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 3: Stakeholder Survey – Deliverable 3

On behalf of the European Commission

Gesundheit Österreich
Forschungs- und Planungs GmbH

SOGETI

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 3: Stakeholder Survey – Deliverable 3

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Introduction

Asking the experts from field organisations is very important to get a holistic impression regarding the ‘state of play’ of the Council Recommendation. Persons working in the field are aware of the obstacles and benefits related to practical work. Through their daily contact with the target group they know which kind of care would be the best for individual clients. Especially – as in our case – when it is not possible to ask the target population directly.

In times of globalisation even NGOs working in drug care are organised in national and international networks; a fact that allows them to share the best practice models and to develop high quality standards. Due to the acquisition of this knowledge, field organisations are a major source of information in estimating the degree to which service capacity matches the demand.

1 Research questions

The research questions for the stakeholder consultation were discussed and elaborated in cooperation with EMCDDA, EAHC, EC (DG SANCO and DG JLS). The consultation should be based on the questionnaire used for the first evaluation carried out by Trimbos in 2006[1] but it should be more detailed and cover more civil society organisations. It was decided that an online tool would be the best option for performing this survey.

It was proposed to collect the following information from civil society organisations:

» Estimation of availability/coverage of services/interventions concerning harm reduction

» Most important steps in the development of services to prevent drug-related harm (in the field of health) since 2003 in the respective country

» Major challenges in the field of harm reduction in the respective country (new substances, local outbreaks of HIV, financing)

» Considerable innovations in the field of harm reduction in the respective country

» Opinions on which harm reduction measures are most effective in reducing the prevalence of drug-related infectious diseases (DRID) and drug-induced deaths among injecting drug users in the respective country/region

» Suggestions for issues concerning harm reduction to be highlighted in follow-up policy work at EU level

In this context the term “coverage” describes the degree to which the service capacity matches the demand. Special attention was given to prison interventions as the coverage in this field seems to vary among the countries investigated.

1 Trimbos (2006): Prevention and reduction of health related harm associated with drug dependence.

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2 Methods

2.1 Development of the questionnaire

Based on the questionnaire used by Trimbos for the first evaluation (see chapter 1) and in consultation with EMCDDA, EAHC, EC (DG SANCO and DG JLS) as well as with the leading experts from Austrian harm reduction organisations, a draft questionnaire was designed.

The questionnaire was programmed using the GlobalPark[2] software. This software represents a dynamic tool for personalised consultation that allows providing items according to previous questions and helps avoiding irrelevant questions.

To carry out a pre-test, experts from field organisations in Germany and Austria were asked to fill in the draft questionnaire and give responses concerning its content and the ease of use. After the pre-test-phase only a few questions had to be reformulated.

It was decided to guarantee anonymity to the participants to be sure that response behaviour would not be influenced by tactical answers, as in some countries only a few field organisations exist and their statements would have the character of official NGO statements in the respective country.

For the full final questionnaire see annex 5.

2.2 Selection strategy

The selection strategy for selection of the field organisations was elaborated in cooperation with Dr. Hans Haltmayer who is a leading expert on harm reduction and Austria's representative in the "European Harm reduction Network" (EuroHRN). It consists of two phases of consultation: in phase one, civil society organisations concerned with harm reduction and organised in international and national networks were contacted; in phase two, ("snowballing") organisations that had been recommended by institutions in phase one were contacted.

In phase one, the first source of data was the list of stakeholders that were involved in the first evaluation carried out by Trimbos. In a second step, the most important harm reduction networks in Europe, the EuroHRN and the "Civil Society Forum on Drugs", were reviewed. The "Directory of European Organisations of People who use drugs", which will be followed up by the

2
Since summer 2012, Global Park is called QuestBack. QuestBack is European market leader for enterprise feedback management.

“European Network of People who use drugs” (EuroNPUD) in the near future, was included in this review. From the EuroHRN and EuroNPUD all partner- and coordinator - organisations were covered by the selection strategy. The organisations, listed in the “Civil Society Forum on Drugs“, were selected by the following characteristic: “working with clients and involved in harm reduction affairs“. Members of the “AIDS Action Europe”-network were reviewed and only those organisations in the list which provide harm reduction facilities for injecting drug users (IDUs) were selected. The same selection strategy was chosen for the members of the “Correlation Network“.

As a last step, a personal recommendation from Eoghan Quigley from Ireland was included. It referred to the two main harm reduction organisations of Ireland which had not been covered by the previous selection strategy. Additionally, Google-research was done for Malta, which was the only way to find a harm reduction organisation in this European Union Member State. In phase one, 92 organisations were contacted.

In phase two, the additional organisations that had been named “one of the three most important harm reduction organisations in your country” by the stakeholders in phase one, and which had not already been involved in phase one, were contacted. 16 “new” organisations were identified by “snowballing” and contacted by GÖG by June 18th 2012. In order to increase the response rate, it was decided to include organisations from the civil society forum on HIV/AIDS, and institutions that had been involved in EU projects concerning drug use/harm reduction in the last years. REITOX Focal Points in Iceland, Cyprus and Turkey were asked for non-governmental organisation (NGO) contacts by EMCDDA.

Overall, 123 institutions from 32 countries were contacted (see Table 2.1).

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Table 2.1:
Organisations contacted by country and by membership in networks

Country	Stakeholder	EuroHRN	First evaluation (Trimbos)	DrugUsersOrganisation	CivilSocietyForumOnDrugs	AIDS Action Europe Network	Correlation Network	Civil society forum on HIV/AIDS
Austria	Ganslwirt-Suchthilfe Wien	1	1	2	2	2	2	2
Austria	Aids Hilfe Wien	2	2	2	2	2	2	1
Belgium	Free clinic	1	2	2	2	2	2	2
Belgium	Modus Vivendi	1	2	2	2	2	2	2
Belgium	Trekt Uw Plant vzw	2	2	1	2	2	2	2
Belgium	Breakline	0	0	0	0	0	0	0
Belgium	Dunes	0	0	0	0	0	0	0
Belgium	Sensoa vzw	2	2	2	2	2	2	1
Bulgaria	Initiative for Health Foundation	1	2	2	2	2	2	2
Bulgaria	Health without Borders	2	2	2	2	1	2	2
Bulgaria	Dose of love Association	2	2	2	2	1	2	2
Croatia	South Eastern European and Adriatic Addiction Treatment Network (SEEAN)	2	2	2	2	2	2	1
Croatia	HELP - Udraga za pomoc mladima	2	2	2	2	1	2	2
Croatia	Life Quality Improvement Organisation "FLIGHT"	2	2	2	2	1	2	2
Croatia	INSTITUT	0	0	0	0	0	0	0
Croatia	udruga terra	0	0	0	0	0	0	0
Cyprus	Center Pollaplis	2	2	2	2	2	2	1
Czech Republic	SANANIM	1	1	2	2	2	2	2
Czech Republic	ANO	2	1	2	2	2	2	2
Czech Republic	Czech AIDS Help Society	1	2	2	2	2	2	2
Czech Republic	Legalize.cz	2	2	1	2	2	2	2
Denmark	Brugerforeningen	2	1	1	2	2	2	2
Denmark	Gadejuristen	1	2	2	2	2	2	2
Denmark	Hiv-Danmark	2	2	2	2	2	2	1
Estonia	Convictus Eesti	1	2	2	2	2	2	2
Estonia	Estonian Network of People Living with AIDS (EHPV)	2	2	2	2	2	2	2
Estonia	AIDS-i Tugikeskus (NGO AIDS Information and Support Centre)	2	2	2	2	1	2	2
Finland	Klinikka Foundation	2	1	2	2	2	2	2
Finland	Suomen Lumme ry	2	2	1	2	2	2	2
Finland	The Finnish Aids Council	2	2	2	2	2	2	1
France	AFR	1	2	2	1	2	2	2
France	ASUD	1	2	1	2	2	2	2

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Table 2.1, continued

Country	Stakeholder	EuroHRN	First evaluation (Trimbos)	DrugUsersOrganisation	CivilSocietyForumOnDrugs	AIDS Action Europe Network	Correlation Network	Civil society forum on HIV/AIDS
France	Medicines Du Monde	0	0	0	0	0	0	0
France	AIDES	0	0	0	0	0	0	0
Germany	Akzept	1	1	2	2	2	2	2
Germany	Fixpunkt	1	2	2	2	2	2	2
Germany	JES-Bundesverband	2	2	1	2	2	2	2
Germany	Deutsche AIDS-Hilfe	2	2	2	2	2	2	2
Germany	Action against AIDS	2	2	2	2	2	2	1
Greece	KETHEA	1	2	2	2	2	2	2
Greece	Diogenis	2	2	2	1	2	2	2
Greece	Synthesis HIV/AIDS Awareness	2	2	2	2	1	2	2
Greece	Doctors of the world	0	0	0	0	0	0	0
Greece	Praksis	0	0	0	0	0	0	0
Greece	Positive Voice	2	2	2	2	2	2	1
Hungary	Hungarian Civil Liberties Union (HCLU)	1	1	2	1	1	2	2
Hungary	Anonimous AIDS Association	2	2	2	2	1	2	2
Hungary	madaszsz	0	0	0	0	0	0	0
Hungary	Madrisz	0	0	0	0	0	0	0
Hungary	PLUSS	2	2	2	2	2	2	1
Iceland	SAA -National Centre of Addiction Medicine	0	0	0	0	0	0	0
Ireland	Irish Needle Exchange Forum (INEF)	1	2	2	2	2	2	2
Ireland	Belfast Users' Group	2	2	1	2	2	2	2
Ireland	Union for Improved Services, Communication & Education (UISCE)	2	2	1	2	2	2	2
Ireland	Merchants Quay Ireland	2	2	2	2	2	2	1
Ireland	Anna Liffey Drug Project	2	2	2	2	2	2	1
Italy	Cooperativa Parsec - Rom - Italien	2	2	2	1	2	2	2
Italy	ITACA	1	2	2	1	2	2	2
Italy	SanPatrignano	2	2	2	1	2	2	2
Italy	Forum Droghe	2	2	2	1	2	2	2
Italy	Lega Italiana per la Lotta Contro l'AIDS (LILA)	2	2	2	2	1	2	2
Italy	LILA Milano	0	0	0	0	0	0	1
Latvia	Red Cross of Daugavpils	2	2	2	1	2	2	2
Latvia	Parents of Jurmala	2	2	2	2	1	2	2
Latvia	Society Association HIV.LV	2	2	2	2	1	2	2

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Table 2.1, continued

Country	Stakeholder	EuroHRN	First evaluation (Trimbos)	DrugUsersOrganisation	CivilSocietyForumOnDrugs	AIDS Action Europe Network	Correlation Network	Civil society forum on HIV/AIDS
Latvia	AGIHAS	2	2	2	2	2	2	1
Lithuania	Dia+logs	1	1	2	2	2	2	2
Lithuania	Baltic NGOs network against drugs	2	2	2	1	2	2	2
Lithuania	Your Butterfly (Tavo drugys)	2	2	2	2	1	2	2
Lithuania	Lithuania	0	0	0	0	0	0	0
Luxembourg	Tox-in	1	1	2	2	2	2	2
The former Yugoslav Republic of Macedonia	Health Options Project Skopje	1	2	2	1	1	2	2
The former Yugoslav Republic of Macedonia	Passage	2	2	1	2	1	2	2
Malta	Caritas Malta	2	2	2	2	2	2	1
Montenegro	Association PROI	2	2	2	2	1	2	2
Montenegro	Montenegrin association vs AIDS	2	2	2	2	2	2	1
Netherlands	Mainline	2	1	2	2	2	2	2
Netherlands	Foundation De Regenboog Groep (FRG)	1	2	2	1	2	2	2
Netherlands	De Hoop	2	2	2	1	2	2	2
Netherlands	AIDS Foundation Esat-West (AFEW)	2	2	2	1	2	2	2
Netherlands	MDHG - Zij die gaan scoren groeten u!	2	2	1	2	2	2	2
Netherlands	LSD bv	2	2	1	2	2	2	2
Netherlands	Straat Consulaat Den Haag	2	2	1	2	2	2	2
Netherlands	Trimbos	0	0	0	0	0	0	0
Norway	Aksept	2	2	2	2	1	2	2
Norway	Foreningen for human narkotikapolitikk (FHN) Association for Humane Drug Policies	2	2	1	2	2	2	2
Norway	ProLAR	2	2	1	2	2	2	2
Poland	Monar	2	1	2	2	2	1	2
Poland	Polish Drug Policy Network	1	2	2	1	2	2	2
Poland	JUMP`93 (National Polish Association of Drug Users and Substitution Patients)	2	2	1	2	2	2	2
Poland	Social AIDS Committee	2	2	2	2	2	2	1
Portugal	Abraco	2	1	2	2	2	2	2
Portugal	APDES - Agencia Piaget para o Desenvolvimento	1	2	2	2	2	2	2
Portugal	Associacao Casorganizados	2	2	1	2	2	2	2
Portugal	Diferenca Real	2	2	1	2	2	2	2
Portugal	GAT	2	2	2	2	2	2	1

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Table 2.1, continued

Country	Stakeholder	EuroHRN	First evaluation (Trimbos)	DrugUsersOrganisation	CivilSocietyForumOnDrugs	AIDS Action Europe Network	Correlation Network	Civil society forum on HIV/AIDS
Romania	Romanian Harm Reduction Network	1	2	2	1	2	2	2
Romania	INTEGRATION Association	2	2	1	2	2	2	2
Romania	Asociatia Romania Anti-SIDA (ARAS)	2	2	2	2	2	1	2
Romania	Romanina Angel appeal foundation	2	2	2	2	2	2	1
Slovakia	Odysseus	1	1	2	2	2	1	2
Slovenia	Project STIGMA	1	1	2	2	2	2	2
Slovenia	AREAL Society	2	2	1	2	2	2	2
Slovenia	Association DrogArt	2	2	2	2	2	2	2
Spain	ABD	1	2	2	2	2	2	2
Spain	Andalucian federation ENLACE	2	2	2	1	2	2	2
Spain	FAUDAS	2	2	1	2	2	2	2
Spain	Plataforma Drogologica	2	2	1	2	2	2	2
Spain	Hispanosida	2	2	2	2	2	2	1
Spain	ARD	0	0	0	0	0	0	0
Sweden	Svenska Brukarföreningen	1	1	1	2	2	2	2
Sweden	HIV-Nordic	2	2	2	2	2	2	1
Turkey	Positive Living Association	2	2	2	2	2	2	1
United Kingdom	Methadone Alliance	0	0	0	0	0	0	0
United Kingdom	UKHRA.org	1	1	2	2	2	2	2
United Kingdom	HRI	1	2	2	1	2	2	2
United Kingdom	M.O.R.P.H	2	2	1	2	2	2	2
United Kingdom	SUGA (Service Users Giving Advice)	2	2	1	2	2	2	2
United Kingdom	Reading User Forum (RUF)	2	2	1	2	2	2	2
United Kingdom	Respect	2	2	1	2	2	2	2
United Kingdom	National Users Network (NUN)	2	2	1	2	2	2	2
United Kingdom	INPUD	1	2	2	1	2	1	2
United Kingdom	AHPN	2	2	2	2	2	2	1

1=yes; 2=no; 0=no ("snowball organisation")

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

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3 Results

3.1 Response rate

Data collection started on April 27th 2012 and ended (after several extensions of the deadline) on October 30th 2012. Overall, 123 organisations were contacted and asked to fill in the questionnaire. It was not possible to reach 3 organisations by using the email addresses listed in the database of the networks and it was neither possible to find an alternative address by Google search.

In order to increase the response rate, it was decided at the end of June 2012 to contact the big harm reduction networks (EuroHRN; Civil Society Forum on Drugs, Civil Society Forum on HIV/AIDS), and to ask them to actively promote the survey among their members. Overall, 5 reminders were sent out. Moreover, stakeholders and members of the National Focal Points were asked for their support at four EMCDDA expert meetings in Lisbon. In the final phase of data collection, GÖG contacted institutions from countries that had not responded till then individually.

43 field organisations from 24 countries completed the questionnaire by October 30th 2012, which signified a response rate of 35 % (see Table 3.1).

Table 3.1:
Number of responding stakeholders by country and level of reference of their estimation

country	Total number of responding stakeholders	Number of responding stakeholders reference		
		national	regional	local
Austria	1		1	
Belgium	2		2	
Bulgaria	1		1	
Czech Republic	2	2		
Denmark	2	1		1
Estonia	2	2		
Finland	1		1	
France	2	2		
Germany	2	1		1
Greece	3	3		
Hungary	2	2		
Ireland	2	2		
Italy	3	2	1	
Latvia	1	1		
Luxembourg	1	1		
Malta	1	1		
Netherlands	4	2	1	1
Portugal	1	1		
Romania	2	2		
Slovakia	1			1
Slovenia	1	1		
Spain	2		1	1
United Kingdom	2	2		
Croatia	2		1	1

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

From Cyprus, Lithuania, Poland, Sweden, the former Yugoslav Republic of Macedonia, Iceland, Montenegro and Turkey no stakeholders completed the questionnaire.

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3.2 Introductory remarks

For 17 of the 24 countries whose stakeholders completed the questionnaire, at least one field organisation indicated that their estimate referred to the whole country. As regards the remaining countries, the estimates referred to the regional level for 6 of them. For one country, data referred to the local level (Table 3.1). In total, there were 8 countries from which no information from stakeholders was available. It was decided to treat the estimates from all stakeholders as if they referred to the whole county. Otherwise, no information would have been available for half of the countries. This decision pertained to a limitation for the analysis that followed but seemed to be reasonable, since there was no objective assessment of the stakeholders' rating anyway.[3]

The following analyses are based on data submitted by 43 civil society organisations. When more than one organisation per country completed the questionnaire the data were weighted[4]. Therefore, the weighted number was N=24 as there were data from 24 countries. Data were presented as percentage – due to weighting. Formulations like "stakeholders from 0,33 countries report full coverage of ..." should be avoided.

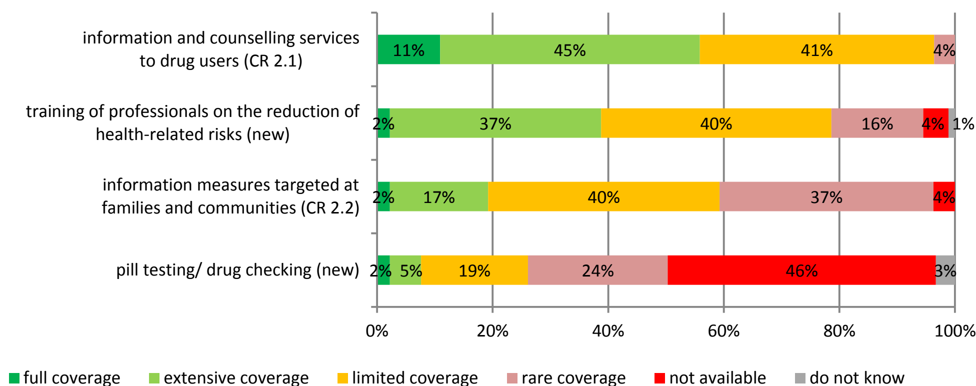
3.3 Prevention of risk behaviour – information, education and communication (CR 2.1; CR 2.2; CR 2.13)

Information and counselling services for drug users are perceived as widely available but still far from full coverage. Training availability for professionals on harm reduction needs to be improved. Moreover, information measures targeted at families and communities are not very common and Drug Checking is still carried out rarely (Figure 3.1).

3
Furthermore, countries where more organisations stated that their estimates refer to the estimations of the whole country were often heterogeneous.

4
E.g. for the countries which completed questionnaires from 3 stakeholders, data for each stakeholder were weighted with 0,33 (for 2 stakeholders with 0.5).

Figure 3.1:
Estimation of availability/coverage of services providing information, education and communication in the field of harm reduction, percentages (n=24), sorted by full coverage



Based on data from: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain, United Kingdom, Croatia

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

3.4 Drug-related outreach work (CR 2.3; CR 2.4; CR 2.5)

Compared to the services providing information, education and communication, the coverage of outreach work (ORW) is perceived as insufficient (Figure 3.2). This could possibly have to do with the fact that outreach work is more often implemented in urban areas where the target group might be easier to reach by this form of intervention. Networking and cooperation between organisations involved in outreach work is considered even more deficient, as organisations active in these fields are frequently situated in different regions. Peer involvement in outreach work is not very common.

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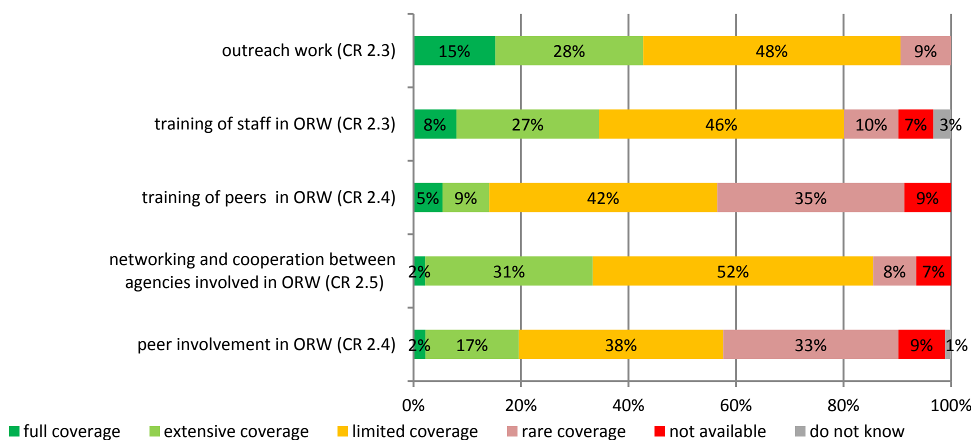
Figure 3.2:
Estimation of availability/coverage of services providing drug-related outreach work in the field of harm reduction, percentages (n=24), sorted by full coverage



Based on data from: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain, United Kingdom, Croatia

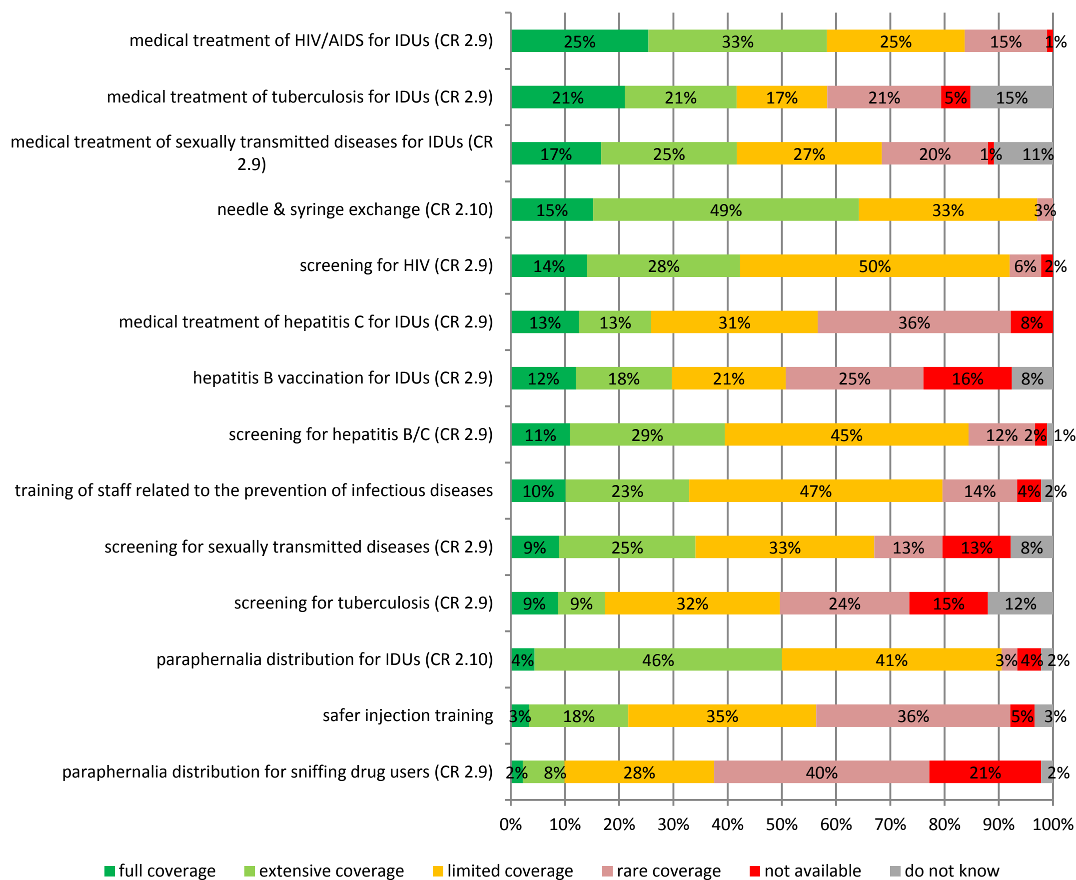
Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

3.5 Prevention of drug-related infectious diseases (CR 2.9; CR 2.10)

Needle and syringe exchange programmes and the medical treatment of infectious diseases are perceived as the most common measures of preventing drug-related infectious diseases. Although both measures have been well known for many years, their coverage is still far away from full. 36 % of the countries report only limited or rare coverage of needle and syringe exchange programmes and 41 % report a limited, rare or non-existent coverage of medical treatment for HIV/AIDS for injecting drug users.

The coverage of screenings for infectious diseases could be improved as well as the coverage of medical treatment for hepatitis C. Safer injection trainings for drug users and paraphernalia distribution for sniffing drug users are rarely provided (Figure 3.3).

Figure 3.3:
Estimation of availability/coverage of services providing prevention of drug-related infectious diseases, percentages (n=24), sorted by full coverage



Based on data from: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain, United Kingdom, Croatia

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

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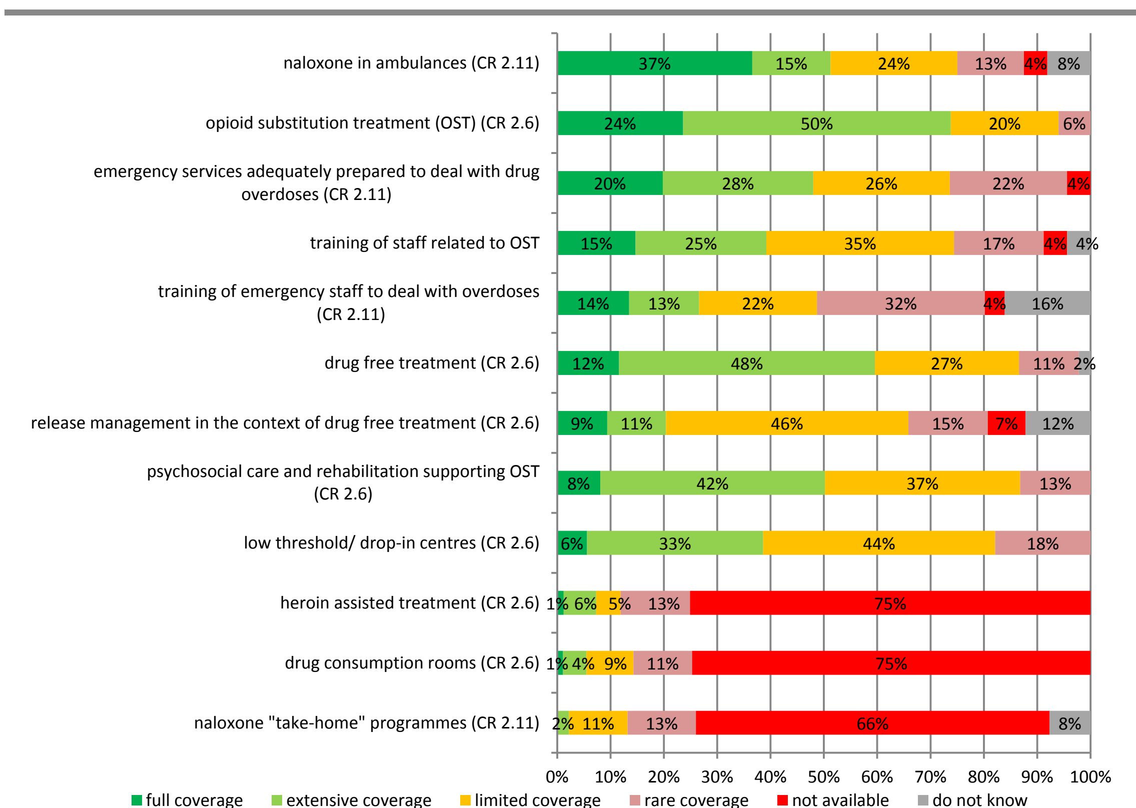
3.6 Prevention of drug-induced deaths (CR 2.6; CR 2.11)

Regarding the prevention of drug-induced deaths, opioid substitution treatment (frequently combined with psychosocial care), with about 75 % of the countries estimating full or extensive coverage, and drug-free treatment (60 % full or extensive coverage) are the most common measures. Not in every country and region ambulances are equipped with naloxone. The coverage of training of emergency staff to deal with overdoses is estimated as low. Full or extensive coverage of release management in the context of drug-free treatment is only reported by 20 % of the countries. The availability of heroin assisted treatment, drug consumption rooms and naloxone “take-home” programmes (see also literature review in annex 2b) is still extremely low (Figure 3.4).

Figure 3.4:
Estimation of availability/coverage of services for the prevention of drug-induced deaths, percentages (n=24), sorted by full coverage



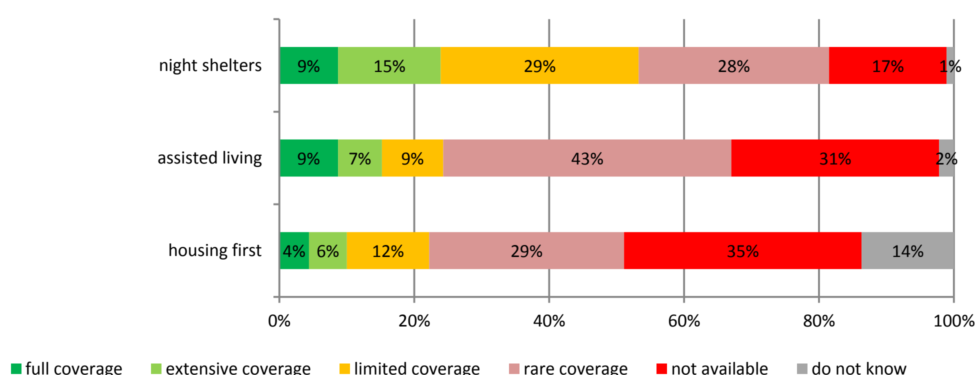
Based on data from: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain, United Kingdom, Croatia

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

3.7 Housing

Housing seems to be a field of harm reduction were still a lot of improvement is necessary as all the measures are estimated to have a rather low coverage. For night shelters, the measure with the highest coverage in general, only 24 % of the countries report full or extensive coverage (Figure 3.5).

Figure 3.5:
Estimation of availability/coverage of services for housing, percentages (n=24), sorted by full coverage



Based on data from: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain, United Kingdom, Croatia

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

3.8 Harm reduction in prison (CR 2.8)

On the whole, harm reduction in prison still appears to be a problem; only 2 % of the countries report full or extensive coverage while more than 30 % estimate that harm reduction in prison is not available at all. Only 7 % of the countries estimate full or extensive coverage concerning prison release management (see also literature review in annex 2b). While the medical treatment of HIV (60 % full or extensive coverage) and the opioid substitution treatment (48 % full or extensive coverage) seem to be reasonably common, the needle and syringe exchange in prison is only provided rarely (Figure 3.6).

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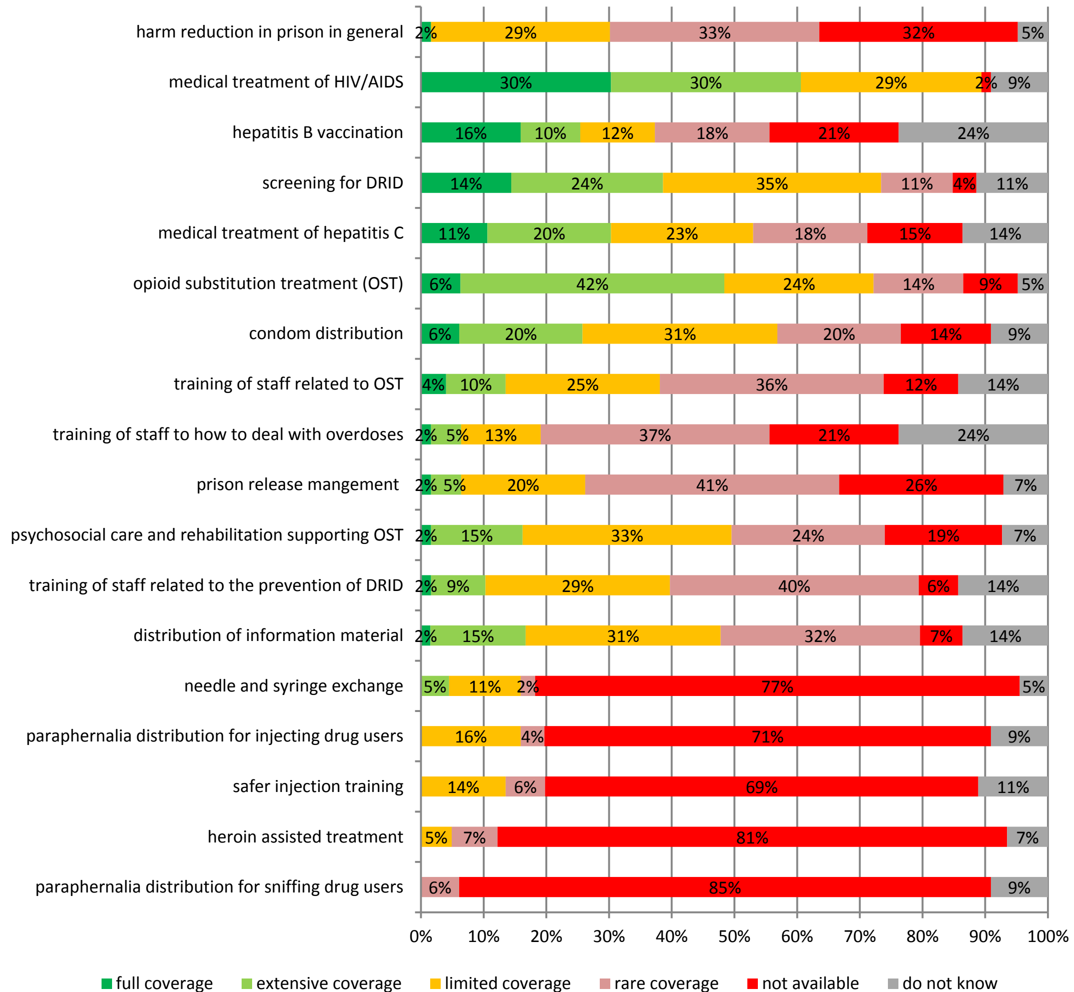
Figure 3.6:
Estimation of availability/coverage of harm reduction measures in prison, percentages (n=22)



Based on data from: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Netherlands, Portugal, Romania, Slovenia, Spain, United Kingdom, Croatia (missing: Malta and Slovakia)

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

3.9 Opinions on the implementation/expansion of the harm reduction measures with the biggest effect

3.9.1 Prevention of drug-related infectious diseases

Regarding the harm reduction measures whose implementation/expansion would have the biggest effect on the prevalence of drug-related infectious diseases among injecting drug users in the respective country/region, needle and syringe exchange was quoted as the most common one, followed by harm reduction measures in prison (Table 3.2). This result is consistent with the limited or rare coverage of needle and syringe exchange (in 36 % of the countries), although it has been a well established measure in many countries for many years (see section 3.5, Figure 3.4). The coverage of harm reduction in prison is considered full or extensive by only 2 % of the countries (see section 3.8, Figure 3.6).

Asked for a ranking of their chosen measures by priority, the picture is similar (Figure 3.7) with one exception: drug consumption rooms are ranked third, as about 30 percent of the countries prioritised this measure as “Top 3”.

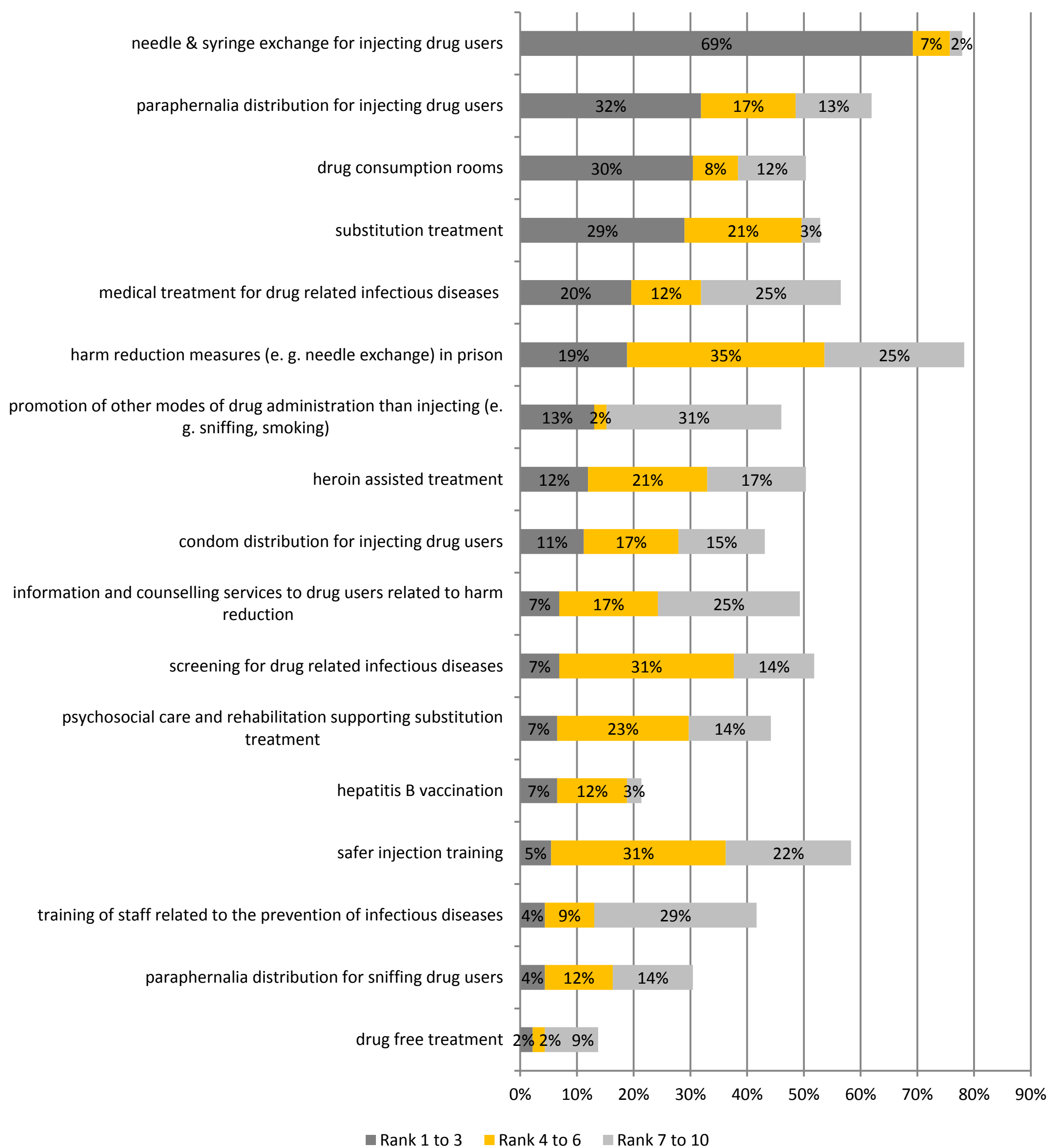
Table 3.2:
"Please indicate the harm reduction measures whose implementation / expansion – in your opinion – would have the biggest effect on the reduction of prevalence of infectious diseases among injecting drug users in your country/region. Please indicate 10 measures at maximum!" (percentages; weighted N=24)

measure	quoted
needle & syringe exchange for injecting drug users	81 %
harm reduction measures (e. g. needle exchange) in prison	77 %
paraphernalia distribution for injecting drug users	64 %
medical treatment of injecting drug users for drug-related infectious diseases (HIV, hepatitis, tuberculosis, sexually transmitted diseases)	55 %
safer injection training	55 %
screening among injecting drug users and their immediate social networks for drug-related infectious diseases	50 %
substitution treatment	49 %
drug consumption rooms	47 %
heroin assisted treatment	47 %
information and counselling services to drug users related to harm reduction	46 %
promotion of other modes of drug administration than injecting (e. g. sniffing, smoking)	46 %
psychosocial care and rehabilitation supporting substitution treatment	45 %
condom distribution for injecting drug users	44 %
training of staff related to the prevention of infectious diseases	41 %
paraphernalia distribution for sniffing drug users	29 %
hepatitis B vaccination	24 %
drug free treatment	13 %
something else (<1 %):	
change in the legislation related to drugs	
direct support for the NGO (4 NGO) who provides the service	
needle exchange programmes in pharmacies	
employment and day structure for OST patients	
heroin assisted treatment in jails	
outreach work	
Use of Fibroscan in harm reduction facilities	

Based on data from: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain, United Kingdom, Croatia

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

Figure 3.7:
"Please rank the measures you ticked on the previous page according to their priority!"
(percentages; weighted, n=23)



Based on data from: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Luxembourg, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain, United Kingdom, Croatia (missing: Latvia)

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

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3.9.2 Prevention of drug-induced deaths (death due to overdoses)

Regarding the measures whose implementation/expansion would have the biggest effect on the reduction of drug-induced deaths (due to overdoses) in the respective country/region, first aid training for drug users, naloxone “take-home” programmes and prison release management were quoted as the most common ones (Table 3.3). As regards the reduction of infectious diseases, the quite common measure of needle and syringe exchange was quoted most often. Concerning the prevention of drug-induced deaths, measures with currently a rather low coverage are recommended by the stakeholders of the countries. Full or extensive coverage concerning naloxone “take-home” programmes was reported by 2 % of the countries, and by 7 % concerning prison release management (first aid trainings for drug users was not part of the questionnaire).

With regard to a ranking of the stakeholders’ chosen measures by priority, the picture is quite similar (Figure 3.8); naloxone “take-home” programmes can be found among the “Top 3” rankings followed by drug consumption rooms and first aid training sessions for drug users. Drug consumption rooms received more top rankings, which indicate that for those who quoted this measure in the previous question, it is more important than other measures.

Table 3.3:
“Please indicate the harm reduction measures whose implementation / expansion – in your opinion – would have the biggest effect on the reduction of drug-related deaths (deaths due to overdoses) in your country/region. Please indicate 10 measures at maximum!” (percentages; weighted, n=24)

measure	quoted
first aid training for drug users	71 %
naloxone "take-home" programmes	63 %
prison release management related to overdose prevention	63 %
information and counselling services to drug users related to harm reduction	59 %
drug consumption rooms	56 %
emergency services adequately prepared to deal with overdoses	55 %
Pill Testing / Drug Checking for drug users	54 %
heroin assisted treatment	47 %
substitution treatment	46 %
medical aid in cases of overdoses without police involvement	46 %
low threshold drop-in centres	44 %
psychosocial care and rehabilitation supporting substitution treatment	40 %
promotion of other modes of drug administration than injecting (e. g. sniffing, smoking)	36 %
naloxone in ambulances	32 %
release management in the context of drug free treatment	25 %
medical aid in cases of overdoses without costs for the drug user	18 %
drug free treatment	9 %

Based on data from: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain, United Kingdom, Croatia

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

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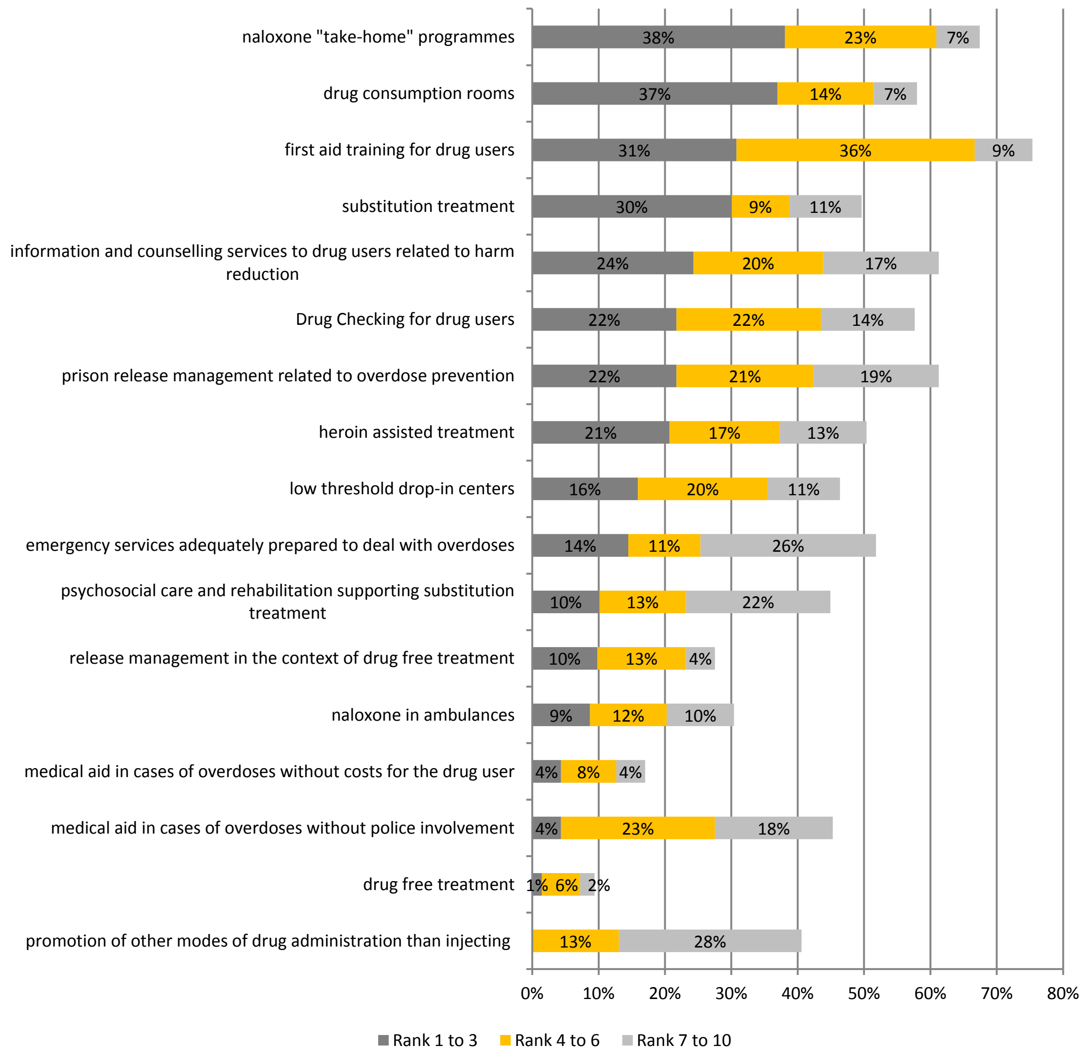
Figure 3.8:
“Please rank the measures you ticked on the previous page according to their priority!”
(percentages; weighted, n=23)



Based on data from: Austria, Belgium, Bulgaria, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Luxembourg, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia, Spain, United Kingdom, Croatia (missing: Latvia)

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

3.10 Opinions on the most important steps, actual challenges, recent innovations and suggestions

This chapter describes the answers to open questions concerning the most important steps in the development of harm reduction in the respective region/country since 2005, actual major challenges, considerable innovations since 2005 as well as suggestions for issues concerning harm reduction to be highlighted in the follow-up policy work at EU level. The exact wording can be found in chapter 5.

As this section consisted of open questions, it is not possible to statistically weight the answers. Therefore, the analysis is based on the opinions of 43 organisations. Interestingly, most of the answers are quite similar; this might be the result of good international networking in the field of harm reduction, as most of the respondents are members of one or more international networks.

3.10.1 The most important steps in the development of harm reduction services since 2005

Most of the countries report an improvement in harm reduction since 2005; only one country[5] reports a worsening of the situation due to a fundamental change in drug policy. Most of the reported improvements concern the availability of opioid substitution treatment, needle and syringe exchange programmes as well as the lowering of threshold for access. Overall, it seems that harm reduction measures increasingly have become part of national drug strategies and also the legal basis has been improved in some countries. The opening of drug consumption rooms, the start of heroin assisted treatment programmes and the providing of opioid substitution treatment in prison were some of the most important steps observed in a number of countries. For the EU 12[6] and for the candidate/acceding countries, the financing provided by the “Global Fund to fight against AIDS, TB and Malaria” was an important accomplishment. As an effect of the financial crisis, the availability of harm reduction measures is regarded endangered in some countries, especially as harm reduction measures are still politically disputable.

5
Italy

6
Countries which joined the EU in 2004 or later.

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3.10.2 Major challenges in the field of harm reduction today

A major challenge in many countries today is the situation of harm reduction in prison. This is not surprising as the coverage of harm reduction in prison is regarded full or extensive by only 2 % of the countries. Besides that, establishing heroin assisted treatment and drug consumption rooms (which represented some major achievements in a number of countries) are still major challenges for many countries. Improvements in testing for HCV and lower threshold access to HCV (and also HIV) treatment, and the expansion of needle exchange, are further challenges, since HCV prevalence among IDUs is still very high and does not seem to decrease. Some stakeholders indicate that in times of a financial crisis it is more important to maintain the current level of service provision rather than to try to expand it. Moral barriers and the prioritisation of abstinence orientated services by some decision makers remain major obstacles for harm reduction services. For the EU 12 member states and for the candidate/acceding countries, the shrinking of the "Global Fund to fight against AIDS, TB and Malaria" financing is a major challenge.

3.10.3 Innovations in the field of harm reduction since 2005

Overall, 12 civil society organisations did not respond to this question while 13 other organisations indicated that there had been no considerable innovations in the field of harm reduction since 2005. Some organisations name the involvement of peers (e. g. in naloxone programmes) as an innovation. Some NGOs indicate the implementation of heroin assisted treatment, drug consumption rooms or opioid substitution treatment in prison as innovations. Others describe the improvement of the coverage of some harm reduction measures as an innovation. In general, it seems that most of the innovations in the field of harm reduction date back to the late nineties and early noughties.

3.10.4 Suggestions for follow-up policy work at EU level

Apart from the aforementioned measures that are regarded as major steps, actual challenges or latest innovations (namely: heroin assisted treatment, drug consumption rooms, harm reduction in prison and naloxone "take-home" programmes), further suggestions for issues that should be highlighted at EU level are housing, reintegration, decriminalisation of drug users and access to harm reduction for young drug users. Some organisations also indicate the importance of harm reduction in the party setting and Drug Checking. Another issue is the request to support research on the impact of harm reduction measures. As harm reduction measures are still politically disputable, many field organisations want the EU to help foster harm reduction in the respective Member States.

4 Conclusions

The most obvious problem areas concern coverage or availability of harm reduction in prison (CR 2.8) and housing (not covered by CR). Only 2 % of the countries report full or extensive coverage of harm reduction in prison; full or extensive coverage for night shelters are reported by 24 % of the countries. Nonetheless, even for well established measures like needle and syringe exchange programmes (64 % full or extensive coverage; CR 2.10) and opioid substitution treatment (74 % full or extensive coverage; CR 2.6) the coverage is regarded as far away from full.

Asked about measures whose implementation or expansion would have the biggest effect on the prevalence of drug-related infectious diseases, needle and syringe exchange (CR 2.10), paraphernalia distribution (CR 2.10), harm reduction measures in prison (CR 2.8) as well as drug consumption rooms (CR 2.6) were the most prominent answers. Concerning the effects on the prevalence of drug-induced deaths, first aid training for drug users (not covered by CR), naloxone "take-home" programmes (CR 2.11), prison release management (CR 2.8) and drug consumption rooms (CR 2.6) were named as the most urgent, precisely because the coverage/availability of these measures is considered extremely low.

The biggest and most pressing issues related to harm reduction measures are heroin assisted treatment (CR 2.6), drug consumption rooms (CR 2.6), harm reduction in prison (CR 2.8), naloxone "take-home" programmes (CR 2.11) and prevention of HCV as well as access to HCV treatment (CR 2.9/10). All these measures have been known at least for some years; most of the innovative ideas in the field of harm reduction date back to the late nineties and early noughties. Today, it seems more and more important for many stakeholders to implement or expand measures already known rather than to generate new approaches.

Harm reduction is still politically disputable; while in many countries harm reduction measures became well-established in the last decade, in other countries opposite tendencies can be observed or are feared. Moral barriers and the prioritisation of abstinence orientated services by some decision makers remain major obstacles for the implementation of harm reduction services. Many stakeholders express concerns regarding the financing of harm reduction measures in the future resulting from the financial crisis and objections by uninformed or despondent decision makers. Some stakeholders indicate that in the light of the aforementioned obstacles it is more important to maintain the current level of service provision than to think of its expansion. For the EU 12 member states and the candidate/acceding countries, the shrinking, or even the near loss, of the "Global Fund to fight against AIDS, TB and Malaria" financing is a major challenge.

Beside the actual discussions, important topics for the future will also be reintegration and the decriminalisation of drug users, as well as access to harm reduction for young drug users. Overall, it can be said that the majority of organisations working in the field of harm reduction hope for political support for harm reduction by the European Union.

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5 Stakeholder survey – answers to open questions

Table 5.1:
“What have been the most important steps in the development of harm reduction services since 2005 in your country/region?”

Answers given by Stakeholders
Wide range of OST coverage. Low threshold access to OST. Implementation and Improvement of pill testing. Increasing number of syringes and paraphernalia exchange. Access for drug users to the shelters.
Permission of testing
More availability of needle exchange – not only in major cities OST Harm reduction as a mainstream approach (but not everywhere!?!)
Sustainable development of the harm reduction services for IDU ; Financing from the Global Fund;
Adopted harm reduction measures into the national programme for fight against drug abuse, as well as developed and made more accessible VCT (Voluntary Counselling Services for HIV/AIDS and hepatitis)
Global Fund programme (2003-2006): increase in service delivery areas – short term training for outreach workers
Early network of HR services
In negative way – limits of finances for drug use programmes since 2008-09. In positive way – the university studies programmes for addiction
The 2010 opening of heroin assisted treatment New 2012 law allowing safe consumption rooms
Heroin treatment was introduced in 2010 and drug consumption rooms from September 2011. Less known but important were new guidelines from the national health board on substitution treatment in 2008. Many of the stigmatising practices and the overall focus on control with the patients were taken out of the guidelines; however the guidelines still have limited focus on patient’s rights and harm reduction. Upcoming important steps: The implementation of drug consumption rooms in several major cities following a new law in spring 2012 allowing municipalities to operate drug consumption rooms. The expected expansion of the existing heroin treatment programme to allow heroin to be administrated as pills. A new decision by government to start a naloxone “take-home” programme in the beginning of 2013, though so far intended for only major cities.
Expanding needle exchange services, substitution treatment in prisons and arrest houses
Needle exchange programme, substitution treatment.
1. The rise of The Drug Users Union 2. Lower threshold to OST programmes
After the creation of the new public health law in 2004 which recognised harm reduction, a series of decrees were published: – national frame of reference concerning harm reduction. This decree defines that drug testing using Marquis' reagent is forbidden. – defines the objectives of harm reduction facilities: welcome, care, social rights, contacts, harm reduction material, mediation, and warning. These facilities are now considered as a part of the medical-social system. In April 2008, capsule of Methadone was available. Until now, only the syrup was available. In 2010 a collective expert report on illicit drugs was published. The same year, an association of elected members from different political parties presented a report and their recommendations on drug consumption rooms.

continued next page

Table 5.1, continued

Answers given by Stakeholders
According to the 2004 law about national involvement in harm reduction, a lot of centres specially dedicated to harm reduction are raised in the country in 2006. They are financed by social security
Heroin assisted treatment, consumption rooms
Development of brief interventions for hepatitis C prevention Starting low threshold testing of BBV (HCV, HIV) and Syphilis, offering rapid tests for HCV and HIV, offering PCR for HCV Preparation of heroin prescription (hopefully starts within 2012)
1. Substitution treatment is embedded in public health services. Many new drug substitution units are situated in the area of public hospitals. This has helped reduce drastically the waiting lists for substitution treatment. Only some problems are left, but in the whole country there are no more waiting lists. 2. Psychosocial care and rehabilitation is an integral part of the treatment 3. It is positive that drug treatment services ("drug free" and substitution treatment) show mutual respect to their work and act complimentary to each other. The acceptance of substitution and harm reduction services by the "drug free" services is of great importance for the promotion of further collaboration
Due to the severe economic crisis, there was an explosion of HIV cases and other diseases among IDUs. That was mainly the result of the drop of the very few drug reduction programmes (e.g. free needles). In response to that explosion, last year the state strives to bring back those programmes and drastically shorten the substitution treatment lists (up to 2011 an IDU would have to wait up to 7 years to access the substitution programmes). Free needles and paraphernalia are now distributed, though not as extensively as they should.
The opening of new NSP and OST centres in the country
The majority of harm reduction services are operated in the format of low threshold service, and they are considered social services. The only exceptions are the substitution treatments as they are healthcare services. The number of harm reduction services has not changed substantially since 2005, but the legal background has become more stable during this period as the act on social services was further developed and low threshold services targeting drug users became a mandatory service to be provided in all settlements where the number of inhabitants was higher than 30.000. This was promising as local governments were supposed to finance all mandatory social services. The situation changed in 2007 when low threshold services were supposed to be financed in a different way: through a grant scheme for which the service providers had to apply and in case of success they were included into the system for a three years period. As far as substitution treatment is concerned a new pharmaceutical was introduced: Suboxone (buprenorphine+naloxone), which is used by most of the service providers who are doing substitution treatment.
We have seen the expansion of the pharmacy needle exchange Harm reduction now within the national drugs strategy There is more awareness about the importance of a harm reduction approach when working with drug users
Development of pharmacy needle exchange - it is not in all areas yet.
Syringe –needle exchange, outreach work
Since 2005 there have been no developments concerning harm reduction services, but there have been steps backwards. Legislation on drugs is punitive; many harm reduction services were closed because HIV infections among drug users have decreased (thanks to harm reduction interventions!!!). Legislators are still rejecting pill testing, drug consumption rooms, heroin assisted treatment, and distribution of needle & syringes, paraphernalia and condom in prison settings.
First programmes in 1992 and extension of programmes until 1995. Few new activities until 2005. Since 2008 HR services decreased for political reasons. There is no sign so far that they will increase in the near future.
Methadone maintenance is available in prisons since April 2012
1. Improved cooperation of all participating institutions in facilities of the harm reduction 2. Planning of a 2nd Drug consumption room (regionalisation) 3. Improved cooperation/coordination with politicians, the judiciary and police
The setting up of a harm reduction shelter at Caritas.
Integrative approach, combining HR and other services under one roof

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Table 5.1, continued

Answers given by Stakeholders
The development of harm reduction since 2005 came to a standstill. No major innovations were implemented. In general, the number of IDUs decreased largely, and as a result of the emergence of hostels for older/homeless drug users (amongst others things), problem drug users became less visible in the streets. Due to changes in our government, the focus from the government shifted from basically the health perspective to public order perspective (with still a health perspective of course). But one could also argue that we consolidated the level of services with regard to harm reduction, and still we have much more services than many other countries: DCR's, HAT, OST etc.
Needle and syringe exchange points. Pilots of substitution treatment. Reduce of stigma and discrimination programmes for drugs users
It was created in the governmental institute for Drugs and drug dependence a department specifically dedicated to harm reduction. From 2007 on, a growing number of harm reduction projects, including low threshold OSP were financed by the State. The first Drug users association was born. Some improvements were made to the injection kit.
Syringe distribution, coverage and rate per SEP client 2008 syringes distributed:1.108.762; IDUs reached:7.284; Total # of IDUs: 17.387; Coverage: 41 %; Rate (# of syringes/SEP client in one year: 152 2009 syringes distributed:1.730.776; IDUs reached:9.417; Total # of IDUs:17.767; Coverage:53 %; Rate:183 2010 syringes distributed:946.820; IDUs reached:8.966; Total # of IDUs:18.316; Coverage:49 % ; Rate:105 2011 syringes distributed:895.160; IDUs reached:9.000; Total # of IDUs:18.000; Coverage:30 % ; Rate:100 HIV prevention services – OST 1998 – OST centre 1998 – 2007 – MoH has the monopoly on OST; poor coverage, high corruption of medical staff (OST patients were paying in order to access a public healthcare system and receive substitution medication) – undocumented and too late to document it. 2007-2011 – National Anti-drug Agency opened three OST centres with UNODC support 2008-2011 – National Penitentiary Administration opened 2-10 OST centres (the centres are operational but they are based on voluntary subscription) 2008-2011 = private sector + NGOs – there is one OST centre operated by an NGO OST coverage: 2009 = 5 % 2011 = 9 % HIV stated increasing among IDUs in 2011. Legal highs are injected starting with 2009-2010 => higher risk for HIV transmission. Funding for harm reduction services operated by NGOs start decreasing in June 2010. As a consequence, several NGOs stopped their needle exchange services.
The opening of a NGO run substitution treatment centre, in 2007, opened by the same NGO that started needle/syringe exchange.
In 2005 we have started the project Testing in the Outreach. Through this project we had access directly in the outreach to tests on HIV, syphilis, hepatitis B and C antibodies, with confirming. Currently we are testing for HIV, HCV, syphilis and tuberculosis. In 2011 we had workshops for overdoses prevention which were including first aid trainings for drug users and also consultations on the theme overdose.
Probably the drop-in centres, the centre for homeless IDUs, vans providing syringes on more remote locations (different cities)
Consumption rooms maintenance. Mediation with the community.
– Increase of number of drug consumption rooms – Opening of two smoking drug consumption rooms – Increase outreach teams – Decrease of needles and paraphernalia left in street – Increase information about harm reduction and infectious diseases in drug users and community

continued next page

Table 5.1, continued

Answers given by Stakeholders
The new government have placed an increased emphasis on "recovery" in their communications around drug treatment, without properly defining what this means. A new Drug Strategy was released in 2010. This came after years of political lobbying by abstinence-based groups before the Conservative Party came into (joint) office, and has caused much anxiety among harm reduction services and people who use drugs. In most cases, 'harm reduction workers' have now been repositioned as 'recovery workers'. Against a broader backdrop of public spending cuts and economic uncertainty, a new system of "Payment by Results" is being implemented for health services. As well as targets for HIV, communicable disease, accidental death etc – the main target for drug treatment is 'full recovery' (with payment withdrawn if a person relapses within 12 months). These concerns came to a head in March this year, when the Government released a document, describing a new "roadmap" focused entirely on "full independence from any chemical". The full implications of this will only emerge in the coming years, but efforts are currently underway to rebuke this approach and call for a more balanced approach.
Heroin prescription becoming a national programme following the successful completion of a trial "take-home" naloxone programmes rolled out.

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

Table 5.2:
"What are the major challenges in the field of harm reduction in your country/region today?"

Answers given by Stakeholders
No Syringe Exchange in Prison. No HAT or intravenous substitution treatment available. Generate better access to HIV and HCV Treatment.
A legal recognition of harm reduction
Drug consumption-rooms HAT "take-home" naloxone Screening and therapy for hep C Needle exchange in prison Needle exchange in more abstinence oriented drug services Harm reduction approach for young drug users
Sustainable financing for harm reduction for IDUs
To enlarge the number of HIV/AIDS testing among drug users HIV positive drug users keep permanently under the medical treatment, because they are usually hard to reach and hidden population. Second problem which they are faced with is centralisation of HIV/AIDS hospitals. Each HIV-person from any part of the country has to go to the capital to take a therapy, which is far away and travelling there is too expensive
- Lack of human resources - Outreach workers that are trained and qualified for the work (very big turn over)
wide coverage
The problem of harm reduction centres to find appropriate place.
- Limited economy - Extreme control demand of observed heroin assisted treatment - Syringes and needles availability in jails
Expand needle and syringe programmes, especially outside the major cities and in prisons. While the spread of HIV seems to be contained a national strategy on reducing the hep c infection is needed. This strategy should contain an expansion of needle and syringe programmes and paraphernalia distribution as well as lowering the thresholds of substitutions treatment since most seem to be infected before first contact with the treatment system. The quality of substitution treatment is the major challenge - people who use drugs are generally not seen as patients with healthcare needs and rights and they are subject to widespread discriminatory practices within the healthcare sector including within the drug treatment facilities. The lack of focus on harm reduction and human rights in the substitution treatment undermines and limits the well documented effect of the treatment as one of the most effective measures to promote healthier choices and risk management and hereby to reduce overdose deaths and infectious diseases.
Limited harm reduction actions in prisons
Enlargement of needle exchange, substitution treatment is more available.
1) HCV prevalence amongst IDU:s is still very high and isn´t going down any more 2) Poly dug use of buprenorphine, benzodiazepines and alcohol
- Changing the law: not criminalise people anymore for using drugs - Harm reduction in prison - Drug consumption rooms - Individual safer injecting training including using the drugs - Drug Checking - Housing
Safe consumption rooms are the major challenge in the very moment. New socialist government has officially decided to experiment DCR but no date is yet decided. Harm reduction is still reserved to adults. Young people are excluded from needle exchange and only allowed to very restricted OST. Most of the communication toward young people is drugs prevention outreach; self support and community based action are very poor. The harm reduction system is very medicalised. Heroin programmes are still forbidden in spite of scientific commission recommendations.

continued next page

Table 5.2, continued

Answers given by Stakeholders
Harm reduction in prison (needle distribution, other options to improve hygiene and harm reduction strategies) Focus on hepatitis C prevention in party settings (early interventions) Synthetic substances including legal highs might enter the heroin/cocaine market Substance testing (not only pills), screening for synthetic substances
1. Substitution treatment in prison settings 2. Experimentation with heroin assisted treatment 3. Drug consumption rooms 4.Methadone or Suboxone prescription by general practitioners *The municipality of the city have agreed to open two consumption rooms in two neighbourhoods in the city. That the issue is very sensitive is obvious. The initiators call them "Hospitality places".
Changing the mindset of conservative organisations and rationalising the distribution of money towards the real needs of IDUs and not in bureaucratic processes and remunerations. There should be a halt in the explosion of new HIV incidences. There should be programmes in prisons.
– Criminalisation of drug users – No harm reduction in prisons – No drug consumption rooms – No heroin assisted treatment – No "take-home" naloxone programmes – Few harm reduction in the party scene
Stable financing Referral system Sufficient financing Networking system of service providers Efficient support from the national drugs coordination Support from high level decision makers To make harm reduction services in the prison setting functioning Evidence informed drug strategy
To keep effective harm reduction services funded and have them available nationwide. The Government seems to be focusing more on the 'recovery' agenda and focusing on drug users being drug free
There are political, economic and moral barriers to the implementation of all Harm Reduction measures. The challenge that lies ahead of us is to ensure that all drug users have access to appropriate Harm Reduction interventions that are available in other EU countries e.g. full geographical coverage of Pharmacy and Specialist Needle Exchange, full geographical coverage of alternative OST therapies, the availability of Drug Consumption Rooms in hot spot areas, etc.
General improvement of HR actions in the entire national territory. Inclusion of HR actions and agencies in the National/Regional Health System (no more short projects) Involvement of GPs in some training actions in order to facilitate individuation and contact of users
Harm reduction intervention should be extended in order to give extensive coverage; harm reduction measures should be extended in prison settings; syringe exchange machines should be put back into place. We need consumption rooms, counselling for drug users, the extension of screening for HIV, HVC, HBV and all other infectious diseases related to drug use.
The national and local non acceptance of HR. Therefore insufficient financing.
1. Professionalisation of staff in the facilities of harm reduction (formation) 2. Improved further orientation of the clients (therapy, etc.) 3. Regionalisation
We do not take harm reduction seriously and we are 100 per cent orientated towards drug free rehabilitation.
To defend hr against tendencies to cut down programmes due to repression and economical crisis
The major challenge is to maintain the current level of services offered and to maintain to commit the government and municipalities to support harm reduction.

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Table 5.2, continued

Answers given by Stakeholders
Financial constraints; inexistence of drug consumption rooms and harm reduction services in prisons; NGOs and people who use drugs getting heard from the governmental structures in order to integrate their contributions in fundamental questions regarding harm reduction.
Funding Professionals Population's and politicians' mentality (the majority considers harm reduction to be a way to promote drug use)
Funding – there is no public funding dedicate to this activity, therefore the number of harm reduction actors has diminished severely since the end of the Global Fund to fight against AIDS, TB and Malaria funding (2010).
There are lot of challenges in this field, however most of them cannot be realised at the moment because of laws. For example Pill Testing/Drug Checking for drug users. There are no drug consumption rooms for drug users at the moment. Naloxone is available just in the ambulances. Naloxone "take-home" programmes would be very important in prevention for overdose deaths. Most of the people are afraid to call the ambulance in situations when someone is overdosed. Other big problem is that active drug users cannot get the treatment for hepatitis C. There is a condition that the patient who wants to undergo the treatment for HCV must abstain or be on methadone treatment for 6 months before the treatment for HCV would start.
The major challenges are syringe exchange in prisons and safe injecting rooms
To empower the drug user's network and survive the economic crisis.
One of the main challenges is to reconsider harm reduction as a more holistic intervention among people who use drugs. REMAINING CHALLENGES: – To achieve the normalisation of DCRs and harm reduction services in a political and social level. – The integration of DCRs in the public healthcare network. – To develop much more comprehensive services to provide harm reduction based healthcare and social attention. – To improve the social conditions of drug users who are in a social deprived situation. – To adapt services to long term and chronic drug users. – To incorporate to DCRs a substance analysis service with the aim to provide more information and safety to drug users. – To increase services addressed to smoking drug users (DCRs for smoked use and the distribution of smoking paraphernalia), to promote and support safer ways to use drugs. – Expand harm reduction services (especially DCRs) in the territory and to extend the timetables. – Heroin treatments should be available. – To improve working conditions for harm reduction professionals. – To improve data collection and the assessment of harm reduction programmes. – To promote research in harm reduction. – To consolidate and stabilise harm reduction programmes in the current economical crisis context.
See above.
New policies being implemented by the Government including a 'recovery roadmap' poses the biggest challenge and threat to harm reduction. The current government has made it clear that they plan to prioritise abstinence based services over harm reduction – especially in the case of OST programmes – ensuring that harm reduction services continue to receive funding will be the main challenge.

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

Table 5.3:
"Are there any considerable innovations in the field of harm reduction in your country/region (e. g. new innovative approaches) since 2005?"

Answers given by Stakeholders
No
Introduction of heroin prescription programme
Yes, - Enlarged the number of VCT centres for HIV and hepatitis - Developed Out-reach work which enlarged the number of drug users involved in HR activities, particularly in rural and isolated areas
- Involvement of gatekeepers - Establishment of network of associations
Peer work
Innovating initiatives have mainly been small scale interventions copying foreign initiatives such as mobile drug consumption rooms and crack pipe distribution.
2010 naloxone training of 14 members of the Users' union.
Naloxone treatment in ambulance services.
I wouldn't say so.
None
Since 2005, there have not been considerable innovations in the field of harm reduction. In the last few years (the last 5 years in particular) the government has preferred to reduce the numbers of drug users than to develop harm reduction. Just a few innovated programmes has been developed until now on housing active drug users, Drug Checking, rapid test (HIV, HCV), using Fibroscan on the streets, individual safer injecting training including using the drugs.
Brief interventions for Hep C prevention HCV, HIV rapid testing
Only that the exchange programmes are brought back and that the substitution waiting lists are shortened. There are certainly much more left to be done.
In the European context there are no innovative approaches, only traditional solutions.
No
We have seen the expansion of the pharmacy needle exchange
Attempts of pill testing, increase of HR services mainly failed
Some, limited, experience in involve peers (users and former users) in HR actions
No. As indicated, after the Nineties (that decade saw an expansion of harm reduction intervention) in the last decade our country took steps backward.
Not known
Not much that I can think of.
Integrative approach
See above, no. At best we have maintained the level and quality of services.
Introduction (although limited) of drug testing in recreational settings; a pilot-experience with peers training and peer integration in some outreach teams; Introduction of OST programmes combined with therapies for HIV, tuberculosis and psychiatric disturbances in proximal contexts.
- Needle exchange programmes in prisons; - OST in prisons.
No
No.
We are working on social enterprise to employ IDUs to some extent, harm reduction for cocaine users in nightlife and counselling service;
No
Drug treatment is more accessible, with shorter waiting lists and more services – against a backdrop of ring-fenced funding. However, new economic pressures on public spending will challenge the progress made. Many services have also become very numbers-focused rather than client-focused as an unintended side-effect of the emphasis on data and targets. However, important steps include the roll-out of "take-home" naloxone and successful pilot programmes, as well as successful pilots of heroin assisted treatment.
Heroin prescription becoming a national programme following the successful completion of a trial "take-home" naloxone programmes rolled out.

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

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Table 5.4
"Suggestions for issues concerning harm reduction to be highlighted in follow-up policy work at EU level (e. g. inclusion of housing / work / reintegration etc.):"

Answers given by Stakeholders
Housing First Fight against stigmatisation Prevent (fatal) ODs HAT / intravenous substitution treatment
The need for drug consumption rooms in every EU country The possibility to have HAT Harm reduction approach for young drug users
Legalisation of drugs
- Party drugs and stimulants harm reduction services - Social services for IDUs
Housing work and reintegration is definitely important to develop, because at this moment there is a huge gap.
- Housing issues - Employment of drug addicts
Naloxone treatment availability at home
Harm reduction should become European standard of taking care of drug users
Member States should 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. In order to reduce injection-drug related health damage (such as HIV, HCV and bacterial skin and systematic infections), Member States should implement facilities with Drug Checking, individual safer injection training including the use of drugs and/or consumption rooms if necessary. Following the Conclusions on the prevention and reduction of health and social risks associated with the use of illicit drugs in recreational settings (Council of the EU, 2010) and the Annex on safer nightlife to the EU Civil Society Forum on Drugs' recommendations (2012), the Member States should support at local level the integrated partnerships implementing health promotion among partygoers and measures for safer recreational settings through the development of training opportunities for staff in recreational venues, safer party labels and peer education approaches. According to the objective 4 - Action 9 of the EU Drug Action Plan 2009-2012, Member States should define their harm reduction policies on the basis of national formal consultations including all relevant stakeholders. Member States should support the harm reduction approach among local and integrated partnerships on drugs, in respect of the Democracy, Cities & Drugs resolution (Vienna, 2011) and the Prague Declaration on the principles of effective local drug policies (Prague, 2010).
Describe and implement best practice standards and quality improvement of needle/syringe/paraphernalia distribution connected with counselling Scale up access to injection/consumption materials Implement screening and maybe preventive therapy of TBC
1. Harm reduction services must be incorporated as a principle in the drug law of the country. 2. The possibility for General Practitioners to prescribe methadone must be regulated in the law on drugs. 3. Job opportunities and promotion of social networks have to be a priority of the treatment programmes. It is the best guarantee for normalisation of the daily life of drug dependent people.
-Housing -Programmes in prisons -Immediate access to both substitution and clean programmes
- Decriminalisation of drug users - Harm reduction in prisons - Drug consumption rooms - Heroin assisted treatment - "take-home" naloxone programmes - Harm reduction in the party scene

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Table 5.4, continued

Answers given by Stakeholders
To ensure that available knowledge is properly distributed and used among professionals and policy makers. To support national and European level research regarding the impact of harm reduction measures. To create the (binding) conditions for high level discussions among decision makers and professionals/experts to make sure that good practices are used and a clear understanding of the concept and actual measures are used as a driving force for future actions.
There are limited harm reduction services across the country Inclusion of Safer Injecting Facilities Inclusion of Community naloxone role out Inclusion of voluntary Pill Testing in clubs
Social integration Heroin substitution with strong evidence in order to be considered by national/local governments
Quality criteria for HR actions Avoid prison as response to drug use (Legal status of use) Reinforce and re-empower HR actions into prisons
Everything needs to be re-designed from the beginning.
Support of housing first projects for consuming and older clients
The government should take the issue seriously and start a harm reduction programme which would be spread throughout the country.
peer and user involvement in the implementation of services and decision making level participation programmes = social firms etc
More political pressure on governments in EECA to change policies re drug possession and use.
Harm reduction only makes sense with a coherent policy of combat of social exclusion, so it is crucial to complement it with strong measures of housing and social support to those who continue to use drugs (because often it is only available when drug users are willing to integrate treatment programmes). Also, very frequently professionals (including those of harm reduction) believe that social reintegration can only begin when abstinence is achieved. This is not true and working social and professional reintegration while consumption is still present is often a fundamental resource to motivate for treatment. The challenge is to find adequate professional activities to those who use drugs, but there are already good experiences of that kind.
- Reinsertion programmes through social enterprises or social cooperatives operated by NGOs in collaboration with drug users as employees or partners. - Drug possession decriminalisation; - Drug consumption rooms; - Research on legal highs - Treatment options; intervention methods, harm reduction for ATS users.
Strong recommendations for governments to include funding for harm reduction in their budgets.
- Decriminalisation of drug users - Better access to treatment and health services - Greater emphasis on human rights of drug users - Make available Pill Testing/Drug Checking for drug users.
Sleep centres for homeless drug users
The need to manage and counter the trend towards “recovery” and the rise of the right wing in many countries, by emphasising the public health and economic arguments for harm reduction, but also the proven and/or modelled costs of abandoning established harm reduction approaches.
It is of vital importance that the EU continues to balance drug policy and have an evidence based harm reduction component within it. The voices of people who use drugs should also be heard at the EU level.

Source: GÖ FP, stakeholder survey; graphic representation: GÖ FP

Abbreviations

AIDS	acquired immune deficiency syndrome
CR	Council Recommendation
DCR	drug consumption room
DRID	drug-related infectious diseases
DG JLS	Directorate-General for Justice, Security and Freedom
DG SANCO	Directorate-General for Health and Consumers
EAHC	Executive Agency for Health and Consumers
EC	European Commission
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU	European Union
EURONPUD	European network of people who use drugs
EUROHRN	European harm reduction network
EU 12	countries which joined the EU in 2004 or later
EU 15	countries which joined the EU before 2004
GÖG	Gesundheit Österreich GmbH
GP	general practitioner
HAT	heroin assisted treatment
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HR	harm reduction
IDU	injecting drug user, injecting drug use
NGO	non-governmental organisation
NSP	needle (and syringe) exchange programme
OD	overdose
ORW	outreach work
OST	opioid substitution treatment
PCR	polymerase chain reaction
UK	United Kingdom
VCT	voluntary counseling and testing
WHO	World Health Organization