Prevention and reduction of health-related harm associated with drug dependence

An inventory of policies, evidence and practices in the EU relevant to the implementation of the Council Recommendation of 18 June 2003

Synthesis report

Contract nr. SI2.397049

Trimbos instituut
Netherlands Institute of Mental Health and Addiction

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This report has been written in preparation of the reporting activities of the European Commission on the implementation of the Council Recommendation of 18 June 2003 regarding the prevention and reduction of health-related harm associated with drug dependence. This report was financed by the European Commission through a call for tenders' procedure (contract DG SANCO SI2.397049).

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Trimbos publication no: AF0699
ISBN-10: 90-5253-564-7
ISBN-13: 978-90-5253-564-7

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1. Introduction

On the 18th of June 2003, the Council of the European Union adopted a Recommendation on the prevention and reduction on health-related harm associated with drug dependence[1], hereafter referred to as 'The Council Recommendation' (CR). It consists of three main parts, namely 1) a recommendation that calls for the adoption of harm reduction as a public health objective; 2) a recommendation, consisting of 13 sub-recommendations relating to harm reduction services and facilities Member States are recommended to implement; and 3) a recommendation consisting of nine sub-recommendations including themes regarding quality assurance, needs driven policies, monitoring and evaluation.

With the adoption of the Council Recommendation, the Council of the European Union recognised the importance of developing responses and strategies to prevent and reduce drug-related harm. The Council Recommendation calls upon the Member States to report on its implementation within two years after its adoption and upon request of the European Commission.

a) Purpose and objectives

Following an open call for tenders[2], the Commission decided to enlist the services of the Trimbos Institute to collect and analyse the basic information a Commission report in accordance with the EU Action Plan on Drugs 2005-2008 and on the basis of the information submitted by the Member States to the Commission and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Furthermore, the Trimbos Institute was asked to provide an overview of the latest scientific evidence for the effectiveness of HR interventions and formulate advice for the follow-up of the Council Recommendation. These activities were planned in close collaboration with and by making use of technical support of the EMCDDA.

b) Methodology, coverage and assessment of scientific literature

At the request of the European Commission, all EU Member States have provided information on the implementation of the Council Recommendation through a reporting tool (RT). Key information sources at the EMCDDA have been analysed and used, including National Reports (NR) of the Member States to the EMCDDA, and Structured Questionnaires (SQ) to the National Focal Points that were specifically designed to monitor the implementation of the Council Recommendation. The National Focal Points actively contributed to this study by verifying the information that was put together on their respective countries, while – to a limited extent - field organisations were invited to provide additional information on harm reduction services and facilities in their country.

Apart from the assessment of the above mentioned available data sources, a literature review was conducted to map the currently available scientific evidence on the main harm reduction interventions as adopted in the Council Recommendation.

In contrast to controlled medical research, interventions in drug demand reduction in general and in harm reduction in particular are often carried out in a complex social environment with many unknown variables that can not easily be controlled in research situations. This means that the evidence-base for harm reduction interventions is slowly increasing step-by-step. And although for many interventions the existing evidence is still insufficient, they *may* still appear to be effective in daily practice. This should be tried out and guided by preliminary outcomes in practical situations. A positive conclusion of this report is that - so far - no evidently *ineffective* harm reduction interventions have been found in the literature. This report uses the term *effective* when sufficient evidence is found in the literature. When evidence is available but not yet sufficient, the intended harm reduction intervention is considered *probably effective*. An intervention may be effective when the evidence is still insufficient.

Effective interventions are available to prevent and treat the spread of infectious diseases (HIV/ AIDS, hepatitis B and C.

Needle and syringe exchange programmes are probably effective (and possibly also cost-effective) in reducing risk behaviours and infectious diseases although HIV-testing and counselling may also be effective. When these interventions are outreaching (targeting hidden drug users in their daily environment) the coverage of these interventions will increase and also the effects on risk

[1] 2003/488/EC.
[2] General invitation to tender SANCO/C4/2004/01. (OJ 10/7/2004 - 2004/S 133-112486).

behaviours of injecting drug use. Combination of harm reduction measures with *informative or educative strategies* may also increase the positive effects on risk behaviours of injecting drug users.
*Maintenance or substitution treatment*s with methadone or buprenorphine are effective in reducing opiate use and related risk behaviours. Both treatments are also effective in keeping opiate users in treatment. Effectiveness tends to increase with individually adjusted higher doses of these substances and when *psychosocial interventions* are added to these maintenance treatment programmes. The most direct and effective intervention to prevent overdose death among drug users is naloxone but additional actions are often needed to increase success. Other interventions e.g. *pre-release counselling* are still studied insufficiently. The establishment of (medically supervised) *drug consumption rooms* may be a potentially effective intervention for reducing needle sharing and drug-related deaths. Although the available evidence is still inconclusive, no negative findings were found. Evidence for effectiveness of *medical heroin (co)prescription* for chronic opiate users shows that this intervention has little adverse effects. It probably improves the health situation of drug users who do not respond to maintenance treatment and it possibly also reduces public nuisance. It may also increase retention to treatment rates. Several new studies are underway that may serve to draw more firm conclusions.

Maintenance or substitution treatment may also be a feasible treatment option in *prisons*, provided (again) that adequate dosages are distributed during the entire imprisonment period. Both methadone and buprenorphine are effective in reducing injecting drug use, needles sharing, and transmission of infectious diseases. These maintenance treatments probably also improve the health situation of drug using prisoners. There is no evidence yet that *pre release counselling* and *after care* are preventing relapse or overdose after withdrawal from drug use and release from prison, because effect studies on these subjects were not found. *Prison-based needle (and syringe) exchange programmes* are probably stabilising or reducing drug use, are reducing needle sharing and consequently the transmission of infectious diseases.

2. Outcomes of the Council Recommendation

a) Recommendation 1 - Harm reduction as public health objective
This study shows that all EU Member States have policies in place that make the prevention of drug-related harm a public health objective and six Member States indicated the Council Recommendation has been a major instrument in that process. All Member States reported that the reduction of drug-related harm is a public health objective and for five Member States the Council Recommendation has played a major role in that regard. In all Member States harm reduction is part of a National Drug Strategy or Drug Action Plan.

b) Recommendation 2 – Harm reduction services and facilities in the Member States
In Table 1.1 a concise but simplified overview is given of the available harm reduction services and facilities in the Member States. Note that some of the interventions (e.g. needle exchange/ substitution treatment) reduce both drug-related infectious diseases and drug-related deaths.

As the table shows, Member States run a variety of Information, Education and Communication programmes. Needle and syringe exchange programmes are available in practically all Member States as well as related facilities such as the distribution of paraphernalia[3] for drug use and condoms. Drug-free treatment[4], methadone maintenance[5] and methadone detoxification[6] programmes are also widely available throughout the EU, while buprenorphine maintenance treatment is catching up fast. Member States pay a great deal of attention to the testing, screening, treatment and vaccination of drug-related infectious diseases. Overdose response measures, e.g., by making naloxone available on ambulances, is available in twenty Member

[3] The term drug paraphernalia refers to equipment used to produce, administer or conceal an illicit drug, e.g. bleach, a spoon, ascorbic acid, pipes, etc.
[4] Drug-free treatment involves the application of psychosocial and educational techniques to achieve long-term abstinence from drugs. Traditionally, drug-free treatment has been residential and long term, e.g. in therapeutic communities. Today, it is often also offered in community-based settings.
[5] In methadone maintenance treatment is a drug user is prescribed methadone as a substitute for heroin, usually in a daily dose and under medical supervision. The main aim of methadone maintenance treatment is to stabilise opiate users' medical and social condition, as such allowing for genuine social re-integration. In this type of treatment the first concern is improving the drug users' personal situation and the aim to become 'clean'.
[6] With methadone detoxification, a drug user is also prescribed methadone as a substitute for heroin, but in this type of treatment, the dosage of methadone is gradually decreased so that the drug user slowly detoxifies and can become 'clean'.

States. However, in only ten of the Member States emergency staff is being trained to respond to drug overdose.

When harm reduction in prison is concerned, table 1.1 clearly shows that there is still a considerable discrepancy between the availability and access to services outside and inside prisons. This difference is most apparent regarding the availability of needle and syringe exchange programmes in prisons.

Overall, Member States have adopted harm reduction policies, services and facilities as recommended by the Council Recommendation and many harm reduction interventions have been implemented. However there are still considerable differences between Member States at the level of implementation.

Table 1.1 – Overview of services and facilities in the Member States

Intervention (service/ facility)	**Nr. MS in which intervention exists**	**CR ref.**
Prevention of risk behaviour		
• ***Information, education & communication (IEC)***		
o Helpline	25	2.1
o Website	22	2.1
o Pill testing	7	2.1
o Safer injection training	13	2.1
• ***Outreach work (ORW)***	23	2.2
o Training of peers	18	2.3
o Involvement of peers	19	2.4
o Networking & cooperation between agencies in ORW	20	2.4
o Training of staff	21	2.13
o Drug Consumption Rooms	4	2.6
Prevention of Drug-related infectious diseases		
• ***Needle & syringe exchange outside prison***	24	2.10
▪ Inside prison	3	2.8
o Training of staff	17	2.13
• ***Paraphernalia distribution outside prison***	23	2.10
▪ Inside prison	11	2.8
• ***Condom distribution outside prison***	23	2.10
▪ Inside prison	16	2.8
• ***Testing/ screening***	22	2.9
• ***Treatment (e.g. Hep. C)***	20	2.9
• ***Vaccination***		
o Vaccination Hep B for drug users	20	2.9
o Vaccination TB for drug users	13	2.9
Prevention of Drug-related deaths		
• ***Low threshold/ drop-in centre***	23	2.6
• ***Substitution treatment***		
o Methadone maintenance outside prison	24	2.6
▪ Inside prison	17	2.8
o Methadone detoxification outside prison	23	2.6
▪ Inside prison	19	2.8
o Buprenorphine outside prison	21	2.6
▪ Inside prison	10	2.8
o Naltrexone treatment outside prison	5	2.6
▪ Inside prison	5	2.8
o Heroin prescription outside prison	4	2.6
▪ Inside prison	-	2.8
o Training of staff	20	2.13
• ***Drug Free treatment***	25	2.6
• ***Response to overdose***		
o Naloxone in ambulance	20	2.11
o Naloxone for 'take home'	6	2.11
o Training emergency staff	10	2.11
Prevention of diversion of substitution drugs		
• Policy to prevent diversion exists	22	2.7
Integration of harm reduction in general health care -including mental health- and social care		
• Policy aim exists to promote integration	23	2.12

c) Recommendation 3 – Quality assurance, monitoring and evaluation
The 3rd recommendation of the Council Recommendation focuses on facilitating the development of a sound infrastructure for the development, assessment, monitoring and evaluation of harm reduction services and facilities. Not all Member States consider quality assurance, monitoring and evaluation as a task for national government. In Member States with a federal or decentralised structure, tasks in these areas are divided among different levels of competence. In other Member States, e.g. the Netherlands and the UK, quality assurance, monitoring and evaluation are seen as a task for independent scientific organisations.

The examples of studies that are presented in the country reports related to the 3rd Council Recommendation suggest that a broad range of Member States make use of scientific research as a basis for selecting appropriate interventions. Research is mainly focused on the most common harm reduction services and interventions, i.e. outreach work, substitution treatment and needle & syringe exchange. Nevertheless, Member States do not yet seem to make use of funding criteria as an instrument to promote quality and evaluation. Only the United Kingdom has reported that i.e., a needs assessment is a pre-condition for the commissioning of projects. Member States are still developing quality control models for harm reduction interventions, including the development of evaluation protocols and criteria. Member States like Luxembourg and Denmark have set up computerised registration systems in which details on programmes and interventions are collected.

The Member States have adopted policies to implement the five EMCDDA key-epidemiological indicators, but in operational terms, not all Member States comply fully with the EMCDDA standards for these key-indicators. The EMCDDA provides Member States with feedback on the quality of these and other data collections and reports.

All EU Member States have developed a National Drug Strategy, Drug Action Plan or other types of comprehensive drug policy documents in which harm reduction has been integrated as part of drug demand reduction. These policies increasingly point out the need of evaluation of interventions and programmes. Yet only a limited number of Member States report examples of evaluation schemes that are designed to inform policy. It seems that the evaluation culture is well developed in countries in North-Western Europe, i.e. in Member States such as the United Kingdom, the Netherlands, Luxembourg and Germany.

The strengthening of an evaluation culture by providing training to staff and by involving stakeholders in evaluation processes is still a point of attention for Member States. Finally, there is a lot of collaboration taking place in the field of drug demand reduction and – to a lesser extent – harm reduction. In addition to EU funded, multilateral programmes (Twinning, Public Health, Focal Point collaborations), Member States also run bi-lateral collaboration programmes.

3. Conclusions and suggestions for follow up

- The Council Recommendation of 18 June 2003 has been successful as it has guided and supported policy development in the Member States and because it set a 'benchmark' for existing policies. Member States have – to a great extent – implemented policies, services and facilities that correspond with the recommendations in the Council Recommendation. It is still early to assess the real impact of the Council Recommendation on the Member States policies, services and facilities.
- The available data at EU level regarding the availability of harm reduction services and facilities in the Member States as collected and disseminated by the EMCDDA is comprehensive and of high quality and – except perhaps for countries like Australia and Canada – probably unmatched outside the European Union. Nevertheless, the quality of data collections on the availability and accessibility of harm reduction services and facilities at national level does still need improvement. And Member States often do not have a complete overview if, by whom and how these services and facilities are used.
- In general, harm reduction services and facilities as one of the possible approaches to respond to problem drug use, are common practice in all Member States, be it to a lesser extent for Cyprus and Sweden. Overall, policies of the European Union Member States are in balance with the recommendations as reflected in the Council Recommendation. However, the available data, which are largely self-reported by the Member States, provide an overview of the availability of services and facilities in the Member States, but not a complete picture of the accessibility and/ or the coverage of these interventions. Such data – in general – are often not available at national level.
- Member States may consider placing greater emphasis on the further integration of harm reduction in a broader public (mental) health and social care and welfare policy, with the aim to provide realistic and sustainable exit options (from drug dependence) for drug users in the long

run. The integration of harm reduction with public health including mental health and social care is of great importance, as an integrated system of care may provide dependent drug users with the best possibilities to improve their social and health situation and facilitate their reintegration in society.

- Harm reduction seems to be an accepted approach in drug demand reduction policies in all EU Member States. Those harm reduction measures that have been implemented most by the Member States (IEC, needle & syringe exchange, maintenance treatment, naloxone availability) are found probably effective or effective in scientific literature, especially when combined in an integrated harm reduction care system. To date, none of the major harm reduction interventions that have been evaluated have been found ineffective or showed unwanted or undesirable results.
- Most harm reduction programmes in the EU Member States are mainly focusing on 'traditional' drug use patterns, especially opiate dependency. Interventions taking into account new trends in drug dependence (e.g. crack cocaine and (Meth-) amphetamine dependence) as well as the growing prevalence of the mixed use of licit and illicit drugs are still scarce.
- The collection of data on problem drug use and drug-related harm at Member States level is still not always comparable due to different estimation systems at local level. Furthermore, more emphasis could be placed upon the prevalence of drug-related harm in relation to the specific at-risk groups in Member States rather than those of the general population. Member States with relatively small groups of problem drug users may still have a high prevalence of drug-related harms such as infectious diseases among these problem drug users. Although the number of problem drug users may be small compared to the general population, the prevalence of drug-related harm may be considerable.
- Scientific evidence on effectiveness is available for many harm reduction interventions. This general conclusion is most promising since effect studies are sometimes hard to conduct in this type of settings. The circumstances in which harm reduction interventions are implemented, hardly accept a division in study groups with different intervention regimes, not in the last place because of ethical reasons. It is important that innovations in harm reduction are allowed to be based on pragmatism and local or regional constructions of 'best-practice'. After this try-out phase, it is sometimes feasible to gather evidence for specific interventions via high-quality effect studies.
- Finally, at EU level and among the Member States there is an increasing awareness of the need to make policies more research-based and facts-driven, including harm reduction policies. This need is reflected by the 3rd Council Recommendation, but also in the European Drugs Strategy 2005-2012 and the EU Action Plan on Drugs 2005-2008.

Résumé exécutif

1. Introduction

Le 18 juin 2003, le Conseil de l'Union européenne a adopté une Recommandation sur la prévention et la réduction des dommages pour la santé liés à la toxicomanie[7], ci-après dénommée 'La Recommandation du Conseil' (RC). Celle-ci comporte trois parties principales, à savoir, 1) une recommandation réclamant l'adoption de la réduction des dommages comme un objectif de santé publique ; 2) une recommandation composée de 13 sous-recommandations relatives aux installations et services pour la réduction des dommages qu'il est recommandé aux États Membres de mettre en œuvre ; et 3) une recommandation constituée de neuf sous-recommandations comprenant des thèmes relatifs à l'assurance qualité, des politiques, un suivi et une évaluation tournés vers les besoins.

Par l'adoption de cette Recommandation, le Conseil de l'Union européenne a reconnu l'importance de développer des réponses et des stratégies pour prévenir et réduire les dommages liés aux drogues. La Recommandation du Conseil invite les États Membres à dresser un rapport de sa mise en œuvre dans un délai de deux ans à dater de son adoption et à la demande de la Commission européenne.

a) But et objectifs

Suite à un appel d'offres ouvert[8], la Commission a décidé d'engager les services de l'Institut Trimbos pour collecter et analyser les informations de base d'un rapport de la Commission conformément au Plan d'action antidrogue de l'UE (2005-2008) et sur la base des informations soumises par les États Membres à la Commission et à l'Observatoire européen des drogues et des toxicomanies (OEDT). En outre, l'Institut Trimbos a été invité à fournir un aperçu des dernières preuves scientifiques de l'efficacité des interventions de réduction des dommages et à formuler des conseils pour le suivi de la Recommandation du Conseil. Ces activités ont été planifiées en étroite collaboration avec l'OEDT et en ayant recours à son soutien technique.

b) Méthodologie, couverture et évaluation de la littérature scientifique

A la demande de la Commission européenne, tous les États Membres de l'UE ont fourni des informations sur la mise en œuvre de la Recommandation du Conseil via un outil de création de rapports (RT). Les sources d'informations clés à l'OEDT ont été analysées et utilisées, y compris des rapports nationaux (NR) des États Membres à l'OEDT et des questionnaires structurés (SQ) adressés aux points focaux nationaux qui ont été spécifiquement conçus pour assurer le suivi de la mise en œuvre de la Recommandation du Conseil. Les points focaux nationaux ont activement contribué à cette étude en vérifiant les informations rassemblées dans leurs différents pays, alors que – dans une moindre mesure – des organisations sur le terrain ont été invitées à fournir des informations complémentaires sur les interventions de réduction des dommages dans leur pays.

Outre l'évaluation des sources de données disponibles mentionnées ci-dessus, une analyse documentaire a été menée pour établir un relevé des témoignages scientifiques disponibles actuellement relatifs aux principales interventions pour la réduction des dommages telles qu'adoptées dans la Recommandation du Conseil.

A la différence de la recherche médicale contrôlée, les interventions dans le domaine de la réduction de la demande de drogues en général et de la réduction des dommages en particulier sont souvent menées dans un environnement social complexe présentant de nombreuses variables inconnues qui ne peuvent pas être contrôlées facilement dans des situations de recherche. Pour cette raison, les données probantes relatives aux interventions de réduction des dommages augmentent pas à pas. Et bien que pour de nombreuses interventions, les données existantes soient encore insuffisantes, elles *peuvent* malgré tout s'avérer efficaces dans la pratique de tous les jours. Il faut l'essayer et l'adapter en fonction des premiers résultats dans des situations pratiques. Une conclusion positive de ce rapport est que – jusqu'à présent – aucunes interventions de réduction des dommages manifestement *inefficaces* n'ont été rencontrées dans la documentation. Ce rapport utilise le terme *efficace* lorsque des preuves suffisantes ont été trouvées dans la littérature afférente. Lorsque des preuves sont disponibles mais pas encore en nombre suffisant, l'intervention de réduction des dommages visée est considérée comme *probablement efficace*. Une intervention peut être efficace alors que les preuves sont encore insuffisantes.

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[7] 2003/488/CE.

[8] Appel d'offres général SANCO/C4/2004/01 (JO 10/7/2004 – 2004/5 133-112486).

Des interventions efficaces existent pour prévenir et traiter la propagation de maladies infectieuses (VIH/SIDA, hépatite B et C).
Des programmes d'échange d'aiguilles et de seringues sont probablement efficaces (et peut-être aussi rentables) en termes de réduction des comportements à risque et des maladies infectieuses bien que le test VIH et l'assistance psychosociale semblent également efficaces. Lorsque ces interventions sont destinées au grand public (visant des utilisateurs de drogues cachés dans leur environnement quotidien), leur couverture augmente, de même que les effets sur les comportements à risque de l'utilisation de drogues par injection. Une combinaison de mesures de réduction des dommages affichant des *stratégies informatives et éducatives* peut également augmenter les effets positifs sur les comportements à risque des utilisateurs de drogues par injection.
Des traitements d'entretien ou de substitution à la méthadone ou la buprénorphine sont efficaces pour réduire l'utilisation d'opiacés et les comportements à risque qui en découlent. Ces deux traitements sont également efficaces pour maintenir les utilisateurs d'opiacés en traitement. L'efficacité tend à augmenter en présence de doses supérieures de ces substances adaptées au cas par cas et lorsque des *interventions psychologiques* viennent s'ajouter à ces programmes de traitement d'entretien. L'intervention la plus directe et la plus efficace pour prévenir les décès par overdose parmi les toxicomanes est la naloxone mais des actions complémentaires sont souvent nécessaires pour augmenter le taux de réussite. D'autres interventions, comme notamment *l'aide psychosociale avant libération,* sont encore insuffisamment étudiées. La mise en place de *lieux de consommation de drogues* (avec supervision médicale) peut s'avérer être une intervention potentiellement efficace pour réduire les échanges d'aiguilles et les décès liés à la drogue. Bien que les preuves disponibles soient encore peu concluantes, aucune conclusion négative n'a été trouvée. Les preuves de l'efficacité des *(co)prescriptions médicales d'héroïne* pour les utilisateurs chroniques d'opiacés montrent que cette intervention présente peu d'effets défavorables. Elle semble améliorer l'état de santé des toxicomanes qui ne répondent pas au traitement d'entretien et réduit aussi probablement les désagréments publics. Elle peut également favoriser le maintien des taux de traitements. Plusieurs nouvelles études susceptibles de permettre l'établissement de conclusions plus fermes sont en cours.

Le traitement d'entretien ou de substitution peut également constituer une option de traitement réalisable dans *les prisons*, pourvu (encore une fois) que des doses adaptées soient distribuées pendant toute la durée de l'emprisonnement. La méthadone comme la buprénorphine sont efficaces pour réduire l'utilisation de drogues par injection, les échanges d'aiguilles et la transmission des maladies infectieuses. Ces traitements d'entretien améliorent aussi probablement l'état de santé des prisonniers toxicomanes. *L'aide psychosociale avant libération* et *les soins après libération* sont peut-être aussi efficaces pour éviter les rechutes ou les overdoses après s'être libéré de la drogue et avoir quitté la prison, mais aucune étude sur ces sujets ne semble disponible. *Des programmes d'échange d'aiguilles (et de seringues) au niveau des prisons* sont probablement efficaces pour réduire le partage des aiguilles et la transmission des maladies infectieuses.

2. Résultats de la Recommandation du Conseil

a) Recommandation 1 – Réduction des dommages comme objectif de santé publique
Cette étude montre que tous les États Membres de l'UE ont mis en place des politiques faisant de la prévention des dommages liés à la toxicomanie un objectif de santé publique et six États Membres ont indiqué que la Recommandation du Conseil a été un instrument essentiel dans ce processus. Tous les États Membres ont déclaré que la réduction des dommages liés aux drogues constitue un objectif de santé publique et pour cinq États Membres, la Recommandation du Conseil a joué un rôle capital en ce sens. Dans tous les États Membres, la réduction des dommages fait partie d'une Stratégie nationale ou d'un Plan d'action en matière de drogues.

b) Recommandation 2 – Interventions de réduction des dommages dans les États Membres
Le Tableau 1.1 offre un aperçu concis mais simplifié des installations et services de réduction des dommages existants dans les États Membres. Il faut souligner que certaines des interventions existantes (par ex. l'échange d'aiguilles/ le traitement de substitution) réduisent à la fois les maladies infectieuses et les décès liés aux drogues.

Comme l'indique le tableau, les États Membres exécutent toute une série de programmes d'Information, d'Education et de Communication. Des programmes d'échange d'aiguilles et de seringues sont disponibles dans pratiquement tous les États Membres ainsi que les installations

correspondantes telles que la distribution de l'attirail[9] du toxicomane et de préservatifs. Des programmes de traitement sans drogue[10], d'entretien à la méthadone[11] et de désintoxication à la méthadone[12] sont également très répandus partout dans l'UE, alors que le traitement d'entretien à la buprénorphine se développe rapidement. Les États Membres accordent une attention considérable à la gestion de tests, au dépistage, au traitement et à la vaccination des maladies infectieuses liées aux drogues. Des mesures de réaction face aux overdoses, par ex., en prévoyant de la naloxone dans les ambulances, existent dans vingt États Membres. Cependant, le personnel des urgences n'est formé pour réagir à une overdose que dans dix de ces États Membres.

En ce qui concerne la réduction des dommages dans les prisons, le tableau 1.1 indique clairement qu'il existe encore une importante divergence entre la disponibilité et l'accès des services à l'intérieur et à l'extérieur des prisons. Cette différence est avant tout constatée en matière de disponibilité de programmes d'échange d'aiguilles et de seringues dans les prisons.

Dans l'ensemble, les États Membres ont adopté des politiques, des services et des installations de réduction des dommages comme le préconisait la Recommandation du Conseil et de nombreuses interventions de réduction des dommages ont été mises en œuvre. Cependant, on constate encore des différences considérables entre les États Membres au niveau de la mise en œuvre.

Tableau 1.1 – Aperçu des interventions dans les États Membres

Intervention (service/ installation)	**Nbre EM dans lesquels une intervention existe**	**CR réf.**
Prévention des comportements à risque		
• ***Information, éducation & communication (IEC)***		
○ Service d'assistance téléphonique	25	2,1
○ Site Web	22	2,1
○ Pill-testing (contrôle des pilules)	7	2,1
○ Formation à des injections plus sûres	13	2,1
• ***Travail de proximité (TP)***	23	2,2
○ Formation de pairs	18	2,3
○ Implication de pairs	19	2,4
○ Mise en réseau & coopération entre agences de TP	20	2,4
○ Formation de personnel	21	2,13
○ Locaux de consommation de drogues	4	2,6
Prévention des maladies infectieuses liées aux drogues		
• ***Échange d'aiguilles & de seringues en dehors des prisons***	24	2,10
▪ A l'intérieur des prisons	3	2,8
○ Formation de personnel	17	2,13
• ***Distribution de l'attirail du toxicomane en dehors des prisons***	23	2,10
▪ A l'intérieur des prisons	11	2,8
• ***Distribution de préservatifs en dehors des prisons***	23	2,10
▪ A l'intérieur des prisons	16	2,8
• ***Tests/ dépistage***	22	2,9
• ***Traitement (ex. Hép. C)***	20	2,9
• ***Vaccination***		
○ Vaccination Hép. B pour les toxicomanes	20	2,9
○ Vaccination TB pour les toxicomanes	13	2,9
Prévention des décès liés aux drogues		
• ***Seuil bas/ centre d'accueil***	23	2,6
• ***Traitement de substitution***		

[9] Les termes 'attirail du toxicomane' désignent tout l'équipement utilisé pour produire, administrer ou dissimuler une drogue illicite, ex. éclaircissant, cuillère, acide ascorbique, pipes, etc.

[10] Le traitement sans drogue implique l'application de techniques psychosociales et éducatives pour parvenir à une abstinence des drogues sur le long terme. Traditionnellement, le traitement sans drogue était résidentiel et s'étendait sur le long terme, par ex. dans des communautés thérapeutiques. Aujourd'hui, il est aussi souvent proposé dans des cadres communautaires.

[11] Dans le traitement d'entretien à la méthadone, le toxicomane se voit prescrire de la méthadone comme substitut de l'héroïne, habituellement sous la forme d'une dose journalière et sous contrôle médical. Le principal objectif du traitement d'entretien à la méthadone est de stabiliser la situation sociale et médicale des utilisateurs d'opiacés, permettant ainsi une véritable réintégration sociale. Dans ce type de traitement, la principale préoccupation consiste à améliorer la situation personnelle des toxicomanes avec pour objectif de devenir 'clean' (désintoxiqué).

[12] Dans le cadre d'une désintoxication à la méthadone, un toxicomane se voit également prescrire de la méthadone comme substitut de l'héroïne, mais dans ce type de traitement, le dosage de la méthadone est progressivement réduit de sorte que le toxicomane se désintoxique peu à peu et devient 'clean' (désintoxiqué).

○ Entretien à la méthadone en dehors de la prison	24	2,6
▪ A l'intérieur de la prison	17	2,8
○ Désintoxication à la méthadone en dehors de la prison	23	2,6
▪ A l'intérieur de la prison	19	2,8
○ Buprénorphine en dehors de la prison	21	2,6
▪ A l'intérieur de la prison	10	2,8
○ Traitement à la naltrexone en dehors de la prison	5	2,6
▪ A l'intérieur de la prison	5	2,8
○ Prescription d'héroïne en dehors de la prison	4	2,6
▪ A l'intérieur de la prison	-	2,8
○ Formation de personnel	20	2,13
• ***Traitement sans drogue***	25	2,6
• ***Réaction à l'overdose***		
○ Naloxone dans l'ambulance	20	2,11
○ Naloxone pour 'prise à domicile'	6	2,11
○ Formation du personnel des urgences	10	2,11
Prévention de détournement de drogues de substitution		
• Politique de prévention de détournement existante	22	2,7
Intégration de la réduction des dommages dans les soins de santé généraux –y compris la santé mentale- et l'aide sociale		
• Un but politique existe pour promouvoir l'intégration	23	2,12

c) Recommandation 3 – Assurance qualité, suivi et évaluation

Le 3ème conseil de la Recommandation du Conseil se concentre sur la facilitation de l'élaboration d'une infrastructure solide pour le développement, le contrôle, le suivi et l'évaluation des services et installations de réduction des dommages. Tous les États Membres ne considèrent pas l'assurance qualité, le suivi et l'évaluation comme une tâche du gouvernement national. Dans certains États Membres présentant une structure décentralisée ou fédérale, les tâches dans ces secteurs sont réparties entre les différents niveaux de compétence. Dans d'autres États Membres, aux Pays-Bas et au RU notamment, l'assurance qualité, le suivi et l'évaluation sont considérés comme une tâche relevant d'organisations scientifiques indépendantes.

Les exemples d'études qui sont présentés dans les rapports nationaux en rapport avec la 3ème Recommandation du Conseil suggèrent qu'un vaste groupe d'États Membres utilise la recherche scientifique comme une des bases de sélection d'interventions appropriées. La recherche est essentiellement axée sur les interventions et services de réduction des dommages les plus communs, à savoir, le travail de proximité, le traitement de substitution et l'échange d'aiguilles & de seringues. Cependant, certains États Membres ne semblent toujours pas prendre en compte des critères de financement comme instrument pour promouvoir la qualité et l'évaluation. En effet, seul le Royaume Uni a indiqué dans son rapport qu'une évaluation des besoins constitue une condition requise pour la mise en œuvre de projets. Les États Membres développent encore des modèles de contrôle de la qualité pour les interventions de réduction des dommages, incluant le développement de critères et protocoles d'évaluation. Certains États Membres, comme le Luxembourg et le Danemark, ont mis au point des systèmes informatisés d'enregistrement dans lesquels sont rassemblées des données détaillées concernant les programmes et interventions.

Les États Membres ont adopté des politiques pour mettre en œuvre les cinq indicateurs épidémiologiques clés de l'OEDT, mais dans la pratique, tous les États Membres ne respectent pas entièrement les normes de l'OEDT pour ces indicateurs-clés. L'OEDT transmet du feed-back aux États Membres concernant la qualité de ceux-ci ainsi que d'autres collectes de données et rapports.

Tous les États Membres de l'UE ont établi une stratégie nationale en matière de drogue, un plan d'action ou d'autres types de documents politiques globaux sur les drogues dans lesquels la réduction des dommages a été intégrée comme élément de réduction de la demande de drogues. Ces politiques soulignent de plus en plus la nécessité d'une évaluation des interventions et des programmes. Mais seul un nombre limité d'États Membres signalent des exemples de systèmes d'évaluation conçus pour guider la politique. Il semble que la culture de l'évaluation soit plutôt développée au Nord-ouest de l'Europe, c-à-d. dans des États Membres comme le Royaume Uni, les Pays-Bas, le Luxembourg et l'Allemagne.

Le renforcement d'une culture d'évaluation en proposant une formation au personnel et en incluant des enjeux dans les processus d'évaluation constitue encore un point de réflexion pour les États Membres. Enfin, une collaboration importante se met en place dans le domaine de la réduction de la demande de drogues et – dans une moindre mesure – de la réduction des dommages. Outre les programmes multilatéraux, financés par l'UE (Jumelage, Santé Publique, Collaborations des points focaux), les États Membres mettent également en œuvre des programmes de collaborations bilatérales.

3. Conclusions et suggestions pour la suite

- La Recommandation du Conseil du 18 juin 2003 a été un succès en ce sens qu'elle a inspiré et soutenu le développement de politiques dans les États Membres et parce qu'elle établit une 'référence' pour les politiques existantes. Les États Membres – dans une large mesure – ont mis en œuvre des politiques, des services et des installations qui correspondent aux avis donnés dans la Recommandation du Conseil. Il est encore tôt pour apprécier l'impact réel de la Recommandation du Conseil sur les politiques, services et installations des États Membres.
- Les données disponibles au niveau européen concernant l'existence de services et installations de réduction des dommages dans les États Membres telles que collectées et communiquées par l'OEDT sont globales et de haute qualité et – à l'exception peut-être de certains pays comme l'Australie et le Canada – elles sont probablement inégalées en dehors de l'Union européenne. Toutefois, la qualité des collectes de données relatives à la disponibilité et à l'accessibilité des services et installations de réduction des dommages requiert encore des améliorations au niveau national. De plus, les États Membres ne disposent généralement pas d'un aperçu complet quant à savoir si, par qui et comment ces installations et services sont utilisés.
- En règle générale, les services et installations de réduction des dommages utilisés comme une des approches éventuelles pour répondre au problème de la toxicomanie, sont une pratique commune dans tous les États Membres, même si ce n'est que dans une moindre mesure en ce qui concerne Chypre et la Suède. Globalement, les politiques des États Membres de l'Union européenne sont alignées sur les recommandations telles que reflétées dans la Recommandation du Conseil. Toutefois, les données disponibles, amplement auto-rapportées par les États Membres, fournissent une vue d'ensemble de la disponibilité des services et installations dans les États Membres, mais pas un aperçu complet de l'accessibilité et/ou la couverture de ces interventions. Ces données – en règle générale – ne sont bien souvent pas disponibles au niveau national.
- Certains États Membres envisagent peut-être de mettre davantage l'accent sur une plus grande intégration de la réduction des dommages dans une politique plus vaste de santé publique (mentale), d'aide sociale et de prévoyance, avec pour objectif de proposer des options de résolution (de la dépendance aux drogues) durables et réalistes aux toxicomanes sur le long terme. L'intégration de la réduction des dommages au sein de la santé publique, incluant la santé mentale et l'aide sociale, est très importante car un système de soins intégré peut offrir aux toxicomanes les meilleures possibilités pour améliorer leur situation sociale et de santé et favoriser leur réintégration dans la société.
- La réduction des dommages semble être une approche acceptée dans les politiques de réduction de la demande de drogues dans tous les États Membres de l'UE. Les mesures de réduction des dommages qui ont été le plus mises en oeuvre par les États Membres (IEC, échange d'aiguilles & de seringues, traitement d'entretien, disponibilité de la naloxone) sont jugées probablement efficaces ou efficaces dans la littérature scientifique, en particulier lorsqu'elles sont combinées à un système de soins intégrant la réduction des dommages. Jusqu'à présent, aucune des principales interventions de réduction des dommages qui ont été évaluées n'a été estimée inefficace ou n'a révélé des résultats non désirés ou non désirables.
- La plupart des programmes de réduction des dommages dans les États Membres de l'UE sont essentiellement axés sur les modèles 'traditionnels' de toxicomanie, et particulièrement la dépendance aux opiacés. Les interventions prenant en considération les nouvelles tendances en termes de dépendance aux drogues (ex. la dépendance au crack, à la cocaïne et à la (méth-) amphétamine) ainsi que la prévalence croissante de l'utilisation mixte de drogues licites et illicites sont encore rares.
- La collecte de données sur le problème de la toxicomanie et des dommages liés à la drogue au niveau des États Membres n'est pas encore comparable dans tous les cas en raison de systèmes d'évaluation différents au niveau local. En outre, une plus grande importance pourrait être accordée à la prévalence des dommages liés à la drogue en rapport avec les groupes à risque spécifiques dans les États Membres plutôt que la population en général. Les États Membres présentant des groupes relativement petits de toxicomanes à problème peuvent malgré tout avoir une prévalence élevée de dommages liés à la drogue comme notamment des maladies infectieuses parmi ces toxicomanes à problème. Bien que le nombre de toxicomanes à problème puisse être petit par rapport à la population globale, la prévalence de dommages liés à la drogue peut s'avérer considérable.
- Des preuves scientifiques d'efficacité sont disponibles pour de nombreuses interventions de réduction des dommages. Cette conclusion générale est d'autant plus prometteuse que les études sur les effets sont quelquefois difficiles à mener dans ce type de situation. Les circonstances dans lesquelles les interventions de réduction des dommages sont mises en œuvre acceptent difficilement une section de groupes d'étude disposant de différents régimes d'intervention, et ce notamment pour des raisons éthiques. Il est important que des

innovations soient autorisées dans la réduction des dommages et se fondent sur le pragmatisme et les constructions régionales ou locales de 'meilleures pratiques'. Après cette phase de tests, il est parfois possible de rassembler des preuves pour des interventions spécifiques via des études de haute qualité portant sur les effets.

- Enfin, au niveau de l'UE et au sein des États Membres, on constate une prise de conscience croissante de la nécessité de rendre les politiques davantage basées sur la recherche et guidées par des faits réels, incluant des politiques de réduction des dommages. Ce besoin se reflète dans la 3ème Recommandation du Conseil, mais aussi dans la Stratégie européenne 2005-2012 en matière de drogues et le Plan d'Action antidrogue 2005-2008 de l'UE.

Kurzfassung

1. Einleitung

Am 18. Juni 2003 verabschiedete der Rat der Europäischen Union eine Empfehlung zur Prävention und Reduzierung gesundheitlicher Schäden im Zusammenhang mit Drogenabhängigkeit[13], im Weiteren gekennzeichnet als 'Die Empfehlung des Rates' (CR). Sie besteht aus drei Hauptteilen, nämlich 1) einer Empfehlung, die Schadensbegrenzung als Zielsetzung des öffentlichen Gesundheitswesens verlangt; 2) einer Empfehlung, bestehend aus 13 untergeordneten Empfehlungen in bezug auf Dienste und Einrichtungen zur Schadensbegrenzung, die den Mitgliedstaaten zur Einführung bzw. Umsetzung empfohlen werden; und 3) einer Empfehlung, bestehend aus neun untergeordneten Empfehlungen u.a. zu Themen der Qualitätssicherung, der bedarfsorientierten Politik, der Beobachtung und der Evaluierung.

Mit der Verabschiedung der Empfehlung des Rates würdigte der Rat der Europäischen Union den Stellenwert der Entwickelung von Strategien und angemessenen Reaktionen, um drogenbedingte Schäden zu verhindern und zu verringern. In der Empfehlung des Rates werden die Mitgliedstaaten ersucht, innerhalb von zwei Jahren nach ihrer Verabschiedung und auf Anfrage der Europäischen Kommission über ihre Umsetzung zu berichten.

a) Zweck und Zielsetzung
Im Zuge einer öffentlichen Ausschreibung[14] beschloß die Kommission, die Leistungen des Trimbos Institute in Anspruch zu nehmen, um im Rahmen eines Kommissionsberichts in Übereinstimmung mit dem EU-Drogenaktionsplan 2005-2008 grundlegende Informationen zu erheben und zu analysieren, basierend auf den Informationen, die durch die Mitgliedstaaten bei der Kommission und bei der EU-Beobachtungsstelle für Drogen und Drogensucht (EBDD) vorgelegt wurden. Ausserdem wurde das Trimbos Institut gebeten, einen Überblick über die neuesten wissenschaftlichen Untersuchungsergebnisse für die Wirksamkeit von Maßnahmen zur Schadensbegrenzung zur Verfügung zu stellen und Empfehlungen für weitere Maßnahmen im Anschluß an die Empfehlung des Rates zu formulieren. Diese Tätigkeiten wurden in enger Zusammenarbeit und mit technischer Unterstützung der EU-Beobachtungsstelle (EBDD) geplant.

b) Methodik, Quellenlage und Auswertung der wissenschaftlichen Literatur

Auf Ersuchen der Europäischen Kommission stellten alle EU-Mitgliedstaaten mithilfe eines Berichtsinstruments (RT) Informationen zur Durchführung der Empfehlung des Rates zur Verfügung. Es wurden Quellen zu Schlüsselinformationen der EBDD analysiert und genutzt, einschließlich der nationalen Berichte (NR) der Mitgliedstaaten an die EBDD und der strukturierten Fragebögen (SQ) der Nationalen Knotenpunkte des REITOX-Netzes, welche spezifisch entworfen wurden, um die Umsetzung der Empfehlung des Rates zu beobachten. Die nationalen Referenzstellen trugen durch die Überprüfung der Informationen über ihre jeweiligen Länder aktiv zu dieser Studie bei, während weitere Organisationen in diesem Bereich – in eingeschränktem Maße - gebeten wurden, zusätzliche Informationen zu Diensten und Einrichtungen zur Schadensbegrenzung in ihrem Land zur Verfügung zu stellen.

Abgesehen von der Evaluierung der obenerwähnten vorhandenen Datenquellen, wurde eine Literaturauswertung erarbeitet, um entsprechend der Empfehlung des Rates die gegenwärtig verfügbaren wissenschaftlichen Untersuchungsergebnisse für die Wirksamkeit von Maßnahmen zur Schadensbegrenzung darzustellen.

Im Gegensatz zu kontrollierter medizinischer Forschung werden Maßnahmen zur Reduzierung des Drogenkonsums allgemein und Maßnahmen zur Schadensbegrenzung insbesondere häufig in einem komplexen sozialen Umfeld mit vielen unbekannten Variablen durchgeführt, die in Forschungssituationen nicht ohne weiteres zu steuern sind. Dies bedeutet, dass die Basis der Untersuchungsergebnisse für Maßnahmen zur Schadensbegrenzung sich Schritt für Schritt langsam erhöht. Und obwohl die vorhandenen Ergebnisse für viele Maßnahmen noch unzulänglich sind, können diese Maßnahmen in der täglichen Praxis durchaus effektiv *scheinen*. Dieses sollte anhand von Vorabresultaten in Situationen der Praxis überprüft und angeleitet werden. Ein positives Fazit dieses Berichts ist, dass - bis dato - keine offensichtlich *unwirksamen* Maßnahmen zur

[13] 2003/488/EG.
[14] Allgemeine Ausschreibung SANCO/C4/2004/01. (Nr. 2004/S 133-112486 Amtsblatt der Europäischen Union).

Schadensbegrenzung in der Literatur gefunden wurden. Dieser Bericht verwendet die Bezeichnung '*wirksam*', '*wirkungsvoll*' oder '*effektiv*', wenn in der Literatur hinreichende Evidenz dafür gefunden wird. Wenn Nachweise vorhanden aber nicht hinreichend sind, wird die jeweils intendierte Maßnahme zur Schadensbegrenzung als '*vermutlich effektiv*' betrachtet. Eine Maßnahme kann wirksam sein, wenngleich die Nachweislage vorerst unzureichend ist.

Zur Prävention und Behandlung der Verbreitung von Infektionskrankheiten (HIV/ AIDS, Hepatitis B und C) liegen wirksame Maßnahmen vor. Nadel- und Spritzenaustauschprogramme sind vermutlich effektiv (und möglicherweise auch kosteneffektiv) indem sie Risikoverhalten und Infektionskrankheiten verringern, obgleich HIV-Tests und –Beratung auch wirkungsvoll sein können. Wenn diese Maßnahmen übergreifend eingesetzt werden (sodass sie auf verdeckte Drogenkonsumenten in ihrem täglichen Umfeld abzielen) erhöht sich die flächendeckende Wirkung dieser Maßnahmen ebenso wie die Effekte auf Risikoverhalten im Drogenkonsum durch Injektion. Die Kombination von Maßnahmen zur Schadensbegrenzung mit Informations- oder Bildungsstrategien kann die positiven Effekte auf Risikoverhalten beim Spritzen durch Drogenkonsumenten ebenfalls erhöhen.

Methadon- oder Buprenorphingestützte *Erhaltungs- oder Substiturtionstherapien* sind effektiv, wenn sie den Opiatkonsum und das damit in Verbindung stehende Risikoverhalten verringern. Beide Behandlungen sind auch dadurch wirkungsvoll, dass sie Opiatkonsumenten in Behandlung halten. Die Wirksamkeit ist tendenziell höher bei individuell eingestellten höheren Dosen dieser Substanzen und wenn *psychosoziale Maßnahmen* zu diesen Erhaltungstherapieprogrammen hinzu kommen. Die direkteste und wirksamste Maßnahme zu Prävention von Todesfällen durch Überdosis unter Drogenkonsumenten ist Naloxon, allerdings sind oft zusätzliche Aktivitäten erforderlich, um den Erfolg zu erhöhen. Andere Maßnahmen z.B. *Beratung vor der Haftentlassung* sind derzeit noch unzulänglich untersucht. Die Einrichtung von (medizinisch betreuten) *Drogenkonsumräumen* kann möglicherweise eine wirkungsvolle Maßnahme für die Verringerung von gemeinsamer Nadelbenutzung und drogenbedingten Todesfällen sein. Obgleich die verfügbaren Untersuchungen noch ohne abschließende Ergebnissse sind, gibt es auch keine negativen Befunde. Untersuchungen zur Wirksamkeit von *medizinischer Heroinverschreibung* für chronische Opiatkonsumenten zeigen, dass diese Maßnahme wenig schädliche Wirkungen hat. Sie verbessert vermutlich die gesundheitliche Situation derjenigen Drogenkonsumenten, die nicht auf Erhaltungstherapien reagieren und verringert vermutlich auch Vorkommnisse von öffentlichem Ärgernis. Sie erhöht möglicherweise auch die Therapieverbleibrate. Es sind einige aktuelle Studien im Gange, die dazu dienen können, verwertbarere Schlüsse zu ziehen.

Für Haftinsassen kann *Erhaltungs- oder Substiturtionstherapie* ebenfalls eine machbare Behandlungsoption sein, vorausgesetzt, dass während der gesamten Inhaftierungszeit ausreichende Dosierungen ausgeteilt werden. Sowohl Methadon als auch Buprenorphin verringern wirksam injizierenden Drogenkonsum, gemeinsame Nadelbenutzung und die Übertragung ansteckender Krankheiten. Erhaltungsbehandlungen verbessern vermutlich auch den Gesundheitszustand drogenabhängiger Haftinsassen. *Beratung vor der Haftentlassung und Nachsorgemaßnahmen* verhindern Rückfälle nach der Haftentlassung oder Überdosen nach Entzug, jedoch wurden keine Wirksamkeitsstudien zu diesen Themen gefunden. *Nadel- und Spritzenaustauschprogramme in der Haft* wirken vermutlich stabilisierend oder reduzierend auf den Drogenkonsum; sie verringern die gemeinsame Nadelbenutzung und somit die Übertragung ansteckender Krankheiten.

2. Resultate der Empfehlung des Rates

a) Empfehlung 1 - Schadensbegrenzungsdienste als Ziel im öffentlichen Gesundheitswesen

Diese Studie zeigt, dass alle EU-Mitgliedstaaten politische Richtlinien etabliert haben, in denen die Prävention drogenbedingter Schäden im öffentlichen Gesundheitswesen ein Ziel bildet; sechs Mitgliedstaaten gaben an, dass die Empfehlung des Rates ein wesentliches Instrument in diesem Prozeß war. Alle Mitgliedstaaten berichteten, dass die Reduzierung drogenbedingter Schäden ein Ziel im öffentlichen Gesundheitswesen ist; für fünf Mitgliedstaaten hat die Empfehlung des Rates in dieser Hinsicht eine wesentliche Rolle gespielt. In allen Mitgliedstaaten ist Schadensbegrenzung Teil einer nationalen Drogenstrategie oder des Drogenaktionsplans.

b) Empfehlung 2 – Schadensbegrenzungsdienste und -einrichtungen in den Mitgliedstaaten

Tabelle 1.1 gibt zusammendfassend einen vereinfachten Überblick über vorhandene Schadensbegrenzungsdienste und -einrichtungen in den Mitgliedstaaten. Besonders zu beachten ist dabei, dass einige der Maßnahmen (z.B. Nadelaustausch- / Substitutionsbehandlung)

drogenbedingte infektiöse Krankheiten und drogenbedingte Todesfälle verringern. Wie in der Tabelle dargestellt, laufen in einigen Mitgliedstaaten eine Vielzahl von Informations-, Aufklärungs- und Kommunikationsprogrammen. Nadel- und Spritzenaustauschprogramme sind in praktisch allen Mitgliedstaaten vorhanden, ebenso wie ähnliche Dienste, etwa die Verteilung von Injektionsmaterial[15] und Kondomen. Drogenfreie Behandlung[16], Erhaltungs[17]- und Entgiftungprogramme[18] mit Methadon sind in der EU mittlerweile weit verbreitet, wobei die Erhaltungstherapie mit Buprenorphin schnell aufholt. Die Mitgliedstaaten richten große Aufmerksamkeit auf Tests und Screenings sowie auf Behandlung und Schutzimpfung im Zusammenhang mit drogenbedingten infektiösen Krankheiten. Überdosisreaktionsmaßnahmen z.B. indem Naloxon in Krankenwagen standardmäßig zur Verfügung steht, existieren in zwanzig Mitgliedstaaten. Jedoch in nur zehn der Mitgliedstaaten wird das Notfallpersonal ausgebildet, auf Fälle von Drogenüberdosis zu reagieren.

Was Schadensbegrenzung in Haftanstalten anbetrifft, geht aus Tabelle 1.1 deutlich hervor, dass es noch eine beträchtliche Diskrepanz zwischen dem Vorhandensein und der Zugänglichkeit zu Diensten außerhalb und innerhalb von Haftanstalten gibt. Hinsichtlich des Zugangs zu Nadel- und Spritzenaustauschprogrammen in Gefängnissen ist dieser Unterschied am offensichtlichsten.

Insgesamt haben die Mitgliedstaaten, der Empfehlung des Rates entsprechend, politische Richtlinien, Dienste und Einrichtungen zur Schadensbegrenzung angenommen, und zahlreiche Maßnahmen zur Schadensbegrenzung wurden eingeführt. Jedoch gibt es auf der Ebene der Durchführung noch beträchtliche Unterschiede zwischen den Mitgliedstaaten.

Tabelle 1.1 – Überblick über Dienste und Einrichtungen in den Mitgliedstaaten

Maßnahme (Dienst/ Einrichtung)	**Anzahl MS in denen Maßnahme existiert**	**Empf. Nr.**
Prävention von Risikoverhalten		
• ***Information, Aufklärung & Kommunikation (IEC)***		
○ Drogen-Notrufstelle	25	2.1
○ Website	22	2.1
○ Pill-Testing	7	2.1
○ Schulungen für sicheres Injizieren	13	2.1
• ***Aufsuchende Sozialarbeit***	23	2.2
○ Ausbildung von Gleichaltrigen und Freiwilligen	18	2.3
○ Einbeziehung von Gleichaltrigen und Freiwilligen	19	2.4
○ Arbeit in Netzwerken & Zusammenarbeit zwischen Einrichtungen, die Aufsuchende Sozialarbeit leisten	20	2.4
○ Mitarbeiterschulungen	21	2.13
○ Drogenkonsumräume	4	2.6
Prävention von drogenbedingten Infektionskrankheiten		
• ***Nadel- & Spritzenaustauschprogramme außerhalb von Haftanstalten***	24	2.10
▪ innerhalb von Haftanstalten	3	2.8
○ Mitarbeiterschulungen	17	2.13
• ***Verteilung von Injektionsmaterial außerhalb von Haftanstalten***	23	2.10
▪ innerhalb von Haftanstalten	11	2.8
• ***Kondomverteilung außerhalb von Haftanstalten***	23	2.10
▪ innerhalb von Haftanstalten	16	2.8
• ***Tests/ Screenings***	22	2.9
• ***Behandlung (z.B. Hep. C)***	20	2.9
• ***Impfung***		

[15] Der Begriff *Injektionsmaterial* bezieht sich auf die Ausrüstung zur Herstellung, Verabreichung oder dem Verstecken einer illegalen Droge, z.B. Bleichmittel, ein Löffel, Ascorbinsäure, Pfeifen etc.

[16] Drogenfreie Behandlung beinhaltet die Anwendung von psychosozialen und edukativen Techniken, um Langzeitabstinenz von Drogen zu erreichen. Traditionellerweise wird drogenfreie Behandlung stationär und langfristig durchgeführt, z.B. in therapeutischen Wohngemeinschaften. Heute wird sie auch häufig im Umfeld von Gemeindeeinrichtungen angeboten.

[17] In Methadonerhaltungstherapien wird dem Drogenkonsumenten Methadon als Ersatzdroge für Heroin verschrieben, gewöhnlich in einer täglichen Dosis und unter medizinischer Aufsicht. Das Hauptziel von Methadonerhaltungstherapien ist es, die gesundheitliche und soziale Verfassung von Opiatkonsumenten zu stabilisieren, um so eine echte soziale Re-integration zu ermöglichen. In dieser Behandlungsform ist die Verbesserung der persönlichen Situation des Drogenkonsumenten die erste Sorge, und nicht das Ziel, 'clean' zu werden.

[18] Bei der Methadonentgiftung wird dem Drogenkonsumenten ebenfalls Methadon als Substitut für Heroin verschrieben, allerdings wird in dieser Behandlungsform die Methadondosierung schrittweise verringert, so dass der Drogenkonsument langsam entgiftet und 'clean' werden kann.

○ Impfung gegen Hep B für Drogenkonsumenten	20	2.9
○ Impfung gegen TB für Drogenkonsumenten	13	2.9
Prävention von drogenbedingten Todesfällen		
• ***Niederschwellige Dienste***	23	2.6
• ***Substitutionsbehandlung***		
○ Methadonerhaltungstherapien außerhalb von Haftanstalten	24	2.6
▪ innerhalb von Haftanstalten	17	2.8
○ Methadonentgiftungstherapie außerhalb von Haftanstalten	23	2.6
▪ innerhalb von Haftanstalten	19	2.8
○ Buprenorphintherapie außerhalb von Haftanstalten	21	2.6
▪ innerhalb von Haftanstalten	10	2.8
○ Naltrexontherapie außerhalb von Haftanstalten	5	2.6
▪ innerhalb von Haftanstalten	5	2.8
○ Heroinverschreibung außerhalb von Haftanstalten	4	2.6
▪ innerhalb von Haftanstalten	-	2.8
○ Mitarbeiterschulungen	20	2.13
• ***Drogenfreie Behandlung***	25	2.6
• ***Reaktion auf Überdosierung***		
○ Naloxon in der Ambulanz	20	2.11
○ Naloxonverschreibung	6	2.11
○ Mitarbeiterschulungen für medizinische Notfalldienste	10	2.11
Prävention der Abzweigung von Substitutionsstoffen		
• Vorkehrungen zur Prävention von Abzweigung existieren	22	2.7
Integration von Schadensbegrenzung in die gesundheitliche - auch im Bereich der geistigen Gesundheit - und soziale Versorgung		
• Integrationspolitik mit speziellen Strategien zur Risikominderung existiert	23	2.12

c) Empfehlung 3 – Qualitätssicherung, Beobachtung und Evaluierung

Die dritte Empfehlung der Empfehlung des Rates konzentriert sich auf die Unterstützung der Entwicklung einer grundlegenden Infrastruktur für die Entwicklung, das Assessment, die Beobachtung und die Evaluierung der Schadensbegrenzungsdienste und -einrichtungen. Nicht alle Mitgliedstaaten betrachten Qualitätssicherung, Beobachtung und Evaluierung als Aufgabe ihrer Nationalregierung. In den Mitgliedstaaten mit einer Bundes- oder dezentralisierten Struktur werden Aufgaben in diesen Bereichen unter unterschiedlichen Kompetenzebenen aufgeteilt. In anderen Mitgliedstaaten z.B. den Niederlanden und Großbritannien, werden Qualitätssicherung, Beobachtung und Evaluierung als Aufgabe für unabhängige wissenschaftliche Organisationen gesehen.

Die Beispiele der Studien, die in den Länderberichten bezüglich der dritten Empfehlung des Rates dargestellt werden, legen nahe, dass die Mitgliedstaaten als Grundlage zur Auswahl angemessener Maßnahmen weitgehend auf wissenschaftliche Forschung zurückgreifen. Das Augenmerk der Forschung richtet sich dabei hauptsächlich auf die üblichen Schadensbegrenzungsdienste und -maßnahmen, d.h. Niederschwellige Dienste, Substitutionsbehandlung und Nadel- und Spritzentausch. Dennoch scheinen die Mitgliedstaaten noch nicht die Finanzierungsförderungskriterien als Instrument zu gebrauchen, um Qualität und Evaluierung zu fördern. Lediglich Großbritannien berichtet, dass dort als Vorbedingung für die Beauftragung von Projekten eine Bedarfsanalyse erforderlich sei. Einige Mitgliedstaaten entwickeln noch Qualitätssteuerungsmodelle für Schadensbegrenzungsmaßnahmen, einschließlich der Entwicklung von Evaluierungsprotokollen und -kriterien. Mitgliedstaaten wie Luxemburg und Dänemark haben Computererfassungssysteme erstellt, in denen Details zu Programmen und Maßnahmen erhoben werden.

Die Mitgliedstaaten haben politische Maßnahmen ergriffen, um die fünf epidemiologischen Schlüssel-Indikatoren der EBDD einzuführen, aber auf operationaler Ebene stimmen nicht alle Mitgliedstaaten völlig mit den EBDD-Standards für diese Schlüssel-Indikatoren überein. Die EBDD versorgt die Mitgliedstaaten mit Feedback zur Qualität dieser und anderer Datenerfassungen und Berichte.

Alle EU-Mitgliedstaaten haben eine nationale Drogenstrategie, einen Drogenaktionsplan oder andere Dokumente einer umfassenden Drogenpolitik entwickelt, in denen Schadensbegrenzung als Teil der Drogennachfragereduzierung integriert wurde. Diese politischen Richtlinien unterstreichen in zunehmendem Maße die Notwendigkeit der Evaluierung von Maßnahmen und Programmen. Dennoch berichten lediglich eine begrenzte Anzahl von Mitgliedstaaten über Beispiele von Evaluierungskonzepten, die so entworfen sind, dass sie die Politik informieren. Es scheint, dass die Evaluierungskultur in den nordwestlichen Ländern Europas, d.h. in Mitgliedstaaten wie dem Vereinigten Königreich, den Niederlanden, Luxemburg und Deutschland gut entwickelt ist.

Die Stärkung einer Evaluierungskultur durch Training der Mitarbeiter und durch die Einbeziehung der Beteiligten in Evaluierungsprozesse, bedarf noch der Aufmerksamkeit für die Mitgliedstaaten. Letztendlich besteht eine Menge Zusammenarbeit im Bereich der Drogennachfragereduzierung und - in geringerem Ausmass – in der Schadensbegrenzung. Zusätzlich zu EU-finanzierten, multilateralen Programmen (Twinning, öffentliches Gesundheitswesen, Knotenpunkt-Kollaborationen), führen die Mitgliedstaaten auch bilaterale Kollaborationsprogramme durch.

3. Schlußfolgerungen und Vorschläge für weiteres Vorgehen

- Die Empfehlung des Rates vom 18. Juni 2003 war erfolgreich, insofern sie die Politikentwicklung in den Mitgliedstaaten unterstützte und anleitete, und weil sie einen 'Bezugswert' für die vorhandene Politik aufstellte. In großem Umfang führten die Mitgliedstaaten Politik, Dienste und Einrichtungen ein, die den Empfehlungen in der Empfehlung des Rates entsprechen. Es ist noch zu früh, die Auswirkungen der Empfehlung des Rates auf Politik, Dienste und Einrichtungen in den Mitgliedstaaten vollständig einzuschätzen.
- Die verfügbaren Daten zur Verfügbarkeit von Diensten und Einrichtungen zur Schadensbegrenzung in den Mitgliedstaaten, auf EU-Niveau zusammengetragen und verbreitet durch die EBDD, sind umfassend und von hoher Qualität und - ausgenommen möglicherweise Länder wie Australien und Kanada - vermutlich außerhalb der europäischen Union unerreicht. Dennoch bedarf die Qualität der Datenerfassung zur Verfügbarkeit und Zugänglichkeit von Diensten und Einrichtungen zur Schadensbegrenzung auf nationalem Niveau noch der Verbesserung. Die Mitgliedstaaten haben häufig noch keinen umfassenden Überblick, ob, durch wen und wie diese Dienste und Einrichtungen benutzt werden.
- Generell sind Dienste und Einrichtungen zur Schadensbegrenzung als eine der möglichen Ansätze, auf Problemdrogenkonsum zu reagieren, in allen Mitgliedstaaten allgemein üblich, wenn auch in geringerem Ausmass in Zypern und Schweden. Insgesamt korrespondiert die Politik der Mitgliedstaaten der Europäischen Union mit den in der Empfehlung des Rates reflektierten Empfehlungen. Dennoch liefern die vorhandenen Daten, die weitgehend von den Mitgliedstaaten selbst berichtet werden, einen Überblick über die Verwendbarkeit von Diensten und Einrichtungen in den Mitgliedstaaten, nicht aber ein vollständiges Bild der Zugänglichkeit und/oder der Reichweite dieser Maßnahmen. Allgemein sind diese Daten häufig auf nationaler Ebene nicht vorhanden.
- Die Mitgliedstaaten könnten erwägen, die Organisation einer weiteren Verknüpfung von Risikominderung und gesundheitlicher, psychologischer und sozialer Versorgung und Gesundheitspolitik mit grösserem Nachdruck zu verfolgen, mit dem Ziel, Drogenkonsumenten langfristig realistische und nachhaltige Ausstiegsoptionen zur Verfügung zu stellen. Die Integration der Schadensreduzierung im Rahmen des öffentlichen Gesundheitswesens einschließlich gesundheitlicher, psychologischer und sozialer Versorgung ist vom großen Wert, da ein integriertes System abhängigen Drogenkonsumenten die besten Möglichkeiten gibt, ihre soziale und gesundheitliche Situation zu verbessern und ihre Wiedereingliederung in der Gesellschaft zu erleichtern.
- Schadensbegrenzung scheint ein akzeptierter Ansatz im Rahmen der Drogennachfragereduzierung in der Politik aller EU-Mitgliedstaaten zu sein. Die Maßnahmen zur Schadensbegrenzung, die in den meisten Mitgliedstaaten eingeführt sind (Information, Aufklärung & Kommunikation, Nadel- u. Spritzentausch, Erhaltungstherapie, Verwendung von Naloxon) werden in der wissenschaftlichen Literatur als vermutlich wirkungsvoll oder wirkungsvoll beurteilt, besonders wenn sie innnerhalb eines integrierten Versorgungssystems zur Schadensbegrenzung kombiniert werden. Bis jetzt sind bei keiner der ausgewerteten Hauptmaßnahmen zur Schadensbegrenzung Ineffektivität oder unerwünschte oder nicht wünschenswerte Effekte gefunden worden.
- Die meisten Schadensbegrenzungsprogramme in den EU-Mitgliedstaaten konzentrieren sich hauptsächlich auf `traditionelle' Drogenkonsum-Muster, besonders auf Opiatabhängigkeit. Maßnahmen, die neue Tendenzen in der Drogenabhängigkeit (z.B. Crack-Kokain- und Amphetamiminabhängigkeit) sowie die wachsende Prävalenz von Mischkonsum legaler und illegaler Drogen in Betracht ziehen, sind noch selten.
- Auf dem Niveau der Mitgliedstaaten ist die Datenerfassung bezüglich der Problemdrogenkonsumenten und drogenbedingter Gesundheitsschäden noch nicht immer vergleichbar, bedingt durch unterschiedliche Einschätzungsysteme auf lokalem Niveau. Ausserdem könnte mehr Gewicht auf die Prävalenz drogenbedingter Schäden in Bezug auf die spezifischen Risikogruppen in den Mitgliedstaaten gelegt werden, anstatt sie in Relation zur allgemeinen Bevölkerung zu setzten. Mitgliedstaaten mit verhältnismäßig kleinen Gruppen von Problemdrogenkonsumenten können dennoch eine hohe Prävalenz von drogenbedingtem Schäden aufweisen, wie etwa Infektionskrankheiten bei diesen Problemdrogenkonsumenten.

Obgleich die Zahl der Problemdrogenkonsumenten verglichen mit der allgemeinen Bevölkerung klein sein kann, kann die Prävalenz drogenbedingter Schäden beträchtlich sein.

- Wissenschaftliche Evidenz von Wirksamkeit ist für viele Schadensbegrenzungsmaßnahmen vorhanden. Diese allgemeine Schlußfolgerung ist höchst vielversprechend, da Effektstudien in solchen Settings manchmal schwer durchzuführen sind. Die Umstände, unter denen Schadensbegrenzungsmaßnahmen eingeführt werden, nehmen kaum ein Kapitel in Untersuchungen mit unterschiedlichen Maßnahmenregulationen ein, nicht zuletzt aufgrund ethischer Gründe. Es ist wichtig, dass Innovationen in der Schadensbegrenzung auf Pragmatismus und den lokalen oder regionalen Konstruktionen von 'best-practice' beruhen dürfen. Nach einer Erprobungsphase ist es manchmal möglich, über hochwertige Effektstudien Nachweise für spezifische Maßnahmen zu erfassen.
- Schließlich existiert auf EU-Niveau und bei den Mitgliedstaaten ein zunehmendes Bewußtsein der Notwendigkeit, Politik auf Forschung und Fakten zu begründen, einschließlich der Schadensbegrenzungspolitik. Diese Notwendigkeit wird durch die dritte Empfehlung des Rates, aber auch in der europäischen Drogenstrategie 2005-2012 und im EU-Drogenaktionsplan von 2005-2008 reflektiert.

Acknowledgements

The authors of this report would like to thank all people that contributed in any way to the development of this report, especially the external experts as well as all the organisations and structures that have contributed to the contents of this report, including service providers, drug user organisations and other organisations and individuals working in the field of prevention and reduction of health-related harm associated with drug dependence.

This report could not have been written without the substantial input and support provided by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the Reitox network of National Focal Points. Although the EMCDDA is one of the main data providers of this report, especially for the country profiles in Annex 2, the Trimbos Institute is responsible for the overall report, its conclusions and recommendations.

We want to express special thanks to Ms Dagmar Hedrich, project manager harm reduction, treatment and social reintegration, who provided high quality information, data and advice throughout the project, as well as to her colleagues that contributed to specific sections in this report.

Special thanks are also expressed to Ms Natacha Grenier (EC, DG SANCO) and Ms Elsa Maia (EC, DG JLS) who offered coordination as well as advice and feedback throughout the project. The authors would also like to thank the representatives of the EU Member States who contributed to this report by providing information through the EC reporting tool. Finally, the authors wish to thank the in-house experts at the Trimbos Institute and Foundation Mainline for their advice and support in writing this report.

Maurice Gallà, project coordinator
Utrecht, December 2006

1. Introduction

On the 18th of June 2003, the Council of the European Union adopted a Recommendation on the prevention and reduction on health-related harm associated with drug dependence[19], hereafter referred to as 'The Council Recommendation'. With the adoption of the Council Recommendation, the Council of the European Union recognised the importance of developing responses and strategies to prevent and reduce drug-related harm. Since it is a Recommendation, it does not contain binding regulations for the EU Member States.

The Council Recommendation consists of the following main recommendations:

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 develops and implements comprehensive strategies accordingly.*
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;*
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.*
4. *Member States should report to the Commission on the implementation of this Recommendation within two years of its adoption and subsequently on request by the Commission with a view to contributing to the follow-up of this recommendation at Community level and acting as appropriate in the context of the European Union Action Plan on Drugs.*

Recommendations 1 and 3 have an emphasis on drug policy development and implementation, while Recommendation 2 represents the key-activities Member States were asked to develop and implement. Recommendation 2 and 3 include 13 and 9 sub recommendations. Recommendation 4 concerns the inventory to which this report contributes and that is planned to be completed by the European Commission, such in line with planning of the EU Action Plan on Drugs 2005-2008. In annex 5 the full text of the Council Recommendation can be found.

The Council Recommendation calls upon the Member States to report to the Commission on its implementation within two years after its adoption. Following an open call for tenders the Commission decided to enlist[20] the services of the Trimbos Institute to collect and analyse the basic information for a Commission report in accordance with the EU Action Plan on Drugs 2005-2008. This analysis included the information submitted by the Member States to the Commission and to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Furthermore, the Trimbos Institute was asked to include an overview of the latest scientific evidence on harm reduction and formulate advice for any follow-up of the Council Recommendation. These activities were planned in close collaboration with and by making use of technical support of the EMCDDA.

This report presents the outcome of the preparatory work. In *Chapter 2,* a brief introduction is provided in the epidemiological state-of-affairs regarding drug-related infectious diseases and drug-related deaths in the European Union.
In *Chapter 3*, the approach and methodology for the development of this report is presented.
In *Chapter 4*, a summary of available scientific evidence regarding the effectiveness of harm reduction services and facilities in provided.
Chapter 5 provides an overview of the state-of-play of policies and activities in the field of prevention and reduction of health-related harm association to drug dependence in the EU Member States, following the structure of the Council Recommendation.
In *Chapter 6* conclusions have been drafted based on the overview presented in this report.
In *Chapter 7* suggestions for future development have been formulated. The details on the situation in the Member States as well as more extensive information on evidence and special issues can be found in the Annexes to this report.

In *Annex 1,* a review of the scientific literature regarding the effectiveness of interventions in the field of harm reduction is presented.
In *Annex 2*, country-by-country reports on the state-of-play regarding the Council Recommendation for each of the 25 EU Member States can be found.

[19] 2003/488/EC.
[20] General invitation to tender SANCO/C4/2004/01 (OJ 10/7/2004 – 2004/S 133-112486).

In Annex 3 attention is paid to four 'special' issues that are often debated in the field of harm reduction (harm reduction in prisons, drug consumption rooms, pill testing and heroin prescription).
Annex 4 includes a list of field organisations in the Member States that provided information to this report.
Annex 5 includes the full text of the Council Recommendation.
Annex 6 contains a list of abbreviations.
Finally, *Annex 7* includes a glossary for the terminology that is used in this report.

2. Epidemiological situation

The title of the Council Recommendation - *prevention and reduction of health-related harm associated with drug dependence* - suggests that it mainly covers harm reduction efforts that prevent drug dependence or reduce the risks associated with it. However, its sub-recommendations reflect a wider scope. In this report we have interpreted the content of the Council Recommendation in such a way that it reflects key harm reduction services and facilities related to problem drug use and acute health risks related to drug use. Given the health oriented focus of the Council Recommendation, other issues related to drug use, such as social related harms and cost-effectiveness of harm reduction, are not covered by this report

The EMCDDA has defined problem drug use operationally as 'injecting drug use' or 'long duration/ regular use of opiates, cocaine and/ or amphetamines'.[21]. A large part of problem drug users, especially when opiates are concerned, is drug dependent[22]. Problem drug users have a high-risk to develop drug-related infectious diseases or suffer from drug overdose with a high risk of mortality. However, there are other forms of health-related harm associated with drug use, such as the consumption of ecstasy that is polluted with dangerous chemicals that induce acute health risks, such as atropine. And the term drug-related harm is also applicable if a first time injecting drug user shoots up an overdose of heroin s/ he is not dependent but the health-related harm may be considerable.

2.1 Preventing and reducing drug-related harm

Harm reduction aims to influence the mediating factors that increase the risk of drug-related health and social harm and mental disorders. These factors include risk behaviours, settings and circumstances that increase the existing risk of health- and social harms associated to drug use. Roughly, drug-related harms can be divided into two types as presented underneath.

2.1.1 Drug-related Infectious Diseases

The main drug-related infectious diseases that are associated with problem drug use are HIV/ AIDS infections, infections with the hepatitis B virus, the hepatitis C virus and tuberculosis (TB). In the long-run, these diseases may be life-threatening. HIV/ AIDS suppress the immune system, with the result that the drug user becomes susceptible to a wide range of infections and other disorders. Hepatitis B and C are serious liver diseases that can result in liver cirrhosis and carcinoma. Tuberculosis is a contagious lung-disease, impairing the lung-functions and that – if remained undetected - may cause a community outbreak of the disease, even in vaccinated populations.–Both short- and long term health effects of these drug-related infectious diseases are generating costs for society, especially if not treated in time. As they are transmissible to the general population (through family, friends, health care professionals, etc.) there is also serious concern for public health. Finally, these diseases are sometimes difficult to treat and cure is not always possible. Different strains of the hepatitis C virus exist which do not react equally to treatment. The progression of AIDS can be stopped, but the disease cannot be cured. So from a public health perspective it is important to place emphasis on the prevention of these drug-related infectious diseases.

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[21] EMCDDA definition of problem drug use: "Injecting drug users" or "long duration/ regular use of opiates, cocaine and/ or amphetamines", EMCDDA [1999]. Methodological guidelines to estimate the prevalence of problem drug use at national level. CT.99.RTX.05, Lisbon, Portugal.

[22] Drug dependence is often defined as (DSM-IV): a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time within a 12-month period. **(1)** Tolerance, as defined by either of the following: (a) need for markedly increased amounts of the substance to achieve intoxication or desired effect; (b) markedly diminished effect with continued use of the same amount of the substance. **(2)** Withdrawal, as manifested by either of the following: (a) the withdrawal characteristic for the substance (refers to Criteria A and B of the criteria sets for withdrawal from the specific substances; (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms; **(3)** the substance is often taken in larger amounts or over a longer period than was intended; **(4)** there is a persistent desire or unsuccessful effort to cut down or control substance use; **(5)** a great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use of the substance (e.g. chain-smoking), or recovering from its effects; **(6)** Important social, occupational or recreational activities are given up or reduced because of substance use; **(7)** the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

2.1.2 Drug-related Deaths

Drug use may also cause death. Drug-related death[23] is defined in this report as: *death caused directly by the consumption[24] of one or more drug(s) and which generally occurs shortly after the consumption of the substance(s). These deaths are known as 'fatal overdoses', 'poisonings' or direct drug-induced deaths.* In the EU the exact definition of drug-related death has been debated a lot, as Member States tend to have different registration criteria. However, the development and implementation of a drug-related death standard by the EMCDDA, which defines the definition for direct drug-related death, has improved standardised data-collection at EU level[25]. Apart from direct drug-related deaths, there are also indirect drug-related deaths.

2.1.3 Special 'at risk' groups

With regard to these two major types of drug-related harm special attention should also be paid to specific 'at risk' groups. These groups include first-time users (who may e.g. inject drugs incorrectly and/ or are unaware of lethal doses) but also drug users in prison. In the literature review (annex 1) attention is paid to harm reduction in prisons. Furthermore, also in Chapter 5, a special section has been included on harm reduction in prisons.

2.2 Magnitude of the problem

In the majority of EU countries, heroin has historically accounted for most problem drug use in the EU countries, with the exception of Finland and Sweden (amphetamine) and the Czech Republic (methamphetamine)[26].

Table 2.1 – Estimated cases of problem drug use per 1000 inhabitants *(Source: EMCDDA, 2006)*

Cases per 1000 inhabitants (aged 15-64 years)	
< 4	Germany, the Netherlands, Poland
4 to 7	Belgium, Cyprus, Czech Republic, Estonia, Greece, Finland, France, Hungary, Lithuania, Latvia, Malta, Sweden, Slovakia, Slovenia
6 to 10	Denmark, Spain, Ireland, Italy, Luxembourg, Austria, Portugal, UK

Table 2.1 presents the estimated prevalence of problem drug use among the European population. It is estimated that on average there are 4-7 problem drug users per 1000 inhabitants aged 15-64 years. This results in estimation that there are 1.2-2.1 million problem drug users in the EU. 850.000 to 1.3 million of these persons are injecting drug users (IDUs). In countries such as the Netherlands, Portugal and Spain, the number of IDUs among the problem drug user population is relatively low, in other EU countries this type of use is the norm[27].

2.2.1 Prevalence of drug-related infectious diseases

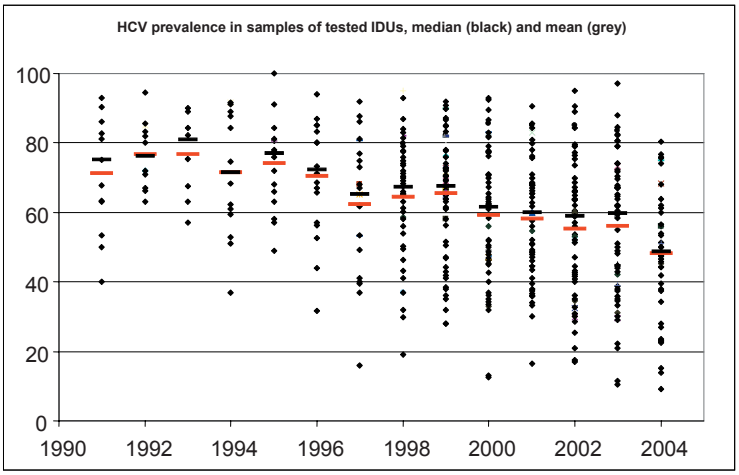
The seroprevalence of HIV in IDUs varies per country, with the highest national estimates found in Italy, Latvia and Portugal (>10% [2002/ 2003])[28]. There are also big variations within countries, even at a local level. The prevalence of antibodies against hepatitis C is in general very high among injecting drug users in the EU. Local prevalence rates of over 60% [2002/ 2003] are reported from Belgium, Estonia, Greece, Italy, Poland, Portugal and Norway. There are indications that the prevalence rate of hepatitis C among tested IDU in the EU seems to decline somewhat[29], but the conclusion can not be drawn that the problem is decreasing. Prevalence rates may vary a lot from location to location (*see figure 2a*). Hepatitis B prevalence also varies within and between countries[30]. IDU samples with prevalence rates of over 60% [2002/ 2003] were reported from Belgium, Estonia and Italy. It must be noted that the collection of data on drug-related infectious diseases is a point of attention in Member States. Prevalence data are usually based on many different and varying data sources that use different estimation and/ or measurement techniques. As a consequence these data are not always easy to compare.

[23] EMCDDA [2006]. Annual Report 2005, p. 69.
[24] Inhaling, injecting, smoking, eating, etc..
[25] EMCDDA [2002]. The DRD-Standard, version 3.0; EMCDDA standard protocol for the EU Member States to collect data and report figures for the Key Indicator Drug-Related Deaths by the Standard Reitox tables; EMCDDA project CT.02.P1.05. Lisbon, Portugal.
[26] EMCDDA [2006]. Annual Report 2005, p. 60-61.
[27] EMCDDA [2006]. Annual Report 2005, p. 60-61.
[28] EMCDDA [2006]. Annual Report 2005, p. 65.
[29] EMCDDA [2006]. Preliminary outlook Annual Report 2006.
[30] EMCDDA [2006]. Annual Report 2005, p. 66.

2.2.2 Number of drug-related deaths

Member States in the EU have reported that on average 7.000-9.000 deaths related to overdose occurred per year in the period of 1990-2002. These data reflect acute drug-related deaths. Indirect drug-related deaths are not included in these numbers[31].

Figure 2a: HCV prevalence in samples of tested IDUs in the EU



NB: Data from all countries and all studies available. Small bar indicates the median, large bar the average value (not weighted for sample size, to avoid very large samples from some geographic regions to dominate). This analysis does not take account of changes in data availability over time from different geographic areas or different settings or measurement methods (diagnostic testing or seroprevalence studies), nor of the fact that some data points are single measurements (mostly prior to 1996) and many are part of time series (after 1996). Thus it cannot be concluded that the apparent decline is real. However it shows that over time the number of samples available strongly increases and that in those samples average and median prevalence decreased, either through selection bias or a real decrease or both.

Source: EMCDDA, Annual Report 2006.

2.2.3 Special groups: drug users in prison

Imprisonment often causes a disruption of care for drug dependent users. Studies conducted in the EU[32] show that about one third of adult male prisoners were drug injectors at the time of entry to the prison system. These outcomes seem to be substantiated by National Focal Point (NFP) data that show that between 0.2% and 34% of inmates have injected drugs while in prison[33]. Due to the lack of preventative measures, infectious diseases may spread among inmates and outside prison (after release). Organisations like UNAIDS[34] are concerned about the lack of harm reduction measures inside prisons and reiterate that there is an estimated turn-over of 30 million prisoners to and from penitentiaries worldwide every year. In the EU it is estimated that 50-100 per 100.000 inhabitants are imprisoned in a year (app. 250-450.000 prisoners)[35]. This entails that society (families, communities) outside prison is at risk if preventative measures remain unavailable.

2.3 Conclusion

Drug use can cause serious health-related and social harms in drug users and the general population as a whole. The numbers of drug-related infectious diseases and drug-related deaths in the European Union are substantial. Investing in improved monitoring systems, prevention and reduction of these health-related harm makes sense from a public health perspective. The situation regarding problem drug use is different from country to country. Harm reduction measures require a tailor made approach for local situations, as the patterns of drug use, the harms associated with it and therefore the need for interventions differs accordingly.

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[31] Indirect drug-related deaths may include: long-term illness due to a drug-related infectious disease, traffic accidents (under the influence of substances), deaths due to bad living circumstances of drug dependent users (e.g. among the homeless).
[32] Bird and Rotily, 2002; in: EMCDDA, Annual Report 2005, p. 81.
[33] EMCDDA [2006]. Annual Report 2005, p. 81.
[34] UNAIDS [2006]. Report on the Global Aids Epidemic, p. 118-122.
[35] WHO/ Pompidou group [2005]. Status Paper on Prisons, Drugs and Harm Reduction, p. 6.

3 Methodology, approach and justification

3.1 Introduction

This study provides a baseline overview on existing policies, services and facilities that exist in the field of harm reduction within the EU Member States. It also includes a summary of available scientific evidence on the effectiveness of harm reduction interventions. The Council Recommendation calls for a report on its implementation by the Member States by June 2005. This entails that the reporting period on the implementation of the Council Recommendation covers a period of 1.5 to 2 years at maximum. This period is short to measure the influence of the Council Recommendation on national harm reduction policies. It does provide a baseline overview of harm reduction policies, services and facilities in the Member States.

In order to provide a good overview of the actual state-of-play regarding the field of harm reduction, this preparatory work includes an inventory of the *existing* policies, services and facilities in the field harm reduction in all 25 EU Member States.

3.2 Tasks performed in development of this report

In preparation to the development of this report, the following activities have been carried out:

1. An overview has been established regarding the question on how the Council Recommendation has been implemented in the EU Member States since 18 June 2003 and what policies and services and facilities covered by the Council Recommendations exist within the Member States. This overview was created by:
   a. The development of a reporting tool. The European Commission disseminated the reporting tool to the Permanent Representatives of the Member States and also distributed it to the Council Health Working Group and the Horizontal Working Party on Drugs, inviting them to provide details on the implementation of the Council Recommendation following the request from the European Commission.
   b. Data referring to the thematic fields in the Council Recommendation was extracted and analysed, primarily from data sources available at the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), and from other sources including the WHO, Pompidou Group, UNAIDS and field organisations[36] in the Member States.
   c. The information on harm reduction services and facilities at the level of the EU Member States was subsequently sent back to the Reitox National Focal Points with the request to correct possible mistakes or misunderstandings, to add missing information and/ or to provide an update on new events. The information that was returned by the Focal Points was processed and returned a second time for final approval.
2. A literature review has been conducted to identify, appraise and summarise scientific evidence on harm reduction interventions and approaches, including those aimed at preventing drug-related infectious diseases and drug-related deaths.
3. On the basis of the collected data and the identified scientific evidence, conclusions and suggestions have been formulated that aim to contribute to the future development and implementation of harm reduction policies, services and facilities within the European Union.

In contrast to the expectations at the beginning of the project, the level of data and information that was available on the three recommendations was both of good quality and abundant. In a few cases only, information was not available because national respondents indicated that interventions or policies did not exist.

3.3 Data collected for this report

Throughout the process of producing this report a wide range of data sources have been consulted with the aim to obtain a comprehensive picture on the state-of-play in harm reduction in the EU Member States as well as on the available evidence from scientific literature. Table 3.1 provides a short overview of the most important data sources used.

[36] These organisations include service providers such as Mainline (NL), A-Clinic Foundation (FI), Abraçao (PT), Stigma (SI), but also drug user organisations such as Brugerforeningen (DK) (See Annex 3).

3.3.1 Reporting tool to the Member States (abbreviated as [RT])

The reporting tool was developed by the Trimbos Institute based on a design provided by the European Commission. The reporting tool was disseminated by the European Commission to the PR of the Member States and also distributed to the Council Health Working Group and the Horizontal Working Party on Drugs. By the end of 2005, 24 Member States had replied.

The reporting tool consistently asked two questions for each of the (sub-) recommendations of the Council Recommendation: "*Does this policy exist in your country* (reflecting the recommendation [Ed.])"; and "*Was this policy based on the Council Recommendation?*" Member States had the opportunity to add comments on each (sub-) recommendation. As Annex 2 shows, Member States made use of this opportunity and included comments. The last completed questionnaire was received in February 2006.

3.3.2 National Reports to the EMCDDA (abbreviated as: [NR (year)])

Annually, the Reitox National Focal Points submit a National Report to the EMCDDA, reflecting on the state of affairs regarding drugs in their country. The information in these reports is presented in a comparable format, with a great number of predefined topics that also include measures in the field of harm reduction. All National Reports that have been submitted to the EMCDDA for the years 2002-2004 have been screened for information on policies and services and facilities regarding the prevention and reduction of health-related harm associated with drug dependence[37].

3.3.3 Other EMCDDA data sources

Overall, it can be said that the EMCDDA data sources regarding drug demand reduction in general and harm reduction in particular are very extensive and among the most comprehensive in the world. The efforts that have been undertaken in the past 5-10 years to harmonise and improve the quality of data collections in the Member States seem to have paid off.

The EMCDDA annually collects information from the EU Member States through a series of Standard Tables which are used for its Annual Report. In addition, the EMCDDA also gathers data through Structured Questionnaires that are used to gather in-depth information on specific themes.

After the adoption of the 2003 Council Recommendation, the EMCDDA has developed special reporting tools to collect data and information on Member States' policies, services and facilities in the field of harm reduction. Two structured questionnaires (23 and 29) were designed to collect information on the key topics reflected in the Council Recommendation. In 2004 Structured Questionnaire 23 on Drug-related Infectious Diseases was sent out to the EU Member States. This questionnaire incorporated a number of questions that matched directly with themes in the 2nd recommendation of the Council Recommendation. In 2005 Structured Questionnaire 29 on Drug-related Deaths was sent out to the Member States, containing in-depth questions on this theme and covering elements of the 2nd and 3rd recommendation of the Council Recommendation. All Member States returned the two questionnaires[38]. The data of these two questionnaires was made available for this project. Regarding the 3rd recommendation of the Council Recommendation, in the 2002 issue of the National Reports to the EMCDDA special attention was paid to evaluation and quality issues, be it not specifically focused on harm reduction.

Apart from the very rich information collected by analysing the National Reports to the EMCDDA and the two structured questionnaires mentioned above, additional information was found in Standard Table 10 (part of standard report format) and in the European Legal Database on Drugs (ELDD). In 2005, the information available through the Exchange on Drug Demand Reduction Action (EDDRA) database was analysed. EDDRA contains hundreds of projects in the field of drug demand reduction. Analysis of the available information showed that the database contained a limited number of projects in the field of harm reduction, but that the nature and relevance, reliability and comprehensiveness of the information was not suitable for the purpose of this inventory report. EMCDDA is discussing a re-engineering of the EDDRA projects database.

In addition to these 'raw' data sources, other EMCDDA information sources were consulted, including the EMCDDA Annual Reports on the State of Drug Affairs in the EU, the Policy Briefings "Drugs in Focus", the EMCDDA Monographs[39] and Insights[40] publications.

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[37] National Reports were available for the years 2002-2003-2004 from all 25 EU Member States, with the exception of the following: Cyprus (only 2004 available), Latvia (2003, 2004), Lithuania (2003, 2004), Malta (2004), Poland (2003, 2004) and Slovakia (2004).

[38] Cyprus and Slovakia did not answer (all) the questions in Structured Questionnaire 29.

[39] E.g. Monograph nr. 4, "Understanding and responding to drug use: the role of qualitative research".

Table 3.1 – Overview of data sources used

Council Recommendation	Data source EMCDDA	Other
Recommendation #1	• National Reports to the EMCDDA 2004 • Structured Questionnaire 23 (2004) • Structured Questionnaire 29 (2005) • European Legal Database on Drugs	• Reporting tool to Member States (2005) • Consultation of national drug strategies/ action plans
Recommendation #2	• National Reports to the EMCDDA 2002-2004 • Structured Questionnaire 23 (2004) • Structured Questionnaire 29 (2005) • Standard Table 10 • European Legal Database on Drugs • EDDRA	• Reporting tool to Member States (2005) • Feedback from National Focal Points (2006) • Questionnaire to field organisations (2006) • Document analysis • DG SANCO projects website/ CORDIS • CEEHRN/ IHRA database & website
Recommendation #3	• National Reports to the EMCDDA 2002-2004 (emphasis on 2002) • Structured Questionnaire 29 (2005)	• Reporting tool to Member States (2005) • Follow-up questions to policy makers and/ or consultation of national drug strategies/ action plans
Literature review	**Primary sources: databases & literature searched**	**Secondary sources**
Drug-related Infectious Diseases; Drug-related Deaths; Other harm reduction interventions (e.g. Prisons, Pill Testing)	• Medline (PubMed) • Embase • PsycInfo • Toxline • Peer-reviewed journals	• UNAIDS • WHO, incl. Health Evidence Network (HEN) • Policy briefings (EMCDDA) & unpublished (overview) reports • Cross references in existing literature • Harm reduction guideline documents • Suggestions from experts

3.3.4 Other sources of information

Between November 2005 and May 2006, information sources, reports and databases other than available at the EMCDDA were identified and analysed[41]. This search did not result in an abundance of suitable information for this report. There are project- and research publications available on (specific) harm reduction interventions[42]. But these publications generally did not provide the scope and overview that was required vis-à-vis the recommendations in the Council Recommendation.

The DG SANCO website contains references to projects funded by the 'Programme of Community Action on the Prevention of Drug Dependence[43]' (1996-2002) and the 'Programme on Community Action in the field of Public Health' (2003-2008)[44]. Many of the recent DG SANCO funded projects dealing with drug prevention and risk reduction are also registered in the EDDRA database of the EMCDDA. These projects did not provide systematically collected information on the state-of-play in the Member States. They were not research projects and as such did not provide scientific evidence on harm reduction interventions. The Commission's CORDIS[45] website contains references to R&D projects funded under the European 4th, 5th and 6th Framework Programmes for Research and Technological Development. Although these Framework programmes fund many R&D projects in the EU, the thematic field of (illicit) drugs and addiction includes less than a dozen projects,

[40] E.g. Insights nr. 2-3-4 on resp. Outreach Work (2), Drug Substitution Treatment (3) and Injecting Drug Use, Risk Behaviour and Qualitative Research (3).

[41] Other sources included the DG SANCO projects' website, the WHO HEN database, the IHRA literature database, reports and publications of UNAIDS, CEEHRN and individual study reports.

[42] E.g. Engelhardt, J. [2006]. 'Living with the Daily Dose – Comparing National policies and practices to improve access and adherence of HIV-infected drug users to Anti-retroviral treatment. Mainline, The Netherlands; Stöver, H. , L. Hennebel, J. Casselman [2004]. 'Substitution Treatment in European prisons: a study of policies and practices of substitution treatment in prisons in 18 European Countries'. ENDHASP, UK.

[43] The programme of Community action on the prevention of drug dependence within the framework for action in the field of public health, adopted by decision N° 102/97/EC of 16/12/96 of the European Parliament and of the Council, OJ L 19, 22.1.1997, p. 25, was extended by DECISION No 521/2001/EC of the European Parliament and of the Council of 26 February 2001 (cf. Decision extending certain programmes of Community action in the field of public health - Official Journal L 79, 17.03.2001).

[44] Adopted by Decision No. 1786/2002/EC of the European Parliament and of the Council of 23 September 2002; OJ L 271, 09/12/2002, p. 1-12.

[45] CORDIS – Community Research & Development Information Service (http://cordis.europa.eu).

mainly concerning fundamental research (genomic studies on i.e. addiction & brain disease and on immunology & viral disorders induced by injecting drug use). Two projects were found that directly focus on harm reduction related areas[46]. Where relevant, the outcomes of these studies have been included in the literature review. Other information providers like the WHO have developed information resources such as the Health Evidence Network (HEN), the contents of which is largely based upon scientific literature available through the primary scientific databases (see table 2.1) that were searched for the literature review in this report. Where specific country information was provided, this information did not add to the in-depth information covered by the National Reports of the Reitox National Focal Points or the information itself originated from EMCDDA data sources.

Some interesting studies were found. One of these studies concerns the Casselman, Hennebel & Stöver report on substitution treatment in prisons, which provides an overview regarding the prison situation in eighteen countries (14 EU Member States (<2004), Poland, Czech Republic, Slovenia and Scotland)[47].

3.3.5 Field organisations

In order to obtain additional perspectives to the EMCDDA data sources, a limited query was set out among field organisations and national harm reduction networks (see Annex 4 for list of organisations). These stakeholders have a leading position in the field of harm reduction in their country and were selected by consultation of network partners of Trimbos Institute and Mainline (i.e. Rezolat). Following this consultation, a final list of organisations and experts was drafted through a 'snowball' process. Ultimately, information was received back from sixteen organisations in the Member States. Not for all Member States a leading harm reduction organisation could be identified. The field organisations did not receive any (country specific) information gathered throughout the project, but were sent a standardised query with questions on their assessment of the main services and facilities in the field of harm reduction in their country. The information gathered through this query has been included in the country reports. It provides additional information to the country reports, but is not suitable for comparison at European level. The information has a special focus on coverage and accessibility of harm reduction interventions.

3.4 Remarks on the information gathered for this report

The main sources of information used in this report concern self-reported data from the EU Member States. The reliability and accuracy of this data provided by national correspondents at policy level and by Focal Points has not been assessed as the assignment of this report was not to *evaluate* harm reduction policy and practice in the EU Member States but to make an inventory what policies and services and facilities exist and to what extent these have been inspired by the Council Recommendation.

The self-reported data Member States present in their National Reports and in the questionnaires and standard tables to the EMCDDA are collected according to agreed definitions and data collection methods. Regarding prevalence data, this mainly concerns estimations. National estimates on problem drug use are produced by making use of the agreed definition on problem use[48]. In recent years, the EMCDDA and the Reitox National Focal Points have invested in improving and standardising the methodology on national estimates. Estimation methods are based on applying multipliers from police data, treatment data, mortality rates or HIV/ AIDS data, capture-recapture and a multi-variant indicator regression, which uses various data sources in combination with local level prevalence estimates. By 2005, many of these estimates were based upon results from more than one estimation method.

In a limited number of cases a small discrepancy may be found between the answers and information provided by the policy makers on the one hand and the National Focal Point on the other. In those cases both opinions are included in the country report. Explanations regarding these minor differences may be found in possible time lags between the production of a National Report and the reporting date of national policymakers. Furthermore, it may be that policies have been adopted in strategies and action plans already and therefore 'exist', but that in practice implementation has not yet been taken at hand. And finally, it may be well so that not every respondent had an up-to-date overview of what is going on in the field of harm reduction in their

[46] The two projects found are: COCINEU (project ref. QLG4-CT-2001-02301 - ZIS/ Germany), titled 'Support needs for cocaine and crack users" and ROSE-EU (QLG4-CT-202-01681 - ZIS/ Germany), titled 'Management of high risk opiate addicts in Europe – risk opiate addicts study – Europe". (Source: CORDIS website).

[47] Stöver, H. , L. Hennebel, J. Casselman [2004]. 'Substitution Treatment in European prisons: a study of policies and practices of substitution treatment in prisons in 18 European Countries'. ENDHASP, UK.

[48] EMCDDA definition on problem drug use: "Injecting drug use or long duration / regular use of opiates, cocaine and amphetamines".

country, especially when data collections and reporting structures (for policy) still need development. The Reitox National Focal Points offered their assistance to the project twice by verifying and confirming data and information they had reported regarding the harm reduction services and facilities in their country that took place in the period of 2002 to 2005[49].

Furthermore, in order to prevent 'overkill' in asking details and information from the Member States, it was decided that ample use was to be made of existing data sources rather than to send extensive questionnaires to the Member States with the risk of duplicating work. In order to provide a manageable overview of the state-of-play in the Member States, the detail of information focused on the thematic areas introduced by the Council Recommendation itself.

3.5 Methodology used for the literature review

An abundance of information, practices and approaches is available in the field of prevention and reduction of health-related harm associated with drug dependence. Assessing the value and quality of all this information is an enormous task, not only because of time limits but also because the considerable variation in the scientific quality of the available studies. Actually there is a lack of consensus of what methods are most appropriate in this broad study domain, which also includes public health, health promotion, and health education.

In selecting the literature first emphasis was placed on studies targeting prevention and reduction of drug-related infectious diseases, drug-related deaths and on maintenance treatment. We additionally report evidence for effectiveness of several interventions (medical heroin prescription, pill-testing programmes, pre-release counselling, and drug consumption rooms, and in-prison interventions.

The literature was selected according to the following criteria:

- Primarily evidence for effectiveness from meta-analyses, systematic reviews and randomised controlled trials;
- Predominantly studies published in the English language (high-quality studies are usually published in scientific journals in the English language but many selected studies also included publications in other languages);
- Only interventions that concern selective and/ or indicative prevention/ brief treatment for at-risk groups and special settings (universal prevention – meant for the general population - was not selected);
- Research published since 1990. When no or limited (high-quality) evidence was available, literature was also included from before 1990 (high-quality evidence on harm reduction interventions became available predominantly in the past one-and-a-half decade and in many harm reduction interventions only during the past years).

The search started with a predefined search strategy but was also sensitive to other sources and suggestions of the EMCDDA and other experts. Finally, references were checked in selected publications on their relevance for this review (when these were not included in already selected and evaluated reviews).

The availability of evidence regarding the effectiveness of harm reduction interventions is in many cases rather limited, because most harm reduction interventions are based on trial-and-error in practical circumstances, largely excluding controlled research. In many countries harm reduction interventions have initially been developed bottom-up and under largely illegal circumstances due to policy restrictions. These circumstances also restrict possibilities for controlled effect studies. Meta-analyses and systematic review studies were in some cases available (e.g. for maintenance treatment) and in other interventions rarely published or not at all (e.g. overdose treatment). In these instances, studies with a less optimal design for determining cause-effect relationships were used and this was mentioned explicitly.

It should be borne in mind that interventions that have not yet been studied enough may show positive results in practice. When no evidence is available for a specific intervention, this does not necessarily mean that the intervention is not effective. It is simply not possible to draw firm conclusions yet. In annex 1 further detail is provided on the appraisal of the literature and on the assessment of the strength of available evidence.

Finally there is a multitude of guideline publications and models of good practice. These are often very diverse and difficult to summarise in a scientifically sound way. Therefore, in this study,

[49] The Swedish Reitox National Focal Point indicated it did not consider checking the country report as its task.

predominantly important parts of general guidelines published by well-known organisations have been included (e.g. from the US National Institute on Drug Abuse (NIDA), the World Health Organisation, and some other institutions). We refer to appendix 1 of annex 1 (the literature review) for a more detailed explanation of this choice.

4 Effectiveness of interventions – A summary

In this chapter a summary is presented on the effectiveness[50] of harm reduction interventions. These interventions have the following order: prevention and treatment of drug-related infectious diseases, prevention of drug-related deaths, other harm reduction interventions and harm reduction in prison settings. This summary is based on the literature review that is included in Annex 1 to this report. Due to several reasons, it is often difficult and sometimes impossible to study the effectiveness of harm reduction interventions in scientific experiments. The consequence is that the evidence for effectiveness of most of these interventions remains unclear. This does not mean that the interventions are ineffective. We simply do not know yet. In daily practice interventions that may be effective should be further tried out. Further research is needed in order to enlarge the evidence-base for these interventions.

4.1 Summary of available evidence

Studies show that *needle and syringe exchange programmes* are easily applicable, safe, and they are probably effective and possibly also cost-effective in reducing risk behaviours and the transmission of infectious diseases. HIV-testing and counselling may also reduce transmission of drug-related infectious diseases and it remains undecided yet which of these interventions is most effective.

It is uncertain whether merely the delivery of relevant *information, education and communication* (IEC) is effective to prevent drug-related infectious diseases among injecting drug users. Effectiveness of other harm reduction interventions may be enhanced by IEC. It is therefore recommended to combine IEC for instance with distribution of sterile needles and syringes and a range of other means to reduce drug-related infectious diseases, e.g. condom distribution, bleach, access to HIV-testing and HIV-counselling programmes (distributing information on programme locations and opening hours) and on injecting equipment. IEC should further be designed for specific drug users instead of for several drug using groups. In general, mass media campaigns are a universal prevention method that is expensive but largely ineffective as a harm reduction strategy. Techniques for enhancing motivation of drug users are prerequisites and effective, thus these should be part of intervention packages.

Community outreach programmes aim to create access to these hidden populations in their daily environment for targeted action against high-risk behaviours. Possible action components are: identifying and accessing injecting drug users, identifying and recruiting peer leaders, increasing risk awareness among drug users, demonstrating skills to avoid or reduce risks, distributing injecting equipment, behavioural counselling, or providing referral to treatment. Drug users participating in community outreach are in general less inclined to expose themselves to risk behaviours (e.g. needle sharing), reduce drug use. There are indications that community outreach programmes improve treatment compliance. Because outreach work is inexpensive, its interventions may in most cases also be cost-effective.

Current *treatments for HIV/ AIDS, hepatitis B and C and tuberculosis and on the other hand preventive vaccination for hepatitis B* are all effective in reducing drug-related infectious diseases. Because these treatments usually take a long time and may have unpleasant side effects, adherence to treatment by drug users should be actively stimulated. Such treatments or therapies

[50] Different levels of evidence are commonly discerned in the review literature. These distinctions in grading evidence are largely arbitrary. Important however is to describe explicitly how the evidence has been appraised and graded. Here, a rough grading procedure was used, i.e. without systematically specifying quantity and quality of the studies. When a systematic review or a meta-analysis of at least three RCTs was available with clear cut outcomes or three separately published RCTs with outcomes that were alike and significant, we considered the evidence sufficient and the interventions *effective*. Two RCTs or one RCT plus at least two lesser quality studies (e.g. well-done time-series or prospective cohort studies) were considered to give indications for effectiveness (interventions are probably effective). In case of doubt, i.e. if only one RCT - or one or two studies of lesser quality - with positive findings were found, phrases like 'may be effective" or "possibly effective" are used. This means that there are still doubts about the effectiveness of these interventions. In case of absence of studies or studies with other designs than the ones described above, we simply do not know enough yet. An intervention is considered ineffective when sufficient evidence is collected on its ineffectiveness. However, there are no harm reduction interventions found that have this judgment. An example of an ineffective intervention in the treatment literature is acupuncture treatment for cocaine dependence (Rigter et al., 2004).

should therefore be supported by health professionals, community volunteers or an involved family member.

Heroin overdose death is most prominent among direct drug-related deaths, although overdose death may also be caused by methadone or other substances. Street injecting, poly drug use, differences in drug purity and relapse after treatment or prison, increase the chance of taking an overdose.
Reducing drug-related deaths may be one of the targets of substitution or maintenance programmes. These programmes are probably reducing mortality among dependent drug users. The strongest evidence for effective prevention of overdose death is for the antidote naloxone. However, this short-acting opioid 'antagonist' does not prevent overdose itself. Instead it can only be effective if well-trained emergency staff, peers or relatives are available. To administer this medication, the enhancement of education and behaviour skills for ambulance personnel, police officers, family members or peers could further increase success rates.

Maintenance or substitution treatment (methadone and buprenorphine) is probably effective in reaching other targets and in daily situations. It improves patient compliance, and reduces opiate use and risk behaviour. These programmes are also effective in increasing treatment retention (staying in treatment) and they improve or at least stabilise daily life situations for chronic heroin users. Effectiveness on these outcomes tends to increase with individually adjusted dosages of these substances and also when psychosocial interventions are added to maintenance programmes.

Medical heroin (co)prescription for heroin dependent drug users has little adverse effects. It probably reduces public nuisance. It probably also improves the health situation of drug users who do not respond to maintenance treatment and retention to treatment rates may be higher. In countries with comprehensive treatment systems (including easily accessible maintenance treatment) heroin prescription may be a valuable additive option for these groups. However, heroin prescription is not considered as a treatment of first choice and there is consensus that it should not be implemented instead of, or on the expense of methadone maintenance treatment. Six new effect studies on heroin prescription are underway.

Due to a lack of high-quality studies, there remain considerable doubts about the effects of both pill testing programmes and drug consumption rooms. Some studies indicate that pill testing may decrease the use of potentially dangerous drugs. *Pill testing programmes* have several disadvantages. Firstly, pill testing methods are not standardised. Secondly, simple tests like colour tests give limited information about the content of synthetic drugs. This necessitates full laboratory analysis. Thirdly, pill testing is only one factor influencing drug use in recreational settings and probably not the most important one. Pill testing is not expected to diminish drug use. On the other hand, pill testing probably does not stimulate non-users to start with drug use, either. An advantage of well organised pill testing facilities is that these allow for the monitoring of trends in the composition of synthetic drugs. Finally, these interventions are prerequisites for early warning systems.
Drug consumption rooms may reduce needle sharing among injecting drug users, and may reduce drug-related death. However, we need more studies to draw more firm conclusions.

Prison-based maintenance treatment appears to be feasible and if adequate doses are distributed during imprisonment, it reduces injecting drug use, needle sharing, and transmissions of drug-related infectious diseases.

The utility of *pre-release counselling* may be equal to information, education and communication (IEC). It is recommended that pre-release counselling is part of other interventions e.g. *after care provisions* in order to prevent relapse or even overdose death after release.

Needle (and syringe) exchange programmes in prison are probably effective in reducing needle sharing among injecting drug users, and the transmission of drug-related infectious diseases. *HIV testing and counselling*, may also reduce needle sharing and concomitant infections. Both experience and scientific evidence show that prison needle exchange programmes have a positive effect on safety in prison, both for staff and prisoners.

There is no evidence of any major, unintended consequences of *condom distribution* for safety and security in prisons. Measures to combat aggressive sexual behaviours in prison remain important.

Counselling (information, education) should be part of the introduction of prison-based harm reduction interventions. The literature suggests that effectiveness of information and education possibly increases when these interventions are part of intervention packages. Evidence is currently lacking for *disinfection and decontamination schemes*, and *strategies to reduce tattooing*.

4.2 Some general suggestions from guideline publications

The success of prevention and treatment of infectious diseases among drug users assumes that these drug users are reached and motivated to participate in the interventions. Guideline publications stress the importance of tackling the consequences of a fairly strong association between drug use, mental illness and bad physical conditions. Since social stigmatisation of drug users remains prominent, both in society in general and in medical care, granting access to medical and psychiatric treatment for drug users remains an important challenge for public health policy. From a common sense perspective, success rates of harm reduction programmes for drug users increase with high accessibility, free-of-charge services, and low threshold provision of services. It has been recommended that these programmes should be part of the general health care system, offering optimal care possibilities per location. Programmes should also be as intensive as is acceptable for individual patients (not driving them away). Possible interactions of different treatment drugs (e.g. maintenance treatment drugs, antidepressants or antiretroviral drugs) have to be carefully monitored so that individual dosages can be adjusted appropriately.

A reduction of overdose death is facilitated by skill training of medical staff or ambulance personnel, peers or relatives who may be present in case of an overdose. Further important messages for prevention of overdose death are: avoid poly-drug use, inform drug users about differences in purity of drugs and when they are released from penitentiary institutions. Finally it has been recommended that naloxone should be easily accessible for family and peers because the majority of overdose occurs in the home of a victim or that of another user.

The effectiveness of drug consumption rooms is largely dependent on their coverage among the drug using population, i.e. they should be located in those places where drug users are concentrated. Coverage can be enlarged by support from the local authorities, including the police, easy accessibility (low threshold), and some control measures (e.g. identity cards) in order to avoid undesirable behaviour.

Starting maintenance treatment with low doses is recommended for prevention of methadone deaths. Each patient should be assessed at least several times annually by an experienced clinician. Effective control procedures and supervised administration of maintenance medication can prevent the risk of diversion or illicit use of maintenance substances. Random urine testing may be indicated for evaluating programme effectiveness. Screening for mental illness (co-morbidity) is recommended. Given the scale of problems, it is also recommended to make maintenance treatment part of community-based health systems, in order to enable continuity and quality of maintenance programmes and to enable counselling and testing for drug-related infectious diseases.

When prison-based maintenance programmes are well implemented, they have additional effects for the health situation of participating prisoners, for the prison system and ultimately also for society. Alternative programmes or treatment options as a substitute for prison for drug users are probably more cost-effective than imprisonment itself. These programmes may cover a range of interventions aiming to avoid, replace, delay or complement prison sentences for drug users. Drug-free units in prisons should also be offered for prisoners who are not using drugs or who do not want to. Finally, prison-based harm reduction activities should best be adapted to meet the needs of both staff and prisoners in order to be successful.

5 Inventory of policies, services and facilities in the Member States

5.1 Main responsible department for Implementation of Council Recommendation

In sixteen EU Member States, the implementation of the Council Recommendation is mainly the responsibility of the Ministry of Health. In one Member State[51] the Ministry of Social Affairs is the main responsible body. In five Member States the task of implementation is mainly the task of a special drug coordination structure[52]. In three Member States the task of implementation is the equal responsibility of two or more departments[53] or divided between national government and regional structures and organisations[54].

5.2 Recommendation #1 - Risk reduction and public health policy

5.2.1 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.

All EU Member States have adopted (public health) policy objectives that have the aim to prevent and reduce health-related harm associated with drug dependence. Belgium indicated that the Council Recommendation has had an impact on the development of a risk reduction policy in the Walloon Region. Five[55] of the ten 'New' EU Member States have indicated that the Council Recommendation had a direct influence on their policies.

All Member States indicate they have stipulated the public health objectives regarding drug abuse in their National Drug Action Plans or National Drug Strategies. Finland clearly links the aims of its Drug Strategy to its national Health Agenda (which in turn is linked to the Health 21 agenda of the WHO). All Member States subscribe to the premises of the Council Recommendation. National Drug Strategies generally reflect the balanced approach that was adopted in the EU Drug Strategy 2000-2004 and the EU Drug Strategy 2005-2012. As such these strategies reflect the spectrum of drug demand reduction and drug supply reduction interventions and actions.

With their adherence to the principles and recommendations made in the Council Recommendation, the Member States of the European Union clearly seem to support the balanced and multidisciplinary approach as laid down in the EU Drug Strategies 2000-2004 and – in particular – 2005-2012. At international level the level of support for harm reduction measures is not as widespread. Within the United Nations Commission on Narcotic Drugs (CND), the term harm reduction is not used and fierce debates have taken place on i.e. the effectiveness of needle and syringe exchange programmes. In recent years, a number of resolutions have been adopted that support the prevention and reduction of (the spread of) HIV/ AIDS and other blood borne infections among drug users[56]. In 2004, an important resolution regarding maintenance treatment was adopted[57] by the UN Economic and Social Council which invited the World Health Organisation (WHO) *"...(..) to develop and publish minimum requirements and international guidelines on psychosocially assisted pharmacological treatment of persons dependent on opioids, taking into account regional initiatives in this field, in order to assist the Member States concerned."*.

The implementation of the Council Recommendation is mostly a task for the Ministry of Health in the Member States, except for those cases where a special coordination structure has been set

[51] Estonia.
[52] Cyprus, Czech Republic, France, Hungary & Malta.
[53] Ireland.
[54] Belgium & Italy.
[55] Cyprus, Estonia, Lithuania, Slovakia and Slovenia.
[56] E.g. 48th Session of the United Nations Commission on Narcotic Drugs [2004]. Expanding the capacity of communities to provide information, treatment, health care, and social services to people living with HIV/ AIDS and other blood-borne diseases in the context of drug abuse and strengthening monitoring, evaluation and reporting systems. Resolution 48/12, Vienna, 2005.
[57] 47th plenary meeting of the United Nations Economic and Social Council [2004]. Guidelines for psychosocially assisted pharmacological treatment of persons dependent on opioids. E/RES/2004/40, New York.

up[58]. In Member States that have a decentralised structure[59], the implementation of the Council Recommendation (and of harm reduction policies and services and facilities) is a shared responsibility. For many of the Member States, the development of Harm Reduction policies and interventions has taken off by the end of the 1990-ies, and in the period since 2000.

The question to which extent the policies in the Member States converge, is reflected in the overview of services and facilities regarding the prevention and reduction of health-related harm associated to drug dependence as covered by the 2nd recommendation of the Council Recommendation. Nevertheless, there is a reasonable consensus among the Member States when the implementation of a 'basic' set of harm reduction services and facilities is concerned: information, education and counselling; needle and syringe exchange, outreach work; maintenance treatment (methadone/ buprenorphine).

5.3 Recommendation #2 – services and facilities in the Member States

This Recommendation calls upon the Member States 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, by making 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.

5.3.1 Recommendation 2.1: provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

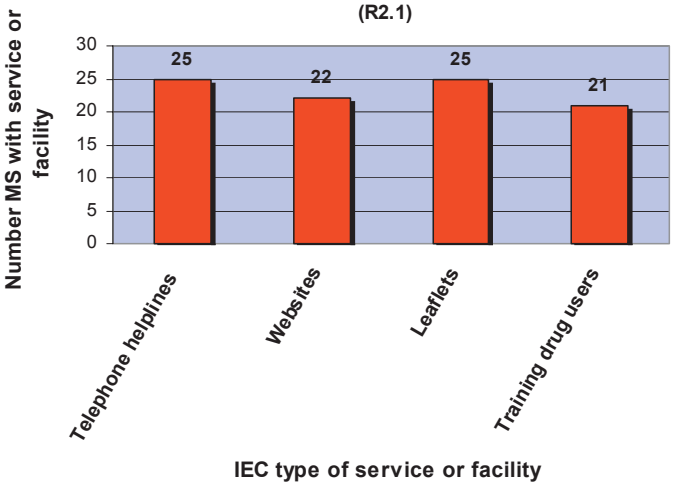
This sub-recommendation calls for harm reduction-based information, education and communication (IEC) services and facilities with regard to drug users. Emphasis is placed on the reduction of drug-related harm to the drug user and may include interventions such as information (leaflets, websites, help lines), education or training (such as *risk education/ response training*: practical training on responses to occurring overdose, or *safer injecting training:* techniques to inject drugs more safely, e.g. by always shooting in the direction of the heart or by using clean equipment) or communication (individual risk counselling, e.g. one-on-one meetings giving practical advice on safer ways of drug taking, and support, among which referral to treatment). Pill testing (the testing of –mainly- ecstasy tablets) can also be viewed as an example of information, education and communication.

A policy on this recommendation exists in all Member States. Five Member States indicate that this policy is the result of the adoption of the Council Recommendation (these are all 'new' Member States: Cyprus, Estonia, Lithuania, Slovakia and Slovenia).

The provision of information and counselling to promote harm reduction is widely available[60] in the European Union. In all Member States telephone help lines and educational leaflets are available to drug users[61], and 22 Member States also run websites[62], while 21 Member States provide training courses promoting harm reduction (see Figure 5.1). Five Member States provide drug testing services (either on site, i.e. at dance events, by using colour tests, or at laboratories) to drug users, mainly pill-testing.

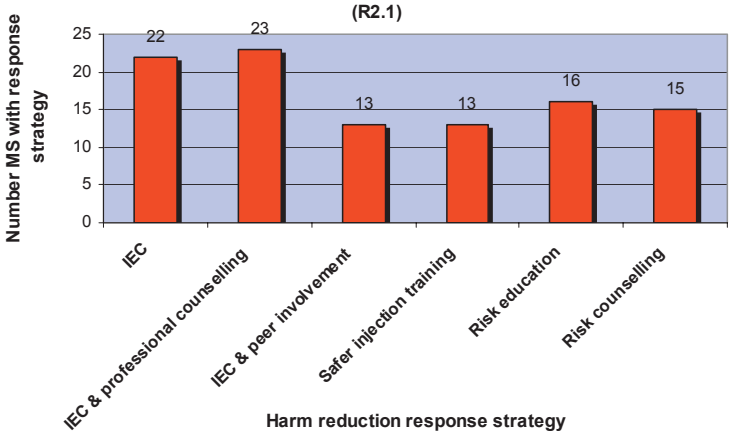
[58] E.g. in Cyprus, Czech Republic, Hungary, Slovenia.
[59] Austria, Belgium, Germany, Italy, UK.
[60] Data have been analysed by differentiating between 'nationwide available', and 'in specific geographical areas only'. The aim was to obtain a picture of the coverage of the respective harm reduction services and facilities. As such these terms can be compared with the EMCDDA terms: predominant and common.
[61] In Krakow, Poland, a magazine for drug users is issued through an NGO. The journal focuses on harm reduction issues.
[62] In a number of Member States internet-counselling is also available.

Figure 5.1 - IEC measures targeting drug users in Member States (R2.1)



The major response strategies to prevent infectious diseases among drug users include information, education and communication (IEC) in general (22 Member States), and IEC via counselling and advice by drugs and health professionals (23 Member States). Training on safer injecting is a common or predominant response strategy on drug-related infectious diseases in thirteen Member States. In order to reduce drug-related deaths among drug users, in sixteen Member States dissemination of information materials and risk education/ response training are either common or predominant measures, as is (individual) risk counselling, which is available in fifteen Member States (see Figure 5.2).

Figure 5.2 - Predominant or common response strategy to prevent DRID (R2.1)



5.3.2 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 sub-recommendation promotes the availability of information materials on the prevention of health risks such as drug overdose and wound infection. It is specifically designed for families and communities. Furthermore, this sub-recommendation promotes the involvement of families and

communities in harm reduction interventions, such as needle and syringe exchange, or calls for training courses for these groups to educate them, e.g., on overdose prevention.

A policy on this recommendation exists in all 25 Member States, and in six Member States this policy was adopted as a direct result of the Council Recommendation.

Nineteen Member States report that communities and families of drug users are involved in harm reduction[63] and in fourteen Member States, specific IEC for communities and families on harm reduction is available.

5.3.3 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

One of the main interventions in harm reduction is the concept of outreach work. Outreach workers reach out to those subpopulations that are not easily found through regular drug services. Outreach work is targeted especially at subgroups (sex workers, homeless injecting drug users) that do not visit regular services and that have a relatively high risk of contracting or transmitting drug-related infectious diseases. One of the aims of outreach work is to get into contact with these groups, gain their trust, give clear and fact-based information on the risks associated with drug use (especially regarding injecting drug use), but also other information is provided on e.g. transmission and prevention of infectious diseases. Another aim of outreach work concerns the referral of drug users to treatment. Two predominant types of outreach work are available: street-based (or community-based) outreach work, which aims to get in touch with (dependent) drug users in their natural environment, e.g. in the streets, at home, in low threshold agencies and other locations where drug users gather. The second type concerns outreach work at dance events, especially targeting young 'amphetamine-type stimulants' drug users at raves and clubs, with a strong emphasis on users of synthetic drugs such as ecstasy.

This policy exists in 24 Member States. In Italy, this policy does not exist at a national level. Five Member States have adopted this policy as a result of the Council Recommendation.

In nine Member States, both street-based outreach work[64] and outreach work at dance parties/ raves and in clubs are available throughout the country. Fourteen Member States report to have street-based outreach work available in specific geographical areas; eleven Member States report to have outreach work at dance parties/ raves, and in clubs, at specific areas. In Cyprus, outreach work does not exist at all; in Malta no street-based outreach work exists. In Latvia, outreach work at dance parties / raves and in clubs is not available at all.

Outreach work is regarded a predominant or common response strategy to prevent drug-related infectious diseases in twenty Member States. Outreach work is a major implementation setting for measures targeting the prevention of infectious diseases in nineteen Member States.

Measures targeting the reduction of drug-related deaths (such as the dissemination of information materials and the deliverance of risk education/ response training), are provided by sixteen Member States.

5.3.4 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

[63] In the United Kingdom, families are involved in overdose training to help reduce drug-related deaths.

[64] Outreach projects and low threshold agencies exist throughout Italy, although they are more predominantly available in urban and northern Regions than in the southern Regions. The 'unità di strada' is a well established drug service. Over time, the facilities provided through outreach have extended and may now include advice and counselling, referral to a range of different services, including drug treatment, provision of information leaflets and guidelines to avoid or deal with drug-related emergencies, provision and/or exchange of sterile injection equipment, guidance on safer sex and the provision of condoms. More recently, in some areas there has been the introduction of mobile methadone treatment services aimed at reaching clients who are not presently able to use the fixed site service.

This recommendation is related to the involvement of peers and volunteers in the practice of outreach work. The use of peers - often current or former drug users - has some advantages over the use of merely harm reduction professionals. The main advantage is that peers know the codes used among drug users, e.g. the daily life rituals. Peers also have personal experience with the effects of specific drugs and therefore can place themselves in the position of drug users much better than professionals might. Therefore peers can be quintessential in transferring knowledge and skills to the target group, such on the basis of trust and equality. But peers also know where to find the hidden drug users, the at–risk groups, and will be accepted in their midst more easy as they are part of the same subpopulation.

A policy regarding this recommendation exists in nineteen Member States and four Member States based this policy upon the Council Recommendation. In Lithuania and Portugal, the implementation of this policy is pending for approval by the national government. In Denmark, Italy, Hungary and Slovakia such a policy does not exist, or is not considered a priority or task for the government.

In eighteen Member States training for peers and volunteers is provided[65], and outreach work agencies involve peers and volunteers in outreach work in nineteen Member States[66].

5.3.5 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 in eighteen Member States. Three new EU Member States based this policy upon the Council Recommendation. In Denmark, Greece, Italy, and Slovakia this policy does not exist (e.g. as it is no priority for government), and in Lithuania, Latvia and Portugal the implementation of this policy is pending for approval.
Networking and cooperation between outreach work agencies is prevalent in twenty Member States. In Luxembourg this policy is not put in practice as – given the geographical dimensions of the country – only one organisation is involved in outreach work.

5.3.6 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

One of the harm reduction interventions most widely implemented throughout the European Union, concerns the provision of maintenance treatment. This type of treatment involves the use of substitution drugs such as buprenorphine and methadone to assist opioid (mainly heroin) users to stabilise their drug use and to move from injecting and other possible hazardous methods of taking drugs to (usually) oral drug consumption. The substitution drug is provided under supervised conditions as part of an intervention that may also involve counselling, primary health care, HIV treatment and other services[67]. In general, there are two types of substitution treatment: maintenance treatment and detoxification treatment.

Maintenance or substitution treatment involves the prescription of a substitution drug to a dependent drug user for a longer period of time (in general, years). Its primary aim is to stabilise one's living and health conditions. Maintenance treatment resulting in abstinence is possible, but less common in practice. Positive side effects include a reduction in the risk of acquiring drug-related infectious diseases and prevention of drug overdose (see literature review in Annex 1). *Detoxification treatment* involves the care that is provided to a dependent drug user who is reducing or terminating the use of a dependence-producing substance, with the aim of withdrawing from the substance safely and effectively[68]. The detoxification treatment is provided until abstinence has been reached. In general maintenance treatment is available to opioid dependent drug users. The most important substitution drugs that replace opioids are methadone and buprenorphine (brand name: Subutex).

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[65] In Belgium, (ex-) drug users are trained to diffuse HIV prevention and overdose prevention messages.
[66] Almost all needle and syringe exchange points in Estonia recruit *hard-to-reach risk groups* in the framework of outreach work; they also provide syringes, needles and/or other injection paraphernalia, condoms, leaflets with risk reduction materials in the framework of outreach work.
[67] WHO [2003]. Training Guide for HIV prevention outreach to injecting drug users. Department of HIV/ AIDS.
[68] WHO [2003].

A third substitution drug is Naltrexone. Naltrexone is an opioid antagonist: it blocks the effects of opioids so that the user does not feel the specific effects of the opioid anymore. As such it can be used as a substitution for heroin. During the withdrawal period it may help dependent drug users to refrain the simultaneous use of opioids. Naltrexone is not as frequently used as methadone and buprenorphine, partly because acceptance is poor. Another, not yet widely implemented, intervention is the prescription of heroin to heroin dependent users (see Annex 3.2).

Maintenance or substitution treatment and detoxification treatment is supported by psychosocial care (such as individual counselling) in all 24 Member States where this treatment is available, thus excluding Cyprus. This psychosocial care is obligatory in 9 Member States, and is available upon request by the client in 10 Member States; 5 Member States report that this treatment-related psychosocial care is sometimes obligatory, sometimes upon request by the client (depending on the prescribing institution or general practitioner).

Another important element of harm reduction involves the provision of low threshold agencies, services that aim to provide basic needs for (homeless) drug users, where the threshold to enter is low (few preconditions, e.g., it is not necessary to express the wish to stop using drugs). By doing so, low threshold agencies can get in touch with a large number of drug users. Drop-in centres and day or night shelters are important low threshold services. Drug consumption rooms are harm reduction facilities that are offered to drug users in only a few EU countries. In general these facilities have a higher threshold (see Annex 3.1).

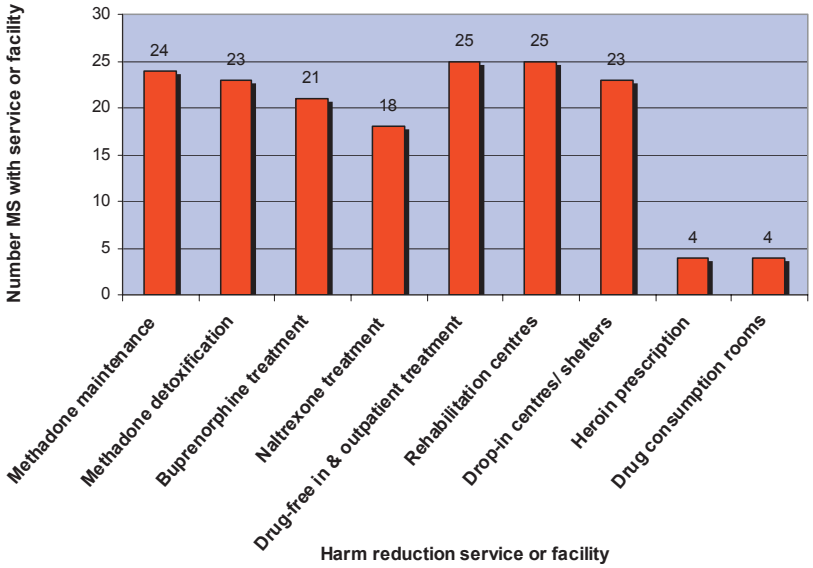
A policy on this sub-recommendation exists in all 25 Member States, and in Cyprus, Estonia, Slovakia, and Slovenia this policy exists as a result of the Council Recommendation.

Methadone maintenance treatment is available nationwide in fourteen Member States, and available in specific geographical areas in ten Member States[69]. In Cyprus, substitution treatment is not provided. Methadone detoxification treatment is nationwide available in sixteen Member States and in specific geographical areas in seven Member States (there is no information about the availability of methadone detoxification treatment in Sweden). Treatment with buprenorphine is available in 21 Member States, and treatment with Naltrexone in eighteen Member States. In all Member States drug-free outpatient and drug-free inpatient treatment and rehabilitation centres are available, and in all Member States except for Latvia and Slovakia drop-in centres/ shelters exist.

Four Member States – Germany, Spain[70], the Netherlands[71] and the United Kingdom[72]- operate heroin prescription programmes. In Luxembourg controlled prescription of heroin may start in 2008[73]. Within the European Union, drug consumption rooms exist in Germany[74], Spain, Luxembourg and the Netherlands. In all other Member States this intervention is not available.
In nineteen Member States, opioid substitution treatment is considered to be a predominant or common response strategy to reduce drug-related deaths (see Figure 5.3).

[69] Sweden was the first Member State to provide methadone maintenance treatment and started this treatment in 1966. Currently, there is a very strict high threshold methadone maintenance programme for in total 800 persons.
[70] Two trials are running.
[71] This includes only medical co-prescription of heroin together with methadone. The government decided that places at treatment units for medical prescription of heroin to chronic treatment resistant opiate addicts can be extended up to 1000 places.
[72] 300-500 persons receive heroin in England and Wales.
[73] In Luxembourg, the introduction of heroin prescription is an aim in the National Drugs Action Plan 2005-2009, but it was decided to wait with introduction until the evaluation of the development and impact of the drug consumption room in 2008 (Source: NFP 2006).
[74] In 2003, there were 24 drug consumption rooms in Germany, in urban areas.

Figure 5.3 - Availability of harm reduction services and facilities (R 2.6)



5.3.7 Recommendation 2.7: establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

Some critics of harm reduction measures are concerned that the prescription of substitution drugs to dependent drug users will result in diversion (leakage) of these substitutions to the illicit drug market, thus adding to the drug problem. This concern is based upon the perception that many dependent drug users will choose their original drug over the substitution drug and will sell the replacement for the 'real thing'. This recommendation calls for action to prevent or reduce such diversion.

A policy regarding this recommendation exists in 23 Member States. Estonia and Slovenia implemented this policy as a result of the Council Recommendation. Hungary does not have such a policy and there is no information about this policy in Slovakia.

Measures to prevent diversion of substitution substances include – among other - supervised consumption, daily pick-up of the substitute drug, urine checking as to check whether the substitution drug has actually been consumed (in that case, traces should be visible in the urine sample) or centralised registration to avoid shopping (collecting the substitution drug at multiple outlets). These measures are available in 22 Member States. In Cyprus, Italy[75] and Malta, measures to prevent diversion of substitution substances are not effectuated.

5.3.8 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

Prisons are a setting with a large potential for increased health-risk related situations for drug users (e.g. re-use of dirty needles among a large population of inmates). The 'principle of equivalence' mentioned in this recommendation has already been adopted by the UN General Assembly[76] in 1990 and by its organisations and agencies including UNAIDS/ WHO[77] and UNODC[78].

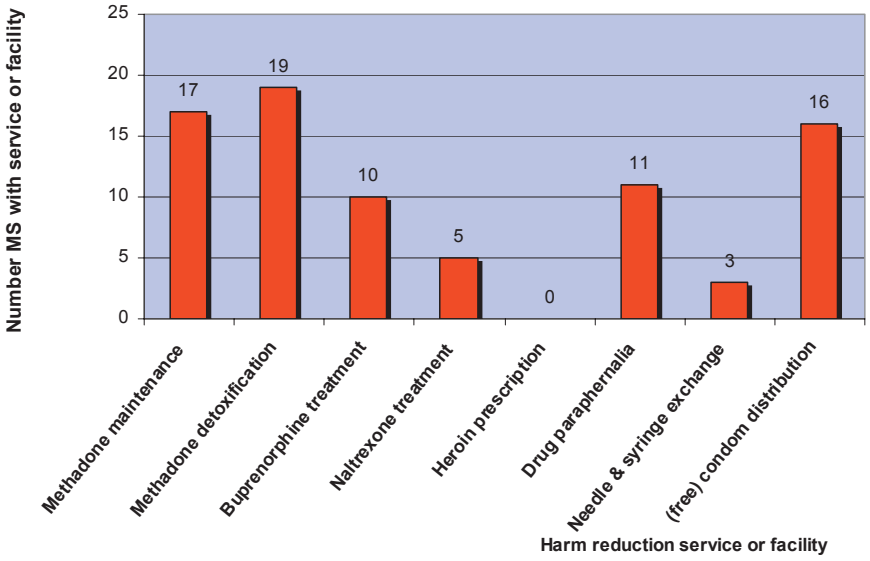
[75] Diversion of substitution substances is a minor problem in Italy.

[76] *"Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."* UN General Assembly, res. 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990).

It promotes the provision of equal health care services and measures, including harm reduction, inside and outside prison (see also Annex 3.4).

A policy on this sub-recommendation exists in twenty Member States. Five of these Member States have based this policy upon the Council Recommendation. In the Czech Republic, this policy does not exist, as it is not a priority for the government. In Greece, Lithuania, Luxembourg and Latvia this policy is pending for approval.

Figure 5.4 - Harm reduction services available in prison (R2.8)



Methadone maintenance treatment is available in prison in seventeen Member States. Nineteen Member States also provide methadone detoxification treatment in prison. Ten Member States provide treatment with buprenorphine, in five Member States antagonist treatment with Naltrexone is available in prison. Heroin prescription programmes in prison are not available in any of the EU Member States or anywhere in the word. In prisons of eleven Member States drug paraphernalia (e.g. bleach) are available, in sixteen Member States, prisons provide condoms and only three Member States –Germany[79], Spain[80] and Luxembourg[81] - allow needle and syringe exchange from within prison walls. In Austria such an intervention is currently under preparation and Portugal may start this type of intervention in 2008.

Measures targeting drug-related infectious diseases are available in prisons in 23 Member States: in prisons in Cyprus and Malta only counselling is provided, and in Latvian prisons no measures are available. There is no information concerning drug-related infectious diseases measures in prisons in Lithuania. In fifteen Member States, prisons are a main implementation setting for drug-related infectious diseases measures, and in ten Member States, prisons are an implementation setting for measures targeted at the reduction of drug-related deaths (see Figure 5.4).

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[77] "*All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality*". WHO/ UNAIDS [1993]. WHO Guidelines on HIV infection and AIDS in Prison. United Nations Joint Programme on HIV/ AIDS, UNAIDS/99.47/E (English original, September 1999), p. 4.

[78] UNODC [2006]. HIV/ Aids Prevention, Care, Treatment and Support in Prison Settings – A framework for an effective national response. Vienna, Austria.

[79] There were 7 pilots but only one prison (in Berlin) continued to operate needle and syringe exchange.

[80] Needle and syringe exchange is available in 38 prisons in Spain.

[81] Needle and syringe exchange is available in prisons in Luxembourg since the end of 2005.

5.3.9 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 recommendation promotes the prevention and treatment of infectious diseases among drug users. Injecting drug use is a risky way of administrating drugs, especially if not done hygienically and without clean injecting equipment. Because of a risky life-style, some drug users also have an increased risk of acquiring sexually transmitted diseases (STD's). The recommendation calls for preventative measures, both by vaccination (only available for hepatitis B and tuberculosis) or other prophylactic measures, and by proactive detection of drug-related infectious diseases through testing/ screening programmes.

A policy on this recommendation exists in all Member States, except for Latvia. Five Member States indicate that this policy was implemented as a result of the Council Recommendation.

Testing/ screening on infectious diseases are available nationwide to drug users in nineteen Member States[82] and in specific geographical areas in three Member States. Prevention and education measures are nationwide available in fifteen Member States and at specific areas in five Member States. Treatment of infectious diseases is available nationwide in fifteen Member States[83], and at specific areas in five Member States[84].
Vaccination campaigns against hepatitis B focusing specifically on drug users are available nationwide in fifteen Member States[85], and at specific areas in five Member states. In Member States where universal vaccination programmes (incl. hepatitis B vaccination) are provided to the general population, programmes targeting drug users in particular may not be necessary, as drug users may have been vaccinated already. Vaccination programmes against tuberculosis targeting specifically at drug users are nationwide available in ten Member States, and in specific areas in three Member States, but data are incomplete. However, many Member States run generic vaccination programmes for the whole population. In Cyprus measures to prevent drug-related infectious diseases (including treatment and vaccination programmes) are not available at all.

Voluntary counselling and testing (VCT) is either a predominant or a common response strategy to prevent infectious diseases among drug users in seventeen Member States. Routine screening of high risk groups and easy access programmes to treatment of infectious diseases for drug users are predominant or common response strategies in eleven Member States (see Figure 5.5).

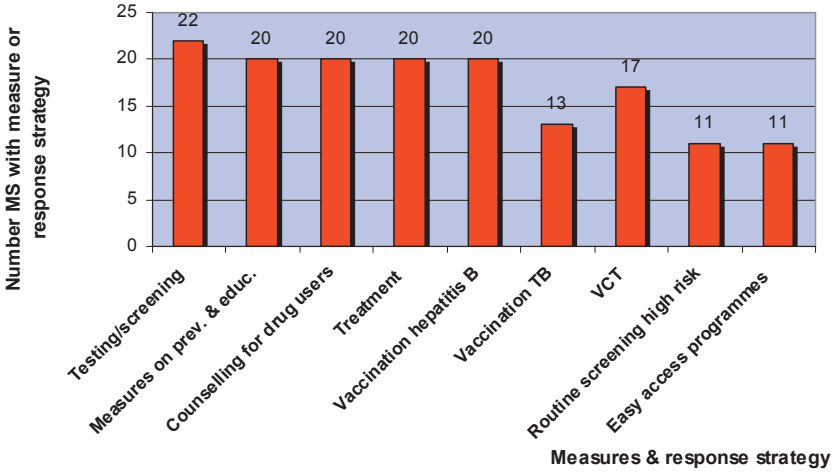
5.3.10 Recommendation 2.10: provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange

Needle and syringe exchange programmes are programmes that aim to reduce the transmission of drug-related infectious diseases by the repeated use and sharing of needles or syringes in order to reduce the transmission of blood-borne viruses.

This policy exists in 23 Member States, and four Member States implemented this policy as a result of the Council Recommendation. A policy on this sub-recommendation does not exist in Cyprus and Italy.

[82] In Luxembourg, an action-research programme was initiated in 2005 by the National Focal Point providing on-site testing (hepatitis A, B, C, HIV) and vaccination (hepatitis A and B) through specialised national NGOs.
[83] In some Member States, such as Latvia, treatment of infectious diseases is available to all people, and specific programmes for the treatment of infectious diseases among drug users are not in place.
[84] Some Member States exclude drug users from treatment of infectious diseases: in Slovakia drug users are excluded from treatment of hepatitis C; in Poland, active drug users are excluded from anti-retroviral treatment against AIDS.
[85] E.g., in Denmark, an executive order from the Danish Government on "Hepatitis vaccination, free of charge for injecting drug users and their relatives" was implemented April 2005.

Figure 5.5 - Measures & response strategies to prevent DRID (R2.9)



Besides Cyprus (where no needle and syringe exchange is available), all Member States provide needle and syringe exchange for injecting drug users. In fifteen Member States, needle and syringe exchange is available nationwide, and nine more Member States providing this intervention in specific geographic areas only[86]. In Estonia and Sweden, drug paraphernalia[87] are not provided to drug users[88]. For Cyprus, no information is available. All other Member States provide drug paraphernalia to drug users[89]. Condom distribution is available throughout the European Union with the exception of Latvia and Malta.

In 21 Member States needle and syringe exchange is considered a predominant or common response strategy to prevent infectious diseases. Needle and syringe exchange programmes are the main implementation setting for measures targeting at the reduction of drug-related deaths in eighteen Member States.

5.3.11 Recommendation 2.11: ensure that emergency services are trained and equipped to deal with overdoses

In case of a drug overdose, immediate professional help is needed. Emergency services are often the first professionals available on the spot. Therefore it is necessary that emergency staff is trained in dealing with drug overdose. Furthermore, it is important that necessary equipment and medication is available, including naloxone. Naloxone is a narcotic antagonist which reverses the respiratory, sedative and hypotensive effects of heroin overdose[90]. In harm reduction, naloxone may be generally available for emergency services or on a 'take home' basis for drug users.

A policy regarding this recommendation exists in all Member States, and in seven Member States this policy was based upon the Council Recommendation.

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[86] In Sweden, 2 needle and syringe exchange programmes exist, in conflict with repressive policy. There are two needle-exchange programmes in the southern county of Skåne – Lund since 1986 and Malmö since 1987 – at the clinics for infectious diseases.

[87] The term drug paraphernalia refers to equipment used to produce, administer or conceal an illicit drug, e.g. bleach, a spoon, ascorbic acid, pipes, etc.

[88] Bleach is not distributed in Ireland, as it is supposed not to prevent the spread of drug-related infectious diseases, e.g. hepatitis C.

[89] Distribution of paraphernalia (spoons, acid, water, also disinfection materials) is a standard part of needle and syringe exchange programmes in the Czech Republic. Syringes are available in pharmacies without prescription, but not free of charge. It is estimated that about a million syringes are sold annually in the Czech Republic in pharmacies to injecting drug users.

[90] UNDCP [2000].

Despite this policy, in only ten Member States training for staff of emergency units is available[91]. In two Member States emergency services are considered a setting for the dissemination of information materials that aim at the reduction of drug-related deaths. In three Member States emergency services are a setting for the deliverance of risk education/ response training. In twenty Member States, ambulances carry naloxone. No information is available on this topic in 4 Member States. In Cyprus, ambulances do not carry naloxone. In six Member States, naloxone is available to drug users on a 'take home' basis.

5.3.12 Recommendation 2.12: promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This recommendation focuses on the integration of harm reduction services and facilities within general health care. If harm reduction is integrated with mental health care (e.g. to deal with co-morbidity) and social care (e.g. reintegration: housing, jobs, income provision), the social and health situation of dependent drug users may be stabilised and possibly improved.
A policy regarding this recommendation exists in 23 Member States and is pending for approval in Lithuania and Portugal.

Risk reduction is part of an integrated health strategy for drug users in nineteen Member States[92], and in four Member States no information is available. In all Member States risk reduction is part of the National drug policy.

5.3.13 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

This recommendation focuses on skills building for staff in harm reduction, with the aim to develop a standardisation of working methods. Ideally skills building programmes should result in a recognised qualification

This policy exists in 22 Member States, of which three Member States based this policy upon the Council Recommendation. This policy does not exist in Cyprus, the Czech Republic and Italy.

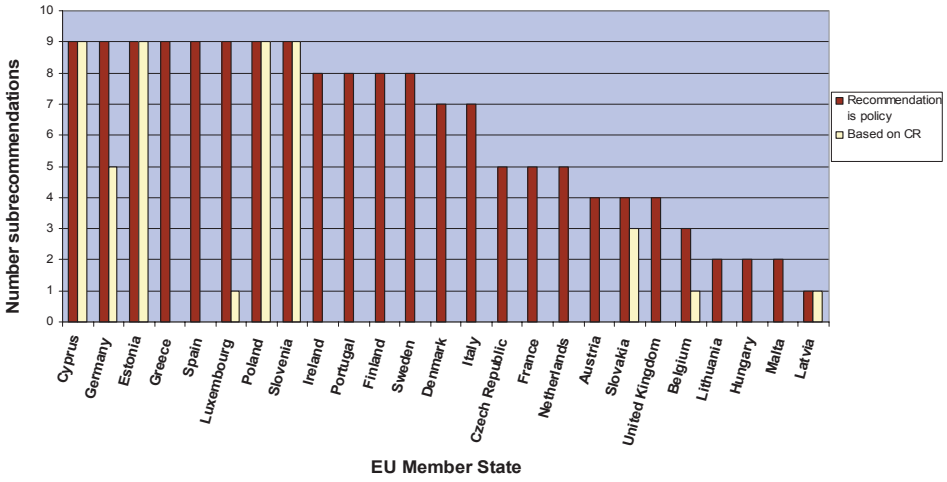
Training for personnel in needle and syringe exchange is available in 1seven Member States, training for professionals in maintenance treatment is provided in twenty Member States[93]. In 21 Member States, training for outreach workers is available. In nineteen Member States training for professionals in low threshold agencies is available. Finally nineteen Member States provide training for professionals in treatment facilities as well as training for prison staff.

[91] In Spain, e.g. "Counselling for emergency services related to young people and drug use" is given by the Department of Health of Catalonia.
[92] In France, risk reduction is part of a larger approach. A concrete example lies in the RMS program ("Réseau Micro-Structures", or Microstructures network), originally based in Alsace: attention and care to any kind of addicted patients are provided by physicians in presence of social-workers and psychologists.
[93] In many Member States, the prescription of substitution substances to drug users is only allowed after training of physicians or other staff.

5.4 Recommendation #3 - information and evaluation

The 3rd recommendation of the Council Recommendation consists of nine sub-recommendations. Where the Member States show good compliance and coverage with the different elements of the 2nd recommendation of the Council Recommendation, compliance with the 3rd recommendation of the Council Recommendation shows a greater deal of diversity.

Figure 5.6 - 3rd CR - Recommendations adopted in policy by MS



Although overall Member States support the need for these recommendations in drug strategies and health policy plans, the overview underneath shows that not every Member State has adopted specific policies (see Figure 5.6) to actively stimulate quality assurance, monitoring and evaluation. Not all Member States value quality assurance, monitoring and evaluation as a task for national government. In Member States with a federal or decentralised structure[94], tasks in these areas are divided among different levels of competence. In other Member States, e.g. the Netherlands and the UK, quality assurance, monitoring and evaluation is often seen as a task for independent (scientific) organisations. The United Kingdom reports to have made compliance with quality assurance models (including needs assessment at the early stages of a programme, R3.2) a condition for funding. Figure 5.7 provides some details on the level of implementation of the sub-recommendations.

5.4.1 Recommendation 3.1: using scientific evidence of effectiveness as a main basis to select the appropriate intervention

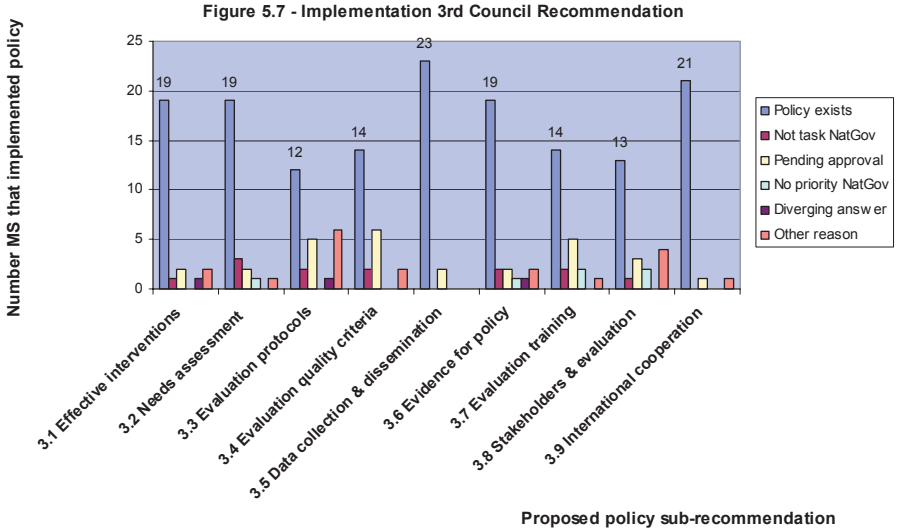
This recommendation was adopted in nineteen of the 25 EU Member States[95]. Five Member States indicate that this was the result of the Council Recommendation[96]. Several Member States run research and evaluation projects regarding interventions in harm reduction[97].

In recent years many national or regional studies have been carried out into maintenance treatment and detoxification treatment. For example, in Italy, a longitudinal study was conducted into the evaluation of effectiveness of methadone treatment [NR 2002]. In Ireland, small scale studies have been conducted into the effectiveness of methadone maintenance treatment [NR 2004]. In Finland similar research was conducted on medical assisted treatment with buprenorphine in two cities [NR 2003]. In Luxembourg, the first scientific evaluation of methadone

[94] E.g. Belgium, Italy, Germany.
[95] Belgium, Hungary, Latvia, Lithuania, Malta and the UK indicate they have not implemented it. In Belgium this is not the case for the whole country. In Latvia and Lithuania, the policy is pending for approval while in the UK the National government does not see it as its responsibility.
[96] Cyprus, Germany, Estonia, Slovakia, Slovenia.
[97] E.g. evaluations of substitution treatment (methadone, buprenorphine, and heroin) have been reported in Germany (Saarland), Finland, Luxembourg, the Netherlands; Evaluations of low threshold agencies are reported in Finland and France.

programmes took place in 1995. In 2002 a report on a comprehensive study on the national substitution programme was published. In the Netherlands, research and evaluation is used to adapt interventions. Examples are the Randomised Controlled Trial into heroin prescription and rapid detoxification studies (e.g. Naltrexone detoxification under general anaesthesia) [NR 2004].

Figure 5.7 - Implementation 3rd Council Recommendation



In Slovenia a needle exchange programme was evaluated (Stigma) [NR 2002], as well as in Portugal [NR 2003]. Other Member States like Slovakia make use of existing (international) evidence to select interventions with [NR 2004].

5.4.2 Recommendation 3.2: supporting the inclusion of needs assessments at the initial stage of any programme

The recommendation was implemented by nineteen Member States[98], while four[99] Member States indicate it was based on the Council Recommendation.
Despite the fact that many Member States indicate that supporting needs assessment at the initial stage of any programme is important, Member States usually do not promote such a policy with specific policy instruments (e.g. adopt such in funding guidelines).

A limited number of Member States has incorporated needs assessment in their drug policies. Luxembourg has included an exploratory study into prevention in nightlife settings in its drug action plan 2005-2009 [NR 2004]. In the Czech Republic, a needs assessment was carried out (Rapid Assessment & Response methodology) for the evaluation of drug policy in the Central Bohemian region [NR 2004], while several Phare Twinning projects were run (incl. on maintenance treatment) that included needs assessment. [NR 2003] In Ireland, a baseline assessment was conducted (incl. hepatitis B vaccination coverage) at the early stages of a pilot project to improve the care for injecting drug users. [NR 2004].

5.4.3 Recommendation 3.3: developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This recommendation has been implemented in twelve Member States[100], while four[101] of these indicate they based there policy on the Council Recommendation.

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[98] The Czech Republic does not see this recommendation as a priority. In Italy the policy exists but is not a task for national government. Hungary and the Netherlands do not consider this recommendation as a task for national government, while a policy on this topic is pending for approval in Malta and Slovakia. Latvia does not indicate a specific reason for not implementing the recommendation.
[99] Belgium, Cyprus, Estonia and Slovenia.
[100] Italy has implemented the recommendation, but indicates this is not a task for national government. Hungary has not implemented it for the same reason. In the Czech Republic, Lithuania, Latvia, Malta and Slovakia a policy on this recommendation is pending for approval. The Netherlands indicate that guidelines and

In Cyprus, in mid-2003 the Anti-drug council's scientific committee developed specific guidelines for drug treatment centres to ensure minimum quality standards. In Denmark the programmes are based on evaluation protocols. In Estonia, a policy on this recommendation was adopted, but still has to be implemented. In Greece, a policy was adopted to include evaluation in every programme. In Finland, evaluation is mandatory for all programmes funded by Ministries. In Luxembourg, evaluation of drug prevention and risk reduction programmes is common practice and evaluation protocols are available in the RELIS database. In Poland, an expert committee has conducted a review of the evaluation process of programmes in treatment, rehabilitation and harm reduction. In Slovenia, a policy on this recommendation has been adopted as an aim in the government Resolution on the National Programme in the field of Drugs (ReNPPD), but still needs to be implemented.

5.4.4 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 recommendation has been implemented by fourteen Member States[102], four[103] of which indicated the Council Recommendation was the basis for this policy. In those countries where a policy has been developed, the establishment of quality criteria is often still in the early stages of development. The EMCDDA has developed several manuals[104] and Monographs[105] on quality and evaluation, but Member States do not specifically refer to the use of these.

In Germany, no unified formal criteria for evaluation of harm reduction programmes exist due to the federal structure of the health system. Quality guidelines are not mandatory, but incorporated by professional organisations and funding institutions. In Denmark, in 2003 a project has been started (DANRIS) that aims to collect documentation and information on drug treatment programmes. It includes aspects of quality control. The Spanish Action Plan on Drugs calls for the evaluation of drug demand reduction programmes and in several autonomous regions quality assessment systems have been set up. In Estonia and Poland, a policy on this recommendation was adopted, but not implemented satisfactory so far. In Finland, the Drug Policy Action Programme 2004-2007 calls for the development of a quality framework for drug service providers. The Finnish Centre for Health Promotion has developed a guidebook on quality criteria for health promotion programmes.

In Italy, programmes have been funded that assess the quality of services offered to drug addicts. In Sweden, the new Drug Action Plan incorporates clear objectives to develop quality criteria for drug treatment services. Finally, in Slovenia, there are general quality criteria for programmes funded by government, but specific evaluation quality criteria for drug demand reduction still have to be developed.

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protocols are available but not compulsory or supported by policies. Sweden has not implemented a policy on this recommendation as methodologies and protocols are under development. In Austria, resources to develop such instruments are no longer available, while the UK reports that performance monitoring is common, but that no established evaluation protocols exist. In the Czech Republic a policy is pending for approval. However, minimum standards for quality as well as evaluation tools are being developed. One of these tools concerns the Minimum Evaluation Set, developed to evaluate treatment effectiveness. For France, no additional information is available.

[101] Cyprus, Germany, Estonia and Slovenia.

[102] A policy on this recommendation is pending for approval or adoption in Belgium, the Czech Republic, Lithuania, Latvia, Malta and Slovakia. The Flemish Community in Belgium is preparing a system of evaluation. In the Czech Republic, quality assurance is a pillar for drug demand reduction. Professional standards have been developed and are being applied. In Hungary, the development of quality criteria for harm reduction is not considered a task for national government. However, an 'EDDRA-style' database has been developed which will incorporate examples of good practice (SZIP). In the Netherlands, several quality assessment protocols and guidelines have been developed by scientific organisations. In Austria, there is no official policy available, but applications for programme funding at national and Laender level have to comply with quality standards. In the UK a policy on this recommendation does not exist, but the National Treatment Agency has developed four Key Performance Indicators for local Drug Action Teams.

[103] Cyprus, Germany, Estonia and Slovenia.

[104] EMCDDA [1998]. Guidelines for the evaluation of drug prevention: a manual for programme-planners and evaluators. Lisbon, Portugal. ISBN: 92-9168-052-4; EMCDDA [2001]. Guidelines for the evaluation of outreach work: a manual for outreach practitioners. Lisbon, Portugal. ISBN: 92-9156-024-3.

[105] EMCDDA [2000]. Understanding and responding to drug use: the role of qualitative research. Scientific Monograph no.4. Lisbon, Portugal. ISBN: 92-9168-088-5.

5.4.5 Recommendation 3.5: organising standardised data-collection and information dissemination according to the EMCDDA recommendations through the REITOX national focal points

This sub-recommendation has been implemented by 23 Member States[106] and seven Member States indicate the Council Recommendation was instrumental for that result[107]. The Member States report compliance with the aim to implement the five key-epidemiological indicators of the EMCDDA[108] [RT] and their participation in the EDDRA database. Adoption of the key-indicators is part of the 'hard' Acquis Communautaire and an important condition participation in the Reitox Network. However, in operational terms quite a few Member States do not comply fully yet with all the EMCDDA standards and methodologies[109].

Comparative overviews regarding the quality of data (and compliance towards information requests) provided by Member States to the EMCDDA, are not available. Annually the EMCDDA provides individual Member States with feedback information of the quality of their input (e.g. of National Reports and regarding specific questionnaires and data tables) and possible deficiencies in information. Member States usually publish their National Reports on national websites. However, there is no clear picture to what extent Member States use data collections including those gathered for the EMCDDA for national purposes.

5.4.6 Recommendation 3.6: making effective use of evaluation results for the refining and development of drug prevention policies

This sub-recommendation has been implemented in nineteen Member States[110], while three[111] Member States indicate this was the result of the Council Recommendation.
In Belgium, a policy on this recommendation exists in the French, Flemish and German Communities, while evaluation of quality to inform policy making was an objective in the Flemish Drug Plan 2002-2005. Evaluation is a task of the Cypriote Anti-Drugs Council. In the Czech Republic, the national drug policy has been evaluated. New initiatives to make use of evaluation for policy development are introduced in various areas of drug policy. In Germany, many different projects on evaluation and monitoring of drug demand reduction interventions have been implemented, including a study on drug consumption rooms (ZEUS). The Bundeslaender are quite active in this area as well and have developed a joint position paper on the future focus of outpatient drug and addiction aid systems. In Denmark, an Act regulating guaranteed social treatment for drug abuse has been adopted that is monitored for evaluation purposes. The results of the evaluation will be used to evaluate the Act.

In Spain, a mid-term evaluation of the National Drug Strategy 2000-2008 has been conducted, while in Catalonia, clinical trials on heroin prescription are being conducted. In Estonia, a policy on this recommendation exists, but still needs further development and content. In Finland a health counselling scheme for drug users has been implemented as part of the HIV/ AIDS strategy. It has been evaluated in 2004. In France, the three-year action plan on drugs 1999-2001 called for the evaluation of five priority programmes/ services, among which harm reduction and social mediation services in Paris.

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[106] In Belgium, the TDI is pending for approval by National government, although other data collections exist. In Latvia the policy is pending for approval.
[107] Cyprus, Germany, Lithuania, Slovakia and Slovenia.
[108] The five key epidemiological indicators are: *prevalence and patterns of drug use* among the general population (population surveys); *prevalence and patterns of problem drug use* (statistical prevalence/incidence estimates and surveys among drug users); *drug-related infectious diseases* (prevalence and incidence rates of HIV, hepatitis B and C in injecting drug users); *drug-related deaths and mortality of drug users* (general population mortality special registers statistics, and mortality cohort studies among drug users); *demand for drug treatment* (statistics from drug treatment centres on clients starting treatment).
[109] EMCDDA [2006]. Progress review of the EU Drugs Action Plan (2005-2008) - EMCDDA thematic paper for objective 39. Lisbon, Portugal.
[110] In Lithuania and Malta a policy on this recommendation is pending for approval. In Austria, a specific policy does not exist, although use of evidence for policy is increasingly common practice at all levels of government. In Latvia, evaluation of drug policy actions is an objective of the Drug Control and Drug Abuse Prevention Programme. In Hungary, there is no formal policy that prescribes the use of evaluation results of drug demand reduction services for the (re-) development of drug policies. However, the government did call for an external evaluation of the National Drug Policy in 2004-2005. In Italy, there is no specific policy on this recommendation, as it is not considered a task for the national government. In Slovakia, this recommendation is not a priority.
[111] Cyprus, Estonia and Slovenia.

In Ireland, one action of the National Drugs Strategy called for the evaluation of outreach work. Based upon the evaluation, quantitative and qualitative indicators for this type of harm reduction were established. In Luxembourg, a study as conducted – in line with the EMCDDA work plan – to assess the direct economic costs of drug policies and interventions. The RELIS database provides ample information to inform drug policy in Luxembourg. In the Netherlands, a five-year programme 'Getting Results' was started in 1999. The programme facilitated the evaluation of many drug demand reduction programmes and interventions and resulted in new tools, protocols, model designs and also policy adjustments. In Poland, an evaluation of drug therapy programmes for women in prisons resulted in new objectives for the National Programme for Drug Prevention. In the UK, the monitoring of performance rather than evaluation of the drug demand reduction sector is broadly implemented. This is a continuous process of quality control.

5.4.7 Recommendation 3.7: setting up evaluation training programmes for different levels and audiences

This recommendation has been implemented in fourteen Member States[112], while three[113] of these indicate this policy was based on the Council Recommendation.

In Austria, quality assurance and evaluation is part of the curricula for drug specific further education. The Reitox National Focal Point is involved in this type of training in Austria, Cyprus and the Netherlands. In the Czech Republic, in the framework of a Phare Twinning project, quality standards for services in addiction treatment were developed and adopted in a training programme for professionals. In Luxembourg, evaluation training programmes are provided by the drug prevention institute CePT and a pedagogical research department. In the Netherlands, the National Consultancy on Prevention (LSP) provides a variety of training programmes for professionals in addiction care. In Poland, evaluation training programmes are available for NGO's at local and regional level; while in Slovenia an expert body is being created that will produce professional standards and guidelines in this field.

5.4.8 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 recommendation has been implemented in fourteen Member States[114], while three[115] of these indicate this policy was based on the Council Recommendation.

Often participation of stakeholders is mentioned as an important factor in the implementation of a national drug strategy. But seldom participation in evaluation is mentioned.

In Spain, the involvement of stakeholders in evaluation is a priority in the National Action Plan on Drugs. In Estonia, there used to be programmes to encourage participation. In Greece, stakeholder involvement is a policy aim, but not a general requirement. The Polish drug coordination promotes the involvement of service providers and users in evaluation of drug demand reduction. The EU funded project "Rezolat" has as one of its aims the development and application of innovative and inclusive evaluation methodologies.
Limited information is available on innovative methods aimed at involving drug users/ family, professionals and/ or the broader community. Methods mentioned include competitions (Germany) and awards (Preffi-award, Netherlands). A European network has been set up (Rezolat) which has innovation and participation as one of its aims.

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[112] In Belgium, a policy on this recommendation is pending for approval in Flanders. In Denmark no policy in this area exists, but at times evaluation training seminars for local and regional drug professionals are organised. In Hungary and in Italy, this recommendation is not considered a task for national government. In Lithuania, Latvia, Malta and Portugal a policy on this recommendation is pending for approval. In Slovakia and the UK, this policy is not considered a priority for national government.
[113] Cyprus, Estonia and Slovenia.
[114] A policy on this recommendation is pending for approval in the Czech Republic, Lithuania and Malta, while it is not a priority for national government in Slovakia and the UK. In Belgium, a policy in this regard is pending for approval in a part of the Communities. In Italy a policy to this extent does not exist. In the Netherlands, a system of client-councils for patients in addiction and mental health care has been created, in which clients of service providers can provide feedback on quality and organisation of services. These councils are mandatory by Law. In Hungary, this recommendation is not considered a task for national government.
[115] Cyprus, Estonia and Slovenia.

5.4.9 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 recommendation concerns the question whether the Member States have a policy to encourage exchange and collaboration with other Member States. All 21 Member States indicate they have such a policy, while seven of them indicate this sub-recommendation was based on the Council Recommendation[116]. The recommendation is formulated quite broadly and does not specify harm reduction collaboration as such.

There is a lot of collaboration between EU Member States (and vis-à-vis third countries outside the EU) in the field of drug demand reduction. Official collaboration takes place in the Horizontal Working Party on Drugs, the Pompidou Group (Council of Europe), the EMCDDA and Europol and international structures such as UNODC.

Both 'old' and 'new' EU Member States, have been or are still collaborating within Phare Twinning projects in the field of drug demand reduction[117]. Member States also participate in the Exchange on Drug Demand Reduction Action (EDDRA) of the EMCDDA, a database with information on projects in the demand reduction field[118]. The 'European Survey Project of Alcohol and Drugs' (ESPAD)[119] is an important monitoring project in which many EU Member States participate. However, ESPAD does not collect any data on harm reduction.

Through the Programme on Community Action on the Prevention of Drug Dependence (1996-2002)[120], bi- and multilateral projects were funded, some focusing at harm reduction services and facilities, involving a variety of Member States[121]. The Public Health Programme 2003-2008[122] provides further possibilities for cooperation, but due to the fact that bigger networks with many partners are funded and the average project duration is extended , the number of projects in the field of drugs and HIV\AIDS has been reduced [123].

EU Member States allocate specific funds to collaboration in the drug field. Several countries such as Italy fund European and international organisations working in the field of drugs. The Netherlands have been running the MATRA projects[124] programme since 1995, which has also funded several projects in the field of prevention and harm reduction in Central- and Eastern European countries.
Several multi- and bilateral networks exist in which countries and/ or organisations from Member States participate, such as the 'Living with the Daily Dose' project, the Rezolat network, BINAD (D-NL), Mondorf (D-B-F-Lu) and – for example – the European Network of Drug and Infections Prevention in Prison (ENDIPP). Finally, EU Member States run projects aimed at other regions

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[116] Cyprus, Germany, Estonia, Luxembourg, Latvia, Slovakia and Slovenia.
[117] There are several examples of such collaboration: Hungary and the Netherlands/ UK; Slovenia and Austria/ Spain, etc. In 2001 the EMCDDA – CEEC Co-operation Project was implemented by the EMCDDA, aiming at the integration of the Accession Countries into the activities of the EMCDDA and establishment of structural links with the REITOX network. References to Twinning collaborations can be found in Phare annual and country reports: www.ec.europa.eu/enlargement/key_documents/ phare_legislation_and_publications_en.htm
[118] Specifically mentioned by UK, Portugal, Lithuania and Germany.
[119] European Survey Project on Alcohol and Drugs, an international prevalence survey among secondary school students aged 15-16, which is conducted every 4 years. The ESPAD project incorporates over 35 European countries. It is run by the Swedish Council for Information on Alcohol and other Drugs (CAN).
[120] The programme of Community action on the prevention of drug dependence within the framework for action in the field of public health, adopted by decision N° 102/97/EC of 16/12/96 of the European Parliament and of the Council, OJ L 19, 22.1.1997, p. 25, was extended by DECISION No 521/2001/EC of the European Parliament and of the Council of 26 February 2001 (cf. Decision extending certain programmes of Community action in the field of public health - Official Journal L 79, 17.03.2001).
[121] Relevant projects include: European Peer Support Programme (harm reduction among drug peers, coordinated by Trimbos Institute), SEARCH (prevention for refugees and asylum seekers, coordinated by Landesverband Lippe-Westphalia), ENDIPP (European Network on Drugs and Infections Prevention in Prisons, coordinated by Cranstoun), EUROMETHwork (exchange on methadone treatment, coordinated by Q4Q), EmTREND (Early Information Function for Emerging Drugs, coordinated by OFDT), etc.
[122] Programme of community action in the field of public health (2003-2008), adopted by Decision No 1786/2002/EC of the European Parliament and of the Council of 23 September 2002; OJ L 271 , 09/10/2002 p. 1–12.
[123] Examples of drug-related projects that were awarded funding in recent years are: European Network on Drugs and Infections Prevention in Prison (ENDIPP), Democracy, Cities and Drugs, Correlation Network;
[124] Maatschappelijk Transformatie Programma voor Centraal- en Oost-Europa; a national funding programme of the Netherlands Ministry of Foreign Affairs, supporting the societal transformation in countries in Central- and Eastern Europe, with the aim to strengthen democracy, civil society and the rule of law.

outside the EU, such as the Candidate Countries, the MAGREB region and South American countries like Peru and Chile.

6 Conclusions

The objective of this report is to provide an overview of existing policies and practices in the EU Member States regarding the implementation of the Council Recommendation on the prevention and reduction of health-related harm associated with drug dependence and an overview on the effectiveness of scientifically evaluated harm reduction interventions.

Like most public health interventions, harm reduction services and facilities are best implemented as part of an integrated system of prevention and care, in conjunction with other areas of drug demand reduction. The general assumption is that drug prevention, harm reduction and drug treatment reinforce each other.

6.1 Inventory of policies and practices in the EU Member States

6.1.1 Recommendation 1 – harm reduction and public health policy

Investment in preventing and reducing drug-related health harms makes good sense from a public health perspective. The short- and long term health effects of drug-related infectious diseases are generating costs for society as they are transmissible to the general population, especially if not discovered and treated in time. Drug-related deaths through drug overdose can be avoided to a great extent.

This inventory shows that harm reduction is accepted as a part of drug demand reduction and public health policy in practically all EU Member States. All Member States have policies in place that reflect the majority of recommendations from the Council Recommendation. The Council Recommendation has provided guidance and a basis for policy development.

Despite the above, there is often a time lag between policy formulation and adoption of harm reduction measures (i.e. in National Drug Strategies and Drug Action Plans) and their actual implementation in practice. The implementation of harm reduction policies takes time and requires regular adjustments because patterns in problem drug use and drug dependency change over time.

6.1.2 Recommendation 2 – harm reduction measures in the Member States

In general, harm reduction services and facilities as one of the possible approaches to respond to problem drug use, are common practice in all Member States, be it to a lesser extent for Cyprus and Sweden. Overall, policies of the European Union Member States are in balance with the recommendations as reflected in the Council Recommendation. However, the available data, which are largely self-reported by the Member States, provide an overview of the availability of services and facilities in the Member States, but not a complete picture of the accessibility[125] and/ or the coverage[126] of these interventions. Such data –in general– are often not available at national level.

> **[R2.1]** *Information, Education and Communication (IEC)* is a harm reduction instrument that is common in the countries of the European Union. Telephone help lines, harm reduction-based websites, educational leaflets and training for drug users focused on the reduction of drug-related harm (safer use, overdose prevention) are available in all or almost all Member States. Pill-testing as an IEC measure is not widely available: currently in five Member States such a service is provided.
>
> **[R2.2]** *Communities and families of drug users* seem widely *involved in risk reduction* in the Member States, and specific information is available to these groups in a majority of these countries. However, more in-depth analysis might be useful regarding the nature of this involvement and/ or the content of the available information. Further information is needed regarding the question how these stakeholders are involved in harm reduction, and what specific materials or courses are available.

[125] *Accessibility* implies that harm reduction services are open to all drug users that are in specific need of these services. For example, drop-in centres may exist throughout a country, but may be accessible to clients of (certain) drug services only (and not to those who are not in touch with these). In that case their accessibility is limited. Another example: treatment of hepatitis C or Aids may be available nationwide. But it may be that drug users are refused treatment. In that case accessibility to treatment is insufficient. Coverage in itself is not an indicator for the level of access drug users have to any given intervention.

[126] *Coverage* refers to the distribution of interventions and services among drug user communities in a country or region. For example, interventions may be available in places where large groups of drug users are situated, in one place only or available throughout a country. Adequate coverage means that interventions and services are in place where they are needed.

[R2.3] *Outreach work*, either street-based or at dance parties/ raves, is quite widespread in the European Union, albeit that in most of the countries this service is not available nationwide but only in specific geographical areas.

[R2.4] *Peers and volunteers* seem to be *involved in outreach work* in the majority of Member States, and this holds true for the availability of training for peer and volunteers too.

[R2.5] *Networking and cooperation between outreach work agencies* exist in the vast majority of Member States, but in some Member States the amount of agencies that exists is too small to really speak of networking and cooperation. In a number of Member States networks of harm reduction-based organisations have been established over the past years, aiming at continuation and improving of services, and to improve users' accessibility, for instance in the Czech Republic. In other countries, such as Spain (with autonomous regions), cooperation and the exchange of information between agencies in outreach work is not established, at least not formally.

[R2.6] (*Substitution) Treatment with methadone and buprenorphine, supported by psycho-social care* is available in almost all Member States. This may indicate that the use of this harm reduction intervention is widely accepted among the Member States. Medical prescription of heroin to opiate dependent drug users, however, is available in only four Member States, and is mainly a Western European phenomenon (except for Spain, heroin maintenance is available in the United Kingdom, Germany and the Netherlands). The same holds true for drug consumption rooms. Similar to heroin prescription, this type of harm reduction intervention is controversial in the majority of Member States, and is only available in Germany, the Netherlands, Luxembourg, and Spain.

[R2.7] *Measures to prevent diversion of substituted substances* are taken in 22 Member States. Diversion of prescribed substances, especially methadone and buprenorphine, is being reported by a number of Member States and measures are taken to prevent the leakage of substituted drugs to the black market; measures include strict registration, supervised consumption, urine check, and daily pick-up of the substance by drug users in maintenance programmes. In Italy, as reported by the National Focal Point, diversion of prescribed drugs is a minor problem that does not call for specific action. Overall, the number of drug users who sell their drugs for opiates, is not estimated to be high.

[R2.8] *Harm reduction interventions in prisons* in the European Union are still not in accordance with the equivalence principle adopted by the UN General Assembly, UNAIDS, WHO and EU and which calls for equivalence in health services and care for drug using inmates (among which harm reduction) inside prison compared to services available in the community outside prison. Substitution treatment is available in prisons in the majority of the Member States, although the coverage in each country varies considerably. Sterile drug paraphernalia like filters, alcohol swabs and spoons, as a means to prevent the transmission of drug-related infectious diseases, are not provided in the majority of prisons in the Member States. Needle and syringe exchange is available in prisons in a limited number of prisons in Germany, Spain and Luxembourg only.

[R2.9] A policy supporting the *prevention of infectious diseases* exists in 24 Member States.
Testing/ screening on infectious diseases are available to drug users in 22 Member States. Prevention and education measures, and treatment of infectious diseases targeting specifically at drug users are available in 20 Member States. Vaccinations programmes exist in all EU Member States but are not always targeting drug users: 13 Member States reported that they have vaccination programmes against tuberculosis that are targeted specifically at drug users.

[R2.10] *Needle and syringe exchange* is available to drug users in 24 out of 25 Member States. In fifteen Member States this service is provided nationwide. Almost all MS also provide (other) drug paraphernalia and condoms to drug users. Generally speaking, this harm reduction intervention is well provided. Needle and syringe exchange is a predominant or common response strategy to prevent infectious diseases among drug users, and low threshold agencies, including needle and syringe programmes are a predominant or common setting for measures targeting at the reduction of drug-related deaths, in the majority of Member States.

[R2.11] Despite the fact that all Member States have a policy that ensures that emergency medical services are trained and equipped to deal with overdoses, only ten Member States report to offer such training to emergency services. Naloxone, an opiate antagonist that counters the effects of opiates and therefore effective in case of an opioid overdose, is reported to be available to ambulances in twenty Member States. Information materials aiming at the reduction of drug-related deaths and risk reduction/ response training are provided to emergency services in just a few Member States.

[R2.12] In total 23 Member States report that a policy is in place that promotes the integration of harm reduction with health, including mental health, and social care. The operationalisation of this policy still needs development as there are no indications that any Member State has succeeded in providing a fully integrated system of care for drug users. Even though the Member States indicate that harm reduction is considered an integrated part of (mental) health care and social care, this integration has not always been realised in practice. Member States continue to struggle with drug users who have both a dependency problem and a mental health problem (co morbidity or double diagnosis) and the reintegration of former drug users to a regular working life and housing is often still problematic.

[R2.13] A policy supporting training leading to a recognised qualification for harm reduction professionals, exists in 22 Member States. Training in major harm reduction interventions such as needle and syringe exchange, outreach work, substitution treatment, low threshold agencies in general and for prison staff exists in the majority of Member States.

6.1.3 Recommendation 3 – harm reduction and monitoring & evaluation

In regards to the 3rd Recommendation of the Council Recommendation, the impression is that Member States – in general – subscribe to the need for greater emphasis and use of scientific evidence for harm reduction practice. There seems to be a difference in approach between Member States regarding the question whether policy should prescribe the use and development of evidence for policy and practice, or whether this is a task for independent (scientific) structures in the drug field.

[R3.1] Member States seek for *scientific evidence to support the selection of interventions*, but this practice is not implemented in every EU Member State. Research that is mentioned in the data reported by the Member States includes research programmes into the effectiveness of e.g. substitution programmes, outreach work and needle exchange.

[R3.2] The 2nd sub recommendation advocates the *use of needs assessment in the selection of programmes*. The inventory shows that this is still an area that needs further development. Member States do subscribe to the need of needs assessment, but have often not implemented it. Yet, needs assessment (e.g. Rapid Assessment and Response) is one of the important tools to assess what the coverage and accessibility of harm reduction interventions is and how it should be improved.

[R3.3] The 3rd sub recommendation that calls for the *development of evaluation protocols for the evaluation of interventions* is among the least implemented sub recommendations. This recommendation is rather abstract from a perspective of policy formulation. A number of Member States considered this recommendation as a task for scientific institutions dealing with quality evaluation. Nevertheless, Member States such as the Czech Republic and Denmark have developed evaluation protocols and guidelines.

[R3.4] Of all Member States, a little more than half have adopted a policy that aims to *support the development of evaluation quality criteria*. In the countries that have developed quality criteria, these are often part of a broader quality assurance programme for drug demand reduction, including prevention and treatment. It is unclear to what extent Member States have implemented quality guidelines in practice. Although the EMCDDA has developed several publications on quality and evaluation, Member States do not refer to these in their reports.

[R3.5] This 5th sub recommendation calls upon Member States to *collect and disseminate data in accordance with EMCDDA guidelines*. Overall, the Member States have adopted the policy aim to implement the EMCDDA five key epidemiological indicators, but in operational terms, not all Member States comply fully with all standards and methodologies of these key-indicators. Furthermore, for the production of National Reports and other information

carriers, standard tables and structured questionnaires are completed by National Focal Points that exist in each Member State. The compliance with the Structured Questionnaires 23 and 29 was satisfactory. However, overall there is no overview available to what extent Member States fully comply with EMCDDA guidelines. Member States do receive individual feedback from the EMCDDA on the quality and completeness of their input every year.

[R3.6] Further *research for scientific evidence on harm reduction measures and interventions* is still needed. As the collection of hard evidence on effectiveness through RCT's is not always possible for public health interventions other forms of evidence are needed. The response from the Member States regarding the use of scientific evidence on harm reduction to inform policy shows that this is not common practice. Member States increasingly report the evaluation of national drug strategies and national action plans, but only a limited number of Member States seem to systematically run evaluation schemes that aim to identify effective interventions. For a number of countries (e.g. France) the field of evaluation for policy is still relatively new. Many evaluation schemes are not specifically targeted at harm reduction interventions, but target a broader drug demand reduction field.

[R3.7] Over half of the Member States indicate that they have policies in place that *promote the development of evaluation training programmes*. Reitox National Focal Points are mentioned frequently as (co-) organiser of such training programmes, but the overall picture is that evaluation training programmes are not yet part of the regular curricula for professionals in addiction care.

[R3.8] More than half of the Member States have adopted a policy that aims to *promote the involvement of stakeholders in the evaluation of (harm reduction) interventions*. However, very few Member States give concrete examples of structural participation and involvement. Limited information is available on the *use of innovative methods* aimed at involving drug users & family/ friends, professionals and/ or the broader community. Methods mentioned include competitions and awards .A European network has been set up (Rezolat) which has innovation and participation as one of its aims.

[R3.9] This sub recommendation has seen quite some follow up. There is and has been a lot of collaboration *between Member States* in recent years *in the field of drug demand reduction* and – in a smaller number of instances – *in the field of harm reduction*, mainly through the DG SANCO Programme 'Community Action on the Prevention of Drug Dependence 1996-2002'. Furthermore, regarding the collaboration between the old and new EU Member States, the Phare Twinning programme has been instrumental. The EMCDDA has served National Focal Points with concrete support and advice. Finally, bilateral and multi-lateral programmes between Member States have been developed as well.

6.2 Effectiveness of harm reduction interventions

Scientific evidence on effectiveness is available for many harm reduction interventions. This general conclusion is most promising since effect studies are sometimes hard to conduct in settings where these interventions take place. The circumstances in which harm reduction interventions are implemented, hardly accept a division in study groups for comparing effects of different intervention regimes. Obstructions may be practical or ethical. It is important that innovations in harm reduction are allowed to be based in the first place on pragmatism and local or regional constructions of 'best-practice'. After this try-out phase, it may in some cases be feasible to gather evidence for specific interventions via high-quality effect studies.

Regarding the prevention of infectious diseases, community outreach programmes are found to be effective in reducing several risk behaviours (e.g. injecting drug use). Interventions that include information, education and communication are possibly effective, when combined with other harm reduction interventions. Needle and syringe exchange programmes are probably reducing risk behaviours (needle sharing) and infectious diseases. They may possibly also reduce hepatitis C transmission.

All existing preventive strategies and treatments of infectious diseases (i.e. HIV/ AIDS, hepatitis B and C) are effective. Due to the long treatment periods and its frequently occurring adverse effects, patient compliance should be stimulated during treatment.

In many different circumstances or settings, methadone and probably also buprenorphine maintenance treatment increases treatment retention and patient compliance, HIV risk behaviours, and opiate use, especially when individually adjusted doses are prescribed.

In avoiding drug-related deaths, naloxone (if properly administered) is an effective crisis-intervention tool. Methadone and probably also buprenorphine maintenance treatment are probably reducing the risk of drug-related deaths. Individually adapted high-doses probably reduce opiate use, and improve treatment retention. Interventions that include information, education and communication may possibly further reduce drug-related deaths when combined with maintenance treatment.

Other harm reduction interventions show fairly positive results as well, but we need more high-quality studies to further confirm or rephrase conclusions. Medical (co)prescription of heroin show promising results. It is probably a safe and manageable intervention for chronic and treatment-resistant opiate users and it probably also improves the health situation of drug users who do not respond to maintenance treatment. Pill testing programmes possibly reduce the use of potentially dangerous drugs (early warning). The fear that pill-testing programmes might encourage non-users to start using drugs in recreational settings may be false. Drug consumption rooms may reduce needle sharing and probably also overdose death.

Maintenance treatment in prisons is effective in reducing drug use, needle sharing and transmissions of drug-related infectious diseases. It possibly improves the health situation of both participating prisoners and prison personnel.

Needle exchange in prisons is probably effective in reducing syringe or needle sharing, the reduction of transmission of infectious diseases.
Information and education services and facilities in prison as well as improved living conditions for prisoners may be effective, but further research is needed. Overdose death after release from prison often results from reduced drug tolerance following a period of abstinence during imprisonment.
Pre-release counselling may reduce overdose deaths after release from prison, but this has not been shown in effect studies.

6.3 Final remarks

Harm reduction seems to be an accepted approach in drug demand reduction policies in all EU Member States. Those harm reduction measures that have been implemented most by the Member States (IEC, needle & syringe exchange, substitution or maintenance treatment, naloxone availability) are found promising or effective in scientific literature, especially when combined in an integrated health care system. To date, none of the major harm reduction interventions that have been evaluated have been found ineffective or showed unwanted or undesirable results.

The Council Recommendation of 18 June 2003 has been successful as it has guided and supported policy development in the Member States and because it set a 'benchmark' for existing policies.

Most harm reduction programmes in the EU Member States are mainly focusing on 'traditional' drug use patterns, especially opiate dependency. Interventions taking into account new trends in drug dependence (e.g. crack cocaine and (Meth-) amphetamine dependence) as well as the growing prevalence of the mixed use of licit and illicit drugs are still scarce.

The available data at EU level regarding the availability of harm reduction services and facilities in the Member States as collected and disseminated by the EMCDDA is comprehensive and of high quality. Nevertheless, the quality of data collections on the availability and accessibility of harm reduction services and facilities at national level does still need improvement because Member States do not always have a reliable overview of these services, nor do they always know by whom and how these services and facilities are used.

Finally, at EU level and among the Member States there is an increasing awareness of the need to make policies more research-based and facts-driven, including harm reduction policies. This need is reflected by the 3rd Council Recommendation, but also in the European Drugs Strategy 2005-2012 and the EU Action Plan on Drugs 2005-2008.

7 Suggestions for further steps on the field of harm reduction at EU level

As reflected in this report, many of the harm reduction services and facilities mentioned in the Council Recommendation are available in the European Union Member States. The Council Recommendation of 18 June 2003 can be seen as an accelerator regarding harm reduction policies, services and facilities. The Council Recommendation seems to have confirmed the existing views and approaches within the EU. At the same time, there are clear differences between Member States regarding the choice for and implementation of specific services and facilities. In order to further develop the scope and quality of harm reduction services in the European Union, as well as to increase the possibilities for further comparison, a number of suggestions for further steps and improvements can be made. These suggestions are presented in the paragraphs underneath.

7.1 Suggestions for further development of harm reduction policies

- Member States may consider placing greater emphasis on the further integration of harm reduction in a broader public (mental) health and social care and welfare policy, with the aim to provide realistic and sustainable exit options (from drug dependence) for drug users in the long run. The integration of harm reduction with public health including mental health and social care is of great importance, as an integrated system of care may provide dependent drug users with the best possibilities to improve their social and health situation and facilitate their reintegration in society.
- All EU Member States are confronted with the phenomenon of dual diagnosis among drug users, both regarding poly-drug use as well as psychiatric co morbidity. Co morbidity requires specific attention, especially when the integration of addiction care, (mental) health care and social care is concerned.
- It is also important that harm reduction is part of an integrated system of addiction care and that different types of problem drug use(rs) are addressed by a diversity of responses. This requires diversity in treatment options that reflect the different stages in the drug addiction cycle and client's needs (prevention, detection and screening, ambulant-care/ outreach, short-term care, long-term care, aftercare and rehabilitation).
- When further developing low threshold approaches to reach problem drug users and/ or to increase the success rates of early detection interventions (especially regarding new types of drug-related risks), Member States may consider to involve to a greater extent the primary health care system, including general physicians, nurses and family care systems.
- It is essential that harm reduction services and facilities are provided structurally and on a continuous basis. Member States sometimes discontinue even successful programmes, because of political or financial reasons or because new approaches and treatments emerge. Discontinuing successful services may prove to be counterproductive and costly when problems re-emerge and/ or no suitable alternatives (with proven effectiveness) are available. In some cases, it may even be unethical if the consequence is that a relatively successful treatment is abolished without having an alternative in place. Professional ethics that apply in general health care should apply in harm reduction as well.

7.2 Suggestions for further development of harm reduction services and facilities

- The effectiveness of maintenance treatment is clearly supported by evidence. Therefore it makes sense to match the accessibility to and coverage of this type of treatment to the demand among drug users.
- It is advisable that maintenance treatment programmes take into account the need of drug users and their response to this type of treatment. Although methadone and buprenorphine are equivalent substances in maintenance treatment, drug users may experience different, sometimes more positive effects from one alternative over the other. It is advisable that both methadone and buprenorphine are available (i.e. covered by health insurance) to meet drug users needs.
- The principle of equivalence regarding health care – including harm reduction – in prisons requires serious attention and ongoing investment. More than a decade of debate on minimum requirements, strategies and approaches towards harm reduction in prison has not resulted in a satisfactory availability, accessibility and coverage of effective measures in prisons.
- The continuity of care and rehabilitation for drug users that are released from prison requires serious attention, as they are important to prevent drug-related death and relapse.

- Given the high prevalence rates among (*former*) injecting drug users, pro-active testing & screening for drug-related infectious diseases among high-risk groups is essential, so that vaccination and/ or low threshold treatment can be made available for all problem drug users.
- It is important that policy makers realise that the visible effects of vaccination and treatment policies on the reduction of drug-related infectious diseases may show serious delays, as viruses may have been transmitted in the past but still cause illnesses and costs (e.g. chronic hepatitis, HIV, cirrhosis, carcinoma).
- It is important that targeted prevention efforts are developed for special at-risk populations, including pregnant women and children, children of parents with psychological and addiction problems (incl. alcohol) co occurring disorders such as ADHD and drug addiction. Through early detection and interventions, problem drug use may be prevented or treated at an early stage.
- In harm reduction, treatment retention by drug users is sometimes difficult to maintain in the long run, i.e. due to their unstable social situation, arrest, relapse, etc. It is therefore important that Member States continue to improve their addiction care system by increasing the accessibility of services and by applying flexible, pragmatic approaches that may provide tailor-made solutions for specific needs.

7.3 Suggestions for further development of quality, monitoring and evaluation in harm reduction

- The use of scientific evidence to select interventions and to inform policy making, needs further encouragement. Needs assessments and the application of quality assurance models are needed to further improve the coverage, accessibility and effectiveness of harm reduction interventions.
- Harm reduction interventions might best be evidence-based where possible. But science alone should not be the only advisor for policymakers and intervention decision makers. The effectiveness of some public health interventions implemented in a real-life situation cannot easily be evaluated through strict evaluation methods, such as RCT's. Therefore it is advisable that appropriate instruments are developed to measure and establish the effectiveness of these interventions.
- The absence of evidence supporting the effectiveness of interventions (in contrast to the evidence that indicates interventions are not effective) should also not stop Member States from implementing harm reduction measures if they seem to make sense from a pragmatic point of view.
- Harm reduction interventions, including drug prevention and risk reduction measures, are culturally sensitive and need to be adjusted to local situations.
- There is a need to improve the quality of data on availability and accessibility of harm reduction interventions in the Member States. In order to do so, it is important to improve the documentation of the range of services provided at specialised low threshold harm reduction agencies in EU Member States. For this purpose a standardised tool may be developed for describing the work of agencies (inventory).
- There is also a need to determine better if harm reduction services are actually used, if they are used by those they are targeting and if those who need services have access to them. In order to do so, it is necessary to increase research on accessibility of services by documenting utilisation patterns on socio-demographic profiles of clients through a standardised client survey. This could be done by using harmonised approach/ tool across all Member States to generate added European value.
- Like many other health-care interventions, some harm reduction services can be costly, especially when provided for a longer period of time. It is therefore useful to evaluate the cost-effectiveness of harm reduction interventions, including social and economic costs to society[127].
- And finally, the development of a bottom-up approach by involving key stakeholders in harm reduction may improve quality.

7.4 The need for further research

- Further research into (scientific) evidence on harm reduction measures and interventions is needed. In some cases – where hard evidence on effectiveness through RCTs is not possible - a further debate and development of innovative research methodologies is required, with the aim to bridge the gap between strictly controlled, often medical research (RCT's) and research in the field of social sciences, including those in the field of public health interventions. For the time being, however, it should be considered to give innovative and pragmatic approaches the

[127] Example: Van den Brink [2003]: the Dutch heroin prescription trial also included a cost-benefit analysis of the intervention versus the original maintenance treatment scheme. A net benefit of US$ 13.000 per client on an annual basis was gained as well as a serious reduction of drug-related petty crimes and misdemeanors (up to 70% reduction).

benefit of the doubt, especially if there are indications that they are successful and do not do any harm in daily practice. Not doing anything in these cases would result in unnecessary harm to drug user's health, which might not only cause risk for public health but would also be questionable from an ethical perspective.

- At the same time, it is advisable that the EU further invests in research and development of harm reduction measures. The European Union Drug Strategy 2005-2012 incorporates a balanced approach towards the drug problem which is relatively unique in the world. Research, including in the field of harm reduction that can provide a sound scientific basis for the principle of that balanced approach is much needed. EU research and development programmes (Public Health Programme, Framework Programmes) may support the development of such a scientific basis. Furthermore, Member States may consider conducting joint research or developing common interventions for specific challenges regarding drug-related harms they may encounter.
- Further research is also needed regarding the effectiveness of Information, Education and Communication interventions to prevent drug-related infectious diseases and drug overdose. And even if the evidence for needle and syringe exchange is showing good indications for effectiveness, more research is required for the implementation of this type of intervention in prison settings.
- Maintenance treatment shows good results in improving drug dependent users' health and social conditions, however further research is needed to examine its effectiveness in combination with psychosocial interventions. Regarding the effectiveness of services and facilities such as drug consumption rooms but also pill-testing programmes, further research is needed, also regarding the interaction of these interventions with other interventions. As stated earlier: by providing an integrated and comprehensive harm reduction response to infectious diseases and drug-related death, the benefits of a combination of interventions may be larger than the effectiveness of isolated interventions.
- Regarding new types of problematic drug use and the drug-related harms associated with it, it is advisable to conduct further research into the effectiveness of selective and indicative prevention aimed at specific groups of drug users. This includes prevention and harm reduction in a-typical drug user communities.
- Research into integrated interventions and treatments for drug users with a co morbid condition requires higher priority so that dependent drug users can receive the support they need.
- Furthermore, research into effective treatments for cocaine and amphetamine dependency is needed as a basis for cocaine maintenance treatment (for heavy cocaine users) and cocaine detoxification treatment. Also contingency management or reward-based interventions (giving rewards to drug users in treatment, e.g. small allowances for not using cocaine) needs more research.

7.5 Final suggestions

- It is important that Member States continue to develop new harm reduction measures - parallel to those that already exist– that address new patterns and emerging trends in drug use and drug dependence. Most harm reduction policies, services and facilities that have been identified in this inventory study concern 'traditional' interventions in response to traditional forms of drug use. Drug use patterns change (e.g. shifts from injecting heroin use to smoking heroin), as well as at-risk groups and the types of drugs used.
- Recently the EC's Horizontal Working Party on Drugs[128] emphasized the developments in Cocaine use among young adults. In several EU Member States recent cocaine use among this group (age 15-34) is rising[129]. Cocaine is often used in combination with other licit and illicit drugs in predominantly recreational, nightlife settings. Against this background, additional harm reduction measures may be developed. Such measures may include:
    - Improvements in data collection, both qualitative as quantitative in order to monitor emerging trends and patters.
    - Innovative methods to reach out to specific 'at risk' groups, e.g. in club settings.
    - Research into effective methods of (maintenance) treatment for cocaine and (meth-) amphetamine dependence[130].
    - Development of preventative interventions for 'at risk' groups.
- The collection of data on problem drug use and drug-related harm at Member States level is still not always comparable due to different estimation systems at local level. Furthermore,

[128] HWPD, Cocaine – Identifying specific demand-reduction measures – Conclusions paper for the meeting of 10 January 2006, CORDROGUE 11083/06, 29 June 2006.
[129] E.g. UK, Spain, the Netherlands, France, Italy, etc. Source: EMCDDA [2006]. Annual Report 2005. p. 56.
[130] New developments in research on the treatment of cocaine addiction include a.o. the development of a vaccine against cocaine dependence and treatment with Modafinil (mainly US based research).

more emphasis could be placed upon the prevalence of drug-related harm in relation to the specific at-risk groups in Member States rather than those of the general population. Member States with relatively small groups of problem drug users may have a high prevalence of drug-related harms such as infectious diseases among these problem drug users. Although the number of problem drug users may be small compared to the general population, the prevalence of drug-related harm may be considerable.

Finally, it might be interesting to examine whether – by the end of the EU Action Plan 2005-2008 – the implementation of policies, services and facilities regarding harm reduction as presented in this report, has progressed. Therefore it might be worthwhile to repeat the exercise that formed the basis of this baseline report and analyse what further progress has been made.

Annex 1 - A brief review of the literature

Effectiveness of harm reduction interventions: A brief review of the literature

Index

Introduction

This literature review primarily summarises scientific evidence for effectiveness of harm reduction interventions for drug users. Harm reduction largely overlaps with treatment, prevention and reintegration. The main focus of this review has been predefined on interventions targeting infectious diseases, drug-related deaths among drug users and maintenance treatment. We additionally report evidence for effectiveness on medical heroin prescription, pill-testing programmes, pre-release counselling, drug consumption rooms and in-prison interventions. The result of this selection procedure is that some prevention and treatment interventions have been kept out of this review, e.g. drug-free treatment or harm reduction interventions for cocaine and amphetamine dependence.

This review also presents some results from general guideline publications that may be important for decision making on a national and European level. While scientific publications tell us what is known, guidelines are telling us what to do. A review of guideline publications is not considered feasible in a scientifically valid manner, because these publications vary too much in level of abstraction and methods. **Appendix 1** of this review gives a more elaborate explanation on this subject. Instead this literature review presents some general remarks and recommendations from guidelines published by (inter)national funding organisations, e.g. the National Institute on Drug Abuse (NIDA), the World Health Organisation (WHO) and some other organisations.

The references that have been used in this review are presented in **appendix 2**.

1 Methods

Medline, PsycInfo, Embase and Toxline were screened with database-specific strings of key terms to identify and select relevant studies. The key terms used focussed on several indicators for effectiveness, (users of) illicit drugs and harm reduction. The literature search went from 1990 until mid 2005. We further checked the indices of several journals and websites in this domain for more recent publications. Reference lists in selected publications were screened on relevant additional publications and some experts were contacted. Predominantly English publications were selected. In many of the review studies however, publications in other languages were included. More recent publications were added based on tips from experts and screening websites of scientific databases and websites, for instance from the Cochrane Library, the World Health Organisation or governmental organisations.

One of the key issues of this literature review is the question when a harm reduction intervention is considered to be evidently effective. An answer to this question assumes a two step procedure: 1) determine the evidence for effectiveness in the scientific literature, and 2) appraise or grade this evidence on a scale of being (in)sufficient for deciding an intervention or programme as (in)effective.

A. Effectiveness

There is an ongoing debate about the best methodology to be used in determining effectiveness of interventions in public health. Traditionally, medical science uses strict rules for experimental research and the gold standard is a so called randomised controlled trial (RCT). However, in public health issues, a design as applied in an RCT is often difficult or even impossible. In a strict scientific sense, alternative designs are not optimal to proof effectiveness. Thus, the methodological debate on the study design suitable to produce evidence of effectiveness in public health currently remains unsolved.

In this report, we have chosen to follow the conservative methodological rules of experiment as applied in medical and psychological research, such in line with well-known scientific networks as the Cochrane Collaboration and the Campbell Collaboration. We have expanded the methodological scope somewhat by including studies that deviate from the RCT design (e.g. time-series or prospective cohort studies, preferably combined with a multivariate analysis, including factors that may also influence the outcomes). Finally, the results of some systematic reviews that used an adapted methodology for grading evidence, were also included in this review. This was done because the methodology used, adds value to the well-known methods for grading scientific evidence that are used in this literature review. Although this alternative methodology still needs to be evaluated, it offers a progressive step in determining the effectiveness of interventions in public health domains where randomised clinical trials are in many cases considered impossible, unfeasible or not desirable due to practical or ethical problems.

B. Evidence
Different levels of evidence are commonly discerned in grading evidence for literature reviews. Distinctions in cut-off-points between what is considered 'sufficient' and 'insufficient' evidence are largely arbitrary. Important however is to describe explicitly how the evidence has been appraised and graded. A rough grading procedure was used, i.e. without systematically specifying quantity and quality of the studies. When a systematic review or a meta-analysis of at least three RCT's was available with equally directed significant outcomes or three separately published RCT's with outcomes that were alike and significant, the evidence is considered 'sufficient', thus the intervention is considered *effective*.-An amount of two RCT's or one RCT combined with at least two studies of lesser quality (i.e. well-done time-series or prospective cohort studies) was considered to give valuable indications for effectiveness. In these cases the intervention is *probably effective*. In case of doubt, i.e. only one RCT (with or without one study of lesser quality) or merely one or two studies that are all of lesser quality but with positive findings, the evidence is in fact still insufficient. In this case we use phrases like '*may be effective*' or '*possibly effective*' because we don't know enough about this subject yet. For some interventions no studies were found or studies showed no consistent positive findings. In this last case there is *no evidence* or the evidence is *unknown* yet.

For many interventions conclusive proof for the effectiveness is not available yet. This does not necessarily mean that these interventions are ineffective. It merely means that we still do not know enough about the effects of these interventions. These interventions may appear to be effective if enough high-quality studies would be available. This implies that many of these interventions are worthwhile trying out in real life situations. Daily experience and results of studies of lesser quality may suggest that these interventions do have positive outcomes on drug users and their environment. However, although this kind of 'evidence' is often used in constructing guidelines, it is not the primary subject of this review.

Note that in most studies that have been evaluated, effectiveness means effectiveness under controlled conditions (efficacy). Effectiveness in everyday practice will be explicitly labelled as such.

2 Prevention and treatment of infectious diseases among drug users
Drug-related infectious diseases can cause serious health problems among drug users that may lead to chronic complications and eventually death. Injecting drug use increases the risk of hepatitis C considerably. Together with unsafe sexual behaviours, injecting drug use increases risks of HIV and hepatitis B infections. Drug-related infectious diseases exert a high financial and social burden on society. Below we report scientific results on the effectiveness of several prevention interventions of drug-related infectious diseases and treatments of viral infections.

2.1 Prevention of infectious diseases
In theory, prevention of injecting drug use could be one of the most effective strategies to reduce drug-related infectious diseases (DRID). However, these diseases are not solely related to injecting drug use but also to unsafe sexual contacts and unsafe life style in general.

2.1.1 Information, education and communication (IEC)
Many types of *information, education and communication* (IEC) are being used in prevention of injecting drug use. IEC-messages may be spread via leaflets, booklets, audio-visual media or advocacy. IEC may be part of any other intervention, e.g. mass media campaigns, outreach and other harm reduction interventions, treatment, HIV-testing and counselling, or harm reduction counselling.

Few high-quality studies can currently be found in the international literature on IEC, and the evidence of effectiveness of IEC is weak. IEC may at best be short-term effective in raising awareness and in more specific variants in changing knowledge and understanding, not in changing behaviour. These interventions are widely used as part of more extensive prevention or treatment packages. In general it is assumed that these interventions are more effective when combined with other prevention strategies (Miller & Rollnick, 1991; Walitzer et al., 1999). The literature also stresses the importance of applying IEC after adapting messages and strategies to the needs of specific target groups (Aggleton et al., 2005).

Many studies concentrate on mass media messages, fear-arousal and motivational enhancement techniques. Mass media campaigns in preventive messages appeared to be largely ineffective (Derzon & Lipsey, 2002; Westat, 2003). Other studies show that when mass media messages are not paternalistic but invite people to make choices based on ones own insights and opinions they tend to be more effective (Burgoon et al., 2002).

Individual motivational enhancement may be a promising intervention (Dunn et al., 2001). Actually, to be motivated is a prerequisite for both the success of treatment and harm reduction (Joe et al., 1998; Dakof et al., 2003).

2.1.2 Community-outreach programmes

Community-based outreach programmes are considered another component of preventing drug-related infectious diseases among risk groups i.e. those exposing sexual risk behaviour or injecting drug use. These outreach programmes aim to create access to hidden populations in their daily environment for targeted action against high-risk behaviours. Outreach activities are matched to the individual needs of members of the target group. Activities include increasing risk awareness, demonstrating skills to avoid or reduce risks, behavioural counselling, distributing injecting equipment (see 2.1.3), or providing referral to regular treatment.

Other components of prevention of infectious diseases are needle and syringe exchange programmes and a range of means to reduce harm indirectly. Examples are promotion of condom use, bleach, access to HIV-testing and counselling programmes, e.g. distributing information on programme locations and times and/ or on injecting equipment.

Contents of community-based outreach programmes may vary widely and have changed in time. Examples of programme components are: identifying and establishing contacts with injecting drug users, identifying and recruiting peer leaders, increasing risk awareness, demonstrating skills to avoid or reduce risks, distributing injecting equipment, behavioural counselling, or providing referral to treatment.

These programmes serve to access (partly) hidden populations of drug users in their natural surroundings and enable them to reduce drug-related risk-behaviours. Desired outcomes were increase in programme coverage, programme participation, and a reduction of both risk behaviour and infection rates.

The results of more than 40 published studies, including multi-country, multi-site studies and meta-analyses (sufficient evidence), reveal that community outreach programmes are effective on several outcomes. Injecting drug users (IDUs) reached by these programmes and who are offered access to harm reduction services, report reducing their risk behaviour and lowering their exposure to HIV (Needle et al., 2004; 2005). IDUs referred by outreach workers to available, accessible and acceptable services (e.g. voluntary testing, counselling, and drug dependence treatment) increasingly use these services and reduce their injecting drug use. In general, drug users who participated in a community-based outreach intervention were also slightly more likely to reduce their sexual risk behaviour, compared to those who followed another (unspecified) intervention strategy. In studies focussing on sex behaviours, there were indications that treatment compliance increased and drug use reduced considerably when the intervention-group was compared to a group that had no intervention at all (Semaan et al., 2002; Des Jarlais & Semaan, 2005). Most findings in the above-mentioned studies were consistently reported in different places, under different circumstances and at different times during HIV epidemics (WHO, 2004a). Besides being effective on several outcomes, outreach programmes are relatively inexpensive interventions for preventing HIV and other drug-related infections among IDUs. Empirical studies of outreach programmes that also include preventing HIV infections (sero-incidence) are rare and of lesser quality, but the outcomes suggest that outreach work may substantially reduce HIV infections among injecting drug users.

The available literature strongly suggests that community-based outreach work for drug users should be made accessible and disseminated. Training, supervision and compensation of outreach workers (often ex-users) are essential for sustaining (the quality of) outreach work. *Prevention of relapse of supporting staff* (partly ex-users) is also important. Advice, information, support is crucial, together with careful selection and debriefing of the outreach workers.

2.1.3 Needle and syringe exchange programmes

Sharing injecting equipment is a main risk factor for the transmission of drug-related infectious diseases. In general, the incidence of these diseases among injecting drug users is highest compared with non-injecting drug users (Anderson & May, 1991). Needle and syringe exchange programmes are meant to reduce the spread of infectious diseases among injecting drug users. The introduction of needle and syringe exchange programmes has grown considerably from 1985 on to 2001 in 24 European countries including Bulgaria and Norway (EMCDDA, 2005).
The WHO published the first comprehensive international review on evidence for sterile needle and syringe exchange programmes (NSPs), showing that these programmes probably reduce HIV transmission (i.e. incidence, prevalence, risk behaviour) that these are probably safe and – based

on one of the added criteria for grading evidence – these programmes are probably also cost-effective (Wodak & Cooney, 2004). A second review showed specifically the cost-effectiveness and even cost-saving effects of needle exchange programmes in HIV prevention. In preventing hepatitis C, cost-effectiveness of needle and syringe exchange programmes is less clear (De Wit & Bos, 2004).
The systematic review of Gibson et al. found that NSPs reduce risk behaviours that are strongly related to HIV infection. Two-thirds of the reviewed studies (28) had positive outcomes of needles or syringe exchange (reductions in HIV infection rates), and one-third had null/ mixed (fourteen) or negative (2) results (Gibson, 2001).
In several studies unanticipated benefits were also found, e.g. increased enrolment in drug treatment or higher treatment retention rates (WHO, 2004a; 2004b). These findings are consistent with earlier reviews (e.g. Satcher 2000; Institute of Medicine, 2001; Gibson et al., 2001).
Wodak and Cooney's review compared changes over time in HIV sero-prevalence rates (traces of HIV-infection in the blood) among IDUs worldwide for cities with and without needle exchange programmes. There was a remarkable difference in average sero- prevalence rate per year between cities without NSPs and those with NSPs. The average annual change in sero-prevalence was significantly lower (11%) in cities with NSPs (Hurley et al., 1997).
Recently Amundsen noted however, that the design of this and some other studies that were analysed in these reviews lack adequate control groups or analysis of confounders. Thus, actually it cannot be decided yet which factors are more important for reducing HIV-transmission, NSPs or - for instance - *HIV testing and counselling* (Amundsen, 2006).

Results of long-term monitoring activities should also be interpreted with caution (cf. Emmanuelli & Desenclos, 2005). French monitoring results show associations between NSPs and several outcomes, i.e.: growing (and later declining) numbers of syringes distributed or sold over a period of 7-8 years; lower HIV prevalence rates among injecting drug users; a decline of deaths due to overdoses; and a decline of injecting drug users that have been arrested by the police. The hepatitis C rate remained high. These results suggest the NSPs may have positive effects on HIV prevalence rates, deaths due to overdoses, and on numbers of arrested drug users by the police. This monitoring study shows that access has improved and that the coverage of NSPs in France is large. Although these are important prerequisites for success, large coverage rates and improved access are not sufficient conditions for reductions in drug-related harm. Monitoring studies can at best give circumstantial evidence for possible causal relationships.

2.1.4 Treatment of drug dependence for preventing infectious diseases

Maintenance treatment involves the prescription of a substitution drug to a dependent drug user for a longer period of time (in general, years). Its primary aim is to stabilize one's living and health conditions. Maintenance treatments are also assumed to be useful for prevention of infectious diseases, e.g. by reducing or stopping injecting drug use. The risk of getting these diseases is on its turn assumed to be reduced. Methadone maintenance treatment is already introduced in most European Member States and buprenorphine maintenance treatment predominantly in France and the Czech Republic.

Methadone maintenance treatment is most studied (see also 4.1) and a narrative review shows that maintenance treatment may prevent needle sharing and HIV infection (Sorensen & Copeland, 2000).
Another narrative review of meta-analyses and systematic reviews (WHO/ UNODC/ UNAIDS, 2004; Farrell et al., 2005) covered methadone, buprenorphine, naltrexone and their effect on preventing HIV/AIDS. Methadone maintenance treatment (MMT) is not only associated with a significant reduction of (injecting) opiate use, but also with a reduction of sharing of injection equipment. It does not seem to lead to more protected sex behaviour. These findings are consistent with those of a Cochrane Review (Gowing et al., 2004; Gowing e.a., 2006).

2.1.5 Vaccination for hepatitis B

Series of vaccination are effective in preventing hepatitis B infections. Hepatitis B infection may ultimately end in serious liver disease (cirrhosis or cancer). Effective vaccination is several decades old and has proven to be effective in protecting against clinical hepatitis B infection and chronic carriage of this disease for those who responded to complete hepatitis B primary vaccination series (three vaccinations). Follow-up studies showed that from ten to fifteen years after completed vaccination, no infections occurred and development of a chronic infection was very rare. These (already) favourable results were valid for infants, children and adults (cf. Jilg & Van Damme, 2004). Larger follow-up periods should be investigated before a firm conclusion can be drawn regarding the duration of this favourable effect.

2.2 Treatment of viral infections

Most studies on treatments of viral infections are not specifically directed to drug users, but the results are also considered valid for this subgroup of patients. In case of doubt this is mentioned explicitly.

2.2.1 Treatment of HIV/ AIDS

Highly Active Antiretroviral therapy (commonly abbreviated as HAART and nowadays more briefly labelled as antiretroviral therapy) became available in 1996 as an effective treatment for HIV infections in general. HAART suppresses the viral HIV load in the human body and this was more than welcome during the epidemic that started two decades ago.
Combination Antiretroviral Therapy (CAT) may be administered to HIV-infected individuals as a maintenance treatment after successful initial antiretroviral mono-therapy. CAT has been shown to decrease viral replication, to improve immunologic function and to delay the progression rate of the infection. But CAT also has some draw-backs. There are concerns about possible cumulative toxicity of CAT. Furthermore, positive outcomes of (combination) antiretroviral therapy require much discipline of patients to adhere to the prescribed regimens in order to stay effective. This adherence is burdened by a range of severe adverse effects of these therapies. The results of a systematic review show that pharmacy-led educational counselling and telephone support is helping those people living with HIV/ AIDS to keep to their therapy regimens (Haddad et al., 2000). Whether this strategy also helps for infected drug users is still questionable.

A second review of four trials showed that reducing the number of treatment drugs in CAT also reduces its effectiveness (Rutherford et al., 2003). Thus the need to find less complicated treatment regimens with fewer potential drug interactions and less adherence difficulties remains. Research should address "(…) longer and more potent initial therapy, alternating drugs, or beginning initial therapy much earlier in the course of infection." (ibid.). People with HIV often seek alternative or 'complementary' treatment for their disease. However, evidence for effectiveness of herbal medicines for HIV-infection is still insufficient. Many small studies have been published but the bulk of these have – on average - low methodological quality (Liu et al., 2005). Finally, people's beliefs about antiretroviral therapy and viral load may be of influence on sexual behaviour (Crepaz et al., 2004).

2.2.2 Treatment of hepatitis B and C

Treating hepatitis B and C with antiviral therapy evolved quickly during the past decade. Injecting drug use appears to be an important way of transmission of hepatitis C although sexual behaviour is probably more important.
One of the aims of antiviral therapies is to interrupt the progression of acute hepatitis B and C. Once chronic, hepatitis B and C may have devastating effects on health. Due to the overall health morbidity of this disease and its long-term consequences, wider availability of a range of interventions (e.g. needle and syringe exchange programmes, maintenance therapies, behavioural interventions, bleach distribution, supervised injection rooms) is very likely to lead to significant health and economic savings (WHO/ HEN, 2005).

Although interferon monotherapy was in former years the best-known intervention for this disease, current evidence points at polyethylene-glycol interferon, i.e. pegylated interferon or abbreviated "peg interferon", administered as a once-a-week injection during a year, as the most effective treatment option now available. When peg interferon is combined with ribavirin it results in a far more effective treatment option compared with interferon monotherapy (Chander et al., 2002; Stein et al., 2002). Depending on the viral strain, six to twelve months of this "new" combination treatment can achieve a stabilisation of viral responses in 46% to 82% of the treated persons. On the other hand adverse side effects are prominent among some three quarters of those who are treated. Medical support is often needed in order to alleviate these side effects. Starting somewhat later with therapy (8-12 weeks after the onset of the disease) does not endanger the success of this treatment (WHO/ HEN, 2005).

A systematic review also assessed beneficial effects of interferon (Alpha-2b) and ribavirin combination therapy when compared with interferon mono-therapy for chronic hepatitis C. Combination therapy was significantly more beneficial. Moreover, this favourable result was also valid for naïve, non-responding and relapsed patients (Brok et al., 2005b). Professionals should be alert to the fact that adding ribavirin to interferon therapy significantly increases several adverse events, e.g. anaemia (22% of the patients), dermatological problems, gastrointestinal problems, cough, fatigue, and some other physical inconveniences.

It should be born in mind that the risk of developing severe liver disease for people with co-infections of HIV and HCV (not uncommon among injecting drug users) is significantly higher.

Timely diagnosis is essential and adjusted treatment regimes should be considered (Graham et al., 2001; Strathdee & Patterson, 2006). Treatment of hepatitis B and C is in principle equally effective for drug users, but it is more demanding for this subpopulation because it requires long-term disciplined behaviour to successfully end this therapy. Finally, interactions between interferon treatment and addiction treatment drugs should be anticipated and monitored.

2.3 Treatment of tuberculosis

Effective tuberculosis treatment has been available since the 1940s. Strategies that improve adherence to treatment with anti-tuberculosis drugs for patients with clinically active tuberculosis are important, because 20 to 50% of these patients do not finish the two-year treatment. Not complying with treatment can result in prolonged infectiousness, relapse in tuberculosis, or even death. For drug users these percentages may even be higher.
Two high quality American studies on completion rates of drug users in tuberculosis treatment were traced. The results showed that when such therapies are directly monitored by a health worker, a community volunteer or a family member, no differences could be observed compared with routine self therapy without monitoring (Volmink & Garner, 2003).

2.4 Remarks from general guidelines

Drug dependent people with infectious diseases are often stigmatised and the risk of neglecting people who are drug dependent among medical treatment professionals is considerably higher than for those who are not drug dependent. Programmes that integrate maintenance treatment with HIV/ AIDS treatment should therefore be encouraged (WHO/ UNODC/ UNAIDS, 2004). Preferences of professionals are even stronger prejudiced for infected dual diagnosis patients who also have psychiatric disorders. Thus, people with mental illness and drug dependence are often "double stigmatised". Mental illness and drug dependence however are related, and co-occurring psychiatric and substance use disorders tend to reduce treatment effects considerably (RachBeisel et al., 1999; Compton et al., 2003). Conclusive evidence for integrated treatment options for dual diagnosis patients is still absent (cf. Nunes et al., 2004). Either the focus of treating infected patients is on mental illness or on drug dependence, but rarely on both (Drake & Brunette, 1998; Shaner et al., 1993).
A clinical practice guideline publication recommends monitoring of symptoms of depression of injecting drug users during the early weeks of interferon treatment. Anti-depressant treatment should start early and continuing this treatment throughout the interferon treatment period is often necessary (De Bie et al., 2005).

In general, granting easy access and taking care of additional supporting activities for improving adherence to medical treatment (or vaccination) of infectious diseases is crucial for drug users. Access should be granted, based on common medical eligibility criteria for antiretroviral treatment, and not on vague non-medical ones that leave much room for individual interpretations by the professionals who are in charge of deciding upon access to treatment or not. Examples of non-medical criteria are unstable living conditions or uncontrolled drug use (Engelhardt, 2005; New York State Department of Health, 2005).
Drug dependence may reduce adherence to therapy. Medical complications and co-morbid infections may further hamper treatment and decrease responses. Because many opiate addicts are also heavy alcohol users, exclusion of alcoholism in RCT's may bias (improve) outcomes (Lehman et al., 1990). Yet, exclusion of drug users from access to tailored treatment of infectious diseases is undesirable both from a health and a human rights perspective. Access and participation may be an entry point to other prevention and treatment options and increase the coverage of care among a risk group that may also infect non drug users.

Interactions between methadone or buprenorphine and antiretroviral drugs or anti-tuberculosis drugs should be anticipated by properly adjusting doses of substitution drugs on individual level. Adverse interaction effects may create distrust in medical providers and result in unwillingness to take medication. In general, people with tuberculosis and HIV should end their tuberculosis therapy first, unless the risk of progression or death from HIV is high. Careful assessment and education of both treatment professionals and participants will maximise treatment adherence for the vulnerable subgroup of drug users (WHO, 2002; WHO/ UNODC/ UNAIDS, 2006).

Some principles for successful medical care programmes for active injecting drug users are:

- High accessibility, and situated in facilities that are part of the general health care system, free-of-charge and low threshold.
- Optimal comprehensiveness of care per location.
- As intensive as is acceptable for individual patients (not driving them away).
- Close linkage between harm reduction services and facilities and treatment programmes. (WHO/ UNODC/ UNAIDS, 2006).

2.5 Conclusions

Information, education or communication may at best be short-term effective in raising awareness and in more specific variants in changing knowledge and understanding, not in changing behaviour. These interventions are possibly most effective when they are part of more extensive prevention or treatment packages.
From a public health perspective, it is recommended that community-based outreach work for hidden populations of drug users should be made accessible and disseminated, since it is an effective strategy. Adequate training facilities, supervision and compensation of outreach workers are essential ingredients for sustaining the quality of outreach work.

Needle and syringe exchange programmes are both probably effective and cost-effective in preventing needle and syringe sharing and the spread of drug-related infectious diseases. Still, prevention by testing on HIV, vaccination against hepatitis B-and C or tuberculosis and counselling are also important activities for of drug users. Effective treatments are also available for HIV/ AIDS, and hepatitis B and C. Treatment is needed for months to years, or even life-long, and needs to be properly monitored on adherence, especially among drug users.

Prejudice and other psychological barriers within medical care services due to prevailing stigmata against drug users, are hampering effective treatment. The same barriers can be found for dual diagnosis patients (drug users who also have mental illnesses).
From a humanitarian and public health perspective these barriers should be alleviated. Current brain research points at drug dependence as a mental illness. It has been recommended to apply medical and mental health criteria for disease or illness in treatment of drug dependence rather than the largely prevailing subjective perceptions among medical professionals (e.g. proclaiming that drug dependence is a matter of choice).

3 Prevention of drug-related deaths

"Death by drug overdose, mostly involving opiates, is a major cause of deaths among young people in Europe, where over 8000 such deaths are recorded each year, and is currently the leading cause of death among drug injectors." (EMCDDA, 2004). Heroin overdose constitute the primary problem when thinking about drug-related death. In many cases death is caused by the use of more than one substance, e.g. heroin, alcohol, benzodiazepines (EMCDDA, 2005). However, overdose death may also be caused by methadone, cocaine and other substances (Caplehorn et al., 1999). A cohort study shows that the risk of methadone overdose death seems to be highest during the first two treatment weeks (Buster et al., 2002). Street injecting, poly drug use and relapse after treatment or prison, increase the risk of overdose (cf. Advisory Council on the Misuse of Drugs, 2000; Zador & Sunjic, 2000; Corkery et al., 2004). The focus in this paragraph is on prevention of death from opiate overdose, due to the paucity of studies on the effects of activities that aim to reduce the risk of an overdose of other drugs. The definition of the EMCDDA is restricted to those deaths that are caused directly by (and in general shortly after) drug use (EMCDDA, 2004). It should be noted however, that many factors in the life of drug dependents may ultimately result in death, e.g. risky behaviours resulting in accidents or infectious diseases that afterwards may result in death.

Drug-related death may be prevented by participating in needle or syringe exchange programmes (see 2.1.3). Examples of other preventive interventions that target a reduction of the number of deaths and that were not mentioned in the paragraph on infectious diseases are: prevention of death caused by an overdose with the antidote naloxone (the most direct way to prevent opiate related deaths); and four interventions with broader targets than exclusively reducing deaths by overdose, for instance: maintenance treatment; pill or drug testing programmes (for users of synthetic drugs but also users of cannabis and cocaine); pre-release counselling (avoiding the risk of drug overdose due to getting out of the habit after leaving prison or treatment); and drug consumption rooms (mainly but not exclusively for injecting drug users). The three last ones are reported in paragraph 4 of this annex. Furthermore, some important conditions for effectiveness of harm reduction interventions are also valid for preventing drug-related deaths, e.g. information and education, increasing access to interventions and behaviour protocols for police officers when in contact with drug users (Warner-Smith et al., 2001).

Most of these interventions cannot be studied on their effectiveness in high quality experiments due to practical or ethical problems. The consequence is that the effects of many probably effective interventions remain somewhat unclear from a scientific viewpoint. As has been stated before, this does not mean that these interventions do not have desirable effects. Daily experience and results of studies of lesser quality may suggest that these interventions do have positive outcomes on drug users and their environment. However, this review is focussing on the available scientific evidence.

3.1 Preventing opiate overdose death with naloxone

Factors associated with overdose are poly drug use, route of administration (injecting drugs), differences in drug purity, and reduced drug tolerance levels due to enforced abstinence or reduced drug use during treatment or in prison settings (Darke & Hall, 2003). Naloxone is known as a specific and effective but short acting and expensive antidote to opiate overdose, without showing adverse effects (Dettmer et al., 2001). Provision of naloxone reverses the effects of acute narcosis, including respiratory depression, sedation, and hypotension (Darke & Hall, 2003).

It should be noted however, that the evidence for avoiding overdose death in real life situations by using naloxone is not straightforward. In real life circumstances administration of naloxone may be hampered by psychological restrictions (misconceptions and negative views of its impact and use). Peers or others who are present are rarely behaving adequately to overdose (ibid.). And even when naloxone is used timely, this potentially rescuing substance alone may be insufficient to keep the victim alive. Especially rescue breathing, may also be needed. Furthermore, an additional dose of naloxone may be necessary depending on the severity of the overdose taken, and sometimes complications will necessitate in-hospital care (Schulz-Schaeffer & Puschel, 1995).

There is little evidence on the safety and efficacy of peer administration of naloxone in the prevention of opiate overdose, nor is there sufficient evidence for take-home naloxone (NACD, 2003) but this does not mean that these activities are ineffective. They probably become more effective when accompanied by training of peers in knowledge about overdose symptoms and administration skills (Worthington et al., in press). And also for take-home naloxone, mortality from overdose may remain unaffected when other persons are not acting properly, or when those who are willing and able to act are absent. Thus peers and others should be trained to act properly in that situation (Baca & Grant, 2005). Pre-hospital, intranasal administered naloxone may also be a safe and effective first line treatment option, both for reducing overdose death and for preventing needle stick injury during the injecting process by semi-professionals or others (Ashton & Hassan, 2006).
Thus, naloxone is an effective drug for prevention of opiate overdose deaths, but additional measures should be taken in order to increase its success.

3.2 Maintenance treatment for opiate dependence and drug-related death

Several studies show a relationship between maintenance treatment of opiate users and a reduction of drug-related death. Most studies address methadone programmes. Though there are hardly any randomised controlled trials on this subject, some studies show that maintenance treatment is still a promising alternative in reducing drug-related deaths.

A meta-analysis of one RCT and five cohort studies (Caplehorn et al., 1996) shows that the risk of dying from opiate use probably reduces when opiate dependent persons participate in methadone programmes (on average to a quarter compared with not attending a methadone programme). High doses of methadone (i.e. more than 80 mg per day) improve treatment retention, patient compliance and reduce other opiate use (Faggiano et al., 2003). Individually adapted high doses may also reduce the risk of overdose. Although only one controlled prospective study reports this outcome, the results are highly plausible. Identical conclusions are probably valid for higher doses of buprenorphine maintenance treatment (Ling & Smith, 2002). Low threshold maintenance treatment will most probably further reduce overdose deaths because it is more attractive for drug users who are not participating in traditional maintenance programmes (Reinås et al., 2002).

Finally, a high-quality Spanish cohort study among more than 5000 opiate dependent people strongly supports a causal relationship between not attending low threshold methadone programmes and overdose death rate (Brugal et al., 2005). The evidence is supported by the number of drug-related deaths analysed, the analysis procedures and the size of the outcomes. All heroin dependents seeking treatment in Barcelona between 1992 and 1997 were (on average) assessed every nine months until the end of 1999. The death rate among this population was some twenty percent (N=1005). Thirty-five percent of those who died in this period, did so from overdose, 38% from AIDS and 27% caused by other factors. Approximately half of this population participated in methadone programmes. Methadone most probably contributed to a reduction in mortality rates or HIV infections. The total death rate reduced from 5.9 per 100 person years in 1992 to 1.6 in 1999. The most important factor associated with mortality was "not participating in a methadone programme".

3.3 Preventing overdose death with information, education and communication

Research on effectiveness of *information, education and communication* (IEC) for injecting drug users was already evaluated in paragraph 2.1.1. The conclusion was that the evidence for effectiveness of IEC still appears to be weak (Aggleton et al., 2005). Possibly IEC works better

when it is combined with other interventions or when it is part of a broader intervention package, specified for different target groups. When this is done, it motivates clients and retains them in treatment (Noonan & Moyers, 1997; Dunn et al., 2001; Burke et al., 2002).

Techniques to enhance motivation to change risk behaviours are not sufficient for success, but may be necessary still (Dakof et al., 2003). Equal to IEC, motivational enhancement techniques may possibly best be used as part of multiple treatment packages. In fact this is already done to a considerable extent. IEC may also be more effective when combined with distribution of sterile needles, syringes or condoms (Miller & Rollnick, 1991; Walitzer et al., 1999).
Firm conclusions about effects of IEC on preventing overdose are not possible but it should be repeated that effectiveness of other preventive intervention packages may be increased by also supplying IEC in these programmes.

3.4 Remarks from general guidelines

Guideline remarks on methadone programmes can be found in paragraph 4.6. Medical guidelines exist for diagnosis and treatment of acute heroin overdose (cf. Sporer, 1999). More general guidelines should address the fact that often medical staff is not trained to treat drug users, nor are peers or relatives who may be present when an overdose occurs (cf. Advisory Council for the Misuse of Drugs, 2000; Darke & Hall, 2003). Key messages for prevention of overdose death for drug users and professionals are: avoid poly drug use, inform drug users when they are released from penitentiary institutions, organise training sessions for medical staff and ambulance personnel, inform peers and families of drug users about the phenomena and about proper actions in case of overdose (e.g. methods of administering naloxone, call an ambulance, take good notice of the need for a second naloxone dose) and organise skill training sessions for peers and family members of opiate users. Finally it has been defended that naloxone should be made easily available for family and peers, because the majority of overdose occur in the home of a victim or that of another user (Zador, Sunjic et al., 1996).

3.5 Conclusions

Maintenance treatment probably reduces overdose mortality among opiate dependent people. Other studies indicate that reductions of drug use and retention to treatment are larger with appropriate higher doses of methadone. This is often assumed to reduce overdose mortality. The most direct and effective intervention to prevent overdose death among drug users is naloxone, provided that it is administered properly. However, in daily circumstances additional measures should be taken in order to decrease the danger of needle stick injury for the treating person and increase recovery rates among the treated ones. In addition, depending on the addict's motivation and the access to it, information and educational interventions (IEC) possibly improve the effectiveness of other interventions.

4 Other harm reduction interventions

Outcomes of prevention and treatment of infectious diseases and drug-related deaths were the subjects of chapters 2 and 3 of this annex. In this chapter several interventions are reported that may also be effective for preventing infectious diseases or drug-related deaths but not specifically. In paragraph 4.1 other outcomes are reported for substitution or maintenance treatment because this is also considered a harm reduction intervention. In the paragraphs thereafter the subjects of medical heroin prescription, pill testing, pre-release counselling and drug consumption rooms are covered.

4.1 Maintenance treatment

Besides lower risks of overdose and drug-related death, often mentioned targets of maintenance treatment are reduction of illegal drug use and drug-related crime, improvement of the social and health situation of the addicted individual, and higher contact rates of dependents with regular addiction care (cf. Dolan et al., 2005).

Methadone is the most frequently studied treatment option for drug addiction and maintenance treatment (Krambeer et al., 2001). Cochrane Reviews and other studies show that maintenance treatment with ***methadone or buprenorphine*** is effective, not only under controlled conditions, but also in daily practice. Both treatments improve treatment retention, patient compliance, and reduce opiate use (Mattick et al., 2003a; 2003b; Barnett et al., 2001; Ling & Wesson, 2003; West et al., 2000) and individually controlled higher doses (more than 80 mg per day) increase effectiveness on these outcomes (Faggiano et al., 2003). Research shows that maintenance treatment is also effective in reducing risky behaviours related to HIV transmission, but it possibly does not reduce risky sexual behaviour (Gowing et al., 2004; 2006). Abstinence is not a feasible objective for most participants in maintenance programmes (Driessen et al., 1999; Hiltunen et al.,

2002) and available studies did not show reductions in drug-related criminality either (Mattick et al., 2003a).
Finally, a systematic review of five Cochrane Reviews shows that retention rates (staying in treatment) are higher for methadone maintenance compared to 1) methadone detoxification, 2) buprenorphine maintenance, 3) maintenance treatment with levomethadyl acetate hydrochloride (LAAM) or 4) heroin plus methadone (Amato et al., 2005a). Methadone and probably also buprenorphine show considerable reductions in opiate use. Buprenorphine is well tolerated by addicts with little side effects. It is considered a qualified alternative maintenance treatment for methadone, when – for whatever reason – addicts are preferring buprenorphine or do not tolerate methadone very well (Davids & Gastpar, 2004).

When psychosocial ***interventions*** are added to maintenance treatment, these possibly tend to increase its effectiveness, although supporting scientific evidence remains weak for several of these interventions when taken separately. It is defendable from daily experience that supportive care by medical nurses during maintenance treatment is more beneficial for participants than merely the act of distribution of the substitution drug (Loth et al., 2003; Hunt et al., 2005). For buprenorphine this combination with psychosocial interventions is less well studied than methadone (Amato et al., 2004) but it is likewise possible that psychosocial interventions will increase the effectiveness of buprenorphine among opiate users. It has also been shown that contingency management (e.g. rewarding abstinence or reductions in drug use) and counselling, when added to maintenance treatment, probably further reduce illegal drug use for three months. Longer-term effects are unknown yet. Contingency management did not always result in increasing rates of treatment retention or counselling participation (Griffith et al., 2000; Preston et al., 2000; 2002). This conclusion also holds true for reducing cocaine and alcohol use among methadone clients (Peirce et al., 2006).

***Levomethadyl acetate hydrochloride* (*LAAM*)** has been a promising maintenance treatment as it is more effective in reducing illegal drug use than methadone or buprenorphine (Longshore et al., 2005). However its adverse effects may be serious (Clark et al., 2002). When dosages of LAAM are adjusted, dependent on professional judgment of individual clients' physical conditions, these side effects may be reduced. LAAM can be equally effective as methadone with regard to treatment retention. Despite its clinical effectiveness LAAM has not been accepted in the European Union because of its potentially serious side effects.

Studies on maintenance treatment or relapse prevention with ***Naltrexone*** (in some studies combined with drug free treatment) do not show enough consistency on its capacity to reduce relapses in opiate use (Minozzi et al., 2006).

4.2 Medical heroin (co)prescription

Medical heroin (co)prescription is exclusively meant for a subgroup of chronic, treatment resistant or treatment refractory patients that did not fare well with other treatment options during their drug taking career. Frequently mentioned aims of medical heroin (co)prescription for this group are improving the physical and psychosocial health situation of opiate dependent persons, a reduction in drug-related criminality, an increase in several beneficial effects on society i.e. a reduction of public nuisance and lower costs of addiction in general. Several European countries are experimenting with medical prescription of heroin to difficult-to-treat chronic opiate dependents.

The only (systematic) review study on this subject, included four trials. Six trials are currently running. One English randomised trial from 1980, two related Dutch trials from 2002 and one German non-randomised experiment from 1998 (Ferri et al., 2005; 2006). The duration of the German trial was six months, that of the other three RCTs twelve months. Overall, the three experiments differed in many aspects, including the outcomes, thus we report some main results.
Retention to treatment did not differ in two trials, while in the other two trials these outcomes contradict each other. In one retention to treatment was more favourable for methadone, in the other this appeared to be so for people who were prescribed heroin. The results of two studies reporting relapses to illegal heroin were also mixed. In one trial illegal heroin use was less in the heroine prescription group, in the other higher. There was no difference in social functioning after heroin prescription in two trials. In the other two, this outcome was part of a multi-domain outcome measure also including integration at work and family relationships. Here people who were in the heroin prescription group improved on this outcome compared to those on methadone.
A separate cost utility analysis of the Dutch experiment showed that the societal costs were on average US$ 13.000 less per patient per year, corrections for judicial costs included (Dijkgraaf et al., 2005). All trials showed that medical heroin prescription is probably safe (few critical adverse events), and manageable (less public nuisance) compared to not prescribing heroin. It was also shown that continued prescription practices probably avoid a quick deterioration of the health

situation of participating addicts. These programmes possibly reduce public nuisance. Finally, stopping these experiments may result in quick relapses of former participants (Perneger et al., 1998; Uchtenhagen et al, 1999; Rehm et al., 2001; Van den Brink et al., 2002). The results of these trials are both mixed and promising. Results of the six trials currently running, will have to be included in due course in order to draw more firm conclusions.

4.3 Pill testing programmes

Purity testing of samples of pills (powders or liquids) that 'go around' in recreational settings serves to warn against the risk of unexpected substances that may be part of substances that are for sale. In some instances, testing practices are not limited to pills (i.e. synthetic drugs) but also cover other substances. Individuals who deliver these pills for testing remain anonymous to the authorities. The tests can be done on-the-spot (simple tests) or office-based (in a laboratory), and it can be combined with preventive information delivery. The results of these tests inform potential users about purity and health risks of substances bought. Drug testing programmes may also be accompanied by distributing leaflets with information. They can also be used for informing the authorities or drug agencies. They give insight in changing patterns of use and are a prerequisite for early warning systems.

From the common sense perspective of the individual drug user, pill testing programmes are useful in minimising the additional risk of synthetic drugs. The direct coverage of these programmes may often be small, but rumours about dangerous pills or mixed drugs seem to be ~~quite~~ effective in terms of potential users being more conscious of potential dangers of certain pills, but not necessarily in reductions of drug use in user groups (Van de Wijngaart et al., 1999; Benschop et al., 2002; Korf et al., 2003).

It has been amply shown that information alone at best changes behaviour in a very limited way. Still, these testing programmes may reduce the use of potentially dangerous drugs in recreational settings or at home. However, delays or reductions of drug use caused by the results of pill testing programmes are hardly measurable via experiments. Making use of these facilities presumes anonymity and easy accessibility. There are no studies showing that on-site pill testing is more effective than office-based pill testing but it is reasonable to assume that office-based testing – when people can deliver their pills for testing voluntarily and without danger for legal authorities – increases the coverage of drugs tested in specific periods. A draw-back of relative simple test methods used in on-site testing is that measurements may not be adequate. Finally, there is some evidence that the often cited fear that pill testing encourages non-drug users to start using drugs is untrue (Benschop et al., 2002).

4.4 Pre-release counselling

Pre-release counselling is often aimed at reducing the high risk of overdose after leaving prison (when drug users are not used anymore to the doses that were consumed before prison). In this case overdose is mainly due to a lowered tolerance for drugs during the period after detoxification or enforced abstinence in prison. From a common sense perspective, information about this risk and what to do against it before inmates are released from prison is certainly helpful. Pre-release counselling may also focus on possibilities for treatment or after care after imprisonment. Realising this type of counselling is largely dependent on local habits and culture. High-quality effect studies on this type of intervention are not known. There are no other studies found that may give more insight in the evidence of effectiveness of pre-release counselling.

4.5 Drug consumption rooms

Drug consumption rooms (DCRs) have several targets that are still insufficiently evaluated. The following targets are mentioned. For the surrounding neighbourhood DCRs are supposed to reduce public nuisance, e.g. publicly using illegal drugs, leaving needles around or drug dealing. Important are also the health benefits for drug users (prevention of infectious diseases and drug-related death) because they can take their drugs in a safe, non-harassing, supervised environment, with clean needles and syringes and medical support on request. DCRs generally have a staff room (also for consultation and screening), a consumption room and a living room (resting, drinks and food, watching TV). They may be independent or part of an existing low threshold facility.

It should be born in mind that DCRs are difficult to evaluate via RCTs. A recent comprehensive study on drug consumption rooms partly reviews studies that focus on relationships between reductions of drug overdose and the availability of drug consumption rooms (Hedrich, 2004). Two well-designed government-commissioned evaluation reports (no RCTs) are interesting in this respect.

During an 18-months evaluation of a consumption room in Sydney, 3810 drug users were registered with an average of fifteen visits. The authors conclude that the numbers of deaths by heroin overdose were not changed after the introduction of these rooms (MSIC Evaluation Committee, 2003). Reductions of overdose ambulance attendances and deaths already occurred in the months preceding the opening of the drug consumption room. These were probably caused by a substantial reduction of heroin supply during the same period. It was not possible to determine which development was more important as a causal factor for the reduction of overdoses or death rates, the reduced heroin supply or the introduction of this drug consumption room.

Poschadel and colleagues (2003) analysed monthly police data on drug-related death on national level and in four German cities over a period of maximum eleven years (1990-2001). In this study, drug-related death is defined broader than the EMCDDA definition. Here this concept also includes indirect mortality (partly) due to drug use. The analysis focussed on long-lasting and stable effects of drug consumption rooms. Equal to the data of the study in Sydney (see above), reductions of drug-related deaths were already present in the period before the establishment of the drug consumption rooms. Nevertheless, a substantial association could be determined between the presence of drug consumption rooms and a reduction of the number of drug-related death. Additionally, this relationship was maintained after corrections for other potential explanatory factors.

A third (prospective cohort) study, indirectly supports the claim that these rooms reduce infectious diseases (Kerr et al., 2005). This study was done in Vancouver and may suggest that drug consumption rooms reduce needle sharing among injecting drug users.

In short, the outcomes of three studies evaluating drug consumption rooms show that these rooms may reduce needle sharing, infectious diseases and drug related death among opiate users but we need more studies to draw more firm conclusions.

4.6 Remarks from general guidelines

For *maintenance treatment*, psychosocial interventions should ideally be delivered as a standard additional type of care, equal to the original methadone programme from Dole & Nyswander in 1967 (Hunt et al., 2005). The practice of maintenance treatment has in some places changed to pure methadone distribution (cf. Loth et al., 2003; Schlusemann, 2006). Therefore it has been recommended that legal arrangements should be made in order to enforce improvements of methadone treatment, e.g. by prescribing sufficiently high doses and adding psychosocial interventions – when needed - for this target group (Schlusemann, 2006). Low doses of methadone are recommended at the beginning of maintenance treatment in order to prevent methadone deaths.
In general, when selecting maintenance treatments the following factors are relevant: patient preference, response to treatment, individual variation in absorption, metabolism and clearance rates, and adverse effects (Lintzeris et al., 2006). Frequency of patient assessment depends on the stability of his/ her situation, but preferably each patient should be assessed at least several times per year by an experienced clinician. Effective control procedures and supervised administration of medication can prevent the risk of diversion or illicit use of substitution substances.
It should be born in mind that effectiveness of maintenance treatment is also dependent on co-occurring mental illnesses (dual diagnosis patients); therefore screening for mental illness (co morbidity) is recommended. All this may best be based on an assessment of the individual patient, i.e. those who need and want it. Random urine testing may be indicated for evaluating programme effectiveness. Given the scale of problems, maintenance treatment should best be part of community-based health systems in order to enable continuity and quality of maintenance programmes and offering counselling and testing for infectious diseases (New South Wales Health Department, 1999; WHO/ UNODC/ UNAIDS, 2004).

Based on the results of the Dutch trials on *heroin prescription* it was recommended that heroin should be registered as a medical product and that quality assurance procedures should be implemented for heroin prescription. Heroin prescription should further be strictly supervised and executed in specialised treatment units offering state of the art medical and psychosocial treatment (Van den Brink et al., 2002). Finally, several trials showed a rapid increase in relapse rates among former participants of heroin prescription. Therefore, setting time limits to heroin prescription is not recommended. Participants in heroin prescription should be enabled to continue this treatment (Uchtenhagen et al, 1999; Van den Brink et al., 2002).
Heroin prescription seems a valuable additive option for some countries with comprehensive treatment systems including easily accessible maintenance treatment. However, heroin prescription is not considered as a treatment of first choice and there is consensus that it should not be implemented instead of, or on the expense of methadone maintenance treatment.

Drug consumption rooms (DCRs) are of growing interest in several European countries. These rooms are in most countries meant for injecting drug users. Thus when street injecting is common practice DCRs may be most useful. First, these rooms should be supported by the authorities and should be non-threatening for drug users themselves, e.g. authorities should keep the police away (De Jong & Weber, 1999). The success of DCRs may be dependent on the perceived usefulness of these rooms for drug users themselves. A second factor is that although DCRs should be easily accessible (low threshold), some control (e.g. identity cards) may be necessary in order to avoid violation of the DCR-rules (e.g. no nuisance and offences in- and outside the consumption room). On the other hand, the coverage of these rooms should be large in order to be effective in reducing the numbers of overdose death (Reinås et al., 2002). It has been mentioned as a guideline, that personnel of DCRs should be a mix of medical professionals, social workers, a judicial advisor or a probation officer and a guard (Linssen et al., 2002).

Data on the effectiveness of *drug testing* or pill testing and *pre-release counselling* are largely anecdotal and based on common sense reasoning. Still, drug or pill testing in combination with early warning systems have been proven useful in some circumstances, e.g. in tracing undesired mixtures of synthetic drugs, in explaining sudden drug-related deaths caused by cocaine combined with atropine or in warnings of increased THC concentrations in cannabis. And it is highly unlikely that (former) drug users, without pre-release counselling, are sufficiently aware of the risk of overdose when starting drug use again after release.

4.7 Conclusions

An abundance of evidence indicates that methadone and buprenorphine are effective in daily practice circumstances for reducing opiate use and improving treatment retention or patient compliance. These effects tend to increase with controlled higher doses of these substances and when psychosocial interventions are added to these maintenance treatment programmes. Considering the indications for effectiveness of buprenorphine as a substitution drug, it remains unclear why methadone is the main maintenance treatment in most EU Member States and buprenorphine only in two. Voucher-based or price-based interventions are possibly most successful in producing short-term reductions in drug use but are rarely used yet in European countries.

The evidence for effectiveness of medical heroin (co)prescription for opiate dependents is still insufficient as a number of studies are still running. This does not mean that it is ineffective. There are indications that it improves health outcomes for seriously drug dependent people that are not willing to enter into maintenance treatment or that do not respond to this treatment (see also special section 5.2). Other interventions e.g. pill testing programmes, and pre-release counselling are in fact variations of information and education (IEC), and are studied insufficiently yet. Pill testing programmes probably increase consciousness of the risks of (synthetic) drug use but have limited effect on reducing drug use.

Drug consumption rooms may be an effective intervention for reducing needle sharing and indirectly in reducing drug-related deaths. Although the available evidence is still inconclusive, study findings did not contradict these desirable results.

5. Prison settings

Life in prison is changing in Europe and the presence of illicit drugs strongly influences this change. Specifically injecting drug use increases health risks that may easily be transported in and out of prison. HIV/ AIDS, hepatitis B and C are a threatening perspective for public health and specifically prisons should cope with these threats inside their institutional settings. "Prisons are extremely high-risk environments for HIV transmission because of overcrowding, poor nutrition, limited access to health care, continued illicit drug use and unsafe injecting practices, unprotected sex and tattooing." (WHO, 2005b).

5.1 Prison settings: maintenance treatment

Maintenance treatment (methadone) is feasible and effective in prison settings, and – if adequate doses are distributed and it is provided for the total duration of imprisonment – it reduces injecting drug use, needle sharing and infections (Dolan & Wodak, 1996; Stöver et al., 2003; Jürgens, 2006). When prison-based maintenance programmes are well implemented, they finally may have additional effects for the health situation of participating prisoners, for the prison system and consequently also for society. Continuity of treatment is possibly required when people move between prison and the community, in order to prevent quick relapses after release and maintain desirable effects of maintenance treatment. Thus, after care is essential.

5.2 Prison settings: prevention of infectious diseases

Data from the EMCDDA show that drug users are over-represented in prison settings. Considering the high turnover rate in prisons, hundred thousands of drug users may annually go through the European prison system (Hedrich et al., 2006).

Prison-based needle (and syringe) exchange programmes (NSPs) are probably effective in reducing needle and syringe sharing and resulting HIV or hepatitis infection (Dolan et al., 2003; Lines et al., 2006). Several studies offer insight in the effects of needle exchange programmes in prisons in Germany, Spain, Switzerland, Moldavia, Belarus and Kyrgyzstan. The reported evaluation studies (predominantly studies with exclusively measurement points before and after treatment and without control or comparison groups) show consistently positive results. Drug use remained stable or decreased. Congruent with the above mentioned reviews, syringe sharing was reported less than before, and HIV or hepatitis B or C transmission rates reduced. Besides, none of the reports could find serious negative events, e.g. initiation or increase in (injecting) drug use or undesired disposal of used syringes. (Dolan et al., 2003; Stöver & Nelles, 2003; Lines et al., 2006).

The effectiveness of **prison-based educational interventions (IEC)** on HIV transmission rates is largely unknown (Jürgens, 2006). IEC should be a component of prison-based HIV-prevention, as these interventions are possibly useful in combination with other interventions (see 2.1.1).
Routinely offering *HIV counselling and testing* on entry to prison, especially when it is part of a comprehensive care and treatment programme for HIV, possibly also increases the acceptance rate among prisoners and staff.

Provision of condoms is probably feasible in a wide range of prison settings. There is still no evidence for effectiveness, but neither are there indications for of any major, unintended consequences of condom distribution for safety and security in prisons. Structural interventions such as better lighting, offering showers and sleeping arrangements, are also needed. IEC activities should anticipate the introduction of such a programme and measures to combat aggressive sexual behaviours in prison are even more important.

Disinfection and decontamination schemes are in principle useful practices although these are not supported by evidence in the community outside prison yet. In prison settings the effectiveness may expected to be even less, because drug use is more hidden and hurried than outside prison.
No evidence is found for effective strategies to reduce **tattooing** practices in prison. Tattooing implies increasing the risk of HCV transmission and to a lesser extent HIV transmission. A large Canadian study is underway that may shed more light on this subject.

5.3 Prison settings: prevention of drug-related death

No specific studies on this subject were found. Pre-release counselling may reduce overdose death but this has not been shown by research (see 4.4). Drug consumption rooms may have the same advantageous effect, but these rooms are still very rare in prisons (see A3.1.8).

5.4 Remarks from general guidelines

Imprisonment of drug users is an expensive intervention and recidivism is - in general - high. These conclusions may even be more valid for inmates with mental health problems or those who use drugs (both are overlapping phenomena). In several guideline publications governments are recommended to adhere to basic principles guiding action for prisoners in general and especially for drug using inmates or those in need of psychiatric care.

Public health in general is served by preventing infectious diseases and health care in prisons. This appears also to increase workplace health and safety for prison staff. Prison legislation and policies should mirror respect for human rights and international law and avoid vulnerability, stigma, discrimination and violence. Prison health care should fit with international health care and health prevention standards. Interventions should as far as possible be evidence-based. It has been recommended that prisons should organise and realise adherence to these principles.

It has further been recommended to affirm and strengthen the principle of providing treatment, education and rehabilitation as an alternative to conviction and punishment for drug-related offences. Alternatives to prison for drug users are most probably more cost-effective. These alternatives may cover a range of sanctions or drug treatment interventions aiming to avoid, replace, delay or complement prison sentences for drug users (Lines & Stöver, 2005).
The prison environment is an opportunity for introducing harm reduction measures among drug using prisoners and consequently also in improving the public health situation over a longer period.

Prisoners who participated in maintenance programmes prior to imprisonment should be enabled to continue this treatment. The available evidence suggests that prison-based treatment may be ineffective in the longer run when no additional care is provided on and after their release.

Drug-free units in prisons are attractive to many prisoners, including those who are not using drugs. Although there is no evidence that these units are successful for drug using prisoners the opportunity should be stimulated to escape from drug use in drug-free units.

HIV counselling and testing on entry to prison should be offered routinely and on voluntary basis. Lessons learned from experience with and evidence for prison needle exchange programmes are that such programmes do not endanger staff or prisoners safety; on the contrary, these programmes make prisons a safer place to live, both for inmates and prison personnel. Methods of needle distribution should be adapted in order to meet the needs of staff and prisoners (Jürgens, 2006).

Prisons systems are recommended to:

- accept the importance of information about the harmful consequences of inappropriate drug use
- acknowledge the limitations of depending on an official enforcement of total abstinence
- receive new drug-dependent prisoners from a public health perspective and with respect for their needs, supporting and providing solutions for immediate problems arising in this target group
- provide what is required for prison staff in order to ensure that all prisoners are informed about risk behaviours and their consequences and the necessary actions to reduce these
- provide clinical management to drug dependent prisoners equal to what is done outside prison
- give sufficient information and guidance at the pre-release stage in order to prevent overdose and other risks outside the closed prison environment
- provide after care with links to community services (WHO, 2005b)

5.5 Conclusions

Both preventing and treating drug-related harm in prison settings offer an opportunity for contributing to improvements of the public health situation in general.

Prison-based maintenance treatment appears to be feasible and if adequate doses are distributed during imprisonment, it reduces injecting drug use, needle sharing, and infections. It should be noted that pre release counselling and after care is possibly necessary to prevent relapse or even overdose death after release. Needle and syringe exchange programmes in prison are probably effective in reducing needle sharing and infections. Lessons learned from experience with and evidence for prison needle exchange programmes are that such programmes do not endanger staff or prisoners safety. Instead, these may possibly make prisons a safer place to live.

There is no evidence of any major, unintended consequences of condom distribution for safety and security in prisons. Important safety measures are sufficient lighting, offering showers and sleeping arrangements, and interventions against—aggressive sexual behaviours. Although counselling (information, education) should be part of the introduction of such activities, the literature does not present much evidence for effectiveness of these activities. Evidence is also lacking for disinfection and decontamination schemes, and strategies to reduce tattooing. Still, these strategies should be stimulated because they have not been proven ineffective.

When prison-based maintenance programmes are well implemented, they possibly improve the health situation of participating prisoners, and prison personnel. Alternatives to prison for drug users are possibly more cost-effective than imprisonment itself, and may cover a range of treatment interventions aiming to avoid, replace, delay or complement prison sentences for drug users. Drug-free units in prisons should also be offered for prisoners, especially those who are not using drugs. In general however, prison-based harm reduction activities should be adapted in order to meet the needs of staff and prisoners.

An overview of effectiveness of harm reduction interventions (evidence tables)

Evidence table 1: Interventions for prevention and treatment of infectious diseases

(Reported outcomes are in cells)

Harm reduction interventions	**Effectiveness** (see evidence grading scores at the end of table 3)		
	Effective (sufficient evidence)	**Probably effective (indications for effectiveness)**	**Possibly (may be) effective (Still doubts about effectiveness)**
1a. Prevention of infectious diseases			
Information, education, communication (IEC)			When combined with other interventions and when tailored for specific target groups
Community outreach programmes	Reduction of risk behaviour (injecting drug use) Improvements in very different settings	Increased treatment compliance	Reduction of HIV infections
Needle and syringe exchange programmes (NSPs)		Reducing risk behaviour (sharing used needles) Reducing HIV infections Unanticipated benefits: Increased enrolment in treatment Higher retention rates	Preventing hepatitis C Overdose death Drug-related criminality
HIV testing and counselling		Reducing HIV infections Unanticipated benefits: Increased enrolment in treatment Higher retention rates	Preventing hepatitis C
Prevention of hepatitis B	Three vaccinations within six months result in absence of infections for 10-15 years Weekly injections and daily additional medication		

Harm reduction interventions	**Effectiveness** (see evidence grading scores at the end of table 3)		
1b. Treatment of infectious diseases	**Effective (sufficient evidence)**	**Probably effective (indications for effectiveness)**	**Possibly (may be) effective (Still doubts about effectiveness)**
	Conditions: Patient compliance should be stimulated in all treatments		
Maintenance treatment	Reducing risk behaviour (sharing used needles)		
Antiretroviral therapy for HIV/ AIDS	Long-term treatment with possible serious adverse effects		
Combination therapy as maintenance treatment for HIV/ AIDS	Long-term treatment with possible serious adverse effects		
Treatment for hepatitis B and C Treatment for hepatitis B and C	Once-a-week peg interferon for six months or longer Peg interferon combined with ribavirin is on average more effective Conditions: Medical support (adverse side effects among ¾ of patients)		

Evidence table 2: Interventions for prevention of drug-related deaths

(Reported outcomes are in cells)

Harm reduction interventions	**Effectiveness** (see evidence grading scores at the end of table 3)		
	Effective (sufficient evidence)	**Probably effective (indications for effectiveness)**	**Possibly (may be) effective (Still doubts about effectiveness)**
2. Prevention of drug-related deaths			
Naloxone	Short-acting, thus sometimes a seond dose is necessary Conditions: Additional measures (education and skills training of partner, family or peers) should be taken for those who administer		Peer administration of naloxone Take-home naloxone
Maintenance treatment		Reduction of risk of overdose death Individually adjusted higher doses of methadone improve treatment retention and patient compliance and reduce opiate use	Low threshold maintenance treatment may further reduce risk of overdose death (attracting hidden populations)
Prevention of overdose deaths by information, education, communication (IEC)			When combined with maintenance treatment and when tailored for specific target groups IEC may help to reduce drug-related deaths
Motivational enhancement techniques			When combined with maintenance treatment and when tailored to individual drug users these techniques may help to reduce drug-related deaths

Evidence table 3: Other harm reduction interventions

(Reported outcomes are in cells)

Other harm reduction interventions	**Effectiveness** (see evidence grading scores at the end of this table)		
	Effective (sufficient evidence)	**Probably effective (indications for effectiveness)**	**Possibly (may be) effective (Still doubts about effectiveness)**
Maintenance treatment: methadone	Improves treatment retention and patient compliance Reduces HIV risk behaviours and opiate use Higher doses further improve these outcomes		Reduction of criminality (?)
Maintenance treatment: buprenorphine		Improves treatment retention and patient compliance Reduces HIV risk behaviours and opiate use Less adverse effects compared with methadone	
Maintenance treatment plus psychosocial interventions			When added to maintenance treatment it may further increase effectiveness of methadone or buprenorphine treatment
LAAM	Improves treatment retention Reduces opiate use May have serious adverse effects		
Medical heroin prescription		Improves the health situation Is safe, manageable and has few adverse effects	Reduces public nuisance Stopping heroin prescription results in relapse
Pill testing programmes			Reduces the use of potentially dangerous drugs in recreational settings Office-based pill testing is probably less accurate compared with on-site testing Pill testing does not seduce non-users to start drug use
Drug consumption rooms			Reduces of needle sharing, and (indirectly) drug-related death

Other harm reduction interventions: ***prison settings***	**Effectiveness** (see evidence grading scores at the end of this table)		
	Effective (sufficient evidence)	**Probably effective (indications for effectiveness)**	**Possibly (may be) effective (Still doubts about effectiveness)**
Prison settings: maintenance treatment	Reduces injecting drug use, needle sharing and infections Conditions: adequate doses during total imprisonment period		When well implemented, maintenance treatment improves health in prison Improves working environment for prison personnel Continued care after-release is necessary
Prison settings: needle or syringe exchange programmes		NSPs reduce syringe or needle sharing, and disease transmission No negative consequences found	
Disinfection and decontamination schemes			No unintended consequences reported
Prison settings: information, education, communication (IEC)			When combined with other interventions Routinely offering HIV counselling and testing increases the acceptance rate among prison personnel and staff No unintended consequences of condom distribution
Prison settings: living conditions			Improvements of lighting, offering shower possibilities, improving sleeping arrangements to prevent violence among inmates

Evidence grading scores:
Effective (sufficient evidence)
One or more systematic reviews or a meta-analysis of at least three RCTs with significant and equally directed outcomes or three separately published RCT's with outcomes that were alike and significant.
Probably effective (indications for effectiveness)
Two RCT's or one RCT plus at least two lesser quality studies, e.g. well-done time-series or prospective cohort studies.
'Possibly effective' or 'may be effective' (still doubts about effectiveness)
In case of doubt, i.e. only one RCT (with or without one study of lesser quality) or one or two studies of lesser quality - with significant and positive findings.
'No evidence' (evidence unknown yet)
(N.B. The judgment 'no evidence' was exclusively given to condom distribution, prevention of tattooing practices, and disinfection and decontamination practices, all in prison settings and not included in these tables)

Appendix 1 - Systematically reviewing guideline publications
A brief exploration of possibilities

Introduction
Guidelines are papers that tell you what to do instead of what is known (Greenhalgh, 2001), but since the nineties these publications are also increasingly based on what is known from scientific studies (Burgers & Van Everdingen, 2004). Many types of guideline-like publications are available nowadays. These publications vary considerably in level of abstraction and labelling (guidelines, status papers, evidence for action papers, protocols, and models of good practice, etcetera). Originally, methods for constructing guidelines vary from informal consensus methods ('old boys' network') to more formal ones (e.g. consensus conferences, Delphi methods and 'evidence-based' guideline programmes).
Construction of *evidence-based* guidelines is increasingly structured and co-ordinated in advance. This does not mean that guidelines about equal practices for the same target groups are look-alikes. It does not mean either that congruent recommendations from guidelines are necessarily more valid than others. The chance of biased information is much larger than in systematic reviews of scientific studies. Nevertheless, guidelines are generally more useful for daily practice than scientific research results. This may especially be true for many interventions in the field of harm reduction, where scientific evidence is not abundant for many interventions. In these cases, the role of daily experience (of professionals and clients) is necessarily more prominent. Still, guideline construction remains a strongly biased process. Thus, summarising the recommendations from various guidelines is even more difficult up to date. However, guidelines for guideline synthesis are underway.

Stages of guideline construction
Guideline construction is a long and arduous process, resulting in an increased risk of *eminence-based*, instead of evidence-based information. Furthermore, in most cases scientific evidence needs to be partly adjusted to national, regional or even local practice. In order to minimise bias, guideline construction has to be structured.
Proposed stages of guideline construction are: preparation by a working group representing the different relevant disciplines; needs assessment; division of work to be done by the workgroup members depending on their expertise; development of a draft guideline text by the members of the working group; an national guideline meeting for discussion and comments; evaluation and integrating the comments; authorisation of the text; dissemination; implementation; evaluation and revision. Guidelines need to be updated regularly (cf. Mickan & Askew, 2006).
Guidelines are expensive, thus increasingly organised by big (supra) governmental organisations. The challenge remains to: 1) summarise the scientific evidence in a consistent manner; 2) structure guideline publications; 3) organise long-term guideline programmes (in order to ensure continuity and updating activities), and to leave the ultimate decision making about best practices to each country or region separately (Burgers et al., 2003a; 2003b; Van Everdingen et al., 2004; Vlayen et al., 2005).

Structuring judgment?
Despite these structuring activities, evidence-based guidelines still show much variation. Expert knowledge may differ considerably between entities with specific interests, i.e. between individual professionals, professional groups, organisations, countries or other contextual boundaries. Social influence mechanisms within multidisciplinary groups may distort judgements (Pagliari et al., 2001). Furthermore, there are considerable differences between judicial systems, health care systems, perceptions of drug dependence, and concomitant perceptions of addictive behaviours. Despite their apparent importance for daily practice, the information in national guidelines may not be valid in other countries and should be tested in national contexts, in order to fit specific situations and to stimulate or enhance implementation. Existent guideline publications should be judged and adapted by consensus mechanisms in every country separately (Van Everdingen et al., 2004). And even then, the problem remains of considerable differences in judgment of the same amount of evidence by different professional participants in consensus groups that are constructing guidelines. Measures should be taken to increase probabilities of neutrality within these groups. Examples given in the literature are: a strong but neutral chairman and a balanced group in order to prevent one professional group from biasing the outcome (Burgers & Van Everdingen, 2004; Raine et al., 2004).

Constructing pathways for synthesis of guideline recommendations
Some suggestions and recommendations that deal with synthesis methods of guideline information (Burgers, personal communication) are submitted for publication. These recommendations cover the following stages of selection and synthesis.
First, existent and well developed *search procedures and data sources* should preferably be used instead of ad hoc developed procedures and sources (e.g. those on PubMed or the database of evidence-based guidelines in the US, www.guideline.gov). *Selection* of guidelines is further facilitated by using the PIPOH principle in specifying guideline subjects: Patients, Population or Problem; Intervention (screening, diagnosis or treatment); Professional target group; Outcome (e.g. survival, quality of life...) and Health care setting. For *critical appraisal of guidelines* the AGREE instrument is recommended. At least two professionals should do this part. This instrument evaluates methods and reporting, but it does not judge the clinical content of recommendations in guidelines (AGREE, 2001, Cluzeau et al., 2003). *Appraisal of clinical content* of guidelines should be done by review experts and clinical experts, who check: the method of systematically reviewing the literature; the fit between results, conclusions and recommendations; and other considerations that may have influenced this all. During the *reporting* phase tables should be used to give an overview of important characteristics.
At best a summary may be possible of some guidelines that may be perceived as good enough, while 'good enough' rather needs judgement from multidisciplinary groups who are vulnerable of bias. Judgments can be at odds with the published literature. If they are, reasons should be made explicit (Raine et al., 2004).

Implementation of guidelines
Evidence-based guidelines develop from a consensus-mix of available scientific evidence, expert knowledge, and client perspectives. Scientific evidence should be updated first, because systematic review knowledge may already be obsolete. The phase of implementation of guideline recommendations generally also lags behind. Practitioners may be selective or it appears to be difficult applying general guidelines to specific situations (Garfield & Garfield, 2000). In the Netherlands and elsewhere it has been shown that a) when guidelines are strictly and specifically formulated, b) when publications are too extensive, and c) when workers of professionals are not involved in guideline formulation, they tend to be less used by practitioners in the field (Greenhalgh, 2001; Van Everdingen et al. 2004; Schippers et al., 2005). Many barriers may delay or even abandon adoption of guidelines in practice. Examples are: disagreement among experts about the quality of evidence, psychological defence mechanisms of professionals in the field, practical constraints, failure of clients to accept procedures, and lack of client feedback. Whether guidelines will be used or not is largely dependent on applying principles of change management that often deliver uncertain outcomes when it deals with non-enforced activities (Grimshaw & Russell, 1999; Greenhalgh, 2001). Incentives to stimulate implementation can be sought in quality care programmes or 'break through'-strategies. In fact guidelines are *guide-lines* and not rules that should be followed completely. All these potential disturbing factors make implementation of guidelines a hazardous but still useful endeavour for guiding and changing professional practice.

Presenting recommendations from guidelines for non-clinical decision making?
Considering the former paragraphs, it is not feasible to present a valid synthesis of guideline recommendations for decision making. Therefore we do not intend to give generally valid instructions for daily practice. Instead, we merely present – when available - more general recommendations, mainly but not exclusively drawn from some exemplary guideline publications in the field of harm reduction that are plausible and straightforward. Because general guidelines are mostly published by (inter)national organisations, specifically these may be considered as useful for decision making on a national or international level. Therefore we also summarise in this report some conclusions from general guidelines that may be useful on European level.

Appendix 2 - References

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Annex 2 – State of play in the EU Member States – Country reports

In the following pages the state of play on the prevention and reduction of health-related harm associated with drug dependence is presented for each of the 25 Member States of the European Union. The overviews per country are categorised in accordance with the structure of the Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence.

For reasons of comparability and transparency, the reports are written in a similar framework, making a clear distinction in feedback obtained from policy-level, the Reitox National Focal Point and their correspondents and other sources of information. The availability of harm reduction services and facilities in the Member States has been presented in overview tables in tables A1 to A14 in the next pages.

In order to keep the information manageable, the selection of information that has been included in this report was guided by the contents of the Council Recommendation. In other words, the Council Recommendation limited the scope and width of the information gathering process.

The main data sources used for this overview are:

- EC reporting tool [RT]
- EMCDDA National Reports to the EMCDDA [NR 200X]: (www.emcdda.europa.eu/index.cfm?fuseaction=public.Content&nNodeID=435&sLanguageISO=EN)
- EMCDDA Standard Table 10 [ST10]: www.emcdda.europa.eu/ ?nNodeID=5777
- EMCDDA Structured questionnaire 23 [SQ23]: www.emcdda.europa.eu/ ?nNodeID=5777
- EMCDDA Structured questionnaire 29 [SQ29]: www.emcdda.europa.eu/ ?nNodeID=1333
- EMCDDA European Legal Database on Drugs [ELDD]: www.eldd.emcdda.europa.eu/

Other data sources:

- CEEHRN website: www.ceehrn.org/
- CORDIS projects database (EU Framework programme): www.cordis.europa.eu
- ESPAD website: http://www.espad.org/
- Community Action Programme on the Prevention of Drug Dependence projects database: www.ec.europa.eu/health/ph_projects/drug_project_en.htm
- PHARE Twinning annual reports: www.ec.europa.eu/enlargement/key_documents/phare_legislation_and_publications_en.htm
- IHRA: http://www.ihra.net/KeyPublications
- WHO Health Evidence Network: www.euro.who.int/HEN
- UNAIDS: www.unaids.org
- UNODC: www.unodc.org/unodc/en/drug_demand_reduction.html

NOTE:
The country reports in this annex have been arranged according to the EU protocol order.

State of play Council Recommendation – overview in tables

Table A1 – state of play on Council Recommendation 2.1

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

	BE	CR	DK	DE	EE	GR	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK	TO
This policy exists, and is based on Council Recommendation					+						+		+								+	+				5
This policy exists, but is not based on Council Recommendation	+	+	+	+		+	+	+	+	+		+		+	+	+	+	+	+	+			+	+	+	20
Telephone help lines promoting risk reduction are available	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	25
Websites promoting risk reduction are available	+	+	+	+	+	+	+	+	+	+	-	+	+	-	+	+	+	+	+	+	+	+	+	-	+	22
Leaflets promoting risk reduction are available	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	25
Pill- testing for drug users is available	+	+	-	-	-	-	+	-	-	-	-	-	-	-	-	-	+	+	-	+	-	-	-	-	-	6
Training for drug users is available	+	+	+	+	+	+	+	+	+	+	-	-	-	+	+	+	+	+	+	+	+	+	+	+	+	22
Information, education, communication (IEC) is a predominant or common response strategy **to prevent infectious diseases**	+	+	+	+	+	-	+	+	+	+	+	+	+	+	+	?	+	+	+	+	+	-	+	+	+	22
IEC via counselling and advice by drugs & health professionals is a predominant or common response strategy **to prevent infectious diseases**	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	?	+	+	-	+	+	+	+	+	+	23
IEC via peer involvement is a predominant or common response strategy **to prevent infectious diseases**	-	+	-	+	+	-	+	+	-	+	+	+	+	-	-	?	+	-	+	+	-	-	-	+	-	13
Safer injecting training is a predominant or common response strategy **to prevent infectious diseases**	-	+	-	+	-	+	+	+	+	-	-	-	-	+	+	?	+	+	+	+	-	-	+	-	-	13
Dissemination of information materials is a predominant or common response strategy **to prevent drug-related deaths**	+	+	+	+	-	+	+	-	-	+	n/ a	-	+	+	-	?	+	+	+	+	+	?	-	-	+	15
Risk education/ response training is a predominant or common response strategy **to prevent drug-related deaths**	-	+	+	-	-	+	+	-	+	+	n/ a	-	-	+	+	+	+	+	+	+	+	?	+	-	+	16
(Individual) risk counselling is a predominant or common response strategy **to prevent drug-related deaths**	-	+	-	+	-	+	+	+	+	+	n/ a	+	-	+	-	?	+	-	-	+	+	?	+	+	+	15

+ = available
- = not available
n/ a = not applicable
? = no information available

Table A2 – state of play on Council Recommendation 2.2

2.2 inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence																									
	BE	**CR**	**DK**	**DE**	**EE**	**GR**	**ES**	**FR**	**IE**	**IT**	**CY**	**LV**	**LT**	**LU**	**HU**	**MT**	**NL**	**AT**	**PL**	**PT**	**SI**	**SK**	**FI**	**SE**	**UK**	**TO**
This policy exists, and is based on Council Recommendation					+						+		+						+		+	+				6
This policy exists, but is not based on Council Recommendation	+	+	+	+		+	+	+	+	+		+		+	+	+	+	+		+			+	+	+	19
Communities and families are involved in risk reduction	+	+	?	?	+	+	+	+	+	+	?	+	+	+	-	+	+	-	+131	+	+	+	+	?	+	19
Specific IEC for communities and families is available	+	-	?	?	+	+	+	+	-	+	?	+	+	-	-	-	+	-	+132	-	+	+	+	?	+	14

131 Related to communities, families are not involved at all.
132 Related to communities, families are not involved at all.

Table A3 – state of play on Council Recommendation 2.3

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																									
	BE	**CR**	**DK**	**DE**	**EE**	**GR**	**ES**	**FR**	**IE**	**IT**	**CY**	**LV**	**LT**	**LU**	**HU**	**MT**	**NL**	**AT**	**PL**	**PT**	**SI**	**SK**	**FI**	**SE**	**UK**	**TO**
This policy exists, and is based on Council Recommendation					+						+		+						+		+					**5**
This policy exists, but is not based on Council Recommendation	+	+	+	+		+	+	+	+			+		+	+	+	+	+		+		+	+	+	+	**19**
This policy does not exist										+																**1**
Street-based outreach work is nationwide available	+	+					+				-			+		-	+	+	+	+					+	**9**
Street-based outreach work is available in specific geographical areas			+	+	+	+		+	+	+	-	+	+		+	-					+	+	+	+		**14**
Outreach work at dance parties/ clubs is nationwide available	+		+				+	+	?		-	-			+			+	+		+				+	**9**
Outreach work at dance parties/ clubs is available in specific geographical areas		+		+	+	+			?	+	-	-	+	-		+	-			+		+	+	+		**11**
Outreach work is a predominant or common response strategy to **prevent infectious diseases** among drug users	+	+	+	+	+	-	+	+	+	+	-	+	+	+	+	-	+	+	+	+	+	-	-	+	+	**20**
Outreach work is a predominant or common implementation setting **to prevent infectious diseases** among drug users	+	+	+	-	+	-	+	+	+	+	-	+	+	+	+	-	+	+	+	+	+	-	-	+	+	**19**
Outreach work is a predominant or common setting for the dissemination of information materials **to prevent drug-related deaths**	+	+	+	+	-	+	+	-	+	+	n/a	-	+	+	-	-	+	+	?	+	+	?	+	?	+	**16**
Outreach work is a predominant or common setting for risk education/ response training **to prevent drug-related deaths**	+	+	+	-	-	+	+	-	+	+	n/a	-	-	+	+	-	+	+	+	+	+	?	+	?	+	**16**

Table A4 – state of play on Council Recommendation 2.4

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	BE	CR	DK	DE	EE	GR	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK	TO
This policy exists, and is based on Council Recommendation					+						+								+		+					4
This policy exists, but is not based on Council Recommendation	+	+		+		+	+	+	+			+		+		+	+	+					+	+	+	15
This policy does not exist										+					+											2
This policy does not exist, as it is no priority, task for national government			+																			+				2
The implementation of this policy is pending for approval													+													1
This policy exists, but implementation is pending for approval																				+						1
Training programmes for outreach workers are available nationwide or in specific areas	+	+	+	+	+	+	+	+	+	+	-	+	+	+	+	-	+	+	+	+	+	+	+	?	?	21
Training programmes for peers and volunteers in outreach work are available nationwide or in specific geographical areas	+	+	+	+	+	+	+	-	-	+	-	+	+	+	+	-	+	-	+	+	+	+	+	?	?	18
Peers and volunteers are involved in outreach work	+	+	+	+	+	+	+	+	-	+	-	?	+	+	+	-	+	-	+	+	+	+	+	?	+	19

Table A5 – state of play on Council Recommendation 2.5

2.5 promote networking and cooperation between agencies involved in outreach work, to permit continuity of services and better users' accessibility	BE	CR	DK	DE	EE	GR	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK	TO
This policy exists, and is based on Council Recommendation					+						+										+					3
This policy exists, but is not based on Council Recommendation	+	+		+			+	+	+					+	+	+	+	+	+				+	+	+	15
This policy does not exist						+				+																2
This policy does not exist, as it is no priority for national government			+																			+				2
The implementation of this policy is pending for approval												+	+							+						3
Networking and cooperation between outreach work agencies is available	+	+	+	+	+	+	+	+	+	+	-	+	+	-[133]	+	+	+	+	-	+	+	?	+	?	+	20

[133] Only one organisation provides outreach work.

Table A6 – state of play on Council Recommendation 2.6

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	BE	CR	DK	DE	EE	GR	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK	TO
This policy exists, and is based on Council Recommendation					+						+										+	+				4
This policy exists, but is not based on Council Recommendation	+	+	+	+		+	+	+	+	+		+	+	+	+	+	+	+	+	+			+	+	+	21
Methadone maintenance treatment is available nationwide	+		+	+			+		+	+	-			+		+	+	+		+	+		+		+	14
Methadone maintenance treatment is available at specific areas		+			+	+		+			-	+	+		+				+			+		+		10
Methadone detoxification treatment is available nationwide	+	+	+	+	+		+		+	+	-			+		+	+	+			+	+	+	?	+	16
Methadone detoxification treatment is available at specific areas						+		+			-	+	+		+				+	+				?		7
Treatment with buprenorphine is available	+	+	+	+	+	+	+	+	+	+	-	+	+	+	-	-	+	+	-	+	+	+	+	+	+	21
Treatment with naltrexone is available	+	+	+	+	-	+	+	-	+	+	-	+	+	-	+	+	+	+	-	+	+	-	+	?	+	18
Substitution treatment is supported by psychosocial care	+	+	+	+	+	+	+	+	+	+	-	+	+	+	+	+	+	+	+	+	+	+	+	+	+	24
Drug-free outpatient treatment is available	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	25
Drug-free inpatient treatment is available	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	25
Rehabilitation centres are available	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	25
Drop-in centres/ shelters are available	+	+	+	+	+	+	+	+	+	+	-	+	+	+	+	+	+	+	+	+	+	-	+	+	+	23
Heroin prescription programmes are available	-/+	-	-	+	-	-	+	-	-	-	-	-	-	-/+	-	-	+	-	-	-	-	-	-	-	+	4
Drug consumption rooms are available	-	-	-	+	-	-	+	-	-	-	-	-	-	+	-	-	+	-	-	-	-	-	-	-	-	4
Opioid substitution treatment is a predominant or common response strategy to reduce drug-related deaths	+	+	+	+	-	+	+	+	+	+	n/a	+	+	+	-	+	+	+	-	+	+	?	+	-	+	19

Table A7 – state of play on Council Recommendation 2.7

2.7 establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment	BE	CR	DK	DE	EE	GR	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK	TO
This policy exists, and is based on Council Recommendation					+						-										+	?				2
This policy exists, but is not based on Council Recommendation	+	+	+	+		+	+	+	+	+	-	+	+	+		+	+	+	+	+		?	+	+	+	20
This policy does not exist															+											1
Measures to prevent diversion of substitution substances are available	+	+	+	+	+	+	+	+	+	-	-	+	+	+	+	-	+	+	+	+	+	+	+	+	+	22

Table A8 – state of play on Council Recommendation 2.8

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																									
	BE	**CR**	**DK**	**DE**	**EE**	**GR**	**ES**	**FR**	**IE**	**IT**	**CY**	**LV**	**LT**	**LU**	**HU**	**MT**	**NL**	**AT**	**PL**	**PT**	**SI**	**SK**	**FI**	**SE**	**UK**	**TO**
This policy exists, and is based on Council Recommendation					+						+								+		+	+				**5**
This policy exists, but is not based on Council Recommendation	+		+	+			+	+	+	+					+	+	+	+		+			+	+	+	**15**
Policy does not exist		+																								**1**
The implementation of this policy is pending for approval						+						+	+	+												**4**
Methadone maintenance treatment is available in prison	+	+[134]	+	+	-	-	+	+	+	+	-	-	-	+	-	+	+	+	+	+	+	-	+	-	+	**17**
Methadone detoxification treatment is available in prison	+	+	+	+	+	+	+	+	+	+	-	-	-	+	-	+	+	+	+	+	+	-	+	-	+	**19**
Treatment with buprenorphine is available in prison	+	-	+	+	?	-	-	+	-	+	-	-	-	+	-	-	-	+	-	+	-	-	+	-	+	**10**
Treatment with naltrexone is available in prison	+	-	+	-	-	-	+	-	-	-	-	-	-	-	-	-	-	-	-	?	+	-	-	-	+	**5**
Heroin prescription in prison is available	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	**0**
Drug paraphernalia are available in prison	+	-	+	-	+	+	+	+	-	?	-	-	-[135]	+	-	-	+	+	-	+	-	-	+	-	-	**11**
Needle and syringe exchange is available in prison	-	-	-	+	-	-	+	-	-	-	-	-	-	+	-	-	-	-/+	-	-	-	-	-	-	-	**3**
(free) condom distribution is available in prison	+	-[136]	+	+	+	-	+	+	-	?	-	+	-	+	-	-	+	+	+	+	+	?	+	+	+	**16**
Infectious diseases measures are provided in prison	+	+	+	+	+	+	+	+	+	+	+[137]	-	?	+	+	+[138]	+	+	+	+	+	+	+	+	+	**23**
Prisons are a predominant or common implementation setting for infectious diseases measures	+	-	-	+	+	-	+	-	+	+	-	-	+	+	-	-	-	+	+	+	+	-	+	+	+	**15**
Prisons are a predominant or common implementation setting for measures aiming at the reduction of drug-related deaths	+	+[139]	-	-	-	-	+	-	-	+	n/ a	-	-	+	-	?	+	-	+	-	+	?	+	-	+	**10**

[134] Since April 2006 in 2 prisons, capacity 80 slots.
[135] Some prisons provide bleach.
[136] But are being sold.
[137] Counselling only.
[138] Counselling only.
[139] Risk education/ response training.

Table A9 – state of play on Council Recommendation 2.9

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																										
	BE	**CR**	**DK**	**DE**	**EE**	**GR**	**ES**	**FR**	**IE**	**IT**	**CY**	**LV**	**LT**	**LU**	**HU**	**MT**	**NL**	**AT**	**PL**	**PT**	**SI**	**SK**	**FI**	**SE**	**UK**	**TO**
This policy exists, and is based on Council Recommendation					+						+			+					+		+					**5**
This policy exists, but not based on CR	+	+	+	+		+	+	+	+	+					+	+	+	+		+		+	+	+	+	**18**
This policy exists													+													**1**
This policy does not exist												+ **140**														**1**
Testing/ screening with regard to infectious diseases is available nationwide to drug users	+	+	+	+	+		+	+	?	+	-		?	+	+	+	+	+	+	+	+	+		+	+	**19**
Testing/ screening with regard to infectious diseases is available to drug users in specific geographical areas						+			?		-	+	?										+			**3**
Measures targeting at the prevention and education of infectious diseases are available nationwide to drug users	+	+	?	+	+	+	+	+	?		-	+	?	+	+		+	+		?	+			+	+	**15**
Measures targeting at the prevention and education of infectious diseases are available to drug users in specific geographical areas			?						?	+	-		?			+			+	?		+	+			**5**
Infectious diseases counselling is available	+	+	?	+	+	+	+	+	?	+	-	+	?	+	+	?	+	+	+	+	+	+	+	+	+	**20**
Treatment of infectious diseases is available to drug users nationwide	+	+	+	+			+	+	?		-	+	?	+	+	?		+		?	+	+	+	+	+	**15**
Treatment of infectious diseases is available to drug users in specific geographical areas					+	+			?	+	-		?			?	+		+	?						**5**
Vaccination against hepatitis B targeting drug users is available nationwide		+	+	+			+	+	?	+	-	?	?	+	+	+	+		-	+	+		+	+	+	**15**
Vaccination against hepatitis B targeting drug users is available in specific geographical areas	+				+	+			?		-	?	?					+	-			+				**5**
Vaccination against tuberculosis targeting drug users is available nationwide		+	?	+	?		?	+	?	?	-	?	?	+	+	+	+		?	?	+	?	?	+	+	**10**
Vaccination against tuberculosis targeting drug users is available in specific geographical areas	+				?	+	?		?		-	?	?					+	?	?		?	?			**3**
VCT is a predominant or common response strategy to prevent infectious diseases among drug users	-	-	-	+	+	+	+	+	+	+	-	+	-	+	+	+	-	+	-	-	+	+	+	+	+	**17**
Routine screening of high risk groups is a predominant or common response strategy to prevent infectious diseases among drug users	-	+	+	-	-	-	+	-	-	+	-	-	+	+	-	-	+	-	-	+	+	+	+	-	-	**11**
Easy access programmes to treatment is a predominant or common response strategy to prevent infectious diseases among drug users	-	+	+	+	-	-	+	-	-	+	-	-	-	+	-	-	+	+	-	+	+	-	+	-	-	**11**

140 Vaccination against hepatitis B is provided for all newborn infants [RT]

Table A10 – state of play on Council Recommendation 2.10

2.10 provide where appropriate, access to distribution of condoms and injection materials, and also to programmes and points for their exchange	BE	CR	DK	DE	EE	ES	GR	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK	TO
This policy exists, and is based on Council Recommendation					+														+		+	+				4
This policy exists, but is not based on Council Recommendation	+	+	+	+		+	+	+	+			+		+	+	+	+	+		+			+	+	+	18
This policy exists													+													1
This policy does not exist										+	+															2
Needle and syringe exchange is available nationwide	+	+	+	+	+	+		+		+	-			+			+			+	+	+	+		+	15
Needle and syringe exchange is available in specific geographical areas							+		+		-	+	+		+	+		+	+					+		9
Drug paraphernalia are available	+	+	+	+	-	+	+	+	+	+	?	+	+	+	+	+	+	+	+	+	+	+	+	-	+	22
(free) condoms are available	+	+	+	+	+	+	+	+	+	+	+	-	+	+	+	-	+	+	+	+	+	+	+	+	+	23
Needle and syringe exchange is a predominant or common response strategy **to prevent infectious diseases**	+	+	+	+	+	+	-	+	+	+	-	+	+	+	+	?	+	+	+	+	+	+	+	-	+	21
Low threshold agencies, incl. needle and syringe exchange programmes, are a predominant or common implementation setting for measures targeting at the **reduction of drug-related deaths**	+	+	+	+	-	+	+	-	+	+	n/a	+	+	+	-	?	+	+	+	+	+	?	+	-	+	18

Table A11 – state of play on Council Recommendation 2.11

2.11 ensure that emergency services are trained and equipped to deal with overdoses	BE	CR	DK	DE	EE	GR	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK	TO
This policy exists, and is based on Council Recommendation					+						+		+	+					+		+	+				7
This policy exists, but is not based on Council Recommendation	+	+	+	+		+	+	+	+	+		+			+	+	+	+		+			+	+	+	18
Training for staff of emergency units is provided	-	+	-	+	?	-	+	-	+	-	-	+	?	+	-	-	+	+	-	-	+	?	-	?	+	10
Emergency units are a predominant or common setting for the dissemination of information materials that aim the reduction of drug-related deaths	-	-	-	-	-	-	-	-	-	-	n/a	-	-	-	-	-	+	-	-	-	-	?	?	?	+	2
Emergency units are a predominant or common setting for the deliverance of risk education/ response training	-	-	?	-	-	-	+	-	-	-	n/a	-	-	-	-	-	+	-	-	-	-	?	-	?	+	3
Ambulances carry antagonists	+	+	?	?	+	+	+	+	+	+	n/a	+	-	+	+	+	+	+	+	+	+	?	+	+	+	20
Naloxone is available on a 'take home' basis	-	-	-	+	+	-	-	-	-	+	n/a	-	-	+	-	+	-	-	-	-	-	?	-	-	+	6

Table A12 – state of play on Council Recommendation 2.12

2.12 promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction	BE	CR	DK	DE	EE	GR	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK	TO
This policy exists, and is based on Council Recommendation					+								+								+					3
This policy exists, but is not based on Council Recommendation	+	+	+	+		+	+	+	+	+	+			+	+	+	+	+	+			+	+	+	+	20
The implementation of this policy is pending for approval												+														1
This policy exists, but implementation is pending for approval																				+						1
Risk reduction is part of an integrated health strategy for drug users	+	+	+	+	+	+	+	+	+	?	?	-		+	-	+	+	+	?	+	+	+	+	?	+	18
Integration between health care and social care takes place													+													1

Table A13 – state of play on Council Recommendation 2.13

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	BE	CR	DK	DE	EE	GR	ES	FR	IE	IT	CY	LV	LT	LU	MT	HU	NL	AT	PL	PT	SI	SK	FI	SE	UK	TO
This policy exists, and is based on Council Recommendation					+								+								+					3
This policy exists, but is not based on Council Recommendation	+	+	+	+		+	+	+	+						+	+	+	+	+	+		+	+	+	+	18
This policy exists, but is not a priority for the government														+												1
This policy does not exist		+								+	+															3
The implementation of this policy is pending for approval												+														1
Training programmes are available for professionals in needle and syringe exchange	+	+	-	-	+	+	+	+	?	-	-	+	+	+	-	+	+	-	+	+	+	+	+	-	+	17
Training programmes are available for professionals substitution treatment	+	+	+	+	+	+	+	+	?	-	-	+	+	+	-	+	+	+	+	+	+	+	+	-	+	20
Training programmes are available for professionals low threshold programmes	+	+	-	+	+	+	+	+	?	-	-	+	?	+	+	+	+	+	+	+	+	+	+	-	+	19
Training programmes are available for professionals treatment facilities	+	+	-	+	+	+	+	+	?	-	+	-	+	+	-	+	+	-	+	+	+	+	+	+	+	19
Training programmes are available for prison staff	+	+	+	-	+	+	+	+	?	-	+	-	+	+	-	+	+	+	+	+	+	?	+	+	+	19

Table A14 - 3rd Recommendation of the Council Recommendation – overview of existing policies

Recommendation		3.1		3.2		3.3		3.4		3.5		3.6		3.7		3.8		3.9		Total	
Policy exists Based upon CR If not: why (2nd column)		Exist	Rec	Exist	Rec	Exist	Rec	Exist	Rec	Exist	Rec	Exist	Rec	Exist	Rec	Exist	Rec	Exist	Rec	Exist	Rec
1	Belgium	-	DIV	+	+	-	DIV	-	PA	-	PA/ OT	+	DIV	-	PA/ OT	-	OT	+	-	3	1
2	Czech Republic	+	-	-	NP	-	PA	-	PA	+	-	+	-	+	-	-	PA	+	-	5	0
3	Denmark	+	-	+	-	+	-	+	-	+	-	+	-	-	OR	+	-	-	OT	7	0
4	Germany	+	+	+	-	+	+	+	+	+	+	+	-	+	-	+	-	+	+	9	5
5	Estonia	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	9	9
6	Greece	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	9	0
7	Spain	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	9	0
8	France	+	-	+	-	-	-	-	-	+	-	+	-	-	-	-	-	+	-	5	0
9	Ireland	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	-	-	8	0
10	Italy	+	-	+	NT	+	NT	+	-	+	-	+	NT	-	NT	-	OT	+	-	7	0
11	Cyprus	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	9	9
12	Latvia	-	OT	-	OT	-	PA	-	PA	-	PA	-	OT	-	PA	-	OT	+	+	1	1
13	Lithuania	-	PA	+	-	-	PA	-	PA	+	+	-	PA	-	PA	-	PA	-	PA	2	0
14	Luxembourg	+	-	+	-	+	OT	+	-	+	-	+	-	+	-	+	-	+	+	9	1
15	Hungary	-	NT	-	NT	-	NT	-	NT	+	-	-	NT	-	NT	-	NT	+	-	2	0
16	Malta	-	PA	-	PA	-	PA	-	PA	+	-	-	PA	-	PA	-	PA	+	-	2	0
17	Netherlands	+	-	-	NT	-	OT	-	NT	+	-	+	-	+	-	-	OT	+	-	5	0
18	Austria	+	-	+	-	-	OT	-	OT	+	-	-	OT	+	N	-	-	-	-	4	0
19	Poland	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-	9	9
20	Portugal	+	-	+	-	+	-	+	-	+	-	+	-	-	PA	+	-	+	-	8	0
21	Slovenia	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	9	9
22	Slovakia	+	+	-	PA	-	PA	-	PA	+	+	+	NP	-	NP	-	NP	+	+	4	3
23	Finland	+	-	+	-	-	OT	+	-	+	-	+	-	+	-	+	-	+	-	8	0
24	Sweden	+	-	+	-	-	OT	+	-	+	-	+	-	+	-	+	-	+	-	8	0
25	Great Britain	-	OT	+	-	-	OT	-	OT	+	-	+	-	-	NP	-	NP	+	-	4	0
	Total	19	5	19	4	12	4	14	4	23	6	19	3	14	3	14	3	21	7		

Explanation Policy not existing:
OT = Other reason | **NP** = Not a priority | **NT** = Not task national government | **PA** = Pending for approval | **NA** = Not available | **DIV** = Diverging answer

Annex A2.1 State of play on harm reduction in Belgium

2.1.1 Summary

Public health policy In Belgium, harm reduction has been adopted as public health objective in most of its independent communities, but policies differ between the Regional communities.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines, websites and a broad range of educational leaflets. Trainings for drug users and pill-testing are available in specific geographical areas only. Specific IEC is available for communities and families of drug users, which are involved in the prevention and reduction of health risks associated with drug dependence in specific geographical areas.

Outreach work. Street-based outreach work and outreach work at dance parties, raves and in clubs are nationwide available. Outreach work as a health education approach is a common response strategy to prevent drug-related infectious diseases among drug users. Outreach work is the predominant setting for the dissemination of information materials on the prevention of drug-related deaths, and a common setting for the deliverance of risk education/ response training. In specific geographical areas, peers and volunteers are trained and included in outreach work practice. Networking and cooperation between outreach work agencies exist nationwide.

(Medically assisted) treatment and specific interventions. Methadone maintenance programmes and methadone detoxification programmes, treatment with buprenorphine and with naltrexone are available nationwide. Drug-free outpatient and drug-free inpatient treatment, rehabilitation centres, and drop-in centres/ shelters are also nationwide available. Drug consumption rooms and heroin prescription programmes do not exist in Belgium. Opioid substitution treatment is a common response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Methadone maintenance and methadone detoxification programmes, treatment with buprenorphine and with naltrexone, and condoms are available nationwide. Drug paraphernalia are available in specific geographical areas. There are no needle and syringe exchange programmes in prisons in Belgium.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening, education, prevention, counselling, and treatment for drug-related infectious diseases are available nationwide. To prevent drug-related infectious diseases among drug users, the predominant response strategies are IEC in general, IEC via counselling and advice by drugs and health professionals, outreach health education approach, condom promotion among drug users, and needle and syringe exchange programmes. Needle and syringe exchange, drug paraphernalia and the distribution of condoms are available nationwide in Belgium.

Drug-related deaths. The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is not available..

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals in needle and syringe exchange programmes and to prison staff. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation Belgium is well underway with the introduction of qualitative instruments to monitor and evaluate harm reduction interventions and policies. Research is increasingly used to adjust and improve interventions and the harm reduction programmes increasingly have to include evaluation in their activities as a condition for funding.

2.1.2 Legal environment and existing policies

Due to the Federal structure of the government in Belgium, the tasks in the field of drug demand reduction and – as a result – also regarding the implementation of the Council Recommendation. As a result, the Federal Government[141] has competence in matters others than prevention and harm reduction (e.g. regarding hospitals, social security, justice). It did adopt a Federal Drug Policy

[141] Minister of Public Health and Minister of Justice.

Note in 2001, which called for harm reduction measures, including the prevention of drug-related deaths. [SQ 29]

The Flemish Community[142] has a large competence in prevention and harm reduction. The French Community[143] and the Walloon Region have also have arge competences in prevention and harm reduction. The same counts for the German Community[144]. [RT]. 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. [RT]

In Belgium, developments took place in each of the Regional Communities. 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. 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. [RT]

In the French Community Commission (Brussels), services providing aid in drug-related matters can be officially approved and financed. 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. [RT]

2.1.3 Recommendation 2: Harm reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation. [RT]
Telephone help lines, websites, and a broad range of educational leaflets are available nationwide in Belgium. Training for drug users is available in specific geographical areas only, and so is pill-testing[145]. [NR 2004; NFP 2006]

To **prevent drug-related infectious diseases** among drug users, providing information, education and communication (IEC) in general is a predominant response strategy; IEC via counselling and advice by drugs and health professionals is a common response strategy. [SQ 23]

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, including needle and syringe exchange programmes, outreach workers and information materials, are commonly disseminated through mass media/ internet, in nightlife or at entertainment venues, rave events/ festivals. [SQ 29]

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

This policy exists, but was not based upon the Council Recommendation.[146] [RT]
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 and specific information, education and communication is available for communities and families of drug users. [NFP 2006]

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[147]. [RT]

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[142] Minister of Public Health.
[143] Minister of Public Health and the Walloon Region.
[144] Minister of Public Health.
[145] Modus Vivendi, www.modusvivendi-be.org.
[146] The Flemish Community has a network of drug prevention workers. Their goal is to raise awareness in the local communities and to promote participation from all kinds of settings in local drug policy.

In Belgium, street-based outreach work and outreach work at dance parties, raves and in clubs[148] are nationwide available. [NR 2003/ 2004; NFP 2006]

To **prevent drug-related infectious diseases** among drug users, outreach work as a health education approach is a common response strategy. 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). [SQ 23]

Low threshold agencies, including needle and syringe exchange programmes, and outreach work are predominant settings for the dissemination of information materials, aimed at the **reduction of drug-related deaths**, and outreach work is a common setting for the deliverance of risk education/ response training. [SQ29]

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 exists, but was not based upon the Council Recommendation[149]. [RT]
Training for outreach workers and for peers and volunteers are organised. In specific geographical areas only, peers and volunteers are included in outreach work[150]. [NR 2003; NFP 2006]

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. [RT]
Networking and cooperation between outreach work[151] agencies exist nationwide. [NR 2003]

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 exists, but is not based upon the Council Recommendation. [RT]
Methadone maintenance programmes, methadone detoxification programmes, treatment with buprenorphine and with naltrexone, drug-free inpatient and drug-free outpatient treatment facilities, rehabilitation centres, and drop-in centres/ shelters are available nationwide. Substitution treatment is supported by psychosocial care, and is sometimes obligatory sometimes upon request by the client (depending on the institution or general practitioner). [NR 2003, NR 2004; NFP 2006]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a common response strategy. [SQ 29]
Drug consumption rooms and heroin prescription programmes do not exist in Belgium[152].

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[147] The Flemish Community has given financial impulses to better integrate the problem of substance use in the daily work of community outreach workers.
[148] French community: information, fresh water, needles, and bad trip management; Flemish community: Partywise (global prevention concept for nightlife).
[149] French Community: this is part of official policy, but due to financial reasons it is limited to distribution of brochures for drug users.
[150] (ex) Drug users are trained to disseminate HIV prevention and OD prevention messages (French Community: by using the snowball method).
[151] Between harm reduction agencies.
[152] An experimental clinical trial project on controlled distribution of heroin is envisaged to start in Liege.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation.[153] [RT]
Measures to prevent diversion of prescribed drugs are available nationwide[154]. [NFP 2006]

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, but was not based upon the Council Recommendation. [RT]
Treatment with buprenorphine and with naltrexone is available in prisons nationwide. Methadone maintenance, methadone detoxification programmes and condoms are available nationwide in prisons, and drug paraphernalia are available in specific geographical areas only. There are no needle and syringe exchange programmes in prisons in Belgium. [NR 2003/ 2004; NFP 2006]

Depending on the region, prisons are a common to rare implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ23] Prisons are a common implementation setting for disseminating information materials on **prevention of drug-related deaths**. [SQ29]

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[155]. [RT]
Testing/ screening, education, prevention, counselling and treatment of drug-related infectious diseases are available nationwide. In specific geographical areas only, vaccination against hepatitis B and/ or tuberculosis, targeting at drug users, is available. [NR 2003/ 2004]

To **prevent drug-related infectious diseases** among drug users response strategies most commonly used are IEC in general, IEC via counselling and advice by drugs and health professionals, outreach health education approach, condom promotion among drug users, and needle and syringe exchange programmes. Low threshold counselling services are a common to predominant setting for measures aimed at the prevention of drug-related infectious diseases among drug users. The use of outreach work and targeted high-risk group interventions as a setting for drug-related infectious diseases prevention measures varies across the country. [SQ23]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Needle and syringe exchange programmes, drug paraphernalia and the distribution of condoms are available nationwide. [NR 2003/ 2004] Needle and syringe exchange programmes are a predominant response strategy to **prevent drug-related infectious diseases** among drug users in Belgium. [SQ 23] 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. [SQ 29]

Belgium has 39 non-pharmacy based and 49 pharmacy-based needle and syringe exchange points. Needle and syringe exchange takes place through fixed sites, through outreach workers/ peers, and via pharmacies. [ST 10]

There are no legal restrictions to the possession of unused sterile needles in Belgium, and also no prescription is required to obtain or exchange[156] needles and syringes. [ELDD]

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[153] A Royal Decree 19/03/2004 ensures coordination of substitution and ensures appropriate access to treatment for opiate users.
[154] Royal Decree 19/03/2004 on substitution treatment.
[155] Commission Communautaire Française (COCOF), Flemish and French Communities promote screening for infectious diseases, safer sex counselling and the use of condoms, but there are no plans to promote hepatitis B vaccination.

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation[157]. [RT]
Belgian ambulances routinely carry antagonists. The distribution, possession or administration of naloxone is regulated by regulations. naloxone is only available on medical prescription and only in hospitals. Naloxone on a 'take home' basis is not available. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in harm reduction

This policy exists, but was not based upon the Council Recommendation. [RT]
Harm reduction is part of an integrated health strategy for drug users[158]. [NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation[159]. [RT]
Training is offered nationwide to professionals in needle and syringe exchange programmes and for prison staff. Training for professionals in substitution programmes, in low threshold agencies and treatment facilities is available in specific geographical areas only. [NR 2003/ 2004]

2.1.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

NOTE: As the competences for public health are spread over several governments in Belgium, an answer whether a policy exists is only positive if it is representative for 90% for Belgium. Furthermore, in the Flemish Community, by 2007 all actions should be evidence-based and focus on clear public health objectives.

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists in Flanders and in the German Community, but is not based on the Council Recommendation. The Flemish Community has adopted a standard procedure for the development of new strategies. The policy does not exist in the Walloon region, French Community and COCOF (Brussels) as research on scientific evidence is not developed sufficiently. [RT]

in Brussels, a research project was run about the pertinence of a harm reduction intervention in recreational settings[160] in 2002. [NR2002] At federal level, the activities take place in research and development of evidence-based new concepts, information, training, networking and coordination. 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. [NR 2003, NR 2004, NR 2005]

3.2 Supporting the inclusion of needs assessments at the initial stage of any programme

This policy exists in the Walloon region, the Flemish, German and French communities, but it is not based on the Council Recommendation. The Flemish Community has adopted a standard procedure for the development of new strategies. The policy does not exist in the COCOF. [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

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[156] The Royal Decree of 5 June 2000 outlines the law on needle exchange for drug users. This decree stipulates that only general practitioners, pharmacies, specialised personnel of drug services, and street corner workers are allowed to exchange needles. The delivery of sterile injection equipment must be accompanied by written information on the good use of the equipment, of accessibility to HIV and hepatitis screening services, to existing services for treatment.
[157] Every hospital in a city has appropriate equipment (such as naloxone) and personnel trained to deal with overdose.
[158] Mentioned in the Federal Drug Policy Note 2001.
[159] Plans and curricula for drug-related training of five selected occupational groups have been completed.
[160] Modus Vivendi research project.

This policy is pending for approval in the Flemish Community. It has ordered a scientific report concerning the feasibility of different kinds of criteria for evaluation. This report will be used for the development of a system of evaluation. The policy exists in the German and French Community. In the other regions of Belgium the policy does not exist. [RT]

Community and Regional stakeholders have power to implement certain drug-related prevention and treatment programmes. Concerning their policy, the French-speaking Community e.g. says to evaluate results, the context and the means used. In the Flemish Community, the government has changed its policy from projects to covenants. 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 in function of indicators specifically created for them. Objectives are to be chosen according to the drug situation, for optimal results to be attained. [NR 2003]

All health promotion projects funded by the French Community must have an evaluation built in the project. 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. [NR 2004]

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 is pending for approval in the Flemish Community. It has ordered a scientific report concerning the feasibility of different kinds of criteria for evaluation. This report will be used for the development of a system of evaluation. In the other regions and communities in Belgium the policy does not exist. [RT]

An organisation in the Flemish Community[161] (De Sleutel) uses the 'European Foundation of Quality Management' model (EFQM). The model has two main principles: self-evaluation and self-control. The model focuses on aspects that can be optimised. It takes into account organisational and results indicators. [NR 2003]

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 collections according to the EMCDDA recommendations is pending for approval in Belgium. Regarding the Treatment Demand Indicator (TDI) a national political decision has to be taken regarding the 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. [RT]

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

This policy exists in the French, Flemish and German Communities but was not based upon the Council Recommendation. Policy does not exist in the COCOF and Walloon region. [RT]

Until 2002, Belgium has lacked any significant, concrete data on the drug policy it is pursuing. No comprehensive overview exists of all the actors directly and indirectly involved, or of differences between funding sources. [NR 2002]. 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 areas of work are: research and development of evidence-based new concepts, information, training, networking and coordination. [NR 2003]

[161] De Sleutel.

3.7 Setting up evaluation training programmes for different levels and audiences

This policy is pending for approval in the Flemish Community, but is not based on the Council Recommendation. The policy does not exist in the other regions and communities. [RT]

A 'research platform substance abuse' was created by the Flemish VAD[162], which aims at bringing research and practice in the Flemish alcohol and drug field closer together. [NR 2005]

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 French Community and Walloon region, but is not based upon the Council Recommendation. The policy is pending for approval in the Flemish Community, but is not based on the Council Recommendation. The policy does not exist in the COCOF and German Community. [RT]

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 in the Flemish and German Community, but is not based upon the Council Recommendation. The policy does not exist in the other communities and regions. [RT]

Since April 2004, Trempoline[163] has introduced the Europ-ASI questionnaire[164] for each client of the institution. 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. [NR 2005]

2.1.5 Information from third data sources

Issues raised by Free Clinic, related to Flanders

Information, education, communication. Information, education and communication is inadequate in coverage and accessibility. Drug testing, mainly pill-testing, does not exist in Flanders.

Outreach work. Outreach work is considered to be adequate in coverage and accessibility.

(Medically assisted) treatment and specific interventions. Coverage and accessibility of medically assisted treatment for opiate users is adequate throughout the country. Medically assisted treatment for amphetamine-type stimulants (ATS) or cocaine users are inadequate, as there is no general policy. Access to treatment depends on the treating physician and is not structurally regulated. There are no heroin, ATS or cocaine prescription programmes. The coverage and accessibility of needle and syringe exchange programmes is adequate throughout the nation. For drug paraphernalia coverage and accessibility is inadequate because of lack of funding. Low threshold agencies are not widely available in Flanders, which means that coverage and accessibility is inadequate. The services are only available in big cities. Drug consumption rooms are not available in Flanders. Specific harm reduction interventions targeted at cocaine or ATS users are not available, although needle and syringe exchange programmes try to focus also on crack cocaine users, cocaine injectors and ATS users.

Prison interventions. Information, education and communication is not available in prison. Outreach work is not available. Medically assisted treatment for opiate users in prison may be limited in access, if drug users were not enrolled in a methadone maintenance programme before incarceration. Medically assisted treatment for ATS or cocaine users is not available in prison. In prison neither needle and syringe exchange programmes nor the distribution of drug paraphernalia exist. In Flemish prisons services to prevent drug-related infectious diseases are considered to be inadequate in coverage and accessibility. In prison, hepatitis B or tuberculosis vaccination programmes are not available.

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[162] Flemish association for alcohol and other drug problems.
[163] Trempoline is a Therapeutic Community.
[164] ASI = Addiction Severity Index.

***Infectious diseases (HIV, hepatitis B and c, tuberculosis and sexually transmitted diseases**).* Measures to prevent drug-related infectious diseases are adequately taken in Flanders and easily accessible for drug users as long as they are not incarcerated. Hepatitis B vaccination programmes are considered inadequate in coverage, as there is not enough funding to conduct them thoroughly.

Annex A2.2 State of play on harm reduction in the Czech Republic

2.2.1 Summary

Public health policy. Harm reduction has been a public health objective within the Czech Republic for a considerable period of time already. The principle has also been adopted in the Czech National Drug Strategy 2005-2009.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through various websites, telephone help lines, training for drug users, educational materials and through pill-testing. For the reduction of drug-related deaths, the dissemination of information materials and risk counselling are the predominant strategies. Communities and families of drug users are involved in the prevention and reduction of health risks associated with drug dependence at specific areas.

Outreach work. Street-based outreach work is nationwide available. Outreach work as a health education approach is a common response strategy to prevent drug-related infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials, as well as for the deliverance of risk education/ response training. Furthermore, peers and volunteers are included nationwide in outreach work practice. Finally, networking and cooperation between outreach work agencies exist nationwide.

(Medically assisted) treatment and specific interventions. Methadone detoxification programmes and treatment with naltrexone, drug-free outpatient and inpatient treatment and drop-in centres are widely available. Methadone maintenance treatment, treatment with buprenorphine and rehabilitation programmes (after-care centres) are available in specific geographical areas only. Drug consumption rooms and heroin prescription programmes do not exist in the Czech Republic. Opioid substitution treatment is a common response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Testing for drug-related infectious diseases and other drug-related infectious diseases measures including treatment are available nationwide in prisons. Methadone detoxification programmes and counselling are available in specific geographical areas only.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening, education, prevention, counselling, treatment and vaccination programmes (hepatitis B and tuberculosis) targeting drug users are available nationwide. To prevent drug-related infectious diseases among drug users, the predominant response strategies are IEC in general, IEC via counselling and advice by drugs and health professionals, safer injection training for drug users, condom promotion among drug users, and needle and syringe exchange. Needle and syringe exchange, drug paraphernalia and the distribution of condoms are available nationwide in the Czech Republic.

Drug-related deaths. Professionals of emergency departments are trained nationwide, e.g., to deal with overdoses. The distribution, possession or administration of naloxone is not regulated. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals in outreach work, needle and syringe exchange programmes and low threshold programmes. Training for professionals in substitution treatment, prison staff and treatment facilities is only available in specific geographical areas. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. The Czech Republic has invested in the development of quality assessment tools and protocols for the evaluation of harm reduction interventions. In 2003, a Minimum Evaluation Set was drawn up with the purpose to evaluate treatment effectiveness. Although the Czech Republic does not have a policy so far on the establishment of quality criteria in demand reduction, it is pending for approval and in practice, initiatives exist that allow for independent evaluation of interventions.

Evaluation to inform policy development exists in the sense that the National Drugs Strategy 2001-2004 has been evaluated, giving feedback on accomplishments.

2.2.2 Recommendation 1: Risk reduction and public health policy

In the Czech Republic, the main responsible body for the implementation of the Council Recommendation is the Office of the Government of the Czech Republic[165]. [RT]

Harm reduction is an objective in public health in the Czech Republic and is part of the National Drug Strategy 2005-2009 and its Action Plan for the years 2005-2006[166] [SQ29] . 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.

2.2.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but is not based upon the Council Recommendation. [RT]
In the Czech Republic, the dissemination of information through various websites, telephone help lines[167], trainings for drug users, through pill-testing and through a broad range of educational materials[168] are available nationwide. [NR 2002; NFP 2006]

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 predominant response strategies, whereas IEC via peer involvement/ peer approach is a common response strategy. Safer injection training is offered in all or most cities[169]. [SQ 23]

With regard to the **reduction of drug-related deaths**, the dissemination of information materials and risk counselling are the predominant response strategies: materials are predominantly disseminated through specialised drug treatment services, low threshold agencies, including needle and syringe programmes, outreach work and they are commonly disseminated through rave events and festivals. A common but not predominant response strategy to reduce drug–related deaths is risk education/ response training. These trainings are delivered predominantly at specialised drug treatment services, low threshold agencies, including needle and syringe programmes and through outreach workers, peers and are common in prisons and rave events. [SQ 29]

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 exists, but was not based upon the Council Recommendation[170]. [RT]
At specific areas only, communities and families of drug users are involved in the prevention and reduction of health risks associated with drug dependence[171]. [NR 2003]

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. [RT]

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[165] Department: Secretariat of the Council of the Government for Drug Policy Coordination.
[166] http://vlada.cz/apac/www.htm.
[167] Approximately 130 telephone help lines exist; (ref. Sadilek, Mravcik, 2005, in press).
[168] The National Focal Point bimonthly publishes fact sheets, and published many other drug-related publications.
[169] Standard service of all 93 low threshold facilities that are available nationwide.
[170] Prevention measures are primarily implemented at the local and regional levels and coordinated by the Addiction Prevention Units of the individual provinces. Work with parents is given more and more importance.
[171] Preventive programmes with active parental involvement.

In the Czech Republic, street-based outreach work is available nationwide, and outreach work at dance parties, rave events is provided in specific geographical areas only. [NR 2002/ 2003]

To **prevent drug-related 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 predominant implementation setting for infectious diseases prevention measures targeting drug users. [SQ 23]

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 in all or most cities in the Czech Republic. [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]
Training in outreach work is provided nationwide for peer and volunteers[172]. Peers and volunteers are included in outreach work nationwide. [NR 2003; NFP 2006][173]

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. [RT]
Networking and cooperation between outreach work agencies exist nationwide[174]. [NR 2002]

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 exists, but was not based upon the Council Recommendation.
Methadone detoxification programmes, drug-free outpatient and inpatient treatment, drop-in centres and treatment with naltrexone[175] are widely available. Methadone maintenance treatment, treatment with buprenorphine and rehabilitation programmes (after-care centres) are available in specific geographical areas only. 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. [NR 2002/ 2003; NFP 2006]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a common response strategy. Drug consumption rooms and heroin prescription programmes do not exist in the Czech Republic. [SQ 29]

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide[176]. [NFP 2006]

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 does not exist, as it is not a priority for national government[177]. [RT]

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[172] Training courses and seminars are organised annually by different NGO's, associations, training institutions.
[173] Secondary needle exchange.
[174] Harm reduction organisations; Czech street work association.
[175] Widely available in medical care facilities, detoxification units and emergency units.
[176] Change in law for prescription of buprenorphine; registration of all patients receiving prescribed drugs.
[177] Treatment and detoxification is available in prison. Substitution treatment is in preparation. Needle and syringe exchange programmes do not exist.

Testing for drug-related infectious diseases and other infectious diseases measures including treatment are available nationwide in prisons[178]. Methadone detoxification programmes[179] and counselling are available in specific geographical areas only. Methadone maintenance programmes[180], treatment with buprenorphine or naltrexone, needle and syringe exchange programmes, drug paraphernalia, and condom distribution[181] are not available in Czech prisons. [NR 2002/ 2003; NFP 2006]

Prisons are an uncommon implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ23]
Information materials aimed at the **prevention and reduction of drug – related deaths** are rarely disseminated in Czech prisons, and the deliverance of risk education/ response trainings for drug users is common practice in Czech prisons. [SQ 29]

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. [RT]
With regard to infectious diseases among drug users, testing/ screening[182], education, prevention, counselling and treatment are available nationwide, as is vaccination (hepatitis B and tuberculosis) targeting at drug users. [NR 2002/ 2003]

Predominant response strategies to **prevent infectious diseases** among drug users are IEC in general, IEC via counselling by drugs and health professionals, safer injection training for drug users, condom promotion among drug users, and needle and syringe exchange. IEC via peer involvement/ peer approach, outreach health education approach, routine screening of high risk groups and easy access' programmes for drug users to treatment of infectious diseases, e.g., at low threshold agencies, are common responses in the Czech Republic. Predominant implementation settings for infectious diseases prevention measures targeting drug users include specialised drug treatment services, low threshold counselling services, outreach work and high risk group interventions. Primary care/ general practitioners are a common setting for infectious diseases prevention measures. [SQ 23]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Needle and syringe exchange programmes, drug paraphernalia and the distribution of condoms are available nationwide in the Czech Republic[183]. [NR 2002/ 2003]. Needle and syringe exchange programmes are a predominant response strategy to **prevent drug-related infectious diseases** among drug users. [SQ 23]

Low threshold agencies, including needle and syringe exchange programmes, are also a predominant setting for providing information materials on the **reduction of drug-related deaths** among drug users and for the deliverance of risk education/ response trainings. [SQ 29]

There are 89 non-pharmacy based needle and syringe exchange programmes[184] in the Czech Republic. Fixed sites and distribution through outreach/ peers are existing types of needle exchange, but there are no vans/ buses, no vending machines, no pharmacy-based and no prison-based needle and syringe exchange programmes in the Czech Republic. [ST 10]

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[178] Special infectious diseases department exists within prison hospital.
[179] Two prisons.
[180] A pilot methadone maintenance programme has started in April 2006 in two prisons with a capacity of 80 slots.
[181] Condoms are being sold in prisons.
[182] A rapid screening hepatitis C antibody test from finger prick was used widely. As of January 2006 this test is not available anymore, and thus availability of IDU tests for HCV decreased dramatically.
[183] Distribution of paraphernalia (spoons, acid, water, also disinfection) is a standard part of needle and syringe exchange programmes in CR. Syringes are freely available in pharmacies. It is estimated, that about 1 million of syringes are sold in pharmacies to injecting drug users annually.
[184] Data from Standard Table 10 (EMCDDA): 89 fixed needle and syringe exchange programmes of which 75-80 also provide the exchange of needles and syringes through street-based outreach work, including peer-distribution.

There are no specific laws on needle and syringe exchange or on the possession of sterile needles in the Czech Republic; it is considered legal. Also no prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation. [RT]
Training programmes for professionals of emergency departments are available nationwide[185]. [NFP 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 training. [SQ 29]
Czech ambulances routinely carry antagonists. The distribution, possession or administration of naloxone is not regulated. Naloxone on a 'take home' basis is not available. [SQ 29; NFP 2006]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation. [RT]
Risk reduction is part of an integrated health strategy for drug users[186]. [NR 2003]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Training for professionals in substitution treatment, prison staff and treatment facilities is available in specific geographical areas only. Training programmes for professionals working in needle and syringe exchange programmes and low threshold programmes and for outreach workers are available nationwide[187]. [NR 2002/2003; NFP 2006]

2.2.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. [RT]

In 2002, upon request of the Secretariat of the National Drug Commission, external experts drew up a draft of individual tools for evaluation of efficiency of field exchange programmes, low threshold outreach centres and therapeutic communities. Several surveys carried out pilot verification of evaluation tools for each of the mentioned types of programmes. The final draft of tools for program efficiency evaluation was reported to the Government Council for Drug Policy Coordination. [NR 2002]

3.2 Supporting the inclusion of needs assessments at the initial stage of any programme

This policy does not exist, as it is not a priority for national government. [RT]

Despite the fact that there is no governmental policy in including needs assessment in programmes, there are quite some examples in the Czech Republic that needs assessments are conducted at operational level. For example, a needs assessment was conducted among clients of

[185] Organised regularly by the Institute for Post-Graduate Studies in Medicine, Prague.
[186] The 1st Medical Faculty at Charles University in Prague has accredited a new bachelors study programme on addiction. The programme aims to provide students with the necessary theoretical knowledge and practical skills required for work in the field of prevention, treatment, aftercare, probation and mediation work, prison and post-prison care, etc. It especially focuses on addictive substances and types of addictive behaviour. Therefore, graduates will be able to work in a wide spectrum of services designed for (not only) drug users.
[187] A summer school of harm reduction is held yearly by one of the biggest providers of services for drug users (SANANIM). This seminar is for professionals from addiction services. Needle exchange is one of the topics on the agenda. The NFP organises national seminars on drug-related infectious diseases for service providers. NSP is a topic on the agenda.

low threshold facilities in the Central Bohemian region by using Rapid Assessment and Response methodology, such within the framework of the project of evaluation of the drug policy in that region [NR 2004]. Needs assessments were furthermore conducted in the framework of Phare Twinning Projects in 2002 and 2003 [NR 2002/ 2003].

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy does not exist yet, but is pending for approval. [RT]

With the objective of finding a systematic solution for assuring quality and efficiency of services in the specific fields of the drug policy (primary prevention, treatment, social services), in 2002 the appropriate ministries started to work on drawing up of minimum standards of quality and on the preparation of tools for evaluation of efficiency of programmes. [NR 2002]

In 2003, a Minimum Evaluation Set (MES) was drawn up for the purpose of evaluation of treatment effectiveness. It consisted of three main parts: a *self-evaluation questionnaire*, a u*niform system of reporting of treatment care*, and a *questionnaire for monitoring of basic economic indicators*. [NR 2004].

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 yet, but is pending for approval. [RT]

Evaluation of quality of services is one of the pillars of a complex evaluation of services. Other pillars involve effectiveness evaluation and economic evaluation (cost effectiveness). Observance of Standards of Professional Competency with an evaluation scheme and series of sample manuals, which are part of the system of certification of competency of services for drug users, contributes to the evaluation of quality and availability of provided services.

According to this system, certification is an assessment and formal acknowledgement that a service complies with the specified criteria of quality and complexity (standards); external evaluators will carry out this assessment according to the criteria specified in standards and in compliance with the Certification Guide and Local Investigation Methodology. [NR 2004]

Standards for low threshold facilities and evaluation tools for the evaluation of the efficiency of services in the field of harm reduction are part of the standards of professional competency and the defining of indicators of evaluation of quality and effectiveness of these facilities.

Guaranteeing the quality of treatment, with the objective of achieving maximum efficiency, has been playing an increasingly important role in the treatment of drug users. Quality assessment can be divided into user assessment and professional assessment. The existence of criteria and introduction of mechanisms that assess the level of service delivery according to these criteria is a prerequisite for professional quality assessment (Kalina, 2001). Standards of Service Quality and the consequent process of certification of quality are tools for the improvement of quality and efficiency of treatment; in addition, they can be used for the monitoring and optimization of treatment costs. [NR 2003]

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. [RT]

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. [RT]

The Secretariat of the Council of the Government for Drug Policy Coordination drew up a Balance Report on the Fulfilment of Targets from the 2001 – 2004 National Drugs Policy Strategy and from

the Government Resolution[188] regarding the outputs of the 2000 Phare Twinning Project "*Strengthening National Drug Policy*". The Secretariat used questionnaires to collect the data for this Balance Report from individual sectors and regions. [NR 2004]

The report showed that the number of unaccomplished tasks increased from 15 in 2002 to 25 in 2003. These unaccomplished tasks especially involved the plans of activities of individual sectors in the field of drug policy, personnel reinforcement and workforce education, introduction of evaluation tools, and the development of the quality of and availability of services. [NR 2004]

The 2001 – 2004 National Drug Policy Strategy has not yet been systematically evaluated according to the determined indicators of success and defined evaluation tools. It is one of the roles of the National Drug Commission to evaluate drugs policy measures and activities and conduct control activities. The National Drug Commission has been asked to prepare an annual Evaluation Report on the Fulfilment of Targets Following from the 2001 – 2004 National Drug Policy Strategy. [NR 2003].

Quality evaluation studies are not available. The current practice is limited to implementation of several types of internal evaluation of programmes according to various criteria.[189] The Ministry of Education, Youth and Physical Education published a publication dedicated to evaluation of preventive programmes.[190] The document was drawn up in a relatively quality manner and it contains explanation of basic terms and starting points of evaluation. [NR 2002].

The General Directorate of the Prison Service evaluated the efficiency of drug activities and quality of treatment programmes of the prisons; in March 2001, on the basis of this analysis it adopted the document "2001 – 2004 Set of Drug Measures during Custody and Execution of Punishment". [NR 2002].

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists, but was not based upon the Council Recommendation. [RT]

The Phare Twinning project 'Strengthening National Drug Policy' included an "Accreditations" working group. During the project, the working group analyzed the development of standards of quality of services in addiction treatment and the process of quality assessment by the Ministry of Health and Ministry of Labour and Social Affairs (see below). The main objective was to assess whether it is possible to consolidate the accreditation processes of both ministries.

After the reviewed version of the standards had been published, a first course for future members of accreditation teams (auditors) was conducted. The training focused especially on three main fields of education: general issues (quality assurance systems, accreditation, verification process, psychology of audit, and execution and evaluation of audit); quality assurance (interpretation and analysis of accreditation standards according to individual service modalities, measurement of system performance, quality, and effectiveness); organisation (accreditation process, organizational guarantee of audit, documentation required for an audit, and consequent evaluation). [NR 2003]

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

The policy does not exist yet, but is pending for approval. [RT]

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. [RT]

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[188] Government resolution No. 549/03.
[189] In most cases, implementation of internal evaluation is usually restricted to a short verbal assessment by the organizer or implementer. Sometimes a short assessment by programme participants is added. However, implementation of these evaluations is not uniform and it is not possible to amend them.
[190] Evaluation and Diagnostics of Preventive Programmes (MŠMT ČR, 2001).

The Czech Republic participates in the ESPAD project[191] [NR2004]. ESPAD does not include information on drug dependence or on harm reduction. As indicated in this chapter, the Czech Republic has been the beneficiary of several Twinning projects in the field of drug demand reduction.

2.2.5 Information from third data sources

Issues raised by ANO/ Sananim

Information, education and communication (IEC). IEC is adequate in coverage and accessibility throughout the country. Drug testing (mainly pill-testing) is available, but inadequate in coverage and accessibility, as funding is limited and the health sector does not regard it as a priority. Measures to involve families and friends of drug users in harm reduction interventions is adequate in coverage and accessibility.

Outreach work. Outreach work is adequate in coverage and accessibility.

(Medically assisted) treatment and specific interventions. Medically assisted treatment for opiate users, which mostly consists of methadone detoxification treatment, is adequate in coverage, but accessibility varies from adequate to inadequate. A heroin prescription program is not available.
Medically assisted treatment for ATS users is inadequate in coverage and varies from adequate to inadequate for accessibility. There is 1 centre prescribing methylphenidate (Ritalin), but this happens occasionally. Elsewhere medically assisted treatment for ATS users is not available. Medically assisted treatment for cocaine users is not available, but needs thereof are limited as cocaine is rarely used. Specific harm reduction interventions targeted at cocaine users are not available. Harm reduction interventions for ATS users are adequate in coverage and accessibility. There are no drug consumption rooms in the Czech Republic. Coverage and accessibility of needle and syringe exchange programmes is adequate throughout the country and drug paraphernalia are adequately available. Low threshold agencies are adequately available and accessible.

Prison interventions. IEC in prison is inadequate in coverage and accessibility. Most IEC is provided by NGOs working in selected prisons. Generally standards in prisons are not adapted to the need for IEC, because prisons are still considered drug free areas. There is no outreach work available in Czech prisons.
Availability of and access to substitution treatment is inadequate, as methadone detoxification treatment is available only in 2 prisons as a pilot, allowing 35 prisoners to participate. Methadone detoxification is the only form of medically assisted treatment for opiate users in prison. Medically assisted treatment for ATS users in prison ranges from inadequate to not available and is purely abstinence-oriented. Pharmacotherapy is only provided in cases of serious withdrawal symptoms. Neither medically assisted treatment for cocaine users nor specific harm reduction interventions targeted at cocaine and ATS users are available in Czech prisons. There are no needle and syringe exchange programmes available in Czech prisons and drug paraphernalia are not available. Measures implemented to prevent infectious diseases are inadequate, because basic harm reduction activities such as the provision of information is missing. Testing is performed, but it lacks integration into a broader range of measures. Hepatitis B or tuberculosis vaccination programmes targeted at drug users are not available in Czech prisons. The involvement of family and friends of drug users in harm reduction interventions is inadequate to lacking.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Measures implemented to prevent infectious diseases are adequate in coverage.
Hepatitis B vaccination programmes targeting drug users are inadequate in coverage and accessibility and not made a priority of the health care system. Tuberculosis vaccination programmes targeted at drug users are not available.

[191] European Survey Project on Alcohol and Drugs, an international prevalence survey among secondary school students aged 15-16, which is conducted every four years. The ESPAD project incorporates over 35 European countries. It is run by the Swedish Council for Information on Alcohol and other Drugs.

Annex A2.3 State of play on harm reduction in Denmark

2.3.1 Summary

Public health policy. In Denmark, harm reduction has been an objective in public health policy for some time already and specified this in its National Drug Action Plan "The Fight Against Drugs" in 2003.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through websites, telephone help lines, and educational leaflets. With regard to the prevention of infectious diseases among drug users, IEC in general, and IEC via counselling and advice by drugs and health professionals are common response strategies. For the reduction of drug-related deaths, the dissemination of information materials is a predominant response strategy. Although this policy exists, it is unclear whether communities and families of drug users are involved in the prevention and reduction of health risks associated with drug dependence.

Outreach work. Outreach work at dance parties/ rave events is nationwide available. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials, as well as for the deliverance of risk education/ response training. Furthermore, peers and volunteers are included nationwide in outreach work practice. Finally, networking and cooperation between outreach work agencies also exist nationwide.

(Medically assisted) treatment and specific interventions. Methadone maintenance and detoxification programmes, treatment with naltrexone, drug-free outpatient and inpatient treatment, rehabilitation centres and drop-in centres/ shelters are available nationwide. Treatment with buprenorphine is only offered in specific geographical areas. Drug consumption rooms and heroin prescription programmes do not exist in Denmark. Opioid substitution treatment is a predominant response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Methadone maintenance and detoxification programmes, buprenorphine treatment and treatment with naltrexone are available nationwide in Danish prisons. Also testing/ screening, prevention, education, counselling and treatment of infectious diseases, as well as vaccination against hepatitis B, are nationwide available. There is no needle and syringe exchange in prison, though drug paraphernalia and condoms are available.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening, and treatment of infectious diseases are available nationwide, just as vaccination against hepatitis B. To prevent infectious diseases among drug users, the predominant response strategies are condom distribution and needle and syringe exchange. Needle and syringe exchange is available nationwide; drug paraphernalia and the distribution of condoms are only available in specific geographical regions in Denmark.

Drug-related deaths. Professionals of emergency departments are not specifically trained, e.g., to deal with overdoses. The distribution, possession or administration of naloxone is regulated by laws. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to prison staff; and to professionals in substitution programmes in specific geographical areas only. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. The Danish government actively uses scientific evidence of effectiveness as a main basis to select interventions. An effectiveness study on methadone treatment is underway. Evaluation of programmes is used to adjust policies, i.e. regarding the Social Services Act, which aims to provide the necessary social services to drug users.

2.3.2 Recommendation 1: Risk reduction and public health policy

The responsible structure for the implementation of the Council Recommendation is the Danish Ministry of the Interior and Health[192]. [RT]

Harm reduction is an objective in public health, but was not based upon the Council Recommendation. The Danish policy is presented in the action plan: "The Fight Against Drugs" (Action Plan Against Drugs, Danish Government, October 2003). The Action Plan has a broad scope and is partly inspired by the international dialogue, including that within the European Community. However, the Council Recommendation was not the primary inspiration of the Action Plan. [RT]

2.3.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation. [RT]
In Denmark, the dissemination of information through various websites, telephone help lines, and through a broad range of educational leaflets are available nationwide. [NR 2003]
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. [SQ 23]

With regard to the **reduction of drug-related deaths**, the dissemination of information materials is a predominant response strategy. Information materials are disseminated at specialised drug treatment services, and are also commonly spread via low threshold agencies, needle and syringe exchange programmes, and schools/ educational systems. Training (safer injecting/ risk education/ response) for drug users is not provided at a national and formal level.[193,194] [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]

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. [RT]
In Denmark, outreach work at dance parties/ rave events is available nationwide. Street-based outreach work is available in specific geographical areas only[195] as well as some other types of outreach work[196,197]. [NR 2003; NFP 2006]

Outreach work as a health education approach is a common response strategy to **prevent infectious diseases** among drug users. Outreach work and targeted high-risk group interventions are a common implementation setting for infectious diseases prevention measures targeting drug users. [SQ 23]

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[192] Division of International Affairs and Narcotic Drugs – Unit Narcotic Drugs.
[193] In some areas trainings for drug users are offered. In Copenhagen there are a number of nurses available for outreach work to drug users' homes and in the down-town area. This counselling includes among other things information on general injecting hygiene.
[194] On an individual basis, workers of treatment centres give counselling.
[195] Several projects for street-based outreach work; street work among youth.
[196] Special "teams" for handling dual–diagnosis and somatic co-occurring disorders are established, but not nationwide.
[197] In October 2005, a Political Agreement was made to fund, by pooled reserves, outreach work initiatives (among other initiatives) in the years to come.

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[198]. [SQ 29]

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 is not a task for national government. [RT]
Peers and volunteers are included in outreach work nationwide[199]. No training for peers and volunteers exist[200]. [NR 2003/ 2004; NFP 2006]

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

This policy is not a task for the national government. [RT]
Networking and cooperation between outreach work agencies exist nationwide[201]. [NR 2003/ 2004]

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 exists, but was not based upon the Council Recommendation. [RT]
Methadone maintenance programmes[202], methadone detoxification programmes, treatment with naltrexone, drug-free outpatient and inpatient treatment[203], rehabilitation centres and drop-in centres[204]/ shelters are available nationwide. Treatment with buprenorphine is limited to specific geographical areas. Substitution treatment is supported by (obligatory) psychosocial care. [NR 2003/ 2004; NFP 2006]
Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a predominant response strategy in Denmark. [SQ 29] Drug consumption rooms and heroin prescription programmes do not exist in Denmark.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists , but was not based upon the Council Recommendation. [205][RT]
Measures to prevent diversion of prescribed drugs are available nationwide. [206][NFP 2006]

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, but was not based upon the Council Recommendation. [RT]
Methadone maintenance and methadone detoxification programmes, buprenorphine treatment and treatment with naltrexone are available nationwide in Danish prisons. There are no needle and syringe exchange programmes in prison, but drug paraphernalia[207] and condoms are available. Testing, prevention, education, counselling and treatment of infectious diseases is available nationwide in prisons, as is testing and vaccination against hepatitis B. [NR 2003; NFP 2006]

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[198] Availability is linked to drug treatment services, mainly in the big cities.
[199] Specific peer teams for young drug users.
[200] Individual training is given regarding the different and specific interventions.
[201] The government supports the building of a network; association of drop-in centres.
[202] Including a methadone injections programme.
[203] About 40 inpatient institutions, of which 31 are drug-free.
[204] Over 70 drop-in centres.
[205] Control measures regarding prescription aim to prevent diversion.
[206] Indirectly by optimizing the treatment system for drug users (ongoing quality assurance of the treatment).
[207] Cleaning liquid is provided.

Prisons are a rare, uncommon implementation setting both for **infectious disease prevention** measures targeting drug users and for measures targeting the **reduction of drug – related deaths**. [SQ 23, SQ 29]

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[208]. [RT]
Testing/ screening and treatment of infectious diseases and vaccination against hepatitis B are available nationwide. [NR 2004]

To **prevent infectious diseases**[209] among drug users, the predominant response strategies are condom distribution and needle and syringe exchange programmes. IEC in general, IEC via counselling and advice by drugs and health professionals, outreach health education approach, routine screening of high-risk groups, hepatitis vaccination programme for drug users, and easy access' programmes for drug users to treatment of infectious diseases are common response strategies. [SQ 23]

Specialised drug treatment services, low threshold counselling, and outreach work and targeted high risk group interventions, are common implementation settings for infectious diseases prevention measures targeting drug users. [SQ 23]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Needle and syringe exchange programmes are available nationwide[210]. In specific geographical areas, including Copenhagen, drug paraphernalia[211] and the distribution of condoms are available. [NR 2004; NFP 2006]

Needle and syringe exchange programmes are a predominant response strategy to **prevent infectious diseases** among drug users in Denmark. [SQ 23]. Low threshold agencies, including needle and syringe exchange programmes, are also a common setting for the dissemination of information materials on the **reduction of drug-related deaths** among drug users, and for risk education/ response trainings for drug users. [SQ 29]

Denmark has 135 non-pharmacy based and 108 pharmacy based needle and syringe exchange programmes, and 7 vending machines. Needle exchange takes place at fixed sites, and through outreach work and peers, but there are no vans/ buses, and no prison-based needle and syringe exchange programmes. [ST 10] There are no legal restrictions to the possession of sterile needles in Denmark, and also no prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation. [RT]
Training seminars for professionals of emergency departments are not available. [NFP 2006]

Emergency departments are not a setting for the dissemination of information materials that aim at the reduction of drug-related deaths. In Denmark, the distribution, possession or administration of naloxone is regulated by laws. Naloxone on a 'take home' basis is not available. [SQ 29]

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[208] An executive order from the Danish Government on "Hepatitis vaccination, free of charge for injecting drug users and their relatives" was implemented in April 2005.
[209] In October 2005, a Political Agreement was made to fund, by pooled reserves, harm reduction initiatives the coming years, to reduce infectious diseases among drug users.
[210] As a supplement for interventions in the Municipality of Copenhagen, members of the drug user association Brugerforeningen, remove used needles and syringes from the streets.
[211] Cleaning tissues, cotton wool, sterile water etc, together with needle and syringe distribution.

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation. [RT]
Risk reduction is part of an integrated health strategy for drug users[212]. [NFP 2006]

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

This policy exists, but is not based upon the Council Recommendation. [RT]
Trainings are offered nationwide to prison staff. Training for professionals in substitution programmes[213] is available in specific geographical areas only. Training programmes for professionals in other areas of risk reduction, except for substitution treatment, do not exist[214]. [NR 2003/ 2004; NFP 2006]

2.3.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. Governmental initiated programmes and projects are based on the available scientific evidence (if available). Informational material, that recommends the implementation of validated methods are produced national and distributed regional and locally. [RT]

Additionally, the Danish Government prioritises the initiation and completion of a quality assessment of methadone treatment as the basis for future quality assurance and development in line with the interventions planned within this area of the health care sector in general. [NR 2004]

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. 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. [NR 2003]

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. Governmental initiated programmes and projects are based on needs assessment. Informational material, that recommends needs assessment are produced national and distributed regional and locally. [RT]

The Government's cross-ministerial action plan, "The Fight Against Drugs", proposes, among other things, that based on the evaluation of a pilot project of health care intervention targeted at the most severely addicted drug abusers, the Government will consider the need for and possibility of providing such services as permanent schemes in particularly affected city areas.

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy exists, but was not based upon the Council Recommendation. Governmental initiated programmes and projects are based on adequate evaluation protocols. [RT]

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. [RT]

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[212] The overall "concept" of interventions towards drug users in Denmark is to integrate treatment approach combining health and social care.
[213] Not for providers of buprenorphine.
[214] Bartenders and employees in night-life-settings are sometimes trained in risk reduction.

No formally drafted strategy or guidelines have been prepared on quality assurance. 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). This is a pilot project with the overall purpose being 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. [NR 2003]

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. [RT]

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. [RT]

On 1 January 2003, the Act amending the Social Services Act (Guaranteed social treatment for drug abuse) came into force. 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. 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 the 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. [NR 2004]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy does not exist. Evaluation trainings seminars for regional and local drug professionals are occasionally part of national programmes. [RT]

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. [RT]

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

Denmark participates in the ESPAD project [NR 2004]. 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. [NR 2003]

2.3.5 Information from third data sources

Issues raised by the Danish Drug User Union Brugerforeningen

Information, education and communication (IEC). IEC is inadequate in coverage and accessibility, as opening hours are insufficient. Drug testing is not available in Denmark. Measures to involve families and friends of drug users in harm reduction interventions are incorporated in some programmes, but these are mostly privately owned or running on a voluntary basis.

Outreach work. Coverage and accessibility of outreach work is not adequate. It is mostly performed by volunteer workers and there seems to be a constant need for more activity.

(Medically assisted) treatment and specific interventions. Coverage of medically assisted treatment for opiate users is adequate, but regional differences in accessibility exist.
There is no heroin prescription program in Denmark. Medically assisted treatment for ATS or cocaine users is inadequate in coverage and accessibility. ATS and cocaine prescription programmes as well as specific harm reduction interventions for cocaine or ATS users do not exist in Denmark. There are no drug consumption rooms.
Needle and syringe exchange programmes and the distribution of drug paraphernalia are inadequate in coverage and accessibility, as there is a big discrepancy between urban centres and the periphery. In rural areas it is nearly impossible to get clean equipment, whereas access in the capital is adequate.
The coverage of low threshold agencies is inadequate throughout the country, whereas it can be considered sufficient in the urban centres.

Prison interventions. IEC in prison is inadequate in coverage as well as in accessibility. Outreach work in prison exists, but is inadequate in coverage and accessibility, as it is performed by volunteers rather than being an integral part of the prison system.
Medically assisted treatment in prison is adequate in coverage and accessibility. The law assures everyone medically assisted treatment within two weeks, but there is no mentioning of which treatment is guaranteed.
The coverage and accessibility of medically assisted treatment for ATS or cocaine users is considered to be inadequate and no specific harm reduction interventions targeted at ATS or cocaine users exist in Danish prisons.
NSPs or drug paraphernalia are not available in prisons and measures implemented to prevent infectious diseases are inadequate, because the individual prisoner is to actively seek such services. Free hepatitis B vaccination programmes are available throughout Denmark, also in the penitentiaries. There is no information available whether tuberculosis vaccination programmes are offered and accessible for drug users in prisons.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Measures implemented to prevent infectious diseases are inadequate.
Free hepatitis B vaccination is available. No information exists on tuberculosis vaccination programmes targeting drug users.

Annex A2.4 State of play on harm reduction in Germany

2.4.1 Summary

Public health policy. The prevention of drug dependence and the reduction of related risks were priority objectives in German Drug Policy before the Council Recommendation was launched. Harm reduction is laid down in action plans at federal and Laender level since the nineties.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines and websites. For the reduction of drug-related deaths, the dissemination of information materials is the predominant response strategy. Further, communities and families of drug users are informed nationwide.

Outreach work. Street-based outreach work and outreach work at dance parties, raves and in clubs (including pill-testing) are available in specific geographical areas only. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials. Peers and volunteers are included in outreach work practice only in specific geographical regions. Networking and cooperation between outreach work agencies also exist in specific geographical regions only.

(Medically assisted) treatment and specific interventions. Methadone maintenance and detoxification programmes, treatment with buprenorphine, drug free outpatient and inpatient treatment and rehabilitation programmes are available nationwide. In specific geographical areas, heroin prescription programmes, drug consumption rooms and drop-in centres are available. Opioid substitution treatment is a predominant response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Methadone detoxification programmes are available nationwide in prison. Methadone maintenance treatment, treatment with buprenorphine, needle and syringe exchange, screening, prevention, education, and treatment of infectious diseases, counselling and the distribution of condoms are available in specific geographical areas only. Drug paraphernalia are not available in German prisons, nor is treatment with naltrexone.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening, education, prevention, treatment and vaccination for infectious diseases are available nationwide. To prevent infectious diseases among drug users, the predominant response strategy is IEC in general. Needle and syringe exchange and drug paraphernalia are available nationwide.

Drug-related deaths. Professionals of emergency departments are trained in specific geographical areas only, e.g. to deal with overdoses. The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is only available to some drug users.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals in substitution programmes, low threshold programmes and treatment facilities. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. Only few evaluation studies on harm reduction are available in Germany. The legal framework how to deal with drug problems is defined by laws and guidelines. It is planned that these guidelines will be monitored and evaluated. A computerised documentation system is set up by the federal government and the Laender in which prevention programmes can be registered. The evaluation of programmes and interventions is a regular practice in Germany. In a city like Hamburg, the addiction care system has been evaluated, resulting in a number of recommendations for policy development. Germany collaborates with many different countries through bilateral programmes.

2.4.2 Recommendation 1: Risk reduction and public health policy

In Germany the governmental body responsible for the implementation of the Council Recommendation is the Federal Ministry for Health and Social Security[215]. This 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 Laender level, which have been further developed in the light of new scientific evidence. [RT]

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. [SQ 29]

2.4.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation. [RT]
In Germany, dissemination of information through various websites[216] and through telephone help lines are available nationwide. Other ways of providing information and counselling to drug users in the framework of risk reduction is available in specific geographical areas[217] only (training, educational leaflets). [NR 2003/ 2004]

To **prevent infectious diseases** among drug users, providing information, education and communication (IEC) in general is a predominant response strategy, whereas IEC via counselling and advice by drugs and health professionals and via peer involvement/ peer approach are common response strategies. Safer injecting training is part of general activities in harm reduction programmes. [SQ 23]

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, including needle and syringe programmes, and through outreach workers, mass media and nightlife or entertainment venues. Common settings are specialised drug treatment services, detoxification services and school and educational systems. [SQ 29]

Risk education/ response trainings as a response to reduce drug-related deaths are uncommon in Germany, but risk counselling is a common response strategy. [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]
Communities and families of drug users are informed nationwide. [NR 2004] At a national level there is no information available about the involvement of communities and families in the prevention and reduction of health risks associated with drug dependence[218]. [NFP 2006]

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. [RT]
In Germany, street-based outreach work and outreach work at dance parties, raves and in clubs are available in specific geographical areas only. [NR 2003/ 2004]

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[215] Responsible unit: Unit Drugs and Substance Misuse (BMGS).
[216] Information on treatment centres, opening hours, location, nature of services. www.dhs.de
[217] Available on Laender and regional level.
[218] However, a lot of preventive activities take place locally with financial support from the municipalities.

To **prevent infectious diseases** among drug users, outreach work as a health education approach is a common response strategy. [SQ 23]. 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.** [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]
In specific geographical areas only, training for outreach workers, peers and volunteers is organised. In specific geographical areas peers and volunteers are included in outreach work practice. [NR 2002, NR 2004]

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. [RT]
Networking and cooperation between outreach work agencies exist in specific geographical areas only[219]. [NR 2001; NFP 2006]

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 exists, but was not based upon the Council Recommendation. [RT]
Methadone maintenance programmes, methadone detoxification programmes, treatment with buprenorphine, drug-free outpatient and inpatient treatment and rehabilitation[220] programmes are available nationwide. 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). In specific geographical areas only, heroin prescription programmes, drug consumption rooms[221]and drop-in centres are available. [NR 2003/ 2004]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a predominant response strategy. [SQ 29]

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide[222]. [NR 2001/ 2003]

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, but was not based upon the Council Recommendation. [RT]
Methadone detoxification[223] programmes are available nationwide in German prisons. Methadone maintenance treatment, treatment with buprenorphine, needle and syringe exchange programmes[224] are available in specific geographical areas only; testing/ screening, prevention, education, treatment of infectious diseases, counselling and the distribution of condoms, are also available, in specific geographical areas only. Drug paraphernalia are not available in German prisons, and neither is treatment with naltrexone. [NR 2003/ 2004; NFP 2006]

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[219] Nowadays in Germany cooperation is considered part of a professional standard in drug treatment and prevention. Institutions working in the field of drug treatment and prevention in a region have regular contacts, both through formal cooperation platforms and through workgroups on addiction.
[220] Third phase of official treatment programme; 5,000 places nationwide.
[221] 24 in 2003 in urban areas.
[222] Measures include: restricted take home doses, a centralized, nationwide substitution registration, special forms for prescription of narcotics.
[223] Drug users with long sentences often get a detox phase, which is not followed by substitution.
[224] Seven pilots, but only one was continued.

Prisons are a common implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]
Measures targeting at the **reduction of drug – related deaths** are uncommon or non existent in German prisons[225]. [SQ 29]

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. [RT]
Testing/ screening, education[226], prevention, treatment[227] and vaccination with regard to infectious diseases targeting drug users are available nationwide. [NR 2003/ 2004]

To **prevent infectious diseases** among drug users the predominant response strategy is information, education, communication (IEC) in general. Other common strategies include IEC via peer involvement/ peer approach, safer injection training for drug users, IEC via counselling by drugs and health professionals, outreach health education approach, voluntary infectious diseases counselling and testing, needle and syringe exchange programmes, hepatitis vaccination programmes for drug users, 'easy access' programmes for drug users to treatment of infectious diseases, e.g. at low threshold agencies. [SQ 23]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Needle and syringe exchange programmes, vending machines[228] and drug paraphernalia are nationwide available. In specific geographical areas only, condoms are distributed among drug users. [NR 2003/ 2004; NFP 2006]

Needle and syringe exchange programmes are a common response strategy to **prevent infectious diseases** among drug users in Germany. [SQ 23] Low threshold agencies, including needle and syringe exchange programmes, are a predominant setting to provide information materials on the **reduction of drug-related deaths** among drug users. [SQ 29]

Available types of needle and syringe exchange programmes in Germany are fixed sites, outreach/ peer, vending machines, pharmacy-based needle and syringe exchange programmes and prison-based NSPs. [ST 10]. There are no legal restrictions to the possession of sterile needles in Germany and also no prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation. [RT]
In specific geographical areas only, professionals of emergency departments are trained. [NR 2003] 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. [SQ 29]

The distribution, possession or administration of naloxone is regulated by laws. Naloxone is only available on prescription and administration is limited to physicians. Naloxone on a 'take home' basis is available to some drug users[229]. [SQ 29]

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[225] Drug users that are released from prison will have the possibility to see a video with information on first aid in cases of a drug-related emergency.
[226] There is a need for training and prevention (materials). Safer use and OD training are available only in specific areas.
[227] It is advised that injecting drug users are enrolled in substitution treatment before accessing HIV or HCV treatment.
[228] Around 200 vending machines.
[229] Naloxone is available on a take home basis as part of a project in Berlin for users who have undergone training in first aid for drug emergencies during the last 12 months.

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation. [RT]
Risk reduction is part of an integrated health strategy for drug users[230]. [NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Training is offered nationwide to professionals in substitution programmes[231], low threshold programmes and treatment facilities. In specific geographical areas training programmes for outreach workers are organised. Specific training programmes for prison staff do not exist.
[NR 2003/ 2004]

2.4.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

Concerning the implementation of the activities of recommendation 3, not only national, regional and local governments are involved, but also the scientific community and NGOs. This multidisciplinary and multi sectional approach has always been a very important aspect in German drug policy. [RT]

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists and was based upon the Council Recommendation. [RT]

In Germany only few evaluation studies are available in the field of harm reduction. Where studies exist, they often do no meet scientific standards. Bundeslaender, for example Saarland, have published reports that critically evaluate 10 years of substitution treatment. [NR 2002]

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. [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy exists and was based upon the Council Recommendation. [RT]

The legal framework how to deal with drug problems is defined by laws and guidelines. It is planned to follow up and analyze the impact of individual guidelines. To this purpose, measures and indicators are to be defined for the assessment of results of the Action Plan on Drugs and Addiction. [NR 2004]

As a prompt transfer of knowledge relating to documented and evaluated interventions and programmes is the prerequisite for quality-assured planning of measures by different players, all institutions active in the field of drug prevention will in future document their measures on a regular basis and in a standardised format using the DoSys documentation system developed by the Federal Government and the Laender. This data collection will be supported by regional systems. [NR 2004].

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 and was based upon the Council Recommendation. [RT]

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[230] National Drug Action Plan (Aktionsplan Drogen und Sucht).
[231] 8,000 GPs are qualified to provide substitution drugs, but only 2,300 of them actually do so.

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. This despite of efforts in the field of prevention to do so. A variety of approaches, methods and instruments are applied in the Laender and by local authority districts. However, there are great differences regarding available resources.

The Federal Centre for Health Education (BZgA) is entrusted with the planning of new measures and campaigns and/ or with the evaluation and further development of existing measures and campaigns based on actual scientific knowledge. The expected result of this exercise is a renewed concept about aims and instruments or measures to reach specific aims.

At the same time, a series of legal framework conditions with regard to substitution treatment have already been changed in order to facilitate access to these services and secure the quality of these measures. Together with other drug policy measures these changes are to be evaluated in the future with respect to their effectiveness. [NR 2003]

Furthermore, there are no uniform formal requirements or criteria for quality assurance with regard to measures aiming at the reduction of drug demand. Approaches moving in this direction – e.g. the development of guidelines and programmes for quality assurance – are solely adopted at a technical level by professional and scientific associations as well as by funding bodies. Their application, however, is not mandatory.

At the national level, the Federal Centre for Health Education (BZgA) is responsible for the planning and implementation of prevention programmes and the monitoring of preventive activities in Germany. [NR 2004]

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

This policy exists and was based upon the Council Recommendation. [RT]

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. [RT]

In Germany, among others, the following activities and procedures for evaluation have been implemented, which had an impact on national and local drug strategies.

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. 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). [NR 2003]

At the level of the Laender, many activities take place. A number of these activities are of special interest to this report. For example, all Laender have formulated a joint position paper on the future focus of outpatient drug and addiction aid systems. 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. Receiving an overall positive response, the authors made a series of suggestions to further improve cooperation and division of work to achieve even better results despite tight budgets. Furthermore, a new orientation on a strongly opiate-centred aid system is currently under discussion. [NR 2004] In the two last mentioned activities, the objective of the measures is to achieve a better interaction and cooperation between aid services regarding licit and illicit substances as well as between drug aid and other complementary aid services. [NR 2004]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists, but was not based upon the Council Recommendation. [RT]

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. [RT]

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. This competition was an attempt to draw the attention of the general public to the development of drug prevention strategies at local level. There were 220 competition entries from 193 towns, rural districts and municipalities. The overall picture that was drawn from these entries was as follows. Half of all the participating municipalities had established a project group or a working group as a tool for regulating municipal cooperation. Forty percent of the municipalities that took part in the competition appointed a drug or prevention commissioner to safeguard long-term drug prevention work. Two-third of the participating municipalities had developed their own, written drug prevention concept. Over 76% of these municipalities planned, started or completed evaluation activities of preventative interventions, while 20% did not have any plans to do so. [NR 2002]

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. [RT]

In 2003, six Buendeslaender[232] participated in the ESPAD survey[233]. The Federal Ministry of Health has financially support the matching of data and the evaluation of the international performance for the participating Laender. [NR 2002]

Germany also participates in the EDDRA[234] database, presenting selected examples of good practice. A team of prevention experts from the Bundeslaender and the Laender coordinators developed - under the supervision of the BZgA - a database in which addiction prevention measures are systematically collected and described. [NR 2002]

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. 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).

2.4.5 Information from third data sources

Issues raised by Fixpunkt/ AkZept

Information, education and communication (IEC). IEC is inadequate in accessibility and coverage, because techniques are not adapted to "hard to reach" users, like hidden users and beginners. Drug testing does no longer exist in Germany.

Outreach work. Outreach work varies greatly in quality and quantity.

(Medically assisted) treatment and specific interventions. In general, medically assisted treatment for opiate users is available and accessible in Germany.[235] The available heroin prescription programmes are considered inadequate in coverage and accessibility. There are no ATS or cocaine prescription programmes available. Specific services for cocaine or ATS users are inadequate in coverage and accessibility. The coverage and accessibility of drug consumption rooms is evaluated as inadequate. Accessibility and effectiveness of consumption rooms is limited,

[232] Bavaria, Berlin, Brandenburg, Hessia, Mecklenburg-West Pomerania and Thuringia.
[233] CAN [2003].
[234] Exchange on Drug Demand Reduction Action.
[235] Substitution drugs used in medically assisted treatment: methadone, levomethadone, buprenorphine, dihydrocodeine and codeine.

as regulations deny access to methadone patients[236]. Coverage and access to low threshold agencies can be improved significantly by the elimination of local differences and by providing adequate funding for activities.

Prison interventions. In prison, IEC is hindered through strict control and a lack of free access to information. Outreach work in prison also lacks sufficient funding and is not available in all German prisons. Availability and accessibility to substitution services vary greatly from *Land* to *Land*.[237] Specific harm reduction interventions for cocaine/ ATS users are not available in prison. Measures implemented to prevent infectious diseases are inadequate because of a lack of awareness and a lack of financial resources to change the situation. Hepatitis B vaccination coverage is inadequate. NSPs have been discontinued for political reasons rather than lack of effectiveness. At the moment, only one NSP in prison remains in the whole of Germany. Drug paraphernalia are not available at all.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Measures implemented to prevent infectious diseases are inadequate because of a lack of awareness in drug services and a lack of financial resources to change the situation. Hepatitis B vaccination is available and covered by the general health insurance, but GPs need to be motivated to encourage drug users to get vaccinated. Tuberculosis vaccination programmes targeting drug users are not available in Germany because of lack of evidence-based research that there is a higher prevalence of tuberculosis in the drug-using population. Coverage and accessibility of NSPs is considered inadequate. Distribution of drug paraphernalia is inadequate, because of local and regional differences.

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[236] Further information on German consumption rooms can be found in**:** Zurhold, Heike, Peter Degkwitz, Uwe Verthein und Christian Haasen [2003]. Drug consumption rooms in Hamburg, Germany: Evaluation of the effects on harm reduction and the reduction of public nuisance. Journal of Drug Issues.

[237] Substitution treatment is provided in most German prisons, although access depends to a great extent on the state in which the prison is located. While in the northern states substitution treatment is common, it is rare to find it provided in the southern states such as Bavaria and Baden-Württemberg. Methadone is the most frequently used substitution treatment for detoxification. In: R Simon, E Hoch, R Hüllinghorst, G Nöcker, M David-Spickermann [2001]. *Report on the Drug Situation in Germany 2001*. German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction.

Annex A2.5 State of play on harm reduction in Estonia

2.5.1 Summary

Public health policy. Harm reduction is part of public health policy in Estonia and it was based upon the Council Recommendation. Harm reduction is part of the National Strategy on Drug Dependence 2004-2012.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide available through telephone help lines and websites. Communities and families of drug users are informed and involved in the prevention and reduction of health risks associated with drug dependence in specific geographical regions only.

Outreach work. Street-based outreach work and outreach work at dance parties, raves and in clubs are available in specific geographical areas only. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is not in use. In specific geographical areas, peers and volunteers are included in outreach work practice. Networking and cooperation between outreach work agencies exist only at specific geographical regions.

(Medically assisted) treatment and specific interventions. Methadone detoxification programmes are available nationwide. Methadone maintenance treatment, treatment with buprenorphine, drug-free outpatient and drug-free inpatient treatment, rehabilitation centres and drop-in centres/ shelters are available in specific geographical areas only. Drug consumption rooms and heroin prescription programmes do not exist in Estonia. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Counselling, testing/ screening, prevention, education and treatment of infectious diseases are available nationwide in prison. In specific geographical areas only, methadone detoxification programmes, condom distribution and drug paraphernalia are provided. There is no needle and syringe exchange. Methadone maintenance therapy is not available.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening, education, prevention, and counselling for infectious diseases are available nationwide. In specific geographical areas, treatment and vaccination against hepatitis B exist. To prevent infectious diseases among drug users, the predominant response strategies are IEC in general, condom distribution and provision and needle and syringe exchange. Needle and syringe exchange and the distribution of condoms are available nationwide in Estonia.

Drug-related deaths**.** There is no information available whether professionals of emergency departments are trained, e.g. to deal with overdoses. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to prison staff. For professionals in needle and syringe exchange programmes, low threshold agencies, outreach work and programmes for substitution treatment, training is available in specific geographical areas only. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. In 2004, Estonia started to develop a system of health education standards and quality assurance management on prevention. The National HIV/ AIDS prevention programme, which also focuses on opiate dependent drug use, incorporates interventions that are – among others – based upon effectiveness and evidence. Estonia is beginning to develop quality criteria and protocols in drug demand reduction. The resources are still scarce, though. There is a policy in place that calls for the incorporation of evaluation results in drug prevention policymaking, but there are not many evaluated programmes available.
Estonia has been participating in bilateral and collaborative programmes with a.o. the Global Fund (Drug Treatment Guidelines) and the Pompidou Group (staff training).

2.5.2 Recommendation 1: Risk reduction and public health policy

The governmental structure that is responsible for the implementation of the Council Recommendation is the Estonian Ministry of Social Affairs[238]. 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 a 4-year Action plan was approved by the Estonian Government on 22 April 2004.

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. [RT]

2.5.3 Recommendation 2: Risk Reduction activities and interventions

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists and was based upon the Council Recommendation[239]. [RT]
In Estonia, the dissemination of information through various websites[240] and through telephone help lines is available nationwide. Training[241] and educational leaflets[242] are available in specific geographical areas only. [NR 2002-2004; NFP 2006]

To **prevent infectious diseases** among drug users, providing information, education and communication (IEC) in general is a predominant response strategy. IEC via counselling and advice by drugs and health professionals, and IEC via peer involvement/ peer approach are common response strategies. [SQ 23]

Response strategies aiming at the **reduction of drug-related deaths** are uncommon in Estonia. [SQ 29]

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 exists and was based upon the Council Recommendation. [RT]
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[243], as well as specific IEC for communities and families of drug users. [NFP 2006]

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 and was based upon the Council Recommendation[244]. [RT]
In Estonia, street-based outreach work and outreach work at dance parties, raves and in clubs are available in specific geographical areas only[245]. [NR 2003/ 2004]

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[238] Public Health Department, Health Policy Unit.
[239] Information on risk reduction and different available services and counselling is provided to drug users and their families in low threshold centres and through outreach work. Existing centres are able to serve only a limited number of drug users, therefore there is a need to extend such services.
[240] www.lapsemure.ee ; www.narko.ee
[241] All needle and syringe exchange programmes are providing training for injecting drug users on HIV/ AIDS and other STDs, safer sex and safe injecting. In 2003 new information materials have been provided to injecting drug users.
[242] It is a common procedure that all clients in substitution treatment receive information from the centre's medical personnel on overdose prevention.
[243] This depends on the financial resources and priorities of the local governments.
[244] There are special programmes for high risk population groups, but not in sufficient number.

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 predominant implementation setting for infectious diseases prevention measures targeting drug users. [SQ 23]

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**. [SQ 29]

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 exists and was based upon the Council Recommendation. [RT]
In specific geographical areas only, peers and volunteers are included in outreach work practice, and training for peers and volunteers is organised[246]. [NFP 2006]

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

This policy exists and was based upon the Council Recommendation. [RT]
Networking and cooperation between outreach work agencies exist in specific geographical areas only[247]. [NFP 2006]

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 exists and was based upon the Council Recommendation[248]. [RT]
Methadone detoxification programmes are available nationwide. Methadone maintenance treatment, treatment with buprenorphine, drug-free outpatient and drug-free inpatient treatment, rehabilitation centres and drop-in centres/ shelters are available in specific geographical areas only[249]. Substitution treatment is supported by (obligatory) psychosocial care. [NR 2002-2004]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is an uncommon response strategy. [SQ 29] Drug consumption rooms and heroin prescription programmes do not exist in Estonia.

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. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide. [NR 2004]

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[250]. [RT]

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[245] Almost all syringe exchange points in Estonia use peers to reach difficult to reach risk groups in the framework of outreach work. They also provide syringes, needles and/or other injection paraphernalia, condoms, leaflets with risk reduction materials in the framework of outreach work.
[246] The National Institute for Health Development (NIHD) runs training courses for service providers. Also some NGOs and or local communities provide regular trainings to their staff.
[247] Some counties are more active in networking and cooperation.
[248] Different services (substitution treatment, detoxification treatment and long term rehabilitation) are available to people with drug addiction. There are not enough treatment and rehabilitation places for drug users.
[249] The current scope of treatment and rehabilitation services is far from sufficient despite some efforts made in this field in 2004. The shift of the treatment of drug users from psychiatric hospitals, historically known as primary treatment providers for problematic drug users, to other types of institutions (i.e day care centres), can be considered as a noticeable development in the field of treatment in recent years.
[250] It has been considered to continue to provide substitution treatment inside prison to those inmates who were enrolled in substitution treatment programmes prior to their imprisonment.

Counselling, testing/ screening, prevention, education and treatment of infectious diseases are available nationwide in Estonian prisons. In specific geographical areas only, methadone detoxification programmes[251], condom distribution and drug paraphernalia[252] are available. There are no needle and syringe exchange programmes in prisons in Estonia and also no methadone maintenance programmes are available. [NR 2002/ 2004; NFP 2006]

Prisons are a predominant implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]. Measures targeting at the **reduction of drug – related deaths** are uncommon in Estonian prisons[253]. [SQ 29]

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 and was based upon the Council Recommendation. [RT]
Nationwide available are testing/ screening, prevention and education with regard to infectious diseases as well as (pre- and post testing) counselling. In specific geographical areas only, treatment[254] and vaccination programmes (against hepatitis B) targeting drug users exist. [NR 2002-2004; NFP 2006]

To **prevent infectious diseases** among drug users the predominant response strategies are IEC in general, condom distribution and provision, and needle and syringe exchange programmes. Other, common strategies include IEC via counselling and advice by drugs and health professionals, IEC via peer involvement/ peer approach, outreach health education approach, voluntary counselling and testing. Predominant implementation setting for infectious diseases prevention measures targeting drug users are outreach work and high risk group interventions, and prisons. Common implementation settings are specialised drug treatment services. [SQ 23]

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

This policy exists and was based upon the Council Recommendation. [RT]
Needle and syringe exchange programmes and the distribution of condoms are available nationwide; drug paraphernalia are not available in Estonia. [NR 2004; NFP 2006]. Needle and syringe exchange programmes are a predominant response strategy to **prevent infectious diseases** among drug users in Estonia. [SQ 23]

Needle and syringe exchange programmes are neither a strategy nor a setting in Estonia for measures targeting the **reduction of drug-related deaths** among drug users. [SQ 29]

Estonia counts in total 19 non-pharmacy based needle and syringe programmes[255]. Needle and syringe exchange also takes place in vans/ buses, and through outreach workers/ peers. [ST 10]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists and was based upon the Council Recommendation. [RT]
No further information is available whether emergency services are trained. Estonian ambulances routinely carry antagonists[256]. Naloxone on a 'take home' basis is not available in Estonia. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists and was based upon the Council Recommendation. [RT]
Risk reduction is part of an integrated health strategy for drug users. [NR 2002/ 2003]

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[251] I.e. a pilot programme for methadone treatment exists in the central hospital of the penitentiary services.
[252] These are only provided through the medical departments of prisons.
[253] In specific geographical areas only, risk education/ response training for inmates is provided.
[254] Anti Retroviral Therapy (ARV) treatment has been funded by the Global Fund Programme since 2003. ARV treatment is available in prisons.
[255] Currently there are 21 needle and syringe exchange programmes in Estonia [NFP 2006].
[256] Flumazenil and naloxone are widely used as an ordinary medication in case of overdose.

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

This policy exists, but was not based upon the Council Recommendation[257]. [RT]
Training is offered nationwide to prison staff [NR 2003/ 2004]. Training for professionals in needle and syringe exchange programmes, low threshold agencies[258], outreach work and substitution programmes treatment facilities are available in specific geographical areas only. [NR 2002, NR 2004]

2.5.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists and was based upon the Council Recommendation. 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 processe and outcome evaluation etc.). [RT]

The National HIV/ AIDS Prevention programme (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. [NR 2004]

Nevertheless, the majority of projects implemented on the national level have not been evaluated according to scientific methods. Ad-hoc evaluation of projects funded by the Alcoholism and Drug Abuse Prevention Programme have been carried out over the last years. [NR 2003]

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. 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. [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy exists and was based upon the Council Recommendation. Estonia is at the beginning of developing and implementing evaluation protocols. The future development depends of the overall implementation process regarding this issue. [RT]

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 and was based upon the Council Recommendation. 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. [RT].

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

This policy exists and was based upon the Council Recommendation. This area is better developed than other areas such as prevention, because of European technical assistance. [RT]

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[257] More training is needed in specialised areas such as quality management (needs assessment, establishment of quality criteria, evaluation in general).
[258] The National Institute for Health Development (NIHD) finances and provides trainings for low–threshold agencies.

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

This policy exists and was based upon the Council Recommendation. 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. [RT]

In 2001 assessment of the ADAPP (Alcoholism and Drug Abuse Prevention Programme) was undertaken. 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. [NR 2002]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists and was based upon the Council Recommendation. [RT]. No examples from implementation are available.

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. In the past, special training programmes existed, but stakeholder involvement and participation (to create advocay) is an area in which training is needed most. [RT]

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. [RT]

A prevalence study on HIV infection (2005) was financed by the Global Fund and carried out in cooperation with London Imperial College. [NR 2004]. 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**.**

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. [NR 2002]

Annex A2.6 State of play on harm reduction in Greece

2.6.1 Summary

Public health policy. Harm reduction is a public health objective in Greece. Measures on harm reduction were implemented in Greece before the Council Recommendation was launched.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through websites and telephone help lines. Families of drug users are informed and involved in the prevention and reduction of health risks associated with drug dependence in specific geographical regions.

Outreach work. Street-based outreach work is available in specific geographical areas. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials, as well as for the deliverance of risk education/ response training. Peers and volunteers are included in outreach work practice in specific geographical areas. Networking and cooperation between outreach work agencies is not an existing policy, although it is practised in specific areas.

(Medically assisted) treatment and specific interventions. In specific geographical areas, treatment with buprenorphine and naltrexone-, methadone maintenance and detoxification treatment, drug-free outpatient and inpatient treatment, rehabilitation programmes and drop-in centres/ shelters are available. Drug consumption rooms and heroin prescription programmes do not exist in Greece. Opioid substitution treatment is a common response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Testing, prevention, education and treatment of infectious diseases are available nationwide in prisons. Drug paraphernalia are available in specific geographical regions. Neither substitution programmes nor condoms are offered in Greek prisons.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Prevention measures on infectious diseases are available nationwide. In specific geographical areas, testing/ screening, education, counselling, treatment of HIV, hepatitis C, tuberculosis and sexually transmitted diseases and vaccination for hepatitis B and tuberculosis, targeting drug users are available. To prevent infectious diseases among drug users, the predominant response strategies are IEC via counselling and advice by drugs and health professionals, and voluntary infectious diseases counselling and testing. Needle and syringe exchange, drug paraphernalia and condoms are available in specific geographical regions.

Drug-related deaths. The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. In specific geographical regions, training is offered to professionals working in needle exchange programmes, in substitution treatment, in treatment facilities, low threshold programmes and in prison settings. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. In Greece, a small number of qualitative and evaluation activities in the field of drug demand reduction exist, but there are only few examples from practice. Since 2005, the first steps have been taken to incorporate evaluation in interventions. Regarding evaluation training programmes, mostly professionals participate in them. Stakeholder participation is not common in Greece.

2.6.2 Recommendation 1: Risk reduction and public health policy

The governmental structure that is responsible for the implementation of the Council Recommendation is the Greek Ministry of Health and Social Solidarity[259]. 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 health-related harm associated with drug dependence were implemented in Greece before the Council Recommendation was adopted in 2003. [RT] The main objectives are stipulated in the Greek National Action Plan on Drugs 2002-2006. [SQ29]

2.6.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation. [RT]
The dissemination of information through many websites and a few telephone help lines is nationwide available[260]. Training and a broad range of educational leaflets is available in specific geographical regions. [NR 2001-2004; NFP 2006]

To **prevent infectious diseases** among drug users, providing information, education and communication (IEC) via counselling and advice by drugs and health professionals is the predominant response strategy. Safer injection training is a common response strategy[261]. [SQ 23; NFP 2006]

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. These trainings are delivered predominantly at low threshold agencies, including needle and syringe programmes and through outreach workers, peers. These trainings are common at specialised drug treatment services. [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]
In specific geographical regions, training seminars for (former) drug users and their families are organised; all specialised treatment units for adolescent drug users address parents and their children equally . The majority of drug-free treatment programmes for adults operate specialised family support programmes or provide specialised services for parents of drug users. [NR 2001, NR 2003; NFP 2006]

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. [RT]

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[259] International Relations Division.
[260] Furthermore, the major drug treatment agencies in Greece organise mass media campaigns with the aim to prevent drug use, to provide information on the drug addiction problem in general as well as on the work of the existing drug services. These campaigns include the development and broadcasting of TV and radio spots, the production of leaflets, posters and brochures, the organisation of events, etc. They address either the general public or special populations and age groups.
[261] Safer injection trainings are provided in those cities where specialised drug treatment centres operate.

In Greece, specific geographical areas provide street-based outreach work and trainings for outreach workers[262]. [NR 2004; NFP 2006]

To **prevent infectious diseases** among drug users, outreaching health education is a rare response strategy. Outreach work and targeted high-risk group interventions are a rare implementation setting for infectious diseases prevention measures targeting drug users. [SQ 23]

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 trainings to drug users. [SQ 29]

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[263]. [RT]
In specific geographical regions, peers and volunteers are included in outreach work and they are offered trainings in outreach work[264]. Training for outreach work is also available in specific geographical areas only. [NFP 2006].

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[265]. [RT]
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. [NFP 2006]

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 exists, but was not based upon the Council Recommendation. [RT]
In specific geographical areas, treatment with buprenorphine and naltrexone, methadone maintenance treatment[266], methadone detoxification treatment[267], drug-free outpatient and inpatient treatment, rehabilitation programmes and drop-in centres/ shelters are provided. Substitution treatment is supported by (obligatory) psychosocial care. [NR 2001-2004; NFP 2006]

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. [SQ 29]
Drug consumption rooms and heroin prescription programmes do not exist in Greece.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation[268]. [RT]
There is a special law stating that psychotropic substances can only be prescribed by specific doctors[269]. [NFP 2006]

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[262] A single uniform training scheme at national level has not been implemented so far. Each agency that implements outreach interventions provides some type of training for its staff with the aim to enhance the services it delivers.
[263] Besides health professionals, another group involved in outreached work concerns former drug users who have completed treatment.
[264] Training is provided to peers and volunteers, such in context of the training programme that are provided to drug services.
[265] However, networking and cooperation has been developed.
[266] Methadone is the most commonly prescribed substance for long-term substitution treatment.
[267] Methadone is the most commonly prescribed substance for detoxification in substitution treatment programmes.
[268] Measures for preventing diversion of substitution substances have been taken, however access to substitution treatment should be improved since not all demand for treatment is currently covered.

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 policy is pending for approval[270]. [RT]
Testing, prevention, education and treatment of infectious diseases are available nationwide in prisons. Drug paraphernalia are available in prisons in specific geographical regions. Condoms are not distributed in Greek prisons. There are no substitution programmes in Greek prisons[271,272]. [NR 2001/ 2004; NFP 2006]

Prisons are a rare implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]. Aiming at the **prevention and reduction of drug – related deaths**, prison pre-release interventions are a common response strategy. Prisons are a rare implementation setting for risk education/ response training for drug users. Information materials are rarely disseminated in Greek prisons. [SQ 29]

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[273]. [RT]
Prevention measures of the drug-related infectious diseases have been put in effect nationwide. In specific geographical areas[274], testing/ screening, education, counselling, treatment of HIV[275], hepatitis C, tuberculosis, sexually transmitted diseases [276] and vaccination programmes for hepatitis B and tuberculosis targeting drug users are available. [NR 2003/ 2004]

Predominant response strategies to **prevent infectious diseases** among drug users are the following: IEC via counselling by drugs and health professionals, and voluntary infectious diseases counselling and testing. Common strategies include safer injection training for drug users, condom promotion among drug users and hepatitis vaccination programmes for drug users.

Predominant implementation settings for infectious diseases prevention measures are specialised drug treatment services. [SQ 23]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Needle and syringe exchange programmes are available in specific geographical regions, as are drug paraphernalia and condoms. [NR 2003/ 2004]. Needle and syringe exchange programmes are a uncommon response strategy to **prevent infectious diseases** among drug users. [SQ 23]

With regard to the **reduction of drug-related deaths** among drug users, low threshold agencies, including needle and syringe exchange programmes, are a predominant setting both for dissemination of information materials and for providing risk education/ response training for drug users. [SQ 29]

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[269] The organisation against drugs (OKANA), which is also the national coordination body on drug affairs, is the only agency who is permitted by law to establish and operate substitution treatment programmes.
[270] The Ministerial Decree 149020/1999 already provides for three types of treatment programmes in the treatment centre for drug dependent prisoners ((KATK): (1) drug free treatment for ≥ 18 years old users; (2) drug free treatment for < 18 years old users; and (3) substitution treatment. However, only the first has been implemented until now.
[271] Nonetheless, the administering of substitution drugs in prison is foreseen for those drug addicts who were attending a methadone substitution programme before incarceration. In these cases, the administering of methadone can be continued in prison but only for a very short time period, thus aiming at detoxification.
[272] Detoxification is treated with painkillers and tranquilizers. Drug dependent prisoners that require emergency treatment are referred to a prison hospital or to public hospitals.
[273] Only for those attending a treatment programme.
[274] Mostly in and around Athens.
[275] HIV cases are to be notified to the Hellenic Centre of Disease Control and Prevention. For every notified case HAART is provided free of charge.
[276] OKANA and specialised medical services, for TB and hepatitis.

Greece has four non-pharmacy based needle and syringe exchange programmes. Types of needle and syringe exchange available in Greece include fixed sites, vans/ buses and outreach/ peers. There are no vending machines, pharmacy-based NSPs or prison-based needle and syringe exchange programmes. [ST 10]

There are no specific laws on needle and syringe exchange or on the possession of sterile needles in Greece. The police has the right to seize syringes if they are used for injection, but no action is taken when syringes are sterile. No prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation. [RT]
Emergency departments are rare settings for risk education/ response training that aim at the prevention of drug-related death. [SQ 29]

Ambulances routinely carry antagonists. The distribution or administration of naloxone is regulated by laws. Naloxone is not available on a 'take home' basis. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation. [RT]
Risk reduction is part of an integrated health strategy for drug users, as it is part of the National Drug Strategy. [NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Training for professionals working in needle exchange programmes, in substitution treatment, in treatment facilities, in low threshold programmes and in prison settings is available in specific geographical regions. [NR 2001/ 2003; NFP 2006]

2.6.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. [RT]

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. [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy exists, but was not based upon the Council Recommendation. Quite recently the importance of evaluation has been recognised in Greece and the first steps have been taken in order to incorporate evaluation into every application. [RT]

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. [RT]

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. [RT]

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. [RT]

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. [RT]

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. Participation of stakeholders is not conducted as a general rule, though. [RT]

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. [RT]

Annex A2.7 State of play on harm reduction in Spain

2.7.1 Summary

Public health policy. Harm reduction is a public health objective in Spain and has been for some time already. The policy objectives on harm reduction have most recently be reiterated in the National Action Plan on Drugs 2005-2008.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through websites, training, educational materials and pill-testing. For the reduction of drug-related deaths, the dissemination of information materials and risk education/ response training are the predominant response strategies. Communities and families of drug users are nationwide informed and involved in the prevention and reduction of health risks associated with drug dependence.

Outreach work. Street- based outreach work and outreach work at dance parties, raves and in clubs are nationwide available. Outreach work as a health education approach is a predominant response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials, as well as for the deliverance of risk education/ response training. Peers and volunteers are included nationwide in outreach work practice. Networking and cooperation between outreach work agencies exist in specific geographical regions.

(Medically assisted) treatment and specific interventions 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, heroin prescription programmes, drug consumption rooms and drop-in centres/ shelters are available in specific geographical areas. Opioid substitution treatment is a predominant response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. 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. Counselling, testing, prevention, education and treatment of infectious diseases are also widely available in Spanish prisons, as well as vaccination against hepatitis B and tuberculosis. Treatment with buprenorphine and heroin prescription programmes are not available.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Treatment of infectious diseases is nationwide available in Spain. To prevent infectious diseases among drug users, the predominant response strategies are IEC in general, outreach health education approach, needle and syringe exchange, a hepatitis B vaccination programme for drug users and easy access' programmes for drug users to treatment of infectious diseases. Needle and syringe exchange and condoms are available nationwide, while the availability of drug paraphernalia is restricted to specific geographical areas.

Drug-related deaths. Professionals of emergency departments are trained in specific geographical areas, e.g. to deal with overdoses. The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to prison staff. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. In the Spanish National Action Plan on Drugs 2005-2008 many different actions regarding quality control, monitoring and evaluation have been included. The plan calls for a systematic evaluation of all Drug Demand Reduction programmes. Furthermore, some of the Autonomous Regions have developed programmes for quality control. Evaluation studies that inform policy have been conducted on e.g. heroin prescription. Spain collaborates in EU Twinning programmes and is active towards countries in Latin America.

2.7.2 Recommendation 1: Risk reduction and public health policy

The structure responsible for the implementation of the Council Recommendation is the Ministry of Health and Consumer Affairs[277]. [RT]

This policy exists, but was not based upon the Council Recommendation. Public Health Policy objectives on the prevention and reduction of health-related harm associated with drug dependence already existed in Spain before the adopted and publication of the Council Recommendation. The policy objectives on prevention of health-related harm have been reconfirmed in the Spanish Action Plan on Drugs 2005-2008, actions 5-17. Policy objectives on the reduction of health-related harm have been reconfirmed in the action 28 of the Spanish Action Plan on Drugs. [RT].

2.7.3 Recommendation 2: Risk reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation[278]. [RT]
In Spain, websites[279], 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. [NR 2002-2004]

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[280] are common response strategies. [SQ 23; NFP 2006]

With regard to the **reduction of drug-related deaths**, the dissemination of information materials and risk education/ response training are the predominant response strategies 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 in some or few 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. [SQ 29]

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 exists, but was not based upon the Council Recommendation[281]. [RT]
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[282]. [NFP 2006]

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[277] Government Delegation for the National Plan on Drugs - Deputy Direction of Institutional Relations.
[278] Spanish Action Plan on Drugs 2005-2008; Action 18.
[279] www.energycontrol.com for recreational drug users; www.sindrogas.es; www.osasunekintza.org; www.pnsd.msc.es.
[280] IEC via peer involvement is expanded to many penitentiaries in Spain, such as Ocaña I and Ocaña II in Castilla-La Mancha. Autonomous Communities (CCAA) use peer approach as "Snow Ball programme" (peer group Programme among drug users of GID –NGO (Madrid). Programme "I decide" CCAA Navarra.
[281] Spanish Action Plan on Drugs 2005-2008; Action 5.
[282] Examples of community and family programmes that work with drug users' families are: the programme "On time" of the Municipal Plan on Drugs of Oviedo; a prevention programme in Basque Country aimed at parents with children with risk behaviours including drug use.

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[283]. [RT]
In Spain, street-based outreach work[284] and outreach work at dance parties, raves and in clubs[285] are nationwide available. [NR 2002/ 2004]

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. [SQ 23]

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 in some or few cities. [SQ29]

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 exists, but was not based upon the Council Recommendation[286]. [RT]
Peers and volunteers are included nationwide in outreach work practice[287], and they are also trained to do so[288]. [NR 2002; NFP 2006]

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[289]. [RT]
Networking and cooperation between outreach work agencies exist in specific geographical areas[290]. [NFP 2006]

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 exists, but was not based upon the Council Recommendation[291]. [RT]
Methadone[292] maintenance and detoxification treatment, drug-free outpatient and drug-free inpatient treatment, and rehabilitation programmes are available nationwide. Treatment with buprenorphine[293], treatment with naltrexone[294], heroin prescription programmes[295], drug consumption rooms[296] and drop-in centres/ shelters[297] are available in specific geographical areas.

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[283] Spanish Action Plan on Drugs 2005-2008; Action 20.
[284] There are 48 mobile units for outreach work.
[285] Various programmes exist, among others 'Energy Control', 'Zona Clave', 'Controla club', etc.
[286] Spanish Action Plan on Drugs 2005-2008; Actions 17 and 44.
[287] In particular young people are involved in peer-to-peer approaches.
[288] There is a course for leisure time monitors and another for volunteers organised by the Drug dependencies Direction of Basque Government. NGO "Punto Omega" Association has a training school for volunteers.
[289] Spanish Action Plan on Drugs 2005-2008; Action 20.
[290] Cooperation networks exist, mainly between NGOs. Examples are: UNAD, a network of NGOs involved in drug dependencies areas such as outreach work. Association ASECEDI, an association of agencies with day care centres. Network ARANA, a network of social agencies for employment.
[291] Spanish Action Plan on Drugs 2005-2008; Actions 22 and 28.
[292] Furthermore, mobile units provide treatment with methadone. Pharmacies are also authorised to dispense methadone.
[293] This takes place in two centres in Madrid, covering 36 patients in 2003.
[294] The Extremadura Autonomous Community runs a treatment programme with Naltrexone. A naltrexone treatment programme is carried out by the Foundation Marbella Solidaria in the City of Marbella (Málaga).
[295] Two clinical trials are currently running.
[296] DCR's exist in Madrid, the Basque Country and in Catalonia.

Substitution treatment is supported by psychosocial care, upon request by the client. [NR 2003/ 2004; NFP 2006]
Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a predominant response strategy. [SQ 29]

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation[298]. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide[299]. [NFP 2006]

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, but was not based upon the Council Recommendation[300]. [RT]
Methadone maintenance and detoxification programmes, treatment with naltrexone[301], needle and syringe exchange[302], 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. [NR 2002/ 2004; NFP 2006]

Prisons are a predominant implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]. 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. [SQ 29]

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[303]. [RT]
Treatment of infectious diseases (HIV, hepatitis C, tuberculosis, sexually transmitted diseases) is nationwide available in Spain. [NR 2003]

To **prevent infectious diseases** among drug users, the predominant response strategies are information, education, communication (IEC) in general, outreach health education approach, needle and syringe exchange programmes, a hepatitis B vaccination programme for drug users, and easy access programmes for drug users to treatment of infectious diseases. Other common strategies include IEC via counselling and advice by drugs and health professionals, safer injecting training, voluntary counselling and testing, condom promotion among drug users and routine screening of high risk groups. Predominant implementation settings for infectious diseases prevention measures targeting drug users include specialised drug treatment services, low threshold counselling services, outreach work and targeted high risk group interventions and prisons. Common implementation settings are primary care/ general practitioners and mass media. [SQ 23]

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[297] Twenty-seven in 2003.
[298] Spanish Action Plan on Drugs 2005-2008; Action 28.
[299] Measures include a restricted prescription system, in which the adequate dose is prescribed to each patient.
[300] Spanish Action Plan on Drugs 2005-2008; Action 50. Agreement between the Ministry of Health and Consumer Affairs and the Ministry of Interior for the treatment of drug abusers in prisons.
[301] Naltrexone treatment is generally provided as an alternative treatment option in all prisons that work under the auspices of the Ministry of Interior.
[302] In 38 prisons.
[303] Spanish Action Plan on Drugs 2005-2008; Action 28.

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

This policy exists, but was not based upon the Council Recommendation[304]. [RT]
Needle and syringe exchange programmes[305] and the distribution of condoms[306] are available nationwide in Spain. Drug paraphernalia are available in specific geographical areas only. [NR 2003/ 2004; NFP 2006]

Needle and syringe exchange programmes are a predominant response strategy to **prevent infectious diseases** among drug users in Spain. [SQ 23] 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. [SQ 29]

Spain has 297 non-pharmacy based, and 946 pharmacy based needle and syringe exchange programmes. Types of needle and syringe exchange that are available in Spain are fixed sites, vans/ buses, through outreach/ peers, pharmacy based and prison based needle and syringe exchange, but no vending machines. [ST 10]. There are no legal restrictions to the possession of sterile needles in Spain, and also no prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation[307]. [RT]
In specific geographical areas only, professionals of emergency departments are offered training[308]. [NFP 2006]. Emergency departments are a predominant setting for risk education/ response training aimed at the reduction of drug-related deaths.

Spanish ambulances routinely carry antagonists. The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is not available. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation[309]. [RT]
Risk reduction is part of an integrated health strategy for drug users[310]. [NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation[311]. [RT]
Training is offered nationwide to prison staff. Training for outreach workers[312], professionals in needle and syringe exchange[313] programmes, low threshold agencies[314], substitution treatment[315] and treatment facilities[316] is available in specific geographical areas only[317]. [NR 2004; NFP 2006]

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[304] Spanish Action Plan on Drugs 2005-2008; Action 28.
[305] Chemists' offices, 2324 pharmacies and 1224 needle exchange centres.
[306] Distribution takes place through treatment centres for drug users; harm reduction facilities.
[307] Spanish Action Plan on Drugs 2005-2008; Actions 22 and 43.
[308] In Castilla La Mancha trainers of the Health Department provide trainings that focus on priorities derived from data on psychoactive drug use in the region. The Health Department of Catalonia provides a training titled: "Counselling for emergency services related to young people and drug use".
[309] Spanish Action Plan on Drugs 2005-2008; Action 22.
[310] National Drugs Strategy 2000-2008: section 4.1.2 describes 7 objectives.
[311] Spanish Action Plan on Drugs 2005-2008. Actions 43 and 44.
[312] In 2003, in Castilla La Mancha 35 courses for outreach workers were organised, including 695 participants. Different courses exist for young outreach workers in health education in Asturias (organised by the Health department and Youth Council of the Principado de Asturias).
[313] Workshops exist on safer injection and other measures to reduce specific risks associated to drug use (CCAA Cataluña). There is a guide for the deployment of needle and syringe exchange programmes, which is published by the sub-commission on Prevention of the National Plan on AIDS. Furthermore, there are training courses for needle and syringe exchange programmes in pharmacies, which are developed in accordance with the cooperation agreement signed between the Pharmacist Association and the Ministry of Health and Consumer Affairs.

2.7.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. It is reflected in the Spanish Action Plan on Drugs 2005-2008 (Action 25).

In Spain, substitution treatment is carried out in the penitentiary settings since 1992, being extended to all prisons in 1998. The wide spread of substitution treatment is explained by its high efficiency, and especially for its proven *effectiveness* to prevent HIV infections. [NR 2004]

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 2005-2008 (Action 56), which calls for systematic evaluation of all DDR programmes. [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy exists, but was not based upon the Council Recommendation. The Spanish Action Plan on Drugs 2005-2008 (Action 56) calls for systematic evaluation of all DDR programmes. [RT]

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. The Spanish Action Plan on Drugs 2005-2008 (Action 56) calls for systematic evaluation of all DDR programmes. [RT]

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 program 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 NGO have included systems of quality management in their programmes and activities.
[NR 2003]

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. The Spanish Action Plan on Drugs 2005-2008 (Action 45) calls for reinforcement of the National Focal point. [RT]

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. One example is the 2003 evaluation report on the Spanish National Strategy on Drugs 2000-2008. [RT]

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[314] The association Proyecto Hombre has a training program for professionals in intervention centres. The association Caritas has received training for professionals and volunteers of residential centres funded by the Government Delegation for the National Plan on Drugs.
[315] Trainings on methadone maintenance programmes in pharmacies are targeted at pharmacists in Catalonia and given by trainers of the Health Department. In Castilla La Mancha, similar trainings are provided by the Health Department under the title "Pharmacist in view to drug dependencies".
[316] The Psychologist Association provides a course on prevention and treatment of drug dependencies among minors and young people. The NGO Socidrogalcoho runs courses for professionals in treatment.
[317] Several Master Programmes in drug dependencies exist: University of Barcelona (virtual), Psychology Centre Alborán, Complutense University of Madrid, University of Valencia, University of Deusto (Bilbao).

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. [NR 2004]

Regarding the National Action Plan on Drugs, a midterm evaluation was conducted in 2003 and a final one is foreseen for 2008. [NR 2003]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists, but was not based upon the Council Recommendation. The Spanish Action Plan on Drugs 2005-2008 (Action 57) calls for evaluation of training programmes for professionals which is not the development of evaluation training programmes. [RT]

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. The Spanish Action Plan on Drugs 2005-2008 (Action 41) calls for innovative methods in drug demand reduction. But this is not the same as stakeholder participation. [RT]

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. The Spanish Action Plan on Drugs 2005-2008 (Action 64) calls for bi- and multilateral cooperation, also with MAGREB countries. [RT]

Spain has participated in several Phare Twinning projects in the field of drugs (e.g. with Lithuania) and is also active in cooperation with Latin America. Furthermore, it participated in several European cooperation projects funded by DG SANCO.

Annex A2.8 State of play on harm reduction in France

2.8.1 Summary

Public health policy. Harm reduction has been a public health policy objective in France since 1993, but it took until 1999 (Three Year Plan on Drugs) until the objective was really made operational.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines, websites and educational leaflets. Communities and families of drug users are nationwide informed, but their involvement in the prevention and reduction of health risks associated with drug dependence is restricted to specific geographical regions.

Outreach work. Outreach work at dance parties/ raves and in clubs is nationwide available, and street-based outreach work is provided in specific geographical areas only. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. Peers and volunteers are included in outreach work practice in specific geographical regions. Finally, networking and cooperation between outreach work agencies exist nationwide.

(Medically assisted) treatment and specific interventions. Treatment with buprenorphine and drug-free outpatient treatment are nationwide available. Methadone maintenance and methadone detoxification treatment, drug-free inpatient treatment and drop-in centres/ shelters are available in specific geographical areas. France does not have drug consumption rooms and has no heroin prescription programmes. Opioid substitution treatment is a common response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Condoms and drug paraphernalia are nationwide available in prison. Counselling, testing, prevention, education and treatment of infectious diseases, methadone maintenance and methadone detoxification treatment and treatment with buprenorphine are available in prisons in specific geographical areas.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening for infectious diseases and vaccination programmes for hepatitis B and tuberculosis targeting drug users are nationwide available. To prevent infectious diseases among drug users the predominant response strategies are IEC in general, IEC via counselling and advice by drugs and health professionals, safer injecting training and needle and syringe exchange. Needle and syringe exchange and drug paraphernalia are available nationwide, but the distribution of condoms is restricted to specific geographical regions.

Drug-related deaths. The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training for professionals working in treatment facilities, in substitution treatment, in low threshold programmes and in prison settings is available nationwide. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. In France, scientific studies are regularly conducted into harm reduction measures, i.e. into low threshold agencies and methadone maintenance treatment. In the Three Year Action Plan on Drugs 1999-2001, recommendations were made regarding quality assurance in drug demand reductions. The plan also initiated a number of priority programmes which involved evaluation and were used to inform policy.

2.8.2 Recommendation 1: Risk reduction and public health policy

In France, drug policy is coordinated by the Interministerial Department for the Fight against Drugs and Addiction[318], which is based at the Prime-Ministers Office. This department is also responsible for the implementation of the Council Recommendation.

Prevention and reduction of health-related harm associated with drug dependence pre-existed in France before the adoption of the Council Recommendation. [RT]. 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). [NR 2002].

2.8.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation. [RT]
In France, information is disseminated nationwide through telephone help lines[319], websites[320], and a broad range of educational leaflets[321,322]. Training for drug users[323] is available in specific geographical regions. [NR 2004; NFP 2006]

To **prevent infectious diseases** among drug users, providing information, education and communication (IEC) in general, IEC via counselling and advice by drugs and health professionals, and safer injecting training are the predominant response strategies. A common response strategy is IEC via peer involvement/ peer approach. [SQ 23]

With regard to the **reduction of drug-related deaths**, individual risk counselling is a common strategy. Dissemination of information materials about this topic is rare. [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]
Specific IEC for communities and families of drug users is available nationwide[324]. In specific geographical regions, communities and families of drug users are involved in the prevention and reduction of health risks associated with drug dependence[325]. [NFP 2006]

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[318] Mission Interministérielle de Lutte Contre la Drogue et la Toxicomanie (MILDT).
[319] Drogues Alcool Tabac Info Service (DATIS).
[320] www.drogues.gouv.fr; www.toxibase.org; www.asud.org
[321] The National Institute for Health Education (INPES) provides educational materials by publishing leaflets and internet sites. Numerous local initiatives, promoted by associations and groups with direct field experience, may pass the message on. A majority of these local structures benefit from State, public financial support.
[322] New initiatives were made possible in the early months of 2006, with the beginning of the Drug-users Shelter, Support, and Risk reduction Centres programme (CAARUD for its French acronym). Following a Government decree adopted in December 2005, this national level program aims at standardizing low threshold agencies. Financing will be placed under responsibility of the National Social Security. Essentially, this is an administrative plan aiming at ensuring the participating NGOs a more stable budget, with more effective and faster cash deposit. NGO willing to benefit from the National Social Security funding is allowed to fulfil administrative procedures until November 2006.
[323] Provided by the Quinquennial Plan, proposed and lead by the MILDT, the cross-ministerial mission on drugs and addictions. In practice, trainings are a local level decision.
[324] The cross-ministerial mission on drugs and addictions (Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie, MILDT) produces flyers, advertising. Information is taken over by local structures and associations. Special attention is paid to urban and party contexts.
[325] Families of drug users' advices are sought but there is no official, institutional active participation. Attention is paid to prevention, but not to risk reduction.

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. [RT]
In France, outreach work at dance parties/ raves and in clubs[326] is nationwide available. Street-based outreach work and trainings for outreach workers[327] are available in specific geographical areas. [NR 2004; NFP 2006]

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 predominant implementation setting for infectious diseases prevention measures targeting drug users. [SQ 23]
Low threshold agencies, including needle and syringe exchange programmes, and outreach work are a rare setting for the dissemination of information materials[328], aimed at the **reduction of drug-related deaths**. Outreach work is an uncommon setting for the deliverance of risk education / response training to drug users. [SQ 29; NFP 2006]

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 exists, but was not based upon the Council Recommendation. [RT]
In France, peers and volunteers are included in outreach work only in specific geographical regions; training for peers and volunteers is not available. [NFP 2006]

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. [RT]
Networking and cooperation between outreach work agencies is nationwide available[329]. [NR 2004]

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 exists, but was not based upon the Council Recommendation. [RT]
Treatment with buprenorphine and drug-free outpatient treatment are nationwide available[330]. Methadone maintenance and methadone detoxification treatment, drug-free inpatient treatment and drop-in centres / shelters are available in specific geographical areas[331]. Substitution treatment is supported by psychosocial care upon request by the client. [NR 2003,2004; NFP 2006]

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[326] The French Monitoring Centre on Drugs and Addictions (OFDT) included a specific study upon drug users in club scenes (SINTES) since 1999. This general information monitoring system will be replaced by an updated system in the coming months.
[327] Beyond standardized trainings, common to outreach workers, there are no specific nationwide on-the-job-trainings. Initiatives are local.
[328] It is difficult to provide information about these specific topics at a national level, due to resistance to evaluation programmes. The implementation of CAARUDS should facilitate the gathering and retrieving of knowledge, particularly regarding needle and syringe exchange programmes.
[329] French National Association of Drug Addiction Workers (ANIT).
[330] Naltrexone has an official license to be released on the market only in the case of treatment of cancer. Naltrexone as substitution treatment is not yet approved of by the Ministry of Public Health. An agreement to that purpose is foreseen this year.
[331] Morphine sulphates and codeine derivatives are not officially used as substitution options, due to lack of support from the public health and political communities. Therefore these substances do not benefit from a strict, legal authorization for being used as substitution. The use of morphine sulphates is rare, sometimes distributed unauthorised by physicians and visible in high-urban areas. The use of codeine derivatives is most residual.

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a common response strategy. [SQ 29] France does not have drug consumption rooms and has no heroin prescription programmes.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation. [RT]
Measures to prevent diversion of prescribed drugs are nationwide available. [NR 2003]

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, but was not based upon the Council Recommendation. [RT]
The distribution of condoms and drug paraphernalia[332] are nationwide available. Counselling, testing, prevention, education and treatment of infectious diseases, methadone maintenance and methadone detoxification treatment and treatment with buprenorphine are available in prisons in specific geographical areas. [NR 2004; NFP 2006]
Prisons are an uncommon implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]

Aiming at the **prevention and reduction of drug – related deaths**, prison pre-release interventions are an uncommon response strategy. Prisons are not in use as a setting for disseminating information materials on prevention of acute drug-related deaths and for providing risk education/ response training for drug users. [SQ29].

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. [RT]
Testing/ screening for infectious diseases and vaccination programmes for hepatitis B and tuberculosis targeting drug users are nationwide available. [NR 2004]

Predominant response strategies to **prevent infectious diseases** among drug users[333] are: IEC in general, IEC via counselling and advice by drugs and health professionals, safer injecting trainings, and needle and syringe exchange programmes. Common but not predominant strategies include IEC via peer involvement/ peer approach, outreach health education approach, voluntary infectious diseases counselling and testing, condom promotion among drug users and hepatitis vaccination programmes for drug users. [SQ 23]

Predominant implementation settings for **infectious diseases prevention** measures targeted at drug users are specialised drug treatment services, low threshold counselling services, outreach work and targeted high risk group interventions and primary care/ GP's. [SQ 23]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Needle and syringe exchange programmes and additional services such as sterile water, bleach and ascorbic acid, are available nationwide. Condoms are distributed among drug users in specific geographical regions[334]. [NR 2004; NFP 2006]

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[332] There are no legal obligations to provide drug paraphernalia such as sterile water, bleach, and ascorbic acid. Imprisoned drug-users may have access to the mentioned paraphernalia only on personal and voluntary requirement. Distribution depends to a strictly personal initiative from the attending physician.
[333] The prevention of infectious diseases among DU's is based on 3 documents: the MILDT 5 year drug plan (2004-2007); the National Plan on HIV/ AIDS (2001-2004), which is being evaluated; the national plan on hepatitis (2002-2005).
[334] Initiatives are mainly local, promoted by associations and groups with direct field experience. A majority of these local structures benefit from state financial support.

Needle and syringe exchange programmes are a predominant response strategy to **prevent infectious diseases** among drug users in France. [SQ 23]

With regard to the **reduction of drug-related deaths** among drug users, low threshold agencies, including needle and syringe exchange programmes, are an uncommon setting both for dissemination of information materials and for providing risk education/ response trainings for drug users. [SQ 29]

France has 240 non-pharmacy based needle and syringe exchange outlets, 18000 pharmacy based needle and syringe exchange outlets, and 250 vending machines Types of needle and syringe exchange include fixed/ sites, vans/ buses, outreach/ peers, vending machines and pharmacy-based. There is no prison-based needle and syringe exchange. [ST10]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation. [RT]
Training programmes for professionals of emergency services are not available. [NFP 2006]. Ambulances routinely carry antagonists. The distribution, possession or administration of naloxone is regulated by law. Naloxone is not available on a 'take home' basis. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation. [RT]
Nationwide, risk reduction is part of an integrated health strategy for drug users[335]. [NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Training for professionals working in treatment facilities, in substitution treatment, in low threshold programmes and in prison settings is available nationwide. In specific geographical regions, trainings for professionals working in needle and syringe exchange programmes[336] are provided. [NR 2004; NFP 2006]

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, but this is planned. [SQ 23]

2.8.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. [RT]

The MILDT has drawn up a risk reduction intervention guideline for prevention actions in the part-scene. Furthermore, several research studies exist in France that are used to further develop and select interventions. Examples are:

During the period 1999-2001, two evaluations directed by the OFDT focused on "low threshold centres". The first concerned an evaluation of the methadone bus in Paris. This evaluation, carried

[335] Risk reduction is provided by the Quinquennial Plan, proposed and lead by the MILDT, the cross-ministerial mission on drugs and addictions. Risk reduction is regarded as a "State responsibility", as stated in the Public Health Decree adopted in August 2004. The Decree spotted three axes including topics like health, spread of diseases, and social damages. Risk-reduction is part of a larger plan of prevention. A concrete example lies in the RMS program (standing for "Réseau Micro-Structures", or Microstructures network), originally based in Alsace: attention and care to any kind of addicted patients is provided by physicians in the presence of social-workers and psychologists. Recently, the RMS has been extended to Marseille (south) and St Nazaire (south-west).
[336] On-the-job-training is commonly proposed by associations and local-groups to their personnel, once a year.

out by the IREP (The Institute for Research on the Epidemiology of Drug Dependency) and INSERM, concerned, on the one hand, the facility's activities and users (effectiveness of the implementation) and, on the other, the changes produced (effectiveness of the results) in terms of access to the social health network (capture/ referral role), the effects on consumption practices and on the health and social rehabilitation of dependent persons. The second study concerned the evaluation of a risk reduction and social mediation pilot project in the 18th *arrondissement* of Paris. This evaluation, conducted by ACT Consultants, provided an assessment of the effectiveness of the programme in relation to its initial objectives and the extent of the effectiveness of the operation with regard to users and residents (interviews and surveys wee conducted). [NR 2003]

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. [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy does not exist. [RT]

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. The culture of evaluation is relatively new to France (and different to a culture of 'control'). [RT].

As a result of the evaluation of the three-year Action Plan 1999-2001, recommendations regarding quality assurance were made, including:

- Ensure that there is an on-going system of quality information, based on a restricted number of sensitive and up-to-date indicators of resources and achievement of result and, to this end, identify such indicators from the definition of the programmes, so as to be able to identify any revisions to be made in existing information systems.
- Procure the necessary resources (personnel and financial) to guarantee the gathering of information and its utilisation while avoiding the resort to statistical categories that differ or are only loosely connected across the various collecting services.
- Assure the quality of implementation, making a mid-term assessment of how professionals in the field interpret the objectives in their professional practice and of the difficulties they encounter [NR 2004].

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. [RT]

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. [RT]

A working group, bringing together the General Health Department (DGS), the French Health Products Safety Agency (AFSSAPS), the MILDT and the OFDT, was set up in 2001 to reassess the programmes for the distribution of heroin under medical supervision. In this context, the OFDT has entrusted a group of foreign researchers with documentary research on the various clinical trials regarding programmes based on heroin prescribed for injection and their effectiveness in the prescribing countries (United Kingdom, Switzerland, Germany, Spain, Australia and the United States). [NR 2003]

In the framework of the three-year action plan on drugs of the French government, five priority programmes and/ or specific facilities were evaluated. These were a) the departmental prevention programmes; b) the inter-ministerial training initiative; c) the approach to specialised alcohol addiction units with a view to general admission; d) the harm reduction and social mediation programme in the 18th arrondissement of Paris; and e) 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. Their specific results were added to the general evaluation report [NR 2003] and resulted in a series of recommendations for policy.

3.7 Setting up evaluation training programmes for different levels and audiences

This policy does not exist . [RT]. The culture of evaluation is relatively new to France (and different to a culture of 'control'). So far there is not a general policy that includes stakeholders at all levels.

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. [RT]

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. [RT] France has participated in a number of SANCO funded projects (e.g. Emtrend project)[337]

[337] The Emerging Trends project focused on the development of an early identification function for the assessment of new drug trends, including riskful drug use.

Annex A2.9 State of play on harm reduction in Ireland

2.9.1 Summary

Public health policy. Harm reduction as a public health objective exists in Ireland, but was not based upon the Council Recommendation. Harm reduction is also reflected in the Irish National Drug Strategy 2001-2008 and its contents are in coherence with the Council Recommendation.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines and websites. With regard to the reduction of drug-related deaths, individual risk counselling is the predominant response strategy. Nationwide, communities and drug users are involved in risk reduction**.**

Outreach work. Street-based outreach work is available in specific geographical areas. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the deliverance of risk education/ response training and a common setting for the dissemination of information materials. Although the policy exists, peers and volunteers are not included in outreach work practice. Networking and cooperation between outreach work agencies exist in specific geographical regions only.

(Medically assisted) treatment and specific interventions. Methadone maintenance and methadone detoxification programmes, drug-free outpatient and drug-free inpatient treatment and rehabilitation programmes are nationwide available. Drop-in centres/ shelters and treatment with buprenorphine and naltrexone are available in specific geographical areas only. Drug consumption rooms and heroin prescription programmes do not exist in Ireland. Opioid substitution treatment is a common response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Testing, prevention, education and treatment of infectious diseases are available nationwide in prisons. There is a limited counselling service and low access to treatment of hepatitis C. In specific geographical areas methadone maintenance treatment and methadone detoxification treatment are provided. Treatment with buprenorphine and naltrexone, needle and syringe exchange programmes, drug paraphernalia and the distribution of condoms are not available in Irish prisons.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). To prevent infectious diseases among drug users, common response strategies include IEC in general, IEC via counselling and advice by drugs and health professionals, safer injection training, outreach health education approach, voluntary counselling and testing, condom promotion among drug users, needle and syringe exchange and hepatitis vaccination programmes. Needle and syringe exchange, drug paraphernalia and the distribution of condoms are available in specific geographical areas.

Drug-related deaths. Professionals of emergency departments are trained nationwide, e.g. to deal with overdoses. The distribution, possession or administration of naloxone is regulated. Naloxone is not available on a 'take home' basis.

Training of staff and risk reduction as part of a complementary health strategy. Trainings for outreach workers is provided in specific geographical regions. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. In Ireland, a small number of studies regarding the effectiveness of harm reduction interventions have been conducted, among others into the use of Iofexidine and naloxone, hepatitis B vaccination and into substitution treatment. Needs assessment is not common practice in drug demand reduction programmes, but assessment of hepatitis C treatment and hepatitis B vaccination coverage have been put in place. Outreach work has been evaluated as part of the National Drug Strategy.

2.9.2 Recommendation 1: Risk reduction and public health policy

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). [RT]

Harm reduction is a public health objective in Ireland, but was not based upon the Council Recommendation. A comprehensive National Drugs Strategy is in place for the period 2001 - 2008. This strategy was developed following widespread consultation. It contains 100 actions under the pillars of supply reduction, education and prevention, treatment and rehabilitation, and research. The Council Recommendation is very much in line with the Irish policy in relation to preventing and reducing health related harm associated with drug dependence. [RT]

A mid-term review of the National Drugs Strategy was finalised in 2005, resulting in (re-) adjusted policy objectives for the period 2005-2008. [SQ29]

2.9.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation. [RT]
In Ireland, the dissemination of information through various websites and telephone help lines is nationwide available. In specific geographical regions, primarily in the Eastern Regional Health Authority, training for drug users and a broad range of educational materials are available. [NR 2004; NFP 2006]

To **prevent infectious diseases** among drug users, providing information, education and communication (IEC) via counselling and advice by drugs and health professionals, IEC in general and safer injection training are common response strategies.[338] [SQ 23]

With regard to the **reduction of drug-related deaths**, individual risk counselling is the predominant response strategy. Risk education/ response training is a common response strategy and is delivered predominantly by low threshold agencies, including needle and syringe exchange programmes, and through outreach workers and commonly by specialised drug treatment services. [SQ29].

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 exists, but was not based upon the Council Recommendation. [RT]
Nationwide, communities and drug users are involved in risk reduction. [NR 2004]

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. [RT]
In Ireland, street-based outreach work is provided in specific geographical areas. In some rural area backpacking needle exchange is available. [NR 2004].

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. [SQ 23]

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[338] In May 2004, senior outreach workers reported two concerns with the current organisation of outreach services. They reported that outreach workers need to work from 2 pm to 11 pm in order to suit their clients' lifestyle. Outreach services needed to be reorganised in order to address the growing cocaine use problem during weekends. Such re-organisation would make their services more appropriate.

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**. Outreach work is a predominant setting for the deliverance of risk education/ response training to drug users. [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]
However, peers and volunteers are not included in outreach work nor is training for peers and volunteers available. Training for outreach workers and training in management for senior outreach workers is organised in specific geographical areas. [NFP 2006]

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. [RT]
In specific geographical regions only (the Eastern Region), senior outreach workers meet on a monthly basis. [NFP 2006]

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 exists, but was not based upon the Council Recommendation. [RT]
Methadone maintenance and methadone detoxification programmes, drug-free outpatient and drug-free inpatient treatment and rehabilitation programmes are nationwide available. Substitution treatment is supported by psychosocial care upon request by the client. Drop-in centres/ shelters and treatment with buprenorphine and naltrexone[339] are available in specific geographical areas only. [NR 2003/ 2004; NFP 2006]

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. [SQ 29]
Drug consumption rooms and heroin prescription programmes do not exist in Ireland.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation. [RT]
Measures to prevent diversion of prescribed drugs are nationwide available. [NR 2003]

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, but was not based upon the Council Recommendation. [RT]
Testing, prevention, education and treatment of infectious diseases are available nationwide in prisons. There is a limited counselling service and low access to treatment of hepatitis C. In specific geographical areas methadone maintenance treatment[340] and methadone detoxification treatment are provided. Treatment with buprenorphine and naltrexone, needle and syringe exchange programmes[341], drug paraphernalia and the distribution of condoms are not available.[342] [NR 2003/ 2004; NFP 2006]

Prisons are a common implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]. Information materials aiming at the **prevention and reduction of drug – related deaths** are rarely disseminated in Irish prisons, as is the deliverance of risk

[339] Naltrexone is rarely used to facilitate a drug free lifestyle following detoxification.
[340] In five prisons in Dublin.
[341] Needles or syringes distributed inside prisons.
[342] Bleach is not distributed in Ireland as it does not prevent the spread of hepatitis C.

education/ response training for drug users. Prison pre-release interventions are also uncommon. [SQ 29]

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. [RT]
Common response strategies to **prevent infectious diseases** among drug users are: IEC in general, IEC via counselling and advice by drugs and health professionals, safer injection training, outreach health education approach, voluntary counselling and testing, condom promotion among drug users, needle and syringe exchange programmes and hepatitis vaccination programmes[343]. An uncommon response strategy is easy access' programmes to treatment of infectious diseases[344]. Predominant implementation settings for infectious diseases prevention measures include specialised drug treatment services and primary care/ GP's. Common implementation settings are low threshold counselling services, outreach work and targeted high risk group interventions, and prisons. [SQ 23]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
In specific geographical areas, needle and syringe exchange programmes[345], distribution of condoms and drug paraphernalia such as sterile water and ascorbic acid are available. [NR 2004; NFP 2006]

Needle and syringe exchange programmes are a common response strategy to **prevent infectious diseases** among drug users in Ireland. [SQ 23]. With regard to the **reduction of drug-related deaths** among drug users, low threshold agencies, including needle and syringe exchange programmes, are a predominant setting for dissemination of information materials and for providing risk education/ response training for drug users. [SQ 29]

Ireland has twenty non-pharmacy based NSPs, no pharmacy-based NSPs and no vending machines. Fixed sites, vans/ buses and outreach/ peer are existing types of needle exchange. There are no vending machines, no pharmacy-based and no prison-based NSPs. [ST 10]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation. [RT]
Training programmes for professionals of emergency services[346] are available nationwide. [NR 2004; NFP 2006] Emergency departments are not in use as a setting for risk education/ response training that aim at the **reduction of drug-related deaths**. [SQ 29] Irish ambulances routinely carry antagonists. The distribution or administration[347] of naloxone is regulated. Naloxone is not available on a 'take home' basis. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation. [RT]
With regard to risk reduction as part of an integrated health strategy for drug users: in theory, the implementation of the National drug Strategy is an action in the National Health Strategy. To promote appropriate integration, in 2002, the National Advisory Committee on Drugs

[343] Ireland has a national hepatitis B immunization programme since 1999; it has also targeted hepatitis B vaccination programmes for drug users, and also programmes in prisons.
[344] In 2003, a protocol has been developed to improve uptake of assessment and access to treatment for hepatitis C among injecting drug users.
[345] Only Eastern Health Authority.
[346] On the management of overdoses.
[347] Since August 2005, Statutory Instrument No 510 of 2005 permits the administration of naloxone by advanced paramedics in line with clinical protocol guidelines, and its administration by paramedics and emergency medical technicians when prescribed by a medical practitioner.

commissioned a team at Dublin City University to explore the management of individuals with a combination of mental illness and substance misuse in Ireland. [NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Training for outreach workers and training in management for senior outreach workers is organised in specific geographical areas. [NR 2004]

2.9.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. [RT].

Two small-scale cohort studies published in 2004 and examining the effectiveness of methadone maintenance as a therapy were positive with respect to internationally accepted indicators. [NR 2004]

Furthermore, the Working Party at the National Medicines Information Centre at St James's Hospital in Dublin were commissioned by the National Advisory Committee on Drugs to review the use of lofexidine and naloxone in the management of opiate dependence.

The effectiveness of hepatitis B vaccination among injecting drug users may be lower than that among the general population because of the generally poorer health status among this group, including HIV co-morbidity (Keating and Noble 2003). [NR 2004]

In the Republic of Ireland, drugs used to detoxify opiate users are methadone, buprenorphine and lofexidine. Research indicates that all three drugs are effective in reducing withdrawal symptoms and completion rates are satisfactory. [NR 2003]

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. [RT]

In 2001 a pilot project was implemented to improve the care of injecting drug users attending general practice and at risk of hepatitis C. Prior to implementing the project, the authors did a baseline assessment that included hepatitis B vaccine coverage. [NR 2004].

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy exists, but was not based upon the Council Recommendation. [RT]

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. [RT]

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

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

Policy exists, but was not based upon the Council Recommendation. [RT]

The Eastern Regional Health Authority (ERHA) commissioned the evaluation of outreach work in response to Action 64 of the National Drugs Strategy. One of the recommendations from the research report was to develop a monitoring system that includes quantitative and qualitative indicators for outreach work. [NR 2004]

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. 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. [NR 2004]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists, but was not based upon the Council Recommendation. [RT]

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. [RT]

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. [RT]

Annex A2.10 State of play on harm reduction in Italy

2.10.1 Summary

Public health policy.
Harm reduction interventions have existed in Italy for many years, primarily at regional level. Harm reduction is a public health objective.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines and websites. For the reduction of drug-related deaths, the dissemination of information materials, risk education/ response training for drug users, individual risk counselling and prison pre-release interventions are predominant strategies. In specific geographical regions, communities and families of drug users are informed and involved in the prevention and reduction of health risks associated with drug dependence.

Outreach work. Street-based outreach work, and outreach work at dance parties/ raves and in clubs are available in specific geographical regions only. Outreach work as a health education approach is a predominant response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials, as well as for the deliverance of risk education/ response training. Peers and volunteers are included nationwide in outreach work practice. Networking and cooperation between outreach work agencies only exist in specific geographical regions and on an informal level.

(Medically assisted) treatment and specific interventions. Methadone maintenance and methadone detoxification treatment, drug-free out-patient 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. Italy does not have drug consumption rooms and has no heroin prescription programmes. Opioid substitution treatment is a predominant response strategy aiming at the reduction of drug-related deaths. Although this policy exists, measures to prevent diversion of prescribed drugs are not available.

Prison interventions. Methadone maintenance, detoxification treatment and treatment with buprenorphine are nationwide available in prisons. Also testing, prevention, education, treatment and counselling of infectious diseases are provided nationwide. In specific geographical areas, naloxone is available on a 'take home' basis.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening and vaccination for infectious diseases are nationwide available. To prevent infectious diseases among drug users, the predominant response strategies are IEC in general, outreach health education approach, voluntary infectious diseases counselling and testing, and needle and syringe exchange. Needle and syringe exchange is available nationwide. Drug paraphernalia and condoms are available in specific geographical regions.

Drug-related deaths. The distribution or administration of naloxone is regulated. Naloxone is available on a 'take home' basis.

Training of staff and risk reduction as part of a complementary health strategy. Training for outreach workers is nationwide available. Training for other professionals is not available. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. An evidence-based approach in addiction treatment has been adopted in 'essential standards of care'. Studies are also frequently conducted. In most regions a system of quality control has been put in place to assess and monitor the activities in the field of drug addiction.

2.10.2 Recommendation 1: Risk reduction and public health policy

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 health care system legislation and planning, services, etc.. Local Health Authorities provide social and health care 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. [RT]

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)[348]. 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. [RT]

2.10.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation. [349] [RT]
In Italy, information[350] is disseminated nationwide through telephone help lines[351] and websites. Training for drug users[352,353], and a broad range of educational leaflets[354,355] are available in specific geographical regions. [NR 2004; NFP 2006]

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. [SQ 23]

With regard to the **reduction of drug-related deaths**, the dissemination of information materials, risk education/ response training for drug users, individual risk counselling and prison pre-release interventions are the predominant response strategies. Predominant settings for the *dissemination of information materials* are specialised drug treatment services, low threshold agencies, including needle and syringe exchange programmes and detoxification centres. Common settings include mass media/ internet, schools/ educational systems, nightlife or entertainment venues. Predominant settings for *risk education/ response training* are specialised drug treatment services, low threshold agencies, including needle and syringe programmes and through outreach workers, peers. Nightlife is a common setting for risk education/ response training. [SQ 29]

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[348] Legislation of reference: Presidential Decree n.309 of 9.Oct.1990; Ministerial Decree n.444 of 30 Nov.1990; Government-Region Agreement of 21 Jan.1999; Decree of the Council of Ministers of 29 Nov.2001 on the Essential Standards of Care (LEA).

[349] Ministerial Decree n. 444 of November 30, 1990 establishing the organisation, functions and staff characteristics of Drug Treatment Services.

[350] The materials are distributed through mass media and the internet and through low threshold facilities, in specialised agencies, in discotheques, in schools, and - to a lesser - extent in prisons and at rave parties, concerts and festivals. [NFP 2006]

[351] DROGATEL, operating since 1993.

[352] Many outreach services use Narcan (Naloxone) for treatment of overdose and inform people how to use it.

[353] Main tools used in educational interventions to protect against the risk of drug-related infectious diseases are street units or peer groups operating in at-risk contexts, low threshold facilities and specialised facilities. In addition, schools and discotheques represent another intervention context. The main activities include risk-protection educational efforts, syringe exchange programmes, distribution of informational materials on at-risk injection activities and on the risks of contracting drug-related infectious diseases, vaccination programmes (hepatitis B), and distribution of condoms.

[354] Many services provide leaflets or cards on how to respond to an overdose.

[355] Information materials (flyers, brochures, multimedia materials) created ad hoc to prevent emergencies and deaths from acute intoxication associated with substance use, contain information on: at-risk behaviours, mechanisms of overdose, methods to avoid it, medical and legal consequences of intervention and the correct use of naloxone.

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 exists, but was not based upon the Council Recommendation[356]. [RT]
In specific geographical regions, families and communities are directly involved in regional and local projects to prevent and reduce drug-related health risks[357]. In some regions, specific IEC for communities and families of drug users is available. [NFP 2006]

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, since it is not a task for the national government[358]. [RT]
In Italy, street-based outreach work and outreach work at dance parties/ raves and in clubs are available in specific geographical regions. [NR 2003/ 2004; NFP 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. [SQ 23]

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. [SQ 29]

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, since it is not a task for the national government[359]. [RT]
In Italy, peers and volunteers are included in outreach work and training for peers and volunteers is nationwide available. [NR 2004]

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, since it is not a task for the national government[360]. [RT]
In specific geographical regions, networking and collaboration between outreach work agencies exist, but only on an informal level. [NR 2004]

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 exists, but was not based upon the Council Recommendation[361]. [RT]
Methadone maintenance and methadone detoxification treatment, drug-free out-patient and drug-free inpatient treatment and rehabilitation programmes[362] are nationwide available. Treatment with buprenorphine and naltrexone and drop-in centres/ shelters are available in specific geographical

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[356] Presidential Decree n. 309/90, art. 1, comma 12 on the promotion of national awereness campaigns in this specific field; art. 106 Creation of info points in schools.
[357] See for instance projects described in the website www.dronet.org.
[358] Actions are carried out by the Regions.
[359] Actions are carried out by the Regions.
[360] Actions are carried out by the Regions.
[361] Ministerial Decree 444 & Government-Regions Agreement on the "Re-organisation of the healthcare system in the drug-addiction field" of January 21, 1999.
[362] Italy does not use the term rehabilitation. Re-integration is usually targeting education, vocational training and supported housing.

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). [NR 2003/ 2004; NFP 2006]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a predominant response strategy. [SQ 29]

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation[363]. [RT]
However, measures to prevent diversion of substitution substances are not available in Italy[364] [NR 2000/ 2003]

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, but was not based upon the Council Recommendation[365]. [RT]
Methadone maintenance treatment, methadone detoxification treatment and treatment with buprenorphine are nationwide available in prisons. Also testing, prevention, education, treatment and counselling of infectious diseases are provided nationwide. In prisons in specific geographical areas, naloxone is available on a 'take home' basis [NR 2003/ 2004; NFP 2006]

Prisons are a predominant implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]

Aiming at the **prevention and reduction of drug – related deaths**, prison pre-release interventions are a predominant response strategy. Prisons are an uncommon setting for disseminating information materials on prevention of acute drug-related deaths and for providing risk education/ response training for drug users. [SQ 29]

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[366]. [RT]
Testing/ screening for infectious diseases is nationwide available[367]. In specific geographical regions education, prevention, counselling and treatment are provided. [NR 2004; NFP 2006]

Predominant response strategies to **prevent infectious diseases** among drug users are: IEC in general, outreach health education approach, voluntary infectious diseases counselling and testing, and needle and syringe exchange programmes. Common strategies include IEC via counselling by drugs and health professionals, IEC via peer involvement/ peer approach, condom promotion among drug users, routine screening of high risk groups, hepatitis vaccination programme for drug users, and easy access programmes for drug users to treatment of infectious diseases[368]. [SQ 23;

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[363] The Presidential Decree n. 309/90 establishes very strict rules on the medical prescription of psychotropics, and especially of those used in substitution therapy. Law n. 12 of February 8, 2001 : "Rules facilitating the medical use of analgesic opioids in pain treatment".
[364] Diversion is a minor problem in Italy.
[365] The legislative decree n. 230/1999 has transferred to the Regions the responsibility for drug-addicts healthcare in custodial settings.
[366] Law no. 135 of 1990 on prevention of HIV infection. Anti-hepatitis B vaccination for new-borns has become compulsory in 1991; it is free for all individuals at risk.
[367] The main interventions aimed at the prevention of drug-related infectious diseases consist of outreach to make contact with drug users who are not in contact with a treatment service or who are engaged in high risk to infection behaviour, efforts to bring drug dependents into treatment and to retain them in treatment and the provision of information, sterile equipment and condoms to those who are not yet prepared to enter treatment or move away from drug injection.
[368] There are also other specific infectious disease response strategies: (1) a substantial number of public drug-addiction agencies in Italy have set up forms of assistance for organic pathologies (physical health problems) related to the use of illegal psychoactive substances. (2)Facilities of addiction departments frequently make agreements with emergency medicine departments in order to diagnose and treat these problems in a fast and

NFP 2006] Specialised drug treatment services and prisons are predominant implementation settings for infectious diseases, where low threshold counselling, and outreach work targeted at high risk group intervention are common settings [SQ 23].

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, since it is not a task for the national government[369]. [RT]
Needle and syringe exchange programmes are available nationwide. Drug paraphernalia such as sterile water, bleach and ascorbic acid, and the distribution of condoms are available in specific geographical regions. [NR 2004]

Needle and syringe exchange programmes are a predominant response strategy to **prevent infectious diseases** among drug users in Italy. [SQ 23] With regard to the **reduction of drug-related deaths** among drug users, low threshold agencies, including needle and syringe exchange programmes, are a predominant setting both for dissemination of information materials and for providing risk education/ response training for drug users. [SQ 29]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation[370]. [RT]
Training programmes for professionals of emergency services are not available. [NR 2003]
Ambulances routinely carry antagonists. The distribution or administration of naloxone is regulated. Naloxone is available on a take home basis. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation[371]. [RT]
No further information is available whether risk reduction is a part of an integrated health strategy for drug users, but prevention of social and health consequences is part of such a strategy. [NFP 2006]

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

This policy does not exist, since it is not a task for the national government[372]. [RT]
Training for outreach workers is nationwide available. Training for other professionals is not available. [NR 2003].

2.10.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. A Decree of the Council of Ministers of 29 Nov. 2001 reflects on the 'essential standards of care'. Evidence-based medicine is largely used in the Italian healthcare system. Staff is permanently trained according to new insights from evidence. [RT]

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appropriate way. (3) Health protective measures for pregnant female dependent drug users is handled according to protocols that are well defined in various addiction services. Furthermore, the municipal social services organise genuine social and psychological support and assistance with economic problems, as well as protection against violence and degradation of these pregnant women.

[369] These actions are carried out by the Regions.

[370] Actions are carried out by the Regions in the whole country. Local actions carried out over the last 5 - 6 years have reduced mortality caused by overdoses (1016 deaths in 2000 against 441 in 2004).

[371] Government-Regions Agreement of 21 Jan.1999 on the "Re-organisation of the healthcare system for drug-addicts", point 4.

[372] Government-Regions Agreement of January 21, 1999 on the "Re-organisation of the healthcare system for drug-addicts", point 2

One major research project is the VeDeTTE Study, co-ordinated by the University of Turin and the Lazio Region and work on rapidly identifying new drugs or new drug using practices co-ordinated by the National Health Institute. Publication of data from both studies is awaited. It is a longitudinal research following clients over time and has as its primary objective an evaluation of the effectiveness of methadone treatment. [NR 2003]

3.2 Supporting the inclusion of needs assessments at the initial stage of any programme

This policy does not exist, since it is not a task for National government. This is stipulated in the Government-Regions Agreement of 21 January 1999. [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy does exist, since it is not a task for the national government. Both the Government and Regions have funded research on the evaluation of actions undertaken in the field of drug-addiction (Government-Regions Agreement of 21 January 1999). [RT]

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. Both the Government and the Regions have financed experimental projects on the evaluation of the quality of services offered to drug-addicts.

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. The National Focal Point of Reitox network is included in the Monitoring Office of the National Department for Drugs Policy. The Government has funded a project for the implementation of EMCDDA standards on data collection ("SESIT" project) at a regional level. [RT]

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

Policy does not exist, since it is not a task for national government. This action is carried out by the Regions. [RT]

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. [NR 2004]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy does not exist, since it is not a task for national government. This action is carried out by the Regions. [RT]

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. [RT]

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 is not based upon the Council Recommendation. [RT]

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. [NR 2003]

Annex A2.11 State of play on harm reduction in Cyprus

2.11.1 Summary

Public health policy. Harm reduction is a public health objective in Cyprus, which was reflected in the National Action Plan on Drug Demand Reduction.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through a telephone help line. With regard to the prevention of infectious diseases among drug users, IEC in general is a predominant response strategy, while IEC via counselling and advice by drugs and health professionals, and IEC via peer involvement/ peer approach are common response strategies. There is no information whether communities and families of drug users are informed or involved in the prevention and reduction of health risks associated with drug dependence.

Outreach work. Street-based outreach work and outreach work at dance parties and in clubs do not exist and therefore, outreach work is neither a common response strategy nor a common implementation setting for measures to prevent infectious diseases among drug users. Peers and volunteers are not included in outreach work practice. Also, networking and cooperation between outreach work agencies do not exist.

(Medically assisted) treatment and specific interventions. In specific geographical areas, there are drug-free inpatient and drug-free outpatient treatment facilities, rehabilitation centres, and drop-in centres/ shelters (low threshold centres). Substitution treatment, drug consumption rooms and heroin prescription programmes do not exist in Cyprus. Measures to prevent diversion of prescribed drugs are not available.

Prison interventions. Counselling with regard to infectious diseases is available nationwide in prison. Other prison interventions are either not available or information is lacking.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Measures targeting infectious diseases do not exist in Cyprus. In specific geographical areas, distribution of condoms is available. Needle and syringe exchange programmes do not exist in Cyprus. There is no information about the availability of (other) drug paraphernalia.

Drug-related deaths. Training for professionals of emergency departments is not provided.

Training of staff and risk reduction as part of a complementary health strategy. In specific geographical areas, training is provided for prison staff and for professionals working in treatment facilities. There is no specific information available whether risk reduction is part of an integrated health strategy for drug users, although this policy exists.

Quality, monitoring and evaluation. In Cyprus, systems for quality control, monitoring and evaluation are scarce. Guidelines have been developed for drug treatment centres, though. Policy evaluation is a task for the Cyprus anti-drugs council.

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

This policy exists and was based upon the Council Recommendation. [RT]
However, networking and cooperation between outreach work agencies do not exist in Cyprus. [NFP 2006]

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 exists and was based upon the Council Recommendation[377]. [RT]
In specific geographical areas only, there are drug-free inpatient and drug-free outpatient treatment facilities[378], rehabilitation centres, and drop-in centres/ shelters (low threshold centres)[379]. Substitution treatment is not available in Cyprus. [NR 2004; NFP 2006]
Drug consumption rooms and heroin prescription programmes do not exist in Cyprus.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy does not exist. [NR 2004]

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[380]. [RT]
Counselling with regard to infectious diseases is available nationwide in prison. Other interventions are not available in prison or reliable information is lacking. [NR 2004; NFP 2006]

Prisons are an uncommon implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]

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 and was based upon the Council Recommendation[381]. [RT]
Measures targeting drug-related infectious diseases do not exist in Cyprus[382]. [NR 2004; SQ 23]

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[383]. [RT]
Nevertheless, in specific geographical areas distribution of condoms is available. Needle and syringe exchange programmes do not exist in Cyprus. There is no information about the availability of drug paraphernalia. [NR 2004; NFP 2006]

The possession of sterile needles is an offence in Cyprus, but no prescription is required to obtain or exchange needles and syringes. [ELDD]

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[377] Substitution treatment is not as yet provided.
[378] Available in 3 centres: Perseas, Prometheas, Toxotis.
[379] An initiative taken by the counselling centre 'Toxotis" which introduced a day centre "Stochos" with counselling and preventing harm reduction activities.
[380] Inadequate services, shortage of staff and resources.
[381] Policy partially being enforced.
[382] Drug-related infectious disease programmes are non-existent.
[383] Only with regard to condom distribution.

2.11.2 Recommendation 1: Risk reduction and public health policy

The main structure responsible for the implementation of the Council Recommendation (and Cypriote drug policy) is the Cyprus Anti-Drug Council. 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. [RT].

In 2005, an Action Plan on Drug Demand Reduction was set in motion, with the aim to implement the 2004 National Drug Strategy. The Action Plan calls for further assessment of the benefits and need for the implementation of harm reduction programmes in Cyprus (incl. methadone substitution, needle and syringe exchange, etc.) [NR 2005].

2.3.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists and was based upon the Council Recommendation[373]. [RT]
A telephone help line promoting risk reduction is nationwide available. In specific geographical areas only, information materials are available. Training for drug users and websites promoting risk reduction do not exist in Cyprus. [NR 2003/ 2004; NFP 2006]

To **prevent infectious diseases** among drug users, providing information, education and communication (IEC) in general and voluntary testing and counselling are predominant response strategies, whereas IEC via counselling and advice by drugs and health professionals, and IEC via peer involvement/ peer approach are common response strategies. Safer injecting training is not available in Cyprus. [SQ 23]

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 exists and was based upon the Council Recommendation.[374] [RT]
No further information is available. [NR 2004; NFP 2006]

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 and was based upon the Council Recommendation[375]. [RT]
In Cyprus, street-based outreach work and outreach work at dance parties, raves and in clubs[376] do not exist. [NR 2004; NFP 2006]

Outreach work is neither a common response strategy nor a common implementation setting for measures to **prevent infectious diseases** among drug users. [SQ 23]

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 exists and was based upon the Council Recommendation. [RT]
Peers and volunteers are not included in outreach work practice and they are also not trained to do so. [NFP 2006]

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[373] Specific action is carried out in a sporadic and non- structured fashion.
[374] There is lack of expertise and necessary mechanisms.
[375] There is lack of expertise and infrastructure for data collection.
[376] It was seldom available in 2003 and 2004, but is not available anymore.

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists and was based upon the Council Recommendation[384]. [RT]
However, trainings for professionals of emergency departments are not provided. [NR 2004]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation. [RT]
No further information is available.

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

This policy is not a priority for the national government. [RT]
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. [NR 2004; NFP 2006]

2.11.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists and was based upon the Council Recommendation. [RT]
Decision-making processes will be based on scientific evidence, as well as on the demonstrated effectiveness of the programmes and actions derived from the experiences of other countries. [NR 2004]

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. [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy exists and was based upon the Council Recommendation. [RT] However, appropriate mechanisms still need to be put in place.

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. [NR 2004]

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 and was based upon the Council Recommendation. EDDRA is extensively used through the Cypriot national Focal Point. [RT]

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. [NR 2004]

[384] Action is in the process.

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

This policy exists and was based upon the Council Recommendation. [RT]

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

This policy exists and was based upon the Council Recommendation. 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. [RT]

The main objectives of the Cyprus Anti-Drugs Council are to record, evaluate, approve, coordinate and reinforce all programmes, actions and activities against drugs by both governmental services and NGO's. [NR 2004]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists and was based upon the Council Recommendation. The National Focal Point is responsible for its implementation. [RT]

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. [RT]

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. Implementation is coordinated by the National Focal Point. [RT]

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. [NR 2004]

Annex A2.12 State of play on harm reduction in Latvia

2.12.1 Summary

Public health policy. Harm reduction is part of public health in Latvia since 2001, when it was adopted in the Public Health Strategy.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines, websites and educational leaflets. In specific geographical areas, special support groups for families of drug users are available.

Outreach work. Street-based outreach work is available in specific geographical areas only. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. In specific geographical areas, training for peers and volunteers is provided. [NFP 2006]. Networking and cooperation between outreach work agencies exist in specific geographical areas.

(Medically assisted) treatment and specific interventions. Drug-free outpatient and drug-free inpatient treatment and treatment with Naltrexone are available nationwide. Methadone maintenance and detoxification programmes, treatment with buprenorphine and rehabilitation centres are available in specific geographical areas only. Drug consumption rooms and heroin prescription programmes do not exist in Latvia. Opioid substitution treatment is a predominant response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. The distribution of condoms is available in prisons in specific geographical areas only. Other harm reduction interventions do not exist in Latvian prisons.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Education and treatment of infectious diseases are available nationwide. To prevent infectious diseases among drug users, the predominant response strategies are IEC in general and needle and syringe exchange. Needle and syringe exchange and the provision of drug paraphernalia are limited to specific geographical areas.

Drug-related deaths. In specific geographical areas, professionals of emergency departments are trained, e.g. to deal with overdoses. The distribution, possession or administration of naloxone is regulated. Naloxone is available on a 'take home' basis.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals in substitution programmes. Risk reduction is not part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. Latvia does not have many quality assurance or evaluation mechanisms in drug demand reduction in general and in harm reduction in particular. Evaluation of the National Drug Control and Drug Abuse Prevention Strategy foresees evaluation of drug policy as a key activity.

2.12.2 Recommendation 1: Risk reduction and public health policy

The Ministry of Health[385] is responsible for the implementation of the Council Recommendation in Latvia. Harm reduction is a public health objective in Latvia, but it was not based on the Council Recommendation. [RT]

The main recommendations reflected in the Council Recommendation were already designated in the Public Health Strategy 2001 and in the Action Programme of the implementation of Public Health Strategy for 2004-2010[386]. Twelve Ministries and 60 institutions are involved in the implementation of the Public Health Strategy. The responsible institution is Ministry of Health. In the process of implementation of the Public Health Strategy directives of European Union have been taken into account and it is linked on WHO European Region Strategy "Health for All in the 21st Century". A Programme on Drug Control and Drug Addiction Restriction 2005-2008 was adopted in August 2005. [RT]

2.12.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation[387]. [RT]
In Latvia, telephone help lines, websites[388] and a broad range of educational leaflets promoting risk reduction among drug users are available nationwide. [NR 2003/ 2004]

To **prevent infectious diseases** among drug users, providing information, education and communication in general (IEC) is a predominant response strategy, whereas IEC via counselling and advice by drugs and health professionals, and via peer involvement/ peer approach is a common response strategy. Safer injecting training is not provided to drug users. [SQ 23]

With regard to the **reduction of drug-related deaths**, individual risk counselling is the common response strategy. [SQ 29]

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 exists, but was not based upon the Council Recommendation[389]. [RT]
In specific geographical areas families of drug users are involved in harm reduction. [NFP 2006]

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 is not based upon the Council Recommendation. [RT]
In Latvia, street-based outreach work is available in specific geographical areas only. Outreach work at dance parties, raves and in clubs is not available.[390] [NR 2003; NFP 2006]

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

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[385] State Agency for Addiction.
[386] Cabinet Order N150 of 9 March 2004.
[387] Cabinet Order N 733, adopted November 27, 2003 "Program of Restriction of Prevalence of HIV and AIDS 2003 - 2007". Main objective is to increase the number of new registered cases of HIV, reduce the prevalence of HIV in Latvia, and its influence on persons and society in general.
[388] Email service and www.narcomania.lv
[389] Programme of Restriction of Prevalence of HIV and AIDS for years 2003 - 2007 includes a range of obtainable goals where serious attention is paid to drug addiction prevention in different groups and settings.
[390] Riga Addiction Prevention Centre is organizing spot- checks at dance parties and in clubs, in order to find out whether the attendance is using drugs. Riga Addiction Prevention Centre staff is specially trained for these spot-checks.

interventions are a common implementation setting for infectious diseases prevention measures targeting drug users. [SQ 23]

Outreach work is not in use as a setting or a response strategy aiming at the **reduction of drug-related deaths** in Latvia. [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]
In specific geographical areas only, training for peers and volunteers is provided. [NFP 2006].

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

This policy is pending for approval. [RT]
Currently, networking and cooperation between outreach work agencies exist in specific geographical areas only. [NR 2003]

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 exists, but was not based upon the Council Recommendation. [RT]
Drug-free outpatient and drug-free inpatient treatment are available nationwide and so is treatment with naltrexone[391]. Methadone maintenance and methadone detoxification programmes[392], treatment with buprenorphine[393] 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 [NR 2003/ 2004; NFP 2006]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a predominant response strategy. [SQ 29].

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide [394]. [NR 2003]

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, but implementation is pending for approval. [RT]
However, the distribution of condoms is available in prisons in specific geographical areas only. Other harm reduction interventions do not exist in Latvian prisons. [NR 2003/ 2004; NFP 2006]

Measures that aim at the **prevention of infectious diseases and/ or reduction of drug – related deaths** do not exist in Latvian prisons. [SQ 29]

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

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[391] Treatment with naltrexone is available nationwide. It is a prescription medicament.
[392] Available only at the Narcology Centre in Riga.
[393] Treatment with Subutex ® (buprenorphine) is available only in specific geographical areas under very strict regulations.
[394] E.g. registration, urine checks.

Vaccination against hepatitis B is provided for all newborn children. [RT]
Education and treatment of infectious diseases[395] are available nationwide [NR 2004, NFP 2006]. Testing/ screening and counselling with regard to infectious diseases are available to drug users in Latvia in specific geographical areas only[396]. [NR 2003/ 2004]

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 counselling (non treatment) services. A common implementation setting for infectious diseases prevention measures among drug users are outreach work and targeted high risk group interventions. [SQ 23]

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

This policy exists, but was not based upon the Council Recommendation[397]. [RT]
Needle and syringe exchange programmes and the provision of drug paraphernalia are limited to specific geographical areas. [NR 2003/ 2004] Needle and syringe exchange programmes are a predominant response strategy to **prevent infectious diseases** among drug users in Latvia. [SQ 23] Low threshold agencies, including needle and syringe exchange programmes, are a common setting to provide information materials on the **reduction of drug-related deaths** and a predominant setting for delivering risk education/ response training. [SQ 29]

Latvia counts in total 22 non-pharmacy based needle and syringe exchange outlets. Needle and syringe exchange takes place through fixed sites, vans/ buses, and through outreach workers/ peers, but not via pharmacies or vending machines, nor in prisons. [ST 10]

There are no legal restrictions to the possession of sterile needles in Latvia. Prescription is not required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation. [RT]
In specific geographical areas only, professionals of emergency departments are trained[398]. [NFP 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 training. [SQ 29]

Latvian ambulances routinely carry antagonists. [SQ29] The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is available[399]. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy is pending for approval. [RT]
Risk reduction is not a part of an integrated health strategy for drug users. [NFP 2006]

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

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[395] Treatment of infectious diseases is available for the general public. There is no special treatment of infectious diseases available only for drug users.
[396] Available in ten HIV prevention units. There is a clear need to open counselling/testing sites in the biggest towns.
[397] Condoms are distributed and syringes exchanged through needle and syringe exchange outlets. There are 11 outlets in Latvia at the moment. Their work is supervised by the Ministry of Health but the action is provided by staff of the AIDS Prevention Centre. Distribution also takes place on streets.
[398] Highly- skilled professionals working in emergency units are trained for different situations.
[399] Theoretically it is possible if a general practitioner prescribes this substance.

This policy is pending for approval. [RT]
Training is offered nationwide to professionals in substitution programmes. Training for professionals in needle and syringe exchange programmes and in low threshold agencies and for outreach workers is available in specific geographical areas[400]. Training programmes for prison staff and for professionals in treatment facilities do not exist. [NR 2003; NFP 2006]

2.12.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy does not exist. There are not enough scientific studies that have data in some specific fields. [RT]

3.2 Supporting the inclusion of needs assessments at the initial stage of any programme

This policy does not exist. [RT]

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. [RT]

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, but is pending for approval. [RT]

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 is pending for approval. Since 1996 The State Addiction Agency is a Reitox National Focal Point in Latvia and the collection of information accordingly to EMCDDA requirements is included in the State program on Drug Control and Drug Addiction Restriction 2005-2008 (Strategy and Action Plan on Drugs 2005-2008). [RT]

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

This policy does not exist. There are evaluation results in some fields. [RT]

The draft Drug Control and Drug Abuse Prevention Programme foresees the evaluation of drug policy as one of the key tasks of the Drug Control and Drug Abuse Prevention Co-ordination Commission. According the proposal of the draft Drug Programme the Reitox Latvian Focal point should be responsible for preparing tools for policy assessment and evaluation.

In 2004-2005 Latvia implemented the project 'Evaluation of Drug Demand and Supply Reduction Activities' within the Transitional Facility programme. The aim of the project was to develop evaluation systems for treatment and prevention and supply reduction activities. [NR 2003]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy does not exist, but is pending for approval.

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. [RT]

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[400] Provided by staff of the AIDS Prevention Centre.

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. [RT] Latvia participated in the ESPAD Survey 2003. [NR 2004]

2.12.5 Information from third data sources

Issues raised by Dia+logs

Information, education and communication (IEC). IEC is inadequate in coverage and accessibility. as the few services providing IEC lack funding.

Outreach work. Outreach work is efficiently implemented and has adequate coverage and accessibility.

(Medically assisted) treatment and specific interventions. Medically assisted treatment for opiate users is inadequate in coverage, but adequate in accessibility. Medically assisted treatment for ATS users is inadequate in coverage, but accessibility of the few places where it is implemented is considered adequate. There is no information available about medically assisted treatment for ATS or cocaine users. Neither ATS nor cocaine prescription programmes are available in Latvia. Specific harm reduction interventions for cocaine or ATS users are not available. There are no drug consumption rooms in the country and an inadequate coverage and accessibility of needle and syringe exchange programmes as not all cities provide the service. Coverage and accessibility of drug paraphernalia distribution is adequate.
Low threshold agencies are inadequate in coverage and accessibility. Existing facilities struggle with lack of funding.

Prison interventions. IEC in prison is adequate in coverage, but difficult to access due to attitudinal barriers put on by prison administration. Outreach work does not exist in prison in Latvia.
No medically assisted treatments for ATS users or specific harm reduction interventions for ATS and cocaine users are available in prison. No information could be provided on the quantity and quality of medically assisted treatment for cocaine users. There are no needle and syringe exchange programmes in Latvian prisons and drug paraphernalia are not available either. Measures implemented to prevent infectious diseases are inadequate because information is not thorough enough. Hepatitis B vaccination programmes targeted at drug users are not available in Latvian prisons.
Measures to involve families and friends of drug users in harm reduction interventions are not available in prison.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Measures to prevent infectious diseases are inadequate in coverage and accessibility. Budgets of institutions providing these services are small. Hepatitis B vaccination programmes targeting drug users in particular, do not exist. Tuberculosis vaccination programmes for drug users are adequate in coverage and accessibility.
Measures to involve families and friends of drug users in harm reduction interventions are inadequate in coverage and accessibility.

Annex A2.13 State of play on harm reduction in Lithuania

2.13.1 Summary

Public health policy. Harm reduction is part of the Public Health policy in Lithuania and this was partly due to the Council Recommendation. Harm reduction was adopted as an aim in the National Plan on Drug Control and Prevention 2004-2008.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines, websites and educational materials. For the reduction of drug-related deaths, the dissemination of information materials is the predominant response strategy. In specific geographical areas communities and families of drug users are informed and involved in the prevention and reduction of health risks associated with drug dependence.

Outreach work. Street-based outreach work and outreach work at dance parties, raves and clubs is available in specific geographical areas. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials. Peers and volunteers are included in outreach work practice in specific geographical areas. Networking and cooperation between outreach work agencies exist in specific geographical areas.

(Medically assisted) treatment and specific interventions. In specific geographical areas, methadone maintenance, methadone detoxification, treatment with buprenorphine and naltrexone are available. Drug-free inpatient and drug-free outpatient treatment facilities, rehabilitation centres and drop-in centres/ shelters are also available in specific geographical areas only. Drug consumption rooms and heroin prescription programmes do not exist in Lithuania. Opioid substitution treatment is a predominant response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Harm reduction measures are not available in prison. Only bleach is available in specific geographical areas.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). 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, needle and syringe exchange, and routine screening of high risk groups. Needle and syringe exchange, drug paraphernalia and the distribution of condoms are available in specific geographical areas.

Drug-related deaths. The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training for professionals in treatment facilities, needle and syringe exchange programmes and prison staff is available nationwide. Integration between health and social care takes place in Lithuania.

Quality, monitoring and evaluation.
The assessment of quality, monitoring and evaluation is not common in Latvia. A needle exchange programme evaluation has been conducted, but other activities are not reported.

2.13.2 Recommendation 1: Risk reduction and public health policy

The implementation of the Council Recommendation in Lithuania is the responsibility of the Ministry of health. Harm reduction is a policy objective in Lithuanian Public Health. Harm reduction policy was (partly) based upon the Council Recommendation. [RT]

The general aims for harm reduction were adopted in the National Plan on Drug Control and Prevention 2004-2008, which was adopted in 2004. [SQ29]

2.12.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists and was based upon the Council Recommendation. [RT]
In Lithuania, a broad range of educational materials on risk reduction is available nationwide and so are telephone help lines[401] and websites promoting risk reduction. [NR 2003; NFP 2006]

Information, education and communication (IEC) via counselling by drugs and health professionals, and IEC via peer involvement/ peer approach are predominant response strategies[402] to **prevent infectious diseases** among drug users, whereas IEC in general is a common response strategy. [SQ 23]

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. [SQ 29]

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 exists and was based upon the Council Recommendation. [RT]
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. [NFP 2006]

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 and is based upon the Council Recommendation. [RT]
In Lithuania, street-based outreach work and outreach work at dance parties, raves and clubs is available, but in specific geographical areas only. [NR 2003/ 2004; NFP 2006]

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. [SQ 23]

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.** [SQ 29]

[401] There are national help lines for youth, psychological help etc. Specifically for risk reduction line is HIV/ AIDS line, but this line is not targeted specifically at drug users, but at youth, risk groups etc.
[402] Substitution treatment is also a predominant response strategy.

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

The implementation of this policy is pending for approval. [RT]
Currently, in specific geographical areas only, training for peers and volunteers is organised [NFP 2006]. Peers and volunteers are included in outreach work practice, in specific geographical areas only. [NFP 2006]

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

The implementation of this policy is pending for approval. [RT]
However, networking and cooperation between outreach work agencies already exist in specific geographical areas in Lithuania. [NFP 2006]

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 exists, but was not based upon the Council Recommendation. [RT]
In specific geographical areas only, methadone maintenance, methadone detoxification, treatment with buprenorphine and naltrexone[403] are available. Substitution treatment is supported by psychosocial care, upon request by the client. Drug-free inpatient and drug-free outpatient treatment facilities, rehabilitation centres and drop-in centres/ shelters are also available in specific geographical areas only. [NR 2003/ 2004; NFP 2006]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is the predominant response strategy in Lithuania. [SQ 29] Drug consumption rooms and heroin prescription programmes do not exist in Lithuania.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide. [NR 2004; NFP 2006]

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 policy is pending for approval. [RT]
Harm reduction measures are not implemented in Lithuanian prisons. [NR 2003] Prisons are a predominant implementation setting for **infectious disease prevention** measures targeted at drug users. Bleach is available in specific geographical areas only. [SQ 23]

Measures targeting at the **reduction of drug – related deaths** are uncommon or non existent in Lithuanian prisons. [SQ29]

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[404]. [RT]

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[403] Both buprenorphine and naltrexone are available; however, the costs are covered by insurance in specific geographical areas only.
[404] For injecting drug users, hepatitis B vaccination is not financed by the National budget. The National Budget does fund hepatitis B vaccination for all newborns (since 1998) and 12 years' old children (since 2002). The Centres for Addictive Disorders, the Lithuanian AIDS centre and Social workers provide prophylactic measures and screening against HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases among injection drug users.

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, condom promotion among drug users.

Predominant implementation settings for infectious diseases prevention measures targeting drug users include low threshold agencies, prisons, and mass media. [SQ 23]

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

This policy exists[405]. [RT]
In specific geographical areas, needle and syringe exchange programmes, drug paraphernalia and the distribution of condoms are available. [NR 2003, 2004]

Needle and syringe exchange programmes are a predominant response strategy to **prevent infectious diseases** among drug users in Lithuania. [SQ 23] Low threshold agencies, including needle and syringe exchange programmes are also a predominant setting for providing information materials on the **reduction of drug-related deaths** among drug users. [SQ 29]

Lithuania counts in total seven non-pharmacy based needle and syringe exchange programmes, no pharmacy-based needle and syringe exchange programmes and no vending machines. Needle and syringe exchange takes also place through fixed sites, through vans/ buses, and through outreach workers/ peers, but is not available in prisons. [ST 10; NFP 2006]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists and was based upon the Council Recommendation[406]. [RT]
Emergency departments are a setting which is not used for dissemination of information materials that aim at the reduction of drug-related deaths or for risk education/ response trainings. [SQ29]. Lithuanian ambulances do not routinely carry antagonists. The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is not available in Lithuania. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists and was based upon the Council Recommendation. [RT]
Integration between health and social care takes place in Lithuania[407]. [NFP 2006]

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

This policy exists and was based upon the Council Recommendation[408]. [RT]
Training for professionals in treatment facilities, needle and syringe exchange programmes and prison staff is available nationwide[409]. Training for outreach workers exists in specific geographical areas. Training programmes for GP's and prescribing physicians in methadone treatment also exist[410]. [NR 2003/ 2004; NFP 2006]

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[405] Distribution of condoms was available in Vilnius and Klaipeda in 2004. Needle and syringe exchange programmes are implemented in 7 cities: Alytus, Druskininkai, Klaipeda, Mazeikiai, Vilnius, Birzai and Siauliai. These programmes are funded from the municipal budget.
[406] In case of an overdose, a drug user can go to the standard emergency services or hospital, or call emergency number where he gets appropriate medical support.
[407] E.g., specifications exist to refer patients leaving drug treatment centres to social care institutions and to rehabilitation centres.
[408] Government institutions support and provide specialized trainings for professionals working in prevention and reduction of health-related risks associated with drug dependence field. Academies run special topics on drug prevention and early intervention, on health-related risks associated with drug dependence, social work in drug field and etc. for public health, psychology, psychiatry and social course students.
[409] In 2006 training programmes for service providers are planned.
[410] According to the executive legal acts, only physicians who took this course are allowed to provide substitution treatment with methadone.

2.13.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy does not exist, but is pending for approval. [RT]

One example of evaluation of the effectiveness of an intervention is the Blue Bus needle exchange project, which is being assessed in monthly reports and by observing changes in the number of new contacts, consultations, and distributed syringes and needles, as well as by performing client surveys. The data of the programme indicate that the programme corresponds to the needs of this marginalised group. [NR 2003]

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. [RT]

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. [RT]

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, but is pending for approval. [RT]

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

This policy exists and was based upon the Council Recommendation. [RT]

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

This policy does not exist, but is pending for approval. [RT]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy does not exist, but is pending for approval. [RT]

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, but is pending for approval. [RT].

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 is pending for approval. Information about best practice examples of prevention and harm reduction programmes and projects implementation in Lithuania will be available in EDDRA Internet database, accessible for everyone. [RT]

A Phare Twinning project was run in 2002 and 2003 with the theme "Strengthening Illicit Drug Demands and Supply Reduction Capabilities" . It had the objective to further align the Lithuanian drug supply reduction and drug demand reduction system with the EU Acquis concerning the fight against drugs. [NR 2003]

Annex A2.14 State of play on harm reduction in Luxembourg

2.14.1 Summary

Public health policy. Harm reduction is part of public health policy in Luxembourg for some time already, but the Council Recommendation was of instrumental value in that regard.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through a telephone help line. For the reduction of drug-related deaths, the dissemination of information materials and individual risk counselling are predominant response strategies. Communities and families of drug users are involved in the prevention and reduction of health risks associated with drug dependence in two main cities.

Outreach work. Street-based outreach work is nationwide available. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials, as well as for the deliverance of risk education/ response training. Peers and volunteers are included in outreach work practice in Luxembourg City. As only one agency in Luxembourg provides outreach work, networking and cooperation between outreach work agencies is not an issue.

(Medically assisted) treatment and specific interventions. Methadone maintenance and methadone detoxification programmes, drug-free out-patient treatment and treatment with buprenorphine are nationwide available. Drug-free inpatient treatment, rehabilitation centres and drop-in centres/ shelters are available in specific geographical areas. Luxembourg has a drug consumption room and a heroin prescription programme is foreseen. Opioid substitution treatment is a predominant response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Testing, prevention, education, counselling and treatment of infectious diseases are available nationwide in prisons. Methadone maintenance and detoxification treatment, treatment with buprenorphine, drug paraphernalia, condoms, syringes and counselling are also provided nationwide.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening, education, counselling, and treatment for infectious diseases are available nationwide as well as vaccination programmes for hepatitis B and tuberculosis targeting drug users. To prevent infectious diseases among drug users, the predominant response strategies are IEC in general, IEC via counselling and advice by drugs and health professionals, voluntary infectious diseases counselling and testing, condom promotion among drug users, hepatitis vaccination programme for drug users, needle and syringe exchange, routine screening of high risk groups and easy access' programmes for drug users to treatment of infectious diseases. Needle and syringe exchange and condoms are available nationwide; drug paraphernalia in specific geographical regions.

Drug-related deaths. Professionals of emergency departments are trained nationwide, e.g. to deal with overdoses. The distribution or administration of naloxone is regulated. Naloxone is nationwide available on a 'take home' basis.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals in outreach work, in needle exchange programmes, in substitution treatment, in treatment facilities, in low threshold programmes and in prison settings. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. Regarding scientific information on drug addiction (for policymakers), Luxembourg runs a database in which interventions are also registered (RELIS). Several studies into needs assessment, effectiveness of interventions and policy evaluations have been conducted. Luxembourg is also collaborating actively in bi- and multilateral networks.

2.14.2 Recommendation 1: Risk reduction and public health policy

In Luxembourg, the department that is responsible for the implementation of the Council Recommendation is the Ministry of Health[411].

A harm reduction policy exists in Luxembourg and was (partly) based upon the Council Recommendation. In 1999 the government entrusted the Ministry of Health with the overall coordination of drug-related demand reduction actions. The national drug coordinator was mandated to elaborate the national strategy and action plan on drugs and drug addiction (2000-2004) in regard to priorities set by the governmental declaration of 1999 and in close collaboration with field actors. To elaborate the successive action plan (2005-2009), national priorities as also the European Action Plan on Drugs (2000-2004/ 2005-2008) and the Council Recommendation of 18th June 2003 were taken into account. The action plan (2005-2009) is based upon two pillars, demand and supply reduction as well as upon 4 transversal axes: coordination mechanisms, risk reduction, ***harm*** and nuisance reduction, research and information and international relations. [RT] [SQ29]

2.14.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation. [412] [RT]
In Luxembourg, information is disseminated through a national telephone help line. Educational leaflets[413] are available in specific geographical regions. [NR 2004; NFP 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 a common response strategy. [SQ 23]

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. [SQ 29]

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 exists, but was not based upon the Council Recommendation[414]. [RT]
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. [NFP 2006]

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[411] Directorate of Health – Drug Coordination Unit.
[412] Policy was implemented before the adoption of the Council Recommendation. Additional information: since the implementation of the first drug action plan (2000-2004), risk reduction constitutes a major governmental priority. The new national drug strategy (2005-2009) considers risk reduction, damage and nuisance reduction as a specific transversal domain of supply and demand reduction.
[413] Flyers exist on synthetic drugs; documentation kit on overdose prevention.
[414] Universal and community based prevention are main priorities of risk reduction strategy of the Ministry of Health since it was entrusted with the overall drug-related demand and risk reduction actions in 1999.

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[415]. [RT]
In Luxembourg, street-based outreach work is nationwide available. Outreach work at dance parties and raves is sporadically provided in specific geographical regions. There is no legal framework for pill testing to date. [NR 2003/ 2004; NFP 2006]

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. [SQ 23]

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. [SQ 29]

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 exists, but was not based upon the Council Recommendation[416]. [RT]
In Luxembourg City, peers and volunteers are included in outreach work. [NFP 2006]

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[417]. [RT]
Networking and cooperation between agencies involved in outreach work does not exist, since only one agency provides outreach work given the geographical dimensions of Luxembourg. [NFP 2006]

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 exists, but was not based upon the Council Recommendation[418]. [RT]
Methadone maintenance and methadone detoxification programmes, drug-free outpatient treatment and treatment with buprenorphine are nationwide available[419]. 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) Drug free inpatient treatment, rehabilitation centres and drop-in centres/ shelters are available in specific geographical areas. [NR 2003/ 2004; NFP 2006]

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. [SQ 29]

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[415] Needs in the domain of outreach work were assessed in 1999 in order to set up the drug action plan (2000-2004). New low threshold facilities were created and existing ones extended. Contacting a hard to reach population of drug users remains a political priority.
[416] This policy objective has been implemented in the national policy as a reaction to the increased number of overdose deaths registered in 1994.
[417] Cooperation, networking and the creation of working groups are a common culture of agencies involved in outreach work since 1999.
[418] The national methadone substitution programme was set up in 1989 jointly by the Ministry of Health and a specialised NGO in response to the increasing number of long-term opiate drug addicts. The national drug action plan foresees the creation of further treatment and rehabilitation offers.
[419] Morphine in salt form is included in the list of legal substitution substances. Diacetylmorphine is included in the national list of legal prescription drugs. It can however only be prescribed in a highly regulated programme supervised by the Ministry of Health (by law).

Luxembourg has a drug consumption room[420] and a heroin prescription programme is foreseen by the national drugs action plan.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but is not based upon the Council Recommendation[421]. [RT]
Measures to prevent diversion of prescribed drugs are nationwide available[422]. [NR 2004]

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 policy is pending for approval. [RT]
However, testing, prevention, education, counselling[423] and treatment of infectious diseases are available nationwide in prisons. Methadone maintenance treatment, methadone detoxification treatment, treatment with buprenorphine[424], drug paraphernalia, condoms and counselling are also provided nationwide in prisons[425]. Since the end of 2005, an officially recognised syringes' distribution programme exists nationwide in prisons. [NR 2003/ 2004; NFP 2006]

Prisons are a predominant implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]

Aiming at the **prevention and reduction of drug – related deaths**, prison pre-release interventions are a common response strategy. Prisons are a common setting for disseminating information materials on prevention of acute drug-related deaths and for providing risk education/ response training for drug users. [SQ 29]

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 and was based upon the Council Recommendation[426]. [RT]
Nationwide, testing/ screening for infectious diseases, education[427], counselling and treatment of infectious diseases are available, as well as vaccination programmes for hepatitis B and tuberculosis targeting drug users [428].
[NR 2004; NFP 2006]

Predominant response strategies to **prevent infectious diseases** among drug users are: IEC in general, IEC via counselling by drugs and health professionals, voluntary infectious diseases counselling and testing, condom promotion among drug users, hepatitis vaccination programme for drug users, needle and syringe exchange programmes, routine screening of high risk groups and

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[420] The drug consumption room has been integrated in an existing structures which currently provides day and night services and the first national drug consumption facility. The new integrated structure is called TOX-IN.
[421] The grand-ducal decree on substitution treatment of January 30, 2002 established the legal framework for drug substitution treatment at national level and foresees control measure to reduce diversion of substitution substances (e.g. centralised register).
[422] Currently there exists a national mandatory notification system for substitution treatments for prescribing authorities. This system will evolve into a national substitution register following the still awaited approval from the National Commission on Data Protection.
[423] Specialised NGOs provide counselling in prison on a routine basis.
[424] Buprenorphine is included in the national list of drugs which may be prescribed in the framework of substitution treatment.
[425] Information and counselling by specialised interviewers.
[426] Screening of infectious diseases among IDUs is proposed by NGO's and prison centres but is not mandatory. Vaccination against hepatitis A and B is free. Prophylactic measures are offered by specialised NGO's at national level. The results of the national action-research are due for 2006.
[427] Education is provided by all specialised drug agencies and also in the framework of the above mentioned action-research project on HIV and hepatitis among PDUs.
[428] An action-research programme started in 2005 by the National Focal Point providing on-site testing (hepatitis a, b, c, HIV) and vaccination (hepatitis a and b) for infectious diseases at all specialised national NGOs.

easy access' programmes for drug users to treatment of infectious diseases. Common strategies include outreach health education approach and safer injecting training.
Predominant implementation settings for infectious diseases prevention measures are specialised drug treatment services, low threshold counselling, and prisons. Outreach work and targeted high risk group interventions, primary care/ GP's and mass media are common settings for this. [SQ 23]

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

This policy exists, but was not based upon the Council Recommendation[429]. [RT]
Needle and syringe exchange programmes[430] and condoms are available nationwide. Drug paraphernalia are available in specific geographical regions. [NR 2004] Needle and syringe exchange programmes are a predominant response strategy to **prevent infectious diseases** among drug users in Luxembourg. [SQ 23]

With regard to the **reduction of drug-related deaths** among drug users, low threshold agencies, including needle and syringe exchange programmes, are a predominant setting both for dissemination of information materials and for providing risk education/ response training for drug users. [SQ 29]
Luxembourg has ten non-pharmacy based NSPs and five vending machines. Types of NSPs available include fixed sites, prison-based programmes and vending machines. There are no NSPs through vans/ buses, and no pharmacy-based[431] NSPs. [NSP1-2; NFP 2006]

The grand-ducal decree of 23 December 2003 regulates the distribution and the exchange of syringes[432]. The police does not confiscate, if syringes do not show traces of illicit substances. No prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists and was based upon the Council Recommendation. [RT]
Training programmes for professionals of emergency services are available nationwide[433]. [NFP2006]. Ambulances routinely carry antagonists. The distribution or administration of naloxone is regulated. Naloxone is available on a 'take home' basis nationwide. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation. [RT]
Risk reduction is nationwide part of an integrated health strategy for drug users. [NFP 2006]

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

This policy exists, but it is not a priority for the national government. [RT]
Training for professionals working in needle exchange programmes, in substitution treatment, in treatment facilities, in low threshold programmes and in prison settings is available nationwide. [NR 2002/ 2004; NFP 2006]

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[429] Distribution of injecting paraphernalia and condoms are assured by low-treshold services at national level. The creation of new treatment offers e.g.consumption rooms, constituting a priority of the drug action plan, will help to enlarge the existing risk reduction measures.
[430] Recently, the opening hours of NSP points improved. The TOX-In structure has joined the national NSP in 2005.
[431] But syringes may be purchases without prescription in all pharmacies.
[432] The decree specifies that the exchange of a sterile syringe to a drug addict can be executed either by a pharmacist, a general practitioner of the substitution programme or designated members of specialised drug agencies. The decree also includes the legalisation of syringe distribution by means of distribution machines.
[433] But mainly provided by foreign training agencies.

2.14.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. Since 1994, the Luxembourg National Focal Point (NFP) of the EMCDDA has created the Luxembourg Information Network on Drugs and drug Addictions (RELIS). RELIS provides scientific data and facilitates political decision processes in the framework of drug action plans and strategies. [RT]

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.

Clear definition of expected outputs, time-limited project funding rather than permanent service funding, scientific evaluation of defined objective and project execution frameworks and the promotion of continuous training are some of the major elements defining the current approach towards a more effective national demand reduction strategy. [NR 2004]

Regarding research, worth mentioning are the first comprehensive evaluation report on the national substitution programme (2003) and the recent study on direct economic expenditures in the field of drug policies and interventions (2002). [NR 2003]

The first scientific evaluation of the methadone programme was conducted in 1995. In 1998, new evaluation software was developed in collaboration with the NFP, which, in the medium term, aims at the integration of substituted patients' data directly in the RELIS database. In 2000 and 2001 a second and third evaluation by an external expert took place on basis of data provided by the evaluation software mentioned earlier. [NR 2002]

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. The implementation of the first Drug Action Plan (2000-2004) required overall analyses of the drug situation at national level. The actions retained in the action plans have all been analysed in terms of needs assessment and in terms of priorities. [RT]

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. After eight months of functioning, there have been no major problems in terms of public nuisance. On the contrary, the night shelter contributed to reduce rough sleeping in streets, squatting and late night disturbances caused by PDUs. The success of the project is believed to be primarily due to the following factors:
a consensual need analysis involving both service demanders and service providers [NR 2004]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy exists, but was not based upon the Council Recommendation. Since 1998, specialised NGO's 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. [RT].

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, which future development has been promoted by the national drugs action plan, the implementation of a computer based evaluation procedure by the national substitution programme and prevention interventions in schools by CePT. [NR 2004]

Although the harm reduction interventions adapt to current professional practices by means of international exchanges and internal quality control measures, there is an obvious lack of external evaluation procedures. [NR 2003]

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. RELIS network aims to implement evaluation quality criteria relating to the recommendations of the EMCDDA.

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. 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. [RT]

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. The National Addiction Prevention Centre in collaboration with the unit of preventive and social medicine of the Directorate assures the development of drug prevention policies. [RT]

The Drug Action Plan 2000 – 2004 has been submitted to an internal evaluation On basis of those evaluation results exercise. The above mentioned new drug strategy and Drug Action Plan is currently elaborated by the national drug coordinators office jointly with concerned ministries and field actors. Both the strategy and the action plan cover the period 2005 to 2009.

Therefore, in accordance with national needs and in accordance with the work plan of the EMCCDA, a national study on direct economic costs of drug policies and interventions was performed from 1999 to 2002 and refers to data from 1999 (Origer 2002 b). (*Etude du coût économique direct des interventions et de la politique publique en matière de drogues et de toxicomanies).* (http:/ / www.relis.lu). One may add that the EDDRA questionnaire is applied as a standard application form for drug-related projects' funding requests addressed to the Ministry of Health.

Also, 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.

On drug-related infectious diseases: 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 health care infrastructures. The provisional budget of the project is estimated at 25.000. - EUR. The NFP has been granted a full financing of the project by the FLTS. Duration of the project :August 2003 - 2005. [NR 2004].

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists, but was not based upon the Council Recommendation. The NFP assures evaluation training in the framework of EDDRA. [RT]

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.' [NR 2004]

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. [RT]

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. [RT]

The Mondorf Group is currently working out a proposal for a interregional training and job opportunity network for former or current drug addicts. The project is meant to take advantage of socio-economic differences of border regions between 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. [NR 2002]

2.14.5 Information from third data sources

Issues raised by NGO Tox-In

Information, education and communication (IEC). IEC is adequate in accessibility and coverage. It is not known whether drug testing is available and if so, accessible to drug users.

Outreach work. Outreach work is readily available and adequately accessible.

(Medically assisted) treatment and specific interventions. In general, medically assisted treatment for opiate users and cocaine users is readily available and accessible for drug users in Luxembourg. Heroin, ATS or cocaine prescription programmes are not available in Luxembourg. There is no information about the existence of specific services provided for cocaine or ATS users. The coverage and accessibility of drug consumption rooms is regarded as inadequate as the opening hours need to be adapted and more personnel needs to be employed. Accessibility and coverage of needle and syringe exchange programmes and the distribution of drug paraphernalia is adequate. Coverage and access to low threshold agencies such as drop-ins and shelters can be considered adequate.

Prison interventions. There is no information available whether IEC in prison is available in Luxembourg at all. There is a good coverage of outreach work in prisons. There is no information about the availability and accessibility to substitution services in prisons. There is no information whether specific HR Interventions for cocaine or ATS users is available in prison. Measures implemented to prevent infectious diseases are considered inadequate. No information is available about needle and syringe exchange programmes and distribution of drug paraphernalia in prison, nor about vaccination programmes for hepatitis B and tuberculosis.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Measures implemented to prevent infectious diseases are adequate in coverage and accessibility. No information is available whether hepatitis B and tuberculosis vaccination is available and accessible for drug users.

Annex A2.15 State of play on harm reduction in Hungary

2.15.1 Summary

Public health policy. Harm reduction has been adopted as key objective in the Hungarian National Strategy to Combat the Drug Problem 2000-2009 and is a public health objective.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines, websites, trainings, and educational leaflets. Communities and families of drug users are neither informed, nor involved in the prevention and reduction of health risks associated with drug dependence.

Outreach work. Outreach work at dance parties/ raves and in clubs is nationwide available. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is a common setting for the deliverance of risk education/ response training. Peers and volunteers are involved in outreach work practice in specific geographical regions. Networking and cooperation between outreach work agencies exist nationwide.

(Medically assisted) treatment and specific interventions. Drug-free outpatient treatment and drug-free inpatient treatment are nationwide available. In specific geographical areas methadone maintenance and detoxification treatment, naltrexone treatment, rehabilitation programmes and drop-in centres/ shelters are available. Drug consumption rooms and heroin prescription programmes do not exist. Opioid substitution treatment is not used as a strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available in some areas.

Prison interventions. Treatment of infectious diseases is nationwide available. Testing on infectious diseases is available on a voluntary basis. Other interventions are not provided.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing, screening, education, prevention, counselling and treatment for infectious diseases are nationwide available. To prevent infectious diseases among drug users, the predominant response strategies are IEC in general, IEC via counselling and advice by drugs and health professionals, and needle and syringe exchange. Only in specific geographical areas, needle and syringe exchange programmes, vending machines, drug paraphernalia and the free of charge distribution of condoms are available.

Drug-related deaths. The distribution or administration of naloxone is regulated. Naloxone is not available on a 'take home' basis.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals working in prison settings. Although the policy exists, integration between health and social care is not promoted as part of risk reduction.

Quality, monitoring and evaluation. Hungary is developing several quality assurance, monitoring and evaluation tools in drug demand reduction. An internet database – SZIP – has been created with information on programmes and their characteristics, with the aim to improve transparency. The Hungarian government allowed for an independent mid-term evaluation to be conducted into the implementation of the National Drug Strategy. Hungary has participated in several Twinning projects.

2.15.2 Recommendation 1: Risk reduction and public health policy

The governmental structure that is responsible for the implementation of the Council Recommendation is the Ministry of Youth, Family, Social Affairs and Equal Opportunities[434]. 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.

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 2002. [NR 2004] [435]

2.15.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation. [RT]
In Hungary, the dissemination of information through telephone help lines, websites, training[436], and educational leaflets is available nationwide. [NR 2003/ 2004]

To **prevent infectious diseases** among drug users, IEC general and IEC via counselling by drugs and health professionals are predominant response strategies. Safer injection training for drug users is a common response strategy[437]. [SQ 23; NFP 2006]

With regard to the **reduction of drug-related deaths**, the dissemination of information materials and individual risk counselling are rare response strategies. Counselling on safe injecting techniques preventing drug-related deaths is provided by almost half of the organisations. [SQ 29; NFP 2006]

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 exists, but was not based upon the Council Recommendation.[438] [RT]
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. [NFP 2006]

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.[439] [RT]
In Hungary, outreach work at dance parties / raves and in clubs is nationwide available. Street-based outreach work is taking place in specific geographical areas. [NR 2003, 2004]

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. [SQ 23]

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[434] Department of Strategic Affairs, Deputy State Secretariat for the Coordination of Drug Affairs.
[435] Ref: Gallà, M.S.J., et. al. [2006]. *Report on the Mid-term Evaluation of the Hungarian National Strategy to Combat the Drug Problem,* Trimbos Institute, The Netherlands.
[436] Education programmes of safe injection through syringe exchange.
[437] Most organisations indicate they offer harm reduction counselling which includes providing information related to risks of drug use, their prevention and treatment of overdoses. These activities are very rare in prisons, hospitals and emergency rooms.
[438] The Ministry of Youth, Family, Social Affairs and Equal Opportunities supports civil organisations which are involved in the above mentioned activities through system of competitions. In 2004 and 2005 the Ministry gave extra attention to those civil organisations that focused on the information of parents.
[439] The Ministry of Youth, Family, Social Affairs and Equal Opportunities supports the Safety Club Programme and the needle-exchange bus of the Hungarian Baptist Aid.

Aiming at the **reduction of drug-related deaths**, outreach work is a common setting for risk education/ response training for drug users. Low threshold agencies, including needle and syringe exchange, and outreach work are rare and uncommon settings for disseminating information materials. [SQ 29]

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, as it is not a task for the national government.[440] [RT]
In specific geographical areas, mobile needle exchange services and street outreach needle exchange programmes (including social workers and peer groups) are involved in reaching hidden injecting drug user groups. In specific geographical areas, trainings are organised for peers.
[NR 2003; NFP 2006]

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.[441] [RT]
Networking and cooperation between outreach work agencies exist nationwide. [NR 2004]

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 exists, but was not based upon the Council Recommendation.[442] [RT]
Drug-free outpatient treatment and drug-free inpatient treatment are nationwide available. In specific geographical areas methadone maintenance treatment, methadone detoxification treatment, naltrexone treatment, rehabilitation programmes and drop-in centres/ shelters are available. Substitution treatment is supported by psychosocial care upon request by the client. [NR 2003/ 2004; NFP 2006]

Opioid substitution treatment (with regard to the **reduction of drug-related deaths**) is not in use as a response strategy. [SQ 29] Drug consumption rooms and heroin prescription programmes do not exist in Hungary.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy does not exist, as it is not a task for the national government.[443] [RT]
In specific geographical areas some measures available to prevent diversion of prescribed drugs, e.g. registration. [NR 2004]

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, but was not based upon the Council Recommendation.[444] [RT]
There are no methadone maintenance, methadone detoxification, buprenorphine or naltrexone programmes in Hungarian prisons[445]. Condoms, additional services such as bleach, sterile water ascorbic acid and needle and syringe exchange are also not available. Testing on infectious

[440] The Ministry of Youth, Family, Social Affairs and Equal Opportunities draws up recommendations only; the elaboration of the professional methodologies is the task of the civil organisations.
[441] The Ministry of Youth, Family, Social Affairs and Equal Opportunities encourages the civil organisations involved in outreach work by competitions. The normative assistance system is under development, the organisations involved in needle exchange already have the opportunity to get normative assistance.
[442] Substitution treatment is based on the use of methadone.
[443] The Ministry of Youth, Family, Social Affairs and Equal Opportunities supports the methadone-programmes, all the other details depend on the contract between the doctor and the patient.
[444] In prisons, programmes that aim to provide maintenance treatment, needle exchange and/or disinfection of needles by the use of bleach is under implementation.
[445] Inmates can take part in drug prevention and methadone programmes in Hungarian penitentiary institutions. [NFP 2006].

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. [NR 2003/ 2004; NFP 2006]

Prisons are rarely used as implementation setting for **infectious disease prevention** measures targeted at drug users [SQ 23]. 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. [SQ 29]

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. [RT]
Testing, screening, education, prevention, counselling and treatment of HIV, hepatitis C, tuberculosis, and sexually transmitted diseases are nationwide available. Since August 29, 2005, HIV and hepatitis C, testing of drug users is provided free of charge by the regional laboratories (5) of the Public Health Office. 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. [NR 2004; NFP 2006]

To **prevent infectious diseases** among drug users, Hungary has a specific, designed strategy. There are also local strategies. Predominant response strategies include information, education, communication (IEC) in general and IEC via counselling, 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. [SQ 23]

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

This policy exists, but was not based upon Council Recommendation.[446] [RT]
In specific geographical areas, needle and syringe exchange programmes, vending machines, drug paraphernalia such as disinfecting swabs and sprays, bleach and ascorbic acid, and the free of charge distribution of condoms are available. Sterile water, vein generating creams and cookers are rarely provided. [NR 2003/ 2004; NFP 2006] To **prevent infectious diseases** among drug users in Hungary, needle and syringe exchange programmes are the predominant response strategy. [SQ 23]

For the **reduction of drug-related deaths** low threshold services, including needle and syringe exchange programmes, disseminate information and provide risk education/ response trainings, though this is rare. [SQ 29]. In Hungary, 12 organisations are involved in needle and syringe exchange and together they operate 18 programmes: 7 fixed, 2 mobile, 4 street-outreach, 5 vending machines. There is no pharmacy-based or prison-based needle exchange in Hungary. [NFP 2006]

There are no legal restrictions to the possession of sterile needles in Hungary, and also no prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation.[447] [RT]
In Hungary, there are no training programmes for professionals of emergency departments. [NR 2004; NFP 2006]

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[446] For the Hungarian government, harm reduction has a high priority; Hungarian National Strategy to Combat the Drug Problem 2000-2009, 2000.
[447] In treatment institutions this recommendation is obligatory.

Ambulances routinely carry antagonists. The distribution or administration of naloxone is controlled by regulations and administration is limited to physicians. Naloxone is not available on a 'take home' basis. [SQ 29; NFP 2006]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation. [RT]
Nevertheless, in practice integration is not promoted. 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. [NR 2003; NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Trainings are offered nationwide to professionals working in prison settings. 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. [NR 2003/ 2004; SQ 23; NFP 2006]

2.15.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy does not exist, as it is not a task for the national government. [RT]

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. [NR 2004]

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. [RT]

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. [RT]

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. [RT]

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. [RT]

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

This policy does not exist, as it is not a task for the national government. [RT]

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. [NR 2002]

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[448]. 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 policymakers indicated it was partly achieved[449].

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. [RT]

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. [RT]

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. [RT]

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.

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'. 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. [NR 2004]

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). [NR 2003]

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. [NR 2003]

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[448] NDS objective III.3.14: "Programmes for high risk-or special populations need to be set up, e.g. long-term care for those struggling with other psychiatric problems (dual diagnosis, co morbidity), medical care for HIV+ and AIDS patients, hepatitis carrying drug users, creation and expansion of special programmes for pregnant women and drug-dependent infants".

[449] Gallà, M. & F. Trautmann & A. van Gageldonk [2006]. 'Report of the Mid-term Evaluation of the implementation of the Hungarian National Strategy to Combat the Drug Problem', Trimbos Institute, Utrecht.

2.15.5 Information from third data sources

Issues raised by Hungarian Civil Liberties Union

Information, education and communication (IEC). IEC is inadequate in coverage, as many organization providing IEC focus purely on primary prevention rather than on harm reduction. Drug testing is not yet available in Hungary, but might be implemented soon.

Outreach work. Outreach work in Hungary lacks adequate coverage and accessibility. There are outreach programmes directly associated with NSPs and a local programme in the area of "Dzsumbuj", an urban living quarter where many IDUs live.

(Medically assisted) treatment and specific interventions. Medically assisted treatment for opiate users is inadequate in coverage and accessibility. Nationwide there are 8 methadone treatment sites treating 757 opiate users in 2004, which is an estimated coverage of 6-10%. There is no heroin prescription programme in Hungary. Coverage and accessibility of medically assisted treatment for ATS or cocaine users is inadequate. Users might be treated with antidepressants. ATS or cocaine prescription programmes are not available. Specific harm reduction interventions targeted at cocaine and ATS users are inadequate in coverage and accessibility. Those interventions that do take place – provision of injecting material for cocaine injectors and harm reduction services at dance events – have very low and thus inadequate coverage. There are no drug consumption rooms in Hungary. NSPs are implemented by 10 organisations throughout the country. In 2004 these NSPs reached 1293 IDUs, which is approximately 10% of all Hungarian IDUs. Except for Budapest, no regional agreements have been made with law enforcement institutions in order to prevent police from arresting IDUs purely for the possession of unused injection materials. Drug paraphernalia are available through the existing needle and syringe exchange programmes, but paraphernalia offered are often incomplete to grant true protection. Only one of 10 needle and syringe exchange outlets provides an adequate range of injecting paraphernalia. Coverage and accessibility for drug paraphernalia is thus inadequate.
Low threshold agencies are inadequate in coverage and accessibility. In 2003 there were 62 organizations nationwide to offer low threshold agencies, but many of the institutions incorrectly define their activities "low threshold".

Prison interventions. There is no information available whether and where IEC in prison is performed. Outreach work in prison exists, but does not focus on harm reduction activities.
Availability and accessibility to substitution treatment is inadequate. In prison opiate users do not receive methadone, but get tranquillizers and benzodiazepines such as rivotril. No information is available whether medically assisted treatment for ATS and cocaine users is available in prison. There are no specific HR interventions for ATS or cocaine users inside Hungarian prisons. NSPs and the distribution of drug paraphernalia are not available in prison. Measures implemented to prevent infectious diseases are inadequate. Testing is available in prisons, but HIV-positive inmates are segregated. Hepatitis B or tuberculosis vaccination programmes targeted at drug users are not available in Hungarian prisons. Families and friends are not involved in harm reduction interventions.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Measures implemented to prevent infectious diseases are inadequate in coverage and accessibility. Hepatitis B and tuberculosis vaccination programmes targeting drug users do not exist. Measures to involve families and friends of drug users in harm reduction interventions are not available in Hungary.

Annex A2.16 State of play on harm reduction in Malta

2.16.1 Summary

Public health policy. In Malta, harm reduction is a public heath objective, but this was not because of the Council Recommendation. Harm reduction programmes exist in Malta for more than ten years already.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through educational leaflets. For the reduction of drug-related deaths, risk education/ response training is the predominant response strategy. Communities and families of drug users are involved in the prevention and reduction of health risks associated with drug dependence in specific geographical areas.

Outreach work. Outreach work at dance parties, raves and in clubs is available in specific geographical areas only. Peers and volunteers are not included in outreach work practice. Networking and cooperation between outreach work agencies exist nationwide.

(Medically assisted) treatment and specific interventions. Methadone maintenance programmes and methadone detoxification programmes are available nationwide. Further, Malta has rehabilitation centres, drug-free outpatient and inpatient centres, and a drop-in centre. Buprenorphine is not available and naltrexone is provided in specific geographical areas only. Drug consumption rooms and heroin prescription programmes do not exist. Opioid substitution treatment is the predominant response strategy aiming at the reduction of drug-related deaths. Despite existing policy, measures to prevent diversion of prescribed drugs not available.

Prison interventions. Methadone maintenance and detoxification programmes, and counselling are available in one Maltese prison. Other harm reduction interventions do not exist in Maltese prisons.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening and vaccination against hepatitis B and tuberculosis exist nationwide. To prevent infectious diseases among drug users, the predominant response strategies are IEC, hepatitis B vaccination programmes for drug users, and voluntary counselling and testing. Needle and syringe exchange and drug paraphernalia are available in specific geographical areas only.

Drug-related deaths. The distribution, possession or administration of naloxone is not regulated. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training for professionals in treatment facilities is available in specific geographical areas only. Risk reduction is part of health strategies promoted through the efforts of drug agencies.

Quality, monitoring and evaluation. Malta does not have an elaborated system of quality assurance and monitoring. The human resources in drug treatment services are limited.

2.16.2 Recommendation 1: Risk reduction and public health policy

The main responsible body for the implementation of the Council Recommendation in Malta is the Ministry for the Family and Social Solidarity[450].

The prevention and reduction of health-related harm associated with drug dependence is part of public health policy in Malta, but was not based on the Council Recommendation. It pre-existed the Council Recommendation for at least a decade already. The National Drug Agency, SEDQA, run by the Government and inauguarated in 1994, is responsible for providing adequate services in prevention and treatment. Over the years, prevention in schools, the community, the work place and for particular risk groups, has been ongoing. Two NGO's (Caritas and Oasi) also run prevention and treatment programmes. [RT]

2.16.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation[451]. [RT]
In Malta, a broad range of educational leaflets is available nationwide. In specific geographical areas only, telephone help lines and websites[452] are available. Training for drug users promoting risk reduction is available in Malta at an individual basis for those who attend the Outpatient Unit. [NR 2004; NFP 2006]

To **prevent infectious diseases** among drug users, free hepatitis B vaccination is available, and also needle and syringe exchange programmes and free pre/ post test counselling and testing for hepatitis B, C and HIV are available nationwide. [NFP 2006]

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[453]. [SQ 29]

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 exists, but was not based upon the Council Recommendation[454]. [RT]
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; specific information, education and communication (IEC) for communities and families of drug users is not available in Malta. [NFP 2006]

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[455]. [RT]
In Malta, street-based outreach work is not available, whereas outreach work at dance parties, raves and in clubs is available in specific geographical areas only. [NR 2004; NFP 2006]

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[450] National Commission on the Abuse of Drugs, Alcohol and Other Dependencies.
[451] Government agency Sedqa and the NGO's Caritas and Oasi provide information to promote risk reduction.
[452] www.sedqa.org.mt
[453] Many consider the centralised detoxification/substitution centre (SMOPU) also to be a 'low threshold' agency. Many clients have been on substitution treatment for many years and go there every morning for their methadone dosage.
[454] Sedqa, Caritas and Oasi provide the necessary information to communities and families.
[455] Outreach work only began in all agencies in 2002.

There is no information available about the use of outreach work as a response strategy or implementation setting for measures to **prevent infectious diseases** among drug users, or for measures aiming at the **reduction of drug-related deaths.** [SQ 23/ 29]

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 exists, but was not based upon the Council Recommendation[456]. [RT]
However, training for peers and volunteers do not exist in Malta. Peers and volunteers are not included in outreach work practice. [NFP 2006]

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[457]. [RT]
Networking and cooperation between outreach work agencies exist nationwide[458]. [NFP 2006]

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 exists, but was not based upon the Council Recommendation[459]. [RT]
Methadone maintenance programmes and methadone detoxification programmes are available nationwide. Further, there are rehabilitation centres, drug-free outpatient and inpatient centres, and a drop-in centre. Buprenorphine is not available and naltrexone is provided in specific geographical areas only. Substitution treatment is supported by psychosocial care upon request by the client. [NR 2004; NFP 2006]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is the predominant response strategy. [SQ 29]
Drug consumption rooms and heroin prescription programmes do not exist in Malta.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation[460]. [RT]
Nevertheless, measures to prevent diversion of prescribed drugs are not available. [NFP 2006]

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, but was not based upon the Council Recommendation[461]. [RT]
Methadone maintenance and methadone detoxification programmes and counselling are available in one Maltese prison. Other harm reduction interventions do not exist in Maltese prisons.
[NR 2004; NFP 2006]

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[462]. [RT]

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[456] Training undertaken by Sedqa, Caritas and Oas.
[457] Networking between agencies is being provided for by the President's Forum since 2002.
[458] between all 3 agencies Sedqa, Caritas and Oasi.
[459] Provided for by Sedqa, Caritas, and Oasi.
[460] Police is deterrent to prevent diversion.
[461] In house drug rehabilitation unit in prison as well as the availability of three programmes for drug users outside the confines of prison.
[462] Provided for by the drug agencies Sedqa, Caritas, and Oasi.

Testing/ screening and vaccination against hepatitis B/ tuberculosis targeting drug users exist nationwide in Malta; prevention and education with regard to infectious diseases is available in specific geographical areas only[463]. [NR 2004; NFP 2006]

To **prevent infectious diseases** among drug users the predominant response strategies are IEC, hepatitis B vaccination programmes for drug users, and voluntary counselling and testing. Predominant implementation settings for infectious diseases prevention measures targeting drug users include specialised drug treatment services and low threshold counselling services. [NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation[464]. [RT]
In specific geographical areas, needle and syringe exchange programmes[465] and drug paraphernalia are available. Condoms are not distributed among Maltese drug users. [NR 2004] Malta has 7 points for the distribution of syringes. [ST 10]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation[466]. [RT]
Maltese ambulances routinely carry antagonists [SQ 29]. The distribution, possession or administration of naloxone is not regulated. Naloxone on a 'take home' basis is not available. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation[467]. [RT]
Risk reduction is part of health strategies promoted through the efforts of drug agencies. [NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation.[468] [RT]
Training for professionals in treatment facilities is available in specific geographical areas only. Training programmes for other professionals in harm reduction services do not exist. [NR 2004; NFP 2006]

2.16.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

Policy does not exist, but is pending for approval. [RT]

Research on the impact, effectiveness and efficiency of prevention activities in Malta has as yet not been carried out. Evaluations by the respective agencies in the form of satisfaction questionnaires following the completion of a specific programme, are administered and evaluated internally. To date, however, Malta does not have a global picture on the overall impact and reach of its

[463] Limited but available to some extent for those clients who are attending treatment at Caritas, Sedqa or Oasi.
[464] Syringe availability provided for by the Department of Health.
[465] There is no needle/syringe exchange but there is syringe distribution reaching national coverage.
[466] There is only one single Emergency Department on the island with the required trained staff to deal with drug overdoses, run by the Department of Health.
[467] The Foundation for Social Welfare Services provides the infrastructure through which such integration may be achieved.
[468] Plans and curricula for drug-related further training of five selected occupational groups have been completed.

prevention programmes, which would be obtained as a result of independent, co-ordinated and continuous monitoring and evaluation of such programmes and their target groups.

Data on co-morbidity in Malta is still quite fragmented and incomplete. Workers in the field have attempted to adapt their existing resources to address the needs of this client group. However, further attention is needed in the form of setting up an expert group whereby certain issues such as defining the broad clinical definitions of psychiatric co-morbidity, its diagnoses and treatment can be discussed. Additionally data sources need to be updated in order to collect more consistent and reliable information. This would provide us with a clearer clinical picture, enhance the signalling of problems or developments that need to be addressed and allow for a more relevant and cost effective implementation of responses.

Other harm reduction measures that have been implemented by treatment agencies include providing information to current clients on the risks involved in sharing needles, the possibilities for random testing, pre/ post test counselling and dispersion of public health promotion material. One area that warrants further attention is that of looking into the sexual behaviour of injecting drug users and promoting safe-sex.
Information obtained from staff at the various treatment agencies indicates that a large number of injecting drug users still engage in unsafe sex, however no documented evidence is as yet available. [NR 2004]

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. [RT]

When considering this action, one must take into consideration the limited human resources in treatment services, when compared to the number of clients. If a common assessment measure were to be used across all types of treatment, one would have to consider the financial and human resources that would be needed in order to effectively embark on this action. This would entail training existing staff members or employing new staff members who are qualified to administer such an assessment. Additionally, treatment centres would have to adapt or extend their current services in order to address the needs of this client group appropriately.

The census scan carried out in October 2001 gave some indications, based on assessments by the care workers on the needs and capacity of clients in treatment at that time, to sustain in the Maltese society. [NR 2004].

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. [RT]

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

Policy does not exist, but is pending for approval. [RT]

There is currently no monitoring body for quality assurance, however the financing body realises the need of introducing such a body due to accountability for funding purposes. The Probation Services have a Supervisory Board that reviews the performance of the Probation Officers and suggests improvements and monitors the administration of discipline. Agencies do carry out internal evaluations and 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. [NR 2004]

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. [RT]

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

This policy does not exist, but is pending for approval. [RT]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy does not exist, but is pending for approval. [RT]

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, but is pending for approval. [RT]

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 is pending for approval. [RT]

Annex A2.17 State of play on harm reduction in the Netherlands

2.17.1 Summary

Public health policy. Harm reduction has been a public health objective in the Netherlands since the 1970'ies as it was one of the cornerstones of public health policy in the field of harm reduction.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines, websites and pill-testing. Communities and families of drug users are also informed and nationwide involved in the prevention and reduction of health risks associated with drug dependence.

Outreach work. Street-based outreach work is nationwide available. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials, as well as for the deliverance of risk education/ response training. Furthermore, peers and volunteers are included nationwide in outreach work practice. Finally, networking and cooperation between outreach work agencies also exist nationwide.

(Medically assisted) treatment and specific interventions. 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 and naltrexone is offered, as well as heroin prescription. Rehabilitation centres, drug consumption rooms and drop-in centres/ shelters are also restricted to specific geographical areas. Opioid substitution treatment is a predominant response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Methadone detoxification programmes are available nationwide in prison. Methadone maintenance programmes, and testing/ screening, prevention, education and treatment of infectious diseases, as well as counselling are available in specific geographical areas only. Treatment with buprenorphine, with naltrexone or needle and syringe exchange programmes are not available. The distribution of condoms and drug paraphernalia is available in Dutch prisons in specific geographical areas only.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening, education, prevention, counselling, and vaccination for infectious diseases targeting drug users are available nationwide. To prevent infectious diseases among drug users, the predominant response strategies are IEC in general, IEC via counselling and advice by drugs and health professionals, and needle and syringe exchange. Needle and syringe exchange, drug paraphernalia and the distribution of condoms are available nationwide in the Netherlands.

Drug-related deaths. Professionals of emergency departments are trained nationwide, e.g., to deal with overdoses. The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals in outreach work, needle and syringe exchange programmes, substitution programmes, low threshold programmes, treatment facilities and prison staff. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. In the Netherlands, many quality assurance systems, monitors and evaluation schemes exist. These instruments are part of an integrated approach in drug demand reduction. Ample research has been done on interventions such as heroin prescription, maintenance treatment, detoxification treatment, drug consumption rooms, etc. Since 2001, a special research programme 'Getting Results' has been run in the Netherlands, which had the specific aim to build the evidence base in drug demand reduction. Trainings on quality assessment for professionals exist. The Netherlands collaborate in many international projects and activities.

2.17.2 Recommendation 1: Risk reduction and public health policy

In the Netherlands, the Ministry of Health, Welfare and Sport is responsible for the implementation of the Council Recommendation[469]. The Netherlands has a long-lasting history regarding harm reduction, which pre-exists the Council Recommendation with several decades. [RT]. 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. [NR 2001/ 2002]. [RT].

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'[470]. 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. [RT].

2.17.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation[471]. [RT]
In the Netherlands, telephone help lines[472], websites and pill-testing[473] are available nationwide. Training[474] and information leaflets are available in specific geographical areas only. [NR 2004; NFP 2006]

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, whereas IEC via peer involvement/ peer approach, easy access' programmes for drug users to treatment of infectious diseases and safer injecting training are common responses. Safer injecting training is offered in all or most cities[475]. [SQ 23; NFP 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. Common response strategies are risk counselling and risk education/ response training. This training is delivered predominantly at specialised drug treatment services, low threshold agencies, through outreach workers and in prisons. Risk education/ response training is delivered in all or most cities in the Netherlands. [SQ 29]

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[469] Department for Nutrition, Health Protection and Prevention.
[470] Parliament ref. 24 077, nr. 2-3, 1994-1995.
[471] There is a large number of information resources aimed at drug users and dependent drug users in the Netherlands, varying from one-on-one counselling to national telephone helplines. Examples are: Drug Information and Monitoring System (DIMS), Uitgaan & Drugs, Mainline and Local Service Providers User Groups
[472] The Drugs Info Line (DIL) and some other telephone or internet help lines offer information & counselling services.
[473] The Drugs Information and Monitoring System (DIMS) analyses drug samples of consumers delivered at drug prevention and treatment services, covering a large part of the country.
[474] E.g. Mainline (see www.mainline.org). However, most training efforts focus on professionals and volunteers (e.g. Train the trainer, Trimbos-Institute).
[475] Mainline (a grass root organisation for drug users in Amsterdam) distributes guidelines for safer injecting practices to all organisations of addiction care.

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 exists, but was not based upon the Council Recommendation[476]. [RT]
Communities and families of drug users are involved nationwide[477] 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[478]. [NR 2003/ 2004]

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. [RT]
In the Netherlands, street-based outreach work is nationwide available. Outreach work at dance parties, raves and in clubs is available in specific geographical areas only[479]. [NR 2004; NFP 2006]

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. [SQ 23]

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 are also a predominant setting for the deliverance of risk education/ response training. [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]
Training for peers and volunteers is organised nationwide. Peers and volunteers are included nationwide in outreach work practice. [NR 2004]

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. [RT]
Networking and cooperation between outreach work agencies exist nationwide in the Netherlands[480]. [NFP 2006]

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 exists, but was not based upon the Council Recommendation[481]. [RT]

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[476] See above. Local prevention services also run specific information services. Projects exist for children of parents with an addiction problem and for parents whose children take drugs. Local Community Initiatives, sometimes also in collaboration with User Groups.
[477] The pilot implementation of the American Strengthening Families Project; Karen Kumpfer.
[478] There is an increasing number of mergers between organisations of mental health care and addiction care, and in some cases also between different organisations of addiction care during the past five years. An important reason for some of these mergers is the growing knowledge from research that addiction is related to psychiatric disorders.
[479] E.g. Drugs and Alcohol Info team (activities among tourists along the coast).
[480] The networking and cooperation between outreach work agencies is *supported* by Trimbos Institute (LSP) and Mainline through dissemination of information and by means of training programmes.
[481] Methadone services exist since 1979 [Buster, published dissertation, 2003]. Other substitution treatment (on a small scale and/or experimental basis): buprenorphine, naltrexon and heroin prescription. Several drug free treatments exist, also in a criminal justice setting.

Methadone maintenance[482] programmes and methadone detoxification[483] programmes are available nationwide. Substitution treatment is supported by psychosocial care upon request by the client. Drug-free outpatient and drug-free inpatient treatment are also nationwide available. In specific geographical areas only, treatment with buprenorphine[484], with naltrexone[485], as well as heroin prescription programmes[486] are available. Rehabilitation centres, drug consumption rooms and drop-in centres/ shelters are also available in specific geographical areas[487]. [NR 2003/ 2004]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a predominant response strategy in the Netherlands. [SQ 29]

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation[488]. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide. [NR 2004]

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, but was not based upon the Council Recommendation[489]. [RT]
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, and needle and syringe exchange programmes are not available in Dutch prisons, and distribution of condoms and drug paraphernalia is available in specific geographical areas only. [NR 2002/ 2004; NFP 2006]

Prisons are an uncommon implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]. Aimed at the **reduction of drug – related deaths**, prisons are a common setting of the deliverance of risk education/ response training. [SQ 29]

2.9 Promote adequate hepatitis B vaccination coverage and prophylactic measures against HIV, hepatitis B and C, 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[490]. [RT]
Testing/ screening, education, prevention, counselling, and vaccination programmes targeting drug users are available nationwide. In specific geographical areas only, treatment of infectious diseases is provided. [NR 2003/ 2004]

To **prevent infectious diseases** among drug users the predominant response strategies are IEC in general. IEC via counselling and advice by drugs and health professionals, and needle and syringe exchange programmes are common response strategies. Other common strategies include IEC via peer involvement/ peer approach, outreach health education approach, condom promotion

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[482] In around 231 facilities for drug treatment (2000).
[483] 80-90% of cases result in maintenance treatment.
[484] Buprenorphine for detoxification and maintenance treatment is used by a minority of professionals in addiction care. Recently, an import license for higher dose buprenorphine (Subutex®) has been realised and registration is underway.
[485] In combination with standardised psychosocial treatment.
[486] Only medical co-prescription. The Government decided in 2005 that places at treatment units for medical prescription of heroin for chronic treatment resistant opiate addicts can be extended from 300 to 1000.
[487] E.g. housing units for older addicts.
[488] Substitution substances are mainly distributed through a 'closed' system of medical prescription. In many cases substitution drugs are administered in a supervised environment. As a result, illegal distribution of personal dosages occurs incidentally.
[489] In recent times, a renewed initiative has been started by the Prison department (Ministry of Justice) to set up a national programme on infectious diseases within prisons. Furthermore, methadone distribution and drug free treatment exist in prison.
[490] 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 hepatitis C screening and vaccination. The Ministry of Health is considering to place hepatitis C on national policy agenda.

among drug users, routine screening of high risk groups, hepatitis vaccination programmes for drug users and easy access programmes for drug users to treatment of infectious diseases. Predominant implementation settings for infectious diseases prevention measures targeting drug users include specialised drug treatment services and low threshold counselling services. Common implementation settings are outreach work and targeted high risk group interventions. [SQ 23]

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

This policy exists, but was not based upon the Council Recommendation[491]. [RT]
Needle and syringe exchange programmes, drug paraphernalia and the distribution of condoms are available nationwide in the Netherlands. [NR 2003, NR 2004; NFP 2006]. Needle and syringe exchange programmes are a predominant response strategy to **prevent infectious diseases** among drug users in the Netherlands. [SQ 23] 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 a common setting for deliverance of risk education/ response training. [SQ 29]

The Netherlands counts in total 120 non-pharmacy based needle and syringe programmes and 3 vending machines. Needle and syringe exchange is not taking place through vans/ buses, and through outreach workers/ peers, via pharmacies or in prisons. [ST 10]

There are no legal restrictions to the possession of sterile needles in the Netherlands, and also no prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation[492]. [RT]
Professionals of emergency departments[493] are trained nationwide. [NR 2004] 'First aid posts' are a common setting for dissemination of information materials that aim at the reduction of drug-related deaths or for risk education/ response training. [SQ 29]

Dutch ambulances routinely carry antagonists. The distribution, possession or administration of naloxone is regulated[494]. Naloxone on a 'take home' basis is not available. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation[495]. [RT]
Risk reduction is part of an integrated health strategy for drug users[496]. [NR 2003]

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

This policy exists, but was not based upon the Council Recommendation. [RT]

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[491] More than 100 free of charge needle and syringe exchange locations exist in all regions and big cities in the Netherlands. Many pharmacies sell needles to IDUs, although the number seems to be decreasing. Only 15% of the Dutch heroin users inject their heroin (85% smokers). Condom distribution is widely available.
[492] Emergency services are responsible for first aid in case of overdose. They are trained for this task. Other training programmes (for drug professionals) are offered by Trimbos Institute (Uitgaan & Drugs) and Mainline. A 'Red Alert' system is in place that provides instant alerts to professionals and the public when dangerous (acute toxic) drugs are detected on the market. Examples from the past years include: ecstasy pills polluted with strychnine or with atropine.
[493] First aid posts.
[494] Naloxone is only administered by, or on behalf of, a medical doctor in case of an emergency.
[495] The integrated care is an official policy objective of the Ministry of Health (Openbare Geestelijke Gezondheids Zorg/ OGGZ) and is being implemented by means of covenants between service providers and municipalities.
[496] Addiction care activities and general (health) care facilities for housing, finance, general health and day care should be better geared to one another. The Netherlands Court of Audit advised to give addiction care a coordinating role in this process.

Training is offered nationwide to outreach workers and professionals in needle and syringe exchange programmes, substitution programmes, low threshold programmes, treatment facilities and to prison staff. [NR 2003/ 2004]

2.17.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

The Netherlands have a strong evaluation and monitoring culture as impetus for policy development. The Dutch drug policy is focusing strongly at 'what works'. The quality of evaluation and monitoring is being improved continuously. At the same time, there is a limited number (and funding for) of large scale evaluation studies available (e.g. Randomised Controlled Trials). The available treatment options should not be offered in an isolated way and only in a clinical setting, but in an integrated and interactive way. This is i.e. reflected in the well formed connection between the clinical settings, ambulatory or out patient treatment services and low threshold agencies can contribute to get more patients into treatment settings. Another example of the integrated approach concerns the chain of early intervention services, in order to tackle the problem before it becomes highly problematic, treatment options, rehabilitation and re-socialisation contributes to higher change for the patients to regain control of their lives. [RT]

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. A seven-year policy programme 'Getting Results' was initiated to push a more evidence-based addiction care [Schippers, van Es et al., 2005]. The results are disseminated through a 'knowledge network' that includes practically all addiction care and mental health services in the Netherlands. [RT]

In the Netherlands, ample research is available on a number of harm reduction interventions. In 2002 the final report on a heroin prescription trial become available. In the study, the effects during treatment and after 12 months have been compared. The effects of stopping prescription have also been evaluated. A current study aims at determining the additional effects of psychosocial treatment. Another (cohort) study evaluates the health and social situation of the participants of the experimental study three and six months after the start. The findings of this report has led to the decision of the government to extend this type of treatment, (which is a harm reduction intervention) from 300 to 1000 users. [NR 2004]

Over a period a three years the National Coordination Structure on Infectious Diseases (*LCI*) published many protocols on infectious diseases, including HIV and hepatitis B and C. The last version (3rd edition) is from 2004.

A recent survey study examined data on syringe exchange in the Netherlands to support activities to enhance the quality of this type of harm reduction. The authors also conducted a literature review on syringe exchange activities, but could not find any recommendations for quality assurance measures. One of their conclusions is that syringe exchange does reduce risk behaviours (such as syringe sharing), and is associated with a reduction of HIV infections.

3.2 Supporting the inclusion of needs assessments at the initial stage of any programme

This policy does not exist, as it is not a task for National government. There is no official guideline for inclusion of needs assessment, but several models of best-practice exist that promote such (e.g. Preffi, Rapid Assessment and Response). [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy does not exist. Several guidelines and protocols for the evaluation of drug prevention and risk reduction programmes exist, but are not compulsory. [RT]

The Amsterdam Institute of Addiction Research (AIAR) is developing criteria and indicators for a monitoring system for addiction care services. The target is to improve the effectiveness and efficiency of drug prevention and treatment programmes. [NR 2003]

Guidelines or protocols to standardise care or prevention activities are not commonly applied and existing protocols or monitoring practices are rarely tested and improved.

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. [RT]

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. 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[497] and the EMCDDA annual Reports. [RT]

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. The National Drug Monitoring reports are disseminated among policymakers and the Parliament. Scientific evaluation results are often used for policy making. One good example: the heroin prescription experiment. [RT]

Two important studies on the effectiveness of addiction care are worth mentioning.

An evaluation of the care for addicts (of alcohol and opiates) with multiple problems organized in the Netherlands was carried out by the Netherlands Court of Audit. The main conclusion was that the activities of the addiction care institutions and general care facilities for housing, finance, general health and day care should be better geared to one another. The advice of the Netherlands Court of Audit is to give the addiction care a coordinating role in this process. In his reaction to this report the Minister of Health announced that he would not develop a separate vision for the addiction care, but these problems should be tackled by the future local social support systems.

The results of a five-year policy programme to improve the quality of addiction care and drug prevention (*Resultaten Scoren* or 'Getting Results') were published in 2004. The evaluation report marks the end of the first phase of five years of activities with 50 publications: e.g. literature studies, instrument development studies, guidelines and protocols.

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists, but was not based upon the Council Recommendation. The national Focal Point cooperates with the National Support Centre for Prevention (LSP) in evaluation training courses. [see EDDRA Progress Reports to the EMCDDA]. [RT]

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. [RT].

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

[497] The Dutch National Drug Monitor (NDM) is among the first of its kind in the EU. It systematically collects and presents data and facts on licit and illicit drug use, prevention, treatment, drug-related harms and drug-related offences. The NDM annually reports to Parliament, Ministries of Health and Justice and to organisations and structures in the drug field. The National Drug Monitor is supervised by an independent scientific council and is hosted by the Trimbos Institute, the Netherlands Institute of Mental Health and Addiction.

This policy does not exist. However, 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. [RT]

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.

2.17.5 Information from third data sources

Issues raised by Foundation Mainline

Information, education, communication (IEC). IEC is inadequate for drug users. Inadequacy and lack of accessibility is explained by the lack of suitable techniques used by many professionals to transfer knowledge to drug users. Often ineffective strategies and an inadequate tone of voice is used to provide IEC. Training and thus funding is necessary to improve efficiency.
Drug testing is widely available in the Netherlands, but accessibility needs to be improved as it is perceived as being high threshold for marginalised users. Most drug testing is aimed at users in the party/ rave scene.

Outreach work. Coverage of outreach work is evaluated as inadequate throughout the country. Accessibility is limited because many organisations work with case management, which excludes unregistered users.

(Medically assisted) treatment and other interventions. The coverage and the accessibility of medically assisted treatment for opiate users is adequate. However, some of the institutions providing opiate substitution – mostly methadone – have a maximum dosage-policy that is not based on medical criteria.

For cocaine users, neither medically assisted treatment nor structural harm reduction intervention is available. Amphetamine type stimulants or cocaine prescription programmes are not available officially, although ATS are prescribed on a small scale to cocaine users. With regards to specific harm reduction interventions for cocaine users, coverage in general is inadequate, because NGO Mainline is the only organisation implementing harm reduction interventions. There is an adequate coverage of needle and syringe exchange programmes and drug paraphernalia throughout the country and accessibility so far has been adequate. Accessibility is however declining as opening hours are cut down and some of the programmes are only accessible for locally registered users. There are sufficient low threshold agencies, drop in centres and shelters throughout the Netherlands and accessibility is generally adequate, although there are local differences. Coverage of drug consumption rooms is adequate, but accessibility is hindered by rules that most consumption rooms can only be accessed by locally registered users.

Prison interventions. IEC is not available to prisoners. The coverage and the accessibility of medically assisted treatment for opiate users is adequate in prisons. No information is available about coverage of specific harm reduction intervention for cocaine users in prison. Needle and syringe exchange in prison is not allowed. In prison coverage and accessibility of outreach work is inadequate as only Mainline is conducting outreach work in a few selected institutions.

Measures to prevent infectious diseases have an inadequate coverage and accessibility for all users in prison. Hepatitis B vaccination programmes especially targeted at drug users are nationwide available in prison. In prison hepatitis-vaccination programmes are easily accessible and coverage is good. There are no TB-vaccination programmes for drug users in the Netherlands for incarcerated drug users.

Infectious diseases. Measures to prevent infectious diseases have an inadequate coverage and accessibility for all users as not enough attention is focused on screening, or the promotion of treatment amongst members of the target group. Hepatitis B vaccination programmes especially targeted at drug users are nationwide available. Accessibility is however judged inadequate, as not enough information is reaching marginalized users to make vaccination programmes effective. There are no TB-vaccination programmes specifically targeting drug users in the Netherlands.

Annex A2.18 State of play on harm reduction in Austria

2.18.1 Summary

Public health policy. Harm reduction is a public health objective in Austria and pre-exists the launch of the Council Recommendation.

Information, education, communication (IEC). Information and counselling to drug users to promote harm reduction and to facilitate their access to appropriate services is nationwide provided through various websites. Telephone help lines, training, educational leaflets and pill-testing are available in specific geographical areas. For the reduction of drug-related deaths, the dissemination of information materials is the predominant response strategy. There is no specific IEC available for communities and families of drug users.

Outreach work. Street-based outreach work is nationwide available. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials, as well as for the deliverance of risk education/ response training. Peers and volunteers are not included in outreach work practice. Networking and cooperation between outreach work agencies exist in specific geographical areas only.

(Medically assisted) treatment and specific interventions. Methadone maintenance programmes, methadone detoxification programmes and treatment with buprenorphine and naltrexone are available nationwide. Drug-free outpatient and drug-free inpatient treatment are available in specific geographical areas only, as well as rehabilitation centres, and drop-in centres/ shelters. Opioid substitution treatment is a common response strategy aiming at the reduction of drug-related deaths. Drug consumption rooms and heroin prescription programmes do not exist in Austria. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Methadone maintenance and methadone detoxification programmes, buprenorphine treatment are available nationwide in Austrian prisons. Condoms are also distributed nationwide. Testing, prevention, education and treatment of infectious diseases is covered by prison staff. Currently, there are no needle and syringe exchange programmes, nor drug paraphernalia other than iodine.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). In specific geographical areas only, vaccination against hepatitis B and tuberculosis targeting drug users exists. To prevent infectious diseases among drug users, the predominant response strategies are IEC via counselling and advice by drugs and health professionals, voluntary counselling and testing, condom distribution, and needle and syringe exchange programmes. In Austria, needle and syringe exchange, vending machines, drug paraphernalia and the distribution of condoms are only available in specific geographical areas.

Drug-related deaths. In specific geographical areas, professionals of emergency departments are trained, e.g., to deal with overdoses. The distribution, possession or administration of naloxone is regulated by laws. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals in substitution programmes. Risk reduction is part of all regional drug strategies.

Quality, monitoring and evaluation. In Austria, evaluation and research play an increasing important role. Several pilot projects have been scientifically evaluated. Evaluations of international literature have been conducted as well. Quality standards exist for prevention and treatment services. Austria participates in many bi- and multilateral projects.

2.18.2 Recommendation 1: harm reduction and public health policy

The Ministry of Health and Women[498] 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.

Measures relevant for this Council Recommendation focus on the prevention of drug-related infectious diseases, thus low threshold assistance aimed at harm reduction prevails. For instance, syringe exchange, hepatitis vaccinations and information on safer sex / safer use are typical services performed by low threshold centres and outreach facilities (street work). Treatment of health consequences is primarily provided by the general health-care system. In the last few years, prevention of overdoses and co morbidity has played increasingly important roles in this context (*see also the overview of activities in the second recommendation of the Council Recommendation).* [RT]

2.18.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation[499]. [RT]
In Austria, the dissemination of information through various websites is available nationwide. Other ways of providing information and 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). [NR 2003/ 2004; NFP 2006]

To **prevent infectious diseases** among drug users, providing information, education and communication (IEC) via counselling and advice by drugs and health professionals is a predominant response strategy, whereas IEC in general is a common response strategy. Safer injecting training and individual risk counselling with regard to safer injecting are provided in specific geographical areas only and are delivered by low threshold agencies, especially outreach work. [SQ 23]

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 through needle and syringe exchange programmes, and they are commonly disseminated through detoxification centres, nightlife and entertainment venues, and at raves and parties. A common response strategy with regard to the reduction of drug-related deaths among drug users is the provision of risk education/ response training. This training is delivered predominantly at low threshold agencies and through outreach workers and is common in nightlife and at rave events. [SQ 29]

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 exists, but was not based upon the Council Recommendation[500]. [RT]
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. [NFP 2006]

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[498] Department for Public Health.
[499] Measures for the prevention of infectious diseases continue to be a major component of harm reduction. Relevant activities in this field include the distribution of information material, syringe exchange and vaccination programmes, as well as counselling on safer drug use and safer sex.
[500] Prevention measures are primarily implemented at the local and regional levels and coordinated by the Addiction Prevention Units of the individual provinces. Work with parents is given more and more importance.

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 channel

This policy exists, but was not based upon the Council Recommendation[501]. [RT]
In Austria, street-based outreach work is nationwide available. Outreach work at dance parties, raves and in clubs is available in specific geographical areas only[502]. [NR 2004; NFP 2006]

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) is a common implementation setting for infectious diseases prevention measures targeting drug users. [SQ 23]
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 in a number of cities. [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]
Peers and volunteers are not included in outreach work practice and they are not trained to do so. [NFP 2006]

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[503]. [RT]
Networking and cooperation between outreach work agencies exist in specific geographical areas only. [NFP 2006]

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 exists, but was not based upon the Council Recommendation[504]. [RT]
Methadone maintenance programmes, methadone detoxification programmes, and treatment with buprenorphine and naltrexone are available nationwide[505]. Substitution treatment is supported by psychosocial care upon request by the client. 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). [NR 2004; NFP 2006]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a common response strategy. [SQ 29]
Drug consumption rooms and heroin prescription programmes do not exist in Austria.

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[501] Outreach work continues to be of central importance among harm-reducing measures. Quality assurance measures are becoming state of the art also in the field of drug-related demand reduction (projects/activities are evaluated, education/ (further) training schemes are organised, quality standards etc.).
[502] ChEckIT! in nightlife and party scene - provides information on-site, by printed material as well as via the website, and also runs an on-site pill testing programme www.checkyourdrugs.at. Outreach work/counselling to overdose patients is also taking place in specific geographical areas (in Viennese hospitals).
[503] Networking and co-operation between drug-specific services is considered to be a relevant requirement of activities in this field.
[504] Austria attributes a great importance to a diversification of treatment options. This approach aims at taking individual needs into account more strongly. As the general aim is to build a comprehensive care network, most centres also provide a variety of preparatory and aftercare measures.
[505] Codidol and slow release morphine are also prescribed nationwide. A review of substitution treatment mainly focusing slow release morphine was carried out. Currently a revision of the regulations on substitution treatment is discussed that might restrict the prescription of slow release morphine in future.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation[506]. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide. [NR 2004]

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, but was not based upon the Council Recommendation[507]. [RT]
Methadone maintenance and methadone detoxification programmes, buprenorphine treatment and codidol and slow-release morphine are available nationwide in Austrian prisons[508]. Condoms are distributed nationwide and testing, prevention, education and treatment of infectious diseases is covered by prison staff.
There are no needle and syringe exchange programmes in prisons in Austria, although a project is under preparation. [NR 2004; NFP 2006] Iodine (for the disinfection of wounds) is the only drug paraphernalium available in prisons in Austria. [SQ 23]

Prisons are a common implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]

Measures targeting at the **reduction of drug – related deaths** are uncommon or non existent in Austrian prisons. [SQ 29]

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[509]. [RT]
In specific geographical areas vaccination programmes against hepatitis B and tuberculosis targeting drug users exists [NR 2004; NFP 2006]

To **prevent infectious diseases** among drug users the predominant response strategies are information, education, communication (IEC) via counselling and advice by drugs and health professionals, voluntary counselling and testing, condom distribution, and needle and syringe exchange programmes. Other, common strategies include IEC in general, outreach health education approach, hepatitis B vaccination programmes for drug users, and easy access' programmes for drug users to treatment. Predominant implementation settings for infectious diseases prevention measures targeting drug users include low threshold counselling services, outreach work and high risk group interventions. Common implementation settings are specialised drug treatment services and prisons. [SQ 23]

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

This policy exists, but was not based upon the Council Recommendation[510]. [RT]
In specific geographical areas, needle and syringe exchange programmes, vending machines, drug paraphernalia and the distribution of condoms are available. [NR 2004]

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[506] Trends towards diversification also show in the field of medically assisted treatment, where a widening range of substances have been prescribed in order to reach different groups of users and to respond to their needs. Control measures regarding prescription aim to prevent diversion.
[507] A lot of services aiming to prevent drug-related harm are also available in prison – substitution treatment, drug free treatment, safer use and safer sex information and counselling etc. A syringe exchange programme has been considered for some time but not implemented so far.
[508] There is no information available whether naltrexone is prescribed in prisons.
[509] In several regions and facilities hepatitis B vaccination as well as testing for hepatitis and HIV is available for free. Prevention of infectious diseases is a relevant priority in the field of drug specific harm reduction.
[510] Syringe exchange is possible in the majority of the provinces. In some of the provinces the distribution of safer use sets is offered, whereas these sets include sterile needles, syringes, swabs (partly condoms) and a safer use booklet including addresses of drug help centres.

Needle and syringe exchange programmes are a predominant response strategy to **prevent infectious diseases** among drug users in Austria. [SQ 23] Low threshold agencies, including needle and syringe exchange programmes also provide information materials on the **reduction of drug-related deaths** among drug users. [SQ29]

Austria runs in total 41 programmes for needle and syringe exchange, 12 vending machines and 29 non-pharmacy based needle and syringe programmes. Needle and syringe exchange takes also place through vans/ buses, and through outreach workers, but not through peers, via pharmacies or in prisons. [ST 10; NFP 2006]

There are no legal restrictions to the possession of sterile needles in Austria, and also no prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation. [RT]
In specific geographical areas only, professionals of emergency departments are trained [NR 2004]. 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 training. [SQ 29]
Austrian ambulances routinely carry antagonists. The distribution, possession or administration of naloxone is regulated by laws. Naloxone is only available on prescription and administration is limited to physicians. Naloxone on a 'take home' basis is not available. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation[511]. [RT]
Risk reduction is part of all regional drug strategies. [NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation[512]. [RT]
Training is offered nationwide to professionals in substitution programmes. Training for professionals in low threshold agencies, outreach work and for prisons staff is available in specific geographical areas only. Training programmes for professionals in needle and syringe exchange programmes and for professionals in treatment facilities do not exist. [NR 2004; NFP 2006]

2.18.4 Recommendation 3: Quality assurance, monitoring & evaluation in harm reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. In Austria, evaluation is of increasing importance in the field of drug demand reduction. Respective activities also include measures aiming at the reduction of drug-related harm (cf. Austrian projects in the EDDRA database of the EMCDDA). [RT]

Generally speaking, evaluation and research have played an increasingly important role. Implementation of drug policies is more and more often accompanied and underpinned by studies assessing the relevant demand situation (e.g. the Tyrol and Styria), **evaluation of pilot projects (e.g. Lower Austria, Carinthia and Vienna**) as well as scientific studies and analyses (e.g. Burgenland, Upper Austria, Vorarlberg and Vienna). [NR 2003]
In Carinthia a working group has been established to develop guidelines for decisions on substitution treatment and drug-free treatment, from which requirements for treatment and care structures are derived [NR 2004, pg 26]. Furthermore, in 2004, the Ludwig-Boltzmann Institute for

[511] Promoting an appropriate integration has been continued. The need to coordinate addiction-related care with general medical and psychiatric treatment still remains a particular challenge.
[512] Plans and curricula for drug-related further training of five selected occupational groups have been completed.

Addiction Research, commissioned by the Vienna Social Fund, drew up an expert opinion on heroin-assisted treatment of chronic opiate addicts, in which the results of existing international programmes were analysed (Springer 2003a). [NR 2004, p. 31]. Carinthia's six-month early intervention service for young drug using first offenders ('Way Out'), was extended due to positive evaluation results (EDDRA). [NR 2004]

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. There are still few programmes and activities where needs assessment is carried out - but the need and usefulness of such an approach is increasingly acknowledged. [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy does not exist. Appropriate resources for implementation were outstanding in the past, but are no longer available. [RT]

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. Appropriate resources for implementation were outstanding in the past, but are no longer available. [RT]

At the Drug help centres whose names have officially been announced after an examination procedure have to meet federal quality standards defined by the Ministry of Health. At the provincial level relevant criteria and standards exist for the field of drug counselling and drug treatment. [NR 2004, pg 26]. The evaluation of the Needles or Pins reintegration project carried out in 2002 (cf. EDDRA) illustrates the success of the measures taken. [NR 2004, p.48]

In the field of prevention a Styrian interdisciplinary decision-making group on addiction prevention as a community task has drawn up quality standards for primary and secondary prevention. [NR 2004, p.18]. The youth department of the competent federal ministry is planning the definition of quality criteria for education and support of peer leaders. This is based on the results of an expert meeting of young peer leaders in prevention projects. [NR 2003, p.59]

The quality circle on evaluation coordinated by ÖBIG and including evaluation experts of various drug help centres in Vienna drew up the paper *Evaluation: Forderungen & Anleitungen* (Evaluation: demands and instructions; ÖBIG 2002c). [NR 2003, pg 60]

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. The further development of the national monitoring system in line with the needs and requirements of the EMCDDA has been a relevant priority for several years. [RT]

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

This policy does not exist . Appropriate resources for implementation were outstanding in the past, but are no longer available. [RT]

Generally speaking, evaluation and research have played an increasingly important role in Austria. Implementation of drug policies is more and more often accompanied and underpinned by studies assessing the relevant demand situation (e.g. the Tyrol and Styria), evaluation of pilot projects (e.g. Lower Austria, Carinthia and Vienna) as well as scientific studies and analyses (e.g. Burgenland, Upper Austria, Vorarlberg and Vienna). In addition Vorarlberg is the first province planning an evaluation of the provincial drug strategy. [NR 2003] In addition at both federal and provincial levels endeavours are made to intensify drug monitoring, which will improve the data situation and thus in future permit a better, and more objective, evaluation of the drug situation.

In Upper Austria a second comprehensive demand survey was conducted in the context of a Rapid Situation Assessment (RSA). The aim of the RSA was to collect relevant data on addition and drug problems as a basis for efficient planning of drug policy interventions. [NR 2003]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists, but was not based upon the Council Recommendation. Quality assurance in general and evaluation more specifically is included in the plans and curricula for drug specific further education (see 2.1 3). Evaluation training was organised the REITOX Focal Point as well as by other institutions during the last years. [RT]

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. The different stakeholders are not always, but often involved in evaluation. [RT]

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 specific policy does not exist. The exchange of results, skills and experience is taken care of by different means: input in the work of the EMCDDA, participation in EU projects and networks etc. Moreover, Austria participated in the drug specific PHARE Twinning activities in order to share with new Member States and applicants Member States. [RT]

Together with other organisations in twelve EU member countries, ÖBIG and the Vienna Social Projects Association participated in the EU project *Living with the Daily Dose*. The main objective of this project was to describe the situation of HIV-positive drug addicts and the development of strategies to improve access to care programmes for this target group (www.oebig.at). The project resulted in an extensive publication. [NR 2003]

Since 2001 the organisation ChEckiT! has taken part in an EU project for evaluating the effectiveness of secondary prevention measures and in particular the effects pill-testing programmes have on consumption patterns and risk awareness among users of synthetic drugs (ecstasy). This project included a comparison of drug screening programmes carried out in Vienna, Amsterdam and Hanover, which used different procedures. [NR 2002]

2.18.5 Additional information

Issues raised by NGO Ganslwirt

Information, education and communication (IEC). IEC is adequate in coverage and accessibility. Drug testing (pill-testing) exists, but is inadequate in coverage and accessibility as it is organized only occasionally and should be developed into regular intervention.

Outreach work. Outreach work is adequate in coverage and accessibility.

(Medically assisted) treatment and specific interventions. Medically assisted treatment for opiate users is available, but inadequately accessible in Austria due to a lack of services. Substitution drugs used are methadone and morphine. Heroin prescription programmes do not exist in Austria. No information is available about medically assisted treatment for ATS users and treatment for cocaine users is inadequate as no specialized services are offered. There are no ATS or cocaine prescription programmes available. Drug consumption rooms do not exist in Austria. NSPs as well as the distribution of drug paraphernalia are adequate in coverage and accessibility throughout the country. Low threshold agencies are adequate in coverage, but inadequate in accessibility as resources have been cut for facilities for homeless drug users. Specific harm reduction interventions targeted at cocaine users are inadequate in coverage and accessibility and no information is available if specific harm reduction interventions exists for ATS users.

Prison interventions. In prison, IEC is inadequate in both coverage and accessibility. Outreach work is performed in Austrian penitentiaries and is adequate in coverage and accessibility.
Availability and accessibility to medically assisted treatment in prison is inadequate, because of a lack of staff in prison facilities. Specific HR interventions for cocaine users are inadequate in

coverage and accessibility as they are not specifically developed for the target group. For ATS users no information is available whether specific HR interventions exist.
In prison, measures implemented to prevent infectious diseases are inadequate. There is no information whether hepatitis B vaccination exists within Austrian penitentiaries. NSPs are not implemented in prisons and the coverage and accessibility of drug paraphernalia distribution is considered inadequate.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Measures implemented to prevent infectious diseases are adequate. Hepatitis B vaccination is available and accessible. Tuberculosis vaccination programmes specifically targeting drug users do not exist.

Annex A2.19 State of play on harm reduction in Poland

2.19.1 Summary

Public health policy. Harm reduction is a public health objective in Poland. Harm reduction was already adopted in legislation in 1997.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines, websites and educational leaflets. For the reduction of drug-related deaths, the dissemination of information materials is the predominant response strategy. In specific geographical areas, communities are informed and involved in the prevention and reduction of health risks associated with drug dependence. Families of drug users are not involved in this.

Outreach work. Street-based outreach work and outreach work at dance parties, raves and in clubs are nationwide available. Outreach work as a health education approach is a predominant response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is a common setting for the deliverance of risk education/ response training. Peers and volunteers are included in outreach work practice in specific geographical areas. Networking and cooperation between outreach work agencies do not exist.

(Medically assisted) treatment and specific interventions. Drug-free outpatient treatment, drug free inpatient treatment and rehabilitation programmes are available nationwide. Methadone maintenance and detoxification programmes and drop-in centres are available in specific geographical areas. Treatment with buprenorphine or naltrexone is not provided, nor are drug consumption rooms and heroin prescription programmes. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Methadone detoxification programmes, distribution of condoms, and testing, prevention, education and treatment of infectious diseases are available nationwide in Polish prisons. Methadone maintenance programmes are available in specific geographical areas. There are neither needle and syringe exchange programmes nor drug paraphernalia available in Polish prisons.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening and counselling for infectious diseases are available nationwide. To prevent infectious diseases among drug users, the predominant response strategies are IEC in general, safer injecting training, outreach health education approach, and needle and syringe exchange. Needle and syringe exchange, drug paraphernalia and the distribution of condoms are available in specific geographical areas.

Drug-related deaths. The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals in substitution programmes. The policy to integrate risk reduction into an health strategy for drug users exists, but there is no clear information regarding its implementation.

Quality, monitoring and evaluation. Needs assessment schemes exist in Poland in the format of so called Rapid Assessment and Response monitors. Evaluation criteria for harm reduction programmes were to be developed by 2004, but have not been established yet.

2.19.2 Recommendation 1: Risk reduction and public health policy

In Poland, the Ministry of Health[513] is responsible for the implementation of the Council Recommendation.

Harm reduction is a public health objective in Poland and this policy is in compliance with the Council Recommendation, but not the consequence of it. Objectives related to the prevention of drug dependence in order to provide for 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. In general, if this report states that Polish policy and harm reduction activities are a consequence of the Council Recommendation, this entails that these measures are in compliance with it but not the result of its existence as the measures were implemented before 2003. [RT] [SQ 29].

2.19.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation[514]. [RT]
In Poland, telephone help lines, websites and a broad range of educational leaflets are available nationwide. Training[515] is available to drug users in specific geographical areas only.
[NR 2002/2004]

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[516] and this is delivered by low threshold agencies, especially outreach work. [SQ 23]

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 rave events. A common response strategy is risk education/ response training, which is delivered in some or few cities[517]. [SQ 29]

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 exists and was based upon the Council Recommendation[518]. [RT]
Families of drug users are not involved in the prevention and reduction of health risks associated with drug dependence; communities are involved[519] in specific geographical areas. Specific IEC is also available for communities of drug users[520]. [NFP 2006]

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[513] National Bureau of Drug prevention.
[514] Information is provided through the media campaign, leaflets, information bulletins or other materials published mainly by NBDP but also by National AIDS Center. Counselling to drug users is provided generally by the outpatient centres, selected recreational settings and HIV prevention centres.
[515] Also safer injection training, safer use, providing first aid, trainings are available especially targeted at people using synthetic drugs.
[516] Street working and syringe / needle exchange is usually connected with the safer injecting training. Training is conducted during outreach work and in a drop-in centre. There are also bulletins for active drug users which includes permanent column on safer injections. The most common topics are hygiene and syringe / needle exchange.
[517] The trainings are available in Warsaw, Krakow, Olsztyn, Pulawy, Lublin, Katowice, Czestochowa, Poznan, Szczecin, Wroclaw, Zgorzelec.
[518] Information is provided mainly through national and local information campaigns.
[519] Some communities support harm reduction programmes.
[520] Journal for drug addicts is issued by a NGO in Krakow. The journal is focused on harm reduction messages.

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 and was based upon the Council Recommendation[521]. [RT]
In Poland, street-based outreach work and outreach work at dance parties, raves and in clubs are available nationwide. [NR 2002- 2004]
To **prevent infectious diseases** among drug users, outreach work as a health education approach is a predominant response strategy. Outreach work and targeted high-risk group interventions are a predominant implementation setting for infectious diseases prevention measures targeting drug users. [SQ 23]

A common response strategy aiming at the **reduction of drug-related deaths** is risk education/ response training through outreach workers. 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. [SQ 29]

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 exists and was based upon the Council Recommendation[522]. [RT]
In specific geographical areas, peers and volunteers are included in outreach work[523] practice and they are also trained to do so[524]. [NFP 2006]

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. [RT]
Networking and cooperation between outreach work agencies do not exist[525]. [NFP 2006]

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 exists, but was not based upon the Council Recommendation[526]. [RT]
Drug-free outpatient treatment, drug-free inpatient treatment and rehabilitation programmes are available nationwide. Methadone maintenance programmes[527], methadone detoxification programmes and drop-in centres are available in specific geographical areas only. Treatment with buprenorphine or naltrexone is not available. Substitution treatment is supported by (obligatory) psychosocial care. [NR 2003/ 2004; NFP 2006]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is an uncommon response strategy. [SQ 29] Drug consumption rooms and heroin prescription programmes do not exist in Poland.

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[521] Special training for outreach workers are organised by NBDP. Within the National Programme standards and methods for this kind of interventions have been elaborating.
[522] In 2004, special training for workers and volunteers working in the dance clubs was organised. Its main topics included methods of work, early interventions and first aid.
[523] For example in Warsaw the peer education approach is used. Also the drug user's network is used for implementation of needle and syringes exchange programmes.
[524] National training programmes or training curricula for peers and volunteers involved in outreach work are not available. The peers and volunteers are trained within programmes.
[525] Only in an informal way.
[526] Availability of substitution treatment is not sufficient. However increase in the access to this kind of treatment is one of the main priorities of the national drug policy. Drug-free treatment is considered sufficient.
[527] Ten centres exist throughout the country.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide[528]. [NFP 2006]

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[529]. [RT]
Methadone detoxification programmes, distribution of condoms, and testing, prevention, education and treatment of infectious diseases[530] are available nationwide in Polish prisons. Methadone maintenance programmes are available in prisons in specific geographical areas only[531]. There are neither needle and syringe exchange programmes nor drug paraphernalia available in Polish prisons. [NR 2002/ 2004]

Prisons are a common implementation setting for the dissemination of information materials on the prevention of **infectious diseases** among drug users, and on the **reduction of drug-related deaths** and emergencies. [SQ 23, SQ 29]

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 and was based upon the Council Recommendation[532]. [RT]
Testing/ screening and counselling with regard to infectious diseases are available nationwide in Poland. In specific geographical areas, education and treatment of infectious diseases are available[533,534]. [NR 2003/ 2004]

To **prevent infectious diseases** among drug users the predominant response strategies are IEC in general, safer injecting training, outreach health education approach, and needle and syringe exchange programmes. Other, common strategies include IEC via peer involvement/ peer approach and condom promotion among drug users. Predominant implementation settings for infectious diseases prevention measures targeting drug users include low threshold counselling, outreach work targeted high risk group interventions. Common implementation settings are specialised drug treatment services and prisons. [SQ 23]

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

This policy exists and was based upon the Council Recommendation[535]. [RT]
In specific geographical areas, needle and syringe exchange programmes, drug paraphernalia[536] and the distribution of condoms are available. [NR 2002/ 2004]

Needle and syringe exchange programmes are a predominant response strategy to **prevent infectious diseases** among drug users in Poland. [SQ 23] Low threshold agencies, including needle and syringe exchange programmes, are also a predominant implementation setting to provide information materials on the **reduction of drug-related deaths** among drug users, and

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[528] Methadone is under strong control. Methadone is given to patients in liquid condition (syrup) and consumed by patients under supervision of staff.
[529] In prisons access to drug-free treatment, and in three custodial institutions substitution treatment is available. In general, access to services for drug addicts in prison is still not sufficient.
[530] Vaccinations and blood tests are carried out.
[531] First project in Krakow, 14 participants.
[532] Drug dependent users who wan to test for HIV can do it anonymously and free of charge in special counselling points. Screening for mentioned diseases and testing on hepatitis B and C among IDUs is not provided.
[533] Current drug users are excluded from ARV treatment.
[534] No specific vaccinations for drug users exist.
[535] 23 programmes of syringe and needle exchange are conducted in 22 cities in Poland.
[536] Sterile kits.

are a common setting for the deliverance of risk education/ response trainings for drug users. [SQ 29]

Poland has in total 29 non-pharmacy based needle and syringe exchange programmes[537]. Needle and syringe exchange takes place through fixed sites and outreach/ peer but not through vans/ buses, vending machines, via pharmacies or in prisons. [ST 10]

There are no legal restrictions to the possession of sterile needles in Poland, and also no prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists and was based upon the Council Recommendation[538]. [RT]
However, in Poland, trainings for professionals working at emergency units do not exist, and emergency departments are not in use as a setting for dissemination of information materials that aim at the reduction of drug-related deaths or for risk education/ response trainings. [SQ 29]
Polish ambulances routinely carry antagonists. The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is not available[539]. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation. [RT]
No clear information is available whether an integrated health strategy for drug users exists in Poland. [NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation[540]. [RT]
Training for professionals in substitution treatment is available nationwide[541]. Training is offered in specific geographical areas to outreach workers, professionals in low threshold programmes, needle and syringe exchange programmes[542], treatment facilities and to prison staff [543]. [NR 2003/ 2004; NFP 2006]

2.19.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

Answers concerning national policy based upon Council Recommendation indicate that national solutions or activities are in the line with the decisions of the Recommendation, but were not directly based on them (were implemented earlier). [RT].

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based on the Council Recommendation. Trainings for professionals working in the field of prevention aimed at increasing the knowledge about evidence based programmes are organized on a regular basis. The NBDP also promote programmes based on standards and include evaluation component in their structure. [RT]

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[537] In 2003 there were 29 points, in 2002 there were 31.
[538] It is in the standards of trainings for people working in the emergency services.
[539] Access to naloxone is limited to medical doctors.
[540] In the special training for people working with drug users, certificated by the Minister of Health, people from different sectors are participating (health care, social care).
[541] The training is provided mainly by Institute of Psychiatry and Neurology or/and by other experienced substitution treatment facilities.
[542] National training programmes or even training curricula for professional needle and syringe exchange programmes are not available. The workers are trained within programmes.
[543] Ad hoc training programmes are organised. They are arranged by the prison administration with collaboration of NGOs and other drug professionals.

Moreover, the National Focal Point conducted and commissioned for implementation and/or participation in the following research projects in the framework of harmonising Polish systems of data collection with the EU standards [NR 2004]:

- Project of "Reporting to treatment due to drug use"
- ESPAD – questionnaire survey on drug and alcohol use at upper-primary schools (age: 15-16) and secondary schools (age: 17-18)
- EDDRA – programme of recording and evaluation of drug demand reduction activities, pg 10

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. [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy exists, but was not based on the Council Recommendation.
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 works on the elaboration of evaluation protocol for risk reduction programmes are conducted. [RT]

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. [NR 2004]

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.

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 on the Council Recommendation.
The evaluation quality criteria are in the process of elaboration. [RT]

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 on the Council Recommendation.
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. [RT]

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

This policy exists, but was not based on the Council Recommendation.
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. [RT]

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.

In 2003 upon commission of the National Bureau for Drug Prevention a research project called "Institutional conditioning of drug prevention". The project covered organisations operating at national level and implementing drug demand reduction programmes. [NR 2004]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists, but was not based on the Council Recommendation.
NBDP commissions the evaluation programmes organized for NGO's workers who created and implemented prevention and risk reduction programme on regional and local level. [RT]

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 on the Council Recommendation.
NBPD promote 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. [RT]

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 on the Council Recommendation.
National experts were involved in the cooperation of the EMCDDA with third countries like Turkey and some republics of Asia. [RT].

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. [NR 2003]

2.19.5 Information from third data sources

Issues raised by NGO Monar

Information, education and communication (IEC). IEC is inadequate in coverage, but adequately accessible. Most IEC is abstinence-oriented. There is little harm reduction information and education available for drug users, but there are some exceptions, e.g. a harm reduction bulletin. Drug testing is not available in Poland.

Outreach work. Outreach work is efficiently implemented only in Krakow, Warsaw and Gdansk, but lacks national coverage and accessibility.

(Medically assisted) treatment and specific interventions. Medically assisted treatment for opiate users is inadequate in availability and accessibility. Nationwide there are 12 methadone programmes. Especially in Warsaw users have to wait for several months to be able to enter the programmes[544]. Generally methadone is the first substitution drug, but buprenorphine (called Bunondol) can be purchased. There is no heroin prescription programme in Poland. There is no medically assisted treatment for ATS or cocaine users nor prescription programmes for users of stimulants. Specific services for cocaine or ATS users are inadequate in coverage and accessibility. Officially there are no drug consumption rooms in Poland. Unofficially there is at least one consumption room. In Krakow, Warsaw and Gdansk there are some very well operating and low threshold NSP, but the majority of Polish cities does not have NSPs. Drug paraphernalia are available through the few NSPs, but no paraphernalia are available for non-injectors.

[544] Poland has an integrated model of treatment and care for HIV positive drug users: The AIDS centre of Chorzow became one of the first sites in Poland for piloting methadone treatment projects in 1998. The centre proposed methadone therapy as part of the AIDS care kit for patients who are IDUs.
In: CEE-HRN. *Scaling Up Provision of Anti-Retrovirals to Drug Users in Central and Eastern Europe and Central Asia*. www.ceehrn.org/arv4idus; visited June 2006.

Low threshold agencies are inadequate in coverage, as there are only two drop-in centres in Poland. Existing facilities are situated in the big urban centres and are considered adequate in accessibility. There are no specific harm reduction interventions for ATS or cocaine users in Poland.

Prison interventions. IEC in prison is inadequate in coverage as well as in accessibility. Outreach work in prison exists in various cities throughout the country, but is underdeveloped.
Availability of, and accessibility to substitution treatment is inadequate as methadone substitution is provided only in three remand prisons (2 in Warsaw, 1 in Krakow) for a small number of inmates. Methadone is the only substitution drug provided in prisons. There are no medically assisted treatments or specific HR interventions for ATS or cocaine users available in prison. There are no NSPs in prisons and drug paraphernalia are also not available. Measures implemented to prevent infectious diseases are inadequate because information is not thorough enough. There is no information available on hepatitis B or tuberculosis vaccination programmes targeted at drug users in Polish prisons.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Measures implemented to prevent infectious diseases are inadequate because the information is provided only through the few NSPs and condom distribution.
Hepatitis B and tuberculosis vaccination programmes targeting drug users do not exist, but everyone has access to the general hepatitis B and tuberculosis (vaccination) services, which are considered inadequate in accessibility for drug users.

Measures to involve families and friends of drug users in harm reduction interventions are underdeveloped and inadequate in coverage and accessibility.

Annex A2.20 State of play on harm reduction in Portugal

2.20.1 Summary

Public health policy. Harm reduction is a public health objective in Portugal. Harm reduction policy exists since 1999.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines, websites, training, and educational leaflets. For the reduction of drug-related deaths, risk education/ response training for drug users is the predominant response strategy. 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.

Outreach work. Street-based outreach work is nationwide available. Outreach work as a health education approach is a predominant response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials, as well as for the deliverance of risk education/ response training. Peers and volunteers are included in outreach work practice in specific geographical areas. Networking and cooperation between outreach work agencies exist nationwide.

(Medically assisted) treatment and specific interventions. Methadone maintenance programmes, drug-free outpatient and inpatient treatment, and rehabilitation centres are available nationwide. Methadone detoxification treatment, treatment with buprenorphine and with naltrexone, and drop-in centres are available in specific geographical areas. Drug consumption rooms and heroin prescription programmes do not (yet) exist in Portugal. Opioid substitution treatment is a predominant response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Counselling and testing, education, prevention and treatment of infectious diseases as well as distribution of condoms and drug paraphernalia are nationwide available in Portuguese prisons. In some prisons, methadone maintenance, buprenorphine, and methadone detoxification treatment are available. Needle and syringe exchange programmes are not available in prisons in Portugal.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening, counselling and vaccination programmes targeting drug users are nationwide available. To prevent infectious diseases among drug users, the predominant response strategies are IEC in general, IEC via counselling and advice by drugs and health professionals, outreach health education approach, condom promotion among drug users, routine screening of high risk groups, easy access' programmes for drug users to treatment of infectious diseases, and needle and syringe exchange. Needle and syringe exchange, drug paraphernalia and the distribution of condoms are nationwide available.

Drug-related deaths. The distribution, possession or administration of naloxone is not regulated. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals in outreach work, substitution programmes, needle and syringe exchange programmes, treatment facilities, low threshold programmes and to prison staff. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation Portugal is developing quality assurance and evaluation tools. The National Drug Strategy 2000-2004 was evaluated and called for further development of harm reduction programmes.

2.20.2 Recommendation 1: Risk reduction and public health policy

In Portugal, the main responsible governmental body responsible for the implementation of the Council Recommendation is the Ministry of Health[545].

Harm reduction is a public health objective in Portugal, but is not based on the Council Recommendation. The policy objectives proposed in the Council Recommendation were already established in the Portuguese Strategy on Drugs, adopted in 1999 and also in the National Action Plan on Drugs 2000-2004. As a result Council Recommendation did not have any impact on these policies. [RT] [SQ29]

2.20.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but is not based upon the Council Recommendation. [RT]
In Portugal, various telephone help lines[546], websites[547], training, and a broad range of educational leaflets are available nationwide. [NR2003/ 2004; NFP 2006]

To **prevent infectious diseases** among drug users, providing information, education, communication (IEC) via counselling and advice by drugs and health professionals; and easy access' programmes to treatment of infectious diseases are predominant response strategies, whereas safer injecting training, and IEC through peer involvement/ peer approach are a common response strategies. [SQ 23]

With regard to the **reduction of drug-related deaths**, risk education / response training for drug users is the predominant response strategy; training is predominantly delivered at low threshold agencies and through outreach workers and they are commonly disseminated through specialized drug treatment services and rave/ festival events. A common response strategy is the dissemination of information materials. This information is predominantly disseminated at low threshold agencies[548] and through outreach workers and is common in specialised drug treatment services, detoxification services and rave/ festivals events. [SQ 29]

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 exists, but is not based upon the Council Recommendation. [RT]
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. [NR 2003]

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 is not based upon the Council Recommendation. [RT]
In Portugal, street-based outreach work is nationwide available[549]. Outreach work at dance parties, raves and in clubs is available in specific geographical areas only. [NR 2003, NR 2004; NFP 2006]

To **prevent infectious diseases** among drug users, outreach work as a health education approach is a predominant response strategy. Outreach work and targeted high-risk group interventions are a predominant implementation setting for infectious diseases prevention measures targeting drug users. [SQ 23]

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[545] Institute of Drugs and Drug Addiction (IDT) – Treatment and Harm Reduction Department.
[546] Linha Vida - SOS Drogas.
[547] www.drogas.pt
[548] At national level an institution exists that developed strategies to prevent infectious diseases among IDU specifically with regard to HIV.
[549] In 2004, 25 projects were implemented throughout the country.

Risk education/ response training for drug users through **outreach workers** is the predominant response strategy, and needle and 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.** [SQ 29]

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 exists, but implementation is pending for approval. [RT]
Currently, peers and volunteers are trained and included in outreach work practice, in specific geographical areas only [NFP2006]

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 implementation is pending for approval. [RT]
However, networking and cooperation between outreach work agencies exist nationwide[550]. [NFP 2006]

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 exists, but was not based upon the Council Recommendation. [RT]
Methadone maintenance programmes[551], drug-free outpatient, drug-free inpatient treatment, and rehabilitation centres are available nationwide. Methadone detoxification treatment, treatment with buprenorphine and with naltrexone, and drop-in centres are available in specific geographical regions. Substitution treatment is supported by (obligatory) psychosocial care. [NR 2003/ 2004; NFP 2006]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a predominant response strategy. [SQ 29] Drug consumption rooms[552] and heroin prescription programmes do not exist in Portugal.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide. [NFP 2006]

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, but was not based upon the Council Recommendation. [RT]
Distribution of condoms, counselling and testing, education, prevention and treatment of infectious diseases and drug paraphernalia are nationwide available in Portuguese prisons. In some prisons, methadone maintenance treatment and buprenorphine treatment and methadone detoxification treatment are available. Needle and syringe exchange programmes are not available in prisons in Portugal. [NR 2003/ 2004; NFP 2006]

Prisons are a predominant implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]. Measures targeting at the **reduction of drug – related deaths** are uncommon in Portuguese prisons. [SQ 29]

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[550] All outreach work agencies have developed protocols and are engaged in cooperation between treatment and social services of the region where the intervention was developed.
[551] Also pharmacy-based methadone maintenance treatment.
[552] Though existing legislation allows for the implementation of drug consumption rooms.

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. [RT]
Testing/ screening[553], and counselling and vaccination programmes targeting drug users are available nationwide. [NR 2003; NFP 2006]

To **prevent infectious diseases** among drug users the predominant response strategies are IEC in general[554] IEC via counselling and advice by drugs and health professionals, outreach health education approach, condom promotion among drug users, needle and syringes exchange, routine screening of high risk groups, and easy access programmes for drug users to treatment of infectious diseases. Other, common strategies include safer injecting training, IEC via peer involvement/ peer approach, and hepatitis vaccination programme for drug users. Predominant implementation settings for infectious diseases prevention measures targeting drug users include specialized drug treatment services, outreach work and targeted high risk group interventions, primary care/ GP's, and prisons. [SQ 23; NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Needle and syringe exchange[555], drug paraphernalia and the distribution of condoms are available nationwide. [NR 2003/ 2004; NFP 2006]. Needle and syringe exchange programmes and condom promotion among drug users are predominant response strategies to **prevent infectious diseases** among drug users in Portugal. [SQ 23]

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. [SQ29]. Portugal counts in 80 non-pharmacy based and 1232 pharmacy-based needle and syringe exchange points. Needle and syringe exchange takes place through fixed sites, vans/ buses, outreach / peer, pharmacy and non-pharmacy based outlets, but not through vending machines or in prisons. [ST 10]. There are no legal restrictions to the possession of sterile needles in Portugal, and also no prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation. [RT]
There are no specific training programmes on drug overdoses available to professionals of emergency departments [NFP 2006]. Emergency departments are an uncommon setting for the dissemination of information materials that aim at the reduction of drug-related deaths or for risk education/ response training. [SQ 29]

Portuguese ambulances routinely carry antagonists. [SQ29] The distribution, possession or administration of naloxone is not regulated. Naloxone on a 'take home' basis is not available.
[SQ 29; NFP 2006]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but implementation is pending for approval. [RT]
Risk reduction is part of an integrated health strategy for drug users[556]. [NFP 2006]

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

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[553] There is a programme (Klotho) that tracks early the infection of HIV virus among drug users.
[554] Through public treatment network and information leaflets.
[555] There is only 1 national needle and syringe exchange programme in Portugal ("Say no to a used syringe") with many outlets/points of distribution.
[556] Responses at this level are integrated with health and social services nation wide.

This policy exists, but was not based upon the Council Recommendation. [RT]
Training is offered nationwide to outreach workers, prison staff, professionals in substitution programmes[557], needle and syringe exchange programmes[558], treatment facilities and low threshold programmes[559]. [NR 2004; NFP 2006]

2.20.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. [RT]

Best practice interventions in Portugal are identified and entered into the EMCDDA's EDDRA database on basis of evaluation forms. An evaluation of buprenorphine treatment was organised in recent years. [2004]

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. [RT]

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. Furthermore, needs assessment was carried out at the start of Reintegration Programmes, (including reintegration of drug users). [NR 2002]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy exists, but was not based upon the Council Recommendation. The outreach work, such as street teams, has evaluation protocols with the IDT. [RT]

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. [RT]

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. [RT]

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. [RT]

The National Drug Strategy 'Horizon 2004' was evaluated internally and externally, followed up by a number of recommendations, among which the following: "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.)". [NR 2004]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy does not exist, but is pending for approval.

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[557] Buprenorphine.
[558] Specific training for pharmacies concerning needle and syringe exchange.
[559] Training programmes concerning harm reduction policies in the Northern Region of Portugal target to Street teams professionals.

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. Rezolat Project integrates an innovative methodology of evaluation. [RT]

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. The IDT exchange programme results, skills and experience with other Member States of the EU, among others through EDDRA. [RT]

Since buprenorphine was first used in Portugal, training and training exchanges have been organised with France. 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. [NR 2004]

2.20.5 Information from third data sources

Issues raised by NGO Abraço

Information, Education, Communication (IEC) IEC is inadequate in accessibility.

Outreach work Outreach work is inadequate in coverage and accessibility. The quality of outreach work is not always adequate.

(Medically assisted) treatment and specific interventions. Medically assisted treatment for opiate users in Portugal is considered inadequate in coverage and accessibility as only about
13 000 of an estimated 65 000- 100 000 problematic drug users are being treated. Availability of treatment access was numerically reduced since 1998 when 35 000-40 000 drug users were in treatment. Currently, access is primarily granted to pregnant or HIV-infected drug users. The coverage and accessibility of medically assisted treatment to ATS users is inadequate as there are no structured programmes and very few specialists can support users in such treatment.
There are no drug consumption rooms in Portugal. The public debate on the topic shows readiness, however, to introduce these services inside and outside prison. Accessibility to needle and syringe exchange programmes or drug paraphernalia is poor due to low coverage. Low threshold agencies are inadequate in coverage and accessibility, because they offer little places and the quality of services is questionable

Prison interventions In prison, access to substitution treatment is only granted if the detainee has received substitution treatment outside prison. Improvements can be expected from the anticipated reform of the prison health services in 2006. Medically assisted treatment to ATS users in prison is not available.
Public debate centering around the topic shows readiness, however, to introduce drug consumption rooms in prison. There are no NSPs or drug paraphernalia distribution programmes in Portuguese prisons. For prisons, outreach work is inadequate in coverage and accessibility. It is difficult to get access to prison in order to perform outreach interventions.
There are no specific harm reduction interventions targeted at cocaine or ATS users in prison
The distribution of information, education and communication (IEC) is inadequate in prison.

Annex A2.21 State of play on harm reduction in Slovenia

2.21.1 Summary

Public health policy. Harm reduction is a public health objective in Slovenia for some years already, and pre-existed the Council Recommendation.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines, websites and educational leaflets. For 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. Communities and families of drug users are informed and involved in the prevention and reduction of health risks associated with drug dependence.

Outreach work. Outreach work at dance parties/ raves and in clubs is nationwide available. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials. In specific geographical regions, peers and volunteers are included in outreach work practice. Networking and cooperation between outreach work agencies exist nationwide.

(Medically assisted) treatment and specific interventions. Methadone maintenance and methadone detoxification programmes, buprenorphine treatment, drug-free in- and outpatient treatment and rehabilitation programmes are nationwide available. Treatment with naltrexone and drop-in centres/ shelters are available in specific geographical areas. Slovenia does not have drug consumption rooms, and has no heroin prescription programmes. Opioid substitution treatment is a predominant response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. 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. Methadone detoxification treatment is available in specific geographical regions only.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening, education, prevention, counselling, vaccination programmes against tuberculosis targeting drug users, and treatment of infectious diseases are available nationwide. To prevent infectious diseases among drug users, common response strategies are IEC in general, IEC via counselling and advice by drugs and health professionals, and outreach health education, voluntary infectious diseases counselling and testing, condom promotion among drug users, needle and syringe exchange, routine screening of high risk groups, a hepatitis vaccination programme for drug users, and easy access' programmes for drug users to treatment of infectious diseases. Needle and syringe exchange programmes and condoms are available nationwide. Drug paraphernalia are available in specific geographical regions.

Drug-related deaths. Professionals of emergency departments are trained nationwide, e.g., to deal with overdoses. The distribution or administration of naloxone is not regulated. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals working in outreach work, emergency departments, in treatment facilities and in prison settings. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. Some programmes for quality assessment and evaluation exist in Slovenia. Needle exchange programmes have been evaluated. In the near future, needs assessment will become a precondition for funding of interventions. There are formal quality assurance guidelines for all governmental programmes.

2.21.2 Recommendation 1: Risk reduction and public health policy

The governmental body that is responsible for the implementation of the Council Recommendation in Slovenia is the Ministry of Health[560].

Harm reduction is a public health policy objective in Slovenia. The Council Recommendation has influenced national policy. The Resolution on the National Programme in the Field of Drugs (ReNPPD) was adopted by the National Assembly in February 2004. It is a result of current social development and signifies a harmonisation of various sectored approaches in relation to aims, priority tasks, sources and costs. The ReNPPD takes into account the international legal framework, UN conventions, the provisions of the Council of Europe and European Union and other international treaties and recommendations in various professional fields. The Act Prevention of the Use of Illicit Drugs and dealing with Consumers of Illicit Drugs sets out the measures for preventing the use of illicit drugs and for dealing with consumers of illicit drugs. [RT]

2.21.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but is not based upon the Council Recommendation [561]. [RT]
In Slovenia, information is disseminated nationwide through telephone help lines, various websites[562] and educational leaflets. In specific geographical regions, training for drug users is organised. [NR 2002-2004]

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. [SQ 23]

With regard to the **reduction of drug-related deaths** the dissemination of information materials, risk education/ response training[563] 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. [SQ 29; NFP 2006]

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 exists and is based upon the Council Recommendation. [RT]
Communities and families of drug users are involved in harm reduction; specific information, education, communication for these target groups is available. [NR 2004; NFP 2006]

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

[560] Office for Drugs.
[561] The aim of the Slovenian Drug Action Plan (ReNPPD) is to support the development of programmes that will help to stabilise or reduce the numbers infected with AIDS and hepatitis B and C and fatal cases of overdose and to ensure more quality programmes for treating drug addiction with the introduction of various approaches
[562] www.drogart.si; www.ivz.si; internet counselling.
[563] Training are available in some or few cities.

This policy exists and was based upon the Council Recommendation[564]. [RT]
In Slovenia, outreach work at dance parties/ raves and in clubs is nationwide available. Street-based outreach work is available in specific geographical regions. [NR 2002/ 2004]
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. [SQ 23]

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. [SQ 29]

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 exists and was based upon the Council Recommendation[565]. [RT]
In specific geographical regions, peers and volunteers are included in outreach work; training for these groups is available also in specific areas. [NR 2002]

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

This policy exists and was based upon the Council Recommendation[566]. [RT]
Networking and cooperation between agencies involved in outreach exist nationwide. [NR 2004]

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 exists and was based upon the Council Recommendation[567]. [RT]
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. [NR 2003/ 2004; NFP 2006]

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. [SQ 29]
Slovenia does not have drug consumption rooms, and has no heroin prescription programmes.

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. [RT]
Measures to prevent diversion of prescribed drugs are nationwide available[568]. [NFP 2006]

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[564] The faculty for Social Work in Ljubljana is permanently involved in development of those organisations that provide low threshold services for drug users. The Faculty has established strong and continuing work in the field of drug use and harm reduction [NFP 2006].
[565] The faculty for Social Work is also regularly involved in the development of new and innovative approaches in the field of drugs. Through training and research a lot of contacts and network have been created, including co-operation with different state and non-governmental bodies and associations.
[566] The Association of NGO's in the field of harm reduction was formally established in 2004.
[567] In the Article 8 of The Act Prevention of the Use of Illicit Drugs and dealing with Consumers of Illicit Drugs is said Treatment of consumers of illicit drugs shall be carried out in the form of hospital and outpatient clinic treatment programmes approved by the Health Council.
[568] The different measures to prevent diversion of prescribed drugs (mostly methadone) are available in CPTDA (e.g., availability in specialised centres, solution form, book of narcotics).

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[569]. [RT]
Testing, prevention, education and treatment of infectious diseases are available nationwide in prisons. Methadone detoxification treatment, treatment with naltrexone[570], condoms, counselling and prison pre-release interventions are also provided nationwide in prisons. Methadone detoxification treatment is available in specific geographical regions only. [NR 2002-2004; NFP 2006].

Prisons are a common implementation setting for disseminating information materials to **prevent infectious diseases** in drug users. [SQ 23]
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. [SQ 29]

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 and was based upon the Council Recommendation[571]. [RT]
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. [NR 2004; NFP 2006]

Common response strategies to **prevent infectious diseases** among drug users are: IEC in general, IEC via counselling by drugs and health professionals, an outreach health education approach, voluntary infectious diseases counselling and testing, condom promotion among drug users, needle and syringe exchange programmes, routine screening of high risk groups, a hepatitis vaccination programme for drug users, and easy access programmes for drug users to treatment of infectious diseases.

Predominant implementation settings for infectious diseases prevention measures are specialised drug treatment services. Common implementation settings include low threshold counselling services, outreach work and targeted high risk group interventions, primary care/ GP's and prisons. [SQ 23]

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

This policy exists and was based upon the Council Recommendation[572]. [RT]
Needle and syringe exchange programmes and condoms are available nationwide. Drug paraphernalia are available in specific geographical regions. [NR 2004; NFP 2006] Needle and syringe exchange programmes are a common response strategy to **prevent infectious diseases** among drug users in Slovenia. [SQ 23]

With regard to the **reduction of drug-related deaths** among drug users, low threshold agencies, including needle and syringe exchange programmes, are a predominant setting both for dissemination of information materials and for providing risk education / response training for drug users. [SQ 29]

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[569] Regarding the ReNPPD treatment of drug addiction is provided in prisons under the same conditions of doctrine as to addicts outside prison.
[570] According to General instructions for treating drug users in prisons adopted in spring 2005, if a patient is free of opiates then therapy with naltrexone can be started in prisons or before visits outside prisons or before release.
[571] Persons in a methadone programme are motivated to be vaccinated against hepatitis B in all centres. During the 1999 to 2003 period HIV prevalence consistently remained below 1% among confidentially tested injecting drug users demanding treatment in methadone programme.
[572] Programmes intended for harm reduction are programmes covering distribution of intravenous injection needles, condoms, advice on reducing the harm caused by the use of illicit drugs, and other programmes intended for harm reduction.

In 2003, Slovenia had 26 needle and syringe exchange programmes. Types of needle and syringe exchange available include fixed sites, vans/ buses, outreach/ peer, vending machines, and pharmacy-based needle and syringe exchange. Prison-based needle and syringe exchange is not available. [ST 10]

There are no legal restrictions to the possession of sterile needles in Slovenia, and also no prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists and is based upon the Council Recommendation. [RT]
Training programmes for professionals of emergency services are available nationwide. [NFP 2006]
Emergency departments are an uncommon setting for risk education/ response training. [SQ29]
Ambulances routinely carry antagonists. The distribution or administration of naloxone is not regulated. Naloxone is not available on a 'take home' basis. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists and was based upon the Council Recommendation[573]. [RT]
Nationwide, risk reduction is part of an integrated health strategy for drug users.
[NR 2002/ 2003]

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

This policy exists and was based upon the Council Recommendation[574]. [RT]
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, professionals working in needle exchange programmes, in substitution programmes, and in low threshold programmes. [NR 2003/ 2004; NFP 2006]

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. [SQ 23]

2.21.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists and was based upon the Council Recommendation. [RT].
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.

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.
Regarding the ReNPPD in the coming medium term period, all programmes funded from the budget must be checked. Similarly in this period, a uniform assessment system must be set up, which must start to apply in all phases of planning and implementation of programmes. [RT]

[573] In all programmes of treatment of drug addiction psychotherapeutic and psychosocial treatment must be provided together with medical treatment, which is carried out by experts trained in the treatment of drug users, and programmes of solving social problems.
[574] In the year 2003/2004 the Faculty of Social Work started with the postgraduate specialist study called drug-related harm reduction. The programme of study includes the bases of harm reduction, approaches to harm reduction and methods of harm reduction, practical work and individual study.

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy exists and was based upon the Council Recommendation.
The aim of the ReNPPD is that the majority of programmes are evaluated by external experts who meet conditions for scientific research work. [RT]

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

Policy exists and was based upon the Council Recommendation.
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. [RT].

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.

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. [NR 2002]

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

This policy exists and was based upon the Council Recommendation.
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 aforementioned European centre. [RT]

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

This policy exists and was based upon the Council Recommendation. [RT]
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 draft programme of evaluation procedures, especially for evaluating strategic documents and legislation. [NR 2003]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists and was based upon the Council Recommendation.
An expert body is being created for this purpose, which will produce professional standards and guidelines. [RT]

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. [RT]

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. [RT]
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. [NR 2003]

2.21.5 Information from third data sources

Issues raised by NGO STIGMA

Information, education, communication (IEC). IEC is adequate in coverage and accessibility. Drug testing for party drugs is available and accessible at one location and considered adequately accessible.

Outreach work. The outreach work network is too small to cover all critical points throughout the country, but accessibility is considered adequate.

(Medically assisted) treatment and other interventions. Medically assisted treatment for opiate users is adequate for drug users in general. There are 18 methadone maintenance treatment centres nationwide, and one detoxification facility.
Medically assisted treatment specifically developed for ATS users and cocaine users are not available in Slovenia. If ATS users seek help in methadone maintenance treatment centres, they are referred to a psychiatrist. Detoxification services are also available.
There are no heroin, ATS or cocaine prescription services in Slovenia. Coverage and accessibility of NSP and drug paraphernalia distribution is adequate in Slovenia. Coverage of low threshold agencies is inadequate, but accessibility of those available is considered good. There are no drug consumption rooms in Slovenia. Harm reduction interventions targeting cocaine and ATS users are implemented at dance parties by one NGO. Their accessibility is not adequate, as they are only implemented at dance parties.

Prison interventions. Brochures, internet information, training sessions and help-lines are not adequately accessible from within prisons. Medically assisted treatment for opiate users is adequate for drug users in prison. Methadone is available and adequately accessible in prisons.[575]
In prison, detainees have access to medically assisted treatment every week. In prison NSP and drug paraphernalia are not available. Outreach work does not take place in all prisons in the country. In prisons there are no specific harm reduction interventions for these target groups. In some penitentiaries infectious diseases counselling based upon harm reduction is possible, but runs short of distributing proactive materials such as clean equipment, which makes services inadequate. Hepatitis B vaccination programmes are an integral part of the methadone maintenance treatment programme in prison.

Infectious diseases. Coverage and accessibility to measures preventing infectious diseases is adequately available in Slovenia. Hepatitis B vaccination programmes are an integral part of the methadone maintenance treatment programme. For those users not in methadone treatment accessibility is inadequate. Vaccination for tuberculosis implemented in MMT-programmes was discontinued after incidence rate showed no need. There no longer is a vaccination programme for tuberculosis in Slovenia.

[575] Also refer to: Sarang, Anya, Raminta Stuikyte and Roman Bykov: "Implementation of harm reduction measures in Eastern Europe and Central Asia: Lessons learned," at: http://www.ceehrn.org/index.php?ItemId=939.

Annex A2.22 State of play on harm reduction in Slovakia

2.22.1 Summary

Public health policy. Harm reduction is a public health objective in Slovakia and is partly based upon the Council Recommendation. Harm reduction has been adopted in the National Programme for the Fight Against Drugs 2004-2008.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through websites and educational leaflets. Communities and families of drug users are nationwide informed, and involved in the prevention and reduction of health risks associated with drug dependence.

Outreach work. Street-based outreach work and outreach work at open–air summer festivals and similar summer events/ musical parties are available in specific geographical areas. In specific geographical areas, peers and volunteers are trained and included in outreach work practice. Networking and cooperation between outreach work agencies is not an existing policy.

(Medically assisted) treatment and specific interventions. Detoxification programmes, drug-free inpatient and drug-free outpatient treatment, and rehabilitation centres are available nationwide. In specific geographical areas, methadone maintenance treatment and treatment with buprenorphine are provided. Treatment with naltrexone, drop-in centres, drug consumption rooms and heroin prescription programmes are not available in Slovakia. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Measures targeting infectious diseases among drug users in prisons are available nationwide. There are no substitution treatment, needle and syringe exchange and drug paraphernalia available in Slovakian prisons.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening, counselling, and treatment of infectious diseases are available nationwide in Slovakia. In specific geographical areas, education with regard to infectious diseases and hepatitis B vaccination are available.
To prevent infectious diseases among drug users, common response strategies are IEC via counselling and advice by drugs and health professionals, voluntary counselling and testing, needle and syringe exchange, routine screening of high risk groups, and hepatitis vaccination programmes for drug users. Needle and syringe exchange is available nationwide, while drug paraphernalia and condoms are distributed in specific geographical areas.

Drug-related deaths. Policy exists to ensure that emergency services are trained and equipped to deal with overdoses, but information on the implementation of this policy is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals in treatment facilities and in harm reduction intervention programmes. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. In Slovakia, policies on quality assurance, monitoring and evaluation exist, but concrete activities have not been developed so far.

2.22.2 Recommendation 1: Risk reduction and public health policy

In Slovakia, the Ministry of Health[576] is responsible for the implementation of the Council Recommendation.

Harm reduction is a public health objective in Slovakia and is (partly) based on the Council Recommendation. [RT] In April 2004, the Slovak Government adopted a National Programme for the Fight Against Drugs 2004-2008, adopted in April 2004. One of the key aims in this Programme concerns the making available of treatment of dependencies and harm reduction programmes to the general public. [NR2004]

2.22.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists and was based upon the Council Recommendation. [RT]
In Slovakia, websites[577] and a broad range of educational leaflets are available nationwide. In specific geographical areas only, telephone help lines[578] and training targeted at risk reduction are offered. [NR 2004; NFP 2006]

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. [SQ 23]

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 exists and was based upon the Council Recommendation. [RT]
Communities and families of drug users are nationwide involved in the prevention and reduction of health risks associated with drug dependence[579], and also, specific information, education and communication available nationwide for communities and families of drug users[580]. [NFP 2006]

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. [RT]
In Slovakia, street-based outreach work is available in specific geographical areas only, and so is outreach work at open–air summer festivals and similar summer events/ musical parties. [NR 2004; NFP 2006]

Outreach work is not a common strategy or setting to **prevent infectious diseases** among drug users. [SQ 23]

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, as it is no priority for national government. [RT]

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[576] Public health Authority of the Slovak Republic – Section of Health Care; Section of Protection, Promotion and Development of Health.
[577] New website www.infodrogy.sk launched in May 2005 is offering 4 on-line counselling services, at least two of them can advice in harm-reduction issues. http://www.infodrogy.sk/index.cfm?module=Advisories.
[578] Telephone contacts available within the operational time of Citizens Association and Centre for Treatment of Drug Dependencies. There is also a helpline of Unicornis, aimed at youth.
[579] 46 offices and 14 branches for social prevention exist.
[580] Available via the network of regional/local offices (branches) of CPSCs. Concept of 8 highly specialised agencies was developed and three of them were functioning in 2004.

However, in specific geographical areas, training for peers and volunteers is organised. Peers and volunteers are included in outreach work practice, in specific geographical areas. [NR 2004]

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, as it is no priority for national government. [RT]
There is no information available about the existence of networking and cooperation between outreach work agencies in Slovakia. [NR 2004; NFP 2006]

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 exists and was based upon the Council Recommendation. [RT]
Detoxification programmes[581], are available nationwide. drug-free inpatient and drug-free outpatient treatment and rehabilitation centres are also available nationwide [NR 2004]. In specific geographical areas, methadone maintenance treatment[582] and treatment with buprenorphine[583] are provided. Treatment with naltrexone and drop-in centres are not available. Substitution treatment is supported by psychosocial care upon request by the client. [NR2004]. Drug consumption rooms and heroin prescription programmes do not exist in Slovakia.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

No information from policymakers with regard to this policy was available. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide in Slovakia. [NR 2004]

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. [RT]
There is no methadone maintenance or methadone detoxification treatment available in Slovakian prisons. There are no needle and syringe exchange programmes or drug paraphernalia available in prisons. [NR 2004; NFP 2006] Measures targeting infectious diseases among drug users in prisons are available nationwide[584]. [NR 2004; NFP 2006] Information materials with regard to the prevention of infectious diseases are not disseminated in Slovakian prisons. [SQ 23]

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. [RT]
Testing/ screening, counselling[585], treatment[586] of infectious diseases are available nationwide in Slovakia. In specific geographical areas, education with regard to infectious diseases and hepatitis B. vaccination targeting drug users [587] are available. [NR 2004; NFP 2006]

To **prevent infectious diseases** among drug users common response strategies are IEC via counselling and advice by drugs and health professionals, voluntary counselling and testing, needle and syringe exchange programmes, routine screening of high risk groups and hepatitis vaccination

[581] Methadone, buprenorphine, codeine, ethyl morphine.
[582] 1 centre only (Bratislava) - most popular drug is pervetine /amphetamine.
[583] Restricted to a maximum period of 2-3 months.
[584] Voluntary treatment of drug users, drug-free zones, hepatitis C treatment.
[585] As part of outreach work.
[586] Free and available, except for treatment of HCV, where active drug users are excluded.
[587] General vaccination programme incl. TB cover 1991-2003/ up to 98-99% of the population (95% on local level in some regions) TB incidence among drug users is not monitored. It is considered to be very low due to national programme of immunisation.

programmes for drug users. Predominant implementation settings for infectious diseases prevention measures targeting drug users are specialised drug services. [SQ 23]

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

This policy exists and was based upon the Council Recommendation. [RT]
Needle and syringe exchange programmes[588] are available nationwide. Drug paraphernalia[589] and condoms are available in specific geographical areas only[590].
Needle and syringe exchange programmes are a common response strategy to **prevent infectious diseases** among drug users in Slovakia. [SQ 23] Slovakia has 11 non-pharmacy based needle and syringe exchange programmes and no vending machines. Types of needle and syringe exchange available in Slovakia are: fixed sites, vans/ buses, and outreach/ peer. No pharmacy based needle and syringe exchange, vending machines or prison-based needle and syringe exchange exists in Slovakia. [ST 10]

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. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists and was based upon the Council Recommendation. [RT]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation[591]. [RT]
Risk reduction is part of an integrated health strategy for drug users. [NR 2004]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Training is offered nationwide to professionals in treatment facilities and in harm reduction intervention programmes[592] [593]. In specific geographical regions, training for outreach workers is organised. [NR 2004; NFP 2006]

2.22.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists and was based upon the Council Recommendation. [RT]
In the Slovak Republic, the results of international research are being used for the development of interventions and policies. For example, WHO reports were and are being 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

[588] Provided by NGO's and by specialised centres in Bratislava and Kosice.
[589] Outside big cities pharmacies sell syringes and paraphernalia.
[590] In general the access to needles and syringes and other paraphernalia should be provided by the network of public pharmacies. Study outputs showed problem in accessibility. Therefore CTDD – IDD drew up an educational leaflet for pharmacists addressing them a message about the need to provide drug users with paraphernalia despite their personal attitude to the problem of drug use.
[591] Promoting an appropriate integration has been continued. The need to coordinate addiction-related care with general medical and psychiatric treatment still remains a particular challenge.
[592] There is no central system for education of different professionals, but each structure (*organisation*) provide its own internal way of education.
[593] There is a possibility to choose as voluntary subject at the University level *(at two Universities in Slovakia)* a subject "Introduction into harm-reduction issues".

Drug Addiction Treatment", which was translated and published in the Slovak language by the Institute for Drug Dependencies in 2000. [NR 2004]

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. [RT]

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. [RT]

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, but is pending for approval. [RT].

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

This policy exists and was based upon the Council Recommendation. [RT]

3.6 Making effective use of evaluation results for the refining and development of drug prevention policies

This policy does not exist, as it is no priority for National Government. [RT]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy does not exist, as it is no priority for National Government. [RT]

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, as it is no priority for National Government. [RT]

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. [RT]

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. 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). 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. [NR 2004]

2.22.5 Information from third data sources

Issues raised by NGO Odysseus Slovakia

Information, education, communication (IEC). IEC in general is inadequate. A successful example of IEC provided is a smaller peer education program provided by an NGO. Drug testing does not exist in Slovakia.

Outreach work. Outreach work is only conducted in 7 cities throughout the country and is thus inadequate in coverage and accessibility for users.

(Medically assisted) treatment and other interventions. Specific interventions for cocaine users are not available. NSPs and distribution of drug paraphernalia show an inadequate coverage and accessibility, as they are only installed in 7 cities and strongly differing in quality. In Slovakia, no medically assisted treatment for ATS or cocaine users is available and neither are heroin, ATS or cocaine prescription programmes. Medically assisted treatment for opiate users is inadequate in coverage and accessibility. Only 2 MMT-Programmes exist in Slovakia. Buprenorphine is more easily available, but it depends on the treating psychiatrist whether it becomes available for the client. For ATS, it is attempted to provide support in some NSP by providing them with the correct material and information. The coverage however is inadequate. The coverage of low threshold agencies is inadequate, as only one service point for sex workers exists nationwide. No information is available whether there are specific HR interventions targeted at cocaine or ATS users, but NSPs also reach the big group of pervertin users reacting to their needs by providing adequate injection material. Drug consumption rooms do not exist in Slovakia.

Prison interventions. IEC is not at all available in prison. No information is available if vaccination programmes exist in prison. In prison outreach work is not available. There is no tuberculosis vaccination program in Slovakia in prison. Needle and syringe exchange and drug paraphernalia are not available in prison in Slovakia. In prison there is no medically assisted treatment for drug users.

Infectious diseases. The coverage and accessibility of hepatitis B vaccination programmes targeted at drug users is inadequate throughout the country as there is only one centre throughout the country providing the vaccination. There is no tuberculosis vaccination programme targeting drug users in Slovakia.

Annex A2.23 State of play on harm reduction in Finland

2.23.1 Summary

Public health policy. Harm reduction is a public health objective in Finland. It pre-exists the Council Recommendation.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines, websites and educational leaflets. In some areas, drug users' family members are informed.

Outreach work. Street-based outreach work is available in specific geographical areas. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials, and a common setting for the deliverance of risk education/ response training. Peers and volunteers are included in outreach work practice in specific geographical areas. Networking and cooperation between outreach work agencies exist in the capital area only.

(Medically assisted) treatment and specific interventions. Methadone maintenance and methadone detoxification programmes, treatment with buprenorphine, drug-free outpatient and drug-free inpatient treatment and rehabilitation programmes are available nationwide. Drop-in centres and naltrexone are available in specific geographical areas only. There is also a medical amphetamine treatment trial ongoing. Drug consumption rooms and heroin prescription programmes do not exist in Finland. Opioid substitution treatment is a common response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Methadone maintenance treatment, methadone detoxification treatment and buprenorphine treatment are available nationwide in Finnish prisons. Testing, prevention, education and treatment of infectious diseases, as well as drug paraphernalia and condoms are also nationwide available.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Treatment of HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, and vaccination programmes for hepatitis B targeting drug users are available nationwide. To prevent infectious diseases among drug users, the predominant response strategies are IEC in general, IEC via counselling and advice by drugs and health professionals, voluntary infectious diseases counselling and testing, condom promotion among drug users, needle and syringe exchange, hepatitis vaccination programmes for drug users and easy access' programmes to treatment of infectious diseases. Needle and syringe exchange and drug paraphernalia are available nationwide in Finland.

Drug-related deaths. The distribution or administration of naloxone is regulated. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals working in treatment facilities, needle and syringe exchange programmes, in substitution treatment, low threshold programmes, and prison staff. Risk reduction is part of an integrated health strategy for drug users.

Quality, monitoring and evaluation. In Finland, several studies into harm reduction have been conducted, including studies on substitution treatment and low threshold agencies. A guidebook on quality criteria for health promotion projects was developed in 2002.

2.23.2 Recommendation 1: Risk reduction and public health policy

In Finland, the governmental structure that is responsible for the implementation of the Council Recommendation is the Ministry of Social Affairs and Health[594].

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. [RT]

These public health objectives are mentioned in the Finnish Drug Policy Action Programme 2004-2007. Special legislation, decrees and action plans exist that include preventative and harm reduction measures[595]. [NR 2004]

2.23.3 Recommendation 2: Risk Reduction activities and interventions

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation. [RT]
In Finland, the dissemination of information through various websites[596], telephone help lines and a broad range of educational leaflets is nationwide available. [NR 2003]

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.[597] Safer injection training is provided in some areas.[598] [SQ 23]

With regard to the **reduction of drug-related deaths**, the dissemination of information materials is an uncommon response strategy whereas risk counselling and risk education/ response training are common[599] and common settings for this training are low threshold agencies, including needle and syringe exchange programmes and through outreach workers/ peers and prisons. [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]
Some NGOs provide information, education and communication on drug use targeting especially drug users' family members[600][NFP 2006].

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. [RT]
In Finland, specific geographical areas provide street-based outreach work. In the capital area, there are some (pilot) outreach projects at dance parties and rave events[601]. [NR 2003; NFP 2006]

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[594] Department for Family and Social Affairs.
[595] E.g. Decree on Substitution and Maintenance Treatment 289/2002.
[596] www.stakes.fi
[597] Health counselling and needle exchange for injectors is increasing in primary health care centres. However, geographically it is still very limited and very few visitors have used the harm reduction services in primary health care centres. Reference: STAKES
[598] Training is provided by needle exchange services in almost all cities >50,000 inhabitants, and some cities with less inhabitants
[599] In those cities where the services for substance abusers are available. Also cities that use services from outside provide education / training services indirectly for drug abusers, if there is need and demand for it.
[600] Reference: STAKES.
[601] References: STAKES and A-Clinic Foundation.

To **prevent infectious diseases** among drug users, outreaching health education is a rare response strategy. Outreach work and targeted high-risk group interventions are a rare implementation setting for infectious diseases prevention measures targeting drug users. [SQ 23]

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. [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]
In specific geographical regions, peers and volunteers are included in outreach work and they are offered training in outreach work[602]. [NR 2003]

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. [RT]
In specific geographical regions (the capital area), some of the NGOs involved in outreach work exchange information and experiences. Furthermore, information is disseminated through a needle exchange sentinel site network, e.g. in annual seminars[603]. [NFP 2006]

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 exists, but was not based upon the Council Recommendation. [RT]
Methadone maintenance[604] and methadone detoxification treatment, treatment with buprenorphine[605], drug-free outpatient and drug-free inpatient treatment and rehabilitation programmes[606] are nationwide available. Drop-in centres[607] and treatment with naltrexone[608] are available in specific geographical areas only. Substitution treatment is supported by (obligatory) psychosocial care. There is also a medical amphetamine treatment trial[609] ongoing. [NR 200/ 2004; NFP 2006]

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. [SQ 29]. Drug consumption rooms and heroin prescription programmes do not exist in Finland.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation. [RT]
Measures to prevent diversion of prescribed drugs are nationwide available[610]. [NR 2004]

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[602] As part of the Viitta project and Operation Snowball.
[603] Reference: STAKES.
[604] Waiting lists exist in Helsinki.
[605] Two third of treated patients receive buprenorphine.
[606] E.g., Kankaanpää A-clinic.
[607] There are drop-in centres for people with dependency problems in larger cities, which also drug users can use. There are no special drop-in centres for drug users only. Reference: STAKES.
[608] There is no estimate on the extent of naltrexone use in treatment. Reference: STAKES.
[609] "The effect of methylfenidate and placebo on amphetamine use among amphetamine dependent patients: a comparative randomized double-blind trial", see http://www.hdl.fi/amfe/index.html). Reference: Helsinki Deaconess Institute.
[610] Prescribed drugs have to be taken under supervision of the health care unit and take home doses are restricted.

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, but was not based upon the Council Recommendation. [RT]
Testing, prevention, education and treatment of infectious diseases are available nationwide in prisons. Methadone maintenance treatment, methadone detoxification treatment and buprenorphine treatment are also available nationwide[611]. Drug paraphernalia such as sterile water, bleach and ascorbic acid, and condoms are nationwide available in prisons[612]. Treatment with naltrexone is not available. [NR 2002/ 2003; NFP 2006]

Prisons are a common implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]

Aiming at the **prevention and reduction of drug – related deaths**, prison pre-release interventions are a common response strategy. Prisons are also a common implementation setting for risk education/ response training for drug users. Information materials are rarely disseminated in Finnish prisons. [SQ 29]

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. [RT]
Nationwide, treatment of HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases, and vaccination programmes for hepatitis B targeting drug users[613,614] are available. In specific geographical areas[615] testing/ screening for HIV, hepatitis tests and education, prevention and counselling is offered.
[NR 2002/ 2004; NFP 2006]

Predominant response strategies to **prevent infectious diseases** among drug users are: IEC in general, IEC via counselling by drugs and health professionals, voluntary infectious diseases counselling and testing, condom promotion among drug users, needle and syringe exchange programmes, hepatitis vaccination programmes for drug users and easy access' programmes for drug users to treatment of infectious diseases, e.g. at low threshold agencies. Common strategies include safer injection training for drug users and routine screening of high risk groups.

Predominant implementation settings for infectious diseases prevention measures include specialised drug treatment services and low threshold agencies. Common implementation settings are primary care/ GP's and prisons. [SQ 23; NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Needle and syringe exchange[616,617] programmes are nationwide available, as are drug paraphernalia[618]. In specific geographical areas[619], condoms are distributed. [NR 2002,2004; NFP 2006]. Needle and syringe exchange programmes are the predominant response strategy to **prevent infectious diseases** among drug users in Finland. [SQ 23]

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[611] If treatment started before imprisonment, treatment can continue.
[612] Reference: Ministry of Justice.
[613] Finland has a national risk-group (among others drug users) targeted hepatitis B vaccination programme since 1998
[614] Hepatitis A vaccination was added to the general vaccination program for injectors and their partners from the beginning of the year 2005.
[615] In health counselling centres in 20 municipalities.
[616] Exchange through 21 health counselling centres; selling of syringes and needles through pharmacies.
[617] Since recently, training is provided for primary health care centres to encourage them to start health counselling and needle exchange in their own premises. Reference: STAKES.
[618] Sterile water and ascorbic acid are not available for free in needle exchange services, but they can be bought in all the pharmacies. Reference: STAKES.
[619] 19 municipalities.

With regard to the **reduction of drug-related deaths** among drug users, low threshold agencies, including needle and syringe exchange programmes, are a predominant setting for dissemination of information materials and a common setting for providing risk education/ response training for drug users. [SQ 29]

Finland has 36 non-pharmacy-based needle and syringe exchange programmes. Fixed sites, van/ buses and outreach/ peers are available types of needle exchange; vending machines, pharmacy based and prison-based needle and syringe exchange programmes. [ST 10; NFP 2006]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation. [RT]
Training programmes for professionals of emergency departments do not exist. [NR 2002] Emergency departments are not in use as a setting for risk education/ response training that aim at the **reduction of drug-related deaths**. [SQ 29]

Opiate and benzodiazepine antagonists are carried by paramedic units and physician staffed mobile intensive care units (MICU) – that is not all ambulances. The distribution or administration of naloxone is regulated by laws. Naloxone is not available on a 'take home' basis. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation. [RT]
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. Development of regional mental health and drug and alcohol treatment services is supported by government funding for development work within social and health care services[620]. However, there is no special focus on drug-related harm reduction in these development projects[621]. [NR 2004; NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Training[622] for professionals working in needle and syringe exchange programmes, in substitution treatment, low threshold programmes, prison staff and training for professionals working in treatment facilities is nationwide available. Training for outreach workers is available in specific geographical areas only. [NR 2003/ 2004; NFP 2006]

2.23.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. [RT]

In Finland, several studies were conducted in the field of harm reduction, which provided input for future interventions. Examples are:

Currently a study on the effects of long-term use of buprenorphine, methadone and benzodiazepines on patients' cognitive abilities being conducted in Finland. Furthermore, a study investigating the effectiveness and costs of buprenorphine treatment provided exclusively in outpatient care is being launched. A double-blind study to investigate the possible side effects of buprenorphine-naloxone preparation is also being planned. Results are not available so far.

In Tampère, an assessment has been made on the role in the local service system of the low threshold unit (Matala) open around the clock. The primary task of the unit, opened in 2002, was

[620] For a joint project of National Development Project for Social Services, see www.sosiaalihanke.fi; and National Programme to Reform Health Care, see www.terveyshanke.fi.
[621] Reference: Ministry of Social Affairs and Health.
[622] Drug training is incorporated into the curricula of social welfare and health care education. Further, there is an annual nationwide Intoxicant Days-seminar.

to motivate and refer clients to treatment. In addition, the unit was supposed to develop treatment practices for clients who are incapable of quitting drugs, but still need services. The idea was that the concentration of drug treatment clients in one place would untangle care chains and reduce waiting lists. [NR 2004].
The first Finnish evaluation of medicinal treatment for drug addicts was completed in early 2002. The study concerned detoxification by buprenorphine that started in October 1997 by an outpatient programme at the Kettutie A-Clinic in Helsinki and by an inpatient programme in Järvenpää Addiction Hospital. The results of the follow-up study suggest that as a medicine, buprenorphine is an effective tool for involving the patients in treatment. The evaluation concluded that the threshold for accessing detoxification by buprenorphine should be lowered and attention should be paid to treatment need assessment, i.e. directing the patients to a form of treatment – be it medicinal or non-medicinal – that best suits them. [NR 2003]

Based upon these evaluations, in Helsinki, a service centre for HIV-positive drug users has been set up. The service centre is the only facility in Finland providing methadone maintenance and this treatment has proved to be an effective way to avoid risk behaviour and to reduce HIV infections. [NR 2003]

The so-called VP Project, developing welfare for prisoners with substance abuse problems, was evaluated in 1999 (Mutalahti 1999). The project showed that good results can be achieved in treatment method development, implementation and evaluation, if the existing resources are retargeted, if networks are created with substance abuse services outside prison and if this responsibility is assumed by the institution as a whole.

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. [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy does not exist.
Evaluation is conducted on all prevention and risk reduction programmes funded by ministries. NGO's programmes are evaluated, when needed. [RT]

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. [RT]

The general principles of the Drug Policy Action Programme 2004–2007 (2004) are being adhered to. One specific objective includes the development of a quality evaluation form which is based on the quality framework for substance abuse services is being prepared for use by municipalities.
[NR 2004]

The Finnish Centre for Health Promotion has made good progress in systematising and published a guidebook on the quality criteria for health promotion projects (Project support – health promotion programme work done by NGOs, 2002). The drug and alcohol prevention project database of the Finnish Centre for Health Promotion gives a picture of the ongoing and completed projects in the field of drug prevention. At the beginning of 2002, external evaluations of the project proposals made by two evaluators were included in the register. The external evaluations were made according to the criteria in the guidebook and included numerical assessments and graphs made by the two evaluators. [NR 2003]

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. [RT]

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. [RT]
At the beginning of 2002, the Ministry of Social Affairs and Health presented the proposal of an HIV expert team for Finland's national HIV/ AIDS strategy, concluding that health counselling for drug users is one of the most important tools for preventing HIV. Health counselling should be made available in all major urban areas in three years, and the activities should include needle exchanges. Furthermore, various types of health counselling should be developed. The effectiveness and implementation of health counselling was to be evaluated nationally by the year 2004. [NR 2002]

In Helsinki, the coverage and efficiency of the local substance abuse services and organisations were assessed.[623] One conclusion was that drug addicts need more low threshold agencies. [NR 2004]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists, but was not based upon the Council Recommendation. [RT]

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. [RT]

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. [RT]

2.23.5 Information from third data sources

Issues raised by A-Klinikka Foundation

Information, education, communication (IEC). IEC coverage and accessibility is inadequate in general setting as many drug users do not visit the low threshold centres where IEC is provided. In prison, there are only two facilities that allow harm reduction based information to be distributed.[624] Drug testing is not available in Finland.
Involvement families and friends is inadequate in all intervention measures.

Outreach work. Coverage and accessibility of outreach work is inadequate as harm reduction based outreach work is only conducted in two Finish cities.

(medically assisted) treatment and other interventions. Medically assisted treatment for opiate users is inadequate in coverage and accessibility as most of the programmes are too demanding for heavy drug users. No medical assisted treatment for ATS or cocaine users is available in Finland, although a study is conducted to check feasibility of treating amphetamine users with benzodiazepine. Finland does not have heroin, cocaine or ATS prescription programmes. The coverage and accessibility of NSPs and distribution of drug paraphernalia in Finland is considered inadequate, as not all Finnish cities have programmes nor is distribution available in

[623] In the Helsinki project, the client feedback data was collected from various types of service units meant for different client groups and having different work practices. Data was collected between 1 November 2002 and 31 December 2002. The respondents included 107 outpatient clients and 177 inpatient clients. In addition, 25 specialists and co-operation partners of substance abuse services were interviewed in autumn 2002 and spring 2003. Questions on the treatment system were also answered by 7 outpatient unit directors and a third of senior social workers. (Törmä et al. 2004).
[624] Tammi, Tuukka (2005): *Discipline or contain? The struggle over the concept of harm reduction in the 1997 Drug Policy Committee in Finland.* International Journal of Drug Policy, Vol. 16, Issue 6, pp. 384-392 and Tammi, Tuukka (2004): *Harm reduction school of thought: three fractions*. Contemporary Drug Problems Vol. 31, no 3, pp. 381-399.

rural areas.[625] Drug paraphernalia distribution is not adequate as most of the programmes refrain from distributing sterile water or proper filters. Low threshold agencies are not adequate for drug users of illicit drugs as most of the facilities target alcoholics as their primary clients. Members of these target groups usually do not interact easily. Drug consumption rooms do not exist in Finland. There are no specific harm reduction interventions targeted at cocaine users. Some interventions that are originally designed for opiate users are also used for ATS users, but results are considered inadequate.

Prison interventions. IEC coverage and accessibility is inadequate in prison setting. In prison, there are only two facilities that allow harm reduction based information to be distributed.[626] In prison coverage and accessibility of hepatitis B vaccination is adequate. In prison outreach work is not available. Drug users that are incarcerated are not eligible for methadone/ buprenorphine treatment inside of prison if they have not been enrolled in substitution programmes outside. In prison NSPs are not available and only disinfection liquids are distributed. There are no specific harm reduction interventions targeted at cocaine users in prison.

Infectious diseases. The coverage of hepatitis B vaccination programmes is considered adequate. A problem occurs with the accessibility as there are not enough low threshold agencies frequented by drug users that implement the vaccination for the specific target group. Tuberculosis vaccination specifically aimed at drug users does not exist in Finland, as this target group shows no higher prevalence than other groups.

[625] Table on distribution and number of NSP programmes in Finland in: Tammi, Tuukka (2005): *Diffusion of public health views on drug policy: The case of needle-exchange in Finland.*p. 190 ff, in: Hoikkala, T., Hakkarainen, P. & Laine, S. (eds.): Beyond Health Literacy - Youth Cultures, Prevention and Policy. Finnish Youth Research Network, publications 52 & Stakes. Helsinki.

[626] Tammi, Tuukka (2005): *Discipline or contain? The struggle over the concept of harm reduction in the 1997 Drug Policy Committee in Finland.* International Journal of Drug Policy, Vol. 16, Issue 6, pp. 384-392 and Tammi, Tuukka (2004): *Harm reduction school of thought: three fractions*. Contemporary Drug Problems Vol. 31, no 3, pp. 381-399.

Annex A2.24 State of play on harm reduction in Sweden

2.24.1 Summary

Public health policy. Risk reduction is part of Swedish public health policy, but not all harm reduction interventions have been implemented so far.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is provided through telephone help lines, training and information leaflets in specific geographical areas only. With regard to the prevention of infectious diseases among drug users, IEC in general is the predominant response strategy. Policy exists to inform communities and families and enable them to be involved in the prevention and reduction of health risks associated with drug dependence, but there is no information available on the implementation.

Outreach work. Street-based outreach work and outreach work at dance parties, raves and in clubs are available in specific geographical areas only. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. Policy exists to encourage the inclusion of peers and volunteers in outreach work practice, and to promote networking and cooperation between agencies involved in outreach work, but information regarding the implementation is not available.

(Medically assisted) treatment and specific interventions. 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. Drug consumption rooms and heroin prescription programmes are not available in Sweden. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Testing/ screening, prevention, education and treatment of infectious diseases, counselling and the distribution of condoms are available nationwide. Treatment with methadone, buprenorphine, needle and syringe exchange programmes and drug paraphernalia are not available in Swedish prisons.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). 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 IEC in general and voluntary counselling and testing. Needle and syringe exchange programmes and the distribution of condoms are available in specific geographical areas only in Sweden.

Drug-related deaths. The distribution, possession or administration of naloxone is regulated. Naloxone on a 'take home' basis is not available.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to prison staff. Policy exists to promote appropriate integration between health and social care for drug users, but there is no information on the implementation.

Quality, monitoring and evaluation. Sweden is still developing quality protocols in the field of harm reduction. Activities implemented through the National Drug Coordinator should be based upon evidence and best-practice.

2.24.2 Recommendation 1: Risk reduction and public health policy

The department that is mainly responsible for the implementation of the Council Recommendation is the Swedish Ministry of Health and Social Affairs[627]. [RT]

The prevention and reduction of health-related harm associated with drug dependence is part of Swedish public health policy, but not based on the Council Recommendation. A Swedish action plan on drugs was already in force as the negotiations resulting in the recommendation took place. The Swedish drugs policy is in line with the Council Recommendation. [RT]
Some risk reduction interventions were already in place in 1999 (e.g. substitution treatment with buprenorphine). [NR 2004]

2.24.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation. [RT]
In Sweden, telephone help lines[628], training[629] and information leaflets are available in specific geographical areas. Websites promoting risk reduction among drug users, do not exist in Sweden[630]. [NR 2002/ 2003]

To **prevent infectious diseases** among drug users, information, education, communication (IEC) in general is a predominant response strategy, whereas IEC via counselling and advice by drugs and health professionals and IEC via peer involvement/ peer approach are common responses. Safer injecting training is not available in Sweden. [SQ 23]

With regard to the **reduction of drug-related deaths**, individual risk counselling is a common response strategy. [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]

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. [RT]
In Sweden, street-based outreach work[631] and outreach work at dance parties, raves and in clubs[632] are available in specific geographical areas only. [NR 2003/ 2004]

However, 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. [SQ 23]

There is no information available with regard to outreach work as a strategy or setting for measures that aim at the **reduction of drug-related deaths**. [SQ 29]

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[627] Division for Public Health.
[628] No staffed help lines are available.
[629] Malmo needle exchange programme offers training in overdose prevention.
[630] Various websites are available, but do not focus on risk reduction.
[631] Outreach work in Sweden is nearly extinct.
[632] However, it is unclear whether this is risk reduction-based.

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 exists, but was not based upon the Council Recommendation. [RT]
No further information available.

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. [RT]
No further information available.

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 exists, but was not based upon the Council Recommendation. [RT]
Methadone maintenance[633] programmes, treatment with buprenorphine[634], drug-free outpatient and drug-free inpatient treatment, rehabilitation programmes and drop-in centres/ shelters[635] are available in specific geographical areas. Substitution treatment is supported by (obligatory) psychosocial care. [NR 2002- 2004]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a response strategy not in use in Sweden. [SQ 29]
Drug consumption rooms and heroin-prescription programmes are not available in Sweden.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide[636]. [NR 2003]

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, but was not based upon the Council Recommendation. [RT]
Testing/ screening, prevention, education and treatment[637] of infectious diseases and counselling and the distribution of condoms are available nationwide [NR 2002/ 2003]. After recent changes in official guidelines, substitution treatment is now available in Swedish prisons [Swedish Ministry of Health and Social Affairs, 2006]. Needle and syringe exchange programmes and drug paraphernalia are not available in Swedish prisons. [NR 2003]

Prisons are a common implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ 23]. Measures targeting at the **reduction of drug – related deaths** are not available in Swedish prisons. [SQ 29]

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. [RT]
Testing/ screening, education, prevention, counselling, treatment and vaccination programmes targeting drug users are available nationwide. [NR 2002-2004]

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[633] Very strict high threshold programme for in total 800 persons.
[634] It is being prescribed since 1999.
[635] Day care units are seldom available.
[636] Urine check.
[637] Vaccination for HBV and HIV guidance is available.

To **prevent infectious diseases** among drug users the predominant response strategies are IEC in general and voluntary counselling and testing. IEC via counselling and advice by drugs and health professionals, IEC via peer involvement/ peer approach, outreach health education approach, condom promotion among drug users, and hepatitis vaccination programme for drug users are common response strategies. Predominant implementation settings for infectious diseases prevention measures targeting drug users include specialised drug treatment services, and primary care/ GP. Common implementation settings are low threshold counselling, outreach work, targeted high risk group interventions and prisons. [SQ 23]

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

This policy exists, but was not based upon the Council Recommendation[638]. [RT]
Needle and syringe exchange programmes[639] and the distribution of condoms are available in specific geographical areas only in Sweden. [NR 2003/ 2004] Needle and syringe exchange programmes are an uncommon response strategy to **prevent infectious diseases** among drug users in Sweden. [SQ 23]. However, in April 2006 the Swedish Parliament decided on a new law, enabling regional health authorities to provide needle exchange facilities, provided that they can guarantee a proper level of treatment and detoxification facilities [Swedish Ministry of Health & Social Affairs, 2006].

Sweden has 2 non-pharmacy based needle and syringe programmes. [ST 10] There are no specific laws on the possession or exchange of needles in Sweden, but if used for illicit drugs, it is considered a criminal offence[640]. Needles can only be bought with a valid prescription. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation. [RT]

Swedish ambulances routinely carry antagonists. The distribution, possession or administration of naloxone is regulated[641]. Naloxone on a 'take home' basis is not available. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation. [RT]

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

This policy exists, but was not based upon the Council Recommendation. [RT]
Training is offered nationwide to prison staff, and in specific geographical areas to professionals working in treatment facilities. [NR 2002/ 2003]

2.24.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy exists, but was not based upon the Council Recommendation. [RT]
The interventions initiated by the National Drug Coordinator according to the Action plan are generally based on evaluated and evidence based methods.

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[638] Needle exchange projects are at present being tried out as a experimental activities. These activities take place in two Swedish cities.
[639] 2 projects exist, in conflict with repressive policy. There are two needle-exchange programmes in the southern county of Skåne – Lund since 1986 and Malmö since 1987 – at the clinics for infectious diseases
[640] Article 6 of the Narcotic Drugs Punishments Act (1968:64).
[641] Only available on prescription or when administrated by medically trained staff in treatment situations.

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. [RT].

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy does not exist.
Evaluation protocols have not yet been implemented within all programmes. The reason for this is that the Swedish methods in this area are still in progress. [RT]

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. [RT]
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.

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. [RT]

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. [RT]
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. [NR 2003]

3.7 Setting up evaluation training programmes for different levels and audiences

This policy exists, but was not based upon the Council Recommendation. [RT]

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. [RT]

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. [RT]

2.23.5 Information from third data sources

Issues raised by Svenska Brukarforeningen

Information, education and communication (IEC). Neither IEC for drug users nor drug testing is available in Sweden.

Outreach work. Outreach work for drug users is not available.

(Medically assisted) treatment and specific interventions. Medically assisted treatment for opiate users is inadequate in coverage and accessibility. In the few places where it is available, resources are scares, which limits accessibility. There is no heroin prescription program in Sweden. Neither medically assisted treatment for ATS or cocaine users nor prescription programmes for users of stimulants are available. There are no drug consumption rooms in Sweden. The coverage

and accessibility of NSPs is inadequate as NSPs are only implemented in two Swedish cities. Drug paraphernalia are not available.
Low threshold agencies such as drop-in centres and shelters for drug users are not available in Sweden. There are no specific harm reduction interventions for ATS or cocaine users.

Prison interventions. Neither IEC nor outreach work exists in Swedish prisons.
In prison medically assisted treatment for opiate users does not exist. There are no medically assisted treatments or specific HR interventions for ATS or cocaine users available in prison. There are no NSPs in prisons and drug paraphernalia are not available. Measures implemented to prevent infectious diseases do not exist. Hepatitis B or tuberculosis vaccination programmes targeted at drug users are not available in Swedish prisons.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Measures implemented to prevent infectious diseases are inadequate in coverage and accessibility as there are only two NSPs through which these measures are taken.
Hepatitis B and tuberculosis vaccination programmes targeting drug users do not exist.

Annex A2.25 State of play on harm reduction in United Kingdom

2.25.1 Summary

Public health policy. Harm reduction is a public health objective in the UK for many years and was stipulated in the National Drug Strategy 'Tackling Drugs for a Better Britain' in 1998.

Information, education and communication (IEC). Information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services is nationwide provided through telephone help lines, websites, training and educational leaflets. For the reduction of drug-related deaths, dissemination of information materials, risk education/ response training and individual risk counselling are predominant response strategies. Communities and families of drug users are informed and nationwide involved in the prevention and reduction of health risks associated with drug dependence.

Outreach work. Street-based outreach work and outreach work at dance parties, raves and in clubs are nationwide available. Outreach work as a health education approach is a common response strategy to prevent infectious diseases among drug users. For the reduction of drug-related deaths, outreach work is the predominant setting for the dissemination of information materials, as well as for the deliverance of risk education/ response training. Peers and volunteers are included nationwide in outreach work practice. Networking and cooperation between outreach work agencies also exist nationwide.

(Medically assisted) treatment and specific interventions. Methadone maintenance and detoxification programmes, and treatment with buprenorphine are available nationwide. Drug-free outpatient and drug-free inpatient treatment, rehabilitation centres, and drop-in centres/ shelters are also available nationwide. In specific geographical areas, treatments with naltrexone and heroin are available. Drug consumption rooms do not exist in the United Kingdom. Opioid substitution treatment is a predominant response strategy aiming at the reduction of drug-related deaths. Measures to prevent diversion of prescribed drugs are available nationwide.

Prison interventions. Methadone maintenance and methadone detoxification programmes are nationwide available in prison, and so are counselling, testing/ screening, education, prevention and treatment of infectious diseases and vaccination of hepatitis B. Treatment with buprenorphine and naltrexone, and the distribution of condoms are available in specific geographical areas only.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Testing/ screening, education, prevention, counselling, and treatment for infectious diseases, as well as vaccination programmes against HBV targeting drug users, are available nationwide. To prevent infectious diseases among drug users, the predominant response strategies are IEC in general, IEC via counselling and advice by drugs and health professionals, and needle and syringe exchange. Needle and syringe exchange, drug paraphernalia and the distribution of condoms are available nationwide.

Drug-related deaths. Professionals of emergency departments are trained nationwide, e.g., to deal with overdoses. The distribution, possession or administration of naloxone is regulated. Naloxone is available on a 'take home' basis.

Training of staff and risk reduction as part of a complementary health strategy. Training is offered nationwide to professionals in needle and syringe exchange programmes, substitution programmes, low threshold agencies, prison, treatment facilities. Risk reduction is part of an integrated health strategy for drug users**.**

Quality, monitoring and evaluation. Evaluation is not a formal aspect of UK drug policy, but it is encouraged. A National Treatment Agency was set up in 2001, to increase the capacity, quality and effectiveness of drug treatment. The Agency has developed key indicators for that purpose. The Scottish Executive has set up an evaluation and assessment scheme, which aims to identify and disseminate effective practice in relation to drug use.

2.25.2 Recommendation 1: Risk reduction and public health policy

In the UK, the main responsible governmental structure for the implementation of the Council Recommendation is the Department of Health[642]. UK policy on prevention and reduction of health-related harm predates the Council recommendation. [RT]. Partnership strategies exist for the Scottish Executive and the Welsh Assembly Government. [SQ29]

One key aim of the Drug Strategy of 1998 to enable people with drug problems to overcome them and live healthy and crime-free lives (UKADCU (United Kingdom Anti-Drugs Co-ordination Unit, 1998). Tackling drugs to build a better Britain. The Stationery Office. London. (http:/ / www.archive.official-documents.co.uk/ document/ cm39/ 3945/ contents.htm) These aims were restated in the 2002 Updated Drug Strategy (Drugs Strategy Directorate (2002). Updated Drug Strategy. Home Office. London) http:/ / www.drugs.gov.uk/ ReportsandPublications/ NationalStrategy/ 1038840683/ Updated Drug Strategy 2002.pdf. With this update there was a commitment to increasing access to treatment and of the prevention of health-related harm. [RT]

2.25.3 Recommendation 2: Risk Reduction services and facilities

2.1 Provide information and counselling to drug users to promote risk reduction and to facilitate their access to appropriate services

This policy exists, but was not based upon the Council Recommendation[643]. [RT]
In the United Kingdom, telephone help lines, websites[644], training[645], and a broad range of educational leaflets are available nationwide. [NR 2003, NR 2004]
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 are predominant response strategies. [SQ 23]

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. [SQ 29]

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 exists, but was not based upon the Council Recommendation[646]. [RT]
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[647] [648]. [NFP 2006]

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[642] Department of Sexual Health and Substance Misuse.
[643] Policy in the UK predates the Council recommendation with a range of HIV information and counselling services since the late 1980s; an action plan to reduce drug-related death in 2001, a hepatitis C strategy in 2002. A tuberculosis strategy was implemented in 2004, but does not focus on drug users.
[644] E.g. www.knowthescore.info, www.talktofrank.com.
[645] Campaigns for safer sex and safer injecting.
[646] A major part of UK Drug Strategy is to inform communities and familes and for example in 2003 a major communication campaign - FRANK - was launched (see http://www.talktofrank.com).
[647] See footnote 2; Also, families are involved in overdose training to help reduce drug-related death (see http://www.nta.nhs.uk/news/040319.htm / National Treatment Agency for Substance Misuse. (2004 Commissioning services to reduce drug-related deaths Resource pack for commissioners. National Treatment Agency for Substance Misuse. London. http://www.nta.nhs.uk/publications/docs/NTACOMMI.pdf
[648] In November 2005 the Scottish Executive Board published its strategy for reducing drug-related deaths and as in England one recommendation was that: *The Scottish Executive and Alcohol and Drug Action Teams (ADATs) should consider methods to raise the level of resuscitation skills among drug users, family members, friends, and social networks. It is recommended that the provision of information and training for families and*

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[649]. [RT]
In the United Kingdom, street-based outreach work and outreach work at dance parties, raves and in clubs are nationwide available. [NR 2003/ 2004]
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. [SQ 23]

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. [SQ 29]

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 exists, but was not based upon the Council Recommendation. [RT]
Peers and volunteers are included nationwide in outreach work practice[650]. There is no information about the availability of training for peer and volunteers. [NR 2003; NFP 2006]

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. [RT]
Networking and cooperation between outreach work agencies is nationwide available. [NR 2003]

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 exists, but was not based upon the Council Recommendation[651]. [RT]
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[652] are also available nationwide. In specific geographical areas, treatment with naltrexone[653] and heroin prescription programmes[654] are available. Drug consumption rooms do not exist in the United Kingdom. [NR 2003/ 2004; NFP 2006]

Aiming at the **reduction of drug-related deaths,** opioid substitution treatment is a predominant response strategy. [SQ 29]

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friends of drug users and drug users themselves is further developed across Scotland. Scottish Executive (2005). Taking Action to Reduce Scotland's Drug-Related Death: The Scottish Executive Response to the Scottish Advisory Committee on Drug Misuse Drug-Related Deaths Working Group, Report and Recommendations. Scottish Executive. Edinburgh.

[649] In the UK Outreach is a well established means of working to contact 'hard to reach' groups (see DH (2002 Models of care for substance misuse treatment: promoting quality, efficiency and effectiveness in drug misuse treatment services. Department of Health. London).

[650] Peer-outreach and needle and syringe exchange is encouraged through user networks.

[651] This has been a key aspect of UK policy with respect to treatment (see UKADCU (United Kingdom Anti-Drugs Coordination Unit), 1998 and Drug Strategy Directorate 2002). UK treatment options include drug free and a range substitution treatments.

[652] There are drop-in centres, often referred to as advice centre or information centres in all areas.

[653] Used after completion of diacetylmorphine treatment.

[654] 300-500 people receive heroin in England and Wales.

2.7 Establish measures to prevent diversion of substitution substances while ensuring appropriate access to treatment

This policy exists, but was not based upon the Council Recommendation[655]. [RT]
Measures to prevent diversion of prescribed drugs are available nationwide[656]. [NR 2003]

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, but was not based upon the Council Recommendation[657]. [RT]
Methadone maintenance and methadone detoxification programmes are nationwide available in prison, and so are counselling, testing/ screening, education, prevention and treatment of infectious diseases and vaccination of hepatitis B. Treatment with buprenorphine[658] and naltrexone[659]and the distribution of condoms are available in specific geographical areas only. [NR 2003/ 2004; NFP 2006]

There are no needle and syringe exchange programmes in prisons in the United Kingdom, and drug paraphernalia are also not available. [NR 2004, NFP 2006]. Prisons are a common implementation setting for **infectious disease prevention** measures targeted at drug users. [SQ23]

Targeting at the **reduction of drug – related deaths,** prison-pre release interventions are a predominant response strategy, and prisons are a predominant setting for disseminating information materials and for delivering risk education/ response training. [SQ29]

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[660]. [RT]
Testing/ screening, education and prevention, counselling and treatment of infectious diseases and vaccination programmes against hepatitis B targeting drug users are nationwide available[661]. [NR 2003/ 2004]

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. Common implementation settings are outreach work and targeted high risk group interventions, primary care/ general practitioners, prison, and mass media. [SQ 23]

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

This policy exists, but was not based upon the Council Recommendation[662]. [RT]

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[655] A number of measures are taken to reduce diversion including pharmacy supervised consumption where diversion is most likely to occur and restrictions on the prescribing of some drugs.
[656] Supervised consumption, urine testing, daily pick up and instalment prescribing.
[657] Prison authorities have been working towards providing services comparable to those in the wider community for a number years; though substitution treatment is only recently being more widely implemented; it is expected that all prisons will offer comparable services by 2007/8.
[658] Theoretically prison provide the same treatments as offered to the general population, but buprenorphine is not widely available.
[659] Theoretically it is available to all prisoners, in practice not widely available.
[660] Prior to the recommendation all drug services, including in prison, have been encouraged to offer information, advice, testing and counselling for all diseases except tuberculosis, and hepatitis B vaccination. "Stopping Tuberculosis in England", an action plan was launched in 2004, but does not target drug users.
[661] Specific campaign on HCV available to all injecting drug users, including those in custody.
[662] Syringe exchange and condom distribution has been established since the 1980s, syringe exchange is not available in prisons, but condoms can be prescribed.

Needle and syringe exchange programmes, drug paraphernalia[663] and the distribution of condoms are available nationwide. [NR 2003/ 2004]. Needle and syringe exchange programmes are a predominant response strategy to **prevent infectious diseases** among drug users in the United Kingdom [SQ 23]. 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. [SQ29]

The United Kingdom has 453 non-pharmacy based and 1607 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. [ST 10]

There are no legal restrictions to the possession of sterile needles in the United Kingdom, and also no prescription is required to obtain or exchange needles and syringes. [ELDD]

2.11 Ensure that emergency services are trained and equipped to deal with overdoses

This policy exists, but was not based upon the Council Recommendation[664]. [RT]
Professionals of emergency departments are trained nationwide[23]. [NFP 2006] Emergency departments are a common setting for dissemination of information materials that aim at the reduction of drug-related deaths or for risk education/ response training. [SQ29]

British ambulances routinely carry antagonists. The distribution, possession or administration of naloxone is regulated by regulation. Naloxone on a 'take home' basis is available[665]. [SQ 29]

2.12 Promote appropriate integration between health, including mental health, and social care, and specialised approaches in risk reduction

This policy exists, but was not based upon the Council Recommendation[666]. [RT]
Risk reduction is part of an integrated health strategy for drug users[667] [668]. [NFP 2006]

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

This policy exists, but was not based upon the Council Recommendation[669]. [RT]
Training is offered nationwide to professionals in needle and syringe exchange programmes, substitution programmes, low threshold agencies, prison, treatment facilities. [NR 2003, 2004; NFP 2006]

2.25.4 Recommendation 3: Quality assurance, monitoring & evaluation in risk reduction

3.1 Using scientific evidence of effectiveness as a main basis to select the appropriate intervention

This policy does not exist.
Evaluation is not a formal aspect of policy, but is encouraged. A National Collaborating Centre for Drugs Prevention was set up in 2004 and may look look at harm reduction projects, evidence based practice is the norm and there is a history of local evalaution of drug services. [RT]

The National Treatment Agency (NTA) was created by the Government on 1 April 2001 with a remit to increase the capacity, quality and effectiveness of drug treatment in England. The NTA will

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[663] Swabs, utensils for the preparation of a controlled drug, citric acid, sterile water, filters (as of august 2003).
[664] Reducing deaths – resource for Accidents and Emergency departments staff was published in 2004 http://www.nta.nhs.uk/publications/docs/reducing_deaths.pdf.
[665] Only in England. This intervention was first piloted in 1999.
[666] This is key aspect of UK Drug Strategy with local Drug Action Teams expected to ensure integration between a range of commissioners and providers.
[667] The main target for drugs misuse is to reduce the harms caused by drugs
[668] In England and Wales the Drug Interventions Programme has been developed to integrated services fully for those accessed in to services through the criminal justice system, while the focus is on crime and social reintegration, health harms are also part of the programme. See http://www.drugs.gov.uk/drug-interventions-programme.
[669] A range of training programmes have been developed for professionals, including GPs (through the RCGPs), prison health care staff and nurses as well as drugs workers.

promote practice which is evidence-based, appropriately delivered, outcome focused, and integrated into a system of co-ordinated drug treatment and care. To equip Drug Action Teams at local level (DAT) and service providers to meet this agenda the NTA will:

- distil and disseminate best practice drawn from research;
- collaborate with others to initiate research into effectiveness;
- support the development of quality systems of treatment promoting and building
- on existing good practice;
- develop systems of standards and accreditation for services, individuals and
- programmes of interventions;
- enhance the competence of managers and staff across the treatment sector; and
- develop and implement a human resources strategy to attract and retain high
- quality staff with drug treatment as a career.

The national drug strategy recognized the need for an increased focus on the provision of effective drug treatment services that will work effectively with other health, social care and criminal justice service providers in order to provide seamless treatment and care to substance misusers. This has resulted in the development of a range of guidance documents on 'what works' based on a review of research evidence. [NR 2002]

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.
Needs assessment is a common aspect of commissioning. [RT]

3.3 Developing and implementing adequate evaluation protocols for all drug prevention and risk reduction programmes

This policy does not exist.
Performance monitoring is common, but there are no established evaluation protocols. [RT]

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.
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 the EMCDDA Evaluation Instruments Bank. [RT]

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. [NR 2003].

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.
UK Focal Point, based in the Department of Health, is responsible for working towards standardised data collection in the UK. [RT]

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.
The Government commissions a range of research projects and evaluations which are taken account of in the development of prevention policy. [RT]

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 no formal evaluation framework, but there is a very large amount of monitoring work on drug prevalence, uptake of treatment and drug supply. This work centres on a framework of drug strategy targets. Although England and Wales, Scotland and Northern Ireland have separate sets of drug targets, essentially all focus on the same key areas.

The Scottish Executive's Effective Interventions Unit (EIU) has a remit to identify and disseminate effective practice in relation to tackling drug misuse in Scotland. Evaluation forms a core element in achieving this. Activities include:

- 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.

3.7 Setting up evaluation training programmes for different levels and audiences

This policy does not exist, as it is not a priority for National Government. [RT]

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, as it is not a priority for National Government. [RT]

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.
UK contributes to the Exchange on Drug Demand Reduction Action (EDDRA). [RT]

2.25.5 Information from third data sources

Issues raised by United Kingdom Harm Reduction Alliance (UKHRC)

Information, education and communication (IEC). IEC is adequate in coverage. Drug testing is not available in the UK.

Outreach work. Outreach work is inadequate in coverage.

(Medically assisted) treatment and specific interventions. Medically assisted treatment for opiate users is adequate in coverage, but inadequate in accessibility as waiting lists are long in some areas of the country. Substitution drugs used are methadone and buprenorphine.
The coverage of the heroin prescription program in the UK is inadequate. No information on medically assisted treatment for ATS or cocaine users is available. The coverage of ATS prescription programmes is inadequate and cocaine prescription programmes are not available. Specific harm reduction interventions targeted at cocaine or ATS users exist in counselling and day programmes which are generally available. There are no drug consumption rooms in the UK. NSPs are adequate in coverage, but there is inadequate access to specialist and pharmacy-based services which constitute optimized provision. Drug paraphernalia distribution is inadequate in coverage. The same holds true for low threshold agencies that are inadequate in coverage

Prison interventions. Availability and accessibility to substitution treatment is inadequate.
There are no needle and syringe exchange programmes in UK prisons and drug paraphernalia are not available. Hepatitis B vaccination is available, but inadequate in accessibility as programmes are not sufficiently user-friendly. Tuberculosis immunization takes place for all nationals at the age 15 rather than in prisons.

Infectious diseases (HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases). Hepatitis B vaccination programmes are offered, but often enough access is not sufficiently user-friendly. Tuberculosis vaccination programmes are offered to the whole population at age 15 while at school.

Annex 3 Special Issues

In this Annex, special attention is paid to issues that are often debated in the field of harm reduction. These specific themes are: drug consumption rooms, heroin prescription, pill-testing and harm reduction in prisons.

A3.1 Drug Consumption Rooms

A3.1.1 Definition

With the term drug consumption rooms (also labelled as 'supervised injection facilities' or 'safer injection rooms), locations are meant that are *legally*[674] established and organised specifically to allow drug users to use their drugs (in general by smoking and/ or injecting) in a (medically) supervised and safe environment. The main objective of creating drug consumption rooms is to reduce health-related harm associated with drug consumption, both for the drug user (*private harm,* e.g. the reduction of overdose (death) or infectious diseases) and his or her environment (*public harm,* e.g. prevent scattering of used needles, open drug scenes).

Type of intervention	Availability in EU Member States	Availability in non-EU Member States
Drug Consumption Rooms (Ref. Recommendation 6.2.6)	Germany, the Netherlands, Spain and Luxembourg, Portugal[670]	Switzerland Norway Canada Australia
Heroin prescription (Ref. Recommendation 6.2.6)	Germany, Spain, the Netherlands and United Kingdom Expected: Luxembourg[671].	Switzerland Canada
Pill testing facilities for drug users (Ref. Recommendation 6.2.1)	Austria, Belgium, Czech Republic, Spain, the Netherlands[672],[673].	Australia

Table 5.1 – Availability of selected harm reduction interventions

In the scientific community there is growing consensus to describe drug consumption rooms as: "*protected places for the hygienic consumption of pre-obtained drugs in a non-judgemental environment and under the supervision of trained staff.*" [675]

A3.1.2 Background history

Drug consumption rooms exist for over two decades. Starting in Switzerland, there are now drug consumption rooms in six European countries (Germany, Spain, the Netherlands and Luxembourg within the European Union, and Switzerland and Norway outside the EU) and in Canada and Australia. In Switzerland and especially the Netherlands, strong emphasis was placed on reducing public nuisance from the start. In other countries, such as Spain and Canada, private health-related harm, in particular overdose deaths, have been a driving force behind the setting up of drug consumption rooms.[676]

A3.1.3 Rationale and objectives

In a recent report on drug consumption rooms[677], the EMCDDA describes that the overall rationale for drug consumption rooms is to reach and address the problems of specific, high-risk populations of drug users, especially injectors and those who consume in public. These groups have important health care needs, which are often not met by other services and pose problems for local

[670] Regulated by Law in 2001, not yet implemented.
[671] In Luxembourg, the introduction of heroin prescription is an aim in the National Drugs Action Plan 2005-2009, but it was decided to wait with introduction until the evaluation of the development and impact of the Drug Consumption Room in 2008 (Source: NFP 2006).
[672] In the Netherlands, on-site pill testing facilities do not exist anymore.
[673] In Portugal, pill testing projects in mobile units are currently suspended, pending regulation (Source: IDT, Lisbon).
[674] Besides these official facilities, illegal or unofficial drug consumptions rooms exist; e.g. ad hoc locations for incidental drug use, but also more structured but not legal places which directly stem from the drug scene.
[675] AkZept [2000] in: Hunt [2006].
[676] Hunt [2006].
[677] Hedrich [2004].

communities that have not been solved through other responses by drug services, social services or law enforcement.

The EMCDDA report also identifies some of the specific objectives of drug consumption rooms, such as: to establish contact with difficult to reach populations of drug users; to provide a safe and hygienic environment for drug consumption, in particular, injecting drug use; to reduce mortality and morbidity associated with drug use as a result of overdose, to prevent transmission of HIV, hepatitis, and bacterial infections; to promote access to other social, health and drug treatment services; to reduce public drug use and associated nuisance.

A3.1.4 State of play

In 1986, the first official drug consumption room was established in Bern, Switzerland. In the early nineties, the Netherlands and Germany introduced drug consumption rooms. In 2000, drug consumption rooms were opened in Spain. In 2005 Norway and Luxembourg opened their first drug consumption room. Outside Europe, legal drug consumption rooms were opened in Sydney, Australia in 2001 and in Vancouver, Canada in 2003. It is estimated that currently around 110 drug consumption rooms exist worldwide. Roughly 40-45 of them are concentrated in the Netherlands, about 25 in Germany and Switzerland. Around 10 drug consumption rooms exist in various geographical areas of Spain. Norway, Luxembourg, Australia, and Canada. The number of drug consumption rooms tends to increase slightly year by year.

A3.1.5 Effectiveness of drug consumption rooms

The results of a long-term study in four German cities show a substantial association between the presence of a drug consumption room and a reduction of the number of drug-related deaths. This relationship was maintained after corrections for other potential explanatory factors.
A second study in Vancouver (among far less participants than the German study) suggests that drug consumption rooms reduce needle sharing among injecting drug users.
Thus, drug consumption rooms possibly reduce needle sharing and overdose death among opiate users but more studies are needed to draw more firm conclusions. For a more detailed description. See Annex 1, paragraph 4.5

A3.1.6 Discussion

In discussions about the establishment of drug consumption rooms, a number of assumed disadvantages are frequently mentioned. Opponents fear that people other than the intended target group might use the service and that new people could be recruited into drug use. Furthermore, drug consumption rooms might attract increasing numbers of drug users from other neighbourhoods or cities ('pull effect')[678]. However, in the available scientific studies, no such negative results of drug consumption rooms were found.

A3.1.7 Factors to increase effectiveness

As indicated above, drug consumption rooms may be effective. However, there are important differences between existing drug consumption rooms that influence effectiveness. It is important to keep the following conditions in mind:

1. Be aware of the consequences of inclusion and exclusion criteria. The establishment of drug consumption rooms is often accompanied by a number of thresholds to limit access to specific groups. If limitations are too strict, an unwanted effect may be that high-risk groups and individuals may be excluded from these facilities with the result that they may continue their risky drug use in public spaces.
2. House-rules inside the drug consumption room would best aim to encourage users to enter (e.g. allow 'street practices' such as drug sharing, allow more visits in line with the consumption pattern of a user).
3. Inside drug consumption rooms it is not allowed to buy and sell drugs. The implication may be that side-effects occur. For example, drug dealers may hang around in the neighbourhood, causing public nuisance for local residents and bad deals for drug users.

A3.1.8 Recent developments

In Catalonia, Spain some new concepts have been introduced last year. These include for example the re-establishment of a mobile drug consumption room (a bus) with facilities to inject drugs, and a treatment centre that includes a drop-in service with 3 injecting places[679]. In Portugal, the

[678] Hedrich [2004].
[679] Source: Xavier Major Roca; Programme on Substance Abuse, Department of Health, Autonomous Government of Catalonia, Spain.

establishment of drug consumption rooms, inscribed in the national legislation since 2001, has been under discussion for some time. Several proposals made in Parliament included their establishment in prison settings as well. In that case Portugal would become the first country in the world to have a drug consumption room in prison[680]. In Summer 2006, the Portuguese government approved the establishment of supervised drug consumption rooms by 2008[681].

A3.2 Heroin prescription

A3.2.1 Definition

Heroin prescription means the controlled prescription of pharmaceutical heroin[682] to heroin dependent drug users. As such, it might also be considered as substitution treatment (it substitutes low purity and usually bad quality street heroin with pure factory-made diacetylmorphine).

A3.2.2 Background history

In the United Kingdom, licensed physicians have prescribed heroin to opiate dependent users since the 1920s.[683] In contrast with the rest of the world, physicians in the United Kingdom are allowed to prescribe any drug that is expected to benefit their patients. Currently, in the United Kingdom 46 general practitioners have a license to prescribe diacetylmorphine to their patients. It was only in 1994, that prescription of heroin was initiated elsewhere in the Western world. In that year, Switzerland started a heroin prescription trial aimed at opiate dependent users. In the years that followed, other trials were conducted the Netherlands, Germany, Spain and Canada (Vancouver).

A3.2.3 Rationale and objectives

Treatment practice for drug users has learnt that for a specific subpopulation of drug users, regular available treatment (e.g. methadone maintenance, detoxification, therapeutic communities, and others) is ineffective[684]. Despite repeated attempts of drug users in this group, treatment does not lead to lasting results such as abstinence, reduced drug use and/ or the improvement of their personal health situation. The prescription of heroin to this group of drug users is expected to have a positive effect on both the personal health of the drug user and his environment.

The assumption behind heroin prescription is that it has many of positive effects:

- it may lead to an improvement of the personal health situation of drug users (physical, mental and social)
- more drug users may be persuaded to seek and continue treatment
- it may help some drug users to reduce or stop their illicit drug use
- it may reduce the number and severity of criminal offences undertaken by the drug users involved in the programme
- it may lead to benefits for society as a whole, e.g. by a reduction in public nuisance (reduction in drug-dealing activities, reduction in drug-related crime, lower health & social costs for society).

In contrast with these assumed benefits to individual and society, opponents of this treatment stress possible disadvantages or risks related to the prescription of pharmaceutical heroin to heroin dependant drug users. The most persistent is that this prescription will de-motivate heroin users to stop their drug use, because the provision of free and pure heroin will not stimulate the recipient to quit the use of this substance. However, once stabilised, part of the participants of heroin prescription treatment are likely to start other forms of treatment, including abstinence oriented treatment[685].

A3.2.4 State of play

In the European Union, four Member States (Germany, Spain[686], the Netherlands[687] and the United Kingdom[688]) run heroin prescription programmes. In Belgium and Luxembourg controlled

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[680] Sources: Luis Mendão (NGO Abraço, Lisbon) and IDT (Lisbon).
[681] Source: www.todayonline.com/articles/138396print.asp
[682] Also known as diacetylmorphine
[683] Jones J. [1995].
[684] Van den Brink [2003].
[685] Rehm [2001]; Naaber & Haasen [2006].
[686] Two trials are running. *Source*: Spanish National Focal Point [2006].
[687] This includes only medical co-prescription of heroin alongside methadone. The government decided that places at treatment units for medical prescription of heroin to chronic treatment resistant opiate addicts can be extended up to 1000 places.

prescription of heroin may start in the near future. Elsewhere in Europe, heroin is prescribed to opiate dependent drug users in Switzerland only, where it is available in a medical setting nationwide. Heroin prescription was also introduced in Vancouver, Canada in February of 2005. Despite discussions about this type of treatment, Australia so far has not provided in heroin prescription.

Other countries, such as the Netherlands, Switzerland and Germany have started heroin prescription through experimental trials. Both countries have prolonged and extended their heroin prescription programmes after finalisation of the trials. In the Netherlands, only medical co-prescription of heroin (in combination with methadone) exists, and takes place in a clinical setting.

A3.2.5 Heroin prescription in practice

Heroin is prescribed in different ways, and under different circumstances. In the UK, a small group of drug users can obtain a prescription for heroin from a licensed general practitioner or drug dependency clinic doctor specialised in drug dependence. The heroin is dispensed from a community or hospital pharmacy for unsupervised injection at home, as part of clinical practice[689]. In the Swiss, Dutch and German trials heroin was dispensed and consumption supervised at the clinic as part of research studies. In the Netherlands a cabin with negative air pressure was provided for those smoking heroin. Patients may receive three dosages a day, seven days a week. The daily maximum is 1000mg, the maximum dose per visit 400 mg.

A3.2.6 Effectiveness of heroin prescription

Medical heroin (co)prescription for heroin dependent drug users probably improves physical health and psychosocial well-being for those who are not responding to maintenance treatment. In countries with comprehensive treatment systems (including easily accessible maintenance treatment), heroin prescription may be a valuable additive option for these groups. However, heroin prescription is generally not considered as a treatment of first choice and there is consensus that it should not be implemented instead of, or at the expense of methadone maintenance treatment. Six new effect studies on heroin prescription are underway. For more detailed information, see annex 1, paragraph 4.2.

A3.2.7 Conclusions

The positive results of heroin prescription include a stronger commitment to (this) therapy among participants, an improved health status, reductions in drug-related offences and stabilised or improved social conditions.

According to the Dutch study, heroin prescription can be recommended in addition to methadone substitution for chronic heroin users who fail in methadone treatment. The German study shows positive results among those not reached by conventional treatment and also without the context of methadone maintenance. These results support implementation of heroin prescription programmes to treat specific subpopulations. However, the trials are conducted in countries with a comprehensive treatment system including easily accessible methadone maintenance treatment. Here, heroin prescription seems to be a valuable addition to the treatment system. However, heroin prescription is not considered as a treatment of first choice and should not be implemented instead of, or on the expense of methadone maintenance treatment.

Further research may explore the generalisibility of the results in heterogeneous social and treatment contexts[690]. It is expected that ongoing studies in Spain and Canada (and in the future possibly Belgium, Luxembourg and Australia) will gain additional knowledge and experience on this topic. In the framework of these future studies, one issue that certainly requires further discussion concerns the question whether it is ethically acceptable to terminate heroin prescription trials for those opiate dependent users that are participating in them, especially if the results are positive.

[688] 300-500 persons receive heroin in England and Wales.
[689] Hunt [2003].
[690] Cochrane collaboration [2005].

A3.3 Pill testing

A3.3.1 Definition

The term pill-testing in the context of illicit drugs usually refers to the testing of ecstasy pills. There are roughly two types of pill testing. On-site pill testing is often done during rave parties or other club scenes and involves a physical test and an acid-test. By making use of the physical test (e.g. diameter, thickness, colour and logo) and the acid test, the pill is classified and compared to an existing list of ecstasy pills. Information is given on-the-spot, accompanied with preventative information. In Spring 2006, on-site pill-testing was available in Austria, Belgium, Czech Republic and Spain. In the Netherlands a test possibility is available to drug users, which includes laboratory analysis. In this test the composition of a pill is tested (e.g. MDMA concentration, other chemicals, etc.). Participating drug users receive the test-results.

A3.3.2 Background

During the eighties, a new cultural phenomenon emerged: the dance, 'house', 'rave', or 'techno' culture. This culture, based on various forms of electronic dance music, quickly gained popularity among young people throughout Europe. This new trend was, among other things, accompanied by the use of new types of drugs. From its start this rave scene was associated with the use of synthetic drugs, especially ecstasy pills. This type of drug use was of a 'recreational' character as its users seemed to manage to use drugs in a more or less controlled way (only during weekends and at parties) as opposed to the traditional opiate dependent drug user.

As a result of these changes, the use of ecstasy called for a different approach from drug prevention workers. Secondary (selected) prevention historically was targeted at opiate drug users. With the increasing popularity of ecstasy, new health-risks emerged that required attention. Among others, there was a growing concern regarding the content of pills that were sold as ecstasy, but that in fact contained a great variety of other substances. Information indicating wide variability in pill composition and a number of deaths across Europe. Particularly in Great Britain this led to widespread popular media coverage alleging contaminated pills"[691].

During the nineties, EU Member States joined forces. In 1997, a Joint Action on new synthetic drugs was set up with a view to serve as an early warning system among Member States to detect and assess the risk of new synthetic drugs[692]. In 2005, this Action was replaced by the Council Decision on the information, exchange and risk-assessment and control of new psychoactive substances[693].

In the early nineties, in the Netherlands the Drug Information and Monitoring System (DIMS) was established. It aims to serve public health by minimizing the adverse consequences of the use of drugs at an individual and societal level. Its foundations lay in information exchange between users and monitoring authorities[694]. In the period 1992-1998, DIMS was engaged in on-site pill testing, but when it was prohibited by law to continue this practice, the service shifted to stationary testing only[695].

In the nineties, other countries such as Germany, Austria and Switzerland introduced pill testing schemes as well. These services mainly concerned on-site pill testing (in clubs and raves). In addition to formally appointed organisations involved in pill-testing, a large number of small-scale services introduced unofficial pill-testing as well, usually as a result of a spontaneous action of clubbers and their networks. Pill testing in other EU countries than those mentioned above usually concerns laboratory testing of pills that were seized by police and/ or customs.

A3.3.3 Rationale and objectives

The overall aim of pill-testing is to warn against harmful and unexpected drugs or 'pollution' of known substances with unexpected and possibly dangerous chemicals that currently are on the market, e.g. on site or via the Internet (harm reduction). As such it is a good outreach mechanism

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[691] Winstock [2001].
[692] EMCDDA [2001].
[693] Council Decision 2005/387/JHA.
[694] Winstock [2001].
[695] Through a countrywide network of local DIMS focal points, (synthetic) drugs are collected from users and forwarded to DIMS for (laboratory) analysis. If tests show the presence of harmful chemicals, a 'red alert' is issued (in consultation with the Ministry of Health) after which all drug prevention services, the media and the Early Warning System is informed about the health hazard. In the past, red alerts have been issued for pills that were polluted with e.g. atropine and strychnine.

to get in touch with potential consumers and those who may engage in risky behaviour. Pill-testing furthermore is a one-on-one prevention tool by properly informing potential users about health-related issues with regard to the use of ecstasy (such as the risk of de-hydration). Finally pill-testing is also an important tool for monitoring and evaluation purposes; by analysing pills, one gains knowledge and insight about which drugs appear on the market but also about changing patterns in drug use.

An important aim of on-site pill-testing practices is to give information about the tested pills, about the presence of dangerous and new pills, but also about the dosage of substances in pills (harm reduction). The choice whether or not to take a drug is the responsibility of the individual user.

Thus, an important feature in pill-testing practice is to inform potential users by enabling them to make an informed choice, i.e. based on available facts. Compared to on-site testing, stationary pill-testing (e.g. in laboratories and only in some countries) is more time consuming and the direct harm reduction impact of this service may be more limited. These testing facilities have an important function in monitoring.

Pill-testing projects usually also offer information talks and crisis intervention[696] (EMCDDA 2001). On-site pill testing is one of the few existing methods to approach drug consumers directly and to transmit "*safer-use*" messages that cover a variety of topics such as acute and short-term hazards to health (e.g. dehydration, overdoses), long-term hazards to health and addiction, legal risks and safer driving messages (EMCDDA, 2001). Pill-testing brings to the surface severe pollutions, and thus it provides important messages to prevention workers, authorities and the public.

From a monitoring perspective, pill testing data are an important prerequisite to set up and improve information and prevention projects and to plan scientific studies on patterns of use and related dangers. Results of on-site pill-testing adds insight information about drug markets. It may also give qualitative and quantitative data on consumers of illicit substances[697].

A3.3.4 Some considerations

Besides the above-mentioned possible benefits of pill-testing, it should also be borne in mind that pill testing remains superficial. An 'OK' test result does not mean that it is safe to take the tested pill. On site colour (or Marquis) tests do not give a 100% secure result about the content of the tablet, and some substances (such as PMA) – if present - are not detected at all. Laboratory testing gives more reliable results, but is less attractive to potential consumers because it takes more time.

A3.3.5 State of play

According to the National Focal Points, in spring 2006, six Member States provided drug testing to drug users, mainly pill-testing. This service is available in Austria[698], Belgium (Walloon Region), the Czech Republic, Spain and the Netherlands[699]. An NGO in Ljubljana also mentions the existence of the service in Slovenia[700]. In a number of countries such as France and Germany, this services has been discontinued as a result of changes in law (making the service illegal) or as a consequence of the discontinuation of funding of these services.

A3.3.6 Effectiveness of pill-testing

Sufficient knowledge on the effectiveness of pill testing programmes is still lacking. Some studies indicate that pill testing may decrease the use of potentially dangerous drugs. Pill testing programmes have several disadvantages. Firstly, pill testing methods are not standardised. Secondly, simple tests like colour tests give limited information about the content of synthetic drugs. This necessitates full laboratory analysis. Thirdly, pill testing is only one factor influencing drug use in recreational settings and probably not the most important one. Pill testing is not expected to diminish drug use. On the other hand, pill testing probably does not stimulate non-users to start with drug use, either. Furthermore, pill testing facilities allow for the monitoring of

[696] E.g. First Aid in case of Drug Accidents: trainings for staff of clubs and pubs.
[697] EMCDDA [2001].
[698] In Austria, the programme ChEckIT! in nightlife and party scene - provides information on-site, by printed material as well as via the website, and also runs an on-site pill testing programme www.checkyourdrugs.at
[699] In the Netherlands, the Drug Information and Monitoring System (DIMS; Trimbos Institute) analyses drug samples of consumers delivered at drug treatment services. DIMS covers a large part of the country, visit www.drugs-test.nl for an overview of cities.
[700] However, it is unclear whether this concerns a test service for drug users or the sale of testing kits.

trends in the composition of synthetic drugs. For more detailed information, see Annex 1, paragraph 4.3.

A3.3.7 Recent developments
In general, the availability of pill-testing services in the European Union changes rapidly and is kept low profile, because this service is often considered controversial. Sometimes, changes in legislation make pill-testing impossible, which leads to a shift in testing practices. Instead of using a Marquis (colour) test, testing practice may move towards thin-layer chromatology (TLC). Finally, pill-testing often takes place in a voluntary, unstructured setting, which may cause some disruptions in terms of continuity in pill-testing practice. Probably therefore an exact number of services is not available.

A3.4 Harm reduction in prison settings

A3.4.1 Definition
The WHO describes harm reduction in prisons as aiming to prevent or reduce negative health effects, among others associated with certain types of behaviour (such as injecting drug use and unprotected sex). According to the WHO, successful harm reduction is based on a policy, legislation and a social environment that minimises the vulnerability of problematic drug use. Such approaches recognise that many drug users cannot totally withhold or withdraw from psychoactive substances in the short term, even when imprisoned. And these approaches aim to help (potential) drug users not only not to start nor to stop drug use, but also to reduce their injection frequency and to increase injection safety[701].

A3.4.2 Background
In prisons, drug users are overrepresented as a percentage of the total prison population when compared to drug users in society (e.g., in the UK the prevalence of heroin use in a prison population has been found to be 40 times higher than would be expected from a random population sample)[702]. With an annual turnover of 50-100 inmates per 100.000 inhabitants in European prisons[703], prisons are an integral part of society.

In a large number of EU countries, the prevalence of HIV and viral hepatitis is also higher among prisoners than in the general population[704]. Because drug users employ in risky behaviours (e.g. sharing of drug equipment or unprotected sex), prisons also play a key role in the spread of infectious diseases. Another specific form of drug-related harm associated with imprisonment is mortality from overdose after release from prison. Drug users who start drug consumption again after a period of abstinence in prison, have a reduced drug tolerance. Consequently their risk of taking an overdose has increased considerably, especially in the first weeks after release[705].

The first harm reduction interventions in prison were introduced in the eighties. In Switzerland interventions were set up in which information leaflets were provided and condoms distributed among prisoners[706]. Today, these interventions are available in prisons in many countries. Although most prisons have a drug-free policy, maintenance treatment in prison is gaining ground (see 5.3.8). At the same time, needle and syringe exchange in prisons is still highly controversial.

In the mid-eighties, the so called *principle of equivalence* has been formulated, which entails "*that prisoners should have access to the same medical and health care services as outside prison, and that the professional standards of care and cure provided outside should be applied also in prison. Prisoners have the right to receive the highest attainable standard of physical and mental health*" [707]. The United Nations have adopted a resolution on the basic principles of the treatment of prisoners, in which it calls for implementation of the same prevention measures in prison as in

[701] WHO/ Pompidou Group [2005].
[702] Boys et al. [2002].
[703] WHO/ Pompidou Group [2005]. p. 6.
[704] WHO/ Pompidou Group [2005].
[705] Seaman et al. [1998]; Bird and Hutchinson [2003].
[706] Nelles et al. [1998].
[707] Stöver, Heino, Laetitia C. Hennebel and Joris Casselman. [2004]. Substitution Treatment in European Prisons: A Study of policies and practices of substitution treatment in prisons in 18 European countries. p.23. London: Cranstoun Drug Services/ENDHASP.

country[708]. This principle is also reflected in sub-recommendation 2.8 of the Council Recommendation.

A3.4.3 Rationale and objectives
Harm reduction interventions in prison aim to reduce transmission of, and provide care for, those infected with drug-related infectious diseases and aim to reduce overdose deaths. Prevention and harm reduction programmes may include: information, education and communication on risk reduction with regard to HIV/ AIDS, other infectious blood-borne viruses and sexually transmitted diseases; pre-release interventions mainly targeting overdose death; voluntary testing and counselling; vaccination programmes for hepatitis B (and sometimes A); distribution of condoms; needle and syringe exchange or distribution and provision of drug paraphernalia and treatment programmes (either maintenance treatment or rapid detoxification focusing upon drug withdrawal).

A3.4.4 State of Play
The availability of harm reduction interventions in prisons differs greatly from outside prisons, which is also reflected by this study. However, policies to make harm reduction services available to drug users in prison exist, or are pending for approval, in 24 of the Member States. Maintenance treatment (methadone, buprenorphine or naltrexone) is provided inside prisons in 17 Member States, against 24 Member States that provide maintenance treatment outside prison. Detoxification treatment with methadone is offered in 23 countries, but is available inside prisons in 19 Member States. Needle and syringe exchange is available in prisons in 3 Member States (Spain, Germany and Luxembourg) but available in all but one Member State outside prison. Drug paraphernalia, such as bleach or sterile water, are provided in prisons in 11 Member States whereas 22 Member States provide this service outside prison walls. Free condoms are distributed in penitentiary institutions in 16 Member States, compared to 23 Members States providing condoms in the community. Prisons are reported to be a predominant or common implementation setting for measures preventing infectious diseases among drug users in 15 Member States, and for measures reducing drug-related deaths in 10 Member States. In 19 Member States, trainings focusing on harm reduction are offered to prison staff.

A3.4.5 Effectiveness of harm reduction in prison
Prison-based maintenance treatment appears to be feasible and if adequate doses are distributed during imprisonment, it reduces injecting drug use, needle sharing and transmissions of drug-related infectious diseases.

The utility of pre-release counselling may be equal to information, education and communication (IEC). It should be part of other interventions, e.g. after care provisions, in order to prevent relapse or even overdose death after release from prison.

Needle (and syringe) exchange programmes in prison are effective in reducing needle sharing, and the transmission of infectious diseases.

HIV testing and counselling may reduce needle sharing and concomitant infections. Both experience and scientific evidence show that prison needle exchange programmes have a positive effect on safety in prison, both for staff and prisoners.

There is no evidence of any major, unintended consequences of condom distribution for safety and security in prisons. Taking care of sufficient lighting, offering showers and sleeping arrangements are important conditions for drug using prisoners. Measures to combat aggressive sexual behaviours in prison are even more important.

Counselling (information, education) should be part of prison-based harm reduction interventions. The literature suggests that effectiveness of information and education possibly increases when these interventions are part of intervention packages.

Evidence is currently lacking for the effectiveness of disinfection and decontamination schemes and strategies to reduce the occurrence of tattooing practices (as a risk factor for the spread of blood-borne infections). For more information, see Annex 1, paragraph 5.

[708] UN General Assembly, res. 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990). WHO [1993]; UNAIDS [1997].

A3.4.6 Conclusions and recommendations

Despite the principle of equivalence, there is a large discrepancy between harm reduction interventions available in the community and in prison. Accumulating evidence on the effectiveness of harm reduction measures in prison further advocates a continuation of care during all phases in the life of a drug user. Also with regard to public health, prevention of disease transmission should have highest priority in order to avoid prisons to become breeding grounds for infectious diseases as HIV, hepatitis, tuberculosis and sexually transmitted diseases.

Since research on the effects of the various harm reduction interventions is limited, it is recommended that speculations about possible effects and side effects of these measures in and outside prison should be replaced by an evidence-based policy. Pilot studies, such as the introduction of drug consumption rooms inside prison walls - is under debate in Portugal - should be encouraged. Finally, drug using prisoners should have access to similar harm reduction services as outside prison.

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Annex 4 – List of consulted field organisations in the Member States

Austria - Ganslwirt
Ganslwirt is a socio-medical drug service and includes a day care centre, ambulant help (such as methadone dispensary) and a crisis night shelter. http:/ / www.vws.or.at/ ganslwirt/ index.html

Belgium - Free Clinic (Flanders)
Free Clinic in Antwerp runs a socio-medical drop-in centre. The aims of Free Clinic include: improvement of the quality of life of drug users, and reducing the harms related to drug use. Free Clinic is responsible for a number of harm reduction intervention in Flanders, among which needle and syringe exchange, substitution treatment, and outreach work.

Czech Republic - ANO/ SANANIM
SANANIM is the largest Czech non-governmental organisation providing prevention, care and treatment services in the field of non-alcoholic drug addiction. It was founded in co-operation with Youth Centre Klíčov in 1990. Today, after 13 years of existence more than 100 of SANANIM´s employees arrange for maintenance and development of eight main projects and some additional ones, which all together make a comprehensive system of prevention, care and treatment. All of SANANIM´s Prague facilities except for the Outreach programme and Drug information centre have the status of health facility. SANANIM is a member of all the important Czech drug associations. SANANIM is a member of FESAT, the European Associations of Therapeutic Communities and an applicant to SCODA. It has participated in many international projects.

ANO (www.asociace.org) is the association of Czech harm reduction associations. It is a voluntary, independent, and apolitical association that serves as umbrella platform and agency for / of non governmental organisations in the field of drug demand reduction.

Germany - Fixpunkt/ AkZept
AkZept is the "Verein für akzeptierende Drogenarbeit und humanitäre Drogenpolitik" (www.akzept.org). In short it is the national network of harm reduction organisations in Germany. It organises – among others - annual conferences.

Fixpunkt (www.fixpunkt.org) is a Berlin based non-profit harm reduction organisation that aims to:
- support drug users to improve the conditions of health and social life, especially those who are infected by HIV or Hepatitis;
- support self-help activities, self-control and survival strategies;
- harm reduction, prevention of infections which are related to injecting drug users;
- offer various low threshold employment facilities.

Denmark – Brugerforeningen (BF)
BF is an interest organisation for opiate and methadone users. The organisation and activities of BF are run by active volunteers, who are methadone users (www.brugerforeningen.dk).

Finland - A-Klinikka Foundation
A-Clinic Foundation is the leading substance abuse service provider in Finland, with 19 outpatient and inpatient service units, and activities in the areas of prevention, training, research and information provision. A-Clinic Foundation is a non-profit, non-governmental organisation. The Foundation receives funding for the provision of treatment services mainly from municipalities. Training, research and information activities are funded through national funding sources, such as Finland's Slot Machine Association and the Ministry of Social Affairs and Health. (www.a-klinikka.fi).

Hungary - HCLU (TASZ)
The Hungarian Civil Liberties Union (HCLU) is a non-profit human rights watchdog NGO established in Budapest, Hungary in 1994. HCLU is a law reform and legal defence public interest NGO in Hungary, working independently of political parties, the state or any of its institutions. The aim of HCLU is to promote the case of fundamental rights and principles laid down by the Constitution of the Republic of Hungary and by international conventions. Generally it has the goal of building and strengthening the civil society and rule of law in Hungary and the CEE region. Since HCLU is an independent non-profit organization the financial resources are largely provided by foundations and more and more likely by individuals (www.hclu.org). HCLU is also active in the field of improving the legal position and rights of drug users in Hungary.

Luxembourg - Tox-in
Tox-in is a harm reduction based NGO in Luxembourg City, providing low threshold agencies during the day (Obrigado) and night shelter (d' Nuetseil). In July 2005, Tox-In opened the first drug consumption room in Luxembourg.

Latvia - Dia+logs
DIA+LOGS, a non-governmental and non-profit organisation which was founded in 2002 as a joint endeavour between the Latvian NGOs AGIHAS (a self-support group for people living with HIV/ AIDS) and LCG (a Latvian Contact Group on Urban, Industrial and Rural Mission). The Board of DIA+LOGS is comprised of key stakeholders and actors in the HIV/ AIDS field in Latvia.

The organisation's primary objective is the development and operation of a low threshold centre for people living with HIV/ AIDS and at-risk groups in greater Riga, including injecting drug users. Conveying knowledge and experience about HIV and AIDS, providing a social environment, one-to-one conversations, group sessions for target groups while empowering people living with HIV/ AIDS and providing advocacy are primary aims. The psychosocial support and prevention information are developed with a focus on strong community involvement.

Netherlands - Mainline
Mainline is a non-governmental organisation based in Amsterdam , the Netherlands . Embracing a Harm Reduction approach, Mainline works to improve the health and quality of life of (injecting) drug users. Cooperating with governmental and non-governmental organizations in various regions of the world Mainline focuses on prevention of drug-related infectious diseases such as HIV and hepatitis B and C as well as care and support for those drug users already infected. Drug abstinence is not a prerequisite. Mainline's approach is pragmatic, holistic and non-judgemental (www.mainline.org).

Poland - Monar
Monar is a longstanding harm reduction organisation in Krakow , Poland. Monars services includes needle and syringe exchange, outreach work, shelters and a drug user-driven magazine for drug users.

Portugal - Abraço

Abraçao is the leading HIV/ AIDS prevention organisation in Portugal, which also provides a range of harm reduction services to drug users. (www.abraco.org.pt).

Sweden - Svenskabrukarforeningen
The Swedish Users Union (SBF) was founded in October 2002 by patients in substitution treatment. In the relatively short period that the Union exists, more than four hundred people have joined in and become members. It's main task is to look after and make visible the needs of the heroin dependent drug users (www.svenskabrukarforeningen.com).

Slovenia - Project STIGMA
Project STIGMA was officially registered in 1992 and offers low threshold programmes for drug users in Ljubljana and in Slovenia. HIV/ AIDS prevention measures among injecting drug users are part of their services, such as needle and syringe exchange and condom distribution. STIGMA also conducts outreach work and other harm reduction interventions. As such, STIGMA is the leading harm reduction organisation in Slovenia.

Slovakia - Odysseus
Odysseus is a Slovak non-governmental organisation, established in 1997. Its aim is to prevent HIV/ AIDS and other blood borne infections and sexually transmitted diseases among drug users and sex workers. Odysseus is involved amongst others in outreach work, needle and syringe exchange and social assistance to drug users and sex workers.

United Kingdom - UK Harm Reduction Alliance (UKHRA)
The United Kingdom Harm Reduction Alliance (UKHRA) is a campaigning coalition of drug users, health and social care workers, criminal justice workers and educationalists that aims to put public health and human rights at the centre of drug treatment and service provision for drug users. It is a campaigning network spread across the UK, as well as promoting harm reduction and evidence based drug policy by writing policy proposals and responses to government consultations (www.ukhra.org).

Annex 5 – Council Recommendation (full text)

Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence (2003/ 488/ EC)

THE COUNCIL OF THE EUROPEAN UNION,

Having regard to the Treaty establishing the European Community, and in particular the second subparagraph of Article 152(4) thereof,

Having regard to the proposal from the Commission(1),

Having regard to the opinion of the European Parliament(2),

Having regard to the opinion of the European Economic and Social Committee(3),

Having regard to the opinion of the Committee of the Regions(4),

Whereas:

(1) In accordance with Article 3(1)(p) of the Treaty, Community action is to include a contribution towards the attainment of a high level of health protection. The third subparagraph of Article 152(1) of the Treaty also makes provision for action in reducing drugs-related health damage, including information and prevention.

(2) The European Council, meeting in Helsinki on 10 and 11 December 1999, endorsed the European Union Drugs Strategy 2000 - 2004 that covers all European Union drug-related activities and sets main targets. These targets include a substantial reduction over five years of the incidence of drug-related health damage (such as HIV, hepatitis B and C and tuberculosis) and the number of drug-related deaths.

(3) The European Council, meeting in Santa Maria da Feira on 19 and 20 June 2000, endorsed the European Union Action Plan on Drugs 2000 - 2004 as a crucial instrument for transposing the European Union Drugs Strategy 2000 - 2004 into concrete actions which provide an effective integrated and multi-disciplinary response to the drug problem.

(4) The Commission, in its Communication to the European Parliament and the Council on the European Union Action Plan to Combat Drugs (2000 - 2004), considered a comprehensive approach that should cover all areas of drug abuse prevention, from discouraging the initial use to reducing the negative health and social consequences as the best strategy.

(5) The European Parliament, in its Resolution on the abovementioned Communication welcomed the objective of reducing the number of deaths among addicts and called on the European Union and its Member States to encourage and develop damage limitation policies, without debarring individual Member States from adopting measures and pilot schemes in this area.

(6) The programme of Community action on the prevention of drug dependence within the framework for action in the field of public health and the programme of Community action on the prevention of AIDS and certain other communicable diseases within the framework for action in the field of public health have supported projects aimed at preventing and reducing the risks associated with drug dependence, in particular by encouraging cooperation between the Member States, supporting their action and promoting coordination between their policies and programmes. Both programmes have been contributing to improving information, education and training aimed at preventing drug dependence and the associated risks, in particular, for young people and particularly vulnerable groups.

(7) The decision of the European Parliament and of the Council adopting a programme of action in the field of public health (2003 - 2008) includes the development of strategies and measures on drug dependence, as one of the important lifestyle-related health determinants.

(8) Since, according to research, the morbidity and the mortality associated with drug dependence affects a sizeable number of European citizens, the health-related harm associated with drug dependence constitutes a major problem for public health.

(9) In accordance with the principle of subsidiarity, any new measure taken in an area which does not fall within the exclusive competence of the Community, such as prevention and reduction of risks associated with drug dependence, may be taken up by the Community only if, by reason of the scale or effects of the proposed action, the objectives proposed can be better achieved by the Community than by Member States. Prevention and reduction of risks

associated with drug dependence cannot be confined to a geographical region or Member State and action therefore requires coordination at Community level.

(10) Provisions should be made on reporting at national and Community level to monitor the measures taken by the Member States in this area, and the results thereof, and the way these Recommendations have been implemented.

(11) The most important measure to reduce the risk associated with drug abuse is to prevent the abuse itself,

HEREBY RECOMMENDS THAT:

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.

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:

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

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

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;

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;

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

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;

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

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;

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;

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

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

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

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

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:

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

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

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

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

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

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

7. setting up evaluation training programmes for different levels and audiences;

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

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.

4. Member States should report to the Commission on the implementation of this Recommendation within two years of its adoption and subsequently on request by the Commission with a view to contributing to the follow-up of this recommendation at Community level and acting as appropriate in the context of the European Union Action Plan on Drugs.

HEREBY INVITES the Commission to:

- cooperate with the Pompidou Group of the Council of Europe, the World Health Organisation, the United Nations International Drug Control Programme and other relevant international organisations active in the field,

- prepare a report, in accordance with the European Union Action Plan on Drugs and with the technical support of the EMCDDA, with a view to the revision and updating of this Recommendation, on the basis of the information submitted by the Member States to the Commission and the EMCDDA, and the latest scientific data and advice.

Done at Luxembourg, 18 June 2003.

For the Council

The President

G. Drys

(1) Proposal of 17 May 2002 (not yet published in the Official Journal).

(2) Opinion delivered on 13 February 2003 (not yet published in the Official Journal).

(3) OJ C 61, 13.2.2003, p. 189.

(4) OJ C 73, 26.3.2003, p. 5.

Annex 6 – List of abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retroviral Therapy
ASI	Addiction-Severity Index
ATS	Amphetamine Type Stimulants
CEEHRN	Central and Eastern European Harm Reduction Network
CND	Commission on Narcotic Drugs
CR	Council Recommendation
DCR	Drug Consumption Room
DIMS	Drug Information and Monitoring System
DG SANCO	Directorate General Consumer Protection and Health
DRID	Drug-related Infectious Disease
DRD	Drug-related Death
EDDRA	Exchange on Drug Demand Reduction Action (EMCDDA)
ELDD	European Legal Database on Drugs (EMCDDA)
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ENDIPP	European Network on Drugs and Infections Prevention in Prison
ESPAD	European Survey Project on Alcohol and Drugs
IDU	Injecting Drug User
IEC	Information, Education and Communication
IHRA	International Harm Reduction Association
HEN	Health Evidence Network
HIV	Human Immunodeficiency Virus
LAAM	Levomethadyl Acetate Hydrochloride
MMT	Methadone Maintenance Treatment
MS	Member State(s)
NGO	Non Governmental Organisation
NIDA	National Institute on Drug Abuse
NFP	National Focal Point (EMCDDA Reitox Network)
NR	National Report
NSP	Needle and syringe exchange programmes
PR	Permanent Representative
PDU	Problem Drug Use
RCT	Randomized Controlled Trial
RT	Reporting tool (European Commission)
SQ	Structured Questionnaire (EMCDDA)
ST	Standard Table (EMCDDA)
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/ AIDs
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

Annex 7 – Glossary

A

Abstinence based therapy
Abstinence-based therapy aims at a drug-free life. Enrolling in abstinence-based treatment, drug users will undergo a phase of detoxification which might be medically supported by the temporary provision of substitution drugs (methadone, buprenorphine, benzodiazepines, etc). The detoxification period can however also be free of medically assisted treatment and may focus solely on socio-psychological support, enrolment in work programmes, individual coaching, or art therapy. Long time enrolment in counselling services or supported housing projects often go alongside with abstinence-based therapy.

Agonist
A substance that acts at a neuronal receptor to produce effects similar to those of a reference drug; for example, methadone is a morphine-like agonist at the opioid receptors.

Antagonist
A substance that counteracts the effects of another agent. Pharmacologically, an antagonist interacts with a receptor to inhibit the action of agents (agonists) that produce specific physiological or behavioural effects mediated by that receptor. Naloxone (Narcan) is antagonist.

Antiretroviral therapy (ARV)
Antiretroviral drugs inhibit the replication of HIV. When antiretroviral drugs are given in combination, HIV replication and immune deterioration can be delayed, and survival and quality of life improved. When selecting a specific ARV-treatment regimen for individual patients the following factors should be consider: potency, frequency of dosage, side effects, maintenance of future treatment options, the anticipated adherence of the patient population to a regimen, need for storage, concurrent conditions, the potential for resistant viral strains, and cost and access. Additional considerations may include access to only a limited number of ARV drugs, limited health service infrastructure, the need to deliver drugs to rural areas, a high incidence of tuberculosis and hepatitis B and/ or C, and the presence of varied HIV groups and subtypes.

B

Bleach
Disinfectant, used to disinfect syringes when no clean syringes are available.

Buprenorphine
Buprenorphine is a mixed opioid agonist/ antagonist which can be used in substitution treatment. It has been used extensively in many countries for the short term treatment of moderate to severe pain. The mixed opioid-action/ blocking-action appears to make buprenorphine safe in overdose. It may also provide an easier withdrawal phase, and due to a longer action, may allow for alternate day dosing. Buprenorphine is also available under the brand name Subutex ®. See also: Methadone, Maintenance treatment.

C

Clinical trial
A clinical trial is a study that is used to test whether one health care intervention is superior to another. Clinical trials are often described in terms of testing drugs, but they can be used to investigate many different types of health care intervention, including vaccination and health education. Clinical trials are always concerned with effectiveness. A characteristic of well-conducted clinical trials is that they identify a set of patients with a diagnosed disease, and then randomly allocate them to new or current best treatment. The focus of the study is on the outcome of the treatments, seeking the one which is superior. Clinical trials are also concerned with the side effect of treatments

CND
The Commission on Narcotic Drugs (CND) is the central policy-making body within the United Nations system dealing with drug-related matters. It analyses the world drug situation and develops proposals to strengthen the international drug control system to combat the world drug problem. In 1991, the UN General Assembly established the Fund of the United Nations International Drug Control Programme (UNDCP) and expanded the mandate of the Commission to enable it to function as the governing body of UNDCP. UNDCP is administered as part of the United Nations Office on Drugs and Crime (UNODC).

Cochrane collaboration
The Cochrane Collaboration is an international non-profit and independent organisation, dedicated to making up-to-date, accurate information about the effects of healthcare readily available worldwide. It produces and disseminates systematic reviews of healthcare interventions and promotes the search for evidence in the form of clinical trials and other studies of interventions. The Cochrane Collaboration was founded in 1993 and named for the British epidemiologist, Archie Cochrane. The major product of the Collaboration is the **Cochrane**

Database of Systematic Reviews which is published quarterly as part of The Cochrane Library. [http:/ / www.cochrane.org/ reviews/ clibintro.htm].

Cohort study
In a cohort study parts of a pre-defined population can be identified who are exposed to factors influencing the occurrence of a disease or other outcome. Essential is the measurement of these factors and outcomes for a sufficient number of person-years to generate reliable incidence or mortality rates in the populations subsets. This generally implies study of a large population and for several years.

Co morbidity
See: **dual diagnosis**

D

DSM-IV
Diagnostic and Statistical Manual of Mental Disorders, IV edition. This manual includes a diagnostic terminology of psychiatric and psychoactive substance use disorders classified by the American Psychiatric Association (APA).

Detoxification treatment
Detoxification treatment is a form of medical care offered to opiate addicts (primarily heroin addicts) based on a similar or identical substance to the drug normally used, by gradually cutting the quantity of the drug to zero.

Drop-in centre
In drop-in centres, some of the basic needs of people, e.g. drug users are met. A drop-in centre is a low threshold service for drug users, usually including needle and syringe exchange, distribution of condoms, free (or cheap) meals, laundry and washing, referral to treatment. Drop-in centres are a characteristic feature of the low threshold approach.

Drug consumption room
There is no universal definition of the term drug consumption room. When the term drug consumption rooms is used in this report. reference is made to *"protected places for the hygienic consumption of pre-obtained drugs in a non-judgemental environment and under the supervision of trained staff."*

Drug dependence
Drug dependence is often defined as: a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time within a 12-month period. **(1)** Tolerance, as defined by either of the following: (a) need for markedly increased amounts of the substance to achieve intoxication or desired effect; (b) markedly diminished effect with continued use of the same amount of the substance. **(2)** Withdrawal, as manifested by either of the following: (a) the withdrawal characteristic for the substance (refers to Criteria A and B of the criteria sets for withdrawal from the specific substances; (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms; **(3)** the substance is often taken in larger amounts or over a longer period than was intended; **(4)** there is a persistent desire or unsuccessful effort to cut down or control substance use; **(5)** a great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use of the substance (e.g. chain-smoking), or recovering from its effects; **(6)** Important social, occupational or recreational activities are given up or reduced because of substance use; **(7)** the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) (*source: DSM IV*).

Drug free treatment
Drug-free treatment involves the application of psychosocial and educational techniques to achieve long-term abstinence from drugs. Traditionally, drug-free treatment has been residential and long term, e.g. in therapeutic communities. Today, it is often also offered in community-based settings.

Drug paraphernalia
The term drug paraphernalia refers to equipment used to produce, administer or conceal an illicit drug, e.g. bleach, a spoon, ascorbic acid, pipes, etc.

Drug-related death
Drug-related death is defined in this report as: deaths caused directly by the consumption of one or more drug and generally occurring shortly after the consumption of the substance(s). These deaths are known as 'overdoses', 'poisonings' or drug-induced deaths..

Drug-related infectious diseases
The most prevalent types of drug-related infectious diseases are Hepatitis B and C, HIV/ AIDS and Tuberculosis.

Dual diagnosis
The term dual diagnosis is a common, broad term that indicates the simultaneous presence of two independent medical disorders. Recently, within the fields of mental health, psychiatry, and addiction medicine, the term has been popularly used to describe the coexistence of a mental health disorder and alcohol and other drug (AOD) problems. The equivalent phrase dual disorders also denotes the coexistence of two independent (but invariably interactive) disorders and is used interchangeably here with dual diagnosis.

The acronym MICA, which represents the phrase mentally ill chemical abusers, is occasionally used to designate people who have an AOD disorder and a markedly severe and persistent mental disorder such as schizophrenia or bipolar disorder. A preferred definition is mentally ill chemically affected people, since the word affected better describes their condition and is not pejorative. Other acronyms are also used: MISA (mentally ill substance abusers), CAMI (chemical abuse and mental illness), and SAMI (substance abuse and mental illness). Common examples of dual disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and poly-drug addiction with schizophrenia, and borderline personality disorder with episodic poly-drug abuse. Although the focus of this volume is on dual disorders, some patients have more than two disorders, such as cocaine addiction, personality disorder, and AIDS. The principles that apply to dual disorders generally apply also to multiple disorders.
See also: **Co morbidity**

E

Evidence-based medicine
Evidence-based medicine consists of carefully, explicitly and judiciously using recent scientific evidence for medical decision making for individual patients. The practice of evidence-based medicine implies an integration of individual clinical expertise with best evidence available in systematic studies. Preferences and expectations of individual patients play a major role in decision making.

H

Harm Reduction
There is no universal definition of the term harm reduction. For this report the definition of the International Harm Reduction Association (IHRA) is used: "policies and programmes which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and their communities"

Hepatitis B
Hepatitis B is a virus spread through the blood and bodily fluids of an infected person. Many people do not realise they have been infected with the virus, because symptoms may not develop immediately, or at all. The hepatitis B virus can then go on to cause a chronic (long-term) illness, which follows the acute infection. This is very common if babies or children contract the virus, but can also occur in adults. The virus is present in body fluids such as blood, saliva, semen and vaginal fluid. It can be passed from person to person, through unprotected sex (without using a condom) and sharing needles to inject drugs. Infected mothers can also transmit the virus to their baby during the delivery process (often without the woman being aware that she is infected). The incubation period (i.e. the time from coming into contact with the virus to developing the infection) is between one and six months. There is a blood test to detect the virus. There is also a vaccine to protect you against hepatitis B.

Hepatitis C
Hepatitis C is a blood-borne viral infection. Rarely it can also be passed on through other body fluids. Drug users sharing needles are particularly at risk. Anyone whose blood has come into contact with the blood of someone infected with the hepatitis C virus is also at risk. Approximately 20% of people will fight the infection and naturally clear it from their bodies within two to six months . Of the rest some will remain well, and never develop liver damage but many will develop mild to moderate liver damage (with or without symptoms). A further 20% will progress to cirrhosis of the liver over a period of 20- 30 years. Excessive drinking of alcohol is often associated with increased likelihood of progression to severe liver complications. There is no vaccine to prevent hepatitis C but treatment can clear the infection in approximately half those infected.

Heroin prescription
Heroin prescription means the controlled prescription of pharmaceutical heroin (diacetyl morphine) to heroin dependent drug users. In this context it may also be considered as substitution treatment (an alternative to low purity 'street' heroin with pure factory-made diacetylmorphine). In a number of the countries with heroin prescription programmes, heroin is prescribed to heroin dependent drug users, for whom regular therapy with methadone or buprenorphine is proven ineffective

HIV/ AIDS
AIDS was first recognised as a new condition in 1981. Since then around 40 million people worldwide have been infected with HIV, the virus which can lead to AIDS. About a third of them have died. However, developments in treatment since the mid-nineties have dramatically improved the life expectancy for those diagnosed with HIV. People with HIV may not have any symptoms at all while they are in the latent phase. However, many people experience symptoms in the first couple of months after getting infected. These symptoms may include high temperature and fever, fatigue, skin rash, muscle pains, headache, nausea, vomiting and diarrhoea. Once someone becomes ill with HIV, they are open to many infections. These can include infections of the mouth,

such as thrush (oral candidiasis), unusual types of pneumonia, tuberculosis (TB), infections of the brain and eyes, unusual skin problems and odd infections of the gastrointestinal tract. Most people with severe HIV infection also experience weight loss, enlargement of their lymph glands and persistent diarrhoea.

Hypotension
(Extremely) low blood pressure during which there is inadequate blood flow to the heart, brains and other vital organs. Hypotension may occur during opioid overdose and can be reversed by the administering of Naloxone.

I

IDU
Injecting drug user. Injections are usually intravenous, but may also be intramuscular, subcutaneous.

IEC
Abbreviation of information, education and communication. IEC is usually the first measure in any response strategy to prevention or reduce infectious diseases among drug users, or to promote less risky, more healthy behaviour and is aimed at raising levels of knowledge, awareness and understanding.

Inpatient treatment
Treatment for drug dependence that takes place in a controlled environment such as a hospital or clinic. The patient is checked into the hospital and remains there until treatment has ended.

Interferon mono therapy
Interferon mono therapy is a treatment option for treating HCV with only alpha-interferon. The treatment with alpha-interferon allowed for only limited healing of chronic HCV infections (8-12%) and was replaced by a combination therapy with ribavirin and alpha-interferon. Treatment results of healing the liver infection caused by HCV rose to 30-40%. Since the year 2000, PEG-interferon was introduced which in combination with ribavirin allows for a healing of up to 80% of all patients infected with genotype 2 and 3 of the hepatitis C virus. For genotype 1, the combination therapy of PEG-interferon and ribavirin still allows for positive treatment results with up to 50% of all patients.

L

LAAM (Levomethadyl Acetate Hydrochloride)
LAAM is a long-acting opiate agonist with a similar action to methadone. However, its half life is longer and it can be administered once in two days. LAAM has been associated with life-threatening heart arrhythmias and therefore it is no longer licensed for treatment in Europe

Low threshold agencies
Low threshold agencies are services for drug users which are easily accessible by clients, and where abstinence is not a prerequisite for service provision. Often, such services work with clients on an anonymous basis. They are designed to attract future clients by offering, beside drug-related services, other services that respond to the immediate needs of clients, such as free or reasonably priced food, clothing or shelter.. Drop in centres, and outreach work are main low threshold agencies

M

Maintenance treatment
Maintenance treatment is a harm reduction intervention aiming at stabilizing opiate users medically and socially allowing for genuine social re-integration. To avoid criminal activity when acquiring the illicit drugs and eliminating high risk situation when administrating the drug via injecting, the treatment provides the patient with a substitution drug, mostly orally administered methadone or buprenorphine. Often maintenance treatment is provided as DOT (Daily Observed Therapy) which allows for thorough monitoring of the effects of the provision of substitution drugs in every patient. Furthermore patients are supported by medical and social service professionals to guarantee beneficial long-term effects on social re-integration of the individual patient.

Medically assisted treatment
Medically assisted treatment (MAT) covers both substitution treatment with agonists (methadone, buprenorphine, dihydrocodeine, heroin, slow-release morphine) and other pharmacological treatments (e.g. with antagonists such as naltrexone) which is targeted at the drug use itself (not anti-depressives and benzodiazepines).

Meta-analysis
Meta-analysis is the statistical component of a systematic review (see systematic review) in which the outcomes of similar studies are statistically drawn together to a mean outcomes for all or for subsets of studies. In the international literature, the terms systematic review and meta-analysis often are used interchangeably.

Methadone
A synthetic opiate drug used in maintenance therapy for those dependent on opioids. It has a long half-life, and can be given orally once daily with supervision. Methadone acts as a replacement for opiates in the body and thus can lessen withdrawal symptoms and cravings. At higher doses, it can also reduce the euphoric effects of

opiates, thereby further protecting opiate users from relapse. Methadone is provided under several brand names.

Morphine (slow-release morphine)
Slow release morphine (SROM) is morphine that is administered orally. It is sometimes used as (agonist) substitution for heroin.

N

Naloxone
Naloxone is a narcotic antagonist which reverses the respiratory, sedative and hypotension effects of heroin overdose. It can be injected intramuscularly, intravenously or subcutaneously. A nasal spray preparation is now also available in some countries. It is an opioid receptor blocker that antagonizes the actions of opioid drugs. It reverses the features of opiate intoxication and is prescribed for the treatment of overdose with this group of drugs. It has a half-life of between 20 and 80 minutes, shorter than the half-life of heroin and much shorter than that for methadone, which means the opportunity for it to reduce the effects of opioids is time-limited. There is therefore a concern that persons treated with naloxone may again succumb to the respiratory depression effects of these other drugs once the effects of naloxone have worn off. Naloxone is also available under the brand name Narcan®.
See also: **antagonist, naltrexone**.

Naltrexone
This is a drug that antagonises the effects of opioid drugs. Its effects are similar to those of naloxone, but it is more potent and has longer duration of action. It is used in various ways in the treatment of opioid dependence and also alcohol dependence. The most widely adopted use is to prescribe at a dose which will block the psychoactive effects of all opioid drugs. The idea is that while the drug needs to be taken daily to maintain this blockade, it will minimize the chance of impulsive decisions to relapse. Naltrexone has also been used more controversially for a treatment known as Rapid Opiod Detoxification in which higher doses are used under a general anaesthetic for the purpose of speeding up the withdrawal process. Deaths have been recorded with this approach and it has many critics as well as a few proponents. Naltrexone is also available under the brand name Nalorex®.
See also: **antagonist, naloxone, drug substitution**.

Narcan ®
Brand name for Naloxone.
See also: **Naloxone**

Needle and syringe exchange
An intervention in which needles, syringes, other injecting equipment (such as alcohol swabs to clean injecting sites, and water with which to mix powdered drugs) are provided to IDUs through outreach, drop-in centres, clinics or shop fronts, mobile units such as vans and buses and/ or vending machines. Most NSPs include a retrieval service for used syringes.

O

Outpatient treatment
Treatment (ambulant) of drug dependency that does not include an overnight stay in a clinic.

Outreach work
A community based activity with the overall aim of facilitating improvement in health and reduction of drug-related risk or harm for individuals and groups not effectively reached by existing services or through traditional health education channels.

P

Paraphernalia
The term drug paraphernalia refers to equipment used to produce, administer or conceal an illicit drug, e.g. bleach, a spoon, ascorbic acid, pipes, etc.

Pill testing
The term pill-testing in the context of illicit drugs usually refers to the testing of ecstasy pills. On-site pill testing is often done during rave parties or other club scenes and involves a physical test and an acid-test. By making use of the physical test (e.g. diameter, thickness, colour and logo) and the acid test, the pill is classified and compared to an existing list of ecstasy pills. A more thorough test includes a laboratory test, in which the substance of a pill is tested (e.g. MDMA concentration, other chemicals, etc.).

Pre-release counselling
Pre-release counselling is a harm reduction activity offered to inmates who are about to be released from prison. Through pre-release counselling inmates are prepared for their return to society outside prison, with the aim to support their reintegration in society. Pre-release counselling also provides drug using inmates the advice regarding the risks of the possible detrimental effects of drug consumption after release, which may

result in drug overdose especially when the inmate has not used drugs or reduced drug use in prison and returns to the drug use patterns he had prior to his incarceration.

Prevalence
Prevalence is a statistic of primary interest in public health because it identifies the level of burden of disease or health-related events on the population and health care system. Prevalence represents new and pre-existing cases alive on a certain date, in contrast to incidence which reflects new cases of a condition diagnosed during a given period of time. Prevalence is a function of both the incidence of the disease and survival.

R

Randomised Controlled Trials (RCT)
Experimental study in which subjects are randomly allocated into groups to receive or not to receive an experimental intervention. Randomisation is meant to minimise systematic bias in outcomes. Outcomes are assessed and explained by rigorous comparison of groups on rates of disease, death or recovery.

S

Safer injecting training
A practical training for injecting drug users with the intent to educate drug users in more safe, less risky ways of injecting. This training may be given by experienced drug injectors, non-injecting professionals, or a mixture of both groups.

Seroprevalence
Seroprevalence denotes the condition that antibodies can be detected in a serum sample. The development of detectable antibodies in the blood are proof that an infectious agent, such as HIV or HCV, is present. It normally takes some time for antibodies to develop after the initial exposure to the agent. This period of time is called seroconversion. Following seroconversion, a person tests positive in tests based on the presence of antibodies.

Substitution treatment
Substitution treatment is a form of medical care offered to opiate addicts (primarily heroin addicts) based on a similar or identical substance to the drug normally used. It is offered in two forms: *maintenance* — providing the user with enough of the substance to reduce risky or harmful behaviour; or *detoxification* — gradually cutting the quantity of the drug to zero. Treatment comes either with or without psycho-social support.

Systematic review
Systematic reviews draw together previously performed research (primary studies). A systematic review is a literature review of the evidence on a clearly formulated question that uses systematic and explicit means to identify, select, and critically appraise relevant primary research. It also systematically extracts and analyses data from the included studies. Statistical methods (meta-analysis) may or may not be used.

T

Treatment retention
The degree of treatment completion of participants in a study.

Tuberculosis
Tuberculosis (TB) is an infection caused by a germ called the tubercle bacillus or Mycobacterium tuberculosis. Until effective anti-tuberculosis drugs were introduced about 50 years ago, TB was one of the main causes of death. TB is still a major problem in many countries. It has been on the increase in the developed world in recent years, probably because of increased air travel and movement of people from areas where it is common. It can affect the lungs (pulmonary TB) or other parts of the body, such as the lymph nodes (tuberculous adenitis or scrofula), the skin and the bones. Tubercle bacilli can remain dormant for years before producing active disease. In most cases lung infection is well controlled by the immune system, and shows no symptoms. Active lung disease occurs if the immune system becomes less effective.

A person may have had an infection with tuberculosis without being aware. This can be discovered by a tuberculin skin test, the Heaf (or Mantoux) test. When positive, it indicates that the person has a degree of natural immunity. People who test negative do not have this immunity and are more susceptible to infection by TB. Tuberculin-negative people may benefit from BCG (bacille Calmette-Guérin vaccine) inoculation. This uses a vaccine made from a modified version of the TB germ. It reduces the risk of developing TB in about 70% of those vaccinated for approximately 15 years.

Twinning
An agreement between a candidate country and one or more Member State administrations to transfer Acquis-related skills and knowledge (progress towards adoption of part of the Acquis).

V

VCT
Voluntary Infectious Diseases Testing and Screening. Programmes specifically targeted at at-risk groups to test and screen for the presence of drug-related infectious diseases.
Virus
A virus is a small infectious organism—much smaller than a fungus or bacterium—that must invade a living cell to reproduce (replicate).

ISBN 90-5253-564-7
ISBN 978-90-5253-564-7

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