CIVIL SOCIETY MONITORING OF HARM REDUCTION IN EUROPE 2022

DATA REPORT

Correlation
European
Harm Reduction
Network

Title
Civil Society Monitoring of Harm Reduction in Europe, 2022. Data Report.

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Recommended citation
Rigoni, R; Jeziorska, I.; Tammi, T.; van der Gouwe, D. (2023). Civil Society Monitoring of Harm Reduction in Europe, 2022. Data Report. Amsterdam, Correlation – European Harm Reduction Network.

ISBN
9789082810974

The preparation of this report has been co-funded by the EU4HEalth Programme of the European Union. The views and opinions expressed are those of the author(s) and do not necessarily reflect those of the European Union or DG Sante. Neither the European Union nor the granting authority can be held responsible for them.

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Co-funded by the European Union

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Civil Society Monitoring of Harm Reduction in Europe
2022

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FOREWORD

We are proud and grateful to present the 2022 Monitoring Report of C-EHRN, representing the perspectives of civil society organisations in the field of harm reduction.

In 2022, C-EHRN received an Operating Grant within the framework of the EU4Health Programme, which provided us with the opportunity to coordinate and implement our monitoring activities.

CHALLENGES IN 2022

2022 has been a year full of challenges and horrifying developments. Countries worldwide are coping with the aftermath and the health, societal and economic consequences of the COVID-19 pandemic. The unjustified and unprovoked war against Ukraine affects the lives of millions of civilians. 7.9 million Ukrainian refugees were registered across Europe, while an estimated 8 million people had been displaced within the country. Many of those still in Ukraine have to live without access to food, water, healthcare and other essential supplies. We also observed the shrinking space for civil society in many European countries and the deepening of socioeconomic inequalities. Marginalised and underserved individuals are disproportionately affected by the consequences of these developments, requiring continued support and advocacy. C-EHRN responds to these challenges through activities and support in the field of networking, cooperation, monitoring and research, capacity building, knowledge exchange and advocacy.

THE IMPORTANCE OF CIVIL SOCIETY AND THE NEED FOR MONITORING

Civil Society Organisations (CSOs) working in the field of health play a crucial role at many levels. They hold governments and donors accountable by engaging in independent monitoring and evaluation of services and programmes. They are a vital partner to European, national and local institutions in shaping and implementing public health strategies and policies. CSOs are also essential in bridging the gap between policymaking and the communities they represent, and they approach this in a professional, efficient and democratic manner. In combination with advocacy, civil society-led monitoring can be a powerful tool, improving the implementation of policies and programmes in line with the needs of people who use drugs and their environments.

The development and implementation of the civil society monitoring tool for harm reduction in Europe is one of the most significant achievements of C-EHRN in recent years. C-EHRN monitoring activities have been implemented since 2019, seeking to reflect the experiences of harm reduction service providers, focusing on how drug policies and specific harm reduction guidelines are (or are not) being implemented at street level. We realise that our monitoring approach has its limitations. Accurate monitoring is a long-lasting process, requiring sufficient resources, annual evaluation, subsequent adjustments and

improvements in its methods and indicators to increase data quality and consistency.

Nevertheless, we have achieved a lot in recent years. The C-EHRN Monitoring Report provides up-to-date data, partly documenting the achievement of internationally agreed health targets (e.g. SDG 3) and complementing data from other agencies, such as the ECDC and the EMCDDA. The mechanism also contributes to a better understanding of emerging local drug trends and potentially related risk behaviours, such as the transmission of blood-borne infections. We share information and monitoring results with healthcare professionals, harm reduction services, researchers and policymakers through targeted publications.

C-EHRN MONITORING IN 2022

The adapted 2022 civil society monitoring absorbed experiences from past years. During the evaluation with our Focal Points and scientific experts, we agreed to focus on our three main key priorities – addressing Hepatitis C and Drug Use, Essential Harm Reduction Services and New Drug Trends. For the last section, we piloted the organisation of online focus group discussions in two countries. This allowed the collection of more reliable qualitative information and the involvement of more experts per country and will therefore be extended to all cities in 2023.

We kept our focus on the situation at city level, which allowed for more accurate and precise information. Consequently, the information provided in this report represents the situation in a particular city or region. Although this information does not describe the national situation, it acknowledges the diversity of local approaches and realities in a country and provides more reliable information at city level.

2022 was also marked by initial concerns over the unclear financial situation of C-EHRN. Only in March 2022 did we learn that our Operating Grant through the EU4Health Programme was to be continued in 2022. The insecure funding situation created substantial problems in organising and implementing our monitoring activities at the beginning of the year. Therefore, we are incredibly grateful for the support of two Finnish C-EHRN member organisations – the Finnish Association for Substance Abuse Prevention (EHYT) and A-Klinikka. Both agreed to provide direct financial support at the beginning of 2022 to ensure the continuation of our monitoring activities.

OUTLOOK AND FUTURE

We are confident that we can sustain and maintain our network activities in 2023 but will remain dependent on Operating Grant funding through the EU4Health Programme. We believe – and our Focal Points have echoed this during the C-EHRN Member and Expert Meeting in 2022 – that our

monitoring activities matter. We not only collect data and information but use this data for advocacy purposes and to push for a positive change where needed. During our Member and Expert Meeting in November 2022, we discussed how to improve the utilisation of our monitoring data and how to support our members in their advocacy activities. We hope that this report will help to strengthen the position, role and perception of community-based harm reduction organisations and - where needed - push for policy changes at European, national and local levels.

THANKS AND ACKNOWLEDGEMENTS

More than one hundred organisations and individuals from 34 European countries have contributed to this Monitoring Report. Thanks go to our Focal Points and associated experts at national and local level who have filled-in the online questionnaire and provided all information and data on time. Without their dedication and commitment, we would not have been able to produce this report.

We are also grateful to the Scientific Advisory Board and the thematic experts who contributed to developing the monitoring framework and the final report by providing input, scientific advice and critical comments.

My specific thanks go to the coordinators and authors of this report: Rafaela Rigoni, Iga Jeziorska, Tuukka Tammi and Daan van der Gouwe.

Last but not least, we thank the European Commission, the Finnish Association for Substance Abuse Prevention (EHYT), the Finnish organisation A-Klinikka, and our host organisation Foundation De Regenboog Groep for providing financial support in 2022.

Katrin Schiffer
On behalf of the C-EHRN Team

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INTRODUCTION

CIVIL SOCIETY-LED MONITORING OF HARM REDUCTION IN EUROPE

Civil society has an important role in holding governments and donors accountable, among others, by engaging in independent monitoring and evaluation of services and programmes [1]. In combination with advocacy, the application of monitoring tools are crucial strategies to hold governments accountable and to improve the implementation of policies and programmes in line with the needs of people who use drugs and their environments [2].

Since 2019, C-EHRN has developed a framework for European civil society-based monitoring of harm reduction [3], aiming, in the long-term, at improving harm reduction responses and policies in Europe. The Monitoring seeks to reflect the experiences of harm reduction service providers, focusing on how drug policies and specific harm reduction guidelines are (or are not) being implemented at the street level. Such in-depth and rich information is crucial to inform the development of policies and services for people who use drugs and can be of great value for civil society organisation (CSO) advocacy and for policymakers.

DEVELOPMENT OF C-EHRN'S MONITORING

This is the fourth annual report of the C-EHRN Civil Society-led Monitoring of Harm Reduction in Europe. Starting in 2018 as a pilot in five countries, C-EHRN Monitoring has developed over the last four years to include cities in more than 30 countries. Modifications have also occurred regarding the thematic areas and methodology of the Monitoring. The first annual report, published in 2019 [4], targeted harm reduction developments in the areas of hepatitis C (HCV), new drug trends, overdose prevention and civil society involvement in drug policies. The themes were chosen by C-EHRN members as strategic for harm reduction development in Europe. The second and third reports [5, 6] added two new themes to cover the effects of the rising COVID-19 pandemic on harm reduction service delivery and map the availability of essential harm reduction services. Since 2020, the focus has changed from collecting data at the national to the local (city) level. This occurred both to address the need for data at the local level, which is where most policies are implemented, and to also take advantage of the fact that C-EHRN Focal Points (FPs) operate mostly at a local level and, therefore, can collect more reliable and in-depth data at this level. Given this change, as well as modifications to the survey questions, data is potentially comparable across the years only from 2020.

In the fourth year of reporting, the aim was to have a more in-depth look at harm reduction in Europe, with three themes chosen for focus: harm reduction essential services, HCV, and new drug trends. To achieve a richer picture of the developments in harm reduction, semi-structured interviews were performed with all FPs, in addition to the data collected via the online survey.

METHODOLOGY AND DATA COLLECTION

Several stakeholders contribute to the development of the Civil Society-led Monitoring of Harm Reduction in Europe. **Expert groups** support C-EHRN's Monitoring team in the development of the monitoring framework, the draft of the questionnaires, the assessment of the data, and the review of the final report. Expert group members are either self-appointed C-EHRN members with interest and expertise on the specific theme or are personally invited by C-EHRN to join one of the groups due to their recognised expertise in the field. For this report, three thematic expert groups contributed: Hepatitis C (HCV), Harm Reduction in Europe, and new drug trends (NDT).

The **scientific advisory board** (SAB) also oversees the methodological framework used and contributes to the revision of the final report. The SAB consists of a chairperson and representatives from different areas of work, ensuring broad scientific expertise. SAB Members are selected by the C-EHRN Management Team and the Steering Committee based on a number of pre-defined criteria, including: relevant organisational position within the broader field of drug policy and harm reduction; commitment to C-EHRN principles, mission and vision at national and European level; ability and commitment to actively support the network with scientific knowledge, experience and advice; and proven thematic expertise in the field of drug use and harm reduction.

As in previous years, the main tool for Monitoring data collection is the online survey disseminated among C-EHRN Focal Points. This year, the survey included three thematic areas: essential harm reduction services (8 questions); hepatitis C (25 questions), and new drug trends (11 questions). The questions asked were either the same (as in the case of new drug trends) or highly similar compared to 2021 (more detailed information about changes can be found in each respective chapter). In addition, in the case of essential harm reduction services and new drug trends, other methods of data collection were used.

In this report, we refer to the information as '2022 data'. However, it is important to note that the data for this report were collected in June 2022 and the respondents were asked to reflect on the situation during the previous year. Precisely speaking, therefore, the data reflects the period from June 2021 until June 2022.

We are aware that data collected by C-EHRN may be anecdotal, small-scale, or considered subjective (as they grasp the perceptions of service providers). However, it is considered not as a limitation, but a feature that makes our data complementary to other sources.

To gather data on the experiences of harm reduction service providers and service users at ground level, C-EHRN builds on a network of **Focal Points** (FPs).

C-EHRN FOCAL POINTS

The Focal Points are organisational members of C-EHRN selected by:

- Their willingness to commit to the network's principles, mission and vision at the national and European level;
- Proven thematic expertise in the field of drug use and harm reduction;
- Connectedness at the national and European level; and,
- Ability to fulfil the role of an intermediary at a national level.

C-EHRN strives to select at least one FP per country, but some countries can have more than one representative if additional thematic expertise is needed, or no FP when no member is available for such a role.

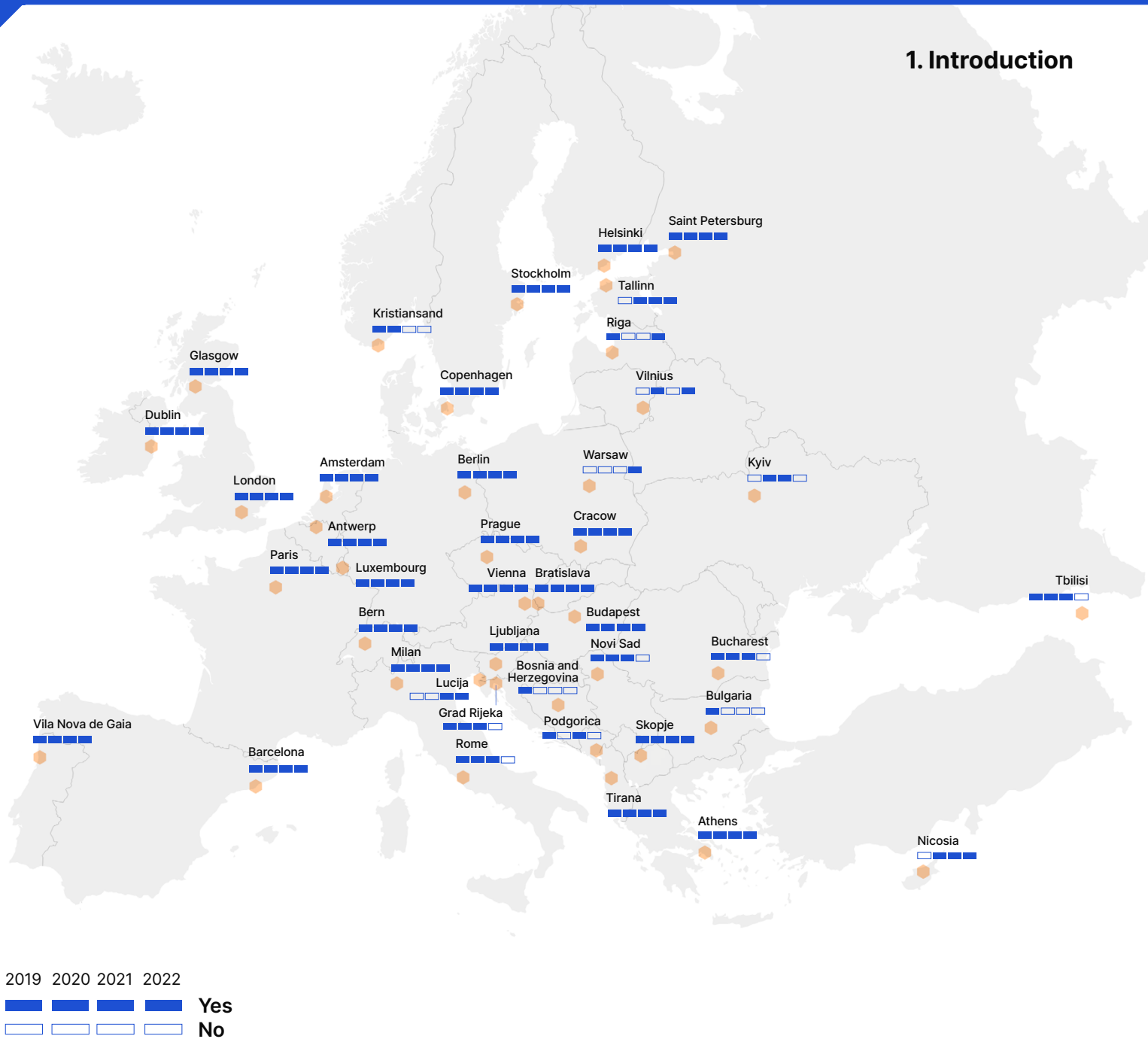
The tasks of FPs include being consulted for specific thematic or regional expertise and providing inputs and information, particularly for monitoring purposes, including answering the monitoring questionnaire annually. FPs do not receive financial support to perform their functions. Nevertheless, they receive a few benefits, such as being invited to the annual C-EHRN conference (one scholarship available per country); free C-EHRN seminars and training; being able to promote their activities on the network's website and through the network's other communication channels, and in speaking on behalf of the network at national level.

Some of the C-EHRN FPs have varied over the 4 years of data gathering and reporting. Map 1 shows how many years a city has been reporting under C-EHRN civil society-led Monitoring. Table 1 describes the C-EHRN FPs undertaking monitoring in the different reporting years (2019, 2020, 2021 and 2022). For the year 2022, 31 FPs in 30 countries have contributed to the Monitoring[1].

Most (70%) C-EHRN FPs[2] have - as the main priority of their organisation - the provision of services, making them highly appropriate in describing how harm reduction activities are implemented in practice. That is followed by advocacy and policy activities (17%), training and capacity building (10%) and, to a much lesser extent, research (2.5%).

The main services provided (offered by more than 50% of FPs) are outreach work; HCV and HIV prevention, testing and treatment; drop-in centres;

1. FP names, organisations, cities and countries can be found under "contributors".
2. Data extracted from the network member survey conducted in 2020.



Map: C-EHRN Focal Points location & contribution years.

needle and syringe exchange; STI prevention; and legal support. Less than 15% of FPs provide housing or shelter, Heroin Assisted Treatment (HAT), or Drug Consumption Rooms (DCRs). Even though research is not a priority for the vast majority of C-EHRN FPs, all of them report being involved in some type of research activity. Besides C-EHRN monitoring, 83% of FPs are involved in data collection for monitoring and evaluating within their own organisations; 53% perform needs assessments; and 52% the monitoring of drug trends; more than 80% use the data collected for advocacy purposes. Virtually all FPs are involved in some kind of policy and advocacy activity, moslty at the local/regional or national level.

THE 2022 SURVEY QUESTIONNAIRE

The survey questionnaires (since 2019) are available on the C-EHRN website[3]. Since 2020, the questionnaire has focused on the city level and the experiences of C-EHRN FPs with harm reduction implementation. As most of the FP organisations act locally, the focus on cities instead of countries takes advantage of their capacity to obtain city level data and is best in respecting this experience and increased data reliability. Also, since 2020, the survey questions have remained similar, with only with small adjustments, allowing the comparison of data reported since 2020. In 2022, a total of 45 questions covered background questions (2), essential harm reduction services (8 questions), HCV (25), and new drug trends (10).

ESSENTIAL HARM REDUCTION SERVICES: EXPERT INTERVIEWS

What is new in the 2022 report is the data collected using qualitative methods. This year, alongside the usual survey, semi-structured interviews were conducted with 25[4] Focal Points to gain a more in-depth insight into the situation of harm reduction services in their respective cities[5]. The online interviews lasted for approximately 60 minutes and were conducted during June-July 2022. They included some questions addressed via the survey in previous years, and several additional, new topics. The main themes discussed in the interviews were: needs of people who use drugs; cooperation of harm reduction services with other services in the drug field (e.g. prevention, treatment); cooperation of harm reduction services with organisations from outside the drug field (e.g. health and social care institutions, the justice system); challenges and well-being of staff of the harm reduction services; and Focal Point experiences in monitoring and evaluation activities.

NEW DRUG TRENDS: FOCUS GROUPS

For this year's monitoring, we asked the FPs whether they would want to help C-EHRN to organise a focus group discussion (FGD) on new drug trends, and 5 FPs responded positively. However, for different reasons, with just 2 FPs a FGD was arranged (FP Budapest and FP Dublin). Topics discussed in the focus groups were very similar to those in the questionnaire. Both FGD's were recorded, then the content was transcribed, and relevant information was added to chapter four.

We can conclude that focus groups are an attractive and possible time and cost-efficient alternative to the questionnaire for both FP and C-EHRN staff. Due to the recent COVID-19 pandemic, normalising working from home, including videoconferencing,

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3. www.correlation-net.org/monitoring/
4. A FP from Malta was also interviewed; however, due to the lack of harm reduction services in the country in general, the data from the interview are not used in chapter 1.
5. With two exceptions, where two FP representatives took part in the interview (FP Barcelona and FP Prague), all interviews were conducted with one representative per FP.

means that people are now used to meeting online and technical issues are easily solved. As such, online meetings are very time efficient (no travel), as well as cost efficient (often takes less time compared to a face-to-face meeting, e.g. travel time and expense). An even more important benefit of FGDs is that it may add to the quality of the data since, within focus groups, consensus is a more common outcome than if the questionnaire was filled out by, for example, 1 or 2 people that may also be working with the same organisation. Finally, FGDs may also improve the quality of the data collected as these group discussions allow for the asking of additional questions for clarification to get a better understanding of local markets. Therefore, it is recommended that further monitoring activities by grassroots organisations be developed using focus groups as an alternative to the lengthy questionnaire.

DATA GATHERING AND ANALYSIS

Data was collected between May and July 2022. Closed survey questions were analysed for general percentages or represented in tables with descriptions of features per city. Open ended survey responses were analysed with thematic analysis and key findings illustrated with quotes. The in-depth interviews where voice recorded, transcribed, and analysed with MAXQDA® (software for qualitative data analysis). When possible, comparative tables and analyses were performed to describe trends and differences between the last three years of reporting. Data were verified and analysed using Excel by the report authors, with the drafted chapters presenting the results. The different chapters were revised by the respective thematic expert groups, the C-EHRN FPs, and the Scientific Advisory Board.

LIMITATIONS

Given the nature of this monitoring structure and the focus of the work of C-EHRN FP organisations, data in this report cannot claim to be representative of Europe or the nations in which FPs are based. Most FPs work locally, or regionally, and have an in-depth knowledge of how harm reduction is implemented on-the-ground. Respecting this experience was chosen over national representativeness to provide a more nuanced analysis of the implementation of harm reduction at the local level. A more complete account of the methodology and its limitations can be found elsewhere (3) and in specific chapters concerning a particular topic.

REPORT STRUCTURE

The report consists of 4 chapters.

This **first** introductory **chapter** provides an overview of the methodology used for the present monitoring and its previous reporting years; a profile of the C-EHRN FPs collecting data for this report; and the limitations of the applied methodology.

Chapter 2 describes the state of essential harm reduction services in FP cities. **Chapter 3** describes experiences with the availability and accessibility of interventions that constitute the continuum of care for hepatitis C. **Chapter 4** focuses on the perceived new drug trends in FP cities.

REFERENCES

1. Gildemyn M. Understanding the Influence of Independent Civil Society Monitoring and Evaluation at the District Level: A Case Study of Ghana. Am J Eval. 2014 Mar 4;35(4):507–24.
https://doi.org/10.1177/1098214014525257

2. Joshi A, Houtzager PP. Widgets or Watchdogs? Public Manag Rev. 2012 Feb 1;14(2):145–62.
https://doi.org/10.1080/14719037.2012.657837

3. Rigoni R, Tammi T, van der Gouwe D, Schatz E. Harm reduction in Europe: a framework for civil society-led monitoring. Harm Reduct J 18, 3 (2021).
https://doi.org/10.1186/s12954-020-00451-7

4. Tammi T, Rigoni R, Matičič M, Schäffer D, van der Gouwe D, Schiffer K, et al. Civil Society Monitoring of Harm Reduction in Europe, 2019. Data Report. Amsterdam; Correlation – European Harm Reduction Network, 2020.
https://www.correlation-net.org/wp-content/uploads/2020/02/C-EHRN_monitoring_web.pdf

5. Rigoni, R, Tammi, T, van der Gouwe, D, Oberzil, V, Csak R, Schatz, E. Civil Society Monitoring of Harm Reduction in Europe, 2020. Data Report. Amsterdam; Correlation – European Harm Reduction Network, 2021.
https://www.correlation-net.org/wp-content/uploads/2021/03/monitoring_report2020.pdf

6. Rigoni, R, Tammi, T, van der Gouwe, D, Moura, J, Prins-Schiffer, K. Civil Society Monitoring of Harm Reduction in Europe, 2021. Data Report. Amsterdam; Correlation – European Harm Reduction Network, 2022.
https://www.correlation-net.org/wp-content/uploads/2022/05/MONITORING-OF-HARM-REDUCTION-IN-EUROPE-2021_web.pdf

Civil Society Monitoring of Harm Reduction in Europe
2022

2

ESSENTIAL HARM REDUCTION SERVICES

INTRODUCTION

2022 marks the third assessment of essential harm reduction services by C-EHRN monitoring. This time, the data was collected from 31 European cities[6]. As in previous years, the survey included two perspectives: different groups of people using services and service providers of different harm reduction services. Several changes (described in more detail in the following sections) were also introduced in the survey to enable the collection of more precise data. The Harm Reduction Essentials section of the survey included eight questions. Conducting the assessment for the third year in a row allows for comparison and analysis of the dynamics of essential harm reduction services in Europe over recent years. The summary of countries participating in the three surveys can be found in Map 1 in the introductory chapter. In total, 27 cities took part in all three surveys on essential harm reduction services, seven cities in two surveys, and six cities in one survey.

What is new in the 2022 report is the data collected using qualitative methods. This year, alongside the usual survey, semi-structured interviews were conducted with twenty-five[7] focal points to gain a more in-depth insight into the situation of harm reduction services in their respective cities.

DIFFERENCES BETWEEN SERVICES AND USER GROUPS

The first question in the survey addressed the extent to which harm reduction organisations are able to deliver services to 15 sub-populations. Compared to previous years, categories of 'EU migrants who use drugs' and 'non-EU migrants who use drugs' were replaced by 'documented' and 'undocumented migrants', respectively. The group of 'people who use drugs in party settings (nightlife)' was added to the survey.

The possible answers were based on a 4-point Likert scale (3 – to a great extent, 2 – somewhat, 1 – very little, 0 – not at all; the response 'not relevant to my city' – 'NR' and 'I don't know' – 'NA' were also available). In 2022, harm reduction services were delivered to a greatest extent to people who inject or smoke opioids, inject stimulants or new psychoactive substances (NPS), and people experiencing homelessness. The groups that services can reach to the least extent are young people who use drugs (under 18 years old), people in prison settings, people who practice chemsex, and undocumented migrants using drugs. Table 2, below, shows the extent of delivering services to the newly introduced target groups.

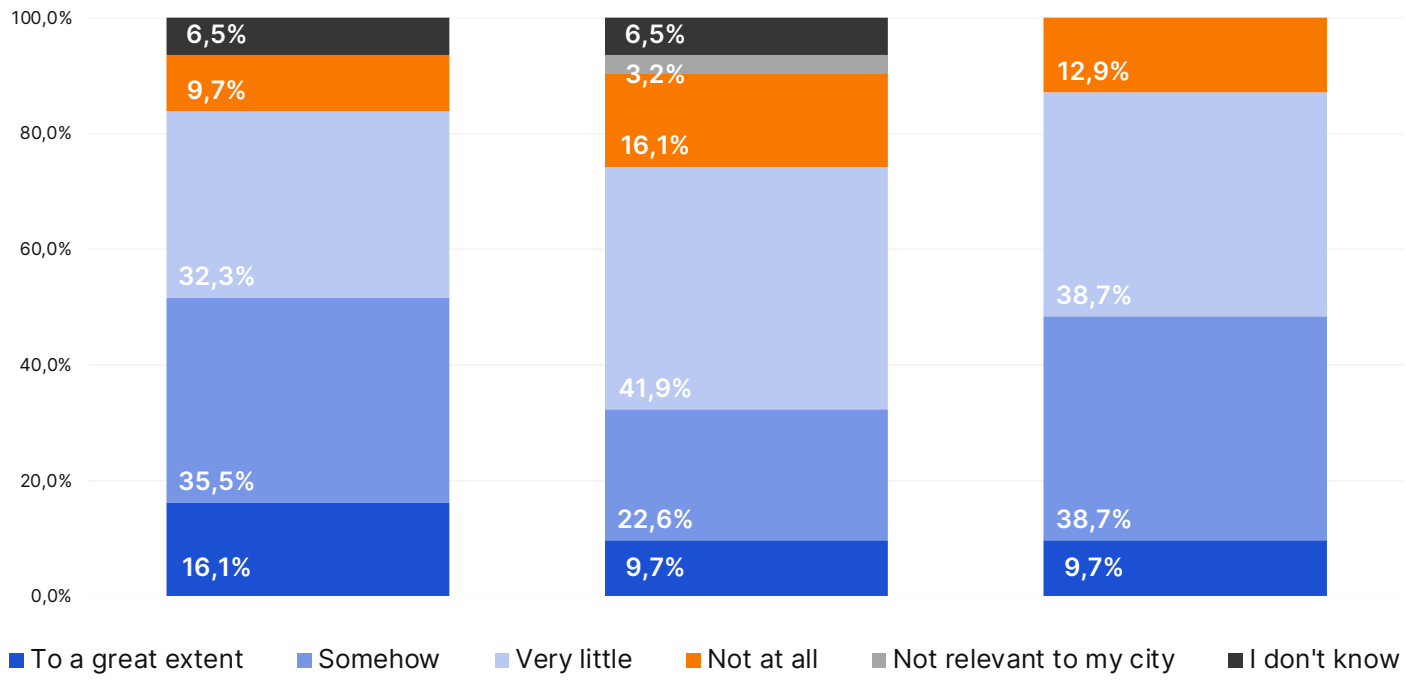
6. Compared to the responses in 2021, Bucharest (Romania), Kyiv (Ukraine), Novi Sad (Serbia), Podgorica (Montenegro), Rijeka (Croatia), Rome (Italy) and Tbilisi (Georgia) are missing. However, data on HR essentials were collected from Vilnius (Lithuania) after an absence in 2021, and – for the first time – Riga (Latvia) and Warsaw (Poland). As in previous years, there were two UK cities taking part in the survey – Glasgow (Scotland) and London (England). Also, two Polish cities responded to the survey – Cracow and Warsaw.
7. For a list of the cities where FPs were interviewed see footnote 1 in chapter 1.

Table 2. The extent of delivering services to the newly introduced target groups.

City	Documented migrants who use drugs (legal right to assistance)	Undocumented migrants using drugs (no legal right to assistance)	People using drugs in party settings (night-life)
Amsterdam			
Antwerp			
Athens - Thessaloniki			
Barcelona			
Berlin			
Bern			
Bratislava			
Budapest			
Copenhagen			
Cracow			
Dublin			
Glasgow			
Helsinki			
Ljubljana			
London			
Luxembourg			
Malta			
Milan			
Nicosia			
Paris			
Porto - Vila Nova de Gaia			
Prague			
Riga			
Skopje			
St. Petersburg			
Stockholm			
Tallinn			
Tirana			
Vienna			
Vilnius			
Warsaw			

To a great extent Somehow Very little Not at all Not relevant to my city I don't know

Figure 1. The extent to which harm reduction services can be delivered to specific sub-populations as assessed by C-EHRN Focal Points.



CHANGES 2020-2022

There are several sub-populations for whom the extent of harm reduction service delivery has changed significantly between 2020 and 2022:

SEX WORKERS

In 2022[8], 6.1 fewer FPs (18.5%) reported that in their cities it is possible to provide harm reduction services to sex workers to a greater extent than in the 2020. At the same time, the proportion of each of the other answers (somewhat, very little, not at all) slightly increased, which may indicate a decreased ability to provide services to sex workers.

PEOPLE EXPERIENCING HOMELESSNESS

In 2022, an average 5.7 more FPs (17.2%) reported that harm reduction services can be provided in their cities to people experiencing homelessness 'to a very little extent' than in 2020. On the other hand, a smaller decrease can be seen in the number of FPs reporting the delivery of services to a greater extent, which may suggest a deterioration in the ability to provide services to people experiencing homelessness.

WOMEN WHO USE DRUGS

In 2022, 6.3 fewer FPs (18.9%) reported that in their cities harm reduction services can be provided to

8. 18.5%; the difference is equal to 6.5 out of 35 FPs in 2020 and 5.7 out of 31 FPs in 2022, with the mean being 6.1. This logic is applied to indicate all subsequent changes during 2020-2022.

women who use drugs to a greater extent than in the 2020. Likewise, 6.3 more FPs (19.2%) reported that services can 'somewhat' be provided to this group. Since the other levels of service delivery remained stable, the data may suggest a slight decrease in the ability to provide harm reduction services to women who use drugs between 2020 and 2022.

Regarding the reasons why specific sub-populations are currently not being reached by harm reduction programmes[9], the lack of funding was mentioned as a barrier across all 15 specific sub-populations, along with limited capacity of service/staff. A lack of specific knowledge / guidelines in the programmes was reported as an obstacle to reaching out in 12 out of 15 sub-populations; a lack of meaningful involvement of the specific community in 11; legal issues (punitive/restrictive laws and policies) in 10; and service accessibility (location, opening hours, language, etc.) in five.

In the case of 10 specific sub-populations, one clearly dominant barrier to reaching out by harm reduction programmes can be identified (mentioned by at least 40% of FPs), as shown in Table 3.

"Chemsex, women and LGBTQI+ populations have very little SPECIFIC support in Czech services. They have access to services but only in general settings (services for everybody). There is a lack of specific services that these populations need." (FP Prague, Czech Republic).

Table 3. Dominant barriers faced by harm reduction programmes to reaching out to 10 specific sub-populations as assessed by C-EHRN FPs.

Subpopulation	Dominant barrier	No. of FPs reporting the barrier
People injecting stimulants	Lack of specific knowledge/guidelines in the programme	3/6 FPs
People smoking opiates	Lack of funding	4/8 FPs
People smoking stimulants	Lack of funding	7/12 FPs
People using intranasally	Lack of funding	6/13 PFs
Sex workers	Legal issues (punitive/restrictive laws and policies)	5/10 FPs
People experiencing homelessness	Lack of funding	5/10 FPs
LGBTQI+	Lack of specific knowledge/guidelines in the programme	6/14 FPs
Youth (<18 years old)	Legal issues (punitive/restrictive laws and policies)	9/21 FPs
People in prison settings	Legal issues (punitive/restrictive laws and policies)	10/18 FPs
People using drugs in party settings	Limited capacity of services/staff	6/15 FPs

9. This question includes six possible barriers and 15 specific sub-populations. The question is addressed only to those respondents who indicated in the previous question that harm reduction services in their cities are able to provide services to these sub-populations to a very little extent or not at all. Hence, the total number of responses in this question varies across sub-populations.

Figure 2. Main reasons why specific sub-populations are currently not being reached by harm reduction programmes as assessed by C-EHRN Focal Points.

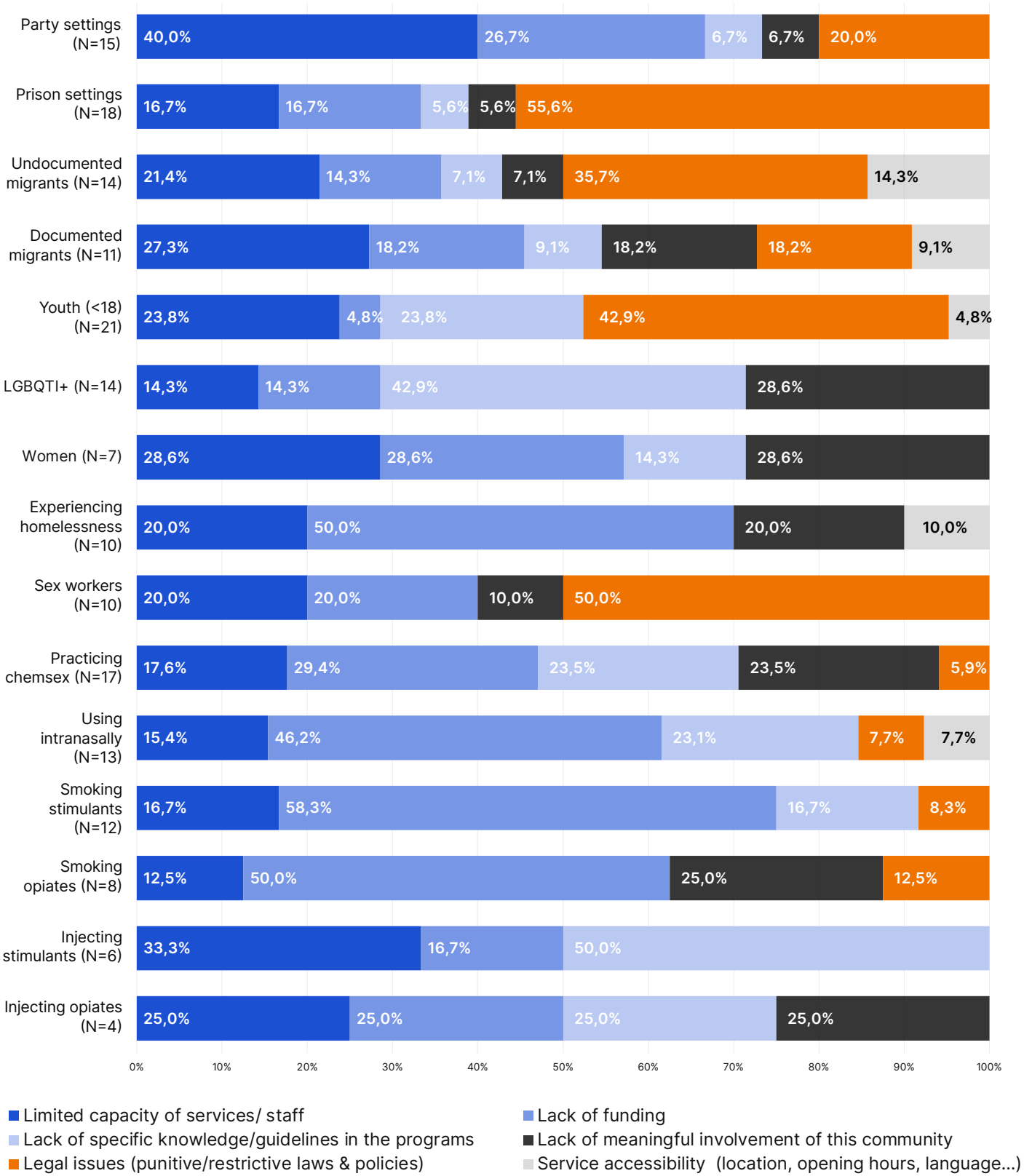


Table 4. The availability of newly introduced categories of service in each city as assessed by C-EHRN Focal Points

City	NSP in prisons	HIV prevention	HIV testing	HIV treatment
Amsterdam				
Antwerp				
Athens - Thessaloniki				
Barcelona				
Berlin				
Bern				
Bratislava				
Budapest				
Copenhagen				
Krakow				
Dublin				
Glasgow				
Helsinki				
Ljubljana				
London				
Luxembourg				
Malta				
Milan				
Nicosia				
Paris				
Porto - Vila Nova de Gaia				
Prague				
Riga				
Skopje				
St. Petersburg				
Stockholm				
Tallinn				
Tirana				
Vienna				
Vilnius				
Warsaw				

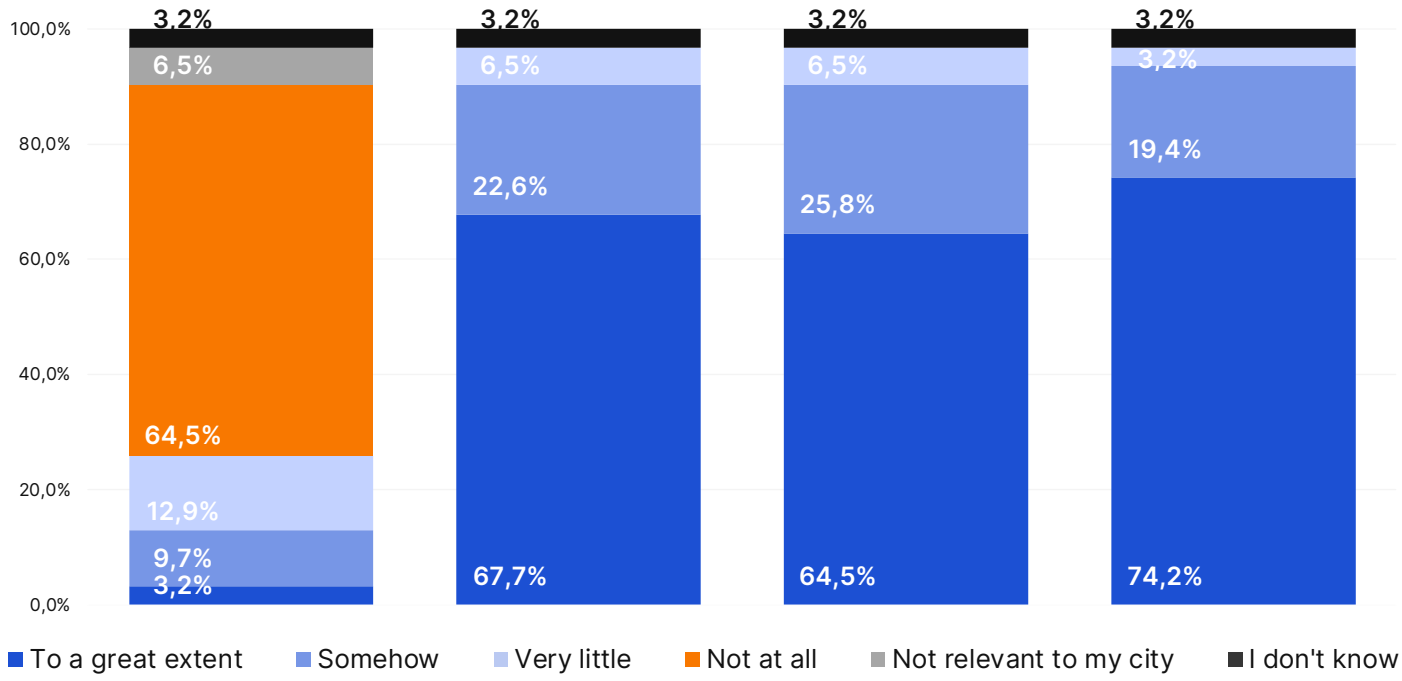
To a great extent Somehow Very little Not at all Not relevant to my city I don't know

The second question focused on the extent to which specific services are available to people who use drugs. Compared to previous years, the 'HIV services' category was divided into three separate areas: 'HIV prevention', 'HIV testing' and 'HIV treatment'. In addition, 'NSP in prisons' was introduced as a new category.

The scale was identical with that used for the first question. In 2022, the services most available to people who used drugs are, in descending order, HIV treatment, NSP, HIV prevention, OST, HIV testing, and outreach work. In contrast, extremely low availability was reported for (in ascending order) fentanyl test strips, NSP in prisons, drug consumption rooms, naloxone in prisons, and drug checking. Table 4 shows the availability of the newly introduced categories of service in each city. In 20 out of 31 cities, NSP are not available in prisons at all, and exists in a further four only to a 'very little' extent. With respect to HIV, on average there are no significant differences between specific HIV services. The cities where there is clear discrepancy between the availability of each service includes Budapest and Stockholm, where in both cases HIV treatment seems to be much more available than prevention and testing.

"Harm reduction in prison settings is actually illegal except a very limited service of OAT provision. There are substance free services and one "community" but that is not harm reduction and, also, sometimes these services are inspired from the "tough love" attitude which contributes to further disconnection with the health system". (FP Athens, Greece).

Figure 3. The extent of availability of specific services for people who use drugs as assessed by C-EHRN Focal Points.



CHANGES 2020-2022

With respect to the dynamics of availability of harm reduction services over recent years, significant differences can be seen in:

PEER SUPPORT

In 2022, an average of 5.8 fewer FPs (17.4%) than in 2020 reported that peer support services are available to a great extent in their city for people who use drugs. At the same time, smaller increases were observed for each of the other answers ('somewhat' – 12.6%, and 'not at all' – 7.9%), which suggests an overall decrease in the availability of peer support.

SAFER SMOKING KITS

In 2022, seven more FPs (21.2%) than in 2020 reported that safer smoking kits are 'somewhat' available in their city for people who use drugs. At the same time, the answer 'not at all' was chosen by 5.4 fewer FPs (16.3%), which may indicate an increase in the availability of safer smoking kits.

SAFER INTRANASAL KITS

In 2022, 5.3 fewer FPs (15.9%) than in 2020 reported that safer intranasal kits are 'not at all' available in their city for people who use drugs. Meanwhile, a slightly smaller increase was observed for the 'somewhat' level of availability (12.6%), which may suggest an increase in the availability of safer intranasal kits.

NALOXONE IN PRISON

In 2022, 6.4 more FPs than in 2020 (20%) reported that they do not know if naloxone is available in prisons in their city for people who use drugs. This proportion was zero in 2020 and in 2021, respectively, which may suggest that the information regarding service availability in prisons has become more restricted/less available. One of the hypothetical reasons for that could be the COVID-19 pandemic.

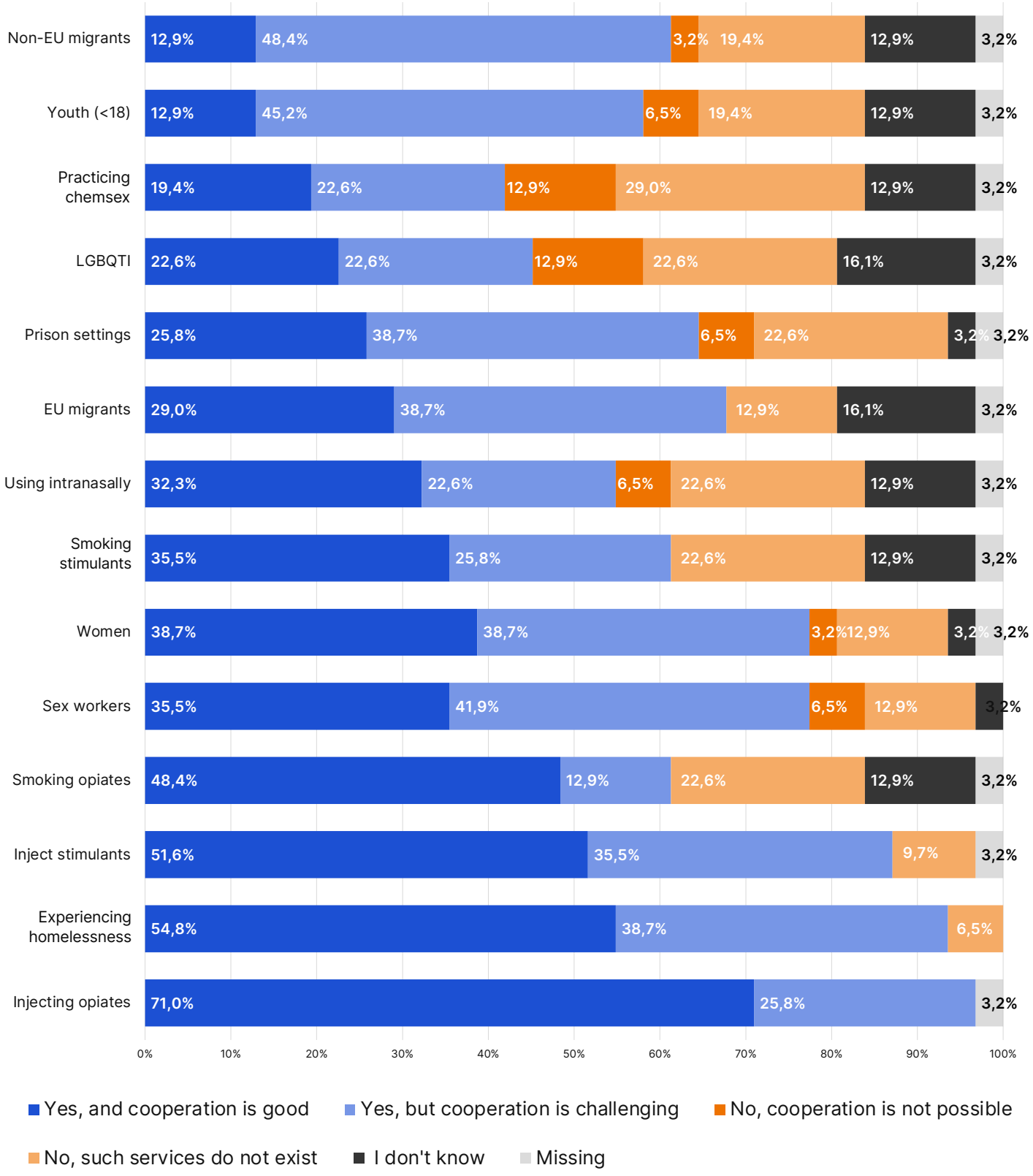
LEGAL SUPPORT

In 2022, 5.5 fewer FPs than in 2020 reported that legal support is 'somewhat' available in their city for people who use drugs. At the same time, a slight increase was observed for 'to a great extent' (5.1%) and 'very little' (7.3%) answers, and a slight decrease for the 'not at all' answer (2.1%). The picture is, therefore, unclear.

COOPERATION WITH OTHER SERVICES AND INSTITUTIONS

Focal Points were also asked to what extent harm reduction services in their cities cooperate with other services reaching 14 listed sub-populations. In 2020, the cooperation is the best for people injecting opiates, experiencing homelessness, injecting stimulants, and smoking opiates. The cooperation is weakest in the case of services for people practicing chemsex, mainly to the non-existence of such services, followed by services for people smoking opiates, and the LGBQTI+ community.

Figure 4. The extent to which harm reduction services cooperate with other services reaching specific sub-populations as assessed by C-EHRN Focal Points. (N=31)



CHANGES 2020-2022

Regarding the dynamics of the situation over the last two years, significant trends can be observed in cooperation with services reaching the following sub-populations:

PEOPLE WHO INJECT STIMULANTS OR NPS

In 2022, 5.1 more FPs (16.1%) than in 2021 reported cases of people injecting stimulants, and harm reduction services in their city cooperating with other services reaching this sub-population, but the cooperation is challenging. At the same time, there was a decrease of slightly lower magnitude in the proportion of answers 'the cooperation is good' (by 11.4%), while other options are stable. This may indicate a deterioration in cooperation with such services.

PEOPLE WHO PRACTICE CHEMSEX

In 2022, 5.7 fewer FPs than in 2021 (17.8%) reported cases of people who practice chemsex and harm reduction services in their city cooperate with other services reaching this sub-population, but the cooperation is challenging. Meanwhile, the number of FPs choosing the answer 'no, cooperation is not possible' increased noticeably (by 13.3% from 0 in 2021). This may suggest deteriorating cooperation with services serving this sub-population.

WOMEN WHO USE DRUGS

In 2022, an average 6.4 fewer FPs (20%) than in 2021 reported cases of women who use drugs and harm reduction services in their city cooperate with other services reaching this sub-population, and the cooperation is good. On the other hand, several more FPs answered that such services do not exist (10.5%), which may indicate deteriorating cooperation due to the disappearance of services for women.

LGBTQI+ WHO USE DRUGS

In 2022, 4.2 more FPs than in 2021 reported cases of LGBTQI+ who use drugs and cooperation of harm reduction services with other services reaching this sub-population is not possible (from zero in 2021). Meanwhile, good cooperation and challenging cooperation were reported by four fewer FPs (12%) each in 2022. This may suggest deteriorating cooperation.

YOUNG PEOPLE WHO USE DRUGS

In 2022, 6 fewer FPs than in 2021 (19%) reported cases of young people who use drugs and harm reduction services in their city cooperate with other services reaching this sub-population, and the cooperation is good. 3.6 more FPs (11.4%) reported challenging cooperation in 2022 than in 2021, and there was a slight increase in the proportion answering 'no, such services don't exist' (1.7 FPs or 5.3%), which may indicate a slight deterioration of cooperation with youth services.

THE QUALITY OF HARM REDUCTION SERVICES AND THE NATIONAL CONTEXT

As shown in Figure 5, most FPs see the current harm reduction services in their cities as meeting the needs of people who use drugs to a moderate extent. Meeting the needs to a great extent was reported by only five FPs: Berlin, Bern, Glasgow, Luxembourg, and Vienna. In contrast, FP Malta reported not meeting the needs of people who use drugs by harm reduction services at all, and Stockholm and Budapest only to a small extent.

The quality of harm reduction services is assessed as relatively high, with the highest performance in confidentiality of client records, informed consent, and accessing health and risk behaviours of clients by the services.

According to the data, in 2022, the majority of FPs still see the situation of harm reduction in their cities as better than in other parts of their country. In several cases, the situation is not straightforward, as reported by, for example, FPs from Barcelona, Bern, Budapest, Cracow, and Warsaw (details can be found in the short city descriptions below).

Figure 5. The extent to which the current harm reduction services in examined cities can meet the needs of people who use drugs.

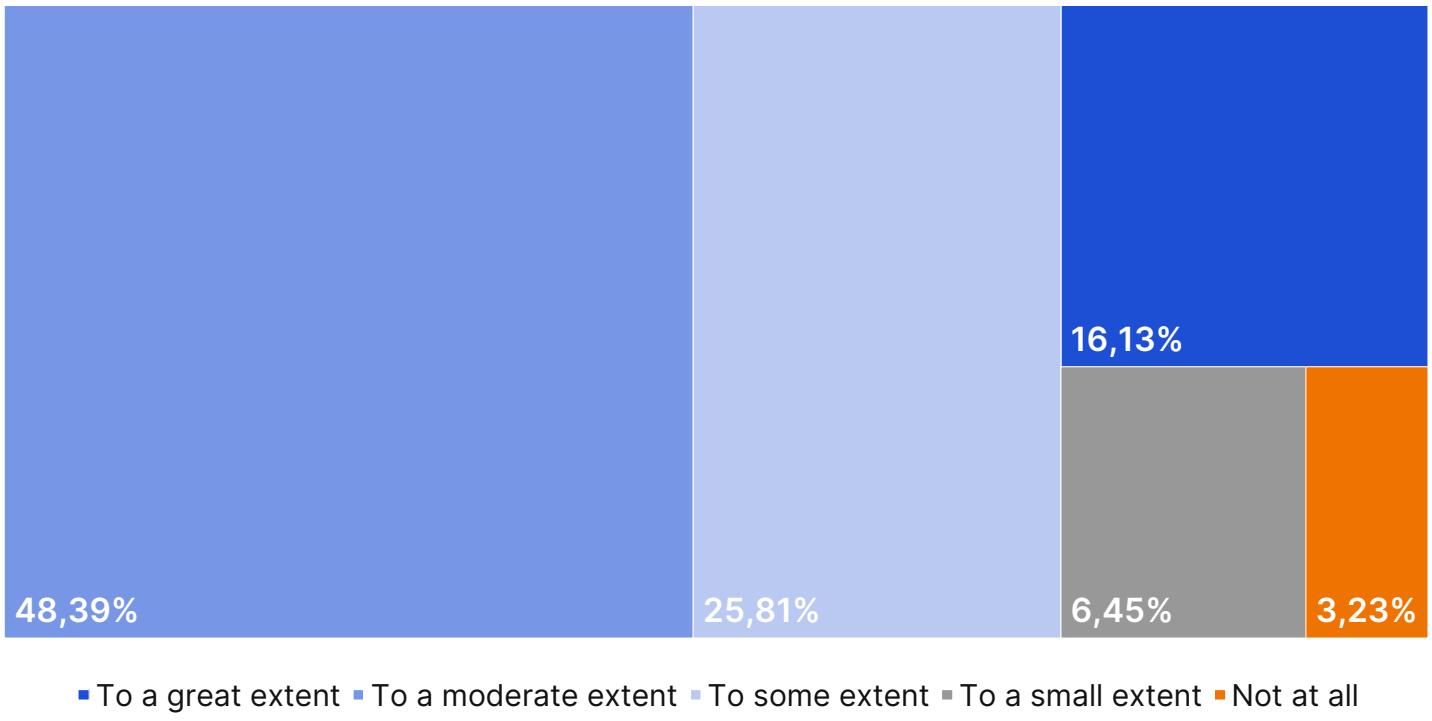


Figure 6. The evaluation of harm reduction services in examined cities across specified criteria.

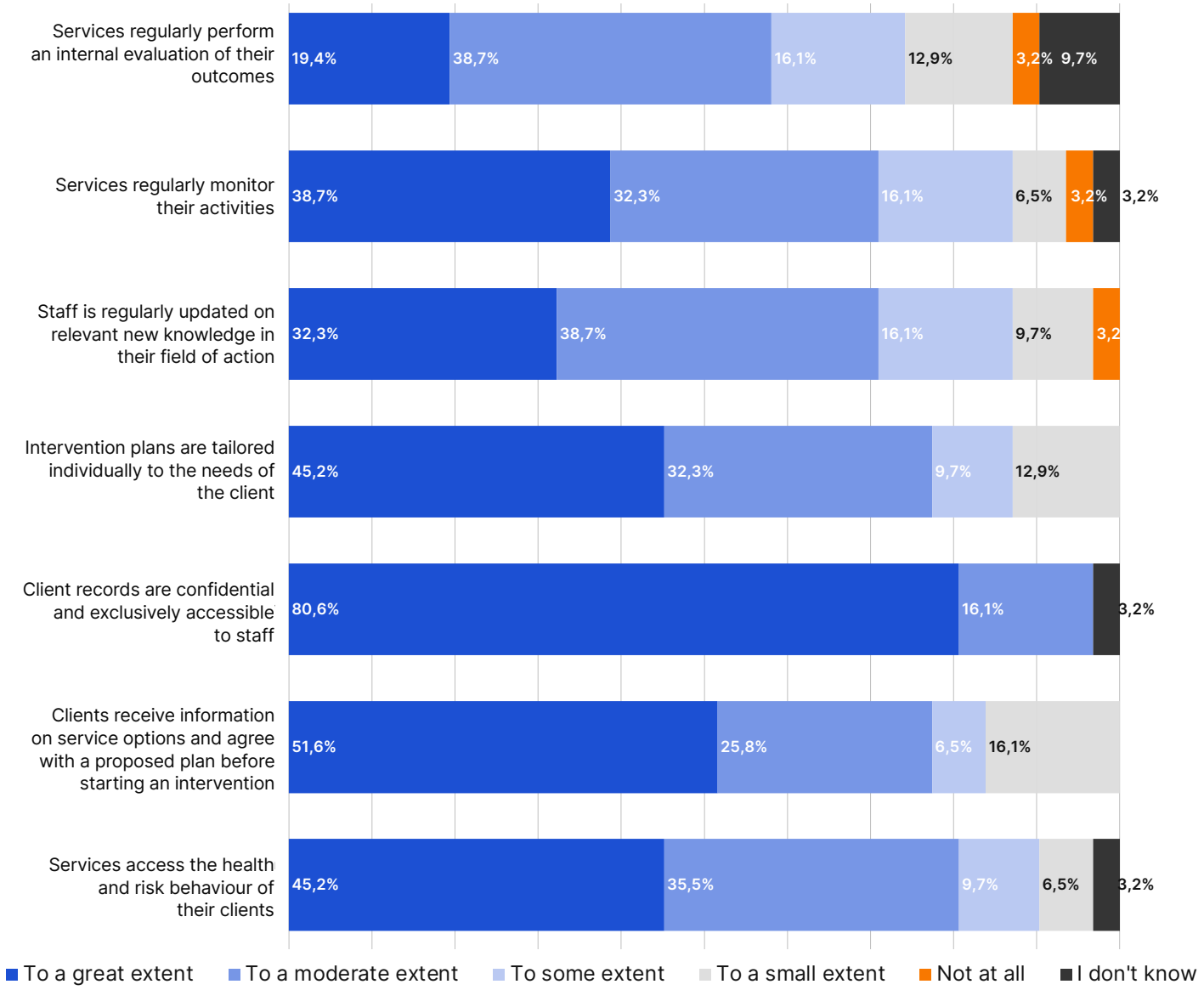


Figure 7. The situation of harm reduction services in examined cities in the national context.

CITY SNAPSHOTS

The city snapshots are summaries of additional comments that some FPs included next to their answers to the main survey questions. The decision about including additional remarks is under the discretion of each FP; hence, the focus and content of snapshots varies between cities.

AMSTERDAM
THE NETHERLANDS

It is difficult to access health care services for non-documented migrants who have to rely on a network of friendly doctors and services.

ANTWERP
BELGIUM

The situation of harm reduction programmes in Antwerp is notably better than in the remaining part of the country. Antwerp has a long tradition in providing harm reduction services. Most pilot programmes start in Antwerp due to the high prevalence of people who use drugs.

ATHENS
GREECE

Access to harm reduction services is extremely limited for people engaging in chemsex, and it is argued that services are designed in a way that exclude non-white, non-heterosexual, non-cis individuals. Another very problematic area is prison settings where harm reduction is prohibited, except for a limited opioid agonist treatment (OAT) provision. Migrants and refugees are also neglected by the system, and there is a range of specific barriers making service delivery to them even more difficult. There are no services tailored to their needs, addressing trauma and mental health, meanwhile, law enforcement is very hostile towards them. Peer support is marginalised and many other services are very limited or unavailable (e.g. naloxone provision, DCR, housing, prevention of sexual risks, HIV prevention and testing).

BARCELONA
SPAIN

In Barcelona, there is a broad offer of services for people who inject opiates, but this doesn't include synthetic opioids. There are only a few safe consumption services in Barcelona and in the region that allow for the use of synthetic opioids, as others only allow the consumption of illicit substances in their premises (i.e. no methadone, fentanyl, etc.). Harm reduction services are accessible only to adults; hence, minors are not covered. There are significant differences in the availability and accessibility of harm reduction services between the nineteen regions of Spain: DCRs are available only in two regions; there is only one shelter for people who use drugs in the country; geographic distribution of NSPs is very uneven as is access to health services.

BERLIN
GERMANY

Safer smoking paraphernalia and equipment for intranasal use are widely available in Berlin and individually composed for each individual (in contrast to pre-packed kits). Staff of harm reduction services have access to naloxone as

'emergency medicine'. There are five fixed-site DCRs and 3 mobile units. Hence, their availability is relatively high, but accessibility is more limited (DCRs work between 15 and 54 hours a week).

BUDAPEST
HUNGARY

In some districts of Budapest there are no harm reduction services at all. In some others, they work better than most of the services in the countryside. Hence, the picture regarding comparability of the situation of harm reduction in Budapest and in the rest of the country is mixed.
Lack of access to harm reduction services is a result of many factors, the core factor being the lack of funding, resulting from political and ideological opposition of the Hungarian government and society against harm reduction.

COPENHAGEN
DENMARK

HIV treatment is available for everybody, also for people who do not have access to general healthcare. The Street Lawyer organisation that closed down in spring 2021, reopened in 2022. There are two street lawyer organisations now in Copenhagen. The COVID-19 pandemic triggered a more inclusive approach, and substitution outreach has become permanent. Still, there is an ongoing problem with funding.

CRACOW
POLAND

No harm reduction measures are available in prisons, except for OAT, despite existing evidence about illicit drug use in this setting. In principle, there are no harm reduction programmes targeting youth specifically; however, some of the programmes (mainly nightlife harm reduction ones) do deliver services to minors.
There are no, or minimal, harm reduction programmes targeting people engaging in chemsex, sex workers and the LGBTQI+ community. There are multiple reasons behind this situation, the major one being the difficulties in acquiring funding due to the very strong discrimination of this community among politicians and decisionmakers. An organisation serving the LGBTQI+ population that the FP started cooperating with recently is not interested in harm reduction, choosing rather to ignore drug use among their clients. The situation of harm reduction services in Cracow, similar to Warsaw and Wroclaw, is better than in the other part of the country, as harm reduction centres function only in these three cities.

LONDON
UK

The accessibility of harm reduction is challenging mainly in respect of equipment other than injecting paraphernalia. There are legal and policy barriers to implementation of DCRs. Naloxone is widely available, and some of the innovations triggered by the COVID-19 pandemic are still being implemented (e.g. peer work, less restrictive prescription of OAT, postal services). On the other hand, staff shortages resulting from the pandemic still affects harm reduction services.
There have been several pilot drug testing projects operating at some music festivals in recent years, and recently the first regular drug checking service was being piloted in Bristol.
Restrictive and punitive drug policy affects service provision to all populations. Besides, there are

multiple other factors hindering harm reduction delivery to different target groups. Distribution of paraphernalia for smoking and intranasal use is prohibited in the UK which has a detrimental effect on the potential engagement of people who use crack cocaine to get them in contact with services. However, a pilot project - including distribution of crack pipes - is about to being launched. COVID-19 triggered a relaxation of the OAT provision schemes, but this has been restricted again in some services. Diamorphine is not available in the country at the moment, and there is a need for a safe supply of other substances to substitute crack cocaine and benzodiazepines.

PRAGUE
CZECH REPUBLIC

In Prague, the state of harm reduction services has not been improving over the years, despite the increasing demand. There is an urgent need for new facilities (including DCR and drug checking), but no sufficient political will to open them, despite the support of field experts. Special populations like people engaging in chemsex, women or the LGBTQI+ community can only access general services and there is lack of offer tailored to their needs. People who use drugs are not organised.

TALLIN
ESTONIA

The war in Ukraine triggered a change in the Estonian system – now people who do not have an Estonian personal identification number can be admitted to OAT, which was not possible before. Improvements can also be observed in the field of nightlife harm reduction where activities are being undertaken by the government to identify the needs of, and develop an implementation plan together with, service providers and the community. Cooperation with other services exists to some extent but is difficult due to inefficient communication channels, stigma, bureaucracy and a lack of understanding.

VILNIUS
LITHUANIA

Harm reduction services for people using drugs in party settings are available at only one annual music festival in the country.

WARSAW
POLAND

There are three harm reduction programmes operating in Poland in three cities (Warsaw, Cracow, Wrocław) offering comprehensive support for people who use drugs. One more harm reduction service in Gdańsk is just getting started. At the national level, NSP and OAT coverage is very low. The number of needle and syringe exchange programmes has decreased dramatically over the past 10 years. The number of OAT clients has remained virtually the same for years (about 2,500 since 1993). Considering the (likely underestimated) number of people with problematic opiate use (15,000-17,000 persons), OAT covers only 15% of those in need. There are no systemic actions in the field of social reintegration, or counteracting homelessness among people who use drugs.

IN-DEPTH INSIGHTS

NEEDS OF PEOPLE WHO USE DRUGS

In the interviews, FPs were asked to summarise the major needs of people who use drugs and the need to improve the harm reduction services in their cities.

Regarding the needs of people who use drugs, there are several issues that most FPs highlight, although clear differences can also be seen. In principle, the situation is more challenging in Central-Eastern Europe. Many services are not available at all in this region (e.g. DCR, drug-checking, take-home naloxone), and those available (e.g. OAT, NSP) are insufficient in the context of need and should be urgently scaled-up.

What seems to be characteristic in the vast majority of studied cities is the obsolete character of harm reduction services. Namely, harm reduction programmes are still highly focused on people injecting opiates, although there is evidence as to the decrease in both opiate use and injecting all over Europe. It appears that services for people using stimulants are virtually absent, also in terms of treatment. Furthermore, although some FPs report the existence of services for specific populations (e.g. FP Antwerp, Belgium), this seems to be an exception. FPs highlight the need for services for youth, women (especially those experiencing violence), and ageing people who use drugs. Also, specialised services for refugees (with experience of violence and trauma) seem to be needed. With respect to the types of harm reduction services that are needed (meaning both those made available or to be scaled-up), the FPs mention DCRs, take-home naloxone, drug checking, and night-time harm reduction. The main barriers emphasised in the context of the inability to establish such services seem to be legal. Scaling-up services, on the other hand, appears to be mostly affected by political will and the attitudes of local communities.

With respect to other services, it seems that housing is the most urgent need, with many FPs mentioning the lack of housing (including housing first) programmes as one of the, or the major, problem. Another challenging field is case management and social reintegration programmes which appear to be highly insufficient, if they exist at all.

Another interesting aspect is access to drug treatment services. In most contexts, drug treatment is only accessible for people with health insurance. Several FPs highlight the need for low-threshold treatment access, essential health care access, and stabilisation (with prescription benzodiazepines). Moreover, it is reported that in public health care institutions, people who use drugs may experience stigmatisation and discrimination. In some contexts, they are denied HCV treatment because of their active drug use. It is also highlighted that health care and counselling services are reluctant to accept people actively using drugs as they are perceived as difficult. In other words, the expectations of services towards people who use drugs do not take into consideration their lifestyle and are unwilling to meet people where they are at. Finally, waiting times to enter treatment (both residential and OAT) were reported as one of the challenges, limiting the ability of harm reduction services to support their clients.

SOCIAL ATTITUDES TOWARDS PEOPLE WHO USE DRUGS AND HARM REDUCTION SERVICES

FPs were also asked what the general societal attitudes are towards people who use drugs and harm reduction services in their city and the relationships of harm reduction services with the local communities where they operate.

In general, social attitudes towards people who use drugs and harm reduction services are mixed, with stigma being widely present among local communities, but also sometimes in politics and health and social services. The picture emerging from the interviews is one including a lack of understanding and knowledge, and reluctance (or even fear) of people who use drugs and harm reduction services or of the unknown reported by FP Prague and FP Ljubljana.

However, FPs also highlighted positive, supportive attitudes that exist. The mixed picture seems to include two main angles. First, some people in local neighbourhoods understand the benefits of having harm reduction services around and support them, sometimes getting involved in communication with them or even service delivery; some other people exhibit negative attitudes towards people who use drugs and the services. Second is the contrast between the general support of society towards harm reduction (at least at the level of declarations), but at the same time unwillingness to have services in the area. Indeed, NIMBY (not-in-my-backyard) attitudes is something that FPs highlight very often, that also has an impact on the functioning of services, the possibilities of opening new facilities or scaling-up of existing ones.

COOPERATION

Another set of questions referred to experiences of cooperation of harm reduction services with other services within the drug field (e.g. prevention, treatment, reintegration, research, advocacy) in FP cities, as well as cooperation of harm reduction services with services outside the drug field (e.g. health care, social support, law enforcement, prisons, etc.), and engagement of harm reduction services with local communities.

With respect to relationships with neighbourhoods, many harm reduction services do extensive community work. They try to maintain communication channels with the local community and inform them about their work. They also try to support local inhabitants in addressing their problems, engage them in the work of services (e.g. through reporting/spotting used injecting equipment in the area), and ‘to be the best neighbour they possibly can be’ (FP Dublin, Ireland). In some cases, open and free HIV/HCV testing days are organised to attract the local community, whilst in others working groups are established involving neighbours, the municipality and NGOs, and in yet others there are personal-level relationships of harm reduction service staff with local institutions, like kindergartens.

Within the drug policy field, it seems that general cooperation between organisations and institutions is good. In some countries, big umbrella organisations or networks of drug-related services exist which facilitates communication,

joint advocacy actions, and cooperation in general. A large portion of cooperation between harm reduction and demand reduction services (abstinence-focused treatment, OAT, detoxication) is focused on ensuring the continuity of care and in referring clients to treatment facilities, should they need it. The referral mechanisms seem to work well. However, their efficiency is often undermined by the lack of capacity of the treatment system and the resulting waiting lists to access services and, sometimes, by the high-threshold character of programmes.

Outside of the drug field, the cooperation of harm reduction organisations seems to be most widespread in relation to health and social care institutions, including local hospitals, individual doctors, clinics, and social housing institutions, but also other NGOs providing services for different populations. However, services report that such cooperation is often not formalised, but occurs at lower levels and is based on personal relationships. As such, it is highly dependent on individuals in relevant positions and their attitudes. Good collaborative relationships with law enforcement (police, probation service) seem less frequent, but existing, and is some cases working very well. The most challenging field is prisons where virtually no cooperation is possible due to the specificity of the functioning of this type of 'total' institution, it's closeness to the outside world and the unique logic governing it.

INVOLVEMENT OF PEOPLE WHO USE DRUGS

FPs were also asked about the extent to which people who use drugs are involved in planning, implementing, and evaluating harm reduction services in their cities. This includes questions about the mechanisms of involvement, levels of involvement (e.g. planning, implementation), paid versus unpaid involvement, and the existence of services led by people who use drugs.

Involvement of people who use drugs in harm reduction services takes various forms and occurs at different levels. Some sort of involvement is characteristic for most of the examined services.

The most widespread form of involvement is collecting feedback on services via suggestion boxes, focus groups, or simply during the everyday work with clients. Via these routes, services collect information on the needs of their clients and possible improvements of the offered interventions, etc. Hence, these inputs inform the planning of services. In many cases, people who use drugs are also engaged in service implementation, delivering interventions as peer workers, usually being employed as a part of the regular staff of a service (in contrast to volunteers), and receiving salary for their work.

The involvement of people who use drugs seems to be lower in the policymaking process and, where they are involved, it is usually people with previous experience of drug use and not current active users. Some FPs reported that even if people who use drugs are involved in policymaking, it is superficial and serves 'ticking the boxes' (FP Porto, FP Athens).

The existence of peer-led services is very exceptional and was reported only by FP Copenhagen and FP Georgia, and the existence of a people who use drugs union by FP Tallin. Lack of organisation of people who use drugs is mentioned as one of the reasons in the context of where they are not meaningfully involved in the

planning and delivery of services and policymaking. Other factors emphasised by FPs include a lack of willingness/readiness, lack of recognition of people who use drugs as individuals who can contribute to the life of the city, a lack of a facilitating legal framework, or difficulties in teamworking and adjusting to work discipline.

CHALLENGES OF HARM REDUCTION SERVICES

Finally, FPs were asked about the functioning of their services and the challenges that harm reduction workers face in their daily jobs, as well as mechanisms ensuring the well-being and professional development of service staff.

The general picture stemming from the data, with a few exceptions, is that of harm reduction still being marginalised in drug policy compared to other demand reduction elements (prevention, treratment) and, sometimes, the need to fight for survival. Insufficient funding is characteristic of virtually all services, although its severity and consequences vary. In some cases, insufficient funding leads to the lack of capacity in terms of being able to cover the target population with the most basic services. In other cases, it can mean an inability to improve the quality of services, such as through hiring medical staff, offering (more extensive) case management, or experiencing interruptions in service operation due to a lack of materials for distribution. Operating harm reduction services seems to be difficult not only due to scarce or precarious funding, but also related (lack of) political will and support, and sometimes challenging relationships with local communities exhibiting NIMBY attitudes. Where harm reduction is more developed, FPs highlighted stagnation, lack of progress and innovation in the field.

With respect to service needs, FPs highlighted higher and more stable funding, training to address new challenges in the drug field, more social awareness and social acceptance, improved linkages to health care and social services, and supervision.

Harm reduction services also experience significant challenges with respect to staff. It seems to be very difficult to find and maintain good staff. Many services experience staff shortages, and in many cases the workers leave the field. The situation is rather complex and multidimensional. One of the major problems is the already mentioned scarce and precarious funding. As a result, harm reduction workers do not earn enough to support themselves and their families, and they do not have the necessary job security, working on short-term contracts.

In addition, harm reduction professionals do not receive the social recognition and appreciation for their work. They work in very difficult conditions, being exposed to high psychological and emotional pressure on a daily basis, working at night and weekend shifts, sometimes experiencing aggression and frustration resulting from seeing individuals being in the same place for years; as well as loss, and often working for weeks or months without salary, waiting for the next grant to pass. Although various supervision mechanisms exist in most organisations, and practitioners support one another at an individual level, it seems that there is a need for more extensive mental health care and policies ensuring the well-being of harm reduction staff. The job situation of harm reduction workers seems to be highly inadequate compared to the educational, emotional and

professional requirements of the job.

Such poor working conditions, uncertainty, overwork (due to low capacity of services and understaffing) and burnout lead some practitioners to leave the field, making the situation yet more difficult for those who stay, creating or reinforcing a vicious cycle of insufficient recognition of harm reduction as a drug policy pillar.

CONCLUSIONS

The overall picture of the state of harm reduction services in European cities seems to be far from optimistic. The survey data suggests the deterioration of services and cooperation with other entities across several areas and target populations over time. The data suggests improvements only in the case of availability of two types of services: safer smoking kits and safer intranasal kits.

An interesting case can be seen regarding the extent to which harm reduction services can be delivered to specific sub-populations. Based on the information reported by FPs, the two groups (sex workers and people experiencing homelessness) that experienced the most significant deterioration of the situation spend a large portion of their lives on the streets (in relation to their housing situation or work). It may be the case that the decrease in the ability of an organisation to provide services to these populations is related to COVID-19 lockdowns, safety and distancing measures introduced by governments all over Europe in the last two years. Funding is one of the major problems in the harm reduction field, having serious consequences on the operation of services. One of the main consequences of precarious funding is staff shortage, with harm reduction professionals experiencing uncertainty, lack of job security, difficult working conditions, overwork and burnout. Despite existing (though often insufficient) mechanisms of supervision and other support, some of the practitioners decide to leave the field. Acquisition of doctors and nurses in harm reduction services also seems to be a challenge. Scarce, precarious funding can be also one of the reasons why people who use drugs are not involved more in service provision; suffering from a constant lack of capacity, harm reduction service staff may simply not be able to undertake the additional task of training peers.

Overall, based on the information collected from service providers, harm reduction does not seem to be a policy priority, with limited political will and funding supporting its implementation. The availability of services is higher in Western European countries than in Central-Eastern Europe both in terms of the types of services available, and the quantity of existing services. However, according to the data, even in Western countries, the harm reduction momentum seems to be over, with decreasing intravenous and opiate use. The data shows that although the availability of safer smoking and intranasal kits seems to have slightly improved, the change in mindset of decisionmakers has not caught-up with the changes in the drug market and drug use patterns to a sufficient extent. Harm reduction services are still highly focused on intravenous (and) opiate use, while services for people using stimulants, using through inhalation and intranasally are scarce. Innovation seems to be in short supply.

Civil Society Monitoring of Harm Reduction in Europe
2022

3

HEPATITIS C

INTRODUCTION

In the spring of 2022, for the fourth year in a row, C-EHRN invited civil society organisations (CSOs) from European countries to complete a 25-item online survey on the availability of, and access to, interventions that constitute the HCV continuum-of-care specific for people who use drugs. Consequently, this section consists of four parts: 1) the use and impact of national strategies and guidelines on accessibility to HCV testing and treatment for people who inject drugs; 2) the functioning of the continuum-of-care in different countries and cities; 3) potential changes in the continuum of services compared to the previous year; and, 4) the role of harm reduction services and NGOs who serve people who use drugs in this context.

In what follows, the focus of different questions varies between national level situations and the city level, with the focus being mainly on the city level. In many themes, the results of 2020, 2021 and 2022 are compared. When making comparisons, however, it should be born in mind that there are some differences in participating countries and cities between the three years.

There are limitations and missing information in the data. Missing data (skipped questions and "I don't know" answers) are presumably often due to the fact that the survey was answered by harm reduction professionals who have expertise when it comes to local harm reduction services, but not so much at the general HCV policy level, or specialised HCV testing and treatment practices and criteria. From all respondents, 30% responded that they answered the HCV-related questions alone, 40% jointly with colleagues, and 17% consulted external experts for their answers. This year, almost all free text fields were removed from the questionnaire. The purpose was to lighten the survey and, thus, the workload of the respondents. Due to this, as in previous years, the data do not contain many free-form descriptions of services and their contexts.

RESULTS

For 2022, for the HCV section, there were responses from 31 cities representing 29 countries: Amsterdam, Antwerp, Athens and Thessaloniki[10], Barcelona, Berlin, Bern, Bratislava, Budapest, Copenhagen, Dublin, Glasgow, Helsinki, Cracow, Ljubljana, London, Luxembourg, Malta, Milan, Nicosia, Paris, Porto, Prague, Riga, St. Petersburg, Skopje, Stockholm, Tallinn, Tirana, Vienna, Vilnius and Warsaw.

Compared to last year, two cities from Poland (Cracow and Warsaw) participated, but only one city from Italy (Milan), not two (also Rome) as was the case last year. There are still two cities from the UK (London and Glasgow). To the national level questions, Glasgow's answer covers only Scotland, not the whole of the UK. For the first time, all the Baltic countries (Riga from Latvia, Tallinn from

10. Together as one respondent.

Estonia and Vilnius from Lithuania) took part in the survey in the same year. Bucharest (Romania), Kyiv (Ukraine), Sofia (Bulgaria) and Tbilisi (Georgia) did not provide data this year. Participating cities, as well as the C-EHRN focal points (FPs) responsible for the data collection, are described in more detail at the beginning of this report (chapter 1).

NATIONAL GUIDELINES AND REAL-LIFE PRACTICES

The first part of the C-EHRN monitoring survey assesses the use and impact of national strategies or guidelines on accessibility to testing and treatment for people who inject drugs. Respondents were asked to assess the use, and impact, of national strategies or guidelines on access to testing and treatment for people who use injectable drugs from the viewpoint of services working with people who use drugs.

Almost all respondents reported that they use their own national guidelines (11 out of 30 countries), EASL guidelines (10 countries) or other guidelines (six countries), such as WHO guidelines, that include people who inject drugs. Respondents from five countries - Lithuania, North Macedonia, Poland[11], Russia and Sweden[12] - reported not having any HCV guidelines related to people who inject drugs.

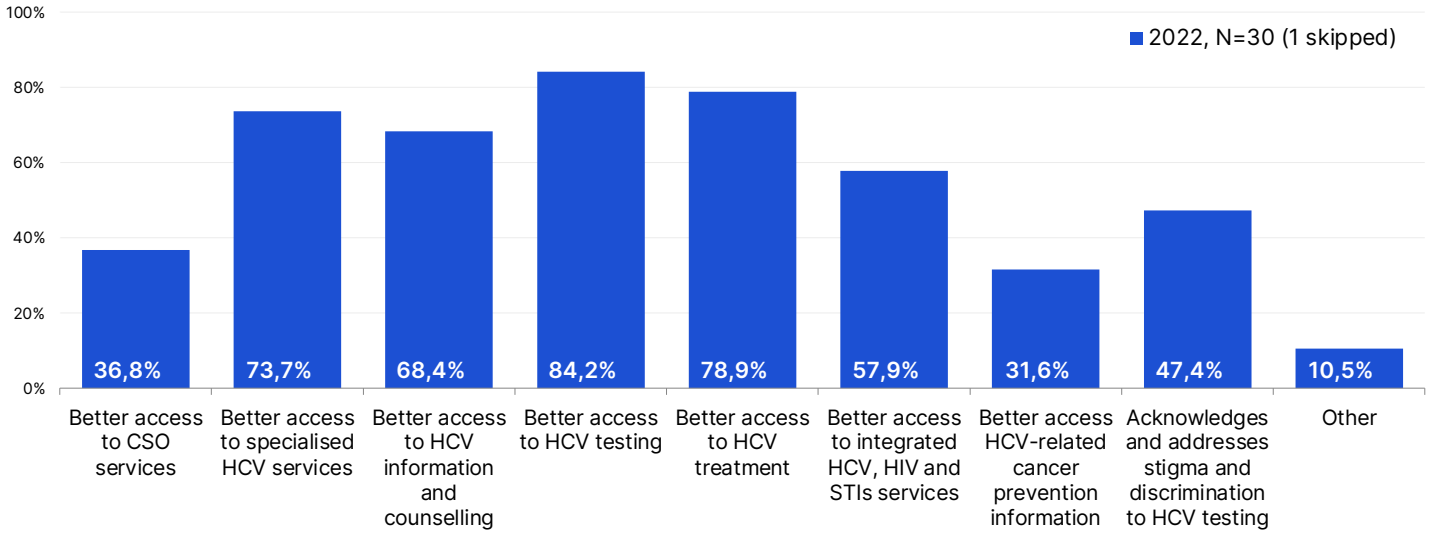
Even if guidelines exist, they might have limited impact in practice. Respondents were asked about the implementation of national HCV guidelines. A number of challenges around the effective implementation of such guidelines were reported, including the guidelines being outdated, complicated local testing and treatment systems, a lack of services and the impact of the COVID-19 pandemic on testing and treatment.

Respondents were asked to assess how these guidelines impact access to HCV testing, treatment and other services for people who inject drugs in their city. Overall, 20 FPs thought the guidelines had a positive impact. All of them mentioned better access to HCV testing and treatment, and many also felt that the guidelines improved the availability of information and services (see Figure 8).

Eight respondents considered there to have been a negative impact from the guidelines as their use has led to excessive specialisation. As a result of the guidelines, HCV treatment is prescribed only by specialists in Barcelona, Bratislava, Copenhagen, Cracow, Malta, Tallinn and Vienna. In Bratislava, Malta, Cracow, Tallinn and Vienna, HCV treatment is not possible outside the specialised health care system as a result of the guidelines.

11. In Poland, there are guidelines by the National Health Fund but there are no procedures for people who use drugs, except that alcohol and people who are drug dependent should not be treated. Doctors treating HCV in Cracow clinics admit such patients for treatment.
12. There are Swedish policy documents which are regarded as such guidelines by many experts, but the Swedish FP (a drug user union) does not qualify those as guidelines.

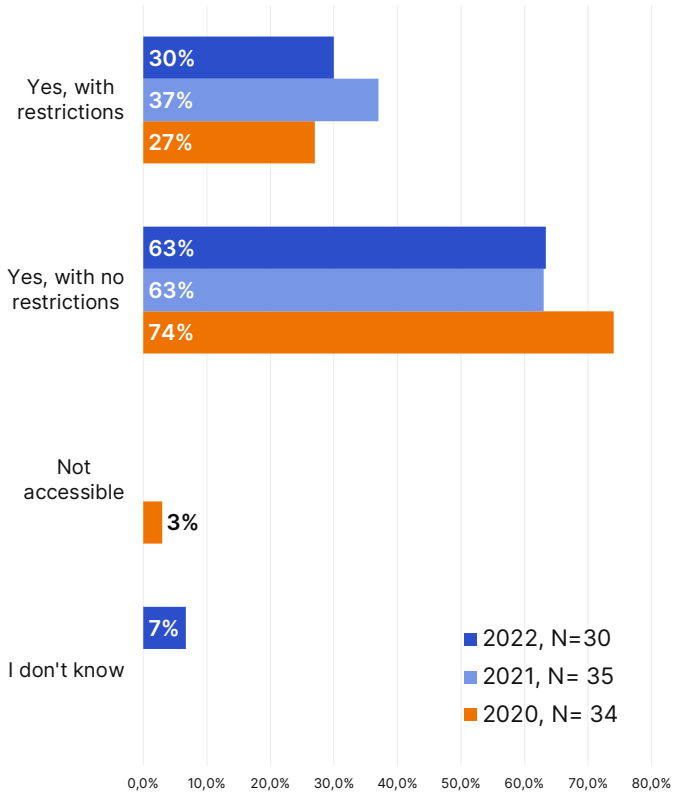
Figure 8. In which areas did you notice that guidelines had a positive impact on access to hepatitis C testing, treatment and other services for people who inject drugs.



AVAILABILITY OF, AND ACCESS TO, NEW DRUGS (DIRECT ACTING ANTIVIRALS, DAAS)

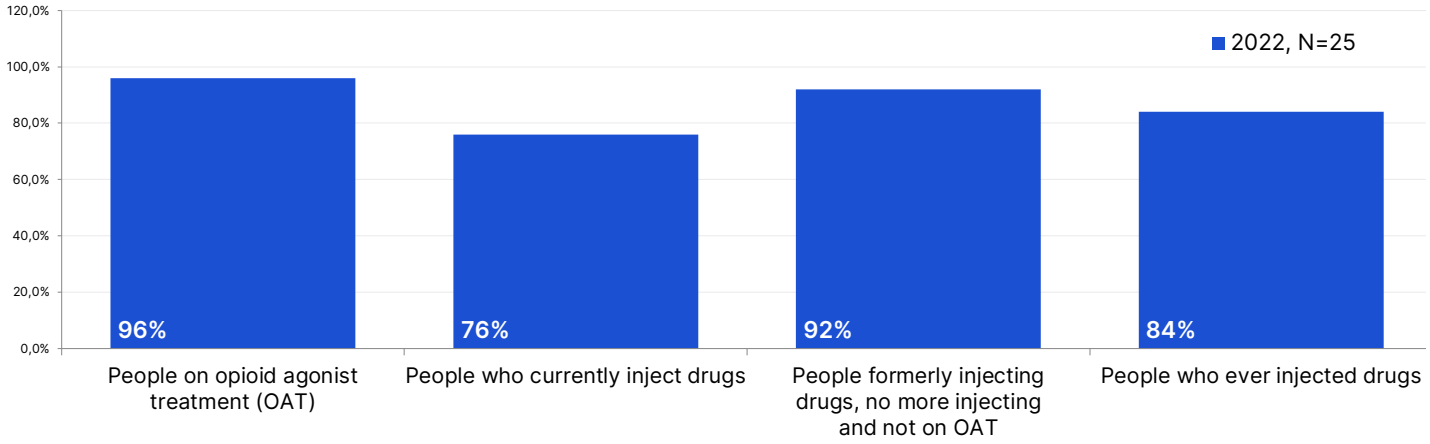
In 2022, as in 2021, the new drugs for HCV treatment (direct acting antivirals, DAAs) were available in all cities. DAAs were accessible without restrictions in 19 cities[13] (63%) and with restrictions in 9 cities (30%). A list of reported restrictions is presented below (see Figure 10).

Figure 9. Are the new drugs for the treatment of hepatitis C (direct-acting antivirals, DAAs) accessible in your city?



13. In 2019, DAA's were unavailable in North Macedonia but are now available.

Figure 10. In case the guidelines allow the use of direct-acting antivirals (DAAs) for people who inject drugs, are they applicable to.

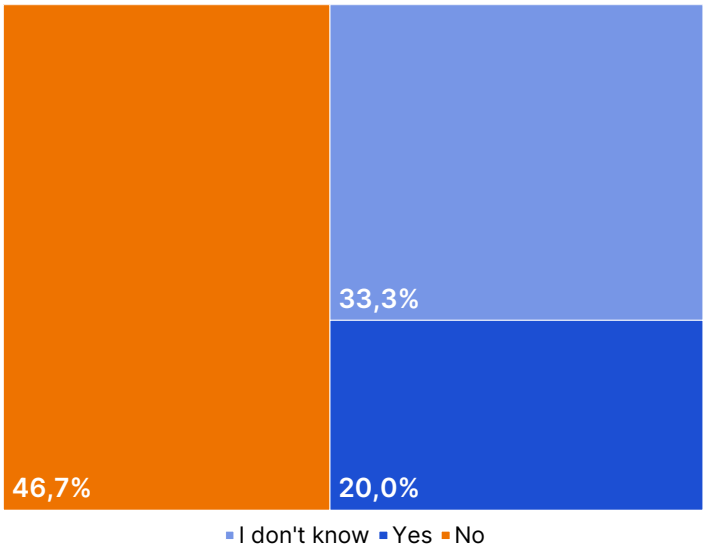


ARE DAAS USED ACCORDING TO OFFICIAL POLICY?

The great majority (83%) of respondents reported that in their countries DAAs are used according to the official policy, but there were also two cities where there is a discrepancy between policy and practice: in Helsinki, it was reported that "Treatment at needle exchange programmes is yet only a pilot phase"; in Milan, it was noted that "In practice, some doctors discriminate against active drug users because they have doubts about their adherence to treatment and think they might get re-infected. It must be highlighted that many doctors follow the official policy". FPs from Paris and Riga did not know if DAAs are used according to the official policy.

This year, the survey contained a new question asking if stigma and discrimination at point of care towards people who inject drugs were monitored and addressed (see Figure 11, below). Respondents from Amsterdam, Barcelona, Berlin, Glasgow, London and Tallinn - 20% of all cities - reported that this was the case but did not provide any further information on how stigma was being monitored and addressed.

Figure 11. Is stigma and discrimination at point of care towards people who inject drugs being monitored and addressed in your city? (%, n=30)

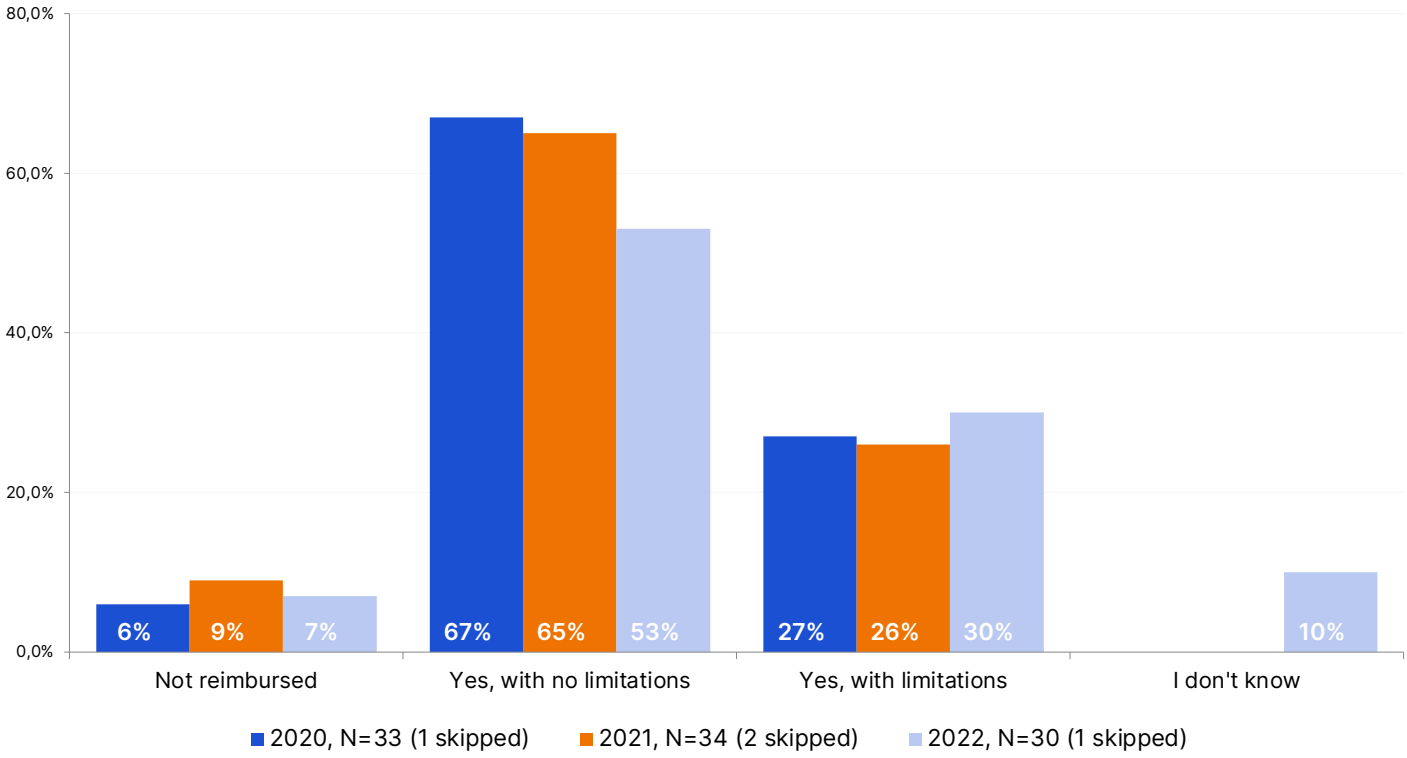


WHO IS PAYING FOR HCV TREATMENT?

HCV treatment with DAAs was reported to be reimbursed by health insurance or the public health service in almost all countries. Only in Albania were the cost of DAAs not reimbursed. In 2022, treatment with the new drugs is reimbursed with no limitations in 17 cities/countries (57%; was 65% in 2021) and with limitations in nine cities/countries (30%). FPs from North Macedonia, Luxembourg and Latvia did not know if treatment is reimbursed.

This year, for the first time, FPs were also asked if treatment with DDAs is reimbursed for people who inject drugs without insurance[14]. Out of those 29 countries who answered this question, treatment is also reimbursed without insurance in nine countries. In 10 countries – Albania, Austria, Estonia, Lithuania, North Macedonia, Poland, Slovakia, Slovenia, Sweden and Switzerland – it is not. In six countries, there were limitations on reimbursement, such as allowing it only at special services or in urgent medical care. Four FPs answered that they do not know.

Figure 12. Is treatment with the new drugs for hepatitis C (DAAs) reimbursed?



14. In 2022, for the first time, respondents were given the opportunity to also answer, "I don't know", and 10% of respondents chose this option.

CHANGES IN THE CONTINUUM-OF-CARE

A well-functioning continuum-of-care, including provision of low threshold and harm reduction services, is important for accessibility and impact of HCV testing and treatment. It is crucial to improve the low uptake of HCV testing and treatment among people who inject drugs by also including harm reduction services in the continuum. The C-EHRN monitoring survey contains questions asking how the continuum-of-care is functioning in different countries and regions.

As Figures 13 and 14 (below) show, the general development picture is that testing has not increased in 2022. Quite the contrary, it has decreased in many services. For quick testing, there was an increase only in self-testing and at GPs. For confirmatory testing, there was an increase of testing only in prison settings.

Figure 13. Proportion of cities performing quick hepatitis C testing for people who inject drugs at various settings in the years 2020, 2021 and 2022

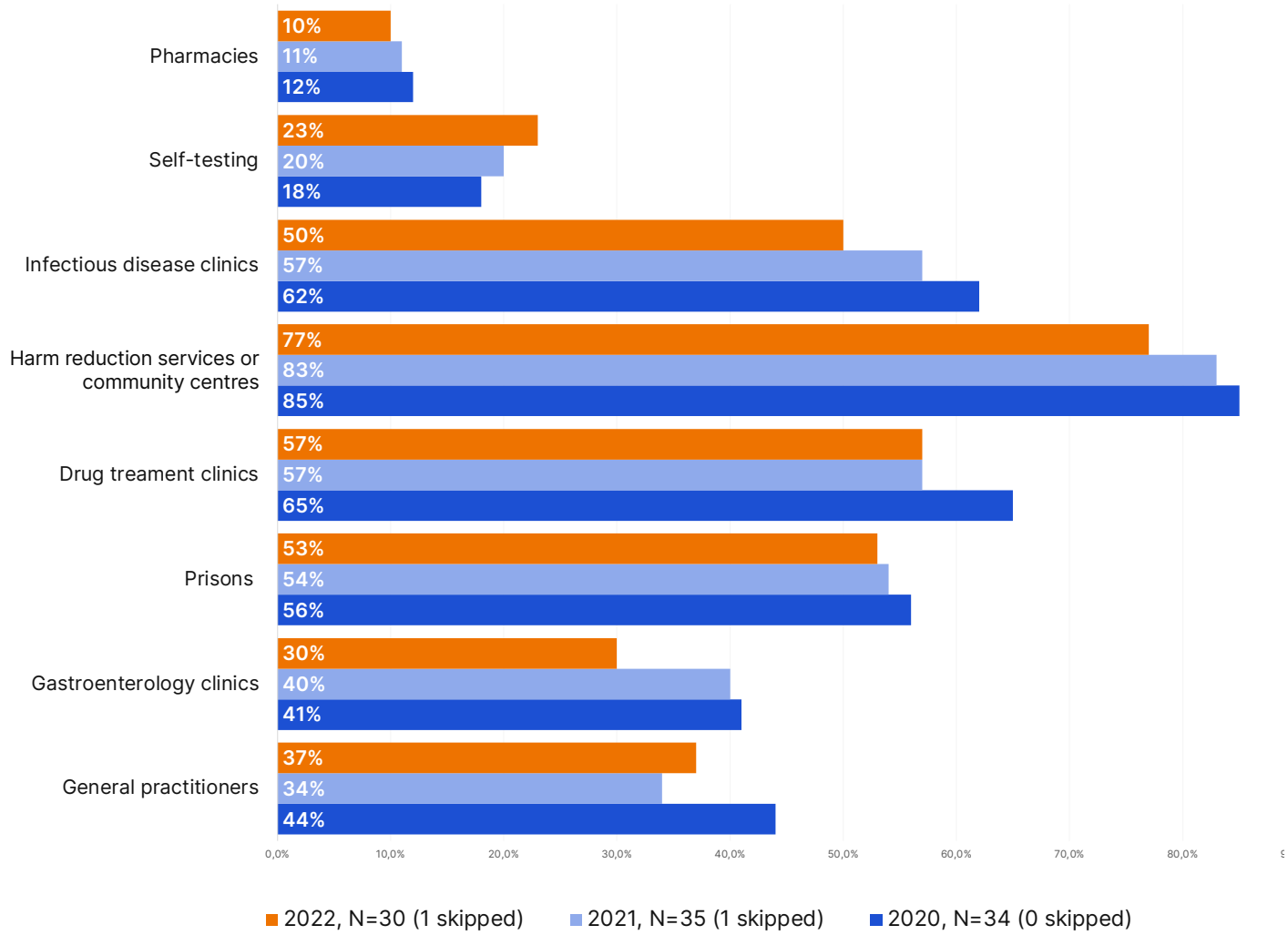
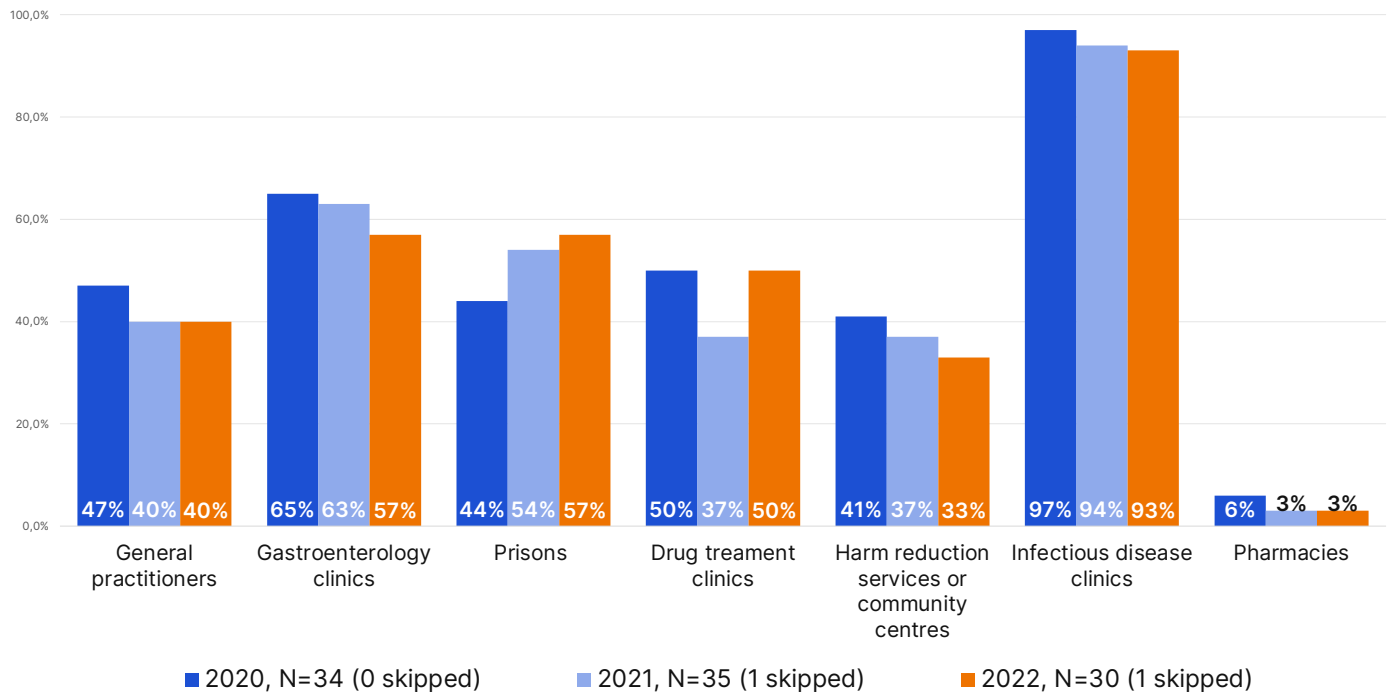


Figure 14. Proportion of European cities performing confirmatory hepatitis C testing of people who inject drugs at various settings during 2020-2022 .



In 2022, for the first time, FPs were asked if free testing is available in their country. 18 FPs (64%) reported free testing in general and 9 (32%) only at specific testing points. Only in North Macedonia is free testing unavailable, and paid testing always requires a prescription.

It is important that facilities offering testing are able to offer both HCV testing and treatment. However, from the results obtained, it can also be concluded that the integration of testing and treatment at the same location is still too rarely the case.

Figure 15. Is free HCV testing available for people who inject drugs in your country? (N=28).

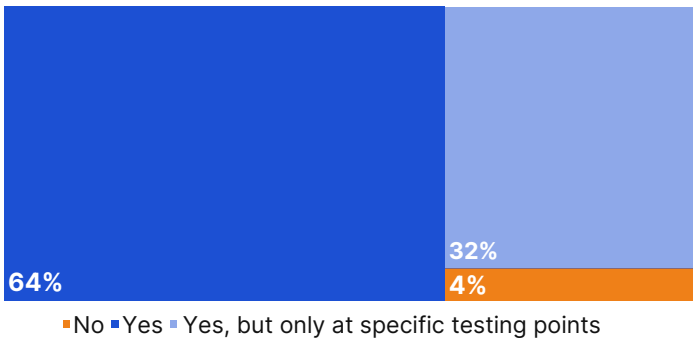


Figure 16. Does HCV testing for people who inject drugs require a prescription? (N=30)

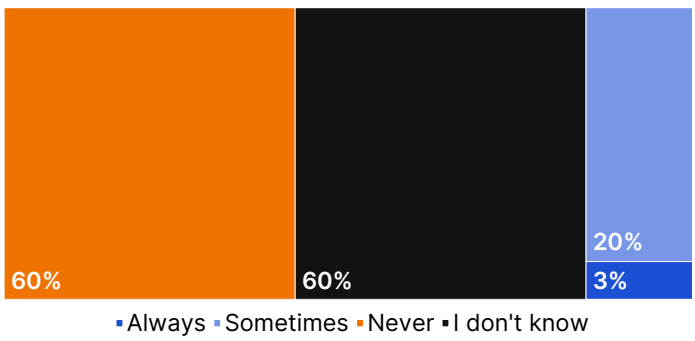


Figure 17. Where can HCV-infected people who inject drugs perform a non-invasive diagnostic procedure for the evaluation of the stage of liver disease (i.e. Fibroscan®)?

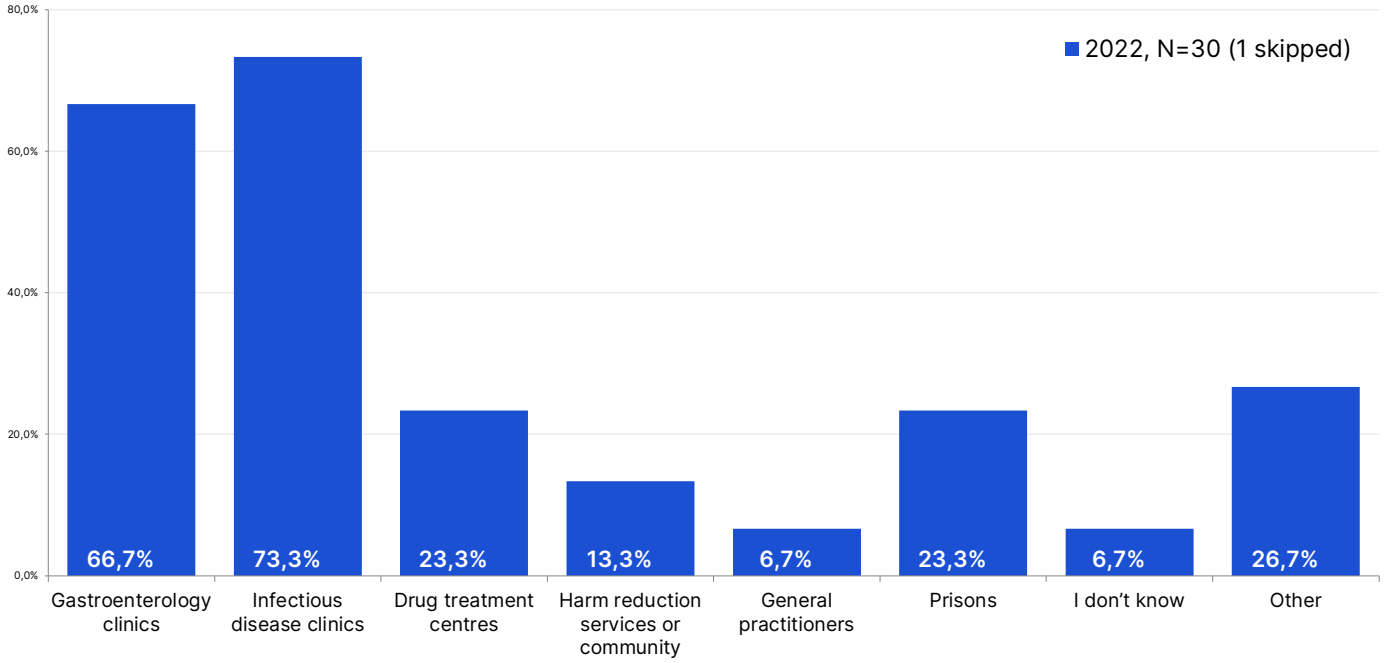
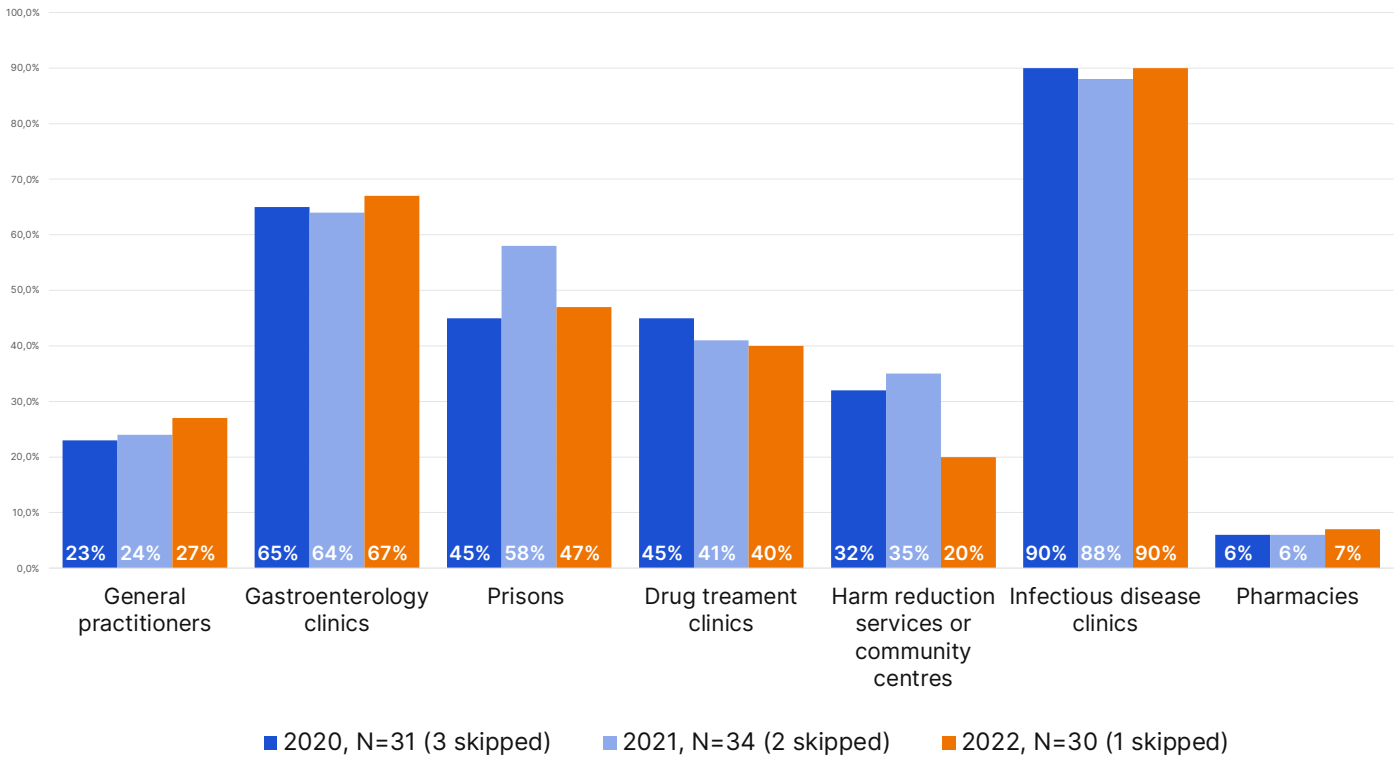


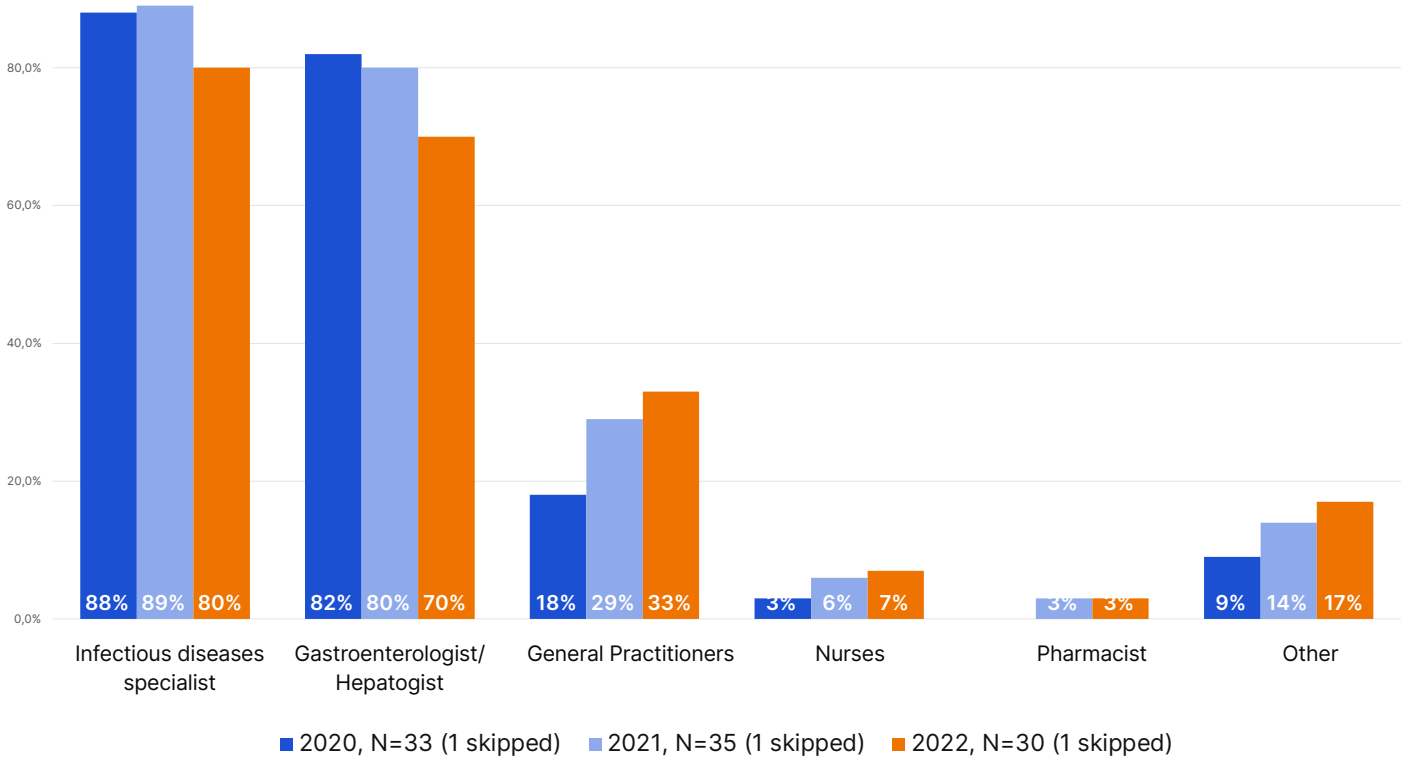
Figure 18. Proportion of European cities providing hepatitis C treatment for people who inject drugs at various settings during 2020-2022



Each year, people who inject drugs have been most commonly treated for hepatitis C at infectious disease clinics and gastroenterology clinics. In 2021, treatment provided at harm reduction services or community centres decreased from 35% to 20% (see Figure 18).

Figure 19 (below) shows that GPs can increasingly prescribe DAAs. In the answer category "other", it mentions that DAAs are prescribed in certain institutions, such as drug treatment clinics and public hospitals by various professionals.

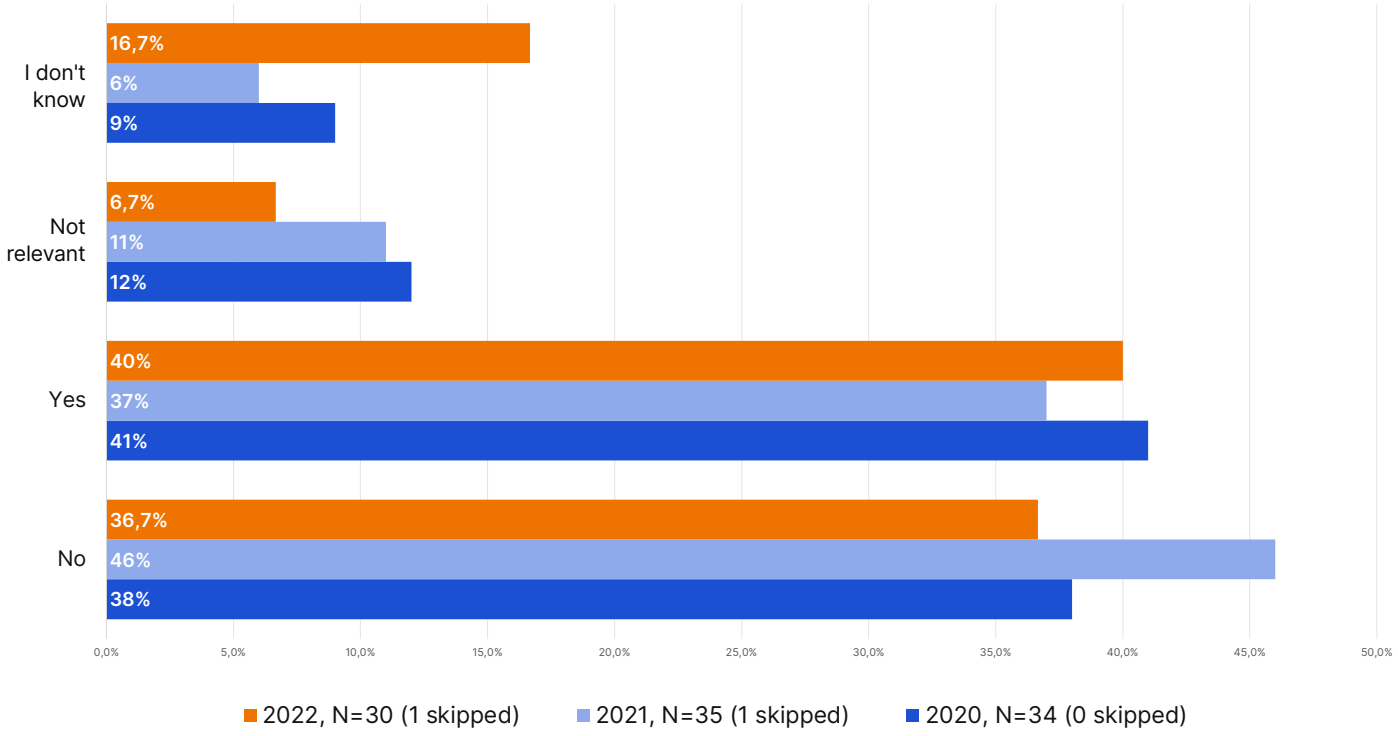
Figure 19. Who can legally prescribe direct acting antivirals (DAAs)?



ARE THERE WRITTEN GUIDELINES FOR THE LINKAGE-OF-CARE?

Respondents were asked if the linkage-to-care for people who inject drugs is achieved by a written protocol or guideline (see Figure 20). More concretely, they were asked to assess if there is, for instance, an agreed protocol to refer clients from harm reduction services to other treatment and care systems. Comparing three years, no positive development can be seen. For 2022, respondents from six cities (17%) could not make an assessment.

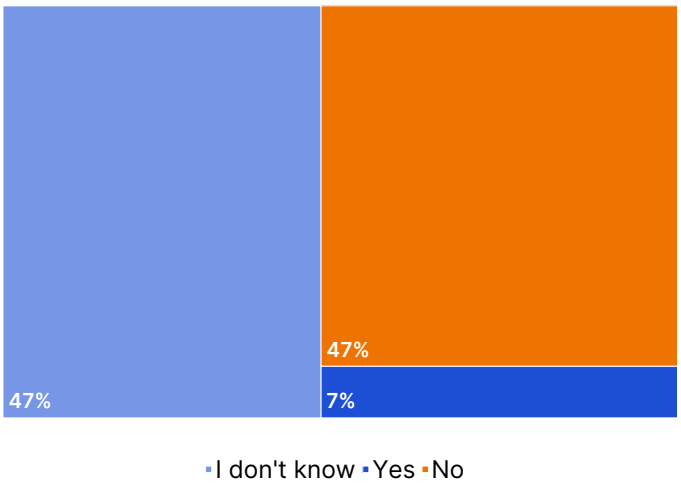
Figure 20. Is linkage-to-care for people who inject drugs achieved by a written protocol/guidelines? Think of an agreed protocol to refer clients, e.g. from a HR service to other treatment and care.



MONITORING OF PEOPLE WHO INJECT DRUGS WITH HCV

There was a new question in 2022 asking whether there are monitoring schemes in place for the post-diagnosis follow-up and monitoring of people who inject drugs with HCV to avoid liver damage and prevent liver cancer. In almost half of the cities, such schemes existed; in the other half, the respondents did not know if they existed.

Figure 21. Are monitoring schemes in place for post-diagnosis follow-up and monitoring of people who inject drugs with HCV to avoid liver damage and prevent liver cancer?[15]



15. New question in 2022.

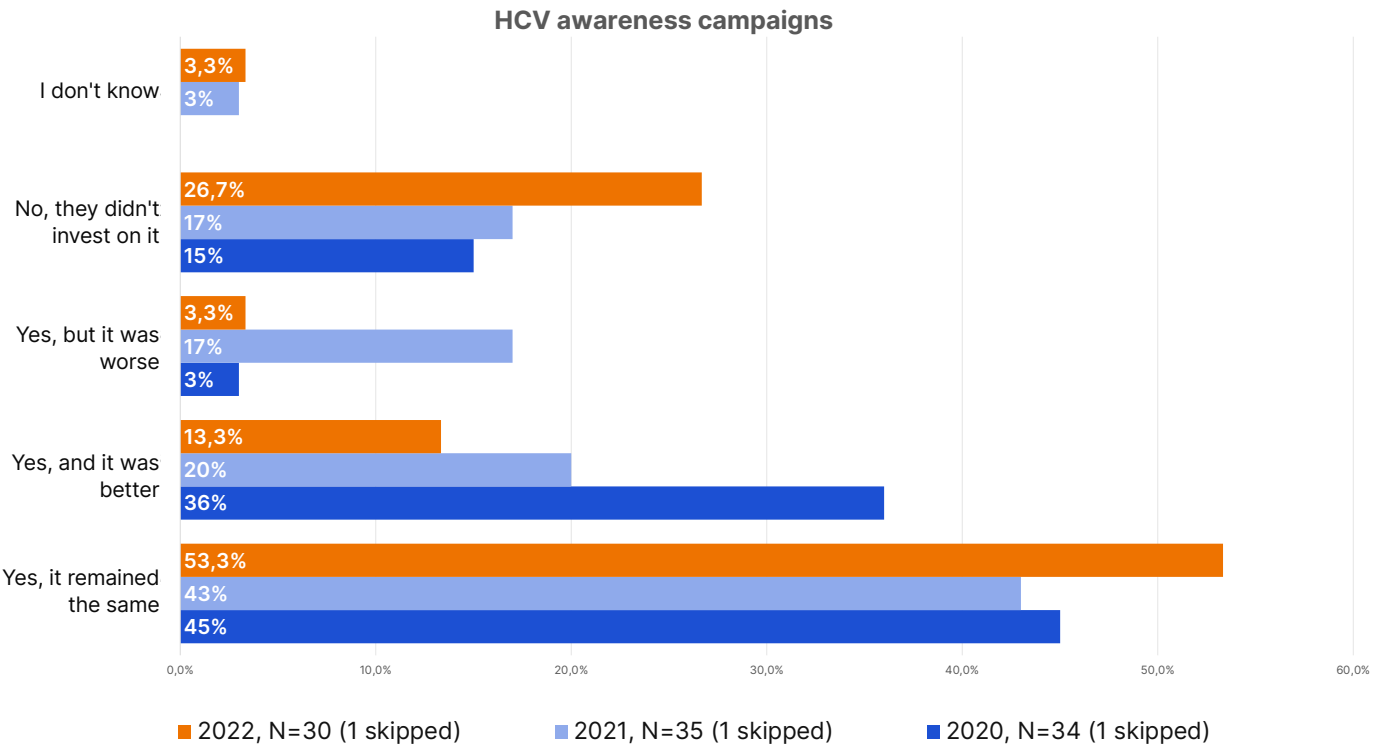
MORE OR LESS ACTION AND COORDINATION ON HCV?

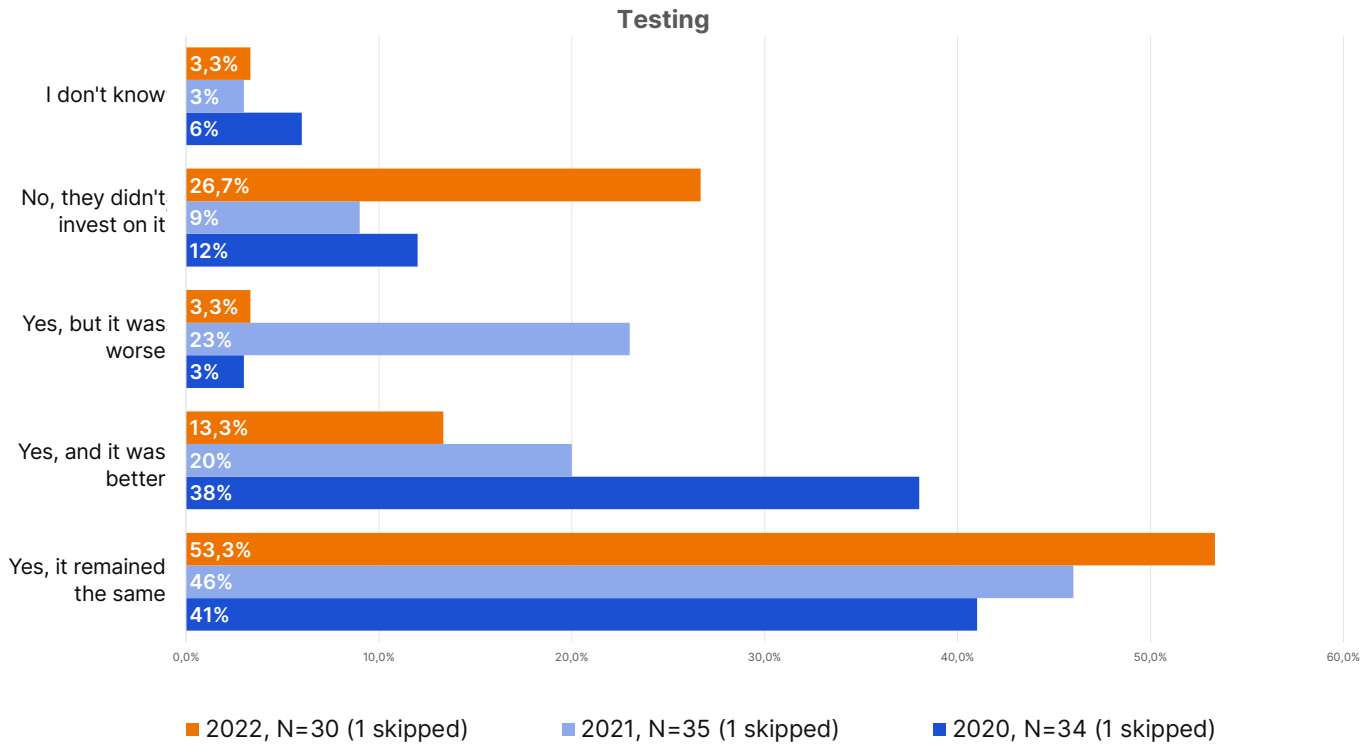
FPs were also asked to compare the changes in HCV activities between 2020, 2021 and 2022: if providers of service for people who inject drugs in their country invested more or less attention to HCV awareness campaigns, testing at their own location, and treatment at their own location? The general picture from two years of the COVID-19 pandemic (2020-2021) is that not much positive progress can be seen.

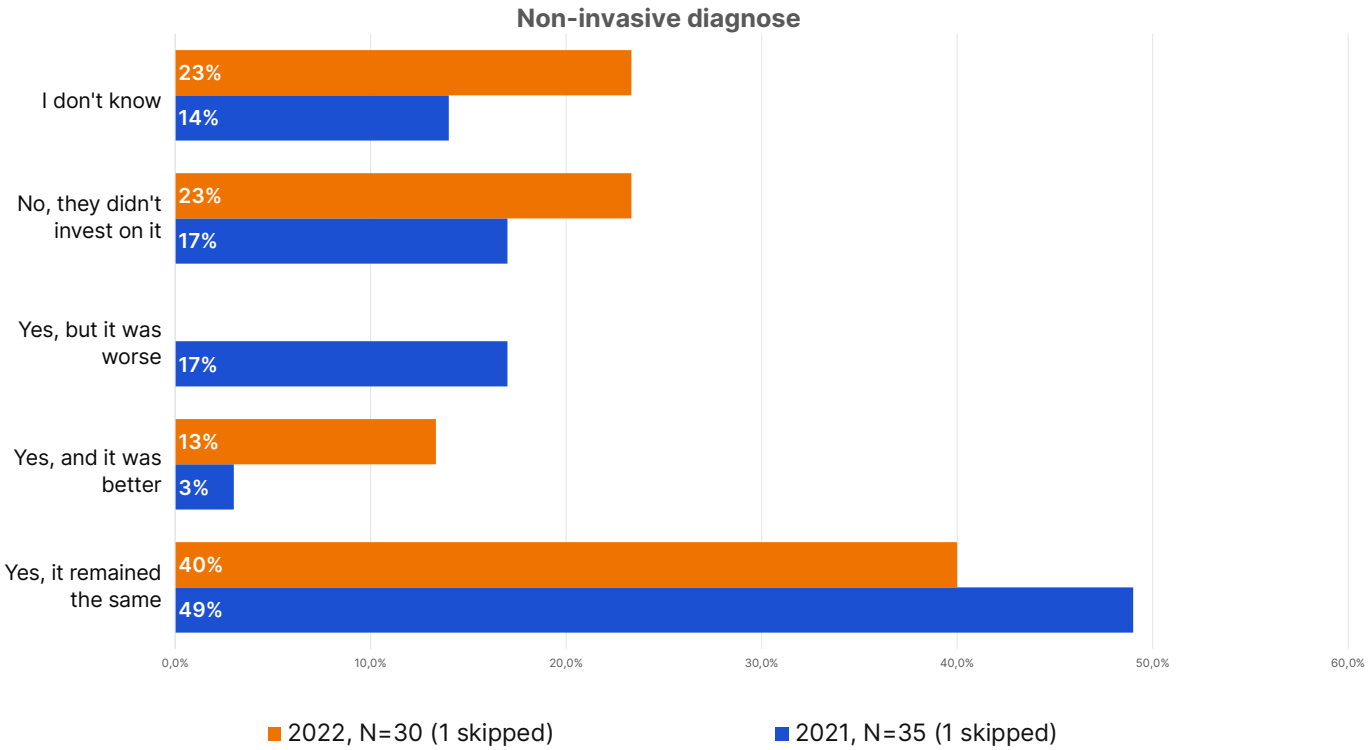
In 2021 compared to 2020, the situation had deteriorated in eight cities for testing and in six cities for other dimensions. In 2022, the situation remained much the same, although there was improvement in nine cities for testing and in seven cities for treatment (See Figure 22).

When asked about progress in coordination between health and social care providers (especially NGOs and harm reduction services), in many cities and in all dimensions (information sharing, communication, service provision) the situation has remained the same in 2022 compared with 2021. Again, not much positive development can be seen (see Figure 23).

Figure 22. Compared to the previous year, have service providers for people who inject drugs in your city invested attention during this year to the following?




Testing
I don't know
No, they didn't invest on it
Yes, but it was worse
Yes, and it was better
Yes, it remained the same
3,3%
3%
6%
26,7%
9%
12%
3,3%
23%
3%
13,3%
20%
38%
53,3%
46%
41%
0,0%
10,0%
20,0%
30,0%
40,0%
50,0%
60,0%
2022, N=30 (1 skipped)
2021, N=35 (1 skipped)
2020, N=34 (1 skipped)


Non-invasive diagnose
I don't know
No, they didn't invest on it
Yes, but it was worse
Yes, and it was better
Yes, it remained the same
23%
14%
23%
17%
17%
13%
3%
40%
49%
0,0%
10,0%
20,0%
30,0%
40,0%
50,0%
60,0%
2022, N=30 (1 skipped)
2021, N=35 (1 skipped)

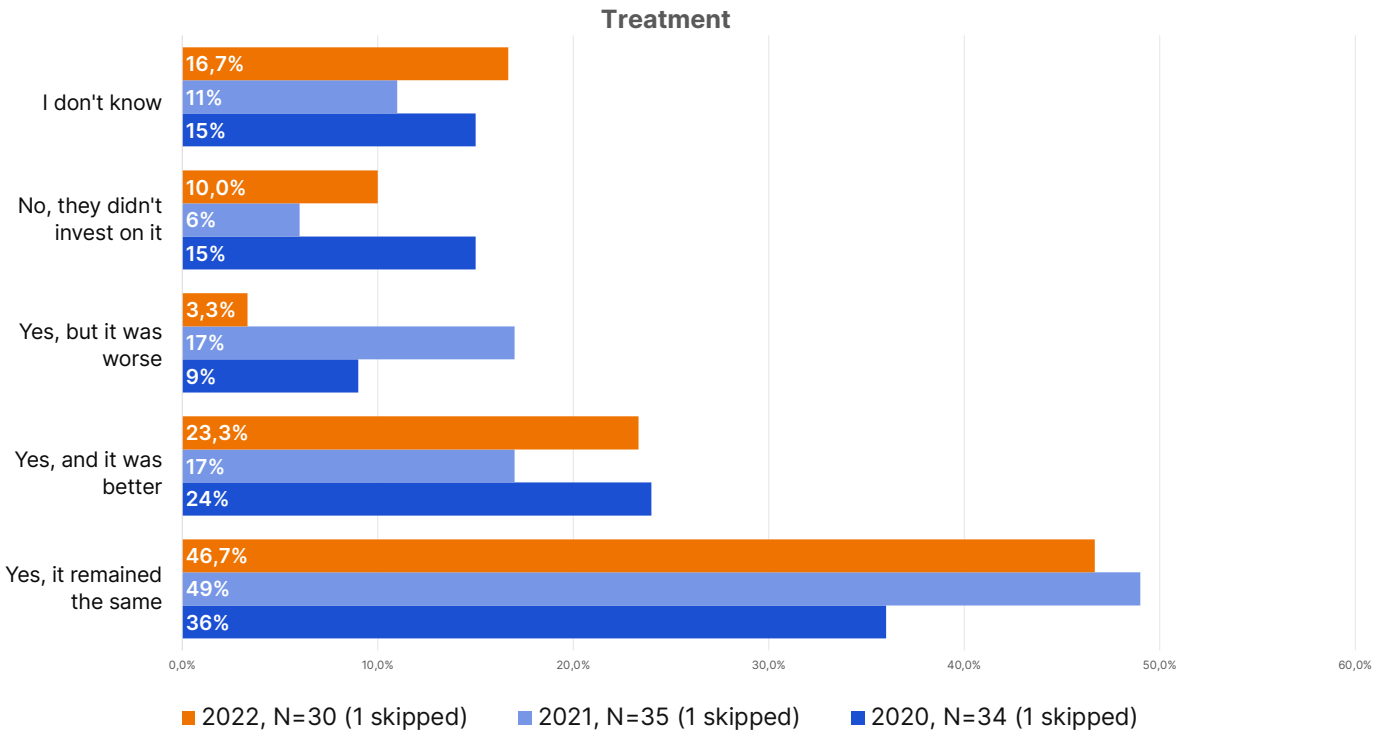
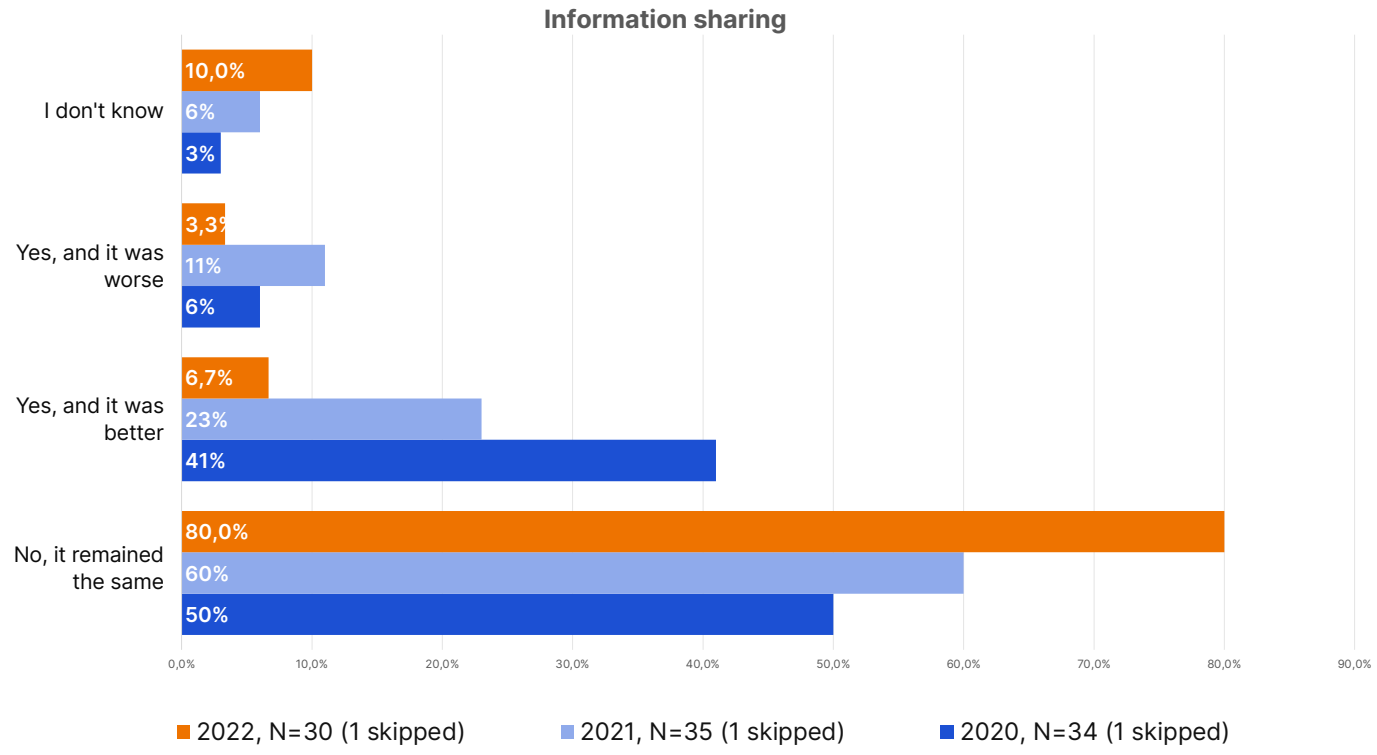
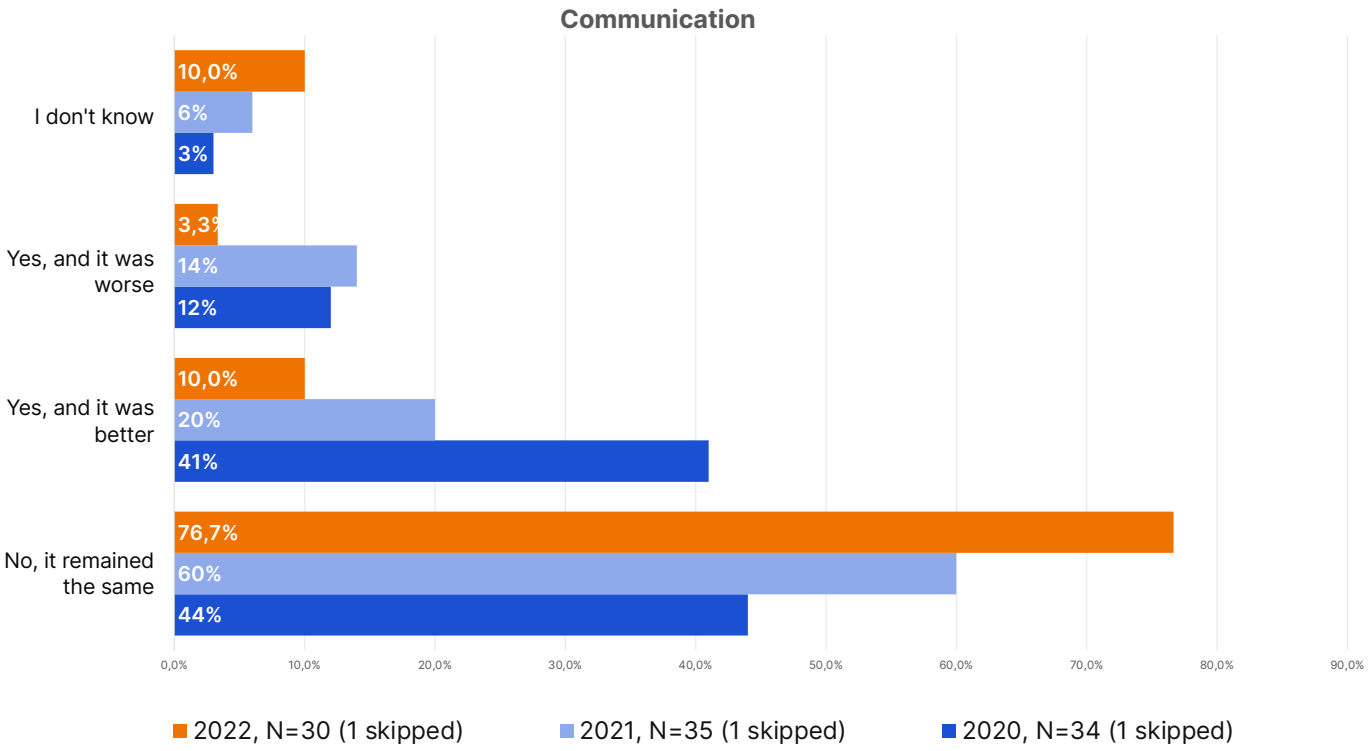
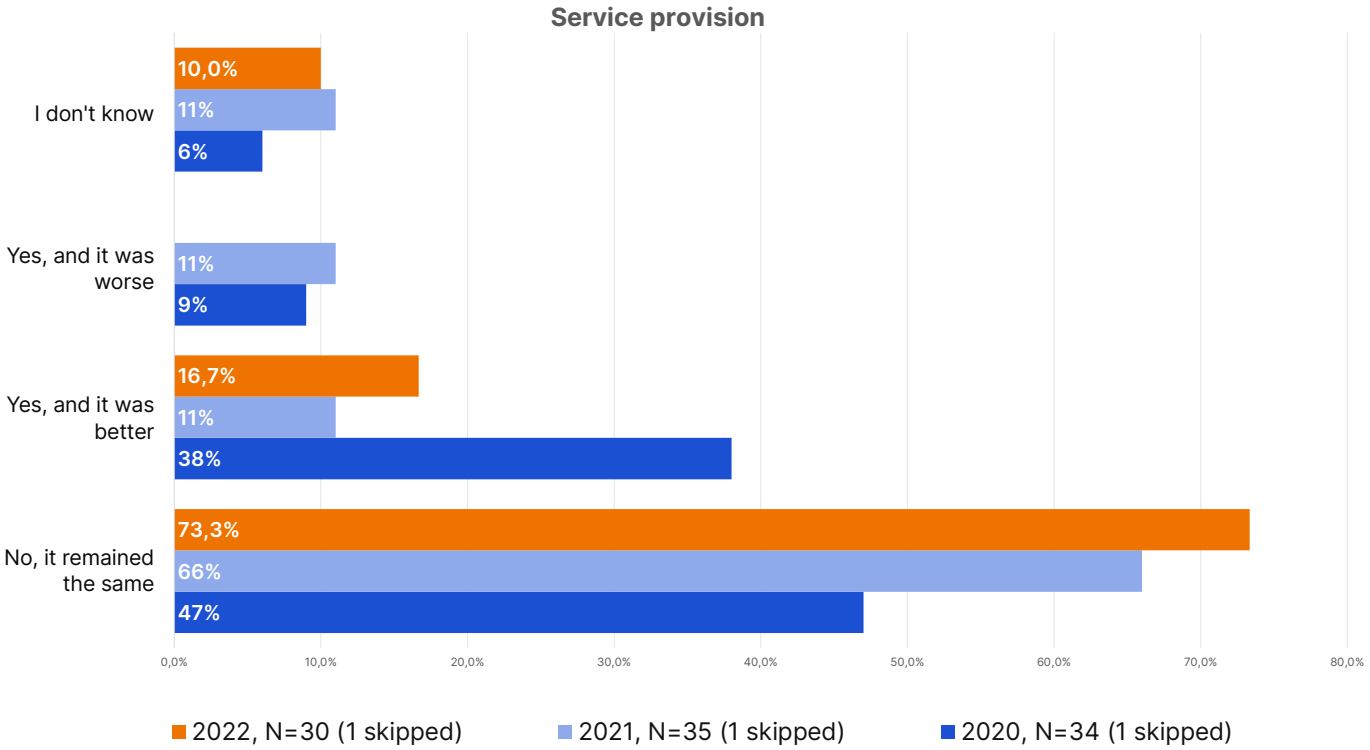


Figure 23. Compared to last year, did the coordination change this year between health care providers (GPs, clinics) and social service providers (like NGOs, HR services) regarding HCV?




Communication
I don't know
Yes, and it was worse
Yes, and it was better
No, it remained the same
10,0%
6%
3%
3,3%
14%
12%
10,0%
20%
41%
76,7%
60%
44%
0,0%
10,0%
20,0%
30,0%
40,0%
50,0%
60,0%
70,0%
80,0%
90,0%
2022, N=30 (1 skipped)
2021, N=35 (1 skipped)
2020, N=34 (1 skipped)

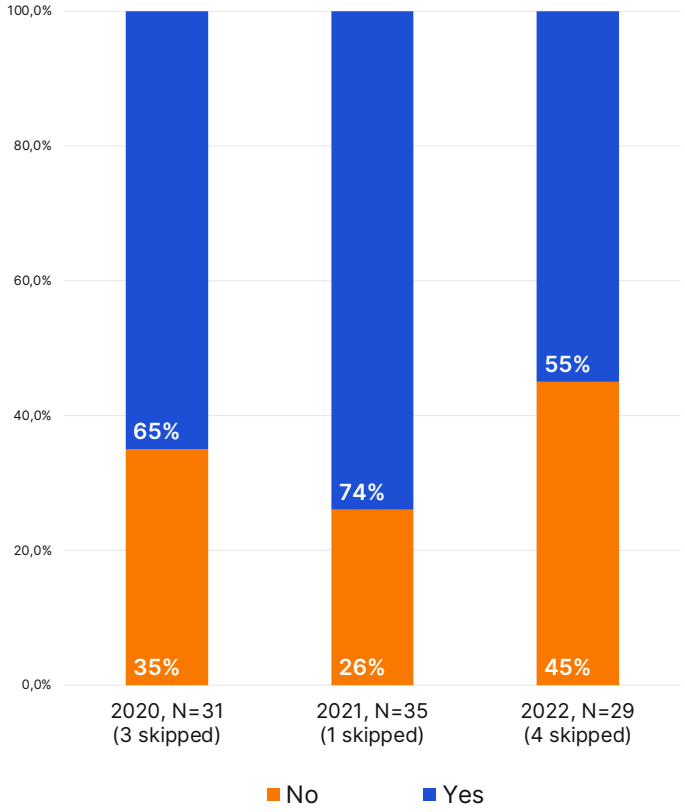

Service provision
I don't know
Yes, and it was worse
Yes, and it was better
No, it remained the same
10,0%
11%
6%
11%
9%
16,7%
11%
38%
73,3%
66%
47%
0,0%
10,0%
20,0%
30,0%
40,0%
50,0%
60,0%
70,0%
80,0%
2022, N=30 (1 skipped)
2021, N=35 (1 skipped)
2020, N=34 (1 skipped)

THE ROLE OF HARM REDUCTION ORGANISATIONS

FPs were asked if there are limitations for the harm reduction organisations in addressing HCV in their cities. Compared to previous years, less cities (17) reported limitations in 2022. When referring to limitations, the most frequently mentioned included, for example, a lack of funding and staff, the lack of care integration, and lack of political support.

Among the recognised limitations for addressing HCV, most common were a lack of integration with health care, the lack of funding, a lack of staff and the lack of political support.

Figure 24. Are there limitations for harm reduction organisations in addressing HCV in your city?



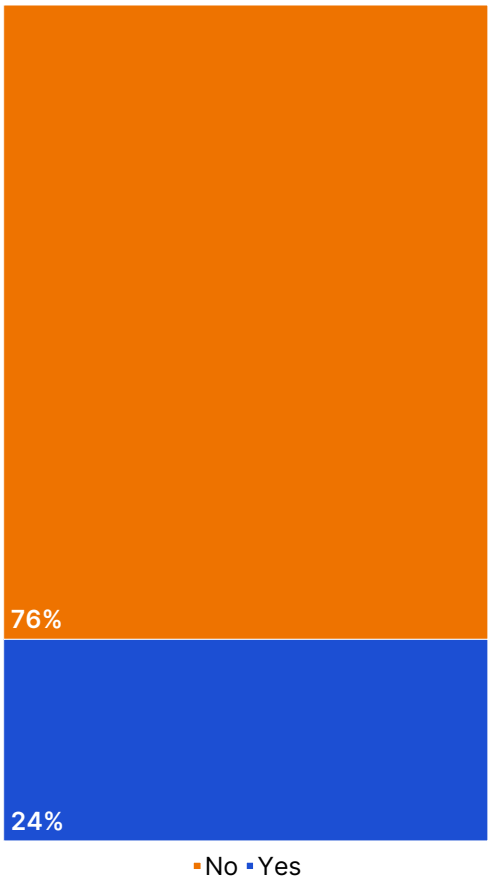
IMPACT OF COVID-19

Many cities still reported on the negative effects of the COVID-19 pandemic. However, details of the effects were not asked in this year's survey unlike in the previous two years when the survey included a separate question on patterns of impact of the pandemic. Data from 2020 and 2021 showed that harm reduction services, their clients and workers were severely affected by pandemic-related restrictions, both regarding their working/living conditions, and general wellbeing. As Figure 25 For this question, FPs were asked to provide additional information on the impact of the pandemic and on how the services have, or have not, recovered from it. Many FPs described how services in their cities had suffered from the pandemic, but now the situation has eased.

For instance, in Estonia, “testing in harm reduction had been interrupted only in the first half of 2020, when COVID had just arrived in Estonia. All services were restored quickly, including testing, and there were no further issues.” In Greece, “the pandemic brought huge disruption to services in 2021. Things are far better now”. Or in England, where “there has been a major improvement in this last year compared to the previous year. The previous year (20/21) presented a large number of limitations due

to national lockdowns. Whilst this year (21/22) has not quite resumed to 'normal' (pre-pandemic), staff enthusiasm and commitment from drug services is very high. Ongoing issues relating to the pandemic include staff absences / sickness / staff loss which continues to impact day-to-day services."

Figure 25. Does the COVID-19 pandemic continue to disrupt HCV testing and treatment services delivered by organisations serving people who inject drugs and harm reduction services?



CONCLUSIONS

In Europe, people who inject drugs represent the majority of new cases of HCV infections, yet HCV testing and treatment for them remains insufficient. To achieve the HCV elimination goal by 2030, a continuum-of-care for people who inject drugs must be implemented and monitored.

There are still major barriers to the scale-up of services and the achievement of elimination targets. These include, for example, restrictions around DAAs and the cost of testing and treatment. There is also a lack of progress in relation to the simplification of the care pathway, task shifting, and community access. Moreover, COVID-19 continues to impact the already stretched services. CSO engagement in HCV awareness, testing and treatment for people who inject drugs remains high. There are, however, major shortfalls in the provision of those services which were additionally decreased during the COVID-19 pandemic.

The good development to achieve the HCV elimination goal has stopped during the pandemic. It is now necessary to get the good development back on track. As part of that, CSOs in the field of harm reduction must be actively engaged in the planning and implementation of the HCV continuum-of-care, and in monitoring progress towards the HCV elimination goals.

4

NEW DRUG TRENDS

INTRODUCTION

The continued appearance and use of New Psychoactive Substances (NPS) on global and European markets remains a major concern for policymakers, law enforcement officers and CSOs working in the field. International agencies have warned of potential health risks for quite some time [1-5]. Indeed, the number of new drugs entering the market every year remains stable and high (in 2021, 52 NPS were identified for the first time within the EU).

Although the body of knowledge regarding NPS is growing, essential information about most of these novel substances is still lacking, such as their effects, side-effects, and risks, etc. Given that CSOs work closely with people who use drugs, in principle they are among the first to observe and detect the emergence and use of new substances by their target groups and, thus, are able to gather essential information about these new substances, information which is difficult to gather by, for example, scientists, or law enforcement officials. New approaches in this field are needed to regularly update existing data on new drug trends and drug use patterns. Harm reduction and community organisations working closely with people who use drugs must play a pivotal role in identifying new drug trends.

Therefore, it is considered important and of significant added value to establish a mechanism to identify, monitor and report on emerging drug trends at a much more rapid pace. The fact that the data collected by C-EHRN may be anecdotal, small-scale, or is appearing for a short period of time, is considered not as a limitation but as complementary to other data sources.

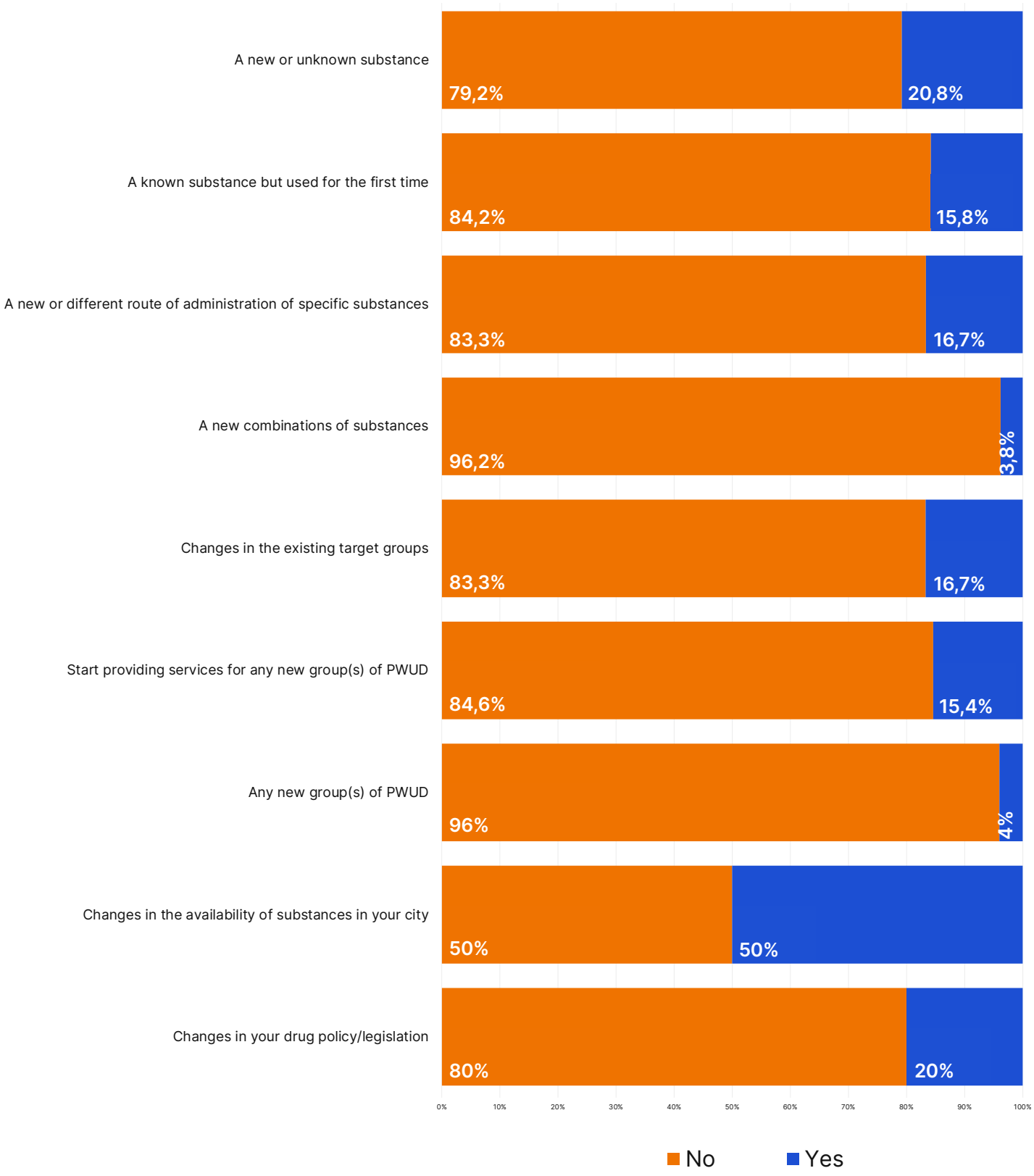
Prompt feedback from CSOs on drug trends is useful intelligence. This is intelligence which has been identified and responded to locally; intelligence which may, or may not, have been fed up through national structures; and intelligence which, in time, can be compared and contrasted with empirical data from official sources.

This chapter looks at the emergence of new substances on local markets of the cities where C-EHRN Focal Points (FPs) are located, but also at other developments regarding the use of ('traditional') drugs, such as new patterns of drug use, new routes of administration, the use of known substances by a different group of people who use drugs, or the combined use of different substances (new and/or known). Hence, the focus of this activity includes a broader field than just the use of new drugs such as NPS.

RESULTS

Below are the highlights gained from the monitoring of New Drug Trends in 2022 that includes both responses to the questionnaire and outcomes of focus group discussions (FGDs).

Figure 26. The proportion of Focal Points reporting specific new drug trends in 2022.



A NEW OR UNKNOWN SUBSTANCE

We have asked FPs to respond if, in the previous year, they have witnessed any new developments regarding the use of drugs in their city amongst their target groups; more specifically, the emergence of a new or unknown substance. The majority of responses mentioned that no changes were witnessed, although 5 FPs did report changes. This is roughly half of the number of FPs that reported new developments regarding the emergence of a new or unknown substance last year (then 10 out of 34 responses). This year, 5 FPs reported a total of 8 substances: NPS (4x), crack (2x), and GHB (1x) and methamphetamine (1x). In addition, the FGD gained intelligence on the rapidly changing crack cocaine market in Dublin (Ireland) (and beyond).

In the cities of 5 FPs, new substances were noted among a known target group. The FP in Vienna (Austria) mentioned that cannabis users starting to involuntarily use synthetic cannabinoids as cannabis is polluted with this substance. In Bern (Switzerland), users mainly in the western French-speaking part of Switzerland started to use crack and as a second new substance the same groups started to use methamphetamine.

> ***"Methamphetamine was formerly used as Thai pills in red light milieu (certain "hotspots") but since 2 or 3 years it is also used by other people who use drugs such as crystal meth and it gained importance during the pandemic."*** **- FP Bern**

In Tallinn (Estonia), street opioid users started to use a substance with the supposed content of metonitazene, which is often sold as fentanyl but also as a new substitute for fentanyl-like drugs. The Amsterdam (Netherlands) FP reports several new or unknown substances in use by different groups: MSM started to use 3-CMC; crack cocaine appeared in the gay community during the COVID pandemic by the end of 2021; and GHB by younger people, by opiate users, and by people in social shelters.

The London (UK) FP notes an increase of people who use opiates who started to use isotonitazene (Iso).

> ***"This (isotonitazene)...entered into the market unknowingly (i.e. iso-contaminated heroin) and, for a minority, isotonitazine was knowingly consumed as an alternative to poor quality heroin."*** **- FP London**

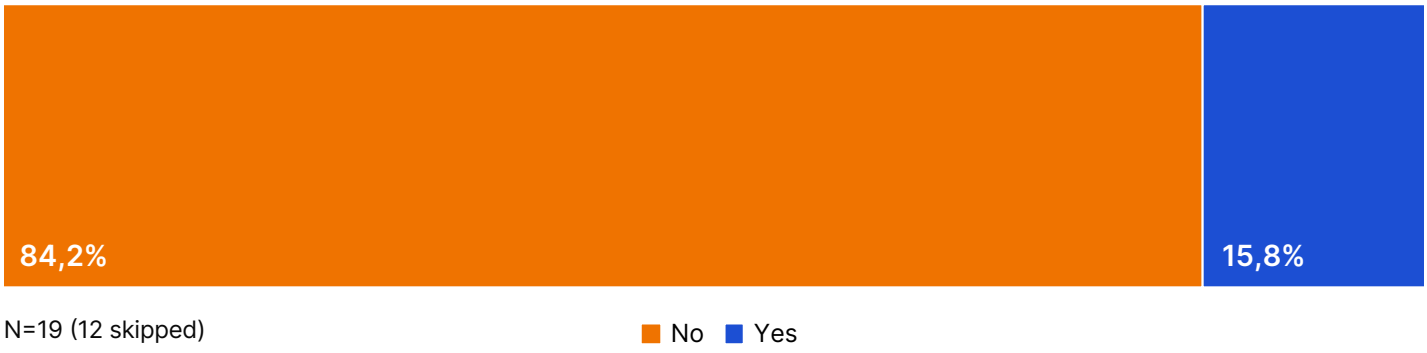
In Dublin (Ireland), crack cocaine is increasingly being used and also among the group of methadone and heroin users.

> ***"There is a big increase in demand for crack pipes. Polydrug use clients, often taking injecting equipment to use heroin after smoking crack cocaine. We notice an increase in clients with breathing problems, burnt hands and such. Many experienced dramatic loss in weight."*** **- FP Dublin**

In conclusion, only a few FPs reported the emergence of a new substance in their city in the past year. It is unclear whether these findings relate to a stable local drug market or that there are other factors contributing to this. However, the low number of FPs reporting new substances is in line with previous monitoring years.

Figure 27. Changes in drug use in your city. In the previous year, have you witnessed any new developments regarding the use of drugs in your city amongst your target group(s): (a). The emergence of a new or unknown substance?

Figure 28. In the previous year, have you witnessed any new developments regarding the use of drugs in your city amongst your target group(s): (b). The emergence of a known substance but used for the first time among (one or more of) your target groups?



A KNOWN SUBSTANCE BUT USED FOR THE FIRST TIME BY A SPECIFIC GROUP

We have asked FPs to respond if, in the previous year, they have witnessed any new developments regarding the use of drugs in their city amongst their target groups; more specifically, the emergence off a known substance but used for the first time among (one or more of) your target groups. The majority of responding FPs (16) mentioned that no changes were witnessed; however, 3 FPs did mention changes. This number is much lower than the number of FPs last year reporting the emergence of a known substance used for the first time by one of the FPs target groups (13 FPs out of 33 responses).

The FP in Berlin (Germany) reports the use of GHB by opioid/cocaine users in public spaces. The Cracow (Poland) FP reports the recent use of clephedrone (4-CMC), 3-CMC, and methamphetamine by opiate intravenous users.

The Greek FP (covering Athens and Thessaloniki) reports the use of GBL (similar to GHB but much more concentrated) and further reports MDA use replacing MDMA in the same club settings.

In conclusion, the target groups of most C-EHRN FPs have not seen changes in the substances used by any of their target groups. This might also indicate that changes in the drug markets do not come overnight.

> ***"GBL use was transmitted to the club subculture from a specific part of the gay community and became popular. Now it appears dynamically in club settings for a mixed crowd, including the heterosexual audience. MDA is much cheaper than MDMA and much stronger."***
> **FP Athens/Thessaloniki**

Figure 29. In the previous year, did you witness in your target group(s) the emergence of a new or different route of administration of specific substances?

N=24 (7 skipped)

A NEW OR DIFFERENT ROUTE OF ADMINISTRATION OF SPECIFIC SUBSTANCES

The majority of responding FPs (20) mentioned that no changes were witnessed, but 3 FPs did – less than half of the number of FPs reporting the emergence of a new or different route of administration last year. Additionally, we gained some information from the FGD with FP Dublin (Ireland) and FP Budapest (Hungary).
New or different routes of administration of specific substances were witnessed by 4 FPs:

The Cyprus FP noted the use of LSD by young people via eye drops; the Berlin FP (Germany) reported the use of fentanyl patches by opiate users, and the Amsterdam FP (Netherlands)

reported the use of 3-MMC in the chemsex scene by injection, snorting and booty bumping (I,e. the use of a syringe but without the needle).

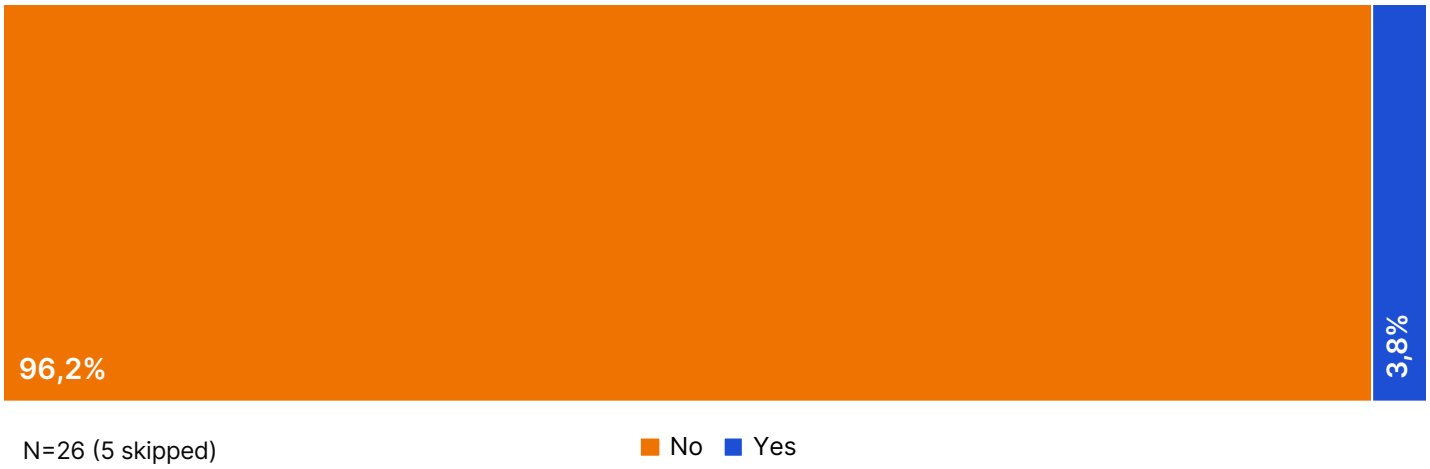
> ***"In the chemsex scene...3-MMC is injected, snorted and through booty bumping [administered via a syringe but without the needle, ed.]. Reasons for this are the stronger flash/rush because of group pressure, and as a result of the normalisation of slamming [injecting methamphetamine, ed.]."*** **- FP Amsterdam**

The FGD with the FP Budapest (Hungary) learned that the injecting of drugs had decreased somewhat over recent years while, at the same time, smoking and sniffing had increased in the same group.

Those FPs reporting new routes of administration shed an interesting light on the route of administration, such as booty bumping that seems a rather new route while eye drops as an administration route is not new, but is not often heard about.

> ***"Those who injected before now probably inject less often than in the middle of the 2010 decade. So, it's like there was a slight decrease in injecting...To the market, adjusted to the market and uh, mostly the cheapest and most available stuff, synthetic cannabinoids mixed with tobacco, so they smoke it. Sometimes they have access to synthetic cathinones, so they sniff it or they snort it or they may even inject it."***
> **FP Budapest**

Figure 30. In the previous year, did you witness in your target group(s) new combinations of substances?



NEW COMBINATIONS OF SUBSTANCES

We have asked FPs if in the previous year the witnessed in their target group(s) new combinations of substances. The majority of responding FPs (25) mentioned that no changes were witnessed. A new combination of substances was witnessed only by one FP in Cracow (Poland) that reported the combined use of opioids and methylphenidate by opiate users who previously had used opioids together with amphetamine-type stimulants (ATS).

New combinations of substances in the FP target groups do not occur regularly. This is in line with previous years.

Figure 31. In the previous year, did you witness any changes in the existing target groups you provide services for (e.g. younger, new immigrant groups)?

N=24 (7 skipped)

CHANGES IN THE EXISTING TARGET GROUPS

FPs also responded if they had witnessed any changes in the existing target groups they provide services for. The majority of responding FPs (20) mentioned that no changes were witnessed, but changes in target groups to whom services were provided were noticed by 4 FPs. The Copenhagen FP (Denmark) mentions a reduction in the number of migrant users from the EU.

> ***"Migrant users from the EU left during COVID; some illegal migrants have disappeared due to tighter rules on where they can stay."*** **- FP Copenhagen**

The FP Tallinn (Estonia) reported an increase in young people with mental health comorbidities and polydrug use, while the FP Vilnius (Lithuania) mentioned the appearance of Ukrainian refugees. Finally, the FP Amsterdam (Netherlands) saw more mixing of subgroups in the chemsex scene: swingers, bisexual and straight users, sex workers, and trans people.

When it comes to existing target groups of the FPs, not much change has been witnessed over time. As expected, there is a certain increase in Ukrainian refugees (FP Vilnius) but, on the other hand, a decrease in the number of people who use drugs with an EU migrant background was witnessed (FP Copenhagen).

Figure 32. In the previous year, did you start providing services for any new group(s) of people who use drugs?

N=26 (5 skipped)

SERVICES FOR NEW GROUP(S) OF PEOPLE WHO USE DRUGS

FPs answered if they have started providing services for any new group(s) of people who use drugs in the previous year. The majority of responding FPs (22) mentioned that no changes were witnessed, but changes in target groups to whom services were provided were noticed by 4 FPs.

FP Albania started providing services (MMT, condom and lubricant distribution as well as free rapid-testing for HIV, HCV, HBV, syphilis and gonorrhoea). FP Antwerp (Belgium) reported a new service - an app. - for people engaged in chemsex,

> ***"A smartphone app was designed for people engaging in chemsex. This was done because of the high risk behaviour of this population. This target group is new for our and several other organisations."***
> **FP Antwerp**

For the same group, the FP Amsterdam (Netherlands) noted the set-up of peer outreach among this population. Finally, FP Helsinki (Finland) mentioned the provision of a harm reduction health counselling service on an anonymous social media platform called **Jodel**.

Although not many FPs started new services for people who use drugs, some of the ones who did are related to internet-based services. This may be a promising alternative for reaching out to groups of people who use drugs that are not easily reached, such as young, closed communities of people who use drugs who use NPS and/or are engaged in chemsex.

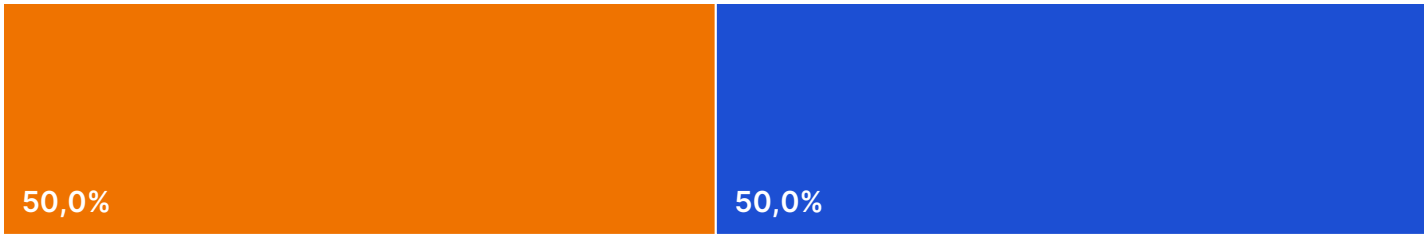
NEW GROUPS OF PEOPLE WHO USE DRUGS

FPS were asked if they came across any new group(s) of people who use drugs for whom their organisation, or any other Organisation in their city, are currently not providing any services. Only one FP, Amsterdam (Netherlands), identified a new group of people who use drugs for whom currently no services are provided, the group of so-called 'swingers'. This group is, in itself, not new, but drug use is new among such community members.

There do not seem to be substantial groups of (new) people who use drugs for whom no services are yet provided. Due to the Russian invasion of Ukraine starting at the end of February 2022, an influx of displaced Ukrainians was witnessed in the cities where FPs are located. However, this had not led to substantial unmet needs from this population in terms of non-accessibility of existing harm reduction services to them, at least not during the time of the data collection, until summer 2022.

Figure 33. In the previous year, did you come across any new group(s) of people who use drugs for whom your organisation, or any other organisation, are currently not providing any services?

Figure 34. In the previous year, has there been any significant changes in the availability of substances in your city?



CHANGES IN THE AVAILABILITY OF SUBSTANCES

FPS were asked if there have been any significant changes in the availability of substances in their city in the previous year. Only three FPs responded to this question, one did so during a FGD. FP Amsterdam (Netherlands) saw a significant change in the availability of substances, namely an increase in methamphetamine and a decrease in 3-MMC.

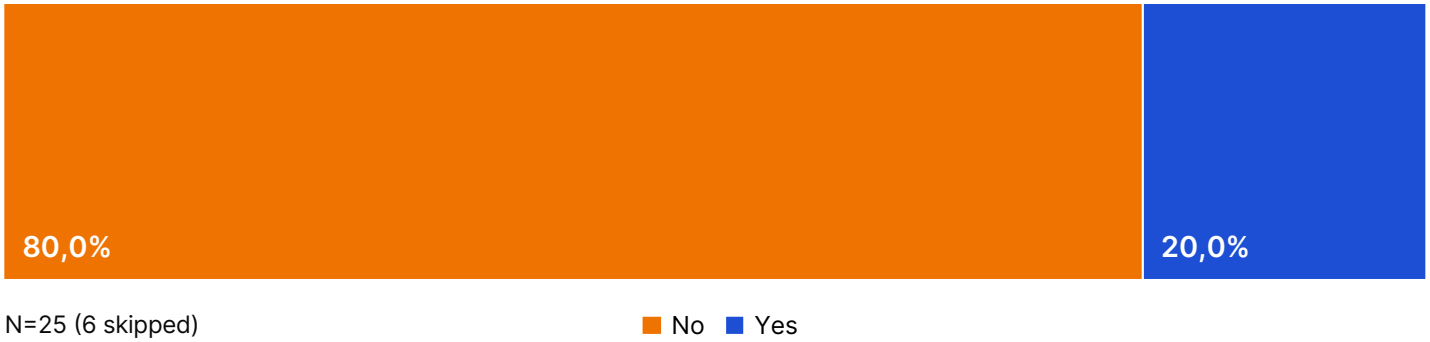
> *"The price of crystal meth is still declining (from €70/€80 a gram from the middle of 2021, to €40/€50 a gram these days. Availability has increased. The availability of 3-MMC has decreased since the drug was prohibited by law in October 2021."*
> **FP Amsterdam**

The FP Dublin (Ireland) FGD took note of an increase in availability of crack cocaine and a decrease in its price.

There are no reports of specific substances becoming less available, except for FP Amsterdam (Netherlands), that reported the decreased availability of 3-MMC after it was banned. The seemingly uninterrupted availability of drugs is in itself not a surprising finding since the supply usually follows demand and easy access to online drug markets in many countries. A notable signal concerns the increased availability of crack in a number of FP cities. This is in line with recent EMCDDA reports.

> *"Look, crack is massive and we're even though obviously within the city, but then you have most of the big cities now like Limerick and stuff cracking. Then what we're stuck, we're starting to see it in smaller towns that are close to big cities that have a problem. So it's seeping output just on the quality on the price because the price years ago was £50 for a rock then went down to £20. Now when it was two for 20 and a lot of people talk about the quality. The quality is obviously gotten poorer and poorer, and we've heard a lot of people talk about that. They've noticed and just from a harm reduction perspective and the damage that they get from smoking it. People are really talking about it saying it's now being mixed with ammonia and it's having a lot more impact on their lungs as opposed to being mixed with baking soda."*
> **FP Dublin**

Figure 35. In the previous year, have there been any changes in your drug policy/legislation that may have affected any of the above-given responses?



CHANGES IN DRUG POLICY

20 FPs reported that no changes in legislation had occurred that may have affected any of the given responses, while 5 FPs did report such changes.

FP Amsterdam (Netherlands) mentioned the ban on 3-MMC leading to the decreased availability of the substance in 2021; FP Luxembourg mentioned the new Drug Action Plan 2022-2025; FP Athens/ Thessaloniki mentioned changes in the legislative framework on the provision of naloxone.

> ***"The legislative framework changed for the provision of Naloxone, but still it is a half measure. Provision finally was allowed for the public State-funded organisations."***
> **FP Athens/Thessaloniki**

FP Vienna (Austria) mentioned change in legalisation for some synthetic cannabinoids, leading to the fact that users can now also be prosecuted. Finally, FP Berlin (Germany) mentioned changes in the laws regarding drug consumption rooms.

> ***"Drug consumption rooms in Berlin can be accessed by OST patients since January 2021 (change in legislation of the City of Berlin). HIV and HCV rapid testing can be performed without the presence of medical doctors (change in federal law in March 2020)."***
> **FP Berlin**

Most FPs did not mention changes in legalisation in the last 12 months affecting their responses, while the rescheduling of one or more specific NPS did in some cases (FP Amsterdam, Vienna).

CONCLUSIONS

Since its start in 2019, monitoring of new drug trends by grassroot organisations within the C-EHRN framework has been a 'learning-by-doing' exercise. Monitoring drug trends requires some specific expertise that is not commonly present among harm reduction staff.
The overall conclusion of this year's monitoring exercise is that most FPs reported no changes in the use of substances, user groups or services rendered, nor demand for the provision of services for the unmet needs of people who use drugs, in the last 12 months (since the previous data collection in the summer of 2021). This is in line with previous years. However, the number of responses indicating changes seems lower now than before.

RICH, ADDITIONAL INFORMATION

As we noticed in previous years, this year's monitoring also showed that these limitations have become less predominant year-by-year. Instead, the information received may be richer (adds more content), especially while most of the data received are more or less in line with the monitoring results of previous years and in line with trends reported by other sources (such as the increase in the use of crack cocaine in some countries and the increase in people engaging in chemsex). As a result, CSO monitoring of new drug trends deepens the information available from national or international agencies (whose reports usually target national overviews that by their nature are more general). This is especially the case concerning the focus groups that have been conducted: this adds essential qualitative information to the data collection as these methods allow for the deepening of answers given and to address findings from other FPs.

TIMELY REPORTING?

However, just 5 FPs reported that a new or unknown substance entered the market since last year and was used by a known target group, which might indicate that changes to local drug markets do not come overnight and that the timeframe of monitoring is too strict; hence, intervals of 2 or 3 years for reporting rather than just 1 year could be more useful. The fact that the EMCDDA currently reports one new substance per week on average somewhere in the EU (52 in 2021) could indicate that its appearance throughout the territory of the EU can take quite some time, if at all. It is also very much possible that most of the FPs do not report new substances in a timely manner because the absence of low-threshold drug checking services means there is no way of knowing what is actually on the market.

DRUG CHECKING

Another recurring issue that seriously limits the ongoing collection of data by CSOs is the fact that in most cities the appearance of a new substance on the local market is based on assumptions, not on laboratory tests. Therefore, it is strongly recommended that drug checking services are implemented at city level throughout the EU. Drug checking services have proven to be an essential tool for EMCDDAs Early Warning System (EWS). Drug checking services are at the forefront when it comes to identifying new, mis-sold or adulterated substances, as examples in this chapter have shown. Drug checking services also allow for quick responses, such as warning campaigns, aimed at preventing unintentional consumption of mis-sold substances or of adulterated substances that may have serious adverse health consequences.

INTERNET-BASED HARM REDUCTION SERVICES

Prior to COVID-19, but also during the pandemic, more people used internet and internet-based tools and social media for selling and buying drugs. During this year's data collection, a few examples of this were reported by C-EHRN FPs. In Eastern Europe, similar services had already been initiated some time ago and online outreach work introduced by harm reduction NGOs [4,6,7]. Among C-EHRN FPs, online harm reduction services could enable the timely monitoring of changing local drug scenes and the needs of people who use drugs. It would certainly benefit many (young) people who use drugs who are online 24/7 and who may not visit existing harm reduction services for a number of different reasons, but who might be attracted to online services and, as a result, receive necessary harm reduction information that they otherwise would not receive.

REFERENCES

1. United Nations Office on Drugs and Crime. Global SMART update: Regional diversity and the scheduling on NPS trends. Vienna; United Nations, April 2021, Volume 25.
https://www. unodc.org/documents/scientific/GlobalSMART_25_web.pdf

2. United Nations Office on Drugs and Crime. World Drug Report 2021. New York; United Nations, 2021.
https://www.unodc.org/unodc/ en/data-and-analysis/wdr2021.html

3. European Monitoring Centre for Drugs and Drug Addiction. European Drug Report 2022: Trends and Developments. Luxembourg; Publications Office of the European Union, 2022.
https://www.emcdda.europa.eu/edr2022_en

4. van der Gouwe D. New Psychoactive Substance Use in Eastern Europe and Central Asia: Regional Report. Vilnius; Eurasian Harm Reduction Association, July 2021.
https:// harmreductioneurasia.org/wp-content/uploads/2021/09/2021_8_24_EHRA_NPS-RegionalReport_EuropeAsia_EN.pdf

5 European Monitoring Centre for Drugs and Drug Addiction. New psychoactive substances: global markets, global threats and the COVID-19 pandemic: An update from the EU Early Warning System, December 2020. Luxembourg; Publications Office of the European Union, 2020.
https://www.emcdda.europa.eu/system/files/publications/13464/20205648_TD0320796ENN_PDF_rev.pdf

6. Davitadze, A., Meylakhs, P., Lakhov, A., et al. Harm reduction via online platforms for people who use drugs in Russia: a qualitative analysis of web outreach work. Harm Reduct J 17, 98 (2020).
https://doi.org/10.1186/s12954-020-00452-6

7. Parkhomenko V., Kurcevic E. Peer-to-peer counselor manual for online counseling. Vilnius, Lithuania; Eurasian Harm Reduction Association, 2022.
https://api.harmreductioneurasia.org/af9ae4e8-316a-44dc-8541-8d569f17a5d6.pdf

Correlation
European
Harm Reduction
Network

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