Report on the current state of play of the 2003 Council Recommendation on the prevention and reduction of health-related harm, associated with drug dependence, in the EU and candidate countries

Final Report – Annex 1: Country Profiles – Deliverable 1

On behalf of the European Commission

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Gesundheit Österreich
Forschungs- und Planungs GmbH

SOGETI

Report on the current state of play of the 2003 Council Recommen-dation on the prevention and reduction of health-related harm, associated with drug dependence, in the EU and candidate countries

Final Report - Annex 1: Country Profiles - Deliverable 1

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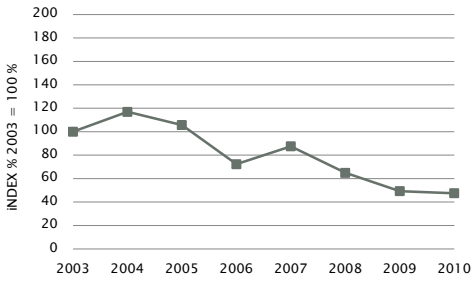
1 Country Profile Austria

1.1 Indicators for drug-related harm

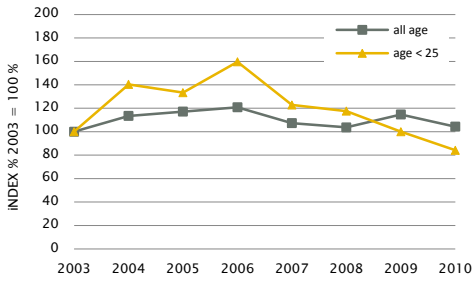
Estimates on the number of **problem drug users (PDU)** in Austria are available for polydrug use, including opiates. The most recent estimate for 2009 indicates a prevalence of 4,6 PDUs per 1.000 inhabitants aged 15-64 (95 % CI: 4,4-4,7) users ranging from 24.867 to 26.687) [CO]. Time trends show an increase of prevalence till 2004/2005 followed by a decrease till 2007. Since then prevalence estimates are quite stable [NR 2011]. The largest groups of clients in outpatient treatment in 2010 have opioids (61 %) and cannabis (26 %) as primary drug. In inpatient treatment the respective proportions are 81 % and 6 % [Statistical Bulletin TDI-19]. According outpatient treatment data just 35 % of opioid users inject the drug (41 % are sniffing) [Statistical Bulletin TDI-17].

Figure 1:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: AHIVCOS 2012[1]

Figure 2:
Number of direct drug-related deaths (indexed - 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

In Austria there is no national registry for new HIV cases but the Austrian HIV cohort study (AHIVCOS) covers almost two third of all HIV positive persons in Austria [GS]. Based on this cohort study it is estimated that in Austria there are living between 1.056 and 2.400 HIV positive persons who acquired the infection via injecting drug use (IDU) [NR 2011]. The number of newly infected IDUs is decreasing (see Figure 1). The prevalence of infectious diseases among IDUs is estimated on the basis of a few small samples from treatment facilities, low-threshold centres and drug-related deaths. In 2010, the national prevalence rates of HIV among IDUs (who had injected drugs at

[1] AHIVCOS (2012). HIV/AIDS in Austria - 22nd Report of the Austrian HIV Cohort Study. Innsbruck

least once in their lives) ranged from 0 to 5 %, with higher rates found among drug-related death than among the clients of drug treatment centres [NR 2011].

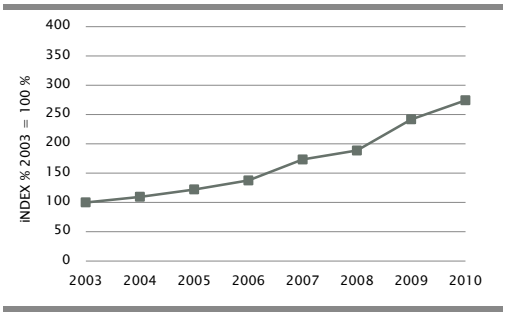
The available data for hepatitis C virus (HCV) prevalence rates indicate a high level of infection. In 2010, rates established based on the same sources as for HIV ranged from 21 to 73 % for HCV [NR 2011]. Compared to the previous year, the ranges for HCV rates slightly increased. However, the data are based partly on voluntary and on mandatory tests, and are thus not independent, which undermines any solid interpretation [CO].

The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased (especially in the age-group <25) till 2006 followed by a decrease. In 2010 number of drug-related deaths is nearly equal to 2003 (see Figure 2).

1.2 Indicators for drug-related harm reduction

Syringe exchange programmes have been successfully established in Austria, as shown by the continuous rise in the number of syringes sold or exchanged, especially in the most recent years. National data on the number of syringes distributed by needle and syringe programmes are available since 2009. In 2010 (4.144.000) the number was slightly higher than in 2009 (3.966.000) [NR 2011]. The number of clients in substitution treatment is increasing continuously (see Figure 3).

Figure 3:
Number of clients in substitution
(indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

In 2010 5.217 clients started an outpatient or inpatient treatment [ST TDI-2].

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1.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

The Ministry of Health is the main responsible department for the implementation of the Council Recommendation. In Austria, harm reduction is part of public health policy. Prevention plays a central role, which is reflected in a wide range of structural measures. Since the early 90's, when Addiction Prevention Units were established, primary prevention was introduced, while secondary prevention was expanded. Responses to health correlates and consequences include a wide range of interventions [Trimbos 2006].

There is no written national drug strategy and also no specific written strategy concerning the reduction of drug-related deaths or infectious diseases. Still, every region (Bundesland) has its own drug resp. addiction strategy or plan, where the strategies concerning prevention and treatment are explained and usually also harm reduction measures are included [NR 2011]. For example the addiction plan 2012-2016 for Carynthia defines as key target the implementation of harm reduction. On federal level a position paper on harm reduction was drawn up and adopted by the Federal Drug Forum. It will be included in the national addiction strategy.

In May 2011 a Delphi-study was commissioned by the Austrian Ministry of Health, which involves experts from ministries, drug/addiction coordinators and regional experts nominated by them, industry as well as experts nominated by the Ministry of Health [SQ 32 2011]. The objective is to generate a common agreement on addiction and on the best strategy to tackle this, which can serve as basis for the development of a national addiction strategy.

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

Information, education and communication (IEC) for drug users is a relevant approach in Austria. The dissemination of information through various websites is available nationwide. Other ways of providing information and specific counselling to drug users in the framework of harm reduction are available in specific geographical areas (telephone help lines, training, educational leaflets and pill-testing) [Trimbos 2006].

The predominant response strategy to prevent DRID is the dissemination of information materials for drug users [SQ 23/29 2011]. Individual counselling is done extensively[2] by drugs and health professionals. Practical advice and training on safer injecting are provided only rarely in the context of specific projects and limited to some geographical areas [SQ 23/29 2011].

In 2010 one low-threshold service in Graz launched a hepatitis prevention campaign, which included lectures, printed material and cooperation with prisons [NR 2011].

Overdose information material for drug users is provided extensively by low-threshold services [SQ 23/29 2011]. Overdose response training is carried out less often [SQ

2
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

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23/29 2011] and individual overdose risk assessment is provided to a limited extent [SQ 23/29 2011].

The provision of information to reduce drug-related harms at night clubs and large music festivals is limited and available only in specific geographical areas.

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Specific materials on the prevention of acute drug-related deaths and drug-related emergencies are not available for communities or families of drug users. There is no formal NSP training available for families of drug users [SQ 23/29 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Low-threshold agencies and street-based outreach work are available nationwide. There is no recognized professional qualification in outreach work or outreach work management in Austria [Trimbos 2006].

Outreach work as a health education approach is a common strategy, but not a priority response to prevent DRID [Trimbos 2006, SQ 23/29 2011]. Regarding health issues, outreach work focuses on needle and syringe exchange programmes [SQ 23/29 2011]. The provision of outreach work to reduce drug-related harms at night clubs and large music festivals is limited and available only in specific geographical areas [SQ 23/29 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are involved in the responses to prevent DRID, but peer involvement is not a priority. Naloxone is not available to peers [SQ 23/29 2011].

For example, the hepatitis prevention campaign of the low-threshold service in Graz included training of drug users as multipliers [NR 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies exists in specific geographical areas [Trimbos 2006].

Networking exists on different levels, but not with a special focus on outreach work, rather to enable and improve cooperation between drug help services on local/regional level in general [GS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Drug free inpatient and outpatient treatment as well as rehabilitation programmes and low-threshold services are available extensively [SQ 23/29 2011]. Special treatment programmes exist for cocaine users, cannabis users, amphetamine users and benzodi-

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azepine users [SQ 27 2011]. In 2009 4.187 clients started an outpatient treatment and 1.662 an inpatient treatment [ST TDI].

Opioid substitution treatment (OST) is available nationwide as maintenance or detoxification treatment. The available substances for maintenance treatment are mainly methadone, buprenorphine and slow-release morphine, Codidol is also prescribed in that context [Trimbos 2006]. OST is supported by psychosocial care extensively [SQ 23/29 2011]. In the year 2009 13.460 clients received OST [SQ 23/29 2011].

There are waiting times for drug-free treatment and recently for substitution treatment too, which can be seen as indicator for the need of more treatment slots [SQ 23/29 2011]. There are ongoing activities to improve the efficiency of existing and to build up new services [NR 2011]. A study showed that senior drug users are hardly integrated in treatment structures and adequate services for this target group are missing. Another target group, which needs specific approaches, are addicted persons with different ethnic origins. In Styria, cooperation with a transcultural centre focusing on mental and physical health and integration started to provide mother-tongue support for clients.

To improve the situation concerning OST is an important issue in Austria several measures have been taken during the last years [NR 2011]. Among those are the issueing and modification of a Further Training Decree as well as remuneration agreements between medical associations and health insurance funds.

Drug consumption rooms and heroin prescription programmes are not available in Austria [SQ 23/29 2011].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are available [Trimbos 2006].

OST can be initiated and continued by medical doctors in treatment centres as well as specialized doctors and the substances used can be dispensed in treatment centres as well as pharmacies [SQ 23/29 2011]. There are two levels of special training for GPs and other doctors. “Take-home” doses are regulated [SQ 23/29 2011]. These regulations became stricter recently [NR 2010].

In addition new measures have been taken to reduce the abuse of substitution medicines and benzodiazepines [NR 2011]: In Vienna the Addiction and Drug Coordination Office (SDW) initiated a cooperation project with the police, the Public Health Services (MA 15) and the Social and Welfare and Public Health Law Department (MA 40) of the city. In the case of a report to the police because of suspected trafficking in substitution medicines, a complex information chain has to be run through including a contact with the responsible doctor. As a consequence "take-home" regulations and regulations for administering the substitution medicine will be restricted. Concerning the misuse of benzodiazepines guidelines were developed, that aim at stabilizing, controlling and reducing the use of benzodiazepines as well as ensuring adequate treatment of any psychiatric diseases among this group of users.

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

The priority responses to prevent DRID in prisons are voluntary counselling and testing for infectious diseases on prison entry, drug-free treatment and OST [SQ 23/29 2011].

HCV testing on prison entry is available extensively, HCV testing on prison release as well as practical advice and training on safer use is provided rarely [SQ 23/29 2011]. Needle syringe programmes are not available in Austrian prisons [SQ 23/29 2011] while condoms are distributed [Trimbos 2006].

OST (as maintenance and detoxification treatment) is provided in nearly all prisons, initiation and continuation of OST are available [SQ 23/29 2011].

Drug free treatment is available extensively on a low, medium and high intensity level and provided by prison health services and mixed teams [SQ 23/29 2011].

Other measures provided in Austrian prisons are the provision of pre-release overdose counselling (rarely) and a risk group specific hepatitis B vaccination programme [SQ 23/29 2011].

The provision of naloxone upon prison release [SQ 23/29 2011] as well as formal NSP training or specific information material on DRD for prison staff is not available in Austria [SQ 23/29 2011].

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Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

The priority response to prevent DRID among drug users is voluntary counselling and testing [SQ 23/29 2011]. Hepatits vaccination and routine screening of high risk groups are not priorities in this context. However, hepatitis B is included in the national vaccination strategy and counselling/testing for HIV and hepatitis are widely available. Information material is distributed nationwide. In some geographical areas there is an additional risk group specific hepatitis B and tuberculosis vaccination programme for drug users. The provision of HCV testing for drug users is limited.

A survey in Tyrol showed that safer use is still not practised as every day routine. The authors concluded that hepatitis A/B vaccination programmes for all injecting drug users would be required and that sterile syringes should be more easily available to drug users [NR 2011].

The treatment of infectious diseases needs multiprofessional networks to be effective [NR 2011]. Therefore, the low-threshold centre Ganslwirt (Vienna) cooperates with the immunology outpatient department of the Otto Wagner Hospital since 2011, to provide new services for HIV-positive clients who are unable to keep regular appointments scheduled at the specialised clinics of General Hospital Vienna or Otto Wagner Hospital.

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

Needle syringe programmes are a priority response to prevent DRID, but they are available only in specific areas [SQ 23/29 2011]. In the year 2010 15 specialist agencies, 4 outreach services and 15 vending machines injectors provided 4.144.000 syringes/injecting kits [ST 10 2011]. The content of the provided kits vary, but nearly all of them contain safer use information [SQ 23/29 2011].

In general, needles and syringes are also available in pharmacies without prescription and there is formal NSP training for pharmacists. Still, IDUs are not welcome in all pharmacies and therefore no information on the actual number of sites is available [ST 10 2011]. The provision of injecting kits, "Folien" for smoking heroin and sniffing paraphanelia for non injecting drug users as well as the distribution of cigarette lighters, with safer use information printed on it, is limited [SQ 23/29 2011].

In 2010 one low-threshold service in Graz launched hepatitis prevention campaign which included a spoon exchange programme [NR 2011].

Condom promotion is not a priority response to prevent DRID [SQ 23/29 2011] but condoms are widely distributed [Trimbos 2006]. They are not available in injecting kits [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Ambulances routinely carry antagonists both for opiates and for benzodiazepines, their personnel is trained in naloxone use. The distribution or administration of naloxone is regulated (prescription is needed) and based on laws. Naloxone is not available on a "take-home" basis [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

The promotion of appropriate integration between healthcare and social care is continuing [Trimbos 2006]. The need to coordinate addiction-related care with general medical and psychiatric treatment still remains a particular challenge.

The National Action Plan on Social Exclusion states that socially assisted housing will be increasingly provided to drug addicts in the future [SQ 28 2011]. Drug users/addicts are also mentioned as target group for several employment measures. Interventions for social (re-)integration are directed at both, clients within or after drug-free treatment, as well as people who are currently using drugs (in that case as

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part of low-threshold services) [NR 2011]. In the recent years several measures were taken to improve the access for clients to support, to increase working periods or to address specifically young people with addiction problems.

There are no formal protocols between different national, regional and local authorities and agencies, but there are agreements between treatment providers and social services on regional/local level and there is a coordination body on federal level (national drug forum), which includes all relevant federal ministries and the regional drug/addiction coordinators [SQ 28 2011]. The most common mechanism for addressing the social needs of drug users in outpatient treatment are informal networks.

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

There is neither recognized professional qualification for professionals in the field of prevention and reduction of health-related risks associated with drug dependence (harm reduction professionals), nor is this planned [Trimbos 2006]. In addition, there is no institution responsible for the development of guidelines, no platform for the provision of professional standards and no national system for continued education in drug treatment [SQ 27 p2 2011]. But there is specialized education/training for psychologists, psychiatrist and medical doctors and the regional medical associations are responsible for the organization and implementation of further education concerning substitution treatment [SQ 27 p2 2011]. This specific training is based on the Further Training Decree, which was issued in 2007 [NR 2007 and GS].

Concerning NSP, there are specific trainings offered for professionals in low threshold agencies, pharmacists and ambulance staff [SQ 23/29 2011]. Other specific trainings are available for professionals in prison settings and staff of police detention centres (Eastern Austria) [Trimbos 2006].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

There are evaluations of different treatment programmes, but they are not systematically done [SQ 27 P2 2011]. This is also the case for interventions/projects in other areas like prevention and harm reduction [GS].

There are no national guidelines for drug treatment [SQ 27 P2 2011], but there are guidelines from different medical associations as well as a law on:

» Psychosocial Interventions (outpatient and inpatient),
» Detoxification (outpatient and inpatient) and
» Substitution treatment (including GPs).

In addition there are several standards or consensus statements, which are either addressing the broad spectrum of treatment (for opioid dependency) or focusing on specific areas like treatment of chronic hepatitis C [NR 2010 and GS].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

There are few programmes and activities where needs assessment is carried out – but the need and usefulness of such an approach is increasingly acknowledged [GS]. There was no change since 2003 [PS].

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Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

There are no research programmes, but some treatment facilities also engage in research, e.g. the ambulance for addiction diseases at the University Hospital of Innsbruck, Department for Psychiatry and the Addiction Research Centre at the Medical University of Vienna, Department of Psychiatry and Psychotherapy [SQ 27 P2 2011].

Evaluation protocols are used to some extent in drug prevention and risk reduction programmes [PS]. There was no change since 3003. Appropriate resources for implementation were outstanding in the past.

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

The Austrian Reitox Focal Point organizes since years a so called “Quality Circle”, where evaluation and evaluation criteria are being discussed with experts from addiction research and the drug help system [GS]. In the year 2002 a paper was produced, which is called “Forderungen/Anforderungen/Herausforderungen” and includes various aspects of evaluation which were discussed in the “Quality Circle”. Besides this, there is no document or manual providing standardised evaluation quality criteria for interventions in the area of drug demand reduction.

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

The Austrian REITOX Focal Point was established in 1995 [GS]. Since that year, the Austrian REITOX Focal Point managed to develop standardized data-collection with

high quality in most areas. In those areas, where this was/is not possible, this is due to the national situation and the distribution of competencies between federal and regional (Bundesländer) level. The Austrian REITOX Focal Point is also disseminating information in the national network. To do so, different approaches were considered and implemented:

» a newsletter is provided regularly together with the DrugNet Europe,
» all reports are published on the website of the hosting institution (Gesundheit Oesterreich GmbH) free of charge,
» National REITOX Academies are organized for specific target groups.

The Austrian REITOX Focal Point developed into the national drug monitoring centre and is involved in many additional activities, like informing the public on the drug help system or supporting the Ministry of Health by participating in the Federal Drug Forum and various working groups but also by providing data and input for international questionnaires and national information needs [GS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

Refining and development of drug policies is more often accompanied and underpinned by studies, evaluations as well as scientific studies and analyses (e.g. Lower Austria, Carinthia, Vienna, Tyrol) [GS]. Evaluation results are also being considered in the Delphi-process, which is carried out since 2011 to develop a basic document for a national addiction strategy.

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

In addition, in 2011 a national Reitox Academy on evaluation of treatment programmes was organized for experts from treatment centres [GS]. Besides this, there are specific trainings on evaluation, which are carried out for example by the Donau Universität Krems, but they are not specific for interventions in the area of drug demand reduction.

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Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

As evaluation is not carried out systematically in Austria, the integration of innovative methods depends on the external contractor [GS]. Usually the following groups are involved: clients and staff of treatment/counselling services, respectively the target group, multipliers and trainers of prevention programmes. If evaluation of policies (e.g. regional drug strategies) is carried out, regional stakeholders are involved.

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

The Austrian REITOX Focal Point participated in different projects/programmes (PHARE Twinning, CARDS, IPA 3) with candidate countries, to exchange the experiences on the implementation of a National REITOX Focal Point, the five epidemiological key indicators as well as other related tasks (e.g. EWS) [GS]. Besides this experts from the Austrian REITOX Focal Point as well as other Austrian experts support activities of the European Commission or projects carried out on behalf of the European Commission.

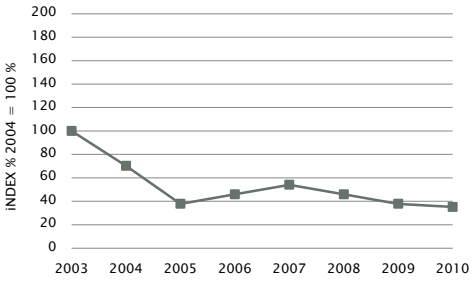
2 Country Profile Belgium

2.1 Indicators for drug-related harm

The national definition of **problem drug use** has been discussed in Belgium without coming to a consensus [CO]. Based on HIV data in 2010 the prevalence rate (per 1.000 inhabitants, aged 15-64 years) of ever-IDUs was estimated to be 3,5 (95 % CI: 2,5-4,8) and the total number of ever-IDUs in Belgium to be 24.664 (95 % CI: 17.565-34.403) [GS]. The largest groups of clients in outpatient treatment in 2010 have cannabis (40 %) and opioids (27 %) as primary drug followed by stimulants (14 %) and cocaine (13 %). In inpatient treatment the respective proportions are 12 %, 52 %, 10 % and 17 % [Statistical Bulletin TDI-19]. According outpatient treatment data just 21 % of opioid users inject the drug (64 % are smoking the drug) [Statistical Bulletin TDI-17].

Regarding **infectious diseases** data provided by the Scientific Institute of Public Health in Brussels show that from the beginning of the epidemic until December 2009, 22.234 HIV-infected patients have been registered.

Figure 4:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

The proportion of IDUs among HIV cases decreased from around 8 % in 1985 to approximately 1 % in 2009 [CO]. The number of persons infected via IDU decreased significantly since 2003 (see Figure 4). Data on HIV prevalence among ever-IDUs from several sources of treatment data vary between 3 % and 6 % in 2010. The rates are moderately fluctuating without clear time trends in the last years [NR 2011].

The HCV prevalence among ever-IDUs varies from 28 % to 80 % based on drug treatment data. Looking into time trends there are no significant changes since 2003 [NR 2011].

There is no recent national statistic on the number of direct **drug-related deaths (drug-induced deaths)**. More recent statistics can be obtained from the regions. For the Flemish region, a recent increasing trend was observed, which is significant when comparing 2006 (40 cases) with 2008 (78 cases). On the other hand, a recent (however not significant) decreasing trend was observed for the Brussels Capital Region (2006:

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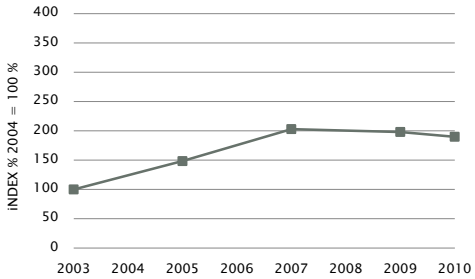
24 cases, 2008: 19 cases). In 2003 the respective numbers of drug-related deaths were 42 and 23 [NR 2011].

2.2 Indicators for drug-related harm reduction

In the French community, needle exchange programmes exist since 1994. In 2000, the Flemish community made the necessary legislative adaptations and in 2001, needle exchange programmes were also officially implemented. Similar coordinating programmes to those in the French community have been implemented (one in each province of Flanders). In 2009, approximately 309.823 syringes were distributed through needle exchange programmes in the French community while in the Flemish community the latest estimate (2009) indicates that approximately 637.000 syringes have been distributed with an exchange rate above 90 % in the French and 97 % in the Flemish communities. In the French community [GS], on top of the syringes exchanged through needle exchange programmes, a substantial amount of syringes are also sold in pharmacies via Sterifix (39.900 syringes in 2009) [CO]. Putting the numbers of syringes provided through needle and syringe programmes in the Flemish and the French community together a significant increase can be observed since 2003 (see Figure 5).

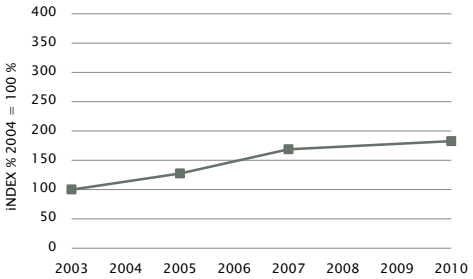
The number of clients in substitution treatment is increasing (see Figure 6). In 2010 8,505 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 5:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 6:
Number of clients in substitution treatment 2003 to 2009 (indexed – 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 HSR 3

2.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

Due to the Federal structure of the government in Belgium, the Federal Government has competence in matters others than prevention and harm reduction (e.g. regarding hospitals, social security, justice) [Trimbos 2006]. Still, it did adopt a Federal Drug Policy Note in 2001, which called for harm reduction measures, including the prevention of drug-related deaths.

The Flemish Community has a large competence in prevention and harm reduction [Trimbos 2006]. The French Community and the Walloon Region have also large competences in prevention and harm reduction [Trimbos 2006]. The same counts for the German Community [Trimbos 2006]. Harm reduction is a public health objective in Belgium, but it was not based upon the Council Recommendation with the exception of risk reduction measures in the Walloon region [Trimbos 2006].

In Belgium, developments took place in each of the Regional Communities [Trimbos 2006]. In the Flemish community, the prevention of drug dependence and the reduction of drug-related risks have been clearly formulated as an important public health objective [Trimbos 2006]. This has been stated in the policy declaration of the Flemish government, and more specifically in the policy note of the Flemish minister of Public Health. Before the end of 2007 the government aims to set clear the policy objectives concerning health damage that is related to the use of illicit drugs.

The five-year programme of health promotion (2004-2009) in the French Community contains a chapter on priority matters [SQ 23/29 2008]. One of these is the prevention of drug addiction, and inside this particular subject, one of the objectives of health promotion is the reduction of harm related to the consumption, given the context of consumption, the age and maturity of the consumers, the products, the environment, etc.. The prevention of acute drug-related deaths is in fact part of that strategy of harm reduction, but not a distinct written programme in itself. The objective of the DRID strategy, which is part of the national drug strategy, is the prevention of blood born viruses.

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In the French Community Commission (Brussels), services providing aid in drug-related matters can be officially approved and financed [Trimbos 2006]. Prevention and harm reduction can be one of their main tasks and goals. In the Walloon Region the policy objectives on the reduction of health-related harm associated with drug use are based upon the Council Recommendation [Trimbos 2006].

In the year 2010 a Communal Declaration was approved by the Interministerial Conference on Drugs, which in general supports the strategies of the previous Drug Policy Note [NR 2011]. It recognizes that the drug phenomenon is primarily an issue of public health and represents an integrated effort from different policy levels. It stipulates action points for future improvements and pursues a global and integral approach. Concerning treatment a diversified offer of treatment facilities, integrated in coordination networks is supported as well as an increase in treatment capacity. The continuation of the cooperation between the criminal justice system and the drug treatment services is supported. Risk reduction remains an objective, but rather implicit than explicit. Three pilot projects, which started in 2002, are still being supported financially by the federal state, to implement the federal drug policy [NR 2011]. These projects contain crisis intervention units and case management, intensive treatment of patients with dual diagnosis as well as the networks for integrated drug treatment programmes with a health coordinator.

In the Flemish Community, drug policy is based on the Action Plan on Tobacco, Alcohol and Drugs 2009-2015, which focuses on the promotion of public health by reducing drug use [NR 2011]. In the French Community, public health objectives including drug-related health issues are tackled within the Programme on Health Promotion 2004-2009 and the corresponding Operational Community Plan 2008-2009 [NR 2011]. Both were prolonged until mid-2012.

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

To prevent drug-related infectious diseases among drug users, providing information, education and communication (IEC) in general is a predominant [Trimbos 2006] but not a priority response strategy [SQ 23/29 2011]. IEC via counselling and advice by drugs and health professionals is a common response strategy in Belgium [Trimbos 2006].

Telephone help lines, websites, and a broad range of educational leaflets are available nationwide in Belgium [Trimbos 2006].

Practical advice and training on safer injecting is not a priority response strategy in Belgium, still it is provided extensively[3] in the Flemish Community and to a limited extent in the French Community [SQ 23/29 2011]. Individual counselling is a priority response to prevent DRID in the Flemish Community and is provided extensively also in the French Community [SQ 23/29 2011]. "Easy-access" programmes to treatment of infectious diseases are not a priority response strategy and there is no information on its availability [SQ 23/29 2011].

3
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

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Concerning the prevention of drug-related emergencies and deaths, there is no specific strategy in Belgium. Overdose information material is provided rarely in the French Community and it is not available in the German Community [SQ 23/29 2011]. Overdose response training is provided to a limited extent in the Flemish Community, rarely in the French Community and it is not available at all in the German Community [SQ 23/29 2011]. This means, that risk education and overdose response training is available in more than a few relevant cities (but not in a majority of them) in the Flemish Community and in just a few relevant cities in the Flemish Community [SQ 23/29 2011]. Individual overdose risk assessment is provided to a limited extent in the Flemish Community and rarely in the French Community [SQ 23/29 2011].

Information material to reduce drug-related harms in night clubs is provided to a limited extent in the Flemish and French Community and rarely in the German Community [SQ 23/29 2011]. At large music festivals this kind of information is provided extensively in the Flemish Community, to a limited extent in the French Community and rarely in the German Community [SQ 23/29 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Specific materials on the prevention of acute drug-related deaths and drug-related emergencies are not available for police, prison staff or family/ friends in Belgium, but in the French Community it is available for night club staff [SQ 23/29 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

To prevent drug-related infectious diseases among drug users, outreach work as a health education approach is a common response strategy in Belgium [Trimbos 2006]

and a priority strategy in the French Community [SQ 23/29 2011]. The availability of outreach work and targeted high risk group interventions as implementation settings for drug-related infectious diseases prevention measures varies greatly in Belgium (in geographical coverage) [Trimbos 2006].

In the French Community the main outreach health education approach is to work with street educators [SQ 23/29 2011]. The main outreach health education approaches in the Flemish Community are peer support and peer education, outreach work and streetcorner work [SQ 23/29 2008]. In the German Community it is basic health education plus specific information, spread through various materials (e.g. flyers) or through one-on-one or group counselling [SQ 23/29 2008]. It is not a systematic health education for drug users, but rather individual education or education based on the present situation/demand.

Outreach work is provided at night clubs in the Flemish Community to a limited extent, in the French and German Community only rarely. Outreach work at large music festivals is provided extensively in the Flemish Community and only to a limited extend in the French Community [SQ 23/29 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer involvement is not a priority response to prevent DRID in Belgium, but peer educators are involved in responses to prevent DRID in the Flemish and the French Community [SQ 23/29 2011]. Training for outreach workers is organized and is also available for peers and volunteers, if they are involved in outreach work [Trimbos 2006].

Naloxone is not available on a “take-home“ basis in Belgium [SQ 23/29 2011].

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Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies exists nationwide [Trimbos 2006].

The Belgian Early Warning System on Drugs exists since 2002 and provides information on new psychoactive drugs, unusually high concentrations or high risk combinations [NR 2011].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Drug-free inpatient and drug-free outpatient treatment facilities, methadone detoxification programmes, treatment with methadone, buprenorphine and naltrexone, rehabilitation centres and drop-in centres/shelters are available nationwide [Trimbos 2006] and are provided fully [SQ 27 p1 2011]. Treatment interventions for specific target groups are available for cocaine and cannabis users [SQ 27 p1 2011].

There are no waiting times for detoxification in the Flemish Community, while the waiting times for outpatient and inpatient psychosocial treatment varies widely between different facilities, due to limited availability/resources [SQ 27 p1 2011].

In 2009 9.300 clients in treatment were registered [NR 2011]. OST is carried out with methadone and buprenorphine [NR 2011]. In the year 2010 15.395 persons received OST with methadone and 2.227 with buprenorphine [NR 2011].

Substitution treatment is supported by psychosocial care and provided fully [SQ 27 p1 2011], sometimes obligatory and sometimes upon request by the client (depending on the institution or general practitioner) [Trimbos 2006].

Drug consumption rooms and heroin prescription programmes do not exist in Belgium [SQ 23/29 2011 and Trimbos 2006].

Specific programmes are carried out as national pilot projects or as a part of an international study [NR 2011]:

» A multidimensional family therapy with a broad array of interventions is offered for adolescent cannabis users since 2003.
» Intensive treatment of patients with double diagnosis is offered since 2002.
» Emergency departments offer since 2002 crisis beds for the treatment of substance-related disorders with a maximum stay of five days, including assessing the acute somatic situation and intensive treatment, and a guaranteed continuity of care afterwards, which lies in the responsibility of a case manager.
» Since 2010 clients are included in a pilot-project on medically assisted treatment with diacetylmorphine, the treatment phase started in January 2011.

Currently, case management of substance abuse patients is very heterogeneous within Belgium. Recommendations propose a systematic implementation of crisis care methods to increase this capacity [NR 2011].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are available nationwide in Belgium [Trimbos 2006].

In the Flemish Community medical doctors at specialised drug treatment centres, specialised medical doctors and any medical doctor can initiate and continue OST with methadone [Statistical Bulletin 2011]. The initiation of OST with high dosage buprenorphine can only be done by medical doctors at specialised drug treatment centres and specialised medical doctors [Statistical Bulletin 2011]. Methadone and high dosage buprenorphine can be dispensed at specialised treatment centres, specialised medical doctors' offices, pharmacies and mobile outreach units [Statistical Bulletin 2011].

In the French Community any medical doctor can continue methadone treatment, while the treatment can only be initiated by medical doctors at specialised drug treatment centres [Statistical Bulletin 2011]. Any medical doctor can initiate and continue treatment with high dosage buprenorphine or the combination of buprenorphine and naloxone [Statistical Bulletin 2011]. Methadone can be dispensed at specialised

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treatment centres, specialised medical doctors' offices, any medical doctor office, pharmacies and mobile outreach units, while high dosage buprenorphine and the combination of buprenorphine and naloxone can only be dispensed at specialised treatment centres and pharmacies [Statistical Bulletin 2011].

There are no conditions of taking substitution substance doses home, but it is stated that: "The general practitioner prescribing substitution treatment can fix other rules for the administration of the product if the medical or psycho-social situation of the patient requires it" [SQ 27 p1 2011].

Since 2009 prescriptions for methadone and buprenorphine are registered in the Pharmanet-system of the National Health Insurance Institution (NIHDI) to avoid multiple prescriptions and allow warnings of concerned practitioners [NR 2011].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

There is a specific strategy for drug-related prison health (separate document) in the Flemish Community, while drug-related health policies for prisons are dealt with at regional level in the French Community [SQ 23/29 2011]. IDUs are mentioned as target group in the national strategy on the prevention of infectious diseases, but no information on drug users in prisons is provided [SQ 23/29 2011]. As special care for certain target groups was reported as inadequate, the Minister of Justice has announced the construction of two Psychiatric Forensic Centers in 2008 to provide appropriate mental health services [NR 2011].

To prevent DRID in prisons, in the Flemish Community, HCV testing on prison entry is provided fully, practical advice and training on safer use is provided extensively and HCV testing on release from prison is provided to a limited extent only [SQ 23/29 2011]. A hepatitis B vaccination programme for PDUs is available in prisons. Diagnosis of HIV and hepatitis B as well as antiretroviral treatment and interferon therapy are also offered [NR 2011].

In the French Community individual counselling on infectious diseases risk as well as HCV testing on prison entry is provided to a limited extent [SQ 23/29 2011]. A hepatitis B vaccination programme for PDUs is not available in prisons. Pre-release overdose

counselling is provided rarely. A peer support project runs repeatedly in several French prisons [NR 2011].

A booklet on drug-related health problems and risk behaviour in prison was made by and for prisoners and is available in French prisons since 2009, in Flemish prisons since 2011 [NR 2011]. In addition, in 2011 a new information campaign on hepatitis C oriented at prisoners was launched [NR 2011].

Since 2010 short duration group therapy is offered for drug users in a pilot prison, preparations for a first therapeutic community in the Belgian prison system are included in the Action Plan of 2010 [NR 2011]. Since 2009 a drug-free section is offered in one prison, using standardized procedures for screening, intake of prisoners and voluntary testing as well as relapse therapy and training of social and administrative skills [NR 2011]. Detoxification as well as initiation and continuation of OST is possible in Belgian prisons [SQ 27 p1 2011]. Substances used for OST are methadone and buprenorphine [NR 2011].

Since 2000 a formalised procedure is in place for testing, screening and treatment of hepatitis and HIV in Belgian prisons [SQ 23/29 2011]. A ministerial draft circular (nr 1785, July 18th 2006) stated that: "The medical services (of prisons) will ensure that the detainees presenting an at risk profile are actively encouraged to let themselves screened and vaccinated for Hepatitis A and B" [SQ 23/29 2011]. Nonetheless, no systematic policy is implemented to lead the detainees to talk about their consumption and risky behaviour, and no systematic policy of vaccination is applied [SQ 23/29 2011].

There are no NSPs in Belgian prisons [NR 2011], but in the Flemish Community formal NSP training is provided for prison staff [SQ 23/29 2011]. Bleach is available as household item in prisons, but is not distributed by Health Care Services [NR 2011]. A special package containing condom and lubricant was developed in 2009, but neither used nor efficiently distributed [NR 2011]. As a consequence, the availability of and low threshold accessibility to condoms was included in the last Action Plan on Drug Policy in Belgian Prisons [NR 2011].

Prison staff is informed during trainings on risk behaviour, drug use, drug policy, effects of drugs and drug users behaviour [NR 2011].

Educational courses are organized inside prisons as well as housing and employment in preparation of release [NR 2011]. These services are not special for drug users. Specific programmes for this target group are available only partially. Since 2011 Central Intake Units are installed in prisons in the Flemish Community, which are responsible for the assessment of treatment needs upon prison release [NR 2011]. Prisoners can apply for a consultation or follow referral of services intramuros or

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extramuros. The implementation of such Central Intake units is planned also in the French Community.

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination scheme, but a risk-group specific hepatitis B vaccination programme is not a priority response strategy to prevent DRID and is not available in Belgium [SQ 23/29 2011].

Voluntary counselling and testing is not but provider-driven infectious diseases testing is a priority response to prevent DRID in Belgium [SQ 23/29 2011]. As a consequence, HCV testing is provided extensively [SQ 23/29 2011].

In specific geographical areas only, vaccination against tuberculosis, targeting at drug users, is available [Trimbos 2006].

Other measures like routine screening of high risk groups and "easy-access" programmes to treatment of infectious diseases are not priority response strategies to prevent DRID in Belgium [SQ 23/29 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

NSPs are a priority response to prevent DRID and they are provided extensively in the Flemish Community and to a limited extent in the French Community [SQ 23/29 2011].

In the Flemish Community since 2001 a network of healthcare professionals and pharmacists is involved in NSPs. NSPs are provided by 20 fixed locations and 25 pharmacies, syringes are provided also by 10 syringe provision points (SPPs) from outreach services [ST 10 2011]. In the year 2010 489.552 syringes were provided by

NSPs in fixed locations in the Flemish Community, 80.250 by pharmacies and 1.941 by outreach services [ST 10 2011]. Standard items in injecting kits in the Flemish Community are injecting material (including syringes) filters, information materials, alcohol pads, sterile water, containers to recover syringes, ascorbic acid and condoms [SQ 23/29 2011 and NR 2011]. If the drug user smokes cocaine, foil and bicarbonate is also available. Injecting kits are provided to a limited extent [SQ 23/29 2011].

In the French Community the NSP, which was running since 1994, was reorganized in 2008 [NR 2011]. NSPs are provided by 16 fixed locations and 18 other services (which are not officially – with a specific accreditation), syringes are provided also by 10 syringe provision points (SPPs) from outreach services [ST 10 2011]. In the French Community 297.260 syringes were provided by NSPs at fixed locations and 38.220 by pharmacies [ST 10 2011]. Standard items in injecting kits are information materials, alcohol pads and water [SQ 23/29 2011]. Injecting kits are provided rarely. In the "Stérifix" project, pharmacists sell special bags for € 0,50 – containing two syringes, two alcohol pads, two dry post-injecting pads, two spoons, two flasks of sterile water and harm reduction information [NR 2011].

Formal NSP training programmes regarding health promotion activities are available for pharmacists in the Flemish Community, but not in the French Community [SQ 23/29 2011]. There have been several surveys on the attitude of pharmacists towards syringe exchange programmes [SQ 23/29 2011]. In the most recent one, the pharmacists of Brussels answered at 92 % that harm reduction was one of their missions and at 79 % that syringe exchange was fulfilling that harm reduction mission [SQ 23/29 2011].

The promotion of condoms is not priority response strategies to prevent DRID in Belgium [SQ 23/29 2011]. Still, condoms are provided at drug agencies with NSPs fully in the Flemish Community and to a limited extent in the French Community [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Belgian ambulances routinely carry antagonists [Trimbos 2006]. The distribution, possession or administration of naloxone is regulated by law and regulations and is limited to medical personnel [SQ 23/29 2011]. Naloxone is only available on medical prescription and only in hospitals. Naloxone on a "take-home" basis is not available [Trimbos 2006].

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Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Harm reduction is part of an integrated health strategy for drug users [Trimbos 2006].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

A system for continued education on drug treatment is available for social workers, nursing staff, psychologists, medical doctors, ortho-pedagogists and criminologists in the Flemish Community but not in the French Community [SQ 27 p2 2008]. Specialised courses/training on drug treatment are implemented for social workers only [SQ 27 P2 2011].

Training for professionals in substitution programmes, in low threshold agencies and treatment facilities is available in specific geographical areas only [Trimbos 2006].

Formal NSP training programmes regarding health promotion activities are available for drug agencies staff, pharmacists, prison staff and other groups (streetcorner work, IDU's and peer support groups) in the Flemish Community but not in the French Community [SQ 23/29 2011].

Occupational standards for drug treatment are not available in Belgium [SQ 27 p2 2008].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

The Flemish Community has adopted a standard procedure for the development of new strategies [Trimbos 2006]. In the Walloon region, French Community and COCOF (Brussels) research on scientific evidence is not developed sufficiently [Trimbos 2006].

In Brussels, a research project was run about the pertinence of a harm reduction intervention in recreational settings in 2002 [Trimbos 2006]. At federal level, the activities take place in research and development of evidence-based new concepts, information, training, networking and coordination [Trimbos 2006]. Provincial networks, involved in the coordination, implementation of concepts and data collection have no longer a covenant with the Flemish government, but will be coordinated by the provinces [Trimbos 2006].

There are no national harm reduction guidelines in Belgium, but several treatment guidelines [Best Practice Portal]:

» Maintenance treatment of opiate addicts with buprenorphine (2005)
» Guidelines for the treatment of opiate addiction (2000)
» Guidelines for the prescription of benzodiazepines to illegal drug users (2008)

There are sub-national guidelines for assessment of infectious disease risk among drug users and for NSPs in the Flemish Community [SQ 23/29 2008]. In the French Community there is a snowball handbook (which is translated in several European languages) and the handbook "Drugs, reduce the risks", on guided distribution of leaflets in recreational settings (peer prevention) [SQ 23/29 2008] and the sub-national guideline "Quality Nights" [SQ 23/29 2011].

The institution responsible for developing guidelines is VAD:
(http://www.vad.be/evidence-based-werken/richtlijnen.aspx) [SQ 27 p2 2011].

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The Communal Declaration 2010 refers to the Belgian Science Policy as an instrument for evidence-based policing [NR 2011].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

The Flemish Community has adopted a standard procedure for the development of new strategies [Trimbos 2006].

Needs assessments are used at the initial stage of programmes to some extent, there was an increase since 2003 [PS]. During the health conference, which was organized in 2006 by the Flemish Community (the subject was prevention of health damage caused by tobacco, alcohol and drugs), effort was invested in involving relevant professionals, working in different settings: drug prevention and care, schools, work, general healthcare, organisations working with families, local government, youth work. They participated in the process of selecting the interventions and strategies included in the action plan 2009-2015.

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

In the Flemish Community a scientific report concerning the feasibility of different kinds of criteria for evaluation was ordered [Trimbos 2006]. This report will be used for the development of a system of evaluation.

Community and Regional stakeholders have power to implement certain drug-related prevention and treatment programmes [Trimbos 2006]. The French-speaking Community e.g. says to evaluate results, the context and the means used [Trimbos 2006]. In the Flemish Community, the government has changed its policy from projects to covenants [Trimbos 2006]. In these covenants clear objectives and indicators are formulated and every organisation reports annually on the basis of these indicators. Within the development of concepts and methods, systematic evaluation of process and implementation is carried out. Some specific drug-related prevention and harm reduction projects or programmes are evaluated at regular basis. In practice the policy

initiatives are evaluated using indicators specifically created for them. Objectives are to be chosen according to the drug situation, for optimal results to be attained.

All health promotion projects funded by the French Community must have an evaluation built in the project [Trimbos 2006]. In addition, the French Community is funding two departments in universities (Promes in ULB and Ceres in ULG) to provide technical support and to advise the promoters of the projects. However, most evaluations are process evaluation and internal evaluations [Trimbos 2006].

There is a research programme for evaluation (http://www.health.belgium.be/eportal/Myhealth/Risksanddiseases/Healthrisks/drugs/index.htm), but there were no relevant research projects on treatment in the last years [SQ 27 P2 2008 and 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

The Flemish Community has ordered a scientific report concerning the feasibility of different kinds of criteria for evaluation [Trimbos 2006]. This report will be used for the development of a system of evaluation.

An organisation in the Flemish Community (De Sleutel) uses the 'European Foundation of Quality Management' model (EFQM) [Trimbos 2006]. The model has two main principles: self-evaluation and self-control. The model focuses on aspects that can be optimized and takes into account organisational and result indicators.

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

The implementation of standardised data collection according to the EMCDDA recommendations is pending for approval in Belgium [Trimbos 2006]. Regarding the Treatment Demand Indicator (TDI) a national political decision has to be taken regarding the

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implementation of the registration data at national level. Some communities already have their own system of data collection, but these are not necessarily in line with the TDI/EMCDDA protocols.

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

Until 2002, Belgium has lacked any significant, concrete data on the drug policy it is pursuing [Trimbos 2006]. No comprehensive overview exists of all the actors directly and indirectly involved, or of differences between funding sources. At Federal level a policy plan was developed in which four domains were defined to implement a Flemish drug policy 2002-2005. The plan contains different actions in each domain, with indicators for evaluation. The main area of work are: research and development of evidence-based new concepts, information, training, networking and coordination.

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Evaluation training programmes for different levels and audiences exist in Belgium to some extent, there was an increase since 2003 [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

A broad range of actors and stakeholders is involved in evaluation to some extent, there was no change since 2003 [PS]. In general, the methodologies used to evaluate prevention activities, have an extensive focus on involving stakeholders in all phases of the programme, including evaluation. Still, experiences from the field show that it is often difficult to motivate stakeholders who are not specifically drug-related. Thor-

ough evaluation demands a considerable amount of resources. The challenge for the future is, to develop a common, standardised and adapted (not only quantitative, but mainly qualitative) protocol and culture of evaluation in the country.

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

Since April 2004, Trempoline has introduced the Europ-ASI questionnaire for each client of the institution [Trimbos 2006]. This tool aims to measure the severity of addiction of new clients, to follow the evolution of the clients and to assess the outcome of the treatment. This instrument also offers the possibility to compare results with other Therapeutic Communities in Belgium and in the EU.

Professionals have access to opportunities for exchange of programme results, skills and experience at European level to some extent, there was no change since 2003 [PS]. Translation of the entire EDDRA database of the EMCDDA in all Member States languages could help to increase opportunities for exchange.

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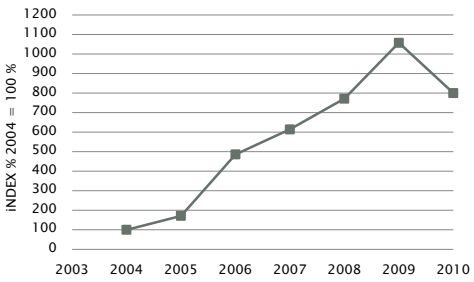
3 Country Profile Bulgaria

3.1 Indicators for drug-related harm

In 2009, based on police data, emergency data and treatment demand data there were estimated to be between 23.050 and 42.920 (4 to 8 per 1.000 inhabitants aged 15-64) **problem drug users (long term/ regular opioid and/ or cocaine or stimulant users)** in Bulgaria [NR 2011]. Almost all clients (97 %) in outpatient treatment in 2010 have opioids as primary drug. In inpatient treatment opioids are the primary drug in 70 % of all clients followed by other substances (18 %) and hypnotics/sedatives (8 %) [Statistical Bulletin TDI-19]. According outpatient treatment data 82 % of opioid users inject the drug [Statistical Bulletin TDI-17].

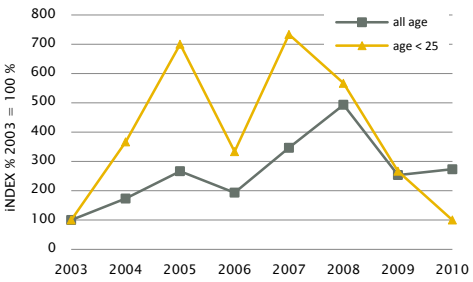
Regarding **infectious diseases** data provided by the National HIV Confirmatory Laboratory (NCL) show a significant increase of persons infected with HIV via IDU since 2003 until 2009. In 2010 the number is lower than in 2009 (see Figure 7). In 2009 74 newly detected HIV-positives stated to have been infected via IDU and in 2010 56.

Figure 7:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2004=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 8:
Number of drug-related deaths (indexed - 2003=100 %) by age



Source: EMCDDA Statistical Bulletin, DRD-2

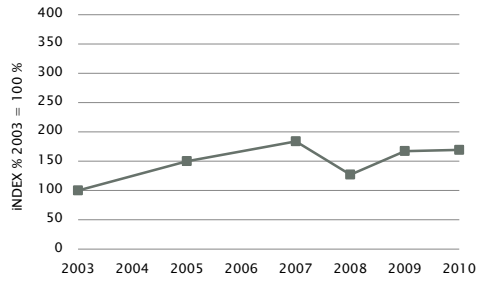
Concerning infections rates among IDUs data for Sofia is available only. Based on different treatment and low threshold samples the prevalence rate of HIV is 2 % and 62 % are HCV positive. The prevalence rate of HCV is slightly higher than in the last years [NR 2011].

The number of **direct drug-related deaths (drug-induced deaths)** increased significantly till 2008 followed by a decrease. (see Figure 8). In 2003 the number of drug-related deaths was 15 and in 2008 74 [Statistical Bulletin, DRD-2].

3.2 Indicators for drug-related harm reduction

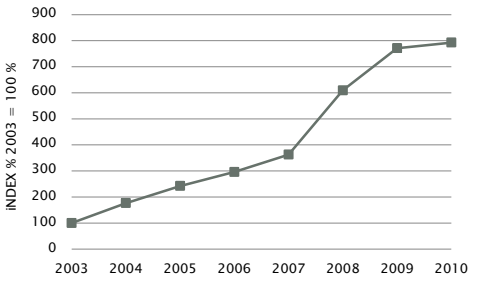
In 2010, eleven non-governmental organisations carried out activities aimed at prevention of drug-related infectious diseases. These NGOs target risk groups such as drug users of Roma origin, sex workers and IDUs, and provide services such as needle and syringe exchange, dissemination of information materials on safe injecting, overdose and infectious diseases. Services are provided through outreach work, mobile units or drop-in centres located in various cities across the country [CO]. The number of syringes provided through needle and syringe programmes increased since 2003 (see Figure 9). Interpreting the time trend it has to be taken into account that in 2008, a new Internet-based system for all needles and syringe exchange reporting agencies was set up (in the previous years the numbers are estimates [CO]. The number of clients in substitution treatment is increasing significantly (see Figure 10). In 2010 1.573 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 9:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 10:
Number of clients in substitution treatment (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

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3.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

Prevention of drug-related infectious diseases is an integral part of the National Programme for Prevention and Control of HIV and Sexually Transmitted Infections in Bulgaria (2008-2015) and the National Anti-Drug Strategy (2009-2013) [NR 2011]. Since 2007 there is also a Programme for Prevention and Control of Tuberculosis [NR 2011].

The national drug strategy includes the objectives to reduce health and social risks and harms associated with drug use as well as to provide support for survival [SQ 23/29 2011]. This includes [SQ 23/29 2011]:

- Developing programmes and services for the reduction of risk behaviour and the provision of support for survival
- Developing programmes and services for the reduction of the prevalence of drug-related infectious diseases HIV/AIDS, Hepatitis B and C, sex transmitting diseases and tuberculosis
- Providing and developing stable funding for needle/syringe exchange programmes and condoms distributing programmes
- Developing activities for screening and voluntary testing (including field testing) for blood and sex transmitting diseases, pre-test and post-test counselling and referral
- Creating opportunities for timely medical assistance and treatment for drug users
- Developing vaccination campaigns and programmes for Hepatitis B and tuberculosis for drug users
- Developing programmes and services for reducing drug-related incidents and mortality
- Developing information and educational programmes for volunteers, drug users and their relatives about practices reducing overdose risk and first aid applying in emergency cases (including Naltrexon)
- Providing training and medicines to the emergency centres on overdose emergency cases
- Providing quality and effectiveness assessment of the harm reduction services

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

The dissemination of information material is a priority response strategy to prevent DRID in Bulgaria, while practical advice and training on safer injecting is not [SQ 23/29 2011]. Still, individual counselling on infectious diseases as well as safer use training is provided, but to a limited extent[4] [SQ 23/29 2011]. "Easy-access" programmes to treatment of infectious diseases is also not a priority and there is no further information on the availability of such programmes [SQ 23/29 2011].

Overdose information material and overdose response training is provided to a limited extent only [SQ 23/29 2011]. Risk education and OD training is not available [SQ 23/29 2011]. Individual OD risk assessment is not available at all [SQ 23/29 2011].

There is no information regarding the prevention and reduction of harm associated with drugs usually consumed at night clubs and large music festivals [SQ 23/29 2011].

4
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Specific material on prevention of acute drug-related deaths and drug-related emergencies is not available for police and there is no information regarding the availability for prison staff, family/ friends, night club staff or other groups [SQ 23/29 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach health education is not a priority response to prevent DRID [SQ 23/29 2011]. Education and outreach have been performed separately by two different organizations in Bulgaria - Municipal Prevention and Information Centers on Drugs on the one hand side and outreach programmes on the other hand [SQ 23/29 2011]. Outreach programmes exchange also syringes and needles, provide condoms, lubricants as well as information and offer blood testing for sexually transmitted diseases [NR 2011].

The provision of outreach work at night clubs and in large music festivals does not exist [SQ 23/29 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer involvement is not a priority response to prevent DRID and peer educators are not involved in the responses to prevent DRID [SQ 23/29 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

The availability/coverage of networking and cooperation between agencies involved in outreach work is rated as limited, there was no change since 2003 [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

In Bulgaria, substitution treatment is provided extensively and detoxification (in- and out-patient) fully, while drug-free psychosocial out-patient and in-patient interventions are available to a limited extend only [SQ 27 p1 2011]. There is a waiting time for OST of more than 6 months in public institutions, whereas in private clinics there is no waiting time [SQ 27 p1 2011]. For detoxification the waiting time is less than 2 weeks and there is no waiting time for outpatient psychosocial treatment [SQ 27 p1 2011]. Concerning inpatient psychosocial treatment there is no information regarding the waiting times [SQ 27 p1 2011].

Specific treatment interventions for target groups are available for benzodiazepine users only [SQ 27 p1 2011].

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Psychological support is provided to OST clients fully [SQ 27 p1 2011].

In the year 2009 3.104 clients received OST in Bulgaria [Statistical Bulletin 2011]. The substances used for OST are methadone and slow-release morphine [NR 2011]. In the year 2010 in Bulgaria 30 substitution and maintenance programmes offered in total 5.210 treatment slots, of which the majority was dedicated to treatment with methadone [NR 2011].

Drug consumption rooms are not available in Bulgaria [SQ 23/29 2011].

A report on the implementation of the 2009 Action Plan came to the conclusion, that there is a well developed network of treatment centres and successfully operating treatment programmes, which is still in a process of development and expansion and is [NR 2011]. But a reduction of treatment slots for psychosocial rehabilitation was reported in 2011 [NR 2011]. In the year 2010 485 clients participated in rehabilitation programmes, TDI data show 1.573 clients starting treatment in the year 2010 (inclusive substitution maintenance and detoxification) [NR 2011].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Medical doctors at specialised drug treatment centres and psychiatrists can initiate and continue substitution treatment with methadone and slow release morphine [Statistical Bulletin 2011]. Both substances can be dispensed at specialised treatment centres only [Statistical Bulletin 2011].

"Take-home" doses are possible under the following conditions only [SQ 27 p1 2011]:

- Current absence of drug use (proven by everyday monitoring of the patient and urine tests)
- Regular visit of the programme
- Lack of criminal behaviour
- Lack of behaviour problems within the programme
- Presence of support in the family and social environment
- Continued period in the programme (most leaders recommend applications to be discussed after a period of at least three months, and the maximal quantity cannot be larger than the doses for one week during the first year and the dose for two weeks during the second year of treatment)
- Stable health status

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Low intensity drug treatment is provided fully by prison health services, community based services and NGOs [SQ 27 p1 2011]. Medium/high intensity drug-free treatment is not available in prisons [SQ 27 p1 2011]. The initiation and continuation of OST in prison is possible [SQ 27 p1 2011]. In 2008 the prison personnel was provided with the appropriate training and meanwhile substitution programmes should have been implemented in 4 prisons [SQ 27 p1 2008].

Prisoners with alcohol and/or drug dependence are placed under observation by a psychiatrist who prepares a treatment schedule [NR 2011]. Compulsory treatment is provided in one prison, prisoners can also be transferred to this treatment on their behalf [NR 2011]. Substitution treatment can be continued in prison or detention facility and is carried out by the responsible medical officers [NR 2011].

IDUs are mentioned as the target group of the DRID strategy, but no information on drug users in prison is provided [SQ 23/29 2011].

There is no information on the availability of specific responses to prevent DRID in prisons, like individual counselling on risks concerning infectious diseases, HCV testing, practical advice and training on safer use [SQ 23/29 2011]. Hepatitis B vaccination programmes for PDUs and NSPs are not available in prisons and therefore also no formal NSP trainings for prison staff [SQ 23/29 2011]. Naloxone is not provided upon prison release [SQ 23/29 2011]. But in 2010 voluntary consultation and testing for HIV/AIDS and sexually transmitted diseases was carried out in penitentiaries and supplemented by group lectures on infectious diseases [NR 2011].

In 2010 a campaign dedicated to health education was carried out in Sofia Prison, which trained prisoners on the following issues [NR 2011]:

- Narcotic drugs, safe injection
- HIV/AIDS, hepatitis, tuberculosis, sexually transmitted infections
- Opportunities for drug-free treatment and substitution treatment
- Prevention of overdoses

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Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination scheme [SQ 23/29 2011] and started in Bulgaria 1993 [SQ 23/29 2008]. But a risk-group specific hepatitis B vaccination programme is not available [SQ 23/29 2011].

Voluntary infectious diseases counselling and testing (VCT) is a priority response to prevent DRID and HCV testing is provided extensively [SQ 23/29 2011]. Hepatitis vaccination programmes, routine screening of high risk groups and "easy-access" programmes to treatment of infectious diseases are not priority strategies to prevent DRID [SQ 23/29 2011]. Testing for HIV as well as treatment of HIV/AIDS, hepatitis C and syphilis is provided in Bulgaria without fee in specialized units [NR 2011].

While the role of substitution treatment in preventing the spreading of HIV and hepatitis B and C is mentioned positively, at the same time difficulties are being reported [NR 2011]. These range from patients dropping out of treatment because of their inability to pay the fees of private treatment services or insufficient funding of the programmes to the impossibility of treating substituted clients for hepatitis C due to a consensus of gastroenterologists [NR 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

NSPs are a priority response strategy to prevent DRID in Bulgaria and are provided extensively [SQ 23/29 2011] at 98 fixed locations of outreach services [ST 10 2011]. NSPs are not available at pharmacies and there is no information on sales of syringes in pharmacies [ST 10 2011]. In the year 2010 676.898 syringes were distributed [ST 10 2011].

Injecting kits are provided rarely, the standard items in these injecting kits are water, containers, acid and condoms [SQ 23/29 2011].

The provision of condoms is not a priority response strategy in Bulgaria, but condoms are provided by drug agencies with NSPs extensively [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Naloxone is regulated by law and administrative regulations [SQ 23/29 2011]. Naloxone is available for the emergency staff only [SQ 23/29 2008]. Naloxone is part of standard ambulance equipment and ambulance personnel is trained in naloxone use [SQ 23/29 2011]. Naloxone is not available on a "take-home" basis [SQ 23/29 2008].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Bulgaria does not have a primary healthcare strategy [SQ 28 2010].

The accomodation needs, education needs and employment needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan or in the written drug policies [SQ 28 2010].

But there are programmes funded by the state which are addressing social issues. The Operational Programme "Human Resources Development" (2007-2013) included activities supporting drug addicts [NR 2011]. One of them is the "National Programme for Employment and Vocational Training of Persons with Permanent Disability", which is accessible for those persons, who are unemployed and successfully completed a course of treatment for drug addiction [NR 2011]. Training for acquisition and improvement of key competencies and of professional qualification is provided as well as employment and social insurance for up to 36 months [NR 2011]. Unemployed drug addicts may also use services under the Law on Employment Promotion like psychological assistance, vocational guidance, inclusion in trainings [NR 2011].

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Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

A national system for continued education in drug treatment is available for social workers, nursing staff, psychologists, psychiatrists, medical doctors and counselors with personal experience (ex-users) [SQ 27 P2 2011]. The National Centre for Addictions is responsible for both, content and implementation of this continued education [SQ 27 P2 2011].

In addition, there are specialised courses/trainings on drug treatment as well as occupational standards for drug treatment available for psychiatrists, medical doctors and counselors with personal experience (ex-users) [SQ 27 P2 2011].

The institution responsible for developing guidelines is National Centre for Addictions (www.ncn-bg.org) [SQ 27 P2 2011].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

There are national quality guidelines for treatment [SQ 27 P2 2011; Best Practice Portal]:

- Consensus regarding good practice in addiction treatment – (2002)
- Consensus regarding good practice in rehabilitation of addictions (2005)
- Guidelines for good practice in psychosocial rehabilitation of addictions
- Guidelines for good practice in substitution treatment – (2008)

There are no national guidelines for harm reduction [SQ 23/29 2011 and Best Practice Portal]. The institution responsible for developing guidelines is National Centre for Addictions [SQ 27 P2 2011].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

This policy does not exist in Bulgaria, but it is pending for approval [PS]. Therefore needs assessments are not used at all at the initial stage of programmes.

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation aspects are included in the national guidelines for pharmacological treatment (outpatient settings), psychosocial assisted treatment (outpatient) and psychosocial treatment only (outpatient and inpatient) [SQ 27 P2 2011]. But drug treatment outcomes are evaluated in the outpatient psychosocial treatment only [SQ 27 P2 2011].

There is no national research programme for evaluation and there have been no relevant research projects on treatment during the last 2 years [SQ 27 P2 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

Quality criteria are used in evaluations to some extent, there was an increase since 2003 [PS].

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Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Standardised data collection exists in Bulgaria to a large extent, there was an increase since 2003 [PS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

This policy does not exist in Bulgaria, therefore evaluation results are not used for further development of drug prevention policies [PS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

This policy does not exist in Bulgaria, therefore evaluation training programmes are not available [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

This policy does not exist in Bulgaria, therefore no broad range of actors and stakeholders is involved in evaluation [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

Professionals in Bulgaria have access to opportunities for exchange of programme results, skills and experience at European level to some extent, there was a strong increase since 2003 [PS].

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4 Country Profile Cyprus

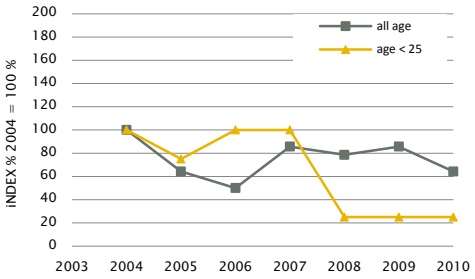
4.1 Indicators for drug-related harm

In 2010, based on treatment demand data there were estimated to be between 578 – 744 opiate users (1,0–1,3 per 1.000 inhabitants aged 15–64) and the total number of **problem drug users (long term/ regular opioid and/ or cocaine users)** was estimated at 774–993 (1,3–1,7 per 1.000 inhabitants aged 15–64) [NR 2011]. There is no clear trend in PDU population sizes over the years and the figures shall be treated with caution due to the methodological limitations. In 2007 and 2009, an increase of estimated PDU population was noted. In the first instance it was attributed to a significant increase of foreigners seeking treatment during a reporting year, but in 2009, to an increase of availability of OST in the country. However, in 2008, a decrease of estimated opiate PDU population was attributed to the lower treatment demand, a lack of prison data and a significant decline of foreigners recorded in treatment [CO].

The largest groups of clients in outpatient treatment in 2010 have cannabis (43 %) and opioids (42 %) as primary drug. In inpatient treatment the respective proportions are 9 % and 84 % [Statistical Bulletin TDI-19]. According outpatient treatment data 64 % of opioid users inject the drug (30 % are smoking/inhaling) [Statistical Bulletin TDI-17].

Regarding **infectious diseases** data provided by drug treatment centres and prisons show that in 2009, 0 to 1,3 % users reported being HIV positive.

Figure 11:
Number of direct drug-related deaths ((indexed - 2004=100 %) by age



Source: EMCDDA Statistical Bulletin, DRD-2

Since 2005, four HIV cases have been reported due to injecting drug use in Cyprus [CO]. HCV prevalence of IDUs tested increased from 46,5 % in 2009 to 51,3 % in 2010. The increase may be explained by the increase in the high risk behaviours reported by the users [NR 2011]. Among 115 tested injecting drug users in 2009, 0,9 % were found positive for hepatitis B. However, the above results should be treated with caution as the data coverage is low [CO].

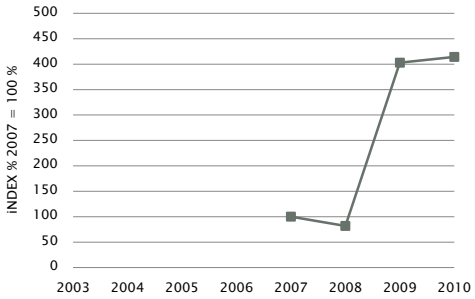
The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** seems to be stable since beginning of data collection in 2004. In the age-group < 25 a decrease can be seen (see Figure 11).

4.2 Indicators for drug-related harm reduction

Syringe exchange programmes are in an initial stage (40 needles exchanged in 2009 and 178 in 2010).

The number of clients in substitution treatment is increasing (see Figure 12) from 71 in 2007 to 294 in 2010.

Figure 12:
Number of clients in substitution treatment (indexed - 2007=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

4.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

The main structure responsible for the implementation of the Council Recommendation (and Cypriote drug policy) is the Cyprus Anti-Drug Council (CAC). The prevention and reduction of health-related harm associated with drug dependence is part of public health policy in Cyprus and was based upon the Council Recommendation [Trimbos 2006].

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In 2008, on the basis of an evaluation of the old Drug Strategy, a new National Strategy on Drugs 2009-2012 was developed [NR 2009]. This new Drug Strategy laid more emphasis on the field of harm reduction and formulated among others the following principles [NR 2009]:

» Introduction of best practice criteria for prevention, treatment, social reintegration and harm reduction as well as a system of quality assurance
» Increase of the access to and the geographical coverage of treatment services
» Strengthening harm reduction interventions in the health system
» Development of the legal status, certification and specialization of professionals in the field of addiction

There is no written strategy concerning the reduction of drug-related deaths [SQ 23/29 2011].

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

Dissemination of information materials for drug users as well as practical advice and training is not a priority response strategy to prevent drug-related infectious diseases in Cyprus [SQ 23/29 2011]. But information, education and communication (IEC) is a common approach and mainly implemented by drugs and health professionals as well as via peer involvement [Trimbos 2006]. Information materials to reduce drug harms in

night clubs and large music festivals as well as the provision of safer use (injecting) training is available to a limited extend[5] [SQ 23/29 2011].

Overdose information material for drug users is provided rarely [SQ 23/29 2011]. Overdose response training is also carried out rarely [SQ 23/29 2011], while individual overdose risk assessment is provided extensively [SQ 23/29 2011].

Whereas a telephone help line promoting risk reduction is nationwide available, information materials are available only in specific geographical areas and websites promoting risk reduction do not exist at all in Cyprus [Trimbos 2006]. Risk education and overdose response training is available in just a few relevant cities [SQ 23/29 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

There is overdose information material on drug-related deaths and emergencies for families, friends and night club staff [SQ 23/29 2011], but not for police and prison staff [SQ 23/29 2008].

5
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

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Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach work is neither a common response strategy nor a common implementation setting for measures to prevent infectious diseases among drug users in Cyprus [Trimbos 2006].

The provision of outreach work at night clubs is limited and in large music festivals is rare [SQ 23/29 2011]. The programme "Safer Nights", which started in 2010, includes also outreach interventions by trained staff [NR 2011]. The staff is identifying those visitors of recreational settings, who are possible users of psychoactive substances, and hands out harm reduction kits [NR 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are not involved in the responses to prevent DRID and their involvement is not a priority. Naloxone is not available on a "take-home" base [SQ 23/29 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies do not exist in Cyprus [Trimbos 2006].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

In specific geographical areas only, there are drug-free inpatient and drug-free outpatient treatment facilities, rehabilitation centres, and drop-in centres/ shelters (low threshold centres) [Trimbos 2006]. Drug consumption rooms and heroin assisted prescription programmes do not exist in Cyprus [SQ 23/29 2011].

Psychosocial out-patient interventions are fully available, detoxification and OST are extensively available, psychosocial in-patient interventions only to a limited extend [SQ 27 2011]. Psychological support to OST clients is rarely provided, treatment interventions for specific target groups are not available at all [SQ 27 2011]. The available substances for OST are methadone, buprenorphine, a combination of naloxone-buprenorphine and slow-release morphine [Statistical Bulletin 2010]. Besides a special programme for Russian speaking Pontian Greeks there is no other specific intervention for specific target groups, but specific interventions for gender and ethnic groups were recommended in the year 2011 [NR 2011].

In the year 2010 885 clients were recorded in treatment, of which 767 started treatment during this year [NR 2011]. 294 of all registered clients received substitution treatment (detoxification and maintenance) [NR 2011]. In 2009 286 clients received OST [Statistical Bulletin 2010].

There is no waiting time for outpatient psychosocial treatment. The waiting time for detoxification, OST and inpatient psychosocial treatment is less than 2 weeks (limited resources and formal procedures) [SQ 27 2011].

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Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are not available in Cyprus [Trimbos 2006].

OST with methadone, a combination of naloxone and buprenorphine as well as slow-release morphine can be initiated by medical doctors based in public hospitals [Statistical Bulletin 2010]. OST with high dosage buprenorphine can also be initiated by other medical doctors [Statistical Bulletin 2010]. There is no “take-home“ OST foreseen in the legal framework [SQ 27 2011]. However, if a client is residing in a city with no substitution agency and under some additional conditions (e.g.no use of any other illicit drugs), some "take-home“ doses" are being dispensed [SQ 27 2011].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Counselling with regard to infectious diseases is available nationwide in prison. Other interventions are not available in prison or reliable information is lacking [Trimbos 2006]. Prisons are an uncommon implementation setting for infectious disease prevention measures targeted at drug users [Trimbos 2006].

Drug-related prison health is addressed in the national drug strategy [SQ 23/29 2011] as well as the provision of a comprehensive treatment facility as well as basic harm reduction practices in prisons [NR 2011]. Still, there is no drug-related treatment (inclusive OST) provided in prisons [SQ 27 2011] and treatment continuation after prison release cannot be secured, although referrals to relevant services are made [NR 2011]. Nevertheless, in 2011 a new rehabilitation programme (“360° STROFI”) for drug users in prisons has been licensed and started in January 2011 [NR 2011]. This is an abstinence-based three day per week programme aiming at rehabilitation and reintegration [NR 2011].

Voluntary infectious diseases counselling and testing on prison entry is the priority response to prevent DRID [SQ 23/29 2011]. In the national infectious diseases prevention strategy drug users in treatment are mentioned but prisoners not [SQ 23/29 2011].

To prevent DRID in prisons, HCV testing on entry into prison is fully provided and individual counselling on the risk of infectious diseases is carried out to a limited extend [SQ 23/29 2011]. Practical advice and training on safer use, Hepatitis B vaccination, HCV testing on release from prison as well as NSP are not available [SQ 23/29 2011]. Pre-release overdose counselling is rarely provided and there is neither overdose information material for prison staff nor naloxone provision upon prison release [SQ 23/29 2011]. There is no training for prison staff focusing on risk assessment and reduction [NR 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination strategy, but a risk-group specific hepatitis B vaccination programme is not available in Cyprus [SQ 23/29 2011]. Voluntary infectious disease counselling and testing as well as hepatitis B vaccination is a priority response to prevent DRID and HCV testing is fully provided [SQ 23/29 2011]. Although condom provision has no priority to prevent DRID, they are fully provided together with injecting kits [SQ 23/29 2011]. Neither routine screening of high risk groups nor “easy-access” programmes to treatment of DRID have a priority in Cyprus [SQ 23/29 2011].

Infectious diseases testing, prevention and harm reduction is offered as an integrated part of treatment by drug treatment centres. The accessibility and the coverage of these programmes are rated high [NR 2011].

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Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

Since 2010 it is no longer a formal offence for treatment unit staff or pharmacists to supply syringes and needles to users, if they are supplied in their initial packaging and for harm reduction purposes in the context with the use of controlled substances [NR 2010].

The objectives of the DRID strategy (as part of the Drug Strategy) are, to reinforce harm reduction practices within the therapeutic continuum [SQ 23/29 2011]. Needle and syringe programmes are a priority response to prevent DRID, but their provision is limited [SQ 23/29 2011]. Although condom provision has no priority to prevent DRID, they are fully provided together with injecting kits [SQ 23/29 2011].

There is only one special agency offering NSP in Nicosia, which distributed 178 syringes in the year 2010 [ST 10 2011]. The standard items in these injecting kits are information, alcohol pads, water, containers, filters, condoms and rubber [SQ 23/29 2011]. Although there are no NSPs running in pharmacies [ST 10 2011] and no formal NSP training for pharmacists exists [SQ 23/29 2011], syringes are available in all pharmacies outside of special programmes [NR 2011]. Paraphernalia for non-injecting drug users are not available [SQ 23/29 2011]. No prescription is required to obtain or exchange needles and syringes [Trimbos 2006].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

The availability and use of naloxone is regulated by law and is limited to medical personnel [SQ 23/29 2011]. Naloxone is not available on a “take-home“ basis [SQ 23/29 2011]. Trainings for professionals of emergency departments are not provided [Trimbos 2006].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

There is no information about policies to improve the social reintegration and reduce the social exclusion of drug users in the context of the primary healthcare [SQ 28 2010]. There is also no information on inter agency partnerships in the context of social reintegration of drug users [SQ 28 2010].

Educational needs of drug users are not explicitly addressed in the 2009-2012 National Drug Strategy [SQ 28 2010]. But there are two actions included in the 2009-2012 National Drugs Strategy within the objective "Support of persons at the social integration stage", which are [SQ 28 2010]:

» Development of cooperative actions aimed at financial assistance, training and job rehabilitation between social integration programmes and various organised groups.
» Implementation of revised financial aid programme.

Accommodation needs of former drug users are addressed by the “Plan for the Financial Assistance for the Rehabilitation of Former Substance-Dependent Persons” [SQ 28 2010]. This plan ensures the provision of rent allowance for one year as well as an allowance to purchase furniture for former drug users participating in social reintegration programmes [NR 2011]. Improvements of the implementation of this plan are necessary to reduce the delays of payments during the vulnerable period upon release from treatment programmes [NR 2011]. There is no specific housing project for current drug users [NR 2011].

Employment needs of drug users are addressed by several plans/programmes. The “Temporary plan for the Training of Unemployed Persons” includes a wide range of training measures and is also accessible to former drug users [NR 2011]. This is also the case for the programme “Improving Employability Amongst the Unemployed”, which is offering some training measures, and the individualised job counselling of the Department of Work [NR 2011].

In addition there is the Ministry's of Labour and Social Insurance "Plan for the Employment and Social Integration of Vulnerable Population Groups”, which is being implemented since 2010. This plan aims to offer employers 65 % of the salary costs for the first year of employment of a person belonging to one of the vulnerable groups categories, one of them being former drug users [SQ 28 2010].

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Since 2007 some treatment centres reported incorporating social reintegration interventions in their programmes [NR 2011].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

In specific geographical areas training is provided for prison staff and for professionals working in treatment facilities. Training for other professionals in the field of risk reduction is not available in Cyprus [Trimbos 2006].

There is neither a national system for continued education and training on drug treatment nor are special training courses offered in that context [SQ 27 P2 2011].

The institution responsible for developing best practice guidelines is Cyprus Anti-Drugs Council (www.ask.org.cy) [SQ 27 P2 2011].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

There are national guidelines for assessment of infectious disease risks among drug users, NSPs and prison counselling interventions [SQ 23/29 2011]. Additional national guidelines were adopted after 2009 on pharmacological assisted treatment (outpatient and inpatient), psychosocial assisted treatment (outpatient and inpatient) and psychosocial treatment (outpatient and inpatient) [SQ 27 P2 2011]. The WHO pharmacological

guidelines are used for pharmacological treatment [SQ 27 P2 2011]. There are also minimum quality criteria for prevention and treatment programmes [NR 2010].

The institution responsible for developing harn reduction and best practice guidelines is Cyprus Anti-drugs Council (CAC): http://www.ask.org.cy [SQ 23/29 2011].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

Needs assessments are used at the initial stage of programmes to some etxtent, there was an increase since 2003 [PS]. In a way needs assessment is made by the National Focal Point (www.ektepn.org .cy) and the evaluation of the national strategy[6].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation of drug-free treatment at national level is not regularly performed. However, based on the Prevention of the Use and Dissemination of Drugs Law 2000, the Anti-Drug Council's scientific committee for tertiary prevention has developed specific guidelines for drug treatment centres to ensure minimum quality standards. The guidelines were developed in June 2003 only, thus treatment centre evaluations have not yet been made [Trimbos 2006].

Evaluation aspects are included in pharmacological, psychosocial assisted treatment and psychosocial treatment only guidelines [SQ 27 P2 2011].

Outcomes are evaluated in psycosocial assisted treatment and psychosocial treatment only, in inpatient settings [SQ 27 P2 2011].

6
Centre for Interdisciplinary Addiction Research of the Hamburg University , 2008, Evaluation of the Cyprus "Action Plan on Drug Demand Reduction and on Supply Reduction - 2004-2008

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There is no national research programme for evaluation and there were no relevant research projects on treatment in the last two years [SQ 27 P2 2011].

A monitoring, licensing and funding mechanism was developed and implemented during the last years. This had an influence on the professional perspective about the quality of the services offered and lead to some adaptations of the treatment programmes [NR 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

EDDRA is extensively used through the Cypriot national Focal Point [Trimbos 2006].

It is the responsibility of the Cypriote Focal Point to ensure quality and compatibility with methodological guidelines provided by the European Monitoring Centre for Drugs and Drug Addiction. As a result the general population surveys will be made fully compatible with the EMCDDA´s guidelines [Trimbos 2006].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

In the EDDRA database of the Best Practice Portal one treatment programme of Cyprus is included while no harm reduction programme is available.

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The implementation is in process. Evaluation as concerns drug prevention as well as the reduction of health-related risks is still in the embryonic stage; tools are being sought [Trimbos 2006].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

The National Focal Point is responsible for its implementation [Trimbos 2006].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

A broad range of actors and stakeholders are involved to some extent in evaluation, there was an increase since 2003 [PS]. The Council Recommendation had a strong impact on the overall development and implementation of evaluation to inform further development of drug prevention and risk reduction in Cyprus.

The major achievements in this area since 2003 have been [PS]:

» 1. Introduction of OST in two cities by public services (2007) and one city by private sector.
» 2. Introduction of basic harm reduction practices in drug-treatment such as information, hepatitis B vaccination, screening for infectious diseases.
» 3. Provision of free syringes and information on safe use in some services.
» 4. Introduction of the Safer Nights programme which is carried out since 2010 in bar/club settings. More specifically the 5 intervention actions are as follows: (1) Reinforcement of the recreational setting's law, e.g. availability of free drinking water and ice in every club; (2) The targeted distribution of objective information

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material on drugs and alcohol, including related health, legal, and psychosocial issues, and services information; (3) Training of the recreational setting's personnel, to recognise alcohol and other substance use and other health-related issues, to deliver first aid and/or call for paramedics; (4) Preparation of information material; and (5) Outreach work/interventions by trained staff targeting recreational setting visitors that are identified as possible users of psychoactive substances, through handing out harm reduction kits, offering voluntary alcohol test and free transportation if needed.

» 5. Promotion of cooperation between agencies through regular network meetings in order to increase accessibility and continuity of care.

» 6. Since 2003, many different kind of treatment services have been created as a result a variety of different treatment options are available for the drug users.

» 7. Recently emergency services were trained to deal with overdoses and drug users.

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

International cooperation will be promoted in relation to the participation of Cyprus in international organizations dealing with the drugs problem as well as on the level of bilateral and multilateral relations [Trimbos 2006].

Professionals in Cyprus have access to opportunities for exchange of programme results, skills and experience at European level to some extent, there was an increase since 2003 [PS].

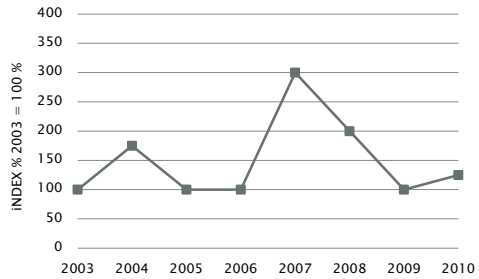
5 Country Profile Czech Republic

5.1 Indicators for drug-related harm

The total number of **problem drug users** in the Czech Republic in 2010 was estimated at 39.200 (95 % CI: 32.300–46.300 – 5,3 PDUs per 1.000 inhabitants aged 15–64), of whom 28.200 (27.300–29.100) were pervitin users, 6.000 (5.500–6.400) were heroin users, and 5.000 (4.700–5.400) were Subutex® users. Therefore, the number of opiate users is estimated at 11.000 (10.400–11.600). The number of injecting drug users (IDUs) was estimated at 37.200 (36.000–38.500). The time trend shows a slight increase of problem drug use in the last years [NR 2011]. The largest group of clients in treatment has pervitin as primary drug (63 %) followed by clients with opiates as primary drug (23 %) and clients with cannabis as primary drug (12 %) [NR 2011].

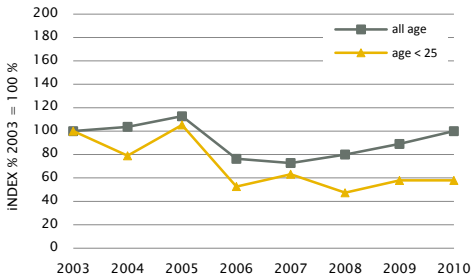
Data on **infectious diseases** are available from national registers and studies involving different drug user groups in the Czech Republic. In 2010, just as in 2009, there were seven newly diagnosed cases of HIV infection in which the route of transmission may have been through injecting drug use; this means a return to the numbers in the period before 2007 (see Figure 13) [NR 2011]. HIV seroprevalence rates among injecting drug users (IDU) remained consistently below 1 % in the Czech Republic between 1996 and 2009 (0,1– 0,5 % in 2009) [CO]. For hepatitis, in 2010, 30 % of all newly reported HBV cases and nearly two thirds of newly reported HCV cases were registered among IDUs [NR 2011]. The HCV prevalence in the population of IDUs has consistently been reported over the last years, from 16 % in 2006 to 22,4 % in 2009 (diagnostic testing of clients in low-threshold services) [CO].

Figure 13:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 14:
Number of direct drug-related deaths (indexed – 2003=100 %) by age



Source: EMCDDA Statistical Bulletin DRD 2

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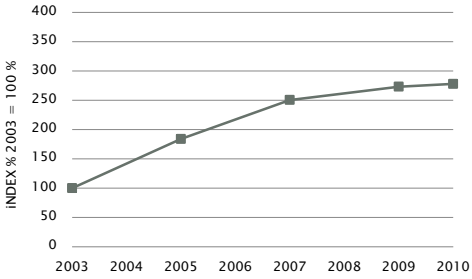
In 2010 the rate was 14 % [NR 2011]. In 2010 the self-reported HCV prevalence among clients in Treatment Demand Register was 30 % [NR 2011].

The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** decreased till 2006/2007 followed by a slight increase. The number of drug-related deaths in 2010 is nearly equal to 2003 (see Figure 14). In 2010, 194 fatal overdoses on illicit drugs, inhalants and psychotropic medication were identified. In 55 cases the cause of death were illicit drugs and inhalants (according to EMCDDA definition these cases are included in the number of "direct drug-related deaths" only) and 139 cases involved psychotropic pills. Till 2010 there was a slight year-on-year increase in the number of fatal illicit drug overdoses, especially as a result of the increase in the number of fatal inhalant overdoses, from eight cases in 2009 to 16 cases in 2010; the number of cases of fatal pervitin and heroin overdoses remained essentially the same. For the first time in the Czech Republic, fentanyl was identified in cases of fatal (illegal) drug overdoses or drug use [GS].

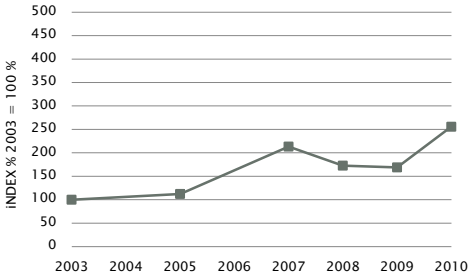
5.2 Indicators for drug-related harm reduction

Figure 15:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 16:
Number of clients in substitution treatment (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

The Czech network of low-threshold facilities established since 1992 includes low-threshold centres (drop-in) and outreach programmes providing needle exchange (altogether, 95 NSPs and one vending machine available in 2009). Programmes operate in all regions of the Czech Republic, providing a wide range of services. The Czech NFP estimates that in the past five years, the rate of problem drug users maintaining contact with these agencies has risen from 60 % to about 70 % (in Prague even about 80 %) of problem drug users. The number of syringes provided by NSPs has been increasing over recent years [CO] (see Figure 15).

The number[7] of clients in substitution treatment is increasing (see Figure 16). In 2010 9.005 clients starting an inpatient or outpatient treatment were reported to the TDI register [NR 2011].

5.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

In the Czech Republic, the main responsible body for the coordination of the drug policy and thus implementation of the Council Recommendation is the Office of the Government of the Czech Republic [NR 2011]. A policy on the prevention and reduction of health-related harm associated with drug dependence already existed in the Czech Republic before the adoption of the Council Recommendation. The Council Recommendation did have impact on the introduction of some additional measures [Trimbos 2006].

Harm reduction is an objective in public health in the Czech Republic and is part of the National Drug Strategy 2010-2018 [NR 2009]. In contrary to the previous Drug Strategies this one is a long-term strategy for 9 years. The priorities for given periods are set in three Action Plans [NR 2009]. The National Drug Strategy includes Harm Reduction as drug policy pillar but formulates also as general objective "to reduce potential drug-related risks to individuals and society" [NR 2009].

The Action plan (2010-2012) was approved in January 2011 [NR 2011]. It includes as objective the development and application of specific programmes for users of opiates and pervitin as well as the reinforcement of control and registration procedures concerning opiate substitution and the reimbursement of this treatment [NR 2011]. Other priorities, which were proposed by the evaluation of the previous Drug Strategy, are:

7
This is an estimate since neither all healthcare facilities providing substitution treatment nor their clients are registered in official substitution register [GS].

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» the development and improvement of the drug policy's overall legislative, financial and coordination mechanisms [NR 2011].
» to implement interventions aimed at reducing the high level of the use of cannabis, in particular, and other legal and illegal drugs [NR 2011].
» to strengthen the drug policy in relation to legal drugs (alcohol and tobacco), primarily in terms of policy and coordination mechanisms and treatment [NR 2011].

Concerning harm reduction there are also specific objectives [NR 2011]:

» To develop interventions, particularly new ones, to reduce the incidence of infectious diseases, overdoses and other health-related consequences of drug use among drug users,
» To increase the level of testing of drug users for infectious diseases and
» To define guidelines for harm reduction services provided in nightlife settings.

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

The dissemination of information materials, "easy-access" programmes to treatment of infectious diseases as well as safer use training are not priority responses to prevent DRID [SQ 23/29 2011].

Still, "easy-access" programmes to treatment of infectious diseases are a common strategy in the Czech Republic and safer use training is fully[8] provided as standard service of all low-threshold facilities [Trimbos 2006, SQ 23/29 2011]. The predominant approach for information, education and communication (IEC) is by counselling and education through drugs and health professionals. Information is also disseminated nationwide by telephone help lines and via e-mail (counselling), websites (information on harm reduction, safer use and overdose prevention) [NR 2011, NR 2010], and also by trainings [Trimbos 2006]. A broad range of educational leaflets is available to drug users [NR 2011], but this information is provided only to a limited extend in night clubs and in large music festivals [SQ 23/29 2011].

The prevention of infectious diseases is a key issue and the prevention of overdoses part of low-threshold services [NR 2010]. Proactive dissemination of information on the prevention of drug-related emergencies and acute deaths takes place mainly at specialised drug treatment services, low-threshold (non-treatment) services, incl. needle and syringe programmes and outreach [NR 2010]. This is also true for risk education / response trainings for drug users, which are also carried out – to a lesser extend – in prisons and at rave events as well as – only rarely – by primary care/general practitioners, emergency departments and in nightlife settings [Trimbos 2006]. While the provision of overdose response training is limited, individual counselling is provided extensively [SQ 23/29 2011]. Overdose training is available in nearly all relevant cities or towns [SQ 23/29 2011]. The provision of overdose risk assessment is extensive [SQ 23/29 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Specific materials on the prevention of acute drug-related deaths and drug-related emergencies are not available for police, prison staff, night club staff or others, but they are available for families and friends [SQ 23/29 2011]. Harm reduction prevention

8
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

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programmes with active parental involvement are available only in specific areas [Trimbos 2006].

In general, books, bimonthly bulletin and info materials are published, addressing among others substitution treatment, syringe exchange, application rooms, new drugs and harm reduction, which are disseminated also to each municipality with „extended liability" (approx. 230 in total) [GS].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach health education is a common response and is predominantly implemented by outreach work and targeted at high risk groups [Trimbos 2006, SQ 23/29 2011]. The content is safer use/safer sex information, health information, infectious diseases counselling, motivational training (change of risk life style) [SQ 23/29 2011]. The provision of outreach work at night clubs and large music festivals is limited [SQ 23/29 2011].

The outreach programme is one of the type of services which are subject of the certification of the quality of drug services [GS]. There is an association of outreach work as such with drug outreach being part of that which is very active, offering supervision, guidelines, quality assessment etc.

There is also officially recognized profession of adictologist [GS]: The profession of adictologist (the professional competences required for the performance of the profession of an addictologist) is stipulated in the law on non-medical health professions since 2008. According to this stipulation, an addictologist performs activities within the framework of prevention, treatment, and rehabilitation provided as part of the discipline of addictology. The stipulation of the profession of adictologist in the national law provided the legal basis for the profession of an addictologist in relation to the accreditation of a study programme in addictology, which has been provided by the Department of Addictology of the Psychiatric Clinic, 1st Faculty of Medicine, and General University Hospital, Charles University in Prague (the Centre for Addictology) since the academic year 2005/2006 in bachelor's degree.

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer involvement is not a common response to prevent DRID and peer educators are involved in the responses to prevent DRID (secondary needle exchange) nationwide [GS].

Naloxone is not distributed to drug users, peers and families on a “take-home“ basis [SQ 23/29 2011]. As there is a low percentage of heroin users among problem drug users in the Czech Republic and a high percentage of buprenorphine users, the distribution of naloxone is not seen as crucial [GS].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies and between harm reduction agencies is common. The Czech street work association promotes the cooperation and quality [GS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Drug free outpatient and inpatient treatment as well as detoxification treatment are available nationwide [Trimbos 2006] and extensively [SQ 27 2011]. Rehabilitation programmes and after-care are less available and accessible [GS]. In 2009 9.005 drug users received treatment according to the Register of Treatment Demands [NR 2011].

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But the coverage of TDI is not full, there were for example approx. 15.000 and 5.000 patients – drug users reported in outpatient and inpatient psychiatric facilities respectively [GS].

Opioid substitution treatment (OST) is available extensively [SQ 27 2011]. The available substances are methadone (in approx. 15 specialised centres only; [GS]), buprenorphine and a combination of buprenorphine and naloxone [NR 2011]. All substitution drugs are administered only orally in treatment [NR 2011]. The combination of buprenorphine and naloxone is partially reimbursed by the health insurance system since 2010 [NR 2011]. In the year 2009, 4.000 clients were estimated to receive OST [GS]. Psychosocial support is provided to OST clients extensively [SQ 27 2008].

There are waiting times for detoxification and substitution treatment of less than 2 weeks and for psychosocial inpatient treatment between 2 weeks and 1 month [SQ 27 2011]. The reasons are formal procedures and other issues, which are not specified further [SQ 27 2011]. There is no information regarding regional differences [SQ 27 2011].

Drug consumption rooms and heroin prescription programmes are not available in the Czech Republic [Trimbos 2006, SQ 23/29 2011].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are available [Trimbos 2006]. OST can be initiated and continued by medical doctors in treatment centres and, in the case of buprenorphine (as high dosage or as combination with naloxone), also by any medical doctor [Statistical Bulletin 2011]. The dispensing of substitution medication also happens in treatment centres or, in the case of buprenorphine, it is prescribed by the offices of medical doctors [Statistical Bulletin 2011, GS].

“Take-home” doses (usually for one week) are available for prescribed buprenorphine and the combination of buprenorphine and naloxone [SQ 27 2011]. In the case of methadone “take-home“ doses are only provided to those clients, who don’t use any illicit drug (negative drug tests during the treatment) and adhere to the other rules of the treatment centres [SQ 27 2011]. But in the Czech Republic, especially in the capital city Prague, there is also a low-threshold methadone programme, which doesn’t have such strict rules for clients entering treatment (and does not provide “take-home“

doses), as well as high-threshold programmes with stricter rules (they can provide "take-home" doses) [SQ 27 2011].

The medicinal product Subutex (buprenorphine) has been registered since 2000, and it can be prescribed by every physician, regardless of his/her specialisation [GS]. However, there is a certain limitation because of the fact that it is necessary to use a so-called "opiate prescription with a blue stripe" – i.e. a prescription with a higher degree of registration and control. Since 2006 all health centres providing substitution treatment have to be registered in the Substitution Treatment Register. This also applies to treatment with Subutex in outpatient clinics, at general practitioners or specialists. Non compliance with this rule can be sanctioned.

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

The priority responses to prevent DRID in prisons are medium/ high intensity drug-free treatment (prison-TCs, specialised prison treatment wards), continuation of opioid substitution treatment and medium/ long-term maintenance treatment [SQ 23/29 2011].

Individual counselling on infectious diseases risk is available in prisons to a limited extent, HCV testing on entry into prison and on prison release is provided rarely [SQ 23/29 2011]. There is no practical advice and training on safer use as well as no specific hepatitis B vaccination programme available in Czech prisons [SQ 23/29 2011]. Needle syringe programmes are not available and therefore also no corresponding training measures [SQ 23/29 2011]. There is no systematic distribution of condoms in prisons, but prisoners may purchase condoms in the prison canteens [NR 2011]. In fact, the current legal situation hinders the implementation of harm reduction measures in Czech prisons, because there is an interpretation of existing regulations, which even classifies the distribution of printed harm reduction materials describing safer use as illegal [NR 2011]. Therefore only counselling and the distribution of disinfectants for safer use are possible according to the current regulation [NR 2011].

Still, drug-related health issues are addressed in the national prison health strategy and the national drug strategy, and there is also a specific strategy for drug-related prison health (separate document) [SQ 23/29 2011]. Drug users in prisons are not

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explicitly mentioned as target group in a national infectious disease prevention strategy [SQ 23/29 2011].

The distribution of naloxone among prisoners upon prison release is not available in the Czech Republic [SQ 23/29 2011].

Drug treatment is available on a low intensity level extensively and on a medium/high level (as drug-free treatment) to a limited extent. It is provided by prison health services and NGOs [SQ 23/29 2011].

OST is provided in prisons since 2006 to a limited extend only, but only continuation is officially/formally possible [SQ 27 2011]. There is a special internal regulation (substitution treatment guideline) as well as the generally applicable Substitution Treatment Standard updated in 2008 [NR 2011]. Criteria for OST are the initiation before imprisonment and a written agreement [NR 2011]. Methadone is used mainly for OST in prisons and the costs are covered by the Prison Service [NR 2011]. Clients, who started with buprenorphine before imprisonment, may continue with this but have to pay for it themselves [NR 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination strategy, but hepatitis vaccination is not a priority response to prevent DRID in the Czech Republic in high-risk groups and there is no risk-group specific hepatitis B vaccination programme – apart from some professional groups and children born to HbsAg+ mothers [SQ 23/29 2011, GS]. The priority response to prevent DRID among drug users is voluntary counselling and testing and this is provided for PDUs extensively [SQ 23/29 2011]. Testing is available in a varying number of low-threshold facilities for HIV, hepatitis B and C as well as syphilis [NR 2011]. Testing for infectious diseases increased among drug users, who are in contact with low-threshold services, although the overall level remained low [NR 2010].

Treatment and care of HIV and AIDS patients is organized within a network of 7 AIDS centres, problems are reported for clients without health insurance and this might also be relevant for injecting drug users [NR 2011]. Treatment of viral hepatitis C is carried

out by specific treatment centres. Almost all require abstinence from (illegal) drugs or – in case of opiate users – the involvement in substitution therapy [NR 2011]. In most cases a trial period before the treatment itself is used to test the adherence of the clients [NR 2011]. Only few centres have an addictologist in their therapeutic team and substitution treatment is offered only rarely in these centres, but over half of them cooperate with other healthcare or non-healthcare facilities in the case of addiction [NR 2011].

There are no specific TB measures towards drug users, but general surveillance in place [GS]. TB was part of regular vaccination in children till 2011, since then just for children in high risk of TB infection.

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

The objectives of the National Drug Strategy are, to increase the access to testing among problem drug users and to increase the proportion of PDUs tested on DRIDs as well as to decrease health-related harms caused by drug use among problem drug users [SQ 23/29 2011].

Needle Syringe Programmes (NSPs) are a priority response to prevent DRID in the Czech Republic and they are provided fully by specialist agencies (including outreach and mobile units) and one vending machine [SQ 23/29 2011]. In the year 2009 4.942.816 syringes were provided by specialist agencies and 3.927 by the vending machine [ST 10 2011]. A needs assessment showed that NSP, as a basic and free service of low-threshold programmes, is crucial for the adherence of clients to these programmes [NR 2011].

NSPs are not implemented by pharmacies and prisons [SQ 23/29 2011]. According to estimations in the year 2007 1.500.000 syringes were sold in pharmacies to injecting drug users [NR 2008].

Injecting kits contain alcohol pads, dry wipes, water, filter, acid and condoms, but they are rarely provided [SQ 23/29 2011]. There are several kits with different contents (two types of syringes) offered [NR 2008].

Condoms are provided to injecting drug users extensively [GS].

Paraphernalia for non-injecting drug users are provided by some low-threshold services, like aluminium foil for smoking heroin and gelatine capsules for swallowing drugs (especially for metamphetamine users) [SQ 23/29 2011]. In 2010 approximately half of the low-threshold programmes distributed 56.868 capsules to pervitin-using clients [NR 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Ambulances routinely carry naloxone and their personnel is trained in its use [SQ 23/29 2011]. The distribution or administration of naloxone is regulated (prescription is needed and the use is limited to medical personnel) within the medicines regulation like other (psychoactive) medical drugs [SQ 23/29 2011]. Naloxone is not available on a "take-home" basis [SQ 23/29 2008].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

There is no national primary healthcare strategy, but there is the HEALTH 21 programme (Health for all in the 21st century) [SQ 28 2010]. Drug users and drug use including licit and illicit drugs are mentioned in some of the targets. The reduction of harm caused by alcohol, drugs and tobacco is one of the objectives [NR 2011]. Neither accomodation needs nor educational needs of drug users are explicitly addressed in the National Social Protection and Social Inclusion Plan [SQ 28 2010]. The employment needs of drug users are not explicitly addressed in the National Employment Plan [SQ 28 2010].

The main social reintegration-related objectives and actions included in the National Drug Strategy or Action Plan are to propose the guidelines for the systematic forwarding of clients/drug users from treatment to after-care/reintegration programmes as well as of clients/drug users released from prison to community after-care/reintegration programmes and to achieve cooperation of prisons with community services, especially in post-penitentiary care [SQ 28 2010].

The Council of the Government for the Drug Policy Coordination (CGDPC) is the main coordination and advisory body to the government in drug issues. It is an inter-ministerial and inter-disciplinary body (members are ministers and representatives of the regions, medical association and association of NGOs dealing with drug prevention, treatment, harm reduction and reintegration). In addition, there are different advisory boards, which achieve inter-ministerial/sectoral/disciplinary coordination of decision making processes at the lower (political) levels. The ministry of social affairs is a member in all these councils and boards [SQ 28 2010].

There are protocols between different national, regional and local authorities and agencies involved in addressing the health and social needs of drug users in treatment and there are agreements between treatment agencies and social services [SQ 28 2010]. Still, the partnership between residential treatment and general social services is limited, while the partnership between residential treatment and drug services, offering also social services for drug users is rather good [SQ 28 2010, GS]. Informal networks are the most common mechanism for addressing the social needs of drug users in outpatient treatment. The employability of drug users in treatment is an objective of the care plan. It is part of the assessment of the social situation of clients [SQ 28 2010].

Aftercare for drug users and their social inclusion is provided by outpatient aftercare programmes, but also as intensive aftercare (long-term structured programme involving sheltered housing and employment) [NR 2011]. Most services offer interventions in form of coordinated care (case management approach), to react to the multiple needs of the clients (health, social, labour market, drug use and other problems) [NR 2011].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

The institution responsible for developing quality standards is the Council of the Government for Drug Policy Coordination (www.drogy-info.cz; www.vlada.cz) [SQ 27 2011]. There are curricula for professionals in addictology (multidisciplinary study at Department for Addictology, 1st Medical Faculty of Charles University, Prague; www.adiktologie.cz) [SQ 27 2011]. There is specialised education/training for social workers, nursing staff, psychologists, psychiatrists, medical doctors and addictology professionals and also a national system for continued education for almost all of these groups [SQ 27 2011].

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Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

There are several national guidelines ensuring the implementation of scientific evidence of effectiveness. The institution responsible for developing quality standards is the Council of the Government for Drug Policy Coordination (www.drogy-info.cz; www.vlada.cz) [SQ 27 2011].

There are national guidelines on harm reduction [Best Practice Portal]:

» Testing infections among drug users in low threshold services (2007).

There are national guidelines and quality standards on treatment [Best Practice Portal, GS]:

» General Standard (2003)
» Specialized quality standards for out-patient treatment (2003)
» Specialized quality standards for in-patient treatment (2003)
» Specialized quality standards for lowthreshold facilities and treatment facilities (2003)
» Specialized quality standards for detoxification (2003)
» Specialized quality standards for substitution treatment
» Specialized standards for aftercare and treatment facilities (2003)
» Health standard for substitution treatment (2008)

Certification standards for Drug services in Prisons and for services in nightlife settings were drafted, but not adopted yet [SQ 27 2011].

And there are guidelines for prison pre-release counselling [SQ 23/29 2011].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

Needs assessment is a part of quality standards of drug services [GS]. There are also studies carried out, for example a needs analysis was conducted among the clients and staff of the low-threshold services in Prague [NR 2011].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation aspects are included in quality standards [SQ 27 P2 2008].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

Evaluation aspects are included in quality standards [SQ 27 P2 2008]. Process of assessment and certification of quality (compliance with quality standards) functions as evaluation [GS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

The Czech Republic complies with the EMCDDA data collections but this was not the result of the Council Recommendation [Trimbos 2006].

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Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The drug policy strategies and plans are evaluated on an ongoing basis from the point of process and outcomes [GS].

The 2005 – 2009 National Drug Policy Strategy and the 2007 – 2009 Action Plan have been systematically evaluated [NR 2009]. The results showed that the low level of infectious diseases among injecting drug users and other health risks was maintained as was the network of services with a relatively wide range of programmes for drug users [NR 2009]. Still, a decline in the number of outpatient healthcare facilities specializing in drug treatment was observed and only some success was identified concerning the areas of funding and coordination [NR 2009]. The results of this evaluation were considered for the development of the new National Drug Strategy. It is planned to evaluate the new Action Plans annually [NR 2011]. The evaluation of the National Drug Strategy showed that it was not possible to assess the objective on the evaluation of activities, due to insufficient information [NR 2009].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Training and support of members of accreditation teams (auditors) within the system of the certification of quality of drug services take place on ongoing basis [GS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

This policy exists in the Czech Republic and is based on the Council Recommendation [PS]. A broad range of actors and stakeholders is involved to some extent in evaluation [PS]. The Council Recommendation had little impact on the overall development and

implementation of evaluation to inform further development of drug prevention and risk reduction in the Czech Republic [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

The Czech Republic has been the beneficiary of several Twinning projects in the field of drug demand reduction [Trimbos 2006]. The Czech experts have been active in a number of twinning, technical assistance or capacity building projects in number of candidates, potential candidate and third countries since 2004 [GS].

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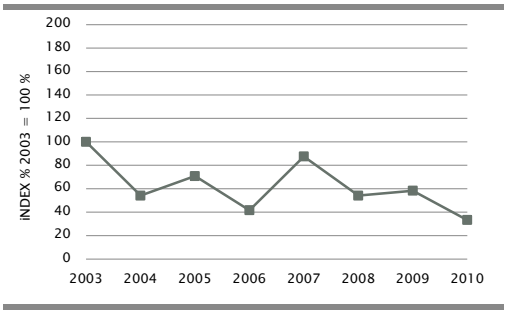
6 Country Profile Denmark

6.1 Indicators for drug-related harm

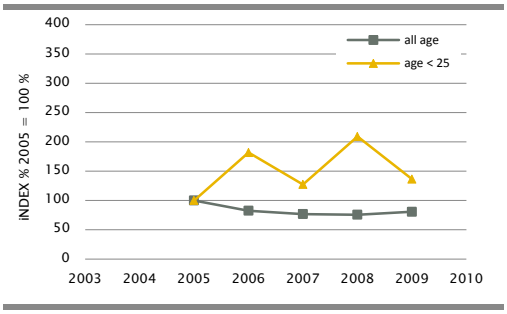
The most recent estimation of the number of **problem drug users** was carried out in 2009, applying the capture-recapture method and including two data sources (the National Registry of Patients and National Register of Drug Users Undergoing Treatment). Problem drug users were defined as drug users reporting persistent use of illegal drugs, including cannabis, which leads to physical, psychological and social consequences. The total number of drug users was estimated to be 33.074, of which 11.000 are estimated to be cannabis users. Compared to the estimates from 2001, 2003 and 2005, the number of estimated problem drug users appears to be increasing, due to raising numbers of cannabis and stimulant users seeking treatment, however the actual number of opioid/heroin users seeking treatment is decreasing [CO]. During the period 2004-08, the National Board of Health supported the 'DEADHEP' project, which started to estimate the number of intravenous drug users. The number of intravenous drug users at 2009 is estimated to be about 13.000 (3,6 per 1.000 inhabitants between 15 and 64 years) in Denmark. (95 % confidence interval of 10.066-16.821; 2,8-4,6 per 1.000 inhabitants between 15 and 64 years) [NR 2011].

Figure 17:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 18:
Number of direct drug-related deaths (indexed - 2005=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

The largest groups of clients in outpatient treatment in 2010 have cannabis (50 %) and opioids (32 %) as primary drug. In inpatient treatment the respective proportions are 38 % and 34 % [Statistical Bulletin TDI-19]. According outpatient treatment data just 16 % of opioid users inject the drug (59 % eat/drink the drug and 20 % smoke/inhale it) [Statistical Bulletin TDI-17].

Concerning **infectious diseases** data on HIV infections throughout Denmark are based on anonymous reporting and voluntary testing. In 2010, 5 % of newly-diagnosed HIV

positive persons, for which the source of infection was known, were intravenous drug users. This percentage has remained more or less the same between 4 % and 11 % over the past 10 years [NR 2011]. In general the number of new detected HIV-cases, where the infection happened via IDU is slightly decreasing (see Figure 17).

A special study from 2004-08 indicates the HIV prevalence level among injecting drug users at 4 %. In the same study the prevalence of HCV among injecting drug users was around 50 %. The HCV rate seems to be more or less stable or possibly decreasing while the HIV rate seems to be stable [NR 2011].

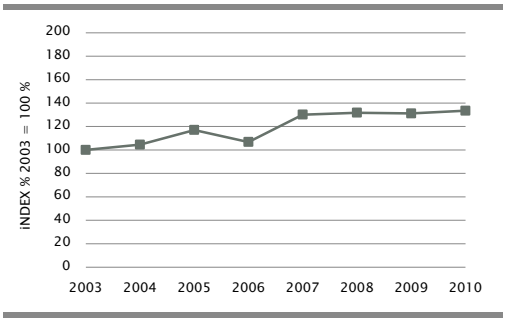
The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** decreased slightly since 2005 in general but there is an increase of cases in the group aged < 25 years (see Figure 18).

6.2 Indicators for drug-related harm reduction

Syringe exchange schemes have been established in Denmark since 1986. The amount of syringe exchange programmes are not monitored in Denmark, but the 2009 evaluation confirmed high access of drug users to clean injecting equipment across municipalities. The services are administered either through dispensing and sales at pharmacies or through dispensing machines with clean needles in public sites. Some municipalities also dispense needles and syringes through shelters and boarding houses [CO].

The number of clients in substitution treatment is increasing (see Figure 19) In 2010 5.337 clients started an inpatient or outpatient treatment [ST TDI-2]

Figure 19:
Number of clients in substitution treatment (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

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6.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

Harm reduction is an objective of public health. The policy of the former Danish Government was presented in the action plan: "The Fight Against Drugs" (Action Plan Against Drugs, Danish Government, October 2003). The Action Plan had a broad scope and was partly inspired by the international dialogue, including that within the European Community [Trimbos 2006].

In October 2010 the national action plan was intensified, and specific actions and new initiatives for all elements of drug policy, including harm reduction, were launched [NR 2011]. As a consequence, a social reserve agreement for 2011 was signed, which ensures the financing of initiatives for prevention, harm reduction and treatment [NR 2011]. These initiates will be monitored and evaluated and fed back into the national drug policy [NR 2011].

The Danish Government, which was formed in October 2011, is determined to maintain and develop prevention and harm reduction [GS]. In that sense the fundament of the national drug policy has not been changed though there is now a special focus on the reduction of drug-related deaths. The Government's determination and focus have been expressed in e.g. the government platform "A Denmark That Stands Together" from October 2011 but an overall drug policy paper comparable to e.g. the EU Drugs Strategy and Action Plan has not yet been launched.

The DRID strategy is part of the national drug strategy and its objective is primary as well as secondary prevention: Screening and counselling shall arouse the awareness of the infection risk in the infected as well as the non-infected and clearing of the virus in the body when treating those who are already infected will reduce the risk of these drug users transmitting the virus to non-infected persons [SQ 23/29 2011]. Another objective is to initiate appropriate treatments to HIV-infected persons with a need and to point out that vaccination against hepatitis A and B will protect the general health of those who are HCV-infected [SQ 23/29 2011].

There is a strategy for prevention of drug-related emergencies and deaths [SQ 23/29 2011]. It states that treatment and harm reduction initiatives are adequate measures to

reduce the number of drug-related deaths. The following measures/activities are mentioned [SQ 23/29 2011 and GS]:

» Law binding guidance for opioid substituion treatment for opioid dependence (http://www.sst.dk/publ/Publ2008/EFT/Substitbehl_en/Guide_Substreatm_Drugabuse.pdf)
» Street level treatments projects (healthcare projects)
» Needle and syringe exchange
» Naltrexone project – there is an ongoing trial in Copenhagen
» Guidelines on the acute handling of acute drug toxicity (published in 2012)
» Guidelines on treatment of abuse of cocaine and other central stimulants (published in 2012)
» Guidance on prescription of injectable diacetylmorphin for opioid dependence, (march 2010)[9]
» Law implemented for giving the municipalities possibilities for establishing local drug consumption rooms

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

Information, education, communication (IEC) in general, and IEC via counselling and advice by drugs and health professionals are common response strategies to prevent infectious diseases among drug users [Trimbos 2006].

[9] (http://www.sst.dk/publ/Publ2009/EFT/Ordination/Rules_guidance_diacetylmorphine_27oct09.pdf)

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The dissemination of information through various websites, telephone help lines, and through a broad range of educational leaflets is available nationwide [Trimbos 2006], although it is not a priority response strategy to prevent DRID [SQ 23/29 2011].

Practical advice and training on safer injecting and "easy-access" programmes for drug users to treatment of infectious diseases are also not priority response strategies to prevent DRID in Denmark [SQ 23/29 2011]. Still, individual counselling on infectious diseases and safer use training is provided extensively[10] [SQ 23/29 2008].

Overdose information material, overdose risk reduction training and individual overdose risk assessment is rarely provided to prevent DRD in Denmark [SQ 23/29 2008].

Information material to reduce drug-related harm in large music festivals is fully provided, while there is no information regarding the provision at night clubs [SQ 23/29 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for night club staff, but nor for family/friends or other groups [SQ 23/29 2011].

10
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly all of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach work as a health education approach is a common [Trimbos 2006] but not a priority response strategy to prevent infectious diseases among drug users [SQ 23/29 2011].

Low threshold agencies, including needle and syringe exchange programmes, and outreach work are a common setting for the dissemination of information materials, aimed at the reduction of drug-related deaths, and outreach work is a predominant setting for the deliverance of risk education/response training, which is delivered in all or most cities [Trimbos 2006].

Outreach work is provided extensively at night clubs and in large music festivals [SQ 23/29 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peers and volunteers are included in outreach work nationwide [Trimbos 2006], but peer involvement is not a priority response strategy to prevent DRID [SQ 23/29 2011]. Peer educators are not involved in responses to prevent DRID [SQ 23/29 2011] and there is no training for peers and volunteers [Trimbos 2006].

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Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies exists nationwide in Denmark [Trimbos 2006].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

In general there is a treatment guarantee for drug abusers at the age 18 and above [NR 2011]. The Social Services Administration is responsible for preparing a treatment plan for each individual [NR 2011]. In 2010 943 clients were admitted to inpatient treatment in Denmark [NR 2011].

Psychosocial drug-free outpatient treatment, detoxification and substitution treatment is provided fully nationwide, while psychosocial drug-free inpatient treatment is provided only to a limited extent [SQ 27 p1 2011]. Treatment with naltrexone, rehabilitation centres and drop-in shelters are available nationwide [Trimbos 2006]. Treatment interventions for target groups are available for cocaine, cannabis and amphetamine users [SQ 27 p1 2011]. A number of new treatment programmes were initiated in 2011 [NR 2011]:

- a working group was established to analyse the possibilities for preparing a Danish model of forceful restraint of pregnant drug addicts and alcoholics,
- a model project was developed for a combined treatment of cocaine abuse with cannabis and alcohol abuse (guidelines and material is prepared currently),
- a model project is being developed with a focus on screening and diagnosis of drug abusers with mental disorders,
- external intervention is offered in youth education institutions to ensure tracking, easy access to counselling and motivational approaches with the aim of retaining young people in the educational system,
- special regional family outpatient units for pregnant drug users and their children have been established.

The waiting time for detoxification and outpatient psychosocial treatment is less than 2 weeks, for OST it is between 2 weeks and 1 month and there is no information regarding inpatient psychosocial treatment [SQ 27 p1 2011], inpatient treatment is not a part of the treatment guarantee [SQ 27 p1 2008]. The reasons for waiting times are formal procedures [SQ 27 p1 2011].

Aiming at the reduction of drug-related deaths, opioid substitution treatment is a predominant response strategy in Denmark [Trimbos 2006]. Substances used for OST are methadone, high dosage buprenorphine and a combination of buprenorphine and naloxone [Statistical Bulletin 2011]. Buprenorphine is defined as first-line preparation [NR 2011]. Substitution treatment is supported by (obligatory) psychosocial care, which is provided extensively [SQ 27 p1 2011]. In the year 2010 7.850 clients, including those in prisons, received OST in Denmark [NR 2011].

Since 2010 treatment with heroin is possible for a limited group of drug abusers free of charge [NR 2011]. Doctors responsible for this treatment have to provide individual-based reports to the National Board of Health. Individual and an overall evaluation will be carried out at the end of 2011 a final evaluation is planned two years after all clinics have been established. At the end of 2010 all five planned clinics have been established. The overall experiences have been positive. The general condition and the cognitive functions of the clients have improved significantly. Most of the clients accept accompanying social support, still, this turned out to be a challenge for all the clinics. Users admitted to heroin treatment are pleased with it and stop treatment with methadone and its many side effects. The introduction of heroin in tablet form in order to reach a broader group is now under preparation [GS].

The legal foundation for the establishment of drug consumption rooms has been established and the first government approved facility has opened in the city of Copenhagen [GS].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are available nationwide in Denmark [Trimbos 2006].

OST can be initiated and continued by specialised medical doctors, any medical doctor as well as prison and probation services, no matter which substance (methadone, high

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dosage buprenorphine or the combination of buprenorphine and naloxone) is used [Statistical Bulletin 2011]. All substances can be dispensed at specialised treatment centres, pharmacies and mobile outreach units [Statistical Bulletin 2011].

Concerning "Take-home" regulations, the Guidance no. 42 on "Medical Treatment of Drug Abusers in Substitution Treatment for Opioid Dependence" from the National Board of Health, July 1st 2008 states [SQ 27 p1 2011]:

» New courses of treatment: In all new courses of treatment the prescribed substitution preparation should as a general rule be taken daily and with supervision until adjustment of an appropriate dose for the drug abuser has been achieved and the drug abuser's compliance with the treatment has been secured.
» Stable course of treatment: When the treatment has been stabilized, medicine for self-administration may be dispensed. As a general rule medicine should not be dispensed for more than a week at a time and such administration must be carefully assessed in relation to the drug abuser's current capacity for self-administration. There may be exceptions to this, e.g. in connection with holidays. Supervised taking of medicine should be resumed at any point during the course of treatment if the doctor considers this to be appropriate with a view to achieving the agreed aims of the treatment.

Since 2010 treatment with prescription heroin is possible in Denmark [NR 2011]. Start-up of treatment with heroin must take place in facilities granted special permission by the Danish Medicines Agency in accordance with its requirements for safety measures on storage, reception and accountability of the drug. Treatment can take place either in the hospital or under the auspices of the Danish Prison and Probation Services. Specific knowledge is necessary about treatment and patient safety. Doctors responsible for treatment must be approved by the National Board of Health and can be supported by other doctors, who have attended a particularly relevant training programme. Prescripted heroin is solely administered by the client himself and under supervision of the medical staff at the clinic, typically two times a day. For the night, oral methadone is given. Therefore, the heroin clinic has to be open 8-10 hours daily, every day of the year.

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Drug-related health issues are addressed in the national prison health strategy and drug-related prison health is addressed in the national drug strategy [SQ 23/29 2011]. The national strategy is primarily based on an import model, which means that private and public treatment institutions offer drug treatment in prisons in close cooperation with the prison and probation service [NR 2011]. According to the normalization principle different methods within drug abuse treatment, which are provided to the general society, are also offered in most prisons. Denmark has had a treatment guarantee since 2007 for the majority of the inmates, and in 2011 this was expanded to all prisoners [NR 2011]. This treatment guarantee applies to social treatment and states that if an inmate requests treatment, within 14 days treatment needs must have been defined and referrals made resp. treatment initiated.

Treatment types offered in prisons are motivation and pre-treatment projects (which are not part of the treatment guarantee), treatment units isolated from ordinary prison environment and focusing on complete abstinence from drugs, follow-up treatment units for inmates with long-term sentences who have completed primary treatment and where the degree of freedom is gradually increased as well as programmes for psychosocial support in connection with substitution treatment [NR 2011]. Specific treatment is also offered for cocaine abusers in open prisons and for cannabis abusers in all prisons. Cannabis and substitution treatment is defined as primary treatment but is less intensive than treatment in specialized treatment units. The municipalities are responsible for the continuation of treatment after prison release [NR 2011]. To ensure this, since 2010, detailed collaboration agreements are being negotiated and signed between municipalities and the prison and probation service [NR 2011].

Low intensity drug treatment is provided in Danish prisons extensively [SQ 27 p1 2011]. Specialized treatment units exist in almost all prisons, follow-up treatment units only in selected prisons [NR 2011]. OST is provided fully in prisons, initiation and continuation is possible [SQ 27 p1 2011].

Priority responses to prevent DRID in Danish prisons are individual risk assessment and one to one counselling on infectious diseases [SQ 23/29 2011]. Voluntary infectious diseases counselling and testing for hepatitis A, B, C and HIV on prison entry and vaccination against hepatitis A and hepatitis B is offered to all intravenous drug abuser in prison who have not been infected previously [GS]. Medical staff informs about

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infection risks in general [NR 2011], but individual counselling on infectious diseases risk is provided to a limited extent only [SQ 23/29 2011]. NSPs are not available at all [NR 2011]. But prisoners have access to disinfection fluid for cleaning of used syringes and needles as well as to information material on correct disinfection in several languages [NR 2011]. Information material on hepatitis B and C as well as HIV is also available in several languages for inmates [NR 2011]. In addition, the prison and probation service provides information on infectious diseases for staff. Condoms are provided free of charge and are placed in the visiting rooms [NR 2011].

Pre-release overdose counselling is rarely provided [SQ 23/29 2011]. Naloxone is not provided upon prison release and there is no specific material on prevention of acute drug-related deaths and drug-related emergencies for prison staff [SQ 23/29 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is not included in the national vaccination scheme, but a risk-group specific hepatitis B vaccination programme is available [SQ 23/29 2011]. The basis for this is an executive order from the Danish Government on “Hepatitis vaccination, free of charge for injecting drug users and their relatives”, which was implemented in April 2005 [Trimbos 2006].

Voluntary counselling and testing, routine screening of high risk groups as well as "easy-access" programmes for drug users to treatment of infectious diseases are no priority response strategies to prevent DRID in Denmark [SQ 23/29 2011]. But a hepatitis vaccination programme and provider-driven infectious diseases testing are priority responses to prevent DRID in Denmark [SQ 23/29 2011] and testing/screening and treatment of infectious diseases are available nationwide [Trimbos 2006].

In 2007, the National Board of Health drew up an action plan for the prevention of hepatitis C, which recommends the implementation of systematic preventive measures (information and counselling), screening for hepatitis A, B, C and HIV, partly vaccination against hepatitis A and B as well as referral to treatment for all intravenous drug abusers admitted to treatment [NR 2011]. The aim is to ensure treatment and vaccination (against hepatitis B and C) for those individuals infected with hepatitis C. By 2009 almost all municipalities had taken action and implemented these measures [NR 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

NSPs are a priority response strategy to prevent DRID in Denmark, but formal NSP training programmes regarding health promotion activities are not available for pharmacists [SQ 23/29 2011].

There is no detailed information from the municipalities regarding distribution of syringes etc. [ST 10 2011]. However, in the year 2009 the Local Government Denmark (interest group and member authority of Danish municipalities) on the basis of a request from the former Ministry of Health and Prevention has studied the prevalence of syringe exchange programmes in the Danish municipalities [ST 10 2011]. From this study, the Local Government Denmark has concluded, that the number of drug abusers who have access to sterile syringes is high. This is due to the fact, that all large municipalities, who have a relatively large number of drug abusers, distribute sterile syringes. The study is not broken down by municipality level, but the Local Government Denmark has estimated that the study draws a clear picture of current practice in the municipalities.

Sterile syringes are usually distributed via drug treatment institutions, the local pharmacies, drop-in centres or shelters [ST 10 2011]. At some places syringe dispensing machines, where the drug abusers can access the sterile injecting equipment, have been introduced [ST 10 2011].

It must be noted that the municipalities are not legally obliged to distribute sterile syringes to drug abusers [ST 10 2011]. It is common practice in most municipalities, though. Expenses for the distribution of sterile syringes are financed by the municipal operating budget within the drug abuse area [ST 10 2011]. The municipalities are compensated, via the 2004 social reserve fund, with 800.000 DKK annually with a view to distribute water ampoules together with the syringes that are already being handed out [ST 10 2011].

Injecting kits are provided extensively [SQ 23/29 2011]. Standard items in the injecting kits are alcohol pads, water, containers, filters and acid [SQ 23/29 2011]. The Citric/ascorbic lies "beside" the "injecting kit", but is not included in the kit.

Condoms are provided at drug agencies with NSPs extensively, although it is not a priority response strategy to prevent DRID [SQ 23/29 2011].

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Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Emergency departments are not a setting for the dissemination of information materials that aim at the reduction of drug-related deaths and training seminars for professionals of emergency departments are not available [Trimbos 2006].

Naloxone is dispensed to some drug abusers participating in a special project in Copenhagen. They are registered as the prescribing doctor's assistant and are instructed in their responsibility through delegation of treatment competence. The experience so far is positiv, and some overdosis has been avoided and prevented [NR 2011].

Because of the positive experiences from the naloxon-project carried out by and in the City of Copenhagen, and extension of the project to other cities in Denmark is now under preparation [GS].

Guidance on the treatment of acute poisoning cases was published in 2012 [GS]. This should contribute to a better knowledge among doctors for treating such complex clinical conditions.

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Risk reduction is part of an integrated health strategy for drug users [Trimbos 2006].

Denmark has a national primary healthcare strategy, but drug users are not explicitly addressed [SQ 28 2010]. There is information on other groups that may include drug users. One of the main principles in the strategy concerns social responsibility towards vulnerable groups. The strategy aims to increase the general high level of knowledge about healthy lifestyle in the overall population and specificly among vulnerable groups with risk behaviour [SQ 28 2010]. The municipalities have the overall field of responsibility concerning primary health, addressing drug users [SQ 28 2010]. The increasing access of drug users to relevant healthcare programmes is an objective of projects funded by social reserve fund agreements [NR 2011]. By social interventions

on street level and healthcare interventions a link to the established healthcare system can be provided. This turned out to fulfill the needs of the target group.

Municipalities have to offer drug abusers a social action plan, with individual goals and strategies, and support by local case managers [NR 2011]. Social skills are usually developed in programmes at drop-in centres.

In the "Homeless counting 2009", 870 persons (23 % of all homeless) were drug users [SQ 28 2010]. Drug users are included in the National Strategy to reduce homelessness in Denmark 2009 – 2012 [SQ 28 2010]. This strategy hast four long-term objectives [NR 2011]:

» no citizen should life on the street,
» there should be alternatives to temporary nursing homes for young people,
» a stay in a temporary nursing home/shelter should not last more than 3-4 months and
» housing alternatives should be organized prior to the release from prison or hospital/treatment.

There are different housing alternatives: temporary nursing homes offer help for sorting out social problems, alternative homes are rented flats offered to individuals and alternative nursing homes is a kind of long-term accommodation for those, who are not able to look after themselves.

The education needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan, but other target groups are mentioned [SQ 28 2010]. There are different opportunities to catch up with lost education in general and there is a special programme for long-term unemployed drug abusers and other socially vulnerable individuals to rekindle their professional competencies [NR 2011].

The department of employment is in charge of implementing the employment policy [SQ 28 2010]. The Social Ministry is in charge of the social inclusion and reintegration of drug users [SQ 28 2010]. The action plan "det Fælles Ansvar II" is a cross-sector action plan including both departments – and it has an employment focus and drug users are mentioned as well as other social vulnerable groups [SQ 28 2010]. While former drug users are offered the same employment programmes as other social vulnerable groups, drug users in long-term substitution treatment are primarily offered programmes established at drug use centres or drop-in centres [NR 2011]. Mentor schemes have been established, to assist drug users with advice and guidance and to relieve companies of difficulties in such employments [NR 2011].

There are interagency-partnership agreements between the social services and the health services to meet the needs of drug users in treatment, but no further information on this is available [SQ 28 2010].

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Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

A national system for continued education is not available for social workers, nursing staff, psychologists or medical doctors [SQ 27 P2 2008]. Specialised courses/training on drug treatment is not available for social workers or medical doctors [SQ 27 P2 2008]. But there are trainings for prison staff and – in specific geographical areas only – also for professionals in substitution programmes [Trimbos 2006]. Formal NSP training programmes regarding health promotion activities are available for drug agencies only [SQ 23/29 2011]. They are not available for pharmacists, prison staff or other groups [SQ 23/29 2011].

Occupational standards for drug treatment are available for medical doctors and psychiatrists [SQ 27 P2 2011].

From 2007 to 2010 the government tried to improve the quality within drug treatment with a number of initiatives [NR 2011]. In April 2010 a book ("Drug use viewed from a social perspective") was published and distributed to drug abuse therapists, referral personnel, case managers and other professionals [NR 2011]. From 2010 to 2013 training should be provided to professionals, as part of the social diploma programme, with a focus on a broad upgrade of drug abuse therapists in relation to social treatment plans [NR 2011]. Four schools for social education have developed modules for drug abuse and started them in summer 2011. In addition, professionals working with socially marginalized clients with a chaotic polydrug use shall have the possibility to enhance their competencies [NR 2011]. Information material was also prepared to increase the knowledge among professionals working with clients with co-morbidities [NR 2011]. This material focuses on the distribution of responsibilities between various sectors and the good experience and cooperation between those sectors. Examples of principles for good treatment/good aid for young drug abusers shall be published in 2012 [NR 2011].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

Governmental initiated programmes and projects are based on the available scientific evidence [GS]. Informational material, that recommends the implementation of validated methods, is produced nationally and distributed on regional and local level [Trimbos 2006]. As regards prevention, the counties regularly conduct evaluations of local programmes. These evaluation reports typically describe experience gained and are included in the continuing work [Trimbos 2006]. The methodological quality of these studies covers a wide field. Actual scientific evaluations are rare, given that on a local level, there is a shortage of resources and competencies [Trimbos 2006].

The institution responsible for developing guidelines (including harm reduction guidelines) is the National Board of Health [SQ 27 P2 2011].

There are treatment guidelines [Best Practice Portal, SQ 27 P2 2011, GS]:

- Guidance no. 42 on medical treatment of drug abusers in substitution treatment for opioid dependence (2008)
- Prescription of injectable diacetylmorphine (heroin) in case of opioid dependence; Rules of guidance no. 9240, May 11th 2009
- Pharmacological guidelines (outpatient and inpatient treatment)
- Guidelines on the acute handling of acute drug toxicity (published in 2012)
- Guidelines on treatment of abuse of cocaine and other central stimulants (published in 2012)

Concerning harm reduction, there are national guidelines for the assessment of infectious disease risks and for the prevention of hepatitis C among drug users (http://www.sst.dk/Tilsyn%20og%20patientsikkerhed/Laegelig%20behandling%20stofmisbrug/Hep%20C.aspx) [SQ 23/29 2011].

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A study on the scope of cocaine abuse in socially marginalised persons with a chaotic polydrug use is planned, to ensure, that initiatives are developed which are targeting the specific cocaine problem [NR 2011].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

Governmental initiated programmes and projects are based on needs assessment [Trimbos 2006]. Informational material, that recommends needs assessment is produced nationally and distributed on regional and local level [Trimbos 2006].

Needs assessments are used at the initial stage of programmes to a large extent, there was an increase since 2003 [PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Treatment evaluation aspects are included in the pharmacological guidelines [SQ 27 P2 2011].

From 2011 on a quality assurance process related to core services in the national guideline of the medical treatment of substitution treatment for opioid dependence, which includes the pharmacolgical treatment and the treatment for somatic (incl. prevention and treatment for HIV and hepatitis) and mental comorbidity, have been implemented. All municipalities have to report annually on services delivered to all new clients in treatment [SQ 27 P2 2011].

Drug treatment outcomes are evaluated in pharmacological treatment, psychosocial assisted treatment as well as in psychosocial treatment [SQ 27 P2 2011].

There is a national research programme for evaluation (http://crf.au.dk/en/publications/reports/) and there are relevant research projects on treatment during the last years [SQ 27 P2 2011]: Every third year the Center for Alcohol and Drug Research (Aarhus University) will evaluate inpatient and outpatient treatment of drug abusers, as

well as treatment of adolescents with drug problems (http://crf.au.dk/en/research/; http://kabs.dk/media/25008/oplæg%20konference%20oslo,%20maj%202010.pdf).

The Center for Alcohol and Drug Research has placed its attention on the following issues [NR 2011]:

» treatment of special groups of clients using specific methods,
» treatment of young drug abusers,
» treatment in a planning and group perspective and
» prison-based drug treatment in the Nordic countries.

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

No formally drafted strategy or guidelines have been prepared on quality assurance [Trimbos 2006]. However, within the in-patient treatment sector, the Ministry of Social Affairs, the Association of County Councils in Denmark and the Centre for Alcohol and Drug Research have launched a documentation and monitoring system within the drug use area (DANRIS) [Trimbos 2006]. This is a pilot project with the overall purpose to achieve registered and documented treatment programmes as well as to monitor the quality and effects of the various kinds of drug treatments. The system is being developed over a three-year-period in the counties of Copenhagen and Aarhus. From the government's action programme for the most marginalized groups, it appears that the DANRIS system as a new initiative will be extended to include the entire country within the next few years [Trimbos 2006].

Quality criteria are used in evaluations to some extent, there was an increase since 2003 [PS].

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Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Standardised data collection and information dissemination is organized and carried out by the Danish Focal Point [GS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

On 1st January 2003, the Act amending the Social Services Act (Guaranteed social treatment for drug abuse) came into force [Trimbos 2006]. According to the Act, county authorities must provide social treatment for drug abusers no later than 14 days after referral to the county. Also, the drug abuser has the right to choose between public and private approved treatment services similar to those offered by the county.

The Act subjects the implementation of the scheme to monitoring for evaluation purposes [Trimbos 2006]. In the evaluation it will be determined whether the effects of the proposed scheme are consistent with the intentions of the law. Based on this evaluation, a report will be prepared and after a hearing in other authorities and organisations, the report will be submitted to the Social Committee of the Danish Parliament after the Law has been in effect for three years.

Danish drug policy in general and concrete initiatives, are evaluated on an ongoing basis, with a view to assessing the need for adjusting the policy and adjusting initiatives/praxis [GS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Evaluation trainings seminars for regional and local drug professionals are occasionally part of national programmes [Trimbos 2006].

Evaluation training programmes are available in Denmark to some extent, there was an increase since 2003 [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

A broad range of actors and stakeholders is involved in evaluation to some extent, there was an increase since 2003 [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

Results, skills and exprerince are shared through international co-operation in general [Trimbos 2006].

Denmark participates in the ESPAD project [Trimbos 2006]. This does not concern harm reduction. International Cooperation is a priority aim of the cross-Ministerial Action Plan “The Fight Against Drugs”, which was adopted in 2003 [Trimbos 2006].

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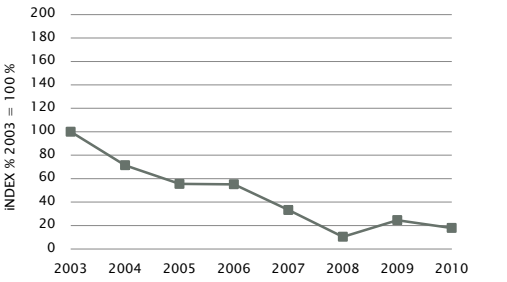
7 Country Profile Estonia

7.1 Indicators for drug-related harm

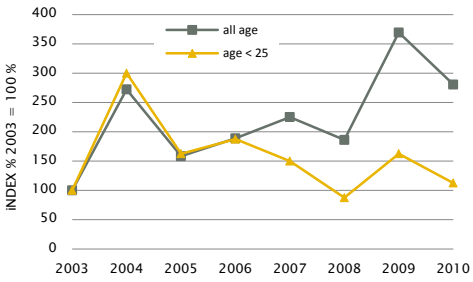
So far, there is no new estimate for **problem drug use** in Estonia, but as a minimum approximation, the latest existing injecting drug use estimate may be used. In 2004, the prevalence of IDU was estimated at 15 cases per 1.000 inhabitants aged 15-64 (13.886 users). This result is exceptionally high compared with EU Member States [CO]. A new prevalence estimate will be published in 2012 [NR 2011]. Almost all clients (95 %) in outpatient treatment in 2010 have opioids as primary drug [Statistical Bulletin TDI-19]. According outpatient treatment data 87 % of opioid users inject the drug (11 % are smoking it) [Statistical Bulletin TDI-17].

Figure 20:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 21:
Number of direct drug-related deaths (indexed - 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

Concerning infectious diseases the very high prevalence rate of HIV among IDUs is a big problem. As of 31 December 2010, in Estonia a total of 7.692 people have been cumulatively diagnosed with HIV. In 2010 the Health Board registered 39 HIV-infected persons less than in 2009 (411 in 2009 and 372 in 2010). The number of new HIV cases has decreased year by year, probably thanks to well organised prevention work. However, it is worrying that the transmission route of infection is only known in more than one third of all new HIV cases (35 %). Almost half (48 %) of persons infected with HIV for whom the transmission route is known are injecting drug addicts [NR 2011]. Due to the fact that in many cases the way of infection is not known Figure 20 has to be interpreted with caution although the overall declining trend seems to be realistic. Nevertheless cross-sectional surveys using respondent-driven sampling conducted in recent years show that the spread of HIV among Estonian IDUs is high - more than 50 % of injecting drug users are HIV-infected (54 % in 2005, 55 % in 2007, 51 % in 2009). However, a positive sign is the fact that the spread of HIV has decreased among

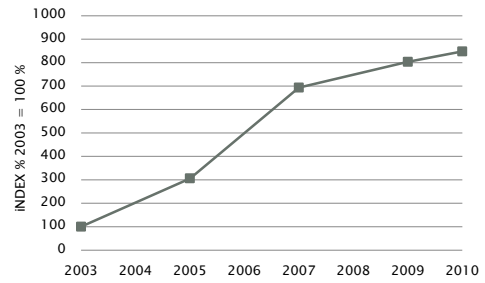
new IDUs, which has probably been contributed to by the expanded provision of harm reduction services [NR 2011]. Concerning HCV information on acute hepatitis C is available only. While in 2003 there were 75 newly registered cases who acquired their HCV infection via IDU in 2009 the number was 16 [NR 2011].

The number of overall direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased dramatically since 2003 but the number of cases in the age-group < 25 in 2010 is the same as in 2003 (see Figure 21).

7.2 Indicators for drug-related harm reduction

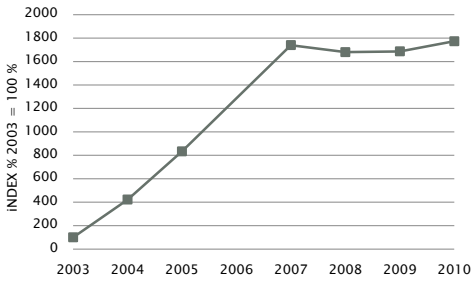
In 2002, the spread of HIV/AIDS was recognised in Estonia as a serious health problem and in 2003, the government began to fund syringe exchange within the framework of the national HIV/AIDS prevention programme. As a consequence, the coverage and quality of syringe exchange programmes has improved [CO]. Nine institutions provide syringe exchange and services and in 2010, there were a total of 36 syringe exchange points, thirteen of which were stationary centres. These centres were visited by 2.800 first-time visitors and approximately 7.500 repeat customers. There were approximately 173.000 visits to syringe exchange points, and a total of 2.403.480 syringes were distributed [NR 2011]. Figure 22 shows the huge increase of syringe provision since 2003.

Figure 22:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 23:
Number of clients in substitution treatment (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

The number of clients in substitution treatment has increased dramatically too (see Figure 23). In 2010 665 clients started an outpatient treatment [ST TDI-2].

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7.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

The governmental structure that is responsible for the implementation of the Council Recommendation is the Estonian Ministry of Social Affairs. The prevention and reduction of health-related harm associated with drug dependence is a public health objective in Estonia. It was based upon the Council Recommendation. The National Strategy on the Prevention of Drug Dependence 2004-2012 and an Action Plan was approved by the Estonian Government on 22 April 2004 [Trimbos 2006]. The latest Action Plan refers to the years 2011 to 2012 [GS].

The National Strategy provides an integrated approach to both drug demand and drug supply reduction and includes six fields: prevention, treatment-rehabilitation, harm reduction, supply reduction, drugs in prison and monitoring of drug situation and evaluation. The Council Recommendation had an important influence on the relevant sections in the strategy [Trimbos 2006].

The last Action Plan (2011-2012) was approved in March 2011. As the National Strategy was not assessed during the whole period, there were no changes [NR 2011]. But legislative amendments were made in the year 2011 to establish a legal basis for the application of drug treatment as alternative to imprisonment [NR 2011].

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

Information, education and communication (IEC) in general is the predominant response strategy to prevent DRID in Estonia. This is done mainly via counselling and advice by drugs and health professionals, but also via peer involvement/peer approaches [Trimbos 2006].

The dissemination of information material, practical advice and training as well as "easy-access" programmes to treatment of DRID in general have no priority in Estonia [SQ 23/29 2011], but access to antiretrovial treatment has [GS]. The dissemination of information through various websites and through telephone help lines is available nationwide [Trimbos 2006]. Information to reduce drug-related harms is rarely[11] provided in night clubs and large music festivals [SQ 23/29 2011]. Training for injecting drug users is included in the Action Plan but hasn't been initiated yet [NR 2011]. But, all needle and syringe exchange programme (NSP) or syringe exchange points are providing training for injecting drug users on prevention of HIV/ AIDS and other STDs, safer sex and safe injecting [SQ 23/29 2011; NR 2011]. In addition, individual counselling on infectious disease is provided extensively [SQ 23/29 2011].

11
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

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Specific responses to prevent DRD are uncommon in Estonia, but information on overdose risk reduction is available through low threshold centres and outreach work to a limited extend [Trimbos 2006]. Overdose information material is also provided to a limited extend for IDUs [SQ 23/29 2011]. Individual overdose risk assessment and overdose training is not available and there is no strategy to reduce DRD in Estonia [SQ 23/29 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

In specific geographical areas only, communities and families of drug users are involved in the prevention and reduction of health risks associated with drug dependence [Trimbos 2006].

Information on risk reduction and different available services and counselling is provided to families of drug users in low threshold centres and through outreach work [SQ 23/29 2011]. There is also specific (but not systematic) information material on prevention of acute drug-related deaths and drug-related emergencies available for family/friends [SQ 23/29 2008], but there is no information regarding the availability of specific materials for police or night club staff [SQ 23/29 2011]. Since 2011 a special handbook for prison staff on how to deal with drug users in the prison is supposed to be available [GS].

NSP trainings are available for HIV counselling centres and medical personnel providing drug treatment and anti-retroviral treatment (last with limited extent) [SQ 23/29 2008].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach health education approach is a common response strategy [Trimbos 2006] and has high priority in the context of DRID in Estonia [SQ 23/29 2011]. Still, street-based outreach work is available only in specific geographical areas [Trimbos 2006], and outreach work at night clubs and large music festivals is rarely provided [SQ 23/29 2011].

Outreach work is neither a common response strategy, nor a common implementation setting for measures targeting the reduction of drug-related deaths among drug users [Trimbos 2006].

Outreach services are used to provide needle/syringes, condoms and information materials for IDUs [SQ 23/29 2011]. Also low-threshold centres provide outreach work to engage IDUs with their services and to select motivated service users to engage with treatment services.

Standards for services are provided as annexes of contracts [GS].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer involvement is not a priority response to prevent DRID in Estonia, but peer educators are involved in the responses to prevent DRID [SQ 23/29 2011]. This is the case in specific geographical areas only, where peers and volunteers are included in outreach work and receive training for this [Trimbos 2006]. Almost all syringe exchange points in Estonia use peers to reach difficult to reach risk groups in the framework of outreach work [Trimbos 2006].

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Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies exist [Trimbos 2006], but only rarely [PS]. A major challenge to development in this area was to create a platform for this kind of cooperation.

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

In Estonia drug-free psychosocial out-patient and in-patient interventions, detoxification as well as substitution treatment are available only to a limited extend [SQ 27 p1 2011]. Except methadone detoxification, all treatment interventions are available in specific geographical areas only [Trimbos 2006]. This is also the case for rehabilitation centres and drop-in centres/ shelters [Trimbos 2006]. Specific treatment funded by state is available for amphetamine users to a limited extent only, but there is a growing need for treatment facilities for this target group [GS].

The majority of healthcare institutions provide treatment as outpatient treatment. In-patient treatment is provided only by one hospital and has to be paid by the clients themselves [NR 2011]. Detoxification treatment has been provided in the year 2010 for 65 clients [NR 2011].

(Obligatory) psychological support is provided to OST clients only to a limited extend [SQ 27 p1 2011]. The substances used for OST are methadone, high dosage buprenorphine and a combination of buprenorphine/naloxone [Statistical Bulletin 2011]. In the year 2010 1.064 clients received methadone substitution treatment in Estonia [NR 2011].

Drug consumption rooms and heroin prescription programmes do not exist in Estonia [Trimbos 2006, SQ 23/29 2011].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are available nationwide [Trimbos 2006].

OST can be initiated and continued only by medical doctors at specialised drug treatment centres [Statistical Bulletin 2011]. The substances used for OST (usually methadone, buprenorphine only for pregnant opioid addicted women or those paying on a privat basis for this treatment [GS]) can only be dispensed at specialised drug treatment centres [Statistical Bulletin 2011]. "Take-home" doses are not a commonly recommended practice, but they are available for exceptional cases [SQ 27 p1 2011].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Drug-related prison health is addressed in the national drug strategy and prisoners are mentioned in the DRID strategy as a target group [SQ 23/29 2011].

The priority responses to prevent DRID in prison are voluntary infectious diseases testing on prison entry, medium/high intensity drug-free treatment (prison-TCs, specialised prison treatment wards) as well as the initiation of opioid substitution treatment [SQ 23/29 2011]. Testing for HIV and other DRID is done within the first medical examination and includes pre- and post-testing counselling [NR 2011, GS].

Individual counselling on infectious diseases risk as well as HCV testing on entry into prison and on release from prison are provided fully [SQ 23/29 2011]. There is no information on practical advice and training on safer use and NSPs are not available in Estonian prisons [SQ 23/29 2011]. There is a risk-group specific hepatitis B vaccination programme for PDUs in prison [SQ 23/29 2011]. Testing and treatment of Hepatitis as well as anti-retroviral treatment is organized by the medical departments of prisons [NR 2011]. A support service as group work is provided for imprisoned persons, including HIV-positive drug users [NR 2011].

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Pre-release overdose counselling is provided to a limited extend only and neither is naloxone provided upon prison release [SQ 23/29 2011] nor is specific information material on DRD and emergencies available for prison staff [SQ 23/29 2008].

Drug-free treatment is provided by prison health services on low, medium and high intensity level, but only to a limited extend [SQ 27 p1 2011]. Methadone detoxification and maintenance is available in prisons since 2008 [NR 2011]. It significantly increased in the year 2010, when the continuation of treatment was ensured [NR 2011].

Specific addiction rehabilitation departments were established in Estonian prisons with the objective to reintegrate drug users [NR 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination strategy, but there is no risk-group specific (IDUs etc) hepatitis B vaccination programme [SQ 23/29 2011]. Voluntary infectious disease counselling and testing is a priority response to prevent DRID [SQ 23/29 2011]. While HIV testing is fully available, testing for other drug-related infectious diseases is provided only to a limited extend [GS]. Hepatitis vaccination programmes, routine screening and "easy-access" programmes to treatment of infectious diseases are no priority strategies [SQ 23/29 2011].

There are HIV counselling rooms (which are called AIDS prevention cabinets [GS]), where visitors (including drug users) receive counselling and testing for HIV [NR 2011].

Prevention and treatment of tuberculosis is carried out on the basis of the National Tuberculosis Prevention Strategy 2008-2012 [NR 2011], which includes healthcare and social services for anyone who belongs to risk groups (including HIV-positive persons) [NR 2011]. Regular prophylactic surveys are being conducted among HIV-infected persons and other risk groups for the early discovery of tuberculosis, which are also used to disseminate information material [NR 2011]. The results of a study on injecting drug users showed the need to implement tuberculosis screening more actively in methadone treatment programmes [NR 2011].

In two regions free and anonymous diagnostic and treatment for sexually transmitted infections was provided for IDUs and their sexual partners [NR 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

The priorities of the DRID strategy are the provision of harm reduction services for IDUs, a focus on young people and HIV-related specific healthcare as well as social support services for specific target groups [SQ 23/29 2011]. There are a lot of concrete actions such as: HIV testing (for different target groups), healthcare and social support services (incl. healthcare services, psychosocial support, case management system, prevention of mother to child transmission of HIV), HIV prevention in general population (Prevention and health promotion councils in county municipalities), harm reduction (needle and syringe distribution through Syringe Exchange Points, condom provision, testing for HIV, substitution treatment) [SQ 23/29 2011].

NSPs are a priority response to prevent DRID [SQ 23/29 2011], but NSPs are provided only in limited geographical areas [SQ 23/29 2008]. NSPs are provided by specialists agencies (NSP), in addition there are outreach services acting as syringe provision points (SPPs) [ST 10 2011]. In the year 2009 2.403.480 syringes were provided by NSPs [ST 10 2011].

NSPs are not available in pharmacies, there is also no formal NSP training for pharmacists [SQ 23/29 2011]. A survey on the attitudes of pharmacists towards syringe exchanges has been carried out[12] ([SQ 23/29 2011].

Injecting kits include information materials, but they are only provided through syringe exchange points [GS].

The distribution of condoms is a high priority [GS], condoms are provided extensively [SQ 23/29 2011].

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Should Pharmacists have a Role in Harm Reduction Services for IDUs? A Qualitative Study in Tallinn, Estonia; authors: Sigrid Vorobjov; corresponding author: Anneli Uusküla, Katri Abel-Ollo, Ave Talu and Don Des Jarlais; http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2791822/)

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Paraphernalia for non-injecting drug users are not provided in Estonia at all [GS].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Naloxone is regulated by administrative regulation [SQ 23/29 2011]. The use of naloxone is limited to medical personnel (emergency staff) and naloxone is not available on a "take-home" base [SQ 23/29 2011].

Naloxone is part of standard ambulance equipment and the ambulance personnel is trained in naloxone use [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Estonia has a national primary healthcare strategy, where drug users are explicitly addressed [SQ 28 2010].

Specific needs of drug users, like accommodation, education or employment, are not explicitly addressed in the National Social Protection and Social Inclusion Plan, the National Drug Strategy, the Action Plan or the National Employment Plan [SQ 28 2010]. Also the employability of drug users in treatment is not an objective of the care plan [SQ 28 2010]. But social issues are addressed in the rehabilitation centres [NR 2011].

There is no information regarding interagency coordination or corresponding protocols or agreements [SQ 28 2010]. But there are case management teams for HIV-positive persons [GS], including nurses and social workers and concentrating on health and social issues [NR 2011].

A study on treatment/rehabilitation services for minor drug addicts highlighted the cooperation between different institutions and showed the lack of specifically trained (for drug issues) personnel working with this target group [NR 2011]. The education of new specialists and the motivation of personnel in existing healthcare and social welfare institutions for the issue of juvenile drug addicts are recommended [NR 2011].

Council Recommendation 2.13

support training leading to a recognized qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Trainings to increase the knowledge on drug-related health risks are available for drug agencies staff, pharmacists, prison staff and other groups - HIV counselling centres, youth centres, medical personnel providing drug treatment and anti-retroviral treatment (last with limited extent) [GS and SQ 23/29 2008]. There is also appropriate in-service training concerning tuberculosis for healthcare professionals and social workers [NR 2011].

The institution responsible for developing best practice guidelines for drug treatment is Estonian Psychiatric Association along with the National Institute for Health Development [GS].

For social workers, nursing staff, psychologists and medical doctors a national system for continued education as well as specialized education/training is available [SQ 23/29 2008].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

Estonia has just started to develop health education standards and quality assurance management in prevention. Estonia is running pilot prevention projects, which are supported by quality management: (Planning according to the needs assessment, using process and outcome evaluation etc.) [Trimbos 2006].

The National HIV/AIDS Prevention strategy (which includes elements regarding opiate dependent drug use) includes principles of effectiveness, responsibility, transparency, research, evidence-based and targeted activities, comprehensiveness, administration and respect for human rights, co-ordination and partnership [Trimbos 2006].

There is no information about national harm reduction guidelines [Best Practice Portal], but there are sub-national guidelines for NSPs, drug treatment for opiate users, harm reduction, HIV testing and prison counselling services [SQ 23/29 2008 and GS]. The institution responsible for developing harm reduction guidelines is the National Institute for Health Development [SQ 23/29 2011].

There are national guidelines on drug problems [SQ 27 p2 2008] and Guidelines for the Treatment of Drug Addiction (2001) [Best Practice Portal].

There is a practical guide for drug addiction and HIV/AIDS prevention work in prisons [NR 2011].

The institution responsible for developing best practice guidelines is Estonian Psychiatric Association [SQ 27 p2 2008]. There are updated guidelines for opiate addicts drafted by this Association along with the National Institute for Health Development (NIHD) [GS]. NIHD has drafted also a few other guidelines, but they are rather "good practice" guidelines for service providers.

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

It is not the rule, but Estonia has examples of the application of needs assessments in early stages of programmes. Estonia has a strategy action plan for the implementation of quality management, which includes needs assessment in planning processes. [Trimbos 2006]

In 2010/2011 a mapping of services that are targeting minor drug addicts was carried out, which showed a need for more facilities in two counties as well as a need for juvenile rehabilitation in the region of Southern Estonia [NR 2011].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation and Monitoring is a part of the Action Plan for the National Drug and HIV/AIDS Strategy. Evaluation aspects are also partly included in drug problems guidelines, psychosocial interventions guidelines, detoxification guidelines, OST guidelines and social reintegration guidelines [SQ 27 p2 2008].

There is no separate research programme for evaluation and improvement of drug treatment intervention and therefore these activities (evaluation research etc) are implemented on the framework of the Action Plan for the National Drug and HIV/AIDS Strategy or funded by foreign funders [SQ 27 p2 2008].

Outcomes are sporadically evaluated in psychosocial interventions, detoxification, OST, social reintegration interventions and other interventions [SQ 27 p2 2008].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

There are some examples of the implementation of evaluation criteria, but this area should be much better developed. There is general need for training in quality management, but there are not enough trained specialists in prevention [Trimbos 2006].

Quality criteria are used in evaluations to some extent, there was no change since 2003 [PS].

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Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Standardised data collection exists to some extent, there was an increase since 2003 [PS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The policy about effective use of evaluation results exists, but in terms of quality management Estonia does not have enough correctly evaluated programmes. This is mainly due to the lack of resources to conduct evaluations [Trimbos 2006].

In 2001 assessment of the ADAPP (Alcoholism and Drug Abuse Prevention Programme) was undertaken [Trimbos 2006]. The purpose of the assessment was to improve the quality and efficiency of the programme as well as develop the quality criteria of the programme. Within the framework of this assessment procedure, five subordinate projects of the ADAPP were assessed. In the framework of an UNODC project, the assessment of access and quality of methadone maintenance treatment was conducted by the National Institute for Health Development[13].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Evaluation training programmes are available in Estonia to some extent, there was an increase since 2003 [PS].

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See more http://www.unodc.org/documents/balticstates//Library/PharmacologicalTreatment/Metadoon_Eesti_keelne.pdf

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

In the past, special training programmes existed, but stakeholder involvement and participation (to create advocay) is an area in which training is needed most [Trimbos 2006]. The good example demonstrating involvement of all actors and stakeholders is the evaluation of access and quality of methadone treatment conducted in 2008 by the National Institute for health Development and Trimbos institute [GS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

A prevalence study on HIV infection (2005) was financed by the Global Fund and carried out in cooperation with London Imperial College. For the purpose of the development of the national drug strategy, also, to ensure its compliance with the European Union Acquis in the drug field, the Ministry of Social Affairs of the Republic of Estonia has entered into a project agreement with the Ministry of Social Affairs of Schleswig-Holstein, Germany [Trimbos 2006].

Estonian experts drafted "Guidelines for Drug Treatment" within the framework of the Council of Europe Pompidou Group Drug Demand Reduction Staff Training Project (DRSTP II). The above-mentioned guidelines were approved and published by the Estonian Psychiatric Association and Guidelines for Drug Treatment for Opiate Addicts were drafted on the framework of UNODC project in Estonia [GS].

In addition, a few cross-sectional studies using respondent driven sampling methodology aimed to assess risk behaviour and HIV, HCV and HBV prevalence among IDUs were conducted in Tallinn (2005, 2007, 2009), Kohtla-Järve (2005, 2007, 2012) and Narva (2010) [GS]. These projects were funded from different sources such as EC, national funding, NIH US etc. All papers refer to high HIV prevalence among the studied IDUs. Some (Vorobjov 2011 and Talu 2010) show, that the HIV among fentanyl and amphetamine injectors is very high, fentanyl injectors also have higher odds for overdose [GS].

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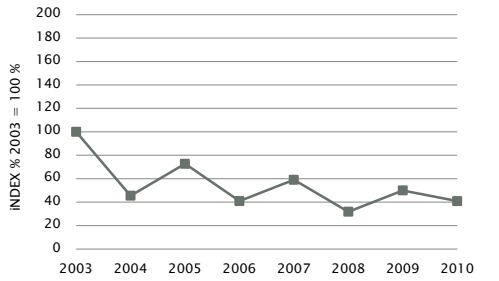
8 Country Profile Finland

8.1 Indicators for drug-related harm

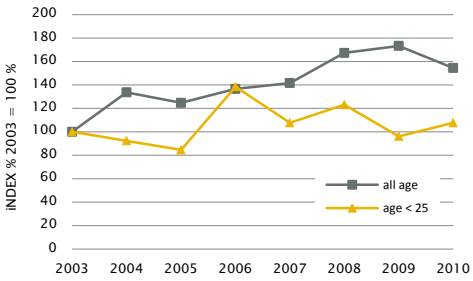
Estimates on the number of **problem drug users** including problem amphetamine and opiate users come to 14.500 -19.100 in 2005 (with 16.600 as a central estimate and rate 4,8 per 1.000 inhabitants aged 15-54, with a 95 % confidence interval of 4,2-5,5). According this study nearly four fifths of problem drug users use amphetamines. The opiate most commonly abused is buprenorphine and polydrug use is very common among the problem drug users [CO]. The largest groups of clients in outpatient treatment in 2010 have opioids (51 %), cannabis (24 %) and stimulants (15 %) as primary drug. In inpatient treatment the respective proportions are 58 %, 10 % and 23 % [Statistical Bulletin TDI-19]. Stimulants are stated as one main problem in Finland. Treatment data shows that they are often used as secondary drug by polydrug users (primary drug opioids) [NR 2011]. According outpatient treatment data three quarter of clients with opioids as primary drug as well as three quarter of clients with stimulants as primary drug inject their primary drug [Statistical Bulletin TDI-17].

Figure 24:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 25:
Number of direct drug-related deaths (indexed - 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

According to the HIV **infectious diseases** statistics 188 new HIV infections were reported in 2010 (178 in 2009). The number of intravenous infections has remained low: in 2010, only 8 infections caused by intravenous drug use were reported, which is only 4 % of the reported total (7 % in 2009). The longer term time trend shows a decrease of new detected HIV infections acquired via IDU (see Figure 24). According to results of surveys among IDUs, the prevalence of HIV has remained at some 1 % to 2 % [NR 2011]. In 2010, the number of new hepatitis C infections reported was 1.132. The majority of cases in 2010 (596) were reported in intravenous drug users [NR 2011].

HCV prevalence among 682 clients of nine needle and syringe programme sites in 2009 was 60.5 % [CO].

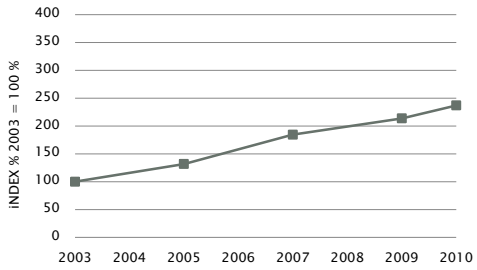
The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased since 2003 (see Figure 25).

8.2 Indicators for drug-related harm reduction

In 2009, there were 40 health centres that exchanged needles and syringes to prevent infectious diseases, located mainly in cities with over 50 000 inhabitants [CO]. The number of syringes provided through needle and syringe programmes increased significantly since 2003 (see Figure 26).

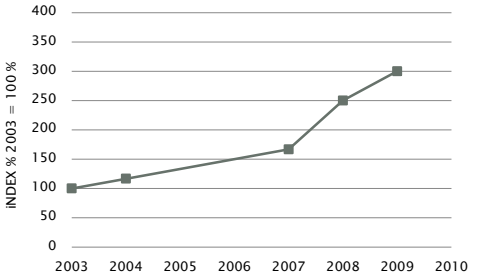
The number of clients in substitution treatment is increasing (see Figure 27). In 2010 1.364 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 26:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 27:
Number of clients in substitution treatment (indexed – 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 HSR 3

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8.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

In Finland, the governmental structure that is responsible for the implementation of the Council Recommendation is the Ministry of Social Affairs and Health [Trimbos 2006].

The prevention and reduction of health-related harm associated with drug dependence is a public health objective in Finland, but was not based upon the Council Recommendation as it existed already prior to its adoption [Trimbos 2006].

These public health objectives are mentioned in the Finnish Drug Policy Action Programme 2004-2007 [Trimbos 2006]. Special legislation, decrees and action plans exist that include preventative and harm reduction measures [Trimbos 2006].

An action plan for 2011-2015 for reducing drug use and its adverse effects, based on the Government Programme 2008-2011, was under preparation lately [NR 2011]. The Government Programme states, that low-threshold services, medical counselling and outreach work for drug users will be increased, the efficiency of treatment referrals carried out by the police will be enhanced and opportunities for the treatment of drug problems during imprisonment will be increased [NR 2011].

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

To prevent infectious diseases among drug users, providing information, education and communication (IEC) via counselling and advice by drugs and health professionals and IEC in general are the predominant response strategies [Trimbos 2006].

In Finland, the dissemination of information through various websites, telephone help lines and a broad range of educational leaflets is nationwide available [Trimbos 2006], although it is not a priority response strategy [SQ 23/29 2011]. The websites of the health and social security counselling centres provide information on their location, on harm reduction, on field work and on peer support activities [SQ 23/29 2011]. The websites also give access to a materials databank with information for instance on infectious diseases, various drugs, health counselling, sexual health and first aid in an overdose emergency [SQ 23/29 2011].

Individual counselling on infectious diseases as well as safer use training is provided extensively[14] [SQ 23/29 2011]. This is done by needle exchange services in almost all cities >50.000 inhabitants and some cities with less inhabitants [Trimbos 2006].

14
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

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A DRD strategy is part of the national drug strategy and aims at maintaining a low level of acute drug-related deaths via health promotion [SQ 23/29 2011]. This should be reached by the following activities [SQ 23/29 2011]:

» to continue the development and increased provision of treatment services, with the aim of ensuring equal access to services for all citizens,
» to offer drug users a range of treatment options, appropriate to the type of addiction in question,
» to increase treatment, health counselling and support directed at reducing drug-related harm (such as diseases, mental health problems and accompanying crime),
» to facilitate access to treatment for opioid addicts, and to increase treatment volumes to meet demand on a more comprehensive basis, and
» to make referral to treatment by the police more efficient.

Overdose information material as well as overdose risk assessment is provided extensively, while overdose response training is provided to a limited extent only [SQ 23/29 2011]. Overdose training is available in a majority of relevant cities (but not in nearly all of them) [SQ 23/29 2011]. This refers to those cities where the services for substance abusers are available [Trimbos 2006]. Also cities that use services from outside provide education/training services indirectly for drug abusers, if there is need and demand for it [Trimbos 2006].

Information materials to reduce drug harms in night clubs is provided rarely and in large music festivals only to a limited extent [SQ 23/29 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Some NGOs provide information, education and communication on drug use targeting especially drug users' family members [Trimbos 2006].

Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for police [SQ 23/29 2011]. It's not available for prison staff or night club staff [SQ 23/29 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach health education is a priority response strategy to prevent DRID in Finland [SQ 23/29 2011].

Outreach work is done by professionals and peer workers of some of the low threshold health centres [SQ 23/29 2011]. Some health counselling centres also undertake field work [SQ 23/29 2011]. The purpose of field work is to reach substance abusers not normally reached by the service system and to make services available to them [SQ 23/29 2011].

The provision of outreach work at night clubs is rare and in large music festivals is extensive [SQ 23/29 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer involvement is not a priority response strategy to prevent DRID in Finland, but peer educators are involved in such measures [SQ 23/29 2011].

In recent years, the opinions of peer groups are increasingly considered in the planning, implementation and evaluation of services to better meet the client´s needs [NR 2011]. But besides this, active participation of substance abusers is seen as crucial to reach the most excluded and most concealed client groups and to provide access to services with a low threshold [NR 2011]. This approach is used for example by the Vinkki outreach street clinic, the drug user association Lumme and the project Osis, a centre of excellence in peer support for drug users in the Greater Helsinki area [NR 2011].

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Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

In specific geographical regions (the capital area) some of the NGOs involved in outreach work exchange information and experiences [Trimbos 2006]. Furthermore, information is disseminated through a needle exchange sentinel site network, e.g. in annual seminars [Trimbos 2006].

Networking and cooperation between agencies involved in outreach work exists rarely, there was an increase since 2003 [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Drug-free psychosocial outpatient and inpatient treatment, methadone detoxification treatment, substitution treatment as well as rehabilitation programmes are available nationwide [Trimbos 2006]. Drop-in centres and treatment with naltrexone is available in specific geographical areas only [Trimbos 2006]. Detoxification is provided fully, psychosocial outpatient interventions extensively and psychosocial in-patient interventions as well as substitution treatment to a limited extent only [SQ 27 p1 2011]. There are no specific treatment interventions for specific target groups [SQ 27 p1 2011]. But there are activities aiming at securing treatment for substance-abusing pregnant women as well as on support services for children of parents with substance abuse problems [NR 2011]. And there is non-medical treatment and short-term detoxification for amphetamine problem users [NR 2011]. Estimates indicate that 15.000 persons receive treatment every year in Finland [NR 2011].

There are waiting times for all treatment options with a varying duration: for detoxification it is less than 2 weeks, for psychosocial outpatient treatment it ranges between 2 weeks and 1 month, for psychosocial inpatient treatment it ranges between 7 and 30 days [SQ 27 p1 2011]. The waiting times for psycho-social rehabilitation services vary due to formal procedures [SQ 27 p1 2011]. The funding arrangements may delay the

long term treatment even longer than this approximation suggests [SQ 27 p1 2011]. The criteria for accessing long term in-patient treatment have become stricter in Finland in general during the last few years due to the economical reasons (global and national economical crisis) [SQ 27 p1 2011]. The municipalities offer short term detoxification and housing services rather than long term psychosocial in-patient treatment [SQ 27 p1 2011].

In 2008 a new Decree of the Ministry of Social Affairs and Health on the detoxification and substitution treatment of opioid addicts entered into force, which had the objective to lower the threshold for treatment and emphasis its role in outpatient settings instead of institutions [NR 2011]. Substitution treatment is supported by (obligatory) psychosocial care to a limited extent [SQ 27 p1 2011]. According to the Decree on substitution treatment, medical treatment requires an individual treatment plan [SQ 27 p1 2011]. This should specify other medical and psychosocial care as well as a follow-up for the patient along with pharmaceutical therapy with buprenorphine (with or without naloxone) or methadone [SQ 27 p1 2011]. This principle should ensure that all persons receiving substitution treatment have also access to psychosocial support [SQ 27 p1 2011]. However, due to increasing OST aiming mainly at harm reduction, there is less emphasis in psycho-social support aiming at rehabilitation [SQ 27 p1 2011]. In the year 2009 1.800 clients received OST [Statistical Bulletin 2011]. Pure buprenorphine is also used for OST, but only rarely [NR 2011].

The waiting time for OST ranges between 1 and 6 months [SQ 27 p1 2011]. Due to the treatment guarantee, which was imposed by the Decree on substitution treatment, assessment of treatment needs has to be carried out within 3 days for non-urgent cases and access to treatment should be provided within 3 months, while in case of specialist treatment these time limits are 3 weeks and 6 months [NR 2011]. In those cities, where OST has been re-organised, so that the primary healthcare has started to provide long term opioid substitution treatment, the waiting times have clearly shortened [SQ 27 p1 2011]. In other cities, where OST is provided mainly by specialized drug treatment units, there is less flexibility to start new OST episodes [SQ 27 p1 2011]. Besides this, clients who don't have to wait for treatment assessment still have to wait afterwards for the actual treatment [NR 2011].

Drug consumption rooms [SQ 23/29 2011] and heroin prescription programmes do not exist in Finland [Trimbos 2006].

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Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

According to the Decree governing the detoxification and substitution treatment for opioid addicts (33/2008) (in common with the old decree), buprenorphine, the combination of buprenorphine and naloxone or methadone can only be prescribed (initiation or continuation of treatment) for substitution treatment of opioid addicts by a physician employed by a healthcare unit (specialized drug treatment centre) and responsible for its operation or by the physician who assigned this task to him/her [SQ 27 p1 2011 and Statistical Bulletin 2011]. Medical treatment may be conducted and the medication administered to the patient only under the supervision of the healthcare unit. If the patient's commitment to treatment is high, the healthcare unit can give him/her pharmaceuticals equivalent to a maximum of eight daily doses (15 in exceptional cases under the Decree) [SQ 27 p1 2011]. However, as an exception to the above and to the old Decree, the Decree allows the combined preparation of buprenorphine and naloxone to be issued from a pharmacy under a pharmacy contract signed by the patient, during the validity of the contract [SQ 27 p1 2011 and Statistical Bulletin 2011]. A pharmacy contract refers to a contract by which the patient commits to collect the pharmaceuticals specified in the contract only from one pharmacy and agrees that the pharmacy may transmit treatment-related information to the physician treating the patient and notify other pharmacies of the existence of the pharmacy contract [SQ 27 p1 2011].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Drug-related health issues are addressed in the national prison health strategy, drug-related health policies for prisons are dealt with at regional level [SQ 23/29 2011].

In the prison health strategy, the priority lies on rehabilitation interventions [SQ 23/29 2011]. These consist of a substance abuse rehabilitation needs assessment, substance abuse rehabilitation guidance, motivational instruction, relapse treatment, group-format rehabilitation programmes of varying intensity, personal therapy, the possibility

of placement in an external substance abuse treatment facility, release training and networking services after release. Various forms of substance abuse rehabilitation are available in nearly all closed prisons. Some of the open prisons specialise in substance abuse rehabilitation. The rehabilitation is mainly undertaken by rehabilitative prison personnel: psychologists, instructors and social workers. There are some 50 instructors specifically engaged for substance abuse work in prisons. The Health Care Unit participates in substance abuse rehabilitation for prisoners only to a very limited extent due to a lack of human resources.

The motivation and effectiveness programmes used in prisons must be approved through an accreditation procedure [SQ 23/29 2011]. The preference is for international programmes with research findings to back up their effectiveness. In addition to group sessions, one-on-one discussions are held with prisoners for whom group work is not suitable; they can discuss substance abuse issues in confidence by appointment. One-on-one discussions are also often used as an extension of group sessions. Peer groups in prison (NA and AA groups) and KRIS-Finland are important contributors to abstinence from substance abuse. But after 2008 accredited substance abuse rehabilitation programmes have been cut back due to a lack of resources [NR 2011].

Low intensity drug treatment is provided in prison fully, while medium/high intensity drug-free treatment is provided to a limited extent only [SQ 27 p1 2011]. OST is provided in prisons rarely, but initiation and continuation of OST is possible [SQ 27 p1 2011]. The basis for this is a Decree of the Ministry of Social Affairs and Health on substitution treatment (2008) [NR 2011]. But until now, no treatment assessments or initiations of OST were carried out in prisons, only continuation of treatment – which was begun before prison entry – was offered [NR 2011].

Due to the Communicable Diseases Act, it is the duty of healthcare personnel to ensure that prisoners are instructed on how to protect themselves particularly against diseases transmitted by blood contact or sexual contact and to prevent their spreading [NR 2011]. This is done in prisons by health education and by ensuring opportunities for protection [NR 2011]. The hygiene package issued to each prisoner contains instructions on condom use and on the cleaning and disposal of injection syringes and needles as well as a personal hygiene kit [NR 2011]. Prisoners are recommended to take tests for hepatitis A, B and C and any vaccination they regard as necessary [NR 2011].

Specific responses to prevent DRID in prison are therefore HCV testing on prison entry and release, which is fully provided, as well as individual counselling on infectious diseases risk, which is extensively provided [SQ 23/29 2011]. Practical advice and training on safer use is provided only to a limited extent [SQ 23/29 2011]. A hepatitis B vaccination programme for PDUs is also available in prisons, while NSPs are not [SQ 23/29 2011]. Disinfectant suitable for cleaning needles and syringes is available at the

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prison clinic, as well as condoms [NR 2011]. Disinfectant should also be available in common facilities of prisons, but in practice, this is not being used by prisoners because of their fear of being monitored [NR 2011].

Pre-release overdose counselling is provided extensively, while specific materials on prevention of acute drug-related deaths and drug-related emergencies for prison staff is not available [SQ 23/29 2011]. Naloxone is not provided upon prison release [SQ 23/29 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is not included in the national vaccination scheme, but free hepatitis A and B vaccinations have been included in the vaccination programme for intravenous drug users [SQ 23/29 2011]. Routine screening of high risk groups and "easy-access" programmes to treatment of infectious diseases are no priority responses to prevent DRID [SQ 23/29 2011]. Still, treatment of HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases is available nationwide [Trimbos 2006].

The treatment of infectious diseases related to drug use is provided within primary healthcare services, specialised services within healthcare and substance abuse services and health counselling centres [SQ 23/29 2011]. HIV infected patients are treated at university hospitals and at central, regional and psychiatric hospitals in the area [SQ 23/29 2011].

Voluntary counselling and testing is a predominant response strategy to prevent DRID [Trimbos 2006], but not a priority response strategy [SQ 23/29 2011]. It is provided by health counselling centres in all municipalities with more than 100.000 inhabitants and, overall, at more than 35 locations [SQ 23/29 2011]. The basis for these services is the Communicable Disease Decree of 2003, which states that municipalities must, within their health centres' operating areas, conduct prevention work against infectious diseases, including the dissemination of information on infectious diseases and health counselling [SQ 23/29 2011]. The scope of the Act encompasses health counselling for intravenous drug users [SQ 23/29 2011]. There is quite wide national coverage of low threshold health service centres.

These health counselling centres offer exchange of syringes and needles and also provide counselling on health issues, small-scale healthcare, testing and vaccination services and case management [SQ 23/29 2011]. Many counselling centres offer anonymous instant HIV tests free of charge [SQ 23/29 2011]. The user's family members and acquaintances may visit the counselling centre, too, if they wish [SQ 23/29 2011]. According to an evaluation study, the services of health counselling centres have played a central role in the prevention of HIV, hepatitis A and B and, to some extent, hepatitis C, as well as in combating epidemics among intravenous drug users and therefore indirectly in the population at large [SQ 23/29 2011]. The ambitious objectives set for the HIV infection situation have been attained, namely stopping the epidemic and bringing the annual number of new cases below 30 [SQ 23/29 2011]. The health counselling centre model has proven to be a very cost-effective health intervention, and safeguarding its continuation and further development is very important [SQ 23/29 2011].

Basic approach in low threshold health services centres is anonymity (visiting without a name or any kind of identification), easy reachability of the location and the services, user-friendly atmosphere, dialogue with the users and ideological and moral non-judgementality [SQ 23/29 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

NSPs are a priority response to prevent DRID and they are provided extensively [SQ 23/29 2011].

The scope of the Communicable Disease Decree of 2003 encompasses health counselling for intravenous drug users, and exchanging syringes and needles where necessary [SQ 23/29 2011]. There are separate health and social security counselling centres for drug users at about 35 locations in Finland [SQ 23/29 2011]. Drug users can exchange used syringes and needles for clean ones in these centres [SQ 23/29 2011]. Pharmacies play an important role in exchanging syringes and needles in areas where there are no health counselling centres [SQ 23/29 2011].

In the year 2010, 3.066.500 syringes were provided at 40 fixed locations for NSPs and at 5 SPPs located in outreach facilities as well as 2 mobile units [ST10 2011].

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In the year 2008 449.000 syringes and needles in total were estimated to be sold by pharmacies [ST10 2008]. The estimate is based on the sales statistics provided by the Association of Finnish Pharmacies and the Pharmacy of University (the latter company is owned by the University of Helsinki and is not a member of the Association) [ST10 2008]. Patients who need to inject (e.g. diabetics) are provided free needles by the health services [ST10 2008]. Still, a notable bias is caused by the syringes and needles sold for injectors of illicit steroids [ST10 2008].

Standard items in the injecting kits, which are provided extensively, are information materials, alcohol pads, dry wipes and containers [SQ 23/29 2011]. Not in the injecting kit, but provided extensively to all customers are Hirudoid cream, filters, condoms and lubricants [SQ 23/29 2011]. As Finnish tap water is very pure, water provision is not seen necessary [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Training programmes for professionals of emergency departments do not exist [Trimbos 2006]. Emergency departments are not used as a setting for risk education/response training that aims at the reduction of drug-related deaths [Trimbos 2006].

Opiate and benzodiazepine antagonists are carried by paramedic units and physician staffed mobile intensive care units (MICU) – that is not all ambulances [Trimbos 2006].

The distribution or administration of naloxone is regulated by laws [SQ 23/29 2011]. Naloxone is available on medical prescription, but not on a "take-home" basis [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Risk reduction is part of an integrated health strategy for drug users, as it is one of the goals of the Drug Policy Action Programme 2004-2007 [Trimbos 2006]. Development

of regional mental health and drug and alcohol treatment services is supported by government funding for development work within social and healthcare services [Trimbos 2006]. However, there is no special focus on drug-related harm reduction in these development projects [Trimbos 2006].

Finland does not have a primary healthcare strategy [SQ 28 2010].

The accomodation needs, education needs and employment needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan or in the written drug policies [SQ 28 2010]. But concerning employment needs there is information about target groups like people with special obstacles such as substance abuse problems or mental health need special services [SQ 28 2010]. Sections on early action, treatment and harm reduction, criminal system's emphasis on substance abuse include action towards social reintegration [SQ 28 2010]. Besides this, employability of drug users in treatment is part of treatment care plan and is often placed as a long term objective in the rehabilitation plan, but will be put into practice in advanced state of rehabilitation [SQ 28 2010]. Under the Government Programme 2012-2015 everyone under the age of 25 and all new graduates under the age of 30 shall be provided with a job, traineeship, placement in studies, workshops or rehabilitation within three months of becoming unemployed [NR 2011]. The implementation will begin in 2012.

It has to be mentioned, that there are separate national or regional social inclusion or housing strategies or action plans addressing specifically the accommodation needs of drug users [SQ 28 2010]. The programme "Decreasing the long term homelessness" is based on the government decision-in-principle in 2008 [SQ 28 2010]. The aim is to reduce the long term homelessness about 50 % in Finland until 2011. The programme includes both, an increase of housing facilities as well as increasing adequate support services for those living in these housing facilities [SQ 28 2010]. Drug use is explicitly mentioned as one of the risks of prolonged homelessness. In the national drug policies, reintegration of those released from prison includes housing and is identified as point of action [SQ 28 2010].

On national level there is often shared responsibility between the Ministry on Social and Health and the relevant other ministries, such as the Ministry of Employment and Economy, the Ministry of Education and Culture and the Ministry of Environment [SQ 28 2010]. On local level the municipalities coordinate different actions [SQ 28 2010]. Social services are mostly accountable of case management when helping marginalised clients with complex, long term problems [SQ 28 2010].

There are partnership agreements between the social services and the health services to meet the needs of drug users in treatment [SQ 28 2010]. Agreements between outpatient treatment facilities resp. residential treatment facilities and social services exist extensively [SQ 28 2010].

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Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

There is a common substance abuse degree, lasting one and a half years, which is open for all workers at the social and health sector. (http://www.paihdelinkki.fi/tietoiskut/661-paihdetyon-ammattitutkinto) [SQ 27 p2 2011]. It includes some parts of drug treatment. Students are usually social workers, nurses and persons who previously have had substance abuse problems.

There is special programme called "Medicine on Substance Abuse" targeted at medical doctors, which lasts two to three years (http://www.paihdelinkki.fi/tietoiskut/664-paihdelaaketieteellinen-erityispatevyyskoulutus) [SQ 27 p2 2011]. In addition, there is a national system of continued education, offering specialised courses/training on drug treatment for social workers, nursing staff and psychiatrists [SQ 27 p2 2011].

Formal NSP training programmes regarding health promotion activities are available for drug agencies staff, but not for pharmacists [SQ 23/29 2011].

There is no institution responsible for developing guidelines [SQ 27 p2 2011].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

Guidelines for physicians for the care of drug addicts (see http://www.kay-pahoito.fi/web/kh/suositukset/naytaartikkeli/tunnus/ccs00013, published originally

in year 2006) are at the moment under up-dating [SQ 27 p2 2011]. The guidelines cover aspects of out-patient/in-patient psychosocial and pharmacological treatment. These recommendations have been augmented in the past years with several published treatment studies on different treatment aspects (like patients using new psychoactive substances, treatment at emergency clinics, treatment of cannabis users in basic healthcare, opioid substitution treatment (OST) for young people) [NR 2011].

The national plan for mental health and substance abuse work outlines the core principles and priorities for the future of mental health and substance abuse work until 2015 [SQ 27 p2 2011]. The plan starts from the premise that mental health problems and substance abuse play a major role in public health. For the first time in Finland, the plan sets joint objectives for mental health and substance abuse work at the national level: (http://www.stm.fi/c/document_library/get_file?folderId=1082856&name=DLFE12329.pdf).

Concerning harm reduction there are national NSP guidelines as well as guidelines for outreach work and peer training [SQ 23/29 2011]. There is no institution responsible for developing HR guidelines [SQ 23/29 2011].

In Finland, several studies were conducted in the field of harm reduction, which provided input for future interventions [Trimbos 2006]. Examples are:

» a study on the effects of long-term use of buprenorphine, methadone and benzodiazepines on patients' cognitive abilities,
» a study investigating the effectiveness and costs of buprenorphine treatment provided exclusively in outpatient care,
» a double-blind study to investigate the possible side effects of buprenorphine-naloxone preparation
» an evaluation of medicinal treatment for drug addicts (2002), which focused on detoxification with buprenorphine as well as
» an evaluation of the VP Project (welfare for prisoners with substance abuse problems, 1999).

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

The health centre concept has proved to be a good way to make contact with drug users [GS]. The guidance and advice provided at health centres is driven by clients' needs. Goals are set according to clients' wishes and abilities. The primary goal is to prevent the transmission of infectious diseases through intravenous drug use by

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encouraging users to employ practices as hygienic as possible. If a client expresses a desire to cut down or quit drug use, various alternatives for attaining this goal are discussed.

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Care Guidelines refer to the importance of evaluation (good practice), but are not binding in nature [SQ 27 p2 2011]. The treatment outcome evaluation is often made as part of the individual treatment plan together with the client, but is not reported collectively [SQ 27 p2 2011].

There is no national research programme for evaluation [SQ 27 p2 2011]. Concerning the improvement of drug treatment there were some research programmes in Finland [SQ 27 p2 2011]:

- A specific "Intoxicants and Addiction Programme" for the years 2007-2010 was funded by the Academy of Finland and supported drug-related research with in total 5,5 million Euros.
- A Clinic Foundation used to engage actively in addiction research and has for example run projects focusing on the life patterns of patients in outpatient and inpatient care in substance abuse services, drug users in Helsinki, families using substance abuse services, substitution treatment, substance abuse rehabilitation in prisons as well as on the work of organisations founded by drug users and patients themselves. However, the research at the A-Clinic Foundation is now more limited, due to a change in RAY's (Finnish Slot Machine Association) funding policy.
- RAY (Finnish Slot Machine Association) seeks to promote the health and social welfare of people in Finland. It uses gaming profits to support activities and projects undertaken by organisations in the health and social welfare fields. One central theme is promotion and evaluation of treatment services for substance abusers. Research is not financed anymore by RAY.

There were no relevant research projects on treatment in the past two years [SQ 27 p2 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

Quality criteria have been determined for substance abuse prevention [GS]. The criteria are qualitative and suited to the prevention and reduction of harm related to substance abuse. The practical implementation of the quality criteria is considered a central tool in improving the quality of substance abuse prevention. These quality criteria do not separate drug prevention from other substance abuse prevention.

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Finland has organised standardised data-collection and information dissemination according to the EMCDDA through the National Focal Point [GS]. For each of the key indicators there is a national expert network.

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The Ministry of Social Affairs and Health presented Finland's national HIV/AIDS strategy, concludes that health counselling for drug users is one of the most important tools for preventing HIV [GS]. The strategy is being revised currently. Health counselling is available in all major urban areas, and the activities include needle exchanges. Furthermore, various types of health counselling have been developed [NR 2011].

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Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Evaluation training programmes are available in Finland to some extent [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

A broad range of actors and stakeholders is involved in evaluation, there is no change since 2003 [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

The model – or different applications derived from it – has also been transferred to Finland's neighbouring regions [GS]. For example, in Estonia, Latvia and Lithuania, as well as in the Russian region of Murmansk, there are prevention projects in operation that are based on the low threshold services model[15]. The National Institute for Health and Welfare has conducted an evaluation study examining the effectiveness of the health centres' operations [GS]. The model of health centres has proven to be a very cost-effective health intervention, and safeguarding its continuation and further development is very important.

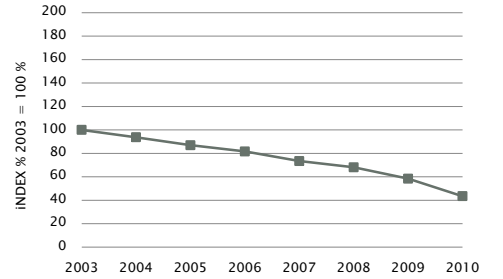
15
See http://www.ktl.fi/attachments/suomi/julkaisut/julkaisusarja_b/2008/2008b24.pdf and https://wcd.coe.int/ViewDoc.jsp?id=1570617&Site=DG3-Pompidou&BackColorInternet=DF3988&BackColorIntranet=DF3988&BackColorLogged=CCCCCC

9 Country Profile France

9.1 Indicators for drug-related harm

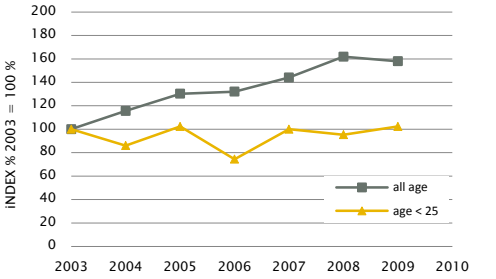
The total number of **problem drug users** (regular users of opioids, cocaine or amphetamines, whose use habits have led to them encountering major problems regarding both their health and their social situation) in France according the most recent estimate for the year 2006 was estimated to be between 210.000 and 250.000 problem drug users (5,4 and 6,4 per 1.000 inhabitants aged 15 to 64 years) [NR 2011]. It is also estimated that approximately 145.000 people have had at least one prescription for an opioid substitution drugs during the first half of 2010 [GS]. When examining the various surveys to establish the proportion of heroin users and applying this to the number of problem users, the number of active heroin users (i.e. those who took the drug during the last month) is estimated at almost 75.000. The same approach when applied to intravenous drug users gives a figure of 81.000 people taking intravenous drugs during the month gone by and 145.000 over the course of their lifetime [NR 2011]. The largest groups of clients in outpatient treatment in 2010 have cannabis (46 %) and opioids (43 %) as primary drug. In inpatient treatment the respective proportions are 17 % and 57 % [Statistical Bulletin TDI-19]. According outpatient treatment data just 23 % of opioid users inject the drug (53 % are sniffing) [Statistical Bulletin TDI-17].

Figure 28:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 29:
Number of direct drug-related deaths (indexed - 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

There are no national estimates on prevalence rates for drug-related **infectious diseases** among injecting drug users in France [CO]. However a large survey has been carried out in five cities covering the main different parts of France in 2004. The prevalence among injecting drug users was 11,3 % for HIV and 73,8 % for HCV [GS]. The number of new diagnosed HIV cases with IDU as route of administration decreased

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significantly since 2003 (see Figure 28). Between 2003 and 2009 IDU was the way of infection with HIV in 1,5 % of all HIV diagnoses [NR 2011]. Data from several studies show a decrease of HCV prevalence among IDUs from 50 to 60 % in 2003 to 40 to 50 % in 2007/2008 [NR 2011] after a dip in the prevalence curve in the beginning of the 2000s.

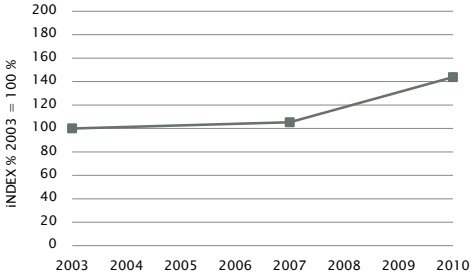
The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased since 2003 (see Figure 29).

9.2 Indicators for drug-related harm reduction

Overall, the risk and harm reduction system covers most of the French territory, partly due to the sale of syringes through pharmacies. In 2008, the estimated total number of syringes distributed or sold in France to IDUs is 13,8 million syringes among them 4,3 million have been distributed from specialist agencies (needle and syringe programmes and dispensing machines) [CO]. The number of syringes provided through needle and syringe programmes increased significantly since 2003 (see Figure 30).

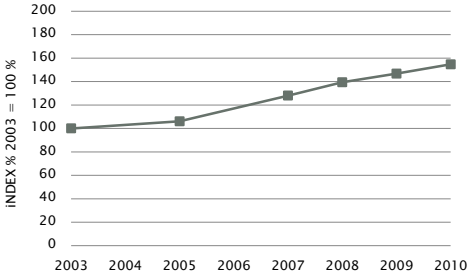
The number of clients in substitution treatment is increasing (see Figure 31)

Figure 30:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 31:
Number of clients in substitution (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

9.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

In France, drug policy is coordinated by the Interministerial Department for the Fight against Drugs and Addiction which is based at the Prime-Ministers Office. This department is also responsible for the implementation of the Council Recommendation [Trimbos 2006].

Prevention and reduction of health-related harm associated with drug dependence pre-existed in France before the adoption of the Council Recommendation. The reduction of health harms associated with drug dependence has been part of French drug policy since the Drug Act of 21 September 1993, but this part of drug demand reduction was 'boosted' with the coming into force of the Three-Year Plan for the Fight Against Drugs and the Prevention of Dependence 1999-2001 (extended to 2002). This plan placed emphasis on drug demand reduction activities, including prevention of drug dependence, early detection of problematic drug use and harm reduction (including needle and syringe exchange programmes and re-enforcement of substitution treatment) [Trimbos 2006].

A government "drugs" plan for 2008-2011 exists, which includes the measures of the addictions plan ("Dealing with addiction: 2007-2011"[16]) of the ministry of Health in its "health" section [NR 2011]. The main objectives of this plan are to improve the way in which addictions are handled in health establishments and in medical/social establishments, to improve the range of treatment provided by general physicians and their interface with the health and medical/social sector as well as to improve training and research [NR 2007]. The government plan has to be adapted to local situations and characteristics, which is the responsibility of local drug project leaders [NR 2011]. Since 2009 also the planning and assessment of health actions has to be carried out regionally, so the local drug project leader have to ensure, that local health activities meet the requirements of drug users [NR 2011].

16
(http://www.sante.gouv.fr/htm/actu/plan_addictions_2007_2011/plan_addictions_2007_2011.pdf)

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In addition there is a "Hepatitis plan" for 2009–2012 of the Ministry of Health, focusing on specific target groups like (injecting) drug users and aiming on the improvement of prevention and the accessibility of screening, effective treatment and care [NR 2011]. Additional measures for prisons are also mentioned as well as the quality of care and the quality of life of people suffering from hepatitis B and C [NR 2011].

More specific objectives for the fight against hepatitis were set by the 2004 public health law: a rising coverage of children and adolescents by primary vaccination, an increasing screening of infected people and a reduction of HCV prevalence among illegal drug users under 25 years [NR 2011].

The 2009–2013 "cancer plan" includes also measures against hepatitis and addresses the following transversal priority themes [NR 2011]:

» To better take into account health inequalities for greater care equity and effectiveness
» To analyse and take into account individual and environmental factors in order to personalize the health response before, during and after the disease and
» To increase the role of general practitioners at all steps of care.

Other health-related consequences of drug use than infectious disease or – since recently only – drug-related emergencies and deaths have not been the subject of specific responses from public authorities yet [NR 2011].

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

The predominant strategies to prevent health-related harm among drug users are information, education and communication (IEC) in general, IEC via counselling and advice by drugs and health professionals as well as safer injecting training [Trimbos 2006]. IEC via peer involvement/peer approach is a common strategy [Trimbos 2006]. Information is disseminated nationwide through telephone help lines, websites and a broad range of educational leaflets [Trimbos 2006].

The dissemination of information materials is a priority response to prevent DRID, while practical advice and training on safer injecting isn't [SQ 23/29 2011]. While safer use training is extensively[17] provided, individual counselling on infectious diseases is not always available in low threshold services but widely available in the anonymous free screening HIV counselling centres (CDAG) [SQ 23/29 2011, GS].

There is no specific text defining strategies to reduce DRD [SQ 23/29 2011]. Reducing DRD is commonly quoted as a general objective, in particular in the Plan 2008-2011 edited by the interministerial mission for the fight of drugs and addictions (MILDT), nevertheless without any specific ways to achieve this goal [SQ 23/29 2011]. Overdose

17
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

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information material is available extensively, while overdose training and risk assessment is provided only rarely [SQ 23/29 2011].

Information regarding the prevention and reduction of harm associated with drugs usually consumed at night clubs and large music festivals, is provided to a limited extend resp. extensively [SQ 23/29 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

In specific geographical regions, communities and families of drug users are involved in the prevention and reduction of health risks associated with drug dependence [Trimbos 2006]. But specific information material on DRD and formal NSP training is not available for other groups [SQ 23/29 2011].

In 2008/2009 the operation of the health warning system started [NR 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach work as a health education approach is a common response strategy and a predominant implementation setting for infectious diseases prevention measures targeting drug users [Trimbos 2006], but outreach health education is not a priority response to prevent DRID [SQ 23/29 2011]. The main outreach health education approaches are information and peers education [SQ 23/29 2011]. The promotion and integration of outreach work at night clubs is rare, while it is extensive in large music festivals [SQ 23/29 2011].

Trainings for outreach workers are available in specific geographical areas [Trimbos 2006]. Beyond standardized trainings, common to outreach workers, there are no specific nationwide on-the-job-trainings, only local initiatives [Trimbos 2006].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are involved in the responses to prevent DRID, but peer involvement is not a priority [SQ 23/29 2011]. Training for peers and volunteers is not available as such at national level in France but some interesting experiences exists since the early 90s [GS].

Naloxone is not available on a “take-home“ basis to drug users, peers and relatives [SQ 23/29 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies is nationwide available [Trimbos 2006], and encouraged by the ministry of health and its regional representative authorities.

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

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Drug-free psychosocial out-patient interventions are available extensively and nationwide [Trimbos 2006; SQ 27 p1 2008]. Substitution treatment with buprenorphine is available fully and nationwide [Trimbos 2006; SQ 27 p1 2008]. Drug-free psychosocial in-patient interventions, substitution treatment with methadone, detoxification treatment and drop-in centres are available in most French regions, while shelters are available to a limited extent only and only in specific geographical areas [Trimbos 2006; SQ 27 p1 2008, GS]. There are no specific treatment interventions for specific target groups [SQ 27 p1 2011]. No information is available on waiting times for detoxification, psychosocial inpatient and outpatient treatments [SQ 27 p1 2008]. In the year 2008 approximately 96.000 persons received outpatient treatment, while approximately 2.000 were accommodated in residential treatment [NR 2011].

Natrexone and codeine are not available for substitution treatment [Trimbos 2006]. Some clients receive morpine sulphate-based treatment and since 2006 generic preparations containing high dosage buprenorphine are available [NR 2011]. Substitution treatment is supported by psychosocial care extensively and there is no waiting time for OST [SQ 27 p1 2008]. In the year 2010 approximately 145.000 clients received reimbursement for OST by Social Security Organisations [NR 2011]. The percentage of OST clients receiving methadone is increasing, which was a recommendation of the Consensus Conference on substitution treatments in June 2004 [NR 2011]. This is also the case for substitution treatment in hospital settings (and an effect of circular no. 2002/57 of 30 January 2002) [NR 2011].

Treatment access points also provide information or sterile, single-use equipment, but they also contribute to the reduction of risks by providing substitution treatment [NR 2011]. To reach the most vulnerable drug-using groups, health-care professionals can initiate methadone substitution treatment in a hospital or prison setting. This has been limited previously to physicians in low-threshold structures [NR 2011].

France does not have drug consumption rooms or heroin prescription programmes [Trimbos 2006].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are nationwide available [Trimbos 2006].

OST (with methadone or buprenorphine) can be initiated and continued by medical doctors at specialised drug treatment centres and by medical doctors based at public hospitals [Statistical Bulletin 2011]. Treatment with high dosage buprenorphine can also be initiated and continued by any medical doctor [Statistical Bulletin 2011]. Any medical doctor can also continue methadone treatment and initiate treatment with slow-release morphine [Statistical Bulletin 2011].

Methadone can be dispensed at specialised treatment centres, pharmacies and mobile outreach units, high dosage buprenorphine can be dispensed at pharmacies and mobile outreach units and slow-release morphine can be dispensed at pharmacies only [Statistical Bulletin 2011].

Conditions concerning "take-home" doses only exist for methadone for stabilized patients (HDB can be provided by GP's without initial prescription by a primary care or hospital structure) [SQ 27 p1 2011].

Since the implementation of the French National Health Insurance Fund's plan to control opiate substitution treatments the proportion of high dosage buprenorphine being misused diminished [NR 2011]. One indicator used for this assessment is the reduction of the average daily dose higher than 32 mg/d [NR 2011]. Still, the measures taken had only limited impact on the availability of high dosage buprenorphine in the black market: while fewer users re-sold their excess, there was better organized health insurance fraud carried out (theft of "carte vitale", recruitment of false users, consultations in several departments...) NR 2011]. Misuse of methadone rises parallel to its wider application, but the capsule form available since 2008 is not affected by the black market NR 2011].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Drug-related prison health is addressed in the national drug strategy and drug-related health issues are also addressed in the national prison health strategy [SQ 23/29 2011]. The 2010-2014 strategic action plan addresses all aspects of prison health policy and states as objectives the strengthening and development of the existing health systems as well as the reinforcement of measures for certain detainee categories (especially addicted people) [NR 2011]. Access to HIV and hepatitis screening is one of the main strategies [NR 2011]. But it also emphasizes the importance of conti-

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nuity of care after release from prison as well as consistent housing for people released from prison to ensure continuity of care [NR 2011].

The priority responses to prevent DRID in prisons are voluntary infectious diseases counselling and testing on prison entry [SQ 23/29 2011, GS]. There is mandatory tuberculosis and syphilis screening as well as optional confidential HIV testing [NR 2011]. Hepatitis B and C screening and hepatitis B vaccination is also offered, but not mandatory [NR 2011]. Available treatments in prisons include opioid substitution treatment, medical support for withdrawal and counselling, but there is no therapeutic community in prison settings [NR 2011]. Despite the recommendations of 1994 treatments started before arrival at prison are not systematically continued and the accessibility to treatment varies [NR 2011]. This is also the case for continuation of treatment after release from prisons, which is often insufficient [NR 2011]. Whereas the average initially prescribed amounts of methadone in prisons are similar to those outside of prisons, there is still a need to improve continuity of this kind of maintenance treatment in prisons (particularly when leaving prisons) [NR 2011].

HCV testing on entry into prison is provided in prisons extensively, individual counselling on infectious diseases risk is provided only rarely and practical advice and training on safer use as well as NSPs are not available in prisons at all [SQ 23/29 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is not included in the national vaccination strategy, but a risk-group specific hepatitis B vaccination programme targeting drug users is available [SQ 23/29 2011] nationwide [Trimbos 2006]. There is no vaccination programme for tuberculosis targeting drug users, but drug users have an easy access to vaccination programme (all French and foreign citizens living in France) [GS].

The priority response to prevent DRID among drug users is voluntary counselling and testing [SQ 23/29 2011]. HCV testing is provided fully [SQ 23/29 2011]. Routine testing/screening for infectious diseases targeting drug users is not a priority [SQ 23/29 2011], but it is available nationwide [Trimbos 2006].

The 2009-2012 action plan includes systematic activities in all structures visited by drug users to inform about the importance of screening and the efficacy of treatments – especially unstable and migrant drug users [NR 2011]. The cost of screening for HIV and hepatitis C infection is covered by the French national insurance system, the search for chronic hepatitis B markers is covered only partly [NR 2011]. The screening is offered free of charge and anonymously by specific centres [NR 2011].

"Easy-access" programmes to treatment of infectious diseases are not a priority response strategy in France [SQ 23/29 2011]. In 2005 a coordinated treatment procedure for hepatitis C was created and organized around hospital contact points in order to improve liaison between GPs and specialised medical services [NR 2011]. A doctor's guide for hepatitis C was produced in 2006 and should be followed by a hepatitis B guide [NR 2011].

The provision of condoms is not a priority response strategy, although they are provided together with injecting kits fully [SQ 23/29 2011].

Council Recommendation 2.10

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provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

The objective of the DRID strategy, which is part of the Drug Strategy, is to reduce morbidity and mortality due to hepatitis C in drug users [SQ 23/29 2011].

Needle syringe programmes are a priority response to prevent DRID in France and they are extensively provided [SQ 23/29 2011]. NSPs are provided by 116 specialists agencies, 276 vending machines and 29 NSP in pharmacies, but not in prisons [ST 10 2011]. In addition there are 91 syringe provision points (SPPs) in outreach work and 49 mobile units [ST 10 2011, GS]. In the year 2008 3.398.875 syringes were provided by NSPs in specialists agencies and 453.876 syringes by vending machines [ST 10 2011]. In 2009, 4.850.228 syringes have been sold by pharmacies to drug users. This number is an estimation elaborated by the main syringe manufacturer and supplier (Becton and Dickinson): 70 % of all syringes sold in pharmacies over the counter (1ML) are bought by IDUs [ST 10 2011]. Still, formal NSP training is not available for pharmacists [SQ 23/29 2011].

Standard items in injecting kits, which are provided through drug agencies extensively, are information, alcohol pads, dry wipes, water, containers, filters and condoms [SQ

23/29 2011]. As paraphernalia for non-injecting drug users, straw is provided for sniffers (sniff kits) and pipes for crack/free base smokers (base kits) [SQ 23/29 2011].

Condom promotion among drug users is a common response strategy to prevent DRID [Trimbos 2006], although not a priority response strategy [SQ 23/29 2011]. Condoms are provided in injecting kits fully [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Training programmes for professionals of emergency services are not available, but ambulances routinely carry antagonists [Trimbos 2006].

Naloxone is regulated by administrative regulation and its use is limited to medical personnel [SQ 23/29 2011]. Naloxone is not available on a "take-home" basis [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Nationwide, risk reduction is part of an integrated health strategy for drug users [Trimbos 2006].

France has a national primary healthcare strategy and drug users are explicitly addressed by it [SQ 28 2010]. In addition to this national primary healthcare strategy, for the period 2007-2011, the Ministry of Health has adopted a national plan for the management and prevention of addictions. The stated objective of this plan is to improve the health cover of addicts [SQ 28 2010].

While educational needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan or the National Drug Strategy, their accomodation needs and employment needs are mentioned in the National Drug Strategy [SQ 28 2010]. Access to employment is not stated as a specific measure but, rather, as one of the components promoting integration and reintegration, alongside the fight

against precarious living conditions and housing issues [SQ 28 2010]. Concerning accommodation, priority should be given within the integration accommodation reception system on release from prison to persons in difficulty with their consumption of alcohol or illegal drugs and partnerships with medical-social structures should be developed [NR 2011].

Policies to improve social reintegration and reducing social exclusion of drug users are [SQ 28 2010]:

» To extend the medical microstructures network model that already exists in three fairly urban sectors (http://www.reseau-rms.org/) to a new rural sector.
» To experiment with new methods of social care for drug users treated in towns, by completing health networks specialising in addictions through the inclusion of a social activity time in the care programme.

In terms of inter-institutional national partnerships, a working framework agreement was signed between the interministerial mission for the fight of drugs and addictions (MILDT) and the DGCS (Directorate General for Social Cohesion) in order to improve the link between the government action plan and social integration. In addition, there are partnership agreements between the social services and the health services to meet the needs of drug users in treatment. Agreements between outpatient treatment facilities resp. residential treatment facilities and the social services exist extensively. The most common mechanism of interagency coordination is the structured protocol. The employability of drug users in treatment is not an objective of the care plan [SQ 28 2010].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

In general, training for professionals working in treatment facilities, in substitution treatment, in low threshold programmes and in prison settings is available nationwide [Trimbos 2006]. This specialised education/training is available for social workers, nursing staff, psychologists and medical doctors [SQ 27 P2 2008]. Still, there is no recognised professional qualification for professionals in the field of prevention and reduction of health-related risks associated with drug dependence in France [Trimbos 2006] and there are no professional standards [SQ 27 P2 2008].

In specific geographical regions, training for professionals working in needle and syringe exchange programmes is provided [Trimbos 2006], but there is no formal NSP

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training for drug agencies staff, pharmacists, prison staff and other groups [SQ 23/29 2011].

The institution responsible for developing best practice guidelines is the Health high authority (www.has.sante.fr) [SQ 27 P2 2008].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

The institution responsible for developing HR guidelines is INPES – National Institute for Prevention and Health Education (www.inpes.fr) [SQ 23/29 2011].

There are guidelines on harm reduction [Best Practice Portal]:

» Infectious risk reduction among injecting drug users (2009).

And there are several treatment guidelines [Best Practice Portal]:

» Modalités de sevrage chez les toxicomanes dépendant des opiacés. Conférence de consensus des 23 et 24 avril 1998 – Texte long des recommandations
» Conférence de consensus Stratégies thérapeutiques pour les personnes dépendantes des opiacés: place des traitements de substitution 23 et 24 juin 2004 Texte des recommandations
» Consensus conference Vaccination against the hepatitis B virus 10-11 September 2003 Guidelines
» Strategies of care for cocaine users (2010)
» Reducing the misuse of opiate substitution medication (2004)
» Abuse, addiction and polydruguse: strategies of care (2007).

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Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

Needs assessments are used at the initial stage of programmes to some extent, this increased since 2003 [PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation aspects are not included in the guidelines [SQ 27 P2 2008].

There is a national research programme for evaluation and improvement of drug treatment. Each year, the national institute of health and medical research (INSERM) and the interministerial mission for the fight of drugs and addictions (MILDT) launch a bid to fund research teams committed to evaluation on drug topics. Information can be found on the website of the interministerial mission for the fight of drugs and addictions (MILDT): www.drogues.gouv.fr [SQ 27 P2 2008].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

The culture of evaluation is relatively new to France [Trimbos 2006]. As a result of the evaluation of the three-year Action Plan 1999-2001, recommendations regarding quality assurance were made.

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Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

No information available.

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

In the framework of the three-year action plan on drugs of the French government, five priority programmes and/or specific facilities were evaluated [Trimbos 2006]. These were:

- the departmental prevention programmes,
- the inter-ministerial training initiative,
- the approach to specialised alcohol addiction units with a view to general admission,
- the harm reduction and social mediation programme in the 18th arrondissement of Paris and
- the departmental agreements on health and justice objectives.

These programme evaluations, which were part of the three-year plan, were managed by the OFDT in collaboration with the institutions concerned and were carried out by independent teams selected in a call for tenders' procedure [Trimbos 2006]. Their specific results were added to the general evaluation report and resulted in a series of recommendations for policy.

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Evaluation training programmes are available in France to some extent, there was an increase since 2003 [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

A broad range of actors and stakeholders is involved to some extent in evaluation, there was an increase since 2003 [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

France has participated in a number of SANCO funded projects (e.g. Emerging trend project, Twinning projects with Poland, Slovakia and Turkey) [GS].

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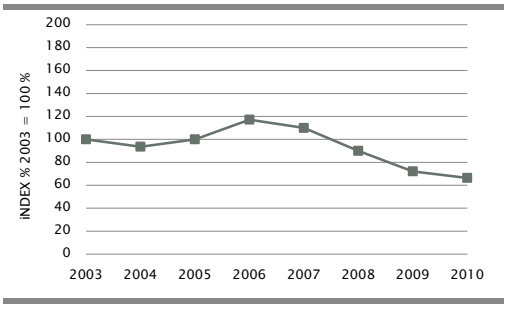
10 Country Profile Germany

10.1 Indicators for drug-related harm

The most recently available estimate of **problem drug use** including the users of opiates, cocaine and amphetamines is based on treatment data and refers to the year 2008. According to the data, the prevalence is estimated to be between 196.836 and 233.743 (3,6–4,3 per 1.000 inhabitants, aged 15–64). Calculations based on figures collected from treatment, police contacts and drug-related deaths lead to an estimated figure of problem heroin users ranging between 81.000 and 71.000 persons (with the estimates of the year 2009 serving as a calculation basis). This corresponds to a quota of 1,5 to 3,2 persons in 1.000 inhabitants in the age of 15 to 64 years [NR 2011]. Looking at time trends there are no clear indications for an increase or decrease of the prevalence of problem drug use.

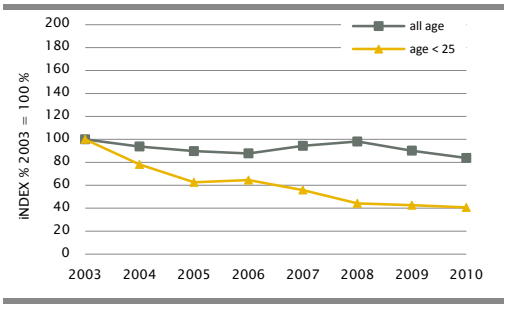
The largest groups of clients in outpatient treatment in 2010 have opioids (46 %) and cannabis (36 %) as primary drug. In inpatient treatment the respective proportions are 38 % and 26 % [Statistical Bulletin TDI-19]. According outpatient treatment data just 36 % of opioid users inject the drug (40 % eat/drink the drug and 17 % smoke it) [Statistical Bulletin TDI-17].

Figure 32:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 33:
Number of drug-related deaths (indexed – 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

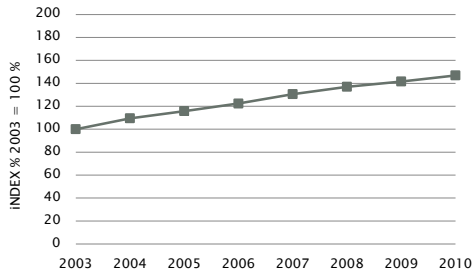
There are no national estimates on prevalence rates for drug-related **infectious diseases** among injecting drug users in Germany. The number of new diagnosed HIV cases with IDU as route of administration decreased since 2006 (see Figure 32). Data from several local studies in treatment or low threshold facilities give a prevalence rate of HIV among IDUs between 4 % and 7 % in 2009 [NR 2011]. The same sources reported HCV infection rates between 48 % and 65 % among IDUs [NR 2011].

The national statistic on **drug-related deaths** includes direct cases (deaths due to overdoses, drug-induced deaths) as well as indirect cases (e. g. accidents under influence of drugs). The number of **drug-related deaths** decreased since 2003, especially in the age group < 25 (see Figure 33).

10.2 Indicators for drug-related harm reduction

Needle and syringe exchange programmes exist nationwide since 1984. Although data on the number of distribution points or the number of distributed syringes are not available for the country as a whole Germany has the highest number of needle and syringe vending machines in the World. Around 161 vending machines are installed in 9 Länder [CO]. The number of clients in substitution treatment is increasing (see Figure 34). In 2010 71.507 clients started an inpatient or outpatient treatment [ST TDI-2]

Figure 34:
Number of clients in substitution treatment (indexed - 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 HSR 3

10.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

In Germany the governmental body responsible for the implementation of the Council Recommendation is the Federal Ministry for Health and Social Security. HR policy exists, but was not based upon the Council Recommendation. Prevention of drug dependence and reduction of related risks were already priority goals in German drug policy before the Council Recommendation was launched. Since 1990 there have been comprehensive, multidisciplinary action plans on federal and Länder level, which have been further developed in the light of new scientific evidence [Trimbos 2006].

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Harm reduction is part of the 'Aktionsplan Drogen und Sucht' of the Federal Government, which was adopted in 2003 and covers the period of 2003-2008 [Trimbos 2006]. A new strategy for drug and addiction policy was developed in 2010 [NR 2011]. Objectives of this strategy are for example to expand special help offers for older people and for people showing new use patterns [NR 2011].

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

Providing information, education and communication (IEC) in general is the predominant strategy in Germany to prevent drug-related infectious disease as well as drug-related deaths and is done mainly via counselling and advice by drugs and health professionals as well as via peer involvement/peer approach [Trimbos 2006]. In addition, the dissemination of information through various websites and through telephone help lines is available nationwide [Trimbos 2006].

Individual counselling on infectious diseases as well as safer use (injecting) training is provided extensively[18] [SQ 23/29 2008]. But there are considerable differences between regions, communities and institutions in the approaches used and in the

18
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

implementation of the measures [NR 2011]. While the dissemination of information materials for drug users and safer use training are the priority responses to prevent DRID, the provision of "easy-access" programmes to treatment of infectious disease has no priority [SQ 23/29 2011]. A review, carried out on safer use initiatives showed deficits especially in rural areas and particularly in prisons, safer use trainings seem to be exceptions and it is unclear to what extent pharmacies and doctors are active in this area [NR 2011].

A strategy for the prevention of DRD is part of the National Drug Strategy [SQ 23/29 2008]. The objectives are to decrease more risky ways of drug consumption through the development of information material and training of staff of low threshold facilities [SQ 23/29 2008]. There is also an option for further consumption rooms and the improvement of emergency care through training of users to assist each other is mentioned [SQ 23/29 2008]. The target groups of this DRD-strategy are users of heroin and cocaine in contact with low threshold facilities [SQ 23/29 2008].

Overdose information material is provided extensively [SQ 23/29 2008]. Overdose risk reduction training is provided to a limited extend, but it is available in nearly all relevant cities or towns [SQ 23/29 2008]. Another measure is the provision of immediate help ("therapy now") [NR 2011].

Information regarding prevention and reduction of harm associated with drugs consumed in night clubs and at large music festivals is rarely provided [SQ 23/29 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

There is no information regarding the availability of specific information material on the prevention of acute drug-related deaths and drug-related emergencies for police, family/friends or others, but this kind of material is available for prison staff and night club staff [SQ 23/29 2011].

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Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

To prevent infectious diseases among drug users, outreach work as a health education approach is not a priority response [SQ 23/29 2011], but a common response strategy [Trimbos 2006]. The main outreach health education approach is via streetwork and mobile vans (serviced by staff of drug and addiction counselling centres), while outreach work at night clubs and large music festivals is rarely provided [SQ 23/29 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are involved in the responses to prevent DRID, but peer involvement is not a priority [SQ 23/29 2011]. In specific geographical areas only, peers and volunteers are included in outreach work practice and training for outreach workers, peers and volunteers is organized [Trimbos 2006].

Naloxone on "take-home" basis is available in the context of trainings to prevent drug emergencies [SQ 23/29 2011, NR 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies exist in specific geographical areas only [Trimbos 2006].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Drug-free psychosocial outpatient and inpatient treatment, methadone maintenance and detoxification programmes, treatment with buprenorphine and rehabilitation programmes are available nationwide and extensively [Trimbos 2006, SQ 27 p1 2011]. Heroin prescription programmes, drug consumption rooms and drop-in centres are available in specific geographical areas only [Trimbos 2006].

Most of the treatment facilities offer treatment for different user groups, considering not only substance-specific aspects but also a series of psychological, social and health aspects, that are partly associated with certain periods of life or age groups [NR 2011]. There are very different counselling and treatment concepts within the framework of person-centered addiction help, as well as various forms of interventions, focusing on the reduction or cessation of substance use and the combat against associated problems as equally valid objectives of therapy [NR 2011]. There are specific treatment interventions for cocaine, cannabis, amphetamine and benzodiazepine users [SQ 27 p1 2011] but there is also the diamorphine-assisted therapy for heavily dependent opioid users [NR 2011]. In the year 2010 60.473 treatments were started or completed in outpatient psychosocial addiction support centres and 8.746 clients were treated in inpatient facilities because of problems with illicit drugs [NR 2011].

Substitution treatment is supported by psychosocial care extensively [SQ 27 p1 2011], sometimes obligatory, sometimes upon request by the client (depending on the prescribing institution or general practitioner) [Trimbos 2006]. In the year 2009

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74.600 clients received OST [Statistical Bulletin 2011]. The substances used for OST are methadone, high dosage buprenorphine and a combination of buprenorphine and naloxone. The expansion of substitution therapy is defined as the most important measure to prevent drug-related emergencies and deaths [NR 2011].

There are waiting times for the different treatment options, which are rather short (< 2 weeks) for detoxification and psychosocial outpatient treatment and a bit longer (between 2 weeks and 1 month) for substitution treatment and psychosocial inpatient treatment [SQ 27 p1 2011]. The reasons for waiting times are in the case of detoxification and substitution treatment formal procedures, for other treatment options the limited availability is leading to waiting times [SQ 27 p1 2011]. In case of OST there are also regional differences [SQ 27 p1 2011].

Drug consumption rooms play an important role in the prevention of DRID and DRD [NR 2011]. Infection prophylaxis forms a systematical part of this service, paraphernalia brought to the consumption rooms may not be used [NR 2011]. Minimum requirements are defined for the operation of these facilities based on the §10 of the Narcotics Act. 6 out of 16 Länder passed also corresponding regulations [NR 2011]. In the year 2010 28 drug consumption rooms with 251 consumption places [NR 2011] were available in 16 German cities [SQ 23/29 2011].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are available nationwide [Trimbos 2006].

OST can be initiated and continued by medical doctors at drug treatment centres, specialised medical doctors and any medical doctor [Statistical Bulletin 2011]. The dispensing depends on the substance: while all substances can be dispensed by specialised treatment centres, specialised medical doctors' offices, pharmacies and hospitals, only methadone can be dispensed also in any medical doctor's office [Statistical Bulletin 2011].

In 2010 the "Bundesärztekammer" renewed their guidelines on opioid substitution treatment: for the newer option of substitution treatment with diamorphine, it is forbidden and it is a criminal act to give out "take-home" dosis. All other regulations didn't change [SQ 27 p1 2011].

Besides this, the provision of drug consumption rooms and the extensive availability of different treatment options are reported as measures to prevent diversion of prescribed drugs [SQ 27 p1 2011].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Drug-related prison health is addressed in the national drug strategy [SQ 23/29 2011]. It includes as specific objective "the promotion of measures targeting reduction of infectious diseases within the penal system" and addresses therefore the specific group of prisoners [SQ 23/29 2008]. It foresees, for instance, the implementation of education programmes and the exploration of the extent to which vaccination programmes and substitution treatment for opiate addicts are provided [SQ 23/29 2008]. Finally, the testing of the distribution of sterilised syringes to injecting users in prisons is foreseen [SQ 23/29 2008].

Besides this, drug-related health policies for prisons are dealt with at regional and at prison level [SQ 23/29 2011]. Prisons are a common implementation setting for infectious disease prevention measures targeted at drug users [Trimbos 2006], but there is no special DRID strategy [SQ 23/29 2011].

The priority responses to prevent DRID in prisons are the dissemination of information materials, a hepatitis vaccination programme and the initiation of opioid substitution treatment [SQ 23/29 2011].

A survey of the DBDD showed that anti-retroviral therapy (against HIV) and antiviral therapy (against HCV) is possible in most provinces, but no further information is available [NR 2011]. According to this survey condoms and sometimes lubrication is distributed to inmates free of charge and tests for infectious diseases are offered in almost all provinces [NR 2011]. Another survey showed that it is possible to be inoculated against hepatitis B free of charge in most provinces, while vaccination upon request for risk groups is provided to a lesser extent [NR 2011]. According to this survey tests for HIV and hepatitis B/C are either offered on voluntary level or all prisoners are tested upon prison entry in most provinces, while testing for infectious diseases before prison release is available only in few provinces [NR 2011]. HIV counselling before and after the test is done in most provinces, as is the case for the distribution of condoms free of charge [NR 2011].

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There is only one NSP in one prison in Berlin existing, where addicted women can exchange sterile syringes at a vending machine anonymously [NR 2011]. This is combined with regular information and counselling discussions with external experts and without the presence of a guard [NR 2011].

Measures targeting at the reduction of drug-related deaths are uncommon or non-existent in German prisons [Trimbos 2006]. Still, there is specific information material on DRD and emergencies available for prison staff [SQ 23/29 2011]. A survey of the DBDD showed that in some provinces an increase of the dosage within an ongoing OST is offered prior to prison release [NR 2011]. In a few provinces inmates are referred to external addiction therapies (including OST), in one province a transition substitution treatment is possible after release from prison and another province offers general transition management [NR 2011]. Another survey showed that information material is handed out and counselling on risks and prevention is available in almost all provinces, in most provinces inmates are referred directly to external drug help services, while substitution treatment can be initiated prior to release in a few provinces only [NR 2011].

Drug treatment is provided by prison health services, community-based public health services and NGOs [SQ 27 p1 2011]. Low intensity drug treatment is provided fully, while medium/high intensity drug-free treatment is provided extensively [SQ 27 p1 2011]. OST is provided in prisons to a limited extent, but initiation and continuation are possible [SQ 27 p1 2011]. There are regional differences and differing results in various surveys, which it make it hard to assess the availability and the conditions of OST in German penal institutions [NR 2011]. A survey of the DBDD showed, that detoxification and substitution treatment is offered to inmates in 13 Länder [NR 2011]. There are considerable differences concerning the objective/duration of OST: sustained OST is carried out in 9 Länder while 3 Länder use OST only to reduce dosage levels among new inmates, initiation of OST is offered shortly before release in one while high dosage OST is possible before release in 6 provinces [NR 2011]. Another survey showed that rapid medically assisted detoxification, rapid detoxification without medication, abstinence-based treatment with psychosocial assistance, treatment with antagonists and substitution treatment are offered from between four to nearly all provinces [NR 2011]. The conditions vary from OST being available for all prisoners to being decided on case-by-case basis and dependent on individual factors like serious illness or pregnancy [NR 2011]. Up to now, diamorphine-assisted treatment is not possible in prisons. The implementation of this kind of treatment would require sufficient political backing and different attitudes towards drug users in prisons [NR 2011].

In 2010 the German Medical Association included in its guidelines the recommendation, that a reasonable substitution treatment in prison can reduce drug-related fatalities after prison release [NR 2011]. On the basis of this idea, a national model

project was developed for the prevention of drug-related emergencies, but it hasn't been integrated as a regular element in prisons yet [NR 2011].

The principle "Therapy instead of penalty" is also seen as successful approach in the rehabilitation of drug using offenders [NR 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is not included in the national vaccination strategy [SQ 23/29 2011]. Voluntary infectious disease counselling and testing, hepatitis vaccination programmes for drug users and routine screening of high risk groups are not priority responses to prevent DRID [SQ 23/29 2011], but they are available in Germany [Trimbos 2006]. This is also the case for "easy-access" programmes to treatment of infectious diseases [Trimbos 2006].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

A strategy for the prevention of DRID is part of the National Drug Strategy [SQ 23/29 2008]. In general, the objective related - among others - to the prevention of drug-related diseases is "prevention and reduction of illegal drug consumption", since risky behaviour during the consumption of illegal psychoactive substances increases the infection risks significantly [SQ 23/29 2008]. Numerous regional and local initiatives and studies address the topic of infectious diseases among drug users [SQ 23/29 2008]. No dedicated national strategy exists, that defines concrete measures or targets to reduce e.g. the prevalence rate of HBV/HCV among drug users [SQ 23/29 2008].

Needle and syringe exchange programmes are a priority response strategy to prevent DRID among drug users in Germany [SQ 23/29 2011] and NSPs are provided extensively [SQ 23/29 2008], although there still is no NSP in six Länder [NR 2011]. NSPs are

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implemented by specialist agencies, pharmacies and one prison [ST 10 2011]. In addition there were 160 vending machines in the year 2009 [NR 2011]. In the year 2010 2.113.242 syringes were provided by specialist agencies and 251.072 by vending machines [ST 10 2011]. Syringes can easily be bought by everybody (e.g. diabetics) in every standard pharmacy, but information on who purchases them and for what purpose is not registered [ST 10 2008].

Injecting kits contain information materials, alcohol pads, water and acid [SQ 23/29 2011], the provision of these kits is rated as limited [SQ 23/29 2008].

The distribution of condoms is no priority response to prevent DRID [SQ 23/29 2011], but they are distributed among drug users in specific geographical areas [Trimbos 2006].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Naloxone is regulated by law [SQ 23/29 2011]. Naloxone is only available on prescription and administration is limited to physicians [Trimbos 2006]. Besides this, naloxone is available on a "take-home" basis for drug users in the framework of a project implemented in Berlin [SQ 23/29 2008]. Specifically, opiate misusers attending a healthcare project (operating from a mobile van or ambulance) were offered training in emergency resuscitation after overdose, provided with naloxone, needles, syringes, an emergency handbook, and information on naloxone [SQ 23/29 2008].

In specific geographical areas only, professionals of emergency departments are trained [Trimbos 2006]. Emergency departments are an uncommon setting for dissemination of information materials that aim at the reduction of drug-related deaths or for risk education/ response trainings [Trimbos 2006].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

There is no national primary healthcare strategy. Primary healthcare is provided to all persons in possession of health insurance. With very little exceptions, all people in Germany are health insured, as it is obligatory for all employed and unemployed people. Thus, primary healthcare is available to virtually all citizens, without implementing a special strategy [SQ 28 2010].

Health aspects of drug use are addressed by specific services provided for drug users or within the framework of general healthcare. Information is only available on those measures, which are carried out by specific services. Outpatient services facilitate access to medical care, which is provided by office-based doctors working as consultants. Inpatient drug treatment facilities commonly provide dental treatments and other medical treatments. And in a few Länder, specific projects on dental hygiene and infection prophylaxis are offered as part of low-threshold drug help services [NR 2011].

The accomodation and education needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan [SQ 28 2010]. But the Social Service Code (Sozialgesetzbuch) guarantees basic social care for all people needing social support, which includes also accommodation needs of drug users [SQ 28 2010]. Temporary accommodation is offered by inpatient social therapy facilities [NR 2011]. Adaptation therapy, with the aim to master everyday life and to regain working capacity, is offered as integrated approach by independent wards of specialized clinics or by external solitary adaptation facilities [NR 2011]. Education needs are addressed numerous times for specific target groups such as people living in poverty, long term unemployed or homeless [SQ 28 2010]. Drug users are not mentioned explicitly in these programmes, but often they are part of the addressed groups [SQ 28 2010]. Educational support is also part of therapy in many treatment facilities, which relies on close cooperation with craft and industry [NR 2011].

The employment needs of drug users are not explicitly addressed in the National Employment Plan [SQ 28 2010]. But the importance of supporting the employment needs of drug users as well as social and vocational reintegration and employability are mentioned (as general objectives) in the National Drug Strategy [SQ 28 2010]. They are not further specified [SQ 28 2010]. The integrative approach adopted by the Social Security Codes II (SGB II) enables socio-integrative services to be provided in addition to the instruments of employment promotion [NR 2011].

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The cooperation between the "Bundesagentur für Arbeit" (the federal agency) and the communities, is realised in joint ventures, the "ARGEn". These "ARGEn" are responsible for the reintegration of unemployed and therefore build the cooperative structures with organisations or institutions that provide supportive measures (e.g. drug counselling and treatment) on the community level. The cooperative structure between the federal agency and the communities for most of the ARGEn is administered through the social service code (SGB II). There are great regional differences in the implementation (the final report of a research project ("Erhebung guter Praxis zur Integration Suchtkranker ins Erwerbsleben im Rahmen des SGB II") is dealing with these differences and gives an overview of good practice [SQ 28 2010].

Demonstration projects were carried out concerning the professional (re-)integration of addicted individuals in substitution therapy [NR 2011]. They show that a close cooperation between local job centres, psychosocial counselling and the substitution doctors is necessary and the educational staff has an important role [NR 2011].

There are protocols and agreements between different national, regional and local authorities and agencies involved in addressing the health and social needs of drug users in treatment [SQ 28 2010]. A model of cooperation is the cooperation agreement “Provision of services for people with addictive diseases” between the German Statutory Pension Insurance and the regional offices Saxony-Anhalt and Thuringia of the Federal Employment Agency in August 2010 [NR 2011]. This agreement should ensure that people in need of therapy can start rehabilitation therapy at an early stage with as little institutional frictional losses as possible [NR 2011].

While partnerships between outpatient treatment facilities and social services exist to a limited extend only, partnerships between residential treatment facilities and social services exist extensively [SQ 28 2010].

The employability of drug users in treatment is an objective of the care plan. "Drug treatment", as an intensive therapy including medical treatment, psychosocial treatment and sociotherapy, is paid by the German pension insurance funds. Their main objective is employability [SQ 28 2010].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

There is no institution responsible for developing best practice guidelines [SQ 27 p2 2011], but there are professional standards for social workers, nursing staff, psychologists and medical doctors [SQ 27 p2 2008].

There is specialised education/training for social workers, nursing staff, psychologists, psychiatrists, medical doctors, group managers (within the area of self-help) and substance abuse therapists [SQ 27 p2 2011]. There is formal NSP training for drug agencies staff [SQ 23/29 2008].

There is a national system for continued education for social workers, nursing staff, psychologists, psychiatrists and medical doctors [SQ 27 p2 2011]. Generally, education, continued education and training are not organised nationally, but in responsibility of the federal Bundesländer. Professional societies of the Bundesländer and their national umbrella organisations co-operate to set common standards [SQ 27 p2 2011].

The ministries of Justice of the provinces are responsible for training of prison guards and developed initial and continuing training programmes for drug-related knowledge [NR 2011]. In a few provinces there is also special training on first-aid measures and training in prevention programmes for inmates [NR 2011]. A manual was issued by the Scientific Institute of Physicians in Germany for continuing training of prison staff [NR 2011].

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Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

There is no institution responsible for developing HR guidelines [SQ 23/29 2011] or best practice guidelines [SQ 27 p2 2011]. There is no information on national guidelines for harm reduction, but there are various treatment guidelines in Germany available, though most of them were published before 2009 [Best Practice Portal]:

- Acute treatment of opiate use disorders (2003)
- Postacute treatment of opiate abuse and dependence (2004)
- Treatment for cannabis use disorders (2004)
- Treatment of disorders related to cocaine, amphetamines, ecstasy and hallucinogens (2004)
- Standards for substitution treatment of opiate addicts (2002).

National guidelines adopted after 2009 are [SQ 27 p2 2011]:

- Pharmacological (outpatient and inpatient)
- Psychosocial assisted treatment (outpatient and inpatient)
- The Guidelines by the German Medical Association on opioid substitution treatment have been updated in February 2010.

Currently, treatment guidelines are in the process of being renewed, following a certain protocol [SQ 27 p2 2011].

Furthermore, numerous quality guidelines i.e. on psychosocial treatment only exist in the federal "Bundesländer" in Germany. It is virtually impossible to assess all of these documents. There is no systematic information available, if these guidelines were updated since 2009 [SQ 27 p2 2011].

There are sub-national guidelines for NSPs and for the NGO "akzept e.V." on acceptance-oriented drug work.

The ministries of Justice of the provinces are responsible for control and quality assurance of healthcare in prisons and they are also supervising the facility physicians [NR 2011]. In accordance with the principle of equivalency the guidelines of the German Medical Association also apply to facility physicians [NR 2011]. Still, some provinces developed their own recommendations, regulations or decrees [NR 2011].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

Needs assessments are used at the initial stage of programmes to some extent, there was no change since 2003 [PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation aspects are included in pharmacological guidelines, but not in the guidelines for psychosocial assisted treatment. Outcomes are regularly evaluated in pharmacological and psychosocial interventions, in both outpatient and inpatient settings [SQ 27 p2 2011].

From 2001 to 2007 addiction research was funded by the Federal Ministry for Education and Research via four research networks [NR 2011]. This funding stopped in 2007, but it was expected, that the networks continue common research activities with the help of other funding sources [NR 2011].

There is a national research programme for evaluation and improvement of drug treatment [SQ 27 p2 2011]:

» http://www.suchthilfestatistik.de/
» http://www.premos-studie.de/
» http://www.zishamburg.de/projekte/projektdetails/Qualitaetssicherung-der-Diamorphinbehandlung/

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There are research projects on treatment [SQ 27 p2 2011]:

» http://www.drogensoforthilfe.de/standard.xml?vpID=18&SID=1316081049_b8d50000001248cdca62
» http://www.drogennotdienst.org/content/aktuelles/Contraddict.php
» http://www.sucht.de/wirksamkeitsstudien.html

Recently published studies on treatment interventions analysed the results of the CANDIS therapy for cannabis-related disorders, the effectiveness of a short intervention in the inpatient treatment of cannabis users or the peculiarities of inpatient treatment of addicted migrants from the Russian language territory [NR 2011]. A literature review on the effectiveness of substitution treatment in prison showed, that it reduces heroin use as well as the frequency of injections and the risks of infections associated with this risk behaviour [NR 2011]. It also showed that long-term substitution treatment during imprisonment can encourage inmates to undergo drug treatment after being released from prison [NR 2011]. In addition there is a positive effect for prisons, because withdrawal symptoms can be controlled more effectively, the ability of inmates to work is raised and their integration in everyday prison life is improved [NR 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

Due to the federal structure and the subsidiary principle in the German health system there are no unified formal requirements or criteria for quality assurance of measures for demand reduction [Trimbos 2006]. A variety of approaches, methods and instruments are applied in the Länder and by local authority districts.

Quality criteria are used in evaluations to a large extent, there was an increase since 2003 [PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Germany is participating in the REITOX network of the EMCDDA and is implementing a National Focal Point as well as a data collection system according to the EMCDDA recommendations.

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

Within the context of model programmes, new methods of prevention, consultation or treatment as well as new forms of organisation (e.g. 'case management') are tested and evaluated on a regular basis [Trimbos 2006]. Furthermore, experts' reports have been used to gain an overview about the state of research and on current developments in the drug demand reduction field. Different innovative projects were monitored and supervised by scientists, who recorded procedures and results and who carried out evaluations. One recent example of the latter is the study on drug consumption rooms (ZEUS 2002).

At the level of the Länder, many activities take place [Trimbos 2006]. The Land of Berlin has reorganized its out-patient services and their staff situation, based upon the insights gained through a clients' needs assessment. The Land of Hamburg commissioned an evaluation of the addiction care system of the city in order to examine the outcome of its abstinence-based programmes.

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Evaluation training programmes are available in Germany to a large extent, there was an increase since 2003 [PS].

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Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

No specific measures exist for the field of harm reduction. However, in the field of prevention, projects involving stakeholders exist at – primarily – local level. In 2001/2002 the Federal Centre for Health Education organised a competition called 'Model Strategies' of Municipal Drug Prevention [Trimbos 2006]. This competition was an attempt to draw the attention of the general public to the development of drug prevention strategies at local level.

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

In 2003, six Bundesländer participated in the ESPAD survey [Trimbos 2006].

Germany also participates in the EDDRA database, presenting selected examples of good practice [Trimbos 2006].

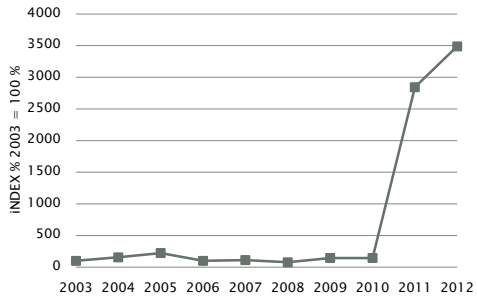
On international level, Germany provides development aid with the aim to improve living conditions of local inhabitants who are dependent on the cultivation of drugs (cocaine, heroin), such with the aim to reduce poverty and offer alternatives [Trimbos 2006]. Germany cooperates with countries in the field of drugs within the European Union (EU Drug Action Plan, EMCDDA, and Europol) and the United Nations (CND, UNODC).

11 Country Profile Greece

11.1 Indicators for drug-related harm

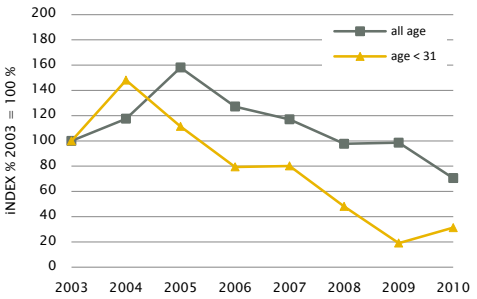
A problem drug user in Greece is defined as someone who will at some point seek treatment for heroin use. Capture-Recapture Analyses estimated that there were 3,0 problem drug users per 1.000 inhabitants between the ages of 15-64 years in 2010 (22.515 for the year 2010, with 95 % confidence interval 20.202 – 25.171). Although the numbers are slightly lower than in 2009 a comparison of the estimates for every year since the first application of this method in 2002 shows an increasing trend, of the order of around 600 additional problem drug users every year. In 2010, the estimated number of injecting drug users was 9.439 (95 % confidence interval 8.110 – 11.060) [NR 2011]. The largest groups of clients in outpatient treatment in 2010 have opioids (78 %) and cannabis (16 %) as primary drug. In inpatient treatment the respective proportions are 89 % and 5 % [Statistical Bulletin TDI-19]. According outpatient treatment data just 38 % of opioid users inject the drug (51 % are sniffing and 11 % smoking) [Statistical Bulletin TDI-17].

Figure 35:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104 and (data for 2012 which refers to the time-span January till August) [HIV-outbreak among injecting drug users in Greece, EMCDDA 2012]

Figure 36:
Number of direct drug-related deaths (indexed – 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

The number of new diagnosed HIV cases with IDU as route of administration was stable on a low level till 2010 (between 7 and 14 cases). In 2011 an outbreak of a HIV epidemic has been observed (see Figure 35). Similarly, while HIV infection rates in IDU entering treatment remained relatively low between 2002 and 2010 (infection rates ranged in 2010 between 0 % and 0.8 %), already in July 2011 infection rates sharply increased ranging from 2.9 % to 5 %, depending on the data source [NR 2011].

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Based on data from IDU tested upon entering treatment infection rates for HCV in 2010 ranged between 44,4 % and 69,3 %. Compared with the last years there seems to be an upward trend since 2008 [NR 2011].

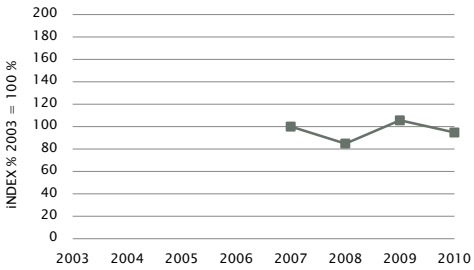
The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** decreased since 2005 (see Figure 36).

11.2 Indicators for drug-related harm reduction

Low-threshold services in Greece implement a very broad range of interventions in the area of harm reduction and prevention and care for infectious diseases, including overdose prevention. Their number, however, continues to be limited: Such services operate only in Attica and Thessaloniki, and there is no coverage for the rest of Greece. In 2010, the total number of syringes exchanged or distributed comes up to 61.516 and is smaller than in the previous year (see Figure 37).

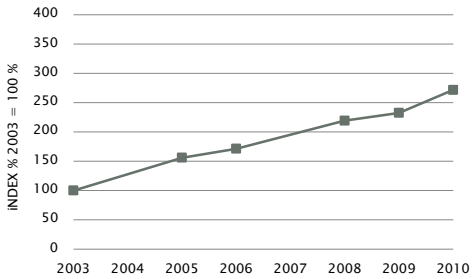
The number of clients in substitution treatment is increasing (see Figure 38). In 2010 5.645 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 37:
Syringes provided through needle and syringe programmes (NSP) (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 38:
Number of clients in substitution treatment (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

11.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

Harm reduction is a public policy objective in Greece, but this was not based upon the Council Recommendation. Measures and public health objectives regarding the prevention and reduction of health-related harm associated with drug dependence were implemented in Greece before the Council Recommendation was adopted in 2003. The main objectives are stipulated in the Greek National Plan against Addictions (2010-2012) [Trimbos 2006; GS].

Most important steps since 2003: Expansion of the opioid substitution treatment (OST) services (particularly in 2011) and availability with nationwide coverage; expansion of needles & syringes program and availability (particularly in 2011); expansion of condom distribution programmes; expansion of "drug-free" services with nationwide coverage; increase in prevention measures aiming at harm-reduction (i.e. information campaigns); expansion of the availability of testing for infectious diseases in IDU population [PS].

Next steps: Further expansion of the OST services and availability in more areas; further expansion of needles & syringes programmes - and of condom distribution programmes; increase in prevention measures aiming at harm-reduction (i.e. information campaigns); further expansion of the availability of testing for infectious diseases in IDU population; serobehavioural research on harm associated with drug dependence [PS].

Reference: Law 3459/25-5-2006 (Official Journal of the Government of Hellenic Republic; A 103 / 2006) “Code of Law for drugs”. The document cited make only implicit reference to harm reduction. To date, no official national policy document explicitly sets as a public health objective the prevention of health risks related to drug dependence. Explicit reference to drug-related harm reduction is made in the Action Plan for Drugs which was drafted in 2008 and put onto internet for public consultation. The latter has nonetheless not been ratified nor has it come into force [PS].

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Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

The dissemination of information through many websites and a few telephone help lines is nationwide available. To prevent infectious diseases among drug users, providing information, education and communication (IEC) via and advice by drugs and health professionals is the predominant response strategy. Safer injection training is a common response strategy.

Individual counselling is a priority response to prevent DRID, the provision of individual counselling and of safer use training is extensive[19]. Risk education and overdose response trainings is available in a majority of relevant cities (but not in nearly all of them) [SQ 23/29 2011].

With regard to the reduction of drug-related deaths, the dissemination of information materials and risk counselling are common response strategies; information is disseminated predominantly by low threshold agencies, including needle and syringe programmes and outreach workers. Specialised drug treatment services are common settings for the dissemination of information materials. A common response strategy to reduce drug-related deaths is risk education/ response trainings for drug users.

19
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

These trainings are delivered predominantly at low threshold agencies, including needle and syringe programmes and through outreach workers and peers. These trainings are common at specialised drug treatment services [Trimbos 2006].

Major challenges in this field were/are the need of improvement of the coordination between the relevant institutions and the need to secure the sustainability of the information and counselling systems [PS].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for family/ friends. Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for sex workers and immigrants [SQ 23/29 2011].

The availability/coverage of information measures targeted at families and communities related to harm reduction is rare [PS].

Formal NSP training programmes regarding health promotion activities are available for undergraduate and postgraduate students of Medical or Health Schools (Universities, Technical colleges) provided by KETHEA - Education Department [SQ 23/29 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

In Greece, specific geographical areas provide street-based outreach work and trainings for outreach workers. To prevent infectious diseases among drug users, outreaching health education is a rare response strategy. Outreach work and targeted high-risk

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group interventions are a rare implementation setting for infectious diseases prevention measures targeting drug users.

Low threshold agencies, including needle and syringe exchange and distribution programmes and outreach work are the predominant setting for the dissemination of information materials and injecting kits. Outreach work is the predominant setting for the deliverance of risk education/ response trainings to drug users [Trimbos 2006; GS].

In 2011 and 2012, as a response to the HIV/AIDS-outbreak in Greece (mainly Athens) information distribution of relevant material has been increased [GS].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are involved in the responses to prevent DRID, but peer involvement is not a priority [SQ 23/29 2011].

Naloxone is not available on a "take-home" basis to drug users, peers and relatives [SQ 23/29 2011; GS].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

This policy does not exist. However, in specific geographical regions, outreach work agencies aim -among others- to refer users to other health services, encourage and consolidate user contacts with the health system and motivate users to join treatment programmes [Trimbos 2006].

Since 2003 there has been an increase in the level of networking and cooperation between key agencies operating outreach work and different governmental and non-governmental agencies and NGOs operating in the drugs field, such as the Hellenic

CDC, medical schools of state universities, NGOs etc. Increased levels of networking and cooperation have inter alia resulted in the improvement of at least the referral system [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

In specific geographical areas, treatment with buprenorphine and naltrexone, methadone maintenance treatment, methadone detoxification treatment, drug-free outpatient and inpatient treatment, rehabilitation programmes and drop-in centres/ shelters are provided. Substitution treatment is supported by (obligatory) psychosocial care.

Aiming at the reduction of drug-related deaths, opioid substitution treatment (with regard to the reduction of heroin/ opiate overdose) is a common response strategy. Drug consumption rooms and heroin prescription programmes do not exist in Greece [Trimbos 2006].

There is no waiting time for outpatient and inpatient psychosocial treatment. The waiting time for detoxification is maximum 2 weeks. Recently the waiting time for OST was more than 6 months. In the Athens units average waiting time was 3 years. For other regions the average waiting time was much shorter. As a response to the HIV/AIDS-outbreak, in 2011, 22 new OST units were established in Athens and Thessaloniki. The waiting time has not been reduced because, as word spread around that the OST opens new units a large number of users started OST [SQ 27 p1 2011; GS].

The overall development of treatment, care and rehabilitation services for drug abusers has been remarkable especially in the last couple of years [PS].

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Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Medical doctors at specialised drug treatment centres can initiate and continue methadone, HDB and buprenorphine/ naloxone combination. Methadone, HDB and buprenorphine/ naloxone combination can be dispensed at specialised treatment centres [Statistical Bulletin 2011].

"Take-home" substitution doses are provided as rewarding of good progress according to the consensus decision of the therapeutic team: abstinence of parallel use for at least two months, good behaviour and compliance to programme regulations. If the above preconditions exist a "take-home" dose is provided for one weekend per month or two days per month for a period of three months. As long as the previous preconditions last for six months the client can "take-home" doses for two more days. Afterwards for each semester "take-home" dose increases for two days up to 8 days per month but not adjoining. After the completion of one year of "take home" provision without problems, the client has the privilege to take once every six months "take-home" dose for 5 working days or for a whole week including the weekend. "Take home" can also be provided on the official holidays under the same conditions after the decision of the therapeutic team. The maximum total amount of methadone that is provided as a "take-home" dose cannot exceed 350 mg. "Take-home" can also be provided in exceptional cases such as marriage, birth, death of a relative, illness or medical admission [SQ 27 p1 2011].

Law 3459/25-5-2006 "Code of Law for drugs" (Official Journal of the Government of Hellenic Republic; A 103/2006) has laid emphasis on diversion of drugs including substitution substances. Opioid substitution treatment (OST) services have also increased their surveillance and monitoring systems in order to prevent the diversion of substitution substances, by also imposing stricter penalties for regulation abusers [PS].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Although the existing law foresees that dependent users arrested for drug-related offences are diverted to treatment, 39 % of the total prison population are imprisoned for that type of offences, the majority of them (62 %) being sentenced for use, possession and cultivation of small quantity for personal use [NR 2011; GS].

Health care in prison is vested by law and according to the principle of equivalence in care. Drug treatment consists only of psychosocial interventions and there is only one public programme the Treatment Centre for Drug Dependent Prisoners which has a limited capacity. KETHEA implements counselling services in prisons aiming mainly at preparing inmates for joining drug-free treatment programmes after release. Substitution treatment is currently not allowed inside the prisons.

Harm reduction services in prison are limited to counselling for safe use. There are also a limited number of therapeutic interventions for released prisoners including social rehabilitation. The major challenges of the system are the multicultural population of drug prisoners (only one fourth of them are Greeks), the difficulty in keeping treatment and detoxification protocols and the absence of OST [NR 2011].

According to Ministerial Decree, (Y5 69750/ 2003) substitution substances (methadone or buprenorphine) can be administrated for 12 days to drug addicts who are under arrest by police or prosecution agencies and are being taken into custody in correctional institutions, with the precondition that they are already under such treatment, in order to prevent withdrawal symptoms when due to the imprisonment the continuation of the programme is not possible (ELDD entry) [SQ 23/29 2011].

However, as far as harm reduction services provided to drug abusers in prison are concerned, there are no major achievements in this area since 2003 [PS].

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Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination scheme. A risk-group specific hepatitis B vaccination programme is available. VCT is not a priority, but provider-driven infectious diseases testing is a priority response to prevent DRID. The provision of HCV testing is extensive. Hepatitis vaccination programme is a priority response to prevent DRID. Provision of condoms at drug agencies with NSPs is full [SQ 23/29 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

Objectives of the DRID strategy are:
1) To retain the low rates of HIV incidence among drug addicts.
2) To reduce Hepatitis B and C incidence considerably.
3) To reinforce harm reduction practices (safer use of drugs, programmes of syringe exchange/distribution) through the development of information material and outreach work interventions (distribution of syringes).
4) Accessiblity to information and harm reduction services.

In Greece (Athens) there are three syringe programmes (2 syringe exchange /distribution programmes provided by OKANA and one by the NGO Medicins du Monde NGO. Two of them (1 syringe distribution programme and 1 syringe exchange programme) are considered to be outreach syringe programmes as they are operated by two street-work programmes implemented by the harm reduction services of OKANA and Medicins du Monde NGO [SQ 23/29 2011, GS].

Syringes are sold at all pharmacies in Greece (11.500 pharmacies). Formal NSP training programmes regarding health promotion activities are not available for pharmacists [SQ 23/29 2011].

Coverage of condom distribution and of injection materials, albeit small and restricted only in the Athens metropolitan area, has been improved since 2003 (with more impressive improvements reported since 2011) [PS].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Naloxone is regulated by law. Naloxone is part of standard ambulance equipment.

Use of naloxone is limited to medical personnel. Ambulance personnel are trained in naloxone use [SQ 23/29 2011]. Naloxone is not available on a "take-home" basis [SQ 23/29 2008].

The OKANA Mobile Unit of Pre-Hospital Medicine responds to overdose emergencies received by the National Centre of Instant Medical Aid [GS].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Drug users are explicitly addressed in the national primary healthcare strategy [SQ 28 2010].

Employability of drug users in treatment is part of treatment care plan. In most reintegration structures, finding a steady job within a certain period of time is a condition for remaining in the programme. Moreover, occupational rehabilitation is thought to be a condition for full social integration and a key relapse prevention factor [SQ 28 2010].

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Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Formal NSP training programmes regarding health promotion activities are available for drug agencies staff and other groups: undergraduate students of the Department of Nursering of the Technonolical Educational Institute of Athens. Training is not available for pharmacists and prison staff [SQ 23/29 2011].

Specialised courses/ training on drug treatment are implemented for social workers, nursing staff, psychologists, psychiatrists, medical doctors, sociologists and art therapists.

KETHEA co-operates with the ICRC (International Certification & Reciprocity Consortium/Alcohol and Other Drugs), which is the internationally recognised authority certifying drug counsellors and prevention specialists, and provides certification of professionals working in the field of drug addiction and the provision of quality services to addicted individuals and their families. With the participation of distinguished scientists from Greece, Cyprus and Malta, KETHEA established the first Scientific Committee for the Certification of Drug Addiction Counsellors within these countries.

The Committee is authorised by the ICRC to examine applications and issue certification to professionals from the three mentioned countries, according to international standards as well as the specific cultural conditions prevailing in each country. The ICRC certification is international in scope and is recognised in all countries where the ICRC is active (Germany, Greece, United Kingdom, USA, Canada, Cyprus, Malta, Sweden)

In addition "18 ANO" Dependence Treatment unit (Attica State Psychiatric Hospital) provides continuous education to all staff members (scientific and medical staff as well as administrative staff) [SQ 27 P2 2011].

Albeit with low coverage, professional training on the reduction of health-related risks associated with drug dependence has increased since 2003 involving more services and personnel [PS].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

There are national guidelines on pharmacological treatment (outpatient) and psychosocial assisted treatment (outpatient).

The operational framework of the substitution units is considered as official guidelines for the implementation of substitution programme, since OKANA is by law the only responsible agency for the implementation of the programme. In this operational framework guidelines for psychosocial support to the clients of the OST are included.

For psychosocial-treatment-only, each agency has developed its own standards and guidelines to ensure and improve the quality of its services [SQ 27 P2 2008]. Interventions selected are almost always based on scientific evidence as most the interventions implemented in Greece have been extensively used in European and North American countries. However scientific evidence is not always referred to by professionals when interventions are introduced and implemented in the field [PS].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006].

The concept of "needs assessment" presupposes that a rigor and systematic procedure for addressing "gaps" in the field of harm-reduction exists. In the strict sense of the

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word, therefore, no "needs assessments" are used at the initial stage of harm-reduction programmes. However, professionals in the field of harm-reduction have adequate knowledge about needs and gaps in the field - however this knowledge is hardly ever codified into a needs assessment document [PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation aspects are not included in the guidelines.

Drug treatment outcomes are evaluated in psychosocial treatment only (outpatient and inpatient). KETHEA conducts continuous and systematic evaluation of its services (drug- free outpatient and inpatient psychosocial treatment programmes).

There are research projects on treatment in the last two years. www.seidproject.eu [SQ 27 P2 2008].

Evaluations protocols have slowly (and only recently) made their way in the field of drug prevention. No evaluation protocols have been used in the field of risk reduction yet [PS].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006].

No evaluation protocols have been employed yet [PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006].

The Greek REITOX Focal Point is in full accordance with the standardized data-collection and information dissemination recommended by the EMCDDA [PS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

This policy exists, but was not based upon the Council Recommendation. Particularly the professionals working in the field participate in training programmes [Trimbos 2006].

Evaluation training programmes are not available [PS].

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Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

This policy exists, but was not based upon the Council Recommendation. But usually participation of stakeholders is not conducted [Trimbos 2006; PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006].

12 Country Profile Hungary

12.1 Indicators for drug-related harm

In 2005, the rate for **problem drug use** was 3,48 per 1.000 inhabitants aged 15-64, corresponding to a number of 24.204 problem drug users (in a range between 19.333 and 29.075). In 2008-09, the number of injecting drug users in Hungary was estimated to be 5.699 with a central rate of 0,8 for 1.000 inhabitants aged 15-64. This estimation was made based on the records in infectious diseases screening programmes [CO]. More recent estimates for the years 2007/2008 were done per drug (not for the overall group - summing up not possible!) and show that amphetamines are the prevailing drug. In the aggregate of the years 2007 and 2008, the total number of men and women using heroin at least once in the given two years altogether was between 2.780 and 3.480, the value of the point estimate is 3.130 persons. The entire population of those, who consumed amphetamines at least once in the given two-year period consisted of 27.323 persons as a result of the point estimation, with 95 % certainty between 18.138 and 36.508 persons. The size of the population using cocaine in the two year 2007-2008 altogether is estimated around 5.600 [GS[20]]

The largest groups of clients in outpatient treatment in 2010 have cannabis (76 %), stimulants (11 %) and opioids (8 %) as primary drug. In inpatient treatment the respective proportions are 17 %, 32 % and 19 % (Sedatives: 25 %) [Statistical Bulletin TDI-19]. According outpatient treatment data 69 % of opioid users and 18 % of stimulant users inject the drug [Statistical Bulletin TDI-17]. On the basis of the client data provided by NSP service providers, it can be stated that in 2010 47 % of IDUs are opiate users, which is 8 % less than in 2009. At the same time the proportion of amphetamine users increased (from 39 % to 45 %) as well as the proportion of IDUs injecting other drugs (from 4 % to 8 %), which is probably due to the increasing injecting use of mephedrone. In 2010 the slow tendency of changing over from injecting opiates to injecting amphetamines continued [NR 2011].

Concerning **infectious diseases** in 2010 in Hungary a total number of 182 newly diagnosed HIV positive cases were reported, the incidence rate was 18 cases/1 million inhabitants. The transmission route was known in the case of nearly four-fifths of the registered HIV positive persons. Within the identified risk groups of the HIV positive persons and clients with AIDS no one belonged to the risk group of IDUs [NR 2011].

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20 http://drogfokuszpont.hu/szakteruleteink/problemas-kabitoszer-fogyasztas/problemas-drogfogyasztas-tenyek-es-szamok/?lang=enNFP

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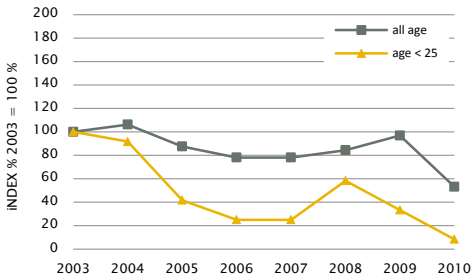
Results from a voluntary testing programme which started in 2010 showed a HIV prevalence among IDUs of 0 % but 21 % proved to be HCV positive [NR 2011]. The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** is stable or decreasing (decreasing especially 2009 to 2010 and in the age group < 25 years (see Figure 39).

Figure 39:
Number of direct drug-related deaths 2003 (indexed – 2003=100 %) by age



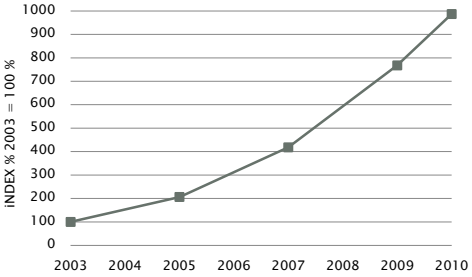
Source: EMCDDA Statistical Bulletin 2012 DRD 2

12.2 Indicators for drug-related harm reduction

In 2010, the number of organizations running NSP increased from 21 to 23 [NR 2011]. The number of syringes provided through needle and syringe programmes increased significantly since 2003 (see Figure 40).

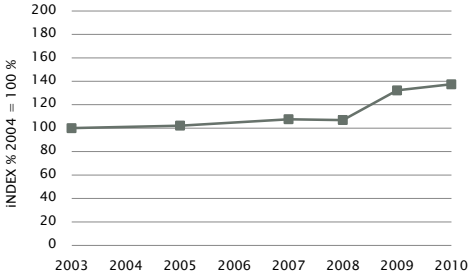
The number of clients in substitution treatment is slightly increasing (see Figure 41). In 2010 4.543 clients started an inpatient or outpatient treatment [ST TDI-2]

Figure 40:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 41:
Number of clients in substitution (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

12.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

In 2005 the low treshold services became nominated within the community care of people affected in addictological problem in the Act No III of 2003 on Social Administration and Social Assistance [PS].

The governmental structure that is responsible for the implementation of the Council Recommendation is the Ministry of Youth, Family, Social Affairs and Equal Opportunities. The prevention and reduction of health-related harm associated with drug dependence has been an objective for Hungarian Public Health prior to the adoption of the Council Recommendation and as such it was not based on it [Trimbos 2006].

Harm reduction is one of the key policy areas in the Hungarian National Strategy to Combat the Drug Problem 2000-2009, which was adopted in December 2000 [Trimbos 2006].

In December 2009 the Parliament accepted the document entitled —National Strategy for Handling the Drug Problem. The national drug strategy determined the national drug policy objectives for the years 2010-2018. In December 2010 however, the drawing up of a new strategy has been decided. The ministry stipulated that the new drug strategy should be drawn up by the end of 2011. At present, Hungary still does not have a valid National Drug Strategy with an Action Plan [NR 2011; GS].

References [PS]:

Semmelweis Plan for the Rescue of Health Care (2011):
http://www.kormany.hu/download/3/c4/40000/Semmelweis%20Terv%20szakmai%20koncepci%C3 %B3 %202011.%20j%C3 %BAnius%2027.pdf

Parlamentary Decree No 46/2003. (IV. 16.) on Public Health Proramme 'Decade of Health' (2003):
http://jogszabalykereso.mhk.hu/cgi_bin/njt_doc.cgi?docid=73928.101463

National Strategy for tackling the drug-problem 2010-2018 (2010):
http://www.szmm.gov.hu/main.php?folderID=900

National Strategy for tackling the drug-problem 2013-2020 - being prepared

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

To prevent infectious diseases among drug users, IEC general and IEC by drugs and health professionals are predominant response strategies [Trimbos 2006].

With regard to the reduction of drug-related deaths, the dissemination of information materials is limited[21] [SQ 23/29 2011; GS] and individual risk counselling is not available [SQ 23/29 2011; GS]. Dissemination of information on safe injecting techniques preventing drug-related deaths is provided by all of the NSPs [NR 2011].

Safer injection training for drug users is not a priority to prevent DRID [SQ 23/29 2008]. The provision of OD risk reduction training is rare. The provision of individual counselling on infectious diseases is limited. The provision of safer use training is limited [SQ 23/29 2011; GS].

The provision of overdose information materials is limited [SQ 23/29 2011; GS].

The provision of information materials to reduce drug harms in night clubs and in large music festivals is limited [SQ 23/29 2008].

21
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Communities and families of drug users are not at all involved in the prevention and reduction of health risks associated with drug dependence, nor is specific information, education and communication available for communities and families of drug users [Trimbos 2006; SQ 23/29 2008 and 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Street-based outreach work is taking place in specific geographical areas [Trimbos 2006].

To prevent infectious diseases among drug users, outreach health education is a common response strategy. Outreach work and targeted high-risk group interventions are a predominant implementation setting for infectious diseases prevention measures targeting drug users. There is no recognized professional qualification in outreach work and outreach work management [Trimbos 2006].
Aiming at the reduction of drug-related deaths, outreach work is a common setting for risk education/ response training for drug users [Trimbos 2006].

Main outreach health education approach: information materials dissemination [SQ 23/29 2008 and 2011; GS].

The provision of outreach work at night clubs is rare and in large music festivals it is limited [SQ 23/29 2011].

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Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are not involved in the responses to prevent DRID. Naloxone is not available on a "take-home" basis [SQ 23/29 2008 und 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies exist nationwide [Trimbos 2006] but the coverage is limited [PS].

Each year there is a national meeting for all the NSPs. (Nearly half of them carry out outreach work as well). Regarding NSPs in Budapest there is a good cooperation between them and they organize meetings on a regular basis (6 times a year) [GS].

Regarding outreach services in the recreational setting, an association of the service providers (Parti Szolgáltatók Szakmai Szövetsége - *PASSSZ*) was founded in 2011 [GS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Drug-free outpatient treatment and drug-free inpatient treatment are nationwide available. In all regions methadone maintenance treatment, methadone detoxification treatment, buprenorphine-naloxone treatment, rehabilitation programmes and drop-in

centres/ shelters are available. Drug consumption rooms and heroin prescription programmes do not exist in Hungary [Trimbos 2006; GS].

The provision of psychological support to OST clients is extensive. The waiting time for detoxification and outpatient psychosocial treatment is less than 2 weeks, due to limited availability and procedural reasons. The waiting time for inpatient psychosocial treatment is between 2 weeks and 1 month. The waiting time for OST is 1-6 months, due to limited availability. There are regional differences in the waiting times [SQ27 2011].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Only medical doctors at specialised drug treatment centres can initiate methadone and buprenorphine-naloxone treatments. Medical doctors at specialised drug treatment centres and specialised medical doctors can continue methadone and buprenorphine-naloxone treatments. Methadone can be dispensed at specialised drug treatment centres only. Buprenorphine-naloxone can be dispensed at specialised drug treatment centres and specialised medical doctors' offices [Statistical Bulletin 2011 Table HSR-2].

Conditions for the "take-home"-OST are good compliance, drug free status and active job status [SQ27 20008]. Guidelines define the "take-home" doses which can be provided for the client: the suggested "take-home" doses is a maximum of 1-3 weeks for methadone.; in case of buprenorphine-naloxone the maximum dose to be prescribed is 2 weeks according to the classification of the medication [SQ27 2011].

References:
Methodological Recommendation on Methadone Treatment by the Ministry of Health of Hungary:
http://drogfokuszpont.hu/wp-content/uploads/tdi_metadon_protokoll.pdf

Act on the medicines of Human Use No XXV of 1998, Schedule B: http://jogs-zabalykereso.mhk.hu/cgi_bin/njt_doc.cgi?docid=33576.602134

Governmental Decree No 66/2012 (2nd April) on the Activities permitted to pursue with drugs, psychotropic substances, and the new psychoactive substances; the procedure of recording them on the schedules; and the modification of these schedules. /Schedule of Drugs 1 (K1); Schedule of psychotropic substances 2 (P2): http://jogszabalykereso.mhk.hu/cgi_bin/njt_doc.cgi?docid=147770.604591.

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Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

There are no methadone detoxification, buprenorphine or naltrexone programmes in Hungarian prisons. Condoms, additional services such as bleach, sterile water, ascorbic acid and needle and syringe exchange are also not available. Testing on infectious diseases is available on a voluntary basis. Treatment of infectious diseases is nationwide available. There are no specific educational activities or training courses for drug users in prison [Trimbos 2006; GS]. Measures targeting at the reduction of drug-related deaths (e.g., prison pre-release interventions, dissemination of information materials) are not in use in Hungarian prisons [Trimbos 2006].

Theoretically there is a possibility to provide opioid maintenance treatment for prisoners, but the number of treated clients was 0 since 2009. Methadone treatment can be provided by community based public health services and buprenorphine-naloxone treatment can be provided by prison health services. Initiation of OST in prison is not available. Continuation of OST in prison is available [SQ27 2011; GS].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Testing, screening, education, prevention, and treatment of HIV, hepatitis C, tuberculosis, and sexually transmitted diseases are nationwide available [Trimbos 2006].

For hepatitis B a universal vaccination programme is carried out at the of age of fourteen years; for tuberculosis universal vaccination takes place between birth and the age of six weeks, but no vaccination programmes targeting drug users exist. HIV and hepatitis C, testing of drug users is provided free of charge by the regional laboratories of the Public Health Office [Trimbos 2006].

Predominant response strategies include information, education, communication (IEC) in general and IEC via advice by drugs and health professionals, and needle and syringe exchange programmes. Common response strategies consist of safer injection trainings for drug users, outreach health education, voluntary infectious disease counselling and testing (VCT). Predominant implementation settings for infectious diseases prevention measures targeting drug users include low threshold counselling (non-treatment) services, outreach work and targeted high risk group interventions; common settings are outpatient and inpatient specialised drug treatment services [Trimbos 2006].

The provision of HCV testing is extensive [SQ23/29 2011].

Between 2006 and 2011 five prevalence studies were implemented to measure HIV, HBV, HCV prevalence among injecting drug users in Hungary. In 2011 altogether 700 people were screened during a certain period of time (food tickets were offered to the clients for the tests and filling the additional questionnaire). In 2010 a number of civil societies offering low threshold services and drug ambulances introduced screening services for the mentioned communicable diseases, which is an ongoing project until the end of 2012. During these two years more than 600 clients were screened, who had the opportunity to have a test on the spot without offering them any payment. The major achievement is that there exists data on this population since 2006, and comparing to 2003 the number of the screened people increased strongly. The major challenge is the decreasing level of financing these projects in the future. In the last 6 years a network of 20 institutions were built, having a good relationship with NCE (National Centre for Epidemiology) which performed the tests and validated the results. From 2013 screening is not available within this network, which means that the number of tests will decrease sharply next year, and no data collection will be available for surveillance and monitoring purposes on this population [PS].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

Needle and syringe exchange programmes are the predominant response strategy to prevent infectious diseases among drug users in Hungary [SQ 23/29 2008]. Needles and syringes are provided at fixed locations, by outreach/mobile services and through vending machines but not at pharmacies [ST10 2011].

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The National Strategy (which was valid between 2000 and 2009) stated that the appearance of HIV (AIDS) and the spreading of hepatitis (primarily Hepatitis C) must be prevented among intravenous drug users. A substantial development of low-threshold services (outreach services, phone services, needle exchange, consulting, legal aid) and the establishment of a model institutional network were called for. The strategy also contained actions in connection with substitution treatment [SQ 23/29 2008]. At present, Hungary does not have a valid National Drug Strategy with an Action Plan [GS]. For the Hungarian government harm reduction has a high priority [PS].

A standard "injecting kit" is not typical in Hungarian NSPs, however, the items are usually available separately at NSPs and can be demanded [GS].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

In treatment institutions this recommendation is obligatory [PS].

Naloxone is part of standard ambulance equipment. The use of naloxone is limited to medical personnel, ambulance personnel are trained in naloxone use [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Harm reduction has not yet become the basic framework for interventions and operations. However, outpatient and special primary health-care, as well as outreach work, are added to the compulsory tasks of all settlements of a population exceeding 30.000 residents and have become state-subsidised in the course of 2005 [Trimbos 2006].

The accomodation needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan, but are mentioned in written drug policies. The employment needs of drug users are a priority in written drug policies [SQ28 2010].

Nearly all outpatient treatment facilities have a partnership agreement with at least one social service. The most common mechanism of interagency coordination is the informal network. Just a few of the residential treatment facilities have a partnership agreement with at least one social service [SQ28 2010].

The different services (social care, healthcare, risk reduction measures) are financed from different sources and by different techniques, that may pose challenges for service providers. Conditions and regulations differ in the different forms of services (technical and staff requirements, data reporting etc.), thus competences of the different forms may not be clear. Though in healthcare guidelines are available, in social care further work needs to be done in developing and updating guidelines, standardizing and evaluating programmes and improve quality standards [PS].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

In specific geographical areas, trainings are provided for outreach workers, professionals in low threshold agencies and for professionals in treatment facilities, but only on a small scale. Trainings for drug service staff (professionals in needle and syringe exchange programmes, and in substitution programmes) are usually organised indoors [Trimbos 2006; GS].

Specialised courses/ training on drug treatment are implemented for social workers, nursing staff, psychologists, psychiatrists and medical doctors [SQ27p2 2011]. Occupational standards for drug treatment are available for social workers, nursing staff, psychologists, medical doctors and addiction consultants [SQ27p2 2008].

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Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

The Hungarian National Institute for Drug Prevention has developed a database 'SZIP', which has the aim to make scientific evidence of effectiveness broadly available. It covers beside prevention programmes science-based research on drug issues, the different organisations and institutions providing care and their programmes and methods applied. The development of the portal started in 2003 and was launched by the end of 2004 [Trimbos 2006].

The quality assurance of social and health services belongs to two different systems. Guidelines for social services are updated/developed by the Specialised Workgroup of Addictions of the National Institute for Family and Social Policy. Guidelines covering health services are updated/developed by the National Advisory Board for Addictions [SQ23/29 2011].

There are several guidelines:

- National guidelines on prison [SQ23/29 2008]
- There are national guidelines for NSPs. [SQ23/29 2011; GS]
- Professional protocol for low-threshold services providing services for patients with addiction problems. [SQ23/29 2008]
- Guidelines for testing HIV, viral hepatitis and other infections in injecting drug users (EMCDDA guidelines translated into Hungarian). [SQ23/29 2011]
- National guidelines on alcohol/ drug problems, OST (outpatient settings) and social reintegration (inpatient and outpatient settings). [SQ23/29 2008]
- Professional guideline for community care for addicts (2008) [Best Practice Portal]
- Professional protocol for addicts' day care centres in the scope of basic social care (2006) [Best Practice Portal]
- The methodological letter of the Ministry of Health on methadone treatment (2008) [Best Practice Portal]

- Professional treatment protocol of the Ministry of Health for opiate use related problems (2008) [Best Practice Portal]
- Professional treatment protocol of the Ministry of Health for amphetamine use related problems (2008) [Best Practice Portal]
- Professional treatment protocol of the Ministry of Health for cannabis use related problems (2008) [Best Practice Portal].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

This policy does not exist, because it is not a task for the national government [Trimbos 2006; PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation aspects are partly included in the alcohol/ drug problems guidelines, psychosocial interventions guidelines, detoxification guidelines and OST guidelines [SQ27p2 2011].

There is a national research programme for evaluation. There is no continuous annual funding, only through researches and studies [SQ27p2 2008, 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

This policy does not exist, because it is not a task for the national government [Trimbos 2006; PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The Hungarian National Drug Strategy to Combat Drugs 2000-2009 is based upon scientific analysis. Accountability is a key principle in the National Strategy. The National Strategy invariably specifies effectiveness indicators to help gauge the extent to which the goals are achieved. This makes the implementation process transparent and the outlays accountable. The National Strategy is reviewed at predefined intervals [Trimbos 2006].

In 2004-2005 a mid-term evaluation was conducted, in which it was concluded that progress had been made, but that in the field of harm reduction more efforts had to be made to meet the objectives stipulated in the National Strategy. In the evaluation, 17 mid-term objectives from the National Drug Strategy had been pre selected, one of them specifically dealing with harm reduction. During the evaluation, over 64 local coordination forums on drug affairs and over 20 national policymakers were asked for their expert opinion whether this objective was achieved. The local representatives indicated it was not achieved (halfway the Strategy), while the national policy makers indicated it was partly achieved [Trimbos 2006].

Final evaluation of The Hungarian National Drug Strategy to Combat Drugs 2000-2009 showed, that the realization of NSPs in Hungary is satisfactory, however it was mentioned that the coverage still needs to be improved. It was also added that other parts of harm reduction should also be introduced or further developed [GS].

Source: Vitrai, J. (2009): Tanulmány a „Nemzeti drogstratégia a kábítószer-probléma visszaszorítására" megvalósulásának dokumentum és mélyinterjú-elemzésen alapuló értékeléséről. (Study on the document - and interview based evaluation of the implementation of "National strategy for tackling the drug-problem.") Egészségmonitor Kft.,

Budapest. (http://www.egeszsegmonitor.hu/dok/Tanulmany%20a%20drogstrategia%20ertekelesehez.pdf

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

This policy does not exist, because it is not a task for the national government [Trimbos 2006; PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

This policy does not exist, because it is not a task for the national government [Trimbos 2006; PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

The above mentioned mid-term evaluation of the Hungarian National Drug Strategy to Combat the Drug Problem was conducted by the Dutch Trimbos Institute in 2004 and 2005 and was funded by the MATRA programme of the Netherlands Ministry of Foreign Affairs [Trimbos 2006].

A second MATRA project has been running in the field of anti-drug policies of Penal Authorities. The penal authorities in Hungary realised that prisoners with drug problems need different treatment/ care than others and an increase in the number of such prisoners can be anticipated. This is why part of the MATRA Project scheduled for the period 2001 to 2004 is titled 'Management of drug problems in penal institutions'.

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Seventy security guards were trained by the penal authorities in the frames of this project. Primary objective of this training was demand-reduction and the identification of drug-using prisoners [Trimbos 2006].

In 2002 and 2003 a PHARE TWINNING PROJECT was carried out titled "Support for the Development and Institutionalisation of the Co-ordination Forums on Drug Affairs (CFDAs) in Hungary". This project was run by the National Institute for Drug Prevention (NDI), the Dutch Trimbos Institute and DrugScope (UK).

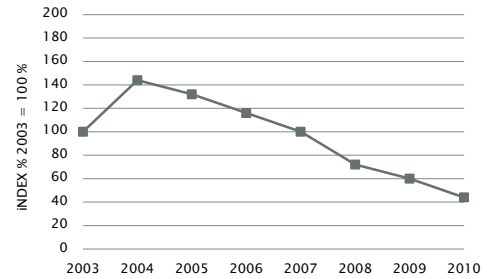
Furthermore, the European Union assisted this by supporting two projects. The PHARE Multi-country programme EMCDDA-I project, involving 10 countries ran from March 2001 to November 2002, while the bilateral PHARE COP'2000 programme HU-0006 twinning project ran from November 2001 to November 2002. The aim of the former was the direct involvement in the activities of the EMCDDA of the Hungarian professionals responsible for data provision, while the main goals of the latter was the creation of the national REITOX Focal Point, the new-data-collection-training of a wide range of professionals in the field, and the introduction of 9 demand-reduction model projects [Trimbos 2006].

13 Country Profile Ireland

13.1 Indicators for drug-related harm

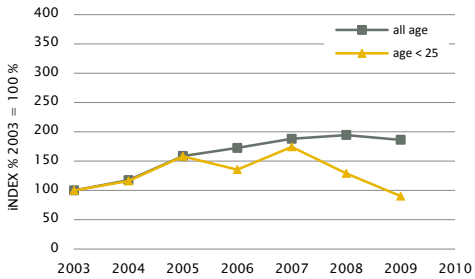
The most recent estimate for problem drug use relates to the year 2006. The total number of opiate users was estimated to be 7,2 opiate users per 1.000 population, aged 15-64 (20.790 individuals). The estimated rate for Dublin in 2006 was 17,6 users per 1.000 inhabitants, aged 15-64 (14.904 users). For the rest of Ireland, the estimated rate in 2006 was 2,9 users per 1.000 inhabitants, aged 15-64. This study included both injecting and non-injecting opiate users [CO]. The largest groups of clients in outpatient treatment in 2010 have opioids (60 %) and cannabis (22 %) as primary drug. In inpatient treatment the respective proportions are 50 % and 30 % [Statistical Bulletin TDI-19]. According outpatient treatment data just 32 % of opioid users inject the drug (61 % are smoking/inhaling the drug) [Statistical Bulletin TDI-17].

Figure 42:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 43:
Number of direct drug-related deaths (indexed - 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

The number of new diagnosed HIV cases with IDU as route of administration decreased significantly since 2003 (see Figure 42). According to registry data, there were 1.255 cases of hepatitis C reported in 2009, compared to 1.527 cases in 2008. Only 40 % of all newly diagnosed cases reported a risk factor, and of these, 71 % reported injecting drug use as their main risk factor. The results of blood-borne viral prevalence studies indicate that around 70 % of injecting drug users attending drug treatment tested positive for antibodies to the hepatitis C virus [CO].

The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased since 2003. From 2007 to 2009 the overall numbers are stable, but a decreasing trend can be observed in the age group < 25 (see Figure 43).

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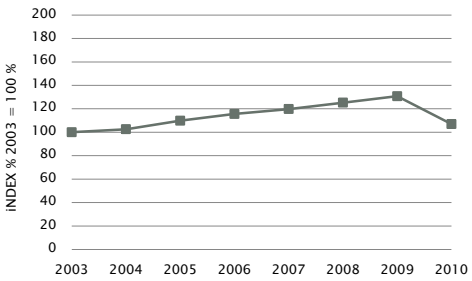
13.2 Indicators for drug-related harm reduction

Needle and syringe exchange services were first provided in Ireland in 1989, when five exchanges were established. There are now 34 exchanges in the country, operating two models of service: fixed-site exchanges (28), and home visit exchanges or back-packing (6) [CO].

There is no national statistics on the number of needles/syringes exchanged. The latest estimate (2007) indicates that nearly 1,1 million syringes were distributed through needle exchange programmes [CO]. The number of clients in substitution treatment is increasing till 2009 but was in 2010 on the level of 2003 again (see Figure 44). In 2010 8.511 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 44:
Number of clients in substitution treatment (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

13.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

The implementation of the Council Recommendation in Ireland is a shared responsibility between the Ministry of Health and Children Unit for Community Health), the Ministry of Community, Rural and Gaeltacht Affairs (Drug Policy Coordination) and the Ministry of Education and Science (Social, Personal and Health Education & prevention) [Trimbos 2006].

Harm reduction is a public health objective in Ireland [Trimbos 2006].

An Interim National Drugs Strategy (NDS) exists for the years 2009-2016, which integrates alcohol and drugs and assignes the responsibility for the NDS to the Department of Health [NR 2011]. The NDS states in Action 40, that [SQ 23/29 2011]:

» Under the pillar of Treatment & Rehabilitation the development of a response to drug-related deaths through a national overdose prevention strategy should be developed. The Health Service Executive (HSE) and the Department of Health are responsible for this.
» A co-ordinated health response to the increase in deaths indirectly related to drug use and a review of the regulatory framework in relation to prescribed drugs is necessary.

In Action 42 the need is mentioned to further involve users of drug treatment services in clinical governance procedures and service planning [NR 2011].

The objectives of the DRID strategy (as part of the Drug Strategy) are [SQ 23/29 2011]:

» to expand the availability of detoxication facilities, opiate substitution services, under - 18 services and needle exchange services where required, as well as
» to maintain and develop treatment services dealing with Blood Borne Viruses (BBVs), with particular emphasis on Hepatitis C treatment services.

In addition, there will be a separate document to deal with hepatitis C [SQ 23/29 2011]. In January 2007, the HSE established a working group on hepatitis C, which is to build on a 2004 unpublished report on hepatitis C carried out by the then Eastern Regional Health Authority [SQ 23/29 2011]. Unlike the 2004 report, the 2007 initiative

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has a national focus. It is examining how Ireland can best respond to hepatitis C in the areas of surveillance, education and treatment. The working group will comment on how the recommendations of the 2004 report have been progressed. It will prioritise recommendations and add estimations of costs. The group has completed its report and has presented it to HSE senior management who are reviewing its cost implications. It may be published by the end of 2011.

In March 2011 a new programme for government was issued (Towards recovery: programme for a National Government 2011–2016), which introduces fairness and equality to social policy and includes measures on social solidarity, social inclusion and reduction of stigma [NR 2011]. Issues concerning drugs are mentioned in the section "Justice and Law Reform" of this programme and include the enhancement of the demand reduction strategies. Under the key priorities for short-term implementation there is only one related to harm reduction: "Needle exchange programmes expanded across the country where needed most".

The HSE National Service Plan 2011 has defined as priority "to continue to address the health impacts of addiction and/or substance misuse" [NR 2011]. For the year 2011 this included an increase in service provision in the South and West regions to reduce waiting times in some locations: total number of clients in methadone treatment should be increased by defined percentages and 100 % of substance misusers should start treatment within one calendar month (for those over 18 years) resp. two weeks (for those under 18 years) of assessment.

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

To prevent infectious diseases among drug users, providing information, education and communication (IEC) via counselling and advice by drugs and health professionals and IEC in general are common response strategies in Ireland [Trimbos 2006].

The dissemination of information through various websites and telephone help lines is nationwide available [Trimbos 2006] although it is not a priority response strategy to prevent DRID [SQ 23/29 2011]. In specific geographical regions, a broad range of educational materials is available [Trimbos 2006]. Individual counselling on infectious diseases is provided extensively [SQ 23/29 2011]. Safer injection training is common [Trimbos 2006], but it is not a priority response strategy to prevent DRID and provided to a limited extend[22] only [SQ 23/29 2011]. "Easy access" programmes to treatment of infectious diseases are uncommon [Trimbos 2006] and not a priority response strategy to prevent DRID in Ireland [SQ 23/29 2011].

With regard to the reduction of drug-related deaths, individual risk counselling is the predominant response strategy [Trimbos 2006]. Overdose information material is provided to a limited extent only [SQ 23/29 2008]. Risk education and overdose

22
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly all of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

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response training is available in a majority of relevant cities (but not in nearly all of them), therefore it is assessed as being provided extensively [SQ 23/29 2008]. Individual overdose risk assessment is also provided extensively [SQ 23/29 2008].

In 2010 a booklet was published with harm reduction information for those using psychoactive drugs, legal highs and others [NR 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Nationwide, communities and drug users are involved in risk reduction [Trimbos 2006].

Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for prison staff and family/friends, but not for police, night club staff or other groups [SQ 23/29 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

To prevent infectious diseases among drug users, outreach health education is a common response strategy [Trimbos 2006]. Low threshold agencies, including needle and syringe exchange, and outreach work are a common setting for the dissemination of information materials, aiming at the reduction of drug-related deaths, as well as a predominant setting for the deliverance of risk education/response training to drug users [Trimbos 2006].

As part of their routine work, outreach workers in the HSE and non-government organisations provide information sessions on safe injecting on a one-to-one basis

[SQ 23/29 2011]. In an interview with the senior outreach workers in 2007/08, they reported that prevention if infection and overdose were equally important objectives of their work. With respect to the prevention of infection, they provide advice on the prevention of localised bacterial infections, blood-borne viruses and sexually transmitted diseases.

In all services, the outreach workers assess each individual's current situation with respect to injecting use, and provide appropriate advice [SQ 23/29 2011]. They use each contact with clients to provide information to increase the safety of the individual's current injecting practices. Safer injecting classes are operated in a number of the needle and syringe-exchange services in three of the four former Health Board Areas.

Their main opportunity for contact with clients is during needle-exchange services which are delivered through a variety of methods [SQ 23/29 2011]. The outreach workers employed through the HSE do some house calls and street work. In addition, Merchants Quay Ireland provides formal safer injecting classes.

In the HSE Northern Area, the senior outreach workers have published a booklet on safer injecting known as the Safer Injecting Guidebook [SQ 23/29 2011]. The booklet was prepared with input from the drug users, clinical team and managers. The booklet provides a comprehensive overview of: the consequences of using unsafe injecting, where to access clean injecting equipment, safe injecting techniques, and what to do in the event of an overdose. In the HSE Northern Area, this booklet is the key text that outreach workers use to discuss safe injecting with clients. This booklet is not used in either the HSE South Western or East Coast Areas. In 2007 the HSE Northern Area, along with a number of non-government organisations published a booklet that provided safe injecting guidelines specifically for cocaine injectors.

The senior outreach workers in the HSE South Western Area use materials purchased in the United Kingdom [SQ 23/29 2011]. They have a range of information leaflets and booklets available and decide which booklet to use based on the client's situation during the contact interview. Their booklets cover: safer injecting, actions when things go wrong, and key points on the prevention of infection and overdose. They provide each injector with a copy of "Better Injecting" which has very little text and is colour coded using green for good practices and red for dangerous practices. The possible consequences of cocaine use are addressed using an information card and a booklet. The nurses working in the HSE South Western Area have produced posters and information leaflets covering the prevention and management of overdose as well as the identification and management of abscess.

The outreach workers in the HSE East Coast and Mid-West Areas use materials purchased in the United Kingdom [SQ 23/29 2011]. These booklets cover a range of topics from safe injecting to overdose prevention techniques. The HSE East Coast also

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uses information leaflets produced in Ireland by the Department of Health & Children, the Health Promotion Unit and the Women's Health Project.

Training for outreach workers and training in management for senior outreach workers is organised in specific geographical areas [Trimbos 2006].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are not involved in the responses to prevent DRID and their involvement is not a priority. Naloxone is not available on a "take-home" basis [SQ 23/29 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

In specific geographical regions only (the Eastern Region), senior outreach workers meet on a monthly basis [Trimbos 2006].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Drug-free psychosocial out-patient interventions are provided fully, drug-free psychosocial in-patient interventions and substitution treatment extensively and detoxification is provided to a limited extend only [SQ 27 p1 2011]. Still, these treatment

interventions as well as rehabilitation programmes are available nationwide, while drop-in centres/shelters and treatment with naltrexone is available in specific geographical areas only [Trimbos 2006]. Substitution treatment with burprenorphine is provided on an extremely limited basis only, over 99 % of clients are treated with methadone [GS]. Treatment interventions for target groups are available for cocaine users only [SQ 27 p1 2011].

On average, the waiting time for detoxification is between 1 week and 1 month [SQ 27 p1 2011]. Depending on the clinical indications, a client may be admitted very quickly [SQ 27 p1 2011]. Also on average, the waiting time for outpatient psychosocial treatment is between 1 week and 1 month, and for inpatient psychosocial treatment it is less than 1 month [SQ 27 p1 2011]. In both cases this is due to formal procedures [SQ 27 p1 2011]. But in fact, access to treatment as well as to detoxification generally differs depending on the region and from centre to centre [GS]. It is often due to limited resources [SQ 27 p1 2011]. A review of the national children's strategy launched in 2000 (Children's Rights Alliance 2011) reports, that specialist drug treatment for under-18-year-olds has been expanded [NR 2011].

Substitution treatment is supported by psychosocial care upon request by the client [Trimbos 2006] and it is provided extensively [SQ 27 p1 2011]. In the year 2009 10.668 clients received OST [Statistical Bulletin 2011]. The waiting time for OST is between 2 weeks and 1 month [SQ 27 p1 2011]. The recent view of the methadone protocol showed that 56 % of the clinics which provided information reported that their average waiting time was less than one month [SQ 27 p1 2011]. The longest average waiting time was reported to be 13,5 months (at a Dublin clinic) but this was due to a small number of clients [SQ 27 p1 2011]. To increase the provision with methadone treatment on local level, GPs are trained and community pharmacists are involved in the dispensing of methadone under the Community Pharmacy Contractor Agreement of the HSE [NR 2011].

Drug consumption rooms and heroin prescription programmes do not exist in Ireland [Trimbos 2006 and SQ 23/29 2011].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are nationwide available [Trimbos 2006].

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Medical doctors at specialised drug treatment centres and specialised medical doctors can initiate and continue treatment with methadone, high-dosage buprenorphine and a combination of buprenorphine and naloxone [Statistical Bulletin 2011]. Other providers (which are not specified further) can only initiate treatment with high-dosage buprenorphine [Statistical Bulletin 2011]. GPs can initiate and continue methadone treatment, if they passed training for level 2 by the ICGP [NR 2011]. Level 1 GPs can only continue methadone treatment for clients, who have been already stabilized on a methadone treatment programme. Methadone can be dispensed at specialised treatment centres, pharmacies and mobile outreach units, while high-dosage buprenorphine and a combination of buprenorphine and naloxone can only be dispensed at specialised treatment centres [Statistical Bulletin 2011]. It has to be considered though, that substitution treatment with buprenorpine is rarely provided [GS].

"Take-home" OST is not specified under law [SQ 27 p1 2011]. In 2008, the Irish College of General Practitioners published updated guidelines for general practitioners working with opiate users in general practice [SQ 27 p1 2011]. They recommend that until the clients are stabilised their consumption of methadone should be supervised daily [SQ 27 p1 2011]. Once stable, the ICGP recommends that their consumption should be supervised at least once per week by the pharmacist [SQ 27 p1 2011]. Exceptions to this are stable patients receiving very low doses (less than 15mls), who may not need supervision, and higher doses (greater than 80mls), who may need supervision more often (twice weekly) [SQ 27 p1 2011].

In May 2010, guidelines on the safe dispensing of non-prescription products containing codeine were published by the Pharmaceutical Society of Ireland [NR 2011].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Drug-related prison health is addressed in the national drug strategy, but there is also a specific strategy for drug-related prison health, the IPS document *Keeping drugs out of prisons* [SQ 23/29 2011 and NR 2011]. Action 43 of the NDS includes the continuation of the expansion of treatment, rehabilitation and other health and social services in prisons and the development of agreed protocols [NR 2011]. With regard to relapse and overdose prevention, the steering group for the NDS reflected on the need for an effective and coordinated interagency approach to ensure seamless transition from prison back into community. This requires a range of supports and clarity on who is

delivering these services. Besides this, drug users in prisons are also mentioned as target group in the DRID strategy [SQ 23/29 2011].

On the basis of the IPS document new services and programmes for addicted prisoners were developed in 2006 [NR 2011]. They are provided by the IPS in cooperation with the HSE and private services.

The priorities to prevent DRID in prison are individual risk assessment and one to one counselling on infectious diseases, a hepatitis vaccination programme as well as medium/long-term maintenance treatment [SQ 23/29 2011].

Low intensity drug treatment is provided extensively by prison health services, mixed teams and NGOs, while medium/high intensity drug-free treatment is provided only rarely and only by prison health services [SQ 27 p1 2011]. OST is provided in prisons fully, initiation as well as continuation are possible [SQ 27 p1 2011]. Methadone is used for both [NR 2011]. Methadone maintenance is available in 8 of 14 places of detention, accounting for over 75 % of Ireland's prisoners [NR 2011].

HCV testing on release from prison is provided extensively, individual counselling on infectious diseases risk and HCV testing on prison entry are provided to a limited extend [SQ 23/29 2011]. A hepatitis B vaccination programme for PDUs is available in prisons and specific materials on the prevention of acute drug-related deaths and drug-related emergencies are available for prison staff [SQ 23/29 2011]. On the basis of a contract with St James Hospital in Dublin, there is also a consultant-led infectious diseases service providing treatment to prisoners suffering from infectious diseases (including hepatitis C and HIV) [NR 2011].

Practical advice and training on safer use, NSPs and the provision of naloxone upon prison release are not available in Irish prisons [SQ 23/29 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination strategy, and a risk-group specific hepatitis B vaccination programme is available [SQ 23/29 2011]. Voluntary infectious disease counselling and testing as well as hepatitis vaccination is a priority response to

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prevent DRID and HCV testing is provided extensively [SQ 23/29 2011]. Neither routine screening of high risk groups nor "easy-access" programmes to treatment of DRID have a priority in Ireland [SQ 23/29 2011].

Access to hepatitis C care, particularly treatment, is suboptimal for injecting drug users [NR 2011]. Several studies were carried out, which showed barriers on the level of the users but also within healthcare services.

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

Needle syringe programmes are a priority response to prevent DRID and they are extensively provided [SQ 23/29 2011]. There are 28 fixed locations for NSPs and 6 home visit approaches for NSPs [ST 10 2011]. In addition there are 4 outreach services offering SPPs [ST 10 2011]. In 2007 1.097.204 syringes were provided by specialist agencies [ST 10 2008], there are no numbers for 2010 [ST 10 2011].

At the conference of The Irish Needle Exchange Forum (INEF) plans were presented to provide additional needle exchange-services through community pharmacies in 65 new locations across the country [ST 10 2011]. It was envisaged that the services would be targeted at areas outside Dublin and the former Eastern Regional Health Authority. The services proposed would come from a new partnership between the Irish Pharmacy Union (IPU), the Health Service Executive (HSE) and the Elton John Aids Foundation (EJAF). The service would be part-funded by the EJAF for three years, with matching funding by the HSE. The HSE would take responsibility for funding in year four. Needle-exchange services will be provided free in pharmacies and will include both custom-made and standard packs. It was envisaged that the service will exchange new injecting equipment for old, provide sharps bins and advice on safe disposal of used equipment, information on safer-injecting and safe sex practices, and advice on drug use and other health-related issues.

In the second half of 2010, the HSE and the Irish Pharmacy Union commenced recruitment of a National Liaison Pharmacist to supervise and support pharmacists who are participating in the pharmacy-based needle exchange service outside Dublin [ST 10 2011]. These exchanges will be provided in all counties and in most urban areas outside of Dublin. The HSE are in the process of agreeing a fee structure with the IPU in regard to payment for participating community based pharmacists. The Irish Centre for Continuing Pharmaceutical Education training programme on needle-exchange for

participating pharmacists commenced on 11 October 2010 and was completed by 16 November, in time for planned roll-out of the programme at the beginning of 2011 (Joe Doyle, HSE, personal communication, September 2010).

A liaison pharmacist for needle exchange has been appointed [ST 10 2011]. The roll out of the proposed pharmacy needle exchange programme has been delayed due to a prolonged negotiation process between the IPU and the HSE on: the fee structure, service to be provided, contents of the exchnage pack and information collection/accountability mechanism. The HSE are happy that they have agreed each of issues and that the services will be rolled out in October 2011. A new training programme (2 days) was provided (in late September 2011) for all participating pharmacists regardless of whether they have previously taken part in training or not. The training consisted of policy and procedures around drug services, BBV, and needle exchange, operation of a needle exchange itself, and data collection. The training was based on the Scottish Needle Exchange training for Pharmacists and HSE drug policy documents.

Some services provide tin foil for heroin smokers, but injecting kits are not available in Ireland [SQ 23/29 2011].

Although condom provision has no priority to prevent DRID, they are extensively provided at drug agencies with NSPs [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Emergency departments are not in use as a setting for risk education/response training that aims at the reduction of drug-related deaths [Trimbos 2006].

The use of naloxone is regulated by law [SQ 23/29 2011]. Naloxone is part of standard ambulance equipment and the ambulance personnel are trained in its use [SQ 23/29 2011]. Naloxone is available on medical prescription [SQ 23/29 2011], but not on a "take-home" basis [Trimbos 2006].

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Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Ireland has a national primary healthcare strategy [SQ 28 2010]. Explicit reference to drug misuse rather than drug users appears once in the National Primary Care Strategy on page 26 as part of a description of the focus of primary care services: "The primary care team will...provide appropriate responses including the range of general medical services in addition to the generalist aspects of services for mental health, elderly care, drug misuse, disabilities, family support and child health. This will necessitate inclusion of personal social services staff on the teams. In addition, there is reference to the provision of methadone (an implicit reference to drug users) on page 54: "Under the Methadone Treatment Scheme, Methadone is prescribed and dispensed by doctors and pharmacists for approved clients. The GMS Payments Board pays capitation fees under this scheme to participating doctors and community pharmacists".

The National Action Plan for Social Inclusion 2007-2016 represents Ireland's integrated approach to social protection and social inclusion [SQ 28 2010]. The accommodation needs of drug users are not explicitly addressed in this plan, however, the plan addresses youth homelessness and research in Ireland demonstrates the enduring association between drug use and youth homelessness. The National Action Plan for Social Inclusion 2007-2016 states on pages 35-36 that 'Young people who are homeless are among the most marginalised and vulnerable of all young people. Their homelessness may be symptomatic of serious underlying personal, family and social problems. To address this problem, therefore, the Office of the Minister for Children (OMC) will undertake a review of progress on the implementation of the Youth Homelessness Strategy and develop a new programme of action in 2007'.

The Annual Report of the Office of the Minister for Children and Youth Affairs 2008 does not contain any reference to the aforementioned review of the Youth Homelessness Strategy and no 'new programme of action' has been developed [SQ 28 2010].

The National Action Plan also addresses 'homelessness' in a broader sense through the following two actions [SQ 28 2010]:

» A revised government strategy on homelessness will be published during 2007 (This plan was published to address homelessness in Dublin. The plan is vague on addressing the accommodation needs of drug users; instead emphasising the need for inter-agency working between health services and accommodation providers).
» Long-term occupancy of emergency homeless accommodation will be eliminated by 2010. This will involve addressing the needs of up to 500 households (p. 63).

This action can, in theory, benefit drug users, however, it is proving difficult to get accurate data on the proportion of drug users, both active and recovering, that are benefitting from this action.

The housing needs of drug users are also mentioned in the written drug policies [SQ 28 2010]: Housing Local authorities should liaise with local drugs task forces to facilitate recovering drug users who wish to return to or move into local authority housing in the community. Dedicated supported accommodation, staffed appropriately, should be provided to cater for clients who have difficulties with an independent living environment. The provision of transitional/half way housing for recovering drug users should continue to be expanded. The long-term housing needs of problem drug users who are capable of independent living should be addressed, for example, through the rental accommodation scheme (Department of Environment, Heritage and Local Government lead).

The Housing First Approach was investigated in context of its applicability to people with substance misuse issues and is piloted by the Dublin Housing First Demonstration Project [NR 2011]. Self-contained, independent, scattered, community-based housing units will be provided for each participant and support will be provided through home visits.

The National Action Plan for Social Inclusion 2007-2016 highlights a number of key targets in the National Drug Strategy including the development of the rehabilitation pillar which addresses the education needs of people in drug treatment [SQ 28 2010]. Factors that make it difficult for recovering drug users to access education should be identified and removed where possible and an education fund for drugs rehabilitation should be established (Department of Education and Science lead). An outreach approach should be developed by the Vocational Education Committees to identify and develop responses to the adult educational needs of problem drug users in rehabilitation.

Under the Community Employment Scheme 1.000 places are dedicated to drug users in recovery, which enables them to return to education and training [NR 2011].

Employment needs of drug users are not explicitly addressed in the National Employment Plan, but are mentioned in the written drug policies [SQ 28 2010]. Stronger links with employers, employer organisations and trade unions need to be established to facilitate ease of access to the workplace for recovering drug users (Department of Enterprise, Trade and Employment lead), while access to ongoing support for employers of drug users and for recovering drug users in employment is recommended (Case managers and rehabilitation co-ordinators lead). The report recommends that research on progression pathways to employment should be undertaken (National Advisory Committee on Drugs lead).

Ready for Work is a supported employment programme which helps homeless people to gain and sustain employment [NR 2011].

Other policies refer to childcare and the role of families [SQ 28 2010]. The HSE, in conjunction with the Office of the Minister for Children should decide on how best to integrate childcare facilities with treatment and rehabilitation services and subsequently progress the matter. Research is recommended to inform this process (HSE lead). Childcare services for children of problem drug users should adopt an approach focused on the development of the children (Office of the Minister for Children lead). Concerning the role of families, service providers should actively encourage family reconciliation, where appropriate. Families should be seen as service users and involved in the recovery of drug using family members (Case managers, HSE and service providers lead). A pilot short-stay respite programme for families of drug users should be developed (HSE lead).

The National Drug Rehabilitation Implementation Committee (NDRIC), chaired by a senior rehabilitation co-ordinator (new post) oversees the process of interagency partnership coordination [SQ 28 2010]. The committee is made up of representatives of the Health Service Executive (HSE), the National Drugs Strategy Team (NDST), the National Advisory Committee on Drugs (NACD), the community and voluntary sectors, rehabilitation and healthcare professionals, problem drug users and families of problem drug users. These agents are currently developing a framework to assist the development of local protocols, service-level agreements, quality standards and care plans, and to the overall tracking of client progression. This National Drugs Rehabilitation Framework created integrated care pathways (ICP) for the cooperation of different service providers [NR 2011]. On this basis an individual care plan is developed for each service user and is delivered by a multi-disciplinary team. In the case of complex and multi-faceted needs, a more intensive case management approach may be used. The ICP is based on four steps (initial contact, initial assessment, comprehensive assessment, implementation of care plan) and is currently piloted at regional and local levels. This should result into the development of protocols.

There are protocols between different national, regional and local authorities and agencies involved in addressing the health and social needs of drug users in treatment [SQ 28 2010].

There are partnership agreements between the social services and the health services to meet the needs of drug users in treatment [SQ 28 2010].

The most common mechanism of interagency coordination is the informal network [SQ 28 2010].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

A national system for continued education is available for social workers, nursing staff, psychiatrists and medical doctors [SQ 27 P2 2011]. The National Addiction Training Programme was established in 2006 under the auspices of the HSE National Drug and Alcohol Working Group to:

» Provide training based upon current evidence-based practice.
» Prioritise training programmes to meet current and emerging service needs both in the HSE and for relevant services operating in the community and voluntary sectors.
» Ensure adequate and appropriate validation for training.
» Support robust systems of treatment for cocaine and other substance users.
» Provide value for money in terms or quality service provision and return on investment

The Irish College of General Practioners provides training for GPs [SQ 27 P2 2011]. The College of Psychiatry in Ireland provides training for Psychiatrists [SQ 27 P2 2011]. Specialised courses/training on drug treatment are implemented for social workers, nursing staff, psychologists, psychiatrists, medical doctors and other drug workers e.g. outreach workers, peer educators [SQ 27 P2 2011].

The ICGP does audit a sample of GPs who provide methadone treatment, although the post of audit nurse has only just been filled after a long period of vacancy [SQ 27 P2 2011]. Those GPs wishing to take part in the programme must undertake training as provided by the ICGP. Depending on the level of the qualification GPs can treat more or less clients and initiate or continue methadone treatment [NR 2011].

The National Documentation Centre on Drug Use at the Health Research Board completes an annual directory of training courses in the drugs area. This Directory contains information about courses and training programmes in drug misuse for individuals and agencies interested in developing their knowledge, skills and capacity in this field [SQ 27 P2 2011].

The recent National Drugs Rehabilitation Framework Document states that "Within education, all curriculum provision to service users is quality assured under the requirements of the Qualifications (Education and Training) Act, 1999, as set out in the overarching remit of the National Qualifications Authority of Ireland. There are two awards councils – the Further Education and Training Awards Council (FETAC) and

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Higher Education and Training Awards Council (HETAC), established in 2001 under the Qualifications (Education and Training) Act, 1999 [SQ 27 P2 2011].

The National Qualifications Authority published the National Framework of Qualifications in 2003. There are 10 levels along the lifelong learning spectrum from the basic level 1 to a doctoral level 10. FETAC is responsible for awards at levels 1 – 6 and HETAC for awards at levels 6 – 10." [SQ 27 P2 2011].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

The institution responsible for developing guidelines is the Health Service Executive (www.hse.ie) [SQ 27 P2 2011].

There are no harm reduction guidelines, but treatment guidelines exist [Best Practice Portal]:

- Review of the Methadone Treatment Protocol (2005 and 2010)
- Working with opiate users in community-based primary care (2003)
- Keeping drugs out of prisons: drug policy and strategy (2008)
- Benzodiazepines: good practice guidelines for clinicians (2002)
- National Drugs Rehabilitation Framework Document (2010).

In addition, there are sub-national guidelines for assessment of infectious disease risk among drug users, for NSPs and for overdose risk assessment [SQ 23/29 2011].

There is QuADS (Quality Standards in Alcohol and Drugs Services) which is a quality standards framework that was developed in the UK in 1999 [SQ 27 P2 2011]. This has been chosen as the guiding quality standard framework for HSE Addiction Services in Ireland, however they are no quality guidelines according the definition in the SQ 27. In

the year 2010 30 services were supported as QuADS compliant, 70 more were added in the year 2011 [NR 2011]. To achieve this, a self-review followed by a peer-review (carried out by two organizations within the QuADS network) has to be completed.

In the review of the Methadone Treatment Protocol, several recommendations were made, among them the following [NR 2011]:

» Improvement of access to detoxification treatment, in conjunction with necessary psychosocial support;
» Inclusion of buprenorphine/naloxone treatment;
» Support the concept of the ICP to promote integration between different treatment agencies;
» Need for a concerted approach to achieve tighter and more responsible prescribing of benzodiazepines;
» Development of guidelines for the prescription of methadone in police stations.

A pilot programme for community detoxification has been carried out and expanded, which included the development of two detoxification protocols [NR 2011].

Practical guidelines and standards of drug-related health services in prisons are outlined in the Drug Treatment Clinical Policy, which was published by the IPS in 2008 [NR 2011]. Guidance for the general provision of healthcare in Irish prisons is provided by the IPS document Health Care Standards, which was also published in 2009.

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

In 2001 a pilot project was implemented to improve the care of injecting drug users attending general practice and at risk of hepatitis C [Trimbos 2006]. Prior to implementing the project, the authors did a baseline assessment that included hepatitis B vaccine coverage.

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Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

There are no systematic on-going programmes to evaluate the various treatment programmes however there have been ad-hoc studies [SQ 27 P2 2011]:

» The first prospective study of treatment outcomes for opiate users was ROSIE, for which 404 opiate users have been recruited [NR 2011]. Several papers on the findings were published from September 2008 on.
» In August 2010 Coolmine Therapeutic Centre started a longitudinal research study [SQ 27 P2 2011]. The aims of the study are to: collect baseline data on drug use, health and behavioural status of participants as they enter and progress through primary treatment and aftercare in CTC; follow up participants over time including after leaving the CTC programme, and compare CTC client outcomes with outcomes recorded in other national outcome studies, e.g. ROSIE. There are no preliminary results available at this time form this study.

For the fourth quarter of 2011 an analysis of addiction services for children based on best practice was planned within the HSE National Service Plan 2011 [NR 2011]. This was based on the recommendations in the Report of the Commission to Inquire into Child Abuse.

An evaluation of the National Drugs Rehabilitation Framework for substance abuse is currently underway [SQ 27 P2 2011]. The objectives of the evaluation are to

» ascertain whether the framework has been useful, clear and effective for stakeholders,
» measure client care plan progression over the course of the research period and
» identify the barriers that hinder care planning/case management at the systemic and individual client level.

There is no national research programme for evaluation [SQ 27 P2 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

No information available.

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Standardised data collection exists to a large extent, there was an increase since 2003 [PS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The Eastern Regional Health Authority (ERHA) commissioned the evaluation of outreach work in response to Action 64 of the National Drugs Strategy [Trimbos 2006]. One of the recommendations from the research report was to develop a monitoring system that includes quantitative and qualitative indicators for outreach work.

In June 2001, the Minister of State for Local Development with special responsibility for the National Drugs Strategy, asked the National Advisory Committee on Drugs (NACD) to undertake a review of the use of buprenorphine as an intervention in the treatment of opiate dependence syndrome [Trimbos 2006]. As a result, the NACD commissioned a team of experts at the National Medicines Information Centre to conduct this review. The review examined the effectiveness of buprenorphine as a treatment option, its safety in use, as well as the practical and pharmaco economic considerations associated with its use.

There was no progress report or any review of the NDS until summer 2011 [NR 2011].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Evaluation training programmes are available to a large extent, there was an increase since 2003 [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

A broad range of actors and stakeholders is involved in evaluation to some extent, there was an increase since 2003 [PS]. Major achievements in this area since 2003 are the guidelines of the Drugs Education Workers Forum as well as the evaluation process of the Drugs Task Forces.

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

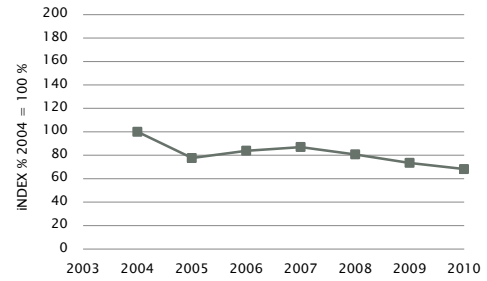
No information available.

14 Country Profile Italy

14.1 Indicators for drug-related harm

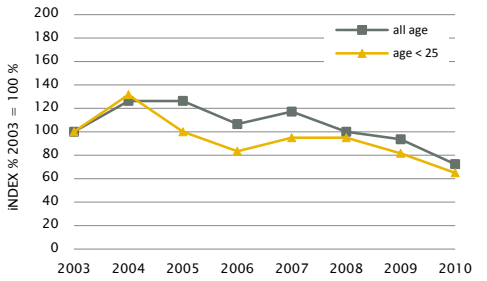
In Italy estimates for **problem drug use** are available for the use of opiates and cocaine separately. In 2010, it is estimated that there were approximately 218.500 subjects in need of treatment for opiate use, a 1,2 % increase over the previous year, which corresponds to a 5,5 per thousand prevalence rate among residents between 15 and 64 years of age. Problem cocaine users are estimated to be 120.000 (3,0 per thousand (15-64 years of age) [NR 2011]. The prevalence estimates indicate an increasing trend in the total number of problem drug users over recent years, and in particular, in the number of problem cocaine users [CO]. The largest groups of clients in outpatient treatment in 2010 have opioids (49 %), cocaine (29 %) and cannabis (20 %) as primary drug [Statistical Bulletin TDI-19]. According outpatient treatment data 53 % of opioid users inject the drug (35 % are smoking). Concerning cocaine/crack the percentage of IDU is just 4 % (57 % sniff and 39 % smoke it) [Statistical Bulletin TDI-17].

Figure 45:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2004=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 46:
Number of direct drug-related deaths (indexed - 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

Concerning **infectious diseases** HIV-registry data show, that the number of HIV infections newly diagnosed which were stated to be acquired by IDU are slightly decreasing since 2003 (see Figure 45). Another important source concerning infection rates are voluntary test data for drug-related infectious diseases. No distinction is made between injecting drug users and non-injectors, although special attention is paid to those with high-risk behaviour. Overall, there has been a continued reduction of the proportion of all clients testing HIV positive for Italy as a whole. In 2010, 11,1 % of the clients tested were HIV positive (14,7 % in 2003). The HCV prevalence rate was 61 % in

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2010 (64,9 % in 2003). Trends are difficult to interpret due to changes in the number of people tested, which varies considerably by region and by year [CO, NR 2011].

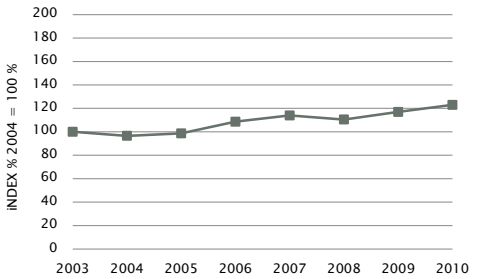
Since 2003 the numbers of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** are stable resp. slightly decreasing in most recent years (see Figure 46).

14.2 Indicators for drug-related harm reduction

Harm reduction interventions are delivered through fixed sites, mobile units, outreach programmes and needle and syringe dispensing machines. In 2008 a survey conducted among the 240 low-threshold services, showed that 157 services aimed to reduce harm and risks related to drug use, while remaining services provided other related services. An in-depth analysis of 55 harm reduction services showed that 41 services provide clean needles and syringes [CO]. Data on the number of syringes provided are not available.

The number of clients in substitution treatment is slightly increasing (see Figure 47). In 2010 56.156 clients started an inpatient or outpatient treatment [ST TDI-2]

Figure 47:
Number of clients in substitution treatment (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

14.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

The coordination and implementation of drug policy in Italy is a shared responsibility between the National government and Regional Authorities. In the field of drug demand reduction, the Ministry of Health is responsible for national coordination, monitoring, quality control and finances. Regional Administrations have the task to ensure regional healthcare system legislation and planning, services, etc.. Local Health Authorities provide social and healthcare services, in cooperation with NGO's (incl. out-reach work). As a result, the implementation of respective elements of the Council Recommendation is delegated to the subsidiary levels of Italian Public Administration. In Italy, prevention and reduction of health-related risks associated to drug dependence was a public health objective prior to the adoption of the Council Recommendation [Trimbos 2006]. For many years Italy has been pursuing a service-oriented policy for drug-addicts. This policy was implemented through a series of legislative and administrative measures in the early '90ies (revised and updated in the late '90ies). The Italian Government has recently approved a National Action Plan, which is being examined by the Regions. The Plan was expected to receive final approval through an Agreement in the framework of the Permanent Government-Regions Conference [Trimbos 2006].

The National Drug Action Plan for 2010-2013 provides a base for the simultaneous development of four components: the National Action Plan (NAP - which contains strategic recommendations); the individual Regional Plans (RP) which will have to be carried out completely independently by the individual Regions and Autonomous Provinces; Methodological Guidelines; National Projects in support of the Plan. Together, these four components comprise the overall action plan, which provides an explanation of general strategies in the form of a list of goals, actions and of the organisations delegated to carry these out as well as a list of outcome indicators [NR 2011].

References [PS]:

piano di azione nazionale (2010):
http://www.politicheantidroga.it/piano-d'azione/piano-di-azione-nazionale-(pan)-sulle-droghe-2010---2013/presentazione.aspx

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measures and concrete actions for the prevention of drug-related diseases (2011): http://www.politicheantidroga.it/media/313164/ppc-eng.pdf

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

To prevent infectious diseases among drug users, providing information, education and communication (IEC) in general is the predominant response strategy. Common response strategies include IEC via counselling and advice by drugs and health professionals and IEC via peer involvement/ peer approach [Trimbos 2006].

For the reduction of drug-related deaths, the dissemination of information materials, risk education/ response training for drug users, individual risk and prison pre-release interventions are predominant strategies [Trimbos 2006].

Common strategies are the provision of information materials to reduce drug harms in night clubs and large music festivals, the provision of overdose information materials, the provision of individual counselling and of safer use training is full. Risk education and OD response training is available in nearly all relevant cities or towns. Overdose information materials are available for police, prison staff, family/ friends and night club staff [SQ 23/29 2008 und 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Overdose information materials are available for families and friends. There is no formal NSP training available for families of drug users [SQ 23/29 2008 und 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

In Italy, street-based outreach work and outreach work at dance parties/ raves and in clubs are available in specific geographical regions [Trimbos 2006].

To prevent infectious diseases among drug users, outreaching health education is a predominant response strategy. Outreach work and targeted high-risk group interventions are a common implementation setting for infectious diseases prevention measures targeting drug users [Trimbos 2006].

Low threshold agencies, including needle and syringe exchange programmes, and outreach workers are the predominant setting for the dissemination of information materials, aimed at the reduction of drug-related deaths. Outreach work is the predominant setting for the deliverance of risk education/ response to drug users [Trimbos 2006].

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Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are involved in the responses to prevent DRID, but peer involvement is not a priority. Naloxone "take-home" doses are distributed to drug users, peers and relatives who have completed a first aid training/ training on overdose management [SQ 23/29 2008 und 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

The availability/coverage of networking and cooperation between agencies involved in outreach work is full. Networking and cooperation has increased since 2003 [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Methadone maintenance and methadone detoxification treatment, drug-free outpatient and drug-free inpatient treatment and rehabilitation programmes are nationwide available. Treatment with buprenorphine and naltrexone and drop-in centres/ shelters are available in specific geographical areas. Substitution treatment is supported by psychosocial care and is sometimes obligatory, sometimes upon request by the client (depending on the prescribing institution or general practitioner) [Trimbos 2006, SQ 27 2011].

Drug consumption rooms and heroin prescription programmes are not available in Italy [SQ 23/29 2008 and 2011].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Medical doctors at specialised drug treatment centres can initiate and continue methadone treatment, high dosage buprenorphine, buprenorphine-naloxone treatment and slow-release morphine treatment. Methadone can be dispensed at specialised drug treatment centres, mobile outreach units and emergency rooms. Buprenorphine treatment can be dispensed at specialised drug treatment centres, mobile outreach units and emergency rooms. Buprenorphine-naloxone treatment can be dispensed at specialised drug treatment centres, and emergency rooms. Slow-release morphine can be dispensed at specialised medical doctors' offices, any medical doctor office and pharmacies [Statistical Bulletin 2011 Table HSR-2].

The conditions for "take-home" OST are at least 3 months of on-going therapy, acceptable patient response to the treatment (patient respects therapy schedule and tests negative for unprescribed narcotic substances) and a valid justification for the patient absence from the treatment centre [SQ 27 2008].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Methadone maintenance treatment, methadone detoxification treatment and treatment with buprenorphine are available in prisons nationwide. Also testing, prevention, education, and treatment for infectious diseases are provided nationwide [Trimbos 2006] .Operative Units of Local Drug Addiction Services are responsible for the provision of OST in prisons [GS].

Prisoners are not mentioned as target group in the DRID strategy but there is a specific strategy for drug-related prison health (separate document) [SQ 23/29 2011].

The provision of pre-release OD counselling is full. Naloxone is provided to prisoners who have been assessed as at risk of relapse into drug use (or to their families) upon

prison release. Overdose information materials are available for prison staff [SQ 23/29 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination strategy [SQ 23/29 2008 and 2011].

Voluntary infectious diseases counselling and testing is a predominant response strategy to prevent DRID. Testing/ screening for infectious diseases is nationwide available [Trimbos 2006].

Condom promotion among drug users, routine screening of high risk groups and easy access programmes for drug users to treatment of infectious diseases are common response strategies to prevent DRID but are not a priority [Trimbos 2006, SQ 23/29 2008 and 2011].

Tuberculosis testing also falls under the umbrella of the national strategy for the prevention of infectious diseases. The guidelines entitled, "Screening and Early Diagnosis of the Principal Drug-related Infectious Diseases", published by the Department for Anti-drug Policies, contain goals and actions to be taken, along with their relative indicators, for the monitoring of prevention programmes to be activated nationwide, as well as procedures and organizational guidelines for Addiction Departments to work with when dealing with the principal drug-related infectious diseases (HIV, HCV, HBV, TB and luetic infections) [GS].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

On a national level needle and syringe exchange programmes are included in the principal goals of the strategies for the prevention of drug-related diseases, which

include infectious diseases. The DPA has, in fact, published specific guidelines entitled, "Measures and Concrete Actions for the Prevention of Drug-related Diseases". Needle and syringe exchange programmes are among the actions included in those guidelines [Trimbos 2006; GS]. Nonetheless, at a regional level, these programmes are not necessarily among the priorities of every local Administration [SQ 23/29 2008 and 2011].

There are sub-national DRID strategies, due to the autonomy afforded to Regions and Autonomous Provinces in healthcare matters [SQ 23/29 2008]. Objectives of the national DRID strategy, included in the National Action Plan published by the DPA and adopted by the majority of the Regions and Autonomous Provinces, are creating conditions that enable early outreach project feasibility, creating actions based on the causes of mortality, creating actions targeting the causes of disability, creating actions that target the causes of psychosocial maladjustment and of discrimination. Possible actions are: information programmes, early outreach programmes, distribution of syringes and condoms, continuing care, establishing early warning systems, naloxone distribution [SQ 23/29 2011; GS].

The distribution of condoms is available and is managed by the Operative Units of Local Drug Addiction Services in accordance with the strategies of the same Services and with Regional strategies [Trimbos 2006; GS].

Council Recommendation 2.11

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ensure that emergency services are trained and equipped to deal with overdoses;

Ambulance personnel are trained in naloxone use. Naloxone "take-home" doses are distributed to drug users, peers and relatives who have completed a first aid training/ training on overdose management. Naloxone is provided to prisoners who have been assessed as at risk of relapse into drug use (or to their families) upon prison release [SQ 23/29 2011].

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Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

The availability/coverage of integration between health services, social care and specialised risk reduction is full and has increased since 2003 [PS].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

There is no recognised professional qualification for professionals in the field of prevention and reduction of health-related risks associated with drug dependence [Trimbos 2006].

Occupational standards for drug treatment are available for social workers, nursing staff, psychologists, psychiatrists, medical doctors, teachers and educators in the field of universal or selective prevention. Specialised courses on drug treatment are implemented for social workers, nursing staff, psychologists, psychiatrists, medical doctors and educators. A national system for continued education is available for social workers, nursing staff, psychologists, psychiatrists, medical doctors and educators. A national training school on dependences has been set up at the Antidrug Policies Department (Multidisciplinary training programme on dependences) [SQ 23/29 2011].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

The Antidrug Policies Department and the Presidency of the Council of Ministers are responsible for developing HR guidelines. There are national guidelines for assessment of infectious disease risks among drug users and OD assessment [SQ 23/29 2011].

There are national guidelines, produced and published by the DPA in 2009, entitled, "Measures and Concrete Actions for the Prevention of Drug-related Diseases" [Best Practice Portal; GS].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

Needs assessments are used at the initial stage of programmes to a large extent [PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

There is a national research programme for evaluation (www.politicheantidroga.it). There are research projects on treatment [SQ 27 P2 2011].

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Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

Quality criteria taking into account the recommendations of the European Monitoring Centre for Drugs and Drug Addiction are used in evaluations to a large extent [PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Standardised data-collection according to the EMCDDA recommendations is organized through the REITOX national focal point [PS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

To facilitate co-ordination and an integrated approach to primary, secondary and tertiary prevention, the Regional Councils in most Regions have adopted formal decisions to provide local arrangements for the establishment, organisation and operation of all activities in the dependency sector. In many cases this involves a technical or advisory committee to advice on strategy, planning and projects and on the evaluation of activities as well as a Department for Dependence which provides the operational support for implementing and monitoring the strategy and programmes and projects funded through resources available to the Region. Commonly representatives of interested sectors in the public and private social services serve on the advisory committee [Trimbos 2006].

Evaluation results are used for further development of drug prevention policies to a large extent; there has been a strong increase since 2003 [PS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Evaluation training programmes are available in Italy to a large extent [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

Actors and stakeholders are involved in evaluation to a large extent [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

Italy is an important donor to international organisations such as UNODC. Recently, three bilateral projects have been undertaken, two in Peru and one in the Maldives and alternative development projects have been funded in Columbia, Ecuador and Bolivia. Italy participates in the ESPAD project [Trimbos 2006].

Professionals have access to opportunities for exchange of programme results, skills and experience at European level to a large extent [PS].

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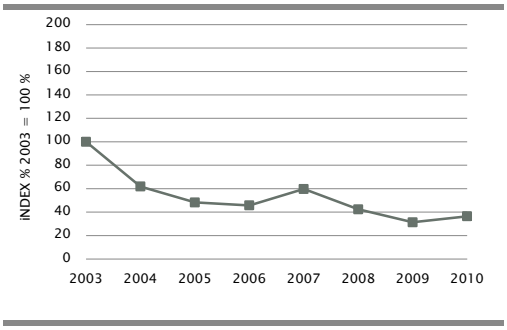
15 Country Profile Latvia

15.1 Indicators for drug-related harm

In 2010, estimates of **problem drug use** (problem opioid use and problem amphetamine use) indicate a prevalence of problem drug use between 9,8 and 16,4 cases per 1.000 inhabitants aged 15-64 years. This means that there are about 18.888 problem drug users (between 15.029 and 25.234) from whom around two thirds are users of heroin or other opioids and one third are problem users of (meth-) amphetamines [CO].

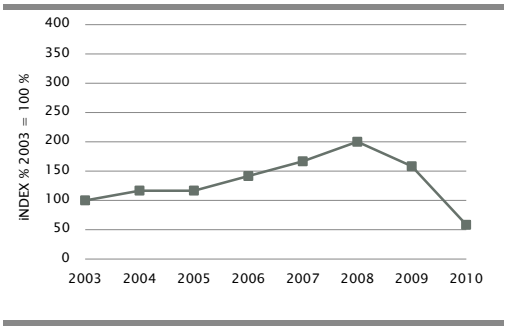
The largest groups of clients in outpatient treatment in 2010 have opioids (56 %) and amphetamines (21 %) as primary drug [Statistical Bulletin TDI-19]. According outpatient treatment almost all (94 %) of opioid users and more than the half of amphetamine users (63 %) inject the drug [Statistical Bulletin TDI-17].

Figure 48:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 49:
Number of direct drug-related deaths (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 DRD 2

Concerning drug-related **infectious diseases** the number of new diagnosed HIV cases with IDU as route of administration decreased significantly since 2003 (see Figure 48). The proportion of IDUs among newly diagnosed HIV cases has decreased gradually and in 2010, 86 cases (31,3 %) were transmitted through injecting drug use. the overall prevalence of HIV among injecting drug users remains high, in 2010, about 6,3 % of the clients of 18 needle and syringe programmes were tested HIV positive. The seroprevalence study conducted in 2007 suggests a HIV prevalence rate among IDUs at 22,6 % [CO].

According the 2007 seroprevalence study the HCV prevalence rate among IDUs was 74,4 %. In 2010, testing of various sub-groups of IDUs indicate HCV prevalence rates from 50 to 58,9 % [CO].

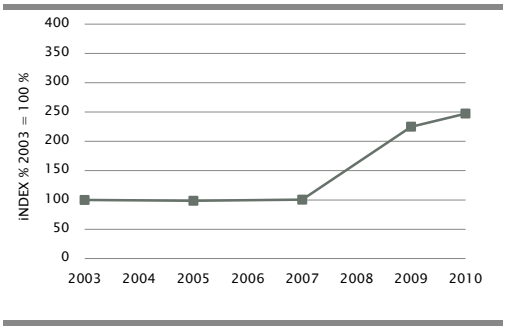
The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased from 2003 to 2008 followed by a decrease (see Figure 49). But the decrease can partly be explained by a decrease of autopsies since 2006.

15.2 Indicators for drug-related harm reduction

The first needle-exchange programme was started in 1997. In 1999, street outreach activities were introduced. By the end of 2009, the network of 18 needle exchange units has been operational in the capital city area (3) and other local municipalities (15). In three sites, mobile needle and syringe programmes are offered [CO]. The number of syringes provided through needle and syringe programmes increased significantly since 2003 (see Figure 50).

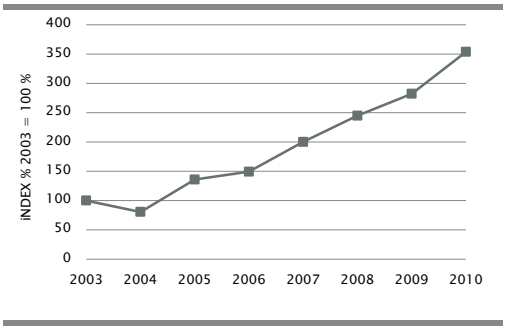
The number of clients in substitution treatment is increasing too (see Figure 51). Although there is a significant increase in the numbers of patients in OST, the increase in absolute numbers is relatively low, i.e. the number of opioid users in OST is among the lowest (or lowest) in the European Union. It is estimated only around 2 % of opioid users have been receiving MMT or HDBT in the last year [GS].

Figure 50:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 51:
Number of clients in substitution treatment (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

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15.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

Latvia's State Programme for the Reduction of Addiction to Narcotic and Psychotropic Substances 2005–2008 was evaluated in 2009. Following this, a new 2011–2017 programme was adopted on 14 March 2011 that covers: prevention, healthcare, supply reduction, policy coordination and analysis of information [GS].

The Health Programme for 2011–2017 was adopted on 27 September 2011. Two of the sub-objectives identified in the Public Health Program are: the reduction of morbidity and mortality from infectious diseases by reducing the negative impacts of risk factors on health, and the effective use of healthcare system management and resources, in order to ensure the optimization of expenditure and sustainability of the healthcare system, as well as equal access for all residents of Latvia to those healthcare services that are funded from the state budget [GS, NR 2011].

The Human Immunodeficiency Virus (HIV) Infection Control Programme for 2009–2013 was adopted on 30 June 2009. This programme aims to limit the spread of HIV infection and ensure that there will be no further increase in the number of new HIV infections [GS, NR 2010].

References [PS]:

Public Health Strategy for 2011–2017 (Ministry of Health 2011): http://phoebe.vm.gov.lv/misc_db/web.nsf/626e6035eadbb4cd85256499006b15a6/ab75e1a6c38b637dc22573d800293aaa/$FILE/POamatnostadnes_eng_pdf.pdf

Human Immunodeficiency Virus (HIV) Infection Control programme for 2009–2013 (Ministry of Health 2009): http://polsis.mk.gov.lv/view.do?id=3061

Drug programme for 2011–2017 (Ministry of Interior 2011): http://polsis.mk.gov.lv/view.do?id=3061

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

In Latvia, telephone help lines, websites and a broad range of educational leaflets promoting risk reduction among drug users are available nationwide [Trimbos 2006].

Information materials to reduce drug harms in night clubs and large music festivals are rare or non-existant. Overdose information materials are available for prison staff only [GS].

The provision of overdose information materials, OD training, safer use training and individual counselling is limited. Risk education and OD response training is available in more than a few relevant cities (but not in a majority of them). The provision of OD risk assessment is rare[23] [SQ 23/29 2011].

At the moment (April 2012) there are 18 counselling points (also needle exchange) in Latvia. Four of them are located in the capital of Latvia in Riga [PS].

23

This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

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Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

In specific geographical regions, communities and families of drug users are involved in the prevention and reduction of health risks associated with drug dependence [Trimbos 2006]. But specific information material on DRD and formal NSP training is not available for other groups [SQ 23/29 2011].

The availability/coverage of information measures targeted at families and communities related to harm reduction is rare [PS].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

There are two major harm reduction responses carried out in Latvia — opiate substitution programmes and a network of low threshold centres (LTCs) for IDUs. The first needle-exchange programme (later LTC) was started in 1997. In 1999, street outreach activities were introduced. By the end of 2009, the network of 18 LTCs has been operational in the capital city area (3) and other local municipalities (15). In three sites, mobile needle and syringe programmes are offered. The network of LTCs is financed by the state and municipalities, as well as additional resources, such as projects which raise funds. Early in 2011, however, the large UNODC-funded project ended which has led to a sharp reduction in a number of street workers operating in LTCs [GS].

The provision of outreach work at night clubs and large music festivals is rare [SQ 23/29 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

In specific geographical areas only, training for peers and volunteers is provided [Trimbos 2006].

Peer educators are involved in the responses to prevent DRD but it is not a priority response. Naloxone is not available on a “take-home“ basis [SQ 23/29 2011].

The United Nations Office on Drugs and Crime (UNODC) implemented the project "HIV/AIDS prevention and care among injecting drug users and in prison settings in Estonia, Latvia and Lithuania" (project time 2006 – 2011). During the project several activities were provided, also trainings for peers and volunteers in outreach work. This lead to many achievements, like – development of counselling and needle exchange services, substitution treatment etc.. Also NGOs (e.g. Jaunatne pret AIDS (Youth against AIDS) provide activities like peer trainings, volunteer work etc. [PS].

Reference [PS]:

Information on Project: http://www.unodc.org/balticstates/en/about/index.html

Information on NGO ,,Youth against AIDS": http://www.jpa.lv/index.php

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Currently, networking and cooperation between outreach work agencies exist in specific geographical areas only [Trimbos 2006].

This policy does not exist because it is not a task for the national government [PS].

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Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Drug-free outpatient and drug-free inpatient treatment are available nationwide and so is treatment with naltrexone. Methadone maintenance and methadone detoxification programmes, treatment with buprenorphine and rehabilitation centres are available in specific geographical areas only. Substitution treatment is supported by psychosocial care upon request by the client. Drug consumption rooms and heroin prescription programmes do not exist in Latvia. Aiming at the reduction of drug-related deaths, opioid substitution treatment (OST) is a predominant response strategy [Trimbos 2006].

In Latvia there are no waiting times in the OST programme but still the number of patients is lowest in the EU. Since 2008/2009 there has been an expansion of availability of OST outside Riga and now MMT is provided in 9 facilities but the numbers of treated drug users outside Riga remains relatively low. Changes in the regulations allow continuing MMT (as of 2012) while inside prison [GS].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Legal framework for OST: Medical doctors at specialised drug treatment centres can initiate and continue methadone treatment, high dosage buprenorphine and buprenorphine-naloxone treatment. Methadone can be dispensed at specialised drug treatment centres. High dosage buprenorphine and buprenorphine-naloxone can be dispensed at specialised drug treatment centres and pharmacies [Statistical Bulletin 2011].

“Take-home” dosage for MMT is available in some cases (based on relationships between doctor and client) but is thought to be rare [SQ 27 p1 2011; GS].

All OST centres work in accordance with the set recommendations (safety issues, etc). Two evaluation reports (surveys) for ST were developed in 2008 and 2011 [PS].

References [PS]:

UNODC. Evaluation of pharmacologically assisted treatment in Latvia, 2011 (http://www.unodc.org/documents/balticstates//Library/PharmacologicalTreatment/MMT_LV_2011.pdf)

UNODC. Evaluation of pharmacologically assisted treatment in Latvia, 2008 (http://www.unodc.org/documents/balticstates//Library/PharmacologicalTreatment/EvaluationPharmaclTreatLV.pdf)

Regulation of the Cabinet of Ministers N429, Procedures for the Treatment of Patients Addicted to Alcohol, Narcotics, Psychotropic and Toxic Substances".

Regulation of the Cabinet of Ministers Nr 70, Procedures for the Treatment of Patients Addicted to Alcohol, Narcotics, Psychotropic and Toxic Substances an Gambling" (January 2012)

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

The distribution of condoms is available in prisons in specific geographical areas only. Measures that aim at the prevention of infectious diseases and/ or reduction of drug – related deaths do not exist in Latvian prisons [Trimbos 2006].

As of 2011/2012 OST is available for inmates that had been in the programme before entering prison. There were 7 clients (September, 2012) who were receiving MMT inside prison. Provision of bleach is done as part of effort to reduce DRID inside prison [GS].

Reference [PS]:

Regulation on the Cabinet of Ministers N70 "Procedures for the Treatment of Patients Addicted to Alcohol, Narcotics, Psychotropic, Toxic Substances and Gambling" (in force since January, 2012.), (http://www.likumi.lv/doc.php?id=243233)

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

To prevent infectious diseases among drug users the predominant response strategies are information, education, communication (IEC) in general, and needle and syringe exchange programmes. Other, common strategies include IEC via counselling by drugs and health professionals, IEC via peer involvement/ peer approach, outreach health education approach and voluntary infectious disease counselling and testing (VCT). Predominant implementation settings for infectious diseases prevention measures targeting drug users include specialised drug treatment services, and low threshold (non treatment) services. A common implementation setting for infectious diseases prevention measures among drug users are outreach work and targeted high risk group interventions [Trimbos 2006].

Hepatitis B is included in the national vaccination strategy. A risk-group specific hepatitis B vaccination programme is not available. The provision of HCV testing is limited. The provision of condoms in injecting kits is full [SQ 23/29 2011].

All medical services are available for Drug users (including treatment and vaccination). Because treatment of previously mentioned diseases is not obligatory (except tuberculosis), level of coverage of the specific services depends on persons own will [PS].

References [PS]:

UNGASS Country Progress Report, Latvia. Reporting period: January 2006 - December2007), http://data.unaids.org/pub/Report/2008/latvia 2008 countrv progress report en.pdf

Ministru kabineta noteikumi Nr.899, „Ambulatorajai ārstēšanai paredzēto zāļu un medicīnisko ierīču iegādes izdevumu kompensācijas kārtība (http://www.likumi.lv/doc.php?id=147522).

Regulation on the Cabinet of Ministers N70 "Procedures for the Treatment of Patients Addicted to Alcohol, Narcotics, Psychotropic, Toxic Substances and Gambling" (http://www.likumi.lv/doc.php?id=243233).

Ministry of Health 18.06.2008 order No. 105 On Establishing Commission for Coordinating the Limiting of Spread of HIV Infection, Tuberculosis and Sexually Transmitted Infections".

Country Progress Report Latvia, Reporting period: January 2010-December 2011.

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

NSPs are a priority response to prevent DRID [SQ 23/29 2011].

Strategy for preventing DRID: The goal of the programme is to limit the spread of HIV infection and to avoid increase in the new HIV cases. Five strategic objectives were identified to reach the goal of the programme:

- Reduce new HIV cases among main groups-at-risk (IDU, prisoners) through targeted HIV prevention activities and through promoting changes in HIV risk related behaviour;
- Implement wider prevention strategies among general population;
- Improve quality of life of PLWHA through provision of health and social care as well as avoiding stigma and discrimination;
- Generate and use evidence for response planning and implementation management;
- Strengthen national coordination capacity to respond to HIV and AIDS [SQ 23/29 2011].

Thanks to successful cooperation between UNODC and government and municipal authorities, as well as the non-governmental sector, it has been possible to increase the number of NSPs nationally, from 12 in 2007 to 18 in 2010, and to increase the number of syringes issued per IDU from 7 in 2006 to 17 in 2010 [GS; NR 2011].

LTCs provide a wide range of low-threshold services: needle exchange, outreach, voluntary HIV counselling and testing (VCT), viral hepatitis C testing, disinfectants, condoms, group and individual risk reduction information, education, etc. In 2010, approximately 311.000 syringes were distributed through the programmes [GS]. The provision of injecting kits through drug agencies is very rare. NSPs are not available in pharmacies [ST 10 2011; GS].

Reference [PS]:

No.437 "Order on Adopting Programme for Limiting Spread of HIV Infection 2009-2013" (adopted 30 June 2009, CoM); Par cilvēka imūndeficīta (HIV) infekcijas izplatības ierobežošanas programmu 2009-2013 gadam:
http://polsis.mk.gov.lvfi/iew.do?id=3061

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MK rīkojums Nr. 98 .Narkotisko un psihotropo vielu un to atkarības izplatības ierobežošanas un kontroles pamatnostādnes 2011-2017 gadam".
http://polsis.mk.gov.lv/wiew.do?id=3601

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Naloxone is included in the State Drug Registry (maintenance of the Registry is the duty of the Latvia State Agency of Medicines, www.zva.gov.lv). Naloxone is part of standard ambulance equipment. Ambulance personnel are trained in naloxone use. Naloxone is available on medical prescription. The use of naloxone is defined only for the ensuring of medical aid at planned out-of-hospital delivery (Republic of Latvia, Cabinet Regulation No. 611, Adopted in 25 July 2006, Order of the ensuring of the medical aid at delivery, Attachment No 2, Mandatory equipment for planned out-of-hospital delivery) [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

The Primary healthcare programme is integrated in General programme of healthcare service developement 2005-2010. But no issue related to the healthcare of drug users or people in drug treatment is mentioned [SQ 28 2010].

The accomodation needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan or in the National Drug Strategy. In National Social Protection and Social Inclusion Plan drug users are addressed as socially vulnerable group. But no programmes or activities for issues like housing, education, primary healthcare have been planed or implemented [SQ 28 2010].

The Council is the coordinating State body whose primary role is to coordinate the operations of government agencies, municipalities and non-governmental organizations in controlling the legal movement of drugs and precursors, and in preventing and restricting their illegal circulation, and addiction to drugs. The Council is also responsible for development, implementation and evaluation of the National Drug Programme

2011–2017. Head of the Council is the Prime Minister. The Coordinator of the Council and National coordinator is one person. It is reported that the coordination system that was implemented in 2004 practically is not working, and a new coordination system should be produced. One of the main activity mentioned in National Drug Programme 2011–2017 is to develop new recommendation for coordination at national/regional and inter-sectoral level. There is no specific programme or an institution related to reintegration of drug users. The social rehabilitation is related to the State Agency of Social Integration that is branch of the Ministry of Wellfare [SQ 28 2010; GS].

There are no protocols underpinning interagency coordination partnerships. There are no partnership agreements between the social services and the health services to meet the needs of drug users in treatment. The most common mechanism of interagency coordination is the informal network [SQ 28 2010].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Formal NSP trainings for low threshold centres/ NSP staff are available [SQ 23/29 2011; GS].

A major contribution to increasing the scope of the harm reduction programme in Latvia has been methodological and financial support provided by the UNODC for the project *HIV/AIDS prevention and care among injecting drug users and prison settings in Estonia, Latvia and Lithuania*, which has been implemented since late 2006, and which ended in early 2011. Within the project prison and police staff have been trained on different harm reduction programmes. Besides teaching material *Reducing risk among drug users in prisons* was translated and adapted into the Latvian language, and prison staff were trained in the use of this material [GS; NR 2011].

Occupational standards for drug treatment are available for medical doctors only. A national system for continued education is available for nursing staff and medical doctors [SQ 27 P2 2008].

Specialised courses on drug treatment are implemented for nursing staff, psychiatrists, medical doctors and narcologists [SQ 27 P2 2011].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

This policy does not exist because it is not a task for the national government [PS].

National guidelines of qualitative counselling are available. The institution responsible for developing HR guidelines is Infectology Center of Latvia. (http://www.lic.gov.lv) [SQ 23/29 2011].

There are guidelines on treatment [Best Practice Portal]:

» Clinical guidelines for psychosocially assisted pharmacological treatment with methadone and buprenorphine of persons dependent on opioids (2009)
» Clinical guidelines for drug and alcohol addiction treatment (2005)
» Guidelines for the Treatment of Misuse and Dependence on Sedative Medications.

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

The final evaluation of the National Drug Programme for 2005-2008 and its results were taken into account in drafting the new Drug Programme for 2011-2017 and for defining tasks and achievable results.

Also Human Immunodeficiency Virus (HIV) Infection Control Programme for 2009-2013 was based on informal needs assessment produced by a working group of experts [GS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

This policy does not exist because it is not a task for the national government [GS; PS]. Evaluation aspects are not included in the guidelines [SQ 27 P2 2008]. Drug treatment outcomes are not evaluated. There is no national research programme for evaluation. There are no relevant research projects on treatment in the last two years [SQ 27 P2 2011]. Only in rare cases is evaluation of the effectiveness of prevention interventions undertaken. This situation is explained by the lack of funding and capacity [GS; NR 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

This policy does not exist [GS], but quality criteria are used in evaluations to a large extent [PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Since 1 April 2012 the Centre for Disease Prevention and Control is a Reitox National Focal Point in Latvia and the collection of information according EMCDDA requirements is included in the Statutes of the Centre and the State programme on Drug Control and Drug Addiction Restriction 2011-2017 [GS].

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Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The final evaluation of the National Drug Programme for 2005-2008 and its results were taken into account in drafting the new Drug Programme for 2011-2017 and for defining tasks and achievable results. In 2014 a midterm evaluation of the national drug programme for 2011- 2017 is planned. The Ministry of Interior is responsible for implementation as well as for evaluation of the drug programme [GS].

Within UNODC project evaluation of MMT was performed twice in 2008 and 2011 [GS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

This policy does not exist because it is not a task for the national government. [Trimbos 2006; PS]. However trainings on evaluation methods are provided by different international organizations like UNODC and EMCDDA [GS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

This policy does not exist because it is not a task for the national government [Trimbos 2006; PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

This policy exists and was based upon the Council Recommendation. Latvia participated in the ESPAD Survey 2003, 2007 and 2011 [Trimbos 2006; GS].

Latvian National Focal Point is taking part in EMCDDA IPA4 project "Preparatory measures for the participation of the candidate and potential candidate countries in the EMCDDA" as Reitox Coach for Kosovo (under UNSCR 1244/99) [GS].

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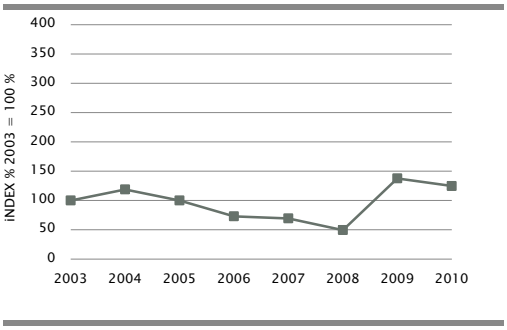
16 Country Profile Lithuania

16.1 Indicators for drug-related harm

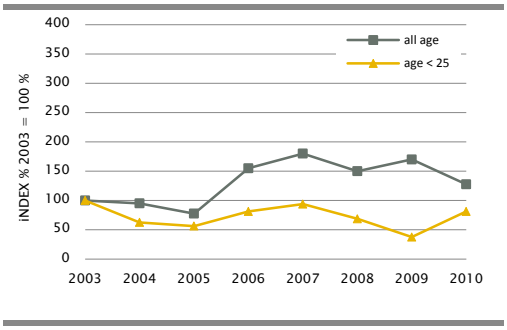
Using the capture-recapture method, there were estimated to be around 2.167 **problem drug users** (1.663-2.934) in Vilnius in 2007 (a rate of 4,1-7,3 per 1.000 inhabitants aged 15-64). A provisional estimate of around 4.300 problem drug users and around 3.200 injecting drug users was constructed for the whole country in 2006 [CO]. More recent estimtates come to a slightly higher estimate for 2007 and resulted in 5.458 problem drug users (95 percent CI (Poisson) 5.314 – 5.605). The times series of the prevalence estimates of problem drug users in Lithuania per 1.000 population in the age group of 15 – 64 years in 2005, 2006 and 2007 show a stable trend. i.e. in 2005 – 2,3 problem drug users per 1.000 population in the age group of 15 – 64 years, in 2006 – 2,5, and in 2007 – 2,4 [NR 2011]. In Lithuania, the data collection system for treatment demand is under development. On 31 December 2010, the healthcare institutions have records of approximately 6.056 individuals registered clients with dependence disorders caused by drugs and psychotropic substances. The largest groups of clients have opioids (80 %) and multiple drugs or other psychoactive substances (13 %) as primary drug. Almost all (99 %) opioid users inject the drug [NR 2011].

Figure 52:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 53:
Number of direct drug-related deaths (indexed – 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

Concerning infectious diseases in 2010, 153 new HIV cases were diagnosed. Among the new HIV cases, 106 (69 %) of individuals were infected with HIV by using injecting drugs, 17 % during the heterosexual intercourse, 3 % during the homosexual intercourse and 11 % whose way of infection is unknown. While the number of persons

newly registered to be HIV-positive stating to have been infected via IDU decreased from 2004 to 2008 in the last years there is an increase (see Figure 52). A survey conducted among 400 active IDUs in Vilnius resulted in a prevalence rate of 8 % for HIV and of 95 % for HCV [NR 2011].

The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased since 2005 and stays on a quite high level compared to 2003 since 2007 (see Figure 53).

16.2 Indicators for drug-related harm reduction

In Lithuania, the implementation of syringe/needle exchange programmes for injecting drug users were started a decade ago. In 2010, in Lithuania 11 harm reduction services units (incl. syringe and needle exchange) were available. The number of syringes distributed is decreasing markedly since 2003. For 2009 and 2010 there are no 100 % coverage data available but in the national report further decrease is notified (see Figure 54 and NR 2011).

The number of clients in substitution treatment is increasing (see Figure 55). On 31 December 2010, the healthcare institutions have records of approximately 6.056 individuals registered with dependence disorders caused by drugs and psychotropic substances [NR 2011, GS].

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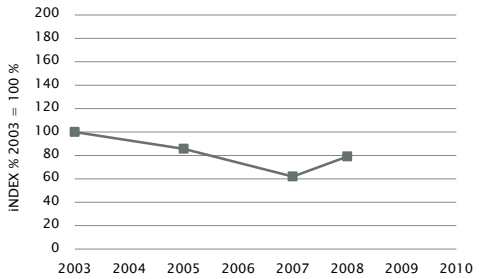
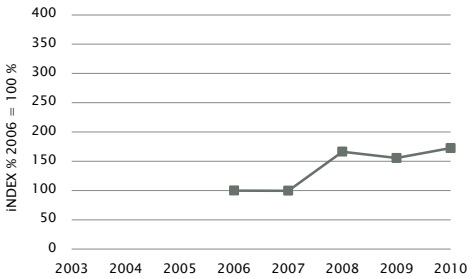
Figure 54:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 55:
Number of clients in substitution treatment 2003 to 2009 (indexed – 2006=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

16.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

Harm reduction is a policy objective in Lithuanian Public Health. The general aims for harm reduction were adopted in the National Plan on Drug Control and Prevention 2004–2008, which was adopted in 2004 [Trimbos 2006].

A DRD strategy is part of the national drug strategy. Objectives are to reduce the number of drug-related infectious diseases and deaths caused by drug addiction [SQ 23/29 2008 and 2011].

References [PS]:

National programme on Drug Control and Prevention of Drug Addiction 2004 - 2008, approved by the Lithuania Seimas (parliament) (2004): Valstybės Žinios, 2004.04.21, Nr.58- 2041: http://www3.lrs.lt/pls/inter2/dokpaieska.showdoc_l?p_id=251981

National programme on Drug Control and Prevention of Drug Addiction 2010 - 2016, approved by the Lithuania Seimas (Parliament) (2010; rev. 2012): National Program on Drug Control and Prevention of Drug Addiction 2010-2016 adopted by Resolution No. XI-1078, of November 4, 2010, of the Parliament of the Republic of Lithuania: http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=385362&p_query=&p_tr2=

Programme of Addictive Disorders 2005-2008, 2009-2012, approved by the Minister of Health (2005; 2008): Valstybės Žinios, 2009.02.21, Nr.: 20- 803; Valstybės Žinios, 2009.01.13, Nr.: 4-108: http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=253300&p_query=&p_tr2=

Action Plan on Drug Control and Prevention of Drug Addiction programme 2010 - 2016, approved by the Lithuania Seimas (parliament)(2011): Valstybės Žinios, 2011.11.10, Nr.: 134-6359: http://www3.lrs.lt/dokpaieska/forma_l.htm

National Mental Health Strategy, approved by the Lithuania Parliament (2007): Valstybės žinios, 2007-04-14, Nr. 42-1572: http://www3.lrs.lt/pls/inter3/ dokpaieska.showdoc_l?p_id=295147&p_query=&p_tr2=2

National programme on HIV/AIDS control and prevention 2003-2008, approved by the Lithuania Government; http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=219430&p_query=&p_tr2=

National programme on control and prevention of HIV/AIDS and sexually transmitted infections 2010-2012, approved by the Lithuania Government more information: http://www.ntakd.lt/en/facts-numbers/

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

Information, education and communication (IEC) via counselling by drugs and health professionals, and IEC via peer involvement/ peer approach are predominant response strategies to prevent infectious diseases among drug users, whereas IEC in general is a common response strategy [Trimbos 2006].

With regard to the reduction of drug-related deaths, the dissemination of information materials is the predominant response strategy. Information materials are predominantly disseminated at low threshold agencies and needle and syringe exchange programmes and are common in specialised drug treatment centres and detoxification services [Trimbos 2006].

The provision of information materials to reduce drug harms in night clubs is extensive and in large music festivals is limited[24] [SQ 23/29 2011].

The provision of overdose information materials is full. The provision of individual counselling is full. Risk education and OD response training is available in nearly all relevant cities or towns. Overdose information materials are available for police, prison staff, family/ friends and night club staff [SQ 23/29 2011].

A legal basis for these programmes was established in Decree No. V-584, of July 5, 2006, of the Minister of Health of the Republic of Lithuania On Approval of Profile of the Implementation Procedures for Drug and Psychotropic Substance Drug Reduction Programmes (Žin., 2006, No. 77-3020, 2008, No. 46-1743). This legislation establishes the mandatory package of services for injecting drug users: syringe/needle exchange, distribution of disinfecting tools, distribution of condoms, health education to reduce risk behaviour and providing of information and counselling. This legislation seeks for attraction of drug users and their partners to institutions and organisations providing health and social services, services of adequate quality and qualification, and

24
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

their integration into the society. This legislation is expected to facilitate development of harm reduction services in Lithuania [PS].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Communities and families of drug users are involved in harm reduction in specific geographical areas only; and in specific geographical areas specific information is also available, as well as education and communication for communities and families of drug users [Trimbos 2006].

Overdose information materials are available for families/ friends [SQ 23/29 2011].

Guidelines on IDU motivational interview (Vilnius Center for Addictive Disorder, 2006; http://www.vplc.lt) exist. Educative materials for general society and patients developed by Vilnius Center for Addictive Disorder, 2006 (http://www.vplc.lt) are available in Lithuanian and Russian [PS]. See also 2.1.

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

In Lithuania, street-based outreach work and outreach work at dance parties, raves and clubs is available, but in specific geographical areas only [Trimbos 2006]. Mobile harm reduction programmes (based on the minivans) are available in 2 cities (Vilnius & Klaipeda). Training materials for outreach workers were developed (2005, 2007) [PS].

To prevent infectious diseases among drug users, outreach work as a health education approach is a common response strategy. Outreach work and targeted high-risk group

interventions are a common implementation setting for infectious diseases prevention measures targeting drug users [Trimbos 2006].

Low threshold agencies, including needle and syringe exchange programmes, and outreach work are the predominant settings for the dissemination of information materials, aimed at the reduction of drug-related deaths [Trimbos 2006]. See also 2.1.

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are involved in the responses to prevent DRID, but peer involvement is not a priority [SQ 23/29 2008 and 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies exists in specific geographical areas [Trimbos 2006].

Collaboration between the low threshold services, social rehabilitation communities and healthcare institutions was developed since 2005. According to data of the Lithuanian Health Information Centre, in Lithuania primary mental healthcare is being implemented by 89 mental healthcare institutions [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychoso-

cial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

The availability of psychosocial out-patient interventions is full, the availability of psychosocial in-patient interventions, detoxification and substitution treatment is extensive. The provision of psychological support to OST clients is full [SQ 27 2011].

There is no waiting time for detoxification and outpatient psychosocial treatment. The waiting time for OST is between 1 and 6 months, due to limited availability/resources [SQ 27 2011].

Drug consumption rooms and heroin prescription programmes are not available in Lithuania [SQ 23/29 2011].

The Law On Amendments to Article 4 of the Law On Social Enterprises of the Republic of Lithuania (Žin., 2010, No. 153-7798) established support to employment in social enterprises of persons dependent on drugs, psychotropic and other psychoactive substances, who have accomplished programmes of psychological social and/or professional rehabilitation, with the unemployment period from the registration date with the labour exchange not exceeding 6 months [PS].

Council Recommendation 2.7

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establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are available nationwide [Trimbos 2006].

Medical doctors at specialised drug treatment centres and psychiatrists can initiate and continue methadone treatment, high dosage buprenorphine or buprenorphine-naloxone treatment. Methadone, high dosage buprenorphine and buprenorphine-naloxone can only be dispensed at specialised drug treatment centres. Patients who are treated at home can be given "take-home" doses. These patients must have a document from a primary healthcare institution which confirms out-patient treatment. Stable patients and patients in critical health conditions can be given "take-home" doses too [Statistical Bulletin 2011 Table HSR-2, SQ 27 2011].

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Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

The implementation of this recommendation is pending for approval [PS].

Drug-related prison health is addressed in the national drug strategy but prisoners are not mentioned as target group in the DRID strategy. But prisoners in Lithuania are understood as a risk group, which is the target group in the DRID strategy [SQ 23/29 2011; GS].

OST is not available in prison. If a person was in methadone maintenance therapy before getting into prison, therapy is interrupted upon entering a prison setting, although no legal obstacles for continuation of the treatment exist [SQ 23/29 2011 and NR 2011].

Overdose information materials are available for prison staff. The provision of pre-release OD counselling is rare [SQ 23/29 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

To prevent infectious diseases among drug users the predominant response strategies are IEC via counselling and advice by drugs and health professionals, IEC via peer involvement/ peer approach, through needle and syringe exchange programmes, and through routine screening of high risk groups. Other common strategies include IEC in general, outreach health education approach and condom promotion among drug users [Trimbos 2006].

Predominant implementation settings for infectious diseases prevention measures targeting drug users include low threshold agencies, prisons, and mass media [Trimbos 2006].

Hepatitis B is included in the national vaccination strategy, but a risk-group specific hepatitis B vaccination programme is not available. Voluntary infectious disease counselling and testing is a priority response [SQ 23/29 2011].

The provision of condoms at drug agencies with NSPs is limited [SQ 23/29 2011].

Based on Decree No. V-646, of September 16, 2004, of the Minister of Health of the Republic of Lithuania On Approval of Children's Vaccination Calendar (Žin., 2004, No. 142-5210), infants and 12 year-old children are vaccinated against viral hepatitis B at the expense of the state, however, in Lithuania no vaccination programmes against viral hepatitis B for injecting drug users exist. Also, Resolution No. 1253 of November 21, 2005, of the Government of the Republic of Lithuania On Approval of the National Program for Prevention and Control of Sexually Transmitted Diseases 2006-2009 (Žin., 2005, No. 138-4973) establishes prophylaxis of hepatitis B for persons in penitentiaries and detention units.

In 2006, the implementation of the Project HIV/Aids Prevention and Supervision among Injecting Drug Users and Prisoners in Lithuania, Estonia and Latvia of the United Nations Office on Drugs and Crime was started. It aims at stopping and reduction of HIV/AIDS epidemics among injecting drug users and prisoners in the three Baltic states. The total budget of the project accounts for 5 million US dollars. The main goal of the projects is to establish favourable environment in all three countries participating in the project in order to better implement HIV/AIDS prevention and supervision activities among injecting drug users and prisoners taking into account regulating policies, capacity strengthening and programme aspects in relation to the national HIV/AIDS prevention activities [PS].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

Needle and syringe exchange programmes are a predominant response strategy to prevent infectious diseases among drug users in Lithuania. Needle and syringe exchange takes place through fixed sites, through vans/ buses, and through outreach workers/ peers, but is not available in prisons [Trimbos 2006].

The provision of NSPs is extensive. Syringe and needle exchange programmes are implemented in 7 cities and are funded from the municipality budget. The provision of condoms at drug agencies with NSPs is limited [SQ 23/29 2011].

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The provision of injecting kits through drug agencies is not available [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Naloxone is regulated by law. Naloxone is available on a “take-home“ basis [SQ 23/29 2008]. Naloxone is part of standard ambulance equipment and ambulance personnel are trained in naloxone use. Naloxone is available on medical prescription [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Lithuania has a national primary healthcare strategy and drug users are explicitly addressed. The accommodation needs of drug users are neither explicitly addressed in the National Social Protection and Social Inclusion Plan nor in the National Drug Strategy. The employment needs of drug users are explicitly addressed in the National Employment Plan [SQ 28 2010].

There are partnership agreements between the social services and the health services to meet the needs of drug users in treatment. The agreements between outpatient treatment facilities and the social services are extensive [SQ 28 2010].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Training for professionals in treatment facilities, needle and syringe exchange programmes and prison staff is available nationwide. Training for outreach workers exists in specific geographical areas. Training programmes for GP's and prescribing physicians in methadone treatment also exist [Trimbos 2006].

Specialised courses on drug treatment are implemented for social workers, nursing staff, psychologists and psychiatrists. There is no national institution, but two centres of Addiction disorders are a clinical base for post-graduate training for doctors [SQ 27 2011].

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Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

There are national guidelines for assessment of infectious disease risks among drug users and for NSPs. There are also national guidelines on pharmacological treatment and psychosocial assisted treatment for both settings, outpatient and inpatient [SQ23/29 and SQ 27 2011].

Existing HR guidelines: [Best Practice Portal]

- Harm reduction programmes (2006)
- Methodological guidelines of outreach workers (2007)
- Mobile services especially for HIV-AIDS vulnerable youth (2005)

Existing treatment guidelines: [Best Practice Portal]

- Early diagnostic and treatment for children who are using drug, psychotropic and other psychoactive substances in primary healthcare institutions (2009)
- Addictive disorders treatment with antagonist naltrexone (for opioid users) (2008)
- Addictive disorders treatment for opioid users with methadone (2009)
- Addictive disorders treatment for opioid users with buprenorphine and buprenorphine/naltrexone (2009)

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006]. Needs assessment is included in funding guidelines of national strategy documents [PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

There is a national research programme for evaluation [SQ 27 P2 2011].

Evaluation aspects are included in the guidelines for pharmacological treatment and psychosocial assisted treatment. Drug treatment outcomes are evaluated in pharmacological treatment and psychosocial assisted treatment [SQ 27 P2 2011].

According to the legislation healthcare institutions assess the effectiveness of substitution treatment at least once a year and send a review to State Mental Health Center [SQ 27 P2 2011]. Evaluation protocols are adopted and are mandatory for all programmes funded from state budget [PS].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

Quality criteria are adopted for maintenance treatment by the order of the Ministry of Health. In Lithuania evaluation quality criteria, taking into account the Recommendations of the EMCDDA are established and implemented. Drug, Tobacco and Alcohol Control Department regularly reports to EMCDDA about the drug situation in Lithuania

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including information on the prevention and reduction of health-related harm associated with drug dependence [PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Since 2011 the Drug, Tobacco and Alcohol Control Department (until 2011 – the Drug Control Department under the Government of the Republic of Lithuania) carries out the functions of the REITOX National Focal Point for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) [PS]..

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

A mid – term evaluation of the National Programme on Drug Control and Prevention of Drug Addiction, approved by the Lithuania Seimas (Parliament) is conducted [PS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

This policy exists, and is based upon the council recommendation. Evaluation training programmes are available to some extent [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

This policy exists and is based upon the council recommendation. Actors and stakeholders are involved in evaluation to some extent [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

This policy exists and is based upon the council recommendation. Official collaboration takes places on the Horizontal Working Party on Drugs, the Pompidou Group, the EMCDDA, Europol and UNODC level [PS].

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17 Country Profile Luxembourg

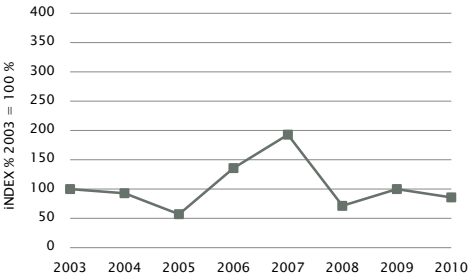
17.1 Indicators for drug-related harm

Prevalence estimates of different types of **problem drug use** are available. The average of estimations performed on 2007 data provides an absolute prevalence of problem so called "high risk drug" users (high risk drugs are opioids, cocaine and amphetamines) of 2.470 persons (C.I. (95 %): 2.089 to 3.199 – 7,67 out of 1.000 habitants aged between 15 and 64 years). For heroin use the prevalence was estimated to be 1.900 (5,9 out of 1.000 habitants aged between 15 and 64 years) and for IDU 1.482 (4,6 out of 1.000 habitants aged between 15 and 64 years). All three types of prevalence are slightly decreasing since 2003 [NR 2011]. Almost all clients in outpatient treatment in 2010 have reported opioids (91 %) as primary drug. In inpatient treatment 76 % of clients have reported opioids as primary drug and 14 % cocaine. According to outpatient treatment data 68 % of opioid users inject the drug (31 % are smoking) [Statistical Bulletin TDI-17].

Regarding infectious diseases in the time span 2003 to 2010 between 1 and 7 of the yearly new registered HIV infected persons stated to have acquired the infection via IDU [Statistical Bulletin INFI-104]. In 2010 IDU was the reported route of HIV infection in 6,4 % of all HIV diagnoses [NR 2011].

HIV rates (self reported data) in current IDUs have been varying since 2003 between 1 % and 6 %. In most recent years there seems to be an increase (2010 7 % to 8 %). HCV rates (self reported data) vary between 59 % and 74 % since 2003 [NR 2011]. A study on prevalence of hepatitis B and C and HIV infections among problem drug users in Luxembourg' assessed for 2005 the serology-based prevalence rate of 71,4 % for HCV, and 2,9 % for HIV [GS[25]]

Figure 56:
Number of direct drug-related deaths (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 DRD 2

25
Origer A, Schmit J.-C. Prevalence of hepatitis B and C and HIV infections among problem drug users in Luxembourg: self-report versus serological evidence. *J Epidemiol Community Health* 2012;**66**: 64-68. doi:10.1136/jech.2009.101378.

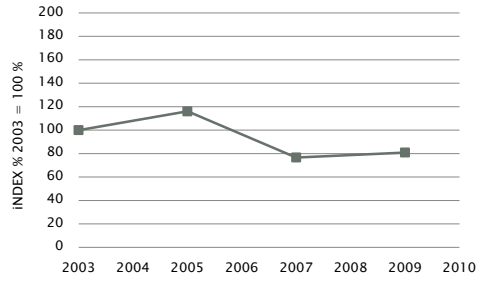
The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased 2006 to 2007 followed by a decrease. In 2010 the number is on level of 2003 (see Figure 56).

17.2 Indicators for drug-related harm reduction

The national needle exchange programme in Luxembourg is decentralised and consists of four fixed sites: drug counselling centres, drop-in centres for sex workers and populations-at-risk, low threshold services and four vending machines situated in the most affected towns throughout the country. One NSP is implemented in prison [CO]. From 2005 to 2007 a decrease of syringes distributed has to be notified. In 2009 the number was on the same level as in 2007 (see Figure 57).

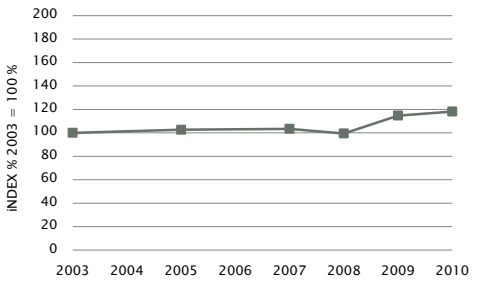
The number of clients in substitution treatment is increasing slightly (see Figure 58). In 2010, 210 clients started an inpatient or outpatient treatment [ST TDI-2]

Figure 57:
Syringes provided through needle and syringe programmes (NSP); (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 58:
Number of clients in substitution treatment (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

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Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

A harm reduction policy exists in Luxembourg [Trimbos 2006]. The national strategy and action plan 2010-2014 rely on two pillars, namely on demand reduction and supply reduction and on four transversal axes: 1. Risk, damage, nuisance reduction, 2. Research and information, 3. International relations and 4. Coordination mechanisms [NR 2011]. A DRD strategy is part of the national drug policy [SQ 23/29 2011].

References [PS]:

Stratégie et plan d'action national en matière de drogues et addictions 2010-2014. Ministère de la Santé (2010). www.ms.etat.lu and www.sante.public.lu

Stratégie et plan d'action national en matière de VIH/sida 2011-2015. Minsitère de la Santé. (2011). www.ms.etat.lu and www.sante.public.lu

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

To prevent infectious diseases among drug users, provision of information, education and communication (IEC) in general, and IEC via counselling and advice by drugs and health professionals are the predominant response strategies. Safer injection training is a common response strategy [Trimbos 2006].

With regard to the reduction of drug-related deaths, the dissemination of information materials and individual risk counselling are the predominant response strategies and predominantly done by specialised drug treatment services and low threshold agencies, including needle and syringe exchange programmes, and commonly in prisons. A common response strategy to reduce drug-related deaths is risk education/ response training for drug users. This training is delivered predominantly at specialised drug treatment services, low threshold agencies, including needle and syringe programmes and through outreach workers, peers; the training is commonly delivered in prisons [Trimbos 2006]. The provision of information materials to reduce drug harms in night clubs and in large music festivals is limited[26] [SQ 23/29 2011].

26
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

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Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

In specific geographical regions (two main cities), communities and families of drug users are involved in the prevention and reduction of health risks associated with drug dependence [Trimbos 2006; GS].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

In Luxembourg, street-based outreach work is available. To prevent infectious diseases among drug users, outreaching health education is a common response strategy. Outreach work and targeted high-risk group interventions are a common implementation setting for infectious diseases prevention measures targeting drug users [Trimbos 2006; GS].

Low threshold agencies, including needle and syringe exchange programmes, and outreach work are the predominant setting for the dissemination of information materials, aimed at the reduction of drug-related deaths. Outreach work is the predominant setting for the deliverance of risk education/ response training to drug users [Trimbos 2006]. There is no recognised professional qualification in outreach work or outreach work management in Luxembourg, nor is it planned [Trimbos 2006].

The availability/coverage of outreach work targeted at drug users is extensive and has strongly increased since 2003 [PS].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peers and volunteers are included in outreach work to prevent DRID. Flyers for saver injection and reduction of drug-related mortality or broadly distributed to users and non-users [GS].

Naloxone is not available on a “take-home“ basis [SQ 23/29 2008].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between agencies involved in outreach work is extensive and has increased since 2003. There are exchange platforms of harm reduction services since 2011. Collaboration conventions are signed between involved stakeholders since 2009 [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

The availability of psychosocial in- and out-patient interventions, of detoxification, of substitution treatment and of psychological support to OST clients is full [SQ 27 2011].

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Luxembourg has a drug consumption room [SQ 27 2011] and a heroin assisted treatment programme is foreseen by the national drugs action plan [Trimbos 2006; GS].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

The grand-ducal decree on substitution treatment of January 30, 2002 established the legal framework for drug substitution treatment at national level and forsees control measure to reduce diversion of substitution substances (e.g. centralised register) [PS].

Duly licensed medical doctors at specialised drug treatment centres can initiate and continue methadone treatment, buprenorphine, buprenorphine-naloxone treatment and slow-release morphine treatment.

During the first two months of treatment, the intake of substitution medications have to be done in face to face situations in pharmacies [Statistical Bulletin 2011 Table HSR-2; GS].

If the client is in a structured programme, "take-home" doses may be possible if the patient is stabilised. If the patient is provided with substitution treatment via freelance licensed MDs, prescription of methadone in pill form can be prescribed for up to 14 days on a "take-home" basis [GS].

One of the objectives of the national drug action plan 2010-2014 is the fight against the diversion of substitution medicaments. A special national substitution register, set up by the Directorate of Health, aims at fighting against the diversion of substitution medicaments as methadone has been increasingly found in drug-related overdose deaths. Each patient receiving substitution treatment has to be notified by prescribing MDs to the register, which allows to rapidly detect multiple prescriptions [GS].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

An officially recognised syringes' distribution programme exists nationwide in prisons. Testing, prevention, education, counselling and treatment of infectious diseases are available nationwide in prisons. Drug paraphernalia, condoms and counselling are also provided nationwide in prisons [Trimbos 2006].

The prison's needle exchange programme has to be further adapted to "prison reality" in order to reach a better coverage [PS]. The provision (initiation and continuation) of OST in prison is full [SQ 27 2011]. The provision of pre-release counselling is part of the so-called "TOX Programe" running in both state prisons [GS].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination strategy. A risk-group specific hepatitis B vaccination programme is not available [SQ 23/29 2011]. Voluntary infectious diseases counselling and testing is a priority response strategy to prevent DRID [SQ 23/29 2011]. HIV and viral hepatitis testing is proposed to all new prisoners nationwide [GS]. The provision of condoms at drug agencies with NSPs is full [SQ 23/29 2011]. Screening for infectious diseases of high risk groups is a predominant response strategy to prevent DRID. A mobile intervention unit for sexual health (DIMPS) provides rapid testing or standard testing for HIV and hepatitis B and C [GS].

Reference [PS]:

Origer A, Schmit J.-C. Prevalence of hepatitis B and C and HIV infections among problem drug users in Luxembourg: self-report versus serological evidence. J Epidemiol Community Health 2012;66:64-68. doi:10.1136/jech.2009.101378.

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

Needle and syringe exchange programmes are a priority response strategy to prevent infectious diseases among drug users in Luxembourg. The provision of NSPs is extensive. NPS is provided by specialist agencies, vending machines and in prison. The provision of condoms at drug agencies with NSPs and in prison is full [SQ 23/29 2011].

Distributed injection paraphernalia includes different types of syringes, spoons, ascorbin, filters for injecting drug users and snorting utensils for cocaine users [GS]. Pharmacy-based NSP is not available in Luxembourg [ST 10 2011, 2010 data].

DRID strategy is part of the national drug strategy. Within the general objective are: Reduction of drug-related risks, damage and nuisances. Specific actions are: Action research on HIV and hepatitis B/C including testing, information and vaccination offers, creation of the first national supervised injection room and a heroin assisted treatment programme [SQ 23/29 2008].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Training programmes for professionals of emergency services are available nationwide. Ambulances routinely carry antagonists. The distribution or administration of naloxone is regulated [Trimbos 2006].

Naloxone is not available on a “take-home“ basis [SQ 23/29 2008; GS].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

The accommodation needs of drug users are explicitly addressed in the National Social Protection and Social Inclusion Plan and they are a priority in the National Drug Strategy. The creation of a socio-professional reintegration centre with accommodation facilities is included in the National Drugs Action Plan [SQ 28 2010; GS].

There are partnership agreements between the social services and the health services to meet the needs of drug users in treatment. The most common mechanism of interagency coordination is the informal network [SQ 28 2010].

The integration between health, including mental health, and social care, and specialised approaches in risk reduction is extensive [PS].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Formal NSP training is available for drug agencies staff and prison staff [SQ 23/29 2011]. Specialised courses on drug treatment are implemented for social workers, nursing staff, psychologists and medical doctors. Specialised NGO budgets foresee resources allocated to training activities for staff members [SQ 27 2011; GS].

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Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

The EMCDDA's EDDRA database has largely contributed to the promotion of a more scientific oriented evaluation approach at the national level. The Ministry of Health has implemented a modified version of the EDDRA questionnaire as a standard for funding requests for and evaluation of drug-related projects [Trimbos 2006].

A close link between the national EMCDDA focal point and the Ministry of Health does exist. The national drugs action plan builds upon national research outcomes and scientific evidence [GS]. There are national quality guidelines on OST (including GPs) [SQ27p2 2008].

A first external evaluation of the national drugs action plan has been performed and outcomes have been integrated together with recommendations from a series of national expert groups and outcomes of user/clients surveys in the elaboration of the new drugs strategy and action plan 2010-2014 [NR 2011].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

An exploratory study on the current situation and needs with regard of prevention in night life settings has been included in the Drug Action Plan 2005 – 2009 [Trimbos 2006]. The first step of the elaboration scheme of successive national drug actions plans is a needs assessment exercise including all nationally involved stakeholders [GS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Specialised NGOs have to prepare on a yearly basis or on demand activity reports containing evaluation data of drug prevention and risk reduction programmes. The Ministry of Health and the NFP promote EDDRA among NGO's. RELIS has implemented standardised evaluation data protocols [Trimbos 2006; GS].

Drug treatment agencies have developed proper evaluation strategies mostly in collaboration with external evaluators. Recent examples are the evaluation of current offers in the field of socio-professional integration, the implementation of a computer based evaluation procedure by the national substitution programme and prevention interventions in schools by CePT [Trimbos 2006].

Although the harm reduction interventions adapt to current professional practices by means of international exchanges and internal quality control measures, external evaluation procedures have to be further developed [Trimbos 2006; GS].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

The national RELIS network aims to implement evaluation quality criteria relating to the recommendations of the EMCDDA [Trimbos 2006; GS].

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Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

The NFP elaborated standardised data protocols for specialised in-and outpatient treatment centres, low threshold agencies, general hospitals, law enforcement agencies and national prisons according to EMCDDA recommendations [Trimbos 2006]. A nationald drug report is published on a yearly basis and broadly distributed [GS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The RELIS database on problem drug users provides relevant data for evaluation purposes since it includes detailed data on drug consume patterns, socio-economic situation, risk behaviour and treatment or law enforcement contacts, etc. In the long run, drug 'careers' can be analysed by means of the RELIS indexing system, which allows following up treatment demands and law enforcement contacts of indexed drug users. These data can be used to assess the impact and the performance of specific treatment approaches. A practical example of the application of evaluation results is to be seen in the conceptualisation of the National Drug Action Plan 2000-2004, which did to a large extent rely on RELIS data and ad hoc evaluation initiatives from field institutions [Trimbos 2006].

According to EMCDDA's key indicators and with a view to improve quality of national data on infectious diseases, the NFP has set up an action-research plan (2002-2004) with the objective to estimate HCV and HIV prevalence in recent drug injectors based on medical diagnosis data (blood sample testing) and to implement required healthcare infrastructures [Trimbos 2006].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Training interventions in drug demand reduction are increasingly developed at national level. The CePT publishes an annual training directory including training activities ranging from evaluation methodologies to demand reduction action-research strategies targeted at drug prevention and public health actors, educators, youth animators and teachers. The 'Recherche et Innovation Pédagogiques et Technologiques (SCRIPT)' department is actively involved in the referred training activities [Trimbos 2006].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006]. An external evaluation of the national drugs action plan was performed in 2009. Most actors and stakeholders were involved at different moments and levels in this exercise [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

The Mondorf Group is currently working out a proposal for an interregional training and job opportunity network for former or current drug addicts. The project is meant to share knowledge, resources and good practice between border regions (Luxembourg, Germany, France and Belgium). Furthermore, synergies between the Ministry of Health and the Ministry of Employment have been set up in the framework of the EU programme: EQUAL 2000-2006 [Trimbos 2006; GS].

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18 Country Profile Malta

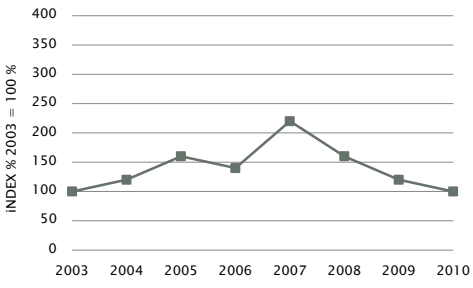
18.1 Indicators for drug-related harm

Concerning **problem drug use** in 2006 the estimated number of daily heroin users stood at 1.606 (95 % confidence interval 1.541 to 1.685). The rate per 1.000 population aged 15-64 was 5,4 (95 % confidence interval 5,1 to 5,6), displaying relative stability since 2004. In 2010 the estimated number of daily heroin users was slightly higher than in 2006: 1.755 (95 % confidence interval 1.643 to 1.891). The rate per 1.000 population aged 15-64 was 6,1 (95 % confidence interval 5,7 to 6,5) [NR 2011]. The largest groups of clients in outpatient treatment in 2010 have opioids (81 %) and cocaine (11 %) as primary drug [Statistical Bulletin TDI-19]. According outpatient treatment data 61 % of opioid users inject the drug (31 % are smoking it) [Statistical Bulletin TDI-17].

The most recent available information on infectious diseases among injecting drug users (IDUs) is derived from the methadone dispensing Substance Misuse Outpatients Unit (SMOPU) and prison unit (CCF). In 2009, no HIV infections were found among 125 tested IDUs and 31 % out of 121 injecting drug users tested positive for HCV. In 2010, 183 tests were conducted, of which 54 (30 %) resulted positive for HCV and none positive for HIV [NR 2011]. Prevalence rates seem to be stable on a very low level.

The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased till 2007 followed by a decrease. In 2010 the number of drug-related deaths is on the same level as in 2003 (see Figure 59).

Figure 59:
Number of direct drug-related (indexed - 2003=100 %)



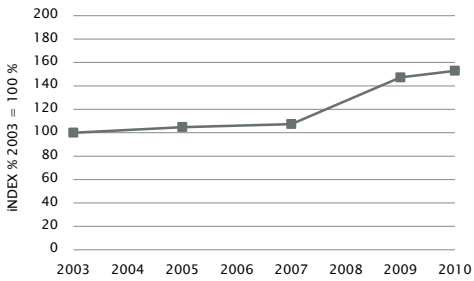
Source: EMCDDA Statistical Bulletin 2012 DRD 2

18.2 Indicators for drug-related harm reduction

Since syringe distribution started in Malta in the 1980s, reaching nationwide coverage in 1994, the number of syringes distributed yearly has risen steadily (see Figure 60). In 2010 the total number of syringes distributed was 321.361 [NR 2011].

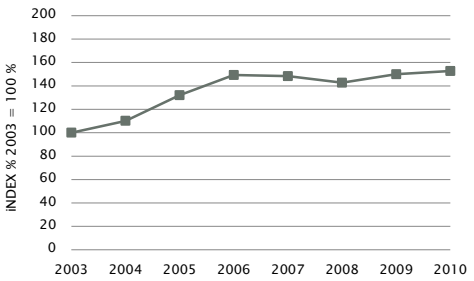
The number of clients in substitution treatment was increasing till 2006 and stable since then (see Figure 61). In 2010 1.936 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 60:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 61:
Number of clients in substitution treatment (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

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18.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

In February 2008, Malta launched its first National Drug Policy with the aim to provide for a more coordinated mechanism through which the supply and demand for drugs are reduced as much as possible in the best interest of society. The policy contains 48 policy actions which are distributed over different sections:

» – Coordination of National Drug Policies
» – Legal and Judicial Framework
» – Supply reduction
» – Demand reduction
» – Monitoring, Evaluation, Research, Information and Training
» – The International Perspective
» – Funding

In 2011 the National Commission on the Abuse of Drugs, Alcohol and other Dependencies (NCADAD) and the National Coordinating Unit for Drugs and Alcohol (NCUDA) conducted a review of the 48 policy actions contained in the National Drugs Policy, with the aim to evaluate the status of each action and set priorities and a plan of action for the implementation of the policy actions [PS].

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

With regard to the reduction of drug-related deaths, risk education/ response training is the predominant response strategy. This training is delivered predominantly at specialised drug treatment services. Training for drug users promoting risk reduction is available in Malta at an individual basis for those who attend the Outpatient Unit [Trimbos 2006].

In Malta, a broad range of educational leaflets is available nationwide [Trimbos 2006]. The provision of overdose information materials is full. The provision of information materials to reduce drug harms in night clubs and in large music festivals is rare [SQ 23/29 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

The involvement of families of drug users is considered an integral part of the services provided by agencies dedicated to provide services for drug users, with services providing assistance to families through dedicated family units [PS].

Overdose information materials are not available for families/ friends [SQ 23/29 2011].

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Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach work began in all agencies in 2002 and has not seen any further development with the exception of presence of drug agencies in major local entertainment events (dance parties organized locally) [PS].

The provision of outreach work at night clubs is rare and in large music festivals is limited [SQ 23/29 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peers and volunteers are not included in outreach work practice [Trimbos 2006]. Peer educators are not involved in the responses to prevent DRID [SQ 23/29 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Outreach work is very limited in Malta, as a consequence there is not much cooperation taking place along these lines [GS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Methadone maintenance programmes and methadone detoxification programmes are available nationwide. Further, there are rehabilitation centres, drug-free outpatient and inpatient centres, and one drop-in centre [Trimbos 2006].

Buprenorphine is available as an alternative to methadone since 2006 [NR 2011]. Naltrexone is provided in specific geographical areas only. Substitution treatment is supported by psychosocial care upon request by the client [Trimbos 2006].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Malta has a centralized system of substitution treatment provision, with SMOPU being the only authorized distributer of methadone. The service is widely available for drug users needing the service. Also methadone treatment which takes place on site is highly supervised. Only a limited number of clients receive “take-home“ doses of methadone, and only in cases were rigorous criteria established by the agency are met fully by the client [PS]. Patients qualifying for “take-home“ doses of substitution treatment must be over the age of 18 years, show stability while attending for methadone treatment and adhere to a list of criteria which is set by SMOPU (National Agency for Substitution Treatment) [SQ 27 2011].

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Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Methadone maintenance (initiation and continuation) and methadone detoxification programmes and counselling are available in one Maltese prison. Other harm reduction interventions do not exist in Maltese prisons [Trimbos 2006 and SQ 27 2011].

The availability of HCV testing on entry into prison is full. A hepatitis B vaccination programme for drug users is available in prison [SQ 27 2011].

Pre-release OD counselling for drug users and overdose information materials for prison staff are not available. Naloxone is not provided upon prison release [SQ 27 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination strategy. There is also a risk-group specific hepatitis B vaccination programme available which is -together with voluntary infectious diseases counselling and testing - a priority response to prevent DRID [SQ 23/29 2011].

The availability/coverage of screening for sexually transmitted diseases among injecting drug users and their immediate social networks is extensive [PS]. The provision of HCV testing is full [SQ 23/29 2011]. Provision of condoms at drug agencies with NSPs does not exist [SQ 23/29 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

Needle and syringe programmes are a priority response strategy to prevent infectious diseases among drug users in Malta. Malta has 8 fixed locations for the distribution of syringes [ST 10 2011], injecting kits are not available. Needles and syringes are not available in pharmacies. Provision of condoms at drug agencies with NSPs does not exist [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Maltese ambulances routinely carry antagonists. Naloxone on a "take-home" basis is not available [Trimbos 2006]. Naloxone is regulated by administrative regulation. The use of naloxone is limited to medical personnel [SQ 23/29 2011]. There is only one Emergency Department on the island with the required trained staff to deal with drug over dose [PS].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Malta has a national primary healthcare strategy and drug users are explicitly addressed. Accomodation, educational and employment needs are not explicitly addressed in the National Social Protection and Social Inclusion Plan or in the National Drug Strategy [SQ 28 2010].

There are partnership agreements between the social services and the health services to meet the needs of drug users in treatment. The most common mechanism of interagency coordination is the informal network [SQ 28 2010].

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Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Training in this area is mainly conducted as in-house training as part of the staff development policies taken up by the agencies involved in drug service provision. Additionally, a number of university courses, mainly in the social and psychology and youth studies fields, have course components dedicated to addictive behaviour [PS].

Formal NSP trainings are available for drug agencies staff only [SQ 23/29 2011].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

This policy exists, scientific evidence is used as basis to select interventions to some extent [PS]. Currently no national guidelines concerning drug treatment exist. Malta currently uses the UK NICE guidelines as point of reference [SQ 27 p2 2011].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

This policy does not exist, but is pending for approval [Trimbos 2006, PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

This policy does not exist, but is pending for approval [Trimbos 2006; PS].

Evaluation aspects are not included in guidelines. Drug treatment outcomes are not evaluated. There is no national research programme for evaluation. There are no relevant research projects on treatment in the last two years [SQ 27 p2 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

In 2004, the Malta National Focal Point was set up in order to establish a common way of collecting, inputting and interpreting data that can be used for monitoring and evaluative purposes [Trimbos 2006]. This policy does not exist [PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Since 2003 Malta, through the National Focal Point for Drugs and Drug Addiction, has been collecting data on the drug situation and has been contributing to EMCDDA through such reporting of data. A network of professionals from different disciplines in the drugs field, contribute to the compilation of these data [PS].

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Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

This policy exists, evaluation results are used for further development of drug prevention policies to some extent [PS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

This policy does not exist [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

This policy exists, actors and stakeholders are involved in evaluation to some extent [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

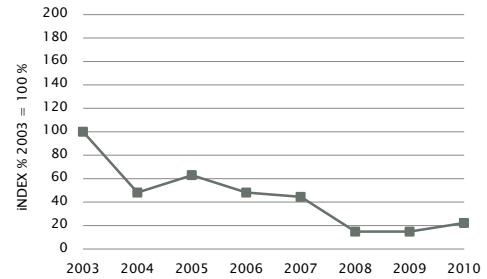
This policy exists, professionals have access to opportunities for exchange of programme results, skills and experience at European level to a large extent [PS].

19 Country Profile Netherlands

19.1 Indicators for drug-related harm

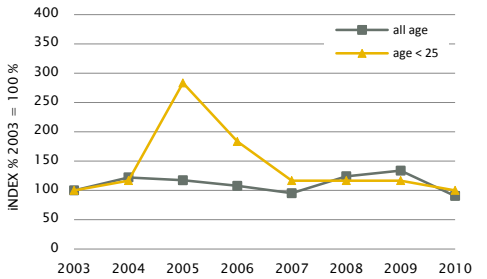
Several national studies have estimated the number of **problem opiate users** in the Netherlands over the past 20 years using different methods. In 2008, the most recent estimate suggests a total of 17.700 opiate users in the Netherlands (95 % confidence interval from 17.300 to 18.100). Available data indicate a decline in the estimated number of opiate users since the beginning of the century [NR 2011, CO]. The largest groups of clients in treatment in 2010 have cannabis (45 %) cocaine (26 %) and opioids (15 %) as primary drug [Statistical Bulletin TDI-19]. According treatment data just 7 % of opioid users and 1 % of cocaine users inject the drug (opioids: 77 % are smoking; cocaine: 58 % sniff and 41 % smoke the drug) [Statistical Bulletin TDI-17].

Figure 62:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 63:
Number of direct drug-related deaths (indexed - 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

Concerning **infectious diseases** the number of new diagnosed HIV cases with IDU as route of administration decreased significantly since 2003 (see Figure 62). In 2010, 826 new HIV diagnoses were reported. In 5 cases (0,6 %) injecting drug use was the most likely route of transmission [NR 2011]. Several non systematic sources of data show a HIV-prevalence of 0 % among IDUs in 2010. Treatment data show a HCV-prevalence between 48 % and 67 % among IDUs [NR 2011].

The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** is more or less stable with little peaks in 2004/2005 and 2008/2009 (see Figure 63) [NR 2011]. In the group aged <25 there was a notable increase in 2005).

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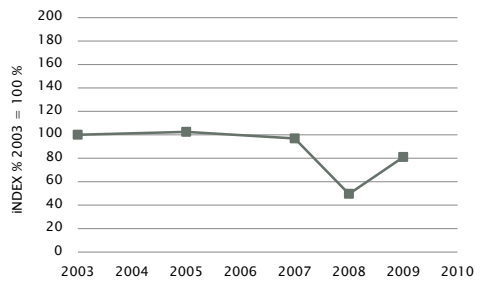
19.2 Indicators for drug-related harm reduction

Facilities for needle exchange or syringe exchange exist for more than 20 years in the Netherlands and are available in all major Dutch cities. Needle exchange programmes are mainly implemented by street workers, workers of institutes for addiction care and, to a much lesser extent, by pharmacists. Around 175 fixed needle and syringe programmes are known in the Netherlands (150 in specialist agencies and 25 pharmacy-based needle and syringe exchange programmes). There is no national registration data on the number of exchanged syringes or needles. However, data from Amsterdam show that from 1990 to 1993, approximately one million needles were exchanged. Since 1993, there has been a sharp decline to 153.600 in 2010 [CO, NR 2011].

The number of clients in substitution treatment is decreasing (see Figure 64) In 2010 12.919 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 64:
Number of clients in substitution treatment
(indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

19.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

The Netherlands has a long-lasting history regarding harm reduction, which pre-exists the Council Recommendation with several decades. Drug policy in the Netherlands has four major objectives: 1) prevention and treatment; 2) harm reduction; 3) maintenance of public order (i.e. reducing public nuisance caused by drug users; 4) supply reduction [Trimbos 2006].

The Netherlands do not have one single National Drug Strategy, but drug policy has been formulated in a number of policy documents. One of the most comprehensive documents is titled: 'Continuity and Change'. This document summarised the Netherlands Drug policy as it had been developed until 1995 and formulated the objectives for the next decade. It might - in general - be regarded as the Dutch Strategy on Drugs. This policy document has seen progress reports in 1996, 1999 and 2001. Many of the Dutch harm reduction interventions and activities have been developed in the seventies and eighties already, often at local level and based upon a pragmatic approach. Many of these local activities have seen follow up in other cities and areas of the Netherlands and have been adopted in official policy. Not all policy actions have been explicitly written down in policy texts, but sometimes adopted in funding guidelines, etc. [Trimbos 2006].

In May 2011, the new government announced its objectives for the near future in a special drugs policy letter (TK 24077-259): http://www.rijksoverheid.nl/onderwerpen/drugs/documenten-en-publicaties/kamerstukken/2011/05/27/kamerbrief-over-ontwikkelingen-van-het-nederlands-drugsbeleid.html. The main advices of the Advisory Committee on Drugs Policy from 2009 are endorsed (Adviescommissie Drugsbeleid, 2009) [NR 2011; PS].

In the new Opium Act Directive the objective of the drug policy is described as: 'The [new] Dutch drugs policy is aimed to discourage and reduce drug use, certainly in so far as it causes damage to health and to society, and to prevent and reduce the damage associated with drug use, drug production and the drugs trade' (Stc 2001, 11134) [NR 2011].

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A DRD strategy is part of the national drug strategy. The objectives are: prevention of social exclusion of drug users and problem drug users, in order to prevent problem drug use in the first place and second the acute drug-related deaths that may result thereof. Actions are: universal prevention campaigns like 'The Healthy School and Drugs', targeted prevention and harm reduction for drug users and safe user rooms (injection rooms) for users of hard drugs like opiates, cocaine, and amphetamines [SQ 23/29 2011].

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

To prevent infectious diseases among drug users, information, education, communication (IEC) in general, and IEC via counselling and advice by drugs and health professionals are predominant response strategies. In the Netherlands, telephone help lines, websites and pill-testing are available nationwide. Training and information leaflets are available in specific geographical areas only [Trimbos 2006].

With regard to the reduction of drug-related deaths, the dissemination of information materials is the predominant response strategy: materials are predominantly disseminated at low threshold agencies, and needle and syringe exchange programmes, and they are commonly disseminated through specialised drug treatment services, mass media/ internet, and at rave events and festivals [Trimbos 2006].

The provision of safer use, overdose information materials, OD trainings and OD risk assessment is extensive[27]. Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for prison staff and night club staff [SQ 23/29 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Communities and families of drug users are involved nationwide in the prevention and reduction of health risks associated with drug dependence, whereas collaboration with professional harm reduction agencies is available in specific geographical areas only [Trimbos 2006].

It is still a challenge to reach the target population, e.g., children of addicted parents. In addiction care, the primary focus is still on the client/ patient self, and not so much on his/her family members [PS].

Overdose information materials are available to all people but there is no specific material for families/ friends or other groups [SQ 23/29 2011; GS].

27
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

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Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

To prevent infectious diseases among drug users, outreach work as a health education approach is a common response strategy. Outreach work and targeted high-risk group interventions are a common implementation setting for infectious diseases prevention measures targeting drug users [Trimbos 2006].

Low threshold agencies, including needle and syringe exchange programmes, and outreach work are the predominant setting for the dissemination of information materials, aimed at the reduction of drug-related deaths. Outreach work/ peer approach ia also a predominant setting for the deliverance of risk education/ response training [Trimbos 2006].

The provision of outreach work at night clubs is rare and in large music festivals it is extensive [SQ 23/29 2008].

There is a strong increase in active case management in several regions. Methadone clients are visited at home by the addiction care professional for supply of methadone. At the same visit, several aspects of the client's life are discussed (financial, family affairs, daily activities etc) in order to lead them to a socially accepted life [PS].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Training for peers and volunteers is organised nationwide. Peers and volunteers are included nationwide in outreach work practice [Trimbos 2006].

Naloxone is not available on a “take-home“ basis [SQ 23/29 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies exist nationwide in the Netherlands [Trimbos 2006].

There is no change since the report in 2005. The addiction care institutes have central meetings for information exchange (GGZ Nederland) on a regular basis. The Network of Infectious Disease and Drug Use is still coordinated by the Trimbos institute and Mainline. It provides a platform for information exchange and organises train the trainer courses in infectious diseases prevention. For recreational drug users, the Drugs Information and Monitoring System (DIMS) supports the testing facilities that are provided by the local addiction care institutes. In addition to the DIMS, since 2009 the Monitor Drugs incidents is collecting information on acute drug use related health incidents. The information collected is distributed in a network of medical services (e.g., ambulances, first aid departments of hospitals, forensic medics and first aid organisations at large parties). The large addiction care institutes in the Netherlands are mostly working according to their own protocols. It is not always easy to cooperate together, or to cooperate with adjacent facilities, such as social work, prison facilities, GPs or hospitals [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Methadone maintenance programmes and methadone detoxification programmes are available nationwide. Drug-free outpatient and drug-free inpatient treatment are also nationwide available. In specific geographical areas only, treatment with buprenorphine, with naltrexone, as well as heroin prescription programmes are available. Rehabilitation centres, drug consumption rooms and drop-in centres/ shelters are also available in specific geographical areas [Trimbos 2006]. Drug consumption rooms are available in 30 cities [SQ 23/29 2008].

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The provision of psychological support to OST clients is extensive [SQ 27 p1 2011].

There is a growing number of (only) cocaine base addicts and it is more difficult to have them in contact with addiction care or social services than it is for heroin addicts [PS].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Medical doctors at specialised drug treatment centres, specialised medical doctors or any medical doctor can initiate and continue methadone, high dosage buprenorphine, buprenorphine-naloxone combination and solw-release morphine treatment. Methadone treatment can also be initialized by medical nurses. . However, this treatment has to be authorised by a doctor. The medical doctor has the lead in the treatment as well as on the dosage, "take-home" dosage or not, etc. [Statistical Bulletin 2011 Table HSR-2; GS].

Methadone, high dosage buprenorphine, buprenorphine-naloxone combination and solw-release morphine can be dispensed at specialised treatment centres, specialised medical doctors' offices and any medical doctor office. In addition methadone can also be dispensed at mobile outreach units [Statistical Bulletin 2011 Table HSR-2].

In recent years, several addiction care institutes changed to supply of melting methadone tablets [PS].

The Guideline Opiate Substitution Treatment states the possibility of "take-home" doses only in case of holidays. It mentions that this should depend on the judgment of the professional about the status of the patient and the stability of the dosage (at least 4 weeks stable) [SQ 27 p1 2008].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Methadone detoxification programmes are available nationwide in Dutch prisons. Methadone maintenance programmes, and testing/ screening, prevention, education and treatment of infectious diseases, and counselling are available in specific geographical areas only. Treatment with buprenorphine, with naltrexone, is done in prison but not very large scale. In principle the treatment that is given outside is prolonged inside, but depends on the prison and budget available. As a result some may shift from buprenorphine outside to methadone inside. Needle and syringe exchange programmes are not available in Dutch prisons but there is no need because intravenous consumption is not common in the Netherlands. Distribution of condoms and drug paraphernalia is available in specific geographical areas only [Trimbos 2006; GS].

Initiation and continuation of OST in prison is available. The provision of OST in prison is extensive that means that it is available for those who need it [SQ 27 p1 2011; GS].

Hepatitis B vaccination programme for PDUs is available in prison. The provision of pre-release OD counselling is limited. Specific information materials on DRD and emergencies are not available for prison staff. Naloxone is not provided upon prison release [SQ 23/29 2011]. The transition from prison to addiction care after release is not always smoothly [PS].

There has been an increase of protocols related to drug use (e.g. methadone provision) and related topics (e.g., hepatitis C treatment), in order to harmonize the practice in all prisons. There are also various programmes targeted at vulnerable drug users, e.g., repeated offenders, or those with psychiatric comorbidity. There are various information programmes related to drugs use before release [PS].

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Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination strategy since 2011. There is a risk-group specific hepatitis B vaccination programme. For the risk group drug users the campaign will stop 1-1-2012. For men who have sex with men and prostitutes the campaign continues [SQ 23/29 2011].

A national hepatitis B vaccination campaign for drug users is running for 4 years and has recently been expanded to prisons. A study is being conducted on how to guide drug users to Hep. C screening and Hep. B vaccination. The Ministry of Health is considering to place Hep.C on the national policy agenda [PS]. Condom promotion is a common response strategy to prevent DRID. The distribution of condoms is available nationwide [Trimbos 2006]. The provision of HCV testing (community) is limited [SQ 23/29 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

Needle and syringe exchange programmes are a predominant response strategy to prevent infectious diseases among drug users in the Netherlands. The provision of NSPs is extensive (150 fixed locations, app. 25 pharmacies, 2 police stations) [SQ 23/29 2011].

Condoms and needles and syringes are widely available for all injecting drug users. Some addiction care institutes also provide other paraphernalia (cotton, clean water, citric acid) or needle disposal boxes. For most of these services, however, drug users have to be registered at the addiction care since a couple of years [PS].

Needle and syringe exchange is not taking place through vans/ buses, and through outreach workers/ peers, via pharmacies or in prisons [Trimbos 2006]. Provision of condoms at drug agencies with NSPs is extensive [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Emergency services are trained and equipped to deal with overdoses [PS].

Naloxone is regulated by law. Naloxone is available on medical prescription the use is limited to medical personnel. Naloxone is part of standard ambulance equipment, ambulance personnel are trained in naloxone use. Naloxone is not available on a "take-home" basis [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Drug users are explicitly addressed by the national primary healthcare strategy. The accomodation needs and the educational needs of drug users are explicitly addressed in the National Social Protection and Social Inclusion Plan and in the written drug policies [SQ 28 2010].

There are protocols between different national, regional and local authorities and agencies involved in addressing the health and social needs of drug users in treatment. There are partnership agreements between the social services and the health services to meet the needs of drug users in treatment [SQ 28 2010].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

A national system for continued education and training in drug treatment is available for social workers, nursing staff, psychologists, psychiatrists, medical doctors and experts by experience [SQ 27 p2 2011].

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Formal NSP training programmes regarding health promotion activities are available for drug agencies staff [SQ 23/29 2011]. There is now an official training Master in Addiction Medicine for medical doctors [PS].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

There are national DRID guidelines and sub-national NSP guidelines. The most important guideline is the RIOB (guideline on substitution treatment). It is not exclusive on infectious diseases but includes a small section on this topic. This year (2011) another guideline is expected which also includes heroin treatment (in addition to other substitutes) [SQ 23/29 2011].

There is not one authorised institution, but several institutions are involved in guidelinea (e.g., GGD Nederland (Scoring Results), Trimbos Institute) [SQ 23/29 2011].

Existing guidelines:

Treatment [Best Practice Portal]:

» Guideline for outpatient and inpatient detoxification (2004)
» Guideline for the treatment of opiate addicts (RIOB -2006)
» Richtlijn Medicamenteuze Zorg aan Gedetineerde Verslaafden (2008).

National guidelines adopted after 2009 [SQ 27 p2 2011]:

» Psychosocial assisted treatment (outpatient and inpatient)
» Psychosocial treatment only (outpatient and inpatient)
» Guideline for the early detection of substance use disorders (Richtlijn Vroegsignalering).
» Atlas inpatient addiction care (Atlas residentiële voorzieningen).

» Guideline Anxiety and Addiction (Richtlijn Angst en Verslaving).
» Cognitive Behavioral Therapy Youngsters (CGT jeugd).
» Guideline Assertive Community Treatment Double Diagnosis (Richtlijn ACT Dubbele diagnose).

See for example the large scientific project around the introduction of heroin assisted treatment in the Netherlands. There are further several programmes that finance scientific projects, e.g., Getting Results (GGZ Nederland) en the ZonMW programmes on Addiction ("Verslaving") [PS].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

There is no official guideline for inclusion of needs assessment and it is not a task for the national government, but several models of best-practice exist that promote such (e.g. Preffi, Rapid Assessment and Response) [Trimbos 2006; GS; PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

This policy does not exist but there are several scientific evaluations, especially of drug prevention programmes. Further, the sector is also using benchmarks [PS].

Evaluation aspects are included in pharmacological guidelines, psychosocial assisted treatment guidelines and in psychosocial treatment only guidelines. Outcomes are evaluated in pharmacological treatment, psychosocial assisted treatment and in psychosocial treatment only [SQ 27 p2 2011].

A trend has now started in the addiction care to perform the evaluations (within the quality management system) by means of Routine Outcome Monitoring (ROM), performed for example by means of measurement instruments such as the Measurements of Addictions for Triage and Evaluation (MATE) [SQ 27 p2 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

This policy does not exist, as it is not a task for national government. These criteria differ between several national evaluation guidelines, e.g. PREFFI, OPUS, MEK [Trimbos 2006; GS; PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

The Netherlands have active involvement in the Reitox Network. The Trimbos Institute was involved in developing the drug-related deaths key epidemiological indicator for the EMCDDA. Several (local) monitors and data collections exist; the data of many of them are integrated into the National Drug Monitor and the EMCDDA annual reports [Trimbos 2006; PS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The National Drug Monitoring reports are disseminated among policy makers and the Parliament. Scientific evaluation results are often used for policy making. One good example: the heroin prescription experiment [Trimbos 2006].

There was a report commissioned "the Evaluation of the Dutch Drug Policy" in 2009, which has been used among others as input for the new drugs policy that is currently being shaped. The advisory committee "Van der Donk" recommended several measures based on evaluation results [PS; GS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

The national Focal Point cooperates with the National Support Centre for Prevention (LSP) in evaluation training courses [Trimbos 2006; PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

This policy does not exist. There is an annual PREFFI (Prevention Effectiveness Instrument) award for the best prevention programme [Trimbos 2006; GS; PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

Professionals have access to opportunities for exchange of programme results, skills and experience at European level to a large extent [PS].

The Netherlands actively participates in several European support and training projects. The Netherlands government is running the MATRA programme, which funds both projects in the field of drug demand reduction (incl. harm reduction) and training courses for civil servants and experts from applicant (& acceded) countries [Trimbos 2006]. In many international projects prevention programmes experiences, evaluations etc. are shared (e.g. as best practice) [GS].

An international action plan on cannabis research was launched in 2003. This is a joint effort of Belgium, France, Germany, the Netherlands and Switzerland to address the most important research questions resulting from an international cannabis conference organised in Brussels in 2002 [Trimbos 2006].

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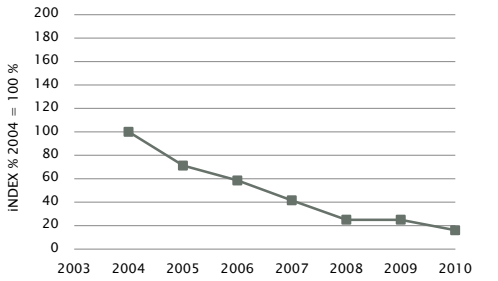
20 Country Profile Poland

20.1 Indicators for drug-related harm

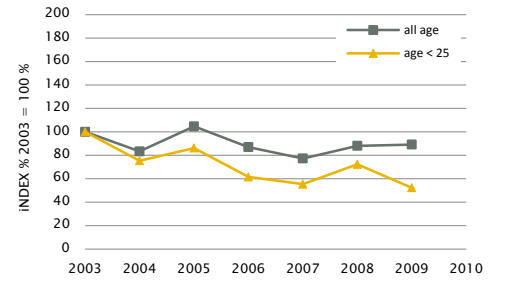
An estimation of the number of **problem drug users** (where problem drug use was defined as regular (daily or almost daily) illicit drug use causing serious problems, with all illicit drugs included) was conducted based on 2005 data, and using the benchmark method within the framework of a country-wide population survey. According to the outcome of the study, it was estimated that there were 100.000 to 125.000 problem drug users in Poland (3,7-4,7 per 1.000 inhabitants aged 15-64), which was a significant increase on a previous estimate made in 2002 with an estimate of 33.000 to 71.000 problem drug users [CO]. In 2009 based on the same method the estimate was 56.000 to103.000 problem drug users [NR 2011]. In 2005, an estimate of problem opioid use was conducted, amounting to 27.000 individuals in a range of 25.000 to 29.000 (0,9 to 1,1 per 1.000 inhabitants aged 15-64) [CO]. The largest groups of clients in outpatient treatment in 2010 have cannabis (42 %), opioids (33 %) and stimulants (17 %) as primary drug. In inpatient treatment the respective proportions are 37 %, 21 % and 34 % [Statistical Bulletin TDI-19]. According outpatient treatment data 66 % of opioid users inject the drug (29 % are smoking) [Statistical Bulletin TDI-17].

Figure 65:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2004=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 66:
Number of direct drug-related deaths (indexed - 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

Regarding **infectious diseases** in 2010, the incidence of newly-reported cases of HIV infections acquired via injecting drug use continued a declining trend (in 2004: 212 cases; in 2007: 88 cases; in 2009: 53 cases and in 2009: 39 cases - see Figure 65). However, there is a risk of underestimation of cases as the transmission route for a large percentage remained unexplained [CO, NR 2011]. In 2010, the estimated prevalence of HIV among 657 tested IDUs in Poland was 6,8 % (2004: 13 %, 2007: 11 %) [NR

2011]. In a HCV seroprevalence study conducted among 184 IDUs in two sites in 2009, the HCV prevalence ranged between 44,3–72,4 % [CO].

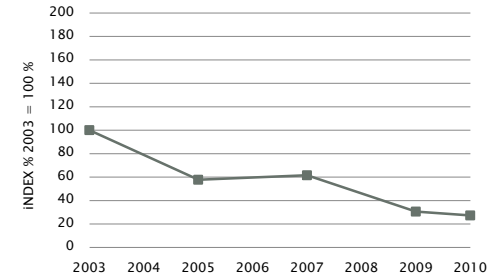
The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** is slightly decreasing since 2003 – especially in the age-group < 25 years (see Figure 66).

20.2 Indicators for drug-related harm reduction

In 2010 eight outreach-based harm reduction programmes, five drop-in centres and two night shelters for drug users exchanged/distributed syringes. The programmes included the total of 5.463 clients. 242.114 needles and 175.902 syringes were distributed or exchanged [NR 2011]. The number of distributed/exchanged needles is decreasing dramatically since 2003 (see Figure 67).

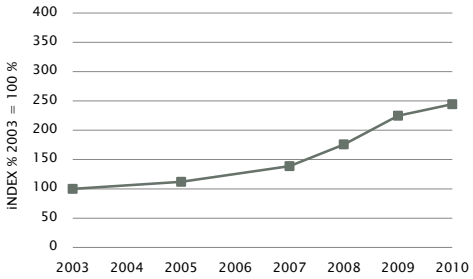
The number of clients in substitution treatment is increasing (see Figure 68). In 2009 14.408 clients started an inpatient treatment [ST TDI-2].

Figure 67:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 68:
Number of clients in substitution treatment (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

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20.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

Harm reduction is a public health objective in Poland. Objectives related to the prevention of drug dependence in order to provide a high level of health protection is included in the Act of Law of 24 April 1997 on Counteracting Drug Addiction and is further developed in the National Programme for Counteracting Drug Addiction for 2002-2005. In addition in the amendment of the Act of Law of 24 April 1997 which was adopted in 2001, a legal basis was created for harm reduction activities [Trimbos 2006].

A DRD strategy is part of the National Drug Strategy [SQ 23/29 2011].

Reference [PS]:

» National Drug Strategy 2006-2010
» National Drug Strategy 2011-2016

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

In Poland, telephone help lines, websites and a broad range of educational leaflets are available nationwide. Training is available to drug users in specific geographical areas only [Trimbos 2006].To prevent infectious diseases among drug users, providing information, education and communication (IEC) in general, and safer injecting trainings for drug users are predominant response strategies. IEC via peer involvement/ peer approach is a common response strategy. Safer injecting trainings and individual risk counselling with regard to safer injecting are provided in specific geographical areas only and this is delivered by low threshold agencies, especially outreach work [Trimbos 2006].

With regard to the reduction of drug-related deaths, the dissemination of information materials is the predominant response strategy: materials are predominantly disseminated at specialised drug treatment services, and low threshold agencies, and they are commonly disseminated through detoxification services, prisons, nightlife or entertainment venues and rave events. A common response strategy is risk education/ response training, which is delivered in some or few cities [Trimbos 2006].

The provision of overdose information materials is extensive [SQ 23/29 2011]. Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for prison staff, night club staff and sex workers using drugs [SQ 23/29 2008]. The provision of overdose response and safer use training is extensive. The provision of individual counselling is full. The provision of information materials to reduce drug harms in night clubs and in large music festivals is limited [SQ 23/29 2011].

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At least 3 projects addressed to drug users and sexual minorities (gay people) and sex workers started during the last years [PS].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

The availability/coverage of information measures targeted at families and communities related to harm reduction is limited [PS].

Specific materials on prevention of acute drug-related deaths and drug-related emergencies are not available for families/ friends [SQ 23/29 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Low threshold agencies, including needle and syringe exchange programmes, and outreach work are the predominant settings for the deliverance of risk education/ response trainings, aimed at the reduction of drug-related deaths [Trimbos 2006].

The main outreach health education approaches (issues) are: "safer" injecting trainings and safe sex education. Apart of injecting paraphernalia and condoms - sometimes written educative materials are also distributed. Among street workers there are often former drug users and active drug users [SQ 23/29 2008].

In Poland harm reduction programmes are implemented on the streets and other places where problem drug users meet. Other types of projects are risk reduction projects addressed to occasionally drug users mostly having fun in clubs, discos and during big outdoor events. Both categories of clients receive information on the risky behaviours, the ways to avoid or minimalise them and information on the ways of

contacting STD and ways to avoid it or at least minimalise the risk. Peer education is also popular but not in such extent like in other countries. Relevant leaflets are also distributed [SQ 23/29 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

From the beginning of outreach work the engagement of peers and volunteers has been observed, however because of the increase of the number and the scope of "party working" projects since 2003 their participation naturally has also increased [PS].

In specific geographical areas, peers and volunteers are included in outreach work practice and they are also trained to do so [Trimbos 2006]. Among street workers there are often former and active drug users [SQ 23/29 2008].

Naloxone is not available on a "take-home" basis [SQ 23/29 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

In Poland networking and cooperation exists between agencies in outreach work. Since 2006 the National Focal Point organises annual national conferences for harm reduction programmes which are a platform for cooperation [GS; PS].

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Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Drug-free outpatient treatment, drug-free inpatient treatment and rehabilitation programmes are available nationwide. Methadone maintenance programmes, methadone detoxification programmes and drop-in centres are available in specific geographical areas only. Since 2008 buprenorphine and naloxone (suboxone) is available as maitenance programme. Substitution treatment is supported by (obligatory) psychosocial care [Trimbos 2006; GS].

There are some regions in Poland with no access to substitution treatment and on the other hand there is full access[28] in Warsaw, where are 5 programmes. The provision of psychological support to OST clients is full [SQ 27 p1 2011].

Since 2003 the access to substitution treatment has been remarkably improved, especially in prisons [PS].

Heroin prescription programmes do not exist, [Trimbos 2006] drug consumption rooms are not available [SQ 23/29 2008].

28
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Medical doctors at specialised drug treatment centres can initiate and continue methadone treatment. Methadone can be dispensed at specialised treatment centres [Statistical Bulletin 2011 Table HSR-2].

Substitution substance can be taken outside the programme when the arrival of the patient is impossible - the patient can "take-home" dosage for 7 days. After 2 years therapy it is possible to "take-home" dosage for 14 days if a patient is in good psychophysical condition and in particular if it is helpful in reintegration [SQ 27 p1 2011].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Drug-related prison health is addressed in the national drug strategy [SQ 23/29 2011].

Distribution of condoms, and testing, prevention, education and treatment of infectious diseases are available nationwide in Polish prisons. There are neither needle and syringe exchange programmes nor drug paraphernalia available in Polish prisons [Trimbos 2006]. It is a challenge to start harm reduction programmes with needle and syringe exchange, because those types of interventions remain illegal in the prisons [PS].

The provision of OST in prison is extensive but it is not possible to start OST in prison [SQ 27 p1 2011].

A hepatitis B vaccination programme for PDUs is not available in prison. Formal NSP trainings are available for prison staff. The provision of pre-release OD counselling is extensive. Specific materials on prevention of acute drug-related deaths and drug-related emergencies are not available for prison staff. Naloxone is not provided upon prison release [SQ 23/29 2011].

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Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination scheme. A risk-group specific hepatitis B vaccination programme is not available. The provision of HCV testing (community) is full [SQ 23/29 2011].

Generally the testing, vaccination as well as treatment of mentioned viruses and diseases has become more available among the whole general population since 2003. In Poland drug users are neither a group more privileged nor less privilege to receive above mentioned services. Therefore when the access to those services has been improved regarding the whole population it has been also improved regarding the drug users [PS].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

A DRID strategy is part of national drug strategy. The provision of NSPs is extensive. Needle and syringe exchange takes place through fixed sites and outreach/ peer programmes but not in prisons. The provision of condoms at drug agencies with NSPs is full [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Dealing with overdoses is part of the standards of trainings for people working in the emergency services [PS].

There are no specific regulations regarding Naloxone but this drug is registered. Naloxone is part of standard ambulance equipment; the use of naloxone is limited to medical personnel. Ambulance personnel is trained in naloxone use [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Drug users are explicitly addressed in the national primary healthcare strategy [SQ 28 2010].

Operational goal of the National Health Programme (for the years 2007 – 2015) is: Reducing the use of psychoactive substances and health harm related with it. One of the task for above mentioned goal is: Creating social readaptation programmes for users of psychoactive substances who use them in a harmful way, especially taking under consideration the issue of vocational readaptation and supporting people who maintain abstinence. One of the expected health advantages is: Reducing of social exclusion of persons using psychoactive substances in a harmful way [SQ 28 2010].

The most common mechanism of interagency coordination is the informal network [SQ 28 2010].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Formal NSP training programmes regarding health promotion activities are available for drug agencies staff and for prison staff [SQ 23/29 2011].

Occupational standards for drug treatment are available for addiction therapy specialists and addiction therapy instructors. Specialised courses/ training on drug treatment are implemented for nursing staff, psychiatrists, medical doctors, addiction therapy specialists and addiction therapy instructors [SQ 27 p2 2011].

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Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

Formal guidelines on harm reduction do not exist, but there is a manual on safer drug injecting ("Do it safer"). The manual is devoted especially to drug users but also for practitioners working with people using drugs [SQ 23/29 2011].

There are guidelines, for pharmacological treatment [Best Practice Portal].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

This policy exists and was based upon the Council Recommendation. Trainings related to the proper construction of the prevention programmes and methods of needs assessment such as RAR for relevant group of people were organized [Trimbos 2006].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Selected programmes were evaluated on national level. Within the National Programme for Counteracting Drug Addiction trainings in the field of evaluation for different

groups were organized and currently an evaluation protocol for risk reduction programmes is in preparation [Trimbos 2006].

In the framework of developing and implementing programmes evaluating treatment, rehabilitation and harm reduction services an expert committee was established that made a review of the definitions of therapy, conducted research as well as theoretical concept of evaluation process [Trimbos 2006].

According to the schedule drawn up in the National Programme for Counteracting Drug Addiction it was planned to develop methods and indicators for the evaluation of drug use related harm reduction programmes in the years 2003 – 2004 [Trimbos 2006].

A national pilot project of evaluation of the drug treatment (drug free: 5 outpatient and 5 impatient facilities and 1 substitution treatment programme) was carried out by the National Bureau for Drug Prevention during the years 2007–2010. The purpose of this project was to elaborate specific tools for evaluation. The tools as well as the foundations for conducting evaluation were elaborated however due to insufficient number of the surveys received from the facilities involved in this project the assessment of the outcomes (individual effects achieved) was not possible [SQ 27 p2 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

The evaluation quality criteria are in the process of elaboration [Trimbos 2006].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

EDDRA questionnaires are in the process of implementation on the national level. Cooperation with the EMCDDA in the field of prevention and risk reduction programmes is developing [Trimbos 2006].

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In the framework of monitoring harm reduction activities in Poland every year data from needles exchanging programmes are collected. Every two year a survey among clients of these programmes is conducted. Additionally the National Focal Point organizes an annual conference for harm reduction programmes in order to analyse the situation [PS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

Results from the evaluation of selected programmes are used to create conclusions and recommendation for prevention and risk reduction programmes conducted on the regional and local level [Trimbos 2006].

The Central Board of Prison Service in cooperation with the Institute of Psychiatry and Neurology and the National Bureau for Drug Prevention conducted two research projects in 2003. The first was titled: „Women drug addicts in European prisons". The aim of the study was the evaluation of drug therapy programmes for women implemented in prisons in terms of their effectiveness in preventing relapses. The 2003 National Programme for Drug Preventions was based upon the conclusions drawn from the above mentioned research projects [Trimbos 2006].

In 2003 upon commission of the National Bureau for Drug Prevention a research project called "Institutional conditioning of drug prevention" was implemented. The project covered organisations operating at national level and implementing drug demand reduction programmes [Trimbos 2006].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

NBDP commissions the evaluation programmes organized for NGO's workers who created and implemented prevention and risk reduction programme on regional and local level [Trimbos 2006].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

NBPD promotes the evaluation aspect of prevention and risk reduction programmes among people who implement them but also among local and regional authorities in order to underline its importance [Trimbos 2006].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

National experts were involved in the cooperation of the EMCDDA with third countries like Turkey and some republics of Asia [Trimbos 2006].

Within the scope of international cooperation particularly important is the Bureau's participation in the proceedings of the Pompidou Group by the Council of Europe, the European Monitoring Centre for Drugs and Drug Addiction in Lisbon, the United Nations Drug Control Programme and the PHARE programme. In 2003 the National Bureau continued performing tasks resulting from the programme of Poland's accession to the European Union. The twinning contract between Poland and France was continued [Trimbos 2006].

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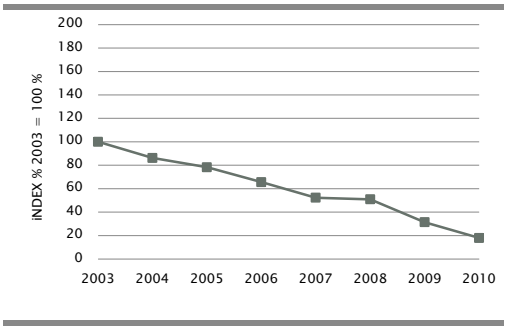
21 Country Profile Portugal

21.1 Indicators for drug-related harm

The most recent estimate of the number of **problem drug users** (long-term/regular users of opioids, cocaine or amphetamines) refers to the year 2005 and resulted in 30.833 to 35.576 problem drug users (4,3 to 5,0 per 1.000 inhabitants aged 15 to 64 years). A broader definition, not restricting the population to long-term and regular users suggested a higher rate of 44.653 to 53.240 (6,2-7,4 per 1.000 inhabitants aged 15 to 64 years). Prevalence of injecting drug use was estimated using two methods to be between 10.950 and 21.900 (1,5 to 3,0 per 1.000 inhabitants aged 15 to 64 years). The estimates are slightly lower than those for the year 2000 but the confidence intervals overlap [CO, NR 2011]. The largest groups of clients in outpatient treatment in 2010 have opioids (65 %) followed by cannabis (16 %) and cocaine (12 %) as primary drug [Statistical Bulletin TDI-19]. According outpatient treatment data just 15 % of opioid users inject the drug (84 % are smoking) [Statistical Bulletin TDI-17].

Figure 69:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

There are no national estimates on prevalence rates for drug-related **infectious diseases** among injecting drug users in Portugal [NR2011]. The number of new diagnosed HIV cases with IDU as route of administration decreased significantly since 2003 (see Figure 69). In 2010, 3 % of drug users treated for the first time, were found to be HIV positive (7 % in 2009, 9 % in 2008 and 2007). The HCV prevalence based on 2010 treatment data was between 24 % and 46 % [CO].

Data on the number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** based on a special register is available since 2008 (2008: 94 cases, 2009: 56 cases, 2010: 52 cases) [Statistical Bulletin 2012 DRD 2].

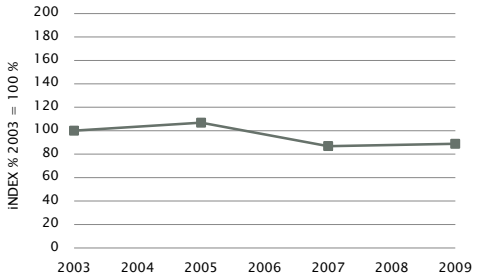
21.2 Indicators for drug-related harm reduction

Prevention of drug-related infectious diseases amongst problematic drug users is mainly ensured through the national syringe exchange programme "Say no to a second

hand syringe". Since it was set up, in October 1993, it has been using the national network of pharmacies and has enlarged its partner network through protocols with mobile units, NGOs and other organisations in order to reach a wider population (49 partners in 2010 and 2009 and 36 in 2008) [NR 2011]. The number of syringes provided through needle and syringe programmes is quite stable / slightly decreasing since 2003 (see Figure 70).

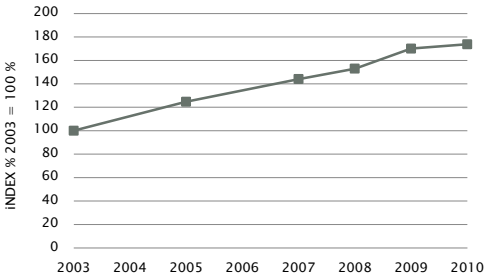
The number of clients in substitution treatment is increasing (see Figure 71). In 2010 29.325 started a substitution which is an increase of 2 % in relation to 2009 (28.708). In 2010 5.179 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 70:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 71:
Number of clients in substitution treatment (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

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21.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

Harm reduction is a public health objective in Portugal [Trimbos 2006]. The most relevant national documents are the National Strategy (National Plan on Drugs and Drug Addiction 2005-2012) and the corresponding Action Plans (the latest is the Action Plan on Drugs and Drug Addiction 2009-2012). The National Plan on Drugs and Drug Addiction 2005-2012 established as priorities concerning treatment [NR 2011]:

» To ensure just-in-time access to integrated therapeutic responses for all who request treatment.
» To make different treatment and care programmes available, based on ethical guidelines and science based practices.
» To implement a continuous process for improving quality for all therapeutic programmes and interventions.

The Harm and Risk Reduction strategy is part of the national drug strategy and includes a DRD objective to promote the creation of experimental spaces for intervention in overdose situations (objective 59) [SQ 23/29 2011]. The following actions are mentioned in the strategy [SQ 23/29 2011]:

» Launch education campaigns on "First aid in overdose situations", addressed to drug abusers and their families or peer groups (action 59.1)
» Develop, together with INEM, projects where ambulances are prepared for interventions in such situations and contexts (action 59.2)
» Strengthen and extend overdose prevention interventions through awareness-raising actions in treatment structures (e.g. CT) (action 59.3)

The Action Plan against Drugs and Drug Addiction 2009-2012 mentions also as objective:

» To promote the diagnosis, counselling and referral of infectious diseases in the drug users population (objective 42) [SQ 23/29 2011].
» To set up a global network of integrated and complementary responses in the area of harm reduction [NR 2011].
» To target specific groups for risk reduction and harm minimization programmes [NR 2011].

The National Program to Prevent and Control HVI/AIDS 2007-2010 contains the following objectives [SQ 23/29 2011]:

» to reduce the number of new HIV infections and at least 25 % of the number of new cases and deaths by AIDS in Portugal, until 2010, and
» to contribute to the reduction of HIV transmission and better care and support to HIV infected or AIDS patients at an international level, through the public help to development, until 2010.

The National Action Plan against Spread of Infectious Diseases in Prisons provides general recommendations concerning the fight of infectious diseases, but no specific objectives and actions [SQ 23/29 2011].

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

To prevent infectious diseases among drug users, providing information, education, communication (IEC) via counselling and advice by drugs and health professionals is the predominant response strategy [Trimbos 2006]. In Portugal, various telephone help lines, websites, training, and a broad range of educational leaflets are available nationwide [Trimbos 2006].

The dissemination of information material, individual risk assessment, practical advice and training on safer injecting are priority response strategies to prevent DRID in Portugal [GS], whereas “easy access” programmes to treatment of infectious diseases are not [SQ 23/29 2011]. Therefore, individual counselling and safer use training are

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provided extensively[29] in Portugal and information material to reduce drug harms is provided extensively in night clubs and at large music festivals [SQ 23/29 2011].

Overdose information material is fully provided in Portugal [SQ 23/29 2011]. Risk education and overdose response training is available in nearly all relevant cities or towns [SQ 23/29 2011]. Individual overdose risk assessment and overdose response training is provided extensively [SQ 23/29 2011 and GS].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Communities and families of drug users are involved in the prevention and reduction of health risks associated with drug dependence in specific geographical areas only [Trimbos 2006].

The Harm and Risk Reduction model implemented in Portugal aims to propose, through integrated work, to users who are unable or unwilling to renounce drug use, help to reduce harm they cause themselves trough alternatives paths that lead to treatment facilities. The aim is a gradual process of stabilization and organization, which may allow the recovery process [GS]. Thus the focus is the National Network of Harm and Risk Reduction (RRMD) as an integrated intervention model, recommended by the Operational Program of Integrated Responses (PORI), via the implementation of projects under the Program of Integrated Response (PRIs).

With respect to the axe of Harm and Risk Reduction, in 2010, 34 projects were in course under the PRI (29 in 2009) [GS]. In the ambit of Outreach teams, Drop in Centre and PSO-BLE, 7.685 people were covered (5 500 in 2009). In relation to intervention in recreational and/or festivities settings, the 9 projects under PRI covered nearly 40.835 individuals from whom 9.896 were contacted in the bar/disco setting and 30.939 in the party/festival context.

29
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

Specific material on prevention of acute drug-related deaths and drug-related emergencies is available for night club staff but not for police, prison staff or family/friends [SQ 23/29 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach health education is a priority response strategy to prevent DRID [SQ 23/29 2011] and also a predominant one [Trimbos 2006]. Outreach work and targeted high-risk group interventions are a predominant implementation setting for infectious diseases prevention measures targeting drug users [Trimbos 2006]. Main outreach health education approaches are personal counselling, users training, peers training, strategic groups training as well as the dissemination of IEC materials [SQ 23/29 2011].

The provision of outreach work at night clubs and in large music festivals is limited [SQ 23/29 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer involvement is not a priority response to prevent DRID, but peer educators are involved in the responses to prevent DRID [SQ 23/29 2011]. Peers and volunteers are trained and included in outreach work practice, in specific geographical areas only [Trimbos 2006].

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Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies is nationwide available [Trimbos 2006].

Portugal defined in 2001 as one of its main goals the creation of a National Network of RRMD with public and private partners [GS]. This network was established on the basis of territorial diagnoses and was progressively enlarged and consolidated, becoming today a benchmark of community intervention concerning the phenomenon of use and abuse of psychoactive substances in Portugal.

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Psychosocial in- and out-patient interventions, detoxification as well as substitution treatment are provided fully in Portugal [SQ 27 p1 2011]. Treatment with buprenorphine and with naltrexone respectively drop-in centres are provided in specific geographical regions only [Trimbos 2006]. Specific treatment interventions for target groups are available for cannabis users [SQ 27 p1 2011].

Public services, certification and protocols between NGOs and other public or private treatment services ensure a wide access to quality-controlled services [NR 2011]. As a consequence, there is no waiting time for inpatient psychosocial treatment [SQ 27 p1 2011]. Waiting times for detoxification and outpatient psychosocial treatment exist, but they are less than 2 weeks and due to formal procedures and limited availability [SQ 27 p1 2011]. For public therapeutic programmes the average waiting time in 2010 was 10,5 days [NR 2011]. In the year 2010 3.120 drug users received first treatment according to TDI data [NR 2011].

Substitution treatment is supported by (obligatory) psychosocial care [Trimbos 2006], which is provided to OST clients fully [SQ 27 p1 2011]. Aiming at the reduction of

drug-related deaths, opioid substitution treatment (OST) is a predominant response strategy [Trimbos 2006]. It is widely available and the substances used are methadone, buprenorphine and a combination of buprenorphine and naloxone [NR 2011]. There is also a low-threshold substitution programme (PSO-BLE) [NR 2011]. The waiting time for OST is between 2 weeks and 1 month due to limited availability [SQ 27 p1 2011]. In the year 2009 28.708 clients received OST in Portugal [Statistical Bulletin 2011].

Drug consumption rooms and heroin prescription programmes do not exist in Portugal [SQ 23/29 2011 and Trimbos 2006].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are nationwide available [Trimbos 2006].

Treatment with methadone only can be initiated by medical doctors at specialised drug treatment centres [GS], while only medical doctors at specialised drug treatment centres can continue methadone treatment [Statistical Bulletin 2011]. Treatment with high-dosage buprenorphine and a combination of buprenorphine and naloxone can be initiated and continued by medical doctors at specialised drug treatment centres, specialised medical doctors and any medical doctors [Statistical Bulletin 2011].

Methadone can be dispensed at specialised treatment centres, specialised medical doctors' offices, pharmacies and mobile outreach units [Statistical Bulletin 2011]. High-dosage buprenorphine and a combination of buprenorphine and naloxone can also be dispensed at any medical doctor's office, but won't be dispensed at mobile outreach units [Statistical Bulletin 2011].

The conditions for "take-home" OST are regulated and include the following requirements [SQ 27 p1 2011]:

- to be in treatment at least 3 months;
- to go to regular appointments;
- to show abstinence from heroin and cocaine confirmed by urine sample and absence of intoxication signals or alcohol abuse.

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Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Drug-related health issues are addressed in the national prison health strategy, but drug-related prison health is also addressed in the national drug strategy [SQ 23/29 2011]. Drug users in prisons are mentioned as target group in the DRID strategy, which is part of the national drug strategy [SQ 23/29 2011]. Drug-related health policies for prisons are dealt with at prison level [SQ 23/29 2011].

Low intensity drug treatment as well as medium/high intensity drug-free treatment is provided extensively in prisons by the prison health services alone or by mixed teams [SQ 27 p1 2011]. OST is provided in prisons extensively, initiation and continuation is available [SQ 27 p1 2011]. The referral to different treatment responses is encouraged across the prison system to ensure the continuity of pharmacological treatment initiated in freedom [NR 2011]. A working group on Drug Free Wings started in 2010 to analyse this model, the corresponding working programmes and regulations [NR 2011].

The priority response strategies to prevent DRID in prisons are the dissemination of infectious diseases information material, voluntary infectious diseases counselling and testing on prison entry as well as a hepatitis vaccination programme [SQ 23/29 2011]. Hepatitis vaccination is provided routinely for inmates and prison staff [NR 2011]. Individual counselling on infectious diseases and HCV testing on prison entry are provided extensively [SQ 23/29 2011]. Practical advice and training on safer use is provided to a limited extend and NSPs only rarely [SQ 23/29 2011]. Formal NSP training programmes regarding health promotion activities are available for prison staff [SQ 23/29 2011]. There is no information concerning HCV testing on release from prison [SQ 23/29 2011].

Measures targeting at the reduction of drug-related deaths are uncommon in Portuguese prisons [Trimbos 2006]. Pre-release overdose counselling is provided to a limited extent [SQ 23/29 2011]. Specific materials on prevention of acute drug-related deaths and drug-related emergencies are not available for prison staff [SQ 23/29 2011]. Naloxone is not provided upon prison release [SQ 23/29 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination scheme [SQ 23/29 2011] since 1999 [Trimbos 2006]. In addition, a risk-group specific hepatitis B vaccination programme is available [SQ 23/29 2011]. The harm reduction agencies togethere with public health services offer this vaccination to drug users [SQ 23/29 2011].

Voluntary counselling and testing is a priority response strategy to prevent DRID in Portugal [SQ 23/29 2011], but hepatitis vaccination programmes, routine screening of high risk groups and "easy access" programmes to treatment of infectious diseases are also important according to the Portugese Strategy [GS]. HCV testing is provided fully [SQ 23/29 2011] and a hepatitis vaccination programme is a common response strategy to prevent DRID [Trimbos 2006].

In 2010 the Institute of Drugs and Drug Addiction (IDT), I.P. has invested in the enlargement of the Harm Reduction Network, new interventions based on the identified needs were implemented in all regions [NR 2011]. There is a project on early identification and prevention of HIV/AIDS directed to drug users (Program Klotho) which was started in 2007 as a pilot project [NR 2011]. The objective is to develop a network for early identification of HIV/AIDS through integration of local healthcare providers. Meanwhile the programme was incorporated as integral part of all RRMD structures.

Treatment for HIV/Aids and hepatitis B and C is included in the National Health Service and free for those who need it [NR 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

NSPs are a priority response to prevent DRID among drug users and they are provided fully [SQ 23/29 2011]. There are no legal restrictions to the possession of sterile

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needles in Portugal, and also no prescription is required to obtain or exchange needles and syringes [Trimbos 2006].

In the year 2010 NSPs were provided at 14 fixed locations, at 1.336 pharmacies and by 246 other sites [ST 10 2011]. Among these other sites are 2 units from the National Pharmacies Association in partnership with municipalities, mobile units and street teams [ST 10 2011]. In addition there are 96 syringe provision points at outreach services and 149 mobile syringe provision points [ST 10 2011]. In the year 2010 945.560 syringes were provided by NSPs at fixed locations and 900.000 by pharmacies [ST 10 2011]. In the year 2010 2.057.497 syringes were exchanged by NSP in total [NR 2011]. There are also two prison based NSPs, but none of them has exchanged syringes in 2010 [ST 10 2011].

Standard items in the injecting kits, which are fully provided, are: information material, alcohol pads, dry wipes, water, containers, filters, acid and condoms [SQ 23/29 2011]. Foil for inhalative drug use, crack pipes as well as straws for intranasal consumption are provided for non-injecting drug users [SQ 23/29 2011].

The distribution of condoms is not a priority response strategy to prevent DRID in Portugal, but condoms are provided at drug agencies with NSPs fully [SQ 23/29 2011].

Formal NSP training programmes regarding health promotion activities are available for pharmacists [SQ 23/29 2011]. There is also a manual for the procedures of the national syringe exchange programme which is being distributed to the services involved [NR 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

There are no specific training programmes on drug overdoses available to professionals of emergency departments [Trimbos 2006]. Emergency departments are an uncommon setting for the dissemination of information material that aims at the reduction of drug-related deaths or for risk education/ response training [Trimbos 2006].

The distribution, possession or administration of naloxone is regulated by law [SQ 23/29 2011]. Naloxone is part of the standard ambulance equipment and ambulance personnel is trained in its use [SQ 23/29 2011]. Naloxone is available on medical prescription only [SQ 23/29 2011], it is not available on a “take-home“ basis [Trimbos 2006].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Risk reduction is part of an integrated health strategy for drug users [Trimbos 2006].

Drug users are explicitly addressed in the national primary healthcare strategy [SQ 28 2010]. The Portuguese National Health Plan (2004-2010), includes for its execution 40 national health programmes in different domains, including drug addiction, alcohol and infectious diseases [SQ 28 2010]. Both in the Portuguese National Health Plan and on the Mental Health Plan (part of the National Health Plan), IDT's different treatment structures are mentioned as the main providers for healthcare needs of drug users.

The housing needs of drug users are explicitly addressed in the National Social Protection and Social Inclusion Plan [SQ 28 2010]. The accommodation needs of drug users are addressed through the National Strategy for the Integration of Homeless People, which includes responses in the housing and accommodation ambit, where users of psychoactive substances are explicitly included.

The accommodation needs of drug users are also a priority in the written drug policies [SQ 28 2010]. The Action Plan on Drugs and Drug Addiction 2009-2012 defines the following objectives/actions:

» Objective 57 - ensure the existence of conditions that promote the autonomy and full citizenship are planned.
» Actions: (57.2) establishing partnerships with entities promoters of housing responses;(57.3) support the promotion of renting solutions in collective residencies for population groups with specific or temporary needs, Door 65 - Residence (cohabitation) supported and (57.4) Development of the Programme Door 65 - Stock Houses and mobility, provide habitations of public and private property for direct or mediate renting through a system of stock houses available.
» Objective 58 - Assure the efficiency and effectiveness of the available answers.
» Actions: 58.2. Creation, adoption and qualification of the existing social responses and equipment (namely the Social-reintegration Apartments and Direct Intervention Teams) to the needs of the target public.

These actions have as responsible entities the Housing Institute and Urban Rehabilitation, the National Association of Portuguese Municipalities and other public and private entities [SQ 28 2010]. Residential units of long term (permanence for life) are also referred in the Action Plan and the National Strategy for the Integration of Homeless. This strategy was elaborated with the collaboration of IDT and foresees the restructure

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of the existing social answers. In addition to the housing/residence answers for people with different levels of exclusion and drug-related problems, the Social Security Institute supports rent payments through social protective measures. The National Plan on Drugs and Drug addiction 2005-2012 mentions the need to create accommodation responses for drug addicts without socio-family framing inserted in the national harm and risk reduction network.

In 2007 an inter-institutional protocol was agreed upon, which aims to promote a more efficient intervention for those users, who have insufficient resources and to promote their access to a network of resources and social protection measures [NR 2011]. This includes payment of rented bedrooms or small flats, temporary apartments or referral to social services.

The educational needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan [SQ 28 2010]. The Plan has national character (basis) but at regional level there are adjustments to specific regional and local needs. The existing academic qualification measures are not specifically aimed to drug addicts, however, in most cases they suit (correspond) to the profile of IDT users, namely the course of recognition and validation of competences that give academic/school equivalence.

The education needs are also mentioned in the written drug policies [SQ 28 2010]. The Action Plan on Drugs and Drug Addiction 2009-2012 foresees:

» Objective 57 – to ensure the existence of conditions that promote the autonomy and full citizenship are planned in the following action.
» Action: 57.1 – easier access to academic training, professional and employment responses.

Employment needs of drug users are explicitly addressed in the National Employment Plan and are a priority in the written dug policies [SQ 28 2010]. The Action Plan on Drugs and Drug Addiction 2009-2012, foresees – as mentioned above – easier access to academic training, professional and employment responses.

The Program Vida-Emprego is targeted specifically to people with addiction problems in treatment, and is a joint responsibility of Institute for Labour and Professional Training and IDT [SQ 28 2010].

At regional and local level needs are identified and the structures develop their action in this area, trying to prepare the social systems of training and employment to accommodate users [SQ 28 2010]. Nationally there is an Employers Stock, a database with employers as partners of IDT, which is an important tool in identifying potential employers at local level [SQ 28 2010].

In addition, there are other social reintegration related objectives in The Action Plan on Drugs and Drug Addiction 2009-2012 [SQ 28 2010]:

» Objective 59 - Promote the responsibility of Social systems in the promotion of reintegration responses and to avoid exclusion.
» Objective 60 - Promote the supervision, monitoring and evaluation of regional and local interventions in the framework of reintegration.
» Objective 61 - provide the social systems actors of knowledge and competences in the context of intervention in reintegration and to avoid exclusion.

Concerning the coordination of interagency partnerships, the Interministerial Technical Committee, which includes representatives of 11 Ministers and the National Coordinator, has to be mentioned [SQ 28 2010]. This Technical Committee is responsible for monitoring the implementation of the Action Plan on Drugs and Drug Addiction 2009-2012. This is an on-going process with all the stakeholders involved on the implementation of the several objectives defined in the Action Plan. Through this Committee all the Services are involved in the implementation of the Action Plan, namely those in charge of implementing the objectives related to the reintegration of drug users.

There are protocols between different national, regional and local authorities and agencies involved in addressing the health and social needs of drug users in treatment [SQ 28 2010]. These structured protocols are the most common mechanism of interagency coordination.

There are also partnership agreements between the social services and the health services to meet the needs of drug users in treatment [SQ 28 2010]. These partnerships and agreements exist extensively.

The employability of drug users in treatment is part of treatment care plan [SQ 28 2010]. The IDT believes that this is the main goal of reintegration. The integration approach focuses on the acquisition and consolidation of conditions that allow individuals to access and maintain decent and qualified jobs. Of course, taking into account the specific situation in relation to the consumption of each individual and the degree of exclusion, there are intermediate objectives, whose range is in itself an added value in the individual process, and in some cases this process stops there.

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Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

A national system for continued education is available for social workers, nursing workers, psychologists, psychiatrists, medical doctors and other professions like psychosocial experts and physiotherapists [SQ 27 P2 2008]. Specialised courses/training on drug treatment are implemented for social workers, nursing workers, psychologists, psychiatrists, medical doctors and other professions like psychosocial experts and physiotherapists [SQ 27 P2 2008]. Formal NSP training programmes regarding health promotion activities are available for drug agencies staff, pharmacists and prison staff [SQ 23/29 2011].

Occupational standards for drug treatment are available for social workers, nursing workers, psychologists and other professions like social educators and physiotherapists [SQ 27 P2 2008].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

There are guidelines on harm reduction [Best Practice Portal]:

» Guia para intervenção em Redução de Riscos e Minimização de Danos (2009)
» Manual de boas práticas de troca de seringas

And there are guidelines on treatment [Best Practice Portal]:

» Circuito do Utente Ambulatório (2008)
» Regulations for inpatient treatment in private institutions and their governmental financial support (2008)
» Normas Orientadoras dos Programas Terapeuticos com Agonistas Opiaceos em Portugal (2006)
» Manual de orientações tecnicas para a implementação de programas de substituição opiacea de baixo limiar de exigencia (not yet published).

In addition, the guidelines for interventions with children and youth with behavioural risk in the field of dependencies as well as for children of consumers of psychoactive substances were updated in 2010 [NR 2011]. Guidelines on attendance to drug users were elaborated in 2010 by the IDT, I.P. Harm Reduction Unit [NR 2011].

There are also guidelines for social interventions (Intervention Model in Reintegration), which were launched in 2009 and adopted by all Integrated Response Centers in 2010 [NR 2011]. Guidelines for workplace interventions were developed during 2010/2011 [NR 2011].

The institution responsible for developing guidelines is the Institute for Drugs and Drug addiction (IDT, www.idt.pt) [SQ 27 P2 2008 and SQ 23/29 2011].

Best practice interventions in Portugal are identified and entered into the EMCDDA's EDDRA database on basis of evaluation forms [Trimbos 2006].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

In 2003, the National Commission for the Fight against AIDS started a series of initiatives to implement until 2006 with a view to improve the efficiency of this programme, namely to elaborate, in cooperation with the IDT, a needs assessment document for professional training to outreach workers in order to develop a national training programme for HIV/AIDS infection prevention [Trimbos 2006].

Needs assessments are used at the initial stage of programmes to a large extent and there was an increase since 2003 [PS]. For example, a needs assessment was carried out at the start of Reintegration Programmes (including reintegration of drug users) [Trimbos 2006].

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Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

There is the RRMD Evaluation Model [GS]: Within the scope of the partnership (and detained in a protocol) established between the State and civil society (NGO) a monitoring and evaluation model for the intervention in RRMD was developed, encompassing a set of guiding instruments of the intervention to be performed, creating thus conditions for realization of a evaluation based in concrete, detailed and objective data, at different levels: Local, regional and national.

This evaluation model consists in the analysis of the implementation of the intervention in relation to the results achieved [GS]. The principle dimensions of analysis considered are effectiveness and efficiency of interventions. It combines qualitative and quantitative data collected through the year.

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

In 2010 the terms of references for the external evaluation of the National Plan on Drugs and Drug Addiction were approved by the Interministerial Technical Commission [NR 2011].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

In 2010 a pilot project for intervention in overdoses was built, which consists mainly of an information system to follow the acute cases of over-use [NR 2011]. The form for this information system is completed by the stakeholders of the National Network of

Harm and Risk Reduction (RRMD) and disseminated to key interlocutors of IDT, I.P. In addition the collection and systematization of data on the whole interventions undertaken within the network RRMD started in 2010.

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The National Drug Strategy 'Horizon 2004' was evaluated internally and externally, followed up by a number of recommendations, e.g.: "To improve the risk reduction and harm minimisation systems through further development of the initiatives already in place (substitution programmes, syringe exchange, campaigns for the use of condoms, etc.)" [Trimbos 2006].

Evaluation results are used for further development of drug prevention policies to a large extent and there was an increase since 2003 [PS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Evaluation training programmes are available in Portugal to a large extent and there was a strong increase since 2003 [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

The project Rezolat integrates an innovative methodology of evaluation [Trimbos 2006].

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Project REZOLAT (2004) intended to draw a picture of the state of the art concerning interventions in risk and harm reduction through a DELPHI evaluation model [GS]. In this evaluation structure there were 4 main goals:

» Perception of the evolution of harm reduction practices;
» Uniformization of harm reduction concepts;
» Innovate through the dissemination and sharing of new experiences;
» Create intervention consensus, particularly at local level.

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

IDT directors participated in the 1st ACCESS Trainning Academy (York, UK, October 2011) – Intervention models for drug users in the criminal justice system and interaction between treatment and other elements are present in a full "intervention package" (including housing, education, employment) [GS].

The IDT exchange programme results, skills and experience with other Member States of the EU, among others through EDDRA [Trimbos 2006].

Since buprenorphine was first used in Portugal, training and training exchanges have been organised with France [Trimbos 2006]. Portuguese professionals have participated in trainings in France, Germany, Spain, and Scotland. Collaboration, education and information have been shared with the European Network T3E and also with the Euro-Methwork, in the development of the European Methadone Guidelines.

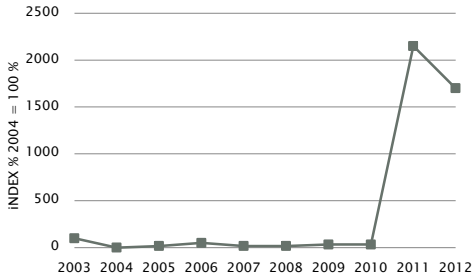
22 Country Profile Romania

22.1 Indicators for drug-related harm

There is no national estimate for **problem drug use** in Romania. For Bucharest there are several estimates for the prevalence of IDU based on the multiplier method ranging from 8.776 to 20.389 in 2010. A time series of estimates using the same method since 2007 shows an increase of the number of IDUs (2007: 16.867 and 2010: 18.316 – 17,4 resp. 19,2 persons per 1.000 inhabitants in the age group 18 to 49[30]) [NR 2011]. The largest groups of clients in outpatient treatment in 2010 have opioids (70 %) and cannabis (13 %) as primary drug. In inpatient treatment the respective proportions are 42 % and 5 % [Statistical Bulletin TDI-19]. According outpatient treatment data the vast majority (91 %) of opioid users inject the drug (7 % are smoking/inhaling) [Statistical Bulletin TDI-17].

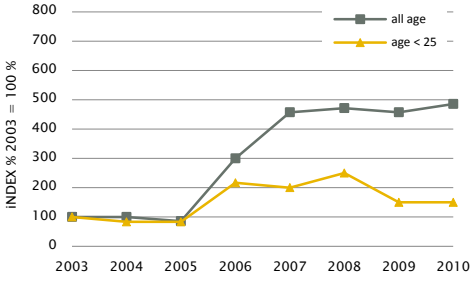
The number of new diagnosed HIV cases with IDU as route of administration was very low and ranged from 1 to 6 cases till 2010 followed in 2011 by a HIV-outbreak (see Figure 72). Data from treatment facilities show a HIV rate of 4 % in 2010 with an increasing tendency since 2008 (2008: 1 %, 2009: 3 %) [NR 2011].

Figure 72:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: [HIV/AIDS among injecting drug users in Romania, EMCDDA 2012

Figure 73:
Number of direct drug-related deaths (indexed – 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

HCV prevalence based on the same data source was at 64 % in 2010 (2004: 48 %. 2006: 46 %, 2008: 73 %) [NR 2011].

30
This rate is not comparable to other countries due to the different age range – the standard age range in other countries is 15 to 64

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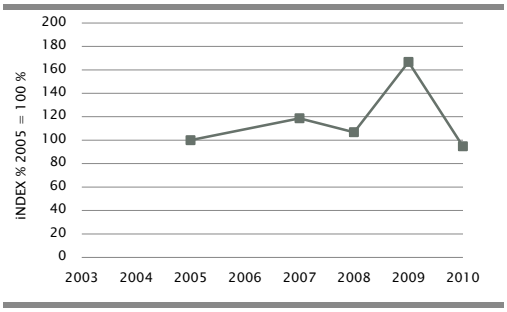
The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased since 2005 (see Figure 73) but are still on a very low level (2010: 34 cases). The increase seems to be more an expression of improving data quality than an epidemiological trend [NR 2011].

22.2 Indicators for drug-related harm reduction

Most preventive interventions of drug-related infectious diseases, as well as some of the substitution treatment interventions were supported by international funding (Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, UNODC), mainly for NGO-run programmes. The end of the mentioned programmes in 2010, in connection with the lack of feasible governmental measures, might be a future cause of the radical reduction of this type of services [NR 2011]. Syringe exchange programmes are implemented only in four regions of Romania, which are considered to have the most serious problems related to injecting drug use. NGOs are the main service providers, carrying out outreach programmes, addressing injecting drug users and sex workers, as well as providing syringe exchange programmes, both in fixed locations and via street workers. Together, NGOs provided services to more than 9.400 drug users and giving out in 2009 1,7 million syringes [CO, NR 2011]. In 2010 the number of syringes distributed dropped down to the level of 2005 (see Figure 74).

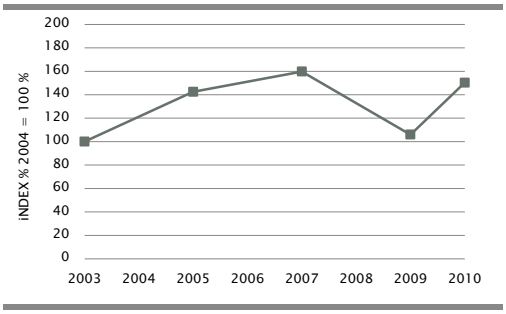
The number of clients in substitution treatment is increasing, although there was a drop down in 2009 to the level of 2003 (see Figure 75). In 2010 2.163 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 74:
Syringes provided through needle and syringe programmes (NSP) (indexed - 2005=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 75:
Number of clients in substitution treatment (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

22.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

A DRID strategy is part of the national drug strategy. The general objective is: Ensuring the drug users' access to harm reduction services, by promoting and developing adequate programmes and policies necessary in the medical care system, outside it and in the penitentiary system.

Specific objectives:

» Creating and continuously improving the organizational framework in order to ensure all the measures for harm reduction (exchanges of sterile medical equipment, including needles and syringes, psychological and pre/post-test counselling, substitutive treatment programmes, etc.), for drug users and addicts in the medical care system, outside it and in penitentiaries;
» Developing community and professional measures to reach out to all drug users groups, with a view to enhancing the support granted to them and diminishing their social marginalization;
» Creating the organizational framework and adopting the required regulations to ensure epidemiological monitoring;
» Developing and improving the framework for basic, specialized and in-service training of professionals working in the harm reduction field [SQ 23/29 2011].

In Romania, the medical, psychological and social assistance system targeting the drug users is divided on 3 levels of intervention. The first level represents the main access to the assistance system, having as main objective the reduction of risks associated to drug use, with direct access, upon the request of the drug users. The aim of this level is to ensure the identification, enticing, motivation and referring of drug users to the specialized services, to approach the main social and medical needs of the drug users and the necessary coordination with the resources from levels 2 and 3. The importance of level 1 is emphasized by the contact and the enticing of population from outside the treatment network, the assurance of the epidemiologic vigilance, the decrease of the negative consequences associated to drug use, the narrowing of social conflicts, the increase of motivation for change, in order to start an adequate treatment [PS].

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Decision no 1862/ 2006 on the approval of Minimum Quality Standards for the prevention of drug use in school; http://www.ana.gov.ro/vechi/rom/decizia_1862064.pdf

Decision no 1862/ 2006 on the approval of standards for drafting the school programmes for spending free time, information, education and communication, in order to increase the influence of protection factors regarding the use of drugs and other

substances, in accordance with the assessments/ researches carried out at the national and/ or local level; http://www.ana.gov.ro/vechi/rom/decizia_1862065.pdf

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

Risk education and OD training is available in just a few relevant cities in Romania. The provision of individual counselling is limited. The provision of information material is not a priority response to prevent drug-related infectious diseases. The provision of information materials to reduce drug harms in night clubs and in large music festivals is rare[31] [SQ 23/29 2011].

There has been a strong increase in the availability/coverage of information and counselling services since 2003 in Romania [PS].

31
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for family/ friends. Formal NSP trainings are available for other groups: commercial sex workers, homeless people, roma people [SQ 23/29 2011].

The availability/coverage of information measures targeted at families and communities is limited but has strongly increased since 2003.

Major challenges are:

» Lack of financial resources for motivating the families of drug users;
» Low interest of families of drug users for information, counselling, therapy activities or support groups;
» Altering the perception of drug user from offender to a person who needs help;
» Recognizing the drug use both as a public health and as an order and public safety issue at the community level;
» Creating and supporting teams of professionals for a toxic dependency unit with the purpose to receive, assess (medical, psychological, social issues), orientation (within the network), treatment, research and education, for the identification of neonatal and fetal risks of the maternal toxicomania [PS].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach health education is a priority response to prevent DRID. The approaches are based on harm reduction counselling and needle exchange programmes addressed to IDU's. The programmes target in general IDU's but also some of them have a focus on groups at risk like commercial sex workers, prisoners, homeless people and roma

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minority [SQ 23/29 2008]. Currently, outreach services operate in Bucharest, but at a low capacity [PS].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are involved in the responses to prevent DRID but it is not a priority [SQ 23/29 2008]. The availability/coverage of peer involvement in outreach work is limited but has strongly increased during the last years [PS].

Naloxone "take-home" doses are distributed to drug users, peers and relatives who have completed a first aid training/ training on overdose management [SQ 23/29 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

The availability/coverage of networking and cooperation between agencies involved in outreach work is extensive. Establishing and developing the Romanian Harm Reduction Network, which determined the increased cooperation of NGOs in the field; there is also a strong partnership between NAA, the Romanian Harm Reduction Network and the NGOs [PS].

Council Recommendation 2.6.

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Outpatient and inpatient psychosocial treatment and detoxification are available in Romania, the waiting time for OST is between 1 and 6 months due to limited availability/resources [SQ 27 p1 2011]. Drug consumption rooms are not available [SQ 23/29 2008].

Substitution treatment and needle exchange programmes are available in community and prisons. Besides the services provided by the Ministry of Health, the NAA provides methadone treatment, buprenorphine and naloxone and naltrexone since 2007, through its 3 centres in Bucharest and 2 at the national level. Through its 47 CAPEC, the NAA has established the integrated system of assistance for drug users, providing case management services, medical, psychological and reintegration services for drug users [PS].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Medical doctors at specialised drug treatment centres and any medical doctor can initiate and continue methadone treatment and buprenorphine/ naloxone combination. Methadone and buprenorphine/ naloxone combination can be dispensed at specialised treatment centres, any medical doctor office, pharmacies and mobile outreach units [Statistical Bulletin 2011 Table HSR-2].

Substitution substance can be taken outside the programme when patients demonstrate clinical, social, cognitive and emotional stability to assume responsibility for the care and safeguarding of methadone, and use it only as prescribed [SQ 27 p1 2011].

Measures to prevent diversion of substitution substances are extensive: Special legal regime in pharmacies, strict recording of the drug administration, video cameras, urine

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tests, daily individual prescription of the treatment, internal functioning reglementations, periodical check-ups [PS].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Drug-related prison health is addressed in the national drug strategy. Priorities are the dissemination of information materials concerning infectious diseases, low intensity drug treatment and initiation of opioid substitution treatment (OST) [SQ 23/29 2011]. Initiation and continuation of OST in prison is available. The provision of OST in prison is limited [SQ 27 p1 2011]. The provision of pre-release OD counselling is limited. Naloxone is not provided upon prison release [SQ 23/29 2011].

Regarding the assistance provided to drug users in prisons, even though at an early stage, there are steps taken towards completing the therapeutic chain: the available data show a focus in psycho-social assistance, education for health, training as peer-educators for the prevention of HIV, HVB and HVC infection and specific treatment of infectious diseases associated to drug use, prevention of drug use and support for the social reintegration after the imprisonment is over.

Between 2001-2010, the numbers of detained persons, self declared as drug users at the beginning of their sentence doubled (from 1.065 to 2.043), while the numbers of detained persons, for the same reference period, were reduced by half. A decrease in the number of those who did not use drugs in or outside the prison is noticed, together with a slight increase in the number of those who used drugs outside the prison and continue to do so. Heroin continues to be the main drug used (more than 2/3), followed by cannabis and cocaine. In relation with the type of drug used, the injection is the most frequent method used. In 2010, there is an increase by 4 times of those who declared poly-drug use (from 2,54 % to 12,18 %) [PS].

Reference:

Prevalence of drug use in prisons in Romania – 2006 and 2011:
http://www.ana.gov.ro/studii/studiu%20penitenciare.pdf [PS].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination scheme since 1996. A risk-group specific hepatitis B vaccination programme is available, implemented by ARAS NGO (Romanian Association against AIDS), only in Bucharest. Coverage is rated as limited (around 100 persons/year) [SQ 23/29 2011].

The provision of HCV testing is limited. Provision of condoms at drug agencies with NSPs is extensive [SQ 23/29 2011].

The situation of injecting drug users changed considerably between 2003 and 2012, being strongly influenced by the emergence of new psychoactive substances in recent years. The official data show 114 new HIV cases among injecting drug users in 2011. Between 2007 and 2009 there was 1 % of injecting drug users among the total persons newly infected with HIV, in 2010 there were 2,7 %, followed by 18,4 % in 2011.

In 2009, the main injecting drug was heroin (75 %), in 2010 there is a poly-use of heroin and new psychoactive substances (76 %). In 2009, the percentage of early injecting was 7 % for persons aged 8-13, in 2010 it increased to 15 %. In 2009, 19 % of drug users used injections minimum 4 times a day, in 2010, the percentage increased to 45 %. In 2009, 83 % were infected with HCV, in 2010, there were 88 % [PS].

Reference:

Survey regarding the prevalence of HIV and/ or HVC infections among injecting drug users in Bucharest, placed under treatment and syringe exchange programmes: http://www.ana.gov.ro/studii/Raport_final_studiu_boli_infectioase_bucuresti.pdf [PS].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

A DRID strategy is part of national drug strategy. NSP is provided at fixed locations, in prisons and -in Bucharest - also by outreach programmes. Provision of condoms at drug agencies with NSPs is extensive [SQ 23/29 2011].

The availability/coverage of condom distribution and of injection materials is limited but has increased since 2003 [PS].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

The availability/coverage of emergency services adequately prepared to deal with drug overdoses is limited [PS].

Naloxone is regulated by administrative regulation. Naloxone is available on medical prescription. Naloxone "take-home" doses are distributed to drug users, peers and relatives who have completed a first aid training/ training on overdose management [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Drug users are not explicitly addressed in the primary healthcare plan, but there is information on other target groups that may include drug users: HIV, HCV, HBV positive persons [SQ 28 2010].

Policies to improve social reintegration and reducing social exclusion of drug users are:

» Developing the necessary resources for active interventions to attract drug users who did not interact with the integrated medical care system nor are prepared for a behaviour change, and providing them with basic medical and social care;
» Customizing the medical, psychological and social interventions, based on multi-dimensional evaluation and case management, applied to drug users who interact with the medical care services in a coordinated framework;
» Developing the policies and measures, ensuring the legal framework and resources for the development and strengthening of the outpatient medical services (2nd tier of medical care) – a central element of the public system of medical, psychological and social care – in order to guarantee access of all drug users to this level of medical care;
» Ensuring and implementing the legal framework for the development and definition of the specific and specialized roles of 3rd tier resources, as a constitutive and essential part of the public system of medical, psychological and social care for the rehabilitation and social reinsertion of drug users in outpatient units;
» Developing the legislative and institutional framework ensuring the general and early access of children and young people to psychological, medical and social services, specific for the treatment of drugs use;
» Developing an integrated programme of medical, psychological and social care, providing a network of resources and guaranteeing the universal access and availability to all drug users in the penitentiary system, with a view to their social reintegration;
» Developing and implementing the standardization in the medical, psychological and social care system, thus allowing the monitoring and assessment of processes and their outcome;
» Developing and improving the framework of basic, specialized and in-service training of professionals providing medical, psychological and social care to drug users [SQ 28 2010].

There are protocols between different national, regional and local authorities and agencies involved in addressing the health and social needs of drug users in treatment. The most common mechanism of interagency coordination is the structured protocol [SQ 28 2010].

Employability of drug users in treatment is part of treatment care plan. The case management approach is a holistic approach addressing all social, psychological, medical and educational needs of the client aiming a reintegration process in the society. Finding a stable job for their clients is one of the main tasks of the multidisciplinary team in order to assess that the client is stabilized [SQ 28 2010].

One major step was the setting up of the NAA (REITOX National Focal Point) as the main institution in the field, which established the outlook and coordinates, assesses and monitors, at the national level, the policies in the field of prevention and combating trafficking and illicit drug use, as well as the integrated assistance of drug users, implemented by the institutions with attributions in the field. Through its territorial structures, the NAA provides integrated services of medical, psychological and social assistance, as well as prevention services. Through the CAPEC, the NAA ensures the relationship with the other community services, especially through the case manager, who coordinates, plans and monitors the medical, psychological and social services, depending on the individual needs of the drug user.

One of the 4 Integrated Assistance Programmes of drug users in Romania is focused on reducing the risks associated to drug use, being divided in: opioid substitution treatment and a syringe exchange programme and/ or other measures for harm reduction [PS].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Formal NSP training programmes regarding health promotion activities are available for drug agencies, prison staff and NGOs staff. It's not available for pharmacists [SQ 23/29 2008].

Occupational standards for drug treatment are available for social workers, nursing staff, psychologists and medical doctors. Specialised courses/ training on drug treatment are implemented for social workers, psychologists and medical doctors [SQ 27 p2 2008].

A national system for continued education is available for social workers, nursing staff, psychologists and medical doctors [SQ 27 p2 2011].

Major achievements since 2003 have been the setting up of the National Training and Documentation Center on Drugs, which has as attributions the identification of training needs of professionals working in the field of drugs, for their continuous professional development, the accreditation and coordination of training programmes and the developing the occupational standard for addiction counselor and its inclusion in the Romanian Job Directory [PS].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

Scientific evidence is used as basis to select interventions to some extent [PS].

There are national guidelines for assessment of infectious disease risk among drug users, NSPs and for prison pre-release counselling: ARAS NGO, Decreasing HIV transmission in the penitentiary system http://www.arasnet.ro/materiale.php [SQ 23/29 2008].

There are sub-national NSP guidelines: Management of the needle exchange programme by the Romanian Harm Reduction Network -RHRN Romanian Anti AIDS Association -ARAS Unicef [SQ 23/29 2011].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

Needs assessments are used at the initial stage of programmes to some extent [PS].

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Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Drug treatment outcomes are sporadically evaluated in psychosocial treatment, detoxification, OST and social reintegration treatment [SQ 27 p2 2008].

There is no national research programme for evaluation. There are no relevant research projects on treatment in the last 2 years [SQ 27 p2 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

Quality criteria are used in evaluations to some extent [PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Standardized data-collection and information dissemination according to the EMCDDA recommendations is organized through the REITOX national focal point [PS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

Evaluation results are used for further development of drug prevention policies to a large extent [PS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Evaluation training programmes are available to some extent [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

Actors and stakeholders are involved in evaluation to some extent [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

Professionals in Romania have access to opportunities for exchange of programme results, skills and experience at European level to some extent [PS].

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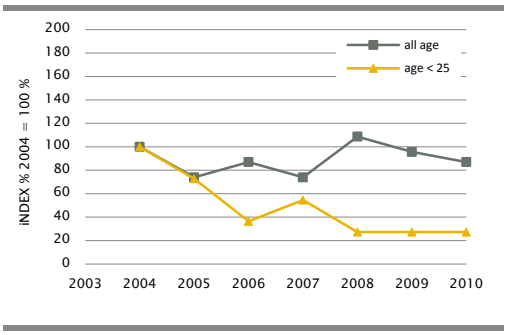
23 Country Profile Slovakia

23.1 Indicators for drug-related harm

In 2008, around 10.600 persons (8.200-33.500) were estimated to be **problem drug users** (2,7; 2,1-8,5 per 1.000 inhabitants). Users of opioids were estimated in the range of 4.000-9.800 (approximately 46 % of the estimated population of problem drug users) and users of pervitin 2.500-9.900. Practically all of the estimated problem drug users were injecting drug users [CO]. The largest groups of clients in outpatient treatment in 2010 have opioids (39 %) and stimulants (mainly pervitin - 34 %) or cannabis (21 %) as primary drug. In inpatient treatment the respective proportions are 31 %, 39 % and 18 % [Statistical Bulletin TDI-19]. According outpatient treatment data 78 % of opioid users inject the drug (12 % are sniffing), Stimulants (pervitin) are mainly sniffed (56 %), 26 % use stimulants by injecting and 17 % smoke them [Statistical Bulletin TDI-17].

The number of new HIV cases with a history of IDU reported is between 1 and 3 cases in the last years [EMCDDA Statistical Bulletin 2012 INF 104]. Long-term HIV/AIDS infection among injecting drug users is one of the lowest in the world. In 2010, about 0,3 % of HIV testing samples collected from 371 drug users in different care settings is reported as HIV positive [CO]. Data on HCV prevalence among IDUs are available for Bratislava only.

Figure 76:
Number of direct drug-related deaths (indexed - 2004=100 %)



Source: EMCDDA Statistical Bulletin, DRD-2

The percentage of cases reporting with antibodies to the hepatitis C virus (HCV) among patients entering treatment for the first time was 40.3 % in 2009 [CO]. The trend in this source of data are quite stable since 2001 [NR 2010].

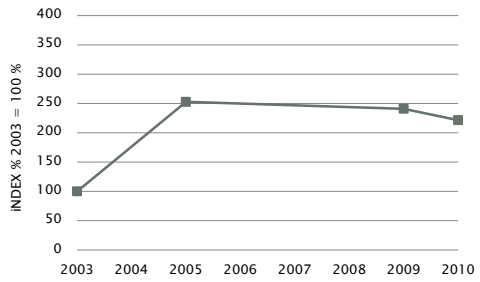
The overall number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** is stable since 2004 while the number of death case aged under 25 decreased markedly (see Figure 76).

23.2 Indicators for drug-related harm reduction

In 2010, there were five organisations running outreach needle and syringe exchange programmes (NSP) in four towns. In three towns there were both types of outlets: mobile/outreach and stationary syringe exchange programmes. An estimated 21 % of problem drug users could be reached by existing low-threshold services [CO]. The numbers of syringes provided through needle and syringe programmes increased markedly from 2003 to 2005 and are quite stable since then (see Figure 77).

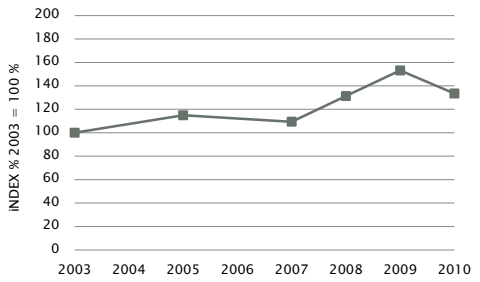
The number of clients in substitution treatment was increasing – especially from 2007 to 2009 followed by a slight decrease in 2010 (see Figure 78). In 2010 2.266 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 77:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 78:
Number of clients in substitution treatment (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

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23.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

In Slovakia, the Ministry of Health is responsible for the implementation of the Council Recommendation [Trimbos 2006].

Harm reduction is a public health objective in Slovakia. In April 2004, the Slovak Government adopted a National Programme for the Fight against Drugs 2004-2008 [Trimbos 2006]. One of the key aims concerns the availability of treatment of dependencies and harm reduction programmes for the general public.

A DRD strategy is part of the national drug strategy, but the objectives are not specified there [SQ 23/29 2011]. The objectives are to be elaborated and implemented by respective departments/ministries' action plans.

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

To prevent infectious diseases among drug users, providing information, education and communication via counselling and advice by drugs and health professionals is a common response strategy in Slovakia [Trimbos 2006]. Websites and a broad range of educational leaflets are available nationwide. In specific geographical areas only, telephone help lines are available.

Dissemination of information materials for drug users as well as practical advice and training is not a priority response strategy to prevent drug-related infectious diseases in Solwakia [SQ 23/29 2011]. "Easy-access" programmes to treatment of infectious diseases are not a priority response strategy either [SQ 23/29 2011].

Information material to reduce drug harms is provided in night clubs rarely, but at large music festivals extensively[32] [SQ 23/29 2011]. Individual counselling on infectious diseases is provided extensively while safer use training is provided to a limited extend only [SQ 23/29 2011].

32
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

Overdose information material for drug users is provided rarely [SQ 23/29 2011]. Risk education and overdose response training is carried out rarely – in just a few cities [SQ 23/29 2011]. Individual overdose risk assessment is not available [SQ 23/29 2011].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Communities and families of drug users are nationwide involved in the prevention and reduction of health risks associated with drug dependence, and also, specific information, education and communication are available nationwide for communities and families of drug users [Trimbos 2006].

Specific materials on prevention of acute drug-related deaths and drug-related emergencies are not available for family/ friends or other groups [SQ 23/29 2011]. Formal NSP training programmes regarding health promotion activities are also not available for other groups [SQ 23/29 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach work is not a common or priority strategy or setting to prevent infectious diseases among drug users [Trimbos 2006, SQ 23/29 2011].

Main outreach health education approaches are individual for clients and the provision of educational material (flyers, brochures, booklets) [SQ 23/29 2011]. Campaigns in recreational settings (summer festivals) and education of specific population in prisons (educational lectures) is only provided within specific projects. The provision of outreach work at night clubs is limited and in large music festivals is extensive.

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer involvement is not a priority response to prevent DRID [SQ 23/29 2011]. However, in specific geographical areas, training for peers and volunteers is organized and peers and volunteers are included in outreach work practice [Trimbos 2006].

Naloxone is not available on a “take-home“ basis [SQ 23/29 2011].

In 2007 a new system of emergency first aid was implemented in the whole country [NR 2010]. This system increased indirectly but significantly the availability of healthcare also for urgent drug-related health threats. In this context, medical education of drug users became an important part of prevention of health threats due to drug use.

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

There is no information available about the existence of networking and cooperation between outreach work agencies in Slovakia [Trimbos 2006]. Cooperation is not coordinated and exists on ad hoc base [GS].

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Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Treatment with naltrexone and drop-in centres is not available at all [Trimbos 2006]. Drug consumption rooms and heroin prescription programmes do not exist in Slovakia [Trimbos 2006, SQ 23/29 2011].

Psychosocial out- and in-patient interventions, detoxification and substitution treatment are fully available, psychological support is provided to OST clients extensively, there is no waiting time for any kind of treatment [SQ 27 p1 2011]. Treatment interventions for target groups are available for cannabis, amphetamine and benzodiazepine users. Treatment of other mental disorders together with the treatment of drug addiction became an essential part of drug treatment [NR 2010].

In the year 2009 700 clients received OST [Statistical Bulletin 2010]. 1.909 drug users received treatment in health facilities or prisons in 2009 [NR 2010]. Treatment is mainly carried out as outpatient treatment, but there are also specialized treatment centres and psychiatric wards of hospitals offering inpatient treatment.

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are available nationwide in Slovakia [Trimbos 2006].

OST with methadone, HDB and a combination of buprenorphine and naloxone can be initiated and continued by medical doctors at specialised drug treatment centres [Statistical Bulletin 2010]. Methadone, HDB and a combination of buprenorphine and naloxone can be dispensed at specialised treatment centres. Condition for “take-home“ OST with methadone is clean urines [SQ 27 2011]. There are no conditions for “take-home“ OST with buprenorphine.

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Measures targeting infectious diseases among drug users in prisons are available nationwide (voluntary treatment of drug users, drug-free zones, hepatitis C treatment). Drug paraphernalia are not available in prisons. Information materials with regard to the prevention of infectious diseases are not disseminated in Slovakian prisons [Trimbos 2006].

Drug-related prison health is addressed in the national drug strategy [SQ 23/29 2011]. A DRID strategy is part of the national drug strategy, the target group is drug users in broad sense.

Priority responses to prevent DRID in prison are individual risk assessment and one to one counselling infectious diseases, low intensity drug treatment as well as medium/ high intensity drug-free treatment (prison-TCs, specialised prison treatment wards) [SQ 23/29 2011].

Low intensity drug treatment as well as medium/ high intensity drug-free treatment is provided extensively by prison health services, while continuation of OST in prison is not available [SQ 27 p1 2011]. Individual counselling on infectious diseases risk is provided to a limited extend and HCV testing on entry into prison is provided fully. Practical advice and training on safer use as well as NSPs are not available in Slowakian prisons.

Concerning the prevention of acute drug-related deaths, pre-release OD counselling is provided rarely and naloxone is not provided upon prison release [SQ 23/29 2011].

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Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination scheme since 1998 [SQ 23/29 2011]. A risk-group specific hepatitis B vaccination programme is not available, however vaccination is recommended to risk groups of drug users. Voluntary infectious disease counselling and testing as well as Hepatitis vaccination programmes are a priority response to prevent DRID in Slovakia. Routine screening of high risk groups as well as "easy-access" programmes to treatment of infectious diseases are not a priority response strategie to prevent DRID in Slovakia.

Concerning TB the general vaccination programme covered 1991-2003 up to 98-99 % of the population (95 % on local level in some regions) [Trimbos 2006]. TB incidence among drug users is not monitored. It is considered to be very low due to national programme of immunisation.

Condom promotion is not a priority response strategy to prevent DRID and they are provided at drug agencies with NSPs to a limited extent [SQ 23/29 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

Needle and syringe exchange programmes are a common response strategy to prevent infectious diseases among drug users in Slovakia.

A DRID strategy is part of the national drug strategy. Under the domain "Drug demand reduction" the objective No. 5 includes: To ensure access to services in the area of reducing the damage caused by drugs with the aim to slow down the spread of HIV/AIDS, hepatitis C and other drug-related infectious diseases transmitted via blood and reduce the number of drug-related deaths [SQ 23/29 2011].

Needle and syringe exchange programmes are a priority response strategy to prevent infectious diseases among drug users in Slovakia [SQ 23/29 2011]. There are no legal restrictions to the possession of sterile needles in Slovakia, and also no prescription is required to obtain or exchange needles and syringes [Trimbos 2006]. NSPs are provided extensively [SQ 23/29 2011]. NSPs are located at 5 fixed locations and provided 317.416 syringes in the year 2010 [ST 10 2011]. In addition there are 5 Syringe Provision Points (SPPs) provided by 5 outreach and 3 mobile units [ST 10 2011]. Injecting kits are not provided by harm reduction organisations [SQ 23/29 2011].

Pharmacy-based NSP is not available [ST 10 2011] and no formal NSP training programmes regarding health promotion activities exist for pharmacists [SQ 23/29 2011]. However, pharmacies sell syringes and paraphernalia, which is relevant for area outside big cities, where no alternatives exist [GS]. There was a survey on the attitude of pharmacists towards syringe exchange in 2005 [SQ 23/29 2008].

Provision of condoms at drug agencies with NSPs is not a priority and condoms are provided to a limited extent only [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

The availability of naloxone is regulated by administrative regulation [SQ 23/29 2011]. The use of naloxone is limited to medical personnel [SQ 23/29 2011]. Naloxone is available on medical prescription [SQ 23/29 2011], but not on a "take-home" basis [SQ 23/29 2008]. Ambulance personnel are trained in naloxone use [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Risk reduction is part of an integrated health strategy for drug users [Trimbos 2006].

There are several relevant policies to improve social reintegration of drug users in different areas [SQ 28 2010].

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There is a national primary healthcare strategy ("State Health Policy") which doesn´t mention drug users explicitly. According to the law, the primary healthcare is provided to everyone with health insurance. Health insurance for socially excluded groups (unemployed, children, old people and people without income) is paid by the State. The treatment of drug dependence in the health facilities is covered by the health insurance.

Drug and other dependent people are not explicitly mentioned in the National Action Plan on Social Inclusion for 2008-2010. In practice (when they are treated by social services, they are associated with people discharged from prison). Residential phase of drug therapy (12-15 months) is provided by the RCs. The stay of the client in RC is partly paid by social services and by him/herself.

The housing needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan, but there is information about other groups. Temporary accommodation is provided by social services for socially vulnerable groups (incl. drug users in treatment). Temporary accommodation starts from low/emergency level of hostel and shelters (one day/one night) up to crisis centre and half way home (3 months - 12 months). There is also the opportunity to gain social benefit for paying households and rent costs if socially excluded people are living at their original home. Social housing (in EU term) is very rare in Slovakia due to the lack of relevant social flats.

The educational needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan, but there is information about other groups. Individuals from socially vulnerable groups (incl. drug users in treatment) are in contact with social services, which are to discover applicants´ abilities for employment. Education level is the key point to be successful in the work market. Social services are offering some short time courses for re-qualifying and can provide (co-operation with the Education services) the completing of compulsory/primary education to early school leavers.

Employment needs of drug users are not explicitly addressed in the National Employment Plan, but there is information about other target groups. The category of socially vulnerable/marginalised groups covers also ex-users. In general ex-users or drug users in treatment are associated with the group of ex-prisoners. Such clients are addressed by the social curacy agenda.

The Ministry of Labour, Social Affairs and Family is in charge to implement the National Plan on Employment as well as the National Plan on Social Inclusion through its special institutions - Offices of Labour, Social Affairs and Family. Those (state) institutions are located in each district (79 plus Headquater of LSaAF) to meet the needs of socially vulnerable and marginalised groups - mostly children and old people - on local level.

Former drug users and/or treated persons are not specifically mentioned as such vulnerable group. People with drug problems are primarily treated in Health Facilities (Ministry of Health). Health Facilities can recommend further steps of residential form of psychotherapy (group therapy in community) in social reintegration centres (Resocialisation Centres) or outpatient forms of care within the Health Facility and Health Services (group therapy, daily clubs ...AAA).

Health Facilities can organise the contact of its former patients with Resocialisation Centres directly (informal way) or more formally via Offices of LSAF. On the other hand clients of Resocialisation Centres can participate in the residential programme of resocialisation without completing drug treatment in Health Facilities, the proposal of the psychiatrist or addictologist is sufficient. Such conditions are set by the Act on social curacy and protection of children.

There are protocols between different national, regional and local authorities and agencies involved in addressing the health and social needs of drug users in treatment.

There are partnership agreements between social services and health services to meet the needs of drug users in treatment. Agreements between outpatient treatment facilities and the social services exist rarely. The most common mechanism of inter-agency partnership is the informal network. Partnership agreements between residential treatment facilities and social services exist to a limited extent only.

The employability of drug users in treatment is part of treatment care plan, but not in general. Resocialisation Centres prepare together with the clients individual reintegration plans where further steps for improving the employability can be involved. There is no information about this, but there is probably no link between health services and the drug treatment process and "employability" issues [SQ 28 2010].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Formal NSP training programmes regarding health promotion activities are available for drug agencies staff only [SQ 23/29 2011]. Training is not available for pharmacists, prison staff or other groups [SQ 23/29 2011]. In specific geographical regions, training for outreach workers is organized [Trimbos 2006].

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There is no institution responsible for developing guidelines [SQ 27 P2 2008]. Occupational standards for drug treatment are available for nursing staff and medical doctors. Specialised courses/ training on drug treatment are implemented for medical doctors. There is no information about other professions. A national system for continued education is available for medical doctors.

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

In the Slovak Republic, the results of international research are being used for the development of interventions and policies [Trimbos 2006]. For example, WHO reports were and are used to diagnose the 'harmful use' of drugs and 'drug dependency', and/or other health disorders related to such diagnoses. The system of drug treatment is based on scientifically verified approaches.

Furthermore, the key background document for the development of drug treatment programmes is a research manual published in 1999 by the U.S. National Institute on Drug Abuse, "Principles of Drug Addiction Treatment", which was translated and published in the Slovak language by the Institute for Drug Dependencies in 2000 [Trimbos 2006].

There are guidelines for alcohol/ drug problems (outpatient and inpatient), detoxification and OST (GP settings) [SQ 27 P2 2008 and Best Practice Portal]:

- Professional regulation of standards for diagnostic and treatment in the drug dependence specialisation (2003)
- Methodical instruction on the provision of MMT maintenance treatment for patients with dependece on opiates and with chronic course of the disease (2004)

There are no guidelines for harm reduction [Best Practice Portal] and there is no institution responsible for developing such guidelines [SQ 23/29 2011].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

No information available.

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation aspects are not included in the guidelines [SQ 27 P2 2008]. Drug treatment outcomes are evaluated rarely, but a prospective cohort study on treatment outcomes has been conducted repeatedly at the Centre for Treatment of Drug Dependencies in Bratislava [GS]. Those patients who had finished their treatment were contacted one year and three years after and were asked about their drug use.

There is no national research programme for evaluation, but there are research projects on treatment (www.cpldz.sk) [SQ 27 P2 2008].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

Within the expert group meetings on prevention, the NFP points out the importance of evaluation in any preventive activity [GS].

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Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

No information available.

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

No information available.

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

No information available.

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

Deep attenuation reigns over the research, training and evaluation activities in drug field [GS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

The Slovak Republic is involved in co-operation with EU Member States and regional and local institutions and forums, such in line with the global, multidisciplinary and integrated EU strategy for combating drugs [Trimbos 2006]. Furthermore, the Slovak Republic will continue to develop co-operation with the Council of Europe's Pompidou Group in line with the Work Programme for 2004-2006. Slovakia will take a more active part in the work of the European Council's advisory group – the Horizontal Working Party on Drugs (HWPD).

The Slovak Republic will participate in projects and work of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) [Trimbos 2006]. Being part of the European Information Network on Drugs and Drug Addiction (Reitox), it will co-operate with national monitoring centres for drugs in other EU Member States.

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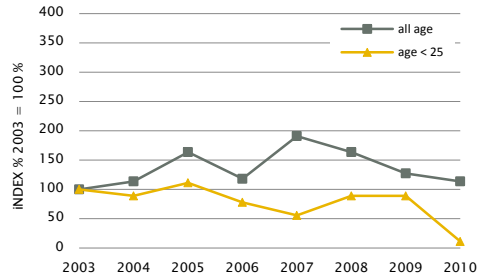
24 Country Profile Slovenia

24.1 Indicators for drug-related harm

The most recent estimate of the number of **problem drug users** (injecting of drugs or long-tem/regular use of opioids, cocaine and/or amphetamines) in Slovenia refers to the year 2004 and amounts to 10.654 problem drug users (95 % confidence interval: 9.078-12.593). In terms of rate per 1.000 inhabitants aged 15-64 years, this corresponds to 7,8 (6,6-9,2) per 1.000 [CO]. Almost all clients in outpatient treatment in 2010 have opioids (91 %) as primary drug (cannabis 5 %) [Statistical Bulletin TDI-19]. According outpatient treatment data 52 % of opioid users inject the drug (35 % are smoking, 11 % are sniffing) [Statistical Bulletin TDI-17].

There has been no new HIV case with a history of IDU reported since 2001. Several studies indicate a HIV prevalence rate below 1 % among confidentially- and voluntarily-tested IDUs who were treated for the first time in the network of outpatient centres and non-governmental needle and syringe exchange programmes in 2010 [CO]. The prevalence rate of HCV among IDUs (based on treatment data was around 22 % in 2010 [CO, NR 2011]

Figure 79:
Number of direct drug-related deaths (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 DRD 2

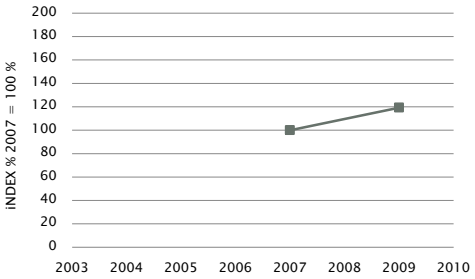
The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased from 2003 to 2007 followed by a decrease and was in 2010 on the same level as in 2003 (see Figure 79).

24.2 Indicators for drug-related harm reduction

Needle exchange services for injecting drug users exist in the capital city of Ljubljana and other regions and cities. Syringes are mainly made available through day-care centres, outreach and mobile services, but also through five pharmacy-based exchange sites [CO]. National data on syringes provided through needle and syringe programmes exist for 2007 and 2009 showing an increase (see Figure 80).

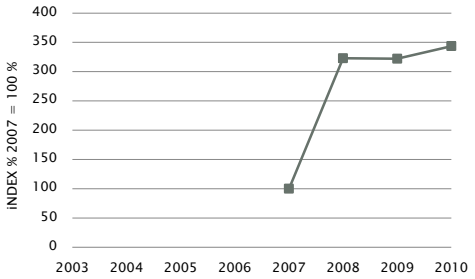
The number of clients in substitution treatment is increasing especially from 2007 to 2008 (see Figure 81). In 2010 797 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 80:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2007=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 81:
Number of clients in substitution treatment (indexed – 2007=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

24.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

In the new draft National Programme in the Field of Drugs for the 2011 – 2020 Period, the main emphasis is placed on a comprehensive and balanced continuous development of all measures, programmes and activities that contribute to solving the problems with illicit drugs in Slovenia.

Among other objectives and tasks of the new National Programme in the Field of Drugs, special emphasis is placed on providing support:

» to programmes aimed at preventing use of illicit drugs with the aim of reducing the number of new drug users among the younger generation and reducing the number of offences and criminal acts relating to illicit drugs,
» to programmes that are aimed at helping maintain or reduce the number of those infected with HIV and hepatitis B and C and overdose deaths,

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» to programmes providing psychosocial assistance to drug users, therapeutic communities and communes and reintegration programmes for former drug addicts,
» to co-ordinating structures in the field of drugs on local and state level,
» to activities aimed against organised crime, illicit trafficking in drugs and precursors, money laundering and against other forms of drug-related crimes.

Furthermore, this document wishes to contribute to different activities in the region in the broader European area, especially through our active participation in international organisations [NR 2011].

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

In Slovenia, information is disseminated nationwide through telephone help lines, various websites and educational leaflets. In specific geographical regions, training for drug users is organised [Trimbos 2006].

To prevent infectious diseases among drug users, providing information, education and communication (IEC) in general, and IEC via counselling and advice by drugs and health professionals are the predominant response strategies. Safer injection training is provided in some cities. [Trimbos 2006].

With regard to the reduction of drug-related deaths the dissemination of information materials, risk education/ response training for drug users, and individual risk counselling are the predominant response strategies. Predominant settings for the dissemination of information materials are specialised drug treatment services and low

threshold agencies, including needle and syringe exchange programmes, outreach workers, detoxification services, prisons, and rave events and festivals. Common settings include mass media/ internet, doctors' practices and emergency departments. Predominant settings for risk education/ response training for drug users are specialised drug treatment services, low threshold agencies, including needle and syringe programmes, prisons and rave events. Common settings include outreach workers and nightlife [Trimbos 2006].

The provision of information materials to reduce drug harms in night clubs is limited[33] and in large music festivals is extensive. Information materials on DRD and emergencies are not available for police. Risk education and overdose response trainings for users are available in several programmes [SQ 23/29 2011; GS].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Communities and families of drug users are involved in harm reduction; specific information, education, communication for these target groups is available [Trimbos 2006].

Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for family/ friends and other groups [SQ 23/29 2008].

Formal NSP training programmes regarding health promotion activities are available for social workers. It is also available on the medical faculty. The red-cross has several seminars for first aid for drivers and teachers where the first aid in the case of overdosis is included [SQ 23/29 2011; GS].

33
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

In Slovenia, outreach work at dance parties/ raves and in clubs is nationwide available. Street-based outreach work is available in a half of Slovenia [GS].

To prevent infectious diseases among drug users, outreaching health education is a common response strategy. Outreach work and targeted high-risk group interventions are a common implementation setting for infectious diseases prevention measures targeting drug users [Trimbos 2006].

Low threshold agencies, including needle and syringe exchange programmes, and outreach work are the predominant setting for the dissemination of information materials, aimed at the reduction of drug-related deaths. Outreach work is a common setting for the deliverance of risk education/ response training to drug users [Trimbos 2006].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

In specific geographical regions, peers and volunteers are included in outreach work; training for these groups is available also in specific areas [Trimbos 2006]. There are regular trainings for outreach workers [PS].

Peer educators are involved in the responses to prevent DRID but peer involvement is not a priority. Naloxone is not available on a “take-home“ basis [SQ 23/29 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between agencies involved in outreach exist nationwide and on the regional and local level [Trimbos 2006; GS].

In 2010 the project "Empowering NGO harm reduction sector – informing, knowledge and connecting" was carried out. The main aim of the project was the empowerment and development of non-governmental organisations working in the field of reducing harm related to illegal drugs and alcohol in the Republic of Slovenia. Empowerment concerns strengthening the role of NGOs within the dialogue and cooperation with other non-governmental organisations, the state (ministries, local community, agencies) as well as experts and broader public [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Methadone maintenance and methadone detoxification programmes, drug-free in- and outpatient treatment and rehabilitation programmes are nationwide available. Buprenorphine was registered in Slovenia in May 2004 and started to be prescribed nationwide in 2005. Treatment with naltrexone and drop-in centres/ shelters are available in specific geographical areas. Substitution treatment is supported by psychosocial care, upon request by the client. Slow release morphine is also used for OST in Slovenia. Aiming at the reduction of drug-related deaths, opioid substitution treatment (with regard to the reduction of heroin/ opiate overdose) is a predominant response strategy. Slovenia does not have drug consumption rooms (but there are discussions about this topic), and has no heroin prescription programmes [Trimbos 2006; GS; PS].

The provision of psychological support to OST clients is extensive [SQ 27 p1 2011].

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Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are nationwide available [Trimbos 2006].

Specialised medical doctors with the permission of psychiatrist can initiate and continue methadone, buprenorphine/ naloxone combination and slow-release morphine treatment. Specialised medical doctors and prison and probation services can initiate and continue high dosage methadone and buprenorphine treatment [GS].

High dosage buprenorphine and buprenorphine/ naloxone combination can be dispensed at specialised treatment centres, specialised medical doctors' offices and any medical doctor office. Methadone can also be dispensed at pharmacies, slow-release morphine can only be dispensed at specialised treatment centres [Statistical Bulletin 2011].

There are no legal regulations concerning “take-home“ doses of methadone. On the basis of doctrine the patients could “take-home“ the doses of methadone for one week, but there are also some exceptions in very exceptional circumstances [SQ 27 p1 2008]. The conditions for “take-home“ OST are that the patient should be stabilized and has to proof abstinence from other drugs with tests [SQ 27 p1 2011].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Testing, prevention, education and treatment of infectious diseases are available nationwide in prisons. Methadone detoxification treatment, treatment with naltrexone, condoms, counselling and prison pre-release interventions are also provided nationwide in prisons.

Prisons are a common implementation setting for disseminating information materials to prevent infectious diseases in drug users. Aiming at the prevention and reduction of

drug – related deaths, prison pre-release interventions are a common response strategy. Prisons are a predominant setting for providing risk education/ response training for drug users [Trimbos 2006].

Drug-related prison health is addressed in the national drug strategy [SQ 23/29 2011]. Initiation and continuation of OST in prison is available in Slovenia [SQ 27 p1 2011]. NSP are not available, naloxone is not provided upon prison release [SQ 23/29 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Nationwide, testing/ screening for infectious diseases, education, prevention, counselling, vaccination programmes against tuberculosis, targeting drug users, and treatment of HIV, hepatitis C, tuberculosis and sexually transmitted diseases are available [Trimbos 2006].

Hepatitis B is included in the national vaccination scheme [SQ 23/29 2011]. There are targeted hepatitis B vaccination programmes for drug users, and also in prisons [SQ 23/29 2011, Trimbos 2006]. Provision of condoms at drug agencies with NSPs is extensive [SQ 23/29 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

A DRID strategy is part of the national drug strategy. The objective is to support the development of programmes that will help to maintain or reduce the numbers infected with AIDS and hepatitis B and C and fatal cases of overdose. The following measures in particular must be taken: (1) setting up a network of harm reduction programmes in Slovenia; (2) easier access to harm reduction programmes and to various informative material; (3) more programmes and higher quality fieldwork with drug addicts; (4) programmes of exchanging needles in chemists in environments where there are no

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such programmes, and automatic needle dispensers; (5) encouraging the development of safe rooms, night and day shelters for drug users from the streets; (6) inoculations for drug addicts; (7) introduction of public works for drug users; (8) educating persons addicted to drugs concerning the dangers of drug use and safer ways of drug use; the stress will be on the prevention of over-large doses of psychoactive substances and first aid [SQ 23/29 2008].

The provision of NSPs is extensive. Types of needle and syringe exchange available include fixed sites, vans/ buses, outreach, and pharmacy-based needle and syringe exchange but not prisons. Formal NSP training programmes regarding health promotion activities are not available for pharmacists. Provision of condoms at drug agencies with NSPs is extensive [SQ 23/29 2011]. In the last three years more money for material for safer injection and condoms is spent. The money comes from Health Insurance [PS].

Standard items in the injecting kit are: alcohol pads, dry wipes, water, filters, acid, condoms, trash bags (specific containers for safe disposal of syringes) and first aid kit (plasters, bandages etc.). As paraphernalia for non-injecting drug users, sticks for nasal use of drugs are available [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Emergency services adequately prepared to deal with drug overdoses [PS]. Naloxone is regulated by administrative regulation. Naloxone is not available on a "take-home" basis [SQ 23/29 2008]. Naloxone is part of standard ambulance equipment, Ambulance personnel is trained in naloxone use [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Nationwide, risk reduction is part of an integrated health strategy for drug users [Trimbos 2006].

There is no special paper of national health strategy. But there is a more detailed description about treatment of drug users in the health system in the law and in the national drug strategy [SQ 28 2010; GS].

The housing needs, educational needs and employment needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan or in the written drug policies [SQ 28 2010].

There are no protocols between different national, regional and local authorities and agencies involved in addressing the health and social needs of drug users in treatment. There are no partnership agreements between the social services and the health services to meet the needs of drug users in treatment. The most common mechanism of interagency coordination is the informal network and agreement on the political level in national commission on drugs [SQ 28 2010; GS].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Training for professionals working in emergency departments, in treatment facilities and in prison settings is available nationwide. Specific geographical regions provide training for outreach workers and for professionals working in needle exchange programmes, in substitution programmes or in low threshold programmes. There is a special 60 hours training for staff in low-threshold centres and outreach workers [Trimbos 2006; GS].

There is no recognised professional qualification for professionals in the field of prevention and reduction of health-related risks associated with drug dependence in Slovenia, neither is this planned [Trimbos 2006].

Formal NSP training programmes regarding health promotion activities are available for drug agencies staff, prison staff and social workers [SQ 23/29 2011].

A national system for continued education and specialised courses/ training on drug treatment are implemented for social workers, nursing staff, psychologists, psychiatrists and medical doctors [SQ 27 P2 2011].

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Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

The needle exchange project 'Stigma' has been evaluated, but not through a standardised protocol. The effectiveness (of the Stigma needle exchange) was evaluated through informal contacts with drug users and through statistical data: number of visits/ clients, number of needles issued and returned, number of contacts within the counselling programme and outreach work [Trimbos 2006].

There are national guidelines for assessment of infectious disease risk among drug users, for NSPs, for OD assessment [SQ 23/29 2008]. There are sub-national guidelines for prison pre-release counselling [SQ 23/29 2011].

There are national guidelines for [SQ 27 P2 2008, 2011]:

- Alcohol and drug problems (outpatient and inpatient)
- Psychosocial interventions (outpatient and inpatient)
- Detoxification (outpatient and inpatient)
- OST (outpatient and GP)
- Social Reintegration (outpatient and inpatient)
- Pharmacological treatment (outpatient and inpatient)
- Psychosocial assisted treatment (outpatient and inpatient)
- Psychosocial treatment only (outpatient and inpatient
- Social work in the field of addiction (1995) [Best Practice Portal].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

Regarding the ReNPPD in the coming medium term period, all programmes funded from the budget must be checked. Similarly in this period, an uniform assessment system must be set up, which must start to apply in all phases of planning and implementation of programmes [Trimbos 2006].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

The aim of the ReNPPD is that the majority of programmes are evaluated by external experts who meet conditions for scientific research work [Trimbos 2006].

Treatment evaluation aspects are partly included in the guidelines for alcohol and drug problems, psychosocial interventions, detoxification, OST and social reintegration [SQ 27 P2 2008]. Treatment evaluation aspects are included in the guidelines for pharmacological treatment, psychosocial assisted treatment and psychosocial treatment only [SQ 27 P2 2011].

There is a national research programme for evaluation. In 2007 the Ministry of Health co-financed an evaluation of substitution/maintanance treatment programme in Slovenia within the Twinning Light project together with the Dutch Ministry of Health, Social Welfare and Sport. The evaluation was conducted by Trimbos Institute from Netherlands and with co-operation of the Faculty of Social Work University of Ljubljana [SQ 27 P2 2008; GS].

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Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

In cooperation with various faculties and research institutions and individual researchers, a coordination system for preparation and regular implementation of various qualitative and quantitative researches must be set up [Trimbos 2006].

There are formal requirements for quality assurance for all governmental and non-governmental programmes, especially regarding to staff and responsible persons for implementation of programmes. They must have proper professional education, professional state examination and additional expert knowledge, especially regarding to competing for state grants. The supervision of grant-spending and programme-implementation is assured through partial and final reporting questionnaires. There is a number of academic institutions that are involved in the monitoring and evaluation of programmes that receive funding. In 2002, quality assurance was introduced as part of the selection criteria in Terms of Reference for financial tenders. Quality guidelines were also introduced for reports on programme implementation [Trimbos 2006].

Slovenia has established quite a number of different programmes which include evaluation mechanisms. Usually programmes are evaluated internally. The programmes co-financed by the government or ministries are also evaluated externally. Expertise in this field was mostly provided by professional associations or chambers, while the control of the organisational and administrative implementation of programmes was the responsibility of different competent ministries or government offices through specialised councils or similar committees [Trimbos 2006].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Inter-sectored working groups for individual indicators, harmonised with EMCDDA, have been created in information units, which are the basis for preparing annual national reports for the EMCDDA. Data are also disseminated in Slovenia [Trimbos 2006; GS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The New National Drug Strategy envisages regular evaluation of implementing the strategy and procedures of implementation, evaluation of achievement of aims regarding to results (through indicators) and evaluation of all verified programmes. The Government Office for Drugs took the initiative in 2002 for establishing an interministerial group, which should be responsible for preparing a draft programme of evaluation procedures, especially for evaluating strategic documents and legislation [Trimbos 2006].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

An expert body is being created for this purpose, which will produce professional standards and guidelines [Trimbos 2006].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

This policy exists and was based upon the Council Recommendation [Trimbos 2006].

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Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

Slovenia worked together with Spain and Austria in a Phare Twinning project that was aimed at supporting drug-demand-reduction programmes and reducing the supply of drugs. Furthermore, Slovenia is participating in several international programmes and co-operating with several international organisations dealing with drug issues. International co-operation has played an important role in facilitating certain activities such as realising harm-reduction approaches. It has also provided knowledge and international experience to our experts. Although international co-operation has clearly influenced drug policy in Slovenia, all the programmes and measurements have been adapted to national circumstances. Drugs, organised crime and money laundering are considered a serious international problem [Trimbos 2006].

The exchange of good practice and study visits is supported [PS].

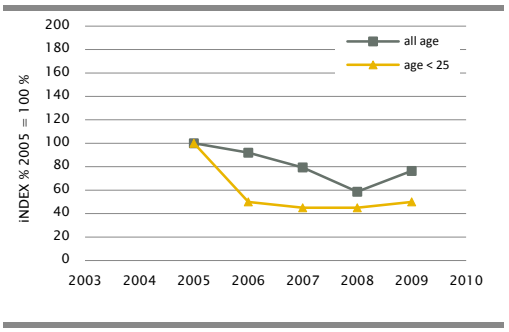
25 Country Profile Spain

25.1 Indicators for drug-related harm

Concerning **problem drug use** there exist several substance specific estimates for 2009 (mainly based on the multiplier method) ranging for problem heroin use from 36.932 to 96.624 (1,2 to 3,1 per 1.000 inhabitants aged 15 to 64 years), for recent intravenous drug use from 14.042 to 26.516 and for problem cocaine use from 130.409 to 140.525 (4,1 to 4,4 per 1.000 inhabitants aged 15 to 64 years) [NR 2011]. The largest groups of clients in outpatient treatment in 2009 have cocaine (44 %) and opioids (34 %) as primary drug [Statistical Bulletin TDI-19]. According outpatient treatment data just 16 % of opioid users inject the drug (71 % are smoking/inhaling). Cocaine is mainly sniffed (81 %) or smoked (15 %) [Statistical Bulletin TDI-17].

There are no national estimates on prevalence rates for drug-related **infectious diseases** among injecting drug users in Spain. The national register of newly diagnosed HIV cases (with way of infection via IDU) improved coverage over the year (no national time series are available). But the absolute number of people infected via IDU as well as the proportion of IDU as way of infection decreased significantly since 2004 [CO]. Data from 9 Spanish regions (Balearic Islands, Canary Islands, Catalonia, Ceuta, Extremadura, Galicia, Rioja, Navarre and Basque Country) where data are available since 2004 show that the number of new diagnosed HIV cases with IDU as route of administration decreased from 306 to 126 in 2009 [NR 2011].

Figure 82:
Number of direct drug-related deaths (indexed - 2005=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

The prevalence rate of HIV among IDUs (ever in life-time) admitted to treatment for psychoactive drug abuse and dependence in Spain in 2009 was 32 %. Prevalence rate for HIV among recent IDUs (injection in the last 12 months) is decreasing (2003: 33 %, 2009: 27 %) especially in the group aged < 25 years (2003: 9 %, 2009: 2 %). Concerning infection rates of IDUs with HCV there is no information available [NR 2011].

The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** decreased since 2005 (see Figure 82) but the data available refers to the six

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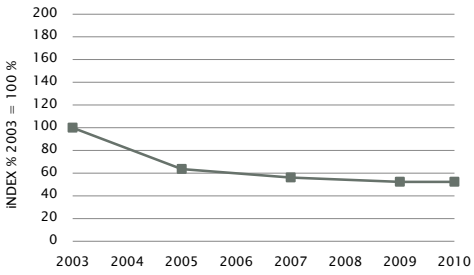
major cities: Madrid, Barcelona, Valencia, Zaragoza, Sevilla and Bilbao only [Statistical Bulletin DRD-2].

25.2 Indicators for drug-related harm reduction

National priorities in the prevention of infectious diseases among drug users include needle and syringe programmes, voluntary counselling and testing of infections and hepatitis vaccination programmes. These services are provided by a large public network of facilities, including 40 social emergency centres, 32 mobile units and 1.246 pharmacies. In 2009 3.264.000 syringes were distributed via special needle exchange programmes [CO]. The number of syringes distributed dropped markantly from 2003 to 2004 and is quite stable since then (see Figure 83).

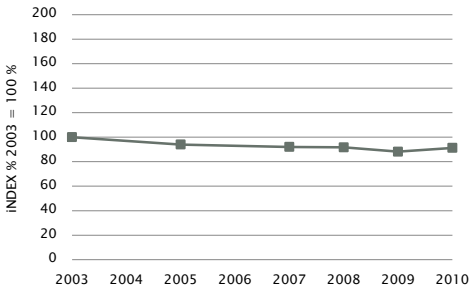
The number of clients in substitution treatment is slightly decreasing since 2003 (see Figure 84). In 2009 52.549 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 83:
Syringes provided through needle and syringe programmes (NSP) (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 84:
Number of clients in substitution treatment (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

25.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

In 2010, the National Plan on Drugs marked the 25th Anniversary of its creation, this Plan now has become well-established as the most effective level for administrative coordination and cooperation for combating drugs and drug addiction [NR 2011].

The 2009-2012 Action Plan highlights the public health dimension as a social component in the drug policies, entailing a firm commitment to improving the interventions and guaranteeing their quality by way of the coordinated activity among all the administrations, which, in turn, may rely upon the indispensable collaboration of the non-governmental organizations for starting up the measures set out therein [NR 2011].

This Plan is organized into 6 areas: coordination, demand reduction, supply reduction, improvement of knowledge, training and international cooperation. These areas include 14 objectives, which are the same as those included under the 2009-2016 Strategy and which are divided, in turn, into 68 actions. This Plan also includes the description of the players involved in getting it under way and the evaluation indicators of each one of the actions [NR 2011].

The area on which most relative importance is placed is that of "demand reduction", divided into three sections (prevention, risk and harm reduction plus social assistance and reintegration), thus entailing practically 53 % of all the actions, most of the actions within this area being preventive, totaling 25 % of all of the actions included under the plan, followed by the actions related to "social assistance and integration", totaling 19,11 % of all the actions [NR 2011].

The National Drugs Strategy 2009/2016 (Harm Reduction Area) and the Drug Action Plan 2009-2012 include the following objectives:

» Reduce or limit damage to health of people who use drugs and, in general, and social effects undesirable health-related with its use.
» Promote the development of specific programmes to reduce damage to prevent health problems and acute poisoning and overdose.

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» Develop harm reduction programmes for people with alcohol problems, with special emphasis on prevention of traffic accidents related to it, by itself alone or with other substances.

Specific objectives are included in the chapters referring to harm reduction policies implemented by each of the Autonomous Communities [SQ 23/29 2011].

Reference:

NATIONAL DRUG STRATEGY 2009-2016 and SPANISH ACTION PLAN ON DRUGS 2009-2012: http://www.pnsd.msc.es/Categoria2/publica/pdf/PlanAction_ingles.pdf [PS].

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

In Spain, websites, training and educational materials promoting risk reduction among drug users including pill-testing, are nationwide available. Telephone help lines are available in specific geographical areas only [Trimbos 2006].

To prevent infectious diseases among drug users, providing information, education and communication (IEC) in general and easy access programmes for drug users to treatment of infectious diseases are predominant response strategies. IEC via counselling and advice by drugs and health professionals, safer injecting training and IEC via peer involvement/ peer approach are common response strategies [Trimbos 2006].

With regard to the reduction of drug-related deaths, the dissemination of information materials and risk education/ response training are the predominant response strate-

gies and individual risk counselling is common. Information materials are predominantly disseminated at specialised drug treatment services, low threshold agencies, including needle and syringe exchange programmes, and through outreach workers, detoxification services, prisons, and emergency departments/ hospitals. Risk education/ response training is available nationwide in big cities and is delivered predominantly at specialised drug treatment services, low threshold agencies including needle and syringe exchange programmes, through outreach workers/ peers, and emergency departments/ hospitals and is commonly delivered in prison [Trimbos 2006].

The provision of information materials to reduce drug harms in night clubs is rare and in large music festivals is limited. Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for police, prison staff and family/ friends [SQ 23/29 2011].

As far as the new National Drug Strategy 2009-2016 is concerned reducing drug-related mortality is actually one of the main objectives of this document. There are also sub-national DRD strategies. Specific objectives are included in those chapters referring to harm reduction policies implemented by each Autonomous Communities [SQ 23/29 2008].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Communities and families of drug users are nationwide involved in the prevention and reduction of health risks associated with drug dependence and specific information, education and communication is nationwide available to communities and families of drug users [Trimbos 2006].

Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for family/ friends [SQ 23/29 2011].

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Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

To prevent infectious diseases among drug users, outreach work as a health education approach is a predominant response strategy and also a predominant implementation setting. Low threshold agencies, including needle and syringe exchange programmes, and outreach work are the predominant setting for the dissemination of information materials, aimed at the reduction of drug-related deaths, and outreach work is also a predominant setting for the deliverance of risk education/ response training, which is delivered nationwide in big cities [Trimbos 2006].

The provision of outreach work at night clubs is rare[34] and in large music festivals it is limited [SQ 23/29 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are involved in the responses to prevent DRID, but peer involvement is not a priority [SQ 23/29 2011]. The availability/coverage of peer involvement in outreach work is limited [PS]. Naloxone is not available on a "take-home" basis to drug users, peers and relatives [SQ 23/29 2011].

34
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

The availability/coverage of networking and cooperation between agencies involved in outreach work is extensive [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Methadone maintenance and detoxification treatment, drug-free outpatient and drug-free inpatient treatment, and rehabilitation programmes are available nationwide. Treatment with buprenorphine, treatment with naltrexone, drug consumption rooms and drop-in centres/ shelters are available in specific geographical areas. Substitution treatment is supported by psychosocial care, upon request by the client [Trimbos 2006]. As a pilot project a small heroin prescription programme is available in Andalucia [GS].

Aiming at the reduction of drug-related deaths, opioid substitution treatment (OST) is a predominant response strategy [Trimbos 2006]. Drug consumption rooms are available in 2 cities [GS].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are nationwide available [Trimbos 2006].

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In Spain, high dosage buprenorphine is not commercially available. Medical doctors at specialised drug treatment centres can initiate methadone and buprenorphine/ naloxone combination. Medical doctors at specialised drug treatment centres can continue methadone treatment. Methadone can be dispensed at specialised treatment centres, pharmacies and mobile outreach units. Buprenorphine/ naloxone combination can be dispensed at pharmacies [Statistical Bulletin 2011].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Methadone maintenance and detoxification programmes, treatment with naltrexone, needle and syringe exchange, drug paraphernalia and the distribution of condoms are nationwide available in Spanish prisons. Treatment with buprenorphine and heroin prescription programmes are not available in prison. Widely available in prisons are counselling, testing, prevention, education and treatment of infectious diseases and vaccination against hepatitis B and tuberculosis [Trimbos 2006, GS].

Prisons are a predominant implementation setting for infectious disease prevention measures targeted at drug users. Prison pre-release interventions are the predominant response strategy targeting the reduction of drug - related deaths in Spanish prisons. Prisons are a predominant setting for the dissemination of information materials aiming at the reduction of drug-related deaths and a common setting for the deliverance of risk education/ response training [Trimbos 2006, GS].

Naloxone is not provided upon prison release [SQ 23/29 2011].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination scheme. A risk-group specific hepatitis B vaccination programme is available. Hepatitis vaccination programme and VCT are priority responses to prevent DRID. The provision of HCV testing is extensive. Provision of condoms at drug agencies with NSPs is extensive [SQ 23/29 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

Needle and syringe exchange programmes and the distribution of condoms are available nationwide in Spain. Drug paraphernalia are available nationwide in big cities.

Needle and syringe exchange programmes are a predominant response strategy to prevent infectious diseases among drug users in Spain. Low threshold agencies, including needle and syringe exchange programmes, are also a predominant setting for the dissemination of information materials on the reduction of drug-related deaths among drug users and for risk education/ response training [Trimbos 2006].

Needle and syringe exchange programmes are available at fixed locations, pharmacies, prisons and NGO centres [ST 10 2011]. Provision of condoms at drug agencies with NSPs is extensive [SQ 23/29 2011].

Formal NSP training programmes regarding health promotion activities are available for pharmacists [SQ 23/29 2011].

Specific paraphernalia for drug smoking/inhaling provided are lighters and aluminium foil [SQ 23/29 2011].

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Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Nationwide, professionals of emergency departments are offered training [GS].

Naloxone is regulated by administrative regulation. Naloxone is not available on a "take-home" basis [SQ 23/29 2008]. Naloxone is part of standard ambulance equipment. Naloxone is available on medical prescription [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Spain has a national primary healthcare strategy, but drug users are not explicitly addressed. There are no protocols between different national, regional and local authorities and agencies involved in addressing the health and social needs of drug users in treatment. The most common mechanism of interagency coordination is the informal network. Employability of drug users in treatment is part of treatment care plan [SQ 28 2010].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Formal NSP training programmes regarding health promotion activities are available for drug agencies staff, pharmacists and prison staff [SQ 23/29 2011].

There are many documents which are useful to this type of professionals and are widely and extensively used in the whole country but none of them establish national requirements to qualify for these specific work positions [SQ 27 P2 2011].

Specialised courses/ training on drug treatment are implemented for social workers, nursing staff, psychologists and medical doctors [SQ 27 P2 2008].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

Scientific evidence is used as basis to select interventions to a large extent [PS].

There are sub-national national guidelines for assessment of infectious disease risk among drug users, for NSPs, OD assessment and national guidelines for prisons [SQ 23/29 2011].

The institution responsible for develping HR guidelines is the Government Delegation for the National Plan on Drugs.http://www.pnsd.msc.es/" [SQ 23/29 2011].

There are guidelines on harm reduction and treatment [Best Practice Portal]:

» Best Practice Manual for drug users using emergency centres (2005)
» Manual de buena pratica para la atencion a drogodependientes en los centros de emergencia (2003)
» Intervención sobre Drogas en Centros Penitenciarios (2006)
» Guía clinica de intervencion psicologica en addiciones (2008)
» Guía para el tratamiento de la dependencia de opiáceos (2007)

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Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

This policy exists, but was not based upon the Council Recommendation. It is reflected in the Spanish Action Plan on Drugs 2009–2012, (action 57) which aims to boost the evaluation processes and results, the valuing of the satisfaction of the users and the validation of the instruments used for the evaluation of programmes and services [GS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

The Spanish Action Plan on Drugs 2009–2012 (action 57) which aims to boost the evaluation processes and results, the valuing of the satisfaction of the users and the validation of the instruments used for the evaluation of programmes and services [GS].

Evaluation aspects are partly included in the guidelines for alcohol/ drugs problems, psychosocial interventions guidelines, detoxification, OST and social reintegration interventions [SQ 27 P2 2008].

Drug treatment outcomes are evaluated in pharmacological treatment and psychosocial assisted treatment, for both settings, inpatient and outpatient [SQ 27 P2 2011].

There is no national research programme for evaluation. There are many programmes for evaluation of drug treatment running in most of the Autonomous Communities, but these programmes are tailored and adapted to each community so that comparison becomes rather difficult [SQ 27 P2 2011].

There are research projects on treatment. Although the results have not yet been published, there are some clinical trials and multicentric studies dealing with:

» Use of heroin for opiate dependence
» Use of caffeine for cocaine dependence.

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

The Spanish Action Plan on Drugs 2009-2012 (action 57) aims to boost the evaluation processes and results, the valuing of the satisfaction of the users and the validation of the instruments used for the evaluation of programmes and services [GS].

In Spain, some Autonomous Communities have started programmes and systems to guarantee quality. Those activities cover a wide range of possibilities: Cantabria applies the certification ISO 9002 to every process and resources in its Autonomous Plan, Andalucia has certified with ISO its programme management processes, Galicia has started to introduce the model EFQM in its Plan, Valencia has developed tools to evaluate the perceived quality, etc.. Besides, an important number of NGOs have included systems of quality management in their programmes and activities [Trimbos 2006].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

The Spanish Action Plan on Drugs 2009-2012 calls for the collaboration with EMCDDA [GS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

One example is the 2008 evaluation report on the Spanish National Strategy on Drugs 2000-2008 [GS].

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Clinical trials involving the administration of diacetylmorphine (heroin) have recently been conducted in Catalonia and Andalusia. In Catalonia, the Regional Department of Health and Social Security initiated two clinical tests to evaluate the effectiveness of oral heroin and oral morphine, after the Spanish Drug Agency authorized the Department to undertake two surveys on treatment with heroin and morphine for patients for whom methadone maintenance programmes had failed. The results of these trials have not yet been published [Trimbos 2006; GS].

Regarding the National Action Plan on Drugs 2009–2012, a midterm evaluation has been conducted recently and its results will be published shortly [Trimbos 2006; GS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

The Spanish Action Plan on Drugs 2009–2012, objective 13 calls to improve and extend the training of professionals working in this field, including volunteers [GS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

The Spanish Action Plan on Drugs 2009–2012 calls for the promotion and development of participative research involving other actors beyond professionals and experts [GS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

The Spanish Action Plan on Drugs 2009–2012 objective 14 calls to optimize the coordination and cooperation in the European and International framework [GS].

Spain has participated in several Phare Twinning projects in the field of drugs (e.g. with Romania and Turkey) and is also active in cooperation with Latin America. Furthermore, it has participated in several European cooperation projects funded by DG SANCO and currently is leading the COPOLAD project [Trimbos 2006; GS].

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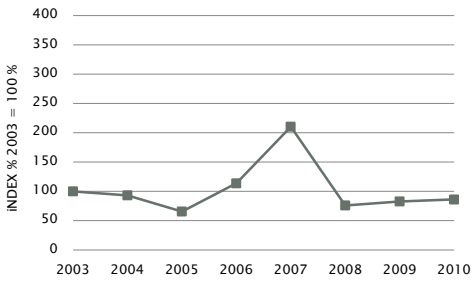
26 Country Profile Sweden

26.1 Indicators for drug-related harm

The most recent estimate (2007) on the number of **problem drug users** was 29.513 (4,9 problem drug users per 1.000 inhabitants). According to the available estimates, the number of PDUs has been more or less constant over the years since 1998, with a peak in 2001 of close to 28.000 problem drug users. Problem drug use in Sweden is dominated by amphetamines and heroin [CO]. The largest groups of clients in outpatient treatment in 2010 have cannabis (41 %), opioids (25 %) and stimulants (22 %) as primary drug. In inpatient treatment the respective proportions are 14 %, 32 % and 36 % [Statistical Bulletin TDI-19]. According outpatient treatment data 59 % of opioid users inject the drug (28 % state to eat/drink the drug and 11 % are smoking it). Stimulants are used via IDU by 58 % of outpatient treatment clients [Statistical Bulletin TDI-17].

Figure 85:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 86:
Number of direct drug-related deaths (indexed - 2003=100 %) by age

Source: EMCDDA Statistical Bulletin 2012 DRD 2

Regarding **infectious diseases** the number of new diagnosed HIV cases with IDU as route of transmission in 2010 was nearly on the same level like in 2003 (see Figure 85) In 2006-07 a sharp increase was observed which was attributed to a HIV-outbreak in the domestic IDU population in Stockholm [CO]. Fewer cases were reported among injecting drug users (IDU) in 2010-2011 compared to 2008-2009, as 24 cases were reported in 2010 and only 14 cases in 2011 [Global AIDS Response Progress Report 2012 - Sweden]. By the end of 2011 IDU accounted for 7 % of all people living with a known HIV-infection in Sweden, which equals about 400 IDUs (or former IDUs). In May 2012 an outbreak of HIV was detected among IDUs in Kalmar including 6 cases. The outbreak investigation is currently ongoing and possibly more cases will be detected. Since the detection of the outbreak a needle-syringe programme has been launched in

Kalmar which hopefully will prevent new cases [GS]. Local studies have shown a prevalence of HIV among IDUs of between 0 and 8,4 percent [NR 2011].

In Sweden the prevalence of hepatitis C among injecting drug users is very high. In various studies conducted during the last 15 years, the prevalence has been reported to be between 60 and 92 percent. In total 2.086 cases of hepatitis C were reported in 2011. Intravenous drug use is the dominant transmission route and most cases are domestic. Seen in a longer perspective the total number of reported cases is decreasing. However, when looking by age group, no decreasing trend is apparent the last 10 years in 15-29 year olds. In 2011 724 cases were reported in this age group and 48 cases were reported in people younger than 20 years. This indicates that there is an ongoing recruitment to injecting drug use among young people and transmission of the disease among young intravenous drug users in Sweden. The trend analysis is aggravated by the fact that it is not possible to differentiate between acute cases and chronic cases of hepatitis C in the surveillance data [GS].

The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased since 2003 especially in the years 2007 to 2009 (see Figure 86).

26.2 Indicators for drug-related harm reduction

Until 2009, no needle exchange programmes (NEP) had been established in addition to the two programmes already in place in the Skåne region in southern Sweden (Lund since 1986 and Malmö since 1987). In 2010 a new NEP was launched in Helsingborg Municipality in Skåne region. In addition, a political majority decision was taken at both county council and municipality level to start NEP in Stockholm in 2012. For the time being, only individuals aged 20 or over can participate in a NEP despite evidence from studies suggesting that the median age in Sweden for the first narcotics injection is 19 years. New needles and syringes can normally be distributed only in exchange for used ones [Global AIDS Response Progress Report 2012 - Sweden]. In addition, a new NEP was launched in Kalmar County in May 2012, the first NEP to be launched outside the Skåne region [GS].

By the end of 2011, the Helsingborg NEP had 178 active IDU participants, compared to 755 in Malmö and 208 in Lund. Together the three programmes accounted for 1.141 active IDU participants in the Skåne region, out of which 18 % were new recruits, compared to 1.059 in 2010, with only two programmes up and running. With 1.141 enrolled IDU in the NEPs would suggest a calculated coverage rate of 28 - 37 % of the IDUs in the whole region [GS]. In 2009, 85.000 syringes were given out at the two programmes. This number is lower than in the years before (see Figure 87). Compared to 2011, where the three NEP distributed a total of 77.391 needles and 167.102

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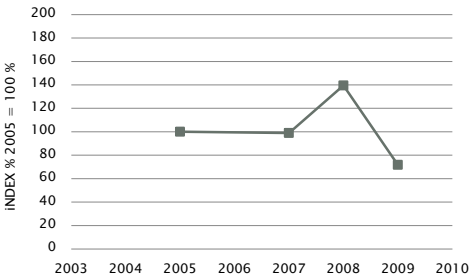
syringes, averaging total of 68 needles and 146 syringes per enrolled IDU. The return rate for 2011 was above 95 % for needles and 98 % for syringes [GS].

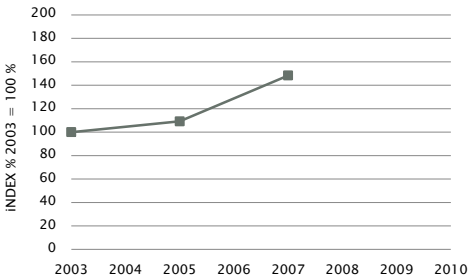
The number of clients in substitution treatment is increasing (see Figure 88). About 3.700 IDUs in Sweden were on opioid substitution treatment (OST) in 2011, which is about 50 % of the total number of estimated opioid users [GS, Global AIDS Response Progress Report 2012 – Sweden]. In 2010 6.424 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 87:
Syringes provided through needle and syringe programmes (NSP) (indexed – 2005=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 88:
Number of clients in substitution treatment (indexed – 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

26.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

The Swedish Parliament adopted a new strategy for alcohol, narcotic drugs, doping and tobacco policy for the period 2011–2015. The main objectives include a society free from narcotics and doping, decreased medical and social harm from alcohol and a decrease in the use of tobacco. The strategy contains seven long-term objectives of lasting relevance with attached priority goals that are to be achieved during the strategy period [NR 2011] (Reference: A cohesive strategy for alcohol, narcotic drugs, doping and tobacco (ANDT) policy) [PS].

In 2006, the new Act on Exchange of Syringes and Needles entered into effect (SFS 2006:323). The purpose of this Act is to prevent the spread of HIV and other blood-borne infections through the exchange of syringes and needles, and this is to be carried out in connection with interventions aimed at motivating the individual to accept care and treatment. Exchanges may not be done without the permission of the National Board of Health and Welfare [NR 2011; GS].

The prevention of drug-related infectious diseases is covered in the National Strategy to Combat HIV/AIDS and certain Other Communicable Diseases adopted by the Swedish Parliament in 2006. Objectives (among others) are to decrease the incidence of endemic HIV cases by half by 2016, specifically by putting emphasis on epidemiological and behavioural surveillance, VCT and to prevent the spread of Hepatitis B and C and other sexually transmitted diseases (STI). The strategy also recognizes the need for the profession working with IDUs to strengthen its knowledge about HIV/AIDS as well as stigma and discrimination. The strategy underscores the importance of offering comprehensive drug abuse treatment to those in need due to the increased high-risk behaviour within the group with regards to the use of non-sterile injecting equipment and/or unprotected sex. Actions: NEPs, VCT including vaccinations against hepatitis B, Health promotion education (Sentinel surveillance, second generation surveillance), substitution maintenance programmes, low threshold services for health and treatment and outreach activities [SQ 23/29-2011; GS].

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Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

SMI is currently developing a national guideline for the "Preventive work with hepatitis and hiv in relation to injecting drug use" [working title]. This guideline bases its core on the guideline developed by ECDC and is adapted to fit regional and local circumstances in Sweden. By default, all key stakeholders including peers are involved in the strategic work on national level. To prevent infectious diseases among (injecting) drug users, treatment, risk-reduction counselling using motivational interviewing (MI) and general health promotion (information, education, communication (IEC)), are predominant response strategies used. Safer injecting training and material are available in Sweden foremost via NGOs, specialized healthcare units (Infectious diseases clinics and Addiction clinics etc) as well as active NEPs (www.svenskabrukarforeningen.se/ files/ Injektionshandboken.pdf) [GS].

With regard to the reduction of drug-related deaths, individual risk counselling is a priority response strategy. The provision of safer use training is limited[35]. The provision of information materials to reduce drug harms in night clubs and in large music festivals is limited [SQ 23/29 2008].

[35] This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

In Sweden, outreach activities via e.g. NGOs, specialized VCT including motivational interviewing and risk-reduction counselling within general healthcare, active NEPs telephone help lines, training and information leaflets as well as the prison and probation service etc are available. Websites promoting risk reduction among drug users are also used [GS].

The provision of overdose response training is limited (just a few relevant cities). Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for police, prison staff and other groups. It's not available for family/ friends or night club staff [SQ 23/29 2011].

Council Recommendation 2.2

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inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for family/ friends [GS].

Council Recommendation 2.3

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include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

To prevent infectious diseases among drug users, outreach work is a common response strategy on regional and local level. Outreach work and targeted high-risk group interventions are a common implementation setting for infectious diseases prevention measures targeting (injecting) drug users [Trimbos 2006; GS].

NGO driven outreach activities are an important factor in reaching hard-to-reach most at risk populations such as IDUs. Outreach activities are conducted throughout the country targeting locations/areas known to be frequented by IDUs [GS].

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Outreach work at dance parties, raves and in clubs are available in specific geographical areas only [Trimbos 2006].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are involved in the responses to prevent DRID. As described under Council Recommendation 2.3, the majority of outreach work carried out in Sweden is done by NGOs using peer-to-peer methodology [GS].

Naloxone is not available on a “take-home“ basis [SQ 23/29 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006]. It is integrated in the objectives of the national strategy [proposition 2005/06:60] [GS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Methadone maintenance programmes, treatment with buprenorphine, drug-free outpatient and drug-free inpatient treatment, rehabilitation programmes and drop-in

centres/ shelters are available in specific geographical areas. Opioid substitution treatment (OST) is supported by (obligatory) psychosocial care. Drug consumption rooms and heroin-prescription programmes are not available in Sweden [Trimbos 2006; GS].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of prescribed drugs are available [Trimbos 2006].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Testing/ screening, prevention, education, opioid substitution treatment (OST), treatment of infectious diseases and risk-reduction counselling (MI) and the distribution of condoms are available in all prisons nationwide. Needle and syringe exchange programmes and drug paraphernalia are not available in Swedish prisons [GS].

Prisons are a common implementation setting for infectious disease prevention measures targeted at drug users. In Sweden, having access to healthcare and treatment is a mandatory right for the prisoners. In some settings this is conducted via the specialized Swedish Prison Program [GS].

Measures targeting at the reduction of drug - related deaths are not available in Swedish prisons [Trimbos 2006].

Prison pre-release counselling on overdose risk and prevention does not exist. Naloxone is not provided upon prison release [SQ 23/29 2011].

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Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Testing / screening, education, prevention, counselling, treatment and vaccination programmes targeting drug users are available nationwide. To prevent infectious diseases among drug users the predominant response strategies are; treatment, voluntary counselling and testing (VCT) including risk-reduction counselling (MI) within a general health promotion approach; i.e. Peer involvement/peer-to-peer approach, outreach activities, health education, condom distribution, hepatitis vaccinations, provision of sterile needles and syringes and other paraphernalia are common response strategies. Predominant implementation settings for infectious diseases prevention measures targeting (injecting) drug users include specialised drug treatment services, primary care/ GP, prisons, institutional care institutions for young and adults with substance abuse problems (SIS) and fixed locations e.g. low-threshold-services and mobile outreach to caravan sites [GS].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

The distribution of free condoms is available throughout Sweden [GS].

Sweden has 4 needle and syringe programmes. A fifth programme is planned to start in late 2012. Pharmacies can sell syringes under certain restrictions. However, it is dictated that syringes can be bought for medical purposes by prescription and other legal aims only. It was previously forbidden by law to sell syringes to a person who was thought to use it for injecting illegal drugs. However, this prohibition has been revoked with a new suggested law that will come into effect in 2012. The new law doesn't concern this aspect of intended use however states that one can buy syringes/needles for one owns medical purposes/usage thus making it legal to purchase these via pharmacies in Sweden [GS].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Naloxone is part of standard ambulance equipment. Use of naloxone is limited to medical personnel. Ambulance personnel are trained in naloxone use. Naloxone is available on medical prescription [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Sweden has a primary health strategy, but drug users are not explicitly addressed. Universal welfare policy forms the basis to create a community that accommodates everyone. Specialized services for drug misusers are provided by the municipalities (the social services system), the county councils (the regional healthcare system, the state (compulsory care and treatment within the criminal justice system) and as well by various voluntary organization and private care providers [SQ 28 2010].

(Injecting) Drug users are addressed through complementing and stand-alone strategies such as the National Strategy Against HIV/AIDS and Certain Other Contagious Diseases (2005/06:60) [GS].

The national guideline for "Preventive work with hepatitis and HIV in relation to injecting drug use" [working title] currently under development, is constructed in such a way that it links into complementing initiatives facilitated by other governmental bodies. This guideline is a stand-alone guide targeting foremost people with injecting drug use and people who are at risk of developing an injecting drug use [GS].

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Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Formal NSP training programmes regarding health promotion activities are available for drug agencies staff. There is no information on training for other professionals [SQ 23/29 2011]. It's not available for pharmacists or prison staff [SQ 23/29 2008].

Occupational standards for drug treatment are available for medical doctors. A national system for continued education and specialised courses/ training on drug treatment are implemented for social workers, nursing staff, psychologists, medical doctors, mental healthcare workers and social pedagogs [SQ 27 p2 2011].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

The interventions initiated by the National Drug Coordinator according to the Action plan are generally based on evaluated and evidence based methods [Trimbos 2006]. There are national guidelines for assessment of infectious disease risk among drug users and at NSPs [SQ 23/29 2008]. There are alcohol/ drug problems guidelines, detoxification and OST guidelines [SQ 27 p2 2008].

Treatment guidelines [Best Practice Portal]:

» Nationella riktlinjer for missbruks- och beroendevård (2007)
» Läkemedelsassisterad behandling av heroinmissbrukare (2004)
» Läkemedelsassisterad underhållsbehandling vid opiatberoende (2009)

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006].

The national guideline for "Preventive work with hepatitis and HIV in relation to injecting drug use" [working title] will suggest concurrent usage of needs assessment as a methodological approach in any programme development. The needs assessement should be complemented by an evaluation strategy, in accordance with the principles of the Logcial Framework Approach (LFA) [GS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation protocols are used in drug prevention programmes and risk reduction programmes to a large extent [PS]. See comment regarding evaluation and LFA under council recommendation 3.2 above [GS].

Evaluation aspects are included in the alcohol/ drug problems, detoxification and OST guidelines. Drug treatment outcomes are sporadically evaluated in psychosocial treatment and OST. There is a national research programme for evaluation.

http://www.sorad.su.se/,
http://www.drogportalen.se/CANTemplates/PartnerPage____52872.aspx,
http://www.stat-inst.se/document/Forskningsprogram_dec06.pdf [SQ 27 p2 2008].

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Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

The new Swedish Drug Action Plan has started a mobilization process based on quality assurance and certain central agencies are in a process to develop quality assessment instruments [Trimbos 2006].

These are, together with the ECDC, WHO and UNAIDS (UNGASS) guideline criteria, accounted for and implemented within the national guideline for "Preventive work with hepatitis and HIV in relation to injecting drug use" [working title] under development. Where deemed necessary, suggested criteria from the above mentionend institutions are adapted to regional and local need [GS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The interventions and efforts initiated by the National Drug Coordinator (NDCo) are in general based on the application of evaluated and evidence-based methods. This approach is progressively being adopted also in the regular preventive and demand-reduction work in municipalities not yet directly involved in the NDCo's campaign [Trimbos 2006].

Evaluation results are used for further development of drug prevention policies to a large extent [PS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006]. Key stakeholders are as a default mechanism always included when developing any form of national strategy work at SMI [GS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

This policy exists, but was not based upon the Council Recommendation [Trimbos 2006].

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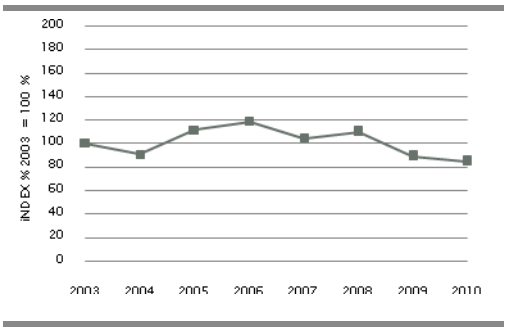
27 Country Profile United Kingdom

27.1 Indicators for drug-related harm

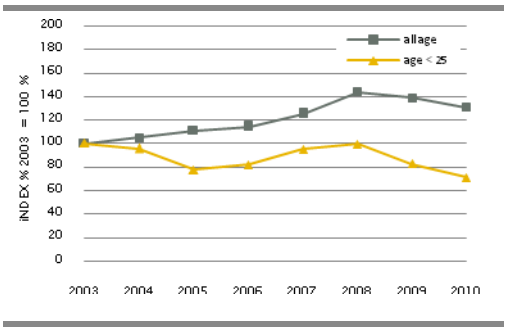
Latest estimates (2004–2009/10) for the UK suggest that there are 379.262 **problem drug users** (with a 95 % confidence interval of 368.711 to 402.640), a rate of 9,3 (9,1–9,9) per 1.000 population aged 15 to 64. This estimate is based on different definitions of problem drug use and different time periods. In England (2009/10), case definition is the use of opiates and/or crack cocaine and injecting of these drugs; in Scotland (2009) it is the use of opiates (including prescribed and illicit methadone) and/or the illicit use of benzodiazepines and injecting of these drugs; in Northern Ireland (2004), it is opiate and/or problem cocaine powder use and for Wales (2006/07 and 2009/10), it is long duration or regular use of opiates, cocaine powder and/or crack cocaine [CO]. The number of injecting drug users is estimated to be 133.112 (3,3 per 1.000 population aged 15 to 64 [GS]. The largest groups of clients presenting to outpatient treatment in 2009/10 have opioids (59 %), cannabis (21 %) and cocaine (13 %) as primary drug. For those presenting to inpatient treatment the respective proportions are 80 %, 2 % and 13 % [Statistical Bulletin TDI-19]. According to outpatient treatment data just 33 % of opioid users presenting to treatment inject the drug (55 % are smoking) [Statistical Bulletin TDI-17].

Figure 89:
HIV infections newly diagnosed in injecting drug users by year of diagnosis (indexed 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 INF 104

Figure 90:
Number of direct drug-related deaths (indexed – 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

Concerning **infectious diseases** the latest data show that in 2010, there were 141 new HIV diagnoses, where infection was thought to have been acquired through injecting drug use. The numbers show a slight decrease since 2006 after a slight increase (see Figure 89). In England and Wales HIV prevalence among IDUs in 2010 was 1,1 %, although in London, prevalence was higher at 4,3 %. In 2010, no HIV infections were detected in Wales or Northern Ireland [CO].

Data available from all UK countries show different HCV infection rates for IDUs (45 % in England, 29 % in Northern Ireland and 39 % in Wales); levels of infection among IDUs surveyed in Scotland in 2010 are higher still (55 %) [GS[36]]. The prevalence of antibodies to hepatitis C amongst recent initiates in England, Wales and Northern Ireland (those injecting for less than three years) has been elevated in recent years [NR 2011].

The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased from 2003 to 2008 followed by a slight decrease. Interestingly in the age-group < 25 there was no increase from 2003 to 2008 but a decrease since then (see Figure 90) while deaths amongst those aged > 40 more than doubled between 2003 and 2008.

27.2 Indicators for drug-related harm reduction

Syringe exchange is offered by a wide range of services, including specialist syringe exchange services, detached outreach and mobile units, pharmacies, and accident and emergency services. Services are available across all regions in England but data on syringes distributed in England are not yet available. Latest available estimates (2010/11) for Wales are 2.980.000, for Northern Ireland 180.000 and for Scotland, 4.506.325 needles/syringes [CO, GS[37]]. The number of syringes provided through needle and syringe programmes in Scotland and Northern Ireland (where time series are available) show a significant increase in Northern Ireland and stable numbers in Scotland (see Figure 91).

The number of clients in substitution treatment in England and Northern Ireland (where time series are available) increased significantly since 2005 (see Figure 92). In 2009 127.893 clients started an inpatient, GP or outpatient treatment [ST TDI-2].

36
Hepatitis C in the UK (HPA 2012)
http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317135237627

37
http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2012-07-31/2012-07-31-Injecting-Equipment-Report.pdf

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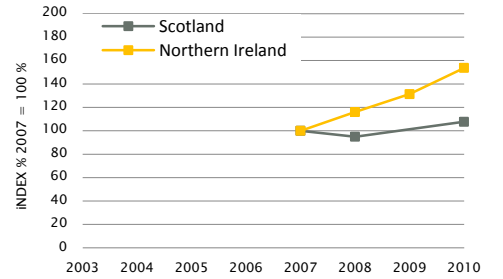
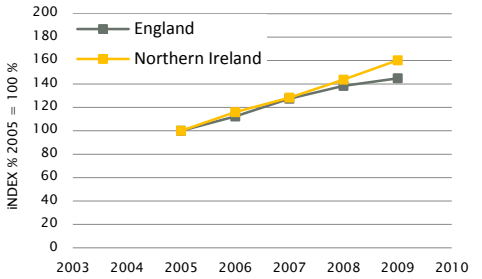
Figure 91:
Syringes provided through needle and syringe programmes (NSP) (Scotland and Northern Ireland only; indexed – 2007=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 92:
Number of clients in substitution treatment (England and Northern Ireland only; indexed – 2005=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

27.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

The United Kingdom Government is responsible for setting the strategy and for its delivery in the devolved administrations only in matters where it has reserved power. A new drug strategy was launched in December 2010 replacing that of the previous Government, which was published in 2008. Within the strategy, policies concerning health, education, housing and social care are confined to England; those for policing and the criminal justice system cover England and Wales [NR 2011; GS].

The Scottish Government and Welsh Government's national drug strategies were published in 2008, the latter combining drugs, alcohol and addiction to prescription drugs and over-the-counter medicines. All three strategies aim to make further progress on reducing harm and each focuses on recovery. The Scottish and Welsh strategy documents are also accompanied by an action or implementation plan, providing a detailed set of objectives; actions and responsibilities; expected outcomes; and a corresponding time scale. Each plan reflects the devolution of responsibilities to the national government [NR 2011; GS].

Northern Ireland's strategy for reducing the harm related to alcohol and drug misuse, the New Strategic Direction for Alcohol and Drugs (NSD), was launched in 2006. The NSD contains actions and outcomes, at both the regional and local level, to achieve its overarching aims. A review of the NSD was conducted in 2010, and a revised document was issued for public consultation in March 2011. The revised document, entitled The New Strategic Direction for Alcohol and Drugs Phase 2 – 2011-2016 was published in January 2012 [NR 2011; GS].

References [PS]:

DH (Department of Health) (2007). Drug misuse and dependence: UK guidelines on clinical management. Department of Health:
http://www.nta.nhs.uk/uploads/clinical_guidelines_2007.pdf

NICE (National Institute for Clinical Excellence) (2009).Needle and syringe programmes: providing people who inject drugs with injecting equipment . Public health guidance PH18 (NICE 2009)
http://www.nice.org.uk/PH18

WAG (Welsh Assembly Government) (2010). Blood borne viral hepatitis Action Plan for Wales (2010-2015):
http://www.wnef.org.uk/category%20pages/BBVactionplanen.pdf

The Scottish Government (2011). Sexual Health and Blood Borne Virus Framework (Scotland) 2011-15 :
http://www.scotland.gov.uk/Resource/Doc/356286/0120395.pdf

NTA (National Treatment Agency for Substance Misuse) (2008). Good practice in harm reduction:
http://www.nta.nhs.uk/uploads/nta_good_practice_in_harm_reduction_1108.pdf

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Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

In the United Kingdom, telephone help lines, websites, training (including peer to peer work), and a broad range of educational leaflets are available nationwide.

To prevent infectious diseases among drug users, providing information, education and communication (IEC) in general, and via counselling and advice by drugs and health professionals and peers are predominant response strategies.

With regard to the reduction of drug-related deaths, dissemination of information materials, risk education/ response training and individual risk counselling are predominant response strategies. Information materials are predominantly disseminated at specialised drug treatment services, low threshold agencies, incl. needle and syringe programmes, outreach workers; detoxification services; prison; and emergency departments, and they are commonly disseminated through mass media/ internet, schools and education systems, nightlife and entertainment venues, and rave events and festivals. Risk education/ response training is offered in most cities, and is delivered predominantly at specialised drug treatment services, low threshold agencies, through outreach workers, and in prisons, and is common at primary care/ general practitioners, emergency departments, nightlife and at rave events [Trimbos 2006; GS].

The provision of individual counselling is limited. OD training is available in nearly all relevant cities or towns. The provision of OD risk assessment is extensive[38] [SQ 23/29 2011; GS].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Communities and families of drug users are involved nationwide in the prevention and reduction of health risks associated with drug dependence, and also specific information, education and communication is available nationwide for communities and families of drug users [Trimbos 2006, SQ 23/29 2011].

In Scotland the Scottish Families Affected by Drugs (SFAD) work with families at a local and national level across Scotland, advocating and promoting the essential role of families and communities in supporting sustained recovery from problem drug use. SFAD raises awareness of the issues associated with drug misuse; provides information through seminars and training events for families and family support groups; and provides constant access to support through their national helpline, email service and website [GS].

Specific materials on prevention of acute drug-related deaths and drug-related emergencies are available for ambulance staff and accident and emergency department staff [SQ 23/29 2011].

References [PS]:

ACMD (Advisory Council On the Misuse of Drugs) (2003) Hidden Harm - responding to the needs of children of problem drug users. Advisory Council on the Misuse of Drugs, London:
http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/hidden-harm-full?view=Binary

38
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

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ACMD (Advisory Council On the Misuse of Drugs) (2007) Hidden Harm Three years on - Challenges and Opportunities. Advisory Council on the Misuse of Drugs, London: http://www.homeoffice.gov.uk/publications/agencies-public-bodies/acmd1/HiddenHarm1.pdf?view=Binary

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Low threshold agencies, including needle and syringe exchange programmes and outreach work are the predominant setting for the dissemination of information materials, aimed at the reduction of drug-related deaths. Outreach work is also a predominant setting for the deliverance of risk education/ response training, which is delivered in most cities [Trimbos 2006].

Outreach in the UK is predominantly concerned with the prevention of infectious disease, initially with HIV prevention. Information and advice are paramount, but the main aim is to bring drug users into treatment services, where they can be encouraged to begin engaging with the recovery process by making changes in their drug using behaviour, such as stopping injecting [SQ 23/29 2011; PS].

The provision of outreach work at night clubs and in large music festivals is rare [SQ 23/29 2011].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer educators are involved in the responses to prevent DRID and National Drugs Strategy highlights the importance of peers in providing the social capital and support so often needed as part of someone's journey to recovery [SQ 23/29 2011; GS].

In Scotland the National Forum on Drug Related Deaths makes recommendations to Scottish Government Ministers, Alcohol and Drug Partnerships and other agencies, as appropriate, on action and policy changes relating to the reduction of drug-related deaths. [GS]

Pilot "take-home" naloxone and overdose awareness training schemes have been operating across the UK in the past 12 months. The implementation of national programmes has begun in Scotland, Wales and Northern Ireland [NR 2011; GS].

Naloxone "take-home" doses are distributed to drug users, and with their consent, to their peers and relatives who have completed a first aid training/ training on overdose management [SQ 23/29 2011; GS].

England and Scotland are progressing peer work with prisioners to reduce drug-related deaths. Recruitment to the N-ALIVE randomised controlled trial (RCT)[39] commenced in 2011 with the aim of reducing DRDs amongst newly released prisoners in the United Kingdom. The pilot trail will demonstrate feasibility by recruiting the first 10 % of participants and assessing what happens to the naloxone and participants in the first few months after release. The main trial will aim to answer the question of whether the provision of naloxone to individuals with a history of injecting drug use

39
Funded by the Medical Research Council (MRC), See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124595.pdf. The aim of the project is to recruit 56,000 participants. In the pilot phase 5,600 participants will be recruited to assess feasibility of the study and qualitative data will also be collected from these participants who give consent. See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124595.pdf

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significantly reduces heroin overdose deaths in the first 12 weeks post-release. The trial will take place in remand prisons in English and Scottish prisons [GS].

The Scottish Government is providing support to the Scottish Prison Service (SPS) to establish a prison-specific naloxone programme. SPS started provision of naloxone and associated training for prisoners in February 2011. All prisons are now offering at-risk prisoners this intervention [GS].

The growing recognition in the role of peers in supporting engagement in treatment and recovery from dependence has been supported by National policy on involvement in England, embedding an user led and peer development approach to the delivery of drug treatment services including specific training for families and peers in the use of naloxone in overdose. Examples would include;

» NTA (National Treatment Agency for Substance Misuse) (2008) NTA policy on involvement of users and family members, London: http://www.nta.nhs.uk/uploads/nta_user_and_family_member_involvement_0308.pdf
» NTA (National Treatment Agency for Substance Misuse) (2007) Nothing about us without us, London: http://www.nta.nhs.uk/uploads/nta_nothing_about_us_without_us_irha2007.pdf
» NTA (National treatment Agency for Substance Misuse) The naloxone overdose and naloxone training programme for families and carers, London: http://www.nta.nhs.uk/uploads/naloxonereport2011.pdf [PS].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between outreach work agencies is nationwide available, and has increased during the last 10 years [Trimbos 2006; PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Methadone maintenance, methadone detoxification programmes and treatment with buprenorphine are available nationwide. Substitution treatment is supported by (obligatory) psychosocial care. Drug-free inpatient and outpatient treatment, rehabilitation centres, and drop-in centres/ shelters are also available nationwide. In specific geographical areas, treatment with naltrexone and heroin prescription programmes are available. Drug consumption rooms do not exist in the United Kingdom [Trimbos 2006; GS].

References [PS]:

UK guidelines on clinical management (2007)

NTA (National Treatment Agency for Substance Misuse) (2010). Routes to Recovery: Psychosocial interventions for drug misuse, London: http://www.nta.nhs.uk/uploads/psychosocial_toolkit_june10.pdf

NTA (National Treatment Agency for Substance Misuse) (2012). Medications in recovery: re-orientating drug dependence treatment, London: http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Any medical doctor and pharmacist independent prescribers and nurse indepedent prescribers can continue methadone, HDB, buprenorphine and naloxone combination and slow-release morphine treatments. But these treatments should only be prescribed by those with appropriate specialist competencies (Drug misuse and dependence -UK guidelines on clinical management (2007).

Methadone, HDB, buprenorphine, naloxone and slow release morphine combination can be dispensed at specialised treatment centres, any medical doctor office and pharmacies under an appropriate prescription [Statistical Bulletin 2011; GS].

In the UK, clinicians responsible for substitution treatment are asked to practice according to the following guidelines: National Institute for Health and Clinical Excellence (NICE) Technology Appraisal of methadone and buprenorphine for managing opioid dependence and, Drug Misuse and Dependence: UK Guidelines on Clinical Management. These provide expert advice on clinical decisions to start, relax or stop supervised consumption and recommend regular reassessment of any changed circumstances. Individual responsible clinicians decide which individuals on OST can be put on unsupervised consumption, this is usually considered for stable patients or if a patient in regular, full-time work where supervision would be a clear barrier to engagement in treatment. Guidelines are discuss situations where supervised consumption should not be relaxed, including where there is a `concern that the prescribed medicine is being, or may be, diverted or used inappropriately.

It is simpler to explain the conditions under which "take-home" doses should not be prescribed - where:

» a patient has not reached a stable dose
» the patient shows a continued and unstable, pattern of drug misuse, including a significant increase in alcohol intake, the use of illicit drugs, benzodiazepines or other tranquillizers
» the patient has a significant, unstable psychiatric illness or is threatening self-harm
» there is continuing concern that the prescribed medicine is being, or may be, diverted or used inappropriately
» there are concerns about the safety of medicines stored in the home and possible risk to children.

In some of these cases, especially the latter, "take-home" doses might be permitted but the dose taken home limited by frequent dispensing [Statistical Bulletin 2011].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Drug use amongst prisoners is explicitly mentioned in drug strategies in the UK and there are specific prison drug strategies. Responsibility for health in prisons has been transferred to health services from prison services and a wide range of interventions for drug users is provided. Interventions include information provision, BBV services, prescribing programmes, and psychosocial programmes. There is increasing availability of naloxone programmes on release from prison. A number of guidelines, prison service instructions and prison service orders exist to ensure quality and consistency of service [GS].

Drug-related health issues are addressed in the national prison health strategies of each UK country [SQ 23/29 2011].

The availability of individual counselling on infectious diseases risk, practical advice and training on safer use and NSP is limited. Testing and antiviral treatment for hepatitis C are both widely available across Scottish prisons. The provision of HCV testing on release from prison is extensive [SQ 23/29 2011; GS].

Hepatitis B vaccination programme for PDUs is available in prison. In the UK, since 2011, all blood-borne viruses (BBVs) are tested whilst in prison. In Scotland, HBV since 1999. HAV for those prisoners diagnosed with Hep C was offered since 2000, and since 2009 both vaccines have been routinely offered to all drug using prisoners on admission [SQ 23/29 2011; GS].

The impact of the provision of naloxone the drug-related death rates of prisoners newly released from prisions is being formally evaluated in England and Scotland. Recruitment to the N-ALIVE randomised controlled trial (RCT)[40] commenced in 2011

40
Funded by the Medical Research Council (MRC), See:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124595.pdf.
The aim of the project is to recruit 56,000 participants. In the pilot phase 5,600 participants will be recruited to assess feasibility of the study and qualitative data will also be collected from these participants who give

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with the aim of reducing DRDs amongst newly released prisoners in the United Kingdom.

The Scottish Government is providing support to the Scottish Prison Service (SPS) to establish a prison-specific naloxone programme. SPS started provision of naloxone and associated training for prisoners in February 2011. All prisons are now offering at-risk prisoners this intervention. National Naloxone Programme Scotland Monitoring Report – Naloxone Kits Issued in 2011/12', July 2012: http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2012-07-31/2012-07-31-naloxone-monitoring-report.pdf [SQ 23/29 2011; GS].

Since April 2011 there has been consistent delivery of clinical treatment across adult prisons in England. The Integrated Drug Treatment System (IDTS) which is underpinned by NICE guidance and in line with community based services is now funded in all prisons in England. There has been a dramatic reduction in suicides amongst this client group since IDTS was implemented. From April 2011, over £108m made available to local partnerships to continue this programme [SQ 27p1-2011].

Initiation and continuation of OST in prison is available. The provision of OST in prison is full [SQ 27p1-2011].

References [PS]:

DH (2009). Improving health, supporting justice: the national delivery plan of the Health and Criminal Justice Programme Board, DH, London: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108606

HM Government (2010). Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life. The Stationery Office, London.: http://www.homeoffice.gov.uk/publications/drugs/drug-strategy/drug-strategy-2010?view=Binary

Ministry Of Justice (MoJ) (2008). The National Offender Management Service Drug Strategy 2008-2011 Action Plan.: http://www.justice.gov.uk/noms-drugs-action-plan.pdf

Patel, K. (2010). THE PATEL REPORT PRISON DRUG TREATMENT STRATEGY REVIEW GROUP. DH, London:

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consent. See: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124595.pdf

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_119850.pdf

MoJ (2010) IDTS Guidance:
http://www.nta.nhs.uk/uploads/psi_2010_45_idts.pdf and
http://www.nta.nhs.uk/prison-based.aspx

DH et al. (2006). Clinical management of drug dependence in the adult prison setting including psychosocial treatment as a core part. DH, Department of Health; National Treatment Agency for Substance Misuse; Royal College of General Practitioners; Royal College of Psychiatrists; Royal Pharmaceutical Society of Great Britain.:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063064

Department of Health (2009). Prison Health Performance and Quality Indicators. Department of Health, London.:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_097117.pdf

HPA (2011) Health protection in prisons. HPA, London:
http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1296682990869

SPS Framework for the Management of Substance Misuse in Custody' (2010):
http://www.sps.gov.uk/Publications/Publication97.aspx

SPS Health Care Standard 7 'Blood Borne Viruses':
http://www.sps.gov.uk/Publications/Publication-3264.aspx

SPS Health Care Standard 10 'Clinical Management of Drug, Alcohol & Tobacco Dependency':
http://www.sps.gov.uk/Publications/Publication-3342.aspx

SPS Health Care Standard 10 'Drug Misuse and Dependence: Operational Guidance':
http://www.sps.gov.uk/Publications/Publication-3344.aspx

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Testing/ screening, education and prevention, counselling and treatment of infectious diseases and vaccination programmes against hepatitis B targeting drug users are nationwide available.

To prevent infectious diseases among drug users the predominant response strategies are IEC general, IEC via counselling by drugs and health professionals, and needle and syringe exchange programmes. Other, common strategies include outreach health education approach, voluntary infectious diseases counselling and testing, condom promotion among drug users, and hepatitis vaccination programme for drug users. Predominant implementation settings for infectious diseases prevention measures targeting drug users include specialised drug treatment services and low threshold counselling services and needle and syringe programmes. Common implementation settings are outreach work and targeted high risk group interventions, primary care/ general practitioners, prison, and mass media [Trimbos 2006; GS].

Hepatitis B is not included in the national vaccination scheme. A risk-group specific hepatitis B vaccination programme is available (Immunisation Against Infectious Disease – 'The Green Book' (2006), Dept of Health, UK). The provision of HCV testing is extensive [SQ 23/29 2011; GS].

References [PS]:

The increase in the uptake of screening and testing for BBV's as reported by the Health Protection Agency; HPA (Health Protection Agency) (2010). Shooting up – infections among people who inject drugs, London: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317131377664

The decrease in injecting behaviour across the UK reported by the HPA in the report reference above and the decrease in injecting reported by a review of the data from drug treatment in England; NTA (National Treatment Agency for Substance Misuse) (2010). Injecting Drug Use in England: A Declining Trend, London: http://www.nta.nhs.uk/uploads/injectingreportnov2010finala.pdf

The publication of a range of guidance other related guidance:

Health Protection Agency (HPA) (2010). Hepatitis C in England, the Health Protection Agency Annual Report 2009. Health Protection Agency, London.

NICE (2009). Needle and syringe programmes: providing people who inject drugs with injecting equipment . Public health guidance PH18 http://www.nice.org.uk/PH18

Advisory Council on the Misuse of Drugs (2009) The Primary Prevention of Hepatitis C among Injecting Drug Users http://www.homeoffice.gov.uk/publications/drugs/acmd1/acmdhepcreport2?view=Binary

Jones, L., Pickering, L., Sumnall, H., McVeigh, J. and Bellis, M.A. (2008). A review of the effectiveness and cost-effectiveness of needle and syringe programmes for injecting drug users. National Institute for Health and Clinical Excellence, London. http://www.nice.org.uk/nicemedia/pdf/PH18EffectivenessReviewRevised.pdf

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

DRID strategy is a separate document.

- The good practice in harm reduction guide is based on practice in areas that performed well in the 2006/07 Healthcare Commission and NTA Improvement Reviews. The aim of this report is to highlight good practice in harm reduction, based on interviews with local drug partnerships that performed well in the reviews to identify good practice in interventions to reduce drug-related harm related to blood-borne virus and overdose.
- The aim of reducing drug-related harm: an action plan is to reduce the number of drug users contracting blood-borne virus infections (and dying through either infectious disease or drug-related death). It sets out actions within three strands: campaigns improving delivery and surveillance.
- Needle and syringe programmes: providing people who inject drugs with injecting equipment, published in February 2009 by the National Institute for Health and Clinical Excellence (NICE) sets out a blueprint of best practice for those working in the NHS, local authorities and the wider public and voluntary sector about the role that needle and syringe programmes play in tackling the spread of blood-borne viruses. Subsequently, NICE published a commissioning guide for NSPs, to support the local implementation of the guidance. The aim is to reduce the harm caused, particularly the spread of viruses such as hepatitis and HIV.
- The Primary Prevention of Hepatitis C among Injecting Drug Users (ACMD, 2009) reviews the prevention of hepatitis C and what actions could be taken to reduce its transmission and improve knowledge and awareness among injecting drug users.
- In Scotland, the Hepatitis C Action Plan came to an end in March 2011 and was superseded by the Sexual Health and Blood Borne Virus Framework. This aims to support progress towards a small number of high level Outcomes including a reduction in newly acquired blood borne virus and sexually transmitted infections in Scotland and people affected by blood borne viruses leading longer healthier lives. While the Framework takes an outcomes based approach, it also provides a number of recommendations for NHS Boards, local authorities, the third sector and other partners which set out the key approaches or deliverables that will support achievement of these and other outcomes. Further national initiatives include:
  - Needle Exchange Surveillance Initiative (NESI): Prevalence of HCV and injecting risk behaviour (2008, 2009, 2010)
  - Injecting Equipment Provision in Scotland Survey 2010/11, (ISD 2012)

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» The Framework does not focus solely on drug users but it identifies injecting drug users as a key target population, particularly in relation to Hepatitis C, acknowledging that the great majority of hepatitis C transmissions in Scotland occur within the injecting drug user population.
» The Blood Borne Viral Hepatitis Action Plan for Wales 2010 – 2015 sets out the programme for hepatitis B and hepatitis C in Wales and provides a clear, costed and time defined framework for the planning and delivery of key services in Wales that:
  » Reduce the transmission of blood borne viral hepatitis infection in Wales
  » Reduce the pool of undiagnosed infection via implementation / rollout of dried blood spot testing in substance misuse services and prisons in addition to venepuncture testing
  » Improve the provision of treatment and support to infected individuals
  » Monitor and evaluate treatment and prevention programmes [SQ 23/29 2011; GS].

Needle and syringe exchange programmes, drug paraphernalia and the distribution of condoms are available nationwide. Needle and syringe exchange programmes are a predominant response strategy to prevent infectious diseases among drug users in the United Kingdom Low threshold agencies, including needle and syringe exchange programmes, also are a predominant setting to provide information materials on the reduction of drug-related deaths among drug users and for the deliverance of risk education/ response training. The United Kingdom has 453 non-pharmacy based and 1.607 pharmacy-based needle and syringe exchange points. Fixed sites, van/ bus, outreach / peer and pharmacy based outlets are available types of needle and syringe exchange in the United Kingdom [Trimbos 2006].

Standard items in the injecting kit: information materials, alcohol pads, water, containers, filters, acid, bleach and condoms. Kits are standard to local areas, based on local need. In Scotland Scottish Prison Kits also include foil and safer injecting advice on first contact, no needle/syringe is included in kit and these are only currently being distributed widely in one prison, the other prisons are in the process of implementation. there has been a significant increase in the provision of injecting equipment in Scotland' and a national contract has been established providing a range of equipment and a series of kits which local areas can select to provide in line with local need. Sharps bins are provided for disposal of used needles and syringes [SQ 23/29 2011; GS].

In SPS prisoners have access to sterile harm reduction kits whilst in custody. The kits contain: sterile water for injection, ampoule snapper, post-injection swab, pre-injection alcohol wipe, cooker, filter & foil. Each recipient also has regular contact with an addiction nurse and priority into substitute prescribing treatment. These kits do not contain a sterile needle and syringe and thus only offer limited protection against BBV transmission. The protocol outlining this intervention has been in place since January

2008; Information relating to uptake is not available however, anecdotal evidence suggests prisoners do not wish to access the service due to a perceived risk of higher scrutiny and cell searching from security staff. Harm Reduction Packs are only issued after rigorous assessment, and are a short-term measure for each individual as part of their Care Plan [SQ 23/29 2011; GS].

Provision of condoms at drug agencies with NSPs is extensive. Condoms are provided to all drug users, especially those involved in the sex trade [SQ 23/29 2011].

References [PS]:

Water for injection – Statutory Instrument 2005 No.1507 The Medicines for Human Use (Prescribing) (Miscellaneous Amendments) Order 2005: http://www.legislation.gov.uk/uksi/2005/1507/contents/made

The agreement of statutory instrument – SI 2005 (2846) – adding ascorbic acid (VitC) to the list of items that it is legal for services to supply.

NICE (2009). Needle and syringe programmes: providing people who inject drugs with injecting equipment. Public health guidance PH18 http://www.nice.org.uk/PH18

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Naloxone is part of standard ambulance equipment, ambulance personnel are trained in naloxone use. Naloxone is available on medical prescription. Naloxone "take-home" doses are distributed to drug users, and by consent, to their peers and relatives who have completed a first aid training/ training on overdose management41. It is permissible to prescribe "take-home" naloxone to named patients (Drug Misuse and Dependence: UK Guidelines on Clinical Management). In 2005 the law was amended to permit emergency administration by any member of the public [SQ 23/29 2011; GS].

41
National Take Home Naloxone Programme. Information available in UK focal point report 2011- http://www.nwph.net/ukfocalpoint/write-dir/userfiles/file/FOCAL%20POINT%20REPORT%202011%20FINAL%20HR.pdf

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Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

The accomodation needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan, but there is information about other target groups that may include drug users. (e.g. Public Service Agreement 16) [SQ 28 2010]

The education needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan [SQ 28 2010]. However accommodation needs, employment and the importance of education are all recognised within the UK 2010 drug strategy. This places emphasis on providing a more holistic approach, by addressing other issues in addition to treatment to support people dependent on drugs or alcohol, such as offending, employment and housing. The strategy recognises that recovery can only be delivered through working with education, training, employment, housing, family support services, wider health services and, where relevant, prison, probation and youth justice services to address the needs of the whole person [GS].

Health policy is devolved in Scottish drugs strategy. The Scottish drugs strategy, Road to Recovery' explicitly recognises the strong links between tackling problem drug use and the Government's wider policies such as mental health, early years and growing the economy [GS].

The employment needs of drug users are explicitly addressed in the National Employment Plan. The intention to explore linking receipt of benefit to treatment for problem drug users was outlined in the Government's 2008 Drug Strategy for England Drugs: protecting families and communities. Proposals were set out in the Welfare Reform Green Paper No one written off: reforming welfare to reward responsibility published in July 2008, and subsequently in the White Paper Raising expectations and increasing support: reforming welfare for the future which followed in December 2008. The Welfare Reform Act 2009 provides the legislative framework for the current drugs strategy.

Employment needs are a priority in the written drug policies. It is widely acknowledged that problem drug use is a major cause of social exclusion and bears significant social costs for drug users, their families and wider society. In England, the Government has acknowledged that to help achieve this we need to better integrate drug treatment and employment services. The initiatives that have already been introduced - the appointment of drug coordinators in Jobcentre Plus Districts, and the voluntary referral (England only) to a drug treatment provider aimed at assisting Jobseekers Allowance

and Employment and Support Allowance customers who take heroin and/or crack cocaine and their drug use is identified as a barrier to them finding work [GS].

In Scotland job centre plus are members of Alcohol and Drug Partnerships across the 30 ADPs in Scotland and contribute to decision making at a local level on alcohol and drugs [GS].

The Mental Health Act 2007 introduced the approved mental health professional (AMHP) which broadened the group of practitioners who can take on the functions previously performed by the approved social worker (ASW) increasing potential integration between social care and mental health services [PS].

An important step was the publication of guidance to promote multidisplinary team working across health and social care services such as the royal college of Nursings publication on tuberculosis care; RCN (Royal College of Nursing) (2012). Tuberculosis Case Management and Cohort Review -Guidance for health professionals. London: http://www.rcn.org.uk/__data/assets/pdf_file/0010/439129/004204.pdf [PS].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Formal NSP training programmes regarding health promotion activities are available for drug agencies staff, pharmacists and prison staff [SQ 27 P2 2008]. The institution responsible for developing guidelines is NICE (www.nice.org.uk) [SQ 27 P2 2011].

Occupational standards for drug treatment are available for nursing staff, medical doctors, social workers, and drug and alcohol workers.) [SQ 27 P2 2008, 2011]. Specialised courses/ training on drug treatment are implemented for social workers, nursing staff, psychologists, medical doctors and drug and alcohol workers [SQ 27 P2 2011]. A national system for continued education is available for nursing staff, psychologists and medical doctors [SQ 27 P2 2008]. A major achievement since 2003 was the development of a range of training programmes for professionals including GPs (through the Royal College for General Practitioners (RCGP), prison healthcare staff, nurses, pharmacists as well as drug workers. More information on the RCGP training course is available: http://www.rcgp.org.uk/college_locations/rcgp_wales/initiatives_and_projects/drug_misuse_training.aspx [PS].

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Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

There are national guidelines for assessment of infectious disease risk among drug users, for NSPs, for OD assessment and for prison pre-release counselling [SQ 23/29 2011].

Institutions responsible for developing HR guidelines [SQ 23/29 2011]:

- Department of Health www.dh.gov.uk
- National Institute for Health and Clinical Excellence http://www.nice.org.uk/
- Health Protection Agency
- National Treatment Agency for Drug Misuse http://www.nta.nhs.uk/
- Scottish Government http://www.scotland.gov.uk/
- Health Protection Scotland;
- Scottish Intercollegiate Guidelines Network (SIGN)
- Healthcare Improvement Scotland
- Department of health, Social Services, and Public Safety, Northern Ireland http://www.dhsspsni.gov.uk/
- Public Health Agency, Northern Ireland http://www.publichealth.hscni.net/
- Welsh Government http:// www.wales.gov.uk/
- Public Health Wales http://www.wales.nhs.uk/sitesplus/888/

There are guidelines for alcohol/ drug problems, psychosocial interventions, detoxification, OST and social reintegration guidelines [SQ 27 P2 2008]. See also selected issue in 2010 National Report.

There are guidelines on harm reduction [Best Practice Portal; GS]:

- Needle and syringe programmes: providing people who inject drugs with injecting equipment (2009)

» Guidance for the Prevention, Testing, Treatment and Management of Hepatitis C in Primary Care (2007)
» A guide for all professionals working within an outreach setting (2009)
» Good practice in harm reduction (2008)
» Reducing drug-related deaths - guidance for drug-treatment providers (2004)
» Drug overdose: prevention and response - guidance for helplines (2004)
» Guidelines for services providing injecting equipment: Best practice recommendations for commissioners and injecting equipment provision (IEP) services in Scotland (Scottish Government,2010)
» Management of Hepatitis C, SIGN Guideline 92 (2006)
» Hepatitis C Quality Indicators, Healthcare Improvement Scotland, (2011)
» UK consensus guidelines for the use of the protease inhibitors boceprevir and telaprevir in genotype 1 chronic hepatitis C infected patients, 2012, (full guidelines)

Treatment guidelines [Best Practice Portal]:

» Drug misuse and dependence: UK guidelines on clinical management (2007)
» Drug misuse: Psychosocial interventions (2007)
» Naltrexone for the management of opioid dependence (2007)
» Drug Misuse: Opioid detoxification (2007)
» Methadone and buprenorphine for the management of opioid dependence (2007)
» Models of care for treatment of adult drug misusers: update (2006)
» Models of residential rehabilitation for drug and alcohol misusers (2006)
» Young people's substance misuse treatment services, essential elements (2007)
» Planning, commissioning and delivering the training and employment pathway for problem drug users (2009)
» Non-medical prescribing, patient group directions and minor ailment schemes in the treatment of drug misusers (2007)
» Renewed guidance for treating heroin addicts in prison (2010)
» Guidance and training protocol for the development of the introduction of "take-home" naloxone (Wales) (2010)
» Treatment of offenders (Wales) (2009)
» Guidance for the pharmacological management of substance misuse among young people in secure environment (2009)
» Towards successful treatment completion - a good practice guide (2009)
» Needle and syringe programmes: providing people who inject drugs with injecting equipment (2009)
» NTA Policy on involvement of users and family members (2008)
» Supporting and involving carers (2008)
» Guidance for the planning and provisions of substance misuse services to children and young people in the care of youth offending services (2009)
» Substance Misuse Service and System Improvement - National Core Standards for Substance Misuse Services in Wales (2009)

» Prisons Integrated Drug Treatment System: Continuity of Care Guidance (2009)
» Undertaking needs assessment: drug treatment. Recovery and reintegration in the community and prisons (2009)
» Clinical governance in drug treatment: a good practice guide for providers and commissioners (2009)
» Residential drug treatment service: a summary of good practice (2009)
» Residential drug treatment services: good practices in the field (2009)
» Commissioning for recovery Drug treatment, reintegration and recovery in the community and prisons: a guide for drug partnerships (2010)
» Routes to Recovery: Psychosocial interventions for drug misuse. A framework and toolkit for implementing NICE-recommended treatment interventions (2010)
» Substance Misuse Detainees in Police Custody Guidelines for Clinical Management
» Safer Prescribing in Prisons Guidance for clinicians

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

Needs assessment is a common aspect of commissioning [Trimbos 2006; PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation aspects are included in the guidelines for alcohol/ drug problems, psychosocial interventions, detoxification, OST and social reintegration guidelines [SQ 27 P2 2008].

Drug treatment outcomes are regularly evaluated in psychosocial treatment, detoxification, OST and social reintegration interventions. [SQ 27 P2 2008]

In England, The Drug Misuse Research Initiative was a major research programme funded by the Department of Health: http://www.lshtm.ac.uk/research/dmri/ Also, the National Treatment Agency funds research:
http://www.nta.nhs.uk/publications/default.aspx

The Treatment Outcomes Profile is used in England and Wales to evaluate outcomes from drug treatment. Evaluation protocols are commonly provided as part of the implementation tools provided alongside the guidance produced by the National Institute for Clinical Excellence (NICE). For example the audit support provided to support the implementation of NICE guidance on needle and syringe programmes. NICE (National Institute for Clinical Excellence) (2009) Needle and Syringe Programmes Audit Support – Implementing NICE Guidance, London 2009: http://guidance.nice.org.uk/PH18/AuditSupport/doc/English

In addition the Medical Research Council, in coordination with the National Institute for Health Research (NIHR) has made research in to addiction (not only drugs) a priority within its current research period, and will be made available. http://www.mrc.ac.uk/Opportunities/index.htm

Audit Reports of the Throughcare Addiction Service: www.scotland.gov.uk/Publications/Recent

National Quality Standards for Substance Misuse Services: http://www.scotland.gov.uk/Resource/Doc/149486/0039796.pdf

Hepatitis C Action Plan for Scotland Phase II: May 2008 – March 2011: http://www.scotland.gov.uk/Resource/Doc/222750/0059978.pdf

In Scotland, The Scottish Government funds such research, for example: Evaluation of the Scottish Prison Service transitional care initiative 2006: http://www.scotland.gov.uk/Resource/Doc/92720/0022217.pdf

How many people are receiving methadone hydrochloride mixture for opiate dependence in Scotland and what are the prescribing costs per person: http://www.drugmisuse.isdscotland.org/publications/local/isd_methadone.pdf

Needle exchange provision in Scotland: a report on the national needle exchange survey 2006: http://www.scotland.gov.uk/Resource/Doc/130349/0031220.pdf http://www.drugmisuse.isdscotland.org/eiu/pdfs/sprr.pdf

Service provision for drug users in rural and remote areas of Scotland: a qualitative study: http://www.scotland.gov.uk/Resource/Doc/127647/0030582.pdf

Evaluation and description of drug projects working with young people and families funded by Lloyds TSB foundation partnership drugs initiative: http://www.drugslibrary.stir.ac.uk/documents/spspathways.pdf

SPS Strategy on the Management of Drug Misuse – Pathways and Progression: An Evaluation of Referral, Assessment, and Intervention 2006: http://www.scotland.gov.uk/Resource/Doc/924/0011993.pdf

The Role of Methadone Maintenance in Scottish Prisons: Prisoners Perspectives 2006: http://www.sps.gov.uk/default.aspx?documentid=cc184716-8b2a-4bc9-a403-007ee8282cbf [SQ 27 P2 2008; GS].

Recent publications on drugs research in Scotland are available on the Scottish Government and ISD websites: for example research for recovery, evaluation of DTTO 11 pilots.

Scottish Government:

http://www.scotland.gov.uk/Topics/Research/by-topic/crime-and-justice/publications/Q/pno/0

ISD Scotland: http://www.isdscotland.org/publications/index.asp [GS].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

This policy does not exist [Trimbos 2006].

It is not known whether any organisations involved in evaluation in the UK actively take account of evaluation tools developed by EMCDDA or held by the EMCDDA Evaluation Instruments Bank. However, UK countries refer to EMCDDA guidelines when thinking about research and evaluation of new projects and seek advice from the UK focal point.

Evaluation of quality criteria is included within the independent regulation of all health and social care services by the Care Quality Commission (CQC). This includes all residential treatment provision and all providers of regulated activities. Improving quality is also a key consideration in the production of all NICE guidance, including that for drug treatment provision.

The NTA has identified four Key Performance Indicators (KPIs) to review the provision of services in each DAT area. The purpose of the KPIs is to allow meaningful comparison of services provided to local populations. These KPIs will provide information to assess the quality of local service provision, and therefore assist DATs and commissioners to make informed commissioning choices by enabling meaningful comparison between local service providers and the system of service provision in one DAT area with another.

Through the DAT plans, DATs have to report on organisational arrangements, planning process, implementation, performance monitoring and communication with stakeholders. DATs have to comply with quality standards across these core activities [Trimbos 2006; GS].

Scottish Government has committed to redeveloping National Quality Standards for service delivery in order to set expectations for operation and management that are clear to all concerned – service providers, service users and their families – and help to drive a culture of continuous evaluation and improvement for services across the country. Current quality standards:
http://www.scotland.gov.uk/Publications/2006/09/25092710/0 [GS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

UK Focal Point, based in the Department of Health, is responsible for working towards standardised data collection in the UK in partnership with each of the UK countries [Trimbos 2006; GS].

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

The Government commissions a range of research projects and evaluations which are taken account of in the development of prevention policy.

National prevention campaigns such as talk to frank have been subject to evaluation and review. http://www.talktofrank.com/

National drugs strategies are also subject to review in all UK countries. The breadth, complexity and intensity of drug policies means that the UK drug strategy is 'monitored', 'tracked' and 'performance managed' rather than 'evaluated'. There is now a formal evaluation framework, and a very large amount of monitoring work on drug prevalence, uptake of treatment and drug supply. This work centres on a framework of

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drug strategy targets. Reference: HMG (Her Majesties Government) (2012) Drug Stategy 2010 –Annual Review – May 2012, London: http://www.homeoffice.gov.uk/ publications/alcohol-drugs/drugs/annual-review-drug-strategy-2010/drug-strategy2010-review-may2012 [PS]

The Scottish Executive's Effective Interventions Unit (EIU) had a remit to identify and disseminate effective practice in relation to tackling drug misuse in Scotland. Evaluation formed a core element in achieving this. Activities included:

» Reviewing, distilling and disseminating evidence from existing evaluation literature, e.g. on specific interventions such as training and employment initiatives for drug users;
» Supporting efforts to improve evaluation practice, e.g. commissioning evaluation workshops for every Drug Action Team (DAT) in Scotland;
» Providing accessible and practical evaluation guides to inform policy makers and practitioners working to tackle drug misuse, e.g. EIU series of Evaluation Guides covering issues such as definitions, planning and outcomes;
» Commissioning evaluations of key initiatives or programmes e.g. evaluation of Scottish Prison Service Transitional Care Initiative [GS].

The Effective Interventions Unit was disbanded in 2005 [GS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

This is delivered as part of wider work-force training programmes. Because the delivery services is devolved to local areas, much of the training and evaluation is commissioned at a local level rather than national level [GS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

All drug treatment workers providing key work interventions are required to support drug users to complete and review self reported information on their outcomes whilst in structured drug treatment (England and Wales only). This information is used to

inform the ongoing development of a client's care plan at an individual level and is also collated at a local and national level to inform service planning and national policy. The system to collect information treatment outcomes is known as the Treatment Outcomes Profile (TOP).

The TOP is a 20 item measure that focuses on four important treatment domains as defined in the NTA care planning practice guide:

» Substance use
» Injecting risk behaviour
» Crime
» Health & social functioning

Unlike proxy indicators, these domains reflect the problem areas that can make a real difference to clients' lives and that of wider communities. It is designed to be completed by the keyworker and with the client, at the start of treatment, periodically throughout treatment and at the end of treatment. TOP information is submitted to the National Drug Treatment Monitoring System (NDTMS) where quality assurance and analysis are undertaken. The information is fed back to the local treatment system to help commissioners and providers improve, where necessary, the quality of services that are provided.

Equally in Scotland, involving stakeholders in evaluations is an essential part of policy and programme development.

The National Naloxone Advisory Group is a good example of where stakeholders involved in the delivery of the programme have also been involved in the design of the monitoring and evaluation of the programme (eg. the dataset for the monitoring of the programme and the baseline measure for the programme).

The work to date on naloxone is published online by ISD Scotland and further information has been provided within the UK Focal Point on Drug Annual Report provides further information on Scotland's "take-home" naloxone programme [GS].

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Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

UK contributes to the Exchange on Drug Demand Reduction Action (EDDRA) [Trimbos 2006].

In November 2007, the UK Focal Point hosted a Turkish delegation to exchange knowledge and experience of drug policy and the monitoring of drug problems.

The UK Focal Point along with colleagues from the Czech Republic was involved in the IPA3 Project for the exchange of information and knowledge with Bosnia-Herzegovina, 2009-2011 [GS].

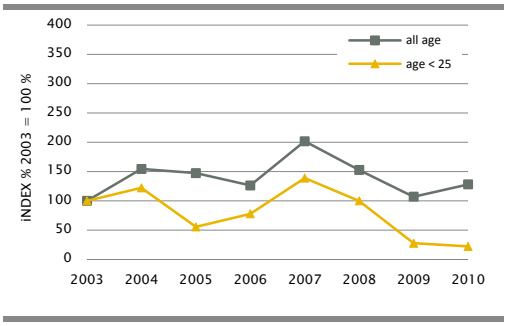
28 Country Profile Croatia

28.1 Indicators for drug-related harm

The total number of **problem drug users** (intravenous addicts or long-term/regular opiate, cocaine and/or amphetamines addicts, including all persons on substitution opiate treatment) in 2010 was estimated to be between 7.882 and 13.029 (2,7 and 4,4 per 1.000 inhabitants aged 15 to 64 years) [NR 2011]. The largest groups of clients in outpatient treatment in 2010 have opioids (84 %) and cannabis (12 %) as primary drug. In inpatient treatment the respective proportions are 57 % and 9 % (hypnotics/sedatives: 14 %, other drugs: 14 %) [Statistical Bulletin TDI-19]. According outpatient treatment data the majority (73 %) of opioid users inject the drug (20 % are sniffing) [Statistical Bulletin TDI-17].

Regarding drug-related **infectious diseases** among injecting drug users in Croatia the prevalence of HIV is very low. The number of new diagnosed HIV cases with IDU as route of administration varies between 1 and 4 infections per year (2010 1 HIV-infection was due to IDU) [EMCDDA Statistical Bulletin 2012 INF 104]. The latest data from the seropreva-lence study in 2007-08, indicates very low prevalence of HIV among IDUs and it is estimated to be approximately 0 %. For HCV the national estimate form the seroprevalence study in 2007-08 indicates that the prevalence is around 44 % among IDUs [CO]. This corresponds to anamnestic data from drug treatment where the prevalence is 46 % for HCV and on similar Figure 93level since 2004 [NR 2011].

Figure 93:
Number of direct drug-related deaths (indexed - 2003=100 %) by age



Source: EMCDDA Statistical Bulletin 2012 DRD 2

The number of direct **drug-related deaths (deaths due to overdoses, drug-induced deaths)** increased since 2003 till 2007 followed by a decrease. The decrease since 2007 in the age-group < 25 years is stronger than in the whole group (see Figure 93) [NR 2011].

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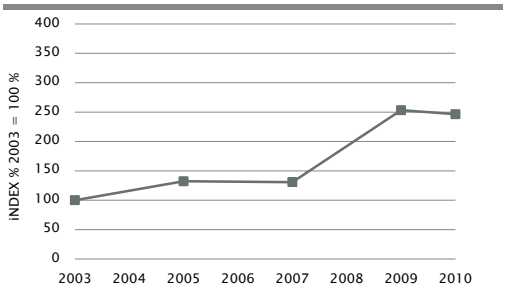
28.2 Indicators for drug-related harm reduction

In Croatia, the first harm reduction programmes focusing on problem drug users were introduced in 1996. Today these programmes are regularly conducted in 96 locations. In 2010, approximately 282.000 syringes were distributed, which is slightly less than in 2009, but almost double in comparison with 2006 data (see Figure 94) [CO].

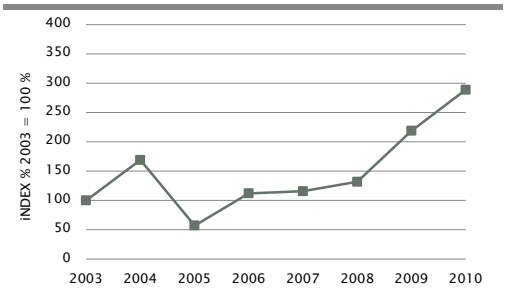
The number of clients in substitution treatment is increasing (see Figure 95). In 2010 7.550 clients started an inpatient or outpatient treatment [ST TDI-2].

Figure 94:
Syringes provided through needle and syringe programmes (NSP) (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 5

Figure 95:
Number of clients in substitution treatment (indexed - 2003=100 %)



Source: EMCDDA Statistical Bulletin 2012 HSR 3

28.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

The National Strategy on Combating Narcotic Drugs Abuse in the Republic of Croatia for the period 2006-2012 aims on an integrated, multidisciplinary and balanced approach to tackling the drugs phenomenon [NR 2011]. This strategy is implemented by triennial Action Plans on Combating Narcotic Drugs Abuse in the Republic of Croatia, the last one was adopted for the period 2009-2012.

The national drug strategy includes a strategy to prevent drug-related deaths, with the objective to improve the system on collecting information on drug-related deaths [SQ 23/29 2011]. The national drug strategy also includes a strategy to prevent DRID [SQ 23/29 2011]. As objective of harm reduction programmes it is stated, that they

» contribute to the prevention of harmful health and social consequences that arise as a result of drug abuse,
» reduce or prevent the transmission of infectious diseases, and
» consequently prevent the deterioration in health and the social condition of drug users.

As corresponding action it is foreseen to develop the network of harm reduction programmes which are focused on informing drug users on the dangers of drug use and on safer ways of using drugs as well as counselling, exchange of syringes and needles programmes, outreach work, methadone maintenance treatment programmes and drop in daily centres [SQ 23/29 2011].

The Action Plan sets also the following objectives, among others [NR 2011]:

» To improve the measures concerning therapy, treatment and social reintegration of addicts and to set up multidisciplinary teams for working with addicts and their families.
» To establish better cooperation with institutions at local level to improve the connection between the different phases (early detection, detoxification, treatment and social reintegration).

To implement the national drug policy on local level there are also County Action Plans on Combating Narcotic Drugs Abuse 2009-2012 [NR 2011].

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Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

The dissemination of Information material is a priority response to prevent DRID in Croatia, while safer injecting training for drug users and "easy-access" programmes to treatment of infectious diseases are not [SQ 23/29 2011]. Still, safer use training and individual counselling on infectious diseases is provided extensively resp. fully[42] [SQ 23/29 2011].

Overdose information material and overdose risk assessment is fully provided [SQ 23/29 2011].

Information materials to reduce drug harms in night clubs and in large music festivals are not widely present, but periodically, some organizations create educational materials for population in nightlife setting [GS]. For instance, in 2003 Office for Combating Drugs Abuse created a leaflet on ecstasy consumption, and in 2012 NGO Institut organized activity at Valcane Summer Beach Festival (27-29 July 2012) where condoms and educational materials on sexually transmitted diseases were distributed. Likewise, NGO Hepatos marked the International Day against Hepatitis (28 July) at the popular beach Zrće, Novalja, by distributing educative materials.

42
This is a rating from the SQ 23/29, the selection and corresponding definitions are:
full: nearly all persons in need would obtain it
extensive: a majority but not nearly alls of them would obtain it
limited: more than a few but not a majority of them would obtain it
rare: just a few of them would obtain it

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Specific materials on the prevention of acute drug-related deaths and drug-related emergencies are available for family/friends only [SQ 23/29 2011]. Croatian Red Cross and NGO LET have leaflets on prevention of overdoses for friends of IDUs, and NGO Terra and BENEFIT network have information on this topic on their web sites.

Within the education framework for police officers and prison staff information on the prevention of drug-related deaths is implemented, but there are no specific information materials for these groups [SQ 23/29 2011].

Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach health education is not a priority response to prevent DRID in Croatia [SQ 23/29 2011]. The main outreach health education approach consists of needle and syringe exchange activities and informing drug users on prevention of drug-related infectious diseases.

Outreach work at night clubs and in large music festivals is provided occasionally by NGOs [GS].

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Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer involvement is not a priority response strategy, although Peer educators are involved in the responses to prevent DRID in Croatia [SQ 23/29 2011].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

With the aim of networking and enabling better users' accessibility to the harm reduction services, in 2009 non-governmental organizations Let, Help, Institut and Terra created an association network "BENEFIT" [GS]. The network provides information on harm reduction programmes, substitution treatment, drug-related infectious diseases in the population of injecting drug users, sexually transmitted diseases in general, and outreach work. The goals of networking the associations are providing mutual help and cooperation of the network members, joint representation towards the local and regional self - government units and state in representing interests of programme users and civil society organisations that conduct harm reduction programmes; strengthening the role of associations in providing health and social services and promotion of positive experiences of Croatian programmes in international cooperation; active inclusion of network members and services users into the public health policy and health system reform etc.

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Psychosocial in- and out-patient interventions, detoxification and substitution treatment are provided fully in Croatia [SQ 27 p1 2011]. Treatment interventions for target groups are available for cannabis and benzodiazepine users [SQ 27 p1 2011].

The addiction system in Croatia is based on outpatient treatment at the county level [NR 2011]. In addition there is a good geographical coverage with inpatient treatment services (therapeutic communities, county hospitals…). So treatment services are equally and sufficiently available for all clients. In 2010 7.550 clients were treated in the healthcare system [NR 2011].

There is no waiting time for all the treatment interventions [SQ 27 p1 2011].

OST is provided with methadone, buprenorphine was replaced by the combination of buprenorphine and naloxone in 2009 [NR 2011]. Psychological support to OST clients is provided fully [SQ 27 p1 2011]. In the year 2009 4.684 clients received OST [Statistical Bulletin 2011].

DCRs are not available in Croatia [SQ 23/29 2011].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Substitution therapy for treatment of opiate addicts can be initiated and prescribed only by authorised medical doctors in centres specialized for treatment of drugs addicts [SQ 27 p1 2011]. This applies to methadone, high dosage buprenorphine, the combination of buprenorphine and naloxone as well as slow release morphine.

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Substitution therapy for treatment of opiate addicts can be continued by any medical doctor, which applies for methadone, high dosage buprenorphine, the combination of buprenorphine and naloxone as well as slow release morphine [SQ 27 p1 2011].

The medication can be dispensed through specialized treatment centres, specialized medical doctors offices and any medical doctors office in case of methadone, the combination of buprenorphine and naloxone as well as slow release morphine [SQ 27 p1 2011]. High dosage buprenorphine can also be dispensed through pharmacies (along with specialized treatment centres, specialized medical doctor offices and any medical doctor offices).

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Drug-related prison health is addressed in the national drug strategy [SQ 23/29 2011]. Harm-reduction programme activities involve all (not easily reachable) drug abuse individuals and groups, who are not successfully covered by traditional health measures and activities within the health system. Generally everyone arrested or detained is entitled to healthcare equal to those who are not arrested or detained, including medical examinations, counselling, psychiatric treatment, infectious disease testing, substation therapy and others [NR 2011].

The priorities to prevent DRID in prison are low intensity drug treatment (incl. counselling), medium/high intensity drug-free treatment (prison-TCs, specialised prison treatment wards) and the initiation of opioid substitution treatment (OST) [SQ 23/29 2011]. Low intensity drug treatment and medium/high intensity drug-free treatment are provided fully by prison health services and mixed teams [SQ 27 p1 2011]. OST is provided in prisons to a limited extent only, but initiation and continuation are possible [SQ 27 p1 2011]. In the past year number of inmates on substitution therapy is increasing [GS].

Addicts that serve the prison sentence are obliged to enroll in the special programme for addiction treatment, with the primary objective of rehabilitation and social reintegration [NR 2011].

Responses to prevent DRID in prison, which are provided fully, are individual counselling on infectious diseases risk as well as HCV testing on prison entry and prison

release [SQ 23/29 2011]. Practical advice and training on safer use as well as NSPs are not available in Croatian prisons [SQ 23/29 2011]. There is no immunization schedule for hepatitis B or hepatitis A on regular basis in prisons, but all inmates get information and counselling on hepatitis, and they can be tested on these diseases [SQ 23/29 2011]. Testing and counselling is provided by the Centre for Anonymous and Free of Charge Hepatitis and HIV Counselling and Testing in Prison Hospital [SQ 23/29 2011].

Pre-release overdose counselling is fully provided, but naloxone is not provided upon prison release [SQ 23/29 2011]. Within the education framework for police officers and prison staff information on prevention of drug-related deaths are implemented, but there are no specific information materials for these groups.

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B is included in the national vaccination scheme [SQ 23/29 2011]. Since 1999, 12-year-old children are vaccinated by the standard scheme and get three doses of vaccine. Since 2007 all newborn children are also vaccinated.

A risk-group specific hepatitis B vaccination programme is available [SQ 23/29 2011]. Hepatitis B vaccination programme is voluntary and free of charge for IDUs since 1989.

Voluntary infectious disease counselling and testing is a priority response to prevent DRID in Croatia and HCV testing is fully provided [SQ 23/29 2011]. A central role in this have the Centers for Anonymous and Free-of-Charge HIV Testing and Counselling (CTS), which offer testing and counselling on anonymous and voluntary level [NR 2011]. Routine screening of high risk groups and "easy-access" programmes to treatment of infectious diseases are no priority response strategies [SQ 23/29 2011].

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Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

NSPs are a priority response to prevent DRID in Croatia and they are provided extensively [SQ 23/29 2011].

NSPs are provided at 6 fixed locations and syringe provision points (SPPs) by 43 outreach services and 47 mobile units [ST 10 2011]. Needles and syringes may be bought in pharmacies, but there is no data on those sold to drug users [GS]. In the year 2010 281.953 syringes were provided by NSPs [ST 10 2011].

The standard items in injecting kits are information material, alcohol pads, water and condoms [SQ 23/29 2011]. Injecting kits are provided fully [SQ 23/29 2011]. As harm reduction programmes are mainly focused on IDUs, there are no paraphernalia for non-injecting drug users provided [SQ 23/29 2011].

The promotion of condoms is not a priority response strategy, but they are provided at drug agencies with NSPs fully [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Naloxone is regulated by administrative regulation [SQ 23/29 2011]. Its use is limited to medical personnel [SQ 23/29 2011]. Naloxone is not included in the list of essential medicines of the Croatian Institute of Health Insurance [NR 2011], but it is part of standard ambulance equipment and Ambulance personnel are trained in its use [SQ 23/29 2011]. Naloxone cannot be purchased in pharmacies without prescription [GS].

In 2010 the establishment of a network of emergency medical services was initiated. The Umbrella organization for these services is the Croatian Institute for Emergency Medical Service [GS].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Drug users are explicitly addressed in the primary healthcare strategy [SQ 28 2010].

Considering chronic recurrent type of disease, the basis of organization of drug treatment in Croatia is the outpatient treatment. In treatment a Croatian model compliant by experts is applied, which is known by its name in international expert circles [SQ 28 2010]. The model implies constant cooperation and common actions of specialized outpatient prevention centres and outpatient treatment of addicts and primary healthcare doctors, as well as family medicine teams, in administering addict treatment.

Through this model, a wide availability of treatment within primary healthcare was achieved, while at the same time ensuring expert guidance from a specialist, integrated comprehensive addict care, de-stigmatization and treatment normalization, decentralization and de-ghettoisation of addicts, as well as low cost of programmes. In case of non cooperation and aggression of addicts and when, due to non-implementation of therapeutic procedures, their life would be endangered or would be in danger of severely damaging their own health or health of others, a compulsory treatment must be provided, in accordance with legal regulations pertaining to the subject.

The accommodation needs of drug users are not explicitly addressed in the National Social Protection and Social Inclusion Plan, but it's mentioned in the written drug policies [SQ 28 2010]:

» Foundation of housing communities for addicts which cannot return to their old environments after completing rehabilitation or jail sentence, either because of social or housing issues (such as homelessness);
» Provision of conditions for post treatment admission for minors and adults returning from jail sentences and from educational institutions.

The education needs of drug users are explicitly addressed in the National Social Protection and Social Inclusion Plan [SQ 28 2010].

In accordance with re-socialization Project, the addicts have a right to [SQ 28 2010]:

» Re-vocational and re-educational training which is done during a stay at a therapeutic community, home for addicts or prison.

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» Finishing a started high school education after leaving a therapeutic community or prison.
» Education in accordance with the labor market demands.

The measure of financial support of education is aimed at inclusion in programmes for education of special groups, which include unemployed treated addicts, in order to improve their employability and provide employment, and is implemented in compliance with National Plan for Promotion of Employment 2009-2010 [SQ 28 2010].

The Government of the Republic of Croatia issued the Re-socialization of Drug Addicts Project, for those that finished one of rehabilitation or disuse programmes in therapeutic community or prison, as well as for addicts that are in outpatient treatment and are, for a longer period of time, maintaining abstinence and implement a prescribed treatment, with intent to stimulate the work of all subjects on addict re-socialization, and especially education and employment as the most important parts of their social integration [SQ 28 2010].

The education needs of drug users are also a priority in the written drug policies [SQ 28 2010]. The priorities for education of addicts are:

» Helping the addicts in treatment or those which finished the treatment, in completing school education or re vocational courses.
» Preparing an expert occupational retraining based on relevant statistic data about professional qualification of addicts and their motivation for the programme, as well as actual labor market demands.
» Implementation of education programmes according to labor market needs.

The employment needs of drug users are explicitly addressed in the National Employment Plan [SQ 28 2010].

Aiming to successfully employ treated addicts as well as other socially sensitive groups, the Government of Croatia adopted the National Employment Promotion Plan 2009-2010 and Small and Mid-size Enterprise Promotion Plan 2008-2012 [SQ 28 2010]. The National Plan defines the area of labor market and employment policies and is in accordance with goals defined by the Lisbon strategy. Measures for promotion of employment of rehabilitated addicts which are enlisted in Employment Promotion Plan are in accordance with guidelines and recommendations of European employment strategy – EU Guideline 7 (Promotion of integration and battle against discrimination of persons in unfavourable position on labor market). These measures are aimed towards realization of one of general goals of the project (the inclusion of treated addicts into labor market and life in the community), by which they aim to prevent their discrimination and recidivism after completed treatment.

The employment needs of drug users are also a priority in the written drug policies [SQ 28 2010]: drafting of an expertise on vocational training based on relevant statistical data about professional qualifications of addicts and their motivation for education or re-vocational training and real needs of the labor market.

Other policies [SQ 28 2010]:

» Inclusion in programmes for education of special groups of unemployed persons, including treated addicts, with aim to increase their employability and competitiveness on the labor market.
» Inclusion in educational programmes with aim to raise their qualification and to easier include them into labor market.

During 2008 and 2009 all responsible Ministries and other State bodies, in accordance with their authorities and responsibilities mentioned in Re-socialization of Addicts Project, have implemented project activities in order to re-socialize and socially re-integrate rehabilitated drug addicts [SQ 28 2010]. According to reports from responsible institutions, during 2009, much larger number of addicts started to join the Project than in previous year, and especially great interest was expressed for inclusion in re education and re vocational training and completion of high school education programmes. Regional offices of Croatian Employment Institute have during 2007, 2008 and 2009 constantly implemented measures for promotion of education and employment of treated drug addicts. Measures for promotion of education and employment were accomplished through activities of professional guidance counselling and measures of active co financing and financing of education and employment policies from National Employment Promotion Plan 2009-2010.

On national level, The Office for Combating Drugs Abuse coordinates the work of ministries and departments in charge of implementation of measures from National Action Plan [SQ 28 2010]. On regional level (counties and cities) Social Care Centers are responsible for informing the addicts from the target group about all the possibilities for inclusion in the Project as well as for provision of other forms of social care and support for addicts during re-socialization process [SQ 28 2010].

There are protocols between different national, regional and local authorities and agencies involved in addressing the health and social needs of drug users in treatment [SQ 28 2010]. There are no partnership agreements between the social services and the health services to meet the needs of drug users in treatment [SQ 28 2010].

The most common mechanism of interagency coordination is the structured protocol [SQ 28 2010].

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Employability of drug users in treatment is not part of treatment care plan [SQ 28 2010]. In certain therapeutic communities and prisons employability is a standard, but within healthcare system it is not so [SQ 28 2010].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Formal NSP training is available for drug agency staff [SQ 23/29 2011]. But there is no information on continued education for different professions [SQ 27 P2 2011].

Since 2007 Office for Combating Drugs Abuse has been conducting regional workshops for professionals involved in the Reintegration of Drug Addicts Project [GS]. On average, two workshops are being organized annually. Education targets representatives from relevant ministries, social welfare centres, and employment services on county level, services for mental health protection and addiction prevention, prisons, non-governmental organizations, therapeutic communities, representatives from county committees and employers' organizations.

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

There are no harm reduction guidelines in Croatia [SQ 23/29 2011]. But there are guidelines for treatment [Best Practice Portal]:

» Guidelines for the use of Methadone in the substitution therapy of opiate drug users (2006)
» Guidelines for the use of Buprenorphine in the substitution therapy of opiate drug users (2006)

In addition there are Guidelines for Therapy Community Standards and Proposal for Issuance of Work Permits for Therapeutic Communities (2007) and the Rulebook on the Type of Social Care Home Activities, the Way of Providing Care Outside Your Own Family, the Conditions of Space, Equipment and Employees in a Care Home/Center, Therapeutic Community, Religious Community, Association and Other Legal Entitites (2009) [NR 2011].

There is no institution responsible for developing guidelines for best practice in drug treatment or harm reduction [SQ 27 P2 2011].

Individual programmes are often evaluated by the County Committees on Combating Drugs Abuse, as they finance such programmes [NR 2011].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

At the end of 2010 the Office for Combating Drugs Abuse initialized building the Database of Programmes / Projects which are conducted in the Drug Combating Field [GS]. This Database includes prevention, treatment, social reintegration and harm reduction programmes. Programme Database supports the inclusion of needs assessment at the initial stage of any programme, since it is one of the obligatory questions in the Database questionnaire.

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Treatment evaluation aspects are not included in the pharmacological guidelines [SQ 27 P2 2011].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

Recommendations of the European Monitoring Centre for Drugs and Drug Addiction have been taken into account in the process of Program Database building [GS]. The main goal of the Database is not only getting insight to implemented programmes, but primary to encourage development of quality services. Moreover, establishing and implementing evaluation quality criteria is one of the goals of the Database.

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

A Prevention Programmes Database should enable the collection of information on all prevention activities (including treatment, harm reduction, social reintegration) and contribute to the improvement of the programmes and their quality levels as well as to the dissemination of good practice [NR 2011].

In 2010 the members of work groups within the National Drug information System in the Republic of Croatia were officially appointed [NR 2011]. Trainings on various methods were carried out within the IPA 3 programme of the EMCDDA. Data exchange on treated addicts shall be improved and streamlined with EMCDDA standards with the help of agreements between relevant institutions. Preparations for this started in 2010.

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

Evaluation is one of the components of the Action Plan 2009-2012 [NR 2011]. The National Strategy and the Action Plan are being evaluated annually. The first scientific

evaluation was carried out within 2011. The drafting process of the new strategy was based on the results of this evaluation.

Evaluation criteria are implemented in the Program Database [GS]. The idea is that evaluated and effective programmes get a "quality certificate", a warranty of programmes effectiveness. Programmes with this certificate will have priority at financing on national and local level.

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Education is one of the components of the Action Plan 2009-2012 [NR 2011].

In November 2012, Office for Combating Drugs Abuse will, with the TAIEX assistance, organize regional workshops on standards on drug demand reduction [GS]. One session at the workshop will be focused on evaluation - key element of effective drug demand reduction project.

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

A broad range of actors and stakeholders are involved to some extent in evaluation in Croatia, there was no change since 2003 [PS]. The Council Recommendation had medium impact on the overall development and implementation of evaluation to inform further development of drug prevention and risk reduction in Croatia.

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Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

International cooperation is one of the components of the Action Plan 2009-2012 [NR 2011].

29 Country Profile of the former Yugoslav Republic of Macedonia

29.1 Indicators for drug-related harm

Surveys, enumeration, multiplier, capture-recapture and network analysis methods are used to estimate the prevalence of problem drug use in the country. The NFP collected data from treatment and syringe and needle exchange programmes, on police contacts and drug-related deaths to estimate the number of problem drug users, mainly opiate users, for the former Yugoslav Republic of Macedonia. The estimated size of the **injecting drug users population** is 8.000. The figure obtained correspond to a rate of 1,5 per 1.000 inhabitants aged 15-64 [CO].

As regards the **primary drug** use of clients entering treatment data for 2008 are available for a total of 10 treatment centres submitting treatment demand data. There were 1.212 clients in treatment. 91 % of all clients entering treatment reported opioids as their primary drug, 7 % cannabis and 1,3 % cocaine [CO]. Concerning route of administration there is no data available.

Regarding **HIV** the Former Yugoslav Republic of Macdonia is a low prevalence country and has reported the lowest number of HIV positive cases so far among the countries in the south-eastern European Region [CO]. From 2004 to 2009 only one case of infection with HIV via IDU was notified [ECDC/WHO, HIV/AIDS surveillance in Europe 2009]. The data from the clinic for infectious diseases received by the national focal point indicate in 2009 there were 20 drug users with **hepatitis C** and in 2010 there were 16 drug users with hepatitis C [CO].

Data for **direct drug-related deaths (drug-induced deaths)** are collected by the national focal point from three entities: the Institute of Forensic Medicine, Criminology and Medical Deontology at the Medical Faculty in Skopje; the Institute of Forensic Medicine Bitola and the Institute of Forensic Medicine Tetovo. In 2009, the total number of drug-related deaths reported by these entities was 16 (15 men and one female), main cause of death was opioid intoxication — poisoning with heroin. The total number of drug-related deaths reported up to October 2010 by the above-mentioned institutions was 14 (13 male and one female), the main cause of death was opioid intoxication with heroin [CO].

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29.2 Indicators for drug-related harm reduction

Fifteen needle exchange programmes (units) were identified, which are managed by local NGOs. In 2008, the needle exchanges programmes had contact with 1.615 regular clients, all injecting drug users [CO].

Methadone was introduced as a substitution substance in 1992, and it remains the main substance prescribed for substitution maintenance treatment. Buprenorphine, which was introduced in 2010, is also used in detoxification and substitution treatment in the Former Yugoslav Republic of Macdonia. Approximately 1.232 drug users are included in the methadone maintenance treatment programme, and receive the substance daily or weekly.

29.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

The former Yugoslav Republic of Macedonia has a National Drug Strategy 2006 – 2012 [CO 2011]. The general objectives are

» to keep a high level of health protection, well-being and social cohesion by preventing and reducing drug use, dependence and drug-related harms,
» to ensure a high level of security for the general public by preventing drug-related crime – including actions against drug production, cross-border trafficking of drugs and diversion of precursors.

These two main objectives are amended by three cross-cutting issues: coordination, international cooperation and monitoring/information/research/evaluation. More specific objectives were defined in the pre-implementation drug action plan 2007-2008 as well as the national drugs action plan 2009-2012.

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

Information and counselling services to drug users related to harm reduction is available fully, there was a strong increase since 2003 [PS].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Information measures targeted at families and communities related to harm reduction are available extensively, there was an increase since 2003 [PS]. A lot of seminars and working groups were organised since 2003 by Inter Ministerial Commission for narcotic drugs together with NGOs and supported by EU and WHO.

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Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach work is part of the harm reduction activities in the former Yugoslav Republic of Macedonia [CO 2011].

Outreach work targeted at drug users is available extensively, there was a strong increase since 2003 [PS]. There are four general aims of drugs outreach work: to identify and contact hidden populations, to refer members of these populations to existing care services, to initiate activities aimed at prevention and at demand reduction, and to promote safer sex and safer drug use. These activities are carried out by 13 NGOs for harm reduction which are financially supported by a Global Fund project against HIV/AIDS and Tuberculosis.

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer involvement in outreach work is available to a limited extend only, but there was an increase since 2003 [PS].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between agencies involved in outreach work is available fully, there was a strong increase since 2003 [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

Drug-related treatment is available nationwide within the framework of the national public health network [CO 2011]. Medically assisted treatment is provided mainly by the public sector either in hospitals or in addiction treatment centres, but also by three private psychiatric services. The treatment system provides outpatient and inpatient treatment, detoxification as well as opioid substitution treatment (OST) (as maintenance treatment). Detoxification treatment and psychosocial interventions are provided in inpatient and outpatient settings, while opioid substitution treatment (OST), individual or group counselling as well as social and psychotherapy is available in outpatient services only.

Methadone, the main substance used for OST, is available since 1992 [CO 2011]. Around 1.232 clients receive methadone maintenance treatment. Buprenorphine is available since 2010 for detoxification as well as for OST.

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Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of substitution substances are available fully, there was a strong increase since 2003 [PS]. The major challenges to development in this area were/are organization, establishment, management and control.

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

Since 2006 one prison (Idrizovo Prison) provides methadone maintenance in a treatment centre with 120 beds [CO 2011]. Since 2010 professional teams of psychologists and social workers provide psycho-social treatment for drug users in prisons.

In 2012 methadone maintenance programmes are available in all prisons in the former Yugoslav Republic of Macedonia [PS].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B vaccination and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases for injecting drug users as well as screening for HIV, Hepatitis B/C, tuberculosis and sexually transmitted diseases among injecting drug users and their immediate social networks is available extensively [PS]. Medical treatment of HIV/AIDS for injecting drug users is available fully, medical

treatment of Hepatitis C, tuberculosis and sexually transmitted diseases is available extensively. There was a strong increase concerning these measures since 2003.

A major achievement since 2003 is, that hepatitis B vaccinations have been integrated into the standard package of immunization [PS].

Council Recommendation 2.10

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provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

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15 needle and syringe programmes are available and implemented by local NGOs [CO 2011]. In 2008 they were in contact with 1.615 clients.

11 cities have high coverage, 60 % of all NGOs offer needle and syringe programmes (Access and coverage of needle and syringe programmes in Central and Eastern Europe, WHO Regional Office Europe; CEEHRN –Vilnius, Lithuania) [PS].

Council Recommendation 2.11

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ensure that emergency services are trained and equipped to deal with overdoses;

Emergency services, which are adequately prepared to deal with drug overdoses, are available extensively, there was an increase since 2003 [PS].

Council Recommendation 2.12

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promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Integration between health services, social care and specialised risk reduction is available fully, there was a strong increase since 2003 [PS]. A major achievement since 2003 is the fact that besides Treatment centres for methadon substitution therapy

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there are 3 centres for resocialization and social integration of drug dependant persons and 1 therapeutic community.

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Professional training on the reduction of health-related risks associated with drug dependence is available extensively, there was a strong increase since 2003 [PS]. Global Fund against HIV/AIDS and Tuberculosis and the World Health Organization are actively involved in training of professionals. However further trainings of joined teams are needed.

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

Scientific evidence is used as basis to select interventions to a large extent, there was a strong increase since 2003 [PS].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

Needs assessments are used at the initial stage of programmes to a large extent, there was a strong increase since 2003 [PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation protocols are used in drug prevention programmes as well as in risk reduction programmes to a large extent, there was a strong increase since 2003 [PS].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

Quality criteria are used in evaluations to a large extent, there was a strong increase since 2003 [PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Standardised data collection is used to a large extent, there was a strong increase since 2003 [PS]. CARDS and IPA Projects were main initiators for establishing a NFP for

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the cooperation with EMCDDA and to set up indicators, a network of institutions and to implement standardised data collection.

Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

Evaluation results are used for further development of drug prevention policies to a large extent, there was a strong increase since 2003 [PS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Evaluation training programmes are available to a large extent, there was a strong increase since 2003 [PS].

In 2011 an evaluation was carried out by a working group of 15 persons, composed of representatives of the Office of the Global Fund for HIV/AIDS in Skopje, UNICEF, UN joint programme on HIV/AIDS, NGOs, representatives of the Ministries of Education, Labour and Welfare, Health [PS]. The methodology of the survey consisted of interviews with a questionnaire with the option of selecting more than one answer. Evaluation is made of all methadone centres in the former Yugoslav Republic of Macedonia through questionnaires for staff and users of methadone. Filled total: 276 questionnaires, 224 questionnaires were filled out methadone users in methadone centres and 52 completed questionnaires staff methadone centres. Within the evaluation in methadone centre in main Prison “Idrizovo” were fulfilled: 51 surveys questionnaires of users of methadone and 4 questionnaires from staff working in methadone centres.

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

A broad range of actors and stakeholders is involved in evaluation to a large extent, there was a strong increase since 2003 [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

Professionals have access to opportunities for exchange of programme results, skills and experience at European level to a large extent, there was a strong increase since 2003 [PS]. EMCDDA and the IPA Project are very meaningful partners to MKD NFP and all stakeholders. Opportunities can be increase with study visits, participations in Workshops, Conferences and Forums organised at EU level for concrete areas of interest. Membership of the European Union is the highest strategic interest and priority for the Government of the former Yugoslav Republic of Macedonia. All Council Recommendations and Suggestions are implemented by the relevant institutions. Institutions and professionals with hard work, commitment and adherence to standard practices established in the EU, strengthen capacities in the system for treatment and harm reduction of drug addiction. We hope that EU support will continue in the forthcoming period.

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30 Country Profile Iceland

30.1 Indicators for drug-related harm

The only data which could be identified for the current report is the number of HIV infections acquired via IDU. From 2004 to 2009 11 persons have been infected with HIV in Iceland [ECDC/WHO, HIV/AIDS surveillance in Europe 2009].

30.2 Indicators for drug-related harm reduction

Needle exchange and substitution treatment are available in Iceland. Coverage of substitution treatment is estimated to be extensive, and for needle exchange limited [PS].

30.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

Ministry of Welfare and Directorate of Health are currently working on developing policy in this area [PS].

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

This policy does not exist in Iceland. The availability/coverage of information and counselling services to drug users related to harm reduction is limited but has increased since 2003. Harm reduction still needs more attention by both government as well as NGO [PS].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

This policy does not exist in Iceland. The availability/coverage of information measures targeted at families and communities related to harm reduction is rare but has increased since 2003 [PS].

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Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

This policy does not exist in Iceland. The availability/coverage of outreach work targeted at drug users is limited but has increased since 2003 mainly by Reykjavik city, Samhjalp (NGO) and the Salvation army.

Icelandic Red Cross, Reykjvik branch started a mobile healthcare team assisting injecting drug users by providing equipment of injection materials in exchange of used needles, distributing condoms, treating wounds and general physical as well as mental health consultations. Addiction services at Landspitali university hospital are planing an outreach team serving individuals with dual diagnosis in variable stages of substance/drug use [PS].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

This policy does not exist in Iceland. The availability/coverage of peer involvement in outreach work is rare but has increased since 2003. Peers voluntarily working for the Red Cross, Reykjavik branch as part of the mobile health team [PS].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

This policy does not exist in Iceland. The availability/coverage of networking and cooperation between agencies involved in outreach work is rare but has increased since 2003. There is cooperation between Red Cross, Samhjalp (NGO) and Reykjavik city [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

The availability/coverage of drug-free treatment is full, the availability/coverage of substitution treatment is extensive and has increased since 2003, the availability/coverage of psychosocial care and rehabilitation supporting substitution treatment is full.

High availability of treatment by Landspitali, SAA (NGO), Samhjalp (NGO), Krýsuvíkursamtökin (NGO). The NGOs receive financial support from the government.

At SAA over 80 individuals are receiving substitution treatment as a part in their rehabilitation [PS].

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Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Abuse as a result of diversion of substitution substances is not common most likely due to the fact that substitution treatment is only given at SAA under strict protocol [PS].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

The availability/coverage of harm reduction services provided to drug abusers in prison is rare [PS].

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

The availability/coverage of screening for HIV and Hepatitis B/C among injecting drug users and their immediate social networks is extensive. The availability/coverage of screening for tuberculosis is rare.

The availability/coverage of medical treatment of HIV/AIDS and Hepatisits C for injecting drug users is limited. There was an HIV-outbreak in the injecting drug population 2010, 10 new cases were diagnosed HIV positive. HIV positive individuals and individuals with active Hepatitis C infection need in most case to be free from drug misuse for a period of time (6 months+ for Hepatitis C).

Individuals in risk groups generally offered screening for HIV and Hepatitis B/C when receiving treatment for their drug dependence [PS].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

The availability/coverage of condom distribution for injecting drug users is rare, the availability/coverage of distribution of injection materials is limited.

Icelandic Red Cross, Reykjvik branch started a mobile healthcare team assisting injecting drug users by providing equipment of injection materials in exchange of used needles, distributing condoms, treating wounds and general physical as well as mental health consultations [PS].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Emergency services are adequately prepared to deal with drug overdoses; there is a high standard of medical care in the emergency services [PS].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

The integration between health services, social care and specialised risk reduction is rare [PS].

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Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Professional training on the reduction of health-related risks associated with drug dependence is not available [PS].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

Scientific evidence is used as basis to select interventions to a large extent.

Directorate of Health (landlaeknir.is) has among other functions the following functions:

- To advise the Minister of Welfare and other Government bodies, health professionals and the public on matters concerning health, disease prevention and health promotion.
- To sponsor and organise public health initiatives.
- To promote improvements of healthcare quality.
- To inspect the healthcare services and monitor healthcare workers.
- To monitor prescription medicines and promote their rational use.
- To collect and process data on health and healthcare services and promote research in that field [PS].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

This policy exists, needs assessments are used at the initial stage of programmes to some extent [PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

This policy does not exist. No evaluation protocols currently in use [PS].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

This policy does not exist. So far Iceland has not participated in either EMCDDA or Reitox [PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

This policy does not exist but data collection regarding drug use and alcohol intake is done by the government (Directorate of Health, Statistics Iceland (hagstofan.is), The Icelandic Centre for Social Research and Analysis (ICSRA), SAA [PS].

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Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

This policy does not exist but evaluation results are used for further development of drug prevention policies to some extent [PS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

This policy does not exist [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

This policy does not exist, actors and stakeholders are not involved in evaluation [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

This policy does not exist, but professionals in have access to opportunities for exchange of programme results, skills and experience at European level to some extent [PS].

31 Country Profile Montenegro

31.1 Indicators for drug-related harm

Estimates of **problem drug use** for the whole country are not available. According to the available results of a capture-recapture study based on validated and adjusted counts, the number of injecting drug users was 660 (95 % CI 520-909) in Podgorica, 0,7 % of the 15- to 49-year-old population in 2005/2006 [CO]. Data on **primary drug** or **route of administration** are not available.

Regarding **infectious diseases** since the first registered case of HIV/AIDS in Montenegro in 1989, up to the end of 2009, a total of 101 HIV-infected individuals were registered. 4 % of cases were infected through injecting drug use [CO]. From 2004 to 2009 only one case of infection with HIV via IDU was notified [ECDC/WHO, HIV/AIDS surveillance in Europe 2009]. In 2008 a survey on risk behaviour related to seroprevalence of HIV/AIDS, HIV, HCV and HBV among injecting drug users in Montenegro showed a very low HIV prevalence (0.4 %) opposed to very high HCV prevalence (53,6 %) [CO].

Over the period 2005-08 there were 20 **direct drug-related deaths (drug-induced deaths)**. Of these 20 drug-related deaths, in 19 cases overdose was caused by heroin, and in the other case the death was caused by cocaine combined with heroin. The trend in drug-related deaths is as follows: four deaths in 2005, four in 2006, seven in 2007; five in 2008 and ten in 2009. Among those ten drug-related deaths cases in 2009, nine resulted from overdose with heroin, and in one case, due to overdose with cocaine [CO].

31.2 Indicators for drug-related harm reduction

From February 2005, needle and syringe exchange programmes have been implemented both in the institutional setting (Health Centre Podgorica, through 13 distribution points in primary healthcare centres) and by the NGOs (outreach field harm reduction interventions in Podgorica, Bar, Nikšić and Kotor: CAZAS works with IDUs, Juventas works with commercial sex workers who are IDUs) [CO].

In 2010 the Podgorica health centre has served 847 clients and distributed 2.092 needles and 1.370 syringes. In 2008 Juventas has served 538 clients, distributed 11.564 needles and 7.049 syringes. In the same year, CAZAS served 262 clients, and distributed 5.455 needles and 3.820 syringes [CO].

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Methadone maintenance is available in three centers, one is the Health Centre Podgorica within the Mental Health Centre opened in 2006. In August 2010, two new Centres for substitution therapy were established. One of the Centres is located within the Health care centre Berane in the North, and the other one is located within the Health care centre Kotor in the South [CO]. In 2010, data on 94 new patients entering in a methadone maintenance treatment programme were provided by the Podgorica Health Centre [CO].

31.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

Montenegro has a National Drug Strategy ("National Strategic Responses to Drugs 2008-12") and an Action Plan for the Implementation of the Strategy [CO 2010]. General objectives include a reduction of drug demand and a reduction of drug supply. Specific objectives are for example,

- to ensure qualitative and continual cooperation between different care providers in the country and
- to support development of programmes that will contribute to stabilizing or reducing the number of HIV, HCV and HBV infected individuals, as well as the number of fatal overdoses.

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

Information, education and communication (IEC) is – besides the methadone programme and the needle and syringe exchange programmes – the main response strategy to prevent infectious diseases in Montenegro [CO 2010].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Information measures targeted at families and communities related to harm reduction are available extensively, there was an increase since 2003 [PS].

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Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

Outreach work targeted at drug users is available to a limited extend only, although there was an increase since 2003 [PS]. Main achievements in this area since 2003 were the inclusion of outreach work in the national health and social policies for drugs, the support of appropriate outreach work training and the development of working standards and methods. A main challenge in this area is to contact individuals or groups, which belong to especially vulnerable populations, and cannot effectively contacted or reached by existing services or traditional channels of health education.

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer involvement in outreach work is available extensively, there was an increase since 2003 [PS].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

Networking and cooperation between agencies involved in outreach work is implemented to a limited extent, there was an increase since 2003 [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

There is no national treatment policy/plan but drug treatment is defined in the National Drug Strategy [CO 2011]. The objectives are among others:

» to ensure integral, constant and approachable treatment of drug users,
» to make treatment equally approachable to patients of both genders, different age groups and to users of all kind of drugs as well as
» to ensure diversification and high quality of capacities and programmes of drug treatment by introducing different approaches.

Treatment has to be available for anyone at anytime. It is structured in two levels: outpatient and inpatient services. Outpatient psychosocial and medical treatment is provided by 18 health centres across the country. Inpatient detoxification treatment is provided in detoxification units in all seven general hospitals. Inpatient psychosocial treatment is provided in three public psychiatric hospitals and four private psychiatric units. In 2009 160 clients were treated in inpatient units and 388 in outpatient units.

Methadone maintenance and detoxification treatment is provided by five centres. Rehabilitation/re-socialisation is provided by the Public Institution for Accomodation, Rehabilitation and Re-socialisation of Drug Users and a therapeutic community (RETO).

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

Measures to prevent diversion of substitution substances are available extensively, there was an increase since 2003 [PS].

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Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

The National Drug Strategy includes also as objective, to create conditions for increasing institutional treatment programmes in penal institutions [CO 2011].

There is a Special Prison Hospital for the treatment of inmates.

In 2009 37 convicted drug users were treated by the Institute for Execution of Criminal Sanctions. In 2009 six prisoners received methadone, in 2010 this number raised to ten prisoners. They had to be included in a methadone maintenance programme before prison entry.

In 2010 the NGO Juventas run the project "Open with Prisoners" in Podgorica Prison, which provided information and educational materials on harm reduction to prisoners and prison staff. A counselling centre was established within the prison and in the Special Prison Hospital, which covers also the issue of harm reduction during counselling sessions with prisoners.

Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

Hepatitis B vaccination as well as prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases for injecting drug users is available extensively, there was an increase since 2003 [PS].

Screening for HIV, tuberculosis and sexually transmitted diseases among injecting drug users and their immediate social networks is available extensively, there was a (strong) increase since 2003. Screening for Hepatitis B/C among injecting drug users and their immediate social networks is available to a limited extent only, but there was also an increase since 2003.

Medical treatment of HIV/AIDS, Hepatitis C, tuberculosis and sexually transmitted diseases for injecting drug users is available fully, there was a strong increase since 2003.

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

From 2005 on, needle and syringe exchange programmes were implemented [CO 2011]. 13 distribution points are provided in primary healthcare centres and additional programmes are provided by NGOs. In 2010 the Health Centre Podgorica distributed 2.092 needles and 1.370 syringes, while two of the NGOs distributed 11.564 and 5.455 needles as well as 7.049 and 3.820 syringes in 2008.

In 2009 the drop-in centre was established, which provides free access to counselling, educational materials, needles and syringes and other support for former and current drug users.

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

Emergency services which are adequately prepared to deal with drug overdoses are available extensively, there was an increase since 2003 [PS].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

Integration between health services, social care and specialised risk reduction is implemented extensively, there was an increase since 2003 [PS].

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Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Professional training on the reduction of health-related risks associated with drug dependence is available extensively, there was a strong increase since 2003 [PS].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

The development and advancement of an effective, comprehensive and scientifically based system of drug demand reduction is an objective of the National Drug Strategy [CO 2011].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

Scientific evidence is used as basis to select interventions to some extent, there was an increase since 2003 [PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

Evaluation protocols are used in drug prevention programmes and risk reduction programmes to some extent, there was an increase since 2003 [PS].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

Quality criteria are used in evaluations to some extent, there was an increase since 2003 [PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

Specific objectives of the National Drug Strategy are also to create conditions for establishing an informational system with a view to collecting, administering, processing and managing information in the field of drugs as well as to build capacities for establishing a national focal point for the EMCDDA in Montenegro.

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Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

Evaluation results are used for further development of drug prevention policies to some extent, there was an increase since 2003 [PS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

Evaluation training programmes are available to a large extent, there was a strong increase since 2003 [PS].

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

A broad range of actors and stakeholders is involved in evaluation to some extent, there was an increase since 2003 [PS].

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

Professionals in Montenegro have access to opportunities for exchange of programme results, skills and experience at European level to a large extent, there was a strong increase since 2003 [PS].

32 Country Profile Turkey

32.1 Indicators for drug-related harm

In 2009, a population size estimate of **problem opiate users** was performed using the mortality multiplier method. The study suggests that there are around 17.392 opiate users (lowest estimate 15.197; highest estimate 36.246) which correspondents to a rate of 0,3 opiate users per 1.000 population aged 15-64 in 2010 [CO]. Based on the capture recapture method for Istambul an estimation of problem opiate use came to 25.035 (95 % confidence interval: 17.968 to 39.949) and for Ankara to 5.844 (95 % confidence interval: 4.109 to 12.601) [NR 2011].

In 2010 treatment data are reported from 15 out of 22 inpatient treatment centres. A total of 2.900 inpatient clients entered treatment, out of which 69,1 % of reported opioids as the **primary drug**, followed by 18,2 % for cannabis and 2,2 % for cocaine [CO]. 33 % of 1.974 clients receiving treatment for heroin addiction stated that they used heroin through injecting while 39 % used through sniffing, 11 % through eating/drinking and 9 % used heroin through smoking [NR 2011].

Examining classification of 4.525 **HIV/AIDS** cases notified between 1985 and 2010 by potential transmission means, injecting drug use corresponds to a portion of 3,25 % (147) [NR 2011]. Out of 644 HIV tested injecting drug users in addiction treatment centres in 2010 0,5 % were tested positive and out of 666 HCV tested injecting drug users in addiction treatment centres in the same year 33 % were tested positive [NR 2011].

In 2010, there were 126 direct **drug-related deaths (drug-induced deaths)** reported (153 in 2009, 159 in 2008, 147 cases in 2007 and 51 cases in 2006). The toxicological analysis confirmed that opiates (alone or in combination with other substances) were involved in 88,9 % of reported death cases [CO].

32.2 Indicators for drug-related harm reduction

The third 'National strategic AIDS action plan for the years 2007-11' was adopted in 2006. This action plan includes targets and strategies concerning prevention, diagnosis and increased access to treatment, increased education, development of legislation, social support, monitoring, and evaluation of activities regarding HIV/AIDS/HBV/HBC [CO]. In 2009, a combined buprenorphine and naloxone medication has been licensed in Turkey and its use in drug addiction treatment for detoxification and substitution

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since 2010 [CO]. In 2010 and the first six months of 2011 3.525 boxes of Suboxone 8 mg/2 mg and 5.248 boxes of Suboxone 2 mg/0.5 mg were sold [NR 2011].

32.3 Implementation of CR

Council Recommendation 1

Member States should, in order to provide for a high level of health protection, set as a public health objective the prevention of drug dependence and the reduction of related risks, and develop and implement comprehensive strategies accordingly.

Harm reduction is part of: National Mental Health Action Plan 2011-2013 and National Drug Action Plan of Turkey (2010-2012) (TUBIM) [PS]

References:

National Mental Health Action Plan 2011-2013: http://www.saglik.gov.tr/TR/belge/1-13933/ulusal-ruh-sagligi-eylem-plani.html

National Drug Action Plan of Turkey (2010-2012): http://www.kom.gov.tr/Tr/Dosyalar/2_ulusal_uyusturucu_eylem_plani.pdf

Council Recommendation 2

Member States should, in order to reduce substantially the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths, make available, as an integral part of their overall drug prevention and treatment policies, a range of different services and facilities, particularly aiming at risk reduction; to this end, bearing in mind the general objective, in the first place, to prevent drug abuse, Member States should:

Council Recommendation 2.1

provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services;

Information materials dissemination is a priority response to prevent DRID [SQ 23/29 2011].

This policy exists but was not based upon the Council Recommendation. The availability/coverage of information and services to drug users related to harm reduction is extensive and has strongly increased since 2003 [PS].

Council Recommendation 2.2

inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence;

Specific materials on prevention of acute drug-related deaths and drug-related emergencies are not available for family/ friends and other groups [SQ 23/29 2011].

This policy exists but was not based upon the Council Recommendation. The availability/coverage of information measures targeted at families and communities related to harm reduction is limited [PS].

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Council Recommendation 2.3

include outreach work methodologies within the national health and social drug policies, and support appropriate outreach work training and the development of working standards and methods; outreach work is defined as a community-oriented activity undertaken in order to contact individuals or groups from particular target populations, who are not effectively contacted or reached by existing services or through traditional health education channels;

This policy exists but was not based upon the Council Recommendation. The availability/coverage of outreach work targeted at drug users is rare but has increased since 2003 [PS].

Council Recommendation 2.4

encourage, when appropriate, the involvement of, and promote training for, peers and volunteers in outreach work, including measures to reduce drug-related deaths, first aid and early involvement of the emergency services;

Peer involvement is not a priority response to prevent DRID. Peer educators are not involved in the responses to prevent DRID. Naloxone is not available on a "take-home" basis [SQ 23/29 2011].

This policy exists but was not based upon the Council Recommendation. The availability/coverage of peer involvement in outreach work is limited but increased since 2003. Main challenges are insufficient coordination among related stakeholders and the lack of qualified staff [PS].

Council Recommendation 2.5

promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility;

This policy exists but was not based upon the Council Recommendation. The availability/coverage of networking and cooperation between agencies involved in outreach work is limited and has not changes since 2003 [PS].

Council Recommendation 2.6

provide, in accordance with the individual needs of the drug abuser, drug-free treatment as well as appropriate substitution treatment supported by adequate psychosocial care and rehabilitation taking into account the fact that a wide variety of different treatment options should be provided for the drug-abuser;

This policy does not exist in Turkey but is pending for approval. The availability/coverage of drug-free treatment is rare, but has increased; the availability/coverage of substitution treatment is extensive and strongly has increased since 2003; the availability/coverage of psychosocial care and rehabilitation supporting substitution treatment is rare but has increased. Overall the Council Recommendation had little impact on the overall development of treatment, care and rehabilitation services for drug abusers [PS]. The availability of psychosocial in- and out-patient interventions, of detoxification and substitution treatment is extensive [SQ 27 p1 2011]. Substitution treatment (buprenorphine/naloxone) was introduced in 2010 [NR 2011].

Council Recommendation 2.7

establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment;

This policy exists and was based upon the Council Recommendation [PS].

Council Recommendation 2.8

consider making available to drug abusers in prison access to services similar to those provided to drug abusers not in prison, in a way that does not compromise the continuous and overall efforts of keeping drugs out of prison;

This policy exists and was based upon the Council Recommendation [PS].

Substitution treatment (buprenorphine/naloxone) was introduced in Turkey in 2010, but it is not implemented in prisons yet [PS].

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Council Recommendation 2.9

promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, as well as screening for all the aforementioned diseases among injection drug users and their immediate social networks, and take the appropriate medical actions;

This policy exists but was not based upon the Council Recommendation. The availability/coverage of hepatitis B vaccination for injecting drug users is full and has strongly increased since 2003. The availability/coverage of prophylactic measures against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases for injecting drug users is extensive and has increase since 2003. The availability/coverage of screening for HIV; HCV and tuberculosis among injecting drug users and their immediate social networks is extensive. The availability/coverage of medical treatment of HIV/AIDS, HCV and tuberculosis for injecting drug users is full [PS].

Hepatitis B is included in the national vaccination scheme. A risk-group specific hepatitis B vaccination programme is available [SQ 23/29 2008].

The provision of HCV testing is limited [SQ 23/29 2011].

Council Recommendation 2.10

provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange;

This policy does not exist in Turkey [PS].

A DRID strategy is part of the national drug strategy. According to the National Strategy (2006-2012), the objectives are increasing the access to treatments of substance-related contagious diseases (HIV/AIDS, hepatitis etc.) According to the National Action Plan (2007-20099), the objectives are: the number of intravenous drug abusers will be identified, necessary arrangements will be made to identify the number of patients with HIV, Hepatitis B and Hepatitis C, consultancy services including harm reduction will be delivered to the intravenous drug abusers. Voluntary HIV counselling and test units will be established. A technical working group will be established for trainings on intravenous drug abuse, HIV, Hepatitis B, Hepatitis C and training modules will be developed. According to the National HIV/AIDS Strategic Action Plan (2007-2011) of

the MoH, the objectives are: special informing for vulnerable groups those also covering intravenous drug users and commencing incentives for developing secure attitudes and its wide spreading, providing protective services for hazards reduction are among the protective and preventive measures [SQ 23/29 2008]. NSP is not available [SQ 23/29 2011].

Council Recommendation 2.11

ensure that emergency services are trained and equipped to deal with overdoses;

This policy exists and was based upon the Council Recommendation. Emergency services are adequately prepared to deal with drug overdoses [PS].

Naloxone is not available on a "take-home" basis. [SQ 23/29 2008]. Naloxone is regulated by administrative regulation. [SQ 23/29 2011].

Council Recommendation 2.12

promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction;

This policy does not exist but is pending for approval. The availability/coverage of integration between health services, social care and specialised risk reduction is rare but has increased since 2003 [PS].

Council Recommendation 2.13

support training leading to a recognised qualification for professionals responsible for the prevention and reduction of health-related risks associated with drug dependence.

Occupational standards for drug treatment are available for nursing staff, psychologists and medical doctors [SQ 23/29 2008].

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Specialised courses/ training on drug treatment are implemented for nursing staff, psychologists, psychiatrists and medical doctors [SQ 27 P2 2011].

A national system for continued education is available for nursing staff, psychologists and medical doctors [SQ 27 P2 2008].

This policy exists in Turkey and is based upon the Council Recommendation. The availability/coverage of professional training on the reduction of health-related risks associated with drug dependence is extensive, professional training leads to a recognised qualification in the reduction of health-related risks associated with drug dependence [PS].

Council Recommendation 3

Member States should consider, in order to develop appropriate evaluation to increase the effectiveness and efficiency of drug prevention and the reduction of drug-related health risks:

Council Recommendation 3.1

using scientific evidence of effectiveness as a main basis to select the appropriate intervention;

This policy exists and is based upon the Council Recommendation. Scientific evidence is used as basis to select interventions to a large extent [PS].

Council Recommendation 3.2

supporting the inclusion of needs assessments at the initial stage of any programme;

This policy exists but is not based upon the Council Recommendation. Needs assessments are used at the initial stage of programmes to some extent [PS].

Council Recommendation 3.3

developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes;

There is no national research programmes for evaluation and improvement of drug treatment. There are no relevant research programmes on treatment in the last two years [SQ 27 P2 2011].

This policy does not exist in Turkey [PS].

Council Recommendation 3.4

establishing and implementing evaluation quality criteria, taking into account the Recommendations of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA);

This policy does not exist in Turkey [PS].

Council Recommendation 3.5

organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points;

This policy exists and is based upon the Council Recommendation. Standardised data-collection and information dissemination according to the EMCDDA recommendations is done to a large extent [PS].

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Council Recommendation 3.6

making effective use of evaluation results for the refining and development of drug prevention policies;

This policy exists and is based upon the Council Recommendation. Evaluation results are used for further development of drug prevention policies to some extent [PS].

Council Recommendation 3.7

setting up evaluation training programmes for different levels and audiences;

no information

Council Recommendation 3.8

integrating innovative methods that enable all actors and stakeholders to be involved in evaluation, in order to increase acceptance of evaluation;

no information

Council Recommendation 3.9

encouraging, in collaboration with the Commission, the exchange of programme results, skills and experience within the European Union and with third countries, especially the applicant countries;

This policy exists and is based upon the Council Recommendation. Professionals have access to opportunities for exchange of programme results, skills and experience at European level [PS].

Data sources

[CO]	EMCDDA country overview
[GS]	gap survey (the raw version of the country profiles have been sent out to NFPs for comments and amendments)
[NR + year]	National report on the drug situation of the respective year
[PS]	policy maker survey
[SQ+respective number]	EMCDDA structured questionnaire – filled in from REITOX-Focal points on regular base
[ST+respective number]	EMCDDA statistical table – filled in from REITOX-Focal points (NFP) on regular base
[Statistical Bulletin]	EMCDDA statistical bulletin

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Abbreviations

AIDS	acquired immune deficiency syndrome
BBV	blood borne virus
CI	confidence interval
CR	Council Recommendation
DFT	drug free treatment
DRD	drug-induced death
DRID	drug-related infectious diseases
EC	European Commission
ECDC	European Centre for Diseases Prevention and Control
EDDRA	Exchange on Drug Demand Reduction Action
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
EUROHRN	European harm reduction network
GÖG	Gesundheit Österreich GmbH
GP	general practitioner
HBV	hepatitis B virus
HCV	hepatitis C virus
HDB(T)	high-dosage buprenophine (treatment)
HIV	human immunodeficiency virus
IDM	interactive domain model
IDPC	International Drug Policy Consortium
IDU	injecting drug user, injecting drug use
IEC	information, education and communication
IPA	Instrument for Pre-Accession Assistance
MMT	methadone maintenance therapy
NFP	national focal point
NHS	National Health Service
NSP	needle (and syringe) exchange programme
OD	overdose

ORW	outreach work
OST	opioid substitution treatment
PDU	problem drug use
PHARE	Poland and Hungary: Assistance for Restructuring their Economies
POU	problem opiate use
PSC	psychosocial care
REITOX	Réseau Européen d´Information sur les Drogues et les Toxicomanies
SQ	standard questionnaire
ST	standard table
STD	sexually transmitted diseases
TB(C)	tuberculosis
UNAIDS	United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
UK	United Kingdom
VCT	voluntary infectious diseases counselling and testing
WHO	World Health Organization

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