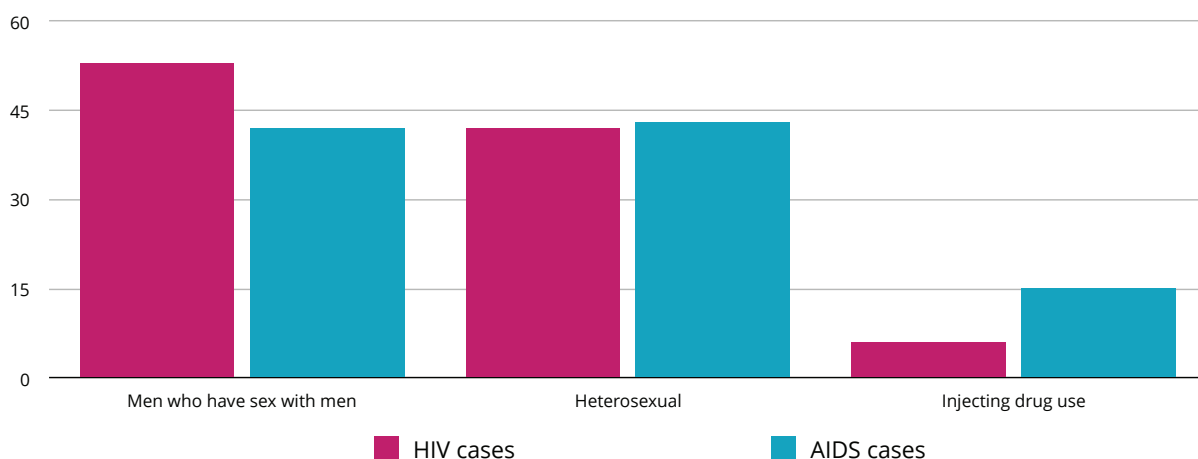
The DETECT-TB (Early Detection and Integrated Management of Tuberculosis in Europe) project launched in 2016 aims to contribute to the decline and eventual elimination of TB in the European Union. Its objectives state the importance of the early diagnosis of vulnerable populations, including people who inject drugs and prisoners, and the sharing of best practices between programme countries. The project works through a network of partners in six states, four of which are in Western Europe (Italy, the Netherlands, Sweden and the United Kingdom).<sup>[174]</sup>

### 5.3 HIV and antiretroviral therapy (ART)

Across the EU, 5% of new HIV infections in 2016 were due to injecting drug use, a proportion that has remained low and stable for a decade.<sup>[32]</sup> Overall, new HIV cases among people who inject drugs in the region have declined 51% from 2007 to 2016.<sup>[32]</sup> However, in Cyprus, Denmark, Luxembourg, Malta, Spain and Sweden there were increases in the number of new HIV cases among people who inject drugs from 2015 to 2016.<sup>[9,11,20,24,35,129]</sup> In Switzerland, 6% of all new HIV infections among women and 1.7% of all new HIV infections among men in 2017 were related to injecting drug use.<sup>[40]</sup> Overall, 6% of new HIV cases for which the route of transmission is known were due to injecting drug use.<sup>[40]</sup>

Challenges remain in ensuring that people who inject drugs receive timely and adequate treatment: in 2016, half of new HIV infections among people who inject drugs were diagnosed late (when the immune system had already sustained damage) and 13% of AIDS diagnoses were from HIV infections due to injecting drug use.<sup>[32]</sup> This pattern recurs in Switzerland, where injecting drug use accounted for only 6% of new HIV cases in 2017, but 15% of new AIDS diagnoses (see Figure 5.3).<sup>[40]</sup> Early diagnosis and treatment offers people living with HIV a normal life expectancy; health systems must ensure that people who inject drugs are able to benefit from these services on the same basis as the general population.

Figure 5.3: New HIV infections and new cases of AIDS in Switzerland by route of transmission, 2017



Organisations in Spain, Switzerland and the United Kingdom attribute the region's success in maintaining low HIV prevalence among people who inject drugs to the implementation of harm reduction interventions, notably NSPs and OST, early in the HIV epidemic.<sup>[23,30,31,175]</sup> A 2017 Swiss study found that harm reduction programmes in the country had prevented 15,903 new HIV infections up to the end of 2015, and warned that an abrupt closure of services would result in a significant outbreak of HIV.<sup>[175]</sup> Similarly, civil society organisations in the United Kingdom have noted that the continuation of low prevalence of HIV relies on access to harm reduction services, and that further investment in these services is required.<sup>[30]</sup> In recent years, outbreaks of HIV in Greece, Ireland, Luxembourg and the United Kingdom have demonstrated the importance of continued provision of harm reduction services.<sup>[133,176,177]</sup>

While prevalence of HIV among people who inject drugs in the United Kingdom as a whole is estimated at 0.9%, the prevalence in Glasgow is 20-25%, with more than 100 of Glasgow's 400-500 people who inject opioids thought to be living with HIV.<sup>[133]</sup> The outbreak began rapidly in 2015 and has been durable, with similar numbers of new infections each year from 2015 to 2017.<sup>[133,178]</sup> In 2016, provision of low-dead space syringes (associated with a lower risk of blood-borne virus transmission) was rolled out in Scotland, and a new NSP was opened at Glasgow Central railway station.<sup>[28,133]</sup> The new NSP became Scotland's busiest, serving 2,000 individuals and providing more than 40,000 sterile injecting kits over the course of its operation.<sup>[133]</sup> However, it was closed just 14 months after opening, with the building's owner citing the fact that used injecting equipment was being left nearby in public areas as the reason.<sup>[133]</sup> Civil society organisations cite the closure of the Glasgow Central NSP as a major factor in the failure to control the HIV epidemic in the city.<sup>[30]</sup>

HIV testing and treatment is available to people who inject drugs on the same basis as the general population in much of the region, covered either by health insurance or public health services.<sup>[4,23,30,41]</sup> Coverage of ART is generally very high, with 80-90% of people living with HIV receiving treatment in most countries.<sup>[179]</sup> Pre-exposure prophylaxis is increasingly available in Western Europe; for example, Portugal launched a pilot programme for men who have sex with men in 2017.<sup>[41]</sup>

People who inject drugs continue to face formal and informal barriers to HIV treatment in Western Europe. A decreasing trend in people who inject drugs

accessing HIV testing has been noted in Italy, while in the United Kingdom, people who inject drugs are less likely to access treatment after HIV diagnosis than the general population.<sup>[18,30]</sup> Homelessness, poverty and social isolation, as well as stigma and discrimination, often based on the criminalisation of drug use, are also reported as key barriers to accessing HIV treatment for people who inject drugs in Italy and Portugal.<sup>[18,30,41]</sup> The unequal geographic distribution of service providers within countries also forms a barrier to people who inject drugs living in underserved regions. For example, in some areas of Portugal a lack of integration between harm reduction services and hospitals means that people who inject drugs are less likely to access treatment.<sup>[41]</sup> In addition to these informal barriers, some people who inject drugs face higher formal barriers to treatment. For example, the United Kingdom recently introduced higher charges for undocumented migrants accessing health services, and civil society organisations also report that migrants in Germany may also face difficulties in accessing services.<sup>[15,30]</sup>

Under the new Italian national AIDS plan, non-governmental organisations are increasingly able to offer community-based HIV services, and have seen good uptake of their services. HIV self-testing kits also became available in 18,000 Italian pharmacies.<sup>[18]</sup> Community-based and outreach services are essential to ensuring that people who inject drugs can access HIV treatment. Furthermore, it is necessary for these community-led services to have resilient referral mechanisms, in order for people testing positive for HIV to be effectively linked with care.

## 6. Harm reduction in prisons

### 6.1 Drug offences and incarceration

Drug offences continue to be a major contributor to incarceration in Western Europe. In all but four countries in the region (Luxembourg, Malta, Portugal and Spain), simple possession of even a small amount of illegal drugs can lead to a prison sentence.<sup>[180]</sup> The proportion of prisoners incarcerated for drug offences varies across the region, from 8% in Turkey to 33% in Italy.<sup>[27]</sup> Civil society organisations across the region continue to campaign for decriminalisation of personal drug use and possession, for example during the 2018 elections in Italy.<sup>[4,18]</sup> In the United Kingdom, Release launched a smartphone app in 2017 which serves as a guide to self-representation for drug possession offences, assisting people who use drugs to navigate the criminal justice system and avoid punitive penalties.<sup>[31,181]</sup>

In Switzerland, drug policy is based on a four pillar strategy, of which only one pillar refers to criminal sanctions and policing.<sup>[182]</sup> While possession of all drugs except less than ten grammes of cannabis remains subject to legal prosecution, the cantons have discretion over policing of drug use and personal possession is punished in most cases by an administrative fine rather than a prison sentence.<sup>[183,184]</sup> Nevertheless, 22% of Swiss prisoners are incarcerated for drug offences, and 809 people were sentenced to prison terms for drug offences in 2014.<sup>[185]</sup>

Portugal decriminalised personal possession and use of all drugs in 2001, with positive effects on the health and wellbeing of people who use drugs in the country.<sup>[186]</sup> However, a 2018 community-led report by the International Network of People Who Use Drugs (INPUD) raised several concerns about the use of Portugal as a model for advocacy.<sup>[186]</sup> The report expressed concerns over the continuation of stigma, discrimination and abstinence-oriented interactions with health professionals, as well as about the absence of full legalisation of drugs ensuring that people who use drugs still encounter the dangers of obtaining substances on the illicit market.<sup>[186]</sup>

### 6.2 Drug use in prisons

Across Western Europe, drug use in prisons is prevalent. For example, according to the most recent available data (from 2010 to 2014), 32.9% of prisoners in Belgium, 34% in Portugal and 42% in Norway report having used illicit drugs at some point while incarcerated.<sup>[1]</sup> Cannabis is the most used drug in Western European prisons; however, 13.3% of Belgian prisoners, 9.4% of Portuguese prisoners and 31.4% of

Spanish prisoners report having used heroin at some point while incarcerated.<sup>[1]</sup> In addition, prevalence of blood-borne infections such as viral hepatitis and HIV are known to be significantly higher among people with a history of incarceration.<sup>[32,187]</sup> This information clearly demonstrates the need for harm reduction services in prisons.

New psychoactive substances (NPS) have rapidly emerged as substances of concern in Western European prisons. In particular, the use of synthetic cannabinoids in prisons is an issue in Germany, Sweden and the United Kingdom.<sup>[31,188]</sup> A minimum of 58 deaths in British prisons have been attributed at least in part to NPS use, for example through psychotic episodes, suicide and drug poisoning,<sup>[189]</sup> and non-fatal overdoses related to NPS have also been reported in Germany and Italy.<sup>[188]</sup> Responses to these issues in Western European prisons remain focussed on supply reduction, drug testing and smoking bans.<sup>[188]</sup>

### 6.3 Harm reduction services in prisons

Access to harm reduction services in prisons varies significantly between and within countries in the region. For example, services appear to be widespread in Spain, with service coverage similar in prison to in the community.<sup>[23]</sup> Conversely, no harm reduction services are available in Turkish prisons.<sup>[190]</sup> The UN Basic Principles for the Treatment of Prisoners and UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) state that all prisoners should have access to the equivalent healthcare services available in the country, without discrimination on the grounds of their legal status.<sup>[191,192]</sup>

NSP provision in Western European prisons is inadequate, with only four countries formally providing such programmes. These are: Spain (all prisons), Switzerland (15 of 106 prisons), Luxembourg (one of two prisons) and Germany (one female prison in Berlin).<sup>[14,19,26,193,193]</sup> In addition, a NSP is provided by the prison health service at the Villeneuve-lès-Maguelone prison in France,<sup>[194]</sup> which operates despite formal requests from the prison authorities to close it, with health staff citing the Nelson Mandela Rules as justification for continuing to provide the service.<sup>[194]</sup> In Italy, a pilot programme was launched by the Ministry of Health in 2017 to distribute safe injecting equipment to prisoners on release from four prisons.<sup>[18]</sup>

The Swiss Epidemics Act 2016 obliges penal



institutions to make safe injecting equipment available to prisoners;<sup>[195]</sup> however, civil society organisations report that prisoners remain a key population left out of NSP provision.<sup>[50]</sup> In reality, only 14% of Swiss prisons offer NSPs, making sterile injecting equipment available to just 21% of people incarcerated in the country.<sup>[26,196]</sup> This is despite NSPs in prisons having been shown several times, including by Swiss studies, to be an unproblematic harm reduction intervention.<sup>[196]</sup>

With regard to OST, the continuity of access between the broader community and prisons is particularly important in preventing overdose deaths in people who use opioids, as well as helping to reduce high-risk injecting behaviour.<sup>[197]</sup> In all countries in the region except Turkey, Iceland and the Western European microstates, OST is available to prisoners. However, OST is very often available on more limited terms than in the broader community. For example, in Flanders, Belgium, OST is only available to those who began the therapy outside prison.<sup>[4]</sup> In Malta and Portugal, prisoners in certain establishments must be transferred to external medical facilities before they can commence OST, raising a barrier to access as they rely on prison authorities for travel.<sup>[20,41]</sup> OST provision in prisons can also vary within countries. For example, in Ireland only 11 out of 14 prisons provide OST.<sup>[36]</sup> In the United Kingdom, regulations state that OST should be available on the same basis as in the broader community.<sup>[199]</sup> However, in practice its availability can depend on the authorities at each prison, and data is generally unavailable on the extent to which it is accessible.<sup>[31]</sup>

In Switzerland, 30% of Swiss prisons provide no OST at all, and a lack of awareness and training among prison health staff is noted as a key barrier to OST implementation in places of detention.<sup>[26,48]</sup> While heroin-assisted therapy (HAT) is available at 23 sites across Switzerland, it is only available in one prison: Realta Prison in Cazis, Grisons.<sup>[26,58]</sup> As is the case in most HAT facilities in Europe and Canada, enrolment is based on strict criteria: the individual must be older than 18 years, have at least two years of “proven dependence” and have attempted to enter another form of treatment at least twice.<sup>[200]</sup> Additionally, the circumstances around the individual’s release from prison must allow for continuation of the therapy.<sup>[200]</sup>

A 2016 ruling by the European Court of Human Rights determined that denying OST treatment to a prisoner while in detention violates Article 3 of the European Convention on Human Rights, which prohibits inhuman or degrading treatment.<sup>[201]</sup> Every country in

Western Europe is currently subject to the convention, and therefore is obliged to provide OST in all prisons.

The period after release from prison is a particularly high-risk time for opioid overdose, due to lower tolerance after a period of abstinence or low dosage, making the availability of naloxone vital.<sup>[32]</sup> Four countries (Denmark, France, Norway and the United Kingdom) provide naloxone to prisoners on release.<sup>[202]</sup> While the practice is not universal in the United Kingdom (for example, only half of Welsh prisons distribute take-home naloxone), 1,355 naloxone kits were distributed by Scottish and Welsh prisons alone in 2016-2017.<sup>[75,203]</sup> Naloxone is also available in some prisons in the Netherlands, Switzerland and an estimated 82% of prisons in Italy, but can only be used by medical personnel and is not given to prisoners on release.<sup>[21,34,48,59]</sup> Pilot projects delivering naloxone kits and training directly to prisoners while incarcerated have operated since 2016 in Germany, Italy and Norway, with evidence from Norway suggesting that naloxone training and provision has significantly increased prisoners’ awareness of overdose prevention measures.<sup>[18,142,204]</sup> Studies in the United Kingdom clearly demonstrate that increasing provision of take-home naloxone on release from prison prevents overdose deaths among prisoners, their peers and in the wider community, and therefore it should be a priority for prison health authorities across the region.<sup>[205]</sup>

With hepatitis C prevalence considerably higher among prisoners than the general population, the EU must urgently scale up testing and treatment among prisoners if it hopes to eliminate the virus.<sup>[32,206]</sup> HIV prevalence is also alarmingly high among prisoners in Western Europe: prevalence is 9.5 times higher among prisoners than the general population in Ireland and 13.5 times higher in Spain.<sup>[207]</sup> A recent review of hepatitis C and harm reduction services in prisons found that all Western European countries studied offered hepatitis C treatment in prisons. However, it also found a distinct lack of data on the extent of treatment coverage in prisons in these countries.<sup>[193]</sup> HIV testing and treatment are broadly available in prisons across the region, with Italy, Portugal and the United Kingdom all routinely testing incoming prisoners for HIV.<sup>[18,30,41]</sup> However, implementation of these services is sometimes inadequate or uneven within countries. This gap between policy and implementation risks leaving behind a key population in viral hepatitis and HIV control, in clear violation of individuals’ fundamental human rights.

In Switzerland, the level of resources available to prison

health services varies across the country, meaning that hepatitis C screening is available more widely in some detention centres than others and is rarely routine.<sup>[26,208]</sup> A recent modelling study conducted in Geneva found that comprehensive screening of all people entering prison – rather than just those who self-identify as being from a high-risk group – would be a cost-effective means of addressing hepatitis C in settings of detention.<sup>[208]</sup> However, this strategy would be undermined by current low levels of access to hepatitis C treatment for people in detention, with many prisoners not covered by health insurance.<sup>[26]</sup> A further issue highlighted by civil society organisations and the World Health Organization relates to the large number of small (capacity fewer than 50 people) prisons in Switzerland.<sup>[26,209]</sup> The concern is that these small prisons may not have the necessary health facilities to provide comprehensive care to prisoners, such as those living with hepatitis C and HIV.<sup>[209]</sup>



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Harm Reduction International is a leading NGO dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies.

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