Regional Overview
2.3 Western Europe

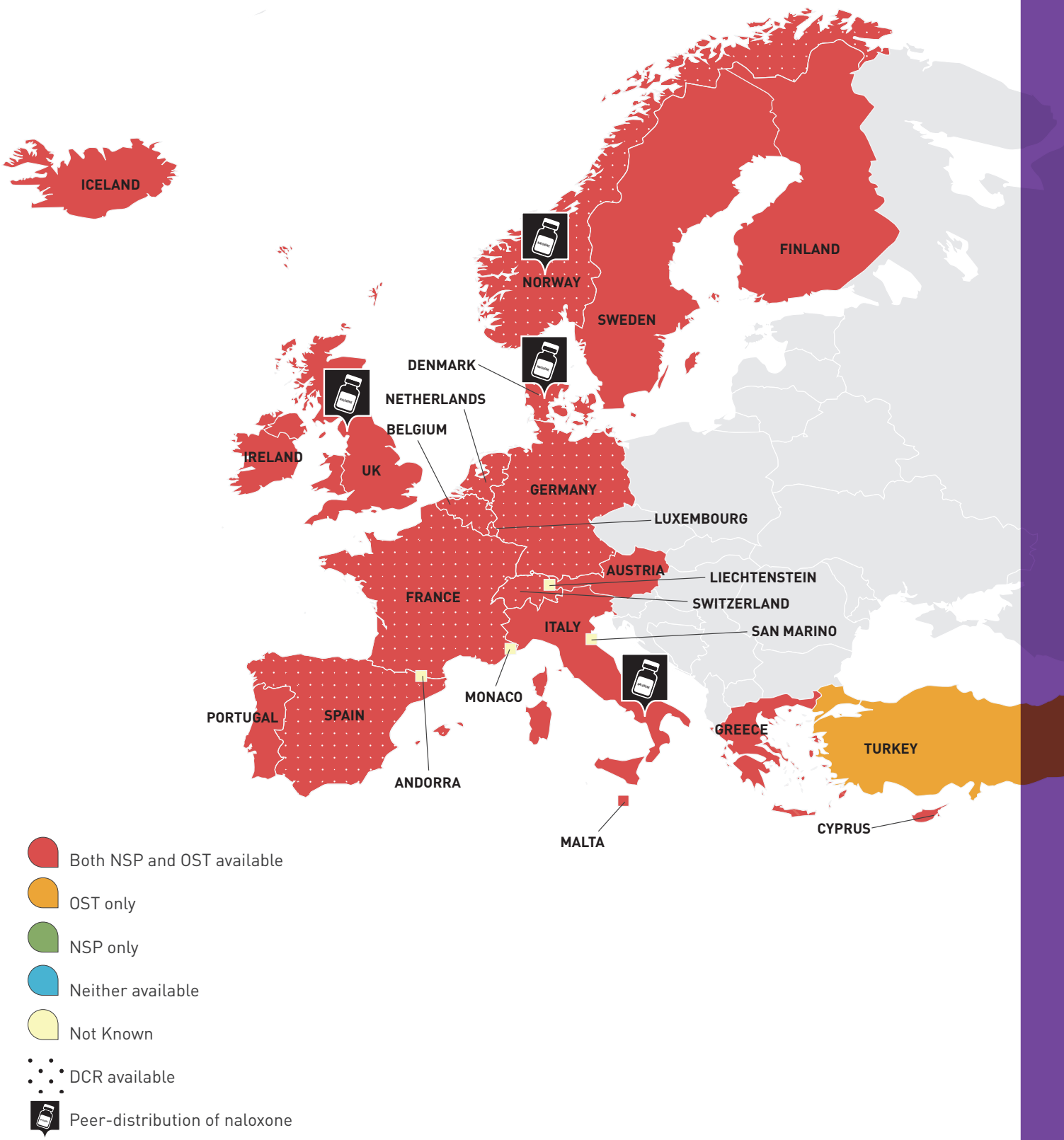
Table 2.3.1: Epidemiology of HIV and viral hepatitis, and harm reduction responses in Western Europe

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

nk – not known

a Unless otherwise stated, data is from 2016.
b All operational needle and syringe exchange programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = pharmacy availability.
c Opioid substitution therapy (OST), including methadone (M), buprenorphine (B), (H) medical heroin (diamorphine) and any other form (O) such as morphine and codeine. Figures for the number of sites are often not available in Western Europe due to a variety of service providers, which includes general practitioners.
d Drug consumption rooms, also known as supervised injecting sites.
e Based on subnational data from 2016.
f People who inject drugs population estimate refers to lifetime injecting drug use and is based on national data from 2015. Infectious disease prevalence estimates based on subnational data from the Flemish community from 2015.
g One drug consumption room operates in Liège with the approval of local government, though no national legislation permits such facilities.[5-7]
h Year of estimate: 2008.
i Year of estimate: 2012.
j Based on subnational data from 2014.
k Year of estimate: 2014.
l Derived from treatment data based on self-reported injecting in the last three months.
m Year of estimate: 2015.
n Year of estimate: 2015.
o Based on subnational data from 2011.
p Based on subnational data from 2011.
q While take-home naloxone is available in France, it can only be acquired with a personal prescription.
r Based on subnational data from 2013-2014.
s Based on subnational data from 2013-2014.
t Based on subnational data from 2013-2014.
u A total of 172 syringe dispensing machines operate in Germany, but the total number of NSPs is unavailable.[14,15]
v Year of estimates: 2010.
w Year of estimate: 2015.
x While take-home naloxone is available in Ireland, it can only be acquired with a personal prescription.
y Year of estimate: 2015.
z Year of estimate: 2015.
aa Year of estimate: 2015.
ab Based on subnational data.
ac Based on subnational data.
ad Year of estimate: 2015.
ae Based on subnational data from 2015.
af Year of estimates: 2015.
ag Estimate derived from treatment data and relates to people reporting injecting in past year.
ah Years of estimate: 2008-2011.
ai Based on subnational data from 2013.
aj Based on subnational data from 2013.
ak Year of estimate: 2015.
al Year of estimate: 2011.
am Based on a subnational estimate and number of high-risk opioid users, including but not exclusively people who inject drugs.
an Year of estimate: 2015.
ao Year of estimate: 2015.
ap Years of estimate: 2004-2011.
aq Based on data from England and Wales only.
ar Hepatitis C prevalence among people who inject drugs is 51% in England, Wales and Northern Ireland, and 58% in Scotland.
as Based on data from England, Northern Ireland and Wales only.
at This figure does not include NSPs in England due to a lack of national data.
au In the United Kingdom, peer-distribution of naloxone is limited to a small number of projects.

Map 2.3.1: Availability of harm reduction services



Harm reduction in Western Europe

Overview

The state of harm reduction in Western Europe has remained largely stable since the *Global State of Harm Reduction* last reported in 2016. From a global perspective, the region has an extensive harm reduction response to illicit drug use, with a wide range of services adapted to the needs of people who inject drugs operating in almost all countries. Despite this, there remains room for improvement.

As reported in 2016, opioid substitution therapy (OST) is available in all countries in Western Europe for which there is data on harm reduction services, and needle and syringe programmes (NSPs) are available in every country except Turkey. In this respect, Western Europe is one of the regions in the world with the widest availability of these key harm reduction services. Within countries, experiences have varied. In Spain and the Netherlands, the number of syringes distributed has reduced since 2016 in line with decreases in the population of people who inject drugs in those countries,[32,33] while elsewhere in the region (for example in Ireland and Sweden) programmes have been expanded and more syringes have been distributed over the period.[24,34] Expansions of existing NSP programmes have also incorporated the increasing use of syringe dispensing machines, for example in Cyprus and the United Kingdom.[9,35,36]

A rising concern in Western Europe is overdose deaths, which have increased in number since 2016.[1] An estimated 84% of overdose deaths in the region involved opioids in 2016, and almost two thirds occurred in Germany, Turkey and the United Kingdom.[1,37] As part of the public health response to this, 89 drug consumption rooms (DCRs) exist in Western Europe, with Belgium opening its first facility in 2018. However, at the time of publication no DCRs existed in the UK. Naloxone, an opioid antagonist that can reverse the effects of overdose, is available to medical personnel in most countries in the region. However, take-home naloxone, in accordance with World Health Organization recommendations, is only available in eight countries (Denmark, France, Germany, Ireland, Italy, Norway, Spain and the UK), and peer-distribution networks are only permitted in four (Denmark, Italy, Norway and the UK). An emerging phenomenon of fentanyl presence in drug-related deaths in England and Wales makes overdose responses even more vital, and is a development that must be monitored closely across the region.[38]

Interventions targeted at the use of amphetamine-type stimulants (ATS) and new psychoactive substances (NPS) form an increasing proportion of harm reduction services in Western Europe. This includes needle and syringe programmes and DCRs, which in some locations provide facilities specifically for inhaled or injected consumption of ATS.[23,39] On-site drug-checking services at parties and festivals have expanded greatly since 2016, and are now available in at least seven countries (France, Italy, Luxembourg, the Netherlands, Portugal, Spain, Switzerland and the UK) to address harms caused by high-purity and adulterated substances. However, in many countries drug-checking services continue to suffer from a lack of legal and financial support from the state. Beyond drug-checking, the harm reduction response to new psychoactive substances, such as synthetic cannabinoids and synthetic cathinones, remains stunted.

Controlling infectious diseases among people who inject drugs remains a primary driver of harm reduction in the region. Unrestricted universal access to direct-acting antivirals for hepatitis C is only available in 10 out of 25 countries (see viral hepatitis section below), with most countries placing limitations on access based on either disease stage or injecting drug use.[13,18,23,40,41] Incidence of HIV among people who inject drugs halved between 2007 and 2016, though injecting drug use was still responsible for 5% of new HIV infections in the European Union (EU) in 2016.[37] People who inject drugs continue to face formal and informal barriers to testing and treatment for blood-borne diseases. Stigma, self-stigma and criminalisation all contribute to lower testing and access to treatment among people who inject drugs than the general population[18,42], and migrants, women and people in rural areas are reported to face compounded barriers.[15,43]

The policy environment has continued to progress gradually in favour of harm reduction. At least 17 of the 25 countries in the region have policy documents supportive of harm reduction, and the EU has renewed and expanded its commitment to harm reduction through the Action Plan on Drugs 2017-2020.[44] Perhaps the most significant development in the region was in Italy, where harm reduction programmes were for the first time included in the Livelli Essenziali di Assistenza, the package of basic services that must be guaranteed across the country.[18] While policy has progressed in the region, funding for harm reduction remains a key concern. The funding landscape varies across the continent, from near-crisis in Greece to sustainable and sufficient investment in harm reduction in the Netherlands.[45] In all countries of Western Europe, however, the transparency of state investment in harm reduction is insufficient or poor, with investment rarely disaggregated from other

spending.[45] Civil society organisations across the region have warned that the sustainability of harm reduction services and funding remains vulnerable to changes in the political make-up of national and local governments.[18,45]

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

The number of countries in Western Europe in which NSPs operate is unchanged since the *Global State of Harm Reduction 2016*, with services available in all countries except Turkey (and no data on Andorra, Liechtenstein, Monaco and San Marino). However, individual countries in the region have experienced both increases and decreases in availability and coverage.

Austria, Belgium, Finland, Ireland, Luxembourg, Portugal and Sweden have all seen increases in the number of syringes distributed over recent years.[24,34,40,46-49] In Sweden, low threshold NSPs now operate in eight council areas, compared with three in 2015, and changes in legislation effective from March 2017 have facilitated the establishment of new NSPs.[24] In Luxembourg, a new mobile outreach service was launched in November 2017.[49] In Ireland, NSPs operate through fixed-site facilities, outreach services and pharmacies, where packs are distributed containing injecting equipment for between three and 10 injections, with an average of 1,614 people using the services per month.[34] Since 2016, syringe dispensing machines have been introduced in Cyprus, meaning that they are now available in at least six countries in the region (Cyprus, Denmark, France, Germany, Luxembourg and the United Kingdom).[9,11,15,36,49,50] Though there has been an increase in the number of NSPs operating in the Flemish areas of Belgium, and from 2014 to 2016 the total number of syringes distributed annually increased to 1.1 million, 80% of people who inject drugs in the country claim to know other people who use drugs who do not use NSPs.[47] This is a clear indication that, despite successes in increasing coverage, more outreach work is necessary to ensure that all people who inject drugs have access to sterile injecting equipment.

In other countries in the region, distribution of needles and syringes has decreased over recent years. In some cases, such as in Spain and the Netherlands, this is the continuation of a long-term trend attributed to a reduction in heroin use and injection in general, as well as the success of harm reduction programmes.[32,33] Due to budget cuts in Italy, the number of harm reduction services offering NSPs fell from 106 in 2012 to 66 in 2015, a negative trend that civil society organisations expect will continue unless the new Livelli Essenziali di Assistenza is implemented properly.[18,51] Though the proportion of people sharing needles in England, Wales and Northern Ireland appears to have fallen from 23% in 2006 to 17% in 2016, a survey of people who inject drugs in the United Kingdom found that only 46% indicated that service provision was adequate in 2016.[28,30] Civil society organisations in the UK report that there has been no government effort to expand coverage to address this deficiency.[30,52]

A recurrent issue in the implementation of NSPs in Western Europe is the geographical distribution of services within countries. For example, six of Italy's 20 regions have no NSPs (though civil society organisations expect this to improve over the coming years), and coverage is decreasing in southern Portugal even while it increases elsewhere in the country.[18,42,51] There are no NSPs in the German-speaking part of Belgium.[47] In Austria, Greece and Spain, people who use drugs living in rural areas have difficulty accessing harm reduction services that are primarily located in provincial capitals and other large cities.[23,46,53] In Berlin and North-Rhine Westphalia in Germany, syringe dispensing machines have been effective in providing access to these populations,[14,15] a model which could be introduced elsewhere in Western Europe.

A further concern is whether current NSPs are meeting the needs of all groups of people who inject drugs. For example, in Portugal and the United Kingdom, it is unclear whether the needs of people who inject performance- and image-enhancing drugs are being met in harm reduction services focused on people who inject opioids.[31,42] Similarly, men who have sex with men are forming an increasing proportion of people who inject drugs (up from 4.4% in the United Kingdom in 2006 to 7.9% in 2016) and have a distinct profile from other people who inject drugs; for example, being more likely to inject methamphetamines or ketamine, and more likely to share syringes.[28] In England and Wales, injection of crack cocaine is also an increasing phenomenon, up from being reported by 35% of people who inject drugs in 2006 to 53% in 2016.[28] Some efforts have been made to create services for specific groups of people who inject drugs; for example, an NSP for women who inject drugs in Malta.[20] Also of note, in 2015 a Health Service Executive Ireland review recommended that the contents of injection packs be better adapted to the needs of people

using the equipment by including a wider range of paraphernalia, such as sterile spoons, filters and foil.[34,54]

Opioid substitution therapy (OST)

In the European Union and Norway there were 636,000 people receiving OST in 2016, corresponding to approximately half of people who are dependent on opioids in these countries.[37] This is a small decrease of 1.2% since 2016 and a decrease of 10% since 2010.[55] Coverage in most countries has been largely stable over the last two years, with no serious contractions or expansions in access.

Methadone remains the most commonly prescribed medication for OST across the region, and is especially dominant in outreach services such as those in Portugal.[42] A buprenorphine-naloxone combination (sold under the brand name Suboxone) forms a growing proportion of OST in Germany, Italy and Spain, and is the main substitution medicine in Finland. However, the cost to the patient is higher in Spain and it is only available in high-threshold facilities in Portugal.[23,42] In Germany and Switzerland, slow-release morphine is also available for OST. [14,15,26,39,56,57]

Heroin-assisted therapy (HAT), the prescription of medical heroin (diamorphine) for OST, continues to be available in six countries in the region: Belgium, Denmark, Germany, the Netherlands, Switzerland and the United Kingdom.[2,14] A pilot programme using diamorphine also started recently in Luxembourg[19] and in 2018 the Norwegian government announced a diamorphine trial that will begin in 2020.[58] Implementation varies by country, but HAT is generally reserved, as in Denmark, for people who use opioids for whom other substitution therapies have not been successful.[2,11] Studies and trials in Belgium, as well as elsewhere in the region and the world, have found that HAT can be highly successful among this population in that it produces greater adherence than other forms of OST, reduces street heroin use and criminal involvement, and leads to better health outcomes.[59] In the UK, HAT remains available, but civil society organisations report that there are fewer prescribing doctors than in 2012, and that services are reluctant to prescribe diamorphine because of the high cost.[31] In Switzerland, the availability of HAT in the French-speaking region is poor, and there is no HAT in the Italian-speaking region.[26]

A key barrier to the successful implementation of OST programmes is that they often continue to target abstinence from illicit drug use rather than harm reduction. Even low-threshold OST programmes in Luxembourg require abstinence from all illicit drugs while undergoing therapy, as do higher-threshold services in Portugal.[19,42] On the other hand, new regulations in Germany (driven by harm reduction organisations and people who use drugs) have changed the official objective of OST from striving for abstinence from all illegal substances to striving for abstinence from heroin only.[14] While this is still problematic for some people who use drugs, it represents a significant step in the right direction. In the United Kingdom, civil society organisations report that some OST clients are being forced to reduce their dosage to a sub-optimal level, and can be subject to drug testing.[30,31] This appears to be the result of a lack of funding combined with clinical guidelines and key performance indicators that lack commitment to a harm reduction framework.[30,31] A 2018 United Kingdom government report into drug-related deaths indicated that the role of sub-optimal doses of methadone in opioid overdose deaths requires greater attention and research.[60]

Migrants also frequently experience difficulties in accessing OST, as reported in Belgium and Switzerland.[4,57] Conversely, OST was included in new guidelines on basic medical care in Italy in 2017, ensuring that it is officially available to all in the country, including non-citizens and undocumented migrants (though civil society organisations report some issues in access for these populations in practice).[18] In Germany, people living in rural areas are often forced to travel 30 to 50km in order to access OST due to the low number of physicians who apply to be authorised to prescribe substitution medication. A 2017 revision of the legal framework seeks to address this issue.[14] Further barriers to accessing OST in the region include age restrictions, limited opening hours and long waiting lists, all of which contribute to limiting the proportion of people who inject drugs able to access OST.[4,14,31,42] A 2018 Freedom of Information request to the Northern Irish government found that the average waiting time for OST in Belfast is 29 weeks.[61] In particular, women are reported to face more restrictions than men, including a lack of childcare at OST services, hostile and judgemental attitudes from health professionals, and an absence of women-specific services.[31,42,62]

A Swedish study published in 2017 found that people who have received OST are four times more likely to die from a drug-related death during periods away from treatment than while on treatment.[63] This emphasises the need to reduce barriers to OST adherence, such as stigma and the requirement to abstain from illegal drugs.

Amphetamine-type stimulants (ATS) and new psychoactive substances (NPS)

Use of ATS in Western Europe has stabilised over the last two years following a decline since the early 2000s.[37] However, consumption varies considerably between countries in the region. For example, last-year prevalence of MDMA use among people aged 15-34 ranges from 0.2% in Portugal to 7.4% in the Netherlands.[37] Evidence from across Europe suggests ATS are primarily used by young people (with a mean age of 23 years) in party contexts.[18,64]

As with ATS, prevalence of NPS use varies by country and substance. Synthetic cannabinoids, often referred to as "Spice," are the most prevalent category of NPS in Western Europe, with high prevalence reported in France, Germany, Spain, Sweden and the United Kingdom.[65] For example in 2016, prevalence of use among students in Germany was 6%.[65] The potential harms from synthetic cannabinoids vary considerably with the strength of particular strains. These can include severe seizures, psychosis and heart attacks, and there have been several outbreaks of fatal poisoning, including in Manchester in the United Kingdom in 2018.[65] The harm reduction response to synthetic cannabinoids in Western Europe appears to be limited to providing information on the potential risks of use, such as that provided by Release in the United Kingdom.[66]

NPS are also present in party contexts. In the Netherlands, almost one quarter of young adults in the nightlife scene have used 4-FA, a stimulant associated with around 8% of drug-related health incidents in the country.[av][67] In Italy, 3.5% of people aged 15-19 have ever used an NPS, mostly hallucinogens such as DMT at psychedelic trance parties.[18] This figure increases to 11.9% when including synthetic cannabinoids.[18] Across the region, a significant barrier to data collection and harm reduction for NPS is that use is often unintentional or people do not know what they are taking.[18,23,26,42] For example, the Be Aware On Night Pleasure Safety (BAONPS) drug-checking project has found that one third of NPS samples collected in Italy do not contain what was expected.[18] This has been found to be a particular issue with online purchases.[18] For this reason, drug-checking services offer an opportunity to people who use these substances to ensure they are aware of the contents and the potential harms they may cause.

Drug-checking services operate in at least nine countries in the region: Austria, France, Italy, Luxembourg, the Netherlands, Portugal, Spain, Switzerland and the United Kingdom. Services operated by civil society organisations have served people who use drugs in Italy for many years, and since 2016 now do so with support from public institutions in some regions.[18] In the region of Piedmont, drug-checking has been included as an essential public health service in regional guidelines.[18] The Loop in the UK and the Pipapo project in Luxembourg offer on-site drug-checking services at festivals,[31,68] while the Drug Information and Monitoring System (DIMS) in the Netherlands is a national network of permanent testing facilities that offers consumers the chance to check their drugs anonymously.[69] In Switzerland, on-site drug-checking services are now operated with local government approval at nightclubs and festivals in Basel, Bern, Zürich and since 2018, Geneva.[26] In Bern and Zürich, walk-in services are offered on a weekly and twice-weekly basis respectively.[70]

Drug-checking services offer harm reduction for both high-purity and highly adulterated substances, though the former category appears to be more prevalent in Western Europe. For example, DIMS has found that the average dose per MDMA pill increased 27% from 123mg in 2012 to 156mg in 2016.[69] The strongest pill checked by DIMS in 2016 contained 266mg of MDMA, more than twice the maximum dose recommended by harm reduction organisations.[69] In one year from 2015-2016, the average MDMA content of samples checked in Zürich rose by 27% from 120mg to 152mg.[71] DIMS has found that common adulterants include substances such as PMMA, which can cause an overdose at lower doses than MDMA.[69]

Legal and regulatory issues related to the handling of illegal substances continue to be a barrier to drug-checking services. For example, the Danish national health board has declined to permit drug-testing services, pending evidence from the United Kingdom and the Netherlands.[72] Though legislation allowing for drug-checking exists in Portugal, it is restricted to on-site testing and samples cannot be removed to a laboratory for further checks.[42] The geographically isolated nature of some festivals with heavy ATS and NPS use in Portugal has also been identified as a barrier to harm reduction programmes.[42] A lack of state funding for drug-checking has also been highlighted as a major obstacle to carrying out these projects, for example in Italy and Portugal.[18,42]

In addition to drug-checking services, other harm reduction interventions exist in Western Europe to address ATS and NPS use. Informational projects run by civil society organisations or groups of people

av There were 456 health incidents related to 4-FA in 2016, two of which were fatal.[67]

who use drugs operate in several countries to ensure people who use drugs are aware of the potential risks and best practices.[4,14,31] Ensuring that water and calm spaces are accessible at parties and festivals forms part of the harm reduction response in the Netherlands and elsewhere.[21] To reduce the harm caused by inhaling MDMA and cocaine, organisations in Italy provide "safer sniffing kits". These include paper straws to prevent nasal damage, chewing gum and sweets to prevent excessive teeth grinding, and water and fruit juice to prevent dehydration.[18]

Though routine data collection in Western Europe often does not differentiate between amphetamine and methamphetamine use, there is some evidence that methamphetamine use has increased over recent years in some populations in the region.[37] Civil society organisations in both the United Kingdom and the Netherlands report that there has been a rise in the prevalence of methamphetamine and NPS use among men who have sex with men, sometimes associated with use in sexual contexts.[30,67,73] While data on this relatively recent phenomenon (known as "chemsex") is generally unavailable and the extent of these practices may be overstated,[31,74,75] a sharp rise was observed in men who have sex with men accessing health services for issues related to methamphetamines, GHB and mephedrone from 2005-2012.[30,73] From the available data, it is impossible to determine if this is related to drug use in sexual contexts or other factors.[76] Nevertheless, there is a clear demand in the UK from patients in sexual health clinics for harm reduction measures associated with the use of these substances, which may include NSPs and other services adapted to the needs of this population.[77] For example, the Dean Street Clinic in London offers an NSP together with informal counselling and advice specifically tailored to men who have sex with men who use drugs in sexual contexts.[31,78]

Chem-Safe, a website operated from Spain by Energy Control since 2017, aims to provides online harm reduction information to men who have sex with men who use drugs in sexual contexts.[79,80] The anonymity and confidentiality provided by an online platform is considered particularly important, given the sensitive nature of the information and service users who may be stigmatised because of their sexual orientation, HIV status or drug use.[80] Despite early successes in accessing this population, Chem-Safe currently has no ongoing financial support and relies on the uncompensated work of the project's coordinator.[80]

People who inject amphetamines are able to access NSPs and most drug consumption rooms in the region. Furthermore, facilities in Germany, Switzerland and Catalonia, Spain specifically serve people who inhale drugs such as methamphetamines.[15,23,39] However, civil society organisations in Portugal and the United Kingdom report that an emphasis in harm reduction facilities on people who use opioids can discourage people who inject ATS from accessing them, indicating the need for tailored harm reduction services for people who use ATS.[31,42]

Cocaine remains the most commonly used illicit stimulant in Western Europe.[37] There appear to be marked differences in consumption patterns and behaviours between different populations of people who use cocaine in the region, particularly between those who use powder cocaine and those who use crack.[18,37] Most datasets in the region do not distinguish between crack and powder cocaine use, making the observation of trends in use of each form challenging.[37]

Harm reduction for cocaine use varies considerably according to differing patterns of use. For people who use powder cocaine recreationally, drug-checking services can have a significant impact in identifying high-purity and dangerously adulterated samples. Purity of cocaine has increased significantly in samples checked in Zürich, with the average cocaine content rising from 41.7% in 2009 to 76.7% in 2016.[81] An increase in purity has also been observed in the Netherlands.[67] Harm reduction for crack use appears to be mostly absent from Western Europe, though innovations providing sterile inhalation equipment to prevent the spread of infectious diseases are being implemented in Ireland, in development in Spain and in demand in Portugal.[23,42,54,82] Portuguese civil society organisation GIRUGaia operates a harm reduction outreach programme in Porto providing clients, 90% of whom use crack, with legal support and assistance in attending court appointments.[42] The harm reduction response to crack use in Western Europe is significantly smaller than the response to opioid use, in part because of lower prevalence. The European Monitoring Centre for Drugs and Drug Addiction have highlighted the need for more research to establish best practices in harm reduction in this area.[83]

Overdose, overdose response and drug consumption rooms (DCRs)

According to data covering the European Union, Norway and Turkey, there were 9,138 overdose deaths in the region in 2016, approximately 84% of which involved opioids.[1] Drug-related deaths have steadily declined in some countries (such as Spain,

Denmark and Portugal),[1,23] and increased in others, with almost two thirds of drug-related deaths taking place in just three countries: Germany, Turkey and the UK.[37] In Germany, there were 1,333 drug-related deaths in 2016, up 40% compared with 2012.[1] In Turkey, the number of drug-related deaths almost doubled from 2015 to 2016, with a particularly stark rise in deaths related to amphetamine-type substances and synthetic cannabinoids (synthetic cannabinoids were present in one third of cases in 2016).[84]

In the UK, the number of drug-related deaths continued to be among the highest on record with 3,756 in 2017, and experienced a 101% rise in deaths related to heroin and/or morphine from 2012 to 2017.[30,38] The situation is particularly grave in Scotland, where 2017 was the fourth consecutive year that drug-related deaths have been the highest on record (934 deaths).[85] In 2017, there were five times as many deaths from drug use as from traffic accidents in the country.[85,86] According to official statistics, 87% of these deaths involved opioids and 59% involved benzodiazepines; in all but 52 cases, more than one drug was found in the body.[85] High numbers of drug-related deaths have also been observed in Scandinavia.[1]

In 2014, the European Harm Reduction Network published a report recommending the widespread implementation of overdose prevention sites, also known as drug consumption rooms (DCRs), and naloxone distribution in order to counter the rise in opioid use across the region.[87] As of 2018, implementation has been highly varied.

Eight countries in the region (Belgium, Denmark, France, Germany, the Netherlands, Norway, Spain and Switzerland) now host a total of 89 DCRs. Since the *Global State of Harm Reduction* last reported, new facilities have opened in Belgium, France, Spain, Switzerland and Norway, with Belgium being the only new country to open such a facility. Lisbon is preparing to open its first three DCRs: a mobile facility in 2018 and two fixed-site DCRs in 2019.[8,42] Plans and legislation exist for a facility in Dublin[88] and for a second drug consumption room in Luxembourg.[19] In Belgium, a DCR in Liège has operated since September 2018 with the support of local officials, but is not officially sanctioned at the national level.[5-8] Civil society organisations, harm reduction service providers and people who use drugs succeeded in winning the support of the Scottish Parliament for the establishment of a DCR in Glasgow in 2018, in response to the high number of drug-related deaths, high HIV prevalence among people who inject drugs, and concern over public injecting and publicly discarded injecting equipment in the city. However, the Scottish government's proposal for a DCR was blocked by the United Kingdom government.[30,31,89]

In 2016, 1,717 people used DCRs in Luxembourg,[49] 3,110 people used DCRs in Spain,[33] and 7,155 people used DCRs in Denmark.[11] Four DCRs in Frankfurt, Germany oversee 200,000 injections annually,[15] and the DCR in Oslo, Norway has supervised more than 300,000 injections since opening.[22]

Western European DCRs are increasingly adapting to the needs of people who use drugs. For example, two mobile DCRs operate in Berlin in order to access harder-to-reach populations. [14,90] In Luxembourg and Switzerland, all DCRs permit the consumption of drugs through inhalation as well as injection,[39,49] and three rooms specifically for inhalation exist in Spain.[aw][23] This enables not only people who inject drugs, but also people who smoke cocaine, heroin and methamphetamines to benefit from the enhanced safety and supervision in DCRs. In the Netherlands, DCRs mainly target people who smoke their substances (in line with the breakdown of drug use in the country and harm reduction information promoting smoking over injecting).[80] As well as providing safer equipment and a safer environment for drug use, DCRs in the Netherlands increasingly offer integrated social services to clients, which include warm meals, recreational activities and employment-oriented projects.[80] In Basel and Zürich in Switzerland, feasibility studies are currently being carried out into providing drug-checking services in DCRs.[26]

While DCRs operate in many cities of the Netherlands,[32,56] in other countries regional variation in service provision presents a barrier to access for people who inject drugs. For example, only two of Spain's 19 autonomous communities (Catalonia and the Basque Country) have DCRs,[23] leaving people who inject drugs elsewhere in the country (including in Madrid) without such services. Only eight of Switzerland's 26 cantons have a DCR, with fewer available in the French- and Italian-speaking regions.[26] Similarly, only six of Germany's 16 states offer DCRs.[14,90] In Bavaria, the state government has consistently rejected calls from civil society to introduce DCRs, despite a high number of drug-related deaths in its major cities, such as Munich, Augsburg and Nuremberg.[15]

By law, in Luxembourg and some regions of Germany, DCRs exclude people on OST.[14,19] However,

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

since 2016 two German states (Hesse and North-Rhine Westphalia) have amended state laws to allow access to people on OST.[14] Migrants are also often unable to access services, particularly undocumented migrants, for example in Dutch DCRs.[80] In several countries, access is also limited to people over the age of 18.[19]

A 2016 qualitative study of the experience of people who use drugs in Danish DCRs found that the facilities provide the population with a safe place in which they are protected from police and others in the community. The non-judgmental interaction with staff and peers was reported to have helped forge a sense of social acceptance and trust that made them more likely to be comfortable when referred to other health services. This was identified as the most important feature of DCRs for people who inject drugs, and paves the way for overdose prevention and greater access to general healthcare.[91]

World Health Organization guidelines recommend that all people likely to witness an overdose, not only medical professionals but also people who inject drugs, their family and their peers, should have access to naloxone, an opioid antagonist that can reverse the effects of overdose.[92] Evidence from Norway suggests that take-home naloxone distribution programmes are effective in ensuring naloxone reaches these populations and ensuring that naloxone is present at a target proportion of witnessed overdoses.[93] A new, more concentrated nasal spray form of naloxone was approved by the European Commission in November 2017.[37] These nasal forms have the advantage of reducing injuries and may be perceived as being easier to use.[94]

Naloxone peer-distribution programmes currently operate in four countries in Western Europe (Denmark, Italy, Norway and the UK)[ax] with take-home doses available in a further four (Germany, France, Ireland and Spain). Plans are in development for take-home naloxone in three more countries (Austria, Cyprus and Luxembourg).[9,19,46] Peer-distribution programmes for naloxone have existed in Italy since 1991, and people who inject drugs are heavily involved through both training and policy-making.[18,96] The national health system in Italy is able to access large amounts of relatively low-cost naloxone by buying in bulk for distribution to healthcare facilities, pharmacies and harm reduction services.[96] In Norway and Ireland, take-home naloxone pilots have recently been extended,[22,34,94,97] while in Catalonia, Spain over 7,000 people (including people who use or have used drugs, prisoners, families and professionals) have been trained in naloxone delivery and more than 9,500 doses have been distributed.[23] An increase in drug-related deaths has led to the implementation of small-scale naloxone distribution in some German states, where nasal sprays have been approved and are reimbursable by health insurance since September 2018.[14,15] In France, nasal spray, approved in 2017 and initially only given out by emergency services and hospitals during a trial phase, is now also being distributed in all harm reduction services, with those who have undergone OST prioritised due to the higher risk of overdose.[13] In Belgium, a recent pilot of naloxone peer-distribution was closed down due to legal issues, with naloxone only permitted for use by medically trained personnel.[4]

While take-home naloxone is available in the United Kingdom, research from Release found that 9% of local authorities in England were not supplying it in 2017, and only 12 naloxone kits were distributed for every 100 people who use opioids in 2016/17.[31,98] Barriers to access in parts of the country include requirements that people who use opioids have a prearranged appointment, are assessed by a naloxone provider or are referred into a service providing naloxone.[31,98] Additionally, people under the age of 18 are given access to naloxone on a more limited basis than adults.[31,99] Despite this, a successful peer-distribution network for naloxone exists in north-eastern Glasgow, and more than 40,000 naloxone kits have been distributed in Scotland, Northern Ireland and Wales.[100] In Wales alone, naloxone is reported to have been used in 1,654 overdoses from 2009-2017, with all but 23 (98.6%) incidents ending without fatality.[101]

The emergence in Europe of fentanyl, a highly potent synthetic opioid, should instil greater urgency in preventing drug-related deaths. While Europe is not yet experiencing the level of fentanyl use seen in North America, its rise as a public health concern and its high risk of overdose adds weight to already strong arguments for increasing the availability of naloxone and DCRs.[37] From 2016 to 2017, fentanyl- and fentanyl analogue-related deaths increased by 80% in England and Wales, though the total number of deaths remained relatively small (106).[38] New, non-injectable formulations of naloxone (such as nasal spray) may facilitate its use in a wider range of settings, for example by bystanders not used to injecting.[37] In order to address the current rise in overdose deaths, a combination prevention approach including naloxone, DCRs, OST and drug-checking services should be encouraged across Western Europe.[96]

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ax In the United Kingdom, this refers to a programme in Glasgow.[95] In Norway, this refers to a multi-site pilot programme.[93]

Viral hepatitis

The prevalence of hepatitis C antibodies varies widely across Western Europe, with reported prevalence among people who inject drugs ranging from 22% in Belgium to 96.8% in Sweden (as shown in Table 2.3.1). Data from the European Union and Norway indicates that prevalence is higher among older people who inject drugs, demonstrating the accumulation of risk over years of potential exposure.[37] Overall, the availability and quality of national-level data on viral hepatitis among people who inject drugs is poor.

With the advent of new direct-acting antivirals, capable of curing 95% of cases, prevalence of hepatitis C is projected to fall over the coming years.[102] However, there is some evidence that prevalence of hepatitis C has grown since 2012 in the United Kingdom, where 92% of new infections occur among people who inject drugs; and[28,30] there was an outbreak of hepatitis C among people who inject drugs in Northern Ireland in 2016.[28] While prevalence of viral hepatitis is expected to decrease in the region in future, morbidity and mortality is projected to rise,[103] highlighting the need for ongoing interventions to address the viral hepatitis epidemic.

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

Previously, the high cost of direct-acting antivirals has led to limitations being placed on eligibility for treatment under national and private health insurance schemes; for example, caps on the number of patients or prioritisation of those with advanced liver damage. These costs have fallen over the last two years, and as of 2018 only four countries in the region enact these restrictions on access to treatment (Austria, Belgium, Greece and Switzerland).[56,103] A recent study by the European Monitoring Centre for Drugs and Drug Addiction found only two Western European countries officially continue to restrict access to hepatitis C treatment for people currently using drugs (Cyprus and Malta).[104] In Denmark (from November 2018),[105] France, Germany, Iceland, Ireland, Italy, Luxembourg, the Netherlands, Portugal and Spain, the treatment is officially available to all people who inject drugs living with hepatitis C, regardless of the state of the disease.[13,18,23,40,41,103] In Austria and the Netherlands, guidelines state that people who inject drugs and people on OST should be actively sought out to receive treatment.[32,46] In Iceland, the Treatment as Prevention programme focused efforts on treating people who inject drugs with free direct-acting antivirals in order ultimately to achieve hepatitis C elimination, and saw a 65% reduction in hepatitis C prevalence among people who inject drugs accessing addiction treatment from 2015-2017.[106]

Despite advances in accessibility, cost remains a significant barrier to hepatitis C treatment for people who inject drugs, particularly for those without health insurance in insurance-based health systems (such as in Germany, Luxembourg and Switzerland).[15,19,39] In September 2018, the European Patent Office dismissed a challenge to Gilead Science's patent on sofosbuvir, a key component of hepatitis C treatment. The ruling allows Gilead Science to continue charging extremely high costs for patented direct-acting antiviral treatments as the production of generic alternatives in Europe remains a violation of the patent.[107] Stigma and discrimination, related to a lack of knowledge and awareness among both health professionals and people who inject drugs, has also been cited as a barrier to treatment across the region.[18,42,56,108] People currently using drugs also face exclusion from hepatitis C treatment by health professionals, even where this is explicitly against national guidelines (for example in Germany and Portugal).[14,42] The result is that many people living with hepatitis C go without treatment, even though it is available to them. For example in the UK, no health authority outside London regularly meets its quota of people treated with direct-acting antivirals.[30]

Modelling studies for three settings in the United Kingdom underline the importance of direct-acting antiviral treatment in combination with harm reduction interventions in preventing hepatitis C among people who inject drugs. One suggests that without OST, new infections would rise by 483% by 2030.[109] Scaling up current NSP and OST services could achieve a 90% reduction in incidence.[109] This must be combined with awareness-raising campaigns and proactive testing to reduce stigma and ensure everyone who requires treatment receives it, as recommended by people living with hepatitis C in a 2017 survey.[108] Direct-acting antivirals present an opportunity to eliminate hepatitis C in Western

Europe. However, this can only be achieved by ensuring that all people at risk of hepatitis C have access to preventative services, testing and treatment.

Tuberculosis (TB)

Incidence of TB in Western Europe is generally low, ranging from 2.4 cases per 100,000 in Iceland and 4.5 per 100,000 in Greece, to 18 per 100,000 in Turkey and 23 per 100,000 in Portugal.[110] These cases are predominantly concentrated among certain groups, such as recent migrants, prisoners and people who inject drugs.[110] The level of integration of TB into harm reduction programmes also varies across the region, with good integration in Belgium, the Netherlands, Spain and Switzerland, and little integration in Italy and Portugal.[4,18,21,23,56,103] Good practice notes that outreach to marginalised populations may help to mediate between these groups and formal health services.[42] Similar to other infectious diseases associated with injecting drug use, stigma and a lack of awareness also play a significant role in compounding the TB epidemic among people who inject drugs.[18,42,56]

The DETECT-TB (Early Detection and Integrated Management of Tuberculosis in Europe) project launched in 2016 aims to contribute to the decline and eventual elimination of TB in the European Union. Its objectives state the importance of the early diagnosis of vulnerable populations, including people who inject drugs and prisoners, and the sharing of best practices between programme countries. The project works through a network of partners in six states, four of which are in Western Europe (Italy, the Netherlands, Sweden and the United Kingdom).[111]

HIV and antiretroviral therapy (ART)

Across the EU, 5% of new HIV infections in 2016 were due to injecting drug use, a proportion that has remained low and stable for a decade. [37] Overall, new HIV cases among people who inject drugs in the region have declined 51% from 2007-2016.[37] However, in Cyprus, Denmark, Luxembourg, Malta, Spain and Sweden there were increases in the number of new HIV cases among people who inject drugs from 2015-2016.[9,11,20,24,33,49] Challenges remain in ensuring that people who inject drugs receive timely and adequate treatment: in 2016, half of new HIV infections among people who inject drugs were diagnosed late (when the immune system had already sustained damage) and 13% of AIDS diagnoses were from HIV infections due to injecting drug use.[37] Early diagnosis and treatment offers people living with HIV a normal life expectancy; health systems must ensure that people who inject drugs are able to benefit from these services on the same basis as the general population.

Organisations in Spain, Switzerland and the United Kingdom attribute the region's success in maintaining low HIV prevalence among people who inject drugs to the implementation of harm reduction interventions, notably NSPs and OST, early in the HIV epidemic.[23,30,31,112] A 2017 Swiss study found that harm reduction programmes in the country had prevented 15,903 new HIV infections up to the end of 2015, and warned that an abrupt closure of services would result in a significant outbreak of HIV.[112] Similarly, civil society organisations in the UK have noted that the continued low prevalence of HIV relies on access to harm reduction services, and that further investment in these services is required.[30] In recent years, outbreaks of HIV in Greece, Ireland, Luxembourg and the UK have demonstrated the importance of continued provision of harm reduction services.[52,113,114]

While prevalence of HIV among people who inject drugs in the United Kingdom as a whole is estimated at 0.9%, the prevalence in Glasgow is 20-25%, with more than 100 of Glasgow's 400-500 people who inject opioids thought to be living with HIV.[52] The outbreak began rapidly in 2015 and has been durable, with similar numbers of new infections each year from 2015 to 2017.[52,115] In 2016, provision of low-dead space syringes (associated with a lower risk of blood-borne virus transmission) was rolled out in Scotland, and a new NSP was opened at Glasgow Central railway station.[28,52] The new NSP became Scotland's busiest, serving 2,000 individuals and providing more than 40,000 sterile injecting kits over the course of its operation.[52] However, it was closed just 14 months after opening, with the building's owner citing the fact that used injecting equipment was being left nearby in public areas as the reason.[52] Civil society organisations cite the closure of the Glasgow Central NSP as a major factor in the failure to control the HIV epidemic in the city.[30]

HIV testing and treatment is available to people who inject drugs on the same basis as the general population in much of the region, covered either by health insurance or public health services.[4,23,30,42] Coverage of ART is generally very high, with 80-90% of people living with HIV receiving treatment in most countries.[116] Pre-exposure prophylaxis is increasingly available in Western Europe; for example, Portugal launched a pilot programme for men who have sex with men in 2017.[42]

People who inject drugs continue to face formal and informal barriers to HIV treatment in Western

Europe. A decreasing trend in people who inject drugs accessing HIV testing has been noted in Italy, while in the UK, people who inject drugs are less likely to access treatment after HIV diagnosis than the general population.[18,30] Homelessness, poverty and social isolation, as well as stigma and discrimination (often based on the criminalisation of drug use), are also reported as key barriers to accessing HIV treatment for people who inject drugs in Italy and Portugal.[18,30,42] The unequal geographic distribution of service providers within countries also forms a barrier to people who inject drugs living in underserved regions. For example, in some areas of Portugal a lack of integration between harm reduction services and hospitals means that people who inject drugs are less likely to access treatment.[42] In addition to these informal barriers, some people who inject drugs face higher formal barriers to treatment. For example, the UK recently introduced higher charges for undocumented migrants accessing health services, and civil society organisations also report that migrants in Germany may also face difficulties in accessing services.[15,30]

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

Harm reduction in prisons

Drug-related offences continue to be a major contributor to incarceration in Western Europe. In all but four countries in the region (Luxembourg, Malta, Portugal and Spain), simple possession of even a small amount of illegal drugs can lead to a prison sentence.[117] The proportion of prisoners incarcerated for drug-related offences varies across the region, from 8% in Turkey to 33% in Italy.[27] Civil society organisations across the region continue to campaign for decriminalisation of personal drug use and possession, for example during the 2018 elections in Italy.[4,18] In the United Kingdom, Release launched a smartphone app in 2017 which serves as a guide to self-representation for drug possession offences, assisting people who use drugs to navigate the criminal justice system and avoid punitive penalties.[31,118]

Portugal decriminalised personal possession and use of all drugs in 2001, with positive effects on the health and wellbeing of people who use drugs in the country.[119] However, a 2018 community-led report by the International Network of People Who Use Drugs (INPUD) raised several concerns about the use of Portugal as a model for advocacy.[119] The report expressed concerns over the continuation of stigma, discrimination and abstinence-oriented interactions people who use drugs have with health professionals, as well as about the absence of full legalisation of drugs, which means that people who use drugs still encounter the dangers of obtaining substances on the illicit market.[119]

Across Western Europe, drug use in prisons is prevalent. For example, according to the most recent available data (from 2010-2014), 32.9% of prisoners in Belgium, 34% in Portugal and 42% in Norway report having used illicit drugs at some point while incarcerated.[1] Cannabis is the most used drug in Western European prisons; however, 13.3% of Belgian prisoners, 9.4% of Portuguese prisoners and 31.4% of Spanish prisoners report having used heroin at some point while incarcerated.[1] In addition, prevalence of blood-borne infections such as viral hepatitis and HIV are known to be significantly higher among people with a history of incarceration.[37,120] This information clearly demonstrates the need for harm reduction services in prisons.

A notable development since 2016 has been the rapid emergence of new psychoactive substance (NPS) use in prisons. In particular, the use of synthetic cannabinoids in prisons is an issue of concern in Germany, Sweden and the United Kingdom.[31,121] At least 58 deaths in British prisons have been attributed in part to NPS use, for example through psychotic episodes, suicide and/or drug poisoning.[122] Non-fatal overdoses related to NPS have also been reported in Germany and Italy.[121] Responses to these issues in Western European prisons remain focused on supply reduction, drug testing and smoking bans.[121]

Access to harm reduction services in prisons varies significantly between and within countries in the region. For example, services appear to be widespread in Spain, with service coverage similar in prison to in the community.[23] Conversely, no harm reduction services are available in Turkish prisons.[84] Ensuring that all prisoners have access to harm reduction services is essential in order for states to be compliant with their right to health obligations, as prescribed under Article 12 of the International Covenant on Economic, Social and Cultural Rights.

As reported in the *Global State of Harm Reduction 2016*, NSP provision in prisons is inadequate, with only four countries in Western Europe providing such programmes. These are: Spain (all prisons), Switzerland (15 out of 117 prisons), Luxembourg (one of two prisons) and Germany (one female prison in Berlin).[14,19,26,123,123] In Italy, a pilot programme was launched by the Ministry of Health in 2017 to distribute safe injecting equipment to prisoners on release from four prisons.[18]

The continuity of access to OST between the broader community and prisons is particularly important in preventing overdose deaths in people who use opioids, as well as helping to reduce high-risk injecting behaviour.[124] In all countries in the region except Turkey, Iceland and the Western European microstates,[ay] OST is available to prisoners. However, OST is very often available on more limited terms than in the broader community. For example, in Flanders, Belgium OST is only available to those who began the therapy outside prison.[4] In Malta and Portugal, prisoners in certain prisons must be transferred to external medical facilities before they can commence OST, raising a barrier to access as they rely on prison authorities for travel.[20,42] OST provision in prisons can also vary within countries. For example, 30% of Swiss prisons provide no OST at all.[26] Similarly, in Ireland, only 11 out of 14 prisons provide OST.[34] In the UK, regulations state that OST should be available on the same basis as in the broader community.[126] However, in practice its availability can depend on the authorities at each prison, and data is generally unavailable on the extent to which it is accessible.[31]

A 2016 ruling by the European Court of Human Rights determined that denying OST treatment to a prisoner while in detention violates Article 3 of the European Convention on Human Rights, which prohibits inhuman or degrading treatment.[127] Every country in Western Europe is currently subject to the convention, and therefore is obliged to provide OST in prisons.

The period after release from prison is a particularly high-risk time for opioid overdose, due to lower tolerance after a period of abstinence or low dosage, making the availability of naloxone vital.[37] Four countries (Denmark, France, Norway and the UK) provide naloxone to prisoners on release.[128] While the practice is not universal in the UK (for example, only half of Welsh prisons distribute take-home naloxone), 1,355 naloxone kits were distributed by Scottish and Welsh prisons alone in 2016-2017.[az][101,129] Naloxone is also available in some prisons in the Netherlands, Switzerland and an estimated 82% of prisons in Italy, but can only be used by medical personnel and is not given to prisoners on release.[21,32,57] Pilot projects delivering naloxone kits and training directly to prisoners while incarcerated have operated since 2016 in Italy and Norway, with evidence from Norway suggesting that naloxone training and provision has significantly increased prisoners' awareness of overdose prevention measures.[18,90,130] Studies in the UK clearly demonstrate that increasing provision of take-home naloxone on release from prison would prevent overdose deaths among prisoners, their peers and the wider community, and therefore it should be a priority for prison health authorities across the region.[131]

With HCV prevalence considerably higher among prisoners than the general population, the EU must urgently scale up testing and treatment among prisoners if it hopes to eliminate the virus. [37,132] HIV prevalence is also alarmingly high among prisoners in Western Europe: prevalence is 9.5 times higher among prisoners than the general population in Ireland and 13.5 times higher in Spain.[133] A recent overview of hepatitis C and harm reduction services in prisons found that all Western European countries studied offered hepatitis C treatment in prisons. However, it also found a distinct lack of data on the extent of treatment coverage in prisons in these countries.[123] HIV testing and treatment are broadly available in prisons across the region, with Italy, Portugal and the UK all routinely testing incoming prisoners for HIV.[18,30,42] However, implementation of these services is sometimes inadequate or uneven within countries. This gap between policy and implementation risks leaving behind a key population in viral hepatitis and HIV control, in clear violation of individuals' fundamental human rights.

Policy developments for harm reduction

At least 17 of the 25 countries in Western Europe have adopted national drug or addiction strategies that express support for harm reduction.[ba] In at least five of these countries (Cyprus, Germany, the Netherlands, Portugal and Switzerland), harm reduction forms a pillar of national drug policy separate from treatment and

ay Andorra, Liechtenstein, Monaco and San Marino. In total, the four countries are estimated to hold fewer than 100 prisoners.[125]
az Data for England and Northern Ireland is unavailable.
ba Austria, Belgium, Cyprus, Denmark, Finland, France, Germany, Greece, Ireland, Luxembourg, Malta, the Netherlands, Norway, Portugal, Spain, Switzerland and the United Kingdom.

rehabilitation.[9,32,39,40,90,134] In Turkey, the National Anti-Drug Strategy Paper contains no reference to harm reduction.[84] National plans for the response to HIV and viral hepatitis also frequently include references to the role of harm reduction. For example, the new HIV policy documents introduced since 2016 in Italy, Luxembourg and Portugal include harm reduction as a key element of the response.[18,19,42]

Several countries and entities in the region have introduced new drug policy documents since 2016. An independent evaluation of the European Union Action Plan on Drugs 2013-2016 found that harm reduction was lagging behind other pillars of the EU Drug Strategy 2013-2020, noting that there was more significant opposition to this element of the strategy from certain member states.[135] Following this evaluation, the EU adopted the Action Plan on Drugs 2017-2020. The new plan includes emphasis on scaling up harm reduction, with reference to OST, NSPs, naloxone peer-distribution, DCRs and drug-checking.[44]

In Italy, harm reduction is not mentioned in the National Action Plan on Drugs, which has not been updated since 2010.[18] However, harm reduction interventions were included in 2017 for the first time in the Livelli Essenziali di Assistenza, the package of basic health services that must be guaranteed across the country; as of 2018, civil society organisations are in negotiations for the implementation of this policy.[18] In 2018, the health ministry of the Piedmont region of northern Italy created new harm reduction guidelines in collaboration with civil society organisations. The new document includes drug-checking as a basic health service, and is considered by civil society organisations to be Italy's most advanced policy plan for harm reduction.[18]

In 2017, the United Kingdom adopted a new National Drugs Strategy for the first time since 2010,[30] which mentions OST and NSPs, but only uses the term "harm reduction" in reference to tobacco.[30,31,136] New clinical guidelines brought in alongside the new strategy are comparatively more supportive of evidence-led policy, and give a greater role to harm reduction.[30,126]

On the international stage, Western European governments have been largely supportive of harm reduction agendas. The Irish delegation at the Commission on Narcotic Drugs in 2018 made a statement supportive of harm reduction,[137] and a joint EU statement (also supported by Norway and Liechtenstein) in the same forum later in 2018 was strongly supportive of shifting to a human rights and health-centred response to drugs.[138] Civil society organisations in Germany, Italy, the Netherlands and Spain have also highlighted that their respective governments have been vocally supportive of harm reduction in international fora.[15,18,21,23]

Civil society and advocacy developments for harm reduction

Civil society organisations continue to form an important part of the harm reduction movement in Western Europe, as service providers, campaigning groups and advisory bodies to governmental agencies. In several countries, civil society cooperation in harm reduction is led by national harm reduction networks, such as the English Harm Reduction Group in the United Kingdom[31] and Suchtverband Leutzebuerg in Luxembourg.[19] Akzept is a national umbrella organisation for harm reduction in Germany, and has published alternative drug and addiction reports in response to official government documents.[14,15] In Italy, the Rete Italiana Riduzione del Danno (ITARRD) is an informal organisation of approximately 200 individuals, including professionals, activists, researchers, people who use drugs and harm reduction groups.[18] Though no national harm reduction network exists in Switzerland, regional networks exist in most cantons.[26,39]

A longstanding European regional network of civil society organisations working in the field of drugs and harm reduction received a grant in 2018 from the European Commission and began to operate under the name Correlation – European Harm Reduction Network.[8,21] Correlation works to improve international collaboration on harm reduction through a network of focal points in each country.[21] In November 2018, the European Harm Reduction conference was held in Bucharest, Romania.[21]

Networks of people who use drugs exist at a national level in several countries, including Germany and Portugal, and at a local or regional level in Spain and the UK.[14,15,23,31,42] These groups often work in association with the European Network of People who Use Drugs (EuroNPUD), which was launched in 2011 to coordinate advocacy strategies in the European Union and its neighbourhood.[42,139]

Civil society organisations in Western Europe have organised advocacy campaigns on a national and international basis. Internationally coordinated campaigns, such as Support. Don't Punish, International Overdose Awareness Day and World AIDS Day have been used for harm reduction

advocacy purposes in several countries, including Portugal and Spain.[23,42] Campaigns aiming to directly influence national policy since 2016 have included Belgian movements in favour of decriminalisation (such as 1921 in Wallonia and Smart on Drugs in Flanders);[4] campaigns by Release in the UK in favour of drug consumption rooms and improving naloxone provision;[31] ITARRD's Harm Reduction Works, Let it Work! (La Riduzione di Danno Funziona, Facciamola Funzionare!) campaign pressing for increased political and financial support in Italy;[18] and civil society campaigns for drug consumption rooms and increased funding in Portugal.[42] Additionally, there have been several civil society-led events, such as a conference dealing with ATS use (among other topics) in Berlin called NIGHTS: Stadt Nach Acht (NIGHTS: City After Eight),[14] and an annual training event on harm reduction and recreational drug use in Switzerland.[26]

In Germany, Portugal, Spain and Switzerland, civil society organisations have been regularly and systematically involved in policy consultations at both regional and national levels; for example, the Portuguese National Harm Reduction Network (R3) has an ongoing informal relationship with the government drug and addiction agency, and met with the Secretary of State for Health in 2017.[42] In 2018, the Swiss Federal Office of Public Health launched an Expert Group on Harm Reduction, bringing with it greater involvement of civil society in the policy development process;[26] however, some actors have expressed concern at a lack of representation of people who use drugs in government consultations with civil society.[57] Though civil society organisations in Italy and the United Kingdom have been regularly involved in national policy consultations on harm reduction and drug policy in the past, they report that this cooperation has reduced in recent years. In the UK, civil society was not consulted in the development of the 2017 National Drugs Strategy, and in Italy non-governmental service providers now only participate in policy processes sporadically.[18,31]

Significant civil society advocacy successes have occurred in Western Europe since 2016. In Italy, civil society organisations lobbied the national government to include harm reduction in the National HIV Plan 2017-2019, resulting in specific reference to harm reduction interventions and indicators in the final plan.[18,140] In Portugal in 2018, the Agência Piaget para o Desenvolvimento (APDES) succeeded in securing a non-binding resolution in the Portuguese parliament for the full funding of harm reduction programmes.[42] A coalition of civil society organisations in the United Kingdom successfully campaigned to have drug-related deaths included as an indicator of public health outcomes for local authorities, where previously the main indicator of drug policy success was completed treatments.[30,31] These examples demonstrate the concrete progress that has been made in the region through the dedication of civil society actors to the cause of harm reduction, and can serve as an example to actors elsewhere in the region and across the world of the impact on national policy that is possible through targeted campaigns.

Funding developments for harm reduction

A 2017 report by Harm Reduction International found that certain parts of the European Union are experiencing a funding crisis for harm reduction.[45] This crisis is observed to be more serious outside Western Europe; however, in several countries of the region, particularly Greece, concerns were raised. Six Western European countries (Belgium, France, Germany, Ireland, the Netherlands and the United Kingdom) were assessed to have a high levels of government investment in harm reduction, providing over 90% of funding (see Table 2.3.2).[45]

Trends in harm reduction investment since 2016 vary across the region. Belgium is the only country in which funding for harm reduction is reported to have increased over recent years, though civil society organisations there still note that gaps remain in the public health response to illicit drug use.[45] In the Netherlands, civil society organisations report that the level of investment has remained stable since 2016 and the quality and availability of services is sufficient.[21,45] Elsewhere in the region, the long-term effects of European austerity since the economic and financial crisis continue to be felt. In Germany, Greece, Ireland and the UK, investment in harm reduction has fallen over recent years due to broader budget cuts.[45] In the United Kingdom, funding for harm reduction and prevention fell by 8% from the 2015/2016 financial year to 2016/2017, a disproportionately greater cut than in other areas of public health.[30,31] In Ireland, harm reduction interventions now operate with 30% less investment that in 2009.[45] Civil society organisations have expressed concerns that these reductions in funding will lead to rising HIV and hepatitis C incidence among people who inject drugs, among other drug-related harms.[45]

Local, regional and national government bodies provide the majority of investment for harm reduction in Western Europe. For example, all funding for NSPs and OST in Belgium, Germany, Luxembourg, Sweden; 95% of harm reduction

funding in Italy; and 80% of funding in Portugal and Greece come from either national or local governments.[18,19,42,45] In Belgium and Germany, state funding is sourced from a mixture of national and regional or city-level governments, while in Switzerland all harm reduction funding comes from the cantonal and city governments.[26,39,45] Significantly, implementation of harm reduction services, though state-funded, is often left to non-governmental organisations, as in Greece, Norway and Switzerland.[26,45] Where funding cuts result in threats of service closure, it is essential that emergency funding (such as from the European Commission) is made available to sustain these programmes. However, emergency funding must be available without cumbersome application processes or the requirement to match funding.[45] A potential model for this is the Norway NGO Fund, where local civil society is involved in the management of grants.[45]

Harm Reduction International's research also highlighted poor transparency on harm reduction investment across the region (see Table 2.3.2). No country in Western Europe received a positive rating for the transparency of their harm reduction investment, and Greece and Italy were given the lowest rating. Levels of budgetary disaggregation vary across Western Europe, and rarely allow identification of harm reduction investment in wider budgets. Where harm reduction services are managed locally, a lack of national-level data collection also contributes to a lack of transparency, for example in Germany, Switzerland and the United Kingdom.[45,57] Small improvements have been noted; for example, eight of the 20 regions of Italy currently disaggregate harm reduction investment from other spending.[18,45]

In Western Europe, there is limited data on the proportion of total state drug spending that is invested in harm reduction. From what little information is available, it is clear that harm reduction investment is dwarfed by spending on drug law enforcement. In Italy, an estimated €1.1 billion is spent on drug law enforcement annually, including €953 million on prisons, while the United Kingdom spent an estimated £1.6 billion on drug law enforcement in 2014/2015.[18,141]

The sustainability of harm reduction investment in the EU has been recorded by Harm Reduction International as ranging from fairly certain to extremely insecure.[45] The continuing impact of austerity policies in certain countries threatens the effectiveness of harm reduction services. This has had the greatest impact in Greece, where cuts to harm reduction services put the country at risk of public health emergencies.[45] In the UK, civil society organisations anticipate further reductions in harm reduction investment over the coming years, driven by increasingly limited resources available to local authorities for overall spending and the fact that they are not obliged to provide any drug services.[30,45] The European Monitoring Centre for Drugs and Drug Addiction has highlighted the role of austerity and cuts to the budgets of drug-related health initiatives in the rise of public health emergencies.[142]

Table 2.3.2: Harm reduction funding in selected Western European countries at a glance[45]bb

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

bb This table uses a traffic light system designed to provide an at-a-glance indication of the health of harm reduction funding, and first appeared in a 2017 report from Harm Reduction International entitled Harm Reduction Investment in the European Union.[45]

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